

# Strategic Purchasing in Home and Community Care across Canada: Coming to Grips with “What” to Purchase



PURCHASING

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## **Introduction**

Over the past two decades Ontario's healthcare system, like those in other industrialized jurisdictions nationally and internationally, has experienced converging demographic, economic and political pressures. These pressures have pushed policy-makers to rethink how health services should be funded and delivered.

On the one hand, after a period of constrained spending during the mid-1990s governments are once again confronted with rising healthcare costs, a situation that fuels public and political concerns about system sustainability. On the other hand, there is a growing sense that simply spending more

money might complicate, rather than cure, health-system ills. While Ontario's healthcare system continues to provide a wide array of publicly funded services on the basis of need, it is also characterized by a lack of integration between healthcare silos, including hospitals, physicians, home care, long-term care (LTC) facilities, community-based support services and public health. This lack of integration erects barriers to accessing care, thereby undermining care coordination and continuity and raising important questions about the appropriateness of the care that is provided. Rather than encouraging efficiencies or more innovative, cost-effective approaches to care, this fragmented system has instead reinforced

a tendency, particularly under conditions of fiscal constraint, for providers to attempt to shift costs elsewhere through referrals, earlier discharges, tighter eligibility requirements and service restrictions. It has also led the provincial government to try to limit its costs through capping service budgets, de-listing certain insured services and an unwillingness to cover new procedures and treatments.

It is in this context that, in 2006, Ontario established 14 Local Health Integration Networks (LHINs) responsible for planning, funding and monitoring hospitals, home care, community-based support services, community-based mental health and addictions services and LTC facilities (albeit not physicians, drugs or public health). According to the Government of Ontario (2006), “LHINs are a critical part of the evolution of health care in Ontario from a collection of services to a true system that is patient-focused, results-driven, integrated, and sustainable.”

Like other provinces, Ontario is now attempting to integrate its healthcare system at the regional level, emphasizing that cookie-cutter approaches will not work. Unlike regional authorities in other provinces, however, LHINs will not provide any services directly; rather, they will use budgets set by the province to purchase services from multiple and potentially competing providers (e.g., hospitals) that will continue to operate under their own governance. Policy-makers in Ontario thus confront a key question: What mechanism or mechanisms can LHINs employ to ensure their funding and purchasing decisions create the right incentives to generate a high-performing, responsive and innovative healthcare system?

In responding to this question, I focus in this paper on home and community care (H&CC), a sector that falls under the auspices of LHINs. Located outside of the medicare mainstream of medically necessary hospital

and physician care, H&CC encompasses a wide range of professional and non-professional health and social services (e.g., nursing and rehabilitation therapy services, Meals on Wheels, homemaking and transportation) aimed at helping people who need assistance to live as independently as possible in the community. Consumers include those who require minimal assistance with activities of daily living, as well as individuals with such high needs that they are at risk of hospitalization or LTC facility placement. Most of these consumers are seniors; however, other needs groups – including acute care patients discharged from hospital earlier than was previously typical before the number of hospital beds was reduced, persons with disabilities and a growing number of medically fragile children and their families – also utilize H&CC. A growing body of international research suggests that, when appropriately targeted, managed and integrated into the broader health services continuum, H&CC can play an important role in maintaining the health, well-being and autonomy of individuals and families, while reducing demand for more costly emergency, hospital and LTC facilities.

In the sections below, I briefly review the logic of strategic purchasing, now being positioned in Ontario as a key lever for forging a closer link between health outcomes and the approximately \$35 billion the province spends annually on healthcare (Ministry of Health and Long-Term Care 2006-07). I then describe the mix of approaches for funding H&CC currently used across Canada, noting that these almost always include some service provision by in-house staff. Additional questions arise out of my review of these approaches:

- To what extent can strategic purchasing, which assumes a high degree of individual agency and choice on the part of consumers, be applied in a sector populated by

- vulnerable and often dependent individuals (e.g., frail seniors)?
- To what extent can forms of strategic purchasing, particularly those involving elements of market competition, be expected to achieve performance gains in areas where services are in short supply or for relatively small but specialized-needs populations such as technology-dependent children?
  - Are there other, more fundamental, changes that need to be made before strategic purchasing can be expected to deliver on the promise of achieving a high-performing healthcare system?

