

# Community-Based Reform Efforts: The Case of the Aging at Home Strategy

## Efforts pour une réforme axée sur la communauté : le cas de la stratégie Vieillir chez soi



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### Abstract

This paper considers one of Ontario's largest reform efforts: the Aging at Home Strategy (AHS). The AHS was initiated in 2007 to enable people to live independent lives in their own homes. A document review was conducted on relevant government materials to assess the goals and objectives of the AHS as it was rolled out over the course of three years. The findings identify that by the third year of the AHS, there was a reduction in the discretionary powers of the regional health authorities to allocate funds based on local priorities. These findings also highlight that the "mainstream" subsectors of the healthcare system – medical

and hospital services – and those outside the mainstream (or the “marginal” subsectors) face different institutional boundaries, policy legacies, political actors and policy agendas. While interests within the mainstream subsector are organized and institutionalized, the marginal subsectors are fragmented, creating a power imbalance where the priorities of the mainstream subsector dominate.

## Résumé

Cet article traite d'un des plus grands efforts de réforme en Ontario : la stratégie Vieillir chez soi (VCS). Cette stratégie a été créée en 2007 afin de permettre aux personnes de vivre en autonomie dans leurs propres foyers. La documentation gouvernementale pertinente a fait l'objet d'une revue afin d'évaluer les buts et objectifs de la stratégie VCS sur une période de trois ans. Les résultats indiquent qu'après trois ans, il y a réduction du pouvoir discrétionnaire des autorités régionales de la santé leur permettant d'allouer les fonds selon les priorités régionales. Ces résultats mettent également en lumière le fait que les sous-secteurs « dominants » du système de santé – services médicaux et hospitaliers – et ceux hors du courant dominant (c'est-à-dire les sous-secteurs « marginaux ») font face à différentes limites institutionnelles ainsi qu'à divers acteurs, programmes ou traditions politiques. Alors que les intérêts du sous-secteur dominant sont organisés et institutionnalisés, les sous-secteurs marginaux demeurent fragmentés, ce qui crée un déséquilibre des pouvoirs où les priorités du sous-secteur dominant l'emportent.



## Introduction

Policy makers across high-income countries face the challenge of sustaining already stretched health and social care systems while also meeting the needs of aging populations. In addition, increasing evidence suggests a need for broader community care options (Donner et al. 2015; Drummond et al. 2012; McNeil and Hunter 2014; Sinha 2012; Williams et al. 2016). Community care aims to maintain people and their caregivers as independently as possible, for as long as possible, in their own homes and communities through coordinated access to health and social supports – professional homemaking, attendant care, affordable housing. Such policies respond to the desire for people to age in familiar settings, and the growing perception that lower cost community-based care can substitute for more costly, and often inappropriate, care in hospitals and long-term care institutions. Yet, as we demonstrate, policy change aimed at building up community care options has been hard to achieve.

This paper considers the historical legacy of policy decisions for older persons in Ontario, Canada. We discuss policy priorities in the community subsector and the implications this has for the delivery of long-term care services. To do this, we rely on an analysis of one of Ontario's largest community-based reform efforts: the Aging at Home Strategy

(AHS). The AHS was initiated in 2007 by the Government of Ontario to enable “people to continue leading healthy and independent lives in their own homes” (Williams et al. 2009). The strategy was supported with a financial outlay of approximately \$1.1 billion over four years seeing an increase of \$143.4 million for community-based programming in the first year alone. The AHS was a provincial-level strategy, to be implemented regionally by the newly created Local Health Integration Networks (LHINs). This was the first large-scale initiative to be led by the newly implemented regional health authorities in Ontario – the LHINs (MOHLTC 2007). The LHINs were established in 2006 under the authority of the *Local Health System Integration Act* (LHSIA). The LHSIA set out that each LHIN be governed by a board of directors appointed by provincial Cabinet, and each LHIN establish an accountability agreement with the province that outlines performance goals, targets and standards (LHSIA 2006). The LHSIA also ensured that the provincial government may set provincial priorities in order to provide direction to the regions. The LHINs’ mandate included the planning, funding, and coordination of hospital, community support, long-term care, mental health and addiction, and limited primary care services within their respective regions. Independent physician services remained outside of the LHIN mandate. The LHSIA provided LHINs with the ability to reallocate funds among service providers, but unlike regional health authorities in other provinces, the LHINs had no responsibility for service delivery. This means that pre-existing healthcare delivery organizations remained intact.

