

CARP'S  
**REPORT  
CARD**  
On Home Care in Canada  
2001

**Home Care  
by Default**

**Not  
by Design**

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# SECTION A

## 1 Introduction

Although more people are receiving home care than ever before, and more money is being directed to home care, relatively little is known about it when compared to the other health sectors. Policy-makers have increasingly difficult resource allocation decisions around how, where and when to spend public dollars on home care when faced with growing fiscal pressures. There are also increasing demands for accountability in health care generally and home care specifically. These demands are difficult to address when there is a lack of evidence and limited quality data upon which policy can be guided and subsequently developed.

### Purpose of this Report

#### The purpose of this report is:

- Apply a grade to the progress made in policy and practice in home care in Canada.
- To provide a snapshot of the status of home care.
- To provide a comparison of the issues (funding, human resources, etc.) where possible over time within and between provinces and territories.
- To stimulate discussion and debate about home care.

This report builds upon the 1999 CARP Report on Home Care in Canada. That study, a wide consultation with stakeholders in home care across the country, identified a number of issues to be addressed (see Appendix 1). This year the issues reviewed fall under seven key areas.

### Background

- Strategic Direction
- Funding
- Human Resources
- Service Delivery
- Family Caregivers
- Data
- Knowledge about Home Care

## Rationale

The rationale for these areas, all of which are closely inter-related, is as follows: For the development of home care to realize its fullest potential, there must be a clear sense of direction. Adequate funding must also be in place, as must a stable and capable workforce to provide the care needed by an aging population and a growing number of post-acute care clients. A number of changes are occurring in the way that care is provided, and there is substantial variation in how and what services are provided by publicly funded home care programs across the country. The last few years have seen an increasing amount of care being shifted to the family caregiver.

This shift in responsibility from the publicly funded programs has occurred with little or no public discussion or debate. Equally significant is the fact that there is little quality data and information on home care at present, which has made effective, evidence-based decision-making challenging, and at times very difficult.

## The Approach

Information was collected from a variety of primary and secondary sources. Some of the information is province specific, while other material is presented at the national level. This combination reflects the scope of the report and the reality that there is not the extent of information on home care that is desirable to providers, policy-makers, researchers, and the clients and families who are involved with home care (a list of key areas and data sources used in this report is provided in Appendix 2).

Each area is given a letter grade to indicate the direction of change. Grades for policy are also given in the sections on Service Delivery and Family Caregiving. The gradings are followed by an interpretive discussion of the data, as the complexities of home care do not easily allow themselves to simple reporting of descriptive information. Such discussion is critical for two reasons:

1. Broadening the understanding of each of the areas, and of home care as a sector.
2. To ensure that the oversimplification of tabulated information does not mask the complexities.

## What the Report Does and Does Not Do

The report attempts to weave the complex, inter-related pieces of home care in a manner that tells the reader very broadly about the changes that are occurring – or not occurring. Following a review of each of the key areas that have been graded there is a discussion of Canadian values and their importance to developing home care in Canada. The definitions used and background information on home care in Canada are provided in Appendices 3 and 4.

The report does not state that one jurisdiction is better than another. The quality and nature of the provincial data do not allow a common interpretation between and among provinces. This makes it impossible to conduct a rigorous comparative analysis. The report also errs on the side of caution with much of the provider survey data collected, because of the relatively small sample size and the concern that the information could be misused or misinterpreted.

We have graded several policy and practice areas in the Report. What has not been feasible, however, is to comment directly on the *quality* of home care that we have been grading. For example, we have given a high grade if a province has a self-managed care program, but we cannot grade the quality of that program, the number of clients it serves or could potentially serve, and whether or not it is adequately funded. The high grade is only for the program's existence. To fully determine the quality of every single program offered across the country is beyond the scope of the study.

We have given a grade for funding, based on whether funding has increased or decreased over a three year period. But we have not gone into the details of where that funding has been allocated within a home care budget, or the variability of allocation among regions or home care organizations within jurisdictions. This also raises the issue of the extent of regional and local allocation of resources to services. The data we have provided at the provincial level will mask changes in allocations to services at the regional level. Unfortunately, in most jurisdictions data have not been available to allow for a breakdown of allocation among programs (e.g., home supports, post-acute care, palliative care and so on).

