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Improving Access to Home and Community Care: An Analysis of the 2017 Health Accord

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A Federal Health Reform Analysis

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Abstract

In 2017, the federal Liberal government confirmed the new Canadian Health Accord, which included a targeted transfer of \$6B over ten years to the provinces and territories to improve access to home and community care services. Although there were previous federal initiatives aimed at enhancing home and community care services, challenges remain. Many Canadians cannot access home care, and a high burden of care is placed on formal and informal caregivers. These challenges partly stem from an unregulated home care sector and a societal undervaluing of the caregiving role. In 2016, federal, provincial, and territorial governments met and established home and community care as a Canadian health priority. Funding was agreed to in principle from 2016 to 2017 and finalized from 2017 to 2019 through a series of bilateral agreements. The targeted transfer appears to be boosting investments in the home care sector and fostering collaboration across jurisdictions. However, it is unclear whether there have been improvements in access to home and community care.

En 2017, le gouvernement libéral fédéral a confirmé le nouvel Accord canadien sur la santé qui comprenait un transfert ciblé de 6 milliards de dollars sur 10 ans aux provinces et aux territoires pour améliorer l'accès aux services de soins à domicile et en milieu communautaire. Bien qu'il y ait eu des initiatives fédérales antérieures visant à améliorer les services de soins à domicile et en milieu communautaire, des problèmes subsistent : de nombreux Canadiens ne sont pas en mesure d'accéder aux soins à domicile et le fardeau des soins pour les proches aidants est élevé. Ces problèmes découlent en partie d'un secteur de soins à domicile non réglementé et d'une sous-valorisation sociétale de l'importance des services prodigués par les aidants et du fardeau qu'ils représentent. En 2016, les gouvernements fédéral, provinciaux et territoriaux ont convenu d'établir les soins à domicile et en milieu communautaire comme une priorité de santé au Canada. Cependant, il a fallu attendre jusqu'en 2019 pour la conclusion de tous les accords bilatéraux de financement. Un an plus tard, ce transfert ciblé semble avoir réussi à stimuler les investissements dans le secteur des soins à domicile et à favoriser la collaboration entre les juridictions. Cependant, il n'est pas encore possible de déceler s'il y a eu des améliorations dans l'accès aux soins à domicile et dans la communauté.

Key Messages

- There are several challenges in Canada's home care sector due to its lack of regulation and undervalued services. The 2017 targeted transfer aims to address these challenges.
- The targeted transfer incorporates key accountability mechanisms, a lesson learned from previous health accords. Further, the targeted transfer reflects the Liberal Government's aim for 'collaborative federalism.'
- While this targeted transfer appears to boost investments in the home care sector and foster collaboration across jurisdictions, it is unclear whether there have been improvements in access to home and community care.

Messages-clés

- *Le secteur des soins à domicile au Canada fait face à plusieurs défis attribuables notamment à son manque de réglementation et au fait que ses services sont peu valorisés par la société. Le transfert ciblé de 2017 vise à surmonter ces défis.*
- *Le transfert ciblé intègre plus explicitement des mécanismes de reddition des comptes, une leçon tirée des accords précédents sur la santé. Ainsi, le transfert ciblé constitue un exemple de 'fédéralisme collaboratif' promu par ce gouvernement.*
- *Ce transfert ciblé semble stimuler les investissements dans le secteur des soins à domicile et favoriser la collaboration entre les juridictions. Toutefois, il n'est pas possible de tirer des conclusions à ce stade-ci quant à l'effet de ce transfert pour l'amélioration des soins à domicile et communautaires.*

1 DESCRIPTION OF THE POLICY REFORM

In Canada’s 2017 Budget, the federal government confirmed its direction for the Canadian Health Transfers (CHT). In addition to setting a 3% minimum annual growth rate for the CHT, Budget 2017 included the following targeted transfers to address shared health priorities: \$6B over ten years to improve access to home and community care services, \$5B over ten years for mental health, and \$544M over five years to federal and pan-Canadian health organizations to support innovation and pharmaceutical initiatives (Department of Finance Canada 2017).

