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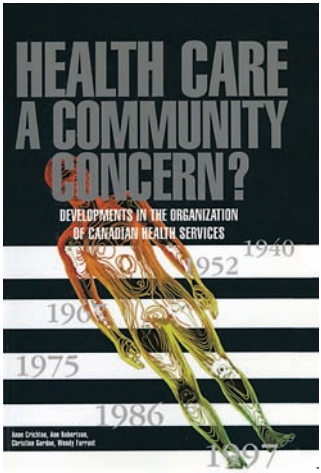

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 13

Community Care for the Elderly

It is impossible to discuss the provision of community-based services to older adults without consideration of the range of services variously known as home care, continuing care, community care, long term care, *les services à domicile*, home support, etc. Part of the confusion over the use of terms is that they are used to refer to services organized for either episodic (acute) or chronic care. This linguistic confusion appears to reflect a confusion or conflict over the intended purpose of these services, a point which will be returned to later in the discussion. For the purposes of this discussion the term "community care" will be used to refer to the entire range of community-based services provided to seniors. Indeed as Jamieson (1989) has observed: "Before policies of community care there were no explicit [health care] policies for elderly people" (p. 450).

The major feature of these community care programs is their stated overall objective of supporting older adults to stay in their own homes as long as possible, with a wide variety of services depending on the jurisdiction but which can include: home nursing, involving a range of clinical services such as dialysis, IV therapy, etc.; homemaker services; respite care for family caregivers; some kind of meals program ("meals on wheels" or "wheels-to-meals"); supplements to public transportation; "friendly visiting"; handyman services; and other services depending on the community. These programs are also available to young adults with disabilities and to families with children with disabilities or in distress; by far, however, the over sixty-five group comprises the majority of the users of these services (Richardson 1990).

What characterizes these services from an organizational point of view is their overwhelming multiplicity, variability, public/private mix and lack of coordination at either a policy/planning level or a service delivery level (Marshall 1987; Richardson 1990; Ontario 1990a).

Home Care

Of all the components of community care, the oldest is home nursing care, alternatively known as home care. Home care originated in Canada almost one hundred years ago with visiting nursing services provided by the Victorian Order of Nurses (VON) and by public health nurses in urban and rural areas (Richardson 1990). After the Second World War home care programs were begun in several communities, combining other services with the nursing services, and often using local hospitals as a base. By the late 1970s all provinces and territories, except Newfoundland, had introduced some form of provincial/territorial-wide program.

Home care programs in Canada typically include home nursing and other clinical services such as physiotherapy, speech therapy, respiratory therapy, as well as a range of non-clinical support services. There is great variability across these programs in terms both of their organization and administration, and of the degree to which health and social services are integrated. As was noted by the Federal/Provincial/Territorial Sub-Committee on Home Care (Canada 1986e): "At this time there is no consensus on which services should be basic components of a home care program."

Richardson (1990) provides a good succinct overview of the characteristics of these provincial/territorial programs (Table 13.1).

Many reviews of home care programs in Canada have been conducted over the last ten to fifteen years (Canada 1975, 1977, 1986e; Shapiro 1979; Crichton 1980; Howell 1988; Striast 1989; Richardson 1990), and no attempt will be made to duplicate those reviews here. What is pertinent to the present discussion are the organizational issues that have been raised, particularly in the more recent reviews. These include:

1. Should home care programs operate on a medical entry model (demonstration of medical need) or on a social entry model (need for home support)? This issue is related to the issue of whether the program is organized around episodic (acute) care or chronic care. British Columbia, Manitoba and Quebec have social entry models; Ontario's home care program was originally a medical entry model but has recently incorporated chronic care, New Brunswick has a medical entry model (New Brunswick 1990, n.d.); Alberta has been moving from a medical to a social entry model (Alberta 1990a; Richardson 1990)
2. As a corollary of this, what is the most appropriate base of operation for home care programs: the hospital or the community? Many home care programs had their origin in the provision of hospital services in the home, and continue to derive their justification, in much of the discussion, from their role as hospital replacements. The implications of this will be discussed later in the conclusion to this section.

