

Home Care in Ontario: The Case for Copayments

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I. Introduction

“Home care” in Canada is not universally defined across various provinces, and falls outside the ambit of “insured services” in the *Canada Health Act*.¹ That being so, provision of home care varies from province to province. Since home care is not an insured service, provinces are free to impose user fees and copayments if they so desire without contravening the *Act*. All but three provinces, Manitoba, Québec and Ontario, have imposed some form of copayments for home care.² Out of those three provinces, however, only Ontario has no policy to provide publicly funded services to those with the lowest incomes first.³

If home care services are analogized to acute care, private payments seem antithetical to the spirit of the *Canada Health Act*. On the other hand, if these services are seen as more similar to long-term care, copayments, especially if means and needs tested, appear to be justified.

This paper will argue that, in a properly structured assessment system with a single entry point, copayments for home care services could serve many diverse and useful ends in Ontario’s health care system. By increasing the pool of resources available for home care, accessibility can be broadened. Quality of care could also improve with more funds available for tendering contracts to providers. More costly institutional care can be delayed longer if more individuals needing assistance are able to access at least a base level of home care services. Finally, the proposal put forth here will be sensitive to the hidden costs on informal caregivers by not penalizing, and in fact rewarding, to the extent possible, clients who have family supports available and willing to provide care. This should be done through tax credits for informal caregivers in recognition of the fact that they substitute for public employees.

Though Canadians may feel they have a right to health care, home care is a unique and special case. Since it is extremely varied and ranges from acute services

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¹S.C. 1984, c.6 [hereinafter *CHA*].

²Federal-Provincial-Territorial Advisory Committee on Health Services Working Group on Continuing Care, Health Canada, *Provincial and Territorial Home Care Programs: A Synthesis for Canada* (Ottawa: Minister of Public Works and Government Services, June 1999) at 22 [hereinafter *FPTWG 1999*].

³*Ibid.*

to unskilled homemaking, it cannot be treated the same as either acute care or social services. In this case, it is best to sacrifice some universality of public coverage for greater accessibility to a core of medically necessary services.

II. A Definition of "Home Care"

There is no national Canadian definition of home care that applies to every province. Some provinces have enacted legislation in an attempt to define such services. For example, British Columbia defines home care services in its *Continuing Care Act*, while Manitoba and Prince Edward Island have no legislation governing the provision of home care services.

Generally, home care can be thought of as serving three possible roles. As defined by the Federal/Provincial Working Group on Home Care, it is "an array of services which enables clients incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long term care or acute care alternatives."⁴ Thus, home care may help those who otherwise have to remain in or enter acute-care facilities ("acute care substitution model"), or it can substitute on a long-term basis for institutional care for chronic illnesses ("long-term-care substitution model"), and lastly it may allow independence and delay institutionalization ("maintenance and preventive model").⁵

III. Home Care in the Canadian Context

Home care falls under the ambit of "extended health care services" in the *Canada Health Act*.⁶ It is left up to the provinces to set regulations to define such services in s.22.(1)(a). Unlike insured services, that is, physician provided or in-hospital services, there are no requirements for universality, comprehensiveness, accessibility, portability, or public administration for extended health care services.⁷ As well, user charges are permitted with these latter types of services, in contrast with insured services.⁸

As a result of this flexibility and lack of national standards, there is a patchwork of different home care programs across provinces in Canada.⁹ Provinces vary with respect to, *inter alia*, fees charged to clients, referral source, and admission criteria. There is also no portability across provinces for home care services.¹⁰

⁴Federal-Provincial-Territorial Working Group on Home Care, Health and Welfare Canada, *Report on Home Care* (Ottawa: Health Services and Promotion Branch, 1990) at 2 [hereinafter *ROHC 1990*].

⁵*Ibid.* at pages 13-15.

⁶*CHA*, *supra* note 1, s.2.

⁷*Ibid.* ss. 9-12.

⁸*Ibid.* ss.18-19.

⁹M.W. Sorochan, "Home Care in Canada" (1997) 10:4 Int. J. Health Care Quality Assurance v at v.

¹⁰*Ibid.*

The prominence and importance of home care in Canada has grown in recent years for a variety of factors. Health care restructuring has resulted in bed and hospital closures. New, more efficient treatments as well as cost-containment considerations have resulted in shorter hospital stays.¹¹ More people with chronic conditions are living in the community now than ever before.¹² In addition, the use of home care is sure to grow as the population ages, as the use of such services increases with age. While only 1% of Canadians under 65 years of age received home care services in 1994-95, 22% of those aged 80 or older made use of such services in 1994-95.¹³

Public expenditures on home care in Canada have grown considerably in recent years. According to Health Canada and the Canadian Institute for Health Information (CIHI), total per capita spending by provinces increased from \$37 per individual in 1990/91 to \$69.20 per individual in 1997/98.¹⁴ Still, as a percentage of provincial health care budgets, home care has made up very little of the total spending. In Ontario, for example, provincial home care spending in 1997-98 was projected to make up only 5.3% of the total health care budget.¹⁵

Governments, in an era of fiscal restraint and deficit reduction, are looking for ways to reduce costs, and home care is seen as a cheaper alternative to either acute hospital care or institutionalization. This lends political appeal to spending on home care. However, since home care services could in theory be almost limitless in scope, from professional services replacing acute care to light housecleaning, most provinces have instituted cost-sharing initiatives to their programs. While all provinces and territories cover client assessment, case coordination and management, and nursing services, the range of professional services publicly funded varies.¹⁶ As will be discussed, Ontario is unique in its lack of explicit client cost sharing.