These targeted transfers reflect shared federal-provincial-territorial (FPT) health priorities established in 2016 and formalized in *The Common Statement of Principles on Shared Health Priorities* in 2017 (Canadian Intergovernmental Conference Secretariat 2016; Health Canada 2018a). The four critical priorities for home and community care included:

- Enhancing home care infrastructure, such as digital connectivity, remote monitoring technology and facilities for community-based service delivery;
- Spreading and scaling evidence-based models of home and community care that are more integrated and connected with primary health care;
- Enhancing access to palliative and end-of-life care at home or in hospices; and
- Increasing support for caregivers (Health Canada 2018a, 2).

A series of bilateral agreements were finalized from December 2017 to May 2019, including an asymmetrical agreement with Québec (Health Canada 2019). These agreements provide details regarding how much each province and territory will receive annually until 2021/2022, activities to meet key priorities, and a commitment to report performance measures to the Canadian Institute for Health Information (CIHI) (Health Canada 2019).

2 HISTORY AND CONTEXT

Home and community care services help people receive care at home rather than at a hospital or long-term care facility and help people live as independently as possible in their communities (Health Canada 2016). Regulated health care professionals (e.g., nurses), non-regulated workers (e.g., personal support workers), volunteers, friends and family caregivers all help deliver home and community care (Health Canada 2016). The goals of home and community care are to help people maintain or improve their health status and quality of life; assist people in remaining as independent as possible; support families in coping with a family member’s need for care; help people stay at or return home and receive needed treatment, rehabilitation, or palliative care; and provide informal/family caregivers with the support they need (Health Canada 2016). Home and community care services are for seniors and individuals living with health problems or a disability (Health Canada 2016). Much of the provision of home and community care is affected by its absence from the *Canada Health Act*. Additionally, previous home and community care reforms influenced the 2017 target transfer and its focus on home and community care.

2.1 Legacy of the *Canada Health Act*

The *Canada Health Act* (1985) sets the criteria and conditions that must be met by provincial and territorial public health insurance plans to receive the CHT. The *Canada Health Act* has a deep but narrow definition of what services must be covered through provincial and territorial health insurance plans, mainly medically necessary physician and hospital services. It is up to provinces and territories to decide how and to what extent to cover other health services. As a result, each province and territory have independent frameworks for providing home and community care. These different frameworks lead to substantial disparities across Canada regarding who is eligible for home and community care, which services are publicly covered, and whether a portion of all home care services are privately delivered (Canadian Healthcare Association 2009).

2.2 Previous home and community care reforms

Since the 1990s, the federal government has tried to address the limitations/challenges around home and community care. In 2002 two influential reports, commonly referred to as the *Romanow Report* and *Kirby Report*, recommended that the *Canada Health Act* expand to cover home and community care services (Government of Canada 2002; Standing Senate Committee on Social Affairs, Science and Technology 2002). Following these recommendations, the 2003 and 2004 Health Accords included funding to improve home and community care.

Even though improving home and community care was a federal priority and given federal funding, there were minimal home care improvements. First, the funding scope was limited to acute care, and there was no commitment to address the longer-term needs of people with chronic conditions, particularly seniors, or the needs of informal caregivers (Health Council of Canada 2013). Second, provincial and territorial requirements throughout the accords (e.g., reporting on comparable indicators) were revoked a few years into the accords when the Conservative Government took leadership (Health Council of Canada 2012). Therefore, even though provinces and territories were given funding to improve home care services, there was no funding accountability. The funding allocated to home care remained unchanged in the provinces and territories (Health Council of Canada 2013).

