5. Experiences with Two-Tier Home Care in Canada: A Focus on Inequalities in Home Care Use by Income in Ontario

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CHAPTER 5

Experiences with Two-Tier Home Care in Canada: A Focus on Inequalities in Home Care Use by Income in Ontario

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As we debate the future of two-tier care for physician and hospital services, we do not have to look abroad for lessons of the impact of two-tier care. Within Canada, home care is an example of a system where blended public-private financing has always been permissible. Over the past decade, home care use has increased both in Canada and in other high-income countries, largely due to efforts to shift care out of institutions and into the community.

Home care services fall outside the protections of the *Canada Health Act*.[1] Therefore, there is no requirement for services to be delivered on a uniform basis; nor do they need to be publicly administered, portable across the provinces, accessible without financial barriers, and provided on a universal basis. In contrast to "medically necessary" physician and hospital services for which private pay options are curtailed by regulation, individuals seeking home care can choose among a wide variety of private pay options.[2] Moreover,

1 RSC 1985, c C-6.

2 Cloutier-Fisher & Alun E Joseph, "Long-term care restructuring in rural Ontario: retrieving community service user and provider narratives" (2000) 50:7–8 Soc Sci Med 1037–1045; Tavia Grant, "Private home care fills big service gap for seniors," *Globe and Mail* (14 April 2011), online: <https://www.theglobeandmail.com/report-on-business/private-home-care-fills-big-service-gap-for-seniors/article576860/>; A Paul Williams et al, *Integrating Long-Term Care into a Community-Based Continuum* (Montreal: Institute for Research on Public Policy, 2016), online: <hsprn.ca/uploads/files/IRPP_2016.pdf>.

while residency is the only requirement for eligibility for hospital and physician services, access to home care services in Canada is determined in each province and territory on the basis of a formal and generally standardized needs assessment.[3] Over time, the provinces and territories have implemented systems of publicly funded home care to provide some social protection for their residents. Yet little attention has been paid to the potential interaction between the public and private home care sectors.

In light of the ongoing court challenge to the regulatory restrictions on private finance for physician and hospital services (e.g., the restrictions on dual practice, extra-billing, price regulation) in *Cambie*,[4] this chapter takes a closer look at the evidence regarding the functioning of Canada's two-tiered home care sector. In the home care sector, the lack of constraints on the development of a two-tiered system allows for the private sector to offer home care services that can compete with, or top up, publicly funded services. One of the concerns with respect to two-tier systems is the potential to draw health professionals away from the public system to the more profitable private pay sector. Another concern, which is the focus of this study, is how two-tier systems impact persons with lower socio-economic status, and, specifically, whether they contribute to inequalities in access to and quality of care among seniors. The objective of this chapter is twofold: to describe the trends over time in the use of publicly and privately funded home care, and to estimate the association between income and home care use among older people in Ontario. The focus of this study is on Ontario, since home care funding and delivery varies across provinces/territories, and Ontario is the only province with available data on both public and private home care use.

In what follows, we first define key terms and, in the second section, describe Ontario's home care sector in order to shed light on the ways in which the publicly and privately funded home care systems interact. We explain eligibility criteria, assessment processes, and trends in funding and supply. In the third section, we describe the methods and data used to examine the receipt of public and

3 Income, or means, is not an eligibility criterion in any province; however, in some provinces (e.g., British Columbia, Saskatchewan, Nova Scotia), there are copayments for publicly funded home care services that vary depending on level of income.

4 *Cambie Surgeries v Medical Services Commission of British Columbia*, Statement of Claim, No S-090663 (Supreme Court of British Columbia).

private home care in Ontario, and, in the fourth section, we summarize the results of our empirical analysis. Our results suggest there are regressive impacts in relying upon private finance for home care under Ontario's current two-tier system. We find that people with higher income are more likely to use private home care and this primarily tops up the publicly funded home care services they receive. In conclusion, we map out questions remaining for future research as well as provide insights into the potential impact of allowing two-tier care.

1.1 Defining Home Care: Care or Support Offered to Older People in their Homes

Home care includes a broad range of health or support services for people with "acute, chronic, palliative, or rehabilitative health care needs" in their homes.[5] These services are delivered by both regulated and unregulated professionals, and paid and unpaid caregivers (e.g., family members, volunteers, friends). Services cover a wide range of health and nursing care, help with activities of daily living, mobility, self-care, and emotional support services. Home care includes short-term care, such as short-term "post-acute" care in the home following a hospital discharge. It also includes long-term care to support clients with chronic needs. Consistent with the literature[6] and Ontario regulations pertaining to home care,[7] we distinguish between home health care services, delivered by health care professionals such as nurses and physiotherapists, and home support and "homemaking" services, delivered mostly by personal-support workers (PSWs) and unpaid caregivers. However, given the nature of the survey question (described in section 2) we are not able to distinguish between short-term care, which is more likely to be professional or nursing services,

5 Canadian Home Care Association, Canadian Nurses Association & The College of Family Physicians of Canada, *Better Home Care in Canada: A National Action Plan* (2016), online: <https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/better-home-care-in-canada_a-national-action-plan-copy.pdf> at 1.

6 Audrey Laporte, Ruth Croxford & Peter C Coyte, "Can a publicly funded home care system successfully allocate service based on perceived need rather than socioeconomic status? A Canadian experience" (2006) 15:2 Health Soc Care Community 108–119; Gustavo Mery, Walter P Wodchis & Audrey Laporte, "The determinants of the propensity to receive publicly funded home care services for the elderly in Canada: A panel two-stage residual inclusion approach" (2016) 6:1 Health Econ Rev 8.

