Institute of Health Policy, Management & Evaluation
UNIVERSITY OF TORONTO

Canada's Health Care System and Frailty

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CIHR Summer Program on Aging

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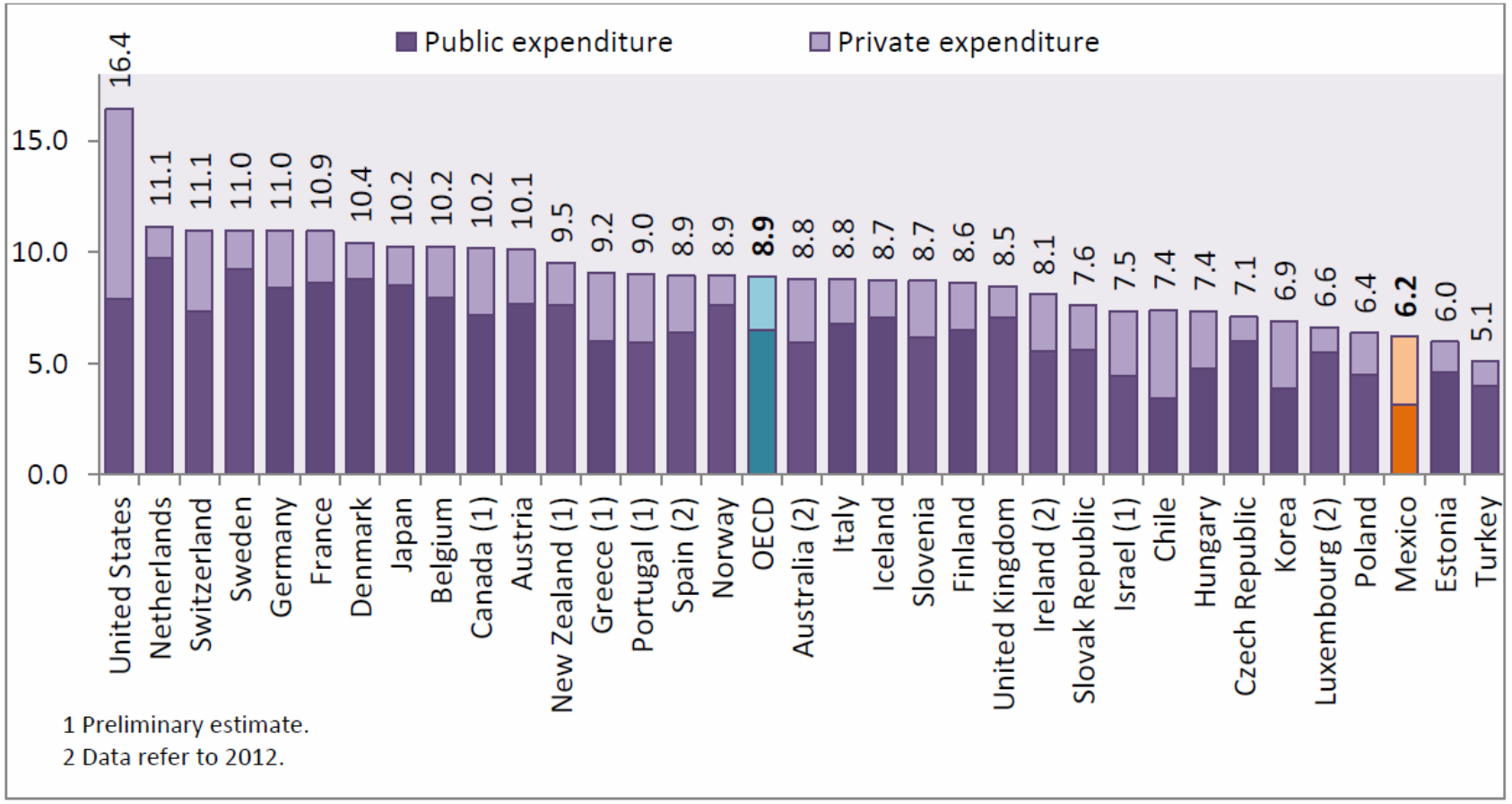
Objectives

- Provide a high level overview of the Canadian Health Care System in the context of frailty
  - Health and Health Care
  - Canadian Medicare's principles, benefits and key design dimensions
  - Sub-fields including home and community care
- Consider emerging challenges with changing population needs
  - Demand and supply issues
  - Institutional and structural factors shaping current and future policy-making

Part 1

Health Care? Who Cares?

What Countries Spend: OECD 2012



Source: OECD Health Statistics 2015.
https://www.oecd.org/els/health-systems/Country-Note-CANADA-OECD-Health-Statistics-2015.pdf

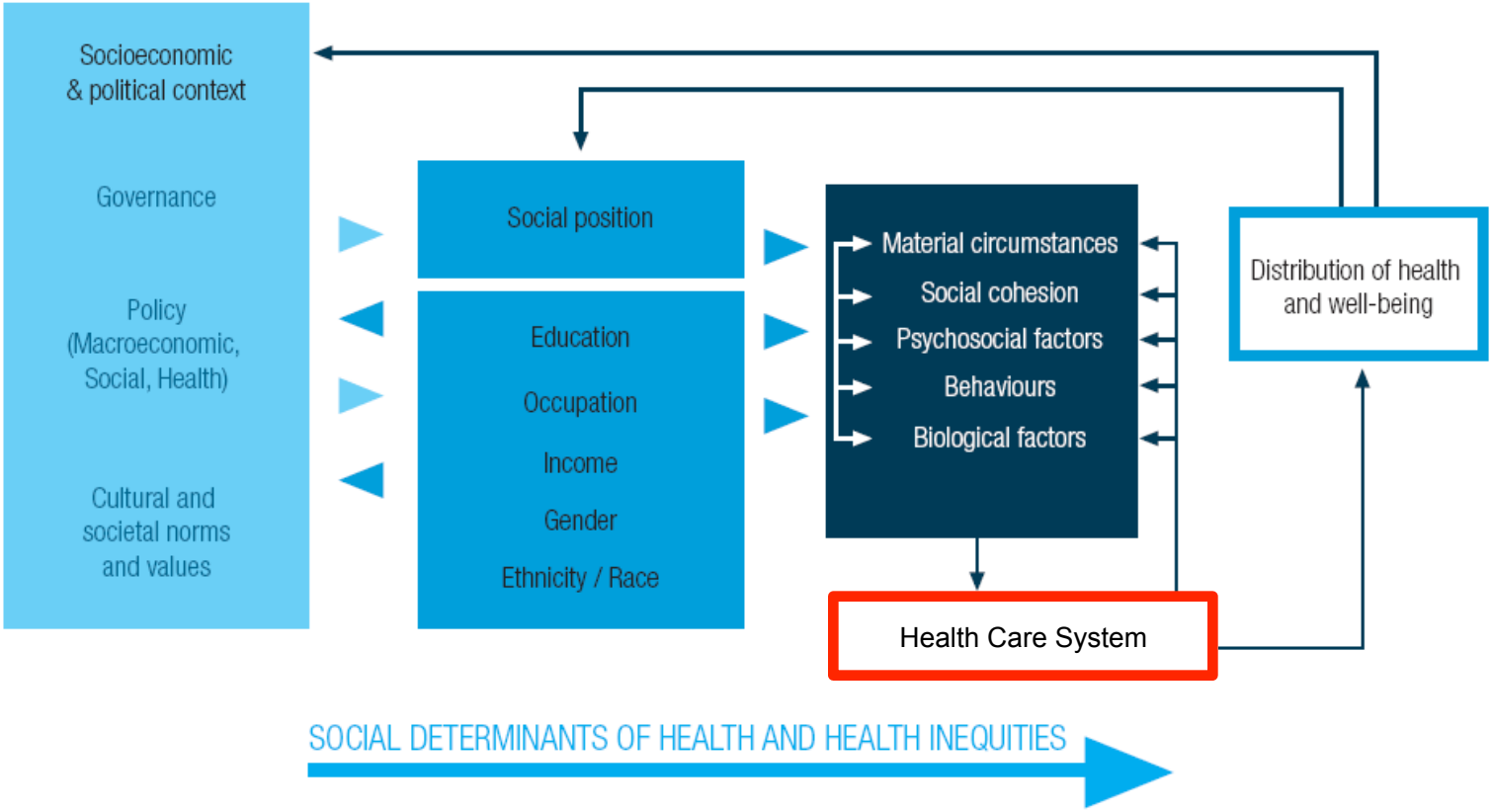
Health Systems Don't Create Health

- Little direct impact on poverty, poor housing, poor sanitation, poor nutrition, lack of education, unemployment
- WHO top 10 risk factors for mortality
  - Underweight
  - Unsafe sex
  - High blood pressure
  - Tobacco use
  - Alcohol
  - Unsafe water, sanitation, hygiene
  - Indoor smoke from solid fuels
  - Iron deficiency
  - Obesity
  - High cholesterol

Health Care Only One Factor

WHO, Commission on Social Determinants of Health (2008)

Figure 4.1 Commission on Social Determinants of Health conceptual framework.