3 GOALS OF THE 2017 REFORM

While this targeted transfer primarily aims to improve access to home, community and palliative care, it also seeks to strengthen the home care sector. Without this federal transfer, provinces and territories may not have the resources necessary to address this sector's challenges. In addition, this targeted transfer aims to provide more support to informal (unpaid) caregivers, most of whom are women (Department of Finance Canada 2017). The targeted transfer also has several implicit goals. First, the transfer showcases the Liberal

government’s aim for collaborative federalism, a direct contrast to the previous Conservative government’s hands-off approach of open federalism (Liberal Party of Canada 2015; Schertzer 2016). The collaborative federal leadership approach intends to foster collaboration between provinces and territories, leading to an increase in innovative solutions and reduced health inequities between provinces and territories (Johnson et al. 2017). The second implicit goal is cost-effectiveness. As the cost for health care continues to rise, “economic adjustments among provinces is expected to be the single largest theme over the near term” (Canadian Medical Association 2016). In Saskatchewan, for example, an hour of home care costs \$108 compared to one day in hospital \$1,381 and a day in a long-term care facility \$218 (Health Canada 2018b). Further, informal caregivers provide services for free that could cost as much as \$25B annually if provided by paid home care workers (Hollander, Liu and Chappell 2009).

4 FACTORS THAT BROUGHT HOME AND COMMUNITY CARE TO THE AGENDA AND INFLUENCED THE POLICY CHOICES

4.1 How the issue came onto the government’s agenda

Despite an increase in home and community care funding through the 2003 and 2004 Health Accords, challenges remained. In 2016, many Canadians were unable to access home care services. One in four of the 1.2M Canadians who identified a need for home care in 2015/2016 reported that these needs were unmet (Statistics Canada 2018a). Individuals with multiple chronic conditions were more likely to have unmet home care needs than those with fewer conditions (Statistics Canada 2018b). Individuals with unmet home care needs are associated with a higher risk of injuries, hospitalization rates, and premature death (LaPlante et al. 2004; Sands et al. 2006).

Formal caregivers (including personal support workers and home care providers) and informal caregivers (generally unpaid friends and family) who provide the majority of home and community care services face significant challenges. First are economic challenges. Formal care providers have limited pay and job security in general and relative to their counterparts working in hospitals (Government of Ontario 2014; Lilly 2008; Lum, Sladek and Ying 2010). Part of this issue stems from Canada’s National Occupational Classification system, which classifies personal care provided in hospitals as a ‘health occupation’ within the public sector but a private ‘sales and services’ occupation for the same services provided in the home (Lilly 2008). Further, formal caregivers’ economic challenges arise from a lack of regulation in the sector leading to different employment conditions depending on which organization the employee is hired by (Kalenteridis 2018). Informal caregivers also experience economic challenges as they provide care for their family member or friend. Specifically, informal caregivers encounter disruptions to their employment, including re-

stricted work hours, absences and leaves, exits from the workforce, career limitations, and reduced productivity (Fast, Eales and Keating 2018). These disruptions have immediate and long-term consequences on the informal caregiver’s benefits, pension entitlements, and income (Fast, Eales and Keating 2018). Second, formal and informal caregivers face significant impacts on their own health. In Ontario, nearly two-thirds of personal support workers reported burnout, and informal caregivers experience high distress—45% of those caring for seniors with dementia, and 26% of those caring for seniors without dementia (Canadian Institute for Health Information 2018a; Laucius 2017). The challenges faced by formal and informal caregivers point to undervaluing caregiving and its workforce.

The undervaluing of care is notably linked to the gendered nature of care work (Fast, Eales and Keating 2018; Fredriksen-Goldsen and Bonifas 2013; Lilly 2008). In Canada, women are more likely to be caregivers (formal and informal) than men (Sinha 2013). As informal caregivers, women spend more time providing care than men, which leads to women experiencing greater employment consequences (i.e., exits from the workforce) (Fast et al. 2013; Sinha 2013).

These issues in home and community care will only exacerbate as Canada’s population ages. By 2036 a quarter of the population will consist of seniors, who make up 70% of publicly funded home care recipients (Canadian Home Care Association et al. 2016; Statistics Canada 2010).

