

***“Home is where the heart is: The Benefits of Home Care and Community Services”
-- and why they are so hard to realize in Canada***

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As always

DETAILS
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DEVIL

Will an aging population all need lots of care?

- Some will, some won't
- On average, health expenditures increase with age
- CIHR estimates
 - Average spending per capita, 2011 approximately \$5,800
- Should we beware “The Boomer Tsunami”?

But what do averages mean?

“With one foot in a bucket of ice water, and one foot in a bucket of boiling water, you are, on the average, comfortable”



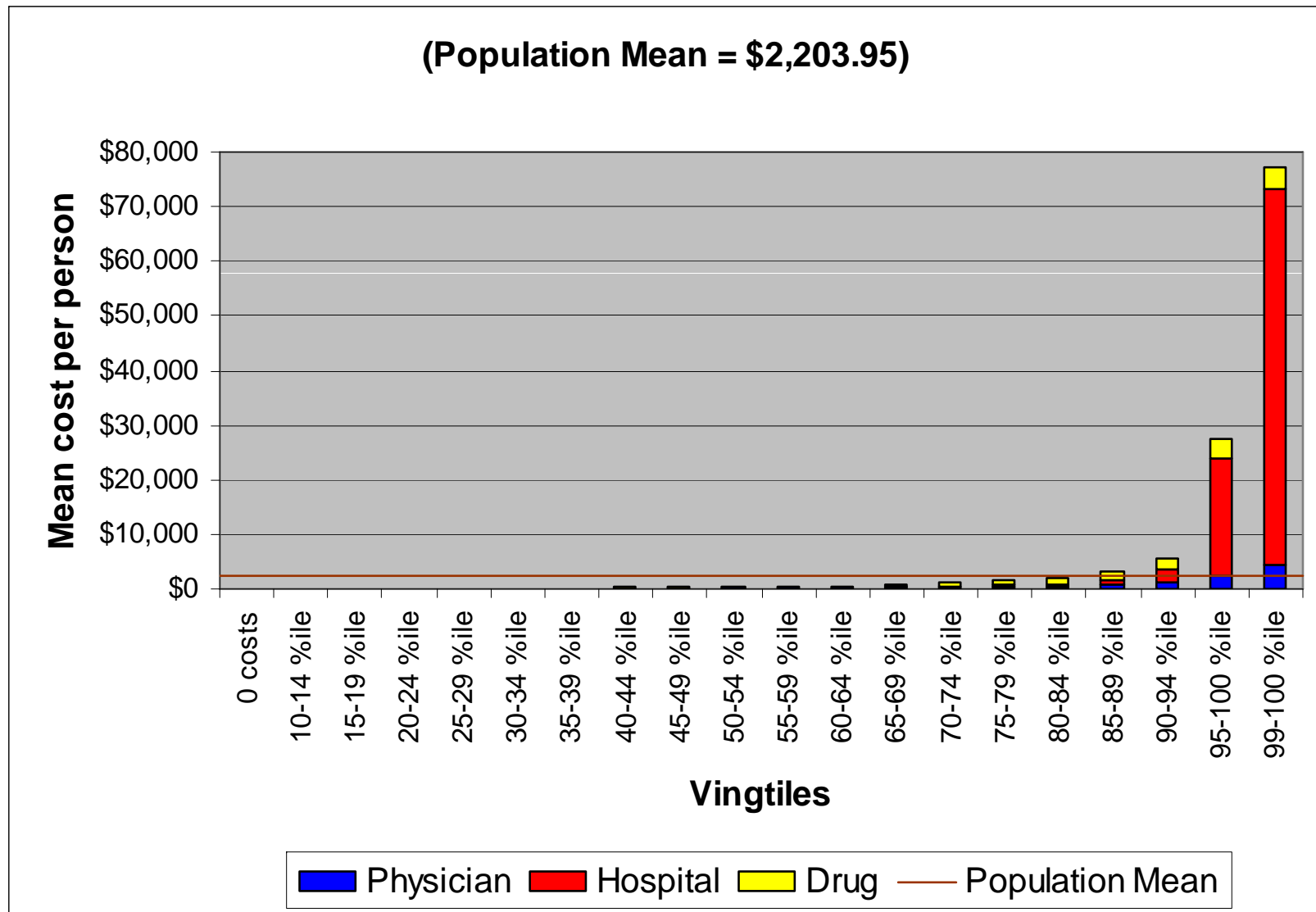
What did we do?