Source: Amended from Solar & Irwin, 2007

Health Systems Do Determine Who Bears the Costs of Illness

- Private, commercial health care markets place costs on the ill
  - Access based on ability to pay
  - Promotes social inequality
- Universal health care systems share costs across society as a whole
  - Access based on need
  - Promotes social equality

Part 2

Canada's Health Care System

Institution of Canadian Medicare:
Canada Health Act (CHA), 1984

- Lasting impact on the way health care is viewed and delivered
- Set a foundation for past, present, and future definitions of what constitutes health and related care.

Canadian Medicare:
"A Sacred Trust"

- Medicare defining characteristic of Canadian identity
- Top policy issue
  - Continuing strong political and public support for publicly-funded health insurance (Medicare)

Canadian Medicare:
Universal Health Insurance

- Public Financing/Private Delivery
  - 13 separate provincial/territorial health care insurance programs (10 provinces, 3 territories)
  - Universal public coverage for “medically necessary” services provided by private physicians and mostly not-for-profit hospitals

Health Care Systems:

Design Dimensions

	Public Financing	Private Financing
Public Delivery	National Health Service (UK)	---
Private Delivery	Medicare (Canada)	Private Insurance (US)

Canadian Medicare:
Federal-Provincial Roles

- Cost-shared between federal government (which holds economic power) and provinces/territories (which hold jurisdiction over health care)
  - Provinces/territories must follow Medicare principles to receive full federal funding

Medicare Principles

- *Universality:* The plan must entitle 100% of the insured population (i.e. eligible residents) to insured health services on uniform terms and conditions
- *Comprehensiveness:* The plan must insure all medically necessary services provided by hospitals and physicians

Medicare Principles

- *Accessibility:* The plan must provide, on uniform terms and conditions, reasonable access to insured hospital and physician services without economic barriers
- *Portability:* Residents are entitled to coverage when they travel to other Canadian provinces (or internationally)
  - Subject to negotiation among provinces

Medicare Principles

- *Public administration:* Administered and operated on a not-for-profit basis by a public authority accountable to the provincial/territorial government
  - Delivery can be (and often is) private

Canadian Medicare's Boundaries:
Still Focused on Illness Care

- Medicare does require coverage for …
  - "Medically necessary" hospital and doctor services
- Medicare does not require coverage for …
  - Even medically-necessary services provided outside of hospitals or by non-physicians (e.g., home care, drugs, rehabilitation)
  - Although provinces/territories may choose to do so and most do (e.g., drug coverage for older persons and poor)

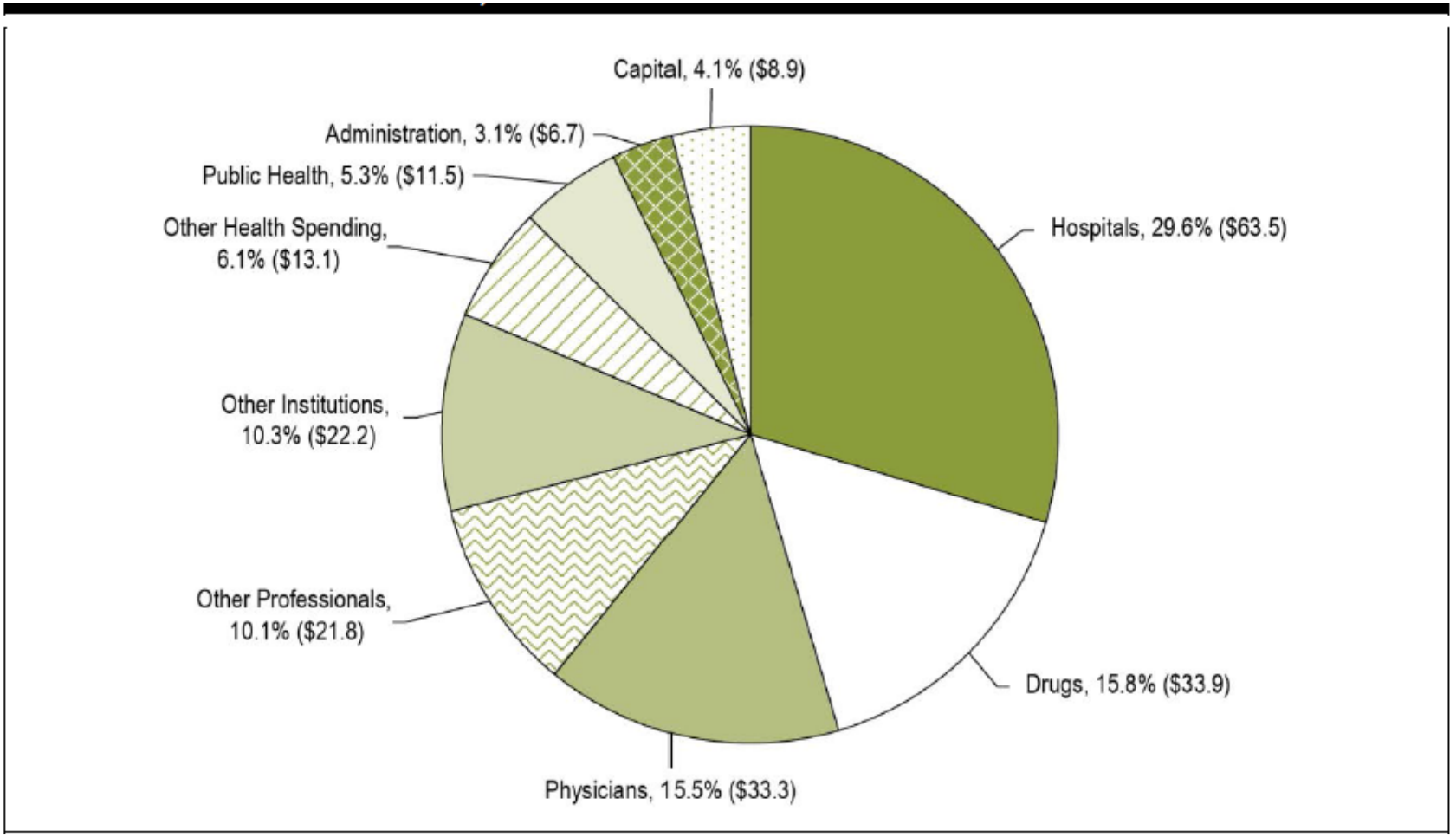
CHA has positively contributed to care of frail elderly

- Provides a large measure of
  - *security* through universal access to publicly funded "medically necessary" hospital or physician care
  - *equity* where provision of care is based on need and not ability to pay

however,

- new areas of need that span across the health and social care continuum have emerged calling for a more integrated approach to health and well-being

What Canada Buys *(2014)*



National Health Expenditure Trends,1975-2014. Canadian Institute for Health Information (CIHI), 2014

Extended Health Care Services

- Long-term homecare is not considered "medically necessary" as per the terms outlined in the CHA
  - Does not fall under the national terms and conditions with which provincial governments must comply to receive federal cash transfers
- CHA does make mention of "extended health care services," however…
  - No real rules were attached to this money
  - Resulted in wide variations in eligibility, access and costs for these services across provinces