To address these challenges, the Liberal party’s 2015 election platform included an immediate commitment of \$3B over four years to deliver more and better home care, an item left off the Conservative party platform (Harper 2015; Liberal Party of Canada 2015).

The Liberals won the 2015 election and received their most significant share of votes from the baby boomer generation since 2004 (Abacus Data 2017). The baby boomer population stood to benefit the most from improvements to home care in the shorter term, not only for themselves but also as caregivers to older parents.

Following the 2015 election, advocacy groups representing the home care sector increased their efforts to keep home and community care a priority. The Canadian Home Care Association (CHCA) published two notable reports in 2016 and 2017 in collaboration with the Canadian Nurses Association and College of Family Physicians: *Harmonized Principles for Home Care* developed in consultation with more than 350 stakeholders, and *Better Home Care in Canada: A National Action Plan* (Canadian Home Care Association 2017; Canadian Home Care Association et al. 2016).

4.2 How the final decision was made

In 2017, the CHT was scheduled to decrease from a 6% annual increase to 3%; a decision made unilaterally by the previous Conservative government. In 2016, the federal, provincial and territorial governments were willing to negotiate a new health accord; however, their expectations for the new accord differed substantially.

The federal government insisted the new health accord include targeted transfers tied

to specific health priorities (e.g., home and community care) and additional accountability measures (Tasker 2016). Provinces and territories opposed targeted transfers, especially Québec, stating issues over provincial jurisdiction (Tasker 2016). Instead of targeted transfers, the provinces argued for a raise to the CHT annual increase, specifically an annual increase of 5.2% from the federal government’s proposed increase of 3% (unchanged from the existing CHT) (Marchildon 2017).

These negotiations occurred against the backdrop of long-standing institutional tensions underlying federal-provincial/territorial relations concerning the responsibility for health. Health falls mainly under provincial and territorial jurisdiction; the federal government has limited legislative authority. Additionally, the federal government has limited control over its health-specific funding contribution as transfers are added into general provincial revenue (Marchildon 2017; The Canadian Press 2016). The proposed targeted transfers were a way for the federal government to control health and health spending in provinces and territories.

Since health falls under provincial and territorial jurisdiction, and provinces and territories contribute more to their health care spending than the federal government, they were reluctant to give up control and accept federal oversight. Under the previous Conservative Government’s open federalism approach, provincial and territorial governments had little accountability to the federal government concerning health while still enjoying a relatively generous 6% annual increase (though that was expiring in 2017). Additionally, federal support for provinces and territories has decreased over time (Naylor, Boozary and Adams 2020). Since the 1990s, the bulk of health care’s financial risk has fallen on provincial and territorial governments (Hartmann 2017).

5 HOW THE REFORM WAS ACHIEVED

Following a meeting early in 2016, federal, provincial, and territorial Ministers of Health released a joint statement identifying shared health priorities: home care and mental health, prescription drugs, and innovation (Canadian Intergovernmental Conference Secretariat 2016). This statement laid the groundwork for the health accord negotiations. It was formalized in 2017 as *The Common Statement of the Principles on Shared Health Priorities* which includes principles of collaboration, innovation, and accountability and identifies four key priorities for home and community care (Health Canada 2018a).

In October 2016, the federal government met with provincial and territorial premiers with a proposed offer for the new health accord: an annual CHT increase of 3% and an additional \$3B over four years for new investments to home and community care and mental health (Galloway and Grant 2016). The provincial and territorial governments refused their offer, arguing that an annual increase of 3% was not a sustainable funding source for the projected growth in health care costs (Institute of Fiscal Studies and Democracy 2017). In addition, the provinces and territories argued that the funding increase should be

through the CHT annual increase, not targeted funds (Marchildon 2017). The provinces and territories countered with a 5.2% annual increase (a number echoed by the Conference Board of Canada and Parliamentary Budget Office) (Institute of Fiscal Studies and Democracy 2017).

