Models of Publicly Funded Home Care and their Characteristics

A Scoping Review

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Prepared By:
Marilyn Macdonald, Nadia Stec, Paulina Carrasco Salazar, Kristy Hancock

Contact:
Marilyn Macdonald

Email: marilyn.macdonald@dal.ca

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SPOR Evidence Alliance operates from the St. Michael's Hospital, Unity Health Toronto which is located on the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island.

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We are grateful to have the opportunity to work on these lands.

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Project Contributors

Marilyn Macdonald, Co-PI, Dalhousie University
David Litvack, Co-PI, Citizen Partner
Rochelle Litvack, Co-PI, Citizen Partner
Paulina Carrasco Salazar, PhD Candidate, Dalhousie University
Nadia Stec, Research Associate, Dalhousie University
Ali Hammoud, Research Assistant, Dalhousie University
Alysa Barker, Research Assistant, Dalhousie University
Grace Magro, Trainee, Dalhousie University
Kristy Hancock, Librarian, Maritime SPOR SUPPORT Unit

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Abbreviations and Definitions

Abbreviations

CHA	Canada Health Act
AHS	Alberta Health Services
OHIP	Ontario Health Insurance Plan
HCP	Home Care Package(s)
CDC	Consumer-Directed Care
ICHC	Increasing Choice in Home Care
HCSS	Home and Community Support Services
DP	Direct Payment
CfC	Cash-for-Care
NHS	National Health Service

Key Definitions: None.

EXECUTIVE SUMMARY

Background: The proportion of older adults in Canada is growing, and the resulting increase in individuals with health challenges requiring home care will have implications for home care services. The staffing resources required to meet home care clients' needs, particularly matching needs to home support worker skills and the lack of continuity of care, leave clients and families stressed and worried about the availability and the quality of care.

Objectives: To identify models of home care and associated characteristics within Canada, the United Kingdom (England), Denmark, Sweden, Australia, and New Zealand (countries with similar publicly funded systems), and to include evaluation information where available of the identified models in relation to quality, patient and family satisfaction, and level of integration with the health and social care systems.

Design: JBI Methodology for Scoping Reviews.

Methods: The search aimed to identify published and unpublished literature about community-dwelling older adults living in their own home, with a caregiver and receiving home care and/or home support. Published literature was sourced from MEDLINE, Embase, and CINAHL, and grey literature was sourced from Google and relevant websites. All citations were uploaded to Covidence, and duplicate references removed. Screening of titles, abstracts, and full texts was completed by two independent reviewers against inclusion criteria. The exclusion reason was recorded for sources excluded at full text review. Data extraction for included full texts was completed by two independent reviewers and recorded in Covidence. Extracted data related to characteristics of home care models underwent qualitative content analysis.

Results: The search returned 8513 references, and 3163 duplicate references were removed in Covidence, 5350 titles and abstracts were screened and 5224 excluded. One hundred twenty-six (126) full texts were screened, and 112 excluded, and a total of 14 citations underwent data extraction. The grey literature search found a total of 69 citations, and after screening, 4 were included. Six models of home care were identified; Integrated Primary Care/"Home is Best", Ontario Health at Home, Consumer Directed Care, the Nordic Welfare Model, Cash for Care/Direct Payments, and Family Model of Care. Analysis of the associated characteristics identified the following themes: relational quality as a foundational element of care, workforce sustainability, autonomy and administrative responsibilities, integration, cultural responsiveness and community governance, and pressures and adaptability.

Conclusion: Analysis of home care model characteristics identified two overarching insights: relational and equity dimensions consistently shaped how home care was experienced, and the evidence base remains dated, with few outcome-focused evaluations since 2019. Trends in integration of primary care, home care and social support are noted across models. Generating robust, outcome-focused, and comparative evidence will be essential in guiding reforms that uphold equity, relational quality, and sustainability in publicly funded home care for older adults.

Introduction

As the proportion of older adults in Canada and elsewhere grows, the increase in individuals requiring home care and or home support will have implications for health and social care services, including home care. Home care supports include services such as nursing, rehabilitation, personal support services (e.g., bathing, repositioning, assistance with grooming), as well as respite for caregivers.[1] These services are intended to help older adults remain safely in their own homes for as long as possible.

A major concern for home care clients and family caregivers is the matching of human resources to meet client and family caregiver needs; the match is fundamental to satisfaction of both the clients and caregivers. Additionally, older adults with chronic health conditions and disabilities have greater support needs and require consistency in their support.[2] In a systematic review of home care for older adults in Canada, Johnson et al. (2018) stated that there is still little known about home care, including gaps in service and interventions to support client needs.[3] In Canada the structure, provision, and funding of home care services are decided by each province/territory and as a result, there is variability in service and priorities across the country.[4]

Home care is not an insured service under the Canada Health Act. Despite this, all Canadian jurisdictions have home care programs that vary in nature, level of integration with health and social services systems and funding model. Recognizing this variation and knowing that Canadians want to remain in their homes for as long as possible the Canadian Home Care Association published *The Enhanced Framework for Integrated People-Centered Care* in March of this year.[5] A framework that calls for the integration of primary care, home care, and community services. More than a decade ago, Fraser Health, one of five Health Authorities in the province of British Columbia (BC) initiated "Home is Best" integrating acute care medicine, primary care and community care under a single executive lead.[6] The goal is to optimize the time clients remain in their home. The BC model does capture the spirit of the integration called for in the Enhanced Framework for Integrated People-Centered Care. The framework acknowledges the need for resources but not funding which rests with each jurisdiction.

There are countries that have a universally publicly funded health and social care system that includes home care and social supports. For example, Sweden and Denmark are known for the Nordic Welfare Model, which emphasizes social rights with egalitarianism as a goal.[7] The universalism central to this model means services are offered based on need rather than purchasing power, making them accessible to all socioeconomic levels.[8] Overall, for older individuals requiring care, it is more common in Denmark to receive tax-funded home care, whereas in Sweden help from one's family is more common.[7] In Australia, government-funded home support for older individuals is provided through home care packages, and since 2015, packages have been "consumer directed"[9], meaning clients have the right to choose and change their provider, know their budget, and be involved in choosing their services.

Few recent evaluations of models of home care were captured in the searches except for Australia, where five-yearly evaluations have been conducted since the introduction of consumer-directed-care in 2011. Evaluations reveal that quality of life and financial autonomy improved among participants while no significant changes were reported in relational or psychological outcomes, perceptions of information, support quality and confidence in self-management.[10]

Models of Publicly Funded Home Care and their Characteristics

The conduct of a scoping review necessitates a search for existing and or related reviews on the topic. One related review was located, conducted in 2018 to "identify characteristics of home care recipients, gaps in service, or interventions to support home care clients".[3] The review followed PRISMA reporting guidelines, however, no design was identified, and models of home care were not identified or examined. Among the findings of note are that funding models and eligibility criteria contribute to unmet needs, satisfaction reports were mixed and the home care workers needed further education and training as well as remuneration. The authors also called for research to identify best practices, models for service provision and national standards.

The projected need for home care and social support in Canada is well documented.[11,12] All Canadian jurisdictions are responsible for the delivery of health care including home care. Models vary across jurisdictions as does accessibility. Little is known about the various models, their characteristics and recent evaluations of models here and elsewhere.