IV. Copayments for Home Care in Canada

Seven of the ten provinces have client income assessment arrangements for home support services, with eligibility for services based primarily on need.¹⁷ Official income assessment instruments are used to determine how much the client must privately pay for home support services, with at least two provinces considering assets as well (New Brunswick and Newfoundland).¹⁸ Only Manitoba,

¹¹G.M. Andersen, "Hospital Restructuring and the Epidemiology of Hospital Utilization: Recent Experience in Ontario" (1997) 35:10 (Suppl.) *Medical Care* OS93.

¹²Statistics Canada, *National Population Health Survey Overview, 1996/97*, Catalogue 82-567 (Ottawa: Minister of Industry, 1998).

¹³K. Wilkins & E. Park, "Home Care in Canada" (1998) 10:1 *Health Reports* 29 at 31.

¹⁴M. Anderson & K. Parent, *Putting a Face on Home Care: CARP's Report on Home Care in Canada 1999* (Kingston: Queen's Health Policy Research Unit, 1999) at 9 [hereinafter *CARP 1999*].

¹⁵*Ibid.* at Appendix 2.

¹⁶FPTWG 1999, *supra* note 2 at 14.

¹⁷*Ibid.* at 19.

¹⁸*Ibid.* at 22.

Québec and Ontario do not require copayments or have formal income assessment processes. Yet, both Québec and Manitoba have policies to give priority for home support to low-income clients or clients with no option for informal care.¹⁹ Ontario, then, is unique in having no income assessment process for home support. Still, as will be discussed, Ontario imposes limits on the number of hours and costs of nursing and other supports,²⁰ and accessibility to the home support package is subject to availability of funds from the yearly budget.

V. The Situation in Ontario

Ontario has moved to a single-entry system for access to home care services, following the lead of other provinces. In January 1998, 43 Community Care Access Centres (CCAC) were established in the province to serve as a single point of access to the long-term care system, including home and facility-based care. They act to provide information and referral to all long-term care services, plan and monitor home care services, provide case management, and coordinate placement of clients into long-term care facilities.²¹ The CCAC are given annual budgets from the government to buy services for the community they serve. Thus, purchasing decisions are made by the CCAC themselves.²² The CCAC are governed by independent, incorporated, non-profit boards of directors that are appointed members of the corporation.²³ The Ministry sets broad guidelines and policy for the CCAC, including guidelines for Requests for Proposal (RFP) for home care services, medical supplies and equipment.

As of spring 1998, the Ontario government began a competitive bidding process among private home care providing agencies for RFPs.²⁴ The dominant perception is that cost, rather than quality, is the primary criterion for the awarding of contracts under this process because of the scarcity of funds.²⁵

Eligibility for home care services is based on living in the area of the CCAC, having a suitable home to provide care, and having an assessment that home care is needed and that these needs cannot be met by family and community. Professional services are provided in the home if these needs are not met by hospital outpatient services. If there is a risk of the client requiring institutional care or an assessed need for assistance with personal care, he or she may be eligible for homemaking and personal services.²⁶

¹⁹*Ibid.* at 19.

²⁰*Ibid.* at 58.

²¹Canadian Home Care Association, "Portrait of Canada: An Overview of Public Home Care Programs" (Paper prepared for the National Conference on Home Care, Halifax, 8-10 March 1998) [hereinafter CHCA].

²²*Ibid.*

²³FPTWG 1999, *supra* note 2 at 39.

²⁴A. Lindgren & M.D. Tandt, "Home Care: Sold to the Highest Bidder" *The Ottawa Citizen* (1 June 1998) A6.

²⁵CARP 1999, *supra* note 14 at 47.

²⁶FPTWG 1999, *supra* note 2 at 58.

As mentioned, no income assessment is performed for home support services in Ontario, and no copayments are levied on clients. However, there is a maximum of 80 hours funded in the first month, and 60 hours per month thereafter for homemaking services, and a nursing services maximum of 4 visits per day or dollar equivalent up to 28 visits per week.²⁷ If the home care budget runs out, no services are provided. Thus, services are provided on an all-or-nothing basis.

CCAC case managers assess needs and eligibility of eligible clients. Unlike some other provinces, there is no uniform assessment tool yet in Ontario. A pilot project was attempted in the summer of 1999 with a common assessment instrument,²⁸ and, as will later be outlined, an integrated system is imminent in Ontario.²⁹ The case managers are usually registered nurses, but can also be social workers, occupational therapists, or physiotherapists.³⁰ To aid in the education and development of case managers, the Ontario Case Manager's Association (OCMA) was incorporated in 1997.³¹ It is a voluntary organization set up to provide representation and education for managers, as well as promoting the professional role, function and practice of case management to consumers, health and social service providers and government. The OCMA provides a library of publications and community college courses on case management.³²

There are relatively few Ontario regulations governing home care. Regulations under the *Health Insurance Act*³³ and the *Homemakers and Nursing Services Act*³⁴ were changed in 1995 so that a physician no longer needs to authorize provision of home care.³⁵ The *Long-term Care Act*,³⁶ which defines such terms as "caregiver support services," "personal support," and "community support," does not regulate the CCAC' decisions. The only regulation under the *Long-term Care Act* is one which allows a CCAC to convey an interest in an asset it acquires from the province, so long as the asset does not exceed \$500 in value.³⁷ Case managers of CCAC are not governed by any regulations, nor are their assessments held to any legislative standard.

²⁷FPTWG 1999, *supra* note 2 at 58.

²⁸Canadian Institute for Health Information, *Home Care: Health Information Standards and Related Initiatives*, Working Document (Ottawa: Canadian Institute for Health Information, September 1999) at 32.

²⁹CCACIMS Governance Council, "Who We Are and How We Came to Be" (September 1999) 1:1 The Informer 2.

³⁰FPTWG 1999, *supra* note 2 at 16.

³¹Ontario Case Managers Association, "About OCMA..." online: <www.ontcasemanagers.on.ca/about.html> (date accessed: 23 December 2000).

³²*Ibid.*

³³R.S.O. 1990, c.H.6.

