



CANADIAN HOME CARE HUMAN RESOURCES STUDY

ETUDES NATIONALE DES RESSOURCES HUMAINES
DU SECTEUR DES SOINS À DOMICILE

Canadian Home Care Human Resources Study

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Final Report

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|---|-----|
| TABLE OF CONTENTS | i |
| List of Tables..... | iii |
| List of Figures | iii |
| INTRODUCTION | 1 |
| AN OVERVIEW OF HOME CARE..... | 4 |
| The Legislative Basis of Home Care..... | 4 |
| Definition of Home Care..... | 4 |
| The Organization of Home Care Services | 5 |
| Emerging Trends in Home Care | 10 |
| OVERVIEW OF MAJOR FINDINGS | 11 |
| Introduction | 11 |
| The Changing Context..... | 11 |
| The Supply and Characteristics of Home Care Workers..... | 15 |
| Sector-Level Issues | 15 |
| Individual-Level Issues | 21 |
| – Paid Home Care Workers | 21 |
| – Informal Caregivers | 22 |
| – Volunteers | 22 |
| Recognition and Image of the Home Care Sector and its Workers | 24 |
| Sector-Level Issues | 24 |
| Individual-Level Issues | 24 |
| Education and Training..... | 26 |
| Sector-Level Issues | 26 |
| Individual-Level Issues | 27 |
| Funding..... | 28 |
| Sector-Level Issues | 28 |
| Individual-Level Issues | 29 |

| | |
|--|----|
| Changing Nature of Work | 30 |
| Sector-Level Issues | 30 |
| Individual-Level Issues | 31 |
| – Introduction | 31 |
| – Employment Stability..... | 32 |
| – Continuity and “Commodification” of Care..... | 32 |
| – Isolation and Lack of Support..... | 32 |
| – Occupational Health and Safety..... | 33 |
| – Informal Caregivers | 34 |
| Wages and Benefits | 34 |
| Sector-Level Issues | 34 |
| – Overview | 34 |
| – Hourly Wages | 34 |
| – Benefits | 36 |
| – Other areas of compensation | 37 |
| – Unpaid Work | 38 |
| – Satisfaction with Salaries | 39 |
| Individual-Level Issues | 40 |
| Nature of Home Care Services | 41 |
| Sector-Level Issues | 41 |
| Individual-Level Issues | 41 |
| RECOMMENDATIONS AND STRATEGIES..... | 43 |
| Introduction | 43 |
| Strategies Related to Policy..... | 43 |
| Strategies Related to Human Resources Issues..... | 45 |
| APPENDIX A: An Overview of Emerging Issues and Trends in Home Care Service Delivery | |
| APPENDIX B: An Overview of Emerging Issues and Trends Related to Informal Caregivers | |
| APPENDIX C: Survey of Formal Home Care Providers: Data Limitations | |

LIST OF TABLES

| | | |
|-----------|---|----|
| Table 1: | Similarities and Differences Among Canadian Provincial and Territorial Home Care Programs..... | 7 |
| Table 2: | Components of Home Care Services..... | 8 |
| Table 3: | Home Care Sector Human Resource Themes and Issues..... | 12 |
| Table 4: | Percentage Of People Receiving Home Care In The Past Year By Age Group, Gender And Year, For Persons 20 Years Of Age Or Older..... | 13 |
| Table 5: | Percentage of People Receiving Home Care in the Past Year by Health Related Factors and Year, for Persons 20 Years of Age or Older..... | 14 |
| Table 6: | Comparison of Home Care Client Based on the 1996 Population Distribution Compared to Actual Age and Sex Projections..... | 15 |
| Table 7: | Overview of Types of Paid Care Providers in the Home Care Sector..... | 16 |
| Table 8: | Estimates of the Number of Formal, Paid Care Providers in the Home Care Sector..... | 19 |
| Table 9: | Percentage of Formal Care Providers, by Type of Employer..... | 20 |
| Table 10: | Comparison of the Number of Professional Home Care Personnel Required Based on the 2001 Population Distribution Compared to the Actual Age and Sex Projections..... | 20 |
| Table 11: | Comparison of the Number of Home Support Workers Required Based on the 2001 Population Distribution Compared to Actual Age and Sex Projections..... | 21 |
| Table 12: | Percentage of People who were Volunteers, by Age Group, Gender and Year, for Persons 20 Years of Age or Older..... | 23 |
| Table 13: | Types of Training Received in the Past 24 Months..... | 27 |
| Table 14: | Average Hourly Wages by Union Status and Type of Employer..... | 35 |
| Table 15: | Care Delivery Models..... | 36 |
| Table 16: | Unpaid Hours in an Average Week..... | 39 |
| Table 17: | Percent “Satisfied” or “Very Satisfied” with Their Current Level of Pay..... | 40 |

LIST OF FIGURES

| | | |
|-----------|---|----|
| Figure 1: | Experienced Difficulties in Providing Care in Home Care Settings..... | 25 |
| Figure 2: | Specific Services Provided..... | 31 |
| Figure 3: | Current Benefits Contributed to at Least in Part By the Employer..... | 37 |
| Figure 4: | Other Areas of Compensation..... | 38 |

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The Canadian population is aging. The proportion of Canadians aged 65 and older is projected to rise from 12.7% in 2001 to 21.4% by 2026. It is also estimated that close to one-third of people between the ages of 65 and 74 are limited in their daily functioning. This figure rises to 45% among those who are 75 years of age and older.¹ These factors may predict a continuing increase in the demand for home care services well into the future.

Home care is also becoming more complex. This fact, and a range of other trends, indicate increasing pressure on the sector and provide the context for the study of home care, particularly home care human resources. Key trends are:

- Growing expenditures as a result of consumer preferences, acuity changes, growing reliance on the sector, an aging population, and health care reform;
- Changing profile of users in many provinces/territories;
- Increasing acuity/complexity of client caseloads as changes in delivery allow more treatment interventions at home versus in hospital;
- Continued movement from facility-based to home and community-based care;
- Changing public-private mix and increasing availability of private pay services;
- Changing and growing human resources pressures;
- Expanding use of in-home medical technology to improve service delivery; and,
- Strengthening data and information systems for program planning and evaluation.²

In addition, the numbers of volunteers and family members available to assist are decreasing due to lower fertility rates, increased participation in the labour force by women, and higher divorce rates.

The need for an analysis of the home care sector's human resources, based on the above trends, was identified in a number of consultations held across the country with various stakeholder groups. In response to these consultations, the departments of Health Canada and Human Resources Development Canada (HRDC) sponsored an information meeting in February 1999. Agreement among the participants to move forward with a national human resources study of the home care sector was reached at that meeting. This resulted in a large scale study of health human resources in the home care sector called the Canadian Home Care Human Resources Study, which dealt with paid and unpaid service provision for the general population and included a literature review of issues for the Aboriginal population.³ The importance of home care in the broader health care system has also recently been noted by the recent Romanow and Kirby reports.⁴ Their recommendations, the August 2002 report of the Annual Premiers' Conference, and the February 2003 First Ministers' Health Accord, all serve to confirm that governments across Canada recognize the importance of home care and the need to move the sector forward.

This document constitutes the final report of the Canadian Home Care Human Resources Study. The Study was carried out in three phases. Phase One: *Setting the Stage: What Shapes the Home Care Labour Market*, was designed to provide the context of the sector, to synthesize existing knowledge and informa-

¹ Ministère de la santé et des services sociaux. (1988). *Rapport de la Commission d'enquête sur les services de santé et les services sociaux*, Québec: Les Publications du Québec; Statistics Canada, 1990 in Armstrong, P., Armstrong, H., Choinière, J., Feldberg, G. & White, J. (1994). *Take care: Warning Signals for Canada's Health System*. Toronto: Garamond Press.

² Premiers' Council on Canadian Health Awareness. (2002). *Strengthening home and community care across Canada: A collaborative strategy. Report to the Annual Premiers' Conference August 2002*. Ottawa.

³ The term *Aboriginal* refers to all status or non-status, and on or off reserve, First Nations, Inuit and Metis. As no additional in-depth study on Aboriginal home care, aside from the literature review, was conducted for this study, this report does not deal with Aboriginal home care issues.

⁴ Kirby, M.J. (2002). *The health of Canadians: The federal role. Volume Six: Recommendations for reform*. Ottawa, Ontario: Standing Senate Committee on Social Affairs, Science, and Technology. Romanow, R.J. (2002). *Building on values: The future of health care in Canada*. Ottawa: Commission on the Future of Health Care in Canada.



tion, and to provide input into the information gathered in Phase Two. Phase Two: *The Human Resources Environment in Home Care* focused on human resources in the home care sector. The objective of this phase was: to describe the human resource environment and management practices; to identify the trends and changes which may occur in the next three to five years and assess their implications for the sector; and, to assess current and future training and professional development needs and opportunities. Phase Three: *Analysis*, was designed to analyze the results of Phases One and Two, to identify both the capacity of the home care sector and shared views of the issues and challenges facing the sector, and, finally, to present a consensus on future courses of action to address the key challenges concerning human resources in the home care sector. This report is intended for a wide audience including policy makers, care providers, government officials, industry organizations and the public. Thus, it presents a summary of the findings of this project (for more detailed information, the reader is referred to the Phase One and Phase Two reports) and a set of coherent strategies which can be used to improve human resources in the home care sector.

In this report, home care incorporates all human resources involved in delivering care in the home and community. Consequently it includes profiles of informal caregivers⁵ (such as family and friends) and volunteers, as well as formal or paid care providers who are employed individually, by an agency, or by a government program, to deliver home care services. It should be noted that home care is provided to people of all ages, including children and their families. Most such services are publicly funded but people can also purchase services privately, as needed.

The terms *public funding* and *publicly funded* refer to services paid for by government. These services can be delivered by public servants working in government agencies, staff in regional health authorities, private not-for-profit home care agencies and private for-profit service providers (organizations or individual health care professionals such as physiotherapists, psychologists, and physicians). Given the confusion which can arise if one uses the term “public” and “private” we shall in this report refer to organizations providing home care as: government/regional health authorities; private not-for-profit agencies and private for-profit agencies. The term “private” refers to independent service provider organizations which are not part of government or regional health authorities. Private agencies generally provide contracted services.⁶

The terms *private funding* and *private pay* refer to services fully paid for by individuals and/or their families. These services are generally provided by private for-profit providers but can also be provided by private not-for-profit home care agencies or individual professionals. When individuals pay for part of the cost of care, from any of the four main service provider groups (government agencies, regional health authorities, private not-for-profit home care agencies and private for-profit care providers), and the remainder of the cost is provided through public funds, the portion paid for by the individual is generally referred to as a co-payment or user fee.

⁵ Informal caregivers are family and friends providing unpaid care to individuals. The Steering Committee for this study agreed to the use of the term “informal caregiver.” The Steering Committee recognizes that other terms, such as “family caregiver”, may also be used. Nevertheless, given that this type of care can be provided by friends and neighbours, as well as family members, the term “informal caregiver” is used in this report.

⁶ Private or third-party service providers can operate on a not-for-profit or for-profit basis.



The Legislative Basis of Home Care

The *Canada Health Act*, passed in 1984, sets out two major categories of service: Insured Health Services (IHS) and Extended Health Care Services (EHCS). IHS include hospital care (acute and chronic) and services provided by physicians. In the Act, the five principles of the Canadian health care system (universality, accessibility, comprehensiveness, portability, and public administration), and the restrictions on user fees and extra-billing, apply only to IHS. EHCS, which include nursing homes or long-term residential care, home care, adult residential care and ambulatory health care services, are *not* insured services. Other, non-professional, home and community based services, such as home support services and adult day care, are not covered by the *Canada Health Act*. They were cost-shared through the Canada Assistance Plan (CAP) but now come under the general transfer provisions of the Canada Health and Social Transfer. As health is a provincial responsibility, provincial governments also have their own legislation related to home care. The federal government is, however, also involved in the delivery of home care services as part of its obligations under the Canadian constitution which makes certain areas of health care a federal responsibility. Veterans Affairs Canada supports home care services to consumers with wartime or special duty service, and First Nations home care is offered jointly by the Department of Indian Affairs and Northern Development (DIAND) and Health Canada. The Department of National Defence also has its own health services.

Definition of Home Care

Although there is no precise or universally accepted definition of home care, the following comprehensive definition, outlined by the Federal/Provincial/Territorial Working Group on Home Care⁷, provides an important reference point in stating that home care is:

an array of services which enable consumers incapacitated in whole or in part to remain in their own homes, often with the effect of preventing, delaying or substituting for long term services ... it may address needs specifically associated with a medical diagnosis, and/or may compensate for functional deficits in the activities of daily living ... to be effective it [home care] may have to provide services which in other contexts might be defined as social or educational services (e.g., home maintenance, volunteer visits) Home care may be appropriate for people with minor health problems and disabilities, and for those who are acutely ill requiring intensive and sophisticated services and equipment. There are no upper or lower age limits on the age at which home care may be required, although as in other segments of the health care system utilization tends to increase with age.

The Working Group also outlined three main functions of home care:

- **The maintenance and preventive function**, which serves people with health and/or functional deficits in the home setting, both maintaining their ability to live independently and, in many cases, preventing health and functional breakdowns and eventual institutionalization.
- **The long term care substitution function**, in which home care meets the needs of people who would otherwise require institutionalization; and,
- **The acute care substitution function**, in which home care meets the needs of people who would otherwise have to remain in, or enter, acute care facilities.

⁷ Federal/Provincial/Territorial Working Group on Home Care. (1990). *Report on home care*. Ottawa: Health Services and Promotion Branch, Health and Welfare Canada.

The Organization of Home Care Services

There is both consistency and variability in home care services across Canada. The Canadian Institute for Health Information reported that, in 1999, all jurisdictions covered basic services such as assessment and case management, nursing care, and home support for eligible individuals. There is, however, variation in the conditions under which services are provided (e.g., co-payments, different eligibility requirements). Some jurisdictions may offer additional programs, such as prescription drugs and various types of therapy (e.g.,

physiotherapy, occupational therapy, psychological services), in publicly funded home care programs, whereas in other jurisdictions such services may be paid for privately or through insurance.⁸ The similarities and differences among provincial and territorial home care programs are summarized in Table 1.

As can be seen in Table 1, there is a degree of commonality across jurisdictions in terms of broad concepts such as similar sets of services and a commitment to coordinated and integrated care. There are also numerous differences, at the operational level, in terms of policies on consumer⁹ contributions, the level of funding, the models of service delivery and the

Table 1: **Similarities and Differences Among Canadian Provincial and Territorial Home Care Programs**

Similarities:

- Home care responsibility falls under the jurisdiction of departments/ministries of health, although in some provinces and territories, responsibility for health is combined with social or community services.
- A common base of services exists, including nursing, personal care, and homemaking services.
- A diverse clientele is served, considering factors such as age, health status, medical and social needs, and the duration of services. Individuals requiring long-term services represent approximately two-thirds of those served.
- The coordination and integration of service provisions are in place, including a single point of access, comprehensive needs assessment, case management, and access to long-term institutional care, including care for respite purposes.
- Case management functions are the responsibility of public employees.
- Increasing standardization exists within individual jurisdictions with respect to both the processing of demand and the management of service information in home care.
- Professional nursing services are provided without charge to consumers, although limitations may apply to client eligibility, intensity, and the duration of provided care.

Differences:

- The regulatory status of home care programs varies from one jurisdiction to another.
- Arrangements for charges to consumers and/or the assessment of client contributions for home support services differ among provinces and territories.
- The range of professional services available varies among provinces and territories, with services generally being fewer in rural and isolated areas.
- The models of service delivery reflect a diverse mix of public and private sector workers in the provision of publicly funded services.
- Variations among jurisdictions in the development of databases and information systems contribute to the difficulty in obtaining various kinds and levels of data on a national basis or for interprovincial and territorial comparisons.
- Levels of funding for home care have increased in most jurisdictions, but actual funding levels vary, depending on the province or territory.
- Variations in policy exist in certain areas, for example, client access to services, equity in the provision of services, service standards and quality, client obligation to pay for publicly funded services, the obligation of family members to provide care – all of which remain a consideration in all provinces and territories.