The objectives of this scoping review are (1) to identify home care models and their characteristics in Canada and countries with somewhat similar healthcare systems (United Kingdom, Denmark, Sweden, Australia, and New Zealand); and (2) to include evaluation information where available of the identified models in relation to quality, patient and family satisfaction, and level of integration with the health and social care systems. The research question is: what is known about home care models for community dwelling older persons, their characteristics and quality in Canada, Denmark, Sweden, Australia, New Zealand and the United Kingdom? In collaboration with Citizen Partners, the goal is to share the findings of this review to assist decision and policymakers in optimizing home care delivery that meets the needs of clients and their families.

Methods

Eligibility, Inclusion/Exclusion Criteria

This review included citations involving individuals aged 60 years and older, living with a caregiver (e.g., family member or close friend), community-dwelling (living in their own home) and receiving publicly funded home care.

All study designs were included, as well as citations specifically about models, programs, or frameworks of home care in Canada, Sweden, Denmark, the United Kingdom, Australia, and New Zealand, published in 2005 or later. Additionally, citations were included if they described characteristics and/or evaluations of home care models or programs, as well as outcomes and quality of the models or programs (e.g., client and caregiver satisfaction). Excluded were individuals aged 60 and older living alone, in assisted living or in an institution (for example, a long-term care home), or designated as receiving palliative care.

Searches – Sources of Data

The searches aimed to identify published and unpublished literature. Published literature was sourced from MEDLINE (Ovid), Embase (Elsevier), and CINAHL Ultimate (EBSCO). The initial database search was developed in MEDLINE (Ovid) using keywords and subject headings to

describe the following concepts: older adults, home care, caregivers, and workforce. Some search terms for older adults and home care were sourced from a systematic review protocol.[13] Search results were limited to studies published from 2005 onwards to capture more recent home care models, particularly within the last decade. No other search limits were applied. The MEDLINE search was peer reviewed by a second librarian using the PRESS checklist[14] and adapted to the other databases. All database searches were executed on July 19, 2024, and are reported in Appendix I.

Unpublished literature was sourced using Google and relevant websites on January 20th, 2025, and January 28th, 2025. The search used in Google was "[country/province] home care policy", and each website on the first page of results was manually browsed to check for relevant information. In addition to the searches, government websites that had been considered high-level sources of background information prior to the grey literature search were also further manually browsed to determine whether they should be included in grey literature. Grey literature searches and websites are also reported in Appendix I.

Data Collection

All search citations were uploaded to Covidence (Veritas Health Innovation, Melbourne, Australia) and duplicate references removed. Screening of titles and abstracts was completed by two independent reviewers against the inclusion criteria. Full texts of potentially relevant studies were retrieved, and their citation details imported into Covidence.

Full texts of included citations were assessed by two independent reviewers against inclusion criteria, and reasons for exclusion were recorded for full text articles that did not meet inclusion criteria. Any disagreements between reviewers during this process were resolved through discussion or through consensus with a third reviewer. All results of the search and selection process are presented in a Preferred Reporting Items for Systematic Reviews (PRISMA) flow diagram (Figure 1).[15] Additionally, the PRISMA-ScR checklist is incorporated in this review for full transparency.[16]

Data extraction from included citations was performed by two independent reviewers using a pilot-tested data extraction tool adapted for this review (Appendix II). Data extracted includes details about the author(s), year, country, sex and gender, citation, aim/purpose/objective(s), design, methods, population, context, model, characteristics, reported outcomes (health and social), evaluation, and key findings related to the research question and objectives. Any disagreements between reviewers during data extraction were resolved through discussion or through consensus with a third reviewer. Extracted data is presented in Appendix III.

Data analysis

Extracted data where appropriate underwent qualitative content analysis[17] to address the scoping review aims and question. This included identifying the respective models and their characteristics by country and jurisdiction within a country if applicable. Evidence of evaluation of a model of home care that underwent evaluation was examined. The findings from the analysis are reported in narrative summary and the PRISMA flow diagram to detail the screening process, as well as tabular summaries to illustrate the findings.

Diversity and Sex and Gender Equity in Research Frameworks

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The PROGRESS-Plus Characteristics framework[18] was used to assess the diversity and intersectionality across the population in each study. The framework is designed to capture the following characteristics: disability, equity, ethnicity, gender, race, religious background, sexual orientation, and social capital.

This review is specific to older adults receiving home care or home support, who may be living with disabilities. During the data extraction portion of the review, data from included full text sources was extracted according to the listed characteristics where possible. In the analysis of the findings, attention was given to outcomes reported in relation to priority populations. The review findings are discussed in relation to PROGRESS-Plus characteristics, applicability for populations experiencing inequities and how they may affect study findings.

The Sex and Gender Equity in Research (SAGER)[19] guidelines are a comprehensive tool for standardized reporting of sex and gender information in study design, data analysis, results, and interpretations. These guidelines were also used to report on priority populations (if reported) in extracted data from full text sources. Whether authors address gender and sex in their studies will be reported in this review.

Results

The database search returned 8513 citations, 3163 duplicates were automatically removed upon uploading the citations to Covidence, and 5350 citations were reviewed at the title and abstract screening stage and 5224 records excluded. One hundred twenty-six citations were included and their full texts screened for eligibility; 112 full texts were excluded, and 14 citations underwent data extraction. The screening process is summarized in the PRISMA flow diagram (Figure 1). The grey literature search resulted in a total of 69 citations, and after screening, 4 citations were included.

The 14 citations from databases were published between 2009 and 2023. The countries of origin for the citations were Canada[20–23], Sweden[7,24,25], Australia[10,26–29], the United Kingdom[30], and Denmark[7,31]. Among the 14 publications, two were not research studies.[20,21]

Designs included cross-sectional surveys[10,24,25], interrupted time-series analysis[26], secondary data analysis[7], discrete choice experiment[27], randomized controlled trials with add on qualitative descriptions[30], implementation research[23], case study participatory action research[28], and qualitative studies with designs including thematic analysis[10,22], constructivist grounded theory[29], and reflective ethnographic approaches[31]. The two non-research publications included a descriptive “portrait” of Canadian urban home-based primary care programs and their features,[20] and a reflection on home care needs of rural and remote individuals in Ontario, Canada.[21]

The number of older persons that participated in the included studies is approximately n=66,166. This number is approximate because it was not always clearly delineated. The numbers of people over the age of 80 receiving home care is higher than for people aged 60-80 years.

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Diversity and Sex and Gender Equity

Overall, the data extracted reported biological sex and not gender with one exception. One included study was with an Indigenous population in Australia[28], gathered gender specific data and stressed the importance of attending to the cultural context and ethnic origins of populations in home care, while another reported the diversity of the study sample[30]. A Swedish study[24] used an equity lens to examine the views of older users' experiences of choice in relation to the traditional provider driven model versus client choice of provider and services or client choice of services. Likewise, a study comparing the Nordic Model between Denmark and Sweden an equity lens was employed[7].

Several home care models were described across the included publications, such as; Integrated Primary Care/"Home is Best"[20,22,23], Ontario Health at Home[21],[34], Home Care Packages Program[10,26], Consumer Directed Care[10,29], the Nordic Welfare Model[7,24,25,31], Cash for Care/Direct Payments,[30] and Family Model of Care[10].