Our analysis is presented in two sections: first, we highlight the history of community care in Ontario and present an overview of reforms to the community care subsector over nearly a decade. Here we also briefly discuss strategies that were intended to fundamentally redesign our health and social care structures.

Second, we highlight one of Ontario’s largest attempts at community care reform: the AHS. We rely on findings from a document review where we track the objectives of the AHS over a three-year period. We conclude with an analysis of the AHS within the context of the policy literature to identify theoretical lessons learned and explore the challenges of attempting to implement reform efforts in the community care subsector.

## Background

Canada’s healthcare system is an amalgamation of 13 provincial and territorial healthcare systems. National consistency in the funding and delivery of healthcare services is maintained by federal contributions to healthcare funding, which are conditional on the provinces and territories adhering to the provisions of the *Canada Health Act*. The *Canada Health Act* applies only to “medically necessary” services, which has been interpreted to refer only to hospital and physician care (Romanow 2002b). Other healthcare sectors, including the community care subsector, remain largely on the periphery and the funding and delivery of these services varies considerably across Canada.

In Ontario, starting in the early 1990s, community care has seen a series of significant and contrasting reform efforts and recommendations that altered the delivery of

community-based services. The first significant change was implemented in 1993 when the left-of-centre New Democratic Party government introduced the Multi-Service Agency (MSA) model (Williams et al. 2016). The implementation of the MSA legislation formally moved community care outside the auspices of the “mainstream” medically necessary hospital and physician services – thereby having distinct sub-entities that compile Ontario’s healthcare sector.

Appeals for the expansion of community care were featured in the recommendations of the Ontario Health Services Restructuring Commission (HSRC) – a body established in 1996 with a mandate to make decisions on restructuring Ontario’s public hospitals, and to make reinvestments in other subsectors to support the restructuring process (Baranek et al. 2004; HayGroup 1997; Ontario Health Services Restructuring Commission 2000; Williams et al. 2016). The HSRC recommended an expansion of the number of long-term care “places,” which included increased community care capacity, institutional care beds and maintenance of patients in the lowest level of care possible. In fact, the HSRC recommended an expansion of 388 long-term care places by 2003, 40% of which were to be beds in institutional settings. However, in 1998, the Ontario Progressive Conservative Party led by Harris responded with the announcement of a 20,000 institutional long-term care bed expansion over the following six years (Williams et al. 2016). These investments largely failed to address demands to improve capacity in the community care subsector. In 2002, the “Romanow Report” noted that community care needed to be considered the next “essential service” in order to see gains made to improve the health sector (Romanow 2002a; Williams et al. 2016).

In 2007, the Ontario Government announced the implementation of the \$1.1 billion AHS, which had the explicit aim of enabling people to live independently in their own homes, by shifting resources to the community (MOHLTC 2007). In 2008, the provincial government championed a parallel initiative in the hospital subsector aimed at reducing alternative levels of care (ALC; people who remain in the hospital but who do not require that level of care) and emergency department wait times (Guerriero and Nord 2009).

Recommendations to place greater attention on the community subsector are not new – the AHS was a continuation of previous efforts to shift care to the community to lower the burden on the hospital and physician subsectors. However, the AHS was also a test case for regionalization in Ontario, and the ability of the LHINs to deliver on their promise of local integration. In addition, the AHS brought greater attention to the issue of aging in place and to the expanding role of the community care subsector.

Although, as we will demonstrate, large-scale initiatives like the AHS are not implemented in a vacuum. Historical factors impact implementation and decisions are made in a context that has deep-rooted models, practices, and established actor/institutional networks (Rayner and Howlett 2009). Particularly relevant is the *Canada Health Act* of 1984, which guarantees comprehensive coverage only for physician and hospital services. This established

a biomedicalized approach to care where the medicare mainstream (hospital and doctor care) is guaranteed and the marginal community subsector is delivered, funded, and governed outside of the the medicare mainstream (Canadian Healthcare Association 2009; Tuohy 1999). This complicates the funding, eligibility, and universality of these non-medicare mainstream services across and within jurisdictions in Canada.

As we will see, the objectives of the AHS have been difficult to achieve, in large part due to the imbalance between the mainstream and marginal subsectors. The Ontario AHS failed to realize significant shifts in the balance of resources from the mainstream to the marginal community care subsector. Even with ongoing stated objectives noting a desire to structurally reform the funding and delivery of community care services, competing policy agendas developed into contradictory policy outcomes.

