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HOME CARE IN MANITOBA, SASKATCHEWAN, ALBERTA AND BRITISH COLUMBIA: STRUCTURE AND EXPENDITURES

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INTRODUCTION

Over the past 20 years, home care expenditures in Canada have increased exponentially, at an average annual rate of 11.3%. In 2000-2001, those expenditures (public and private) totalled nearly $3.5 billion.(1) Between 1980-1981 and 2000-2001, home care expenditures as a percentage of overall health care spending in Canada increased from 1.2% to 3.5%. This rapid growth can be attributed in large part to a number of significant changes affecting health care in Canada and Canadian society in general, notably to the aging of the population.

Since home care is not considered a "medically required" service under the *Canada Health Act*, the structure and delivery of home care services differ from province to province, more so than medical and hospital services insured under the Act. In fact, each provincial and territorial government currently administers its own home care program.

This paper is the last in a series of three(2) that provide an analytical overview of government-run home care programs in all Canadian provinces. It focuses on home care in Manitoba, Saskatchewan, Alberta and British Columbia and examines public home care programs in each province in terms of:

- responsibilities and objectives;
- services provided;
- service delivery and eligibility;
- available coverage and co-payment charges;

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(1) Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001, Provincial and territorial government and private sector expenditures.

(2) See P. Le Goff, *Home Care in the Atlantic Provinces: Structure and Expenditures* (PRB 02-30E) and *Home Care in Quebec and Ontario: Structure and Expenditures* (PRB 02-31E), Parliamentary Research Branch, Library of Parliament, October 2002.

- public and private expenditures – total and by recipient age group.

HOME CARE

Generally speaking, the term "home care" applies to a wide range of social and medical services provided to persons in their home, as opposed to care provided in private or public institutions. Home care is associated with many health and social services such as primary care, acute care, long-term care, palliative care and community support programs. It can include medical intervention, nursing care, various support services and help required by family members and informal caregivers, as well as a range of social, educational and health services enabling persons in need of assistance to live and function in the community, rather than in an acute or long-term care facility.(3)

More specifically, home care falls into one of the following three broad categories:(4)

- *supportive home care* – helps recipients with a chronic illness or disability to maintain a stable level of health that allows them to remain at home;
- *long-term home care* – substitutes for care provided in an institution such as a residential or health care facility;
- *post-acute home care (post-hospitalization)* – is provided to patients requiring major medical care, such as post-surgical care.

MANITOBA

A. Responsibilities and Objectives

Manitoba's Department of Health is responsible for setting policies and directions, for research, for establishing guidelines and for program monitoring and evaluation. As in the majority of provinces, the government has delegated responsibility for planning, day-to-day management and delivery of home care to Regional Health Authorities, which receive funding from the province.

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(3) See the Appendix for a more detailed definition of "home care" and related terms used in this publication.

(4) Categories are based on *Home Care in Canada*, Working Paper of the Commission on the Future of Health Care in Canada, May 2002.

The objectives of the Manitoba Home Care Program are as follows:

- to prevent hospitalization;
- to reduce the length of a patient's stay in an acute care facility through the provision of post-hospitalization support and care;
- to provide an alternative to stays in long-term care institutions;
- to provide support to informal caregivers.

B. Services

Each of the 11 regional authorities operates a "single window" access point that coordinates delivery of short-term and long-term home care services. These authorities are responsible for general services related to:

- case assessment, coordination and management;
- management of the quality of care delivered;
- management of professional services (nursing care, rehabilitative care, etc.);
- management of home support services;
- client placement in long-term care facilities in the event of significant loss of independence.

Regional authorities provide the following services to members of the public, at various locations:

- nursing care;
- rehabilitative care (physiotherapy, occupational therapy, speech therapy, social work, respiratory care, dialysis);
- services related to daily activities (for example, help with dressing, personal hygiene, meal preparation and getting around inside and outside the home);
- respite services for informal caregivers;
- day care centres;
- palliative care;
- light housekeeping services;
- certain medical supplies and equipment;
- supervised and special needs housing.