A key take-home message is that, particularly in the complex field of H&CC, decisions about what services to purchase and for whom are as important, or even more important, than decisions about how to purchase services and from whom. Indeed, as the examples I give below demonstrate, a robust understanding of the purchasing context at the local level – including both demand- and supply-side variables and the social, political and economic forces that shape them – is a crucial prerequisite for defining clear objectives for purchasing, developing appropriate purchasing mechanisms and linking services to people in ways that serve their needs and contribute to health system sustainability. Even if efficiently purchased, the wrong services are never a bargain.

### **The Logic of Strategic Purchasing**

Strategic purchasing is only narrowly interpreted in the literature as a purchasing mechanism per se. Rather, it is a broad conceptual approach that emphasizes the active involvement of funders and consumers in decision-making around healthcare planning, funding and delivery.

Although the need for such involvement

might seem self-evident, it stands in contrast to the historical logic that governments should finance healthcare but leave responsibility for service delivery largely in the hands of providers. Canadian medicare is essentially a funding mechanism for medically necessary hospital and physician services. It sets clear conditions for eligibility, access and administration but does not direct service mix, volume or quality.

In Ontario, a main role of the provincial government has been to negotiate the size of the insured fee-for-service payment pool for physicians and the amount to be transferred to individual hospitals and community care access centres through annual global budgets – albeit with few performance benchmarks. While minimizing many of the perceived pitfalls of bureaucratic command-and-control structures, this approach has left the province with few tools (short of the blunt instrument of funding constraints) to encourage high performance, integrate care or ensure the attainment of social goals. However, as political pressure has built to address concerns around access, equity and quality – in the face of rising costs – there has been a push away from government as a passive purchaser to a more active role that requires “a continuous search for the best interventions to purchase, the best providers to purchase from, and the best payment mechanisms and contracting mechanisms to pay for such interventions” (World Health Organization 2000: 105; see also Custers 2006; Preker et al. 2006; McKee and Brand 2005; Duran et al. 2005; Department of Health 2006a, 2006b). Rather than withdrawing from healthcare in favour of private markets, since this could also make the attainment of social goals such as equity and access problematic, strategic purchasing points toward public agencies taking a stronger role in the quest to ensure that such goals are met by assessing health needs, using evidence to develop models of care that meet priority

needs, creating the appropriate combination of regulations and economic incentives to implement those models and then evaluating the results (Preker et al. 2006).

The idea of individual choice and agency is also key to the logic of strategic purchasing. In its groundbreaking report on improving health system performance, the World Health Organization (WHO) describes strategic purchasing and emphasizes that final purchasing decisions are to be made by individuals armed with sufficient knowledge to select among high-performing providers (2000). Rather than following the money and taking what's given, consumers are now to use evidence to choose among alternatives, thus establishing incentives for providers to be more responsive and to perform at a higher level. As the recent report in the United Kingdom (UK) on the commissioning of health services also points out, however, individual choice will almost always be qualified by structural factors, including an individual's capacity to access and apply often complex technical information about services and service alternatives and by the availability (and sometimes short supply) of needed services (Department of Health 2006a). Such qualifications might be particularly marked in H&CC, where relevant information about alternatives; remains difficult to access; where, particularly outside of urban centres, there might be few providers and few service alternatives; and where vulnerable, often dependent individuals – such as frail seniors and those with cognitive impairments, mental illness or literacy problems – might face formidable obstacles in navigating healthcare silos.