- Looked at Manitoba data
- They have attributable costs for hospitals, physicians, and pharmaceuticals (all payers) for each person in population (but this data does not include long-term care or home care!)
- Privacy caveat: Manitoba Health pays very careful attention to privacy - impossible to identify individuals; aggregates only

What did we do?

- Take costs for each person
- Order these from lowest to highest spenders, breaking into 5% units (“vingtiles”)
- Graph also breaks out the top 1% separately! (double counting)
- If spending equal, bars should be the same height

Mean total expenditures for the full population by vingtiles in Manitoba, fiscal 2005-2006

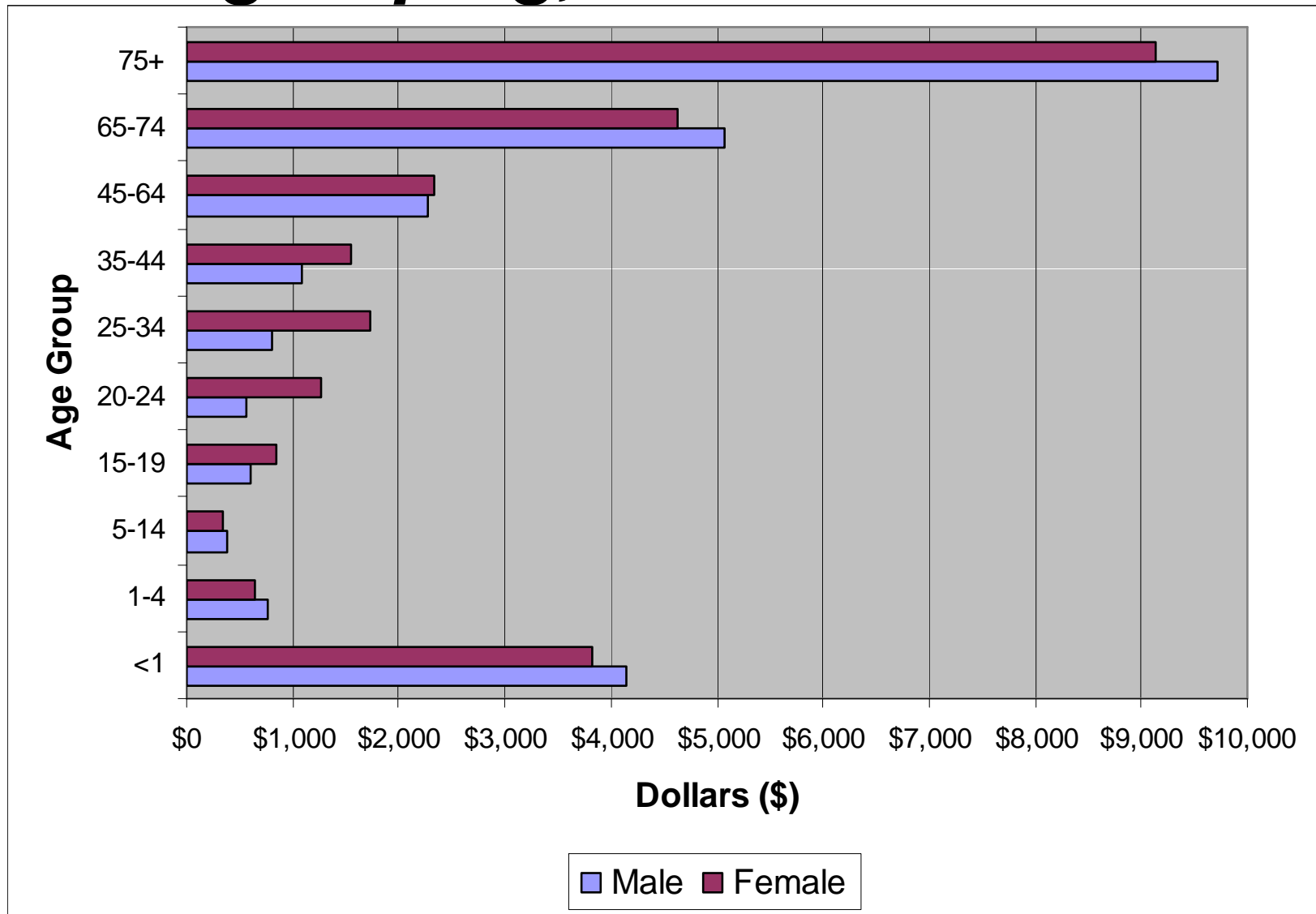


What should funders do?

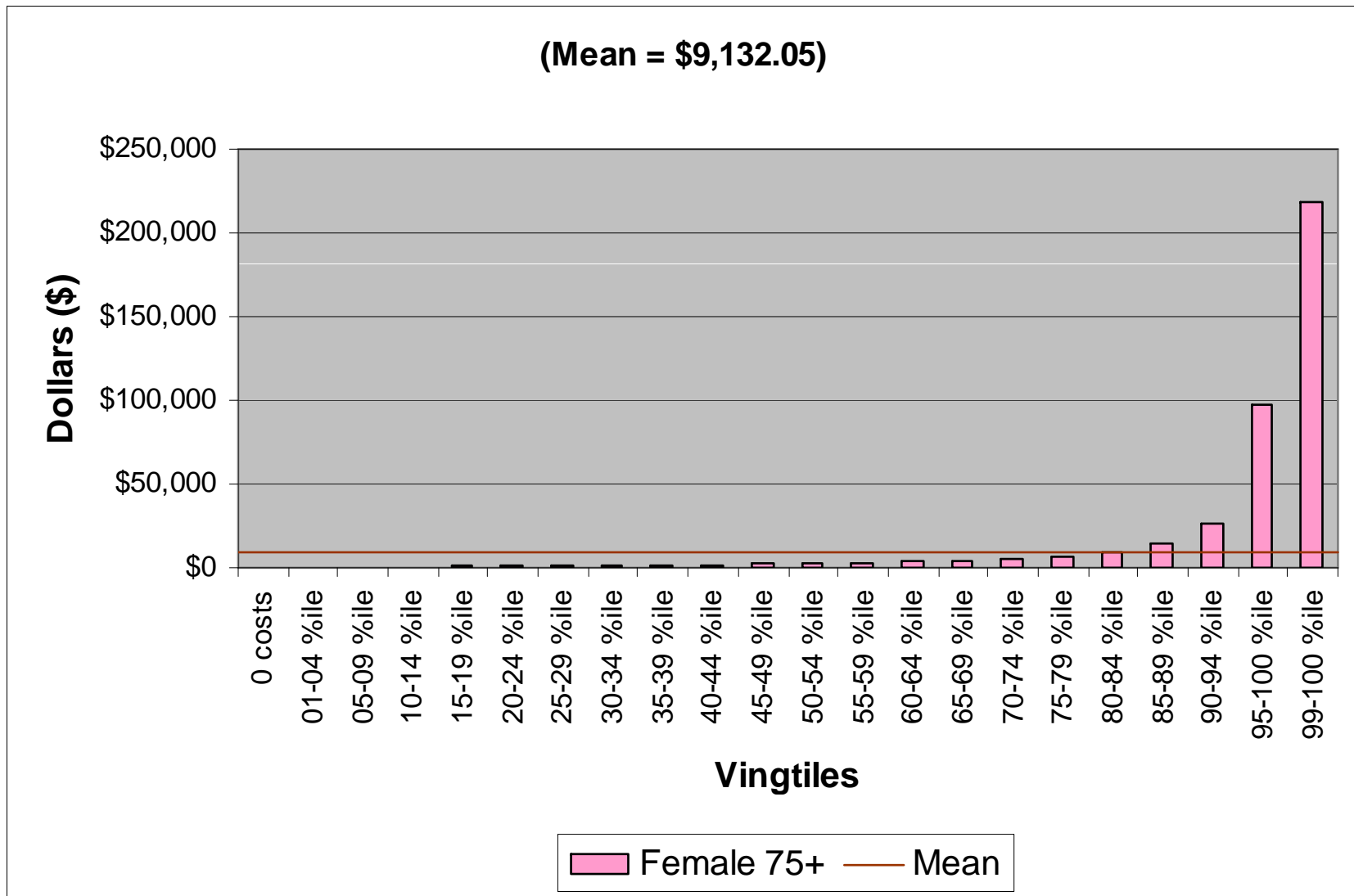
- Considerable variation in costs
- Is it sufficient to control for age and sex?

