



# The First Ministers' Accord on Health Renewal and the Future of Home Care in Canada

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## ABSTRACT

On February 5, 2003, the Prime Minister and Premiers of seven provinces signed an agreement, the First Ministers' Accord on Health Care Renewal, outlining the direction of public healthcare in Canada in the near future. The Accord addressed several key issues in healthcare, namely prescription drug coverage, home care, diagnostic services, timeliness of care and primary healthcare reform. This paper critiques the home-care initiatives outlined by the First Ministers, on the grounds that they do not speak to issues of access to long-term care or to non-professional home care – services that are deemed critical by the elderly who wish to stay at home and who represent an increasing proportion of the country's population. Furthermore, the Accord does not establish legislative protection or separate funding, both of which are necessary to ensure that home care as a whole receives an adequate share of resources and political attention over the medium and long-term.

## INTRODUCTION

The evolving healthcare needs of Canadians have brought home care to the forefront of the healthcare debate. Although home care still accounts for only 4.5% of current healthcare spending (Coyte and McKeever 2001), it is the fastest growing sector. Between 1975 and 1992, spending on home care grew at a rate of 19.9% compared to the 10.8% growth in healthcare spending as a whole (Premiers Council of Canada 2002). Each province has its own home-care program, and there are no national standards in place – resulting in a patchwork of entitlements. Two recent and highly publicized healthcare commissions, the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Commission) and the Commission on the Future of Health Care in Canada (Romanow Commission), recommended the establishment of a national home-care program with a basic package of publicly funded home-care services offered across Canada. In February 2003, the First Ministers' Accord on Health Care

Renewal was released, which outlined the federal and provincial agreement on future healthcare initiatives, including home care.

In this paper, we review and critically examine the agreement reached on home care in the First Ministers' Accord. We argue that (1) the initiatives presented in the Accord preserve the existing bias towards post-acute and professional home-care services and (2) the Accord does not address the need for legislative protection of home care as an insured service. We specifically discuss three main shortcomings of the Accord: (i) the failure to address the need for non-professional or social services; (ii) the failure to expand coverage for long-term home care and; (iii) the failure to acknowledge home care as a critical component of healthcare, either through its inclusion in the Canada Health Act or through the establishment of separate national legislation.

## WHAT IS HOME CARE?

It is difficult, if not impossible, to find a universally accepted definition of

home care. The most widely recognized and cited definition is that provided by Health Canada: “an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying or substituting for long-term or acute care alternatives” (Health Canada 1990).

Home care is unique in that it “straddles the medical care and social services sectors” (Flood and Choudhry 2002: viii). It comprises a professional medical component, which includes nursing and rehabilitation therapy services, and a non-medical or social service component, which encompasses homemaking and personal support provided to assist clients with activities of daily living (ADLs). Homemaking services include cleaning, laundry and meal preparation, while personal support includes help with dressing, bathing, grooming and transferring (CHCHRS 2002). In defining home care, it is important to recognize the contributions of both the medical and social service sectors.

Home care is usually distinguished as being post-acute or long-term. Post-acute home care refers to home-care services required following hospital discharge (Coyte 2002). The Kirby Commission defined post-acute home care as all home-care services received starting from the first date of service provision following hospital discharge, if that date occurs within 30 days of discharge, to a maximum of three months (Kirby 2002). Long-term, continuing or chronic home care refers to care required on an on-going basis, and has been defined as home care provided for a minimum duration of 17 weeks (Laporte et al. 2002). Long-term care (LTC) clients include mentally and physically debilitated people of all ages and elderly people with chronic illnesses. The distinction

between post-acute and long-term home care is not always apparent: some home-care clients can be classified under both categories, for example, chronically ill clients discharged from hospital who resume receipt of long-term home-care services and also receive additional home-care services as a consequence of their hospitalization.