Appendix III provides a comprehensive summary detailing the key characteristics of all included studies. This table offers an overview of study designs, participant demographics, data collection methods, and key findings for each study included in this scoping review. Appendix IV contains characteristics of the home care models in the countries included in this scoping review. The following section describes these models of home care by country.

Canada

Home care is not an insured service under the Canada Health Act (CHA).[1] The focus of insured services under the act is physician and hospital services. Home care is considered an extended service and all provinces and territories in Canada vary in the nature and extent of services provided. All provinces and territories are responsible for the delivery of home care. These jurisdictions receive transfer payments in compliance with the requirements of the act that do support efforts to deliver home care, yet not to the extent afforded hospital and physician services. Each province and territory in the country decide what home care services are delivered and how. Examples of what the models look like in the provinces of British Columbia, Alberta, Manitoba, Ontario, and Nova Scotia are outlined below.

British Columbia

Home and community care is cost shared and means tested between the Ministry of Health and home care clients and administered through the Health Authorities (five plus the First Nations Health Authority). One of these five is Fraser Health serving approximately two million people making it one of the largest in the country. The model in Fraser Health is known as "Home is Best" integrating acute care medicine, primary care and community care under a single executive lead. The goal is to optimize the time clients remain in their home. Regular case review meetings are conducted by a partnership beteween a Case Manager and a General Practitioner.[23] The Ministry of Health 2017-2021 Action plan injected 500 million dollars? to strengthen home and community care for seniors.[6]

Characteristics

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BC home care is characterized by coordinated and integrated community care; home and community care actively working with primary care practices; comprehensive case management and coordination of services across medical specialists, home nursing, and home support; negotiated increases for home support service hours; leveraging of other health care professionals and technology for in-home monitoring; linkage and coordinated access to other health services including diagnostic, hospital care, and specialized regional and provincial services.[23] Health Care Assistants complete a recognized training program to be added to the care assistant registry.

In tandem with coordination and integration of home, community, primary care and hospital care is connecting older people with HealthLink BC and the Office of the Seniors Advocate to build BC's Aging Well Strategy. Integral to the strategy is health promotion, introducing older people to actions that can be taken to maintain health and independence in their 60/s, 70's, 80's and beyond. Such actions include services offered by the office of the Provincial Dietitian, physical activity services at HealthLink BC, healthy eating for seniors handbook, farmer's market nutrition coupon program, food skills for families and and active seniors curriculum.[23]

Alberta

Alberta Health Services (AHS) Continuing Care Act (April 1, 2024)[32] includes home care, long-term care, hospice and assisted living to enable people to live at home as long as possible. Services are publicly funded and means tested. AHS and their contractors provide in-home support, healthcare services are supported by a team of professionals depending on expertise required including nursing, social work, occupational therapy, physiotherapy and others. Health Care Aides receive an 8-12 month training program via AHS. Information resources provided include client directed home care, client and family information packages, keeping well brochure and client directed home care invoicing information

Characteristics

Home care in Alberta is characterized as being publicly funded; means tested; offering clinical care and home support; care coordination; Self-Managed Care option available; client/family centered; promotes aging at home; supplies information resources and a Health Care Aide Training Program.

Manitoba

Manitoba Health established Home Care Services[33] more than 50 years ago and is considered to be the first "comprehensive, province-wide, universal service in Canada". Healthcare and support services are provided based on assessed need. The five regional health authorities in the province plan, deliver and manage home care.

Characteristics

Home care is characterized as universal; publicly funded; needs assessed; offering clinical care and home support; a Self/Family Managed Care Option; and in-home respite for short periods of time.

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Ontario

Ontario Health atHome[34] is delivered by 58 Health Teams across the province. Teams are made up of providers and organizations representing primary care, hospitals, home and community care, mental health and addictions and long-term care. One patient record and one care plan shared across providers. The Ministry of Health and Ontario Health began this year to support 12 teams to implement a seamless transitioning of individuals with chronic illnesses through primary care, hospital, and community care. Teams are located in urban, rural and First Nation communities. Coverage is provided via the Ontario Health Insurance Plan (OHIP).

Characteristics

Ontario Health atHome characteristics include anyone may refer; assessment of need; care coordination; care teams comprised of - Nursing, Physiotherapy, Occupational Therapy, Nutritional counseling, speech therapy, social work, personal support, supplies and equipment Telehomecare and the option of Family Managed Home Care.

Nova Scotia

Home First, Nova Scotia Health Continuing Care[35] including home care is funded by the government of Nova Scotia through the Ministry of Seniors and Long-term care. The model is deemed evidence based, person-centered and aims to provide care where you live. Older people receive nursing services either short or long-term as well as means tested home support. Nursing services are provided by either the Victorian Order of Nurses or Nova Scotia Health. Home support is contracted through several for profit and not-for-profit home care agencies.

Characteristics

Home care in Nova Scotia is characterized by valuing aging in place; provision of nursing care and means tested home support; care coordination; the option of self-managed care; respite and caregiver support as well as provision of health-related equipment.

Australia

Australia's home care system is built around the Home Care Packages (HCP) Program, which represents the country's publicly funded system enabling older adults with complex needs to remain at home. The Living Longer Living Better reforms (2013) introduced Consumer-Directed Care (CDC) principles that emphasized choice, flexibility, and consumer input.[26,27,29] Building on this, the Increasing Choice in Home Care (ICHC) reforms (2017) shifted package allocation from providers to individuals, ensuring that funding follows the consumer and can be transferred between providers. Care is organized into four levels (Levels 1–4) aligned with escalating intensity of care and support needs.[26]

Self-management (HCP-CDC) is an option offered by some providers as an extension of the Consumer-Directed Care approach. With this approach, consumers or their representatives assume greater responsibilities in managing their packages. This may encompass directly

recruiting and supervising support workers, paying wages, using a debit card to make authorized purchases, and reducing administration costs charged by providers.[10]

Characteristics

The Australia HCP model is characterized by being publicly funded; providing nursing and home support services, autonomy through a consumer directed option; choice; portability allowing individual allocations to follow consumers if they change providers[26]; integrated case management and clinical oversight, including care planning, coordination and information resources [29] and integration with the Commonwealth Home Support Program that delivers meals, transport and domestic help enabling older people to remain at home. This model is also characterized by cultural responsiveness, illustrated by the Yuendumu Old People's Programme's "Family Model of Care," which integrates Warlpiri cultural protocols, kinship governance, and community control. This model demonstrates the importance of cultural safety as a quality dimension in Indigenous contexts.[28]

Evaluations

A 2022 mixed-methods evaluation of self-management demonstrated significant improvements in quality of life and financial independence among participants and no changes in relational or psychological outcomes. Qualitative findings included reports of increased choice, control and access to community resources. No evidence of fraud was found contradicting concerns about consumer capacity for self-management.[10]

A 2020 grounded theory study reported home care staff as trustworthy, dementia literate and having communication skills. Findings related to service quality were mixed with positive teamwork and responsiveness but offset by poor communication, staff retention challenges and task orientation. Consumers actively managed service quality by establishing criteria for desired staff characteristics and providing feedback to providers.[29]

