

The Role of the Public and Private Sectors in Long-term Care

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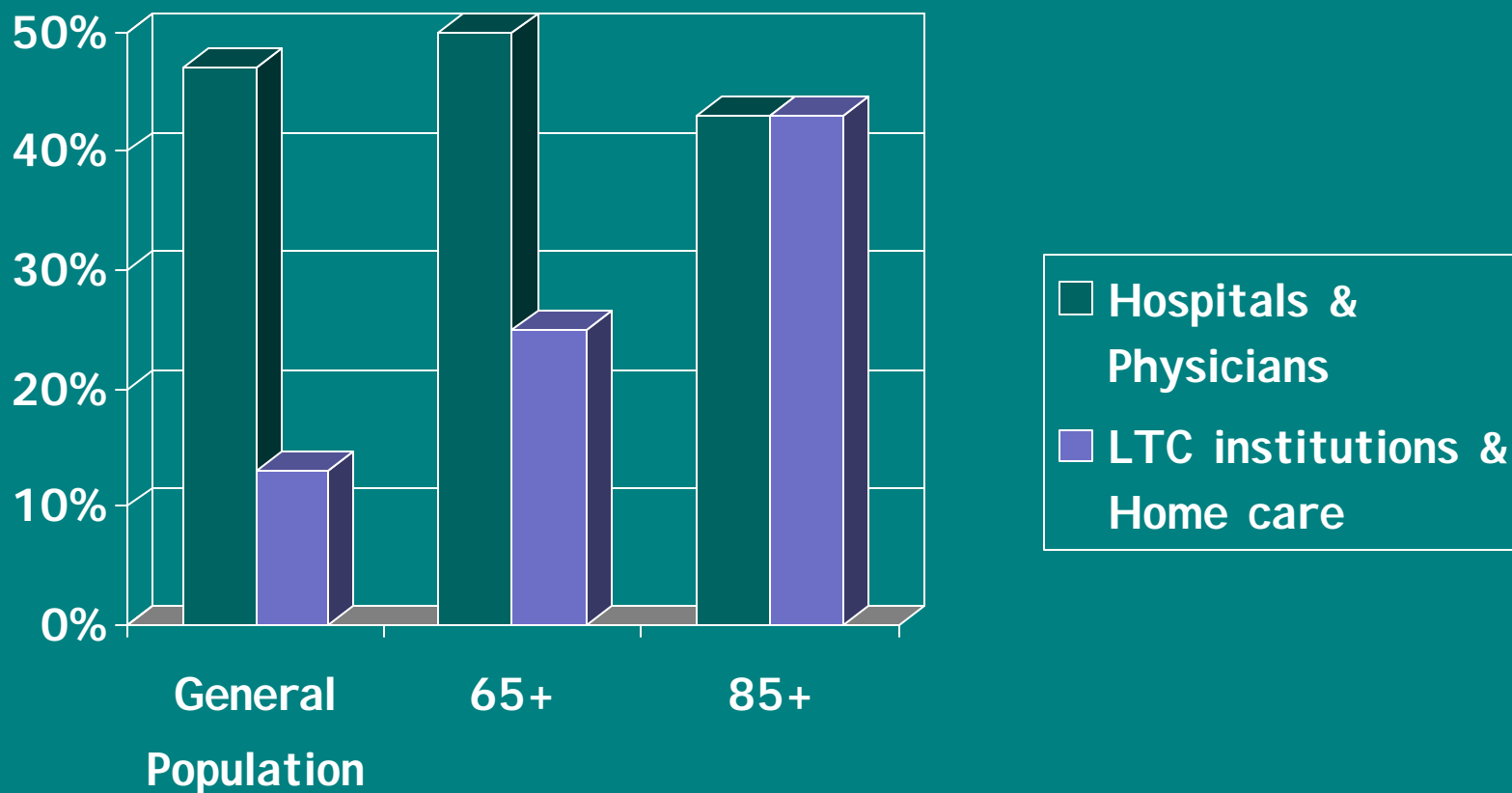
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Why Focus on Long-term Care (Institutional and in-Home)?

