Best Brains Exchange – February 9th, 2017

Funding and Financing Home Care: Issues and Options Summary Document

Summary prepared by: Continuing Care Branch, Alberta Health
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The content in this document reflects the presentation materials and discussions held by participants at the February 9, 2017 Best Brains Exchange. It does not necessarily reflect the opinions of Alberta Health.

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About the Best Brains Exchange

The Canadian Institute of Health Research's (CIHR) Best Brains Exchange Program is designed to deliver high-quality, timely, and accessible research evidence that responds to health system policy issues and gaps in knowledge, to inform policy development, planning and program implementation. These one-day, in-camera meetings bring together policy makers and researchers and promote interaction, exchange and mutual learning.

Background

Home care is an increasingly important service to address the health needs of an aging population and of individuals living with disabilities and to reduce expensive and unnecessary institutional care. With expanded home (e.g., services delivered in peoples' homes) and community-based (e.g., services delivered at central locations in the community, like adult day programs) services demonstrating potential for improved health system effectiveness and sustainability, both the Alberta and Federal governments have identified expansion of home care as a priority.

In Alberta, publicly-funded home care offers personal and professional services aimed at addressing professionally assessed unmet healthcare needs. Home care also provides respite and caregiver support services, and may provide assistance for homemaking tasks such as meal preparation, laundry and light housekeeping (sometimes at a shared cost to the client). It has been proposed by experts in home care that the scope of services provided to support home care clients should be expanded and complemented by other support services such as grocery shopping, heavier household tasks (e.g. indoor/exterior home maintenance, yard work, snow removal) and/or transportation options. It is argued that expanding the basket of services provided to include homemaking tasks and support services, can directly promote health and wellness and prevent injury and disease supporting people to live safely in their homes and communities for longer. However, increased demand for all types of home care services, and expanding the delivery of homemaking and support services, come with increased costs. It also comes with operational challenges whether fully publicly-funded or financed/cost-shared through the collection of client fees. Further evidence and discussion is required to determine:

- whether the provision of any or all of such services is key to supporting people to remain at home;
- whether they should be provided through a blend of home care and other non-health service providers;
- which areas of government/programs shall hold primary responsibility for these services; and,
- what mix and method of financing and funding could support expanded provision of these types of support services.

The Best Brains Exchange explored evidence and experiences from other jurisdictions to help better understand the role that provision of home care services, including support services, and by whom, plays in supporting people to remain at home. The purpose of this report is to summarize the key points

from the presentations and discussions (Appendix 1), identify the themes and highlights that emerged from the day and discuss next steps.

Overview of Day

Thirty-one participants attended the Best Brains Exchange including representatives from Alberta Health Services, the governments of Alberta, British Columbia, Nova Scotia, the federal government (First Nations and Inuit Health Branch), industry representatives, and researchers. The objectives of the day were to:

1) Understand the experiences, achievements and challenges of jurisdictions, both nationally and internationally, in implementing expanded options for home and community-based care services;
2) Understand and discuss the existing evidence related to the financing and funding of services that help people to stay in their homes as they age, including considerations of responsibility for providing supports (health care, social services, municipalities); and,
3) Gather evidence that could inform changes to Alberta's home care policies and governing legislation.

The day was structured around the 3 objectives, and included presentations followed by group discussions. The presentations were given by Dr. Virpi Timonen, Dr. Jose-Luis Fernandez, Dr. Colleen Flood and Dr. Walter Wodchis. Participants received four background readings on the topic prior to the event. Dr. Robyn Tamblyn facilitated the day.

Part I: Which Support Services Are Considered Key to Enabling People to Remain at Home?

Shared Concerns, Diverse Responses: Reforming Home Care for Older Adults in Europe

Dr. Virpi Timonen, Professor, Social Policy and Aging, Trinity College Dublin

Background

- High level overview of social care reforms in 9 European countries as part of the LIVINDHOME Project.
- From the mid-1990s on, the percentage of people aged 65 and older receiving care in institutions has generally remained stable or decreased; the percentage of people aged 65 and over receiving formal care at home has generally increased, except in a few countries.
- Shared concerns as more people stay home longer with high needs are: ensuring adequate care, monitoring quality, family care-formal care interactions and distribution of costs.
    - Policy issues in European reforms include: eligibility and need, what kind of care is provided, who provides care, who finances care, how is quality assured, and how are care providers employed?

