Economic Security Project

Towards an Enhanced and More Accessible Home Support System for BC's Seniors

Introduction

HOME SUPPORT ENABLES frail seniors and people living with chronic conditions or disabilities to live independently in their own homes and maintain their quality of life. It includes a broad range of personal care services, including bathing, grooming and basic medical care, such as help with medications or changing wound dressings. Home support also allows convalescing patients to be released from hospital earlier, providing support in the patients' own homes and thus relieving pressure on acute care settings.

Home support can fulfill important preventative health functions by ensuring good nutrition and hygiene and by providing early warning of health deterioration that may result in hospitalization or institutionalization if left untreated. As the baby boomer generation ages, the need to strengthen and expand the supports available to seniors in their homes becomes more pressing.

In BC, the pressures created by the aging population have been compounded by sharp cuts in the numbers of acute care and long-term care beds over the last decade. These changes shifted the burden of care for the frail elderly onto community-based services and individual families. Home support services were now required to provide more medicalized care to an increasingly higher-needs client population.[1] Without adequate funding to match the increased need, basic services deemed "non essential" have been scaled back, and access to services has been reduced for those with more moderate needs,[2] undermining the preventative functions of home support at a time when they are most needed.

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May 2009

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Home support has been shown to be a cost-effective health intervention for vulnerable seniors. A study conducted in BC in the late 1990s found that seniors whose basic supports were cut in an effort to control health care costs ended up using more health care services over a three-year period, including long-term institutional care, acute care, emergency, and in-patient services, thus incurring considerably higher health care costs than seniors who continued to receive basic home support services.[3]

Several recent reports have argued that the current levels of home support available to BC seniors are inadequate, and have advocated for a funding increase that would permit an expansion of home support services.[4]

There is clearly a need for improving and enhancing BC's home support system, and for the first time in a decade, the political will may be present as well. The Minister of Healthy Living and Sports, Mary Polak, has acknowledged that the system needs to be expanded and that such an expansion would require additional funding—although this is not yet forthcoming.[5] Determining exactly how the home and community care system should be expanded to provide better care for seniors is one of the core tasks facing the newly formed Seniors' Healthy Living Secretariat, which will also monitor progress on seniors' issues in general.

While the government's interest in addressing seniors' issues is to be commended, there is concern about the potential for a disconnect between existing home support and other community health care services delivered through the Ministry of Health Services and a potential expansion of "non-medical" home support services such as housekeeping and transportation through the new Ministry of Healthy Living and Sports. It is essential that all home support services for frail and vulnerable seniors are integrated with other community health care services, such as home nursing, to form a seamless continuum of care. This would allow seniors to move smoothly between services as their needs change. Fragmenting services could easily compromise the quality of care provided.

This policy paper provides a plan for expanding home support in ways that support service integration and continuity of care, based on best evidence.

Three major areas within the home support system are identified as in need of immediate attention: recruitment and retention, the organization of home support delivery, and the level of service hours provided. We propose a three-pronged approach to reforming and expanding home support in BC that would address each of these areas in tandem, taking into account the interconnections between the quality of service for clients and the working conditions of staff. We cost out the additional resources required for the implementation of these recommendations and demonstrate that the proposed reforms are not only sensible, but affordable.

Key Concerns about BC's Home Support System

A review of the literature on home support in BC and Canada indicates that the main concerns in delivering home support are recruitment and retention issues, tensions created by the increased complexity of client needs and the tight time demands, and inadequate capacity in the system to meet the needs of seniors. These issues are closely linked and each has serious implications for the quality of service provided, which is why we recommend that they be tackled jointly through mutually reinforcing reforms.

