

Yes to Home Care, but Don't Forget Older Canadians

Réjean Hébert
Scientific Director
Institute of Aging
Canadian Institutes of Health Research

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Réjean Hébert, MD MPhil
1036, Belvédère Sud
Sherbrooke, QC J1H 4C4
<rejean.hebert@Usherbrooke.ca>

The publication of the Romanow Report (Commission on the Future of Health Care in Canada, 2002) is an important step in the evolution of the Canadian health care system. Apart from federal-provincial squabbles that the report has rekindled, the commission has given the government a lucid and wide-ranging analysis of our health care system and suggested some interesting solutions. Its greatest merit lies in its reliance on solid data from Canadian and international research on health care systems and programs. The report rises above dogma, opinions, and partisanship, and charts the course for a true and necessary reform of the system. But what does the report mean for older Canadians?

Right from the outset, Commissioner Roy Romanow reaffirms the desirability of a public health care system. The commission did not accept, then, the apocalyptic view of the aging of the population that, according to some, would make it impossible to maintain a public health care system in the face of this impending "catastrophe". As we showed in our submission to the commission (Hebert, 2002), the expected aging of the population will not have a major impact on health care expenses, especially if we take into account the expected improvement in the health of future generations of seniors. Opening the door to private funding would have harmed older Canadians, who, because of their income and health risks, are less attractive as clients for private insurers. This does not even take account of the reduced accessibility to the public system that an exodus of professionals to a parallel private network would inevitably produce.

The report also recommends a major reinvestment in the system, which has been underfunded for many years. Many of the accessibility problems are the result of this underfunding, which must be corrected without delay. Among the most vulnerable clientele, seniors who require long-term care are hit particularly hard. With the shift towards ambulatory care in recent years, some convalescent care has been transferred from short-term hospitals to home care services. Without an increase in the budget for home care, this has had the perverse effect of reducing the coverage of home care services for the frail older individual, while benefitting post-hospital care (Chappell, 2001; Penning, Allan, Roos, Chappell, Roos, & Lin, 2002). The same phenomenon has been observed for palliative care, which has also siphoned off increasing funds from the home care budget to the detriment of frail older people.

The community of researchers and those who work with older people applaud many of the recommendations in the Romanow Report, especially improved access to care for rural and remote communities, the integration of services and support for the use of case managers, the development of a primary health care network, the provision of support for informal caregivers, and improved coverage for the cost of prescription drugs, especially for chronic illnesses.

One of the most important elements in the report concerns home care. Based on a number of studies, especially those by Hollander and Chappell (2001), the commission recommends, with good reason, expanding home care to cover medically necessary

services as defined in the *Canada Health Act*. However, it identifies three priority clienteles in this regard and recommends specific funding for setting up home care services for these three groups: mental health clients, patients in the post-acute phase, and persons needing palliative care services.

Although seniors may make up a significant proportion of each of these groups, the majority of the frail older people are not targeted by these three priorities. First, older people suffering from Alzheimer's Disease are mentioned in the mental health group but, traditionally, in most parts of the country, these individuals do not come under the current mental health programs. And it is doubtful if this will change with the injection of additional funding. Furthermore, patients themselves and their families would dread the association with mental health, as it would enhance the stigma already associated with this disease. Second, defining post-acute care (2 to 4 weeks after discharge from hospital) as a priority could have a serious, perverse, and costly effect by increasing or perpetuating the use of hospitals to gain access to home care services. We will then see a real revolving door, with repeated hospitalizations to re-establish eligibility for home care. Finally, it is difficult to include vulnerable seniors dealing with various chronic diseases in the definition of palliative care. At what point will they become eligible for end-of-life care? Furthermore, these two last priorities will also have the effect of increasingly marginalizing the frail older people in need of home care services, a need initiated by the shift towards ambulatory care.

Frail seniors make up the majority of home care clients and the solid data on which the commission relied were rightly obtained primarily from these subjects. Not just Hollander and Chappell (2001) but other studies done with frail older people (Hébert et al., 2001) have shown that it is more cost-effective to provide care for these individuals at home than in a residential facility or hospital setting. A major improvement in the efficiency of the health care system could be obtained by a real "shift towards community care," providing long-term care and services at home rather than in an institution. In view of the likelihood of a substantial increase in this clientele with the expected aging of the population, the gains could be considerable.

Without denying the importance of the three groups identified in the report, we urge the government

clearly to identify frail older people as one of the priorities for home care. This expansion would have the effect not only of recognizing the importance of this growing group of clients, who are suffering from the under funding of health care and the shift towards ambulatory care, but also of offsetting the perverse effects related to the inappropriate inclusion of these clients in the three groups currently identified.

Finally, we must congratulate the commission on its insistence on supporting health research as a way of providing solid data for adapting the health care system to the changes in demand for services and evaluating the impacts of new policies and programs. The creation of the Canadian Institutes of Health Research, and the Institute of Aging in particular, provides an outstanding tool for shaping an efficient, cost-effective health care system, designed to improve the health and quality of life of Canadians, especially older Canadians.

To apply the recommendations of Romanow's report will obviously improve care and services to older people and their caregivers. However, frail older people need to be clearly identified among the priorities for home care.

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