- Remember the saying:
- Old epidemiologists never die;
- they just get broken down by age and sex!

Mean total expenditures for all age-sex grouping, Manitoba 2005-06



Mean spending by vintile for females Age 75+, Fiscal 2006



The same pattern holds

- In every age-sex group, approximately 80-90% of the population spends less than the mean of that group

Aging is a relatively minor cost driver for publicly funded health care

- More important issues involve:
- How care is organized and delivered
- What services are provided
- How aggressively conditions are treated
- How much the services cost
- Etc., etc., etc.
- Brief message - the sky is not falling.
- Longer message - cost pressures are highest for social care services to maintain health and lifestyle (and for pensions!)

Best practices for home and community care?

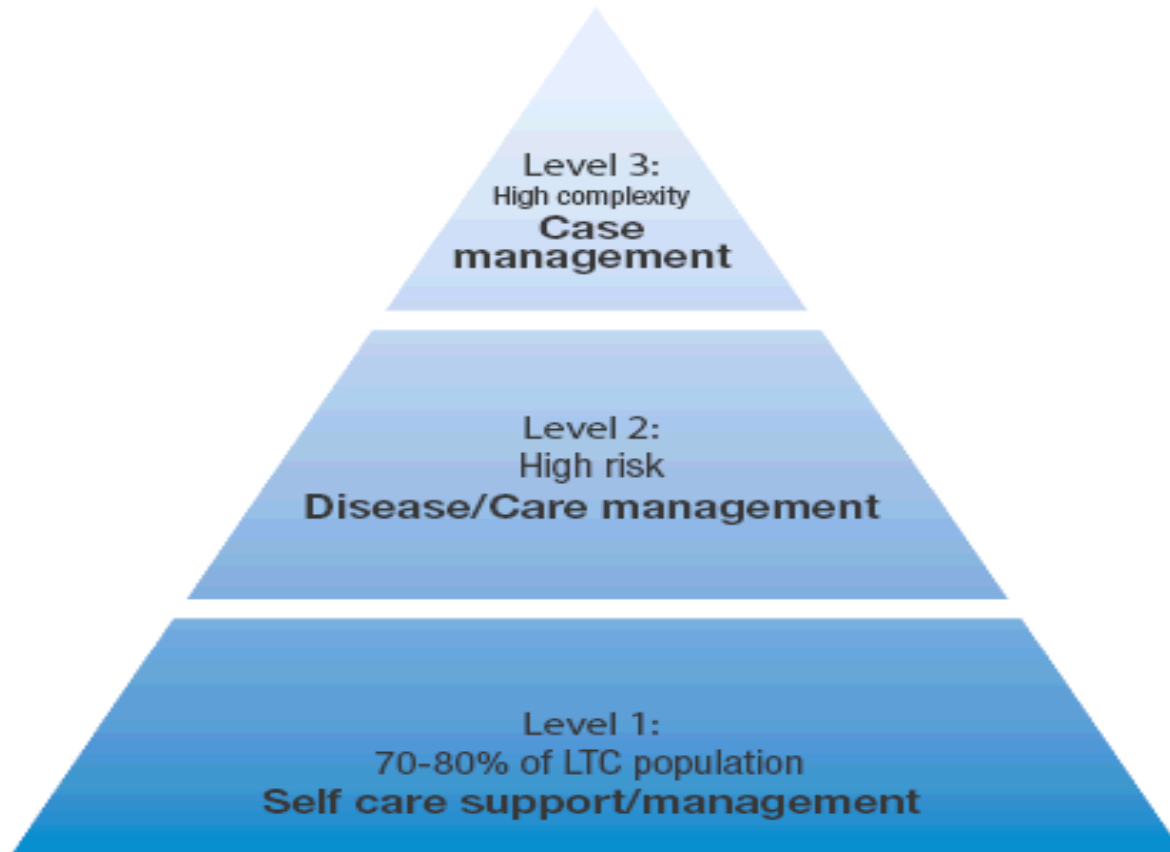
- Our review of the international literature suggested three recurring themes are important for successful outcomes