RECRUITMENT AND RETENTION OF COMMUNITY HEALTH WORKERS

Home support employers across the province identify recruitment and retention of community health workers—those who provide home support—as one of their top concerns.[6] Staffing shortages mean that employers must dedicate more resources to hiring and training workers and are increasingly relying on their current workers to put in overtime, which raises costs.[7]

Worker shortages had historically been a challenge in rural and remote areas, but the problems have worsened and spread province-wide over the past decade as cuts in home support led to a serious deterioration in the working conditions for community health workers, driving many out of the field. For example, the shift to higher-needs clients and the lack of adequate funding has created pressures for community health workers to deliver more complex care in less time, without a corresponding increase in training, professional support or pay. At the same time, cost pressures have led to increased reliance on non-permanent staff and irregular scheduling, which requires workers to be available during extended periods of the day, without predictability in their actual hours of work or incomes.[8]

The shortage of community health workers has direct implications for the quality of care provided. Seniors may not always receive the care they need as workers are forced to rush so they can take care of more and more clients in the space of the workday, and services may be temporarily rolled back because of lack of staff.[9]

At a minimum, high turnover rates disrupt continuity of care. Having the same worker or group of workers consistently provide services to one client allows for changes in the client's health status to be quickly detected and reported, which immensely improves home support's capacity to function as a preventative health mechanism. Continuity of care has also been found to increase patient satisfaction and reduce hospitalizations and emergency room visits.[10]

Recruitment and retention issues must be addressed to ensure that BC's home support system can reliably provide high quality care to those who need it. Understanding the root causes of the worker shortage is an essential first step. When asked about the causes of staffing issues, home support employers in BC point to low wages, unpredictable hours, and split-shift scheduling as the main culprits, and acknowledge the competition with long-term care facility jobs that require the same level of training, but offer regular hours and higher pay.[11] A related issue is that many of the costs of providing home support are passed on to community health workers. For example, workers are required to use their own vehicles and are responsible for maintenance costs, which puts a financial burden on workers and can act as a barrier to employment in the home support sector.

Therefore, to successfully tackle the existing worker shortage, we need to address both the low pay of community health workers (through increasing their wages) and deteriorating working conditions (through reorganizing the way home support is delivered).

THE NEED FOR IMPROVED TEAMWORK AND STABILITY IN SERVICE DELIVERY

As noted above, there is evidence that the intensification of work and the deterioration of working conditions for community health workers in BC over the past decade have diminished continuity of care and compromised care quality.[12] Many of the recent changes, such as the introduction of shorter home visits and split shifts and the increased reliance on casual labour, have also exacerbated existing recruitment and retention issues.

The isolation of community health workers from other health providers, such as nurses, and the lack of communication between different workers assigned to provide care to the same client(s) pose additional challenges to the responsiveness and consistency of care provision.

Home support managers around the province have recognized these problems and there have been efforts in a number of BC communities to improve the continuity of care through focusing on teamwork and better working conditions. Innovative system-redesign projects were piloted in Kelowna in March 2006 and in Sechelt in June 2007.[13]

Both projects implemented a team-based approach to the delivery of home support, assigning community health workers to teams covering a particular geographical area. A new workflow lead position was created to support the teams—a community health worker assumed team lead responsibilities for a

portion of each shift (he or she provided client care for the remaining time). To improve communication between and within teams, regular meetings were held at the start of each shift and cell phones were provided to community health workers.

To further improve working conditions, scheduling was changed so that regular staff had predictable shifts with breaks scheduled into the workday and were no longer required to work split shifts or be on call throughout the day. Scheduling was handled differently in the two projects: regular shift rotations were used in Kelowna, while Sechelt workers, who were consulted during the design phase of the project, opted for fixed weekly schedules. However, both systems provided much needed predictability in the hours and incomes for community health workers.

The initial evaluations of these projects reveal a number of positive outcomes both in terms of client and worker satisfaction.[14] In Kelowna, staff surveys and focus groups indicated improved worker satisfaction, and evaluators found evidence of improved staff morale and accountability. Recruitment and retention problems greatly diminished, overtime hours were substantially reduced, and both paid and unpaid sick time decreased. In Sechelt, workplace injuries were substantially reduced, resulting in considerable savings in Workers' Compensation Board (WCB) payments over the first year of the project.

The quality of home support care provided across the province would be greatly improved if service delivery were redesigned to improve teamwork and take into account the close links between the quality of working conditions for care providers and the quality of care received by clients.

