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INVESTIGATION REPORT
BY THE QUÉBEC OMBUDSMAN

IS HOME SUPPORT ALWAYS THE OPTION OF CHOICE?

Accessibility of home support services for people with significant and persistent disabilities

Québec City, March 30, 2012

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1.1 *The Québec Ombudsman's mission*

The Québec Ombudsman ensures that citizens' rights are respected by intervening with regard to Québec government departments and agencies and the various bodies within the health and social services network to request that situations detrimental to citizens or groups of citizens be corrected. Appointed by members of the National Assembly from every political party and reporting to the National Assembly, the Québec Ombudsman is independent and impartial, whether it acts in response to a complaint or a series of complaint or on its own initiative. Generally speaking, in matters involving health and social services, it provides second-level recourse for citizens who have filed a complaint. It can also act directly with regard to the instances within its purview further to reports or on its own initiative.

1.2 *Background*

This investigation concerns the long-term home support component of the home support program, namely:

- **personal assistance services for people with disabilities or a loss of independence, such as help with hygiene, eating, and moving about;**
- **domestic help services, such as housekeeping, meal preparation, shopping and other errands, and clothing care and laundry;**
- **support for civic participation, such as help with budgeting.**

This investigation therefore does not cover home healthcare (such as nursing care) or short-term support for people with temporary disabilities (for example, after surgery).

In the past year, in most regions of Québec, the Québec Ombudsman has noted a sizable increase in the number of complaints about the home support services delivered by health and social services centres (CSSSs) through their CLSCs. In three years, the number of complaints it received concerning

conclusions by service quality and complaints commissioners (first-level recourse) went from 89 (2009-2010) to 142 (first nine months of 2011-2012). In 2009-2010, 38.2% of these complaints were substantiated, but by 2011-2012, 55.6% were.[1] As a result, the Québec Ombudsman decided to conduct a special investigation to determine whether recommendations on overall corrective measures were needed to prevent the situation from worsening.

This investigation covers how institutions apply the home support program and not how formal caregivers do their job. In fact, as a rule, service quality is not an issue. That is why this aspect was omitted from this report. However, the Québec Ombudsman will remain alert to any complaints it may receive about service quality and investigate as needed.

Problems related to personal assistance services, domestic help services and support for civic participation were noted in several regions of Québec. For the purpose of this investigation, most of our findings and examples were taken from the four health and social service regions with the most complaints (Montréal, Montérégie, Laurentides and Gaspésie–Îles-de-la Madeleine.) These regions represent 50.8 % of Québec's population.

The following documents were the main ones used by the Québec Ombudsman for the investigation:

- *Chez soi : Le premier choix – La politique de soutien à domicile*, Ministère de la Santé et des Services sociaux, 2003;
- *Chez soi : Le premier choix – Précisions pour favoriser l'implantation de la politique de soutien à domicile*, Ministère de la Santé et des Services sociaux, 2004;
- *Plan d'accès aux services pour les personnes ayant une déficience, afin de faire mieux ensemble*, Ministère de la Santé et des Services sociaux, June 2008;

1. The estimated number of complaints for 2011-2012 is 190.

- the reference guides of the health and social services agencies for the Montréal, Laurentides, Montérégie and Gaspésie-Îles-de-la-Madeleine health and social service regions;
- the reference guides and statistical data for the health and social services centres of the four regions concerned;
- the home support complaint files received for all regions of Québec by the Québec Ombudsman between April 2008 and October 2011.

In addition to interviewing users, informal caregivers and healthcare workers, the Québec Ombudsman also talked with representatives from the Ministère de la Santé et des Services sociaux.

2 The Home Support Policy

In 2003, the Ministère de la Santé et des Services sociaux created a home support policy.[2] The policy establishes that in respecting the choices of individuals, helping them remain in their home environment should always be the first option, from the outset and throughout the intervention process.[3] Services must converge to enable people with a loss of independence to continue living at home as long as they can, if that is what they want, up to the amount it would cost for them to be lodged at a public institution. The average net cost to the government of lodging at a residential resource is $42,000 per capita per year everywhere in Québec for all care and services except medical services.[4] This was the figure arrived at when the policy was drafted. With a budget of $42,000 per year, a person can receive between 50 to 60 hours of home support services per week, depending on the hourly rate of the direct subsidy granted in the person's region.