Chart 13.1
Current Status of Provincial and Territorial Home Care Programs in Canada, 1990

Program Variables	British Columbia	Alberta	Saskatchewan	Manitoba
1. Name	Continuing Care	Coordinated Home Care	Home Care	Continuing Care
2. Start date	1978	1978	1980	1974
3. Type: Eligibility, length of stay, administering body	both medical and social entry (ME, SE) components; acute and chronic; health units and municipal health departments	both ME and SE components; acute and chronic; 27 public health units	SE; chronic; 45 separate HC boards, plus 9 community boards in Northern Saskatchewan	SE, acute and chronic; no LOS limit, 17 coordinating agencies
4. Services provided	homemaker (HM), nursing (HN), physiotherapy (PT), respite care	HM, nutrition, handyman (HDM), speech therapy (ST), respiratory therapy (RT), PT, OT, HN	HN, HM, personal care, meals on wheels (MOW), home maintenance, volunteer services, assess and care coord. maintenance	nursing, personal care, medical supplies, meal preparation, household medical supplies, PT, OT, ST, volunteer services
5. Annual expenditure fiscal year	$77.6 million 1986–87	$31.4 million 1987–88	$22.9 million 1987–88	$35.6 million 1987–88 (direct services only)
6. Per capita over age 65 expenditure	$222.00	$158.00	$175.00	$259.00
7. Number of clients served during year	68,200 (1986–87)	23,800 (1986–87)	19,101 (1987–88)	24,800
8. Current caseload	37,000	15,000	11,000	15,000
9. Per cent clients age 65	58.1% (HN) 85.7% (HN)	87%	85%	80%

Chart 13.1: Current Status of Provincial and Territorial Home Care Programs in Canada, 1990 *(continued)*

Program Variables	Ontario	Quebec	New Brunswick	New Brunswick
1. Name	Home Care	Maintien à domicile, and soin intensifes de maintien à domicile (SIMAD)	Extramural Hospital	Short term and long term home care
2. Start date	c. 1972	1970, 1981	1981	1972 and 1980
3. Type: Eligibility, length of stay, administering body	ME; both acute and chronic; 38 agencies, 29 health units, 4 VON, 3 hospitals, 1 independent board, 1 regional government	SE; acute and chronic; 162 CLSC's	ME, acute care (ALOS - 45.9 days), 10 full service units and 1 palliative care unit, covering 56% of N.B. population	public health, nursing and voluntary agencies
4. Services provided	ST, social work, nutrition, ET, RT, homemaking, diagnostic and lab services, medical supplies, medical equipment	nursing, homemaking, meals, errands, companionship and support	nursing, PT, OT, respiratory, dietetic services, homemaker, MOW, basic equipment, patient care supplies, drugs	nursing, PT, nutrition, equipment and supplies, relief care, homemaker, heavy housecleaning, MOW, friendly visiting
5. Annual expenditure fiscal year	$245.1 million 1987–88	$119.7 million 1988–89 budget	$10.1 million 1987–88	$1.5 million annual expenditure
6. Per capita over age 65 expenditure	$364.00	$173.00	$124.00 1987–88	$19.00
7. Number of clients served during year	221,998 (1987–88)	6,236 (SIMAD only)	9,500 (1987–88)	N/A
8. Current caseload	62,965 March 1988	N/A	1,300 March 1988	N/A
9. Per cent clients age 65	62%	60%	51%	80% of clients are long-term care

Chart 13.1: Current Status of Provincial and Territorial Home Care Programs in Canada, 1990 *(continued)*