The role of supportive housing models, Veteran's Affairs, and volunteer sector, or the role of home care on client outcomes are outside the scope of this Report. We also do not comment on the financial efficiency of home care organizations or make statements as to the 'best' or 'most effective model' of home care in the country.

We do not report on innovative models in home care and community-based care for seniors (e.g., such as the SIPA model in Montreal or CHOICE in Edmonton), or other innovative home care initiatives, such as those in the Toronto Community Care Access Centre for people with serious mental illness. We do believe, however, that there is considerable merit in the ongoing allocation of resources to develop successful innovations elsewhere in the country.

It is also important to note that the data were collected, and most of the report written, in the year 2000. The report raises many questions. There is much more discussion and debate required about home care, and it is hoped that this report will stimulate and contribute to the development of home care in Canada.

**2 The Issues in the Year 2000** To help confirm perceptions of what the issues are in home care, a survey was sent to home care provider organizations across the country. One of the questions they were asked was to identify what they considered to be the top issues in their community, and in their province (for more details on the survey see Appendix 2). The data, from a survey of almost 300 organizations were ranked as below in Tables 1 and 2.

**Table 1: Top Home care Issues in the Provinces**

Issues	
1. Funding	7. Post-acute home care
2. Human Resources	8. Family caregiving
3. Needs of the population not being fully met	9. Public awareness of home care
4. Coordination with other parts of health care system	10. Role of home support services
5. Leadership and strategic direction	11. Mix of for-profit/not-for-profit agencies providing care
6. Information technology	12. Role of technology in the home
	13. Research

**Table 2: Top Home Care issues in the Communities**

Issues	
1. Human Resources	7. Post-acute home care
2. Needs of the population not being fully met	8. Family caregiving
3. Coordination with other parts of the health care system	9. Leadership and strategic direction
4. Funding	10. Role of home support services
5. Public awareness of home care	11. Mix of for-profit/not-for-profit agencies providing care
6. Information technology	12. Role of technology in the home
	13. Research

Human resources, funding, meeting the needs of the population, and coordination with other parts of the health care system are the major issues. When comparing the issues of the province and 'the community' some of the rankings move significantly. Funding, for example, is seen as less important in the community, while the issue of public awareness takes on greater significance.

When asked the question 'Overall how has the publicly funded home care program in your province changed over the past 3 years', over 50% felt that home care in their province had 'gotten worse' or 'had deteriorated slightly'. Approximately 27% felt it had improved over that period.

When asked how they rated their publicly funded home care program overall, over 56% replied 'Fair' or 'Poor'.

This report expands on these views. It suggests that the focus for home care development should be on four key areas:

- Identify a strategic direction.
- Respond to the human resource issues.
- Continue to build the knowledge base for improved delivery of services.
- Engage the Canadian public in the process of developing a home care system by design – not default – one in which the values of Canadian society are fully articulated.

The four areas are inter-related. It is unlikely that the full potential of home care can be realized without a commitment to each of them.

# SECTION B

## 3 Giving Home Care a Grade

Giving a grade to home care in Canada is a challenging task given the lack of standardized data on

funding, the allocation of resources and the delivery of programs and services. The approach taken in this Report is one of caution and sensitivity. The grading system considers change in seven KEY AREAS, while in the Service Delivery Area, 'POLICY' is also graded. There are seven main areas of home care discussed in the Report: Strategic Direction, Funding, Human Resources, Service Delivery, Family Caregivers, Data, and Knowledge about home care. The grade is based on whether change has occurred since 1999. The grading takes into consideration two main points: 1.) change, and the direction of the change (if any); and 2.) available data.

The grading is complex when examining 'funding'. Overall, funding has been graded as C, which indicates insufficient change. This grade recognizes the overall increase in funding to the provincial home care programs, but as the section of funding observes there are other funding issues that have not been sufficiently addressed. The grade does not account for any in-depth analysis of funding allocations and priority setting at the regional and local level.

For the most part, the areas are graded at the national level due to the highly differentiated and incomplete data at the provincial level. The following tables show the grading used in the report.

**Key Areas Grading Categories**

Grading	Categories	Grading	Categories
A	Excellent Change	D	No Change
B	Positive Change	E	Negative Change
C	Insufficient Change	F	Failure

A grade for 'Policy' is given at the provincial/territorial level based on whether a policy exists for a certain aspect of service delivery, or not. And if not, whether policy is under development, under consideration, or not being considered at all. Grading policy provides an indication of the general direction provinces have taken or are planning to take. The following table shows the grading approach used in the Report.