Another 2020 study used an interrupted time series design capturing a significant decrease in new recipients at one provider agency after the 2017 reform shifting package allocation from providers to individuals. New recipients were younger and partnered pointing to potential system inequities.[26]

New Zealand

The Continuum of Care Model in New Zealand is publicly funded and integrates retirement villages, serviced apartments, residential aged care facilities, and home care services within the same site. It is designed to provide seamless transitions as care needs change, improve efficiency through shared infrastructure and resources, and enhance resident choice in both accommodation and care options (Wilkes, 2022). New Zealand's home and community support services (HCSS) operate under the National Framework for HCSS (2020), developed to reduce fragmentation across District Health Boards (DHBs) and establish nationally consistent, person-centred care. Eligibility applies to people aged 65 years and over with assessed needs and extends to Māori (55+) and Pacific peoples (60+) in recognition of differential ageing and health inequities.[36]

The model of care prioritizes independence, daily participation, and ageing in place. Core processes include standardized interRAI assessments, person-directed support planning, and a case-mix methodology for equitable funding allocation.

Characteristics

The model is national in scope to reduce fragmentation across District Health Boards; focused on restoration, independence, and participation; person-directed to involve older adults and whānau in goal-setting and decision-making; uses interRAI assessments linked to outcome monitoring; offers an integrated continuum of care; cultural responsiveness, embedded through *te Tiriti o Waitangi* and *He Korowai Oranga*, applying *Pae Ora* principles of *Whānau Ora, Mauri Ora, and Wai Ora;* workforce standards including pay equity.

Evaluation 2023

A 2023 sector analysis of the continuum of care from living at home through institutional care reported multiple benefits, including smoother transitions between levels of care, efficiencies through economies of scale, and streamlined provider coordination. Importantly, the model was noted to expand consumer choice and reduce stigma by encouraging earlier entry into retirement communities with guaranteed access to care if needed. Workforce initiatives such as achieving nurse pay parity with the health sector were also highlighted as critical to improving recruitment and retention. The report emphasized that this model offers valuable lessons for Australia, where aged care continues to face challenges of fragmentation, limited choice, and workforce instability.[37]

United Kingdom – Cash-for-Care/Direct Payments

Healthcare in England is predominantly provided through the National Health Service (NHS) by way of the Ministry of Health and Social Care. Healthcare is publicly funded, and the home support provided is means tested. Home care can be purchased by those requiring services from independent home care agencies or accessed through social service departments of local health authorities.

Local authorities (or trusts in Northern Ireland) offer a Cash-for-Care/Direct Payment (DP) system once potential clients have their care and financial needs assessed, and a care plan is agreed upon.[38] DPs were initially extended to include older people in the year 2000[39], and this option utilizes payments or access to specified monetary resources (at the value of the services they have been assessed as needing) paid directly to clients' bank accounts, allowing them to manage their own care services rather than the authority or trust.[40]

DPs aim to promote consumer choice, control, and personalized support for individuals whereby they are enabled to develop their own support arrangements. Additionally, DP systems aim to stimulate demand for new services, break monopolies, and support family care, and some small studies suggest older people are satisfied with CfC schemes because they do have greater choice and control, improved quality of life, sense of happiness, and can do more for themselves.

As of 2005 Individual Budgets (IBs) were piloted to offer greater choice and control to older/disabled adults in receipt of social care services (piloted in 13 local authorities in England from 2005-2007).[30] The IBs aimed to combine resources from several funding streams into one overall budget, streamlining number of assessments and reviews for service users, allowing budgets to be spent flexibly to meet client needs and desired outcomes. IBs provided even greater advantages along with choice and control such as compensating family and friends for their help, respite, and improved wellbeing and social participation.[30]

Characteristics

The Cash for Care model is characterized by its public funding; choice and control when planning care, continuity of care workers with IBs in place is advantageous and support is personalized; administrative demands daunting in relation to assistance needed with self-management and administrative demands of recruiting and hiring care workers.[30]

Evaluation

No evaluations found between 2019 and 2025.

Sweden

The Nordic Welfare Model emphasizes public-sector responsibility for basic welfare like health, social services, education, and housing.[41] This model is based on a high degree of universalism which entitles citizens to basic social security and services. Health services are funded by taxes and local and regional authorities in 290 self-governing municipalities that organize and provide the services directly.[24] Local authorities work with public and private care agencies, which older people can choose from.[24]

Since April 2016, 158 Swedish municipalities have implemented Systems of Choice (Swedish free choice system), though in municipalities that have not introduced this free choice system, they use their own models of individualised elder care through publicly provided home care services. Ultimately, the municipal board of social welfare leaves discretion with care managers who are expected to make assessments and decisions based on local guidelines for eligibility criteria.[42,43]

Sweden's policies preserve well-being, independence, and dignity of the older person. The preventative approaches keep people in their home as long as possible. Swedish home care is a well-integrated system characterized by providing autonomy, respect, continuity, satisfaction, caregiver benefits, coverage, accessibility, equity, and trust. Although like other countries following the Nordic model, Sweden is more restrictive in its accessibility, focusing on providing care to the frailest individuals.[7]

Characteristics

The Nordic Model as operationalized in Sweden is characterized by a high degree of universalism, public funding, needs-driven – the greater the need, the greater the likelihood of receiving service, and people trust in the system.[7] Local and regional authorities provide health services directly; prioritize well-being, independence/autonomy, dignity, and preventative approaches[7]; embrace continuity in services primarily provided by public sector professionals[7],

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and the interpersonal aspects of care matter: knowing the client, meeting their needs with respect results in quality care (person-centred care).[25] Caregiver benefits are provided however there is an increased reliance on family caregivers and signs of inequity in relation to income.[7]

Evaluation

Dunér et al. (2019)[24] conducted a study to investigate how older home care users view and experience their opportunities of exerting influence and having choice and control in their everyday living, in terms of receiving preferred services that are flexible and responsive to their actual needs and priorities. A postal survey (n=2,792) followed by qualitative interviews (n=28) were completed. The survey of older individuals (aged 65 and older) found that the municipality with provider choice (services are publicly funded but users can choose b/w different providers both public and private) had highest percentages of positive results across three questions (whether they had the possibility to choose provider, whether they got the provider they wanted, whether the staff respected their views and wishes), and the traditional service choice model (services are publicly funded and provided) had most positive results on two questions (whether the care manager's decisions were adjusted to their personal needs, overall satisfaction with their care). The municipality with the service choice model scored lowest on all 5 questions.

Denmark

Denmark, like Sweden, is also considered one of the best countries for older people to live. Danish home care is a well-integrated system and is also characterized as providing autonomy, respect, continuity, satisfaction, and caregiver benefits, as well as accessible and equitable care. In contrast, the coverage in Denmark is broad and inclusive across all social classes, and access is broader to support older adults living independently at home.[7] As a result, there are typically higher rates of public home care use in Denmark.