Source: Adapted from: Health Canada. (1999). *Provincial and territorial home care programs: A synthesis for Canada*.

⁸ Canadian Institute of Health Information (CIHI). (2001). *Health Care in Canada*.

⁹ A consumer is a recipient of care services (generally provided by a paid caregiver and generally, but not exclusively, paid for by public (government) funds).

Table 2: **Components of Home Care Services**

Assessment and Referral Services constitute a process which identifies immediate and long-term needs of consumers and caregivers, referring appropriately to other information sources and services.

Case Management is a multi-disciplinary, collaborative process for identifying and addressing the needs of individuals. Core tasks generally include: screening for eligibility and conducting comprehensive assessments; care planning and arranging; ongoing monitoring; review and adjustment of care plan; and, discharge planning.

Home Nursing Care is the promotion of health, assessment, provision of care and treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.

Adult Day Care Services provide personal assistance, supervision, an organized program of health, social and recreational activities, and caregiver respite and information, in a protective group setting. The program is designed to maintain persons with physical disabilities and/or mental impairments, or restore them to their personal optimum capacity for self-care. Adult day care centres may be established within a residential care facility or may be located in a freestanding building.

Prescription Drugs provided for reason of admission to acute and chronic care substitution and end of life.

Personal Care assistance with activities of daily living which may include help with dressing, bathing, grooming, feeding, toileting, mobilization and transferring.

Homemaking Service provides essential housekeeping tasks necessary to enable the individual to remain at home in a safe and acceptable environment and may include cleaning, laundry, meal preparation, shopping, banking, and transportation.

Home Support Services may provide personal care, homemaking services and/or respite to enable the individual to remain at home in a safe and acceptable environment.

Physician Services provide home visits and consultations to consumers, family, and home care team. May act as medical advisor to home care program.

Physiotherapy Services provide assessment of physical function and treatment, rehabilitation, and prevention of physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function or relieve pain.

Occupational Therapy Services include the assessment of function and adaptive behaviour, and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment functions in the areas of self care, productivity and leisure.

Dietitian Services provide assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition related disorders by nutritional means.

Social Worker Services provide assessment of personal and family circumstances, coping abilities, and social and/or economic supports which may include counselling regarding bereavement, abuse situations, behaviour problems, crisis intervention, financial difficulties, adult protection services, adjustment to an altered health or social status, and support and counselling to care providers.

Speech Therapy Services provide assessment of speech and language functions and the treatment and prevention of speech and language dysfunctions or disorders to develop, maintain, rehabilitate or augment oral motor or communication function.

Home Adaptation refers to adapting or retrofitting homes i.e., bath bars, ramps, accessible doorways, etc.

Home Maintenance includes repairs around the house, yard work and snow removal.

Medical supplies, equipment and assistive devices may be provided as required to maintain a person's health and/or function or for supportive palliative care. Equipment may include medical gases or assistive breathing apparatus, wheelchairs, walkers. Equipment may be loaned, purchased or donated. Supplies include dressings, syringes, continence and ostomy products etc.

Meal Provision can be Meals-on-Wheels, Wheels to Meals for congregate dining, or preparation of meals in home by home support worker.

Respite Services may be provided to primary caregivers to give them temporary relief by providing a substitute for the caregiver in the home or by providing alternate accommodation to the client.

Transportation Services may be provided to for medical appointments, shopping, social functions.

Volunteer Services may provide programs of volunteer help in areas such as meals on wheels, transportation, day programs, friendly visiting, caregiver support, etc.

Source: Federal/Provincial/Territorial Working Group on Continuing Care, General Definitions, September 2001.

sophistication, or lack of sophistication, of existing information systems. Thus, there is still a lack of consistency in home care services across Canada.

Table 2 presents a listing, with definitions, of the types of home care services available in Canada. It should be noted that not all of the services listed in Table 2 are included, on a publicly funded basis, in each provincial/territorial home care program

Home care services are provided by government and/or regional health authorities, private not-for-profit providers and private for-profit providers. Home care services have been available for many years. In most provinces, provincial or regional programs contract with a range of external, private agencies to meet the consumers' needs and/or these programs may provide services directly. Contracts with private agencies may be regional or provincial in scope and provide for either a specific service or a range of services.

Emerging Trends in Home Care

There are a number of trends prevalent in home care across the country. The exact changes that these trends bring will be influenced by the jurisdictional contexts in which they emerge. At the broad level, however, the following emerging trends can be observed:

- Reductions in home support services in spite of continued demand;
- Increasing responsibility being shifted to family caregivers;
- An apparent increase in the amount of private pay home care being provided to individuals;
- Increasing focus on acute home care, resulting in a decrease in long term and preventive home care; and
- Increasing use of technology in the home.

An overview of emerging trends in the home care sector is provided in Appendix A.

The many changes occurring in home care have also resulted in a greater responsibility for care being placed on family members. Not all families can cope with this responsibility, however, and numerous social trends are compounding this shift. The trends which could affect the ability of informal caregivers to actually provide care are presented in Appendix B.



Introduction

The work done in Phase One and Phase Two produced a number of findings about human resources issues in the home care sector. Eight major theme areas emerged which related to the broader home care system. Seven of these same areas also had implications at the individual level. The eight theme areas are as follows:

- Changing context of home care;
- Supply of workers;
- Recognition and image of the sector and workers in the sector;
- Education and training;
- Funding availability;
- Working conditions and the changing nature of work;
- Wages and benefits; and,
- Nature of services offered in the home care sector.

These eight areas are summarized in Table 3.

The following sections outline the major findings of the work conducted in Phase One and Phase Two. Persons who are interested in a more in-depth analysis of findings, and the methods used to obtain the findings, are referred to the Phase One and Phase Two reports.

The Changing Context of Home Care

The demographics of an aging population combined with the overall health care trend of decreasing the amount of care provided in institutions contributes to an increased demand for home care services for all age groups, including adults and children.

Seniors are the biggest group using home care services in Canada. With the changing demographics in Canada – the population is aging – there will be an increasing demand for home care services. This can be seen in Table 4 which provides an overview of the relative proportion of home care consumers by age and

gender. There is evidence of an increase in the proportion of people who received home care services. Overall, people 65 years or older were ten times more likely to receive home care than people under 65. More females receive home care than males (e.g., 3.5% for women compared to 2% for men in 1998).

With regard to socio-demographic indicators, persons who were widowed, divorced or separated were approximately four to five times more likely to receive home care than people who were single, married or common law. Those who lived alone were three to four times more likely to have received home care services in the past year. The use of home care services was also related to income and education as those with lower levels of income and education were more likely to use home care services than the affluent and well educated.

With regard to health status and the use of home care, Table 5 indicates that some 12 to 16% of the people who were hospitalized or used a long term care facility bed also received home care in the past year compared to some 1.5% of people who had not been in institutions. Similarly, the proportion of people who had a disability and received home care was more than ten times the rate for people who did not have a disability. The proportion of people who received home care was also clearly related to self-reported health with 0.5 to 0.8% of people who reported excellent health receiving home care, compared to 20 to 26% of the people who rated their health as poor.

While the above discussion focused on adults, a recent report by the Institute of Child Health entitled *The Health of Canada's Children* provides information about children and families who may require home care.¹⁰ The report notes that some 567,575 children and youth from newborn to 19 years of age, or 7.7% of all children, had at least one activity limitation or disability in 1996. The highest rate of disability was reported for females 15-19 years of age. Parents of children with special needs were less likely to be employed and often found it difficult to arrange for sufficient child care to enable them to go to work on a full-time or part-time basis. This, and other factors, may

¹⁰ Kidder, K., Stein, J., & Fraser, J. (2000). *The health of Canada's children*. 3rd ed. Ottawa: Canadian Institute of Child Health.

Table 3: Home Care Sector Human Resource Themes and Issues

| THEMES | HUMAN RESOURCE ISSUES | |
|--------------------------------|---|---|
| | SECTOR-LEVEL ISSUES | INDIVIDUAL-LEVEL ISSUES |
| Changing Context | The demographics of an aging population combined with the overall health care trend of decreasing the amount of care provided in institutions contributes to an increased demand for home care services for all age groups. | |
| Supply of Workers | Perceived shortages of home care workers in Canada, particularly in rural, isolated areas. | The sector does not tend to attract and maintain young workers or men. This impacts on the supply of potential home care workers available. |
| Recognition and Image | Lack of recognition and an inaccurate image of the home care sector among the general population. | Lack of recognition of the role of both formal and informal caregivers. |
| Education/ Training | There are challenges in ensuring a match between consumer needs and work skills, both at entry into the sector and on an on-going basis. | Home care workers want development opportunities (education and training) to ensure they have the appropriate skills to meet consumer needs and have opportunities for advancement. |
| Funding Availability | The supply of formal home care services depends, to a large extent, on the availability of public funding. There has been an increased demand for services (see Changing Context) without a commensurate increase in funding levels for home care services resulting in increased demand for informal and volunteer caregivers. | Increased demand for services (see Changing Context) without similar increases in funding levels for home care services affects employment stability, compensation and nature of service provided and supports available to formal care providers. This also increases the demands and decreases the supports available for informal caregivers and volunteers. This then affects provider perceptions of the level, continuity and quality of care they can provide. |
| Changing Nature of Work | Nature of the work is challenging and changing. | Formal caregivers have concerns about their working conditions. These conditions act as disincentives for people entering and remaining in the sector. Informal caregivers require additional supports to meet the demands being placed upon them. |
| Wages and Benefits | There is lack of parity in wages and benefits between different sub-sectors in the home care sector and between the home care and institutional sectors, in some regions. | Wages and benefits do not meet the expectations of most formal care providers. They act as disincentives for people entering and remaining in the sector. Some informal caregivers require additional support such as respite or training. |
| Nature of Services | The main distinguishing feature of services is the setting in which they are provided (the home). This differentiates the sector from other sectors that are based primarily on occupation and less on place of work (e.g., physicians, social workers, etc.). The sector involves a range of occupational groups, such as nurses, home support workers, case managers, therapists, dietitians and psychologists. Another defining feature is the diversity both of services and who delivers the services (e.g., professional, home support workers, family members, volunteers, friends, neighbours). | Profile of home care workers is varied with overlap in the services provided by different occupational groups. Informal caregivers and volunteers are providing services previously provided by formal care providers or in institutional settings. |

Source: Expert synthesis, Canadian Home Care Human Resources Study, 2002

**Table 4: Percentage of People Receiving Home Care in the Past Year
by Age Group, Gender and Year, for Persons 20 Years of Age or Older**

| Age Group* | 1994 (%) | 1996 (%) | 1998 (%) |
|--------------------|-----------------|-----------------|-----------------|
| 20-39 Years | 0.934 | 0.940 | 0.703 |
| 40-59 Years | 1.125 | 1.210 | 1.386 |
| 60-69 Years | 3.398 | 3.340 | 2.823 |
| 70-79 Years | 9.655 | 8.020 | 10.075 |
| 80+ Years | 22.280 | 23.987 | 27.990 |
| Less than 65 Years | 1.072 | 1.124 | 1.072 |
| 65 Years or Older | 10.310 | 9.911 | 11.818 |
| Gender | | | |
| Females | 3.317 | 3.335 | 3.522 |
| Males | 1.705 | 1.692 | 2.051 |

Source: National Population Health Surveys, 1994, 1996 and 1998, Statistics Canada

*Comparable data for children were not available in these surveys.

account for the finding that children with disabilities were more likely to live in low income households and that 66% of such families experienced severe or high amounts of tension.

Table 6 presents estimates, based on Statistics Canada projections, of the number of potential home care consumers. The first column provides projections based on the assumption that the age distribution of the population remains the same as in 1996 for all subsequent years. Thus, this is a projection of the number of people who would receive home care if all conditions, other than the overall growth of the population, remain constant. In the second column are 1996 age and sex utilization ratios for home care consumers and multiplication of these ratios by the projected age and sex distributions in future years. The difference between columns one and two provides information about the added number of home care consumers related to changes in the demographic structure of Canada. If everything stays as it was in

1996, there would be some 759,046 people on home care in 2046; however, due to changes in the age distribution of the population, there could actually be an additional 701,042 people on home care. This means that in 2046, home care services may be required for almost twice as many people as received care in 1996.

Fiscal restraint in the institutional sector has led to an increasing reliance on home care as a lower cost alternative for acute and long-term institutional care. Recent studies have demonstrated the potential cost-effectiveness of home care services.¹¹ Increased demand for home care services is also seen among groups that may have previously received services in institutional settings, such as people receiving palliative care, people with dementia, children with special needs, and persons with disabilities. Advances in medical technology and pharmacology have also made home care services possible in more cases.

¹¹ Hollander, M.J. and Chappell, N.L. (2002). *Final report of the national evaluation of the cost-effectiveness of home care*. Victoria: National Evaluation of the Cost-Effectiveness of Home Care.

Table 5: **Percentage of People Receiving Home Care in the Past Year by Health Related Factors and Year, for Persons 20 Years of Age or Older**

| Health Related Factors | Percent Using Home Care | | |
|---|-------------------------|--------|--------|
| | 1994 | 1996 | 1998 |
| Use of home care by persons who were overnight patients in hospitals or nursing homes in past year | | | |
| Yes | 12.593 | 14.357 | 15.869 |
| No | 1.412 | 1.394 | 1.661 |
| Use of home care by persons who had a restriction of activities in past year | | | |
| Yes | 8.966 | 10.070 | 11.144 |
| No | 0.739 | 0.924 | 0.805 |
| Use of home care in relation to self-reported health | | | |
| Poor | 20.534 | 19.802 | 26.248 |
| Fair | 8.310 | 8.899 | 10.492 |
| Good | 2.706 | 2.655 | 3.007 |
| Very Good | 1.140 | 1.083 | 1.094 |
| Excellent | 0.491 | 0.802 | 0.529 |

Source: National Population Health Surveys, 1994, 1996 and 1998, Statistics Canada

Table 6: **Comparison of Home Care Client Based on the 1996 Population Distribution Compared to Actual Age and Sex Projections**

| Year | National Projection Using 1996 Population Distributions | National Projection Using Future Population Distributions | Difference |
|------|---|---|------------|
| 1996 | 539,597 | 539,597 | 0 |
| 2006 | 624,684 | 729,930 | 105,246 |
| 2016 | 687,526 | 874,278 | 186,752 |
| 2026 | 730,626 | 1,093,415 | 362,789 |
| 2036 | 753,324 | 1,335,633 | 582,309 |
| 2046 | 759,046 | 1,460,088 | 701,042 |

Source: Based on the 1996 National Population Health Survey and Population Projections, Statistics Canada.

The Supply and Characteristics of Home Care Workers

Sector-Level Issues

There is a perceived shortage of home care workers in Canada, particularly in rural, isolated areas.

There is a perceived shortage of home care workers, which is particularly acute in rural and isolated areas. Shortages in the home care sector are combined with a general shortage of nurses in Canada. Focus group participants and key informants indicated that, with the nursing shortage, home support workers (HSWs) are replacing health care aides in institutional settings, which limits the availability of HSWs in the home care setting.

The majority of personnel employed in the home care sector are at entry-level positions and perform a range of basic activities to support daily living for consumers who have been assessed and found unable to do these activities for themselves. Titles for such personnel include homemaker, home health aide, personal care worker, home health attendant, and home support worker. The term “home support worker” will be used to refer to these individuals in this report. Most home care needs (70–80%) are met by home support workers.¹² Other home care providers are described as professional workers and include nurses, case managers, physiotherapists, and occupational therapists. Table 7 provides an overview of paid providers in the home care sector.

