Moving Towards Autonomy: Self-Directed Care

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Presentation to Canadian Homecare Association
Edmonton: October 16, 2017

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Outline

- **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)**

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- **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?**

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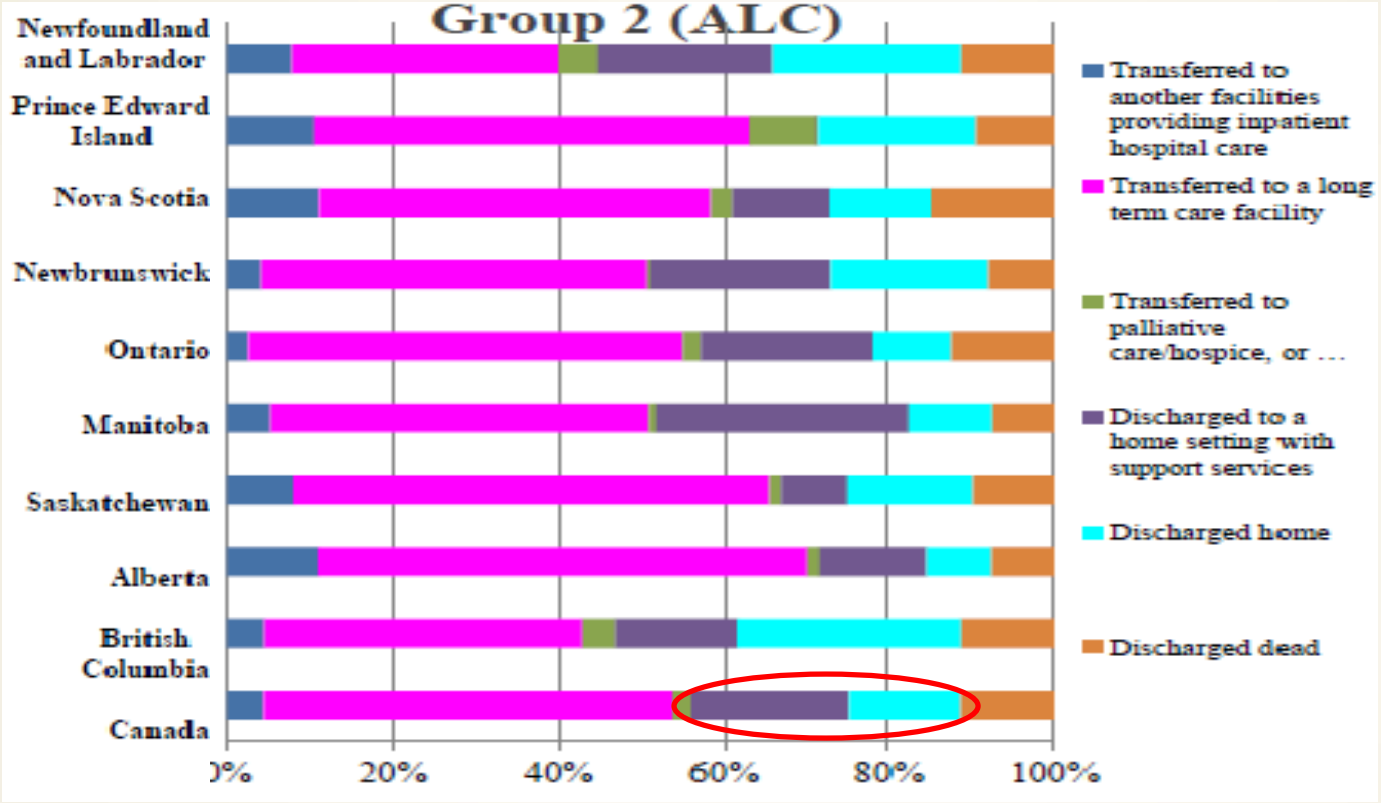
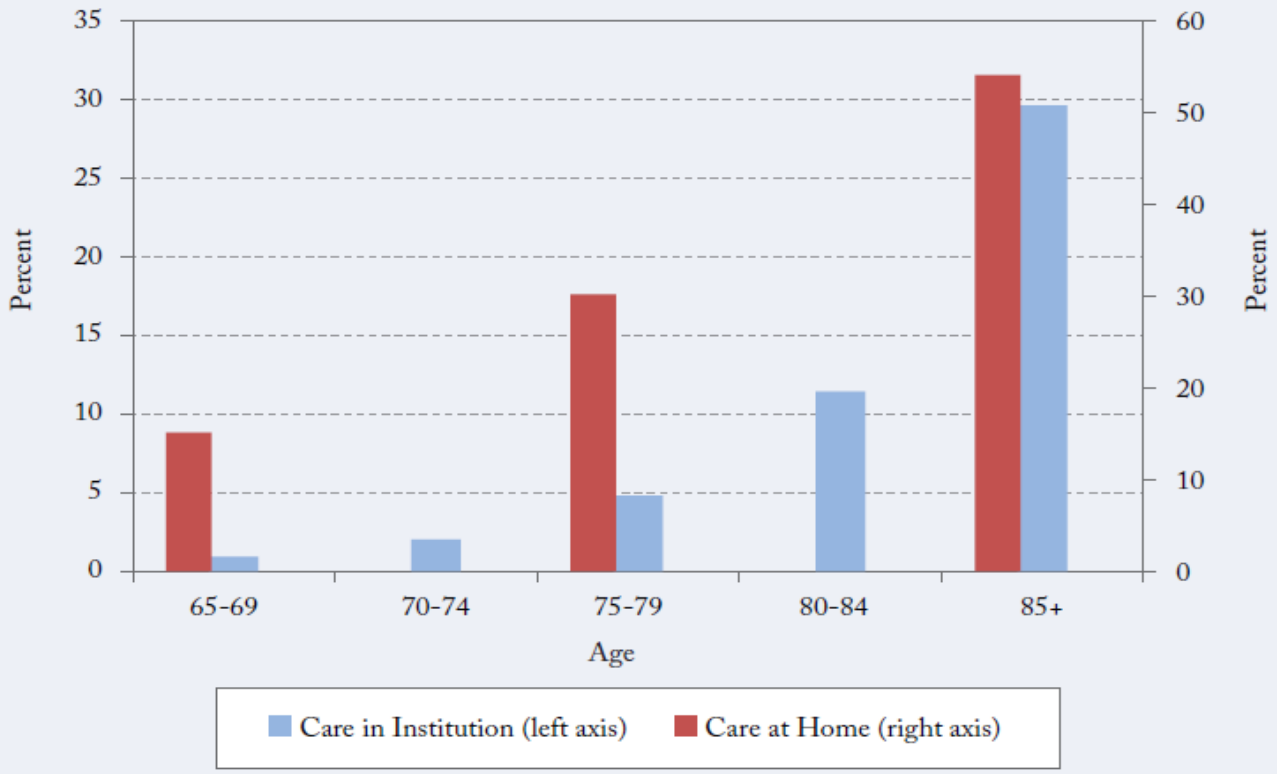
Home care patients among ALC discharges, 2010