REDUCED ACCESS TO SERVICES

It has been widely acknowledged that more seniors would benefit from having access to home support services and that existing clients would benefit from more direct hours of service. Table 1 shows that in BC, both the number of home support clients and the hours of home support provided fell between 2000/01 and 2006/07, a period when the province's population increased by 7 per cent and the number of seniors grew by 14 per cent. In fact, the declines in home support services began in the mid-1990s, when the federal government significantly reduced healthcare transfers to provinces, as an earlier CCPA study documents.[15]

Table 1: Home Support Clients and Hours in BC, 2000/01 to 2006/07[16]

Fiscal year	Client count	Hours
2000/01	40,067	7,120,967
2001/02	38,245	7,198,396
2002/03	34,060	6,611,702
2003/04	32,046	6,424,922
2004/05	30,322	6,287,137
2005/06	31,870	6,668,163
2006/07	33,327	6,884,486
Percentage change 2000/01 to 2006/07	-16.8%	-3.3%

Note: Choice in Supports for Independent Living (CSIL) hours are excluded.
Source: Author's calculations using data provided by the BC Ministry of Health Services.

The number of clients declined much more rapidly than the hours of care, which indicates that home support services were shifted to higher-needs clients who require more hours of care. This is the result of a deliberate policy decision to tighten eligibility for home support by scaling back basic services deemed "non-essential" (such as meal preparation, housekeeping and transportation) and limiting access to home support services for individuals with more moderate needs.

The declines in both client counts and hours began to reverse after 2004/05, when they reached their lowest levels, but the increases have not compensated for the substantial decline seen in the early 2000s, let alone those since 1993/94 when 59,857 home support clients in BC received 7,755,166 hours of care.[17]

Data from the BC Ministry of Health Services show that the vast majority (over 85 per cent) of home support clients are aged 65 or older, and that seniors account for about 80 per cent of all home support hours provided each year between 2000/01 and 2006/07.[18] As the population of BC ages, the demand for home support grows. It is, therefore, important to track not just overall numbers of care hours and clients, but also the utilization of home support per 1,000 seniors.

Table 2 shows that the declines in home support hours and clients are greater when expressed as a rate per 1,000 population aged 65 years and older. The data clearly show that access to home support has been significantly reduced for BC seniors.

Improving access would have important benefits for the health and wellbeing of frail elderly individuals who could remain longer in their homes with the appropriate supports. Providing home support to clients with lighter needs could conceivably delay deterioration to higher needs of service and enable care providers to spot problems early so that treatment can be provided in an outpatient setting at much lower costs to the health system.

Table 2: Home Support Clients and Hours in BC per 1,000 Population Aged 65+, 2000/01 to 2006/07

Fiscal year	Clients per 1,000 population aged 65+	Hours per 1,000 population aged 65+
2000/01	64	10,653
2001/02	60	10,505
2002/03	52	9,464
2003/04	49	9,181
2004/05	46	8,922
2005/06	47	9,280
2006/07	47	9,365
Percentage change 2000/01 to 2006/07	-26%	-12%

Note: Choice in Supports for Independent Living (CSIL) hours are excluded.
Source: Author's calculations using data provided by the BC Ministry of Health Services.

A Plan for an Enhanced and More Accessible System of Home Support

We propose a three-pronged approach to reform, which addresses each of the home support concerns identified above. Implemented as a package, these reforms would have mutually reinforcing effects that would ultimately improve the quality and accessibility of care for seniors who need assistance to continue living independently in their homes.

INCREASE THE WAGES OF COMMUNITY HEALTH WORKERS TO IMPROVE RECRUITMENT AND RETENTION

The majority of community health workers in the province are unionized and paid according to the collective agreement negotiated by the Community Subsector Association of Bargaining Agents. Effective April 1, 2009, the hourly wage for a community health worker ranges between $18.39 and $20.11 per hour, depending on seniority. This is substantially lower than the $21.94 hourly rate earned by workers with equivalent training in long-term care facilities. In addition, facility workers have fixed schedules that provide income stability and better work-life balance—an important consideration for community health workers, who are primarily women, many with their own family care-giving responsibilities.[19] Facility health workers are supported by other health professionals who can assist with unexpected difficulties that may arise in the daily provision of care, while community health workers generally work on their own. It is hardly surprising, then, that community health workers would be tempted to leave their jobs for facility work.