Program Variables	Nova Scotia	Prince Edward Island	Northwest Territory	Yukon Territory
1. Name	Coordinated home care program	Home care and support	Coordinated home care	Home care
2. Start date	1988 (start of phased implementation	1970	earliest start 1975 in Yellowknife	March 1988
3. Type: Eligibility, length of stay, administering body	SE; no limitation on LOS; 37 homemaker agencies and 2 municipalities are "access points"	SE; no limit on LOS; administered by department staff with some contract services	SE; no limit on LOS; programs in 6 centres, 5 are hospital-based	SE; no limit on LOS
4. Services provided	HN, HM, volunteers, housing services	nursing, homemaker, OT, PT, meals, transportation, household maintenance, friendly visiting, respite care, case planning	HN, personal care, HM, OT, PT, ST, MOW, equipment loan	HN, OT, PT, personal care, home management, housekeeping, respite services
5. Annual expenditure fiscal year	$8.5 million 1988–89 (8 months only)	$20.0 million 1987–88	$1.0 million 1988–89 budget	$450,000 1989–90 budget
6. Per capita over age 65 expenditure	$79.00	$124.00	$667.00	$500.00
7. Number of clients served during year	estimated 10–17,000 at full implementation	N/A	estimated 400	74 (1988–89)
8. Current caseload	N/A	1,300–1,400 1988	estimated 35–40 clients per program	46 May 1989
9. Per cent clients age 65	estimated 80% at full implementation	80% are over age 60	N/A	56% 1988–89

Note for Chart 13.1: **Newfoundland.** There is no universal program. The regional Home Care Program for St. John's started in 1973. It has three components: acute, continuing and Home Support Program for seniors. The 1986–87 budget for acute and continuing care was $1.8 million. the 1986–87 expenditures for home support were $366,000. A number of hospitals, nursing homes and public health nursing-based programs exist in rural areas, and provide HM, HN services. The Department of Health is planning to provide on a regional basis. The Department of Social Services also provides home support services through community district offices.

Source: Blair G. Richardson, "Overview of Provincial Home Care Programs in Canada," *Healthcare Management Forum* 3, no. 3 (1990): 3–10. Reprinted with permission.

The Verdun Hospital in the Home and the New Brunswick Extra Mural Hospital are clearly home care programs based on this line of reasoning, which are driven by the hospital sector (New Brunswick 1990, n.d.; Marshall 1989; Bouchard 1990). On the other hand, efforts in Quebec to designate the Centre locaux des services communautaires (CLSCs) as the site of delivery of home care programs reflects a community orientation (Fédération des CLSC du Québec 1988b). Several documents from many jurisdictions have argued for a non-institutional base for home care programs (Alberta 1990a; British Columbia 1990a; Ontario 1990b).

3. How should the community/acute care hospital interface be managed, regardless of which is the lead sector in home care? This appears to be handled in a variety of ways. Many hospitals have discharge planning committees (Marshall 1989), while Alberta and the City of Vancouver, where the provision of home care is located in public health units, have public health nurses located in hospitals as "liaison nurses," who coordinate the discharge planning (Alberta 1990a; Vancouver 1981–84). The Capital Regional District of Victoria, British Columbia has responded through the Victoria Health Project — a project developed to facilitate hospital/community partnerships — by creating "quick response teams" which essentially provide hospital-based geriatric assessment and treatment in the community (British Columbia 1988; Marshall 1989; Finnie and Layton 1990).

Long-Term Care

In contrast to home care which often emphasizes professional clinical services, and which may or may not be provided on an episodic or ongoing basis, "long-term care" has been used to designate all those home support services provided on an ongoing basis to assist people with chronic disabilities to remain in their own homes. As such their general purpose is to prevent premature and/or permanent placement in a hospital or a care facility such as a nursing home or other long-term care facility.

The Federal/Provincial/Territorial Sub-Committee on Long-Term Care (Canada 1990i) has produced an extensive overview and program description of long-term care programs across Canada. As with home care programs, there is considerable variability in the range of services provided, client eligibility and the extent of public/private mix of providers. Kane and Kane (1985, 1988) have published detailed descriptions and comparisons of long-term care programs in Ontario, Manitoba, and British Columbia.