C. Delivery and Eligibility

1. Service Delivery

In Manitoba, employees of regional authorities are generally responsible for the delivery of professional home care services to clients (nursing care, rehabilitative care, etc.). However, regional authorities often use their budgets to obtain private nursing care, therapeutic services and home care support services. The development of community and local resources to deliver support services to seniors is encouraged, and a special program has been developed to provide recipients with an allowance with which to manage the services they receive. Services delivered under the medical supplies and devices (such as oxygen concentrators) program have been contracted out to other public or private agencies.

2. Eligibility

Home care in Manitoba is subject to the following eligibility criteria:

- proof of residence in the province;
- assessment of care required prior to the delivery of any services;
- lack or scarcity of informal caregivers to assist the prospective recipient, and the need for assistance in order to remain in the community;
- suitability of the home for service delivery;
- consent of the prospective recipient or of his/her legal representative;
- interprovincial agreement in the case of residents living along the Saskatchewan border.

D. Service Coverage and Co-payment Charges

All citizens of Manitoba can request an assessment of their entitlement to home care services. The list of services available under the Manitoba program is exhaustive. All services are free, but are subject to certain limits as determined during the assessment. Once these limits have been reached, the client must cover certain costs. With respect to home support services, priority is given to clients who have few or no services available to them in their community. Along with Ontario and Quebec, Manitoba is one of the few provinces that do not use a formal process to evaluate a client's income or ability to pay for services.

E. Home Care Expenditures

1. Total Expenditures

Manitoba has one of the most sophisticated provincial home care systems in Canada, as reflected in the level of program spending.

Home care accounted for 4.37% of overall provincial expenditures on health care in fiscal year 2000-2001, a level well above the national average. Per capita expenditures, in particular by the provincial government, were also well above the national average.

These figures do not, however, include direct federal government spending, in particular spending by Health Canada for home care programs for First Nations.

The federal government funds most health care services delivered to Aboriginal peoples living on reserves. Manitoba and Saskatchewan are the provinces that have the largest Aboriginal populations. According to 1996 census figures, Manitoba was home to 128,910 Aboriginal people, accounting for 11.7% of the province's population. Of this number, 47,215 persons lived on reserves, representing more than 4% of Manitoba's total population. Given the demographic strength of the Aboriginal population, it is expected to account for an even larger percentage of the province's population when the 2001 census figures are released. Since the federal government covers the cost of home care for Aboriginal people living on reserves, it is safe to say that the table below underestimates per capita expenditures on home care in Manitoba.

Medical supplies and devices (such as wheelchairs, aids and hospital dialysis equipment) as well as daycare centres and supervised housing are not included in these spending estimates. However, these items are for the most part provided free of charge under the Manitoba Home Care Program.(5)

(5) The potential for underestimating home care expenditures is not limited to Manitoba. Major disparities between provincial programs, and the problems associated with collecting reliable data, mean that caution was undoubtedly exercised when costs were projected.

Home Care Expenditures, 2000-2001				
	Public Sector Expenditures*	Private Sector Expenditures	Total Expenditures	Home Care as a Percentage of Total Health Care Expenditures (%)
Manitoba				
Total expenditures (millions of dollars)	163	14	177	4.37
Per capita expenditures (dollars)	142.01	12.21	154.22	—
All provinces				
Total expenditures (millions of dollars)	2,690.9	764.3	3,455.2	3.54
Per capita expenditures (dollars)	87.51	24.86	112.37	—

* Provincial expenditures (excluding all federal spending under various programs)

Sources: Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001; Library of Parliament, Parliamentary Research Branch, for certain calculations.

2. Expenditures by Age

According to the data for 2000-2001, Manitoba spent more than 75% of its home care budget on persons aged 65 and over. After New Brunswick, Manitoba spent the most on home care for persons in this age group.