## Materials and Methods

A document review was conducted to obtain an in-depth understanding of the context, goals, and objectives of the AHS as it was rolled out over the course of three years. Document reviews have been identified as a valuable tool to track change and development through comparison of documents (Bowen 2009). We accessed newsletters, press releases, policy briefings, reports and budgets that made mention of the AHS. Each of the 14 LHIN websites and the Ontario News Room were searched. To better understand the geographical context of each LHIN, see the map of Ontario's 14 LHIN regions (Figure 1).

FIGURE 1. Map of Ontario's 14 LHIN regions



LHIN = Local Health Integration Network. 1. Erie St. Clair; 2. South West; 3. Waterloo Wellington; 4. Hamilton Niagara Haldimand Brant; 5. Central West; 6. Mississauga Halton; 7. Toronto Central; 8. Central; 9. Central East; 10. South East; 11. Champlain; 12. North Simcoe Muskoka; 13. North East; 14. North West.

Search terms included: “Local Health Integration Network” AND “Aging at Home”, “Erie St Clair LHIN” AND “Aging at Home”, “South West LHIN” AND “Aging at Home”, “Waterloo Wellington LHIN” AND “Aging at Home”, “Hamilton Niagara Haldimand Brant LHIN” AND “Aging at Home”, “Central West LHIN” AND “Aging at Home”, “Mississauga Halton LHIN” AND “Aging at Home”, “Toronto Central LHIN” AND “Aging at Home”, “Central LHIN” AND “Aging at Home”, “Central East LHIN” AND “Aging at Home”, “South East LHIN” AND “Aging at Home”, “Champlain LHIN” AND “Aging at Home”, “North Simcoe Muskoka LHIN” AND “Aging at Home”, “North East LHIN” AND “Aging at Home”, “North West LHIN” AND “Aging at Home”. In total, 62 documents were pulled for further review and analyzed to identify any shifts in mission, vision, or goals over the course of the three-year AHS (see Appendix 1, available at: <https://www.longwoods.com/content/25550>, for a breakdown of number of reports found per year in each LHIN).

### *Analysis*

This document analysis involved two stages. First, it involved reading the documents to classify relevant information. For our case, this included any information on the changes and developments of the AHS as it was rolled out (Bowen 2009). Two members of the research team (JL and AP) used data extraction forms to make note of any relevant details from each of the documents. Using Excel, we captured the data for each LHIN. The Excel spreadsheet included an inventory of documents and key details that were compiled into the following categories:

- Document source: where the document was found.
- Year published: what year the document was uploaded.
- Year of focus: what year of the AHS it was focusing on.
- Overall vision: what is it that the LHINs hope to achieve over time.
- Primary objectives, outcomes and goals: what were the identified outcomes of importance.
- Funding allocation: what types of supports were funded.

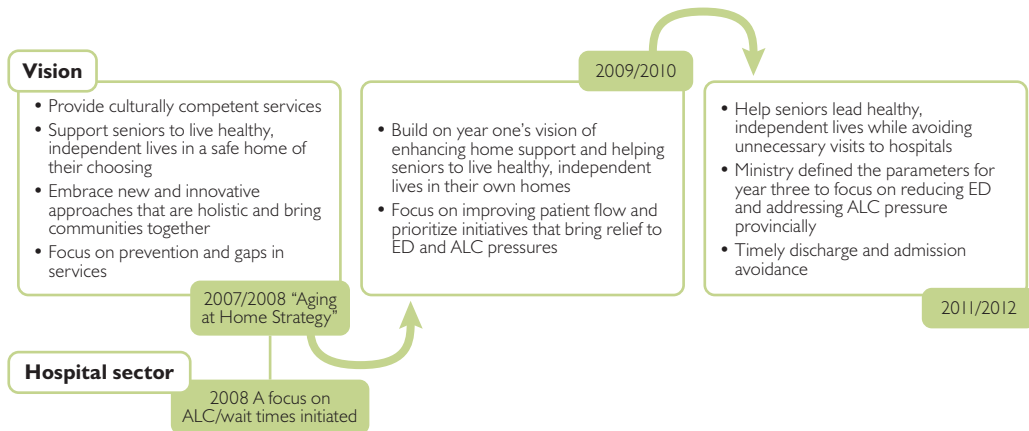
During the second stage of our review, JL, AP and SD conducted a thematic analysis where major themes and trends (i.e., shifts in decision-making concerning the AHS) were categorized based on LHINs and year of focus.