### **Approaches to Funding and Purchasing H&CC across Canada**

In spite of growing interest in improving health system performance in Canada and internationally, there is little published

research documenting and evaluating different funding and purchasing mechanisms, particularly outside of the acute care sector (McNamara 2006). In Canada, a continuing lack of evaluation of regionalization initiatives that integrate H&CC compounds this general lack of evidence.

In part, this lack of evidence reflects policy-makers' continued preoccupation with acute care. It also reflects the challenges associated with measuring soft outcomes such as quality of life and well-being; the fact that many circumstances and factors beyond the healthcare system – including the presence of family carers, social connectedness and the broader determinants of health – strongly affect outcomes; the reality that many individuals – particularly frail seniors – experience functional decline and death regardless of the quality of care provided and that many of those who depend on H&CC – including frail seniors, children with continuing complex care needs and persons with mental health problems – are among those least likely to be able either to exit from services that do not meet their needs or to voice their concerns about inadequate or inappropriate care (Baranek et al. 2000, 2004; Williams et al. 1999).

Nevertheless, the grey literature in this sector is growing, albeit slowly. A scan of this literature suggests that no single approach to funding and purchasing “fits all” – a mix of approaches is currently used for H&CC within and between jurisdictions across Canada. For example, Alberta's East-Central Health Authority directly provides in-home nursing, rehabilitation services, respite and home support personal care; coordinates access to meal programs, home support, homemaking and home maintenance; refers clients to day hospitals and group homes and directly provides or coordinates home care services for children with complex care needs (Hollander 2007). Three cases below highlight

three different approaches: coordination of care across multiple providers, self-managed care models and managed competition.

### **Program of Research to Integrate Services for the Maintenance of Autonomy, Quebec**

An inter-sectoral cooperative model is at the core of Quebec's Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) that aims to meet the care needs of frail seniors (Hébert et al. 2003a, 2003b; Hollander 2007). In contrast to fully integrated models – in which a single entity subsumes different elements of the care delivery system under one administrative structure – this model relies heavily on coordination among independent providers (funded through different sources), which retain their own governance but agree to participate under an umbrella system. Coordination takes place at multiple levels, including the strategic or governance level (through creation of a joint governing board comprising senior directors/decision-makers from different provider organizations); the tactical or management level (through a service coordination committee comprising intermediate-level managers who facilitate and monitor the service delivery continuum); and the clinical or operational level (where case managers evaluate clients' needs and manage care delivery).

PRISMA has several features that promote the most appropriate use of services across the continuum (Hébert 2006):

- A single point of entry
- Support for frail seniors who require multiple services and complex service coordination by case managers who assess needs, plan services, negotiate and coordinate required services and ensure that services are provided
- A single assessment instrument that elaborates a case-mix classification system

used to determine the service needs of individuals and populations

- An inter-institutional electronic clinical chart that makes critical information available to providers and consumers in real time

### **Self-Managed Care Programs, Alberta**

A second approach relies heavily on the capacity of individuals and families to identify needs and purchase services. A range of self-managed care models are now being used by seniors, persons with disabilities and children with continuing care needs (Spalding et al. 2006). Three such models are found in Alberta.

Alberta's Self-Managed Care Program is available to people of any age who are eligible for home care, have stable medical conditions or care needs and require personal care services. Applicants are assessed by an occupational therapist who determines the number of hours of care an individual is eligible for per month and assigns a care budget. Care recipients may receive funds directly into their bank accounts to hire and train care providers or they may elect to have family members or friends manage funds and care on their behalf. Consumers who are legally incapacitated (e.g., people with developmental disabilities, seniors with dementia) may have their care managed by a legal guardian.

Alberta's Individualised Funding Program is available to people over 18 years of age who are assessed (usually by a physician or through a school program) as having a developmental disability (defined as having significantly below-average intellectual capabilities) and require assistance in at least two areas. The majority of individuals in this program require assistance to self-manage. With the aid of a family member or client-service coordinator, the individual must submit a plan of care that outlines his or her support and financial needs. To receive funds, individuals must either

designate a funds administrator or arrange to have their service providers paid directly.