The demand for home care will increase in the coming years as the population ages. Statistics Canada's demographic projections for the province indicate that seniors (persons aged 65 and over) will account for 18.8% of the province's population in 2021, compared to 13.5% in 2000 – an increase of 39%. This increase is more modest than in most other provinces, no doubt because of the province's sizeable Aboriginal youth population.

However, Manitoba will one day have to follow the lead of the other provinces and either allocate substantially more funds to home care or withdraw, fully or partially, from this field and turn responsibility over to the private sector. In Manitoba, private sector spending accounted for less than 8% of total home care expenditures in 2000-2001, the least among all the provinces.

Home Care Expenditures by Age, 2000-2001				
	0-64 Years	65+	85+	Total
Manitoba				
Total expenditures (millions of dollars)	40.3	122.7	52.5	163.0
Per capita expenditures (dollars)	43.41	863.11	2,766.58	154.22
Percentage of total health care expenditures allocated to home care (%)	2.08	6.78	8.63	4.37
Private sector expenditures as a percentage of total home care expenditures (%)	6.50	8.36	8.15	7.92

Sources: Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001, and Library of Parliament.

SASKATCHEWAN

A. Responsibilities and Objectives

In Saskatchewan, 12 Regional Health Authorities are responsible for the planning and day-to-day administration of home care services. The provincial Department of Health assigns an overall budget to each regional authority, using a formula that takes into account the characteristics of the population (age, sex) to which each authority must deliver health services. The department is also responsible for developing major strategic and policy directions and guidelines and for monitoring programs.

The objectives of Saskatchewan's home care program are as follows:

- to prevent or reduce institutionalization;
- to accelerate the release of patients from acute care institutions;
- to assist persons with diminishing abilities to maintain a certain level of independence so that they can continue to live in their community;
- to supplement the support provided by families or loved ones to persons with diminishing abilities;
- to provide acute and palliative care at home.

B. Services

Each regional authority operates a "single window" access point that coordinates delivery of short-term and long-term home care services. Regional authorities ensure delivery of general services related to:

- case assessment, coordination and management;
- management of professional services (nursing care, rehabilitative care, etc.);
- management of home support services;
- management of human and financial resources;
- client placement in long-term care facilities in the event of significant loss of independence.

Services delivered to members of the public include:

- nursing care;
- rehabilitative care (physiotherapy, occupational therapy, social work, respiratory care, laboratory services – the services available vary from region to region);
- services related to daily activities (for example, help with dressing, personal hygiene, meal preparation and getting around inside and outside the home);
- civic support services (for example, accompanying persons on outings, providing help with filling out forms and with budget management);
- respite services for informal caregivers;
- palliative care;
- services related to routine household tasks (for example, cleaning of living areas, laundry, grocery shopping and similar errands, meals-on-wheels).

C. Delivery and Eligibility

1. Service Delivery

In Saskatchewan, professional services such as nursing care, rehabilitative care and nutritional counselling are delivered to clients in their home primarily by employees of regional authorities responsible for home care or community health programs. Home care services are widely contracted out to private agencies or to volunteer and not-for-profit community organizations.

2. Eligibility

Home care in Saskatchewan is subject to the following eligibility criteria:

- proof of residence in the province;
- assessment of care required prior to the delivery of any services;
- lack or scarcity of informal caregivers to assist the prospective recipient;
- suitability of the home for service delivery;
- consent of the prospective recipient or of his/her legal representative;
- interprovincial agreement in the case of residents living along the Alberta and Manitoba borders.

D. Service Coverage and Co-payment Charges

A broad range of home care services is available in Saskatchewan. While some disparities exist between regional authorities, this affects primarily peripheral services (such as laboratory services). Certain rural or remote regions may experience staff shortages, which affect the scope of services delivered to the public. Volunteer community agencies play a key role in the home care support sector. However, the Saskatchewan model is characterized by and weighted heavily in favour of the delivery of professional care by the public sector.

