Providing Care and Support for an Aging Population: Briefing Notes on Key Policy Issues

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Introduction

Researchers, policy makers and healthcare providers agree that frailty has an important impact on the affected individuals, their families – particularly those involved in caregiving – and society. However, frailty remains an enigmatic and controversial concept (Hogan et al. 2003). The Canadian Initiative on Frailty and Aging (CIFA) was initiated with the overall goals of furthering our understanding of the causes, trajectory and implications of frailty and improving the lives of older persons at risk of frailty by disseminating knowledge on its prevention, detection and treatment, as well as the cost-effective organization of services (Bergman 2003). As a first step, CIFA's multidisciplinary team of researchers collated, critically reviewed and synthesized current evidence and identified gaps in existing research on frailty across various fields. The objective of this article is to present the current research on key policy issues related to the frail elderly.

Despite an increasing interest in the concept of *frailty,* there is currently no consensus on how to define it. The term came into common usage in the 1980s and was originally equated with disability, the presence of chronic disease, extreme old age or the need for geriatric services (Hogan et al. 2003). More recently, researchers have uncoupled frailty from the concept of disability (Fried et al. 2001). However, such distinctions have not been adopted in the policy literature. To our knowledge, there are no policy papers on frail older persons without disability. Therefore, this policy review focuses on older persons who have already developed some form of disability.

The key audience for this article is senior decision-makers at the federal, provincial and territorial levels and in regional health authorities. To facilitate the message, it was decided to use a format senior executives themselves use in making policy decisions, the briefing note. As part of the project to address key policy issues for the elderly, in CIFA, the authors of this article identified an initial list of eight possible policy topics for review from existing documents. The authors and four senior experts from across Canada then rated the relative priority of these policy issues. This article presents briefing notes on three key policy issues related to the care of the elderly.

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1 Briefing Note 1: The Organization of Care Delivery Systems for the Elderly

Problem Statement

How care delivery systems are organized and structured can have a significant impact on how efficient and cost-effective they are in practice. In the 1980s and early 1990s, there was a movement across Canada to provide care for the elderly in integrated care delivery systems that included home care, home support, certain community services, case management, residential care and some aspects of acute care. One example of this was the development of continuing care systems in Western Canada.

Regionalization of healthcare services swept much of the country in the mid- to late-1990s. In addition, there was an increasing emphasis on primary healthcare across Canada. As a result of these changes, a range of care delivery models were developed. Thus, there were, and continue to be, competing visions of how to best organize systems of care delivery for the elderly. This briefing note provides a discussion of best practices for organizing integrated care delivery systems for the elderly.

The Weight of the Evidence

In an extensive program of research on the cost-effectiveness of home care, Hollander and Chappell (2002) present a number of policy recommendations regarding how home care services should be structured. They note that in order to more readily make the types of substitutions required to achieve greater effectiveness, home care needs to be part of a broader, integrated system of home care and residential care, often referred to as *continuing care*. By having administrative and fiscal control over such a large, integrated system of care, senior executives and policy makers can take steps to ensure that an appropriate and cost-effective substitution of home care services for acute care and residential care can in fact take place. Simply enhancing expenditures on home care per se may have a limited effect, unless steps are taken to ensure the appropriate substitutions of home care services for acute and/or residential care services. Thus, Hollander and Chappell (2002) recommended a shift in Canadian healthcare policy from a focus on home care on its own to a broader integrated model of continuing care in which cost-effective substitutions of home care for residential care can be facilitated.

It is not well recognized by policy makers that a properly constructed continuing care system, in terms of public expenditures, would constitute the third-largest component of the Canadian healthcare system after hospitals and medical services. Using historical data, Hollander (2004) estimated annual public expenditures on continuing care to be $11–$13 billion in the early 2000s, about twice the amount of public expenditures on drugs for the same time period (Canadian Institute for Health Information 2003).

