

# The Romanow Commission Report and Home Care

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## Introduction

The Romanow Commission Final Report demonstrates that reliance on research evidence and on intensive consultations with a broad segment of the public can make a major, positive contribution to policy development and decision making. The report endorses the values and principles that underpin medicare and calls for increased federal funding to correct the current imbalance in federal/provincial contributions. It also recommends that new, specifically targeted federal funds be directed to promoting needed organizational changes and to supporting the incorporation or expansion of health care programs and that the provinces be publicly accountable for the latter funds, in order to ensure that this money is directed towards the achievement of the proposed objectives. One of the programs targeted for new federal funding is home care. Under this proposal, it would receive \$1 billion for each of the first 2 years, to kick-start the implementation of the changes recommended by the report, monies that would subsequently be incorporated into the annual federal transfer payments to the provinces for health care via what the report calls the *Canada Health Transfer*.

## The Report's Recommendations on Home Care

In the chapter headed "Home Care: The Next Essential Service", the report recommends what it refers to as "Directions for Change". These include (1) using the new Home Care Transfer (i.e., the new monies provided by the federal government) to establish a national platform for home care services; (2) revising the Canada Health Act to include coverage for home care services in three priority areas – mental health, post-hospital acute care, and palliative care during the last 6 months of life; and (3) implementing a new initiative to provide ongoing support for informal caregivers.

The two most important contributions of the recommendations are that they legitimate home care as an essential health care sector and that they legitimate federal responsibility for participating in the funding and development of home care. However, the chapter's heading and some of the assumptions on which specific recommendations are based merit close scrutiny in light of the history of home care in Canada, of how home care is organized and delivered, of whom it serves, and of what is needed to develop a framework for a national home care program. The scrutiny must also include a close look at the extent to which the report's recommendations on home care take account of the research findings summarized in the brief submitted to the Romanow Commission on behalf of the Canadian Institutes of Health Research Institute of Aging (Hébert, 2002) and other relevant research. The following review, therefore, assesses the extent to which the recommendations respond to the current and future needs of home care

## A Reality Check

*Is it realistic or helpful to refer to home care as the "next essential service"?*

The provinces could take umbrage at the use of "next"; they have long recognized home care as essential, having for almost three decades initiated, funded, and provided home care services on the basis of assessed need for help in returning to or remaining at home. Although it is generally acknowledged that the funds allocated to home care are inadequate for the functions these programs are currently expected to perform, the provinces have also substantially increased their budgets over time, because they recognized them as "essential" services. Furthermore, case management, which the report refers to as a key component of each of its chosen priorities, is generally a well-established feature of most, if not all, of the pro-

vincial programs and is provided by the same public or quasi-public sector workers who are responsible for determining eligibility and service requirements.

The use of the term “next essential service”, therefore, appears to have been specifically designed to legitimize the recommendation that the federal government become a partner in funding home care. So, although the word “next” may offend provincial sensibilities, the recommendation makes it possible to use future federal/provincial meetings as an opportunity for both levels of government to participate in a process leading to the development of a national home care program. Such a process would inevitably entail resolving the current policy differences among the provinces in regard to eligibility criteria, service charges by some provinces for non-medical services, and the use of public and/or for-profit resources for service delivery to ensure that all Canadians, no matter where they live or where they choose to move, would be entitled to receive home care services on the basis of assessed need. In fact, the federal government would be hard put to explain its involvement in the funding of home care without being able to show that all Canadians are being treated equally.

*Is revising the Canada Health Act to incorporate the targeted services the right way to provide a “platform” for a national home care program?*

The issue here is not whether we need a national program but whether that use of the Canada Health Act is an appropriate “platform” for achieving a national program, especially when about 75 per cent to 80 per cent of its clients are elders aged 65 or more (Roos, Stranc, Peterson, Mitchell, Bogdanovic, & Shapiro, 2001). One big problem with this approach is that the act requires that access be restricted to persons who require “medically necessary services”. This restriction would medicalize a program that is not simply or exclusively a health program but rather a health and social service program. In fact, more post-acute and long-term clients of all ages require support services than require medical services. Furthermore, the majority of long-term care users are the temporarily or permanently functionally impaired, whose primary and often sole need is for support services, not “medical” services.