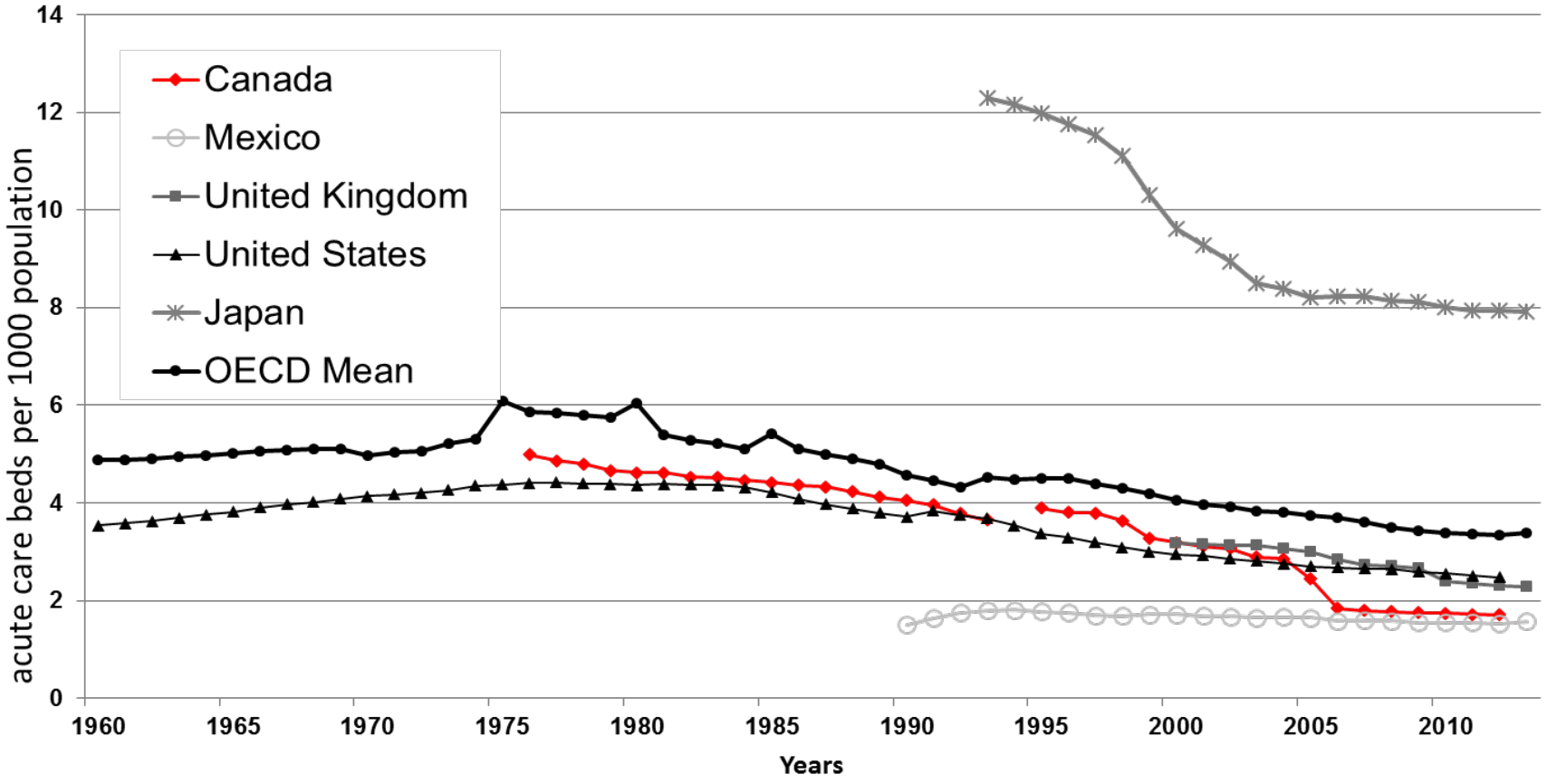
Health Policy Sub-fields:
Homecare

- Services beyond medical model
  - Substitute for acute care in hospitals
  - Substitute for long-term care institutions
  - Maintain functional status/prevent illness and dependence
- Range of professional and para-professional services (e.g., Nursing, PT, OT, SLP, Dietician, PSW)
- Also drugs, assistive devices, personal care, homemaking

Health Policy Sub-fields:
Homecare con't

- Community Support Services
  - Adult/dementia-specific day programs (ADP)
  - Caregiver relief, supports and education
  - Meal assistance, delivery, dinning programs
  - Friendly visiting, security checks, telephone reassurance
  - Transportation programs
  - Friendly visiting
  - Supportive Housing/assisted living (housing with care)
  - Volunteer hospice/palliative care (e.g., end of life care in or out of the home)

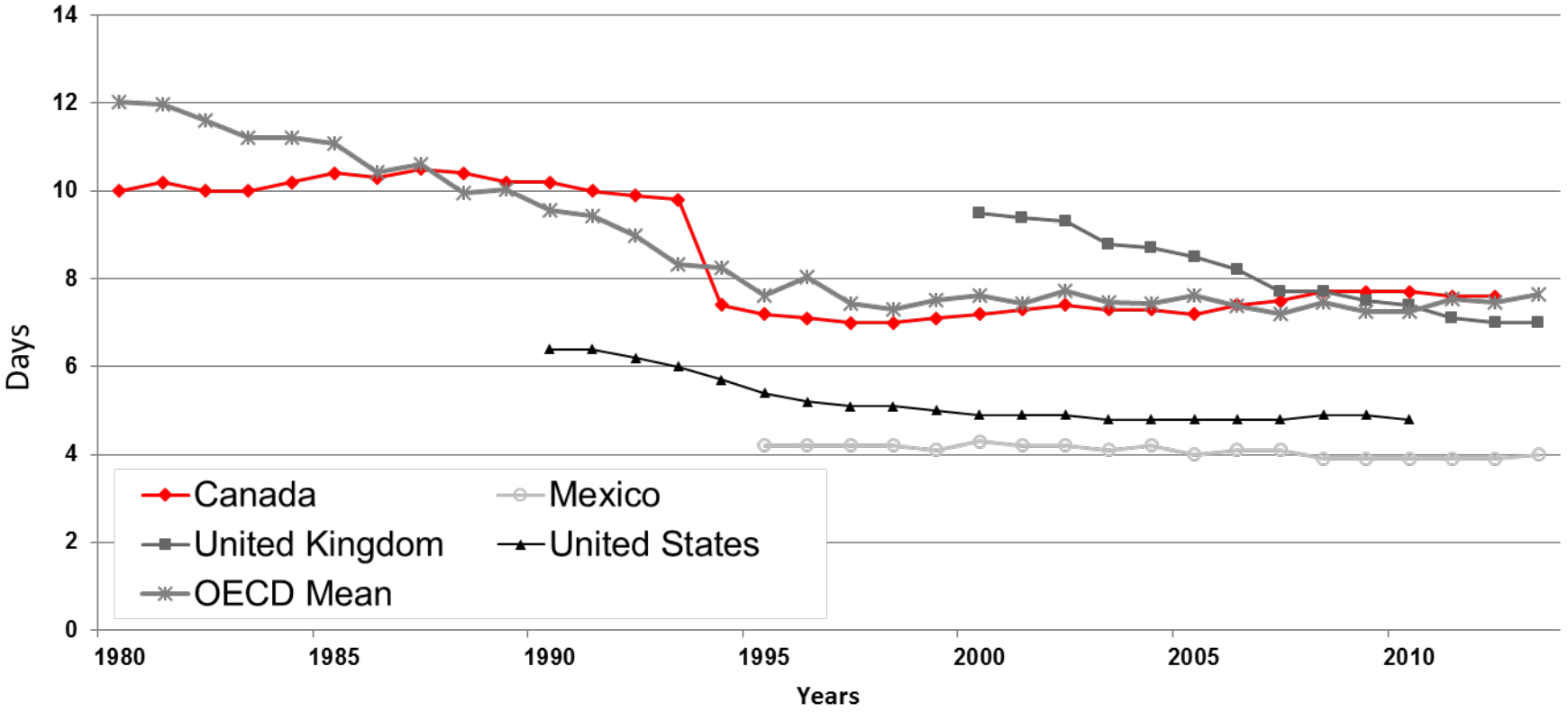
Squeezing Hospitals:
Fewer Beds



OECD Health Data, 2015

Squeezing Hospitals:

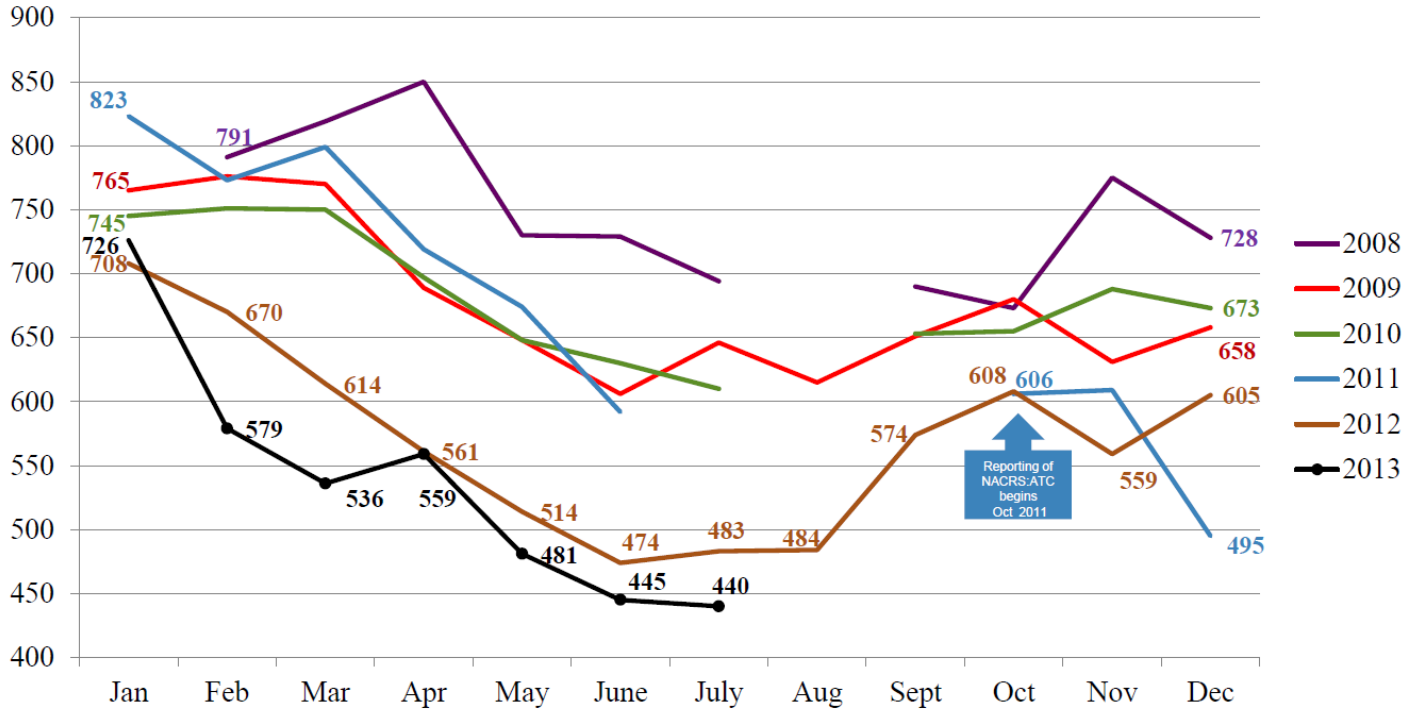
Shorter Stays



OECD Health Data, 2015

New Problems:

Patients Waiting in for an In-Patient Bed, Ontario

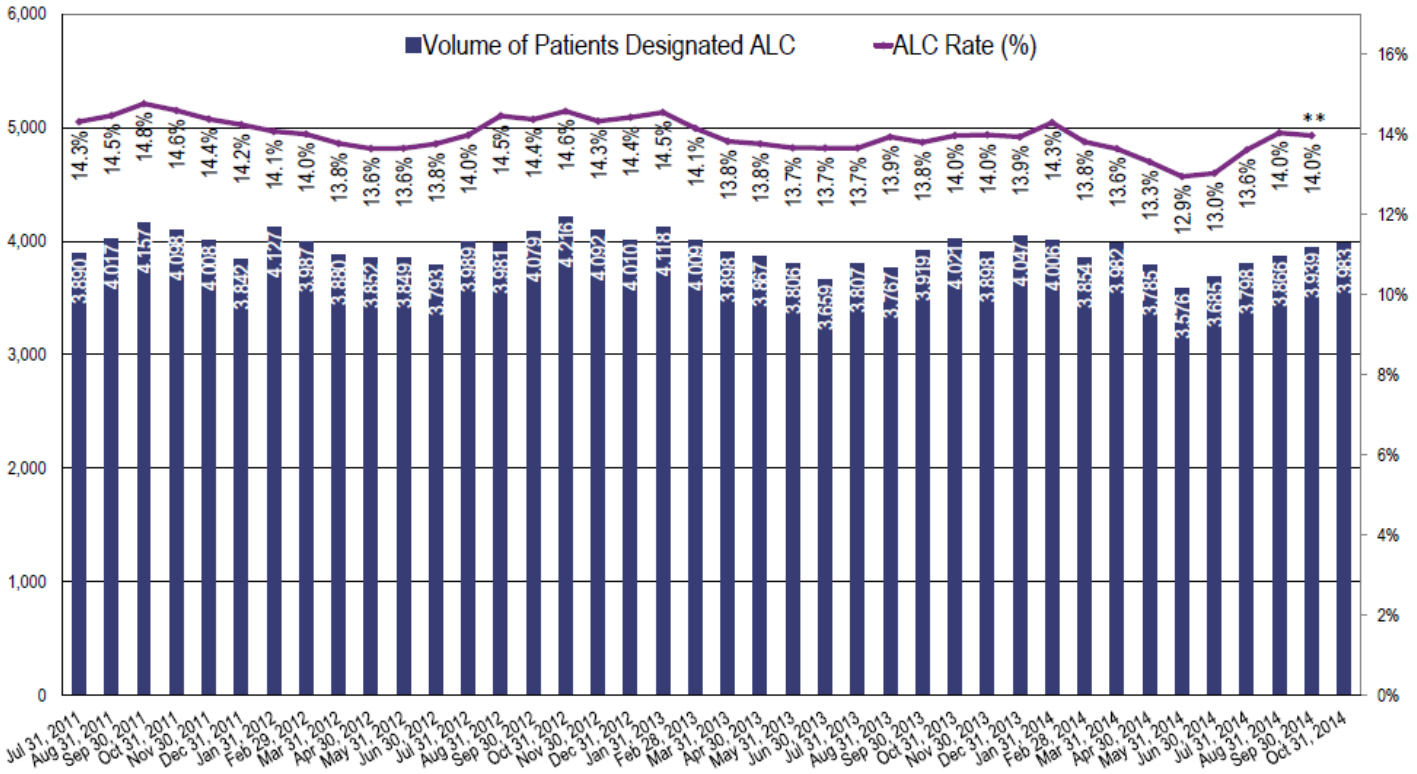


Source: OHA : November 2007 to July 2011 - Number of patients in emergency waiting for an in-patient bed (at any given point in time)
NACRS: Access to Care: October 2011 to July 2013
NACRS: Access to Care Sept 3-13 (Report date); Data cut (Aug 19-13)
Daily average number of patients in ER Waiting for an Inpatient Bed at 8 a.m.

ONTARIO HOSPITAL ASSOCIATION

New Problems: Delayed Discharge, Ontario

Monthly Trend of Provincial ALC Rate and Volume of ALC Patients on the Waitlist: July 2011 to October 2014



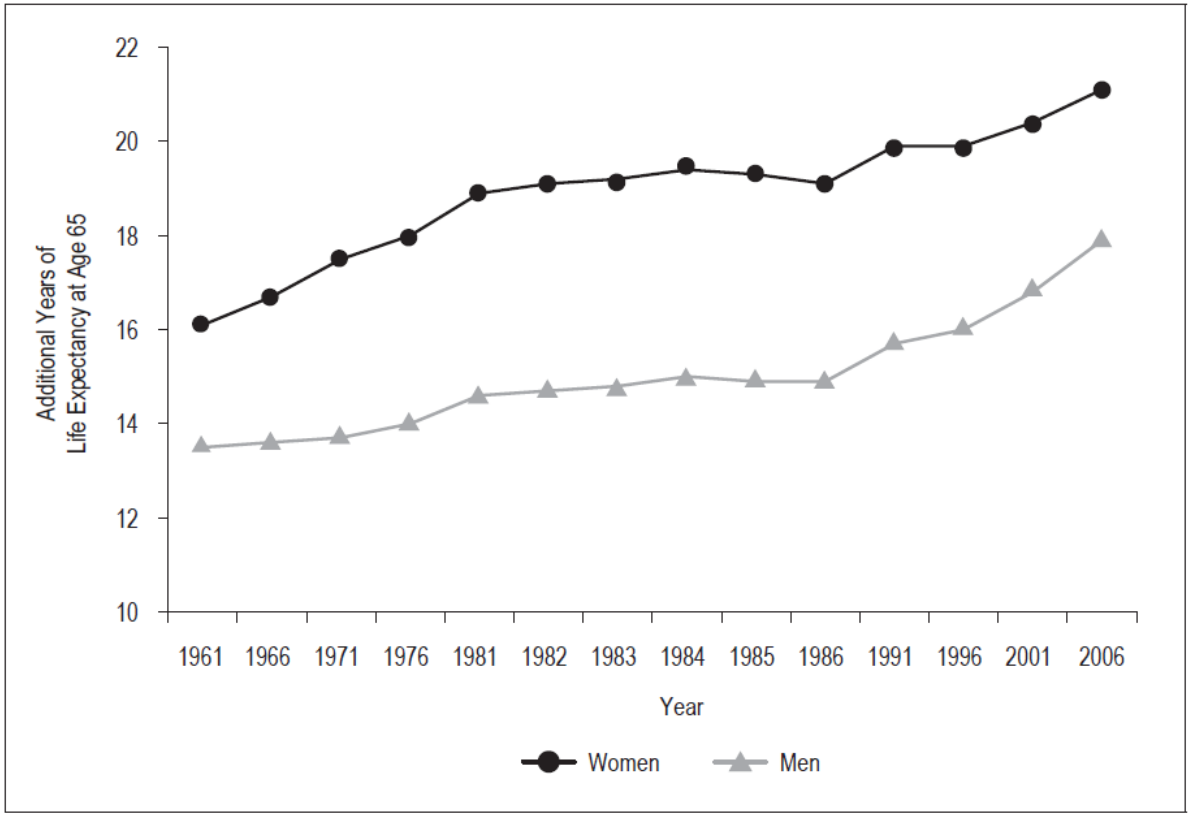
Source: http://www.oha.com/CurrentIssues/Issues/eralc/Documents/ALC%20-%20October%202014.pdf