7 *Home Care and Community Services Act, 1994*, SO 1994, c 26.

and long-term care, which tends to include more home support and homemaking services.[8]

In this chapter, we focus on formal or paid home care for older people—individuals aged sixty-five years and older—living in the community. Older people living at home represent the majority of home care users in Ontario.[9] While the definition of a home can be broad, and often includes group homes and retirement communities, it generally excludes long-term care facilities or similar institutions. The focus on paid care misses the important role unpaid care by family, friends, and neighbours plays in supporting older people in their homes. The literature suggests that, in Ontario, the majority of at-home caregiving is delivered by this informal sector. Studies estimate that 70–90 per cent of home care services are delivered by informal caregivers,[10] with approximately seven hours of informal support for every two hours of professional care.[11]

1.2 Organization of Home Care in Ontario: Evolution of a Two-Tier System

Ontario's publicly funded long-term care sector is comprised of two main components integrated by an access point since the mid-1990s. One component is institutional or facility-based care, inclusive of long-term hospital stays and most nursing homes. The other component, and our focus, is the community-based services, including home care. Professional home care providers include, but are not limited to, registered nurses (RNs), registered practical nurses (RPNs), PSWs, occupational therapists (OTs), and physiotherapists (PTs). Entitlement to publicly funded home care services is determined by the relevant Local Health Integration Network (LHIN)—regional bodies charged

8 Laporte, *supra* note 6.

9 Ontario, Office of the Auditor General of Ontario, 2015 *Annual Report*, Section 3.01 CCACs—Community Care Access Centres—Home Care Program (Toronto: Queen's Printer for Ontario 2015).

10 Vivian W Leong et al, "The Magnitude, Share and Determinants of Private Costs Incurred by Clients (and Their Caregivers) of In-home Publicly" (2007) 3:1 Healthc Pol'y 141–159; Clare McNeil & Jack Hunter, *The Generation Strain: Collective Solutions to Care in an Aging Society* (London: Institute for Public Policy Research, 2014), online: https://www.ippr.org/files/publications/pdf/generation-strain_Apr2014.pdf; Mery *supra* note 6; Allie Peckham, A Paul Williams & Sheila Neysmith, "Balancing Formal and Informal Care for Older Persons: How Case Managers Respond" (2014) 33:2 Can J Aging 123–136.

11 Williams, *supra* note 2.

with coordinating public health care services within a defined geographical area.[12]

Prior to the 1990s, the long-term care model was considered to be disjointed, with little integration between health, social, and community services.[13] In the early 1990s, Ontario's rate of institutionalized seniors was 25 per cent higher than the Canadian average, signalling a need for the provincial government to refocus its attention on the policy and funding surrounding the care of its older population.[14] The *Home Care and Community Services Act*, 1994, formalized eligibility and entitlement requirements to reduce the number of institutionalized seniors and divert them to home care where possible. With minor adjustments, this legislation still exists in largely the same form, and continues to guide eligibility for home care.[15]

Over the previous decade the structures and funding of home care remained largely intact. Although government spending on home care doubled between 2003 and 2013,[16] even with significant reform efforts such as the provincial government's Aging at Home Strategy,[17] spending on home care as a proportion of total health-system spending has represented a relatively stable 4–5 per cent of overall provincial health spending over the past decade.[18] In other words, the public-spending increases seen in home care were not proportionately greater than in other sectors (e.g., physicians, drugs, institutions), nor has there been a change to the balance of home and institutional long-term care in spite of some efforts to do so.[19]

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12 In 2019, the Ontario government introduced new legislation allowing for the consolidation of the LHINs along with other agencies into one provincial agency (Ontario Health); though, to date, these changes have not been implemented, and home care assessment and delivery has not changed.

13 Howard Litwin & Ernie Lightman, "The Development of Community Care Policy for the Elderly: A Comparative Perspective" (1996) 26:4 Int J Health Serv 691–708.

14 *Ibid*.

15 *Supra* note 7.

16 Ontario, Minister of Finance, *2018 Ontario Budget: A Plan for Care and Opportunity* (Toronto: Queen's Printer for Ontario, 2018), online: <budget.ontario.ca/2018/budget2018-en.pdf >.

17 Allie Peckham et al, "Community- Based Reform Efforts: The Case of the Aging at Home Strategy" (2018) 14:1 Healthc Pol'y 30–43.

18 *Supra* note 9.

19 *Supra* note 19.

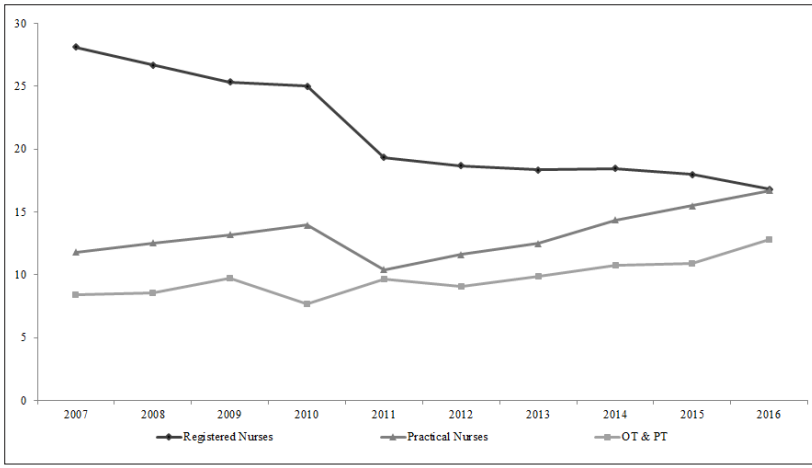

Figure 5.1. Head counts of home care workforce in Ontario, per 100,000 population (CIHI data).

Yet there is some sign that the traditional roles of service providers are changing. For example, figure 5.1 illustrates the trend over time in the registered professionals working in home care (for which there are data available), showing a slight decline in the role of RNs over the past decade, and only a slight increase in the role of practical nurses. With fewer RNs performing home care service roles, their duties are being assumed by PSWs, often without formalized training.[20] The role of PSWs is expanding to include tasks such as assistance with medications, wound care, complex lifts and transfers, catheterization, and feeding pumps.[21] Broadly, these trends in the home care workforce are suggestive of an effort to contain costs by shifting away from higher paid professionals.