³⁴R.S.O. 1990, c.H.10.

³⁵FPTWG 1999, *supra* note 2 at 41.

³⁶S.O. 1994, c.26.

³⁷O.Reg. 179/95.

In 1997/98, the Ontario government estimated that it would spend \$832.7 million on home care, an increase over the \$793.6 million spent in 1996-97.³⁸ Still, according to economist Peter Coyte, for every \$6 removed from hospital budgets, only \$1 is spent on home and community care.³⁹

V. Problems with Ontario's Home Care System

1. Accessibility

Since the assessments done by CCAC in Ontario are based only on need and available support, clients in their region may be rejected for only three reasons. Either it is appropriate for home support to be left to informal, mainly family, caregivers, or the eligibility threshold for "need" is too high for the client to meet, or the CCAC has run out of funds for the year. The first reason, that relying on informal supports is adequate and appropriate and will be dealt with in the next section. The second and third reasons have to do with an inadequate amount of funds in the yearly CCAC budget. A study done by Peter Coyte and Wendy Young showed serious problems with access to acute home care services following hospital discharge in certain regions in Ontario.⁴⁰ Based on "need," those clients at the "front end" being discharged from hospital and needing acute care would displace clients needing more chronic care or those delaying institutionalization. If even the acute care patients were not being served because of inadequate funds, as Coyte and Young found, other patients with chronic care needs clearly would be affected. Indeed, this problem is not limited to Ontario. The 1994/95 Statistics Canada National Population Health Survey, released in July 1998, found that more than half of Canadians with essential needs, including needing help to eat, dress and move about, received no formal home care. Rather, they were required either to rely on informal caregivers, to pay privately, or to do without the needed care.⁴¹ This leads to the second problem, that of equity.

2. Equitable Provision

The current Ontario system of home care assessment is unique in Canada in being blind to income levels. Eligibility is based only on needs. As noted earlier, this creates an "all-or-nothing" scenario for potential clients. While the system incorporates some equity in terms of prioritizing those clients whose medical needs are most acute, if the CCAC uses up its budget on acute patients, no more services are available. As will be proposed later in this paper, cost-recovery in the form of copayments from those able to pay would increase the potential number of clients served by each CCAC while not requiring additional, politically unpalatable, infusions of funds from government.

³⁸CHCA, *supra* note 21.

³⁹P.C. Coyte, "Restructuring Health Finance or Shifting Costs?" (1999)12:8 Hosp. News 10.

⁴⁰See P.C. Coyte & W. Young, "Regional Variations in the Use of Home Care Services in Ontario 1993/95" (1999) 161:4 C.M.A.J. 376.

⁴¹K. Wilkins & E. Park, *supra* note 13.

More funds in the home care budget would allow a lower threshold of “need” to receive home support services. This would further the goal of equity for a number of reasons. However, as less public funds are being expended on home care than are required to meet needs, this has resulted in insufficient access, increased reliance on informal caregivers, and the creation of a two-tiered system. This has occurred even though home care funding has increased. It just hasn’t increased enough to make up for decreases in hospital beds and acute care funding. Those who are able to afford supplemental third party insurance, and those able to pay privately for their own services get care. Others must rely on family members and friends, or do without home care. The elderly would be particularly affected. Not only are they the largest constituents of home care users, but they tend to be less well-off. Twenty two percent (22%) of those aged 65 and over live below the poverty line.⁴²

For those who do receive care, there are caps on the number of hours of services rendered. Once these caps are exceeded, informal care provision, private funding, or institutionalization would be required.

Since acute care services such as nursing and other professional services are generally covered through prioritization and given priority over home support services, it is the realm of home support services where the two-tiered system is most in evidence in Ontario. It is true that hospital replacement services are more needed than homemaking services. However, sometimes the former cannot be provided without enough of the latter. If a client cannot pay privately for such services, or if his or her informal supports are exhausted or absent, medically necessary acute care services cannot be provided in the home. The client would thus have to return to hospital, to an institution, or pay privately. Again, equity could be better achieved through some sort of means testing. More of the poor could gain access in their homes to acute services which are contingent on personal services, if entitlement to the latter is means tested.

3. Lack of Funds Compromising Quality

Constraints on CCAC budgets may compromise quality of home care services, especially with the new RFP system of tendering contracts for private delivery. I will discuss later how the system puts price as the principal concern over quality. An infinite amount of funds does not guarantee infinite quality. Furthermore, infinite funds are not available for publicly funded programs. Thus, there must be some constraints on spending. Still, if demand goes up for home support services, the CCAC will have less budgetary room to work with. They would either have to wait list or reject clients—the accessibility issue dealt with above—or consider attributing more weight to costs than to quality in awarding contracts for providers. In a struggle to provide the cheapest package possible, private providers of home

⁴²C. Lindsay, “Seniors: a Diverse Group Aging Well” (Spring 1999) Canadian Social Trends 24.

care would be driven to casualize their workforce.⁴³ This would lead to compromises in continuity of care, as patients would not be treated by the same people over time.⁴⁴ Barb Wahl, the president of the Ontario Nurses' Association, has spoken on the deterioration of service quality in Ontario under the bidding process.⁴⁵ She cited the example of the nurses at the Kingston branch of Comcare Canada Ltd. With the pressure to offer services at lower costs under the first year of the bidding process, all nurses there are now employed as casual workers but are forced to work as many as 48 hours a week. They serve up to 14 patients a day, some of whom require complex care such as intravenous treatment after heart surgery.⁴⁶

In addition, if firms are unable to offer higher wages, they will lose skilled workers to the acute care and institutional care sector.⁴⁷ Shortage of available health professionals such as physiotherapists and nurses would not only compromise quality, if less qualified personnel are hired instead, but would also affect the aforementioned issue of access. Patients would have to be put on waiting lists until human resources are available.

