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EVIDENCE SYNTHESIS

A REVIEW OF CHALLENGES TO THE PROVISION OF HOME CARE AND HOME SUPPORT SERVICES ACROSS CANADA

OCTOBER 2019

Title: Evidence Synthesis: A Review of Challenges to the Provision of Home Care and Home Support Services Across Canada.

FOR MORE INFORMATION

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The purpose of this document is to inform APPTA's Policy Innovation Lab process in relation to the question "*How can increased investment in home support be leveraged to enhance older adults' ability to age well in their communities?".* The following evidence synthesis was conducted to better understand the difficulties experienced by older Canadians in navigating and accessing the health care system and social support system.

KEY MESSAGES

- Unmet needs of older adults (or home care recipients more generally) are due to a combination of cost of supports required, lack of care continuity, lack of access or information needed to access appropriate services, and limitations on care provision.

- The increasing proportion of older Canadians, with the additional factor of longer lifespans, offers the health care system and governments an opportunity to enhance the supports provided in home. This includes but is not limited to enhancing investment in home care and home support programs to increase affordability (especially for home supports); improve ease of access and system navigation; improve care coordination and continuity of care.

- Home Support workers make up the largest proportion of professionals in home care and help with Activities of Daily Living (ADLs) has shown to be extremely cost-effective for the health care system.

- While often articulated as a burden, this demographic shift offers Canada an opportunity to make sustainable changes in the health care system and build inclusive communities and services for all.

TERMINOLOGY

- **Older Adult/Senior** refers to an individual who is 65 years of age or older.

- Home Care and Home Support services when discussed on a pan-Canadian level carry with them many discrepancies in terms of how they are referred to, as well as the provision of services. For the purpose of this document, Home Support will be considered an extension of Home Care services as it often is in many jurisdictions. When mentioning Home Care in this document, consider Home Support services as included within that scope.

  Home Care is an array of services provided by a health professional in-home based on the assessed needs of the client.

  Home Support often refers to assistance with personal activities of daily living (ADLs) such as grooming, bathing, homemaking, etc.

- **Client/Care recipient** refers to an individual receiving home care or home support services.

- **Activities of Daily Living** (ADLs) refer to daily tasks such as eating, bathing, and toileting.

- **Home Support Worker (HSW)** refers to an unregulated worker who provides personal support services such as home maintenance tasks, bathing, toileting, and meal prep. Also known as personal support worker, health care aide, etc.

BACKGROUND

It is a common topic of discussion that the population of older Canadians is increasing. In just five years (2024), the population of adults over the age of 65 will reach approximately 20% in Canada and 11 years later (2036) the population is projected to increase to 25%[1]. While often articulated as a burden, this demographic shift offers Canada an opportunity to make sustainable changes in the health care system and build inclusive communities and services for all. Interestingly, higher rates of health care usage were not necessarily associated with increasing age as much as the presence of chronic conditions. Focusing on addressing health limitations may be more important than focusing on age alone[2]. However, programs often have an age cut off for eligibility, which creates a service gap for those who have specific needs due to a particular condition.

"Ultimately we want more health… and less health care."
TORC Report on Rural Health, 2009

A recurring consensus in the literature exploring older adults' perceptions and hopes of how they will live their later years, is that they want to be able to age in their own homes or communities[3]. Home care and support offers a cost-effective way for the system to ensure the health of its aging population[4,5]. The purpose of this evidence synthesis we will be exploring the literature around the challenges in the provision of home supports and home care programs.

Home Care Recipients

Older adults represent the largest group accessing home care or home support services.[6,7] In 2012, the General Social Survey (GSS) found 13% of those receiving home care services were 65 to 74 years of age and 27% were 75 years and older. This likely varies between jurisdictions, as demographics change. Furthermore, 56% of care receivers were women, and were more likely than men to be receiving care for age-related needs rather than mental illness and accident-related injuries. This is likely due to the longer lifespan of women than men. Recent CIHI data on home care recipients indicate that a total of 73.6% of clients assessed in community were receiving home support and 44.6% were receiving home care across reporting jurisdictions (Newfoundland and Labrador, British Columbia, Alberta, Yukon and Ontario). This data also reports that of home care clients assessed in community, 76% had heart or circulatory diseases, 36.7% had some form of neurological disease or condition, 18.2% had a sensory disease (glaucoma or cataracts), 23.3% had a psychiatric diagnosis, and 60.5% had some other disease or condition such as cancer, diabetes, COPD, etc.[8] Further breakdown of the home care client profile is offered in **Appendix A**.