Table 7: Overview of Types of Paid Care Providers in the Home Care Sector

| TYPE OF PROVIDER | OVERVIEW |
|--|--|
| Home Support/ Personal Care Workers | Home Support Workers (also called personal care attendants/workers) deliver the basics: a washed floor, a clean bathroom, a stocked fridge, a hot meal, laundered clothes and linens, a safe bath. They perform health care tasks such as changing dressings and urine bags. They provide other essentials, too: a conversation, a watchful eye, a reminder to eat or to take a pill, an escort on a walk to the store. Home Support is supposed to be a preventive service that, in tandem with informal caregivers, helps vulnerable people to stay healthy in their home and involved in their community. Home Support is intended to serve more than individuals in need. It is supposed to act as a buffer against strain on our hospitals, long term care facilities, health personnel and provincial/territorial budgets. |
| Registered Nurses | Home care nursing provides a continuum of nursing services designed to support consumers of all ages to remain in their homes during an acute, chronic or terminal illness. Goals for home care nursing can be preventative, curative, rehabilitative, palliative, or supportive. All nurses are involved in direct patient care, which includes health promotion and education, illness prevention, advocacy and the promotion of self-care. In addition, registered nurses, through case management, often have the responsibility to coordinate all home care services. Employing the nursing process (assessment, diagnosis, planning, implementation and evaluation), home care nursing encourages consumers and their families to be responsible for, and to participate actively in, their own care. Tele-health is emerging as an innovative tool to support home care nursing services. |
| Licensed/ Registered Practical Nurses | The Licensed/Registered Practical Nurse (LPN, RPN), working as a member of the interdisciplinary team, uses the nursing process and nursing concepts to provide care to a diverse population of consumers, and their caregivers, within the community setting. LPNs base their practice on a solid foundation of nursing science, competencies and professional judgment as it relates to health education, health promotion, prevention, rehabilitation and palliation to assist and support consumers and caregivers in achieving their optimum level of functioning. Some challenges faced by LPNs in Canada are an aging population and shortages within the profession, barriers in hiring practices and the inability to practise to the full scope of their abilities in some jurisdictions. |

¹² Canadian Association for Community Care [CACC]. (1995). *Canada home care labour market study*.

Table 7 (continued): **Overview of Types of Paid Care Providers in the Home Care Sector**

| TYPE OF PROVIDER | OVERVIEW |
|--------------------------------|---|
| Physio-therapists | <p>Physiotherapists are becoming more prominent on the home care team. They enable consumers to remain in their home by working to improve the mobility and functional independence of consumers in the home environment. Physiotherapists provide services in a variety of home care settings (e.g., home, community and school). They provide assessment and treatment, including education and pain control, for a variety of conditions related to cardio-respiratory, orthopedic and neurological impairment or injury, and for cancer and arthritic conditions. Physiotherapists work with all age groups and are involved in all levels of home care delivery, that is, post-acute, acute, chronic and palliative care.</p> |
| Occupational Therapists | <p>Occupational therapists collaborate with individuals, groups and organizations to promote, maintain or restore health and well-being through “occupations” or activities. Occupations include self-care, leisure and productivity/work. The home environment has provided a natural and meaningful context to promote a person’s occupational roles. Occupational therapy services in home care are designed to enable the client to participate in daily activities (i.e., bathing, functional mobility, meal preparation, shopping) and support the role of family and caregivers. Occupational therapy services address physical, cognitive and affective components of functioning and include adaptive strategies to perform daily activities, assessment of safety, and recommendation of equipment to help consumers maintain function and independence. Occupational therapists recommend home and environment modifications for safety and independence (i.e., ranging from low technology such as grab-bars to high technology such as environmental controls). Occupational therapists may be involved in community reintegration including home management, time management, banking, and transportation, as well as recommending appropriate community resources.</p> |
| Case Managers | <p>Case managers employed in provincial/territorial public sector home care programs provide the core service of case management in all home care programs in Canada. Case managers are regulated health professionals who: establish client eligibility for home care programs; assess the client’s health, functional, and social status; and, establish the supportive service plan to assist consumers and their families to regain optimum health status or provide the required care, services and supports to ensure the client, caregivers, and/or the community are supported through complex disease issues and end of life care. Case Managers may be registered nurses, physiotherapists, occupational therapists, or social workers with enhanced education and training particularly in case management. The case manager is the educator for consumers and caregivers, and navigates and advocates on behalf of consumers and caregivers to ensure the services required are delivered at the right time. Ongoing service needs, service co-ordination, re-evaluation and adjustments needed by the client are done in consultation with the client/caregivers and include the service providers and other professionals who are working collaboratively with the case manager and the client. Case management provides consumers with quality care, fiscal accountability along with advocacy, resources, and positive outcomes for the client, caregiver and the whole health care system.</p> |
| Social Workers | <p>Social work interventions focus on enhancing social and emotional functioning and preventing problems/situations that reduce coping capacities. Development of a service plan and determination of the most appropriate intervention is based on a bio-psycho-social assessment. Social workers in community-based health care services provide services related to the following needs and conditions: resource issues, adjustment to illness/disability, placement issues, abuse/neglect, palliative care, caregiver burnout, social isolation, marital or family conflict, parenting difficulties, and individual psycho-social issues.</p> |

Source: Literature review, interviews, focus groups and expert input, Canadian Home Care Human Resources Study, 2002.

Table 7 (continued): **Overview of Types of Paid Care Providers in the Home Care Sector**

| TYPE OF PROVIDER | OVERVIEW |
|-------------------------------------|---|
| Dietitians | The presence of dietitians among home care service providers is still a relatively new phenomenon; there is little published literature in this area. The use of dietetic services appears to be available more often in corporate home care agencies, or for people leaving acute care settings. The goal of a dietitian in the home care environment is to teach consumers, their families and other caregivers to provide for consumers' fundamental dietary needs. The dietitian is also able to provide assessment and education to improve nutrition to maintain health. |
| Respiratory Therapists | Respiratory therapists work with physicians and other health care professionals to diagnose, treat and care for patients with respiratory and cardiopulmonary disorders. They monitor vital signs, conduct diagnostic tests, perform cardio-pulmonary resuscitation, administer medical gases and aerosol therapy to manage and control breathing difficulties. They operate, maintain and calibrate respiratory therapy equipment (oxygen masks, humidifiers, ventilators, incubators, and resuscitators). Respiratory therapists may specialize in any of the following areas: neonatology, pediatrics, anaesthesia, critical care, cardiopulmonary diagnostics, and respiratory home care. Respiratory therapists work in hospitals, clinics, critical care transportation teams (air and ground), diagnostic laboratories, educational institutions, private and public home care programs. |
| Speech/Language Pathologists | Speech/Language pathologists provide a vital service for seniors who may have suffered a stroke or other health problem which has affected their ability to speak clearly. They also assist children with special needs both in the home setting and in schools. Services are provided to consumers with neurogenic dysfunction as a result of cerebro-vascular accidents, head injury, progressive disorders, dementia, etc., and other medical/health conditions requiring in-home services. Speech language pathologists provide the following services: assessment and treatment; and school based, health related support services. Paediatric in-home services are also provided to a range of children with complex health needs, primarily preschoolers, but may also include school age children (e.g., following surgery) until they are able to return to school. |
| Physicians | The College of Family Physicians of Canada encourages physicians to take a more active role in home care as members of a multi-disciplinary team. The College also calls for better coordination and integration of service delivery components between hospitals and other institutions and home care. Physicians are indeed starting to play a more active role in home care, particularly in regard to acute care, palliative care, and rehabilitation, and in regard to more complex cases requiring technological responses to care. There is a trend to involve family physicians and specialists more actively in home care. A well-established doctor/patient relationship can strengthen home care services, particularly in regard to the growing number of complex cases now cared for at home. |
| Psychologists | Psychologists provide direct diagnostic and treatment services to patients across the lifespan; consultation to informal caregivers, formal care providers, volunteers and families; information and education about psychological factors in health; and psychological support to care givers, volunteers and families to prevent burnout and related family issues. Psychologists strongly support an integrated and interdisciplinary approach to care that includes the patient, informal caregivers, volunteers, family members and health care professionals. |

Source: Literature review, interviews, focus groups and expert input, Canadian Home Care Human Resources Study, 2002.

As part of the work for this project, an extensive analysis was undertaken to identify all home care provider organizations across Canada, and the number of paid care providers within those organizations. The resulting listing was used as the sampling frame for a survey of paid home care providers. Table 8 presents estimates of the number of paid home care providers in regard to Home Support Workers (HSWs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Rehabilitation and Social Work Therapists (this category includes Occupational Therapists (OTs), Physiotherapists (PTs) and Social Workers (SWs). Occupational therapists, physiotherapists, and social workers were combined into a broader category

(OT/PT/SW) as the sample sizes for each of these professions were insufficient to analyze separately. The reader should be aware that although there are similarities between these three groups, they are distinct professions that have different roles, different practice patterns, and may have different human resources issues.¹³ Table 8 provides estimates based on original work conducted for this study and estimates from the Canadian Institute for Health Information (CIHI) and Statistics Canada's Labour Force Surveys (LFS). Table 9 provides an overview of how these workers are distributed across government departments and Regional Health Authorities (government/RHA) and private not-for-profit and private for-profit providers.

Table 8: Estimates of the Number of Formal, Paid Care Providers in the Home Care Sector

| Group | Survey sample frame | CIHI | LFS 2001 |
|--------------|----------------------------|-------------|-----------------|
| Home Support | 32,304 | n/a | 16,700 – 57,300 |
| RNs | 9,241 | 8,644 | 9,700 |
| LPNs | 2,854 | 2,697 | 2,400 |
| OT/PT/SW | 2,613 | 1,591 | n/a |

Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study, 2002.¹⁴

Table 9: Percentage of Formal Care Providers, by Type of Employer

| Group | Gov't/RHA | Private | |
|--------------|------------------|-----------------------|-------------------|
| | | Not-for-Profit | For-Profit |
| Home Support | 38% | 26% | 44% |
| RNs | 41% | 34% | 30% |
| LPNs | 17% | 58% | 32% |
| OT/PT/SW | 74% | 2% | 25% |

Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study, 2002.

¹³ Similarly, it is not possible, given the way this sample was constructed, to draw conclusions about other therapist groups (e.g., respiratory therapists).

¹⁴ The purpose of the Survey of Formal Caregivers was to collect general, national-level information about human resource issues that currently affect the home care sector. It just begins to fill the gap in information on home care workers. The data should not be used for any purpose other than that for which it was intended. For example, it would be erroneous to use the data to draw conclusions about specific regions, specific employers, or specific sub-groups of workers within the broad occupational groups upon which the survey is based.

It should be noted that not all home care professions could be included in the survey of paid home care providers conducted for this report. For example, case managers, respiratory therapists, speech therapists, dieticians, physicians, psychologists and other professional and para-professional groups were not included in the survey. Finally, as with any survey, there are always methodological issues and data limitations which need to be considered. The approaches to dealing with these matters for the survey of formal, paid home care providers is presented in Appendix C.

A similar approach to the one used in Table 6 was used in Tables 10 and 11 to compare the number of future workers based on a constant age and sex distribution (column one) to the number of workers based on the changing demographic structure over time (column two).

Table 10 indicates that, based on a projection of distribution by age and sex, the number of professional workers (i.e., RNs, LPNs and OT/PT/SWs) will remain

fairly constant. In a reversal of the demographic situation for home care consumers, the numbers in the second column are lower than in the first column as one progresses from 2001 to 2046. This is because the highest proportion of professional workers in home care were in the 40 to 49 and 50 to 59 year age groups (“baby boomers”), which, over time, would decline in numbers as baby boomers move into their senior years. If one compares the projections for professional workers and home care consumers, the ratio of workers to consumers changes from one worker to 37 consumers in 2001 to one worker per 100 consumers in 2046.

With regard to home support workers, a similar analysis was conducted and similar results were found. Comparing the ratio of home support workers to consumers, Table 11 indicates that the ratio changes from one worker to 17 consumers in 2001 to one worker to 45 consumers in 2046. The findings in Tables 10 and 11 indicate the potential pressures on the home care system in future years.

Table 10: Comparison of the Number of Professional Home Care Personnel Required Based on the 2001 Population Distribution Compared to the Actual Age and Sex Projections

| Year | Projections Based on 2001 Population Distribution | Projections Based on Future Population Distributions | Difference (Shortfall) | Ratio of Professional Staff to Consumers |
|------|---|--|------------------------|--|
| 2001 | 14740 | 14740 | 0 | 1:37 |
| 2006 | 15323 | 15842 | (519) | 1:50 |
| 2016 | 16365 | 15371 | (994) | 1:57 |
| 2026 | 17207 | 14480 | (2727) | 1:76 |
| 2036 | 17608 | 14783 | (2825) | 1:90 |
| 2046 | 17604 | 14548 | (3056) | 1:100 |

Source: Based on the Survey of Formal Caregivers, Canadian Home Care Human Resources Study, and National Population Health Survey and Population Projections, Statistics Canada

Table 11: Comparison of the Number of Home Support Workers Required Based on the 2001 Population Distribution Compared to Actual Age and Sex Projections

| Year | Projections Based on 2001 Population Distribution | Projections Based on Future Population Distributions | Difference (Shortfall) | Ratio of Home Support Workers to Consumers |
|------|---|--|------------------------|--|
| 2001 | 32,304 | 32,304 | 0 | 1:17 |
| 2006 | 33,582 | 35,030 | 1448 | 1:23 |
| 2016 | 35,865 | 34,906 | (959) | 1:25 |
| 2026 | 37,710 | 31,477 | (6233) | 1:35 |
| 2036 | 38,590 | 32,876 | (5710) | 1:41 |
| 2046 | 38,581 | 32,327 | (6254) | 1:45 |

Source: Based on the Survey of Formal Caregivers, Canadian Home Care Human Resources Study, and National Population Health Survey and Population Projections, Statistics Canada

Individual-Level Issues

The sector does not tend to attract and maintain young workers or men. This impacts on the supply of potential home care workers available.

Paid Home Care Workers

There are two characteristics of today's home care workers that are particularly significant in defining the shortage of home care workers – the gender and average age of current workers. Since female workers dominate the sector, the supply of potential workers is less than it would be if there were a tradition of both men and women working in the sector in fairly equal proportions. Informal caregivers are also predominantly female. The majority of formal (paid) care providers are currently over the age of 40.

There is a perception that there is a high turnover rate of employees in the home care sector. The formal care provider survey did not, however, find evidence of high turnover in the sector.

- Home care workers had worked, on average, eight to nine years in the sector and six to seven years of that with their current employer.¹⁵ This reflects considerable stability in the workforce. However, these findings do suggest that there are not a large number of new entrants into the sector, given that workers have been with their employer for a relatively long time.
- The length of tenure was significantly different for the four types of providers by union status, with unionized employees having longer tenure (8.1 to 10.7 years) than non-unionized employees (7.0 – 7.9 years). The length of tenure also varied by the type of employer with tenure generally being longest for government/RHA employers. Tenure was also longer for full-time employees, next longest for part-time employees and shortest for casual employees.
- Only about one in 10 home care workers is planning on leaving the home care sector in the next 12 months and about half this group will be leaving home care for another part of the health care system. Those working in the private for-profit sector are more likely to be leaving than their counterparts in other sectors.

- Less than one in five home care workers have definite timeframes for their departure from the sector. However, their departure is not imminent – on average, they plan on working in the sector for about five to seven years. Only about one-third of home care workers intend to continue working in the home care sector indefinitely. Fewer than half the workers were uncertain about the timeframe for their departure from the sector.

Informal Caregivers

A national survey of Canadian adults was conducted as part of this project. The survey included youth and adults 15 years of age or older and identified people who were caring for a family member in the caregiver's home and people who were caring, outside of their home, for a family member, relative or friend.