Once again, cost-recovery would ease some of the strain. In this case, quality could be given greater consideration if budgetary pressures were not so acute.

4. The Hidden Costs of Home Care

One of the reasons home care is so appealing to government is that it results in less public spending. By delaying institutionalization, allowing for shorter hospital stays, and relying on informal caregivers as opposed to public employees, it appears to be cost-efficient. Nevertheless, some of what is saved in terms of public funds is shifted to the private sphere. A recent PriceWaterhouseCooper study showed that 15% of Canadians provided care in the home, and among those people, the average time commitment was 21 hours a week. Women were almost twice as likely to provide care as men.⁴⁸

⁴³See e.g. C. Orridge, Executive Director, Toronto CCAC, "Tough Decisions and New Initiatives Highlight the Year" *Challenge 2000 – CCAC Toronto Annual Report April 1, 1998-March 31, 1999* (1999) at 4, and *CARP 1999*, *supra* note 14 at 46-7 ("Ontario has instituted an RFP process...[with] and open bidding process based, it is stated, on quality, with cost to be considered secondary. The dominant perception, however, is that cost is the primary determinant of contracts" [emphasis original]).

⁴⁴See A. Lindgren & M.D. Tandt, *supra* note 24.

⁴⁵See T. Blackwell, "The Home-Care Business: Ontario's Move to Introduce Competition Under Attack" *The [Montreal] Gazette* (16 February 1998).

⁴⁶*Ibid.*

⁴⁷*CARP 1999*, *supra* note 14 at 69.

⁴⁸A. Picard, "Home Health Care: Only if You Can Afford it" *The Globe and Mail* (7 December 1999) A1.

Fast, Keating and Oakes canvassed the wide range of hidden costs constituencies affected by an increasing reliance on informal personal care.⁴⁹ Patients don't want to feel they are a burden on their family by conscripting their services, preferring instead to be cared for by professionals. Indeed, the National Forum on Health found that "older participants agreed that they did not want to burden their children and spouses. They also emphasized that it was naïve to assume they would even want to be taken care of by their children."⁵⁰

The caregivers themselves may suffer hidden costs such as a decreased physical, emotional, and social well-being, from the fatigue of care itself and lost opportunities in the social and employment spheres.⁵¹ This may also impact on the care the client receives. The informal caregiver may begin to resent him or her, and this would affect the quality of their relationship.⁵²

Employers also encounter costs in accommodating employees' schedules to take care of relatives.⁵³ This, combined with increased absenteeism and need for re-hiring pose indirect, but significant, economic costs not reflected in more narrow studies of the efficiency of informal care.

Care provided by relatives may offer some attractions for the following reasons. It may increase independence, allow greater privacy, cost less in money terms than private care, and arguably result in better, more compassionate care, because providers are tied to the client by caring relationships, rather than financial incentives. Those providing the care benefit through the satisfaction of meeting the needs of a loved one, the maintenance of household privacy, and not having to give instructions to a variety of caregivers. Still, the hidden costs noted above should not be discounted. As this paper will address, some form of compensation for heretofore unpaid care providers, and a home care assessment that does not take such informal care for granted, is warranted.

VII. The Case for Copayments

A system of copayments for certain home care services would help address the problems referred to above. It would recover costs in a way that is acceptable to the public and therefore politically feasible for the government, promote equity, increase access, and actually encourage the use of the economically more efficient option of home care over institutional care. Copayments are justified in this context on legislative, economic and theoretical basis.

⁴⁹See J.E. Fast, N.C. Keating & L. Oakes, *Conceptualizing and Operationalizing the Costs of Elder Care*, NHRDP Project no. 6609-1963-55 (National Health Research and Development Program, 17 March 1997) [hereinafter J.E. Fast].

⁵⁰National Forum on Health, *Canada Health Action: Building on the Legacy*, vol. 2 (Ottawa: National Forum on Health, 1997) at 18.

⁵¹J.E. Fast, *supra* note 49 at 5.

⁵²*Ibid* at 11.

⁵³*Ibid*.

1. The Legislative Justification

The restrictions in the *Canada Health Act* on user charges do not apply to “extended health care services” which, as defined in s.2 of the *Act*, include “(c) home care service”. Therefore, there is no national bar to the provinces charging copayments, which are a form of user charge, for home care services.

It could be argued that the *Canada Health Act* was drawn up before the recent trend towards de-institutionalization. Now, with earlier hospital discharges, and technology able to provide for care in the home, home care is less of a choice and more of an imposition due to fiscal restraints on government. As a result, many advocate bringing home care fully into the *Canada Health Act* as an insured service.⁵⁴ The PriceWaterhouseCoopers poll cited above showed four out of five Canadians wanting free, universal home care services.⁵⁵

To advocate this as an argument against copayments for any aspect of home care services is not warranted if we examine the legislative history of federal funding for health care. There has always been a separation between professional health services and social support services, with means testing for the latter and not for the former. When the *Canada Assistance Plan* (CAP) was enacted in 1966,⁵⁶ most of the services now under the sphere of the continuing care system were in fact in the social services sector. This included long-term care facilities and group homes. The only services administered by the Ministry of Health were professional services such as community nursing.⁵⁷ In 1977, the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* (EPF)⁵⁸ was enacted to allow block funding by the federal government for health expenses. Still, social services were dealt with separately.

This was so despite the findings of the 1964 Royal Commission on Health Services with respect to the range of services under the umbrella of home care. Chief Justice Emmett M. Hall found that:

Home care must be able to provide both the health services proper and such services as home-maker, meals-on-wheels, social welfare and

⁵⁴See e.g. National Forum on Health, *Canada Health Action: Building on the Legacy*, vol. I – *Final Report of the National Forum on Health* (Ottawa: National Forum on Health, 1997) at 20 [hereinafter *NFH Final Report*], Canadian Association for the Fifty-Plus, “Putting a Face on Homecare” *CARP’s National Forum on Homecare – Report and Recommendations* (CARP: Toronto, June 1999) at 12 [hereinafter *CARP 1999 Recommendations*] and National Advisory Council on Aging, *The NACA Position on the Privatization of Health Care* (Ottawa: NACA, 1997) at 18.