2.1 *The broad principles of the home support policy*

The home support policy is based on three broad principles that guide all action undertaken:[5]

- first, the policy must address individual and public expectations and needs;
- home support must have an increasingly high profile within the health and social services system;
- there must be joint, society-wide action to support people with disabilities and their informal caregivers.

2. MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Politique de soutien à domicile "Chez soi : le premier choix." Québec, 2003.*
3. *Ibid.*, p. 5.
4. MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Précisions pour favoriser l'implantation de la Politique de soutien à domicile "Chez soi : le premier choix." Québec, 2004, p. 11.*
5. MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Politique de soutien à domicile "Chez soi : le premier choix." Québec, 2003*, p. 2.

The policy applies to any person, regardless of age, with a temporary or persistent disability the cause of which may be physical, mental or psychosocial, and all or part of whose required services must be received at home.[6]

Furthermore, the policy also lays the groundwork for a new form of relationship between informal caregivers and the health and social services system.[7] It specifically recognizes the participation of natural caregivers in enabling a loved one to continue living at home (recognition of the need for respite) and establishes that this participation must remain **voluntary**.

The policy also insists that access to home support be the same for everyone, without distinction, and that responses must always be based on needs.[8]

The policy provides that domestic help services and personal assistance services, determined in the person's intervention plan or individualized service plan, are offered free of charge to:

- people with a temporary disability;
- people receiving palliative care;
- people with a significant and persistent disability.[9]

Among these people, only those already insured under another public plan (e.g. the public automobile insurance plan or Québec's occupational health and safety plan) for the same kind of services do not qualify.

The policy specifies that:

- people requiring domestic help only are referred to a social economy business;
- low-incomers referred to a social economy business receive the domestic help services specified in their intervention plan or individualized service plan free of charge. Anyone else referred to a

6. *Ibid.,* p.16.
7. *Ibid.,* p. 3.
8. *Ibid.,* p. 3.
9. *Ibid.,* p. 17.

social economy business is eligible for the Financial Assistance Program for Domestic Help Services (PEFSAD),[10] which helps bring down their bill.

2.2 *Who is responsible for enforcing the policy?*

Any ministerial policy, no matter how appropriate, is only as good as its application.

The Ministère de la Santé et des Services sociaux is responsible for application of the home support policy. It adopts general orientations, sets province-wide targets for each client category, and allocates resources (budgets) to health and social services agencies.

Agencies must coordinate the establishment of health services and social services in their area of jurisdiction, in particular with regard to financing, human resources and specialized services, in keeping with ministerial orientations. This means that they must coordinate the home support services provided by the CSSSs in their territory using a global perspective that integrates support for persons with a disability and support for informal caregivers.[11]

Further to the amendments to the *Act respecting health services and social services* in 2004, CSSSs were entrusted with ensuring services to citizens on a territorial basis. The purpose of this re-organization was to bring services closer to people, foster service continuity, and ensure better taking in charge of vulnerable clientele, especially people with disabilities and people with a loss of independence.

So, while new CSSSs were subject to home support policy guidelines, they were given considerable freedom in managing service delivery. They became

10. *Ibid., p. 18.*
11. *Ibid.,* p. *30.*

responsible for choosing how they organize the regional services and resources they are allocated, in keeping with ministerial orientations.[12]

12. *Ibid.*, p. 31.

3 The Québec Ombudsman's Findings

In recent years, most agencies and CSSSs have revised their reference guides for home support services. The guides determine how these services are provided in a given region (regional reference guide) or CSSS territory (local reference guide). **In analyzing the guides, we found that while all of them are based on the policy, there are differences that can have direct adverse effects on the services offered to healthcare users.**

This section presents some elements that stray from the home support policy and some of the consequences for users, based on our analysis of the policy and what we found out about its real-life application. We have also included examples of these deviations. Some of the elements that stood out were:

- **new exclusion criteria;**
- **ceilings on the number of service hours;**
- **disparities in applying the policy;**
- **a decrease in service hours;**
- **longer wait times.**

Alongside this, we saw that there was a correlation between these elements and:

- **informal caregiver burnout;**
- **the impact on the healthcare system.**

3.1 *New exclusion criteria*

The home support policy establishes the exclusion criteria for the home support program. We noted at least three examples of exclusion criteria that did not comply with the policy: refusal due to private insurance; refusal due to the presence of an informal caregiver; and loss of services to private nursing home residents due to the availability of billable *à la carte* services.

