The Authors Respond

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Introduction

We would like to thank all of the commentators for their thoughtful contributions. Our purpose in writing the paper was to stimulate discussion and debate on the issue of an appropriate societal policy response to an aging population in Canada. We wanted to focus on the full range of factors that can have impacts on older persons, from the population health and environmental context to actual care delivery for people with ongoing care needs. Over the next few decades, there will be an increasing number of older people with chronic health conditions in Canada. Over the past decades, we had a younger population whose members often needed acute interventions. Thus, the focus was on acute care hospitals. This pressure, and the Canada Health Act, which insures only hospitals and medical services, has led, as Cripps notes, to a system focused on sickness rather than health. In the future, we shall need a high-priority focus on longer-term healthcare for an aging population. Continuing care, not acute care hospitals, will be the vehicle for providing that care.

While we value the comments of each contributor, something else has emerged from the authors' comments. In our view, taken together they foreshadow much of the type of discussion and debate we shall have in Canada on policies for older adults going forward. As such, we welcome the opportunity to comment on, and clarify, the issues noted in our paper in order to advance, and refine, future policy discussions regarding older persons.

Given the number of commentators and both the commonality of comments as well as the differences of opinion across commentators,

we do not provide specific responses to each one. Rather, we have organized our response into several policy and program issues that have been raised. We do, however, make reference to specific commentators, as appropriate.

What We Mean by Integration

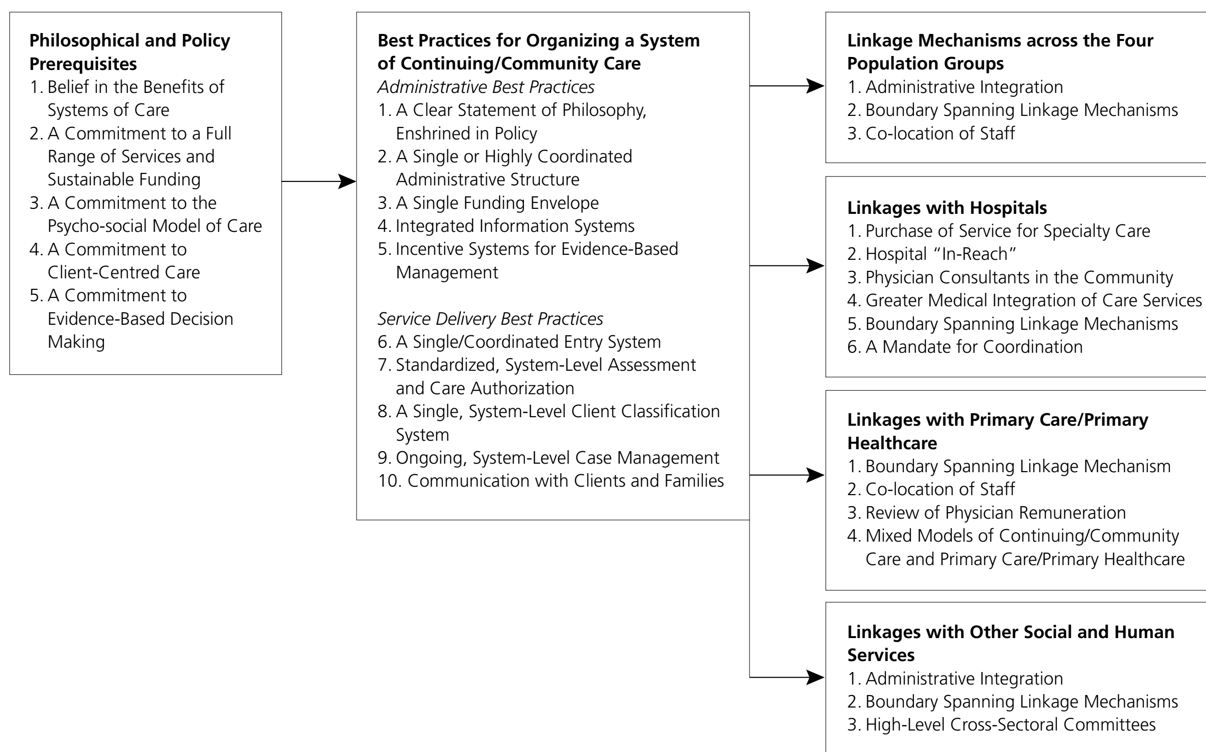
One of the issues that became clear in the commentaries was that, going forward, people may well have different definitions of, or perspectives on, *integrated care*. In addition, some may use the term to call what they are doing integrated care if and when the term becomes the flavour of the month. This is not unreasonable given that one could have integrated systems that go from small to large systems. In addition, systems may be developed locally or at the regional or provincial/territorial levels. Examples of what we would consider complementary subsystems within a broader integrated system are the hospital-based system described by Sinha and the primary care system discussed by Heckman.