The differentials in pay and working conditions between community and facility workers exacerbate recruitment and retention problems in home support that arise from deteriorating working conditions in the field. Community health workers are part of the low-income workforce: two recent studies found that more than half of BC community health workers earn less than $30,000 per year.[20] Therefore, increasing their pay to a level that is on par with facility work will significantly improve the economic wellbeing of workers and their families, thus improving retention of current workers and making the field more attractive to new workers.

We estimate that increasing community health workers' wages to match facility rates would cost an additional $24.1 million per year, if all aspects of the home support system were left unchanged (see Appendix for details on the costing methodology).

REDESIGN HOME SUPPORT TO IMPROVE TEAMWORK AND STABILITY

The successful pilot projects in Kelowna and Sechelt show that by reorganizing service delivery to provide a better working environment for community health workers it is possible to address recruitment and retention problems while at the same time improving the quality of care provided to seniors.

These pilot projects should be used as models and implemented across the province.[21] It is important to note, however, that while health authorities should provide a framework for reorganization, local home support offices should have the flexibility to adapt service delivery to the particular needs of their communities.

Both Sechelt and Kelowna's evaluations indicate that the redesign of home support delivery was associated with additional costs, but they also found that the redesign generated savings in some areas. For example, higher wage expenses resulting from the extra non-service hours worked (e.g., during team meetings and paid breaks that were previously unpaid) were partially offset by a decline in workers' compensation claims and sick time, and a reduction in overtime hours and travel expenses, among other costs. Therefore, we need to examine the net costs of introducing system changes to the delivery of home support in order to estimate the cost increase required for rolling out a similar team-based model of service delivery province-wide.

Assuming that implementing a province-wide home support delivery redesign modeled on the Kelowna and Sechelt pilot projects would increase the average costs of home support delivery by 7 per cent, as was the case in Kelowna's pilot project, we estimate that the additional net cost of implementing team-based home support delivery across the province would be approximately $19.3 million (see Appendix for details).

Note that this represents the net additional cost of providing home support after accounting for the generated cost savings. A larger upfront investment would be required to initiate this project, but the resulting ongoing savings would recover much of the initial investment over time.

INCREASE THE NUMBER OF CLIENT HOURS PROVIDED

It has been widely acknowledged that more seniors would benefit from having access to home support services and that existing clients would benefit from more hours of service. We propose an initial 15 per cent increase in home support hours and estimate the additional costs required. Such an increase would bring home support hours to 7.9 million per year, similar to the number of client hours provided in BC in 1998/99. We do not claim that this is the optimal level of client hours, but it is a good starting point and one that would significantly improve the accessibility of home support in the province.

It should be noted that in its current form, home support in BC is focused on providing personal care and includes very limited provision for basic services such as housekeeping, laundry, meal preparation and transportation, which are also very important for seniors to be able to age safely and comfortably in their own homes.

Our proposed expansion in home support hours would allow for the provision of basic services to more seniors with lighter needs, thus improving the quality and accessibility of seniors' care in BC. Providing these services through the home support team would contribute to creating a seamless continuum of care for seniors who need supports to be able to remain in their homes instead of moving to long-term care facilities. It would also ensure that services are provided by trained staff so that safety can be guaranteed both for the client and the community health workers, and clients receive high quality care that meets their specific needs.

While our proposed increase of 15 per cent, or just over 1 million client hours per year, would strengthen the preventative and maintenance functions of home support in BC, it will not be sufficient to provide basic services, such as meal preparation and housekeeping, to all seniors who need them. In its 2006 report, the Premier's Council on Aging and Seniors' Issues put forward a vision of such a broader home support system and suggested that an additional 6 million hours of client service per year would be required to extend assistance with basic tasks to all seniors who are unable to perform these activities safely for themselves.[22]

We estimate that a 15 per cent increase in client hours over what was provided in 2006/2007 would cost an additional $40.9 million (see Appendix for details). A larger system expansion of the magnitude envisioned by the Premier's Council on Aging would be significantly more expensive and may have to be phased in over more than one year.