### HOME CARE IN CANADA

In Canada, the jurisdictional responsibility for home care, like most other healthcare and social programs, rests with provincial governments. The federal government's role in healthcare is largely the consequence of its spending power, established through its fiscal contribution to provincial health-care programs (Auditor General of Canada 2002). This spending power has allowed the federal government to establish national principles for select healthcare services in the Canada Health Act (CHA), and steer provincial health policy. The CHA, introduced in 1984, outlines the principles that provincial health insurance plans must follow to receive federal funding. The five principles of the CHA – public administration, comprehensiveness, universality, accessibility and portability – apply to “medically necessary” hospital services and “medically required” physician services, and surgical-dental services that are performed in hospitals. The CHA mentions another category of services – “extended health care services” – that are exempt from the application of the five principles. Home care is categorized as an extended service in the CHA. Under the CHA, the federal government can withhold funds on a dollar-for-dollar basis if a province allows user charges or extra-billing for “medically necessary” hospital services or “medically required” physician care.

However, long-term care services provided in hospitals or other institutions are exempt from this stipulation (Canada Health Act 1984).

The federal government has also assumed responsibility for the direct delivery of healthcare (including home care) to specific subsets of the Canadian population, in particular, Aboriginal populations (Health Canada 1999a). In recent years, the federal government has assisted home-care consumers through tax credits and deductions, for example, the Disability, Infirm Dependent, Medical Expense and Care Giver tax credits (Health Canada 1999b). In the 2003 First Ministers Accord, the federal government has promised employment protection for individuals who take time off work to provide palliative care to dying family members.

Provincial governments all, respectively, control the budget and funding for home care. All provinces currently provide both post-acute and long-term home care, with a similar range of basic services: client assessment; case management; nursing services; homemaking and personal support services (Health Canada 1999b). Eligibility for professional services such as nursing and case management is primarily based on need. Seven provinces have income assessment arrangements for home support services (MacAdam 2000a). Alberta charges a flat rate of \$5 per hour for home support services (Health Canada 1999b). There may also be direct charges or income tested co-payments for prescription drugs, medical supplies and adaptive equipment, particularly for long-term care. Waiting lists for home support are common but rare for professional services.

Private sector spending on home care has increased steadily over time as clients who are ineligible for publicly

funded home care, and those who wish to complement the public services they are receiving, turn to the private sector (Premiers Council of Canada 2002; CHCHRC 2002). In 1975, private sector spending accounted for 23.6% of total home-care spending; in 1999, this number had risen to 30.4% (Coyte and McKeever 2001).

### THE NEED FOR HOME CARE

The growing demand for home care as an alternative to traditional “medical care” is attributed to several factors, namely technological advancement, the changing demographics of the Canadian population, patient preference and the presumed cost-effectiveness of home care (CHCA 2002).

Advances in medical technology, improved surgical techniques, development of telehealth and new drugs have increased life expectancy, shortened hospital stays and enabled care that was previously provided in institutional settings to be provided in the community (Flood 2002). Although early discharge from hospital has been made possible because of technological advancement, the expansion of community care to accommodate Canadians in their homes post-discharge has not ensued at an equivalent rate (Kirby 2001). As a result, the cost of care previously publicly insured in the hospital is increasingly being borne out-of-pocket by Canadians.

By 2025, seniors will account for over 21% of the Canadian population (Kirby 2001). The highest use of home care occurs in the senior population, particularly those aged 85 and older (Kirby 2001). With the increasing life expectancy of Canadians (Statistics Canada 2003), an 80% increase in home-care expenditures is expected by 2026 (Coyte and McKeever 2001).

It is generally believed that people

prefer to be cared for in their own homes, rather than in institutional settings such as hospitals and long-term care facilities (Heyland et al. 2000). However, there may be caveats associated with patient preference for home care; research on home-care ethics is now exploring issues of privacy, comfort, invasiveness and social and gender inequality that may compromise the preference for home care (Peter 2003).

### Cost-effectiveness

Perceived cost-effectiveness has been the major driver of home-care expansion. A recent and highly-publicized Canadian study demonstrated that long-term home-care costs are about 40 to 75% of the costs of facility care (Hollander and Chappell 2002). However, in the same study, individuals who lived at home and received home care in the six months prior to death had higher costs than those who were in a long-term care facility in the six months before death. Other studies, particularly relating to supportive and preventative home care, have not found evidence of increased life expectancy or seniors living independently longer than those not receiving preventative care or receiving supportive care in institutions (HSURC 2000). However, these outcomes may not be the best or most appropriate performance measures for home care.