Coordination across a range of long-term care services appears to be left to the service delivery level. Marshall (1989) has conducted an excellent analytical review of the organizational models which are used across Canada in the provision of long-term care services. That effort will not be duplicated here except to outline briefly the conclusions of that review, all of which are familiar themes and all of which have some bearing on the organization of delivery of community-based services to older adults:

1. Long-term care services in Canada are disorganized and fragmented. As discussed earlier, this is largely a result of jurisdictional, bureaucratic and professional territoriality
2. Long-term care services are undermined by cost-benefit analyses which seek to justify long-term care on the basis of its effects on reducing cost in other sectors, especially the institutional sector

As Shapiro (1989) has pointed out: "it is hard to understand why home care is always being studied when home care budgets consume from 2.3 to 4 percent of provincial health care budgets. Why are we not studying the big spenders as assiduously as we studying home care?" (p. 23).

With expenditures on long-term care as proportionately low as they are,[1] cost reductions can only be at the margins (Finnie and Layton 1990). Marshall (1989) and others (Canada 1988f; Institute for Health Care Facilities of the Future 1990) have argued that long-term care should be evaluated on its own terms, that is, because it is a preferred method of delivering service.

3. Related to the above is the fact that the provision of community-based long-term care is threatened by "medical and hospital-based interests, who are the most powerful players in Canadian health (and social service) care [and who] increasingly seek to develop initiatives in the area" (Marshall 1989, 91)

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1 Several provinces have taken steps to revise their funding formulae (e.g., Saskatchewan 1991) in order to increase economies.

Several documents have argued that the physician is the most appropriate single-point-of-entry (Canadian Medical Association 1987; British Columbia Medical Association 1973, 1990). Binney, Estes and Ingman (1990) have cautioned that the increasing medicalization of home health services for older adults in the United States suggests that: "there is a substitution mechanism in effect, wherein the increased provision of highly medical services is replacing the provision of other non-medical or less highly medical services" (p. 770).

There are indications that the same sort of phenomenon may be occurring in Canada; in a discussion paper, one Canadian interest group has emphasized "physical need" as the criterion for eligibility for long-term care (British Columbia Medical Association 1990). In combination with the demand that long-term care prove its effectiveness by reducing other health care costs, such as hospitalization and physician visit rates, this may have the effect of emphasizing a medical rather than a social model of long-term care.

Continuing Care

In many respects, the separation of home care services and long-term care services is an artificial one on both a policy/planning level and a service delivery level. In some jurisdictions, home care and long-term care are administratively combined. Both British Columbia and Manitoba administer and finance both kinds of services, which are delivered from, or contracted out of, regional public health units and municipal health departments, through a provincial Continuing Care Program. The whole range of home support services in Quebec is provided on a coordinated basis through a network of 159 community health centres (CLSCs). Saskatchewan combined the Saskatchewan Home Care and Long Term Care in Special Care Homes and Hospitals programs into a Continuing Care Branch (Saskatchewan 1989).

In many jurisdictions, such as the Province of British Columbia, the Continuing Care Program includes the long-term care facilities and, thus, manages the community/institution interface (British Columbia 1989f, 1990a). In other jurisdictions, the two sectors are administered and financed separately.

Other provinces are moving towards more integrated and coordinated systems of continuing care. As a coordinating mechanism at a service delivery level, Alberta Health is implementing a network of regional Single-Point-of-Entry Committees which will comprise all providers of home care and long-term care services in the region (Alberta 1990a). Ontario's opposition (1986) has recommended an integrated and coordinated provision of com-

munity-based health and social services through fourteen local offices of the new Community Health and Support Services Division (which combines programs of the Ministry of Health and the Ministry of Community and Social Services); the intention is that these offices will work with already existing agencies in the community — District Health Councils, municipalities, local planning organizations, service providers and consumers — in order to "build a coherent integrated service system on the foundation of existing in-home, community support and long term care facility services" (p. 3).