In the GSS 2012, care receivers were asked about the severity of their condition and most reported their condition as being either moderate (38%) or severe (42%). In contrast with health care services, home support services, such as household work, scheduling and coordinating appointments, transportation, help with medical treatments, personal care, etc. were more likely to be taken on by family and friends. Hours of care and assistance correspond with more severe conditions such as Alzheimer's disease or dementia and increases with severity of the condition for hours of family or friend provided care. However, hours of care through professional services were less likely to increase with condition severity[9]. The Canadian Community Health Survey, with more recent reporting, indicated that lower income households (specifically ones where the primary source of income was social assistance) were more likely to receive home care, as well as households that rented rather than owned and households with lower levels of education (Canadian Community Health Survey, 2016).

NOTE: No reports were found that specified older care recipients' cultures, ethnicity or other characteristics aside from what has been reported above.

HOME CARE CHALLENGES

As Canada's population continues to age, the Conference Board of Canada estimates 2.4 million Canadians 65 years and older will require some form of continuing care support by 2026, paid or unpaid[10]. With 75% to 80% of older Canadians reporting having at least one chronic condition, there is a need for a shift in how the health care system operates and serves our older generation. The Canadian Medical Association (2016) states "Canada's Medicare system was established to deal largely with acute, episodic care for a relatively young population" and acknowledges the limitations the system has on properly treating and servicing today's older adults. With the increase in health and social care needs, there is a current and growing demand for home care and support services. Identifying the challenges around home care is an essential step in properly developing sustainable solutions.

Lack of availability, issues with eligibility criteria, personal characteristics (follow through, language barrier, etc.) cost, and deciding to not seek services have been described in the literature as barriers to home care. The most frequently reported barrier was lack of availability of services. All of these barriers contribute to unmet needs and the importance of highlighting these issues is paramount for identifying where improvements and changes need to be made. The 2016 Canadian Community Health Survey (CCHS) reported that of those receiving home care services, over one-third of people had unmet home care needs, most of which being unmet support needs rather than health care needs. This shows the importance and need to better fund home support workers in entering and remaining in the field. Unmet needs are linked to negative health consequences for the client and lead to increased costs to the healthcare system that otherwise may have been avoided by proper home care

provision[11]. For home support services, 46.1% indicated in the 2015/2016 CCHS that their needs were either partially met or unmet. Variations in access to home care services and financial coverage (provincial/territorial/federal) for home care services might be a contributing factor for unmet needs, since one-fifth of respondents cited cost as a barrier. Similarly, analysis from the General Social Survey reveals 24% of those who reported having unmet needs were 65 and older[12]. While the GSS and CCHS both explored unmet needs, the GSS criteria encompassed needs being met by unpaid caregivers, and the CCHS criteria excluded needs met by caregivers to gain a better picture of where the gaps in service provision might be[13]. The themes identified below have been explored as factors that contribute to overall unmet needs of home care recipients.

NOTE: GSS and CCHS surveys contain information from varying years and the results are based on different evaluation criteria.

Home Support Workers

One of the leading issues contributing to unmet care or support needs is a common shortage of Home Support Workers (HSWs) among Canadian jurisdictions. Statistics from 2001 show HSWs provided 70% to 80% of home care needs[14], and although HSWs are the largest occupational group in home care, there are many issues around recruitment and retention of this profession that are worth nothing. Current efforts in health care recruitment primarily focus on doctor and nurse positions, rather than on workers for home care and support services. Therefore, increasing efforts to recruit home care or home support workers has been stated as a key recommendation for policy-makers [15]. Recruitment efforts focusing around the unique attributes of working as an HSW may promote attraction. In a study exploring facilitators for recruitment of HSWs, positive factors were described to be reliable finances and good job flexibility. HSWs enjoyed that they did not have a typical work day, enjoyed working with people, and the ability to have diverse experiences in the field were also described as drivers for HSWs to stay in their positions[16].