3.1.1 Access to private insurance

The Québec Ombudsman found that in two regions, an agency and a CSSS established exclusion criteria limiting eligibility for the program that provides assistance with activities of daily living (ADLs) and heavy housework if users had private insurance. While the Québec Ombudsman does not object to this exclusion criterion per se, it notes that this restriction goes against the policy, which stipulates that the exclusion applies only to people whose services are supplied under another public plan. Nowhere is there any mention that people with private insurance automatically disqualify for the home support program.

3.1.2 Participation of an informal caregiver

The Québec Ombudsman also found that although the policy states that informal caregivers' involvement must be voluntary, the truth is that their participation is not necessarily the result of a free and informed decision. The guide that CSSS caseworkers use to gather data to determine eligibility for home support specifies that to qualify for the ADL program, a person must live alone or under the same roof as someone who has a significant and persistent disability and is unable to carry out activities of daily living. This wording runs counter to the idea that the natural caregiver's involvement must be the result of a free and informed decision. An agency removed this restriction from its normative framework after the Québec Ombudsman issued a recommendation further to the investigation it conducted.

Sudden application of new standards for access to domestic help services

In the course of the annual re-assessment of a user's service plan, the caseworker informed the user that she had to apply the CSSS's new normative framework for the home support program, leading to a significant decrease in the number of service hours he was allocated even though his level of autonomy had not improved. Note that users had not been informed about the new framework. The caseworker explained that from now on, to qualify for domestic help services, users had to either live alone or with a spouse experiencing a significant loss of independence. Since this was not the case, the user's service plan hours were cut from 29 to 15 a week. All of this happened in two weeks. At the same time, the user's spouse left him and the person who provided home support quit because of the decrease in her work hours. In losing his natural caregiver, the user re-qualified, which goes to show what a vicious circle the obligation to involve informal caregivers creates.

3.1.3 Loss of free home support services in private nursing homes

Based on the conclusions of complaints it received, the Québec Ombudsman observed that some CSSSs shirk their obligations by not covering home support services for seniors living in nursing homes. The policy specifies that "private" nursing homes are considered homes. This means that all residents of this kind of resource are entitled to the home support services determined further to an assessment by a CSSS. The Québec Ombudsman found that certain users are deprived of this right because their CSSS forces them to purchase à la carte services from the private residence.

Assuming that users will opt for billable à la carte services

A man deplored that he no longer had the right to home support because he had moved to a private nursing home for seniors that offers billable à la carte services which are not included in his lease. The user complained to the Québec Ombudsman because he could not afford the services. His CSSS had decided to take home care services away from users who move into a private nursing home that offers à la carte services, whether or not they can pay for them.

3.2 *Ceilings on the number of service hours*

Almost all of the reference guides or administrative directives of the CSSSs consulted have ceilings on the number of service hours, which are often well below what is required based on assessed needs.

These limits vary from region to region and range from 3 to 35 hours a week, depending on the type of service or target clientele. Further to an assessment, users are put on a waiting list and the hours that are not allocated may be redistributed to them when the CSSSs are given new budgets. In a context of insufficient or reduced financial resources, the rationale is to offer a minimum number of hours to as many people as possible.

One reference guide contains a note stating that there are not enough resources to fully meet the population's needs and that a constant juggling act is required to decide whether to increase services to existing clientele, provide access to services for new applications, or ensure equitable treatment for all.[13]

The Québec Ombudsman noted that, contrary to what is specified in the home support policy, all the ceilings set are below what it would cost for lodging in a residential and long-term care centre. In the situations analyzed, this could

13. CENTRE DE SANTÉ ET DE SERVICES SOCIAUX DE LA MONTAGNE, *Cadre de référence – Aide à domicile*, January 2011, p.9.

ultimately jeopardize people's safety and ability to continue living at home, especially those who need more service hours, even though the cost of their home support services is lower than the cost of lodging in a residential resource when these hours are offset under the Service Employment Paycheque program.