Our view is that an integrated system needs to be broad and combine a wide range of health and supportive services, including case management, home care and home support services, supportive housing and residential care, and geriatric assessment units in hospitals. It should also have a single administrative authority and a single funding envelope that allows leaders in that system to increase value for money by making proactive trade-offs to substitute lower-cost care for higher-cost care, while maintaining the same, or better, quality of care. In our view, this ability to substitute, and keep the money, is a key hallmark of an integrated system. Thus, an integrated system of care delivery is consistent with the framework present by Hollander and Prince (2007; Figure 1). This framework can be adapted to local conditions. For example, it would be possible to keep many of the best practices in a system that evolves at the local level such as the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) model in Quebec.

There are three components to the framework: values, best practices and linkages with other components of the healthcare system. The framework also notes potential linkage mechanisms. Continuing care could link with hospitals by funding geriatric assessment and treatment centres, and quick response teams, in hospitals. The elder-friendly hospital service delivery model noted by Sinha could form another approach to linkage and collaboration.

There are numerous approaches to linkage with primary care, with excellent developments over the past decade in regard to chronic disease management. The Chronic Care Model would be an excellent component of a broader continuing care system, particularly for patients with high care needs. Examples of this approach include the Comprehensive Home Option of Integrated Care for the Elderly (CHOICE) in Alberta, Système intégré pour personnes âgées fragiles (Integrated System for Frail Elderly Persons; SIPA) in Quebec and the Program of All-Inclusive Care for the Elderly (PACE) in the United States. Thus, one could have linkages between continuing care and the Chronic Care Model by, for example, co-locating case managers in physician group practices. Thus, the Chronic Care Model could be a valued adjunct to continuing care, or even an important type of service within a broader continuing care model; but, in our view, it is not a substitute for a broader system of integrated continuing care. An integrated chronic care model would need, for example, to incorporate capitation funding, general practitioner fund-holding and the ability to purchase a range of services as needed by clients in order to make cost-effective trade-offs. Finally, multidisciplinary teams and the other components of the Chronic Care Model make the

Figure 1. A best practices framework for organizing systems of continuing/community care services



Source: Reproduced with permission from Hollander and Prince (2007).

most economic sense if they are primarily targeted to clients with high care needs.

Finally, we wish to be clear that our vision of an integrated system would also include tertiary prevention and care for people with legitimate, but lower-level, care needs such as home maintenance (e.g., housekeeping). These services are still available to persons with care needs related to the instrumental activities of daily living in a number of provinces and territories and in the Veterans Independence Program at Veterans Affairs Canada. Our approach would mean reintroducing home care/home support for these types of persons in jurisdictions with a current eligibility requirement that the client be in need of personal care services to receive home care/home support services. This would mitigate against the increasing cost spiral noted in our paper.

Current Context and the Federal Role

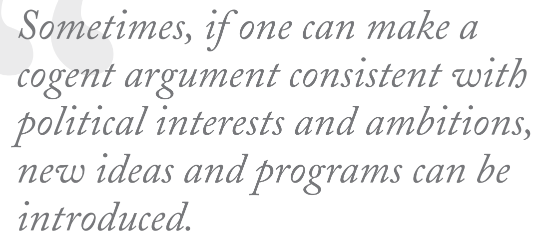
Henningsen, McAlister and other commentators note the importance of renewing the federal/provincial/territorial health accord in 2014. We agree but would prefer that the accord focus on integrated continuing care rather than home care per se. A fear was also expressed that there are those who have an economic interest in making the current healthcare system dysfunctional in order to introduce a private system. As a corollary, concern has been raised that in some quarters efforts may be under way to discredit the perception that government programs can work to the benefit of Canadians. As a counter to these points, a number of commentators state that there is a need for vision and leadership at the federal level. Finally, many commentators note the futility of trying to

bring about change in the current political and social climates.

We are of the view that some form of federal leadership would be helpful. This could be active leadership or more passive leadership where vehicles such as the health accord, or other mechanisms, are used to provide financial support for provincial and territorial initiatives related to enhancing integrated continuing care systems. While federal leadership is preferable, integrated continuing care systems can be mandated and developed at the provincial level without federal leadership.

MacAdam questions our use of the term *re-validate* regarding continuing care. We recognize that there are already a range of different systems across jurisdictions. Our call is for validation, or re-validation, at the federal level. Over the past 10 years, federal/provincial/territorial accords and high-profile commissions and committees have not recognized continuing care as a distinct component of our healthcare system; and the one major national policy document (the report of the Special Senate Committee on Aging [Carstairs and Keon 2009]) that does promote a range of policy options, including an integrated continuing care system, seems to have been ignored by policy makers.

Re-validation of continuing care could have a number of positive consequences. It could mean that the Canadian Institute for Health Information would present health data in such a manner that it would be possible to clearly document the costs (and therefore policy relevance) of continuing care. Federal and provincial/territorial collaboration could result in the establishment of assistant or associate deputy ministers of health for continuing care at the three levels of government and, possibly, their coming together in a federal/provincial/territorial advisory committee on continuing care to further develop and refine the continuing care sector. Provinces could encourage regional health authorities to have vice-presidents of continuing care, providing the sector with senior champions to deal with other components of the healthcare system.