Part 3

Emerging Challenges

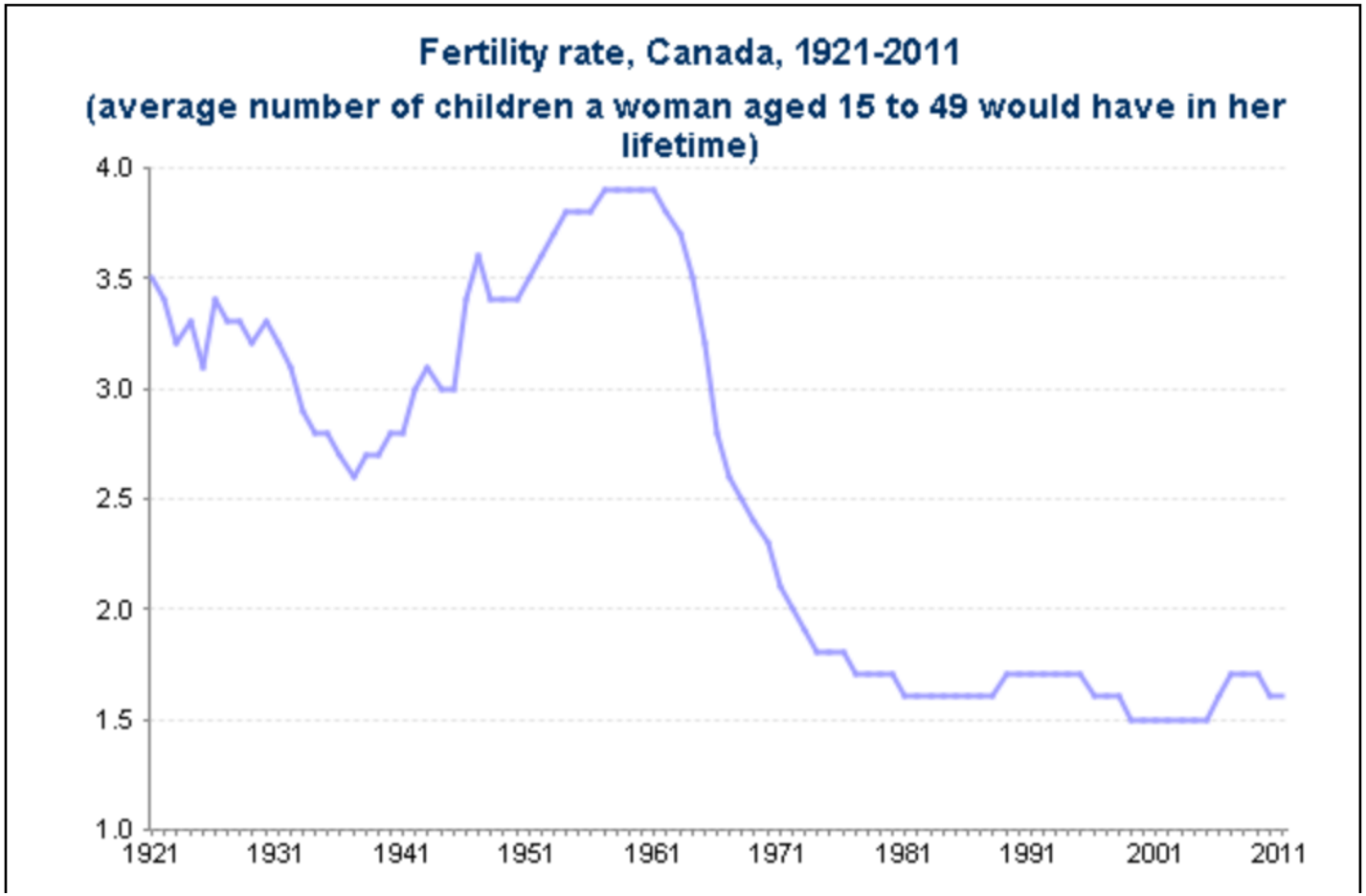
Emerging Challenges:
People Living Longer

Figure 3: Life Expectancy at Age 65, by Sex, Canada, 1961 to 2006

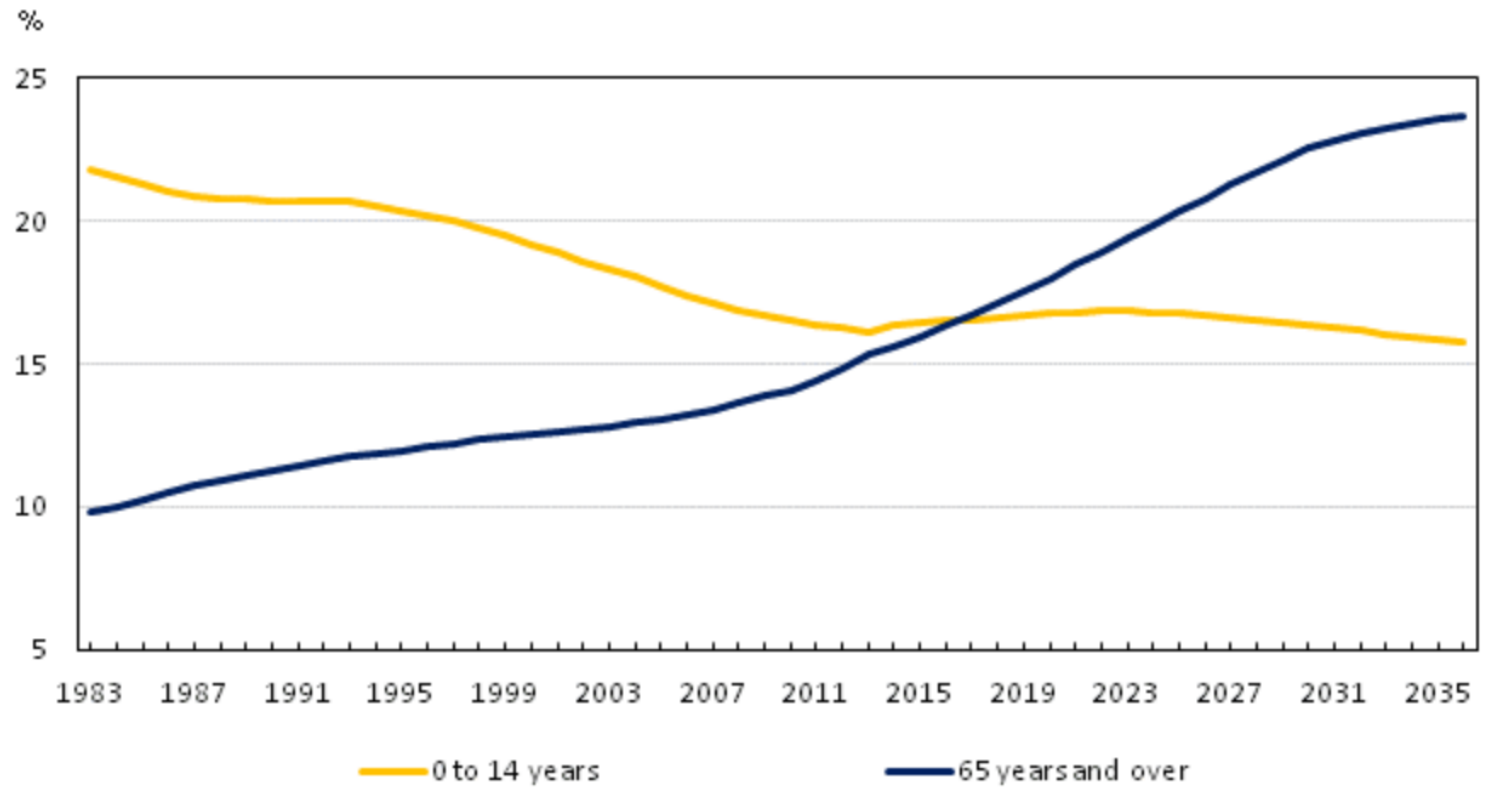


Source
Organisation for Economic Co-operation and Development, *OECD.StatExtracts* > Health: Health Status, 2011 <http://stats.oecd.org/index.aspx>.