"I've known [my homemaker] for a long time. If you send me someone else, I'll be lost."
Low et al. 2011

Issues such as compensation, education and training, quality assurance, and working conditions arose as key barriers to choosing a career as an HSW[17,18]. Similar themes among the literature include lack of general knowledge around important topics such as identifying signs of dementia, fall prevention, or nutrition needs confirm the importance

of proper education and training for HSWs and its impact on client care[19]. In addition to poor wages and working conditions, other challenges were identified as being organizational issues such as ethical challenges of balancing professionalism with clients and providing a sense of social companionship, and safety concerns. Lastly, home support workers are an unregulated profession which brings with it many issues for recruitment and retention. With a lack of regulation, there is a lack of standardized terminology for this vocation that creates confusion and discrepancies for training, certification, and scope of practice, which varies between jurisdictions. For example, these workers can be referred to as home support workers, personal support workers, home-makers, or personal attendants, to name a few. These variances may be at the heart of recruitment and retention issues for this profession.

Provision of Service

Approximately one in every six seniors (aged 65 and older) received home care in 2011. In 2013, approximately 1.8 million Canadians received publicly funded home care services, 70 percent of which were seniors. Home Care is recognized as an "extended health service" under the Canada Health Act and is not an insured service. Home Care expenditures range from $3.7B to $5.9B annually. From the CCHS 2016 data, it is reported that individuals who require home support services are more likely to pay out-of-pocket compared to those who need home health care services, which is more often paid by government or insurance coverage. This is concerning with the additional knowledge that those who are most likely to use home care and home support services are lower income[20,21]. Home supports that are appropriate, affordable, and available have been reported an as essential service for seniors[22].

Other issues around the provision of service include the care planning and regulations of home care, which might contribute to clients perceived unmet needs. For example, home supports are described in one study as "a nine-to-five thing" leading to unmet needs at times of the day where assistance is really needed such as early morning and late evening[23]. Minor daily tasks that may be important to them are not highlighted in their plan, therefore HSWs are less likely to complete those tasks even if they are requested. Furthermore, assistance like transportation is not typically included in a care plan although it would greatly assist home care clients in ADLs and important tasks such as health appointments and prescription pick-up. One of the major barriers to this is a requirement for the HSW to hold a specific insurance policy in order to transport clients, which is not covered by their employer[24]. There is a balance shift in which governments cannot take away funds that currently support the healthcare system as it stands, however, there is a resounding recommendation in the literature that increasing investment in home care will alleviate much of the burden we see in acute care services. There is increasing evidence that not only do proper home care supports allow

older adults to live longer, healthier lives, but also, early admittance into long-term care facilities can have detrimental consequences on one's health[25].

Inequities in service delivery

Another noteworthy issue across health care is the inequities of care provision across the country. Equitable access, defined as the "opportunity for patients to obtain appropriate health care services based on their perceived need for care", speaks to the availability and quality of care and has been described as a challenge for specific population groups[26]. Even if appropriate services are available for more disadvantaged groups, they are not always accessible and lead to negative consequences such as preventable hospitalization. The underlying social and economic factors that contribute to negative, but preventable, health consequences of older Canadians need to be explored and appropriately addressed across jurisdictions.

Low-income seniors

Low-income Canadians are at a disadvantage in the health care system as they face substantial barriers to accessing appropriate and timely services. More specifically, a study in British Columbia found individuals 50 years and over were more likely to use acute care hospital services and emergency medical services if they were of lower income[27]. This supports the notion that services which are accessible to low income seniors are not always timely and lead to preventable health consequences. One of the factors impeding use of appropriate health care services is the cost associated with accessing those services. The CMA report on inequities in care for Canadians identifies many cost-related barriers to obtaining services including cost of transportation, insufficient payment models, and payments for medications or medical devices/treatments. These pose greater barriers on individuals who are living on low and fixed income and many of the other vulnerable groups discussed fall within this population.