As in most other high-income countries, access to home care services in Ontario is needs-based.[22] Using a standardized assessment tool called the Resident Assessment Instrument-Home Care (RAI-HC), eligibility for home care is determined on a case-by-case

20 Margaret Saari et al, "The evolving role of the personal support worker in home care in Ontario, Canada" (2017) 26:2 Health Soc Care Community 240–249.

21 *Ibid*.

22 Francesca Colombo et al, *Help Wanted? Providing and Paying for Long-Term Care* (OECD Publishing, 2011), online: <www.oecd.org/els/health-systems/help-wanted.htm>.

basis by a client-case manager within the LHIN.[23] The RAI-HC entails a face-to-face interview that includes a set of clinical-assessment protocols that identify potential negative outcomes and serves as the basis for the development of a home care service plan.[24] The role of the case manager is to ensure the appropriate services are provided within a timely manner to the clients most in need.[25] Once a client is determined to be long-stay, or in need of at least sixty uninterrupted days of services, the general target has been to complete the RAI-HC within seven to fourteen days.[26]

In response to evidence of regional variations in eligibility and care packages received for similar levels of assessed need,[27] the previous Liberal government implemented a levels of care framework in 2016.[28] This framework allows for clients with similar levels of functional need to receive similar hours of publicly funded support services per month, regardless of which part of the province they live. It remains to be seen whether this approach will reduce the variations in access and eligibility across the province that have characterized home care in Ontario since its inception. The uncertainty that clients face, and the case-by-case determination of eligibility, gives rise to situations where clients may not be deemed eligible and may thus be forced to rely on unpaid care, or privately paid services. Another key feature of the Ontario home care system is the presence of a service maximum, which we discuss further below. Placing a limit on the receipt of publicly funded services may generate demand for an active private sector.

Unlike most OECD countries that have an element of client contributions (e.g., copayments), in Ontario there are no fees for publicly

23 *Supra* note 7.

24 Amanda M Mofina & Dawn M Guthrie, "A comparison of home care quality indicator rates in two Canadian provinces" (2014) 14 BMC Health Serv Res 37.

25 Ontario, Office of the Auditor General of Ontario, 2010 *Annual Report*, Section 3.04 Home Care Services (Toronto: Queen's Printer for Ontario 2010).

26 *Supra* note 9.

27 *Ibid.*

28 Dipti Purbhoo & Irfan Dhalla,"Thriving at Home: A Levels of Care Framework to Improve the Quality and Consistency of Home and Community Care for Ontarians" (Presentation delivered at the HSSOntario Achieving Excellence Together Conference, Toronto, 15 June 2017), online: <https://hssontario.ca/Who/Conference/Documents/2017-Conference-Presentations/TA04_Levels_of_Care_Expert_Panel_Report.pdf>.

funded in-home health and support services.[29] On the other hand, Ontario is one of only three jurisdictions (along with Slovenia and South Korea) that employs a "service maximum" design to contain costs.[30] In Ontario, the maximum home care services a client is able to receive is 120 hours in the first thirty days of service, and ninety hours in any subsequent thirty-day period.[31] Occasionally, the LHIN may determine extraordinary circumstances which justify the provision of additional support hours on a client-by-client basis.[32] Such circumstances might include palliative-care cases or individuals awaiting placement into a long-term care facility.[33] In most cases where the service maximum has been reached, clients must go without the care they need, look to family members or friends, or, if they are able, pay privately.[34]

Notably, despite being a two-tier system, there are significant wait times for the publicly funded home care sector, and this is another factor fuelling demand for private alternatives. In the 2010, the auditor general of Ontario reviewed Ontario's home care programming, and made recommendations to reduce lengthy wait times and strengthen efforts toward timely service;[35] however, at the time of the 2015 audit, there was no evidence of progress.[36] As seen in acute care settings (e.g., specialist services, surgical procedures), wait lists may be a key stimulus for a two-tier sector but causation is much in dispute. For example, it is possible that the existence of a two-tier system actually lengthens wait times in the public sector by undermining political support for further public investments to meet needs and/or drawing away professional labour from the public to private spheres.[37]

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29 *Supra* note 24; Tim Muir, *Measuring social protection for long-term care* (Paris: OECD Publishing, 2017), online: <oecd-ilibrary.org/social-issues-migration-health/measuring-social-protection-for-long-term-care_a4111500a-en>.

30 Muir, *ibid.*

31 *Supra* note 7.

32 *Ibid.*

33 *Supra* note 9.

34 Williams *supra* note 3.

35 *Supra* note 9; *supra* note 14.

36 *Supra* note 14.

37 Jeremiah Hurley & Malcolm Johnson, *A Review Regarding Parallel Systems of Public and Private Finance* (Hamilton: Centre for Health Economics and Policy Analysis, 2014), online: <chepa.org/docs/documents/14-2.pdf>.

To our knowledge, there has been little attention paid to the nature and extent of the privately funded home care sector in Ontario. The limited evidence that does exist has focused on estimating the costs associated with informal caregiving, not the formal, paid sector.[38] The current study examines the impact of the two-tier system of financing home care on persons with lower socio-economic status, by estimating the associations between income and home care use among the full population of community-dwelling seniors in Ontario.

2. Methods and Data

2.1 Conceptual Framework

Our conceptual framework is based on Kemper's model of demand for home care.[39] Kemper suggests that the quantity of formal and informal home care demanded is related to five factors: the need for care, price, income, availability of family support, and individual tastes. This framework suggests that, on average, the demand for formal home care services will increase with need and income, and decrease with price and the availability of family supports.