Emerging Challenges: Fewer Children



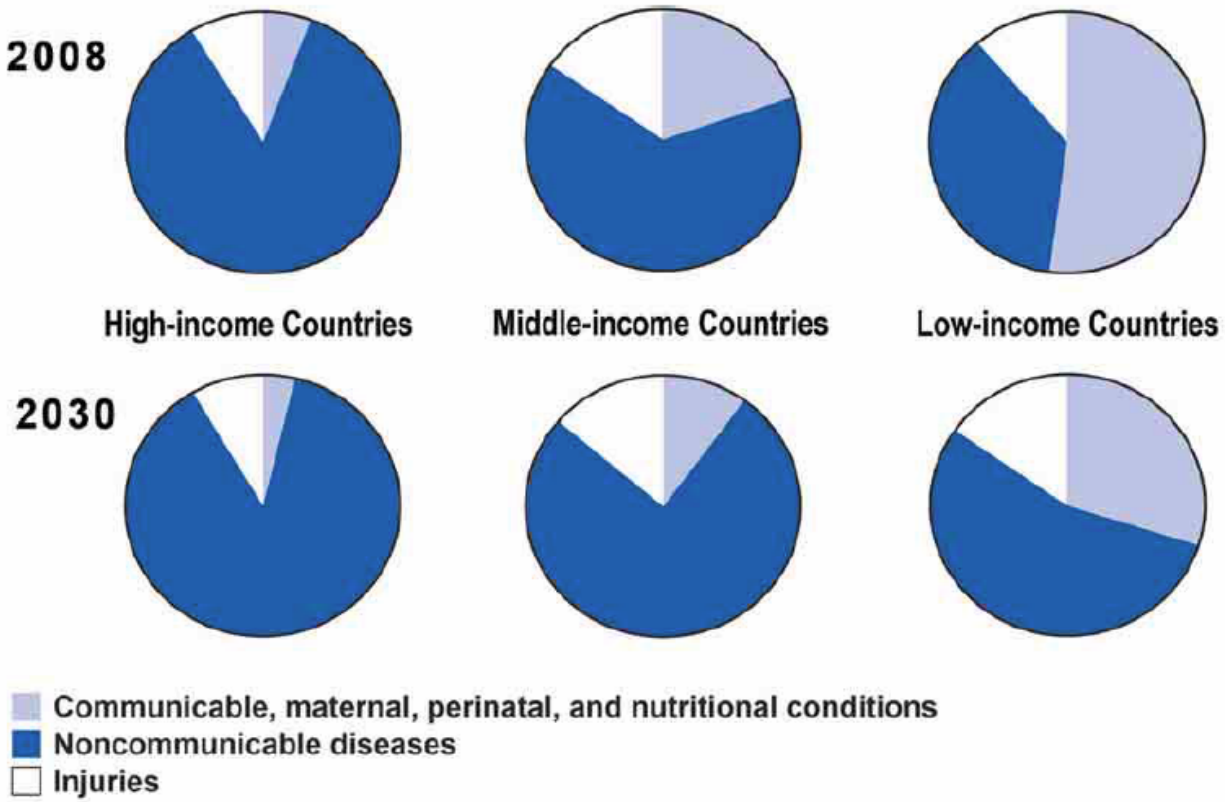
The Result: Decline of Informal Networks



Note: From 1983 to 2013, population estimates. From 2014 to 2036, Population Projections for Canada, Provinces and Territories, 2009-2036, medium-growth scenario (M1), Catalogue no. 91-520-X.

Source: Statistics Canada 2013 http://www.statcan.gc.ca/pub/91-215-x/2013002/ct009-eng.htm

Bad News: More Chronic Diseases



Source: World Health Organization, *Projections of Mortality and Burden of Disease, 2004-2030.* Available at: http://www.who.int/healthinfo/global_burden_disease/projections/en/index.html.

Part 4
Integrated Care

Needs of Adults Experiencing Frailty

- The frail elderly can experience physical, cognitive, and social declines that may limit their ability to remain independent or access health / social care
- Declines may present in a person's ability to manage their own basic activities of daily living (ADLs) and/or an ability to manage more instrumental activities of daily living (IADLs)
- Needs can often be managed outside of hospital or physician services, through long-term home care services

Current Health System Research / Evaluations on Programs Related to Frailty

- Canadian Longitudinal Study on Aging (measuring frailty)
- Manitoba Follow-up Study (1996 roles of physical, mental and social functioning in support of heathy aging)
- Frailty and Falls
- Frailty Index
- Community Based Primary Care
- **Balance of Care**

Balance of Care: The Big Question

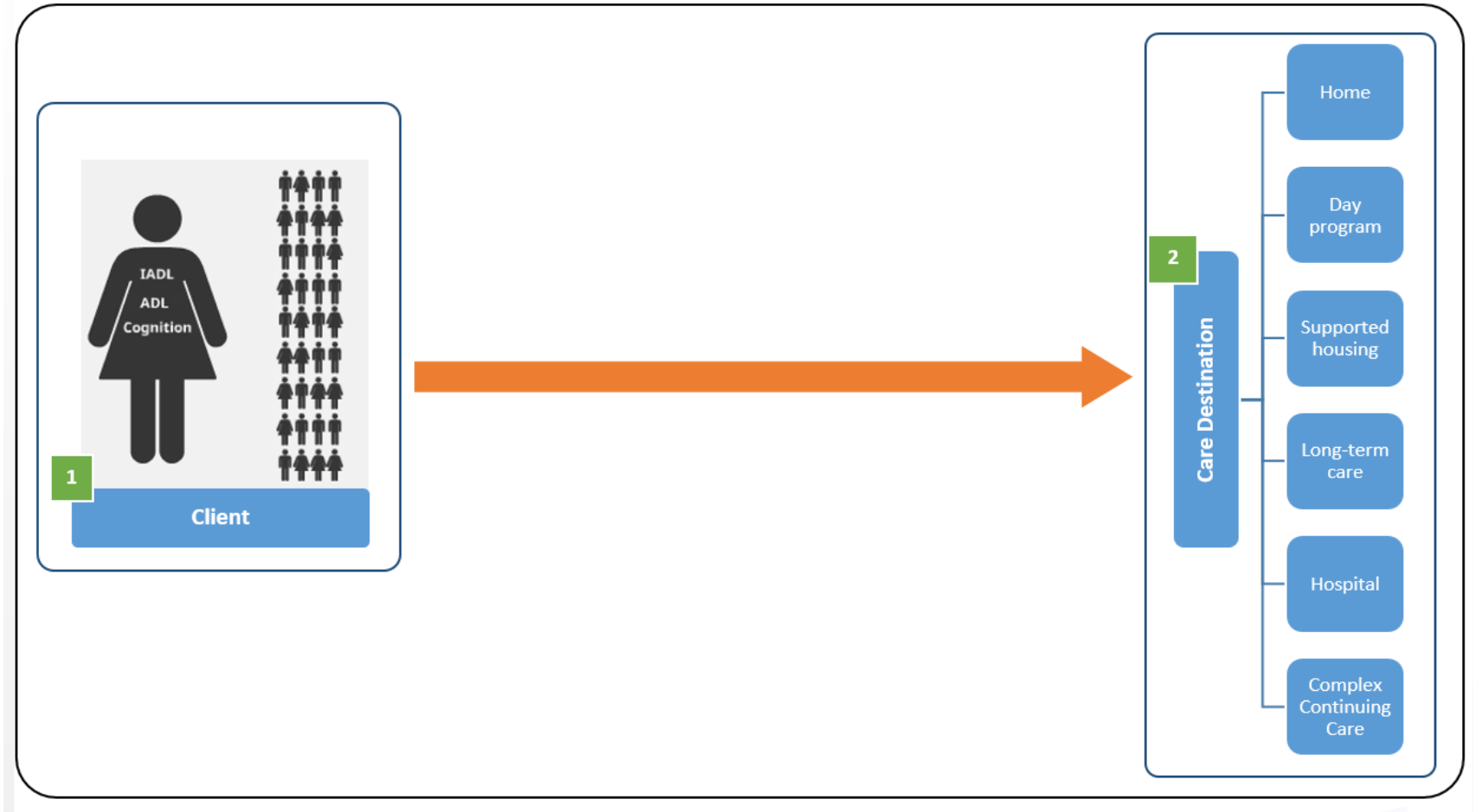
- Why is it that most older persons live safely and independently at home, while others with similar characteristics and needs require institutional care?
  - While most people want to live at home, as independently as possible for as long as possible, many default to hospital and then LTC beds (Walker, 2011)