**Policy Grading Categories**

Grading	Categories	Grading	Categories
1	Policy is in place	3	Policy is under consideration
2	Policy is being developed	4	Policy is not being considered

## Summary of the CARP grading

The overall grading of the key areas in home care are shown in the following table:

Key Area	Grading	
Strategic Direction	D	No change
Funding	C	Insufficient change
Human Resources	E	Negative change
Service Delivery	D	No change
Family Caregivers	D	No change
Data	B	Positive change
Knowledge about Home Care	B	Positive change

This table does not compare the importance of the various areas. They are all important, but some are more significant than others, as will be shown in the report. An overall judgment on Canadian home care based on the scoring in the report is not made.

## Summary of CARP Policy Grading

Provincial Policies and Grading	AB	BC	MB	NB	NFLD	NWT	NU	NS	ON	PEI	QU	SK	YK
Policy on Self-Managed Care	1	1	1	1*	1	3	1	1	1	3	1	3	-
Accountability Framework	2	1	4	4	1	3	-	1	2	2	4	1	-
Policies for Family Caregivers	3	4	4	-	1	4	4	-	4	2	4	4	-
Respite Policies for Family Caregivers	1	4	4	1	4	1	-	-	4	2	4	1	-

\* limited option - not available

The public will increasingly demand direction and support as more and more individuals come into contact with home care. The redirection of funding to home care seems obvious given the shift in resource use to better address the changing needs of an older population – an older population that will likely prove to be more insistent on how publicly funded care be provided. In any case, both providers and consumers (clients and family caregivers) would prefer an improved awareness of home care – what is provided and what is not. Education on this front is essential if we are to have an informed debate on the development of home care in Canada.

## 4 Strategic Direction

One of the key issues identified in the 1999 CARP Report on Home Care

was the lack of strategic direction for developing home care. There has been no change in this area.

A 'D' grade was provided for Strategic Direction for two reasons; 1) there has yet to be a clearly articulated plan for developing home care in Canada, and 2) there has simply been too much rhetoric from politicians regarding the ability of home care to effectively respond to the demographic changes in the population and the fiscal pressures that have seen more care being provided in the community away from the traditional hospital setting.

There has been a growing debate around the nature and function of Medicare, and the federal government has been a leader in extolling the virtues and necessity of home care. Indeed, in 1998 the federal Health Minister, building on the conclusions of the National Forum on Health (1997), is quoted as saying:

- *“Home care is not an add-on. It is an integral part of the health care system and unless we fix it, it will have effects in other parts of the health care system that will be very difficult to manage.*
- *There is a direct connection between the need for home and community care and the pressures now being felt in the acute care sector. Indeed, I go so far as to say that home care is fundamental to saving Medicare.*
- *The need for progress in the development of home and community care in Canada is not a narrow federal government demand, it is an urgent Canadian need - a public need.”*

• Then, in September 1998, the announcement came that “federal, provincial and territorial health ministers agreed on key health priorities for future collaboration. These were health services, including health human resources; **home and community care**; pharmaceutical issues; Aboriginal health and funding; population health, including children and public health protection; and Year 2000 computer issues.”

• The 1999 Throne Speech noted “With its partners, the Government will support the testing of innovations in integrated service delivery in areas such as **home care** and pharmaceutical care, working toward a health system in which all parts operate seamlessly. As the results of these innovations become available, we will be better able to make informed decisions about the next significant investments in health – ensuring that our health system meets the evolving needs of all Canadians.”

• Also in 1999, the creation of the Social Union confirmed that: “Within their respective constitutional jurisdictions and powers, governments commit to the principles of: **access to essential social programs** and services of reasonably comparable quality, **appropriate assistance to those in need, respect the principles of Medicare**: comprehensiveness, universality, portability, public administration and accessibility, **work in partnership with individuals, families, communities**, voluntary organizations, business and labour, and ensure appropriate opportunities for Canadians to have meaningful input into social policies and programs and **adequate, affordable, stable and sustainable funding for social programs”**.