The Québec Ombudsman saw that this measure penalizes people with needs markedly above the prescribed hours more than those whose determined needs are closer to the maximum number of service hours granted.

No matter what the needs, the maximum number of service hours is the same

A severely disabled man was assessed by a CSSS caseworker. He was granted 38 home support service hours a week, but only got 20 hours a week, the maximum for the ceiling established in the normative framework for the CSSSs in his region. Grappling with insufficient resources and with a view to equity and regional consistency, the CSSSs had agreed to a ceiling of 20 service hours a week, whether a person needs 25 or 40 hours.

Some regions go even further by establishing different ceilings depending on whether a person is considered disabled or elderly.

For example, one reference guide states that a disabled person who is under 65 years old can receive up to 21 service hours a week, whereas a senior over age 65 with a loss of independence receives a maximum of 10 service hours a week for the same identified needs. This means that when the person with a disability reaches age 65, he or she loses 11 service hours a week.

3.3 Disparities in applying the policy

Among the difficulties that home support service users face is the disparity between regions, between CSSSs and even between the CLSCs in the same CSSS territory. In concrete terms, this means that there is no guarantee that people with the same assessed needs will get the same number of service hours if they move, even only a few blocks away.

Currently, people who need services hours would be well advised to get information before moving so that they are not dealt any nasty surprises.

A move affects the number of home support service hours

After a user moved, his home support service hours went from 14 to 10 hours a week. His new CLSC refused to recognize the number of hours he had before he moved. The agency had chosen service accessibility over service intensity. A maximum of 10 service hours a week is granted under the home support program. Given the funding allocated and the obligation to maintain a balanced budget, this criterion was established to guarantee a minimum level of services to all the clients in need.

3.4 Decrease in service hours

The desire for harmonization and a balanced budget have led to changes in the provision of home support services. These include a decrease in the number of hours allocated, in particular through the introduction of ceilings on the number of hours and the addition of exclusion criteria, which has had serious consequences for users.

Based on our analysis of citizens' complaints, we can say that some CSSSs have not taken appropriate measures to ensure that the users affected by these

change are sufficiently informed and receive all the support they need in finding alternative resources. The new normative frameworks are restrictive and too often applied without taking into account users' and their family's specific situation.

Because she can tend to her personal hygiene, a blind person loses all forms of assistance

A blind citizen received eight service hours a week for help with errands, grocery shopping, banking, or other domestic activities that required her to get around outside her home. However, she did not need any help inside her home or with her personal hygiene. Her CLSC determined that to qualify for domestic help services, applicants had to need help with personal hygiene. Based on this criterion, the CLSC took away her eight hours of supportive care and attention a week, which compromised her social integration.

In a variety of cases, the decrease in service hours happened within a very short time (two weeks) and just before summer holidays or Christmas. We found that in these cases the changes were ill conceived, with harmful consequences (insecurity, anxiety, distress) for many users. Self-employed workers, whom users come to trust, quit due to the decrease in the number of work hours and the impact on their earnings. This leads to a breakdown in service continuity.

When the reference guides were revised, some CSSSs created guidelines for the time allocated for each of the tasks performed by home support workers. These guidelines do not necessarily take into account users' current condition when homecare workers arrive.

The Department encourages the use of the Functional Autonomy Measurement System (ISO–SMAF). This model has the advantage of standardizing needs assessment and allocation of service hours. Caseworkers use the ISO–SMAF assessment form to measure individuals' autonomy. The scores are entered into a computer system that generates a needs profile. The Québec Ombudsman noticed that some CSSSs assign a rating to the 14 possible profiles to determine maximum funding. Standardized tools must be used with caution so that the response to high needs is not levelled down. A slight error in rating a need can skew results. Averages should never be used because people whose needs are ranked in the upper average zone (the heaviest cases) are always at a disadvantage. Lastly, we must always bear in mind that no matter how good computer tools are, they will never replace professional judgement.