It is important to note that Kemper's model was developed for the US context, where public insurance programs cover a small proportion of home care services.[40] In the Ontario context, where there are dual publicly and privately financed home care sectors, we expect the role of income to be different across these two sectors. We expect income to be negatively associated with the use of public home care services; in other words, we assume that higher-income clients, who have greater ability to pay out of pocket (and may have access to private insurance),[41] are more likely to use private instead

38 Denise N Guerriere et al, "Costs and determinants of privately financed home-based health care in Ontario, Canada" (2007) 16:2 Health Soc Care Community 126–136.

39 Peter Kemper, "The Use of Formal and Informal Home Care by the Disabled Elderly" (1992) 27:4 Health Serv Res 421–451.

40 *Ibid*.

41 The private insurance market in long-term care is very small and private health insurance is held by less than 1 per cent of Canadians. This limited take-up of private insurance may relate to insufficient information on the extent of public coverage of long-term care, and the high price of the insurance relative to its value due to market failure. Michel Grignon & Nicole F Bernier, *Financing Long-Term Care in Canada* (Montreal: IRPP, 2012) at 9.

of public home care services.[42] Another question is whether high income individuals are likely to top up public services with additional privately financed home care. Ontario's two-tier system of home care financing enables clients to pay privately for services to bypass queues for public home care services, expedite their treatment plan, and/or to supplement their publicly funded home care.[43] As in Ontario, where there is no income test on access to home care services, we may see an income gradient as wealthier persons are able to pay a higher price to top up publicly funded services with private services.

Early studies have employed similar approaches for modelling the demand for formal home care services.[44] Following these examples, we estimate the relationship between income and use of formal home care services, while controlling for other determinants of formal home care use.

2.2 Data

This study relied on Canadian Community Health Survey (CCHS) data, analyzed at the Toronto Region Statistics Canada Research Data Centre, at the University of Toronto. The CCHS is a nationally representative cross-sectional survey of persons aged twelve and older.[45] The survey captures data from all thirteen provinces and territories, and information on diseases and health conditions, health status, health care services, lifestyle and social conditions, and mental health and well-being.

The CCHS data is collected on two-year cycles, but an annual microdata file is available. The cross-sectional surveys can be pooled to examine specific populations or rare events, conditions, and characteristics. For this study, we pooled annual cross-sections from 2007 to 2014 for Ontario. Ontario was the only province to capture the home care component of the survey, which was optional content, in

42 Correspondingly, we expect the impact of income to be positively associated with the use of private services.

43 Williams *supra* note 3.

44 Mery *supra* note 6; Helen Stoddart et al, "What determines the use of home care services by elderly people?" (2002) 10:5 Health Soc Care Community 348–360; Courtney Harold Van Houtven & Edward C Norton, "Informal care and health care use of older adults" (2004) 23:6 J Health Econ 1159–1180.

45 The survey does not include full-time members of the Canadian Forces or institutionalized populations.

all of the study years. We excluded all CCHS participants in Ontario who were under the age of sixty-five, or who had missing values for home care service use, self-assessed health, or limitations with activities of daily living (ADLs). The result was a total sample of about 40,000 respondents over the study period.

2.3 Explaining our Variables and Empirical Strategy

This study attempts to identify the relationship between older Ontarians' income and their use of home care (both public and private), controlling for other variables such as health status and access to family supports. All variables for this study were derived from the CCHS data. Our outcome variables focused on home care use and included use of public and private home care, and access to informal care. We also differentiated between in-home health care (e.g., nursing and rehabilitation services) and in-home support (e.g., homemaking) services.

We included explanatory and control variables to account for the different elements of the conceptual framework (above). Our key explanatory variable was income (specifically, household income quintile). Control variables included measures of need (self-reported health status, self-reported limitations with ADLs, and self-reported unmet home care needs) and access to family supports (marital status, whether persons lived alone, and whether they had access to informal care). We also included other socio-demographic variables, which may have had an influence on home care use, including age, sex (male or female), and whether clients lived in an urban community. Detailed descriptions of these variables are included in table 5.1.

Table 5.1. Variable definitions

Variable Name	Description
Any home care	Respondent reported any home care use in the previous year.
Public home care	Respondent received any home care services in the past twelve months, with the cost being entirely or partially covered by government?
Private home care	Respondent received any home care services in the past twelve months, with the cost not being covered by government, and care was provided by a "nurse from a private agency," a "homemaker or other support services from a private agency," or a "physiotherapist from a private agency."

Variable Name	Description
Private + public home care	Respondent reported receiving both public and private home care in the previous year.
Home health care	Defined as any (public or private) home care service use in the previous year delivered by a nurse or other health care service provider (e.g., physiotherapy occupational therapy, speech therapy, nutrition counselling), or that provided support with medical equipment or supplies.
Home support	Defined as any (public or private) home care service use in the previous year that provided support with personal care (e.g., bathing, foot care), housework, meal preparation or delivery, shopping, or caregiver respite. Also includes any services reported as "other."
Receipt of unpaid/ informal care	Respondent reported having access to home care services delivered by a neighbour or a friend, a family member or spouse, or a volunteer.
Age	Age in years.
Fair/poor self-assessed health	Respondent reported having self-perceived poor or fair health (versus good, very good, or excellent health).
Household income quintile	Categorical variable that ranges from 1 = first quintile, to 5 = fifth quintile. The variable is based on the derived variable "incdrca" in the CCHS. This is an indicator of household income distribution. Missing values are coded as = 9.
Live alone	Respondent reported living alone. Derived from the "dhhdlvg" derived variable in the CCHS.
Married	Respondent reported being married or living common law.
One or more activities of daily living (ADL) limitations	Respondent reported requiring help with one or more of the following tasks: preparing meals, getting to appointments/ running errands, housework, personal care, moving about inside the house, and/or personal finances.
Self-reported unmet need	Respondent answers yes to the question "During the past 12 months, was there ever a time when you felt that you needed home care services but you didn't receive them."
Sex	Respondent reported being female.
Urban	Respondent lives in "urban core" community. Urban areas are defined as those with a density of four hundred or more persons per square kilometre.