The goal of elder care in Denmark is to maintain people’s independence and control of their life, improve their quality of life, and remain healthy and living in their own home for as long as possible.[44] This is predominantly achieved through prevention and reablement programmes provided by local authorities, in addition to publicly funded home care services. Municipalities assess individual needs and provide services as required, and since the principle of free choice is critical to Danish aged care, the municipality must provide a choice between at least two different home care service providers.[44]

Characteristics

The Nordic model as operationalized in Denmark is characterized by being publicly funded; providing health care and social support; equitable across social class; integrated; promotion of autonomy; provision of caregiver benefits so that families are not obliged to provide care, particularly women of the family as this work falls on them more often.[7,45]

Evaluation

No evaluations found for years 2019-2025.

Discussion

This scoping review mapped the available literature on publicly funded home care models for older adults across six high-income health systems and synthesized their reported characteristics, with particular attention to quality, client and caregiver satisfaction, and the extent of integration within health and social care. In accordance with JBI methodological standards[16,46], the analysis employed a descriptive and thematic approach, grouping models into four broad categories: provincial and territorial systems in Canada, consumer-directed arrangements in Australia and the United Kingdom, nationally coordinated frameworks in New Zealand, and universal welfare models in Sweden and Denmark.

Despite structural variation, the mapped evidence pointed to several recurring themes that transcend individual contexts. Relational quality and workforce–client alignment were consistently positioned as central to how older adults and caregivers assessed the value of services. Workforce sustainability emerged as a cross-cutting challenge that influences both system performance and client experience. Consumer-directed approaches were marked by tensions between expanded autonomy and administrative responsibilities. Integration was widely described as an aspiration, yet its translation into practice was uneven. Cultural responsiveness emerged as critical to equity and trust, particularly when embedded through governance structures. Universal systems were reported as subject to pressures but also as demonstrating adaptability under demographic and fiscal strain. Across all themes, the literature highlighted a scarcity of robust evaluations conducted after 2019, constraining opportunities for cross-national learning and limiting insight into how models and reforms are performing under contemporary challenges

Relational Quality as a Foundational Element of Care

Within the included literature, relational quality consistently emerged as the primary lens through which older adults judged whether home care was supportive and meaningful. Evidence emphasized that quality was experienced not only through technical service delivery but also through trust, respectful communication, mutual recognition, and continuity of care.[24,25,29,31] In this regard, interpersonal workforce alignment—the extent to which a care worker's skills, communication style, and cultural orientation resonate with the unique needs of clients and their caregivers—was positioned as essential for positive perceptions of quality.

Research conducted in Sweden and Denmark suggests that satisfaction is significantly associated with attentiveness and relational engagement, whereas rigid bureaucratic procedures have been reported to undermine dignity and inclusion.[24,25,31] Evidence from Australia emphasizes the susceptibility of relational quality to workforce turnover, with interruptions in continuity identified as factors that diminish trust, especially within the context of dementia care.[29]

Broader evidence reinforced these findings, indicating that older adults frequently prioritize interpersonal elements, such as trust and personalization, over structural or administrative performance metrics.[47] Continuity of care has also been associated with improved functional outcomes and reduced risks of adverse events.[48] At the same time, conceptual models of relationship-centred care emphasize that supportive environments, which foster recognition and a sense of belonging, are essential for sustaining both client well-being and workforce

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retention.[49] The mapped evidence positions relational quality not as a peripheral aspect of service delivery but as a structural determinant of care experience, foundational to the sustainability of home care reforms.

Workforce Sustainability

The sustainability of the workforce was consistently described as a recurring influence on the quality and reliability of home care. In Australia, high staff turnover was associated with disruption of continuity and erosion of trust, particularly in dementia care where stability and familiarity were reported as essential.[29] Swedish evidence indicated that rigid organizational frameworks limited workers' autonomy, constraining their ability to adapt services to individual needs and undermining sustained person-centred practices.[24] Danish studies pointed to tensions between professional recognition of older adults' needs and standardized delivery models, which, through reliance on predefined functional assessments, reduced flexibility and risked depersonalizing clients with complex conditions.[31] At the policy level, reforms in Sweden that narrowed eligibility to only those with the highest needs shifted responsibility to families, particularly among older adults with limited financial resources, raising concerns about equity and the long-term sustainability of the formal workforce.[7]

The challenges of the workforce were echoed more broadly in research that illustrated how workers derive professional pride from relational engagement, but simultaneously express frustration when structural constraints—such as inflexible scheduling, high caseloads, and a lack of managerial support—restrict their ability to provide individualized care.[50]

In Denmark, reforms that restructured interdisciplinary collaboration by redistributing tasks across assistants, nurses, and therapists further complicated workforce stability by blurring professional boundaries and creating uncertainty over accountability, which magnified the workforce challenges already evident in the mapped studies.[51]

The implications of these workforce pressures were also reflected in client experience reports. In addition to evidence indicating that older adults often value relational consistency and personalization more than structural indicators[47], research suggests that continuity and stability are associated with improved functional status and lower risks of adverse event.[29,48] Despite these insights, few evaluations examined the long-term impacts of workforce reforms, leaving significant uncertainty about how recruitment, retention, and role redistribution shape the resilience of publicly funded home care systems.

Consumer-Directed Models: Autonomy and Administrative Responsibilities

The mapped literature characteristically frames consumer-directed care as a strategy to enhance autonomy by granting older adults' control over service budgets, workforce selection, and care planning. A prominent finding across the evidence is the potential for highly personalized and continuous care. Early research from the United Kingdom suggested that direct payments enabled clients to recruit workers aligned with their preferences, fostering a sense of control.[30] Similarly, Australian evidence associated self-management with perceptions of increased flexibility and independence in daily life.[10]

A consistent theme emerging from the literature, however, is the administrative burden

accompanying this model, which can complicate the realization of its intended benefits. The operational tasks of payroll, recruitment, and regulatory compliance are frequently reported as significant challenges.[10,30,52] A notable observation across several studies is the common reliance on unpaid family assistance to manage these responsibilities, which is identified as a factor that can increase caregiver strain and potentially affect client well-being.

These implementation challenges appear to intersect with considerations of equity. The evidence suggests that the benefits of consumer-directed models may be more readily accessible to individuals with greater administrative capacity or reliable informal resources. For instance, Australian evaluations indicated that reforms shifting control to individuals disproportionately advantaged younger, partnered clients with higher administrative capability.[26] This pattern finds resonance in UK studies, where the model was observed to favour those with strong family networks, raising questions about its inclusiveness for individuals with limited informal support.[30,52] Canadian reviews have highlighted a need for more research into client-responsive models, though evidence specifically evaluating consumer-directed care in this context remains limited.[3]

Collectively, the international evidence underscores a key consideration: the personalization potential of consumer-directed care seems closely tied to the presence of structural supports. Without adequate administrative assistance and explicit safeguards, the transfer of responsibilities to clients and families' risks reinforcing inequities rather than reducing them. These tensions also highlight how autonomy-focused reforms intersect with broader system-level efforts toward coordination and integration

Integration: Reported Aspirations and Implementation Challenges

The mapped evidence consistently portrays the integration of health and social care as a longstanding policy aspiration intended to reduce fragmentation and strengthen continuity for older adults.[22] While governments across high-income systems endorse core integration principles such as coordinated governance, cross-sector collaboration, and workforce stability, the literature reveals that translating these principles into durable home-based care models has proved challenging.[53]

In Canada, interprofessional pilots linking family physicians with home health case managers were described as promising approaches to support frail older adults and streamline care pathways. Yet most accounts remained descriptive reports rather than outcome-oriented evaluations, limiting insight into their impact.[20,23] Australian reforms similarly emphasized coordination but were constrained by persistent barriers, including staff turnover that disrupted continuity and communication gaps that hindered seamless transitions between providers.[27] These challenges illustrated how workforce instability and fragmented accountability hindered continuity, a finding consistent with broader policy analyses that identify governance capacity and retention as preconditions for integrated care.[5]

By contrast, New Zealand's nationally coordinated reforms, underpinned by a unified system design and a continuum-of-care orientation, were reported as strengthening integration in practice. Embedding national governance structures within a cohesive policy framework enabled smoother service transitions and promoted workforce stability by aligning incentives and standardizing communication pathways.[36,37] This case underscores that integration is not

only a technical arrangement but also a function of strong leadership, clear accountability, and coherent system design.