Implementation Costs for the Proposed Reforms

Increasing wages and implementing a team-based service delivery model across the province is estimated to increase the current costs of providing home support by $45.1 million, holding hours of service constant at their 2006/07 levels (see Appendix for details). Note that this number is slightly higher than simply adding together the costs of implementing the two changes separately, as the team-oriented home support redesign somewhat increases the number of community health worker hours required to provide the same level of client service.

Increasing client hours by 15 per cent would add another $47.8 million, bringing the total costs of the home support reforms recommended in this policy paper to an estimated $93.2 million (see Appendix for details).

Our calculations demonstrate that increasing the home support budget by $100 million would provide sufficient resources to implement the three reforms that we propose and have some left over for contingencies that we may not have accounted for or for an additional expansion of direct service hours. This amount represents about 0.7 per cent of provincial health care spending and would raise the overall home support budget to about 3 per cent of total health care spending in BC—a level that it was at in the late 1990s.

Such an increase would actually be smaller than what was recommended by the Premier's Council on Aging and Seniors' Issues in 2006 ($120 million per year) because we propose a much smaller increase in home support hours. Instead, we put forward a package of reforms to address recruitment and retention issues, to improve the quality of services provided by supporting service integration and continuity of care, and to make the system more accessible.

Conclusion and Recommendations

We recommend that the BC government immediately increase the home support budget of health authorities by $100 million per year and ensure that the additional funding is applied towards the package of reforms put forward in this paper, including raising the wages of community health workers, implementing a team-based home support delivery model similar to Kelowna and Sechelt's pilot projects, and increasing the number of service hours provided.

While it is important that the provincial government provide the general framework for reform and reorganization, individual health authorities should retain enough flexibility to adapt the reforms to the particular needs of the communities they serve.

This additional $100 million annually could significantly improve home support in BC. Our calculations demonstrate that such a funding increase would provide sufficient resources to implement the three reforms that we propose and have some left over for contingencies that we may not have accounted for. Such an increase is also entirely affordable even in a recession: $100 million represents just over 0.7 per cent of provincial health care spending for 2007/08.

Further increasing funding for home support (for example, by $120 million as proposed by the Premier's Council on Aging) would allow for the restoration of more basic services such as housekeeping and meal preparation to seniors who need them, thus strengthening the preventive and maintenance functions of home support.

The reforms we propose take into account the important interconnections between the quality of service for clients and the working conditions of care providers, and would have mutually reinforcing effects that would ultimately result in better quality care and more accessible care for the seniors who need assistance to remain in their homes. Injecting new funding into the home support system is an opportunity to make a sound investment in community care and increase the quality of life for frail seniors, while achieving long-term cost savings for the health care system.

APPENDIX

Costing Methodology

All estimates take the number of home support client hours in 2006/07 (the latest available) as the baseline from which cost increases are calculated. Additional assumptions are outlined on the following pages.

Table A1: Home Support Expenditures and Hours of Service, Current and Estimates After Implementing Our Recommendations

	2006/07 (actual)	Higher wages	Team-based service redesign	15% higher client hours	Increased wages and redesign	All three reforms
Client hours	6,884,486	6,884,486	6,884,486	7,917,159	6,884,486	7,917,159
Total expenditures	$272,885,357	$296,981,057	$292,161,917	$313,818,161	$318,322,963	$366,071,407
Average cost per client hour	$39.64	$43.14	$42.44	$39.64	$46.24	$46.24
Community health worker average wages	$19.25	$21.94	$19.25	$19.25	$21.94	$21.94
Additional cost per client hour	-	$3.50	$2.80	-	$6.60	$6.60
Total additional costs	-	$24,095,700	$19,276,560	$40,932,804	$45,437,606	$93,186,050

Note: Choice in Supports for Independent Living (CSIL) hours and costs are excluded.
Source: Author's calculations using data provided by the BC Ministry of Health Services.

1. INCREASING WAGES

To estimate the costs of increasing the wages of community health workers, we assume that the average hourly wage is the mid-point of the wage range for 2009, or $19.25, and that non-wage benefits add an additional 30 per cent to the wage costs. We further assume that community health care workers spend all of their paid time on direct service provision so that client hours correspond to paid hours for community health workers.