In a synthesis of a large, national study on care delivery systems, Hollander and Prince (2002) noted the lack of integration, and the fragmentation, of healthcare delivery systems for four populations: seniors, persons with disabilities, persons with chronic mental health conditions and children with special needs. These are all people who have ongoing or long-term care needs. In addition, there is also fragmentation between health services and other services such as education, social services and transportation.

The authors found a significant overlap in the care services required by the four populations and in problems related to the lack of integration in their respective care delivery systems. They went on to lay out a best practices blueprint for how to organize an efficient and effective healthcare service delivery system for persons with ongoing care needs. Their model extends and/or combines best practices for service delivery systems that currently exist (or have existed) in Canada. Thus, the model has a clear empirical basis in regard to an analysis of current problems and builds on existing Canadian traditions in regard to service delivery systems for persons with ongoing care needs.

The Hollander and Prince Continuing Care Model outlines the 10 best practices for organizing care delivery systems for persons with ongoing care requirements (including the elderly); these practices are divided into administrative and service delivery groups and are presented in Table 1.

Table 1. Key elements of the continuing care model

Administrative Best Practices

1. A clear statement of philosophy, enshrined in policy
2. A single or highly coordinated administrative structure
3. A single funding envelope
4. Integrated information systems
5. Incentive systems for evidence-based management

Service Delivery Best Practices

6. A single or coordinated entry system
7. Standardized, system-level assessment and care authorization
8. A single system-level client classification system
9. Ongoing system-level case management
10. Communication with clients and families

The Hollander and Prince formulation builds on continuing care traditions in Western and Atlantic Canada and applies to large-scale provincial and regional systems.

Another stream of literature in Canada, developed through pilot and demonstration projects in Quebec, addresses care delivery systems from a primary healthcare perspective. The two major primary healthcare delivery models developed in Quebec are the SIPA (System of Integrated Care for Older Persons) model and the PRISMA (Program of Research to Integrate Services for the Maintenance of Autonomy) model.

Table 2. Key elements of two primary care–based models

The SIPA Model	The PRISMA Model
Single entry	Single entry
Case management	Case management
Geriatric assessment and management through the use of interdisciplinary protocols	Individualized service plans
Multidisciplinary teams	Single assessment instrument
Physician involvement in the care team	Single client classification system
Responsibility for delivering integrated care through the provision of community health and social services	Computerized clinical chart available across care provider organizations
Coordination of hospital and nursing home care	Inter-organizational coordination among partners
Inter-organizational coordination	Budget negotiations between partner organizations
Capitation payment (not implemented in the demonstration project)	

PRISMA = Program of Research to Integrate Services for the Maintenance of Autonomy; SIPA = System of Integrated Care for Older Persons.

There is sound empirical evidence regarding the efficacy of the SIPA model (Béland et al. 2006a, 2006b; Bergman et al. 1997; Johri et al. 2003) and the PRISMA model (Hébert et al. 2003, 2005). The key elements of these primary care–based models are presented in Table 2.

There is a great deal of similarity between the continuing care and primary healthcare models noted above. The distinctions between the two approaches seem to focus on the role of physicians and geriatricians, and multidisciplinary care teams. There is also an important distinction between coordination of care across service providers versus more structured control. In the primary healthcare approach, authority over the service delivery system and funding allocations are primarily derived through coordination. In addition, the SIPA model also envisioned a degree of authority through the purchase of services from other, primarily institutional, care providers. In the continuing care model, there is a single funding envelope and all care provider organizations come under a single authority such as a provincial ministry of health or a regional health authority. Nevertheless, both formulations strongly support the need for greater integration in care delivery.

Policy Options

Option 1: The Status Quo

Current federal policy, as noted by the Romanow Commission, the Kirby Committee and recent health accords (Health Canada 2003, 2004; Kirby 2002; Romanow 2002), is to redefine home care from a model with both short- and long-term components and an emphasis on home support to a model with a greater focus on short-term home care (including acute care replacement home care) provided primarily by professionals. This approach serves to further isolate home care from other continuing care services, and also splinters home care itself.