Based on the demographic characteristics of age, marital status, employment status, education and income, informal caregivers were comparable to those in the overall sample. Some 65% of caregivers were under 50 years of age and 65% were married or living common-law. Some 64% of caregivers worked full-time, part-time or were self-employed. However, there was a considerably higher proportion of females than males among the informal caregivers than in the overall sample.

Two-thirds of the caregivers (67%) had been providing care for five years or less. One in five caregivers indicated that they themselves had a long-term physical or mental illness or condition, and were frail, disabled and/or needed help. However, when asked to compare their general health to that of others their age, their assessment of their health status was comparable to the assessment of the overall population sample.

More than two-thirds of informal caregivers cared for only one person. Nearly one-half of them cared for a parent and one quarter cared for other relatives (such as aunts/uncles or in-laws). One in five cared for a friend or neighbour.

Volunteers

Volunteers provide valuable expertise and support to both home care consumers and home care workers. Many Canadians contribute their time as volunteers. There is no descriptive information on volunteers

¹⁵ This is lower than the average of almost 10 years for health care workers more generally (see *Canada's health care providers* (p. 70) at www.cihi.ca).

Table 12: **Percentage of People who were Volunteers, by Age Group, Gender and Year, for Persons 20 Years of Age or Older**

| Age Group | Survey Year | |
|--------------------|-------------|----------|
| | 1994 (%) | 1996 (%) |
| 20-39 Years | 28.3 | 23.3 |
| 40-59 Years | 36.3 | 32.1 |
| 60-69 Years | 43.1 | 38.2 |
| 70-79 Years | 42.3 | 38.3 |
| 80+ Years | 39.9 | 33.2 |
| Less than 65 Years | 32.7 | 28.0 |
| 65 Years or Older | 41.5 | 37.3 |
| Gender | | |
| Females | 33.9 | 30.1 |
| Males | 34.2 | 28.8 |

Source: National Population Health Surveys, 1994, 1996, Statistics Canada.

specific to the home care sector; however, some information about the voluntary sector is available from the National Population Health Surveys (NPHS) conducted in 1994 and 1996. There is also information on volunteers in the 1997 and 2000 National Surveys of Giving, Volunteering, and Participating.

Overall, about one-third of Canadians confirmed that they volunteer in answer to the surveys. However, there was a sizeable drop in the proportion of volunteers between the 1994 and 1996 NPHS surveys (34 % to 29%). In terms of age and gender, the highest percentages of volunteers in the National Population Health Survey were among people aged 60 to 79 years of age. In 1996, 37.3% of seniors were volunteers compared to 28.0% of people less than 65 years of age (see Table 12). There were relatively even proportions of men and women who were volunteers.

Analysis of the data from the National Survey of Giving, Volunteering and Participating reveals a number of interesting patterns about volunteers. In general, people with higher levels of education were more likely to be volunteers. For example, 18.6% of people who did not graduate from high school were volunteers compared to 38.6% of people with university degrees. There was a similar difference in the rate of volunteering by income. Of those with personal

incomes under \$20,000, 24.7% were volunteers while 36.7% of persons with incomes of over \$60,000 were volunteers. Thus, it appears that the rate of volunteering is related to one's socio-economic status. Family patterns of volunteering and religiosity were also related to volunteering. For example, 37.7% of persons who were active in a religious organization were volunteers compared to 23.4% who were not active in such organizations. Also, individuals who had one or both parents who did volunteer work in the community were more likely to be volunteers than those with parents who did not volunteer (38.7% compared to 20.1%). Self-reported health and satisfaction with life were also related to volunteering. For those who reported being in excellent health, 33.2% were volunteers compared to 17.3% of those who said they were in poor health. Similarly, 34.0% of those who were very satisfied with their lives were volunteers compared to 17.0% of those who said that they were very dissatisfied.

There appears to have been a significant decrease in the percentage of people who volunteered between 1994 and 2000 (34 % to 27%). If this trend continues there may be fewer volunteers available to assist people on home care in the future.

Recognition and Image of the Home Care Sector and its Workers

Sector-Level Issues

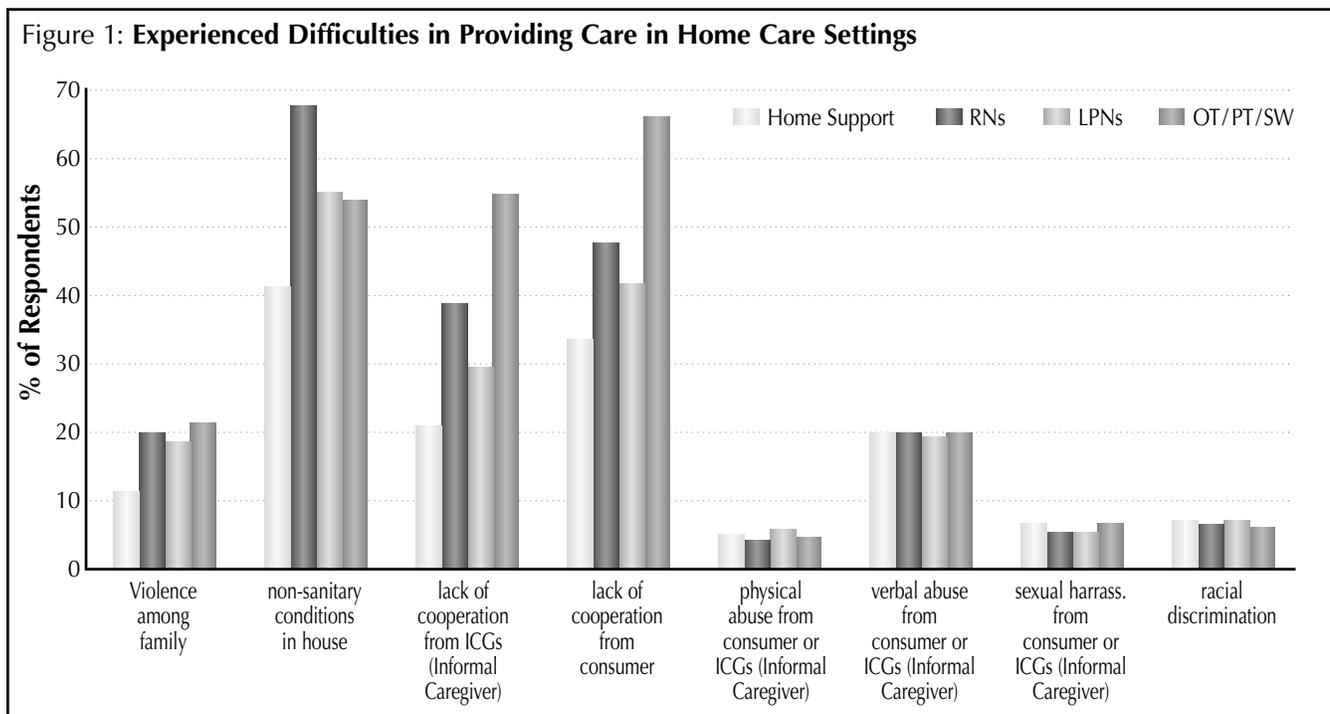
Lack of recognition and inaccurate image of the home care sector among the general population.

The perception of the home care sector among the general population has an impact on home care workers. Home care workers believe that there is a lack of recognition of the value of both home care services and those providing the services. Some people perceive that the services provided by home care workers, and in particular home support workers, are less specialized perhaps than those of more recognized professional occupational groups, and can be provided by anyone.

Individual-Level Issues

There is a lack of recognition of the role of both formal and informal caregivers.

Although studies have demonstrated the quality and efficiency of home care, workers in the sector do not believe that the public and governments have a high regard for the sector as an occupational sector. This issue was raised by participants in the focus groups and by key informants, and applies to both formal and informal caregivers. According to the survey of formal care providers, having more respect for home care workers in today's society was identified as one of the top three ways in which working conditions in the sector could be improved for all formal home care workers.¹⁶ The nature of working conditions in the home care sector is also reflective of the lack of respect for care provides. Figure 1 describes the kinds of difficulties encountered by home care workers.



Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study

Note: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc.

¹⁶ Except for OT/PT/SWs, who identified the following top three priorities: providing ongoing or continuing education and professional development; providing compensation for travel time; and providing better equipment and supplies.

Figure 1 notes the following:

- HSWs indicated that the most frequent difficulties they faced were unsanitary conditions in houses (43%), lack of cooperation from the consumer (33%), and verbal abuse from the consumer or the informal caregivers (20%).
- RNs reported most frequently difficulties in providing home care in houses with unsanitary conditions (67%), lack of cooperation from consumers (47%), and lack of cooperation from informal caregivers (39%).
- LPNs reported a similar pattern of difficulties as those experienced by the RN group. The most frequently cited difficulties were working in unsanitary conditions (56%), lack of cooperation from the consumer (43%), and lack of cooperation from informal caregivers (31%).
- OT/PT/SWs most frequently experienced lack of cooperation from the consumer (66%), followed by similar rates of difficulties with lack of cooperation from informal caregivers (55%) and unsanitary conditions in houses (55%).

Among the nursing and HSW occupations, approximately one in five experienced verbal abuse from consumers or informal caregivers while providing home care. Rates of physical abuse from consumers or informal caregivers ranged from 4% to 7% across the four occupational groups.¹⁷ These rates are of particular concern given the relatively isolated settings within which home care providers work. The possibility of receiving assistance in managing abusive consumers and informal caregivers, or extricating oneself from the situation, is less likely than in an institutional setting where there are other staff and supervisors to provide assistance.

Education and Training Sector-Level Issues

There are challenges in ensuring a match between consumer needs and work skills – both at entry into the sector and on an on-going basis.

Changes to the educational requirements for entry into home care affect the supply of professional workers and home support workers. There are clear requirements for the professionals working in the sector. The requirements for home support workers, however, vary from jurisdiction to jurisdiction. Even in those provinces that have specific requirements, the educational profile required can vary. Among key informants, there was a recognition of the need for standardized training, and to have training that addresses the increasingly complex needs of consumers.

Training and education are significant issues for home support workers, issues that vary by agency, by province, and by level of work.¹⁸ A report by Health Canada reveals examples of systematic training programs for home support workers which are available in British Columbia (22 weeks in a community college program), Saskatchewan (pre-employment program and a two-year on-the-job program), Manitoba (home care attendant certificate from a community college), Ontario (training by community colleges and private vocational schools), Quebec (960 training hours from a community college), and New Brunswick (completion of home care worker program at a community college or similar certified program). The report also notes that Nova Scotia has recently announced an education program for continuing care workers that will encompass responsibilities in both home care and long-term care facilities.¹⁹

¹⁷ The issue of abuse and violence of health care workers is not unique to home care. The Canadian Centre for Occupational Health and Safety, in a review of violence in the workplace, found that health care employees tended to be at greater risk for workplace violence (www.ccohs.ca/oshanswers/psychosocial/violence.html). The Canadian Institute for Health Information found high rates of verbal or physical abuse (38%) in a study of 9,000 registered nurses working in 216 hospitals in Alberta and British Columbia from both patients and other members of the care team (see *Canada's health care providers* (p. 91) at www.cihi.ca).

¹⁸ Canadian Association for Community Care [CACC]. (1995). *Canada home care labour market study*.

¹⁹ Health Canada. (1999). *Provincial and territorial home care programs: A synthesis for Canada*.

As illustrated in Table 13, the most frequently reported types of training were somewhat dependent on the occupation group. Among HSWs, the most frequently reported types of in-service training included first-aid (71%), specific care needs for special populations (69%), and working on a multi-disciplinary team (48%). RNs most frequently reported having training in specific care needs for special populations (69%), assessment and treatment planning (57%), and the use of technology (55%). LPNs most frequently reported having had training in specific care needs for special populations (58%), first-aid (56%), and assessment and treatment planning (49%). OT/PT/SWs reported that they received training in specific care needs for special populations (66%), and in assessment and treatment planning (58%).

Individual-Level Issues

Home care workers want development opportunities (education and training) to ensure they have the appropriate skills to meet consumer needs and have opportunities for advancement.

The challenge in the home care sector is to ensure that workers have the skills necessary to meet consumer needs, and have opportunities for advancement. Even if workers come into the sector as skilled workers, their skills have to be maintained and furthered with the changing nature of the work.

Professional staff, because of the requirements for their professional qualifications, come into the home care sector with recognized skills. However, the requirements for home support workers vary across jurisdictions. The skills HSWs bring to their work can vary considerably. Interviews with unions identified the need for the development of national standards for the training of HSWs.

Formal (paid) care providers indicated that they would like more training opportunities during their employment, so that they can both meet consumer needs and have opportunities for advancement.

- Between three-quarters and four-fifths of home care workers stated that they would like more training opportunities. The most frequently cited type of training was training on the care needs of specific consumer groups.
- Focus group participants and key informants noted the need for more training, given the increased complexity of their work.
- Between half and three-quarters of workers noted that the most common barrier to training is the cost.
- Training opportunities are, however, being made available – about three-quarters of workers did receive training in the previous 24 months.
- The majority (excluding therapists) were not, however, given paid time off for training, although the employer paid the tuition or course fees.

Table 13: **Types of Training Received in the Past 24 Months**

| Type of Training | % Within Occupation Group | | | |
|---|---------------------------|-----|------|-----------|
| | HSWs | RNs | LPNs | OT/PT/SWs |
| Specific care needs for special populations | 69 | 69 | 58 | 66 |
| First aid | 71 | 55 | 56 | 37 |
| Working on a multi-disciplinary team | 48 | 40 | 31 | 39 |
| Self-managed care | 24 | 15 | 19 | 7 |
| Use of technology | 37 | 55 | 42 | 23 |
| Computers | 17 | 27 | 14 | 44 |
| Assessment and treatment planning | 24 | 57 | 49 | 58 |
| Working with informal caregivers and volunteers | 16 | 16 | 9 | 16 |
| Working with children and youth | 11 | 8 | 18 | 15 |

Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study

Note: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc

- Providing development opportunities was noted as one of the top three ways in which working conditions in the home care sector could be improved for all formal home care workers.

The educational profile of informal caregivers is comparable to that of the general population. Approximately one-third of them would like information, advice or training specific to providing home care.

Funding

Sector-Level Issues

The supply of formal home care services depends, to a large extent, on the availability of public funding. There has been an increased demand for services (see Changing Context) without a commensurate increase in funding levels for home care services resulting in increased demand for informal and volunteer caregivers.

There were significant increases in public funding to home care in the 1990s. Home care expenditures for Canada increased to some \$2.7 billion in 2000/2001, up from some \$205 million in 1980-81 (an annual increase of some 21.3%).²⁰ It is not clear, however, whether home care continues to be a priority for funding as the new millennium progresses. The growth rate in publicly funded home care services decreased in the 1990s, averaging 11% from fiscal 1990/91 to 1997/98.²¹ In the period fiscal 1996/97 to 2000/01, the average annual growth rate was 8.9%, while private spending on home care almost doubled during this time period.²²

The proportion of public health care resources currently allocated to home care programs varies significantly from province to province. Public health care expenditures, on a per capita basis, increased from \$37 per individual in 1990-91 to \$69.20 per individual in 1997-98 (there is a range of per capita

spending across the provinces). While there is variation among the provinces and territories in the proportion of public funding allocated to home care, it is estimated that, overall, up to 5% of all publicly funded health expenditures are now directed to home care.²³ In addition, Veterans Affairs Canada also spent an estimated \$161 million providing its Veterans Independence Program (VIP) in 1996-97.²⁴

With regard to privately funded home care, some insurance policies and/or private extended health care policies may also contain provisions for covering the costs of home care. In addition, people with means can also directly purchase such services.

Funding for the home care sector is currently the focus of federal/provincial/territorial discussions. It is clear from the findings of this study that the home care sector is already negatively affected by cost constraint measures and it will continue to require an increasing proportion of additional resources over time.