Source: Canada, Health Canada, *Canadian Community Health Survey*, (National Survey), 2007–2014.

We used the CCHS data to describe home care use and the relationship between home care use and income.[46]

3. Results

Figure 5.2 shows the trends for self-reported public and private home care use (excluding informal care) in Ontario over the study period (2007 to 2014). Self-reported public home care use trended downward, from 10.0 per cent of the sixty-five and older population in 2007 to 7.3 per cent in 2014. In contrast, private home care use showed a slight trend upward, from 1.7 per cent of the population sixty-five and older to 2.6 per cent in 2014. The proportion of the population sixty-five

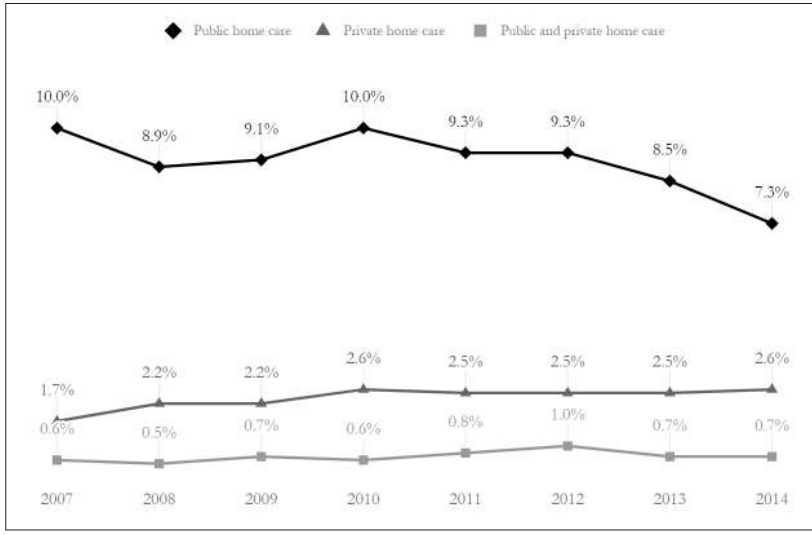

Figure 5.2. Trends of home care use in Ontario, 2007–2014.

46 Multivariate regression analyses of the probability of accessing public and private home care services were estimated using a multinomial logit (MNL) model. The MNL model is used for the estimation of the selection of unordered categories. Respondents could choose to use public, private, or public and private home care services. We estimated this model using the *mlogit* command in Stata 15. Hypothesis tests and confidence intervals were generated using heteroskedasticity robust standard errors. In addition, all descriptive statistics and regressions were weighted using CCHS survey weights. Canada, Statistics Canada, *Canadian Community Health Survey (CCHS): Household weights documentation*, (Statistics Canada, 2010), online: <www23.statcan.gc.ca/imdb-bmdi/pub/document/3226_D57_T9_V1-eng.htm>.

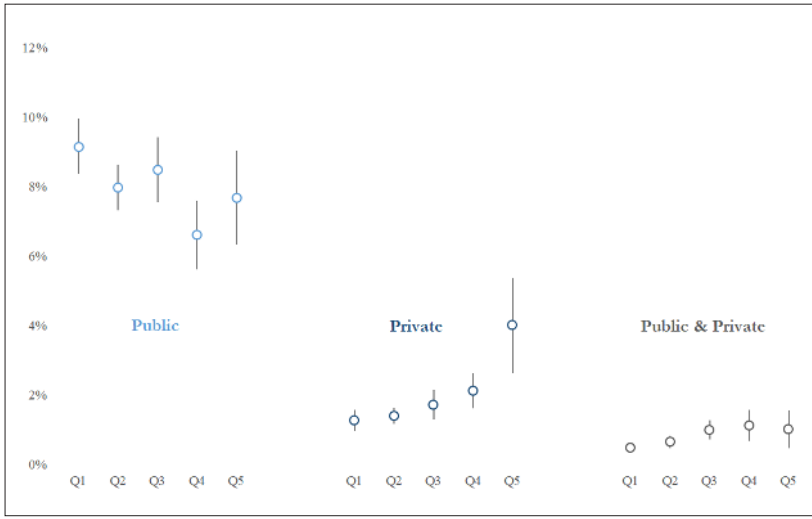

Figure 5.3. Predictive margins of home care use by household income quintile.

and older reporting use of a mix of public and private home care services was constant over the study period.

The results of the regression analysis are presented in table 5.2 and reported graphically in figure 5.3. We only report the results for the relationship between household income and home care use (full results are provided in table 5.3). In our figures, we report the likelihood of receiving home care (after controlling statistically for health status and other variables) for each of the five income groups, or quintiles: the first income group includes the 20 per cent of the population with the lowest income; the fifth income group includes the 20 per cent of the population with the highest income.[47] In 2016 in the Ontario population, the lowest income quintile had an average income, after taxes, of $18,600; the highest had an average income of $103,200.[48]

47 The results for income are reported as predictive margins. To calculate predictive margins we set each observation in our sample to each of the income quintiles holding all other covariates constant. The predictive margins on each income level can be interpreted as the probability of home care use if the entire sample had that level of income.

48 Financial Accountability Office of Ontario 2019. *Income in Ontario: Growth, Distribution and Mobility*, online: <https://www.fao-on.org/en/Blog/Publications/income-report-2019>.