The current policy focus may ultimately serve to disenfranchise the elderly from the care they need over the longer term and reduce the home support that allows them to remain independent. Funding reductions, or reduced relative annual increases, to long-term home care and home support may, over time, lead to escalating healthcare costs and inefficiencies as more and more seniors seek hospital and residential care services as they can no longer cope at home due to possible reductions in home care and home support services.

Option 2: The Primary Healthcare Model of Integrated Care for the Elderly

The primary healthcare model of integrated care may increase horizontal integration across home and community services but may reduce vertical integration. Thus, the main challenge

Integrated care delivery systems for the elderly – whether they are continuing care systems, primary healthcare–based systems or other systems of integrated care – are the best solution when it comes to increasing the efficiency and effectiveness of care delivery for the elderly.

to this approach is to build in coordinating mechanisms with long-term care facilities and hospitals. If this can be done, such as with SIPA and PRISMA, then this could be a viable option. To the extent that vertical links do not exist between primary, secondary, tertiary and quaternary care, or are not well established or cannot be enforced, care coordination across the full continuum of needed care services may cause disruptions and gaps in service delivery.

Option 3: Re-validate and Reinstitute the Continuing Care Model

The continuing care service delivery model, as noted above, has a broad base of home and community services (like primary care) and already has vertical integration across all levels of the healthcare system (like integrated health systems). Case management facilitates horizontal and vertical linkages. Policy and resource allocation decisions are simplified as the model has one administrative authority for all services in the system and a single funding envelope. Thus, potential breakdowns in voluntary coordination across service providers can be minimized. Resource allocation and future planning are also facilitated by having a single, comprehensive assessment and a care level classification system that is the same for all clients, irrespective of the site of care. The single care level classification system allows for planning across the whole continuum of care as one can make "apples to apples" comparisons across types of care services in regard to client needs, the services delivered and the costs of these services. Finally, continuing care has a long tradition in Canada and has been successfully used over many years, and in many jurisdictions, to organize large-scale, provincial and regional models of care delivery for the elderly.

Recommendation

It is recommended that option 2 or 3 be adopted by policy makers depending on the context of the overall healthcare system in their respective jurisdictions. The critical issue is that integrated models of care delivery be established.

Evidence shows that integrated and coordinated care delivery systems, designed to meet the needs of specific populations, are efficient and cost-effective. Hollander (2001) and Hollander and Chappell (2002) argue that it is only possible to make cost-effective substitutions between home care and residential care services *if* there is: a single or highly coordinated administration; a single funding envelope (budget based, capitation or a coordinated model in which parties jointly agree to resource allocations); coordinated case management across all service components in the system; a standardized assessment; and one care level classification system that is the same irrespective of the site of care.

For similar clients, home care can be a cost-effective substitute for residential care. It is the type of system one has that determines the extent to which such substitutions can be made. Such substitutions are much harder to make in splintered systems in which there are several organizational groupings protecting their own turf, setting their own policies and priorities in isolation from each other, and competing for new budget dollars. Integrated care delivery systems for the elderly – whether they are continuing care systems, primary healthcare–based systems or other systems of integrated care – are the best solution when it comes to increasing the efficiency and effectiveness of care delivery for the elderly.

In terms of national policy, federal, provincial and territorial governments may wish to consider developing some form of a new, national policy initiative to support integrated models of care delivery for the elderly.

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Briefing Note 2: Long-Term Home Care 2

Problem Statement

The history of home care and continuing care services is one of an amalgamation of professional *and* supportive services (Hollander 2001b). Recently, fiscal pressures, major commissions (Romanow 2002) and committees (Kirby 2002), and First Ministers' Accords (Health Canada 2003, 2004) have shifted the policy focus on how services to the elderly are to be delivered. The present federal emphasis is on short-term home care that uses a high proportion of professional services. In contrast, supportive services provided for the longer term are coming to be seen as the responsibility of the individual and family, community voluntary agencies and social services. This represents a major and substantial shift in public policy from the trend that was in place from the mid-1970s to the late 1990s.