Individual-Level Issues

Increased demand for services (see Changing Context) without similar increases in funding levels for home care services affects employment stability, compensation, nature of service provided and supports available to formal care providers. This also increases the demands and decreases the supports available for informal caregivers and volunteers. This, in turn, affects provider perceptions of the level, continuity and quality of care they can provide.

The demand for most home care services is directed through the “funnel” of public funding. A significant portion of services in the sector is provided with public money. As a result, the actual demand for workers in the home care sector by employers is a reflection not only of the demand for home care services from the population, but also of the availability of public funding for home care.

²⁰ Health Canada, Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01. See www.hc-sc.gc.ca/english/care/expenditures/expenditure_stats.htm

²¹ Health Canada. (1998). *Public home care expenditures in Canada 1975-76 to 1997-98, Fact sheets*. Ottawa: Policy and Consultation Branch, Health Canada.

²² Coyte, P.C., *Home care: Potentials and problems*. Presentation given at Diagnostics and Solutions: Building Consensus for Health Care Reform in Canada.

²³ Coyte, P.C. (2000). *Home care in Canada: Passing the buck*.

²⁴ Anderson, M., & Parent, K. (1999). *Putting a face on home care: CARP's report on home care in Canada 1999*. Study conducted by Queens' Health Policy Research Unit.

Using demographic projections to 2046 based on census data, in order to meet the increased demand for home care services, within the next 45 years, the sector will have to increase the number of professional providers and HSWs substantially – by a factor of approximately three. Since the increasing demand from the population for home care is not always being met by formal (paid) care providers, there is an increasing trend to rely on informal caregivers (family and friends) and volunteers to meet needs that might otherwise be met by formal care providers. This also distinguishes home care from most other occupational groups. This reliance on informal and voluntary caregivers to meet the growing demand for home care services is occurring at a time when:

- The supply of informal caregivers is decreasing as a result of changing family patterns, lower fertility rate and mobility patterns; and,
- The supply of volunteers is decreasing. The ratio of volunteers of all kinds to home care consumers is projected to decrease by approximately 50% by 2046. (12:1 to 6:1).

Although there has been a significant increase in funding for home care services, funding in the sector remains uncertain. In the current public policy context, the public-private mix of home care services is changing; the evidence is in the increased proportion of care being paid for directly by individuals and/or their families, increased competition and the growth of large, complex delivery organizations.

The limited funding for home care services affects the resources available in the sector. Home support workers indicated that they felt that there is insufficient funding to provide adequate compensation for workers and adequate supports for them to do their work. It means that home care workers are often not able to provide the level and quality of care that they feel they should provide.

Changing Nature of Work

Sector-Level Issues

The nature of the work is challenging and changing.

The sector is defined by where people in the sector work, rather than the work they do. Workers are working alone and in a different setting with each consumer. This presents a number of issues – both positive and negative – for home care workers. In addition, the home care sector is under increasing pressure

due to changes in technology and the increasing complexity of care requirements for home care consumers. There is also increased concern about both formal care providers' and informal caregivers' liability in coping with the possible negative outcomes associated with providing higher levels of care.

Figure 2 provides an overview of the types of activities currently provided by RNs, LPNs, and HSWs from the survey of formal caregivers.

As can be seen from Figure 2, the most common activities for HSWs are meal preparation, personal hygiene and assisting in waste elimination (i.e., toileting). The most common activities for nurses are wound care, monitoring medications, assisting in waste elimination and monitoring the care plan. While there are similarities in the tasks of RNs and LPNs, each brings a level of nursing science knowledge that is reflective of their educational preparation.

Individual-Level Issues

Formal care providers have concerns with their working conditions. These conditions act as disincentives for people entering and remaining in the sector. Informal caregivers require additional supports to meet the demands being placed upon them.

Introduction

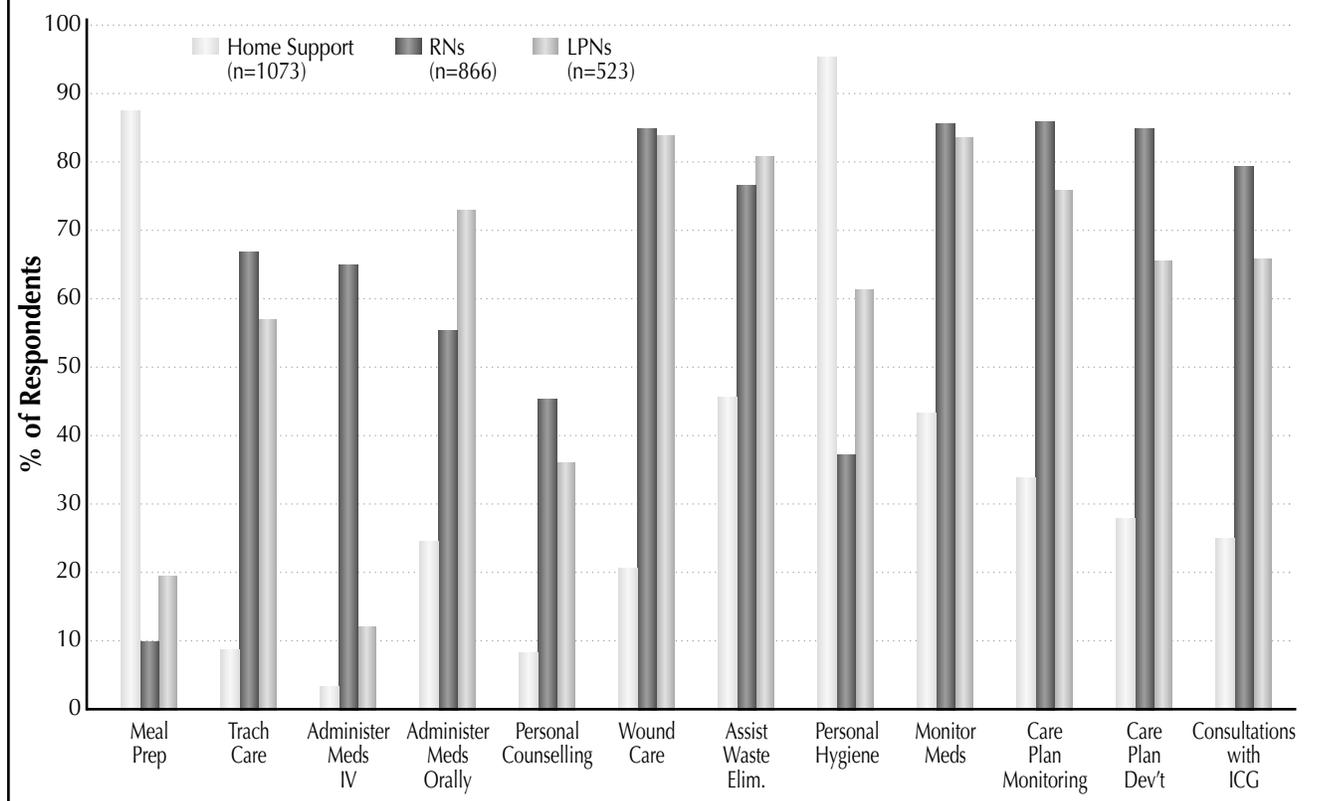
Formal (paid) care providers are concerned about their working conditions, specifically: the lack of stability in their employment; their perception that they are not able to provide continuity and a high level of care; isolation; lack of supports; and, occupational health and safety issues. Informal caregivers also have concerns about their ability to cope and to provide appropriate care.

Employment Stability

About one-third of home care workers (except OT/PT/SWs) are in full-time positions. About half are in part-time positions and the remaining 11% to 18% are in casual employment. Focus group participants and key informants indicated that there was a need to introduce more stability to the home care workforce by reducing casual labour. However, it should be noted that some workers value the flexibility of casual employment.

For those who plan on leaving the sector, employment stability is a key factor. Between 10% and 20% of home care workers are planning on leaving their current employer in the next 12 months. The lack of

Figure 2: **Specific Services Provided** (Data for OT/PT/SW were not available for this figure)



Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study

Note: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc.

job security is among the top three reasons given by home care workers for leaving (after low wages and/or the lack of benefits). This finding is consistent with the finding that the separation rate for child care and home support workers tends to be higher than average.²⁵

Continuity and “Commodification” of Care

Home care workers have indicated that continuity of care is an important expectation in the sector. For them the emphasis on time-for-task in service delivery, and the associated perception of the “commodification” of services, leads to a feeling that they cannot provide the high quality care necessary to meet both consumers’ needs and their own sense of self-worth as workers.

Isolation and Lack of Support

The work setting in the home care sector has both positive and negative consequences. Some workers see working in a home setting as an opportunity to have more independence, autonomy and challenge in

their work. For others, working in private homes can be a source of stress, given the difficulties of working in often unsatisfactory conditions (e.g., unsanitary houses, conflict with family members) and without close professional supports.

Workers noted the lack of supports available for home care workers. This is attributed to isolation in the work setting and also to the lack of time available for supervisors and/or peers to provide support. In addition, because home care workers are working outside institutional settings, they are often faced with providing services without the necessary equipment and supports to provide care. Several facts were noted.

- Between one-third and one-half of home care workers indicated that they occasionally or frequently did not have adequate supplies to provide the appropriate level of care. OT/PT/SWs identified that having better equipment and supplies to assist in the provision of home care services was

²⁵ See the report *Human Resource Issues in Home Care in Canada: A policy perspective* (www.hc-sc.gc.ca/homecare/english/hr1.html).

one of the top three ways in which working conditions in the sector could be improved.

- Approximately 60% of home care workers felt that they did not have adequate time to give the appropriate level of care.
- Approximately 40% of workers felt that they had inadequate information about the care plan.
- About one-third felt that they had inadequate contact with their supervisor or case manager.
- Focus group participants and key informants also noted the limited interface between workers and supervisors in the home care setting.

The level of concern about isolation and quality of care does not vary among workers across types of service delivery organizations or between unionized or non-unionized workers. This suggests that these conditions are realities of the home care workplace, more than a reflection of the worker's relationship with his or her employer.

However, there are areas in which the employer can reduce the isolation and increase integration within the sector, for example, through the use of paid time for staff meetings and meetings with informal caregivers. Yet, the following characteristics were noted.

- While professional staff are more likely to be paid for staff meetings (between 79% and 92% of professional workers), only 50% of HSWs are paid for these meetings. Those in private agencies are less likely to be compensated for this time than those working in government or RHA settings.
- RNs (67%) and OT/PT/SWs (92%) are considerably more likely to be paid for meetings with informal caregivers than HSWs (18%).
- Focus group participants identified the need for more coordination of informal caregivers with the formal care sector.

Occupational Health and Safety

Occupational health and safety is a particular concern for home care workers. Home care workers may face difficulties with unsanitary conditions in the home, lack of cooperation from the consumer, and verbal abuse from the consumer or informal caregiver.

²⁶ This is higher than the average of 7.2% for full-time workers in health occupations across Canada (see *Canada's health care providers*, p. 86, at www.cihi.ca).

²⁷ The lack of competitive compensation, especially for home support workers, relative to workers in hospitals and long term care facilities, is frequently reported as a problem for the recruitment and retention of home care staff (see *Human Resource Issues in Home Care: A policy perspective* (www.hc-sc.gc.ca/homecare/english/hr1.html)). The same report also notes that child care and home support workers had lower wages than other health care workers (annual salaries for full-time workers of \$ 26,900 and \$35,700, respectively, in 1995).

Between 10% and 15% of home care workers (excluding OT/PT/SWs) missed work in the past 12 months because of work-related injury.²⁶ On average, they lost between 1.5 and 1.9 months. Between 7% and 15% home care workers (including OT/PT/SWs) missed work in the past 12 months due to work-related stress. On average, they lost between 0.7 and 1.2 months of work. Focus group participants and key informants indicated that workers were experiencing higher levels of stress because of the increasing complexity of cases and employment instability. Some 14% of OT/PT/SWs plan on leaving their employer within the next 12 months; the top reasons for doing so are job stress and poor working conditions.

Informal Caregivers

Informal caregivers are also concerned about the isolation and the lack of supports for the tasks they are required to perform. Focus group participants identified the need for more coordination of informal caregivers with the formal care sector. Yet, as noted above, there are barriers to formal care providers providing the necessary supports to informal caregivers. Home Support Workers, unlike professionals, tend not to be paid for time spent meeting with informal caregivers.

The isolation faced by informal caregivers leads them to call for a range of supports. One-third wanted someone to provide respite care and one-quarter wanted emotional or mental health support for himself or herself.

Wages and Benefits

Sector-Level Issues

There is lack of parity in wages and benefits between different sub-sectors in the home care sector and between the home care and institutional sectors, in some regions.

Overview

Home care workers in some provinces receive the same wages as their counterparts in institutional settings. However, in most provinces they do not.²⁷ There are no data on the comparability of benefits, but

key informant interviews suggest that benefits in the home care sector are not comparable with those in institutional settings. Key informants and focus group participants indicated that the lack of parity in wages and benefits is a critical issue in the sector in regard to both attracting and maintaining workers.

Hourly Wages

Table 14 provides an overview of average hourly wages by union status and type of employer for RNs, LPNs, OT/PT/SWs, and HSWs.²⁸ Consistently, across all four occupational groups, persons working for

government or regional health authorities received the highest rates of pay. The pay structure between private not-for-profit agencies and private for-profit agencies was mixed. RNs and LPNs typically received higher rates of pay in not-for-profit agencies, while OT/PT/SWs and HSWs received higher salaries in for-profit agencies.

RNs and HSWs in unionized agencies received significantly higher salaries. There was less of a difference in hourly wages in regard to union status for LPNs. However, OT/PT/SWs received higher salaries in non-unionized settings than in unionized settings.

Table 14: Average Hourly Wages by Union Status and Type of Employer

| | Government/Regional Health Authorities | Private Not-For-Profit | Private For-Profit* | Overall |
|--|--|------------------------|---------------------|---------|
| Registered Nurses (RN) | | | | |
| Unionized | \$26.41 | \$23.29 | \$23.57 | \$25.36 |
| Non-unionized | \$24.32 | \$23.13 | \$21.17 | \$22.04 |
| Overall | \$26.36 | \$23.23 | \$21.78 | \$24.38 |
| Licensed Practical Nurses (LPN) | | | | |
| Unionized | \$18.37 | \$18.09 | \$16.64 | \$17.91 |
| Non-unionized | \$19.72 | \$18.10 | \$16.06 | \$17.25 |
| Overall | \$18.59 | \$18.09 | \$16.24 | \$17.63 |
| Occupational Therapists, Physiotherapists, and Social Workers (OT/PT/SWs) | | | | |
| Unionized | \$26.78 | N/A | \$28.63 | \$26.97 |
| Non-unionized | \$30.25 | \$25.56 | \$32.75 | \$31.81 |
| Overall | \$27.04 | \$25.56 | \$31.50 | \$28.17 |
| Home Support Workers (HSW) | | | | |
| Unionized | \$14.65 | \$11.74 | \$13.07 | \$13.49 |
| Non-unionized | \$13.42 | \$11.52 | \$11.79 | \$11.95 |
| Overall | \$14.41 | \$11.66 | \$12.04 | \$12.71 |

* The Survey of Formal Caregivers did not include individuals working in private practice such as psychologists.

Source: Survey of Formal Caregivers, Canadian Home Care Human Resource Study

Note: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, etc

²⁸ The study examined a number of factors that could potentially affect wages (occupational group, service delivery model and union status). However, there are potentially other factors (e.g., tenure, age, education) that might affect wages and that were not examined in the current study.