Sometimes, if one can make a cogent argument consistent with political interests and ambitions, new ideas and programs can be introduced. In addition, as recent international events have demonstrated, what is current now is subject to change, often rapid change. Periods of relative stability, or discouragement, can be used to prepare for unanticipated future events so that proponents of a particular issue (e.g., integrated continuing care) can move quickly and effectively to take advantage of opportunities when they do develop. The political climate, key actors, public perceptions and so on all evolve over time. Opportunities to act do come but are not frequent, and, if missed, one may have to wait several years for another opportunity. As researchers and policy analysts, we have prepared a policy prescription that, while not perfect, seems reasonably credible. It is up to senior officials and political leaders to determine if, and when, action can be taken to implement the policy prescription. At least they will have a prescription to consider. Finally, we expect that the time will come, possibly sooner than people think, that a leading individual, organization or political party will determine that it is in its personal or political interest to become a champion for

seniors and effective policy around seniors' issues. This happened in British Columbia in the late 1970s when the Social Credit government established the continuing care system.

> *To allow prevailing political interests to prevent working toward a different system is to contribute to prolonging the status quo or having undesirable change rule the day.*

Similar events happened in Manitoba and, later, in Saskatchewan and elsewhere. Thus, developing integrated systems of care has occurred in the past in Canada and, in our view, can happen again. To allow prevailing political interests to prevent working toward a different system is to contribute to prolonging the status quo or having undesirable change rule the day.

Policy versus Politics

A few of the commentators make remarks reflective of the tension between policy and politics. For example, Carstairs and MacDonald state that government should reject throwing money at the latest problem to get headlines and should focus, instead, on the longer term. Ellen and Shamian note that cutting social supports can have negative, unintended consequences in terms of productivity losses if people have to leave work to care for a family member. We recognize that popular issues of limited scope make for good politics and that this tension will continue to exist. This does not obviate the need for more comprehensive, strategic thinking (i.e., good policy). Furthermore, if packaged and presented appropriately, with effective knowledge transfer techniques, there are circumstances where good policy can also make for good politics. If one can communicate to the public and decision-makers in such a way as to clearly illustrate the different consequences stemming from an integrated system versus a splintered/stovepiped system, it may be possible to convince those in authority that doing right by Canadian seniors is the right thing to do. In addition, seniors are a significant and growing proportion of the electorate, who can make their voices heard if and when they realize their lives could be significantly improved if governments make different policy choices. Finally, there is now good evidence that we can provide cost-effective care in an integrated system. Failure to do so may lead to continued escalation in hospital costs. Thus, as the expression goes, "you can pay me now or pay me later."

Other Issues

A range of other issues are also raised by the commentators. Evans and Wister each point out that there are mixed results in terms of research on the compression of morbidity. We agree. A few commentators note that Canada spends a relatively small percentage of its gross domestic product on long-term care compared with other countries in the Organisation for Economic Co-operation and Development, and that most of the funds expended go to facility care. Thus, at least on a comparative basis, Canada should have room to make strategic investments in continuing care. Hébert presents a detailed description of a system of social insurance that could provide funding for continuing care services. If there is too much resistance to more fully funding continuing care through the income tax system, his ideas represent an alternative. However, integrated systems are most effective if all of the key components are under one umbrella and are closely linked to other parts of the healthcare system. Thus, it is important to think about

where new money flows and the extent to which, and mechanisms by which, such funds can flow to a broader health and social services system rather than to a stand-alone continuing care system.

Carstairs and MacDonald and others note the importance of population health, health promotion, combating ageism, disease prevention and age-friendly communities. There is much evidence as to their importance as fundamental causes of good health (e.g., see Wilkinson and Marmot 2003); preventing ill health is a major solution for reducing healthcare costs (Keefe et al., 2007) (although improved economic efficiencies will not necessarily follow unless other measures are also put into place). The value-for-money vehicle in our formulation is found in the argument for integrated systems of continuing care. Finally, while we believe that population health and disease prevention are important, we also argue that effective and targeted tertiary prevention could have significant economic benefits.

Finally, a few comments on points raised by Evans, whom we both admire and respect for his intellectual contribution to health economics and health policy, and his stimulating comments. The topic of why continuing care declined in the 1990s would be good for one or more doctoral dissertations in health policy. Space does not permit reiteration of the past here, but we will say that there were very few national level champions for continuing care and it was not possible to counter shifts in policy to other priorities, in addition to the severe budget pressures of the mid-1990s. We do wish to stress that, in our opinion, the decline in continuing care was in no way related to a fundamental flaw in its formulation.

With regard to the issue of "savings," there are always pressures on resources. For example, if one frees hospital beds, they only get filled up again. We argue that the appropriate frame of reference is cost avoidance and value for money. Making the system more cost-effective reduces pressures and allows for delays in, for example, future bed construction. Finally, we would argue, in regard to the iron rice bowl, that a continuing care system would have impacts on healthcare providers as all change results in a shift in winners and losers; but at the level of healthcare workers, it would be a shift from facility care providers to community care providers.

Our hope is that research into a Canadian healthcare system that will meet the needs of an aging society will continue and that, despite the political odds against appropriate changes in the system at any one time, dialogue will persist on how best to change our current system.

References

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