National initiatives currently also focus on home care for specific populations such as mental health and palliative care clients; however, the focus of this briefing note is on the broader issue of re-validating long-term home care and home support for all populations in need of these services. Thus, this briefing note discusses the need for a renewed emphasis on long-term home care, and home support services, within Canada's healthcare system.

The Weight of the Evidence

Preventive Home Care

There is some evidence about the extent to which long-term home care can, or cannot, reduce admissions to hospitals and long-term care facilities. In a 1986 study (Contandriopoulos et al. 1986), researchers studied the impacts of a new home care program in a Quebec community. They concluded that the new home care program did not reduce hospital admissions. In a study in Saskatchewan (Saskatchewan Health Services Utilization and Research Commission 2000), researchers used administrative data to study the impacts of home care. They concluded that persons receiving preventive home care were more likely to lose their independence or die than those not receiving home care. However, the researchers did not have data on the functional status of the people in their study, a key determinant of care needs.

A more recent study indicates that long-term home care can prevent or reduce the rate of admissions to hospitals and long-term care facilities. Hollander (2001a) studied the overall costs to the healthcare system in British Columbia of people who only received housekeeping services and who were cut from home care service in two health regions compared with people not cut from service in two similar regions. In the year prior to the cuts, the average, annual overall healthcare cost per client for those cut from service was $5,052 and the cost per client for the comparison group was $4,535. In the third year after the cuts, the comparative costs were $11,903 and $7,808, respectively, for a net difference of some $3,500. On average, the people cut from care cost the healthcare system some $3,500 more in the third year after the cuts than people who were not cut from service. Total costs over the three-year period after the cuts were $28,240 and $20,543, respectively, for those cut from care compared with those not. Most of the differences in costs were accounted for by increased costs for acute care and long-term residential care.

Two Italian studies on the impact of an integrated home care program (including social and health services) on hospital use indicated a significant reduction in hospitalizations, hospital days and costs when researchers compared data for the same patients before and after the implementation of an integrated, long-term home care program (Landi et al. 1999, 2001).

Reducing resources for long-term home care and home support may bring about an ever-increasing cost spiral as people in need put more pressure on hospital beds and residential care beds – leading to more demands for budget increases from hospitals.

Home Care as a Substitute for Residential Care

In the United States, considerable research has focused on home care as a substitute for residential care services. Given the nature of the American healthcare system in the 1980s, the appropriate way to study whether home care was a cost-effective alternative to residential care was thought to be by introducing case management (often with an enhanced home care program) into a community and then randomly assigning eligible clients to existing community services or to enhanced services. Overall, those with enhanced home care had greater satisfaction and quality of life, and somewhat reduced costs, relative to the comparison group (usual care). However, when the cost of the

enhanced home care program itself was added into the equation, overall costs were generally greater for the enhanced group than for the comparison group (Berkeley Planning Associates 1985; Mathematica Policy Research, Inc. 1986a, 1986b).

While the research noted above suggests that home care is not cost-effective compared with residential care, it generally does not compare the actual costs of community- and home-based services versus the costs of long-term residential care per se. In contrast to the above studies, recent research indicates that when the costs of community-based services are compared directly with the costs of long-term care services, standardizing for the level of care needs, home care has the potential to be a cost-effective substitute for facility care.

With regard to findings from Canada, a study of the cost-effectiveness of long-term home care found that over time, and for all levels of care needs, home care was on average significantly less costly to government than care in a long-term care facility (Hollander 2001b). In a related study (Chappell et al. 2004), similar cost differences were seen even if one adopts a broader societal perspective that incorporates out-of-pocket expenses and the care time of informal caregivers into the analysis.

The savings from substituting home care services for residential services are not only theoretical. Actual savings were achieved in British Columbia by holding down future construction of long-term care facilities and making investments in home care. Over a 10-year period, due to a policy of substituting home care services for residential services, the utilization of some 21 person-years per 1,000 population 65 years or older was shifted from residential care to home care (Hollander 2001b).