⁵⁵See A. Picard, *supra* note 48.

⁵⁶S.C. 1966-67, c.45.

⁵⁷See M.J. Hollander, *Substudy 1: Comparative Cost Analysis of Home Care and Residential Care Services – Preliminary Findings* (Victoria: National Evaluation of the Cost-Effectiveness of Home Care, November 1999) at 33.

⁵⁸S.C. 1976-77, c.10.

friendly visitors needed to provide the adequate environment for the effective functioning of health services.⁵⁹

Even though he took note of the broad range of services under the rubric of home care, he still appears to have recommended separate treatment of acute hospital-replacement services and home support, consistent with the separate legislative coverage in CAP and EPF. In his final recommendations, he writes:

The Commission recommends...

120. That the Hospital Insurance and Diagnostic Services Act regulations be interpreted to cover costs of patient care provided by hospital-based home care programmes.

121. That the Hospital Insurance and Diagnostic Services Act regulations be interpreted to include as *shareable costs payments* made to community-based home care programmes for care provided to hospital patients returned to their homes but retained on the hospital register.⁶⁰

In other words, acute-care replacement would be publicly covered through the *Hospital Insurance and Diagnostic Services Act*, but other services would be subject to costs shared by the clients. A separation between the two types of services is inherent in his financing recommendations, and is reflected in the means testing for CAP in contrast to the universal coverage under EPF.

It was only in April 1996, when the Canada Health and Social Transfer (CHST) was established that CAP and EPF were brought together. The CHST mandated block federal funding for provincial social, health, and educational services.⁶¹

Thus, until 1996, federal funding for social services was dealt with separately from health services. There is some historical basis, then, for charging copayments and assessing means for social support while still providing universal acute care replacement without private contributions.

Ontario has chosen not to include social services under insured health services in the home care sector. Section 552 of the *Health Insurance Act* does not include “social services,” or “personal support” under its list of insured services for care in the home.⁶² Since they are not insured, such services may be subject to user charges

⁵⁹Royal Commission on Health Services, vol. I (Ottawa: Queen’s Printer, 1964) (Commission Chairman: Chief Justice Emmett M. Hall) at 627.

⁶⁰*Ibid.* [emphasis added].

⁶¹M.J. Hollander, *supra* note 57 at 38.

⁶²See definition of “home care services” at O. Reg 375/93, s.13(1). The definition of insured home care services includes, *inter alia*, services from nursing, physiotherapy, occupational therapy, speech therapy, social workers, and nutritionists, as well as diagnostic and laboratory services, hospital equipment, and

by the province. Thus, there is no provincial legislative barrier to introducing copayments.

2. Economic Justification for Copayments in Home Care

If copayments are able to increase accessibility to home care services, it will lighten the burden on institutional care. This would allow more consumer substitution of home care, by allowing the consumer to choose home care over institutional care, or by allowing care providers to recommend home care over institutional care more frequently for more expensive forms of care. Thus, there would be a more efficient allocation of public health care funds, since the cheapest alternative would be used. In a recent study by Hollander in British Columbia, public costs for home care were found to be only 50 to 75% of the costs of institutional care for comparable levels of care.⁶³ Hollander also found that as the number of clients using B.C.'s home care services grew, utilization rates for institutional care fell. He therefore concluded that "at a systems level, it appears possible to substitute home care services for residential care services over time...reduc[ing] overall costs for the system given the cost differentials in home care compared to residential care."⁶⁴

The results of this study and others that show public cost savings in the use of home care services must be balanced with the concerns expressed earlier in this paper about hidden costs to informal caregivers. Still, if copayments increase accessibility, at the very least consumers would have greater freedom of choice. If consumers have the option to access public funding to meet part of their home care needs, the burden of informal care may be lower because it would be more voluntarily borne. Consumers would be able to make substitutions to more efficient choices, creating savings for the overall health budget

If more money is poured into the home care sector by the government at the expense of other areas of the health care budget, these other important areas will suffer. This is another justification for cost-recovery from *within* the home care budget as opposed to diverting funds from other sources. Still, the most efficient option is not always the most effective option. If clients needing chronic care get *better* care with the more expensive option, it would at least serve another goal.

Because of the range of services offered in home care, from acute care substitution to home support, there is a potential danger of moral hazard for the latter type of services. Moral hazard, or the increased use of a good if the costs are borne by another party, is not as relevant in the acute care side. People generally will not seek out painful medical procedures just because they are free of cost to them. However, if housecleaning is offered as a free service, for example, it may

transportation services. It does *not* include personal services, homemaking, or other social support.

⁶³See M.J. Hollander, *supra* note 57.

⁶⁴*Ibid* at 113.

be overused by clients who do not bear the cost. This would strain the amount of resources available for publicly funded home care.

The argument of moral hazard is addressed with a system of means-tested copayments. To begin, under the *Health Insurance Act* in Ontario, if the client does not need any professional services at all, he or she is not eligible to receive public funding.⁶⁵ Copayments would serve to deter overuse of the social services side of a home care package by those most able to afford covering the costs on their own, since the home support services would not be free of cost under the system proposed here. It is true that lower-income clients would not have to pay for home support, but needs-based limits on the total number of hours available, as assessed by case managers, would mitigate the concern.

3. Political Justification for Copayments

To increase the amount of resources available for home care, funds must come either from within the home care system or from other parts of the provincial budget. The latter option was one of the suggestions coming out of the National Forum on Health, recommending more funding for home care from a “reallocation of savings from reductions in the institutional sector”.⁶⁶ Aside from the problem that this option would take funds from acute patient care in hospitals and long-term care institutions to fund more stable patients at home, diversion from these sectors would not be politically feasible with current pressures on government to spend more on acute care and hospitals.