- LTC is larger proportion of health costs, both public and private, in elderly population than in population as a whole

Total spending on hospitals & physicians vs. LTC institutions & home care, Canada 2000-01

Source: Health Canada 2003



Why Focus on Long-term Care (Institutional and in-Home)?

- Public-private balance looms larger: greater role of private sector in both financing and delivery:
 - For-profit providers play a much larger role in delivery than in other areas (except drugs – to be treated by Stabile)
 - Unlike acute care, LTC services tend to be inextricably bundled with non-health-care goods and services (housekeeping, accommodation etc.) – boundary between public and private finance is more difficult to draw

Appropriate balance of public and private finance varies across the spectrum of care

Figure 1 From: Howse et al. 2008

Care Continuum in Canada			
Living Independent	Housing with Supports	Living with Assistance*	Licensed Care Facilities
<ul style="list-style-type: none"> - Living in own home - May have access to home support or home care 	<ul style="list-style-type: none"> - Living in own home - Support (such as meals) - May have access to home care 	<ul style="list-style-type: none"> - Housing Support <ul style="list-style-type: none"> - meals - 24 hour response - Personal assistance - May purchase skilled nursing 	<ul style="list-style-type: none"> - Housing Support - Personal Assistance - Nursing care access to 24 hours
<p>←←← SCOPE OF A WAY FORWARD & THE NATIONAL SNAPSHOT →→→</p>			
<p>* May or may not be licensed or regulated.</p>			

Balance of public, not-for-profit and for-profit provision

- Varies across nations
- In Canada, varies across provinces
- For-profit providers play a substantial role in LTC delivery (institutional or home care or both) in several OECD nations in addition to Canada: e.g. US, UK, Germany, Australia; and a small but growing role in others: e.g. Netherlands, Japan
 - In most nations, LTC has traditionally been provided by public and/or not-for-profit agencies. For-profit providers tend to be smaller and new entrants, often encouraged by public policy
 - Growth of for-profit chains since 1970s in US and Canada, mid-1990s in England

Challenges of disparate provision

- Given providers with different accountability and incentive structures (public, not-for-profit, for-profit):
 - How ensure common quality?
 - How incorporate with acute care sector into an integrated continuum of care?

Different national contexts

- Variation in basic policy approach to ensuring access:
 - Heavy emphasis on public *funding*: Canada, UK, US
 - Leaves privately-financed sector largely unregulated
 - Mixed reliance on *public funding and regulation of private* finance: Germany, Netherlands, Switzerland, (Australia to lesser extent)
 - Incorporates publicly- and privately-financed sectors within common framework of access

Implications of National Contexts: Separated public and private finance

- Leaving privately-financed sector unregulated creates a chasm between public and private sectors
 - Leads to a climate of distrust that extends beyond realm of finance to realm of delivery
 - Associated with adversarial modes of regulating for-profit providers within the publicly-funded sector, extending to all providers – e.g. US, UK, Canada

Evidence of relationship between form of ownership and quality is mixed:

- Most data & studies are from adversarial systems
- US: for-profit nursing homes had more deficiencies in care and lower staffing levels (Harrington et al. 2001)
- US: quality in for-profit nursing homes is inferior only for patients who have no family member visiting (Chou 2002)
- BC: staff hours/ resident day higher in not-for-profit (McGregor 2005)
- BC: quality in for-profit is lower than not-for-profit attached to hospital/health authority or in chain (McGregor 2006)
- Ontario: no significant relationship between quality and for-profit/ not-for-profit status; client satisfaction higher in for-profit (Doran et al. 2006)

Implications of National Contexts: Integrated public and regulated private finance

- Integrated framework of public and private *finance* is associated with more collaborative forms of regulation of providers within publicly-*funded* sector, whether for-profit, not-for-profit or public – e.g. Germany, Netherlands, Australia
- Less detailed prescriptions, more reliance on minimum standards and protocols
- But little data on quality, and virtually none by ownership type

Examples of Differing Approaches

- Germany
- England
- Ontario

Germany – Industry Organization (Institutional Care)