Table 5.2. Effect of household income on home care use in the previous 12 months

		Any home care											
		No home care			***Public***			***Private***			***Private + Public***		
		Marg.	*95% CI*		*Marg.*	*95% CI*		*Marg.*	*95% CI*		*Marg.*	*95% CI*	
Household income quintile	1	.891	.882	.899	.092	.084	.100	.013	.010	.016	.005	.004	.006
	2	.900	.893	.907	.080	.073	.086	.014	.012	.016	.007	.005	.008
	3	.888	.878	.898	.085	.076	.094	.017	.013	.022	.010	.007	.013
	4	.901	.890	.912	.066	.056	.076	.021	.016	.026	.011	.007	.016
	5	.873	.856	.890	.077	.063	.090	.040	.026	.054	.010	.005	.016
Missing		.901	.890	.913	.077	.067	.087	.016	.011	.022	.006	.003	.008
		Home health care											
		No home care			***Public***			***Private***			***Private + Public***		
		Marg.	*95% CI*		*Marg.*	*95% CI*		*Marg.*	*95% CI*		*Marg.*	*95% CI*	
Household income quintile	1	.942	.934	.949	.044	.037	.050	.013	.008	.017	.002	.001	.003
	2	.940	.934	.945	.045	.040	.051	.011	.009	.014	.004	.002	.005
	3	.932	.923	.940	.046	.040	.052	.015	.010	.020	.007	.004	.010
	4	.935	.926	.945	.045	.036	.054	.013	.009	.017	.007	.004	.010
	5	.921	.907	.935	.053	.041	.065	.018	.009	.027	.007	.003	.011
Missing		.938	.928	.948	.045	.036	.053	.014	.008	.020	.003	.001	.006
		Home support											
		No home care			***Public***			***Private***			***Private + Public***		
		Marg.	*95% CI*		*Marg.*	*95% CI*		*Marg.*	*95% CI*		*Marg.*	*95% CI*	
Household income quintile	1	.917	.910	.924	.064	.058	.070	.014	.010	.019	.005	.003	.007
	2	.931	.925	.936	.049	.044	.054	.014	.012	.017	.006	.004	.008
	3	.920	.911	.929	.054	.046	.062	.018	.014	.021	.008	.005	.012
	4	.934	.924	.943	.037	.030	.044	.021	.016	.027	.008	.005	.012
	5	.917	.902	.931	.044	.032	.055	.034	.023	.046	.006	.002	.010
Missing		.932	.923	.941	.048	.041	.055	.017	.011	.023	.003	.002	.005

Notes: 95% confidence intervals calculated using heteroskedasticity robust standard errors.
Table abbreviations: "Marg." = Predictive margins; "95% CI" = 95% confidence interval.
Source: based on the research and analysis of the authors.

Table 5.3. Multinomial logit estimator results for home care use in the previous 12 months (base = no home care use)

	65+ years of age								
	Public			*Private*			*Private + Public*		
	RRR	*95% CI*		*RRR*	*95% CI*		*RRR*	*95% CI*	
Household income quintile (base = 1)									v
2	0.847	0.724	0.991	1.082	0.789	1.484	1.304	0.871	1.952
3	0.943	0.783	1.136	1.406	0.951	2.079	2.116	1.405	3.186
4	0.702	0.562	0.877	1.659	1.128	2.440	2.263	1.341	3.819
5	0.903	0.701	1.162	3.541	2.184	5.741	2.361	1.240	4.495
Missing	0.811	0.665	0.990	1.246	0.816	1.903	1.099	0.613	1.968
Age	1.061	1.052	1.070	1.093	1.073	1.113	1.097	1.075	1.119
Female	0.838	0.743	0.946	1.516	1.134	2.026	1.390	0.992	1.948
Married	0.963	0.792	1.170	1.740	1.248	2.425	1.867	1.177	2.961
Live alone	1.499	1.235	1.821	3.376	2.459	4.636	3.367	2.210	5.129
Urban	0.706	0.629	0.792	1.021	0.823	1.267	0.627	0.464	0.848
Fair-poor self-assessed health	2.036	1.794	2.312	1.349	1.024	1.778	1.786	1.304	2.445
One or more ADL limitations	4.598	4.017	5.263	6.131	4.564	8.236	11.129	7.163	17.293
Access to informal care	2.006	1.705	2.361	1.329	0.992	1.781	2.002	1.439	2.785
Self-reported unmet need	1.469	1.182	1.827	1.787	1.154	2.767	3.832	2.671	5.497
Year (base = 2007)									
2008	0.903	0.725	1.125	1.539	0.955	2.479	0.931	0.488	1.778
2009	0.916	0.733	1.145	1.307	0.868	1.970	1.192	0.656	2.165
2010	0.967	0.783	1.195	1.559	0.966	2.517	1.036	0.560	1.918
2011	0.896	0.713	1.125	1.451	0.953	2.208	1.337	0.751	2.380
2012	0.874	0.689	1.107	1.284	0.824	2.003	1.668	0.974	2.857
2013	0.824	0.651	1.043	1.577	1.010	2.460	1.138	0.671	1.928
2014	0.704	0.563	0.880	1.682	1.070	2.644	1.162	0.658	2.051

Notes: Heteroskedasticty robust standard errors were used to calculate confidence intervals. Table abbreviations: "RRR" = Relative risk ratio; "95% CI" = 95% confidence interval; "ADL" = Activities of daily living.