In a study examining the Arizona long-term care system, Weissert et al. (1997) note that long-term home care can be cost-effective. The investigators suggested that savings probably came from several sources, including the use of a payment methodology that encouraged program contractors to place clients in home- and community-based services rather than risk losing money by using more facility days than their monthly capitated rate allowed.

Denmark has for many years had an integrated system of care delivery for the elderly and persons with disabilities that puts a priority on home care and includes a home support component. Stuart and Weinrich (2001) found that for the period 1985–1997 per capita expenditures on continuing care services, both in the community and in institutions, for persons 65 years of age or older, increased by 8% in Denmark and by 67% in the United States. For persons 80 years of age or older, costs actually decreased by 12% in Denmark while they increased by 68% in the United States. It appears that the savings in Denmark were the result of reducing nursing home beds by 30%. In the United States, over the same period of time (1985–1997) there was a 12% increase in nursing home beds. Thus, an increasing proportion of people were cared for at home in Denmark.

What role has home support played in regard to the cost-effectiveness of long-term, or chronic, home care? It turns out that home support is central to this form of home care and the cost-effective substitutions it can engender. In addition to the role of preventive home care, as noted above, Hollander (2001b) provides evidence on the benefits of home support in long-term home care. He found that approximately 80% of the expenditures for long-term home care for people with higher-level care needs (i.e., at levels similar to people in long-term care facilities) were for home support services, while 20% were for professional services. Thus, the cost-effectiveness of home care compared with residential care is largely due to home support services.

Not fully appreciated in current policy discussions is a seeming paradox of service provision: while elderly persons with functional limitations have health conditions and need medically necessary care, the appropriate responses to their healthcare needs are, in large part, supportive services. Giving a senior who needs care a bath, preparing a meal and feeding the individual, and ensuring a safe and sanitary environment in the home do not have to be done by a nurse. For people who are too frail to shop, cook or take baths on their own due to their medical conditions, this type of personal support can allow them to maintain their independence for as long as possible, and may actually save the healthcare system money by avoiding repeated hospital admissions and premature entry into long-term care facilities.

Policy Options

Option 1: The Status Quo

The status quo recognizes the importance of short-term home care and flows new federal dollars to short-term home care services. Thus, long-term home care dollars may be decreased or held constant (perhaps with an increase for inflation), resulting in a progressive decrease in the proportion of home care budgets allocated to long-term home care. The longer-term impact of this policy is that it will allow policy makers to indicate that long-term home care will continue to be provided. It may, however, represent a withering on the vine of this service.

Option 2: Shift Current Resources to Long-Term Home Care

A shift of current resources to long-term home care would be an option in which the contribution of long-term home care and home support are recognized at the provincial and regional levels. New federal funds for short-term home care would be allocated to short-term home care, but future base budget increases for inflation and changes in demographics within the province or region would be allocated to long-term home care; or there may be actual shifts in previously existing budgets from short-term to long-term home care. This approach would constitute a modest

shift away from the emerging focus on short-term home care while reflecting the continued and growing need for home care services over the longer term.

Option 3: Shift Policy and Resources to Formally Recognize the Importance of Long-Term Home Care and Home Support

The third option is shifting policy and resources to formally recognize the importance of long-term home care and home support, which represents a shift from current policy thinking on home care. When comprehensive home care programs evolved in Canada in the 1970s and 1980s, the primary focus was on long-term home care. With increased cost pressures on the healthcare system in the 1990s, there was a growing priority placed on moving people out of the hospital faster and, as a consequence, on short-term home care. Option 3 would re-balance short- and long-term home care and clearly recognize the importance of long-term home care and home support. The advantages of this approach would be to restore and enhance services to those who are weak, vulnerable and in need of ongoing care services, thereby reducing or delaying their need for institutional care (Hollander and Chappell 2002).