Another alternative is to raise taxes to pay for the increased funding. This, however, would likely be even more politically unattractive option in the current era of tax cuts. Calling on government to just spend more, without efforts to become more efficient with limited resources, will not be in the long-term best interests of Ontario’s health care system.

4. The Theoretical Argument – Improper Analogy to Acute Care

The arguments against user charges in the acute care and hospital setting do not hold in the setting of home care. User charges in hospital may discourage use of needed health services. This may, in the end, result in greater costs on the health care system because it encourages patients to wait until their medical condition gets intolerable before getting treated. More expensive care would then be required. User charges are also inequitable, as the poor would be more discouraged from seeking needed care than the rich.⁶⁷

⁶⁵R.R.O. 1990, Reg. 552, s.13(4)(d).

⁶⁶NFH Final Report, *supra* note 54 at 23.

⁶⁷G.L. Stoddart, M.L. Barer & R.G. Evans, Ontario, The Premier’s Council on Health, Well-being and Social Justice, *User Charges, Snares and Delusions: Another Look at the Literature*, (Toronto: Queen’s Printer, 1994) at 31.

In the home care setting, it could be contended that user fees would discourage use of this more economically efficient option and force more patients into costly institutions. Alternatively, it may force informal caregivers to take on the responsibilities of care, with all the hidden costs alluded to above.

In the system proposed here, these problems are addressed. The goal of copayments is not to discourage use of home care services. Rather, some form of cost-recovery would improve access by increasing the pool of funds available for such services. As it now stands, clients are either accepted, rejected or put on a waiting list for when services become available. If the budget runs out before you as a client are assessed, no services are provided at that time. Greater access to needed services could be achieved by increasing the budget.

Copayments based on a means-based sliding scale would also be of assistance. Those most likely to be discouraged from using home care because of costs, the poor, would have the most help. Those who could afford home care may decide to utilize it even with copayments because the alternative of institutionalization may seem less appealing.

Clients must share costs for institutional long-term care, even in Ontario through means-tested user charges. Arguably, then, co-payments for home care, by themselves, would not discourage use.

Cost recovery may allow for some financial compensation of informal caregivers. As well, if the home care assessment does not take informal supports for granted, there will be less inequities with respect to accidents of family situation.

Another argument *against* user fees is that medical services, by their very nature, are not suitable for the free market. Consumers, in this case patients, are not sufficiently informed to make decisions about whether or not to use the goods in question: medical services. A great deal of information asymmetry exists between the providers, the physicians and other professionals, and the patients.

Again, with a distinction being made between acute, hospital replacement services and home support services, this problem is addressed. Copayments would not be levied against acute care services, but only means-tested social services. While home care clients may not be well-informed about choices in the acute and professionally delivered side of home care, certainly for unskilled and, with training, semi-skilled labour, there is not the same asymmetry. People generally know how to clean a house, and when a house is sufficiently tidy. As well, it is possible to train clients to change dressings or insert catheters themselves.

Lastly, Canadians may argue they have a "right" to health care. Home care in this view may be seen as a package that should not be subject to any charges, for fear of the "Americanization" of our health care system.

“Rights,” however, always have limits. It would be impossible without unlimited public funds to expand indefinitely the scope of what is defined as “health”. Given a limited pool of resources, we must do what we can in the most efficient and equitable manner possible. In the case of home care, it may be that some restrictions in terms of costs and hours on those who actually receive home care are necessary to ensure that no one is denied any base level of needed care in the home setting. That is, universality of coverage must be sacrificed in order to further the goal of accessibility. With a modest system of copayments, greater accessibility to some publicly funded services can be achieved at the expense of other services being privately funded by those able to do so.

As home care services, a basket of health services and social services, become less like professional health services and more like home support, the argument for an absolute “right” to public coverage becomes weaker. This will be reflected in the prioritization of services in the system to be outlined in this paper.

VIII. An Equitable Solution to Improve Access to Home Care

1. Means and Needs Assessment

Case managers of the CCAC could perform assessments based on two independent criteria: needs, then means. Under the first criteria, the needs of the client would be ranked in order of health priority. Generally, the greater the degree of professionalisation involved in the delivery of the service, the greater the priority. First on the list would be acute care substitution services, then other professional home care services such as physiotherapy, occupational therapy, and speech therapy. The list would then run from semi-skilled to unskilled services. Supplies, equipment and pharmaceuticals may be inserted into the list where they are deemed necessary by the case manager.

Once needs are prioritized, means would then be assessed. Household income would be calculated, and assets excluding the primary residence may be taken into account to some degree, as they are in New Brunswick.⁶⁸

A sliding scale would then be applied to the “needed services” list to determine the amount of public coverage for that particular home care client. This sliding scale would begin after taking into account acute care substitution, which would always be publicly covered. The funding allocation for that means-tested client would be held against the list of prioritized home care needs to determine the extent of coverage. What is not fully publicly insured would be subject to copayments by the client. Since home care providers are privately contracted through the CCAC, what is not publicly covered will be recouped by the agencies themselves through the clients. The government thus increases accessibility not through direct payments, but through paying less to more well-off clients.

⁶⁸FPTWG 1999, *supra* note 2 at 60.

As will be discussed in the last section, Ontario is currently studying an integrated standardized assessment tool. This would streamline the process and ensure universality of assessments across the province.

Vertical integration has been suggested in many quarters as a means by which to improve access upon leaving hospital.⁶⁹ With a smooth transition between hospital and the home, with compulsory assessments of home care needs at discharge, less patients discharged from hospital would miss the opportunity to have their home care needs.