Many jurisdictions are using a single-point-of-entry case management approach[2] to coordinating the continuum of services for older adults (Richardson 1990). Again Marshall (1989) provides a good review of the literature on case management models.

Chambers (1985) has reviewed instruments for measuring the quality of long-term care by examining the actions of direct providers.

At the time of writing it was still too early to determine the impact on the structural models for continuing care of recent moves towards regionalization in several provinces.

Day Care, Respite Care and Caregiving

The Ontario Ministry of Community and Social Services (Flett 1990) has reviewed day care programs and respite services in that province and explored the literature. Palliative care is mostly hospital-based but may sometimes be provided at home (Institute for Health Care Facilities of the Future 1990). These services provide important relief for family caregivers and may provide support to workers in the community care services.

Gallop et al. (n.d.) who reviewed the literature on caregiving said: "It is clear that the formal health care system depends on the care these informal care givers provide. ... Evidence of the psychological burden of care giving is well documented. ... It is [also] clear that caregiving is a financial burden to many families" (Executive Summary).

Mohide et al. (1990) found that caregivers looking after demented relatives were suffering from above average levels of depression and anxiety.

Rural hospitals do not always provide outpatient follow-up services for elderly, chronically sick or disabled patients who need intermittent therapy unless special arrangements are made (as in British Columbia for physiotherapy for arthritics) (Pack 1974).

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2 Canada (1988c) have put out *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders* in which four coordinating mechanisms are suggested: (1) determining the catchment area; (2) single entry delivery systems; (3) case management; (4) case registries for patient tracking.

Preventive Approaches

New Horizons Grants from Canada Health and Welfare support the development of projects and activities which intensify contacts and links between seniors, and partnerships between seniors, groups and community organizations. Provincial organizations such as the British Columbia Seniors' Resources and Research Society (1991) are promoting wellness programs. The National Advisory Council on Aging (NACA) is encouraging elderly persons to plan ahead for dependency (Canada 1990k). NACA has been lobbying for continuation of adequate seniors' income support by the federal government, noting the poor financial position of some elderly non-married women (Canada 1991c).

Toronto Senior Link (1991) is a voluntary agency which endeavours to provide neighbourhood services in order to make the transitions from independence to dependency gradually.

Discussion of Community Care Models

Of all the health issues facing Canada in the last decades of the twentieth century — with the possible exception of AIDS — it is the challenges to the health care system of providing for an aging population which highlight the need for a reconsideration of the structural arrangements for the provision of community-based health care services. Several good overviews discuss many of the issues that arise as a result of the "aging of the population" in Canada (Chappell, Strain and Blandford 1986; Marshall 1987; Rathbone, McCuan and Havens 1988; Kane and Kane 1985, 1988; Lewis 1989).

While many have cautioned against a crisis mentality (Evans et al., 1989; Hertzman et al. 1990; Evans, 1989a,b; Barer et al. 1987), nevertheless, an "apocalyptic demography" rhetoric (A. Robertson 1990) appears to drive much of the discussion around health care for older adults. Indeed it is important to consider under what social, political and economic conditions the population group over sixty-five becomes a significant group to health care planning. As Jamieson (1989) says: "The increase in the interest in older people does not reflect a sudden upsurge in the concern with the well-being of this section of the population as such. Rather it reflects a concern with how society in general is to respond to and cope with some major changes which have taken place and are still happening, first in the demographic structure, but also in the economy" (p. 445).

It is clear that more attempts are being made to determine needs and reconsider community service provision for the elderly all across Canada (Hodge and Collins 1987; Canadian Consensus Conference 1989; Joseph and Cloutier 1990).