### **Results**

#### *Vision of the AHS from 2007 to 2012*

Our findings suggest that there were shifts in the vision of the AHS over time (as outlined in Figure 2). In year one, three LHINs made note of holistic approaches to care, specifically for older adults and their caregivers (South West, Central West and North West). The AHS aimed to offer culturally appropriate and preventative approaches to addressing current gaps in services.

FIGURE 2. Timeline of the Aging at Home vision



ALC = alternative level of care; ED = emergency department.

“Embracing new and innovative approaches to offer a full spectrum of services across the continuum that reach out to seniors and their caregivers, focusing on prevention and gaps in services, considering the whole person, the family, the carers and all factors that have an impact on health status” (quotation compiled from various LHIN documents [Central West LHIN 2009, 2010; North West LHIN 2009a,b; South West LHIN 2007]).

In year two, visions built upon year one. Specifically, the AHS sought “to enhance home support and help seniors live independent and healthy lives in their own homes” (Central West LHIN 2009; Champlain LHIN 2009; Erie St. Clair LHIN 2009; Laukner 2009). In addition, focus was on patient flow and to support initiatives that could bring “relief to emergency department and alternative level of care pressures” (Central West LHIN 2009; Erie St. Clair LHIN 2009; Laukner 2009; North West LHIN 2009a,b).

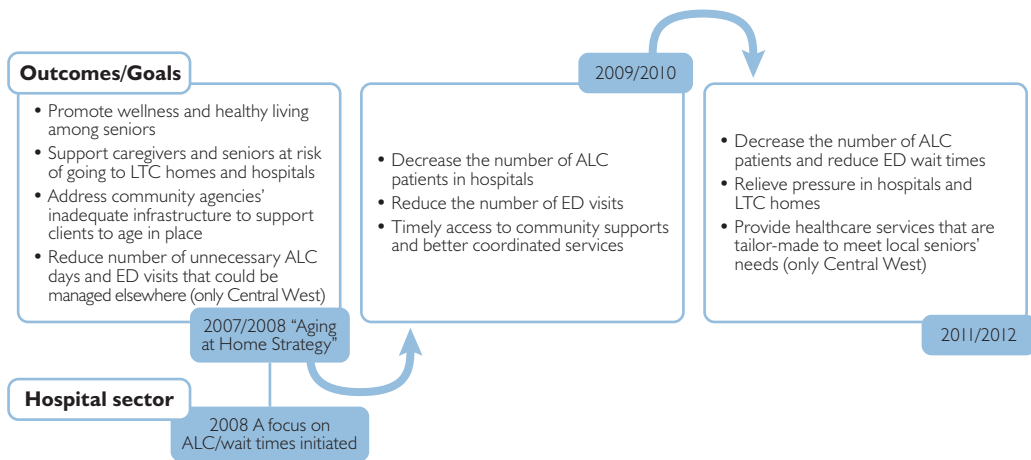
In year three, the vision was to ensure Ontario seniors had access to services to lead healthy independent lives, “while also avoiding unnecessary visits to hospitals” (Central East LHIN 2010; Central LHIN 2010; Central West LHIN 2010). LHINs noted that the ministry defined the parameters for year three to focus on services to enable ALC patients to leave hospital sooner, reducing emergency department and long-term care wait list pressures (Champlain LHIN 2010; Erie St. Clair LHIN 2010; North West LHIN 2010; Waterloo Wellington LHIN 2010b).

### *AHS outcomes and goals from 2007 to 2012*

Outcomes and goals that were identified for the AHS also shifted over time and varied across LHINs (documented in Figure 3). There was one LHIN, Central West, that was an

outlier in terms of its goals for year one of the AHS. In year one, many of the documents reported that the AHS attempted to address inadequate infrastructure that limited the community’s ability to support clients to age in place (Central LHIN 2007a,b), to promote wellness and support caregivers and seniors who were at risk of going to long-term care facilities (Mississauga Halton LHIN 2007; North East LHIN 2008; South West LHIN 2007; Toronto Central LHIN 2007) and, lastly, Central West (Central West LHIN 2007) spoke to reducing the percentage of ALC days and emergency department visits by seniors who could be supported elsewhere.

FIGURE 3. Timeline of the outcomes and goals of the Aging at Home Strategy



ALC = alternative level of care; ED = emergency department; LTC = long-term care.