Their exclusion by this limitation of the Canada Health Act would be particularly unfortunate for three reasons. First, as Hollander and Chappell (2001) and others point out, home care is particularly cost-effective in reducing the need for nursing home beds, which is the only alternative for the growing numbers of elders aged 75 or more whose sole need is for support services. Second, current home care budget constraints and earlier hospital discharges as a result of

hospital downsizing have already led home care programs to favour those requiring post-acute care and to reduce or cut off services to long-term care clients (Chappell, 2001; Penning, Allan, Roos, Chappell, Roos, & Lin, 2002). Research by Hollander and Tessaro (2001) shows that this policy is penny wise and pound foolish. They found that total health care expenditures within the next 3 years were higher in the two provincial regions that cut or reduced services to long-term care clients as compared to the costs for clients in two other regions that did not take such action. And third, denying access on the basis of the need for medical services would particularly discriminate against elders with dementia and their informal caregivers. Half of these elders live in the community, and research indicates that they do not, as a general rule, use medical services but that they do require more support services than other home care recipients (Shapiro & Tate, 1997). Although the recommendation to target mental health as a priority might be used as a lever to include persons with dementia, one would be hard-pressed to justify such a step because they are not usually clients of mental health programs.

*Should the priorities – mental health, post-hospital acute, and palliative home care – be the ones selected for inclusion in the federal Home Care Transfer package, whether or not they are incorporated into the Canada Health Act?*

According to the evidence from research findings (e.g., McEwan, Ritter, & Lawrence, 2002; Shapiro, 2002), mental health programs to help adults return to or remain in the community warrant special attention and increased funding because adults with acute or chronic mental illness encounter serious barriers in accessing home care services. However, more money will likely have only a limited impact unless the structural and practical complexities associated with providing services appropriate to their needs are first addressed. For example, serving mentally-ill persons who are discharged from an acute care facility or who live in the community currently falls within the mandate of the provinces’ mental health programs, but their clients also need help from other community resources such as home care. To help forge partnerships between mental health and home care programs to improve services to the mentally ill, the Health Transition Fund provided some funds to support a small number of experiments designed to test models in which mental health and home care programs coordinate their efforts to reduce barriers and improve services. However, the small number of these experiments, the differences in the processes used in trying to make changes, and the differences in the resulting models did not provide enough reliable evidence on the efficacy of each model.

Therefore, the first question that needs to be resolved is whether current home care programs should incorporate the financial management, case management, assessment, and service provision functions for clients with mental health problems or whether provincial mental health programs should develop their own specialized home care services for this population, or indeed whether home care for this group should be a joint responsibility, with specific functions being assigned to each program. If, for example, the decision were made to assign joint responsibility for the assessment and reassessment processes (a seemingly sensible decision, in view of the specialized professional skills available in mental health programs) and to assign both the case management and service provision functions to the home care programs, the direct service providers would require additional training to be able to provide appropriate support services to this group of clients and to know how to serve as models for those clients who need to improve their independent living skills to return to or to stay in the community.

Targeting palliative home care within a finite time frame as a priority could have positive benefits for dying persons who prefer to be cared for at home and for their caregivers. Although this kind of care is a highly intensive and therefore also a high-cost service component, it may also be cost effective, especially if providing more palliative care at home is accompanied by further hospital bed closures. There are, however, questions that require both research before and evaluation after such expansion. Bearing in mind the importance of pain control, will the program be able to count on the direct participation of each client's physician or will the program have to hire its own physicians? Where will home care clients and their caregivers, especially those with dependents, receive professional social services if they need such direct services as family counselling and employment counselling?

As for post-acute care, research evidence makes it hard to justify putting it on the priority list, even though it has always been an important and necessary component of home care. Its recent accelerated growth has been propelled by the downsizing of the hospital sector within the last decade, the resulting earlier hospital discharges, the major expansion of day surgery, and new treatment modalities that make it possible and desirable to treat people at home rather than in hospital. The reason this component does not merit priority is that it already benefits from its current priority status within home care at the expense of long-term care clients. In fact, the current provision of post-acute care within capped home care budgets is squeezing out the capacity of home care programs to

provide services to those who need long-term care, to the point where, as indicated earlier, some programs in a number of provinces are cutting off and/or seriously reducing the provision of services to persons requiring long-term care. We are seeing longer and longer waiting lists to gain access to needed services, even though this results in higher use and higher costs for other health care resources. It is long-term care for the functionally impaired, community-dwelling elders, the predominant users of long-term care, that is currently in serious trouble. As Hébert's brief (2002) says, "A real shift in resources is needed to reverse the traditional, hospital-centred approach".

Therefore, unless the provinces use the new federal dollars for home care to transfer some of their current resources from short-term care to long-term home care to expand the capacity of the latter, the inadequacy of this already pauperized service component will jeopardize the health and welfare of elders and increase the cost of other health care resources. Increased support for long-term care would provide access and services within a reasonable waiting time to functionally impaired clients, including those with chronic mental health problems, to enable them to remain at home in the community.