CARP GRADE:  
**D**  
NO CHANGE

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- On February 28th 2000, the federal and provincial ministers confirmed that: “This spring, health ministers have an opportunity to develop an action plan that will **“strengthen home and community care and make them an integral part of our health care system”**”.

- In September 2000, the federal and provincial governments announced the Health Action Plan, identifying a number of areas they were committed to working together on to improve the delivery of health care in Canada. Home care was listed as an essential part of the continuum of health care services. Although no targeted funding for home care was established there was a commitment by the provinces and territories to strengthen the investment in home and community care.

Despite these statements confirming ‘commitment’ and the importance of home care, no clear vision or strategic direction has been established. Many observers state there will not be substantive improvement in home care until a comprehensive strategic plan is put into effect.

Although there are mixed views as to whether a national home care program should be developed, and uncertainty as to the roles of the federal and provincial governments in this process, there is growing frustration that not enough has been done.

### **Summary**

There have been continuing calls for national standards in home care, for example, since the National Home Care Conference in Halifax in 1998. Indeed, delegates at that conference emphasized the need to build on the momentum that had developed to that point. Now, reporting on data for the year 2000, there are genuine concerns that the momentum has been lost, and that we continue on a course of home care growth by default, and not by design. To many, it would appear that we are faced with an “all talk, no action” situation that now needs immediate action.

## 5 Funding

Although overall it is a positive sign that more funding is being directed

to home care, the global funding data mask the significant changes occurring within home care, and do not necessarily capture the broader trends in the allocation of resources across health sectors. Funding remains, from the perspective of most stakeholders, inadequate to meet growing demands. For these reasons we have given Funding a C grading.

It is estimated that between 4% and 5% of public expenditures in health (i.e., just over \$2 billion dollars annually) is directed to home care (Coyte, 2000). This is up from 2.25% in 1991 (see Appendix 5).

There is considerable variation in the level of expenditures on home care among the provinces. In 1997-98, for example, New Brunswick was reported as having spent 5.8% on home care, while Alberta spent just 2.77% (Health Canada, 1999). Variations, between provinces and territories, however, may in part be due to how each jurisdiction defines and collects data on home care.

In almost any report published on home care over the past three years there is reference to insufficient funding. Indeed, in our provider survey funding ranked first as the key issue for provinces to address (see section 2), even though over the 1990s there has been an increase in funding to home care by the provinces. Table 3 shows provincial funding directed to home care for the past 3 years. The table shows that all jurisdictions had an increase in funding, with considerable growth occurring in Alberta, Manitoba, New Brunswick, Nova Scotia and Quebec.

**Yet despite this increase in the amount of funding directed to home care over the past three years stakeholders in home care still maintain the levels are not sufficient to address the higher acuity clients, and the general increase in utilization (Provider survey data).**

The global expenditure data in Table 3 mask changes occurring within provincial home care budgets. In one jurisdiction for instance, the aggregate funding level demonstrates that the province is spending more on home care, but within the budget there is a noticeable shift of spending to nursing care for more complex clients, and less spending directed to home support services. For example, the number of clients receiving nursing and rehabilitation services went down while the budget increased by almost \$10 million which may be explained by the higher acuity level and complex care needs of clients. At the same time, the budget for home supports decreased by approximately \$2 million (with the total number of clients falling from 45,818 to 41,418).

CARP GRADE:  
**C**  
INSUFFICIENT  
CHANGE

**Table 3: Change in provincial funding for home care, 1998-2000.**

Province	1997-98: \$ million	1998-99 \$ million	% Change 1997-98 to 1998-99	1999-2000: \$ million	% Change 1998-99 to 1999-00	Total Percent Change
Alberta (Expenditure)	161,672	180,483	11.63%	199,482	10.53%	23.4%
British Columbia* (Budget)	N/A	295,000	-	303,000	2.71%	2.71% (1999-2000)
Manitoba (Expenditure)	111,899	126,737	13.26%	147,232	16.17%	31.58%
New Brunswick (Budget)	67,924	75,032	10.46%	84,938	13.20%	25.05%
Newfoundland (Budget)	26,900***	N/A	-	39,600	-	47.21%
NWT (Budget)	4,275	2,780	-34.97%	2,780	0.00%	-34.97%
Nova Scotia (Budget)	58,000	56,994	-1.73%	75,074	31.72%	29.43%
Nunavut	Not Provided	Not Provided	-	Not Provided	-	-
Ontario (Budget)	1,056,096	1,096,767	3.85%	1,209,550	10.54%	14.53%
PEI (Expenditure)	4,750	5,590	17.68%	5,770	3.22%	21.47%
Quebec (Budget)	430,000	510,000	18.60%	550,000	7.84%	27.91%
Saskatchewan (Budget)	69,309	70,332	1.48%	75,544	6.91 %	8.36%
****						
Yukon	N/A	N/A	-	N/A	-	-