- (Not including various unregulated not-for-profit “quasi-institutional arrangements” cf. retirement homes and supportive housing.)
- Nursing homes traditionally not-for-profit with means-tested public subsidy
- Rise of for-profit providers as deliberate matter of public policy since 1995
- As of 2006: 55% not-for-profit/38% for-profit/ 7% public

Germany – Industry Organization (Home Care)

- State-subsidized **informal** care (typically family member) – >80% of those receiving home care benefits choose informal vs formal care or a mix
- **Formal** care historically provided on mean-tested basis by publicly-subsidized not-for-profit “Social Stations”
- Rise of for-profit providers since 1995 cf. institutional sector as a matter of public policy
- As of 2006: **58% for-profit**/41% not-for-profit/2% public

Germany – Regulatory Context

- 1995 adoption of compulsory Long-term Care Insurance (LTCI)
 - pay-as-you-go program funded through payroll contributions shared by employers and employees
 - Administered by quasi-public sickness (social insurance) funds separately from social health insurance (SHI)
 - ~10% of population (high-income) not eligible for SHI must purchase regulated private LTCI mirroring public program
 - Benefits are limited – e.g. does not include accommodation portion of institutional care
 - Key feature is option to take benefit in cash (at substantial discount from value of in-kind benefit) to remunerate informal care-giver (minimal constraint on use)
 - Largely replaced previous means-tested program
 - Intention was to discourage use of institutional care; but institutional care has grown marginally even controlling for level of need

Germany – Regulatory Framework

- Regulatory mechanism is **contracting** between sickness funds (or private insurers) and providers
- “Medical Review Offices” of sickness funds, and analogous body for private insurers, are enforcement mechanism
- Much more trust-based and **collaborative** regime than in Canada, US and UK
- Minimum standards are **negotiated by coalitions** of insurers and providers; may be supplemented by individual funds through contracting
- Considerable variation across funds, especially re staffing levels
- Informal care-givers are subject to bi-annual “control visits” but sanctions rarely applied

Germany – Regulatory Framework (cont'd)

- LTC institutions are also **licensed** by Lander (states) – largely focus on physical safety, building codes – some coordination with sickness fund inspections
- Between 1996-2003, only about 50% of home care providers and 62% of institutions were inspected
- Some provider associations are developing **accreditation** processes, but very limited so far
 - As of 2003 only 4% of home care providers and 5% of nursing homes had such accreditation
 - Rigour, specificity and empirical base of accreditation standards has been criticized
- **Worker training** requirements & programs being developed. 2000 law requires uniformity across Lander – 3 years now required but programs are uneven

England – Industry Structure

- LTC traditionally provided by facilities and agencies owned and operated by local authorities
- “Internal market” reforms established purchaser-provider split and opened door to for-profit as well as not-for-profit provision
- Nursing homes:
 - >90% now private; rapidly growing share for chains:
 - ~13% in 2003 (more than 2/3 for-profit), more than 40% in 2008 (Laing & Buisson)
- Home care:
 - ~60% provided by private agencies

England – Regulatory Context

- Regulation as key aspect of “third way” approach of Labour government
- LTC (other than nursing and medical care, provided by NHS) provided as in-kind benefit on means-tested basis through local authorities with central funding; considerable role for user charges
- Local authorities contract with providers, at locally-negotiated rates
- Emphasis on quality standards: regulatory architecture mirrors acute care
- Repeated re-organizations have resulted in “churn”

England – Regulatory Framework

- **Prescriptive** approach: National Minimum Standards for nursing homes and home care **specified in legislation** (Care Standards Act 2000)
- Compliance as an issue: in early 2000s <70% of homes met at least half of the standards
- Inspection and enforcement re home care as of 2003
- **Quasi-independent central commissions** enforce standards:
 - Commission for Social Care Inspection (merged into Care Quality Commission as of March 31, 2009) charged with registering all health and social care providers and enforcing standards – moving to strategy of **targeted inspections** cf. approach in acute care
 - General Social Care Commission to regulate (non-healthcare) workforce – **registration and “codes of care”**
 - Social Care Institute for Excellence as best-practice resource
- Inspection reports posted on web

Ontario - Industry structure (Institutional Care):