In December 2016, the federal government tabled a take-it or leave-it offer for the new health accord: an annual CHT increase of 3.5% and an additional \$11.5B over ten years for new investments to home and community care, mental health and pan-Canadian organizations (Institute of Fiscal Studies and Democracy 2017; Tasker 2016). The federal government claimed their offer was more generous than what was tabled by the previous Conservative government. Provinces and territories again refused to sign the offer as it fell short of their ask: an annual CHT increase of 5.2% (Tasker 2016).

With limited progress in negotiations for the new health accord, the federal government opted to push bilateral funding deals one at a time, starting with the Atlantic provinces and the territories (Canadian Health Coalition and Ontario Health Coalition 2017). The federal government was keen to finalize the health accord before releasing their 2017 budget. The bilateral agreements included an amended offer (a minimal annual increase of 3% vs. 3.5%) and a stronger position on accountability considering the limited impact of the multilateral 2003 and 2004 Health Accords.

Although the bilateral funding deals fell short of provincial and territorial asks, their fiscal constraints gave them no other choice but to accept. Bilateral funding deals were agreed to in principle, starting with New Brunswick in December 2016 and ending with Manitoba in August 2017 (Health Canada 2019). After bilateral agreements were signed in principle, details of the agreements were negotiated and finalized, starting with New Brunswick late in 2017 and ending with Manitoba and Nunavut in the spring of 2019 (Health Canada 2019). These bilateral agreements provide details regarding how much each province or territory will receive annually until 2021/2022, activities to meet key priorities, and a commitment to report performance measures to CIHI (Health Canada 2019).

In keeping with Québec's previous arrangement for the 2004 Health Accord, a distinct asymmetrical agreement was developed with the Government of Québec that recognizes Québec's 'exercise of full control' over its health services and sole accountability to the population of Québec (Health Canada 2018c).

6 EVALUATION

6.1 Planned

CIHI worked with provinces and territories (except Québec) to establish five common indicators of improvements in home and community care services (Canadian Institute for Health Information 2018b). The indicators relate to wait times, appropriate care settings, the effectiveness of home care, caregiver experience, and end-of-life care (Canadian Institute for Health Information 2018b). Over the 10-year funding agreements, CIHI will evaluate

and report on these indicators on an annual basis.

Beginning in Fiscal Year 2019/2020, the federal government will monitor the use of funding as provinces and territories are required to provide annual financial statements.

6.2 Impact

As this targeted transfer moves funds from the federal government to provincial and territorial governments, evaluating the transfer at the provincial and territorial level is essential to understanding its impact. First, the funding prioritizes home and community care on provincial and territorial agendas. The funding prompted three new home and community strategies (Manitoba, Ontario, Québec) and supported ten existing strategies (British Columbia, Alberta, Saskatchewan, New Brunswick, Nova Scotia, Newfoundland, Prince Edward Island (PEI), Yukon, Northwest Territories, Nunavut).

Second, the funding promotes pan-Canadian harmonization of home and community care delivery. In the bilateral agreements, provinces and territories (except Québec) outlined their Five-Year Action Plans. While there are differences across these Five-Year Action Plans, some share the same strategies to improve home and community care (see Appendix 1).

Third, the targeted transfer is encouraging collaboration across jurisdictions. In May 2019, CIHI published baseline results for the first harmonized indicator for home and community care—extensions of hospital stays due to lack of home and community care (Canadian Institute for Health Information 2019). That this first indicator was negotiated and reported for each province and territory, except Québec, is evidence of collaboration.

While the targeted transfer does appear to be boosting investments to home and community care and promoting collaboration across jurisdictions, disparities in accessing home and community care remain across jurisdictions. First, there are differences across bilateral agreements with respect to which strategies a province and territory plan to implement (Appendix 1). These differences will result in disparities across provinces and territories; for instance, informal caregivers will receive respite care in Nova Scotia but not in PEI. Second, the first CIHI baseline indicator demonstrates disparities between provinces and territories for home care services. For instance, Northwest Territories and PEI have the longest median length of stay for patients discharged to home care in 2017/2018 with 24 days and 18 days, respectively, and Manitoba has the shortest, three days.