Policy Reforms

- Policy reforms can be classified into two paradigms: family-care oriented and formal-care oriented.
    - Family-care oriented reforms include initiatives that rely heavily on home care cash payments or establishing new insurance schemes that only cover a portion of care needs, while the individual and their family are expected to cover the rest (either through out-of-pocket contributions or direct care labour).
        - Cash-for-care arrangements focus on fueling private enterprise and employment of migrant care workers.
        - These policies are oriented to sustaining and maximising family care, but there is a concern with possible substitution effects (turning family delivered care into a resource that carries a cost to the health system).
    - Formal-care oriented reforms include initiatives that are focusing on delivering care to people with highest level of needs and moving towards efficiency/productivity in formal care. Some of these reforms also make greater use of market mechanisms by encouraging competition among private providers.
        - Family care plays an important role, but families are not seen primarily as untapped care providers.
        - Growing focus on enabling/encouraging older adults to re-learn skills and cope independently. Preventive approaches and notions of self-help/restorative care have entered policy language.

Common Features and Conclusions

- Overall, goals of home care policy are to expand services to protect a vulnerable and deserving population while controlling costs. Actions to achieve these goals include:
    - Increasing focus on those with most extensive needs (narrow eligibility; greater focus on efficiency of care tasks; focusing less on Instrumental Activities of Daily Living (IADL) needs).
    - Greater involvement of non-governmental or private provider organizations.
    - Encouraging and incentivizing private spending (introduction of cash allowances; degree of control over how cash allowances are used varies; tax allowances in some countries encourage and enable private spending especially for IADL tasks).
    - Family and other informal care integration (incorporating family carers as recipients of LTC insurance funding; freedom to employ migrant workers; greater emphasis on care users' choices and designation as purchasers).
- European policymakers have sought to dampen demand and draw on a wider variety of providers, especially (from the state's perspective) 'low-cost' sources of care (families, migrant workers, voluntary sector, older people themselves).
    - The above actors are also increasingly expected to be the primary (or only) sources of assistance other than Activities of Daily Living help.
    - Several challenges arise from this, such as inequalities in access to care; and uneven/unknown care quality that is increasingly difficult to measure or control.

Developing an Evidence-Based Approach to Decision Making in Social Care

Dr. Jose-Luis Fernandez, Deputy Director and Associate Professorial Research Fellow at PSSRU, London School of Economics and Political Science

- Policy questions are the same around the world. There are increased demands for care, increased costs to provide care, and increased pressures on public funds. Therefore, there is a need for more evidence about cost-effectiveness.
- Evidence of the impact of community services/personal budgets:
    - There is growing evidence of the impact of social care services.
    - Community care services (e.g., day programs, home care and respite) delay admission into residential care. The effectiveness of services is usually greater for those who have high needs, and therefore have a greater capacity to benefit from services.
- Personal budgets policy – quality of life measures found that these programs had better outcomes than traditional service delivery models and somewhat lower costs. However, for older people, individual budgets were not associated with significant differences in care costs.
- Social care evidence about cost-effectiveness is less robust than health care evidence. There is an opportunity for strategic partnerships between research and policy/practice communities to develop and analyse evidence.
    - It is difficult to evaluate preventive interventions because of the length of time it takes for benefits/effects to materialize.
- Question is not, is home care the answer? It is, is home care the answer for certain populations and what are the impacts?
    - Consumer-directed care is found to be generally cost-effective when considering outcomes like psychological well-being; however, the evidence for older people is different. This means individual budgets might be more beneficial/cost-effective for younger populations (e.g., 18 – 65 years old), and that older people require support with the implementation of individual budgets.

Part II: Existing Financing and Funding Models that Help People Stay at Home as They Age

Funding Options for Home Care and Long-Term Care: Insights from Germany and the Netherlands

Colleen Flood, Professor, Faculty of Law, University of Ottawa

- The Germans and the Dutch continue to try to shift balance away from institutionalization towards home and community-based care.
    - The rising tide of people living with dementia may mean assessment processes and policies need to be tailored to support these individuals to remain living at home (they are not "disabled" in the traditional sense).
- Consideration could be given to shifting funding for LTC and home care to a social health insurance (SHI) model but requires modeling for impact on employment, as well as other factors, and assessment of political appetite for this.

- SHI may be more appealing than a greater reliance on out-of-pocket payment at the time of service: pay now for benefits later rather than paying at the time when they are in need (i.e., avoid the stress of being a "consumer" in these situations).
- How to drive efficiencies in the system is an ongoing question: the Dutch are shifting home care services to the municipalities in the hope that they will be more aggressive in purchasing services so that price "ceilings" don't become floors.