A third Alberta approach involves the conversion of publicly funded LTC facility beds into designated assisted living units (Armstrong and Deber 2006). While conventional nursing homes offer a range of bundled services paid through a combination of public funding and resident charges, this form of assisted living offers lower accommodation fees but shifts more responsibility onto residents and their families for purchasing and managing services. For instance, according to a recent review (Armstrong and Deber 2006), conversion of a nursing home to assisted living units in the town of Hinton has meant that housing and support services (e.g., meals, laundry, cleaning, emergency call systems) are now private contractual arrangements between operators and residents/families, who must also take on direct financial responsibility for a range of medically necessary products and services and for managing other services (e.g., nursing, physiotherapy) that have moved off site. While thus offering care recipients and carers greater control, questions have arisen regarding the capacity of high-needs individuals who are eligible for LTC placement to access and manage services themselves and about the availability of service options in smaller centres.

### **Managed Competition, Ontario**

A further approach introduces competitive market forces into the purchasing process. In 1996, Ontario launched a managed competition model for procuring home care services as a means of achieving “highest quality” at the “best price” (Randall and Williams 2006). While competition was seen as a mechanism for encouraging innovation, responsiveness and cost-efficiency, the process itself was still to be managed so that the lowest price did not trump goals such as quality and accessibility.

As part of its reform, the government created 43 community care access centres (CCACs) – recently restructured to create 14 larger CCACs under the auspices of LHINs – that serve as single points of access for individuals requiring professional home care services (e.g., nursing, rehabilitation therapy), placement in LTC facilities (e.g., nursing homes) or referral to community-based support services (e.g., Meals on Wheels, transportation) (Baranek et al. 2004).

From an operational standpoint, the CCACs represented a dramatic departure from the logic of the home care programs that preceded them. Rather than more or less automatically relying on established, mostly not-for-profit providers and rolling-forward service contracts, the reform required that contracts be awarded on the basis of a competitive request-for-proposal bidding process open to for-profit and not-for-profit providers. Moreover, often due to difficulties in finding external contractors, CCACs that had previously provided some services (e.g., nursing, rehabilitation) in house were no longer permitted to do so. Instead, they were to divest staff that would then, presumably, compete for service contracts. In a number of cases, however, CCACs were unable to divest because providers were unwilling to bid for contracts (Randall and Williams 2006; Williams et al. 2005).

As the 2004 report of the Office of the Provincial Auditor and a subsequent provincially commissioned report concluded (Caplan 2005), a lack of evidence, information and benchmarks hampered systematic evaluation of the impact of managed competition on quality, client outcomes and overall home care performance. Nevertheless, Caplan concluded that service quality had improved due to the competitive bidding process. Two more recent studies (Randall and Williams 2006; Williams et al. 2005), however, suggest important limi-

tations to this process in two areas characterized by high specialization and low volume: paediatric and rehabilitation home care.

The first limitation involves the introduction of competitive bidding, which appears to have complicated existing health human resource shortages. Uncertainty and the cost of producing bids resulted in few bids from providers, with fewer individuals willing to work in the sector given higher wages and more stable work environments in proximate sectors (e.g., hospitals). Second, the combination of short supply and limited competition contributed to higher bids, particularly outside urban areas where there were fewer providers and individual professionals had more market leverage. Third, significant overhead costs were incurred as a result of the competitive bidding process, both by the CCACs, which managed the process, and by providers, which now had to produce detailed bids. In 2001, for-profit and not-for-profit providers estimated that overhead costs accounted for between 20% and 35% of CCAC expenditures (Ontario Home Health Care Providers Association and Ontario Community Support Association 2001). Fourth, given capped CCAC budgets, higher service costs led to lower service volumes and reduced access. Finally, the competitive process was widely seen to have established a disincentive to collaboration and the sharing of evidence and best practices because providers were increasingly concerned they might lose their competitive edge.