Furthermore, if more resources are provided to short-term home care, the medicalization of services, especially if it is included in the Canada Health Act, may reach the point at which we find the whole home care program returning to "the olden days", when some provinces required physicians to certify that a person required a medical service at home in order that s/he be eligible for admission to home care – a policy that was abandoned decades ago as inappropriate for meeting the needs of most persons requiring help to return home or to remain there, primarily because physicians were not generally conversant with the home circumstances of their patients, but also because the practice made home care inaccessible to the vast majority of persons who needed help to remain at home but did not require medical services.

The last recommendation in the report is to launch a new initiative to support informal caregivers, in order to recognize their important contribution to home care and their forfeiture of employment or of other opportunities to make their contribution. This recommendation does not include the transfer of federal dollars nor does it specify what form this initiative should take. However, it includes a suggestion to explore the possibility of using the Employment Insurance program to provide direct benefits to informal caregivers under certain circumstances.

The issue of "caring about caregivers" continues to generate debate about both the efficacy and equity of

past actions in that area and about what other initiatives should be taken. However, a key factor that is too often ignored in these debates is that one of the most important ways of supporting informal caregivers is to ensure that they can, if needed, depend on the timely availability of a viable and responsive home care program – a program that has the funding, the organizational structure, and both the kind and amount of direct services to provide the appropriate level of service to the home care clients for whom it is caring. The caregivers who need such a program the most are not those helping persons who need post-acute care, because the demand for their help is usually short term; it is the caregivers who provide long-term services and whose burden grows over time who need support. It is, therefore, somewhat ironic that the report's recommendation to provide more money to post-acute care rather than to the needier long-term care segment of home care could keep placing more and more of the burden of providing long-term care on informal caregivers.

*What's missing in the report's chapter on home care?*

The chapter is as interesting for what it omits to highlight or to discuss as for what it does. It omits acknowledging that, even though only a small minority of elderly persons use home care each year, they are by far the largest number of home care clients; actually one would be hard-pressed to find the use of the words "elders" or "elderly persons" in this chapter. Also missing is attention to three important issues raised in Hébert's brief to the Commission on behalf of the CIHR Institute of Aging (2002). First, while the chapter discusses the importance of good case coordination (a case management function) to help ensure continuity of care, it neglects to point out that a critical prerequisite for providing continuity of care is the rapid transmission of information between other health care resources and home care case managers – an issue that sorely requires attention and resources. Second, the chapter pays little attention to currently ongoing experiments to test the efficacy and cost-effectiveness of home care models in improving services to frail elders, thus foregoing the opportunity to acknowledge the importance of encouraging such research efforts. Third, it bypasses the issue raised by Hébert's statement that "there is no scientific data supporting the current trend towards entrusting the private sector with the management and delivery of care and services" – an issue as germane and as important to home care in regards to service delivery as to other health care resources, since the current policy in some provinces is to entrust the delivery of home care services to companies. For example, several recent studies funded by the Health Transition Fund found that the delivery of home care by for-profit pro-

viders reduced the flexibility needed for innovations that require the sustained delivery of services by the same personnel (Shapiro, 2002) and that the 1996 experiment in privatizing service delivery in Winnipeg to save money proved to be a failure (Shapiro, 2000).

## Conclusion

The report of the Romanow Commission deserves high praise, especially when compared to other recently-released reports. The main reasons for its pre-eminence are its focus on values, its consultation process, its reliance on evidence from research findings as the basis for its conclusions, and its call for public accountability for the money provided for new initiatives. Its recommendations regarding our mainstream health care services merit support and implementation. Therefore, to take issue with some aspects of the report's recommendations on home care would appear to be churlish: "looking a gift horse in the mouth" may be perceived not only as ungracious but even as counterproductive. However, the goal of this critique is to take advantage of the time between the report's appearance and the federal/provincial discussions regarding the implementation of the recommendations to revisit the report's recommendations on home care. Given the complexity of home care, its goals, its intimate relationship with both hospitals and nursing homes, and its services, further reflection could help to resolve some of the issues raised here.

No one familiar with home care will argue with the recommendations that home care be recognized country-wide as an essential service, that the federal government share in its funding, that federal/provincial negotiations aim to make home care a national program available to all Canadians on the basis of assessed need no matter where they live. The issues are how best to achieve a national program that recognizes the primary importance of social supports and how best to allocate our current and future home care resources to ensure that persons, most of whom are elders, are treated equitably, whether they need post-acute or long-term care. Such a goal would fit in remarkably well with the main thrust of the report of the Romanow Commission and set us in the right direction.

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