Unintended effects of the assessment tool

After the annual re-assessment of her individualized service plan (ISP), a lady was told that her home support would be cut by two hours a week, even though her situation had not changed. She was not given any explanations. After she complained to the CSSS, the local service quality and complaints commissioner explained the changes made to the management framework and their impact on ISPs. The new framework uses the ISO–SMAF *assessment model promoted by the Department. From then on, the lady would be getting two fewer services hours a week because of this model and its computer application.*

When the Québec Ombudsman examined the grids that had been filled in, it noticed a slight difference in the ratings assigned to certain factors. The result was that the mathematical rule applied in this computer tool lowered the number of service hours required.

3.5 Wait times

We noticed that in certain CSSS territories, new users are put on a waiting list because there is no funding for their needs, and without any real priority management. They can wait for more than a year and sometimes several years.

Furthermore, some CSSSs use home support service budgets for other things when a user dies, is transferred to another region or is admitted to a permanent residential resource.

In the past, the amounts recovered were usually redistributed among people awaiting services, but in recent years, CSSSs have been funnelling these sums back into their general budget so they can achieve a zero deficit, as required by the Minister of Health and Social Services for fiscal 2010-2011. However, this way of proceeding runs counter to ministerial directives according to which achieving a zero deficit must not have a direct effect on services to users. When there was no budget increase, recovering these amounts was the primary way for most CSSSs to meet the needs of new clients.

A user has been penalized for several years because of the limits on the number of hours

A severely disabled woman whose health was deteriorating was evaluated in 2010. Under her individualized service plan (ISP), she was granted 35 hours a week of services. She had been getting only 4.5 hours of services per week since 2002 because that was the maximum amount for her territory of residence. This means that she had had to dip into her own savings to remain in her home and now her net worth was greatly reduced. Furthermore, her CSSS was dealing with a sizable deficit. The Department demanded budget consolidation and the agency was charged with monitoring application of the measures. After

waiting eight years, the woman is still 4th on a list of 87 people waiting for services at her CLSC. The total number of hours on waiting lists is estimated at 1,692 a week, 947 of which are classified priority 1. New applications are put on a waiting list and none of the applicants—whose needs were already recognized—are getting even a minimum number of hours, even in the highest priority cases. Applications for more service hours are also on hold.

3.6 Informal caregiver burnout

The Québec Ombudsman discovered that users on waiting lists are forced to do without basic services or have to ask the people around them or informal caregivers to help out more. We noted that the yawning gap between people's needs and the services offered leads to caregiver burnout, use of emergency services in hospital centres that provide short-term care, and the emergence of health problems related to pre-existing conditions.

The home support policy recognizes informal caregivers as playing a leading role in service continuity for people with disabilities or seniors with a loss of independence. An informal caregiver is defined as a person who provides significant support to a family member or friend.

To support informal caregivers, the policy provides for childcare or sitting services, depending on whether the user is a child or an adult. It also provides for respite care, emergency care, support for daily tasks, and psychosocial services.

As is the case for home support program recipients, there are few and sometimes no services for informal caregivers, and there is a waiting list to address the needs of natural caregivers.

This lack of response to the needs of caregivers leads to burnout, health problems, and a diminished ability to support the person they are caring for.

A few extra hours would make all the difference

The father of a 16-year-old service user contacted the Québec Ombudsman to complain about the wait time for obtaining extra services for his son whose needs had been assessed for all his activities of daily living and domestic activities of daily living. At the time, he was receiving 23 hours of services a week but he would have needed 12 more. He has been waiting for the extra hours since May 2006. We found that because of a budget shortfall, 37 other people were waiting for services from this CLSC, for a total of 407 hours. The father, who is the child's natural caregiver, wants time and energy to devote to his job and the other members of his family, like before. If he had help with daily tasks, he would be better able to fulfill his professional obligations and have some leisure time.

3.7 Impact on the healthcare system

We found that due to the lack of home support resources, people who no longer need to be in hospital continue to fill hospital beds in hospital centres that provide short-term care or in rehabilitation centres for long periods, sometimes for more than a year. In addition to being obliged to stay in hospital or at a rehabilitation centre, these people, through no fault of their own, take beds away from new users who need these kinds of service.

Rehabilitation centre instead of home due to lack of resources

A wheelchair-bound woman with a degenerative disease and a life expectancy of three to five years had been at a rehabilitation centre for seven months. Her home support needs had been assessed by the CLSC and set at 35 hours a week. However, last July she was informed that she would be getting only five hours a week because the CLSC had no money and the budgetary envelope was depleted. The woman could not go home under those conditions. She will continue to fill an active rehabilitation bed because of a lack of resources to enable her to return home.