Increasing community health workers' wages from $19.25 to $21.94 per hour translates to an increase of $3.50 per hour worked after non-wage benefits are included. Multiplying this increase by the total number of client hours in 2006/07, we calculate that raising wages to facility rates would cost an additional $24.1 million per year, if all other aspects of the home support system were left unchanged.

Note that our assumptions about the current average wage and the amount of non-wage benefits provided would likely lead us to overestimate the actual costs of a wage increase. The average wage paid to current community health workers is likely to be higher than $19.25 because many workers have been in the field for a number of years and thus have incurred considerable seniority.[23]

Information from UFCW seniority lists confirms that this is the case. Seniority numbers for over 1,100 community health workers (both regular and casual employees) in a number of health service areas including Richmond, Cowichan and Prince George show that on average, about 59 per cent of workers are paid the top rate, while only 14 per cent are paid the bottom rate. The data suggest that the average hourly wage for community health workers in these areas is about $19.66.

The cost of increasing wages from an average of $19.66 to the facility level of $21.94, given the baseline number of client hours, would be $20.4 million, or nearly $4 million lower than our earlier estimate.

Further, budgeting 30 per cent of wages for benefits is also likely to be a generous estimate: for example, 23 per cent is used as an estimate of non-wage benefits in Interior Health in Kelowna's one year evaluation report.

On the other hand, if client hours have already increased since 2006/07, our cost estimate for the wage increase would be less than the actual costs of increasing workers' wages. For example, a 10 per cent increase in the number of client hours provided would raise costs by $2.4 million per year to a total of $26.5 million.

In summary, increasing the wages of community health workers to match facility levels is estimated to cost between $20.4 and $26.5 million dollars.

2. REDESIGNING HOME SUPPORT TO IMPROVE TEAMWORK AND STABILITY

In costing the system redesign, we draw on the lessons learned in the Kelowna pilot project, where considerable effort was undertaken to collect information on various aspects of the home support system's functioning and on the financial costs and benefits of the project. Kelowna's evaluation report estimates that the redesign increased the average hourly cost of direct client service by 7.1 per cent (from $37.99 to $40.70) after including all the overhead costs. The document notes that further refinements to the model are expected to bring about additional savings, reducing the incremental cost by 15 per cent (to an increase of 6.1 per cent per hour).

We assume that rolling out the redesign projects province-wide would increase costs of service provision by about 7 per cent on average. This is likely to be a generous estimate of ongoing project costs because local home support offices would be able to learn from the experience of the pilot projects in Kelowna and Sechelt and thus avoid some of the pitfalls of these projects and realize more cost savings earlier than was possible with the pilot projects.

To calculate the costs of home support provision we take the total public expenditure on home support and CSIL for 2006/07 ($309.4 million) and subtract from it the costs of CSIL provision at the rate of $25 per authorized hour (as per the BC Ministry of Health Services CSIL Program Review synthesis report from November 2008). This allows us to calculate the cost of providing home support in the province (excluding CSIL), which was $272.9 million in 2006/07. We then divide this number by the number of home support client hours to arrive at the average costs per hour of service provided, $39.64.

A 7 per cent increase in the cost of providing home support amounts to $2.80 per client hour, which then leads us to estimate the additional cost of rolling out the new team-based model of home support provision to $19.3 million.

3. INCREASING THE NUMBER OF CLIENT HOURS PROVIDED

Assuming that increasing direct service hours by 15 per cent would increase total home support costs by 15 per cent, we estimate that such an increase in client hours of service over what was provided in 2006/2007 will cost an additional $40.9 million.

This assumption implies there are no efficiencies to be gained from providing more hours of service and no losses in efficiency either. Note that in the case of a shortage of community health workers, the extra effort required to recruit and train new workers would increase the costs of expanding the system more than proportionally. However, in an environment where workers are available and underemployed (not receiving as many hours as they would like), such a system expansion may save money by providing better work satisfaction and higher incomes for the previously underemployed workers, thus likely improving retention and increasing costs less than proportionately.