The cost-effectiveness of home care may not be as important in government decision-making as is the fact that costs are shifted from the public to the private sector. In the 1990s, with the reduction in hospital beds and the trend towards early discharge, there was a shift of care from hospitals to the home and other community settings. The public savings realized from these cost-shifting measures should not be

mistaken for cost-effectiveness, which is determined through assessment of both costs and outcomes of care, rather than comparison of costs alone.

### THE 2003 FIRST MINISTERS' ACCORD ON HEALTH CARE RENEWAL

On February 5, 2003, the Prime Minister and Premiers of seven provinces signed an agreement, the First Ministers' Accord on Health Care Renewal, outlining the direction of public healthcare in Canada over the next few years. The Accord addressed several key issues in healthcare, namely prescription drug coverage, home care, diagnostic services, timeliness of care and primary healthcare reform.

According to the First Ministers' Accord, the federal government will create a five-year \$16 billion Health Reform Fund targeted at primary healthcare, home care and catastrophic drug coverage. Within the home-care sector, the First Ministers specifically agreed to provide coverage for post-acute home care, end-of-life/palliative care and mental health home care. First Ministers have agreed to provide “first dollar” coverage for a minimum basket of services, that is insurance coverage that requires no co-payment or user fee from the care recipient at the front end. However, the services that will be included in this minimum basket are yet to be determined. The Accord states, “First Ministers direct Health Ministers to determine by September 30, 2003, the minimum services to be provided...First Ministers agree that access to these services will be based on assessed need and that, by 2006, available services *could* [emphasis added] include nursing/professional services, pharmaceuticals and medical equipment/supplies, support for essential personal

care needs, and assessment of client needs and case management" (First Ministers of Canada 2003: 4). The Accord also acknowledges that provinces and territories are at different stages of home-care reform, and that the basket of services covered may vary from province to province. Furthermore, funding for home care is provided as part of a fund that is dedicated to other initiatives as well. Allocation of funds is left to the discretion of individual provinces; as long as the money is spent on at least one of the funded initiatives (not necessarily home care), the provinces will have fulfilled their part of the bargain.

In the remainder of this paper, we discuss the implications of the First Ministers' Accord for home-care clients in Canada. We specifically address the lack of national initiatives for expansion of long-term home care and the failure to acknowledge the social service sector, both of which conversely affect the chronically ill. We also discuss the more general consequences of not establishing legislative protection for home care and integrating federal funding for home care with other healthcare priorities, which affects clients across the entire home-care sector.

### **UNDERMINING LONG-TERM HOME CARE AND SOCIAL SERVICES**

Current resource allocation is already biased in favour of post-acute care: nursing care, which forms the majority of post-acute home care, is generally provided free-of-charge in a timely fashion, and in some provinces, particular services are funded for post-acute patients but not for LTC clients (Health Canada 1999b). This is partly due to the high cost associated with providing services for a long duration of time, as is typical in the LTC sector. Increased early discharge and day

surgery rates have led to a growing number of home-care clients requiring post-acute care (Premiers Council of Canada 2002), which, in turn, has led to waiting lists in the long-term home-care sector (Chappell 2000).

The First Ministers have agreed to provide "first dollar coverage for [a] basket of services for short-term acute home care, including acute community mental health and end-of-life care" (First Ministers of Canada 2003: 3–4). However, the First Ministers' Accord does not specify the services that will be included in the national floor for home care. Although the Accord promised the basket of home-care services covered would be determined by September 2003, as of July 2004, no public announcement had been made regarding the minimum basket of services to be covered. The promise of more money then "has limited utility without a sense of where the funding should be targeted, and for what purpose" (Parent and Anderson 2000: 47).

The Romanow Commission recognized that the largest proportion of provincial home-care budgets goes to support people with chronic health problems and physical disabilities (Romanow 2002). However, neither the Commission nor the First Ministers explicitly suggested injection of national funds towards long-term home care or future steps to determine sound long-term care policies. The Romanow Commission recommended that provincial funds freed up as a result of federal contributions to post-acute home care be used to improve long-term home care. In reality, however, there are many policy and administrative barriers that make it difficult to transfer funds from one area of healthcare spending to another. Moreover, because different provinces and territories are at different stages in

the development of their home-care programs, some regions will have limited funds available to redirect to the long-term home-care sector.