Priority for accessing services is given to low-income persons or to persons lacking the support of family or volunteer help. Professional services are provided free of charge to everyone. However, clients cover a substantial portion of the costs associated with the provision of home support services. In 2000-2001, home care costs totalled $5.2 million.

Home Care Costs: Public Sector Coverage and Co-payment Charges	
Coverage – professional services	Free professional services. Several regional authorities apply an unofficial ceiling on home care costs, including respite services for informal caregivers. This ceiling is equivalent to $2,500-$3,000 per month, an amount approximately equivalent to the cost of delivering the same care in a long-term care facility.
Coverage – home support services	Based on service availability and clients' financial means.
Co-payment charges	Clients pay $5.75[6] for each unit of home support service (one hour of service or one meal), up to a maximum of 10 service units per month. Subsequently, service charges up to a maximum of $347 per month are based on the client's income and ability to pay.

Sources: Health Canada, *CARP's Report Card on Home Care in Canada 2001*, web sites of various provincial ministries, and Library of Parliament.

E. Home Care Expenditures

1. Total Expenditures

According to Health Canada statistics, home care accounted for 3.08% of Saskatchewan's total health care expenditures in fiscal year 2000-2001, a percentage below the national average. Per capita spending was also less than the national average, according to the estimates. However, judging by the wide range of home care services delivered through Saskatchewan's network of regional health authorities, there is reason to believe that actual spending figures have been underestimated.

An analysis of the financial statements of Saskatchewan's Department of Health for 2000-2001 shows that Health Canada appears to have included only home-based services when estimating public sector home care costs. Some regional authorities, however, report only their expenditures on home care support services under this heading. For example, spending on home rehabilitative services is sometimes recorded under "rehabilitation services," while expenditures on nursing care and palliative care are recorded under other headings. Consequently, public sector spending on home care in Saskatchewan is probably much closer to, if not higher than, the national average.

(6) Saskatchewan Health, *Saskatchewan Health Annual Report 2000-01*, p. 25.

As is the case in Manitoba, a portion of the cost of home care for the Aboriginal population (13% of Saskatchewan's total population) is covered by the federal government. Given the size of the province's Aboriginal population, the following table underestimates actual per capita spending on home care by the province.

Home Care Expenditures, 2000-2001				
	Public Sector Expenditures*	Private Sector Expenditures	Total Expenditures	Home Care as a Percentage of Total Health Care Expenditures (%)
Saskatchewan				
Total expenditures (millions of dollars)	82.1	16.9	99	3.08
Per capita expenditures (dollars)	80.16	16.55	96.71	—
All provinces				
Total expenditures (millions of dollars)	2,690.9	764.3	3,455.2	3.54
Per capita expenditures (dollars)	87.51	24.86	112.37	—

* Provincial expenditures (excluding all federal spending under various programs)

Sources: Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001; Library of Parliament, Parliamentary Research Branch, for certain calculations.

2. Expenditures by Age

In light of the above observations concerning Health Canada's figures on home care expenditures in Saskatchewan, a detailed breakdown by age group is not warranted. Most of the general conclusions with respect to the aging of the population and the impact this trend will have on future home care costs apply to Saskatchewan as they do to other provinces.

According to Statistics Canada's demographic projections for the province, seniors (65 years of age and over) will account for 19.5% of the provincial population by 2021, compared to 14.4% in 2000 – an increase of 35%. The Saskatchewan government estimates that the number of residents aged 85 and over will increase anywhere from 20% to 30% over the next 20 years. Furthermore, over the next 50 years, the Aboriginal population will increase to the point where it accounts for one-third of the overall provincial population, compared to the current figure of 13%. At present, seniors and Aboriginal people are major health care consumers, and the demographic outlook for these two groups will have a significant impact on health care expenditures in general and on home care expenditures in particular.