Considerations:

- Promising to tailor services to the individual may be a better route than across the board entitlements to "social" kinds of care. This needs to be set up in a principled manner.
- Cash transfers are politically popular in Germany and the Netherlands.
  - It may reduce pressure on the public purse as they are set at about 50% of formal care funding amount, but you need to control moral hazard (i.e., individuals using more resources unnecessarily as a result of not having to assume financial risk/responsibility for the resources).
  - It can be a means to allow clients to spend on things they really need that are not covered by the formulary for formal home care services.
  - The Dutch have now moved to cash payments for home care only as a direct substitution for those who would otherwise be institutionalized. Perhaps the place to first trial the impact of cash payment would be for this population.
- Issues to consider are: potential for moral hazard (increasing numbers of individuals with lower needs seeking the benefit relative to the past), fraud, impact on woman's participation in workforce and quality/safety of care delivered.

Financing Home Care

Dr. Walter Wodchis, Associate Professor, Institute of Health Policy, Management and Evaluation, University of Toronto

- Different models for home care funding exist, mainly due to local circumstances. These models are the result of political and social discussions, and existing systems of care in different countries.
  - There is little evidence for relative advantages of different systems as universal solution for managing care for all older persons with needs for home care services.

Issues and Considerations

- Some issues and considerations for home care funding and financing mechanisms include:
  - Universality versus income-tested: high administrative costs for income testing and high total costs for universal systems, potentially leading to reduced service maximums.
  - Public pay vs. personal care budgets (contracts & competition):
    - Quality competition enhanced with private choice (even in public payment) but few select personal budgets, and very few individuals ever change providers to maintain continuity (Netherlands).

        - Co-payments can create obstacles to access services.
            - Allowing individual budgets is common with variation in restrictions on use of such budgets (e.g., Restrictions exist in Netherlands, France; No restrictions in Germany, Austria, Italy for example).
    - Benefits/Services to Caregivers: Supports are relatively sparse.
        - Germany offers pensions to individuals employed less than 30 hours per week who provide more than 15 hours per week in support; employers must provide up to 10 days paid leave; 1,510€ provided for caregivers to take holidays.
        - Australia offers a number of in-kind services including education, mental health education and support, and "Carer Gateway" a trusted source for unpaid caregivers to access services; there are also respite services.
        - Non-profit organization in Vermont (Central Vermont Council on Aging) provides $1000 cash grants to caregivers of people with dementia to use for respite and adult day services.
    - The financing option should match the services provided and the timeframe over which they will be provided, and should take into account the number of providers who will be involved.

Methods of Financing/Payment

- There are several methods of financing/payment, including:
    - Fee For Service
    - Levels of care approach
        - Many international examples of programs with 4-7 levels of care with set maximums for cost.
    - Home care only capitation models.
    - Programs of All-Inclusive Care for the Elderly (PACE) type full health care capitation.
    - Some approaches provide global budgets for defined geography.
- Common features:
    - Most programs pay providers directly for services; capitation allows wider array of services to be included.
    - Programs are either financed through general tax revenues or mandatory individual insurance schemes.
    - Most have some form of income testing. Where no income tests are applied, budgetary pressures have led to benefit reductions/freezes (e.g. Sweden, also Netherlands).

Conclusions and Next Steps

The BBE concluded with a facilitated discussion on what the next steps could be for Alberta on the policy issues of funding and financing home care. The suggested next steps align with some of the major themes that emerged during the Best Brains Exchange. These themes include:

- All jurisdictions discussed face similar challenges in terms of quality, access, efficiency, financial sustainability, political will and ability of government to pay.
- The ability to draw from evidence to inform policy options is challenging in light of diverse policy options and a lack of formal and systematic evaluations.
- The service delivery model and funding model should promote integration across the health and social systems, including system-wide case management.
- There may be a need for increased revenues to offer expanded home and community care services, which requires a long-term vision and solution, though it is possible that the revenues are sufficient but not used cost-effectively.
- The funding model needs to align with the values of Albertans, including autonomy, choice and client preference.
- Cash credits or payments are an increasingly common funding option being used in several jurisdictions, though it does appear that they need to be targeted at the right population to see benefits.
    - We have examples of different home care funding models in Alberta, including the Comprehensive Home Option for Integrated Care of the Elderly (CHOICE) Program and self-managed care. There is an opportunity to evaluate these types of programs and pilot them with different populations or parameters.
- Assessments of client needs for home and community supports should be conducted in the community and should holistically assess clients' situations and needs, including financial.
- There is a need to acknowledge and support family caregivers.