A problem for both patients who need short-term home care and those that require long-term home care is that there is no continuity in public coverage of services across institutions and providers and thus people with exactly the same health need will be fully covered in one setting but not in another. For example, services such as food, housekeeping, drugs and laboratory tests are considered "medically necessary" in hospitals and therefore, provided free of charge. However, upon hospital discharge, these services are no longer deemed "medically necessary," and hence, patients who are discharged early face increased out-of-pocket costs. Similarly, non-professional services, which are often essential, have experienced cutbacks across the country to make room for more medicalized post-acute home care (Chappell 2000). The Canadian Home Care Human Resources Study noted that home support workers and home health attendants provide about 70 to 80% of paid home-care services, which consist largely of help with activities of daily living (ADLs) (CHCHRC 2002). Other research has indicated that variations in access to care, for instance rates of hospitalization, may be an outcome of co-payments for home care (Wilson 2002).

The lack of coverage for non-professional services is particularly problematic for those who need home care over the longer-term and more specifically, chronically ill individuals, mainly seniors, who represent an increasing proportion of the Canadian population. For short-term care recipients, personal support services account for 20.6% of services received. In contrast, for long-term care recipients,

personal support services account for 59.2% of services received (Laporte et al. 2002). A recent study conducted in Ontario indicated that more than half of short-term home-care clients require only nursing services and 3.3% require only personal support and/or homemaking. In comparison, 9.7% of long-term home-care clients utilize nursing services alone, and 21.6% utilize personal support and/or homemaking services alone (Laporte et al. 2002). Such statistics demonstrate the very different care requirements of short-term and long-term home-care clients, and the need to adequately address demands of both sets of care recipients. As a result of insufficient public coverage, LTC recipients currently incur a significant proportion of their home-care costs (mainly for social services), and in the future, they may even be dissuaded from seeking the care that they need (Shapiro 2000).

Home-care resource allocation decisions, particularly for long-term care recipients, are often made assuming that unpaid caregivers will provide the necessary social support and personal care. However, with major changes occurring in family composition – falling birth rates, increasing divorce rates, increasing labour force participation of women, more single-parent and blended families, and more geographical dispersion of kin – the pool of unpaid caregivers and volunteers is expected to shrink in the future, which will exacerbate the need for public finance for home care (CHCHRC 2002; Chappell 2002). As prescribed in the Accord, the Government of Canada will provide employment insurance and job protection through the Canada Labour Code, “for those who need to temporarily leave their job to care for a gravely ill or dying child, parent or spouse” (First

Ministers of Canada 2003: 4). We see this as a positive step towards establishment of comprehensive palliative home-care programs and adequate relief for unpaid caregivers.

Research has indicated that Canadians are much more likely to pay privately for home support than for professional services (Chappell 2000). This is mainly because professional services such as nursing care are publicly funded whereas home support services are not. A study of home-care providers reported that Canadian home-care clients incurred 24.5% of the cost of their nursing services and 59.3% of the cost of other support services (Coyte and McKeever 2001). Given the strong evidence that the First Ministers' floor of home-care services will not cover non-professional social services, most home support services will continue to be delivered by private for-profit service providers and the trend towards passive privatization of these services will continue.

It has been argued that public home care has been limited to professional services out of fear of moral hazard – that if access to home support and other services is increased, Canadians will use these services in an unconstrained manner, thereby escalating costs borne by the public system. Moreover, as Béland and Bergman (2000) point out, the lack of support for home making has also been justified on the grounds that unlike “medically necessary” care, homemaking and renovations required to facilitate home care for the elderly can be purchased in the free market. Therefore, having a personal support worker assist with ADLs is not quite comparable to, and maybe not as “medically necessary” as, receiving a heart transplant in a hospital. However, restricting access to cheap

and effective social services is not a means of achieving cost containment, let alone cost-effectiveness. It leads to increased acuity of medical conditions, requiring more advanced and expensive care in the future (Sharkey 2000). What will be needed are strict but fair gate-keeping processes to make sure that only those with sufficient medical need qualify for home support and associated services. It is not beyond the realm of possibility to control for the problems associated with moral hazard and it seems arbitrary and unfair to cover services solely because they are provided in a hospital or by a physician. Services should attract public funding if they respond to healthcare needs or can be demonstrated to result in measurable health improvements. We should be moving towards a system that achieves this rather than creating further silos of funding.