ALBERTA

A. Responsibilities and Objectives

The mission of Alberta's home care program is to give Albertans the opportunity to continue to live independently and in good health at home for as long as possible. Initially, only persons in need of professional health care as a result of a medical condition were eligible to participate in the program. Over time, the program was extended to persons requiring home support services and palliative care.

In Alberta, home care is managed by 17 Regional Health Authorities to which the provincial government has delegated responsibility for planning, day-to-day management and delivery of home care services. Specifically, the provincial Ministry of Health is responsible for developing policy directions, conducting research, establishing guidelines, and monitoring and evaluating programs and funding allocations. Each regional authority receives an overall budget based on a capitation formula. Funding by region takes into account various demographic and socioeconomic criteria, as well as the number of services one region provides to another. With respect to home care, the funding formula is also based on the province's Home Care Information System, which collates data on the type of services received and associated costs for each recipient.

The objectives of Alberta's home care programs are as follows:

- to prevent or reduce institutionalization;
- to accelerate the release of patients from acute care facilities;
- to assist persons with diminishing abilities to maintain a certain level of independence so that they can continue to live in their community;
- to supplement the support provided by families or loved ones to persons with diminishing abilities;
- to provide acute and palliative care at home.

B. Services

Each regional authority operates a "single window" access point that coordinates the delivery of short-term and long-term home care services. Regional authorities ensure delivery of general services related to:

- planning and case management, evaluation and coordination;
- management of professional services (nursing care, rehabilitative care, etc.);
- management of short-term home support services;
- management of human and financial resources.

The following services are provided to the public:

- nursing care;
- rehabilitative care (physiotherapy, occupational therapy, speech therapy, audiology services, social work, nutritional services and respiratory care);
- services related to day-to-day activities (for example, help with dressing, personal hygiene, meal preparation and getting around inside and outside the home);
- civic support services (for example, accompanying persons on outings, companion visits);
- respite services for informal caregivers;
- palliative care;
- services related to routine household tasks;
- medical supplies and devices furnished through the Alberta Aids to Daily Living Program;
- supervised housing ("group homes").

C. Delivery and Eligibility

1. Service Delivery

In Alberta, the vast majority of providers of professional services (such as nursing care, rehabilitative care and nutritional services) are employed by the regional authorities. However, some authorities contract out direct nursing care. Non-professional home care (support) services are delivered by private agencies, community organizations and volunteers. Eligible recipients may manage their own home support under the self-managed home care support program.

2. Eligibility

Home care in Alberta is subject to the following eligibility criteria:

- proof of residence in the province;
- assessment of care required prior to the delivery of any services;
- lack or scarcity of informal caregivers to assist the prospective recipient;

- suitability of the home for service delivery;
- consent of the prospective recipient or of his/her legal representative;
- interprovincial agreement in the case of residents living along the British Columbia and Saskatchewan borders.

D. Service Coverage and Co-payment Charges

All Albertans are entitled to home care. Provincial program guidelines state that recipients must share in the cost of the services, but also that a person's inability to pay for services must not prevent anyone from receiving the care required.

Home Care Costs: Public Sector Coverage and Co-payment Charges	
Coverage – professional services	All professional services are available free of charge, although the range of services may vary from one authority to another, depending on the availability of resources.
Coverage – home support services	Home support services may be obtained directly through the home care program or through the self-managed program, where clients are given a budget.
Co-payment charges	Home support services are subject to user fees based on the recipient's income and the number of dependents. The ceiling on co-payment charges has been set at $300 per month. The hourly rate for housekeeping services is $5, while meals cost $5 each. Generally speaking, home care (professional and home support) costs must not exceed $3,000 per month. With respect to medical supplies and devices (AADL),(7) recipients pay up to 25% of the costs to a maximum of $500 per year per family. There is no cost to persons benefiting from an income support program, and low-income earners may be entitled to financial aid.

Sources: Health Canada, *CARP's Report Card on Home Care in Canada 2001*, web sites of various provincial ministries, and Library of Parliament.