4. IMPLEMENTING ALL THREE RECOMMENDATIONS

We begin with estimating the costs of increasing wages and implementing the service delivery redesign at the same time. Note that this would be higher than simply adding together the costs of implementing the two changes separately if home support redesign increases the number of community health worker hours required to provide the same level of client service.

Both Sechelt and Kelowna's redesign projects diverted some of community health workers' paid time away from direct service provision toward team meetings and other non-service activities. In addition, regular paid breaks were introduced, as many community health workers did not have proper rest and meal breaks prior to the service redesign.[24]

There is reason to believe that the number of community health workers' hours required to deliver the same level of client service has increased. Discussions with Mona Groves, manager of Home Care Services for the Sunshine Coast, reveal that staffing levels (measured in terms of full-time equivalents)

increased by approximately 7.85 per cent per year after the project was implemented. Kelowna's one-year evaluation report found that worked hours for community health workers increased by 6 per cent (although it is noted that non-worked paid hours, including sick time, fell by about 3 per cent).

Assuming that community health workers' hours increase by 8 per cent for the delivery of the same amount of client hours of home support, we can then calculate that increasing wages to facility rates would add $3.80[25] per client service hour to the cost of redesigning service delivery, which we earlier estimated at $2.80 per client service hour. Holding hours of direct client service constant at their 2006/07 levels, we calculate that implementing both of these reforms would cost an extra $45.4 million per year (slightly more than the $43.4 million we estimate by adding up the costs of the two reforms alone).

Increasing client hours by 15 per cent is assumed to add 15 per cent of total costs of providing home support with higher wages and team-oriented service delivery, which would be standing at $318.4 million (or another $47.8 million).

Therefore, adopting all three measures proposed will increase the home support costs by an estimated $93.2 million.

NOTES

1 The 2006 CCPA study *From Support to Isolation: The High Cost of BC's Declining Home Support Services* by Cohen et al. provides a detailed overview of the increasing reliance on home support services and the resulting decline in accessibility of home support between 1997/98 and 2004/05.

2 In the late 1990s, the BC government changed eligibility requirements for home support, restricting access for people with limited care needs who require only non-personal services such as housekeeping, meal preparation and social support to maintain their independence.

3 Hollander and Tessaro (2001).

4 See, for example, the 2006 CCPA study *From Support to Isolation: The High Cost of BC's Declining Home Support Services* by Cohen et al., the 2006 report of the Premier's Council on Aging and Seniors' Issues, *Aging Well in BC*, and the 2008 BCMA policy paper *Bridging the Islands: Rebuilding BC's Home and Community Care*.

5 As quoted in a *Vancouver Sun* article on September 13, 2008, by David Hogman.

6 Martin-Matthews and Sims-Gould (2008).

7 The effects of staff shortages are documented both in academic studies such as Martin-Matthews and Sims-Gould (2008) and in the popular press. See, for example "Care workers needed" in *The Esquimalt News* (November 9, 2005), "Staff shortage taking its toll on northeast home care support" in *Alaska Highway News* (September 27, 2006) and "Home support shortages hit home" in *Peninsula News Review* (October 13, 2006).

8 Home support hours are typically scheduled in short blocks of time at various parts of the day, which can act as a disincentive for an on-call worker to remaining in the home support sector, especially if the worker is also on-call in a long-term care facility where there is a much greater likelihood of getting a full day's work.

9 Reports of services being rolled back due to understaffing appear occasionally in the press. See, for example "Staff shortage taking its toll on northeast home care support" in *Alaska Highway News* (September 27, 2006).

10 Cabana and Jee (2004), Saultz and Lochner (2005).

11 Martin-Matthews and Sims-Gould (2008).

12 Sharman et al. (2008).

13 The Kelowna home support redesign project was developed with the help of management consultants from Deloitte Inc. contracted to analyze the current system and design a new service provision model to better meet the goals of the Home Support Service. The Sechelt project was modeled on Kelowna's example and developed internally in the Sunshine Coast division of Home Care Services of Vancouver Coastal Health Authority.