In some regions, people hospitalized in emergency wards are given short-term intensive home support services (around three months) under programs established by the Ministère de la Santé et des Services sociaux to unclog the system and funded from the home support services budget. These programs do not solve the medium- or long-term problems of people with permanent disabilities. When the short-term intensive home support services program ends, these people become trapped in a revolving door leading in and out of emergency wards.

3.8 Analysis

The data collected during this investigation underscore the inability of certain local and regional bodies to apply the home support policy adopted by the Ministère de la Santé et des Services sociaux in 2003. The Québec Ombudsman has come to the conclusion that they cannot respect the spirit of the policy.

Analysis of the various complaint files reveals that certain users are awaiting services for:

- help with activities of daily living (including hygiene, getting out of bed or getting dressed);
- help with domestic activities of daily living (meal preparation, housework, laundry, etc.);
- support for civic participation.

For lack of resources, local bodies have had to develop practices that deprive users of the services necessary to meet their needs, thereby putting the onus partly or entirely on natural caregivers and contributing to the inappropriate use of beds in hospitals, rehabilitation centres or residential resources.

The Québec Ombudsman noticed that the biggest problems are related to the insufficient number of services hours for the required needs, and the wait time for services. More generally, it saw inflexibility in applying the criteria and a distinct trend towards a decrease in the number of allocated hours.

The main reason cited by health and social services institutions for their lack of compliance with the policy is the need to meet the Department's goal of a zero deficit at fiscal year-end. We found that this financial objective compromises the ability of a vulnerable clientele to continue living at home.

The Québec Ombudsman is deeply concerned about the impact that insufficient home support services have on the quality of life of users with a permanent disability or a loss of independence and on the safety of people living at home but waiting for home support services. We are currently witnessing a distribution of resources and justifications that give the

impression of equal accessibility for all, when, in fact, they barely meet the properly assessed needs of those concerned.

At the same time as an extra $45 million for home support for seniors was announced, the health and social services network was required to absorb $300 million in budget cuts in addition to achieving a balanced budget. Given this, the Québec Ombudsman wonders how the $45 million was really used.

The Québec Ombudsman also noted that clients can wait a long time before their needs are fully met. We found that some users and informal caregivers had been waiting for several years to have some of their needs, assessed and deemed required by professionals, met.

The Québec Ombudsman also saw that lack of home support resources has a direct impact on hospital or rehabilitation centre bed occupancy. For lack of home support, people who no longer need to be in hospital continue to fill hospital beds in hospital centres that provide short-term care or in rehabilitation centres for long periods, leading to clogging of the healthcare system. The official line is that everything is done so that users get the required care and services at the right place at the right time. **As a rule, home support services cost considerably less than hospital care and the Department policy states that users' choice to remain at home must be respected provided their health or safety is not compromised**.

The Québec Ombudsman therefore has cause to wonder why priority is not given to funding of a service aimed at achieving the goal of considering home as the option of choice for citizens.

The latest comparative study of public-sector home support expenditures in Canada,[14] carried out in 2007, found that Québec was below the Canadian average in 1994-1995 ($53.20) and 2003-2004 ($91.15). Figure 3 shows that Québec systematically spent less per capita in 1994-1995 ($41.72) and 2003-2004 ($78.93) than Ontario ($60.79 and $98.74) or New Brunswick ($93.18 and $156.35).

14. Canadian Institute for Health Information, *Public-Sector Expenditures and Utilization of Home Care Services in Canada: Exploring the Data*, March 2007.