E. Home Care Expenditures

1. Total Expenditures

For fiscal year 2000-2001, public spending on home care in Alberta was comparable to the national average. However, private sector spending was well below the national average, according to Health Canada estimates.

(7) Alberta Aids to Daily Living Program.

In Alberta, home care expenditures account for a modest share (2.87%) of overall spending on health care. In fact, only Prince Edward Island allocates a smaller share of its overall health care budget to home care.

Home Care Expenditures, 2000-2001				
	Public Sector Expenditures*	Private Sector Expenditures	Total Expenditures	Home Care as a Percentage of Total Health Care Expenditures (%)
Alberta				
Total expenditures (millions of dollars)	260.4	29.5	289.9	2.87
Per capita expenditures (dollars)	86.89	9.85	96.74	—
All provinces				
Total expenditures (millions of dollars)	2,690.9	764.3	3,455.2	3.54
Per capita expenditures (dollars)	87.51	24.86	112.37	—

* Provincial expenditures (excluding all federal spending under various programs)

Sources: Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001; Library of Parliament, Parliamentary Research Branch, for certain calculations.

2. Expenditures by Age

In 2000, Alberta had the youngest population of any province in Canada: only 10.1% of Albertans were 65 years of age or older. According to Statistics Canada, this figure should rise to 17.1% by the year 2021. This young population explains in part why per capita home care costs are below the national average.

The Alberta government covers approximately 90% of home care costs, while the private sector's participation in the delivery of home care is only one-quarter of the level in Quebec. This situation is somewhat paradoxical, since successive Alberta governments in recent decades have encouraged private sector involvement in this field.(8)

(8) Since home care is not subject to the *Canada Health Act*, the private sector plays an important role in a number of provinces in terms of the delivery of care and the expenditures incurred.

Home Care Expenditures by Age, 2000-2001				
	0-64 Years	65+	85+	Total
Alberta				
Total expenditures (millions of dollars)	95.5	194.4	74.2	289.9
Per capita expenditures (dollars)	35.42	645.43	2,320.28	96.74
Percentage of total health care expenditures allocated to home care (%)	1.52	5.11	7.47	2.87
Private sector expenditures as a percentage of total home care expenditures (%)	8.48	11.00	10.70	10.18

Sources: Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001, and Library of Parliament.

BRITISH COLUMBIA

A. Responsibilities and Objectives

In British Columbia, the Ministry of Health is responsible for matters relating to planning, strategic directions, financing, human resources, service quality and home care. Each regional authority receives a budget from the ministry, based on a capitation formula, with which to deliver acute care and home care and community services. Funding levels by region take into account demographic and socioeconomic criteria, the cost of service delivery in a given region and the level of consumption of health care in each region.

Program management (planning, regional needs assessment, assessment of compliance with provincial standards, etc.) falls to five Regional Health Authorities. Sixteen health service delivery areas have been identified within the province.

The objectives of British Columbia's home care programs are essentially as follows:

- to prevent or reduce institutionalization;
- to accelerate the release of patients from acute care facilities;
- to assist persons with diminishing abilities to maintain a certain level of independence so that they can continue to live in their community;
- to supplement the support provided by families or loved ones to persons with diminishing abilities;
- to direct clients to long-term housing resources in the event of significant loss of independence.

B. Services

Home and community care in British Columbia includes a complex range of services delivered to the public through a "single window" access point. Regional authorities deliver general services related to:

- planning and case assessment, coordination and management;
- management of professional services (nursing care, rehabilitative care, etc.);
- management of short-term home support services;
- management of human and financial resources.