### **UNADDRESSED NEED FOR FEDERAL HOME CARE LEGISLATION**

The Romanow Commission recommended that professional home-care services for post-acute discharge clients be included in the Canada Health Act (CHA) as medically necessary services. The Royal Commission on Health Services (1964), the National Forum on Health (1997), and the Kirby Commission (2002) have made similar recommendations for inclusion of selected home-care services in the CHA. This overwhelming call for inclusion of home care in the CHA is no surprise, considering that 85% of Canadians polled in 1998 wanted to include home care under the Canada Health Act (CHCA 2002). Canadians clearly believe that the core value underpinning the CHA, namely access to care on the basis of need and not ability to pay, should as much

apply to home-care services as it does to physician and hospital services.

Many others have recommended not opening up the CHA but rather enacting separate legislation to address the unique overlap of home care in the health and social service sectors. Separate legislation for home care and pharmacare would allow for establishment of national standards in line with principles of the CHA while allowing, if necessary, income-based user charges for homemaking and personal support services (Flood and Choudhry 2002). To address the shift in costs (from public to private sources) that accompanied the shift in setting of care (from hospitals to the community), it is argued that the CHA should mandate insurance based on the “type” of service rather than its provider or the setting it is provided in (CNA 2000). Whether home care is included in the CHA or equivalent new legislation, there is consensus that professional home-care services must, at a minimum, be protected by equivalent CHA provisions. Moreover, there is also consensus (subject to the debate about some role for income-adjusted user charges for home support services) that most, if not all, of the five principles of medicare – portability, accessibility, comprehensiveness, universality and public administration – should apply to all home-care services.

The First Ministers' Accord does not suggest inclusion of any home-care services in the CHA, or the establishment of separate federal legislation. Exclusion from the CHA undermines the merit of home care and reinstates the legislative superiority of physician and hospital services. Care needed after early discharge is still not considered equivalent to care provided in hospitals. Although the First Ministers' Accord states as its mandate the provi-

sion of healthcare to Canadians based on need, and not ability to pay, it falls short of achieving this. Failure to entrench in legislation protection for home-care services means that provinces are free to establish user fees for any kind of home-care services, even those which are “medically necessary.”

The current imposition of user charges for some home-care services has disproportionately increased the burden of care on low-income families. Previously, some such clients may have extended their hospital stays to convalesce there, but with current hospital cutbacks and early discharge practices, having “bed blockers” in hospital longer than necessary is often not an option.

In response to exclusion of home care from the CHA, it is argued that “medically necessary” home-care services (e.g., professional nursing visits), are already being provided free of user charges, so inclusion into the CHA would not change the status quo (Thompson 2000). While this claim is valid, there are no means of insuring that the status quo is maintained in the future. If a province decides to impose user charges on home nursing visits in the future, there is no federal structure in place to prevent or discourage this through withdrawal of funds. With regards to prohibition of user charges for home care, it is noteworthy that if home care is insured under the CHA as “medically necessary,” private insurance for “top-up” or “higher quality” services will be prohibited, and this may not be appreciated by those who desire additional services and can afford to buy them privately (CNA 2000).

Federal and provincial reluctance to enact new home-care legislation or include home care in the CHA is not surprising as both options necessitate cooperation and increased funding

commitment. It has been argued that the constitutional division of powers prevents the federal government from mandating a particular healthcare program, or earmarking funds to the provinces (Richardson 2000). Furthermore, the federal government's position is that provinces are responsible for the delivery of health services and for determining healthcare policies. “Each province has been making its own policy decisions on home care for the last 20 to 25 years – a long enough time to constitute a significant barrier to change” (Shapiro 2000: 86). The provinces, on the other hand, are resistant to inclusion of home care in the CHA because of the financial obligations that it would entail, particularly with the aging of the baby boomers and escalation of home-care costs (Richardson 2000).