Recommendation

It is recommended that policy makers adopt option 3. The focus on short-term and specialty home care may result in the reduction of services to persons with legitimate medical needs for whom the appropriate response is long-term supportive care to allow them to function at their optimal capacity for as long as possible. In addition, reducing resources for long-term home care and home support may bring about an ever-increasing cost spiral as people in need put more pressure on hospital beds and residential care beds – leading to more demands for budget increases from hospitals. These increases would possibly be paid for by further reductions in resources for long-term home care, thereby igniting another round of demands for beds because people can no longer cope in the community, and so on. Long-term home care may in fact be an important part of the solution to making our overall healthcare system more efficient and effective, and enhancing its value for money.

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Briefing Note 3: Informal Care 3

Problem Statement

Canadian health and social policy has historically assumed and continues to assume that care takes place in the family. The formal care system enters when families "fail." Traditionally, when the formal system entered, it largely ignored family and

informal caregivers. It was assumed that the formal system knew best; families were largely invisible to formal care. The 1990s, however, marked a major shift with government efforts to devolve responsibility back to the community (including its not-for-profit sector) (Gordon and Neal 1997; Rice and Prince 2000). The vision of health reform during this decade brought a formal recognition of the contribution of informal caregivers. Nevertheless, while now giving rhetorical recognition, Canadian policy does not provide substantial support to caregivers, and thereby does not reflect the critical role that caregivers play within society.

This briefing note provides an overview of knowledge on informal caregiving in Canada and policy options for healthcare delivery systems when considering appropriateness and cost-effectiveness for an aging society. In doing so, it discusses the current policy vacuum in relation to informal caregivers.

The Weight of the Evidence

Informal care generally refers to assistance from family, sometimes from friends, that is not paid. Typically, we are not called upon to provide caregiving per se, other than for short periods of illness to those who are younger. However, with old age comes a decline in physical health that frequently calls for assistance. When people become ill or have long-term illnesses and disabilities, the informal network of family and friends is the "first resort" for assistance. Informal care provides the vast majority of care, an estimated 75% of all personal care provided to seniors in industrialized countries, irrespective of whether they have universal healthcare (Kane 1990).

During the 1970s and 1980s, gerontological research exposed the major role played by informal caregivers, especially families and particularly women (wives and daughters) in the care of seniors. This was important within the context of the times when it was commonly believed that seniors in Western industrialized societies were largely isolated from family, living alone and often housed in long-term care institutions. Gerontological research documented the norm of intimacy-at-a-distance, in which neither seniors nor their children wish to live together but have a desire to interact. Indeed, most seniors even today live geographically proximate to at least one of their children (Wolf and Longino 2005). Care from unpaid caregivers is the dominant source of assistance for seniors. In the 1980s, both research and the media saw a major interest in the "hidden victims," – the sandwich generation – raising public awareness of caregiving. During this time, Chappell (1985) reported that almost all community-living seniors receiving any type of assistance do so from the informal network. More recently, Cranswick (2003) confirms that the vast majority of care comes from family and friends (>70%).

Not until the 1990s, however, did caregiving become politicized. When a new vision of health reform emerged, recognition of informal caregivers was embedded. While there was widespread consensus on this vision at the time, the distinction between informal and family care on the one hand and community care on the other was not made and has proven problematic. The distinction is critical because if it is assumed that community care is equivalent to family care, it means an increased burden is placed onto the shoulders of informal caregivers – a burden that they take on willingly and often at great personal sacrifice. Community care, on the other hand, calls for resources in order to build a community infrastructure that includes a social component such as homemaking services for the ill and disabled in their own homes, transportation to and from appointments and community support groups, as well as formal education and recreational systems. It also calls for a strengthening of the infrastructure that will facilitate community development, that is, infrastructure that will facilitate individuals to become and feel that they are useful, meaningful, contributing members of the local community. Community care calls for attention to be directed toward health promotion and disease prevention, and to building the formal community system of care.

Long-term home care may in fact be an important part of the solution to making our overall healthcare system more efficient and effective, and enhancing its value for money.