The following services are provided to the public:

- nursing care;
- rehabilitative care (physiotherapy, occupational therapy, social work and nutritional services);
- respite services for informal caregivers;
- palliative care;
- respiratory care;
- services related to day-to-day activities (for example, help with dressing, personal hygiene, meal preparation and getting around inside and outside the home);
- services related to routine household tasks;
- supervised housing ("Supportive Living BC").(9)

C. Delivery and Eligibility

1. Service Delivery

In British Columbia, the vast majority of suppliers of professional services (such as nursing care, rehabilitative care and nutritional counselling) work for the regional authorities. Non-professional home care services (support services) are delivered by private agencies, community organizations and volunteers. Home support services may be managed by eligible recipients under a self-directed program (Choice in Supports for Independent Living).

(9) Detailed information is available on the BC Housing web site (http://www.bchousing.org/Supp_Liv/).

2. Eligibility

Home care in British Columbia is subject to the following eligibility criteria:

- proof of residence in the province;
- assessment of care required prior to the delivery of any services;
- lack or scarcity of informal caregivers to assist the prospective recipient;
- suitability of the home for service delivery;
- consent of the prospective recipient or of his/her legal representative;
- certain qualifying periods, based on the extent of the loss of independence;
- interprovincial agreement in the case of residents living along the Alberta border.

D. Service Coverage and Co-payment Charges

All professional services are delivered free of charge. However, the cost of home support services is shared by the recipient, based on his or her net income. A monthly ceiling also applies to services delivered, based on the extent of the recipient's loss of independence.

Home Care Costs: Public Sector Coverage and Co-payment Charges	
Coverage – professional services	In theory, all professional services are available at no cost to recipients. However, professional care is subject to monthly quotas based on the recipient's level of independence. In addition, shortages of human resources may result in waiting lists, particularly for therapy services. This situation is not unique to British Columbia.
Coverage – home support services	Public sector coverage of home support services, respite services and meal services is based on the client's income level and on the extent of his/her loss of independence.
Co-payment charges	In the case of *acute care*, the maximum delivery period for such care, including medical supplies, is two weeks. In the case of *long-term care*, recipients are entitled to receive a maximum of 40 hours of personal care per month. This limit may be extended, depending on recipients' needs.

Sources: Health Canada, *CARP's Report Card on Home Care in Canada 2001*, web sites of various provincial ministries, and Library of Parliament.

E. Home Care Expenditures

1. Total Expenditures

In fiscal year 2000-2001, British Columbia spent a total of $388.1 million on home care, or $95.50 per capita – below the national average of $112.37. According to Health Canada estimates, home care spending accounted for nearly 3% of the province's total spending on health care.

Home Care Expenditures, 2000-2001				
	Public Sector Expenditures*	Private Sector Expenditures	Total Expenditures	Home Care as a Percentage of Total Health Care Expenditures (%)
British Columbia				
Total expenditures (millions of dollars)	292.3	95.8	388.1	2.99
Per capita expenditures (dollars)	71.93	23.57	95.50	—
All provinces				
Total expenditures (millions of dollars)	2,690.9	764.3	3,455.2	3.54
Per capita expenditures (dollars)	87.51	24.86	112.37	—

* Provincial spending (excluding all federal spending under various programs)

Sources: Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001; Library of Parliament, Parliamentary Research Branch, for certain calculations.

2. Expenditures by Age

The British Columbia government has earmarked approximately 40% of its budget, or $10.2 billion, for health care in fiscal year 2002-2003. As in other provinces, a large portion of health care spending, including expenditures on home care, is directed to persons aged 65 and over. According to Statistics Canada estimates, persons aged 65 and over will account for 18.8% of the B.C. population by 2021, up from 13% in the year 2000. Several recent announcements and policy statements by the provincial government seem to indicate that it has a clear grasp of the consequences of the aging of the population and that the home care sector will expand at a faster rate over the next few years.(10) Expansion of the home care sector will no

(10) Financial compensation program for informal caregivers; supervised housing construction program for persons with disabilities or diminishing abilities.

doubt alleviate some of the pressure on public finances at a time when health care spending is increasing rapidly.