One positive aspect of this increased interest in older adults as a population group is that many of the issues which arise around health care for this group have been present for other population groups — children with disabilities, young adults with disabilities and persons with mental health problems. However, it is the sheer size of the over sixty-five group, a group with the ability to wield considerable political power, which has forced consideration of the major barriers to the effective delivery of community-based health care services into the discussions of all health care jurisdictions in Canada. In the course of reviewing the literature for this study these have been almost universally identified — in documents prepared by federal, provincial and municipal governments, as well as by research institutes, professional organizations, and academics — as:

1. The inadequacy of a clinical/medical model of health when addressing the health care needs of older adults. Many of the influences on the health of older adults (as indeed with other population groups) have to do with non-medical issues — isolation, the loss of role and status, the death of family and friends — as well as being issues traditionally considered outside of the health sector — poverty, lack of suitable housing, poor transportation (Canada 1982b, 1988c,f; Ontario 1990b, 1991a; British Columbia 1986; Institute for Health Care Facilities of the Future 1990)
2. Bureaucratic and professional territoriality which results in the lack of coordination of health and social services at an overall policy/planning level as well as at a service delivery level (Canada 1982b; Ontario 1990b; Marshall 1989; Schwenger 1989)
3. The institutional bias in the provision of health care services in Canada which inhibits the development of appropriate community-institution interfaces (Marshall 1989; British Columbia 1986, 1988)

In short it is the legislative and financial entrenchment of a medicalized acute care model of health care in Canada which constrains all discussion of the provision of community-based services to older adults. Various documents produced by several governmental and non-governmental jurisdictions in Canada, which have examined the issue of health care in general for older adults, have universally recommended a combined health and social services approach to support the autonomy of older people (Ontario 1986, 1990b,f; Canadian Medical Association 1987; Canada 1988f; Fédération des CLSC 1988b; Dartmouth, Nova Scotia 1989; British Columbia 1990a; Alberta 1990a).

All of these reports also point to the inherently intersectoral nature of the health needs of older adults, not only at central government policy/plan-

ning levels but also at local service delivery levels. As one document (British Columbia 1986) observes: "While not all issues involving seniors are under the control of local communities, their very existence is likely to affect local discussions and planning" (p. 3).

In addition the administrative and financial arrangements put in place at the level of central governments defines and constrains the boundaries of practice at the service delivery level (Marshall 1989).

As discussed above, there are several indications that community-based services to older adults are moving towards a social model of health and towards being coordinated and integrated at both policy/planning and service delivery levels. However, these developments also appear to be occurring in the context of several countervailing trends which have arisen in the context of the cost-containment rhetoric of the 1980s and 1990s:

1. The increasing expectations of home care and long-term care programs to reduce costs in the institutional sector, which may result in:
   A. An increasing medicalization of home care and long-term care services
   B. The proliferation of a rhetoric stressing the "independence" of older adults, and the responsibility of local communities and families for the care of elders, in spite of the fact that families already provide about eighty percent of the care for their older members (Jutras 1990)

All of these trends can be regarded as attempts on the part of federal and provincial governments to reduce collective responsibility for the provision of certain kinds of services, in other words a retreat from the welfare state.

The apparent contradiction in the discussions of health care for older adults have significant implications for the nature of community-based services for older adults and for the organizational arrangements for their provision. The outcome will ultimately be a political one. It will be necessary for the provincial governments to decide on policies and their implementation.

Summary

This chapter reviews the development of programs in the community for the care of the elderly. There is great variability in the programs from one province to another and no consensus on what should be the basic components of these programs.

There are a number of organizational questions for the provinces to answer. Should home care (principally nursing care after an acute care episode) be based on a medical or social model? Should it be hospital- or community-based? How can the hospital/community interface be managed well?

How can long-term care be better coordinated? Does it always have to be justified in terms of cost savings? Can hospitals be persuaded to let go of this sector?

Some provinces have combined home nursing and long-term care into a service called continuing care which manages the hospital/community interface better. Some are using case management models. Some have developed day care and respite care.

There is a real concern about the pressures on caregivers.

Preventive services are available in some provinces.

It is in this service area that ideas about adjustments relating to the shift from a biomedical to a social model of care can most readily be observed. But the problems of cost containment are constraining the governments from moving ahead from the medical into the social model of care.