2. Recognition of Informal Caregivers

This paper argues against the presence of informal support being considered as a reason not to offer formal support. Instead, once the list of needed services is made up and the degree of public funding is determined, the client will be offered the option of formal care providers. If desired by the client, informal care could provide a substitute. As argued by Neysmith and Nichols, we must

unhook the provision of home care from accidents of family structure and attach it to old people as a right of citizenship. Rather than a home care model that supports family caregivers, the policy goal would be to support old people, free of any assumptions about the availability and ability of kin... Such a focus would free kin, primarily women, from the 'mandate of care.'⁷⁰

Moreover, informal caregivers should be offered financial compensation, within budgetary constraints, to recognize their work. The compensation could be through a specific pool of funds, with compensation offered to the poorest clients first. Only three provinces have introduced compensation programs for informal caregivers thus far.⁷¹ Québec offers tax subsidies⁷² while Nova Scotia and New Brunswick offer tax credits.⁷³ Another form of compensation is in the form of wages for informal caregivers, as is done in some Scandinavian countries.⁷⁴

The purpose of compensation can be thought of as social or economic.⁷⁵ A social justification would be that at least some payment would recognize the contribution made by family or other informal caregivers in providing necessary

⁶⁹See e.g., *NFH Final Report*, *supra* note 54 at 24, and *CARP 1999 Recommendations*, *supra* note 54 at 12.

⁷⁰S.M. Neysmith & B. Nichols, "Working Conditions in Home Care: Comparing Three Groups of Workers" (1994) 13:2 *Canadian J. on Aging* 169 at 182-3.

⁷¹J.N. Keefe & P. Fancey, "Financial Compensation or Home Help Services: Examining Differences Among Program Recipients" (1997) 16:2 *Canadian J. on Aging* 254 at 256.

⁷²M.W. Sorochan, *supra* note 9 at viii.

⁷³J.N. Keefe & P. Fancey, *supra* note 71 at 256.

⁷⁴See M. Hokenstad & L. Johansson, "Caregiving for the Elderly in Sweden: Program Challenges and Policy Initiatives" in D. Biegel & A. Blum, eds., *Aging and Caregiving* (Newbury Park, CA: Sage, 1990).

⁷⁵J.N. Keefe & P. Fancey, *supra* note 71 at 256.

service. The informal caregivers may have provided care without reimbursement, so even a small tax credit may be sufficient.

Another possible justification for financial compensation is economic. Providing incentives for informal caregivers to substitute for more expensive, publicly provided, formal care would save public costs. Hourly wages would fulfill such a purpose.

To address the hidden costs outlined earlier in the paper, the social justification is more germane. In fact, the economic justification may turn out to have an adverse impact on the poor. More wealthy family members would not be swayed either way in their decision to provide care by a small hourly wage, but the poor and the unemployed would be more heavily influenced by such inducements.

Tax credits or other compensation would be preferable to tax deductions. Those with low or no income could not take full advantage of tax deductions. Tax credits are a more equitable form of compensation with respect to income.

With a larger pool of funds from copayments, a modest system of tax credits or other compensation for informal caregivers may mitigate some of the hidden costs associated with such care. At the very least, it may decrease some of the resentment they may feel for their otherwise uncompensated labour.

IX. Possible Criticisms of the Proposal

As attractive as equitable cost-recovery from copayments may sound, some may contend that the proposal is financially unrealistic. As noted above, the primary users of home care are the elderly, and the elderly in general are in the lowest income brackets. The “rich” clients providing copayments may not be numerous enough to make such a system worthwhile. As well, a Statistics Canada study showed that in Ontario, 40% of the annual home care caseload was acute care patients, patients who (as will later be outlined) would not pay copayments under the system proposed here.⁷⁶ The administrative costs may be too high to justify the amount that would be collected.

While it may be true that there will not be a huge amount of costs recovered through copayments, this concern does not mean that copayments have no place whatsoever in home care. To begin, all provinces but Ontario have at least some assessment of means, with seven of the ten levying copayments. If the system is not worthwhile, why is it so prevalent in Canada?

An examination of two provinces’ systems of means-tested copayments shows their feasibility. Both Saskatchewan and British Columbia have had left-leaning New Democratic Party provincial governments for at least the last two provincial

⁷⁶P.C. Coyte, W. Young, & D. De Boer, *Home Care Report: Report to the Health Services Restructuring Commission* (Toronto: Health Services Restructuring Commission, 1997).

mandates, and yet have continued to levy copayments. Moreover, Saskatchewan had earlier attempted user charges for hospital inpatients and found it to be problematic.⁷⁷ Notwithstanding this, they later instituted copayments for home care services.

All clients are expected to cover some of the costs of home support services in the home care package in Saskatchewan.⁷⁸ Meals-on-Wheels and home management services, which are provided by employees of the district health boards funded by the Saskatchewan Department of Health, are subject to copayments. Nursing and other professional services are completely publicly funded. During the initial assessment of needs, the case manager also asks about resources, and makes deductions, to arrive at an adjusted monthly income. Services are measured in terms of "units," with each unit being one meal or one hour of service. The cost to the client in copayments is \$5.75 per unit up to 10 units. Each subsequent unit's cost is adjusted to reflect the client's adjusted income. The end result has clients contributing between \$57.50 per month to a maximum of \$347 per month. Cost recovery was \$6.6 million in 1997/1998.⁷⁹ The total government budget for home care in Saskatchewan that year was \$70.3 million.⁸⁰

The case in British Columbia with respect to copayments, however, is perhaps more analogous to Ontario. Unlike Saskatchewan, B.C. contracts for private delivery of home care services, rather than relying on government employees.⁸¹ Income testing for social services, as part of the home care package, does not carry a large administrative cost in client assessments. A standardized assessment computer system is in place throughout the province. The case manager at each health region, in their assessment interview with the client on needs, asks only four additional questions regarding income. The marginal cost, then, is very low for means testing.