Broader frameworks reinforced these observations. The World Health Organization (2016)[53] identified governance capacity, cross-sector collaboration, and supportive environments as essential to people-centred integrated systems. Reviews have highlighted, however, that rigorous evaluations remain concentrated in hospital and residential care contexts, leaving home-based services underexamined and perpetuating knowledge gaps.[54] Danish reforms illustrate the risks of poorly specified implementation: redistributing responsibilities across professional groups without clear accountability mechanisms created role ambiguity and limited collaboration, further complicating integration efforts.[51]

The synthesis of the mapped evidence suggests that integration is more often articulated as a policy aspiration than consistently demonstrated in home-based practice. Effective implementation appears to depend on a combination of strong governance, coherent system design, a stable workforce, and clearly defined professional roles. Without these enabling conditions, integration risks remaining more rhetorical than operational in the delivery of home care.

Cultural Responsiveness and Community Governance

The mapped evidence consistently identified cultural responsiveness as a critical determinant of equity and trust in home care systems. Included studies from Australia and New Zealand highlighted how embedding community governance structures strengthened the legitimacy and sustainability of services. For example, the Yuendumu Old People's Programme in Australia was organized around Warlpiri kinship systems, ensuring that decision-making reflected collective responsibilities and extended family obligations. This grounding in cultural practices was described as fostering trust and aligning services with local values.[28] Similarly, New Zealand's nationally coordinated framework explicitly institutionalized Te Tiriti o Waitangi—the Treaty of Waitangi, which affirms Māori rights and partnership in governance—and the Pae Ora (Healthy Futures) principles, which emphasize holistic well-being, family health, and equity. Embedding these principles within national home care reforms was associated with smoother transitions between services and improvements in workforce retention.[36,37]

Broader scholarship reinforced the argument that cultural safety is not determined by providers but defined by those receiving care. Cultural safety requires attention to structural inequities rather than reliance on individual provider competence.[55] Despite this recognition, Indigenous aged-care providers in Australia continued to report barriers to procurement and scaling, suggesting that even when services aligned with community needs, systemic inequities in funding and regulation hindered their broader adoption.[56] These challenges highlight the limits of cultural responsiveness when not supported by enabling institutional structures.

Overall, the mapped evidence suggests that meaningful cultural responsiveness in home care extends beyond adapting practices to include governance that institutionalizes community authority. Programs grounded in cultural frameworks demonstrated greater legitimacy and trust, while systems that failed to embed these principles risked perpetuating exclusion despite formal commitments to universality. This underscores that equity in home care is not achieved solely through individual provider actions but through structural recognition of cultural authority and the redistribution of decision-making power.

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Universal Welfare Models: Pressures and Adaptability

The evidence indicates that universalist home care systems in Sweden and Denmark serve as fundamental welfare provisions—tax-funded, broadly accessible services that reflect the ideals of Nordic de-familialisation (offloading care from a household). Nonetheless, decades of fiscal austerity and demographic shifts have led to uneven adaptations, thereby challenging the equity of these models. In Sweden, municipal reforms have progressively restricted eligibility criteria to individuals with the greatest needs, thereby transferring care responsibilities back to families and undermining the principle of de-familialisation.[7,24] These restrictive measures have disproportionately impacted older adults with limited private resources, raising concerns regarding fairness for the most vulnerable populations. Conversely, Denmark has maintained more extensive coverage by reinvesting in preventive services and enhancing user choice—approaches credited with preserving inclusivity despite facing similar fiscal pressures.[7]

Rigid administrative frameworks further complicated universalism by constraining workforce flexibility and client experience. Standardized needs assessments and bureaucratic procedures, while designed to ensure fairness and consistency, reduced front-line worker autonomy and risked depersonalizing care for those with complex conditions.[31] Empirical work in Sweden linked these process-oriented governance structures to client dissatisfaction, suggesting that universal coverage without relational engagement may undermine perceived quality.[25]

Recent municipal-level analyses reveal divergent local pathways under universalist regimes. Harnett et al. (2024)[57] document Swedish municipalities that, under fiscal duress, either innovated—investing in preventive models and maintaining eligibility thresholds—or retrenched, narrowing access and deepening inequities. In Denmark, Hjelmar and Rostgaard (2019)[58] trace the rise of supplemental, privately financed home care alongside the public system, questioning whether hybrid models can preserve universalist commitments when user fees and marketization intensify.

These findings demonstrate that universalism in Nordic home care is not an immutable guarantee of equity, but a contingent construct shaped by political choices, funding priorities, and governance designs. The stability often ascribed to these welfare models masks dynamic local adaptations: preventive investment, equitable eligibility criteria, and the regulation—or toleration—of private supplements collectively determine whether universal coverage translates into genuinely inclusive care. Equity in universalist systems thus rests on sustained commitments to policy choices that balance fiscal sustainability with relational, person-centred practice.

Research Gaps

The evidence base demonstrated significant temporal and geographical disparities. Few evaluations have been published since 2019 and were predominantly from Australia, with limited contemporary data from Canada, the United Kingdom, and the Nordic countries. This imbalance restricts insights into the performance of reforms amid current demographic and workforce challenges. Outcomes-focused evaluations are scarce, with most studies relying on process indicators such as satisfaction or perceived autonomy, while giving limited attention to equity, workforce sustainability, cost-effectiveness, or quality-of-life outcomes. Evaluations of cultural governance models are rarely conducted despite their reported significance for trust and

legitimacy. Although integration is frequently described in policy and pilot initiatives, it is seldom supported by outcome-oriented evaluations, resulting in limited evidence on how integrated approaches are operationalized and maintained in daily home-based care. No longitudinal studies were identified, and only limited cross-national comparative analyses are available, which constrain the understanding of the impact of demographic changes and fiscal pressures on the long-term sustainability of home care.

Implications for Research

Future research should prioritize outcome-oriented evaluations that move beyond descriptive accounts to assess impacts on equity, cultural safety, workforce sustainability, client-reported quality of life, and system-level costs. Comparative and longitudinal designs are particularly needed to strengthen cross-national learning and capture the durability of reforms under demographic and fiscal pressures. Evaluations of integration in home-based contexts should systematically examine how governance structures, funding models, and workforce arrangements influence continuity and coordination of care. In addition, there is a pressing need to evaluate mechanisms that embed cultural authority, to determine their scalability and equity impacts. Incorporating participatory and co-design approaches with older adults, caregivers, and providers would further enhance the relevance and applicability of the findings by ensuring that evaluations reflect both lived experiences and system performance.