Indigenous Populations

Indigenous populations do not receive the same level of care as non-Indigenous populations and there is a lack of data available to understand the particular needs of these demographic groups. One important recognition is the varying needs of First Nations, Inuit and Métis populations. Specifically, Métis people have described themselves as "hidden" and often do not receive the same access to programs and services available even to First Nations and Inuit populations. While they have expressed experiencing many hardships felt by other populations in Canada such as poverty, isolation, and poorer health, they ultimately represent a unique and diverse group that needs to be recognized as such[28]. Similarly, when it comes to conditions

such as dementia, Indigenous populations are at particularly higher risks of earlier onset, however, current diagnostics have shown to be less accurate and there is a need for culturally appropriate and safe diagnostic tools. The lack of access to timely and appropriate diagnostic services for these people is a crucial step in identifying care services they require and preventing acute care visits.

Immigrant Seniors

Individuals with immigrant status have a higher likelihood of having unmet home care needs, accounting for 30% of those reporting having unmet needs[29]. These individuals are also less likely to have social networks to rely on for additional supports, leaving them at a particular disadvantage. Newcomer seniors can experience major challenges in receiving appropriate supports adding much stress to an already taxing life transition. Income, social isolation, unmet health care needs, and transportation were described as four major challenges faced by newcomer seniors. Moreover, according to 2004 data among seniors who immigrated to Canada, specifically BC, in the last 10 years 71% were living in poverty[30]. Immigrant seniors too require accessible social and health care services to ensure they can live long and healthy lives.

Rural and remote community dwellers

Generally, individuals living in rural communities face significant service gaps when it comes to health care provision. Regardless of being more likely to have greater health needs, rural residents are less likely to have access to the necessary services[31]. Moreover, rural Canadians are more likely to have lower incomes, have poorer health, and have life expectancies less than the national average. Much of the burden experienced by rural communities is due to shortages among multiple health care providers and the issues around recruitment and retention[32]. This disrupts rural citizens' ability to have consistent and continuous health care that supports the management of current and prevention of future health conditions.

"Twenty-one per cent of the population is rural, fewer than ten per cent of physicians are rural, and only three per cent of specialists are rural."
TORC Report on Rural Health, 2009

CURRENT OUTLOOK

There have been a number of recommendations and acknowledgements around the challenges seniors face related to receiving services in-home. A report prepared by the Federal government identifies the importance of addressing the gaps in the provision of financial support, calls for innovative approaches to providing care, identifies the importance of non-medical services such as home support, and expresses the need to make services more available and accessible, especially in rural areas[33]. Similarly, the CMA has recommended that a targeted home care innovation fund be established in order to address some of the major challenges the system faces[34].

The recently published National Dementia Strategy highlights important issues and perspectives regarding access to care related to the diagnosis and treatment of people living with dementia. This document, *Together We Aspire*, highlights many calls for action including increasing awareness and reducing stigma, development of guidelines for early diagnosis, understanding the effects of dementia on our communities, and support for community-based projects[35]. Movement in this direction will help many seniors at risk for dementia receive appropriate care, specifically those who are more likely to experience inequities in care such as Indigenous peoples, ethnic minorities, low-income, and rural community dwellers.

CONCLUSION

The aim of this review was to understand the multitude of variables that influence access to home care and home support and how these factors contribute to unmet needs. Ultimately, unmet needs are initiated by lack of availability of services, out-of-pocket costs, lack of care continuity and personal characteristics that incline individuals to discontinue their services. It is vital to appreciate how the challenges experienced in receiving home support differs among population groups in order to address their unique barriers. With a better understanding of how unmet needs manifest, there is an opportunity to further explore the gaps within the system and identify appropriate and sustainable solutions.

