An Appropriate and Cost-Effective Health Care System for an Ageing Society

Neena L. Chappell, PhD, FRSC
Canada Research Chair in Social Gerontology
University of Victoria
nlc@uvic.ca

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The Basics

- Old age – mainly chronic conditions & functional disability
- The older we are, the worse it gets
- By definition, no cure
- OA prefer own home and community

- Informal caregivers provide 75% to 80% of personal care, irrespective of type of health care system (Kane, Hebert).
- They often require support to continue.
- Projections: more childless OA in future.
- Also more siblings where there is a baby boom generation
- new arrangements unknown.

- Most OA can stay in the community with social support and proper formal care
- In the West, one of the strongest predictors of institutionalization is lack of social support i.e., not health condition
- To maintain OA in the community requires community care

Homecare/Home Support (Can.)

- Home care costs 2% - 4% of public dollars on health care
- Public dollars, 88% of all
- 2000-2001 -3.4%
- 2003-2004 -.7%
- 18.6% increase in per capita private expenses

- Per capita spending increased more than number of users
- Health component increased as a share of services (CIHI)
- B.C.: number users decreased, service hours increased (CIHI; LeGoff;Penning et al.)

- Shorter hospital stays, increased demand for short term home care services (Deber).
- Hollowing out of medicare and provincial systems (Williams et al.).
- Early 90s, 7 provinces, a person responsible for provincial continuing care system.
- Mid-80s – early 90s, a Federal/Provincial/ Territorial Sub-Committee on Continuing Care.

Previous System

Hospitals	Primary Care	Continuing Care	Drugs	Population and Public Health	Other Services (mental health, Ambulance, etc.)

Current System (National Policy Focus)

Hospitals	Primary Care	Drugs	Population and Public Health	Other Services (long term residential care, home care, palliative care, respite care, etc.)

- Continuing Care was, and would still be today if a system existed, the 3rd largest component of public health expenditures after hospitals and primary care and, as such, deserves a greater policy focus.

Home Care/Home Support can be Cost-Effective

- At same level of need, costs are 40% - 70% of care in a nursing home.
- Only time it's more expensive – dying.
- Due to hospital costs NOT the social components.

Comparative Cost Analysis in 2000/2001 Dollars Including Out-of-Pocket Expenses and Caregiver Time Valued at Replacement Wages

Level of Care	Victoria		Winnipeg	
	Community ($)	Facility ($)	Community ($)	Facility ($)
Level A: Somewhat Independent	19,759	39,255	N/A	N/A
Level B: Slightly Independent	30,975	45,964	27,313	47,618
Level C: Slightly Dependent	31,848	53,848	29,094	49,207
Level D: Somewhat Dependent	58,619	66,310	32,275	45,637
Level E: Largely Dependent	N/A	N/A	35,114	50,560

Source: Chappell, N.L., Havens, B., Hollander, M.J., Miller, J.A., and McWilliam, C. (2004). Comparative costs of home care and residential care. *The Gerontologist*, 44, 389-400.

Savings Accrued in the Past

- The BC Planning and Resource Allocation Model developed in 1989 shifted clientele from residential care to home care, while the overall utilization rate remained relatively constant.
- The substitution of home care for residential care resulted in an annual cost avoidance of some $150 million per year by the mid-1990s.

Comparative Costs

Per Person Average Costs of Care Before and After Cuts for Health Units With and Without Cuts

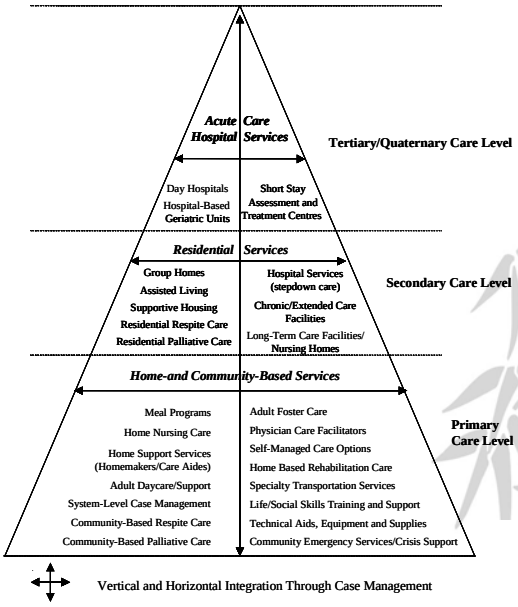
		Period			
		Year Prior to Cuts ($)	First Year After Cuts ($)	Second Year After Cuts ($)	Third Year After Cuts ($)
All Costs	Cuts	5,252	6,688	9,654	11,903
	No Cuts	4,535	5,963	6,771	7,808

Source: Hollander, M.J. (2001). *Evaluation of the Maintenance and Preventive Model of Home Care.* Victoria: Hollander Analytical Services Ltd.

- Community care (including non-professional home support services), in addition to being a stand alone service, can nhance value for money through substitutions of lower cost care, for higher cost care, with equivalent or better outcomes.

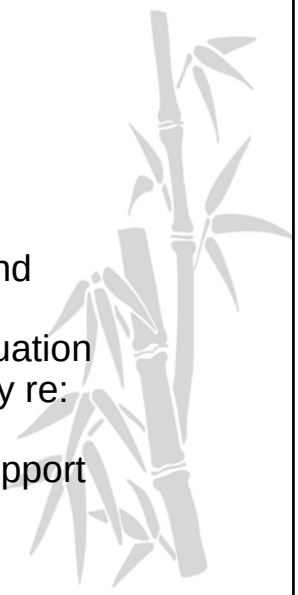
- Requires an integrated system of care.
- Requires single point of entry and assessment
- Can be expanded to include non-health sector

Application of the Framework to the Elderly



Unpaid Caregivers

- Assess the needs of caregivers;
- Provide support for respite care;
- Provide information, resources and counseling;
- Conduct demonstration and evaluation projects to develop informed policy re: direct payment to caregivers;
- Adjust labour and tax policy to support caregivers.



Relevance for Hong Kong

- As applicable to HK as elsewhere
- HK still organizing its system so has the opportunity to build a cost-effective system
- HK should learn from not simply replicate others' experiences