Balance of Care:
Needs & Local Capacity

- **Demand side factors** – needs of people – play an important role in service utilization and policy planning
- **Supply side factors** – particularly system capacity to support PLWD in the community – are also crucial in determining where PLWD end up

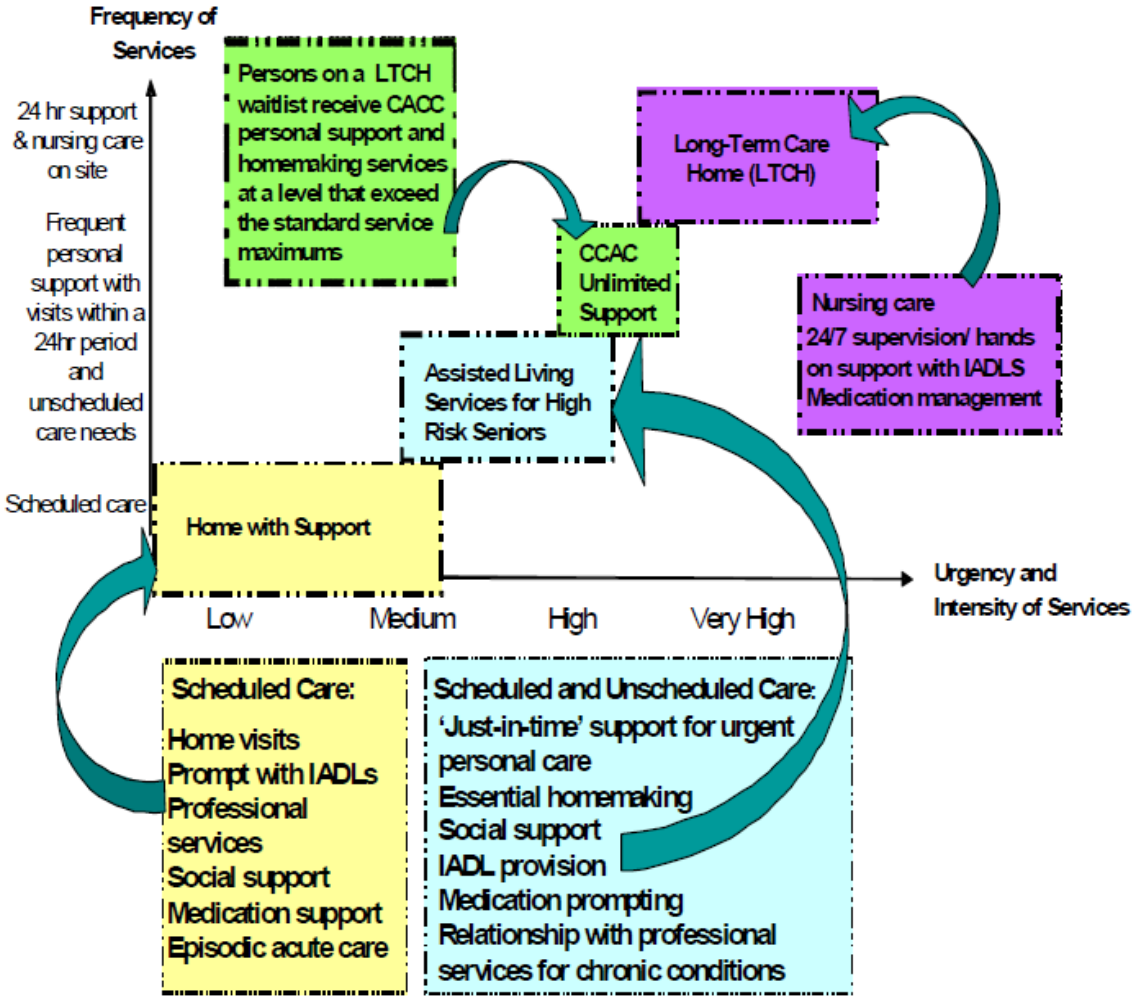
Conventional Wisdom:

Needs Drive Decision Making



Laporte, Williams, et al., 2016

Needs Drive: An Ontario Example



Source: Ontario, Assisted Living Services for High Risk Seniors Policy, 2011 (Updated 2012)

BoC Multi-Stage Methodology

1. Access CCAC RAI-HC assessment data
2. Stratification by 4 key variables
3. Vignette development for each subgroup (those with 2.5% or more of sample)
4. Conduct cross-sectoral expert panels to develop care H&CC packages for sub-groups
5. Consider Alternative Delivery Options
6. Estimate H&CC package costs compared to LTCH costs
7. Calculation of potential diversion rates at the local level if needed H&CC services available

Stratify Clients by Need **(36 sub-groups)**

RAI HC assessment data used to categorize NW CCAC clients into relatively homogeneous groups:

- **Cognitive Performance Scale**: Short term memory, cognitive skills for decision-making, expressive communication, eating self-performance
- **Self-Performance Hierarchy Scale (ADL):** Eating, personal hygiene, locomotion, toilet use
- **IADL Difficulty Scale+**: Meal preparation, housekeeping, phone use and medication management
- **In-home caregiver**

Comparative BoC Findings: Cognition

Cognitive Performance Scale: short term memory, cognitive skills for decision-making, expressive communication, eating self-performance

	Toronto	***Central***	***Central West***	***Cham-plain***	***South West***
Intact	48%	38%	33%	29%	36%
Not Intact	52%	62%	67%	71%	63%

Comparative BoC Findings: ADL

Self-Performance Hierarchy Scale – eating, personal hygiene, locomotion, toilet use

Difficulty	*Toronto*	*Central*	*Central West*	*Cham -plain*	*South West*
Low	43%	41%	34%	42%	43%
Medium	28%	29%	25%	32%	31%
High	29%	30%	41%	26%	27%

Comparative BoC Findings: IADL

IADL Difficulty Scale - meal preparation, housekeeping, phone use and medication management

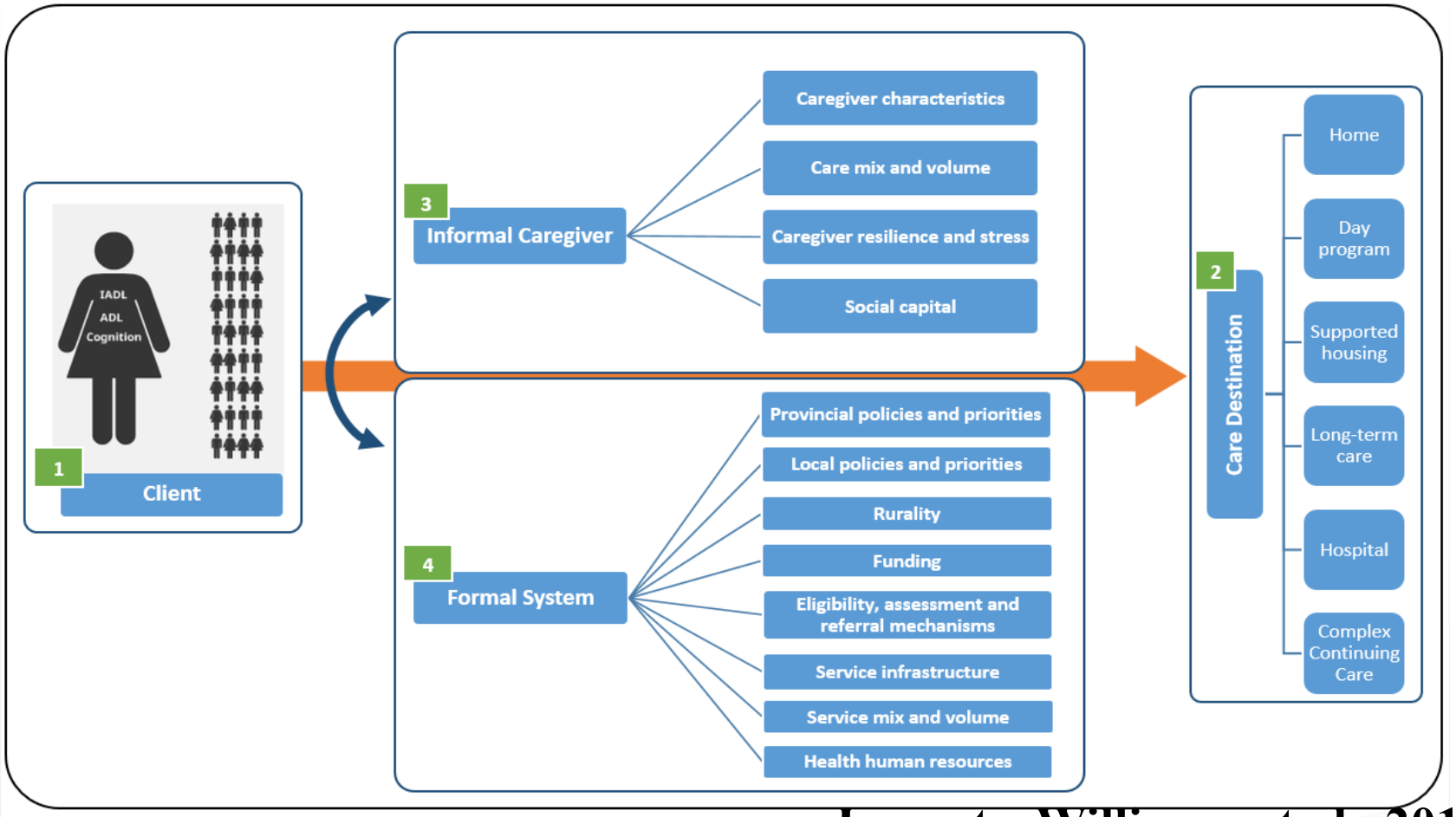
Difficulty	*Toronto*	*Central*	*Central West*	*Cham-plain*	*South West*
Low	3%	1%	1%	1%	1%
Medium	32%	25%	26%	22%	29%
High	65%	74%	73%	77%	70%