APPENDIX A

CIHI 2017/2018 Home Care Client Profile Data

Profile of Home Care Clients		
Age of Home Care Client		
Total in Hospital	81 years of age • NL – 79 years of age • ON- 81 years of age • AB – 82 years of age • BC – 82 years of age	90.7% of home care clients assessed in hospital were over the age of 65
Total in Community	79 years of age • NL – 77 years of age • ON – 78 years of age • AB – 79 years of age • BC – 80 years of age • YK- 75 years of age	86% of home care clients assessed in community were over the age of 65
Assessment of caregivers		
Total in Hospital	54.4% of caregivers of clients assessed in hospital, indicated either distress, anger or depression or that they felt unable to continue caring • NL – 31.3% • ON – 61.4% • AB – 29.5% • BC – 61.5%	
Total in Community	37.2% of caregivers of clients assessed in hospital, indicated either distress, anger or depression or that they felt unable to continue caring • NL – 22.4% • ON – 42.1% • AB – 16.1% • BC – 32.1% • YK – 14.9%	
Self-Performance assessment of ADLs		
Total in Hospital	83.4% of clients assessed had limited independence to total dependence in performing ADLs • NL – 74.1% • ON – 84.8% • AB – 79.1% • BC – 85.9%	

Total in Community	42.4% of clients assessed had limited independence to total dependence in performing ADLs • NL – 32.8% • ON – 44.9% • AB – 31.7% • BC - 38.4% • YK – 6.2%

Home Care Client Health	
Health Conditions	**Breakdown**
• Heart/Circulation diseases	
82.2% of clients assessed in hospital had some heart condition. Majority (68.9%) had hypertension.	• NL – 82.8% • ON – 82% • AB – 32.8% • BC – 82.1%
76 % of clients assessed in the community has some heart condition.	• NL – 79.1% • ON – 76% • AB – 76% • BC – 75.5% • YK – 67.1%
• Neurological diseases	
54.8% of clients assessed in hospital had some neurological condition. Majority had alzheimer's/dementia.	• NL - 39.9% • ON – 51.9% • AB – 60.7% • BC – 68.4%
36.7% of clients assessed in community had some neurological condition.	• NL – 22.9% • ON – 35.2% • AB – 40.4% • BC – 45.7% • YK – 28.3%
• Musculoskeletal disease	
58.8% of clients assessed in hospital had some musculoskeletal condition. Majority (42.3%) had arthritis.	• NL – 57.5% • ON – 60% • AB – 61.5% • BC – 50.6%
62.1% of clients assessed in community had some musculoskeletal condition.	• NL – 66.7% • ON – 63.1% • AB – 62.2% • BC – 54.6%

	• YK – 60.9%
• Sensory diseases	
17% of clients assessed in hospital had some sensory impairments. Majority (11.2%) had cataracts.	• NL – 23.4% • ON – 16.7% • AB – 16.9% • BC – 15.7%
18.2% of clients assessed in community had some sensory impairments.	• NL – 25.7% • ON – 18.4% • AB – 16.6% • BC – 17.1% • YK – 21.3%
• Psychiatric/mood diseases	
25.5% of clients assessed in hospital had any psychiatric diagnosis	• NL – 23.2% • ON – 24.8% • AB – 28.1% • BC – 21.7%
23.3% of clients assessed in community had any psychiatric diagnosis	• NL – 21.5% • ON – 22.9% • AB – 25.9% • BC – 23.7% • YK – 11.2%
• Infections	
18.8% of clients assessed in hospital had some type of infection. Majority (14.1%) had UTIs	• NL – 20.2% • ON – 16.3% • AB – 28% • BC – 19.2%
7.9% of clients assessed in community had infections.	• NL – 8% • ON – 8.2% • AB – 6.9% • BC – 7.1% • YK – 7.8%
• Other diseases or conditions	
64.4% of clients assessed in hospital had some other condition. i.e. cancer, diabetes or other chronic conditions, thyroid disease, renal failure.	• NL – 67.2% • ON – 62.5% • AB – 72.6% • BC – 62.1%
60.5% of clients assessed in community had other diseases as described above.	• NL - 63.2% • ON – 60.3% • AB – 63.5%

	• BC – 58.1% • YK – 63.6%

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