- 3 pillars (not including chronic-care hospitals and ALC patients in acute care hospitals, regulated under Public Hospitals Act, and unregulated retirement homes and supportive housing)
 - Nursing homes: 67% of beds (53% for-profit; 14% not-for-profit)
 - Charitable institutions: 11%
 - Municipal homes for the aged: 22%
- very different histories, missions and incentive structures

Ontario - Industry structure (Home Care):

- Historically provided by not-for-profit agencies with public subsidy
- Federal and provincial tax benefits for informal care-givers
- 1998-2004 – for-profit entrants were encouraged as deliberate matter of public policy under PC government – competitive contracting through Community Care Access Centres
- 2004-2009: moratoria on contracting for more than 3½ years in total under Liberal government
- Data on mix of for-profit and not-for-profit providers are not available; but during the period of competitive bidding 1998-2004 more than half of contracts were awarded to for-profit providers

Ontario - Regulatory Context

- Overall focus on funding as principal mechanism for ensuring access - private finance banned from CHA areas and unregulated elsewhere.
- Home care provided in-kind as universal benefit, based on eligibility
- Institutional care provided in-kind with income-scaled co-payment for accommodation
- 14 regional Community Care Access Centres (not-for-profit provincially-funded agencies) act as placement agencies for both institutional and home care
- “Stewardship” role of Ministry: steering not rowing
 - empowering consumers, holding providers accountable for the quality of care, promoting transparency, and fostering innovation in care delivery
- Repeated re-organizations resulting in “churn” cf. England

Ontario - Regulatory Framework (Institutional Care)

- Only LTC institutions receiving public subsidy are regulated; others (e.g. retirement homes) unregulated beyond building codes
- 3 pillars regulated under separate acts – harmonized in 1993, combined under *Long-term Care Homes Act* in 2007 (not yet in force pending development of regulations)
- Highly prescriptive approach:
 - ~ 200 regulations
 - *Long-Term Care Home Program Manual*, enforced through annual inspections, sets minimum resident care standards and services requirements with which long-term care home operators must comply. The Manual contains 37 Standards, each with supporting criteria. In total, there are **426 supporting criteria**.
- Data on compliance with criteria published, by institution, on Ministry website

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Ontario - Regulatory Framework (Home Care)

- Regulation is through the funding process
- CCAC's contract with home care providers through competitive bidding process (twice suspended by government)
- Contracts are in principle a mechanism of quality control – cf Germany
- But no analogy to German negotiation of standards by coalitions of purchasers and providers
- Ontario Association of Community Care Access Centres is umbrella body for CCACs, acts as information-sharing resource
- Interest-based associations of for-profit and not-for-profit providers act as information-sharing and lobby groups at the provincial level

Regulating quality in the public/not-for-profit/for-profit mix: finding the optimal balance among objectives and instruments

- Need to reconcile multiple objectives
 - minimizing restraint while ensuring the security of the patient;
 - respecting dignity while providing 24-hour attention,
 - developing individual plans of care that provides broad range of social as well as health care while respecting cultural differences.
 - Prescription vs discretion for local adaptation, innovation
- Need to incorporate multiple providers into continuum of care
- Requires trust and “situational knowledge” but also insistence on standards of quality and protection of vulnerable patients

Allowing for contingency

- Recognition that optimal balance will vary depending on nature of issue to be dealt with:
 - Predictability: risk vs uncertainty
 - Local variation
 - E.g. infection control may require standardized, top-down approach; developing continua of care may require more flexible, adaptable, collaborative approach

Some promising options

- “Earned autonomy” vs one-size-fits-all regulation
 - Cf. England: transposition of experience in hospital sector with performance measurement, “star-rating,” targeted enforcement
- Accreditation:
 - Provider-based or third-party industry-wide mechanisms as supplement to state enforcement
 - Cf. Netherlands (home and institutional care), Japan (re dementia homes), Germany (limited), US (limited)
 - Already well-established in Canada for institutional care through CCHSA
- Training and regulation of LTC workers regardless of employer – major emphasis in Japan, beginning in Germany

Link to finance

- More integrated structure of public and regulated private finance could begin to bridge the gulf between the two sectors
- Lay groundwork for more trust-based models of innovation and quality assurance
- Next session