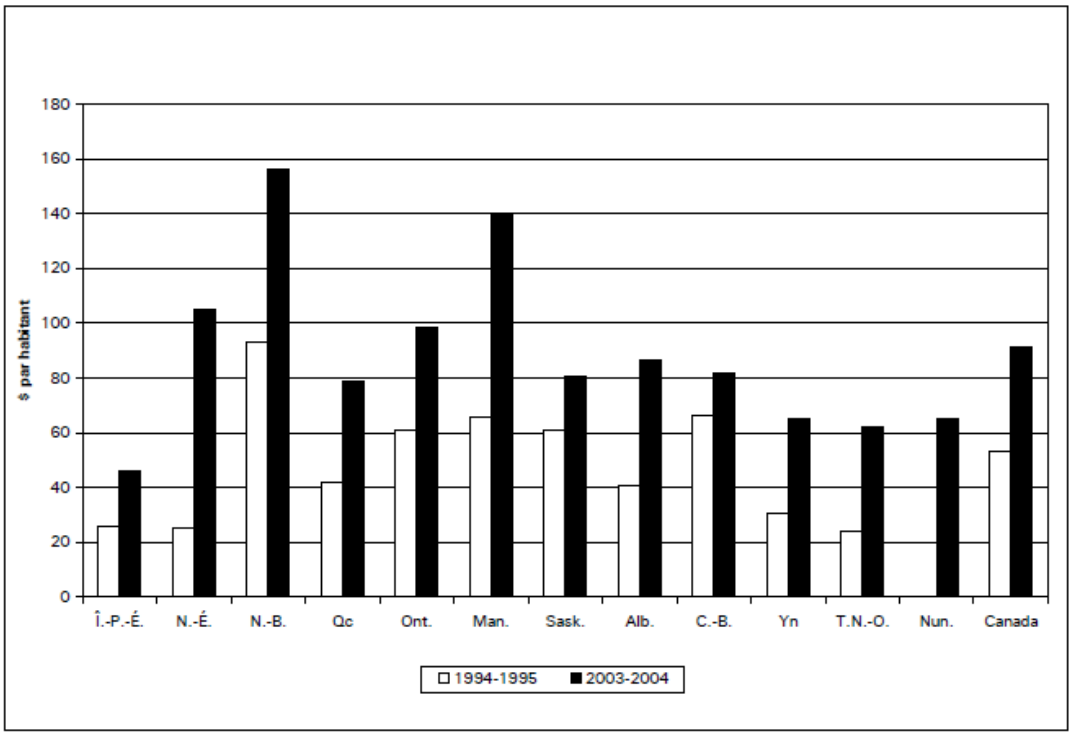

Figure 3: Level of Provincial and Territorial Government Home Care Spending per Capita, 1994-1995 and 2003-2004, Constant 1997 Dollars, Selected Jurisdictions and Canada[15]

A breakdown of spending on home care and home support shows that Québec is near the Canadian average for the former but well below the average for the latter.[16] In 2003-2004, Québec spent $31.79 per capita on home support services compared to Ontario's $54.97 and New Brunswick's $93.59. The authors note that in Québec, "home support growth was much slower than home health growth,"[17] because "home health played an increasingly important role in the delivery of home care services." [18] In short, among the provinces, Québec ranked among "the highest in the number of government-sponsored home health users per 1,000 inhabitants"[19] and Québec hovered around the Canadian average for home support services.

15. *Ibid.*, p. 9.
16. *Ibid.*, p. 16.
17. *Ibid.*, p. 17.
18. *Ibid.*, p. 17.
19 . *Ibid.*, p. 17.