Table 5.3 (continued). Multinomial logit estimator results for home care use in the previous 12 months (base = no home care use)

	75+ years of age								
	Public			*Private*			*Private + Public*		
	RRR	*95% CI*		*RRR*	*95% CI*		*RRR*	*95% CI*	
Household income quintile (base = 1)									
2	0.855	0.713	1.025	1.041	0.721	1.503	1.244	0.777	1.990
3	0.986	0.783	1.242	1.538	0.970	2.441	2.086	1.301	3.346
4	0.683	0.520	0.896	1.380	0.865	2.200	2.236	1.213	4.123
5	0.920	0.660	1.284	3.072	1.731	5.452	2.170	1.044	4.511
Missing	0.864	0.680	1.097	1.217	0.747	1.981	1.327	0.703	2.504
Age	1.082	1.067	1.098	1.108	1.081	1.137	1.101	1.066	1.137
Female	0.827	0.713	0.960	1.518	1.087	2.119	1.315	0.892	1.939
Married	1.022	0.798	1.308	1.882	1.289	2.748	1.858	1.107	3.120
Live alone	1.486	1.173	1.883	3.418	2.364	4.941	3.105	1.960	4.918
Urban	0.785	0.683	0.901	0.979	0.766	1.249	0.678	0.480	0.960
Fair-poor self-assessed health	2.006	1.733	2.322	1.285	0.927	1.783	1.675	1.159	2.419
One or more ADL limitations	4.113	3.490	4.846	4.646	3.441	6.274	10.094	6.102	16.697
Access to informal care	1.842	1.531	2.217	1.176	0.843	1.640	1.725	1.184	2.514
Self-reported unmet need	1.390	1.087	1.777	1.672	0.962	2.903	3.805	2.506	5.777
Year (base = 2007)									
2008	0.884	0.665	1.175	1.587	0.910	2.767	0.949	0.448	2.011
2009	0.919	0.684	1.234	1.184	0.739	1.896	0.932	0.483	1.797
2010	0.886	0.677	1.160	1.221	0.735	2.030	0.829	0.407	1.688
2011	0.873	0.653	1.167	1.269	0.781	2.062	1.425	0.739	2.751
2012	0.846	0.625	1.147	1.175	0.696	1.985	1.611	0.874	2.972
2013	0.809	0.604	1.084	1.421	0.844	2.392	1.184	0.654	2.145
2014	0.737	0.551	0.986	1.643	0.957	2.820	1.146	0.597	2.202

Notes: Heteroskedasticty robust standard errors were used to calculate confidence intervals. Table abbreviations: "RRR" = Relative risk ratio; "95% CI" = 95% confidence interval; "ADL" = Activities of daily living.
Source: based on the research and analysis of the authors.

Our results suggest that the receipt of any (public or private) home care is fairly constant across all income quintiles, holding all else constant (health status, access to family supports). However, the patterns of use by income were different when we examined public and private home care separately. The predicted proportion of the sample that used no home care ranged from 87.3 per cent in the fifth quintile to 90.1 per cent in the fourth. Individuals in the lowest income group were more likely to use public home care than individuals in the higher income groups; the predicted proportion of the sample that used public home care services was 9.2 per cent in the first income quintile (the poorest) and 7.7 per cent in the fifth quintile (the wealthiest). However, this effect differs for in-home health and support services. For home health, the effect is constant across income levels while home support decreases with increasing income (see figs. 5.4 and 5.5 for a graphical depiction of these relationships).

On the other hand, those with higher income were more likely to use private home care services. The predicted proportion of the sample that used private home care was 1.3 per cent in the first income quintile, and 4.0 per cent in the fifth. This positive relationship remained when the results were separated by in-home health and support services, although the relationship was much stronger for in-home support services.

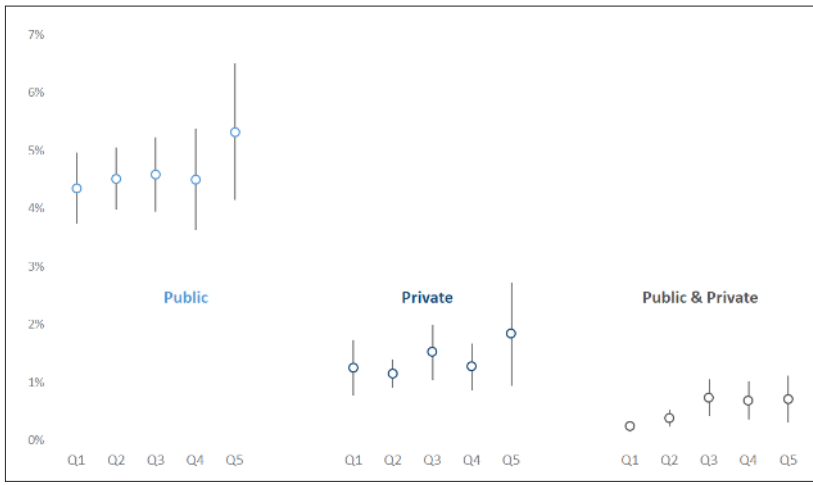

Figure 5.4. Predictive margins of home health care use by household income quintile.

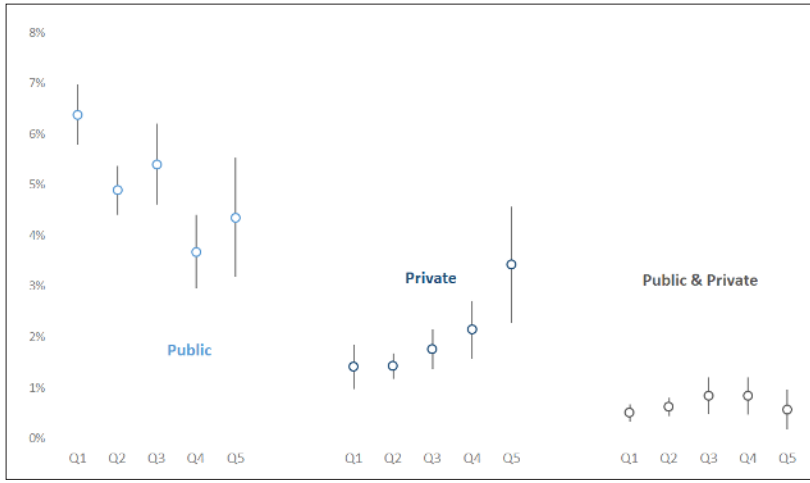

Figure 5.5. Predictive margins of home support use by household income quintile.