Table 15: **Care Delivery Models**

| | |
|---|---|
| Public-provider model (PP) | Professional and home support services are delivered mainly by publicly funded employees. Examples include Manitoba, Saskatchewan, Quebec, Prince Edward Island, Yukon, Northwest Territories and Nunavut. |
| Public-professional and private home support model (PHS) | All professional services are delivered by public employees. Home support services are contracted out to private not-for-profit and private for-profit agencies. Examples include New Brunswick, Newfoundland, and British Columbia. |
| Mixed public-private model | Streamlining functions are provided by public employees. Professional services are provided by a mix of government/RHA employees (predominantly) or through contracting out to private, third-party agencies. Home support services are contracted out to for-profit and not-for-profit agencies. Examples include Nova Scotia and Alberta. |
| Contractual model | Single entry coordinating functions are provided by employees in publicly funded Community Care Access Centres (CCACs). Professional services and home support services are contracted out by CCACs to private agencies (for-profit and not-for-profit) which provide care to consumers. This model reflects home care in Ontario as organized through its Community Care Access Centres. |

There was a consistent difference seen in salaries for RNs and LPNs. Full-time workers had the highest salaries, followed by part time workers, followed by casual workers. However, for OT/PT/SWs the highest wages were received by part-time workers, and for HSWs the highest salaries were paid to casual workers. There was also a fairly consistent pattern for full-time RNs and LPNs working in government/RHAs to receive the highest salaries, part-time workers were the next highest and casual workers had the lowest salaries. However, in private for-profit agencies, casual RNs and LPNs received the highest salaries.

As part of the analysis for this study, home care service delivery models were grouped into four categories. Table 15 provides definitions for the four types of delivery models used for this study.

An analysis was conducted of salary rates for each of the four delivery models. For registered nurses who were unionized, the highest salaries were paid in the public/private model and the lowest in contract models. For non-unionized RNs, the highest salaries were in the public model and the lowest were in the public/private model. While wages in unionized agencies (\$25.22) were higher than non-unionized agencies (\$21.96) overall, the highest hourly wages were in unionized agencies in the public/private model

(\$27.43) followed by non-unionized RNs in the public model (\$26.67). The findings for LPNs were more mixed. Unionized LPNs with the two highest hourly wages were in the public (\$18.49) and contract (\$18.12) models. The highest hourly wages for non-unionized LPNs were paid in the contract model. For unionized HSWs the highest salaries were in public/private (\$16.47) and public (\$14.62) models while for non-unionized HSWs, the lowest hourly wages were paid in these same two models at \$9.36 and \$7.75 respectively.

With regard to RNs, hourly wages in the government/RHAs were highest for public/private models (\$27.92). The highest hourly wages for not-for-profit agencies were in the contract model (\$23.40) and for the for-profit agencies the highest hourly wages were in the public model (\$23.49). Similarly mixed results were also found for the other occupational groups.

Benefits

According to the results from the survey of paid care providers, home support workers reported receiving proportionally fewer benefits compared to the other occupation groups (see Figure 3). The survey collected information on benefits that were either fully or partially paid for by the employer.

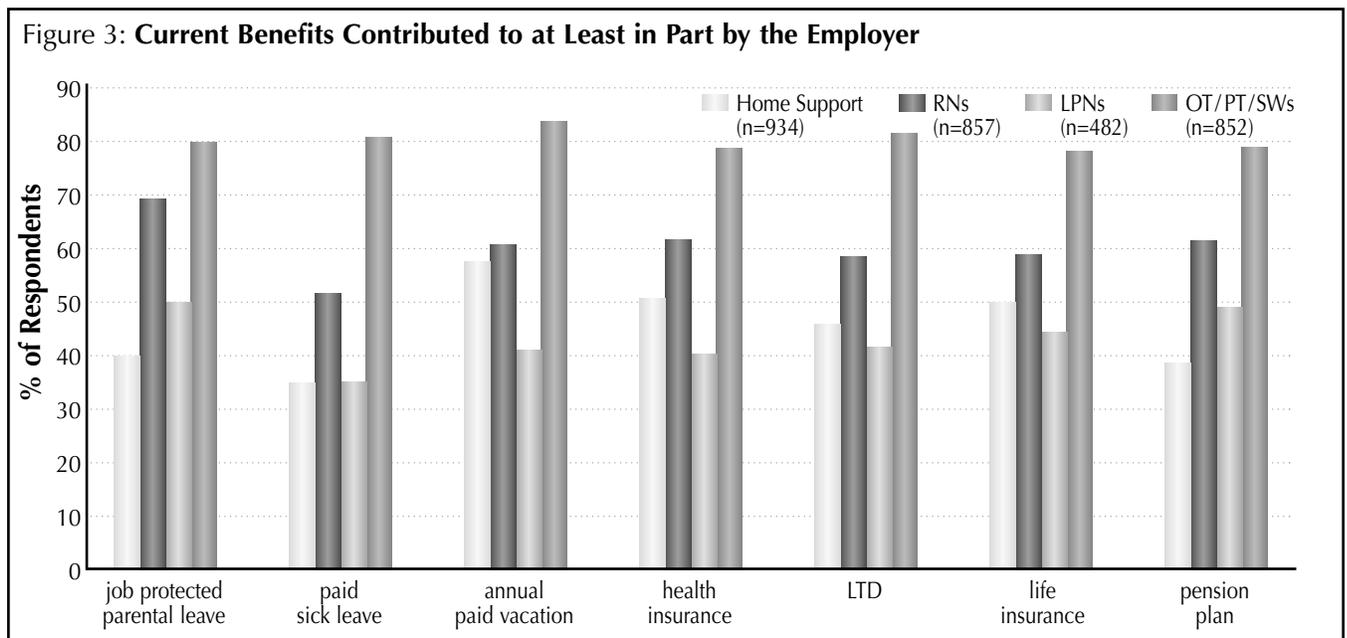
The most frequently cited benefit was annual paid vacation with approximately one-half or more in each group indicating that they received the benefit (except for LPNs). Other benefits were noted as follows.

- Only one-third of home support workers (34%) reported that they received paid sick leave. About one-third of home support workers (38%) had a pension plan to which the employer made contributions. Less than one-half (40%) had job-protected maternity leave.
- With the exception of job-protected parental leave at 50%, less than one-half of LPNs reported employer contributions to other benefits.
- Across all occupation groups, workers with private, third-party employers received proportionally fewer benefits when compared with workers in government or RHAs.

Other areas of compensation

Other compensation issues addressed in the survey of formal care providers were: whether workers were paid for coffee or meal breaks; paid for preparation and planning time; provided association memberships; paid to attend staff meetings; or, paid for meetings with consumers' informal caregivers.

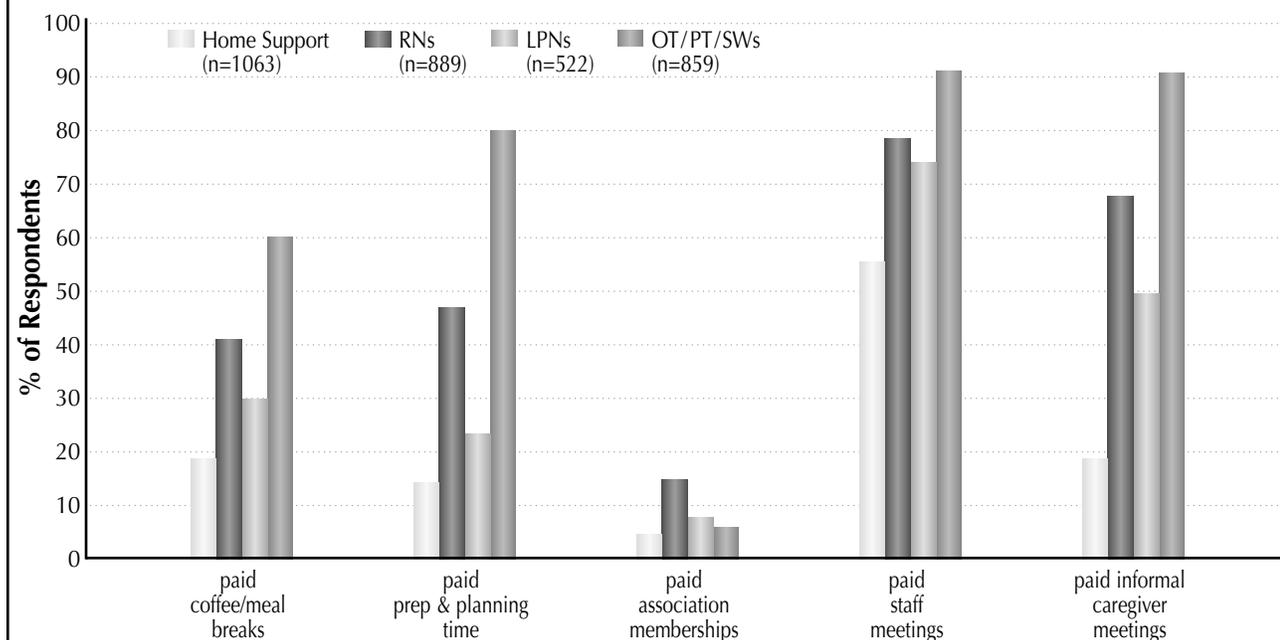
- As illustrated in Figure 4, HSWs most frequently reported rarely being compensated for staff meetings. Slightly more than one in ten workers (13%) reported that they received paid compensation for preparation and planning time. Similarly, small proportions received compensation for coffee or meal breaks (18%) and meeting with informal caregivers (18%). HSWs in private agencies were less likely to receive compensation for these areas in comparison with care providers who worked for government or RHAs.
- RNs were more likely to receive compensation for staff meetings (79%) and meetings with informal caregivers (67%), than compensation for time spent on preparation and planning (47%) or for coffee or meal breaks (42%). Differences were once again found between private agencies and government/RHAs in this area with private employers being less likely to provide compensation.
- LPNs reported a pattern similar to that of the RNs.
- The majority of OT/PT/SWs reported that they received compensation for meetings with informal caregivers (92%), staff meetings (92%), and planning and preparation time (80%). Approximately 60% indicated that they received compensation for coffee and meal breaks.



Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study.

Note: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc.

Figure 4: Other Areas of Compensation



Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study.

Note: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc.

Unpaid Work

One issue that respondents to the survey of formal care providers were asked to comment on was the number of hours they worked in an average week for which they were not paid. As illustrated in Table 16, these ranged on average from over two hours per week for HSWs to over three hours per week for the other three occupational groups.²⁹

With the exception of OT/PT/SWs in private not-for-profit agencies, the average number of unpaid hours was lower for workers in government/RHAs compared to their colleagues in private agencies. In the private agencies, the average number of unpaid hours was higher in the for-profit group compared to the not-for-profit group for RNs.

Within the RN, LPN and OT/PT/SW groups, unionized workers reported on average significantly fewer unpaid hours within a week. However, for HSWs the average hours of unpaid work were higher for union-

ized workers (2.6 hours) compared to non-unionized workers (2.4 hours).

With the exception of HSWs, the average number of unpaid hours was significantly higher for workers in the Contractual Model across all occupational groups (4.0% to 4.9%) compared to the public, public/private, and mixed models of care delivery (1.1% to 2.8%).

Satisfaction with Salaries

According to the survey of formal caregivers, as demonstrated in Table 17, levels of satisfaction with pay varied across occupational groups ranging from a low of 33% among LPNs to a high of 60% among OT/PT/SWs. In all occupational groups, there were higher levels of satisfaction with pay among the persons working for government/RHAs compared with workers in private agencies. However, except for LPNs where there was almost no difference in satis-

²⁹ Some 16% of health care workers worked some paid or unpaid overtime in the year 2000 (see *Canada's health care providers* (p. 71) at www.cihi.ca). In addition, in a series of focus groups in five provinces conducted in 1995, the Canadian Association for Community Care found that workers may have downtime during the day resulting in being on the job for 12-14 hours in order to accumulate 6-8 paid hours of work (see *Human Resource Issues in Home Care in Canada: A policy perspective* at www.hc-sc.gc.ca/homecare/english/hr1.html).

Table 16: Unpaid Hours in an Average Week

| Group | Gov't/RHAs Average | Private Not-For-Profit Average | Private For-Profit Average | Overall Average |
|--------------|--------------------|--------------------------------|----------------------------|-----------------|
| Home Support | 1.8 | 2.8 | 2.9 | 2.6 |
| RNs | 2.1 | 3.6 | 4.8 | 3.5 |
| LPNs | 1.2 | 3.6 | 4.0 | 3.7 |
| OT/PT/SWs | 1.8 | 1.0 | 5.6 | 3.1 |

Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study

Note: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, union status, etc.

Table 17: Percent “Satisfied” or “Very Satisfied” with Their Current Level of Pay

| Group | Gov't/RHAs (%) | Private Not-For-Profit (%) | Private For-Profit (%) | Overall Satisfaction (%) |
|--------------|----------------|----------------------------|------------------------|--------------------------|
| Home Support | 60 | 22 | 32 | 38 |
| RNs | 66 | 29 | 44 | 47 |
| LPNs | 67 | 29 | 28 | 33 |
| OT/PT/SWs | 69 | 40 | 43 | 60 |

Source: Survey of Formal Caregivers, Canadian Home Care Human Resources Study.

Note: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, union status, etc.

faction levels between private not-for-profit and for-profit agencies (29% compared to 28%), satisfaction levels with salaries were higher in for-profit agencies than not-for-profit agencies.

Unionized workers, with the exception of LPNs, reported significantly higher proportions of satisfaction with their current level of pay (45% to 60%) than non-unionized workers (32% to 51%). The percentage of LPNs who were satisfied or very satisfied was 34% for unionized workers and 32% for non-unionized workers. Overall, workers in the Contractual Model were the least satisfied across all occupational groups at 28% to 45%, compared to the other three models of care delivery where satisfaction levels ranged from 34% to 71%.

Individual-Level Issues

Wages and benefits do not meet expectations of formal care providers. They act as disincentives for people entering and remaining in the sector. Some informal caregivers require additional supports such as respite or training.

As was the case with working conditions, wages and benefits generally do not meet the expectations of formal care providers. Some specific issues were as follows.

- On average, home care workers spent five to six hours a week in travel time. Providing compensation for travel time was identified as one of the top three ways in which working conditions in the home care sector could be improved for all formal home care workers.

- Between 10% and 20% of paid home care workers are planning on leaving their current employer in the next 12 months. Low wages and the lack of benefits are among the top three reasons given for leaving.
- Focus groups with home support workers indicated that they do not believe they are paid enough to compensate them for the level of care they provide.

About one-quarter of informal caregivers indicated that they would like financial assistance for providing care as well as various other supports.³⁰

Nature of Home Care Services

Sector-Level Issues

The main distinguishing feature of services is the setting in which they are provided (i.e., the home). This differentiates the sector from other sectors that are based primarily on occupation and less on place of work (e.g., physicians, social workers, etc.). The sector involves a range of occupational groups, such as nurses, licensed practical nurses, home support workers, case managers, therapists, dietitians and psychologists. Another defining feature is diversity, both of services and who delivers the services (e.g., professionals, home support workers, family members, volunteers, friends, neighbours).

The defining aspect of this sector, which makes it distinct from other sectors, is that it is in part defined by where people work, rather than by what people do at work. There is a wide range of services being delivered in the home. These services range from basic activities of daily living (such as housekeeping and meal preparation) to advanced clinical care activities (such as administration of intravenous medications and tracheotomy care). In addition, because home care services are under provincial/territorial jurisdiction, there are different models of delivery of home care services in the various jurisdictions across

Canada. The occupational diversity, combined with different models of delivery, makes the development of cohesive national HR strategies difficult.

Individual-Level Issues

The profile of home care workers is varied with overlap in the services provided by different occupational groups. Informal caregivers and volunteers are providing services previously provided by formal care providers or in institutional settings.

Due to the range of services required in the home care sector, the tasks carried out by workers vary considerably. Consequently, the skill levels required and the education and experience of workers in the sector vary considerably, from some home support workers who have not graduated from high school to professional providers who have graduate degrees.

About one-third of HSWs consider themselves to be underemployed. The tasks carried out by professional home care workers are more likely to be well defined by their profession and, hence, it is less likely that they will feel underemployed. HSWs working in the private sector, and non-unionized workers, are more likely to consider themselves underemployed than those working for government/RHAs or unionized workers. Focus groups and key informant interviews suggest that there could be more delegation of duties from RNs to LPNs and from LPNs to HSWs.