1. Target

- TARGET the most at risk persons
 - Usually, frail older persons otherwise eligible for LTC placement
- But could include others



The Kaiser-Permanente Pyramid



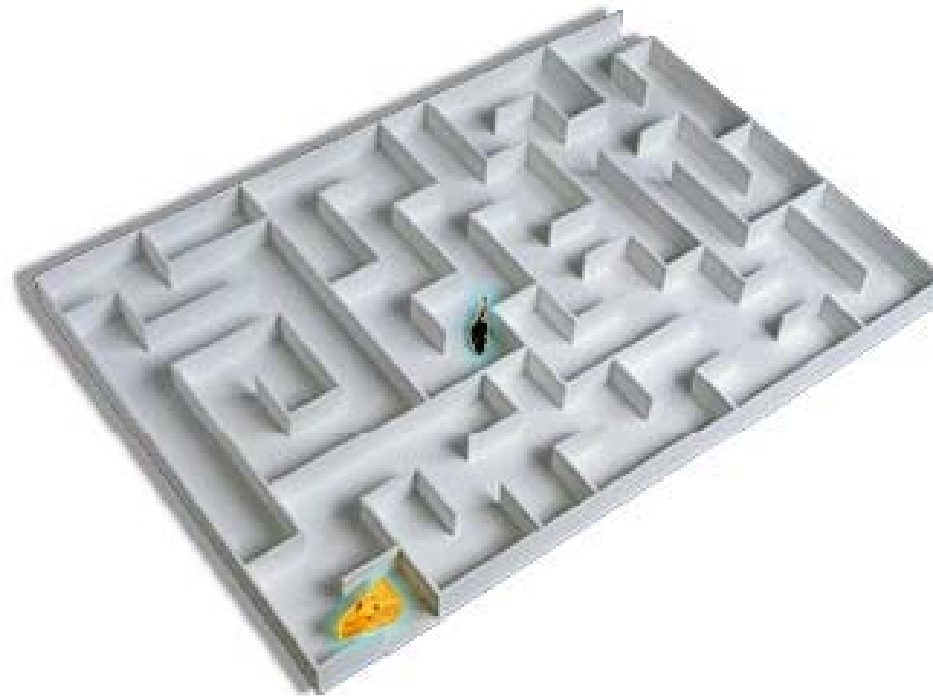
2. Integration

- Provide/offer a wide range of services
- Including both health and social services
- But also transportation, medication dispensing, etc.
- Goal is to use most appropriate, cost-effective services for each client



3. *Case management*

- Variety of approaches can work
- It is a function, not necessarily a person



Multiple services

- Acute services in hospital
- Professional services by physicians
- Professional services by other health professionals
- Long term care - in institutions, or at home
- Pharmaceuticals
- Complementary and alternative medicine?
- Diagnostic tests
- Transportation
- Personal support services
- Etc.
- Does the “system” treat these the same way? Should it?