However, there has been little support provided for caregivers or for community development. Indeed, the Romanow Report and the most recent health accords focus on short-term, not long-term, support to families, a direction that shifts more burden to families (Romanow 2002). Despite the well-documented role that informal caregivers do contribute in our society and the recent recognition of this role in the vision of health reform, neither policy nor services consider their potential need for support. Policies and services are directed toward those in need, not to their informal caregivers, not to their families. Currently, there are three services that tend to be available for caregivers: sitter attendant services, adult daycare and short-term beds within long-term care institutions. The first occurs when an individual comes into the home, allowing the caregiver to attend to other tasks. The latter two are services to which the care recipient is taken in order to provide a break for the caregiver.

Both assessors within the system and caregivers themselves focus on the loved one in need of care. Chappell (1999) revealed how caregivers think first and primarily of their loved ones, not themselves. Furthermore, caregivers continue in this role even as disease and problems of the care recipient increase (Kasper et al. 1994). One of the reasons for a lack of attention to caregivers

is a belief that there would be a deluge of requests were services to be provided to them. Yet, the evidence suggests the contrary. Caregivers make judicious use of the services that are available to them (respite services, the three noted above), even when there is no charge (Chappell 1998; George 1988). The reasons are speculative, with many believing that both seniors and their caregivers are fiercely protective of their independence and autonomy, which they feel is threatened when formal service providers enter the home. Furthermore, Horowitz and colleagues (1983) have shown that when home care services are provided, caregivers are able to provide more care and for longer than those not receiving such services. Caregivers already providing a moderate amount of help *increase* the support that they give. Among caregivers who provided heavy care, over time, those who received home care support continued to provide this care, whereas those in the study who did not receive any home care support had to discontinue providing care, due to burnout and declines in their own health.

In addition, providing home care is cost-effective. Hollander (2001) compared four health units in British Columbia that differentially implemented cuts to home support services. Units that cut homemaking-only services paid for more services for these individuals three years later through the greater use of hospital beds, increased use of homemaker services and increased rates of admission to nursing homes. The greater overall costs did not emerge immediately but, rather, in the second and third years after the cuts. In addition, a higher proportion of those who were cut from the service died. Other recent research has revealed that the cost to government of maintaining those in need at home with provision of long-term home care when compared with maintaining those at the same level of care within long-term residential care is cost-effective, with home care clients costing 40–75% of the costs of facility care. The cost of home care is in the transitions, that is, those who change their type or level of care cost considerably more than clients who remain within their level of care even though transition individuals still cost less than facility clients. In addition, even when taking into account the costs of informal caregiving, home care still costs less than residential care (Chappell et al. 2004; Hollander and Chappell 2002).

As evidence is demonstrating, the cost-effectiveness of long-term home care, policy direction and the delivery of service in Canada is focused in the opposite direction. Both the Romanow Report and recent health accords have focused only on short-term home care to the neglect of long-term home care. The focus on short-term home care has been occurring for several years. Allan and Penning (2001) show that, in British Columbia throughout the 1990s, hospital outpatient surgeries increased, hospital lengths of stay decreased and home care shifted to intensive post-acute care following hospital discharge, that is, to a medical support system. Interestingly, the utilization of costly physician services, especially specialist services, simultaneously increased.

But caregiving to seniors is for the long term, not a few weeks and not a few months. The shift in focus in home care to provide intensive short-term post-acute care signals a lack of understanding of the needs of an aging society. This redirection of home care services away from clients with instrumental care and social needs is also occurring in other parts of Canada (Deber et al. 1998). These are the people who have the greatest potential for prevention. The move to post-acute home care is similar, in its consequences, to earlier moves in the United States to diagnostic-related groups for hospital funding. These moves resulted in earlier discharges and increased demand for intensive post-acute care, with subsequent restrictions of social services and of long-term chronic care available through home care (Estes and Wood 1986). A problem occurs because more post-hospital home care in the absence of long-term chronic home care can increase costs since seniors have to enter hospital in order to receive home care.