By year two, outcomes and goals envisioned for the AHS were aligned across LHINs. Most documents suggested the ultimate outcome was to “decrease [the] number of ALC patients in hospitals” (Champlain LHIN 2009; Hamilton Niagara Haldimand Brant LHIN 2009; Mississauga Halton LHIN 2009; North West LHIN 2009b), and to reduce the use of emergency departments (Hamilton Niagara Haldimand Brant LHIN 2009; Mississauga Halton LHIN 2009; North East LHIN 2008) and ensure there was better coordination of services (Laukner 2009).

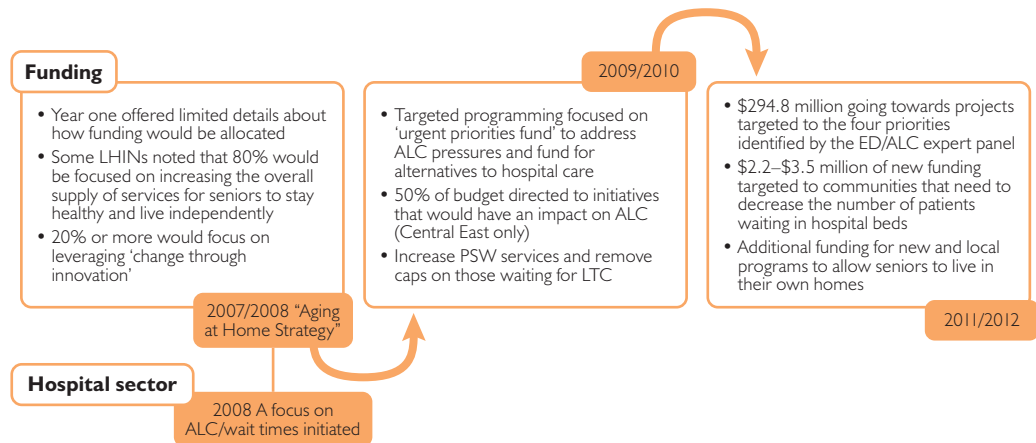
Year three emulated the goals set out in year two. LHINs reported that goals and targets aimed to decrease the number of ALC patients (Central East LHIN 2010; Central LHIN 2010; Erie St. Clair LHIN 2010; North East LHIN 2010; MOHLTC 2007; Waterloo Wellington LHIN 2010a), relieve pressure in hospitals and long-term care homes (Champlain LHIN 2010), reduce emergency department wait times and ALC days to increase temporary bed capacity (Erie St. Clair LHIN 2010). Interestingly, Central West was an outlier; its documents highlighted goals related to providing healthcare services that are tailor-made to meet local seniors’ needs.



### Program funding for the AHS from 2007 to 2012

With respect to programs and services that were funded over the course of the AHS (Figure 4), year one offered limited details around how money was to be spent and on what types of programs, outlining that funding was being directed to local programming (Erie St. Clair LHIN 2007; Erie St. Clair LHIN 2008). Other LHINs were more specific, noting that 80% of the AHS budget was being targeted to increase the supply of services for seniors to stay healthy and live independently with the additional 20% of the budget being spent to “leverage change through innovation” (Central West LHIN 2007).

FIGURE 4. Timeline of documented funding of the Aging at Home Strategy



ALC = alternative level of care; ED = emergency department; LHINs = Local Health Integration Networks; LTC = long-term care; PSW = personal support worker.

By year two, funding directives targeted programming focused on an “urgent priorities fund” to address ALC pressures by delivering alternatives to hospital care (Champlain LHIN 2009; Hamilton Niagara Haldimand Brant LHIN 2009; Mississauga Halton LHIN 2009). It was noted in Central East (Central East LHIN 2009) that 50% of its AHS budget would be directed to initiatives that would have a direct impact on ALC.

By year three, a general AHS document noted that \$294.8 million would be going towards programs to meet the four priorities identified by the emergency department/ALC expert panel (MOHLTC 2007). While other LHIN-specific documents spoke to funding local programming and “new programs” (Central West LHIN 2010; Waterloo Wellington LHIN 2010a,b).

### Discussion and Conclusion

Our analysis demonstrates that by the third year of the AHS there was a reduction in the discretionary powers to allocate funds according to local and regional priorities. New funding was shifted even further away from building capacity in services like supportive housing and caregiver support into services like specialized geriatric emergency teams and post-acute rehabilitation (Central East LHIN 2010).