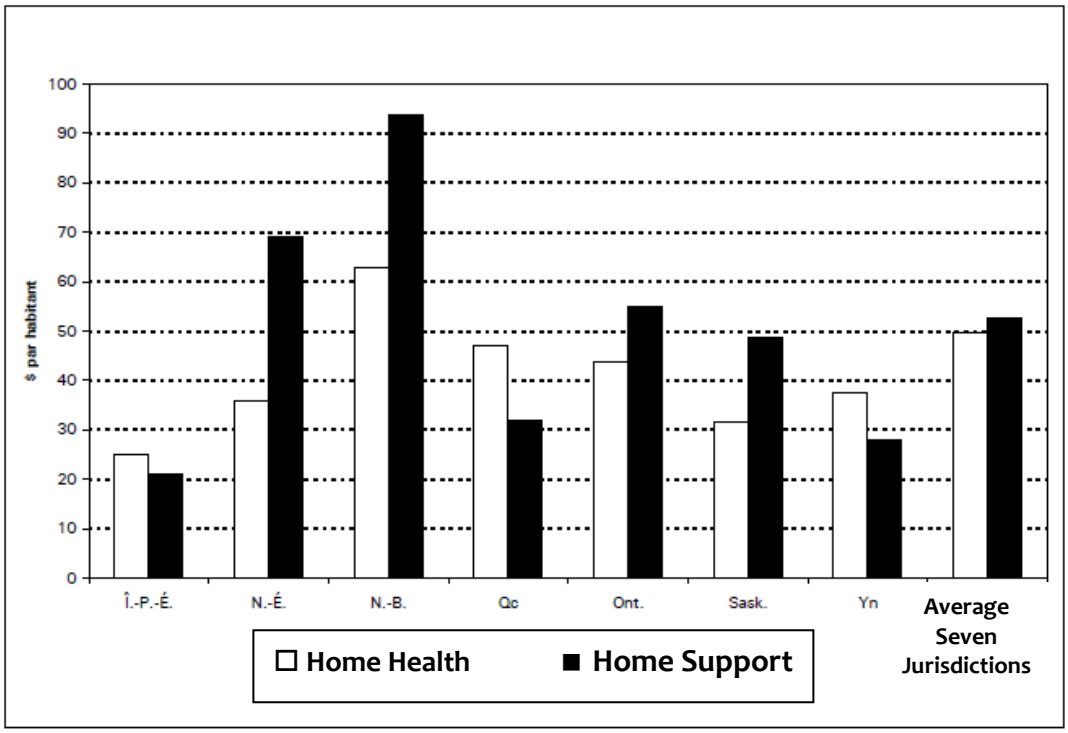

Figure 7. Level of Provincial/Territorial Government per Capita Spending on Home Health Care and Home Support, Seven Jurisdictions, 2003-2004 (Constant 1997 Dollars)[20]

While Québec's home support situation is different because of its use of fiscal measures and its Financial Assistance Program for Domestic Help Services, which factor in users' and their family's ability to pay, these data confirm what the Québec Ombudsman found when it analyzed funding of home support services.

20. *Ibid.*, p. 15.

4 Recommendations

Based on the facts brought to light during this investigation, the Québec Ombudsman made two recommendations aimed at ensuring that institutions can apply the home support policy.

RECOMMENDATION 1

Whereas this investigation showed that exclusion criteria that should not be applied, ceilings on service hours, and wide variations in terms of access to the home support program across the regions of Québec have made their way into home support services;

Whereas the Minister of Health and Social Services adopts general orientations, sets province-wide targets for each client category, and allocates resources to health and social services agencies;

Whereas services provided for pre-assessed needs and home support budgets are disproportionate, with detrimental effects for people awaiting services and for their informal caregivers;

Whereas many seniors or people with disabilities are waiting to receive home support services;

Whereas there is a risk that people with significant and persistent disabilities might be forced to move to residential resources before they need to;

Whereas, according to the latest study, Québec is below the Canadian average in terms of funding of home support services;

The Québec Ombudsman recommends that the Ministère de la Santé et des Services sociaux:

a) determine the level of funding needed for home support services by:

- analyzing the waiting lists for every region in Québec;
- producing a projection of needs for the next few years;
- benchmarking with other governments.

b) plan budget allocation so that the funding target is achieved;

c) allocate resources by differentiating between the various components of home support services (for people with a temporary disability, for people receiving palliative care, and for people with a significant and persistent disability).

RECOMMENDATION 2

Whereas the Ministère de la Santé et des Services sociaux is responsible for application of the home support policy;

Whereas the home support policy was supposed to alleviate disparities in the application of program parameters and the disparities persist in 2012;

Whereas the health and social services system is bearing the brunt of the lack of home support services and this is contributing to hospital bed and emergency ward overcrowding;

The Québec Ombudsman recommends that:

a) **the Ministère de la Santé et des Services sociaux** establish guidelines clearly setting out the slate of services available under the policy, according to the needs of the population;

b) **health and social services agencies and CSSSs** apply these guidelines and adequately inform the people in their region about the services provided and their availability.

The Québec Ombudsman asked that the Ministère de la Santé et des Services send it, no later than June 29, 2012, a work plan for implementing these recommendations, and report to it twice a year on the progress made with respect to this plan, until such time as all the recommendations have been implemented.

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