### **Toward an Integrated Continuum**

My brief review suggests that a range of different approaches to funding and purchasing H&CC are now being used across Canada, albeit with little evaluation of outcomes. Two additional examples, however, offer preliminary but persuasive evidence that, regardless of how services are funded and purchased, integrating and managing H&CC

within the broader healthcare continuum is a crucial prerequisite for attaining many of the individual and system-level goals associated with strategic purchasing.

### **Vancouver Coastal Health**

The first example concerns Vancouver Coastal Health (VCH), a regional health authority in British Columbia (BC) that provides a comprehensive range of health services and programs – including hospitals, community-based care, residential care, home-based care and mental health and public health services – to over one million people (25% of BC's population) in communities stretching from Richmond and Vancouver (Rigg 2006; see also Goodreau's contribution to this collection). VCH is noteworthy in that it has explicitly linked community-based services to performance benchmarks in the acute and LTC sectors. For example, as part of its alternate level of care ALC bed strategy, VCH aimed to reduce the number of acute and rehabilitation in-patient beds occupied by individuals who could not be discharged due to a lack of appropriate community care options. In addition to using costly hospital beds inappropriately, it was estimated that seniors in ALC beds lost up to 5% of their functional capacity each day they spent in hospital. VCH also aimed to reduce the number of LTC beds as well as inappropriate use of hospital emergency rooms (ERs).

Although a comprehensive evaluation has not yet been completed, preliminary results appear remarkable. By providing integrated, case-managed care targeted particularly at high-needs individuals, an estimated 500 LTC beds have been closed; individuals with lower needs can now be directed toward assisted living. Moreover, through a combination of measures – including transitional care units, priority placements for patients waiting in acute care and increased home support budg-

ets – ALC days dropped from 12% to 6% (with a final target of 4%), thereby freeing up additional resources for community care. Finally, through the introduction of geriatric nurses in hospital ERs who diverted inappropriate admissions to community care, an equivalent of 17 in-patient beds were saved. Currently, VCH is developing partnerships with family physicians aimed at integrating primary care into its continuum.

### **The Veterans Independence Program**

A second example is the federal Veterans Independence Program (VIP). This program offers a comprehensive suite of services to 103,000 clients. Services include the following (Pedlar 2006):

- Assistance with daily personal care (e.g., bathing, dressing)
- Health and support services provided by professionals (e.g. nurses, occupational therapists)
- Access to nutrition (e.g., Meals on Wheels)
- Housekeeping (e.g., laundry, vacuuming, meal preparation)
- Grounds maintenance (e.g., grass cutting, snow removal)
- Ambulatory health assists outside the home (e.g., adult day care, health assessments, diagnostic services)
- Transportation to activities (e.g., shopping, banking, visiting friends) when transportation is not otherwise available
- Home adaptations to facilitate access/mobility (e.g., modifications of bathrooms, kitchens, doorways)
- Nursing home care in the client's community if/when he or she can no longer remain at home

VIP's success in substituting community-based support services for residential care is

particularly noteworthy. Prior to VIP's implementation, aging veterans had experienced growing wait lists for contracted LTC beds; it was estimated that 20,000 beds would be required to meet their needs (Pedlar 2006). As an alternative, VIP offered wait-listed veterans community care packages in their own homes or in settings such as supportive housing. The result was that most veterans preferred to stay at home and, following VIP's implementation nationally in 2003, LTC wait lists were virtually eliminated. Moreover, the most-used services for these at-risk individuals proved to be homemaking and grounds maintenance.

Note that most of the services provided by VIP are contracted out, or accessed through provincial programs. What seems to be key is the important role of the case manager in assessing needs, planning care, managing access to appropriate care across the continuum, following up to ensure care continuity and managing care transitions.