Comparative BoC Findings: Caregiver Living with Client?

	Toronto	***Central***	***Central West***	***Cham-plain***	***South West***
Yes	35%	55%	56%	37%	38%
No	65%	45%	44%	63%	62%

Balance of Care Logic:

Needs and Supply Side Factors Matter

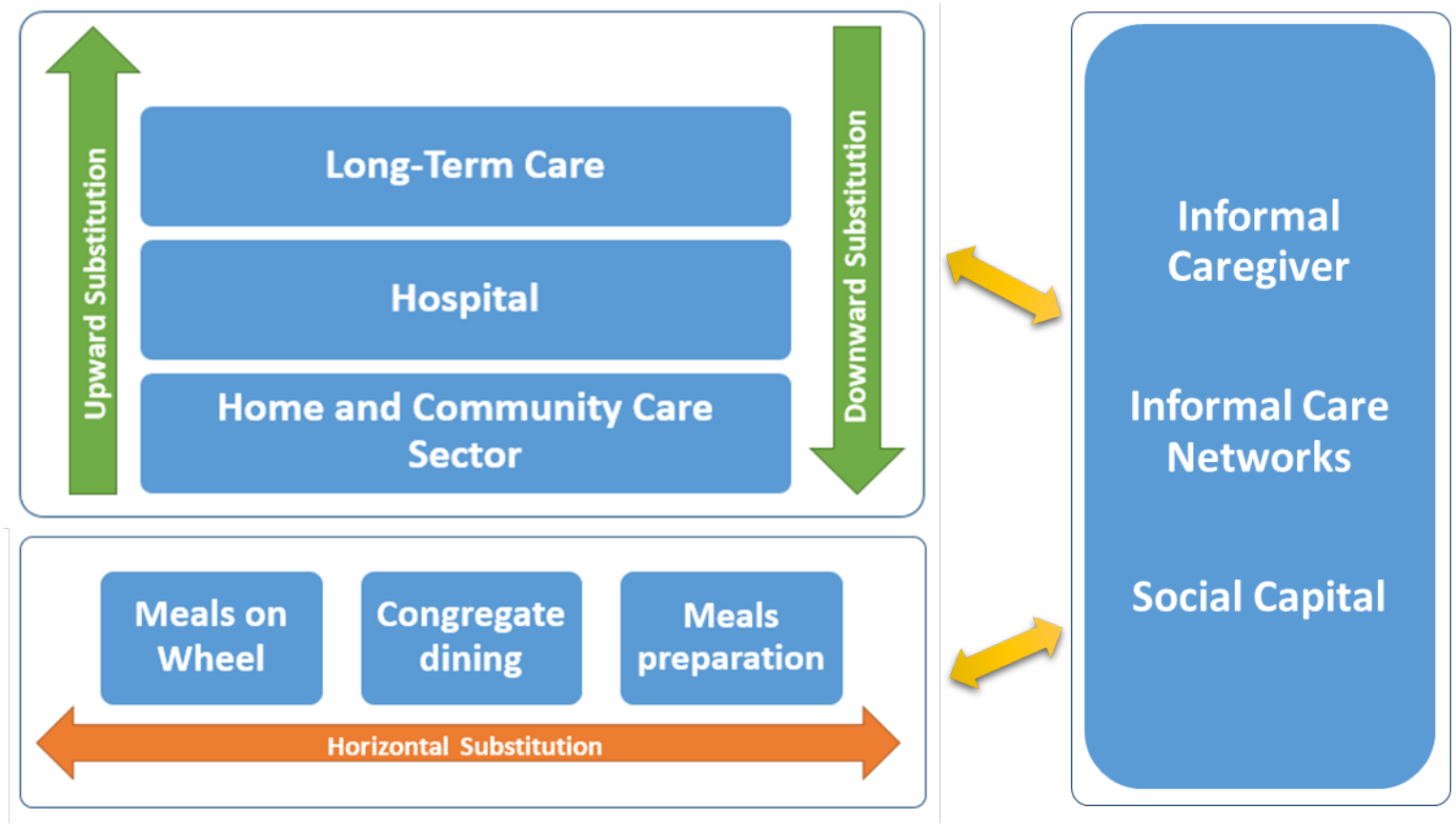


Laporte, Williams, et al., 2016

Consider Substitution Potential

- Local Capacity May Differ
  - Grocery Shopping
  - Meals on Wheels
  - Meal Preparation
  - Congregate Dinning
  - Foster Families
- Hubs of Health and Social Service
  - Supportive Housing
  - Adult Day Programs
  - Community Hubs

Local Approaches Lever Formal & Informal Capacity in Different Ways



Laporte, Williams, et al., 2016

Low Turnover Through…

- Leveraging informal caregivers and social networks to support clients
- Treating care recipient and caregiver as a single unit of care where appropriate
- Ongoing co-creation of care plans and coordination / integration of services
- Opportunities for caregivers to balance personal and social life with caregiving responsibilities
- Help accessing education, support and counselling services and programs in the community (e.g., Alzheimer's Society)

Where we Want to Go:

Beyond Medical Care

General Approach	
• Intervention after a problem occurs • Acute care • Hospital-centric • Silos • Resource-intensive minority of patients in regular system • Accept socio-economic weaknesses • Extraordinary interventions at end of life	• Health promotion • Chronic care • Patient-centric • Co-ordination across a continuum of care • Dedicated channels for the resource-intensive minority • Address socio-economic weaknesses • Pre-agreements on end-of-life care

Commission on the Reform of Ontario's Public Services, February 2012

Prospects for Change:
Paradigm Shift Anyone?

- Medical Model – dominant discourse centred on cure over care, reactive as opposed to proactive, focuses on the provider

- Broader Determinants of Health Model – emphasizes that health is influenced by four factors (lifestyle, human biology, environment and the organization of health care)

Recent Policies & Health System Innovations Pertinent to Frailty

- Canadian Frailty Network (definition of frailty to ACP)
- AgeWell (technology & aging network)
- Carers Canada (acknowledging caregiver contributions)
- Age-friendly/dementia-friendly communities
- Premiers Task Force on Aging
  - National Strategy on Aging (pushed by CMA and CARP)
  - IRPP publication

Part 5
Take Away

Sum

- Canadian Medicare guarantees universal access to high quality, curative hospital and doctor care
  - In doing this, it shifts the costs of illness from the ill to society as a whole
  - Creates a more equitable, cohesive and hopefully healthier society

Sum

- Now the big question is how to move away from after-the-fact curative care to before-the-fact health promotion and chronic illness management

- Support people (including family caregivers) “closer to home”
  - Especially with an aging population and decline of traditional social structures

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THANK YOU

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