Home care has multiple forms

- In 1990, the Federal/ Provincial/ Territorial Subcommittee on Long Term Care suggested 3 home care models

Acute care substitution

- Meet the needs of people who would otherwise have to remain in, or enter, acute care facilities
- This is what most home care programs in Canada tend to do
- Reduce pressure on Alternative Level of Care (ALC) hospital beds
- Usually time limited services

Long term care substitution

- Meet the needs of people who would otherwise require institutionalization in long-term care settings
- Need to build fewer nursing homes?

Maintenance and preventive

- Goals:
 - maintain people's ability to live independently,
 - prevent health and functional breakdowns, and eventual institutionalization

The case of Canada

- What will the Canadian health care system do?

***Trick question:
No such thing as Canadian health care system***

- Constitution Act (BNA Act) placed health care under provincial jurisdiction
- Delivery is private (and often uncoordinated)
- Mix of public and private funding
 - Ca 70% public (among lowest in OECD)
- But...

Canada Health Act: sets terms provinces must meet to get federal money

- Requires coverage based on:
 - Where care delivered (in hospital)
 - Or by whom (physicians)
- Governments can insure beyond this
- But they are not required to
- I.e., not linked to “what” but to “where” and “by whom”

The first law of cost containment

The easiest way to contain costs
is to shift them to someone else

What does not need to be covered in Canada?

An increasing proportion of care, including:

- Outpatient pharmaceuticals
- Dental care
- Vision care
- Rehabilitation
- Home care
- Long term care
- Mental health (by non-physicians)

- It may be, but doesn't have to be

Policy question: Do these services help?

- What is effective?
- What is cost-effective?
- Can we target groups most likely to be helped?
- We need the evidence!

Where can they be delivered?

- People to Services?
- Services to People?
- Many possibilities, including:
 - Hospitals?
 - LTC institutions?
 - Home?
 - Congregate care?
 - Retirement homes?
 - Community centres?
- Note issues of economies of scale
- And minimizing social isolation

Who should pay for what?

- An answer in two parts.
 - Ideas from economics
 - Values
- Economics - what's the best approach for financing health care?
 - Single payer?
 - Competing insurers?
 - Out of pocket?

***Short answer:
For necessary care, single payers are
more efficient***

- Savings from administrative costs (contrast Canadian and US hospitals)
- Eliminates risk selection issues
- Payer can drive tougher deals with providers (which providers obviously don't like)

Values

- Which services meet our ‘medically necessary’/ needs-based definition?
- What is the responsibility of society?
- What is the responsibility of voluntary organizations (including faith-based groups)?
- What is the responsibility of individuals and their families?
- Not a question of evidence, but of values

Vacuuming

- Lum and Ruff show that it can be a critical (and low cost) service for the population they studied
- But – should I be able to get it without paying?



So let's get some evidence!

- Paul Williams, Janet Lum, David Challis, and our team (including Kerry Kuluski, Frances Morton, Allie Peckham, Jillian Watkins) have conducted a series of studies across Ontario
- Study people on wait list for long term care
- How many wait-listed individuals could be diverted safely, cost-effectively to home & community?

Different people, different needs

- What determines whether older persons can age successfully at home?
- Demand side
 - People's needs and characteristics
- Supply side
 - System capacity to provide safe, appropriate cost-effective community-based care

The studies: LTC wait lists

•Waterloo	811
•Toronto Central (+ phase II)	1684
•Central (+ phase II)	2631
•North West (+ phase II)	860
•North East	1500
•South West	2876
•Central West	725
•North Simcoe Muskoka	1758
•Champlain	3724

Categorize

- Based on 4 variables:
- Variable 1 Cognition: Intact? (Yes/No)
- Measured using Cognitive Performance Scale
- Short term memory, cognitive skills for decision-making, expressive communication, eating self-performance
- Our studies found ca 33%-48% on LTC wait lists were cognitively Intact (depends on region)

Categorize (continued)

- Variable 2: Difficulty with Instrumental Activities of Daily Living (IADL). (Low/Medium/High)
- e.g., Meal preparation, housekeeping, phone use, medication management
- Proved to be key variable: very few low (1%-3%)
- Most high (64%-75%)

Categorize (continued)