### **Discussion and Conclusions**

Faced with rising costs and growing challenges on both the demand and supply sides, governments in Canada and other industrialized countries are now seeking ways to provide high-quality, cost-effective and appropriate care to aging and increasingly diverse populations. In Ontario, the government has positioned strategic purchasing as a lever for improving health system performance. In its narrowest conceptualization, strategic purchasing refers to specific purchasing mechanisms. Conceptualized more broadly, however, strategic purchasing encompasses the dynamic processes of strategic thinking and action through which funders continuously assess needs as well as plan, fund and evaluate services. H&CC's greatest potential lies within this broader conceptualization.

An expanding grey literature clarifies that a mix of approaches is now being used across

Canada at the regional level to fund and purchase H&CC. This literature also clarifies that, regardless of the funding and purchasing approach used, the most notable successes involve initiatives that integrate and manage care across the continuum and that therefore permit H&CC to be substituted, where appropriate, for more costly care in hospitals and institutions. When provided in a fragmented system, or to individuals who do not require them to avoid functional decline or related health problems, support services such as grounds maintenance and housekeeping are unlikely to be more than a convenient cost add-on and a source of concern for policy-makers. However, as the VIP example shows, when provided within an integrated package to individuals at risk of becoming ill or losing independence, such services can effectively substitute for LTC facility care. The VHA example further suggests that targeted, managed and integrated H&CC can relieve pressure on hospital ALC and ER beds, key concerns in Ontario and many other jurisdictions.

Conversely, a failure to acknowledge H&CC as a crucial element of the healthcare continuum can have negative consequences for individuals and health system sustainability. For example, Hollander (2004) observes that a continuing preoccupation with curative, institutionally based care actually fuels a cycle of increasing costs as individuals, lacking lower-level community-based care, end up making greater use of more costly hospitals and LTC facilities. This, in turn, draws more resources away from the community sector, leading to further rounds of increased demand on hospitals and facilities.

With respect to the role of individual agency and choice, case-management models seem to be important, particularly for vulnerable, high-needs individuals and their carers. A key factor in VIP's success is the ability of

case managers to select appropriate services from across the continuum. This is consistent with the recent policy thrust in the UK (Department of Health 2005), which differentiates between the majority of the population that requires only minimal support or information to self-manage; a smaller, but still significant group that includes people who require specialist support to manage their care; and a small minority of high-intensity users of unplanned secondary care who are to be assigned a case manager to anticipate, coordinate and integrate needed healthcare and social care services.

The question is not whether individual choice is important, but how best to support choice. Indeed, the Alberta self-managed care options suggest that individuals with different levels of need will require different levels of support. They also underline the fact, recognized by a recent UK report (Department of Health 2006a), that choice depends both on the capacity of individuals to negotiate services (which will be limited particularly for people with complex, long-term conditions) and on the availability of service options (which also may be limited, particularly outside of urban areas).

With regard to the use of competitive market models, Ontario's experience with managed competition suggests some related cautions. Particularly where services are in short supply, competitive models might result in higher service costs, higher overhead costs and reduced access to care. They might also create disincentives toward collaboration and the sharing of best practices, crucial requirements for overcoming silos, allowing cost-effective substitutions and encouraging high performance at both the provider and system levels.

This brings me back to my key take-home message: Particularly in the field of H&CC, which is heavily populated by vulnerable

individuals at the margins of dependency and institutionalization, decisions about what services to purchase and for whom are as important, or even more important, than decisions about how to purchase services and from whom. No matter how efficiently purchased, LTC, ER and ALC beds are never going to be a bargain for individuals or the healthcare system if more appropriate – and more cost-effective – H&CC options are available. Indeed, as noted, a continued preoccupation with finding solutions within the mainstream of the hospital and physician system might actually prove to be counterproductive if it means that individuals lacking lower-level services closer to home can access care only after they become ill or dependent. This point emphasizes the importance of conceptualizing strategic purchasing as a dynamic process of strategic thought and action – one that involves policy-makers, individuals and carers – aimed at integrating services across a continuum that includes both institutional care and H&CC.

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