Home Care Expenditures by Age, 2000-2001				
	0-64 Years	65+	85+	Total
British Columbia				
Total expenditures (millions of dollars)	76.2	311.9	127.3	388.1
Per capita spending (dollars)	21.55	591.20	2,126.62	95.50
Percentage of total health care expenditures allocated to home care (%)	1.04	5.51	6.69	2.99
Private sector expenditures as a percentage of total home care expenditures (%)	22.31	25.27	26.32	24.68

Sources: Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001, and Library of Parliament.

CONCLUSION

Home care planning and delivery models in the four western provinces are similar, and at the same time different, in a number of respects. Manitoba stands out by virtue of the extensive involvement of the public sector in home care funding and by the fact that the province does not use a formal process to evaluate a client's income or ability to pay for services when determining access to publicly funded home care services.

Like Canada's other provinces, Manitoba, Saskatchewan, Alberta and British Columbia are grappling with rising health care costs, and home care is viewed as a modern solution to contain cost increases. Provincial governments in western Canada have all initiated reforms, albeit modest ones, which clearly benefit the home care sector.

Another concern shared by the western provinces is the health of their Aboriginal populations, who represent a large percentage of the overall population. At the same time, rural health issues and the delivery of home care services in remote regions are pressing problems in these provinces where, aside from a few large urban centres, much of the population is scattered over a very wide area.

Finally, the social housing policy set by these provinces is increasingly linked to the delivery of home care. There is nothing unusual about this fact at first glance, since these two components of social policy often benefit primarily the same clientele. Governments have long been involved in building social housing for seniors, while the private sector has been involved in the construction of housing units for semi-autonomous seniors. Until recently, however, the two systems (housing and health) have not been truly integrated on a broad scale, with the exception of highly medicalized long-term care facilities which in practice are more like hospitals than residences. Housing and health remain, nonetheless, the cornerstones of family welfare.

Clearly, delivery of home care is less effective when housing conditions are inadequate. However, and all studies confirm this fact, persons with diminishing independence prefer to live at home rather than in long-term care facilities. As such, the proliferation of supervised housing units in western Canada, although not an entirely new initiative, is a positive step and proof of further progress in developing a coherent health and social policy.

APPENDIX

DEFINITIONS AND METHODOLOGY

The following are definitions of the various terms used throughout this document.

- *Home care expenditures*, as referred to in this publication, include nursing care and support services delivered to a client at home owing to illness or a weakened physical state. Excluded are home support services delivered for reasons unrelated to health (for example, social services).

- *Home care services* include:
  - case assessment and management ("single window" function, information and consultation services);
  - treatment services and health care (nursing care, physiotherapy, occupational therapy, speech therapy, respiratory therapy, nutritional counselling);
  - personal support services (home support, personal care, meals-on-wheels);
  - housekeeping and minor home repairs;
  - social assistance services, social contacts and safety checks (companion visits, telephone contact), when such services are provided to a person because of illness, a physical impairment or health-related problems.

  Medication, and medical supplies and devices (wheelchairs, aids, hospital dialysis equipment, etc.) are not included in these cost estimates.

- *Respite services* (intended to give a break or temporary help to caregivers, who are often family members caring for a person in their own home) are included when such services are provided at home. Respite services provided by institutions, day care centres and group homes are not included.

- *Public sector home care* includes home care expenditures funded by provincial governments. It excludes expenditures incurred by workers' compensation boards as well as through direct federal spending (for example, Health Canada home care programs for First Nations, and Veterans Affairs programs for veterans). Hospital-funded home care is included in the expenditure estimates.

- Data used by Health Canada to estimate *public sector home care expenditures* were extracted from the public accounts, annual reports, budgets, special requests made to provincial ministries of health and social services, and the National Health Expenditure Database maintained by the Canadian Institute for Health Information.

- Health Canada estimates of *private sector home care expenditures* were based on Statistics Canada findings and on data supplied by private sector providers of home care services. However, the share of home care expenditures covered by private insurers was not evaluated and is therefore not included in the calculations.