Care Needs by Setting and Age Group



Source: Statistics Canada (2013).

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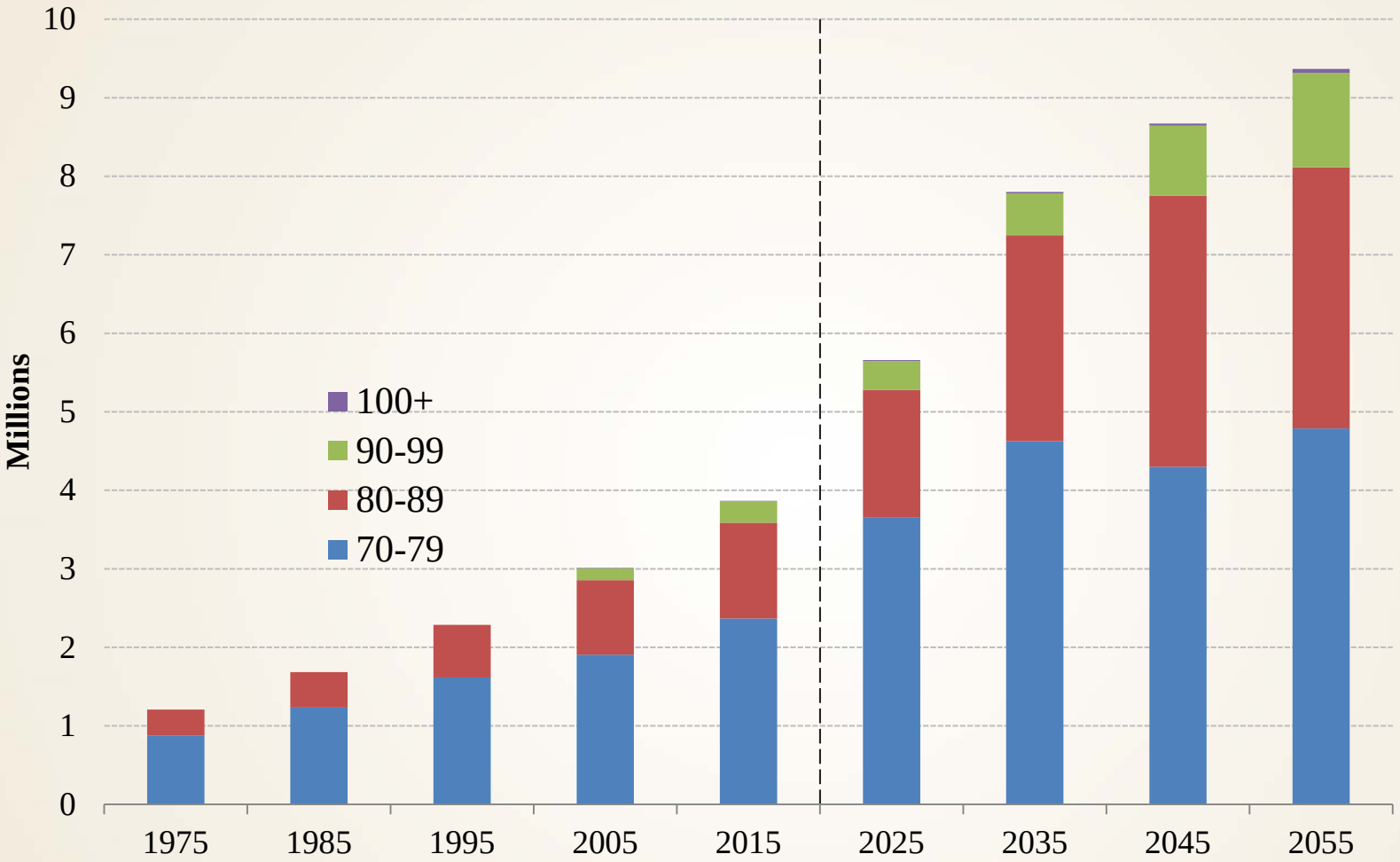
Canada's Population for critical ages, by age group, 1975-2055



Source: Statistics Canada (2017)

