Moving Towards Autonomy: Self-Directed Care

Colin Busby
Associate Director of Research, C.D. Howe Institute

Presentation to Canadian Homecare Association
Edmonton: October 16, 2017
Why autonomy?

Why the current framework for eldercare is poorly suited to future demographic and political pressures

International Models for more self-directed care
  - France
  - Germany
  - Australia

What are the touch points and challenges in moving towards more self-directed care frameworks? (Discussion)
A perceived lack of control and autonomy can hinder physical and mental health among the elderly.

In spite of frailty, autonomy can promote mental alertness and result in high rates of self-rated well being (Johannesen et al 2004; Kane 1995; Rogers and Mitzner 2017).

If people are happier and healthier when they have a greater say and control over their care as they age, how well have our policies and programs been designed?
“Targeted Universality” – those who need home care will have access to it regardless of ability to pay. Many surveys of Canadians show that they think the government will or should cover their health costs as they age.

There is excess demand for subsidized care, with long wait lists in some cases:
- Some patients wait at home – heavy burden on family members
- Current rationing of subsidized homecare inefficient and inequitable
- Many occupy beds in acute-care hospitals
- Raises public healthcare costs and contributes to waiting lists for acute care procedures

How prepared are we for coming demographic push?
Home care patients among ALC discharges, 2010
Care Needs by Setting and Age Group

Source: Statistics Canada (2013).
Canada’s Population for critical ages, by age group, 1975-2055

Source: Statistics Canada (2017)
Female share among high-demand age group, 2015

- 70-79: 53%
- 80-89: 59%
- 90-99: 71%
- 100+: 87%

Source: Statistics Canada (2017)
Provincial home care services are currently negotiated by governments, with patients paying a share of cost.

Other countries (France, Germany, Australia) allow benefits to be received similar to a voucher.
- In some cases, patients can choose between in-kind and in-cash options.

Benefits continue to be means tested but patients can choose among a wider range of options and potentially subsidize informal family caregiver.
- Would lead to more patient selection among providers.
- Reduce wait lists.
- Improve autonomy (Quebec 2012 white paper on Autonomy Insurance).
Increase recognition of diversity in care needs and slow responsiveness of publicly-managed care to these needs
Preference for living in one’s home
Need to ensure choice
Desire to improve consistency of care for all people with similar needs
Desire to introduce competition into care markets
Boost job growth in caregiver services
Promote independence among elderly
Etc.
**Central features**
- A universal assessment system
- Funding mechanism based on need but controls government costs
- Oversight system to ensure quality
- Accountability – who will oversee and coordinate care

**The French and German Models – some important differences in expectations and origins**
### Applicant Characteristics – Degrees of Dependence

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 6*</td>
<td>Autonomous for essential activities of daily life.</td>
</tr>
<tr>
<td>Level 5*</td>
<td>Person who may only need occasional help with toileting, meal preparation and housekeeping.</td>
</tr>
<tr>
<td>Level 4</td>
<td>Some mobility limitations, but can move within his or her housing; needs aid for washing and dressing; or person having no mobility problems but must be helped for body care and meals.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Person with mental autonomy, but who needs daily and several times a day to help for personal care.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Person confined to bed or chair, whose mental functions are not fully impaired and whose condition requires support for most everyday activities; or a person whose mental functions are impaired, but is able to move and requires constant monitoring.</td>
</tr>
<tr>
<td>Level 1</td>
<td>Person confined to bed or chair, whose mental functions are severely impaired and requires an essential and continuous presence of caregivers.</td>
</tr>
</tbody>
</table>

Note: Levels 5 and 6 do not qualify for benefits, but are still used for assessing care needs.
<table>
<thead>
<tr>
<th>Category of Care</th>
<th>Monthly Max. in Euros, 2014</th>
<th>Recipients in Home</th>
<th>Recipients in Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 4</td>
<td>565</td>
<td>36</td>
<td>9</td>
</tr>
<tr>
<td>Level 3</td>
<td>845</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Level 2</td>
<td>1,125</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>Level 1</td>
<td>1,315</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

### Care Needs and Required Services in Aged Care, Germany

<table>
<thead>
<tr>
<th></th>
<th>Care Level I – Need for Considerable Care</th>
<th>Care Level II – Need for Intensive Care</th>
<th>Care Level III – Need for Highly Intensive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help with personal care,</td>
<td>At least once a day for at least two tasks in one or more areas</td>
<td>At least three times a day at different times of the day</td>
<td>Assistance around the clock</td>
</tr>
<tr>
<td>nutrition or mobility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional assistance</td>
<td>Several times a week in taking care of the household</td>
<td>Several times a week in taking care of the household</td>
<td>Several times per week in taking care of the household</td>
</tr>
<tr>
<td>Nursing staff needs</td>
<td>At least 1.5 hours/day on the average</td>
<td>At least 3 hours/day on the average</td>
<td>At least 5 hours/day on the average</td>
</tr>
<tr>
<td>Source: Schölkopf (2013)</td>
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</tr>
</tbody>
</table>
### Size of Monthly Homecare Benefits, Germany

<table>
<thead>
<tr>
<th>Category of Care</th>
<th>Home Care (cash)</th>
<th>Home Care (in kind)</th>
<th>Institutional Care (full time)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>235</td>
<td>450</td>
<td>1,023</td>
</tr>
<tr>
<td>Level II</td>
<td>440</td>
<td>1,100</td>
<td>1,279</td>
</tr>
<tr>
<td>Level III</td>
<td>700</td>
<td>1,550</td>
<td>1,550</td>
</tr>
</tbody>
</table>

*Note: special hardship request possible.
Source: Schölkopf (2013).
Policy Issues

- How do we balance autonomy and risk?
- What about cognitive limitations?
- To what extent should care coordinators take into account the availability of family caregivers?
- How do we ensure quality care?
- Can an effective means test be designed that limits government costs?
End of Slideshow