While the 2017 Health Accord improves the past fragmented situation, improvements to home and community care may still be limited. Provincial and Territorial Health Ministers continue to express concerns that Canadians' health needs are not well served when provincial and territorial governments do not receive fair and sustainable funding through the CHT (Canadian Intergovernmental Conference Secretariat 2018). The onset of the global COVID-19 pandemic and the devastation it has wrought in long-term care facilities threatens home and community care, as governments may realign funding from home and community care to long-term care.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1 – SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Bilateral agreements allow provinces and territories to tailor implementation to their unique needs. • Each province and territory (except Québec) has committed to reporting a common set of indicators to CIHI. • The transfer has strengthened plans to improve home and community care access, with some common themes across jurisdictions (Appendix 1). 	<ul style="list-style-type: none"> • Inconsistencies between agreements undermine the overall impact of the reform. • Agreements and indicators may not directly address formal workforce challenges, which are essential to improving home care services. None of the agreed-upon indicators look at the workforce. Further, data are limited to specific segments of the workforce (e.g., nurses).
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • As collaboration is a critical component of the targeted transfer, home and community service activities and innovations could be scaled up more quickly across provinces and territories through inter-provincial and territorial sharing of innovations. 	<ul style="list-style-type: none"> • The federal government has limited capacity to ensure that provinces and territories direct funds to home and community care. While bilateral agreements include a stipulation to claw back funding if not used for home and community care, such a move from the federal government would damage federal-provincial/territorial relations and be ill-perceived by the public. • The COVID-19 pandemic may divert funding to long-term care facilities at the expense of home and community care.

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APPENDIX 1

We compared the Five-Year Action Plans of each province and territory (Annex 2 of the bilateral agreements). These Five-Year Action Plans outline provincial or territorial plans (except Québec) on how they will use the funding to address the key priorities outlined in *The Common Statement of Principles on Shared Health Priorities*. The Five-Year Action Plans include details about specific programming, services, technologies and systems the province or territory will pursue. We grouped programming, services, technologies, and systems into overarching strategies. For instance, implementing tools to monitor home care provision includes interRAi (PEI, Nova Scotia, Northwest Territories, Nunavut) and a Community and Home Support System (New Brunswick).

Common strategies across jurisdictions are: developing respite care for informal caregivers (7 jurisdictions), increasing palliative care services (6), implementing tools to monitor the provision of home care (4), and creating integrated teams (5) (Health Canada 2019). Although a few bilateral agreements identify the importance of Indigenous populations, only two bilateral agreements explicitly include strategies to improve home and community care services for Indigenous people. Other strategies that appeared in only one agreement were: strengthening relationships with non-governmental organizations (NGOs), developing community health centres, a community resource sharing program, and a paid family caregiving pilot (Health Canada 2019). See Table 2 on next page.

Table 2 – Strategies across bilateral agreements

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	YT	NT	NU
Common Strategies													
Respite care	X	X			X	NA	X	X		X	X		
Palliative care	X	X		X	X	NA		X		X			
Monitoring tools						NA	X	X	X			X	X
Integrated teams	X	X	X			NA		X		X			
Other Strategies													
Indigenous					X	NA		X					
NGOs	X					NA							
Community health centres			X			NA							
Resource sharing						NA		X					
Paid family caregiver pilot						NA						X	

BC (British Columbia), AB (Alberta), SK (Saskatchewan), MB (Manitoba), ON (Ontario), QC (Québec), NB (New Brunswick), NS (Nova Scotia), PE (Prince Edward Island), NL (Newfoundland), YT (Yukon), NT (Northwest Territories), NU (Nunavut)