Strengths and Limitations

This review was strengthened by adherence to JBI methodological guidance, including comprehensive database and grey literature searches, independent dual screening, and structured data extraction.[16,46] Synthesizing evidence across six high-income health systems enabled the identification of recurring patterns not visible in single-country analyses. The inclusion of grey literature also extended coverage to policy frameworks and service guidelines, enhancing the breadth of evidence mapped.

Limitations reflect the characteristics of the evidence base rather than the review process. The literature was unevenly distributed across countries, with a heavy weighting toward older and descriptive accounts, and only a small number of contemporary evaluations were published after 2019. Outcome-focused studies examining client experience, equity, or workforce sustainability were particularly scarce, constraining the ability to assess reforms under current demographic and fiscal conditions. In keeping with JBI methodology, this review did not appraise study quality; therefore, conclusions about effectiveness cannot be drawn.

Conclusion

This scoping review mapped publicly funded home care models for older adults across six high-income health systems. Despite contextual variation, two overarching insights stand out: relational and equity dimensions consistently shaped how reforms were experienced, and the evidence base remains dated, with few outcome-focused evaluations since 2019. Renewed investment in rigorous and comparative evaluations is necessary to inform the development of sustainable, equitable, and person-centred home care systems amid demographic and fiscal pressures. Generating robust, outcome-focused, and comparative evidence will be essential for informing reforms that uphold equity, relational quality, and sustainability in publicly funded home care for older adults.

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Appendix I: Searches

Bibliographic database searches

All database searches were executed on July 19, 2024.

MEDLINE (Ovid)

#	Searches	Results
1	(ag?ing or elder* or senior? or old* age* or geriatric).ti,ab,kf.	773117
2	((old* or aged) adj3 (adult? or person? or people or patient? or individual? or resident? or wom?n or man or men)).ti,ab,kf.	1084283
3	exp Aged/	3538110
4	or/1-3	4528854
5	homecare.ti,ab,kf.	1729
6	((home or homebased or home based) adj (care or health care or healthcare or support)).ti,ab,kf.	24967
7	(home adj (nursing or health nursing)).ti,ab,kf.	1737
8	((companion or domiciliary or personal) adj (care or support)).ti,ab,kf.	8651
9	continuing care.ti,ab,kf.	1937
10	exp Home Care Services/	51716
11	Home Health Nursing/	386
12	or/5-11	74328
13	(caregiv* or care giv* or caretak* or care tak* or carer? or car* partner?).ti,ab,kf.	137960
14	(family or families or familial or relative? or kin* or wife or wives or husband? or spouse? or spousal or partner? or significant other? or child* or dependent? or daughter? or son or sons or sibling? or brother? or sister?).ti,ab,kf.	6810078
15	Caregivers/	53876
16	exp Family/	379989
17	or/13-16	6948389
18	(worker? or staff* or employee? or practitioner? or provider? or professional? or personnel or assistant?).ti,ab,kf.	1318096
19	(workforce? or work force? or labo?r force? or human resource?).ti,ab,kf.	67130
20	(labo?r adj2 (supply or demand or shortage? or absenteeism or distribution)).ti,ab,kf.	1643
21	exp "Personnel Staffing and Scheduling"/	47676
22	exp Workforce/	82195
23	or/18-22	1420679
24	4 and 12 and 17 and 23	3861
25	limit 24 to yr="2005 -Current"	2624

Embase (Elsevier)

No.	Query	Results
1	ag$ing:ti,ab,kw OR elder*:ti,ab,kw OR senior$:ti,ab,kw OR 'old* age*':ti,ab,kw OR geriatric:ti,ab,kw	1059138
2	((old* OR aged) NEAR/3 (adult$ OR person$ OR people OR patient$ OR individual$ OR resident$ OR wom$n OR man OR men)):ti,ab,kw	1508280
3	'aged'/exp	4015072
4	#1 OR #2 OR #3	5375366
5	homecare:ti,ab,kw	4263
6	((home OR homebased OR 'home based') NEXT/1 (care OR 'health care' OR healthcare OR support)):ti,ab,kw	35023
7	(home NEXT/1 (nursing OR 'health nursing')):ti,ab,kw	2189
8	((companion OR domiciliary OR personal) NEXT/1 (care OR support)):ti,ab,kw	10719
9	'continuing care':ti,ab,kw	2482
10	'home care'/exp	94304
11	#5 OR #6 OR #7 OR #8 OR #9 OR #10	117877
12	caregiv*:ti,ab,kw OR 'care giv*':ti,ab,kw OR caretak*:ti,ab,kw OR 'care tak*':ti,ab,kw OR carer$:ti,ab,kw OR "car* partner$":ti,ab,kw	191832
13	family:ti,ab,kw OR families:ti,ab,kw OR familial:ti,ab,kw OR relative$:ti,ab,kw OR kin*:ti,ab,kw OR wife:ti,ab,kw OR wives:ti,ab,kw OR husband$:ti,ab,kw OR spouse$:ti,ab,kw OR spousal:ti,ab,kw OR partner$:ti,ab,kw OR "significant other$":ti,ab,kw OR child*:ti,ab,kw OR dependent$:ti,ab,kw OR daughter$:ti,ab,kw OR son:ti,ab,kw OR sons:ti,ab,kw OR sibling$:ti,ab,kw OR brother$:ti,ab,kw OR sister$:ti,ab,kw	8360965
14	'caregiver'/exp	124603
15	'family'/exp	647067
16	#12 OR #13 OR #14 OR #15	8640588
17	worker$:ti,ab,kw OR staff*:ti,ab,kw OR employee$:ti,ab,kw OR practitioner$:ti,ab,kw OR provider$:ti,ab,kw OR professional$:ti,ab,kw OR personnel:ti,ab,kw OR assistant$:ti,ab,kw	1672224
18	workforce$:ti,ab,kw OR "work force$":ti,ab,kw OR "labo$r force$":ti,ab,kw OR "human resource$":ti,ab,kw	73520
19	(labo$r NEAR/2 (supply OR demand OR shortage$ OR absenteeism OR distribution)):ti,ab,kw	1362
20	'personnel management'/exp	103406
21	'workforce'/exp	75400
22	#17 OR #18 OR #19 OR #20 OR #21	1806425
23	#4 AND #11 AND #16 AND #22	4922
24	#4 AND #11 AND #16 AND #22 AND [2005-2024]/py	3850

CINAHL Ultimate (EBSCO)