There are several key lessons learned concerning the difficulty of sustaining policy change aimed at supporting community-based care. First, community care in Ontario is different by virtue of it being outside Canadian medicare policy, including legislation that only protects the public and universal funding of hospital and physician services. This leaves provincial governments with the responsibility of determining how to respond to increasing demands for services in subsectors outside the mainstream, with no obligation to do so (Baranek et al. 2004). These once medically necessary services provided in the mainstream are now provided in the marginal subsector, placing them beyond coverage (Baranek et al. 2004). Second, health policy change with respect to building capacity of the community subsector remains difficult as a result of competing political agendas. These competing agendas have been a result of persistent fragmentation within the community and social care subsectors, while the mainstream subsectors have remained relatively homogenous. This complexity is a by-product of the subsectors' historical emergence as a collection of community-based initiatives to meet local needs, with variability across and even within jurisdictions around service offerings, entry points, eligibility criteria and accountability guidelines. Community care organizations are also subject to competitive bidding processes, which challenge efforts to unify. Furthermore, community care is often provided by professionals (e.g., personal support workers) who do not share similar mobilizing powers as those in the mainstream subsector like doctors (Baranek et al. 2004; Williams et al. 2016).

This imbalance between subsectors has been the result of a policy legacy of accommodation toward the medical profession. Much of the literature on policy change builds off of the notion of "policy legacies," made famous through the work of Paul Pierson (Pierson 1993; Pierson 2000). The policy legacy literature stresses the importance of history and that there are path-dependent effects of policy decisions that can shape political dynamics and delimit the scope of future decisions (Tuohy 1999). In her book *Accidental Logics*, Carolyn Tuohy discusses the contingent way in which the features of health systems are shaped by political ideas and agendas that appear during windows of political opportunity. Furthermore, these actions create path-dependent effects that shape the subsequent actions of policy makers (Tuohy 1999). According to Tuohy, in Canada, more than any other comparable nation, characteristics of the healthcare system have been shaped by the "logic of accommodation" between governments and the medical profession. In the 1960s, the Canadian government established medicare by agreeing to ensure hospital and physician services, largely based on the existing structure of healthcare delivery in Canada. The establishment of medicare under, what Tuohy calls, "generous terms" has had contingent effects that institutionalized negotiation and funding relationships between the state and the hospital and medical subsectors in Canada (Tuohy 1999). This institutionalized logic of accommodation has limited the scope of policy change by providing these subsectors with the ability to influence policy change and maintain existing structures and resource allocations, resulting in remarkable stability in the Canadian healthcare system and a continued focus on hospital and physician services.

There is value in acknowledging power imbalances within subsectoral policy networks. Competing policy agendas in some subsectors can appropriate competing policy agendas in marginalized subsectors. In the case of AHS, reform efforts that attempted to provide the community with the necessary resources to offer preventative supports for aging populations were largely appropriated by the interests of more dominant actors in the mainstream (hospital) subsectors. With the rollout of the 2008 focus on ALC and wait times, community care was directed to target persons requiring acute level services, leaving fewer services available to offer preventative supports (Baranek et al. 2004; Williams et al. 2016).

Our study had some noteworthy limitations. Firstly, we were not able to retrieve documents equally across all three years for each of the 14 LHINs. This may reflect differences in archiving and public reporting practices. Thus, our findings may not be reflective of the entire province. However, in those LHINs with publicly available records, the story remained remarkably consistent. Second, we retrieved a variety of different document types, including: newsletters, press releases and policy briefings. Since each document type is produced for different purposes and audiences, some documents contained inconsistent data or the information provided was quite vague. Future study could combine document analysis with qualitative methods (e.g., key informant interviews with policy makers) to corroborate the data.

## Conclusion and Future Research

In summary, the Mainstream and Marginal subsectors in Ontario are different by virtue of facing different institutional boundaries and historical policy legacies, having distinct arrangements of political actors and having competing policy agendas. Competing interests within the healthcare sector, and the incongruence of the community subsector, mean mainstream approaches (those of the hospitals, doctors, medical professions) dominate as a result of the historically significant position. We suggest that this explains why it remains difficult to sustain community-based efforts of preventative health and social care and helps us understand why the original intent of the AHS was difficult to maintain. Future research may look to the role that policy feedback may play in implementing future community-based reform efforts; the early shifts to the AHS may explain policy outcomes that have further transformed the community care landscape (Pierson 1993). The direction that the AHS went could set a legacy for future decisions aimed at implementing community-based services.

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