It has been suggested that if home care is a cheaper substitute for more costly institutional care, then increased funding for home care should not be required, since provinces should be able to finance home care from the cost savings derived from reducing more costly institutional care (Thompson 2000). However, in reality, it is more difficult to transfer savings from one healthcare sector to another. Cost cutting measures do not necessarily result in expendable savings that can be reinvested into the system, particularly if they are driven by the need to lower rather than maintain total costs. Even if a surplus results, there are many healthcare sectors and providers rallying for increased funding, some with more organized and powerful interests than others. Acute care, in particular, is often the first sector to receive additional funding, and in contrast, home care sits at the lower rungs of the public financing ladder.

Inclusion of additional services under the umbrella of “medically

necessary” care in the CHA will entail increased fiscal commitment from one or more levels of government. Therefore, we do not argue for the inclusion of all home-care services under the CHA, as we realize the difficulty in implementing such a recommendation. Rather, we urge the federal and provincial governments to take a more holistic approach in insuring healthcare services – an approach that moves beyond the funding of services based primarily on a care provider and health setting hierarchy. We recommend that either new legislation parallel to the CHA be introduced or the CHA be revised, not only to be more inclusive of home care but also of other healthcare services and sectors, for example, diagnostics, pharmaceuticals, mental health and allied health professions. We realize the magnitude of our recommendation and admit that extensive exploration of this issue is required before any steps are taken in the proposed direction. However, we strongly believe that the CHA, in its present form, with its limited scope, is no longer appropriate for addressing the healthcare needs of Canadians.

Some have argued that “if the Canada Health Act were extended to add more health services to its protective umbrella, it is not self-evident home care should be the only or even first addition. Pharmaceuticals are a bigger issue than home care” (Thompson 2000: 64). But the logic of this argument is faulty. Although catastrophic drug coverage is critical for many Canadians, the decision not to insure home care ought not to be justified on the grounds that other important services are also not covered. Moreover, inclusion of home-care services must by necessity embrace provision of prescription drugs which are needed to treat home care patients.

### **INTEGRATED FUNDING FOR HOME CARE AND OTHER HEALTHCARE PRIORITIES**

In the First Ministers' Accord, the federal government has promised to establish a five-year Health Reform Fund with financial support to address primary healthcare, home care and catastrophic drug coverage. The provinces will be allowed flexibility in utilizing the funds for any of the three priority programs. After five years, the funding for these three programs will be incorporated into the general federal healthcare fund, the Canada Health Transfer (CHT). At that point, provinces will not be obliged to utilize CHT funds for primary healthcare, home care or drug coverage.

Since home-care funding will initially be provided as part of the Health Reform Fund, there are no means of ensuring that any portion of the funding goes towards provincial home-care programs. Pooling of funds in the CHT after five years will increase the number of healthcare priorities to be addressed. Since home care interest groups may not be particularly strong, there is concern that “they [may] lose power as bit players competing for parts of the same pie with established interests, notably hospitals and, indirectly if not directly, physicians and pharmacare” (Chappell 2000: 92). It is feared that unless separate funding is established, the development of the home-care sector, particularly its LTC component, will be difficult to address (MacAdam 2000b). In response, Laurence Thompson, formerly CEO of the Saskatchewan Health Services Restructuring Commission, argues that dedicated national home-care funding is contradictory to the constitutional division of powers and historical trend in federal/provincial relations, and that federal attempts to steer provincial delivery of healthcare will lead to

unwieldy political squabble (Thompson 2000). Despite these challenges, Canada has in large measure succeeded in ensuring that Canadians across the country have access to quality facility-based healthcare due to the minimum quality standard mandated by the CHA. Care provided in the home is no less worthy of such protection.

### **CONCLUSION**

In this paper, we have critically examined the First Ministers' Accord with respect to future directives for home care. Although the Accord has not specified which services will be covered, by what time and for whom, we are concerned that home-care services will be limited to post-acute care recipients. If insurance coverage for non-professional services is not expanded, low-income elderly who incur significant costs due to their chronic care needs will continue to face difficulties in financing their home care and may end up costing the system more as a result of inappropriate hospital and facility admissions. Moreover, while we criticize the Health Accord 2003 for not addressing the home care needs of those with chronic illnesses, we also criticize it for not properly dealing with the needs of those receiving post-acute home care, particularly through the lack of legislation, sanctions or other mechanisms to establish national standards for care.