Those with higher incomes were also slightly more likely to use a combination of public and private home care. We predicted that 0.05 per cent of the lowest income quintile would use both public and private home care services, while 1.0 per cent of those in the highest would use both services in the previous year. When we separated our analysis by in-home health and support services, only in-home health care consistently increased with income.

4. Conclusion

To our knowledge, this is the first study to examine the receipt of both publicly funded and private-pay home care services in any Canadian province for the whole population of seniors living in community. Over the past decade, there appears to have been a slight decrease in the proportion of seniors who reported having received publicly funded home care services (including both in-home health and in-home support services), while at the same time the proportion of seniors reporting that they pay privately for such care has increased. The nature of the private market appears to be both to top up publicly funded care and to substitute for these services. In both cases, the private market is still relatively small: our results suggest that, in 2015, less than 3 per cent of seniors in Ontario had reported they exclusively used private in-home health or support services, and

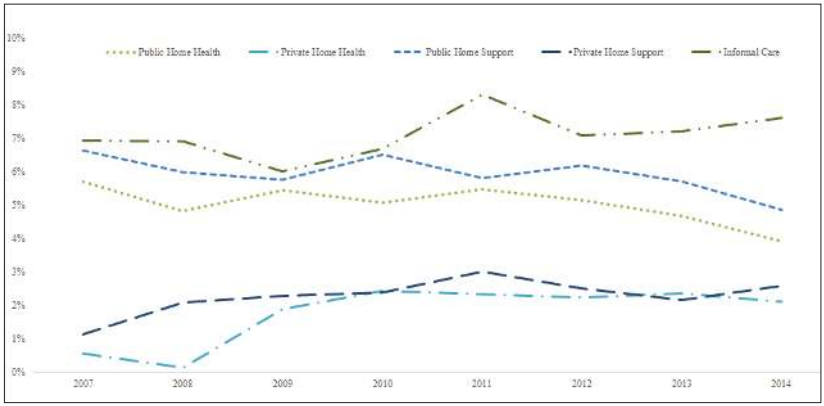

Figure 5.6. Trends of Home Care Use in Ontario for Seniors 65+

less than 1 per cent reported using both. This is not surprising given the limited use of private health insurance for home care, such that people are paying out of pocket for the care they need at a time in their lives when incomes are generally reduced.

We also find evidence that a small proportion of low-income seniors are topping up public in-home health care services with private ones. It is possible that some low-income seniors with unmet needs are seeking additional support, and paying out of pocket to meet these needs. We could not observe the motivation for this decision, but we would expect the financial impact of having to pay out of pocket to have more serious implications for low-income seniors than seniors in higher income brackets.

Overall, the study draws attention to the two-tier nature of home care in Ontario, which has largely gone unnoticed in the debates about two-tier health care in Canada. Another strength of the study is that it exploits rich data over a period of ten years to estimate the size and nature of the private-pay market for home care, and in particular the role of income as a factor in predicting home care use in the different sectors, and separately by health and support services. The analysis was able to control for possible variations in health status across income levels, given that the survey includes questions about general health as well as limitations in activities of daily living. The results of the analysis of income effects largely support our hypotheses: on average, with higher income, public home care use decreases and private home care use increases. We also expected to see a positive association between income and the use

of both public and private services, where older people with greater ability to pay would be more willing and able to top up the publicly funded services to meet their health and other needs. There was a slightly positive association with income, but surprisingly there is some evidence of topping up even among the older people in the lowest income quintiles.

There are several limitations that are worth pointing out, many owing to the nature of the CCHS as the only source of information on the use of both publicly and privately funded home care in Canada. First, we are unable to measure the intensity of service use, as modelled in earlier studies of the public system.[49] We rely on estimating the likelihood/propensity of a visit over a period of a year; this offers a crude estimate of the size of the private-pay market for home care. Second, we cannot observe the impact of receiving home care on seniors' health and well-being, or the extent to which access to home care can prevent or delay admission to institutional care. Furthermore, while we can observe unmet need for home care as reported by seniors in this survey, we cannot determine whether unmet need preceded the receipt of home care (and whether those services met their needs), or unmet need persisted upon receipt of home care (and whether the services they received were inadequate).

Future research is needed to begin to examine some of these unanswered questions. This could be done by exploiting linked data sets or by designing new surveys with more detailed questions on motivations for the types of home services being used. For instance, studies could investigate why seniors are paying out of pocket for home care, even when they have very little income. What impact does this have on their ability to purchase other needed goods or services? As noted by Muir, even if we are able to measure the amount people are paying privately for their home care services, we do not know whether these payments are significantly affecting their well-being (especially for those with little disposable income).[50] We also do not yet know the extent to which the design of the publicly funded system and its service maxima are having the unintended effect of forcing lower-income seniors with more complex needs to institutions, while those with similar needs but with the ability to pay privately for additional home care services are able to stay in their homes.

49 Laporte, *supra* note 6.

50 Muir, *supra* note 30.

Our results suggest there are regressive impacts in relying upon private finance for home care, undermining equitable access to care. From the perspective of the ongoing *Cambie* litigation, challenging various laws protective of public medicare for hospital and physician services, the experience with home care in Ontario suggests that, at a minimum, further privatization is likely to exacerbate inequality. Having said this, the analogy is somewhat complicated because the market for home care includes not only public and private payment but also informal delivery. Further, there is no prohibition on private health insurance for home care or long-term care and yet very little of it is supplied or purchased, and, thus, it seems the private insurance market for home and long-term care differs from the market for hospital and physician services. Further, we don't yet understand, and further research is required on, (i) the extent, if any, to which privately financed home care draws away needed labour from the publicly funded sector; and (ii) the extent, if any, to which public support for further public spending is diminished because of a second, private-tier option.