- \* BC figure % change is for one year only.
- \*\* Newfoundland percent change based on difference between 1994 and 2000 (excludes nursing, which is part of the continuing care funding envelope).
- \*\*\*Excludes Alberta Mental Health Board and ACB (includes Home Care Community Services)
- \*\*\*\*These are budget numbers as found in Saskatchewan Estimates (1997/98-1999/2000)
- # NWT figures reflect the formation of Nunavut during the time period.

A similar trend was evident in other jurisdictions as well. In one province in 1997-98, for example, acute care services took 16% of the home care budget. By 1999-2000 this percentage had increased to 24%. Indeed, post acute care substitution appears to be an increasing focus of home care, and home support services are being reduced from the publicly-funded home care programs. This growing phenomenon in Canada is occurring without opportunity for public debate. Meanwhile, the role of the family caregiver has taken on heightened significance.

While funding for home care has been increasing across the country, in some provinces the dollar contribution to home care has decreased as a proportion of total health care dollars. In Saskatchewan, for example, the proportion has fallen from 4.2% of the health budget in 1997-98 to 3.94% in 1999-2000. The proportion has also decreased in Manitoba and has not significantly increased in many other jurisdictions.

The provision of home care by regional and local services in most provinces also makes tracking expenditures extremely difficult. Provinces will provide an envelope of money to each of the Regional Health Authorities, for instance, which allows them the discretion to allocate home care dollars to meet local needs. While this concept is good in theory, each regional/ provincial jurisdiction needs to develop a more accountable structure for reporting trends in expenditures.

## 6 Human Resources

**The human resource area is the most serious issue in home care at**

**present across the country.** From a policy perspective the concerns focus on reported staff shortages, inadequate compensation (wages & benefits), retention and recruitment difficulties, and conditions in the workplace. Given the lack of explicit policies for developing human resources, and the fact that the provider survey and many documents reviewed indicate a number of concerns regarding human resources and the effects on care, we gave this area an E grade – there has been negative change since 1999 on human resource issues.

In many parts of Canada there are high turnovers of professional, para-professional and other support workers. There are a number of reasons for this: the casual and part-time nature of the work, the low pay when compared to working in an institutional setting or other sectors of health care or the economy more generally, limited benefits, the uncertainty of the home environment (e.g., working alone, hazardous or unsanitary home environments, abusive behavior by clients or family), the costs of travel (in some cases not absorbed by the provider organization or the government), limited job security, long hours associated with travelling or the transit connections if staff do not have their own vehicles, the need to provide care in hours outside the regular working week (e.g., evenings and during the weekend), and the large amounts of ‘down-time’ during the day.

These issues are compounded in small, rural and isolated communities, where it is often difficult to recruit and retain qualified staff. High levels of recruitment and retention are also especially important to ensure specialist care can be provided to clients with specific needs, such as palliative clients, those with HIV/AIDS, clients with serious mental illnesses, people with disabilities and children.

Data gathered in the home care provider survey (noted in section 2) showed that:

- 42.8% of respondents on nursing staff noted they had difficulty retaining nursing staff due to better pay elsewhere (n= 68 of 159).
- 59.6% of respondents of home support workers who noted they had difficulty retaining home supportstaff stated that these workers had left the organization due to better pay elsewhere (n= 90 of 151).
- Only 30.6% of respondents on therapy staff felt that therapists had moved on due to better pay (n= 15 of 49).

(Note: In many cases questions were not applicable to all the organizations surveyed.)

These points are further emphasized in Tables 4a and 4c, which provide data on wage rates for registered nurses and home support workers. The disparities between the institutional and community settings are obvious in some jurisdictions, and they are contributing significantly to the issues of recruitment and retention of staff.

CARP GRADE:  
**E**  
NEGATIVE  
CHANGE