Although First Ministers have taken an initial step towards recognition of home care as a healthcare priority, the 2003 Accord falls short of Canadians' expectations for home-care reform. We recognize that there are significant barriers to success and genuine concerns about the sustainability of our publicly funded healthcare system in the face of increasing calls to expand the range of services included in the

publicly funded basket. However, services should not attract public funding solely because they are provided in a hospital or by a physician. Rather, services should attract public funding because they respond to healthcare needs and can be demonstrated to result in measurable health improvements. We must move towards a system that achieves this rather than creating further silos of funding and delivery. Failure to do so over the longer term will only increase the passive privatization of Canadian healthcare. The status quo is no longer acceptable.

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# Longwoods Review On-line

## Healthcare Costs in Alberta in Context after Corrections for Inflation, Population Growth, and the Aging of the Population: 1975–2001

Angus H. Thompson

<http://www.longwoods.com/LReview/OnlineExclusive/LROct04Thompson.html>

### Abstract

**Background:** Alberta is due for cost-containment and system reform as a consequence of a purported dramatic rise in healthcare costs. The problem with this justification is that the expenditure analyses underlying these claims have not included adequate consideration of the influences of inflation, population growth, the aging of the population or the improved performance of the economy.

**Design:** Estimates of Alberta government health expenditures for the years 1975 through 2001 were adjusted for population growth, inflation and the shift in the age-distribution of the Province's population. To add appropriate context, data were assembled on changes in (1) purchasing power over this time period and (2) out-of-pocket healthcare expenditures over the years 1988 to 2001.

**Results:** Overall government expenditure figures increased by about 900% over the 27 years of the study. However, when population growth, inflation and population aging were considered, the increase proved to be a more modest 65%. Moreover, personal income per person increased by 48.6% over that time leaving an effective increase in government healthcare spending of about 17.5%. For the

years 1988 to 2001, out-of-pocket expenses rose at double the rate of government expenditures. The shift in the age-distribution of the population had a relatively small effect.

**Interpretation:** There has not been a crisis due to rising healthcare costs over the last quarter century in Alberta. Thus, dramatic systemic and policy changes that are based on this belief are not justified.

## Addressing Patient Concerns about Visitor Restrictions During SARS: What Can Hospitals Do?

Joyce Nyhof-Young, Audrey Jusko Friedman, David Wiljer and Pamela Catton

<http://www.longwoods.com/LReview/OnlineExclusive/LROct04NyhofYoung.html>

### Abstract

**Background:** Cancer patients making their first visits to radiation oncologists at Princess Margaret Hospital in April 2003 during outbreaks of Severe Acute Respiratory Syndrome (SARS) were identified by staff as being particularly vulnerable to SARS-related hospital disruptions. The patients' responses to the provincially mandated Visitor Restriction Policy were investigated.

**Methods:** A convenience sample of patients (64 of 223 total visits) was contacted in August and September 2003, and audio-taped, semi-structured telephone interviews were conducted with 42 patients (25 males and 17 females) and eight family members (one husband, five wives, one son and one daughter, either jointly with the patient or separately) about

how SARS affected their treatment experiences at the hospital. The study had a 75% response rate, representing 19% of the patient population. Interviews were halted at data redundancy. Interview transcripts were analyzed and coded for emergent themes in the grounded theory tradition.

**Results:** Good staff communication and information provision within the hospital appeared to guide respondents through cancer treatments and allowed them to respond to the SARS crisis in ways that supported the hospital and helped them to comply better with and understand the exposure-control measures. The lack of such communication, especially before visits, appeared to hinder coping.

**Interpretation:** The provision of correct, relevant and timely patient information about a crisis, both external and internal to an institution, benefits both the hospital and its patients, and is a necessary priority for policy-makers concerned with providing patient-centred care. Hospitals require organizational structures and emergency communication plans that include patient education priorities. Recommendations are provided for patient-centred emergency policy development.

Commentary

## Visitation Restrictions in the Post-SARS Hospital Environment: A Policy Approach

Sharon Rogers and Joyce Nyhof-Young  
<http://www.longwoods.com/LReview/OnlineExclusive/LROct04RogersNyhof.html>