There is also some overlap between the tasks of professionals in the formal caregiving sector and informal caregivers. Up to 8% of informal caregivers are carrying out clinical care tasks, such as wound care, or intravenous or respiratory therapy. However, the majority of informal caregivers are addressing instrumental activities of daily living needs, such as getting home care consumers to appointments, housekeeping, or ensuring home care recipients take their medications. Focus group participants and key informants identified the need for more integration of the services provided by formal care providers and informal caregivers.

³⁰ The recent First Ministers' Health Accord expressed a commitment to recognize the role of informal caregivers with a compassionate care benefit through the Employment Insurance Program.



Introduction

Based on the extensive review of the home care sector conducted for this study, the Steering Committee of the Canadian Home Care Human Resources Study has developed 10 recommendations to decision-makers for improving human resources in the home care sector. Aside from the first recommendation which is an overarching goal, each recommendation has a number of suggested strategies for implementing the recommendation. The recommendations and strategies to be addressed by decision-makers are presented below.³¹ The overall goal is for change in the home care sector. This is also the goal for Recommendation 1.

RECOMMENDATION 1:

Promote the provision of an appropriate supply, distribution and mix of adequately prepared formal care providers, informal caregivers and volunteers to meet population health and social needs for care at home.

The remaining nine recommendations have been broken down into two major groupings: strategies related to policy and strategies more directly related to human resources issues.

Strategies Related to Policy

RECOMMENDATION 2:

Define and promote the profile of the home care sector.

There is a clearly identified need to increase the recognition and the value that Canadian society places on work within the home care sector. The identity of the sector will have an impact on fundamental human resource issues such as recruitment and retention, the roles and relationships of workers, and the

recognition and compensation received by those involved in the sector. It should also be recognized that home care is more than a replacement for short term acute care; it also includes maintenance and preventive home care, and home care which serves as a substitute for care in long term care facilities.

Strategies

1. Gather and disseminate information on employment opportunities at the local and regional levels.
2. Increase the general public and decision-makers' (all levels, including governments, health and social system managers and trustees) awareness and understanding of the importance of the sector in an integrated health system.
3. Promote home care as an integral partner in the planning and delivery of health and social services at the national, provincial/territorial, health authority and local levels.
4. Enable the sector to maintain and enhance its own status and raise the awareness of its services within the overall health community, particularly with other health and social services organizations with which home care shares consumers.
5. Promote the home care sector as an attractive career option within the health care sector by:
 - Emphasizing the opportunities for workers;
 - Emphasizing the independence and diversity of the workplace, and
 - Recognizing the wide range of client groups served.
6. Raise the recognition of the role and contribution of home support services.
7. Raise the profile of the home care team, with emphasis on the integral roles of formal care providers, informal caregivers and volunteers.
8. Provide recognition of the challenges, rewards and benefits of informal caregiving and volunteering.

³¹ The recommendations in this section mirror recommendations from other studies. For example, Andrea Baumann and others, in their report *Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system* (www.chsrf.ca) note the importance of: the need for adequate funding; ensuring an adequate supply of workers; investing in education and training; ensuring reasonable workloads; promoting workplace health and safety; and issues related to recruitment and retention. Similar issues are noted in the final report of the Canadian Nursing Advisory Committee entitled *Our Health, Our Future: Creating quality workplaces for Canadian nurses* (www.hc-sc.gc.ca/english/for_you/nursing/cnac_report/index.html).



RECOMMENDATION 3:

Re-examine the organization and funding of the home care sector.

Broader organizations at regional, provincial/territorial and national levels, and funding issues have had a significant influence on human resources in the home care sector. It is critical that these be addressed in order to ensure that the sector can continue to meet the needs of Canadians.

Strategies

1. Promote the continued integration of home care within health care systems (provincial systems and regional health authorities).
2. Promote the integration of services within/among provincial/territorial ministries (housing, health, social services, education, criminal justice).
3. Promote the need for sustainable funding to provide home care for the short and long term to all populations – e.g., children, persons with disabilities, seniors, Aboriginal peoples, mental health consumers and all individuals with an acute or chronic illness, including specialized care, as required.
4. Encourage home care organizations to become accredited through existing, recognized accreditation programs.
5. Promote and equalize the voices of all members of the team – including home support workers.
6. Introduce or increase multiple supports for informal caregivers, such as income and employment security, and respite opportunities.

Strategies Related to Human Resources Issues

RECOMMENDATION 4:

Promote the provision of appropriate compensation (wages and benefits, including pensions) for people providing home care.

There is a lack of parity in wages and benefits between different sub-sectors in the home care sector, and between the home care and institutional sectors, particularly in some regions. Wages and benefits often do not meet the expectations of formal care providers, thereby acting as disincentives for people entering

and remaining in the sector. Similarly, informal caregivers often face financial hardships as a result of their caregiving responsibilities.

Strategies

1. Address wage and benefit inequalities within occupational groups across settings (comparable to workers in other health sectors)
 - Differences internal to the sector in regard to types of providers;
 - Differences internal to the sector within and across jurisdictions;
 - Differences resulting from the model of service delivery; and
 - Differences across health sectors;
2. Conduct ongoing research on compensation within the home care sector to monitor the relative equity of wages and benefits over time and across geographic areas; and
3. Enable informal caregivers to continue caregiving with full consideration of their needs and responsibilities (e.g., need for emotional and financial support, and flexibility to meet other home and family obligations).

RECOMMENDATION 5:

Improve working conditions for both formal care providers and informal caregivers in the home care sector.

The research documented the need to provide an improved workplace and working conditions for those in the home care sector. Improved working conditions are critical to the retention and recruitment of workers and the provision of high quality care.

Strategies

1. Promote the availability of appropriate equipment and supplies.
2. Enable workers to work at the full scope of their practice and/or training.
3. Review labour practices in the home care sector to ensure that they meet current labour legislation requirements (e.g., unpaid overtime).
4. Provide reasonable compensation for work-related travel time and mileage.
5. Increase flexibility in the work place to accommodate employee preferences (e.g., shifts and schedules) and to improve the continuity of care.

6. Promote a safe and healthy working environment for formal care providers, informal caregivers and volunteers.
7. Provide supportive working conditions for workers, informal caregivers and volunteers to enable them to provide quality care.
8. Promote the provision of adequate supervision and the availability of supports and resources for caregivers and volunteers.
9. Improve the availability of respite services for informal caregivers.
10. Educate informal caregivers and care recipients about the benefits of respite care.
11. Promote the development of a career ladder, particularly for home support workers.

RECOMMENDATION 6:

Enhance management practices and supports.

Similar to improved working conditions, the quality of organizational leadership will positively affect the recruitment and retention of workers as well as the delivery of high quality home care services.

Strategies

1. Encourage employers to create an organizational culture in which direct care providers have meaningful opportunities for ongoing interaction, communication and involvement in decision-making.
2. Provide employer incentives for the creation of a quality work life.
3. Reflect and demonstrate cultural awareness and diversity in hiring practices and service delivery – striving to build a culture of acceptance of diversity among paid care providers, informal caregivers and volunteers.

RECOMMENDATION 7:

Develop strategies for educational preparation, formal continuing education and employer-provided training to facilitate the availability of qualified home care providers.

Research findings indicate that there are challenges in ensuring a match between consumer needs and work skills, both at entry into the sector and on an on-going basis. Similarly, both formal care providers and informal caregivers express a desire for education and training opportunities.

Strategies

1. Promote the development of national occupational standards for home support workers by:
 - Identifying the core competencies for home support workers,
 - Developing educational curricula that address the core competencies, and
 - Increasing access to home support worker educational programs.
2. Promote the basic education of all workers in home care to meet current and evolving needs, including those resulting from technological developments.
3. Integrate home care into health and social services education programs, including home care content and team work concepts as part of the curriculum for all health providers and health administrators.
4. Provide interdisciplinary education programs and practicum opportunities at all levels, as appropriate.
5. Improve access to education and training for rural, remote, inter-provincial and Aboriginal populations.
6. Implement professional development across the home care sector through employer-provided specialty training and continuing education to meet needs related to local demographics and changing population health needs.
7. Develop and implement educational programming at the university/college/ vocational training level that:
 - Provide sufficient time and program content to prepare entry level workers to practice safely in home care;
 - Adjust funding of entry level worker education and training to address the required training and workplace readiness development required by young “recruits”; and
 - Address funding for post-basic education and training for all levels of providers, especially programs that specifically target home care education and competency.
8. Increase the places/seats in educational institutions, as appropriate, for all levels of formal care providers.
9. Promote prior learning assessment and other means of facilitating access to education and the workforce.
10. Target promotion of employment opportunities in the sector to specific groups of new entrants as well as educational institutions.

11. Build on and promote a range of educational opportunities for informal caregivers and volunteers.
12. Develop national guidelines for informal caregivers and volunteers with regard to care provision.

RECOMMENDATION 8:

Address the opportunities and challenges in using technologies to enhance the delivery and quality of home care services, including the impact on caregivers.

Technological changes have, and will continue to have, multiple, significant impacts on the home care sector.

Strategies

1. Identify and promote opportunities to use technology to improve the quality of care and working conditions in the home care field, including diagnosis, care/treatment, occupational health and safety, client and worker education, communication within and across health care teams (e.g., electronic health care record), tele-health, and the provision of support.
2. Provide education and training to address the use of technology.
3. Identify and address current and emerging challenges posed by new technologies.
4. Promote awareness of the impact of new technologies, particularly on paid care providers, informal caregivers and volunteers, and ensure that mechanisms are in place to enable caregivers to effectively use technology.
5. Promote training in tele-health, video conferencing, and other uses of technology that will increase the efficiency and effectiveness of care delivery.

RECOMMENDATION 9:

Develop information systems to collect appropriate data, and conduct timely, policy-relevant research to support health human resources management and planning activities.

The complexity and diversity of the home care sector has contributed to a dearth of consistent, accurate data to inform human resource planning and decision-making. The research for the Home Care Human Resources Study has provided an important base of

data on which to continue to build. In addition, it is crucial that data collected for the home care sector be integrated, on an ongoing basis, into broader health human resources data collection processes.

Strategies

1. Identify and prioritize information required to support health human resources management and planning activities.
2. Promote home care as a priority for the development of a national information system.
3. Identify the data elements for a national Health Human Resources Minimum Data Set (MDS) to facilitate data collection activities pertaining to health human resources in home care.
4. Review existing data, data gaps, processes, and available infrastructure, to support data collection, and develop an implementation plan to collect and integrate the data required.
5. Identify enhancements to existing data collection systems to better meet emerging information requirements pertaining to health human resources in home care (e.g., Canadian Institute for Health Information, Statistics Canada, Citizenship and Immigration Canada).
6. Require that data collection and research activities comply with federal/ provincial/territorial privacy legislation.
7. Educate data providers about the need for data collection and ensure that mechanisms are in place to facilitate the availability of data to support reporting, analysis, and research activities pertaining to health human resources management and planning activities, at local, regional, provincial/territorial and national levels.
8. Initiate research to develop a model for predicting future utilization of home care services.
9. Develop a national health human resources agenda for home care with appropriate targeted funding;
10. Develop a process to ensure that data, analytical reports, and research activities continue to meet the evolving needs of stakeholders.
11. Promote research on home care human resources as it pertains to rural communities and Aboriginal peoples.

RECOMMENDATION 10:

Recognize the central and integral role of informal caregivers and volunteers and the benefits they provide to people's lives and well-being.

By far, the largest portion of home care in Canada is provided by informal caregivers. The range of care and services provided is extremely varied. Often caregiving is a 24-hour-a-day responsibility that is monopolizing of time and resources. Frequently, caregiving responsibilities must also be balanced with other family and work responsibilities. The need to increase the recognition and support for informal caregivers has been clearly documented.

Strategies

1. Recognize the challenges, rewards and benefits of informal caregiving and volunteering.
2. Encourage respect for the client's and informal caregiver's choices.
3. Recognize the right of informal caregivers to choose the nature and duration of their caregiving responsibilities.
4. Recognize the requirement for a safe and adequate working environment to support caregivers providing quality care.
5. Identify existing supports and promote the development, availability and accessibility of multiple supports (e.g., financial, respite, education, job and income protection) to enable informal caregivers to fulfill their roles.
6. Promote the development and availability of multiple supports for volunteerism and volunteers in home care, including: promotion; training; standards; support; and compensation for out-of-pocket expenses.
7. Provide training opportunities for informal caregivers and volunteers.
8. Increase public awareness and recognition of the importance of informal caregiving.



An Overview of Emerging Issues and Trends in Home Care Service Delivery

| Emerging Issue/Trend | Summary of Issue/Trend |
|--|---|
| Pediatric Home Care | The goal of pediatric home care is to teach the family or caregiver ways to provide appropriate care to the child. In pediatric home care, families are necessary participants in the care of the child and often influence the success of the home care service for the child. ¹ Specialized pediatric services can now be provided in the home (e.g., for low-birth weight neonates and children with cancer) with only the very sick remaining in hospital. Such specialized services, however, are generally based only in urban areas. Some community services also have a specialized capacity for assessment and coordination of complex services and can provide direct services to children with complex needs. |
| Home Care for Different Ethnic Groups | There is very limited published research in Canada on the accessibility of home care within various ethnic communities. Although references to specific populations have been made in several reports and presentations regarding the barriers to accessing services because of language and/or cultural traditions, a systematic review of home care accessibility has not been conducted. It is important to recognize that recent immigrants to Canada, coming from non-European countries, may have family and religious/cultural situations that are quite different from those of the rest of the population and may experience barriers in accessing services. |
| First Nations and Inuit Home Care | Canada's First Nations and Inuit (FN&I) have specific issues and desires that need to be part of home care initiatives. Life expectancy for FN&I is much shorter than it is in other populations. Reflecting this lower life expectancy rate, FN&I seniors are defined as age 55 or over. Only 4% of FN&I people are 65 or older, compared with 12% of the rest of the population in Canada. Within First Nations and Inuit communities, diseases and/or disabilities are twice as prevalent as in other communities; diabetes, for example, occurs three to five times more often among FN&I people than in the rest of the population in Canada. ² Despite targeted home care services, the specific needs of these populations are sometimes not taken into account. Thus, home care provided through the First Nations and Inuit Home Care program is a particularly important resource for First Nations and Inuit communities. |
| Home Care for Mental Health Consumers | There is an emerging recognition of the importance of providing home care services for persons who require mental health services. This is also an important area for informal caregivers and volunteers who may have to deal with stress, burnout, and grief related to the death of a loved one. |

¹ Balinsky, W. (1999). Pediatric home care: reimbursement and cost benefit analysis. *Journal of Pediatric Health Care* 13, 288-294.