The **next steps** to build on the Best Brains Exchange and find solutions to the challenges and act on the opportunities that were identified include:

- Work to implement specific policy recommendations, including that client assessments should be conducted in the community rather than in acute care.
- Consider implementing a public awareness campaign for the supports and services available to help individuals in their homes.
- Conduct pilots with cash credit or payment funding models, which might involve testing the parameters or populations served by current programs (e.g., more flexible self-managed care funding).
- Conduct pilot of triaging clients to receive case coordination through primary health care or system-wide case management through the Home Care Program.
- Seek answers to questions about Albertans' ideas about home care, including:

    - Determining what Albertans want to achieve through the home care program, and how/if they are willing to participate in that vision (this involves integrating what was heard through previous public stakeholder engagement sessions); and,
    - Determining if Albertans are willing to contribute more, and how they are willing to finance home care.
- Conduct or collate evaluations of current home care programs (e.g., self-managed care, CHOICE Program).
- Advocate for further Canadian research on home care funding and financing to determine what approaches are most effective, accepted and would be appropriate in the Alberta context.

Appendix 1: Summary of Group Discussions

Part I Discussions

What challenges exist in offering expanded home and community care services?

- There is an opportunity to identify core services.
- We've built a culture where individuals feel entitled to receive services in their homes, rather than in central congregate settings.
    - Clients may also be unwilling to accept a technological support/equipment instead of a face-to-face caregiver/care.
    - Delivering services in people's private residences can increase the risk of social isolation for home care clients.
- Clients and families are not aware of the services and supports available to them, or how to communicate their needs to physicians/case managers/care providers.
- How do we meet the need for client autonomy and choice?
- Where do we get resources for expanding home and community care services?
- Assumption that acute and home care are a direct substitution, but lack of ability to account for the unique context of home (e.g., addressing caregiver burden).
- Case manager time constraints, and not being trained in resource allocation or the ability to knit together services in the home and community context.
- Barriers to data sharing, as well as lack of integration across health and social systems.

What policy changes need to occur?

- Assessments:
    - Do not assess clients in hospital – get them home first.
    - Assessment of need should include available resources (including financial)
    - Need to consider geography of family networks and size of families.
- Reorient families to what supports are available to keep client at home.
- Test models for the direct substitution of enhanced home care for institutional care.
- Put supports in place to alleviate caregiver burden, and consider the health care utilization of caregivers in analyses of home care investment.
    - A rigorous evaluation of caregiver support programs is required.
- Increase technological interventions.
- Provide system-wide case management.
- Enable connections between addiction and mental health, primary health care and continuing care.
    - Incentivize primary health care.
- Model population needs given changing family structures.
- Develop and implement case management decision-making principles.

Who should arrange, provide and pay for care?

- Case managers with the appropriate resources and training to arrange for care. Focusing case management on higher needs clients may make caseloads more manageable.
    - There is an opportunity to integrate more effectively with primary health care. It is possible that individuals with lower/less complex needs could have their care/services coordinated within primary health care.
- In distinguishing between formal and informal care, some countries are worried about genderization of care.
- Need to recognize the difference between family care and family support, and should provide the supports that are appropriate to their role (e.g., their needs may not be the same).
- Find creative ways to finance expanded services – are there ways for individuals to contribute more during income earning years, rather than at the time of service? Consider implementing means testing at point of service or developing a social insurance fund. Where does private insurance fit here? If private insurance plays a role, then it likely needs to be regulated.
- There should be flexibility for allowing families and clients to augment care when appropriate.

Part II Discussions

What can be learned from funding models used in other jurisdictions?

- Service delivery in social insurance funded systems is more consistent/reliable than in tax funded systems, because it is a protected envelope of funding for home care.
- All-in budget programs, like PACE funding or the CHOICE Program, incentivizes integrated care.

Which of the funding models would work best for Alberta? Canada?

- What would work best depends on which outcome (e.g., quality of services, cost containment, client preference/satisfaction/'experience') we are trying to achieve.
- Consulting with Albertans about what their values and expectations relating to home care funding and financing is required to determine what would work best.
- There is a need to create three good options for financing, research and analyze them, and present these options to the public.
- Think about and experiment with cash payments (starting off small and targeted).
    - Although self-managed care already exists, it may be good to look at how to move this program to another client group and test the parameters of the program (e.g., using vouchers, having a less administratively burdensome program).
- Expanding financing/revenue through some modality, or rationing services.
    - Allow for out-of-pocket payments for top-up services above what is provided.
    - Allow clients to tap into assets of home equity for care or home support services (similar to the SHARP-Seniors Home Adaptation and Repair Program).
- Also need to consider congregate service delivery models.

- We need to consider the impact of the political cycle on a long-term solution to financing home care.