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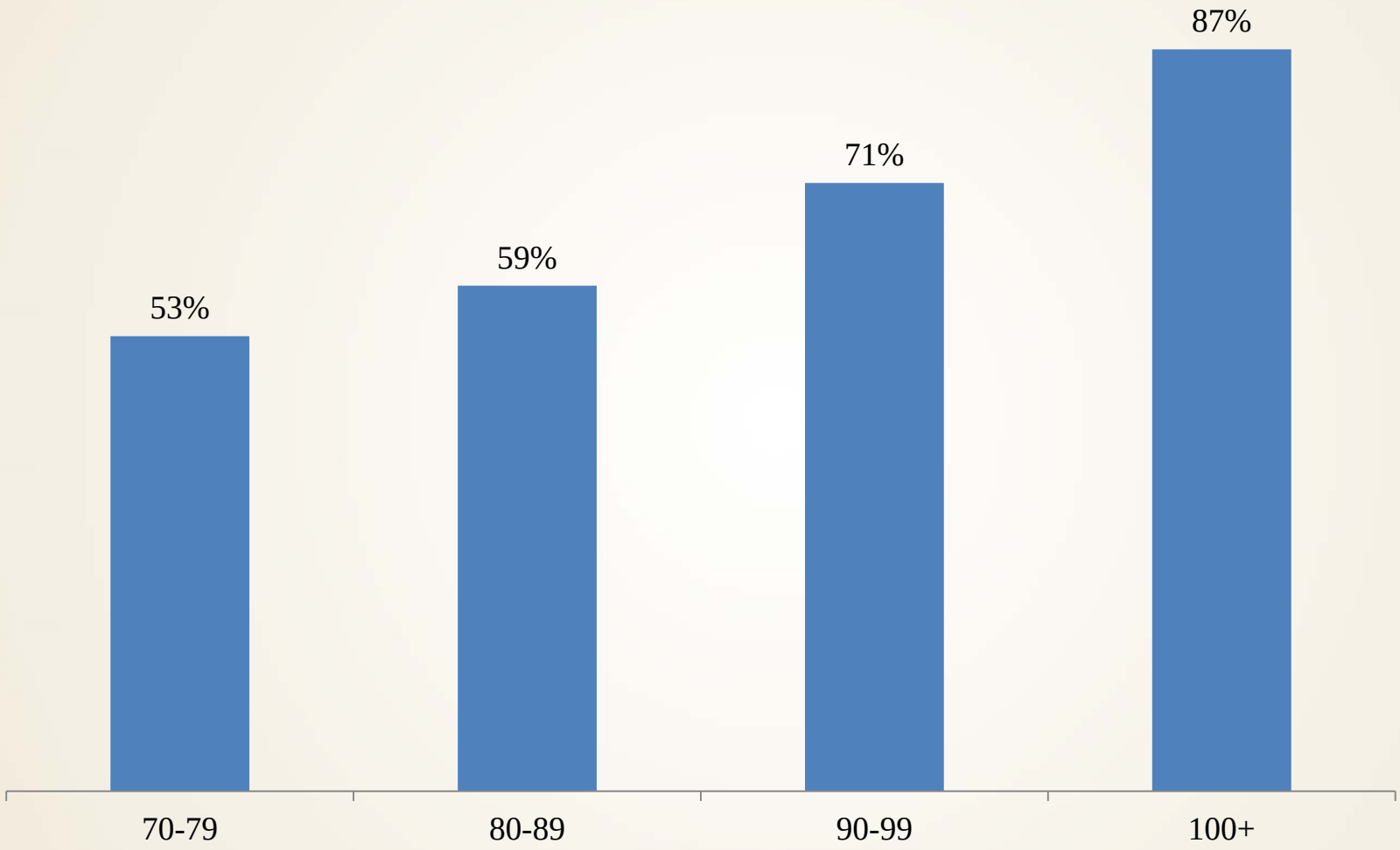
Female share among high-demand age group, 2015



Source: Statistics Canada (2017)

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Elder Care Financing – Policy Debates: What About Cash-like rather than In-kind Subsidies

- **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)**

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Rational for Moving Towards More Self-Directed Care

- **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.**

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- **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**

Assessed Categories of Care, France

	Applicant Characteristics – Degrees of Dependence
Level 6*	Autonomous for essential activities of daily life.
Level 5*	Person who may only need occasional help with toileting, meal preparation and housekeeping.
Level 4	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.
Level 3	Person with mental autonomy,but who needs daily and several times a day to help for personal care.
Level 2	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.
Level 1	Person confined to bed or chair, whose mental functions are severely impaired and requires an essential and continuous presence of caregivers.

Note: Levels 5 and 6 do not qualify for benefits, but are still used for assessing care needs.

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Size of Monthly Homecare Benefits, France

Category of Care	Monthly Max. in Euros, 2014	Recipients in Home	Recipients in Institutions
		percent of all recipients	
Level 4	565	36	9
Level 3	845	13	6
Level 2	1,125	11	18
Level 1	1,315	2	6

Source: France (2015) and Le Bihan and Martin (2013).

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Care Needs and Required Services in Aged Care, Germany

	Care Level I – Need for Considerable Care	Care Level II – Need for Intensive Care	Care Level III – Need for Highly Intensive Care
Help with personal care, nutrition or mobility	At least once a day for at least two tasks in one or more areas	At least three times a day at different times of the day	Assistance around the clock
Additional assistance	Several times a week in taking care of the household	Several times a week in taking care of the household	Several times per week in taking care of the household
Nursing staff needs	At least 1.5 hours/day on the average	At least 3 hours/day on the average	At least 5 hours/day on the average

Source: Schölkopf (2013)

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Size of Monthly Homecare Benefits, Germany

	Benefits in Euros, 2012		
Category of Care	Home Care (cash)	Home Care (in kind)	Institutional Care (full time)*
Level I	235	450	1,023
Level II	440	1,100	1,279
Level III	700	1,550	1,550

Note *special hardship request possible.

Source: Schölkopf (2013).

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- **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