- Variable 3: Difficulty with Activities of Daily Living (ADL) (Low/Medium/High)
- e.g., Eating, personal hygiene, locomotion, toilet use
- Proved to be quite variable, depending on region:
- Many low (34%-53%)
- But many high (19%-41%)

Categorize (continued)

- Variable 4: Presence of a caregiver?
(Yes/No) 35%-55% Yes, depending on region
- The 4 variables yield 36 needs categories.
(2x3x3x2)

Next steps

- See which categories are most highly represented in each region
- Write case vignettes for these
- Ask expert panel to suggest basket of services which would allow this hypothetical individual to remain safely at home (which would depend on what is available locally)
- Cost out the basket

Divert rates summarized

	Divert: Line by Line	Divert: Supportive Housing	Cost Higher Than LTC	LTC Required
Waterloo	49%	N/A	26%	25%
Toronto	37%	46-53%	27%	20%
Central West	30%	TBD	52%	18%
Central	21- 25%*	27- 43%**	47% - 63%***	10%

Some conclusions arising from this work

“Lower Level” needs crucial

- Considerable potential to maintain individuals in their own homes with everyday supports
 - Transportation, housekeeping, nutrition can quickly become medical problems

Navigating disintegration

- Need to strengthen integration “points” to enhance care and achieve cost-efficiencies
 - Crucial for vulnerable individuals with complex needs requiring multiple services, providers
 - Care to people (home care, cluster care)
 - People to care (adult day centres)
 - Supportive housing can be very helpful

Caring for caregivers

- Unit of care = individual and carer
 - Contrasts to acute care focus on individuals or body parts
 - Caregivers are themselves increasingly frail
 - Geography, diversity matter

How to manage transitions?

- Continuity of care issues?
- Linkages across silos?
 - Hospitals
 - Primary care
 - Home care
 - Long term care institutions
 - Labs
 - Etc.

How to manage mission creep?

- Services may be very cost effective for some
- But what about healthier populations who might still value the services?
- Sliding scale of ability to benefit
- Services may be ‘add ons’ (if useful ones) if they are used by people who would otherwise not have been served
- But may be cost-effective if they replace more expensive services (e.g., institutionalization) for targeted population – e.g., Lum shows lower use of 911 for people in supportive housing

Caps?

- On services?
 - By cost?
 - By income?
 - By other criteria? (e.g., veterans)
- How much discretion to case manager?
- What is an entitlement?

What costs and consequences to count?

- Not simple

The first law of cost effectiveness analysis

The cheapest chronically ill person is a dead chronically ill person.

Recognize differences

- Yes, people may continue to deteriorate
- But they can still have excellent quality of life and functioning
- Important to measure the right things!

Key messages

- Government is not required to cover care not delivered by hospitals/doctors – but it can if it wants to,
 - And sometimes it should!
- Proving cost effectiveness may be difficult,
 - But not impossible
- Services and clients are heterogeneous
 - So we may have to pick our spots
- Multiple payers exist
 - Baby boomers will probably be willing to pay for themselves (and their parents)?
- One size will not fit all

There is no quick fix

- Policy choices are often about trade-offs
- As Wildavsky noted:
 - One rarely solves complex policy issues
 - One usually replaces one set of problems with another set
 - The mark of success is whether you prefer the new problems to the old ones

Thanks!

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To get the paper (free)

- Deber and Lam, Handling the High Spenders
- Available for download from
 - http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1450788
- You can also get there via <http://www.teamgrant.ca>

Another reference

- Williams, A Paul; Challis, David; Deber, Raisa; Watkins, Jillian; Kuluski, Kerry; Lum, Janet M; Daub, Stacey (2009): Balancing institutional and community-based care: Why some older persons can age successfully at home while others require residential long-term care. *Healthc. Q.* 12(2), 95-105.

Community Care

- For additional information, see:
 - The Canadian Research Network for Care in the Community, <http://www.crncc.ca>
 - Hollander Analytical Research, <http://www.hollanderanalytical.com>
 - The CIHR Team in Community Care and Health Human Resources, <http://www.teamgrant.ca>

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