While the Romanow Report argues for increased coverage of short-term post-hospital home care because care that used to be covered during hospital stays can now be provided in people's homes, it leaves long-term home care for seniors (who suffer more from chronic conditions than acute illnesses) more likely to be provided by for-profit interests. Multinationals are free to buy up local agencies, and profits are more likely to leave the country. This trend is leading to what Williams and colleagues (2001) refer to as a "hollowing out" of medicare. A major issue with the entrance of multinational profit-making corporations is the lack of public scrutiny. It also increases concern with Canada's participation in international agreements such as the Free Trade Agreement, whereby once for-profit firms enter, it may be very difficult for governments ever to re-enter this area. The Romanow Report devotes an entire chapter to globalization and international agreements, arguing that Canada should, wherever possible, state that Canada's healthcare services are not part of this agreement. (It is worth noting here that jurisdictions across the country are not all the same. Manitoba, for example, reversed a decision to profitize community care services in response to conflict with public sector unions and emerging evidence that private for-profit businesses could not provide services less expensively than the public sector [Shapiro 1997].)

Research suggests that the current direction to shift the focus away from long-term chronic home care is misguided and will result in increased costs down the road. Furthermore, targeting only respite services to caregivers is not the appropriate vision in order to adequately support informal caregivers. Informal caregivers require a comprehensive long-term home care program directed toward the care recipient that takes caregivers' needs into account. In order to provide home care that will assist caregivers, the caregiving unit (usually the family) must be taken into account.

Policy Options

Option 1: The Status Quo

Option 1, the status quo, will see policy makers stay the current course. There will continue to be an emphasis on short-term home care and a continuation of the current reduction of long-term home care in order to meet the increasing demands for more intense short-term, post-acute home care. The consequences will include increased demands on families to provide more care for their elderly members, increased demands on available medical services such as hospitals and long-term care institutions, fewer long-term home care services available for families, and increased profitization of this sector to meet needs that are ignored by governments. Canada's public system will become increasingly medical, opposite to the direction set forth by the vision of health reform of the 1990s.

One of the reasons for a lack of attention to caregivers is a belief that there would be a deluge of requests were services to be provided to them. Yet, the evidence suggests the contrary.

Option 2: Formally Recognize the Needs of Caregivers and Establish More and Expanded Services to Assist Them

Formal recognition of the needs of caregivers and establishment of more and expanded services to assist them comprise option 2. This policy option would see increased resources allocated to both expanded respite services as well as new options to assist caregivers (such as targeted replacement services for some of the tasks caregivers currently provide such as homemaking) but would not constitute a major shift in thinking about services for seniors. Caregivers would be viewed as supplementary players; long-term home care for seniors and their caregivers would not receive major recognition.

Option 3: Formally Integrate Caregiver Needs into the Policy and Delivery of Healthcare Services

Option 3 is the formal integration of caregiver needs into the policy and delivery of healthcare services. This option would formally recognize caregivers as part of the care provider team and integrate the caregiver into the decision-making for long-term home care. It would see the needs of the senior and caregiver jointly assessed. This option requires both policy recognition of the role played by caregivers and additional resources for long-term home care for the senior and caregiver jointly. It would not target services in a limited and specific way to caregivers. It would view the full spectrum of long-term home care services as appropriate for meeting the long-term needs of seniors.

Recommendation

Option 3, to formally integrate caregiver needs into the policy and delivery of healthcare services, is recommended. This option reflects evidence-based decision-making, deriving from the most recent scientific research available for both meeting the needs of an aging population and providing cost-effective care. It would allow families to continue providing care to their loved ones, which they want to do, while also allowing seniors to remain in their own homes in the community for as long as possible, which seniors overwhelmingly choose. This option would help stop the current trend toward increasing demands on informal caregivers, begin the possibility of a comprehensive cost-effective strategy for meeting the needs of Canada's aging population, provide appropriate services that will assist informal caregivers to continue in this role as is their desire, and help prevent the increased use of more costly medical services by both seniors and their caregivers. HQ

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