A sliding scale is then applied for public coverage of home support services, taking the client's means into account. What is not publicly covered must be paid by the client. The private home care agencies whose services are purchased send their bills to the government. The government pays a certain percentage of the labour and other costs, based, as mentioned, on the sliding scale. Thus, the administrative costs of collecting the copayments are borne by the private sector. If the client refuses to pay, it is up to the provider to deal with the matter, not the government. The system of copayments has remained despite the fact that, as a 1993 study showed, 70-80% of assessed home care clients in B.C. were on Old Age

⁷⁷See R.G. Beck & J.M. Horne, "Utilization of Publicly Insured Health Services in Saskatchewan Before, During, and After Copayment" (1980) 18:8 Medical Care 787.

⁷⁸Telephone communication D. Kerr, Program Consultant, Community Care Program, Saskatchewan Department of Health, 13 December 1999. Information on the system of copayments.

⁷⁹FPTWG 1999, *supra* note 2 at 75.

⁸⁰*Ibid* at 72.

⁸¹Telephone communication, M.J. Hollander, President, Hollander Analytical Services Ltd., Victoria, B.C. 13 December 1999. Information on B.C.'s income tested copayment scheme.

Security and Guaranteed Income Supplement.⁸² Thus, copayments were worthwhile even with only 20-30% of clients paying into the system. Indeed, the fact that the system of copayments survived through, as noted above, two consecutive left-leaning New Democratic Party provincial mandates is testimony to their cost-effectiveness.

Ontario is similar to B.C. and differs from Saskatchewan, in that the CCAC purchase home care services from private home care providers with the RFP system. Thus, administrative costs for copayment collection will be borne by the private sector, not by government. Further, following the lead of many other provinces, Ontario is studying a move towards a standardized assessment tool. It expects to have the uniform tool up and running in the next two to three years.⁸³ Entitled the CCAC Information Management and Services (CCACIMS), it is the outcome of discussions by an informal working group composed of the Ministry of Health and the CCAC Governance Council.⁸⁴ The CCACIMS will “deliver an integrated information/computer system to the Ontario CCAC”.⁸⁵ Once a common assessment system is set up, it seems feasible that Ontario could join most other provinces in instituting means-tested copayments at a reasonable administrative cost. Adding a few additional questions on income would not carry a large marginal cost. As well, if copayments based on means are already levied in Ontario for institutional long-term care, it does not seem inconceivable to have such a system for home care assessments. Still, the feasibility of incorporating means testing would have to be studied before its implementation in Ontario.

Second, in all but the acute care substitution model, home care is an alternative to long-term institutional care. In all provinces, including Ontario, clients are expected to privately cover some of their costs in such institutions according to means. Only in hospitals is there no expectation of user charges, and, as argued, no copayments for acute care substitution would be levied in the system proposed here.

Lastly, as submitted above, some universality of public coverage must be sacrificed to ensure greater access. If some clients cannot receive any home support because the CCAC budget has run out, they would in effect be paying a 100% user fee based on an accident of timing. Means testing to ensure more equitable access, even if it would involve some private copayments, would be preferable. As well, any cost-recovery would ease the strain on the CCAC in considering contracts for care delivery. Thus, more effective service with higher quality may be achieved.

Another possible objection to copayments would be that the middle class and the wealthy would simply use the private system if they were forced to pay for

⁸²M.J. Hollander & P. Pallan, “The British Columbia Continuing Care System: Service Delivery and Resource Planning” (1995) 7:2 *Aging* 94 at 98.

⁸³C. Orridge, Executive Director, Toronto CCAC, telephone communication, 9 December 1999.

⁸⁴See CCACIMS Governance Council, *supra* note 29 at 2.

⁸⁵*Ibid* at 3.

possibly substandard public home care. Once they are no longer using the public service, there would not be the incentive to use their political voice to lobby for improvements.

While the argument is a powerful one against separate public and private acute care systems, it is not applicable to the proposal submitted here. The current situation has some clients fully covered for home care, and others paying a 100% user fee on the private market or with informal care, if resources cannot cover the new client. With income-tested copayments, even wealthy clients would have an incentive to use the public system. At least some costs would be covered, namely the acute care substitution, and possibly the less acute but higher priority needed services (depending on the public coverage from the sliding scale). A partial copayment is better than paying the full cost of a home care package. By improving access through a larger budget with cost-recovery, there would be fewer clients outside the public system.

X. Conclusions

This paper has argued that, if properly administered, copayments would be appropriate for some services in the home care setting in Ontario. Such cost-recovery would improve accessibility to needed support on an equitable basis, admittedly at the expense of less universality of public coverage.

Arguments against user charges in other contexts in the health care system would not be valid with respect to social services for home care. Copayments may actually increase accessibility rather than discourage use. Through cost-recovery, there may be more budgetary room to give quality of service considerations greater weight than cost considerations in tendering contracts for delivery through RFPs. Copayments may offer more consumer choice resulting in more efficient substitutions for institutional care. Promoting cost recovery from within the home care sector rather than diverting funds from other areas of the health care system is also more politically attractive.

The plight of informal caregivers, with the attendant hidden costs imposed on the chronic cared-for patients, the caregivers' employees and the caregivers themselves, should not be overlooked. By de-linking the provision of home care support from family situations and offering financial compensation to informal caregivers to the extent financially possible, these costs will be mitigated.

While Canadians expect a "right" to health care services, like all rights, there are limits. With scarce resources, clients cannot demand universal public access to all services surrounding health care on a permanent basis. Efficiency dictates that we make do with what is available. An equitably administered system of copayments based on a sliding scale of means and needs, with an exemption from

private payments for acute care substitution, and a recognition of the work of informal caregivers, would further the goal of efficient and effective health care in the home setting.