² Wentworth, J. (1998). *First Nations home care: Needs and expectations*. Paper presented at the National Conference on Home Care, Health Canada and NS Department of Health, Halifax, Nova Scotia.

| Emerging Issue/Trend | Summary of Issue/Trend |
|--|---|
| Home Care for Persons with Disabilities | <p>The uniqueness of the disabled population needs to be recognized within home care programs that are often designed with the elderly population in mind. Adults with disabilities prefer to have personal assistance services in the community and not just in the home, to enable their participation in the workplace, whereas home care services are viewed by the elderly as an alternative to institutional care and are rarely provided outside the elderly person's home. The disabled population strives to reduce or eliminate involvement from the medical community, while the elderly population frequently encounters professionals. Finally, the extent to which the disabled person is interested in managing his or her own care is much higher than it is among the elderly. In fact, people with disabilities are striving to manage their own care needs. In Canada, the term "self-managed care" describes the method of service delivery that gives consumers more control and responsibility over the coordination, management and provision of their own care.</p> |
| Shift from Acute Care to Home Care | <p>There have been concerns that consumers are being discharged from hospital "sicker and quicker" than ever before, which means that the community-based system of care must be able to address the ever increasing and more complex care needs of consumers. Consumers are now also being discharged with requirements for equipment and high-level nursing care. There is also concern that workers in the home care environment do not have the knowledge base to provide such care adequately. These concerns are even more critical in rural settings, where workers in home care agencies may not have access to the technology required or use it so infrequently that the skill base is not fully developed. Thus, there has been an increasing focus on acute home care, resulting in a decrease in long term and preventative home care.</p> |
| Decrease in Preventive and Maintenance Home Care Services | <p>The rationalization of home care has focused predominantly on the support services, such as housekeeping, meal preparation, and laundry – the very services that many stakeholders and providers generally believe make a difference in determining whether someone remains in the community independently or moves into a long term care facility. Reductions in housekeeping have been occurring for several years, as budgets have not kept up with the increased demand brought about primarily by the increase in post-acute care, the aging population, new drug therapies, and technological advances that have made almost anything possible in home care. Such reductions may lead to a greater dependency on families and more use of privately funded home care (outside the publicly funded system).</p> |
| Issue of the Sustainability of Public Funding for Home Care | <p>Although home care programs are receiving more funding, the funding levels are not enough to address to the care needs of the home care recipients. As a result, decision-makers are rationalizing services, often in the absence of evidence as to which services make a difference and to whom. Home care as an entitlement program has been replaced by programs based on eligibility criteria. Eligibility, however, has been narrowed for some services. There are waitlists for services in many places, and home care organizations are having to triage services. With the public system harder to access, increasingly more individuals seem to be seeking private care outside the publicly funded system.</p> |

| Emerging Issue/Trend | Summary of Issue/Trend |
|---|--|
| The Increasing Role of the Private Sector in Home Care | <p>As the demand for services exceeds the available supply, it can be expected that more and more services will be paid for directly by individuals and/or their families. Among policy-makers, however, there is a recognition that not enough is known about the nature and extent of these “private pay” arrangements. Not having information on the supply of, and demand for, services paid for by individuals and/or families makes it difficult to determine the extent to which programs and services are meeting, or not meeting, the expectations of the general public.</p> |
| Impacts of Information Technology on Home Care | <p>There has been an increasing growth of high technology in the home environment. Intravenous (IV) therapies, chemotherapy, dialysis and epidurals, and tele-home care and tele-distance learning, are some of the technologies being used. Staff providing such services could require higher levels of pay to reflect their backgrounds. With higher pay the cost of providing services goes up and there is also a greater need for technical support for a range of equipment being used. Family members may require training to use the equipment and to fix malfunctions. Their capacity for understanding what is required of them, and indeed, their willingness to operate the equipment, will also vary from home to home. There has also been an increase in matters such as tele-health in the home care sector.</p> |
| Shortages of Home Care in Rural and Remote Areas | <p>Fewer specialists practice in the rural areas because the numbers of consumers do not warrant specialized care at the expense of generalists. For example, there are shortages of speech pathologists, mental health specialists, OT/PTs, and laboratory services are not always accessible. In addition to limited transportation and the associated costs of workers traveling long distances to see very few consumers, the informal support networks of family and friends are relied upon more heavily. In the North, the isolation issue is magnified ten-fold. In Nunavut, for example, there are many isolated communities with limited home care. When individuals can no longer remain independent in their homes, even with the traditional strong family supports, they must be relocated to southern Canada for facility-based care.</p> |
| Changes in the Structure and Funding of Home Care | <p>Home care does not exist in isolation from other services. Traditionally, in Canada, home care has been integrated into, or at least linked with, a range of other services often referred to as continuing care or long term care. It is not clear at this point if home care will continue to be part of a broader, integrated system which contains the full range of home, community, residential and acute care services or if more fragmented models will be adopted. However, whatever model is adopted it should maximize the integration of the full range of care services for home care consumers.</p> |

Source: Literature review, interviews, focus groups and expert input, Canadian Home Care Human Resources Study, 2002.



An Overview of Emerging Issues and Trends Related to Informal Caregivers

| Emerging Issue/Trend | Summary of Issue/Trend |
|--|--|
| Changing Family Patterns and Responsibilities | Over the past 30 years, family life in Canada has undergone major transformations: falling birth rates, the increased participation of women in the labour force, an increase in divorce rates, and a redefinition of family arrangements (e.g., single-parent families, reconstituted families, recognition of gay families). These new family forms vary from the “traditional family,” which seems to be the foundation of most social policies in the area of home care. How obligated and committed will former in-laws or step-relatives be when it comes to providing support to an “ex-in-law” or step-relation? Four central themes can be identified with regard to the changes experienced by family caregivers. First, there has been a significant shift in responsibility to the family caregiver. Second, the shift has led to growing levels of concern regarding the capacity of caregivers to cope (i.e., the negative effects on physical, mental, emotional, and financial health). Third, caregivers have not been engaged in a process to determine whether this shift is something to which they have willingly committed themselves. Fourth, the “value” of the family caregiving role has not been agreed upon in Canada. |
| Lower Fertility Rates | The birth rate of the population has decreased substantially from its peak during the post-war baby boom era of 1946 to 1963, when it peaked at an average 3.5 births per woman, to a current value of 1.6, which fails to replace the current population. The parents of the baby boomers often have many children to care for them. What is unclear is whether baby boomers, due to lower birth rates, will have the traditional family social supports available to them in their “golden years.” For persons with disabilities, this may also mean that fewer siblings will be around to help in providing care in the future. |
| Changing Mobility Patterns | Another factor affecting the accessibility of informal supports is the increased mobility of the population. Adult children’s proximity to elderly parents has been reported to be significant in terms of the amount and type of help they provide elderly kin. ^{1,2} Research on migratory patterns of the population indicate that Atlantic Canada, northern regions, and remote rural areas have historically experienced net out-migration, especially among youthful cohorts, and this will affect the accessibility of informal supports to provide everyday assistance in those parts of Canada. |
| Labour Force Participation of Women | The increased participation of women in the labour force is regularly cited as a factor in the availability of caregivers. Among women aged 30–34, 51% were in the labour force in 1976, compared with 78% in 1996. Relying on the informal support network to provide assistance in everyday activities in the future may not be realistic, given the changes in family structure and the changing role of women. Women who both work and provide care may have less time to devote to caregiving which may have implications for the sustainability of the caregiving relationship. |

¹ Joseph, A. & Hallman, B. (1996). Caught in the triangle: The influence of home, work and elder location on work-family balance. *Canadian Journal on Aging*, 15(3), 378-412.

² Chappell, N. L. (1992). *Social Support and Aging*. Toronto: Butterworths.

| Emerging Issue/Trend | Summary of Issue/Trend |
|---|---|
| Ideological Shifts | There appears to have been a shift in ideology from the position of universal access to health services to one of a shared responsibility for care between the state and families. This shift to an ideology of shared responsibility for care appears to be the result of perceptions about the apparent inability of governments to fully fund health services. This perception appears to persist in spite of recent evidence that home care can be a cost-effective alternative to residential care and acute care services. |
| Men as Caregivers | Research findings on men as caregivers are mixed. A study by Kaye and Applegate indicates that men may be assuming more caregiving responsibilities and providing more hands-on care than in the past. ³ In contrast, Guberman suggests that there is no real evidence that men are becoming more involved in caregiving and in particular that they are assuming, solely or in partnership, the primary responsibility for care. ⁴ It has been suggested that in areas of high male unemployment, such as the Maritimes, where women are often the sole supports to the family, men may have to move into the caregiving role. |
| The Aging of Caregivers | As life expectancy increases, both care recipients and caregivers are becoming older. As the spouse is the first in line to provide care, an increasing number of caregivers in their 80s and 90s are looking after their disabled spouses. Many caregivers are very frail or have chronic illnesses themselves. The Victorian Order of Nurses for Canada cites the following figures: one-third of care given to people over the age of 65 is provided by caregivers over the age of 70, and among daughters providing care, 30% are over 60 years of age. ⁵ The Canadian Study on Health and Aging found that 50% of informal caregivers caring for persons with dementia were over 60 years of age and one-third were over 70. ⁶ |
| Extended-kin and Non-kin Caregivers | The 1996 General Social Survey revealed that 24% of caregivers are non-kin friends, neighbours, co-workers, and ex-partners. ⁷ Within this group, there is a higher percentage of men than is normally found among kin caregivers. As well, among family caregivers, 20% are not spouses or children of the care receiver but rather more distant kin such as grandchildren, nieces, and nephews. |
| Ethno-Cultural Aspects of Caregiving | Some 9% of immigrants to Canada are identified as being older persons. The vast majority of these persons, 85.5%, are accepted to Canada as sponsored immigrants by a family member who is then responsible for them for the next ten years. Sponsored immigrants are ineligible for government assistance, including hospitalization, home care services and institutionalization. This places an extra burden on families when these people become ill or disabled. There is a dominant perception that families of minority ethno-cultural groups are more involved in providing care to their elders. One Canadian study of employed caregivers reported that the greater contributions of certain ethnic groups (e.g., Asian, East Indian) has more to do with structural characteristics than cultural ones. ⁸ Specifically, the structural factors of living arrangements and age were stronger predictors of the level of involvement in helping older relatives than were the cultural factors of filial obligation and belonging to a particular ethnic group. |

³ Kaye, L. W. & Applegate, J. S. (1990). *Men as caregivers to the elderly: understanding and aiding unrecognized family support*. Lexington, Mass.: Lexington Books.

⁴ Guberman, N. (1999). Daughters-in-law as caregivers: How and why do they come to care? *Journal of Women & Aging*, 11(1), 85-102.

⁵ Mellor, R. (1997). *The shift to the community, a home care dilemma: What's it doing to family caregivers?* Ottawa: Victorian Order of Nurses.

⁶ Canadian Study on Health and Aging. (1994). Patterns of caring for people with dementia in Canada. *Canadian Journal on Aging*, 13(4), 470-487.

⁷ Cranswick, K. (1997). Canada's caregivers. *Canadian Social Trends*, 47, 2-6.

⁸ Keefe, J., Rosenthal, C., & Beland, F. (2000). The impact of ethnicity on helping elderly relatives: Findings from a sample of employed Canadians. *Canadian Journal on Aging*, 19(3), 317-342.

| Emerging Issue/Trend | Summary of Issue/Trend |
|--|--|
| Caregiving Careers | Multiple caregiving involves one person looking after two or more dependent persons at the same time or sequentially. For many women, and some men, this reality can be conceptualized in terms of caregiving careers, where for the majority of their adult life, these people will be involved in the care of a dependent family member. The phenomenon of multiple caregiving may accelerate as the supply of caregivers decreases and more distant relatives are called into service. For example, childless elderly persons may turn to nieces and nephews, who may also have their own parents for whom they provide care. |
| Changing Values Concerning the Responsibility of Family Members | Another potential trend is the question of changing values with regard to the responsibility to care for family members. Since most female baby boomers have spent most of their adult lives in paid employment, they may have less of a tradition of caregiving and may not be quite as willing to become family caregivers. In order to juggle work and family demands, women and men have increasingly begun to purchase goods and services such as day care, babysitters, cleaning women, and prepared foods. This may legitimize their eventual recourse to private or public services for parent care. As well, since potential caregivers are now seen as having financial resources, some governments may lean to making home care services subject to a means test. |
| Caregivers Relationships with Home Care Programs | Caregivers are increasingly being identified by health and social service practitioners as having specific and often unmet needs for support, respite, information, and advocacy, which should translate into interventions aimed specifically at them. However, caregivers may not be officially registered as consumers of the health and social service system; the files are generally opened in the name of the care recipient. This ambiguity has led to a situation in which caregivers' needs may not be adequately considered in practitioners' evaluations and interventions. |
| Public Perceptions of Home Care | Research conducted by Anderson and Parent revealed a positive public attitude and desire for home care services to be available. "The appeal of home care was based on the public perception that it has advantages in terms of health outcomes and quality of life." ⁴² Canadians' positive attitudes toward home care were also supported by a public opinion poll conducted for Health Canada. The survey found that 68% of Canadians felt that persons in hospitals could be more efficiently and humanely treated in the comfort of their own homes. They were also somewhat critical of government as 27% felt that home care was just a way of passing off responsibilities for the sick to families who lack the resources to cope. |

Source: Literature review, interviews, focus groups and expert input, Canadian Home Care Human Resources Study, 2002.

⁹ Anderson, M., & Parent, K. (1999). *Putting a Face on Home Care: CARP's report on home care in Canada 1999*. Study conducted by Queens' Health Policy Research Unit.



Survey of Formal Home Care Providers

Data Limitations

When a survey is conducted on a sample of a population (as opposed to the whole population), then a quantifiable amount of error associated with the sampling procedure may occur. This is referred to as 'sampling error'. For the current survey of formal home care workers, the associated sampling error ranged from approximately +/- 2.5% to +/- 3.2% 19 times out of 20 depending on the occupational group (e.g., home support workers, RNs) and the specific proportion expressed (e.g., 25% satisfied, 50% increase, etc.).

In addition to sampling error, there are other components of survey error, known as 'non-sampling error', which are not quantifiable. They are reflected as limitations of the survey that may introduce some level of bias into the overall findings. For the current project, the main sources of non-sampling error include the following.

- *Frame coverage issues* – Since there is no complete listing of workers in home care, the team developed a survey frame by identifying workers through their employers. This led to gaps in the survey frame and the possible double counting of some workers.
- *Non-response bias* – This occurs when those individuals who did not respond to the survey differ systematically from those who did choose to respond. In order to protect the identity of the workers, employers distributed the survey to individual employees. As a result, the team does not know how many surveys were actually distributed or to whom. Assuming that all the surveys were distributed, the minimum response rate would be 39%, however the actual response rate may be slightly higher. The response rate was relatively even across occupational groups and regions. Since the team did not have a survey frame with information about individuals in the whole population, a non-response analysis was not possible.
- *Instrument design weaknesses leading to misleading questions or wrong interpretations by the respondent* – In order to minimize this non-sampling error, the team conducted iterative pre-tests with all of the occupational groups in various regions with different types of employers. In addition, analysis of the response pattern to individual questions did not indicate specific difficulties with any particular question. However, the survey results may be affected by variations in the way respondents understood the survey questions (e.g. how they calculated their hourly wage, what they identified as preparation or planning time).
- *Data processing, analysis and reporting errors* – The team used a number of procedures to reduce these errors, including 100% double key verification for all data entry and two-level review processes for all analysis work and for verification of transfer of results from statistical programming reports into the client reports.

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In addition to these limitations, which could be applicable to any survey, there are a number of areas of caution that the reader should take into account when reviewing the report and drawing conclusions. These include the following:

- *The purpose of the survey was to provide general, national level data to address human resource issues in the sector* – The purpose of the current survey was to collect general, national level information about the human resource issues that currently affect the home care sector. It just begins to fill the gap in information on home care workers. The data should not be used any purpose other than that for which it was intended. For example, it would be erroneous to use the data to draw conclusions about specific regions, specific employers, or specific sub-groups of workers within the broad occupational groups upon which the survey is based.

Given the distribution of workers at a national level, some groupings of data may be masking other important variables, such as the impact of the delivery model or union status. For example, the sample of RNs working for private sector employers comes predominantly from Ontario due to the heavy involvement of the private sector in delivery of professional home care services in that province.

- *The survey collected information on only a subset of occupations that provide home care in Canada* – The scope of the current survey included registered nurses, licensed practical nurses, home support workers, occupational therapists, physiotherapists and social workers. The scope did not include many of the other occupations such as physicians, psychologists, respiratory therapists, dietitians, etc.
- *Data is time sensitive and context-bound* – The data was collected during 2001 – 2002. During this period of number of contextual issues in the home care sector may have affected responses. These included the fact that some occupational groups were either on strike or in a strike position, and that there were major changes and cutbacks in funding for home care in some regions.