14 There are two evaluation reports for the Kelowna project: an interim evaluation prepared six months after the project's implementation by Deb Bourne and Rhonda Kotick and a one-year project evaluation prepared by Katie Hill (available by request from Interior Health). A formal evaluation report for Sechelt is forthcoming, but preliminary findings were presented by the local manager of Home Care Services, Mona Groves, at the Economic Security Project conference on Innovations in Community Health Care on November 6–9, 2008 at UBC and are very positive.

15 Cohen et al. (2006).

16 This excludes hours and clients under the Choice in Supports for Independent Living (CSIL) program. CSIL is a "self-managed" alternative to home support, where clients receive government funding for the purchase of home support services of their choice instead of receiving direct services. The clients are responsible for recruiting, training, scheduling and supervising the workers. This report excludes CSIL as it focuses primarily on services for seniors, while CSIL is a program that mainly serves younger people with disabilities (seniors account for only 20 per cent of all CSIL clients and 14 per cent of all CSIL hours). CSIL as a whole accounts for 17.5 per cent of total home support hours provided in BC in 2006/07.

17 Cohen et al. (2006).

18 This excludes CSIL hours and clients. When CSIL is included, seniors account for 84 per cent of clients and 70 per cent of total hours.

19 A 2003 study from the Simon Fraser University Centre of Labour Studies surveyed over 800 community health workers in BC and found that they are primarily female and that over two thirds have children at home (Harter and Leier, 2003). Other research surveying smaller samples of community health workers confirms these demographic characteristics; see for example, Cohen et al. (2006) or Sharman et al. (2008).

20 Harter and Leier (2003) and Cohen et al. (2006).

21 Innovation in other areas of community health care is occurring on an uneven, ad hoc basis across the province. It is important for the BC Ministry of Health Services to foster better co-ordination at the provincial level to ensure that successful initiatives are identified and then used as models to be implemented throughout BC. This includes providing resources for more formal evaluations of new initiatives so that successful projects can be identified using evidence-based methods.

22 The Premier's Council calculation was based on the assumption that about 7 per cent of BC seniors (approximately 40,000 people) would require additional service for two to four hours per week. The Premier's Council estimated that this system expansion would cost approximately $120 million per year, without redesigning service provision to improve teamwork or increasing worker's wages.

23 This may sound counterintuitive given the earlier discussion of high turnover rates among community health workers, but it should be noted that much of the retention problems seem to be concentrated among casual workers with lower seniority and among new community health workers. This is particularly problematic because it reveals that the home support system is failing to retain young workers at a time when the current community health workforce is aging and many workers are nearing retirement age.

24 As reported by advisory committee members and by Mona Groves, manager of Home Care Services for the Sunshine Coast, who spearheaded the Sechelt home support redesign pilot project.

25 1.08 x $3.50 = $3.78

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The Economic Security Project is a research alliance led by the CCPA's BC Office and Simon Fraser University, and includes 24 community organizations and four BC universities. It looks at how provincial policies affect the economic well-being of vulnerable people in BC, such as those who rely on social assistance, low-wage earners, recent immigrants, people with disabilities, seniors, youth and others. It also develops and promotes policy solutions that improve economic security. The project is funded primarily by a grant from the Social Sciences and Humanities Research Council of Canada (SSHRC) through its Community-University Research Alliance Program.

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ACKNOWLEDGEMENTS

The author is grateful to Mona Groves and Christine Hardt from Vancouver Coastal Health for their willingness to share their experiences with the Sechelt home support redesign pilot project and walk us through the preliminary findings of the project's evaluation. Alice Mah Wren from Interior Health generously provided evaluation reports from the Kelowna home support redesign pilot project, and Martha Burd from the BC Ministry of Health Services provided data on home support utilization and expenditures. The author would also like to thank Carol Adams, Brenda Brown, Teresa Cairns, Ann Chambers, Marcy Cohen, Shannon Daub, Seth Klein, Sarah Leavitt, Zena Sharman and Leah Squance for their contribution to various stages of this report.

Thanks also to the Hospital Employees' Union for its financial support of this project.

The opinions in this report, and any errors, are those of the author, and do not necessarily reflect the views of the CCPA.

Copyedit and layout: www.handsonpublications.com

ISBN 978-1-897569-55-9