#	Query	Limiters/Expanders	Results
S1	TI ((ag#ing or elder* or senior# or "old* age*" or geriatric)) OR AB ((ag#ing or elder* or senior# or "old* age*" or geriatric))	Search modes - Find all my search terms	253,796
S2	TI (((old* or aged) N2 (adult# or person# or people or patient# or individual# or resident# or wom#n or man or men))) OR AB (((old* or aged) N2 (adult# or person# or people or patient# or individual# or resident# or wom#n or man or men)))	Search modes - Find all my search terms	274,923
S3	(MH "Aged+")	Search modes - Find all my search terms	970,959
S4	S1 OR S2 OR S3	Search modes - Find all my search terms	1,179,871
S5	TI homecare OR AB homecare	Search modes - Find all my search terms	1,291
S6	TI (((home or homebased or "home based") W0 (care or "health care" or healthcare or support))) OR AB (((home or homebased or "home based") W0 (care or "health care" or healthcare or support)))	Search modes - Find all my search terms	22,353
S7	TI ((home W0 (nursing or "health nursing"))) OR AB ((home W0 (nursing or "health nursing")))	Search modes - Find all my search terms	1,047
S8	TI (((companion or domiciliary or personal) W0 (care or support))) OR AB (((companion or domiciliary or personal) W0 (care or support)))	Search modes - Find all my search terms	2,800
S9	TI "continuing care" OR AB "continuing care"	Search modes - Find all my search terms	1,386
S10	(MH "Home Health Care+")	Search modes - Find all my search terms	51,928
S11	S5 OR S6 OR S7 OR S8 OR S9 OR S10	Search modes - Find all my search terms	65,950
S12	TI ((caregiv* or "care giv*" or caretak* or "care tak*" or carer# or "car* partner#")) OR AB ((caregiv* or "care giv*" or caretak* or "care tak*" or carer# or "car* partner#"))	Search modes - Find all my search terms	94,763
S13	TI ((family or families or familial or relative# or kin* or wife or wives or husband# or spouse# or spousal or	Search modes - Find all my search terms	1,258,615

	partner# or "significant other#" or child* or dependent# or daughter# or son or sons or sibling# or brother# or sister#)) OR AB ((family or families or familial or relative# or kin* or wife or wives or husband# or spouse# or spousal or partner# or "significant other#" or child* or dependent# or daughter# or son or sons or sibling# or brother# or sister#))		
S14	(MH "Caregivers")	Search modes - Find all my search terms	45,903
S15	(MH "Family+")	Search modes - Find all my search terms	285,877
S16	S12 OR S13 OR S14 ORS15	Search modes - Find all my search terms	1,406,459
S17	TI ((worker# or staff* or employee# or practitioner# or provider# or professional# or personnel or assistant#)) OR AB ((worker# or staff* or employee# or practitioner# or provider# or professional# or personnel or assistant#))	Search modes - Find all my search terms	694,131
S18	TI ((workforce# or "work force#" or "labo#r force#" or "human resource#")) OR AB ((workforce# or "work force#" or "labo#r force#" or "human resource#"))	Search modes - Find all my search terms	39,054
S19	TI ((labo#r N1 (supply or demand or shortage# or absenteeism or distribution))) OR AB ((labo#r N1 (supply or demand or shortage# or absenteeism or distribution)))	Search modes - Find all my search terms	528
S20	(MH "Personnel Staffing and Scheduling+")	Search modes - Find all my search terms	36,162
S21	(MH "Workforce")	Search modes - Find all my search terms	16,803
S22	S17 OR S18 OR S19 OR S20 OR S21	Search modes - Find all my search terms	741,157
S23	S4 AND S11 AND S16 AND S22	Search modes - Find all my search terms	2,541
S24	S4 AND S11 AND S16 AND S22	Limiters - Publication Date: 20050101-20241231 Search modes - Find all my search terms	2,039

Details of Gray Literature Searches

Date	Organization name	URL	# of items screened	Included (italicized)
1-20-2025	Fraser Health Authority (British Columbia)	Community Health Nursing Home Support Services Seniors Community Connector ***Who pays for care?***	4	0
1-20-2025	Alberta Health Services	***Home and Community Care***	1	1
1-20-2025	Nova Scotia Home Care Policy Manual	NS Home Care Policy Manual https://www.nshealth.ca/continuing-care	2	0
1-20-2025	Saskatchewan	SK Home Care Policy Manual Home Care	2	0
1-20-2025	Manitoba	Home Care Self and Family Managed Care ***Home Care Services in Manitoba – Manitoba Health***	3	1
1-20-2025	New Brunswick Extra-Mural Program	Home Care Services	1	0
1-20-2025	Ontario	***Health atHome***	1	1
1-28-2025	Sweden	Google search – sweden home care policy (from pg. 1) • International Health Care System Profiles – Sweden (The Commonwealth Fund) • Sweden's elderly care system aims to help people live independent lives. • Home care for older people in Sweden: a universal model in transition (posted by BC Care) • Case Study – Sweden (Organization for Economic Cooperation and Development) • Eurocarers country profile – Sweden • Long Term Care System Profile: Sweden (GOLTC) • CARER LEAVE POLICIES IN SWEDEN • "Ageing in place": how Sweden provides and pays for universal and comprehensive long-term care for older persons (WHO)	8	0
1-28-2025	Denmark	Google search – denmark home care policy (from pg. 1) • Home Care (Life in Denmark) • Danish home care policy and the family: implications for the United States • Elderly Care (Healthcare Denmark – additional publication at bottom of site page) • **Exploring Denmark's Innovative Senior Care System and Its Implications for the Future of Aging (blog post)** • Home care and Supportive Housing in Denmark • International Health Care System Profiles – Denmark (The Commonwealth Fund) • Home Care for Older Adults During the COVID-19 Pandemic: Lessons from the Netherlands, Denmark, and Germany to strengthen and expand home care in Canada (CanCOVID) • Eurocarers country profile - Denmark	8	0
1-28-2025	UK	Google search – "united kingdom home care policy" (from pg. 1 – lots of results about care homes) • Homecare Association Code of Practice • Care and support (AgeUK) • Home care in the United Kingdom • **Home care: delivering personal care and practical**	8	0

		support to older people living in their own homes (NICE Guideline) • International Health Care System Profiles – England (The Commonwealth Fund) • Help at home from a paid carer (NHS) • NHS funding for care (Independent Age) • Care provided in people's own homes (Health and Safety Executive)		
1-28-2025	Australia	Google search – australia home care policy (from pg. 1) – there is some overlap as these sites link to one another • Home Care Services (ACCC) • Home care packages program (Dept. of Health and Aged Care) • Home services (Dept. of Health and Aged Care) • Home care packaged (MyAgedCare) • Legislation and policies (Dept. of Health and Aged Care) • Consumer Directed Care	5	0
1-28-2025	New Zealand	Google search – new zealand home care policy (from pg. 1) • New Zealand Carer's Strategy • Home Support Services for Older People and Others • Nursing and medical help at home • ***What Can Australia Learn and Adopt from New Zealand's Aged Care Model?***	4	1

Grey literature search re-run at a later date with different key words to target government websites.

Date	**Source/Country**	**URL**	**# of items screened**	**Included**
July 17, 2025	Sweden	**Search:** "Sweden ministry of health home care" • Sweden's elderly care system aims to help people live independent lives • Swedish healthcare is largely tax-funded. And the overall quality is high • Care for older people (Government Offices of Sweden – contains several articles – this one is relevant?)	3	**0**
July 17, 2025	Denmark	**Search:** "Denmark ministry of health home care" • Elderly Care (Healthcare Denmark) • Danish Health Authority (navigate to Publications > See all > select "Elderly" subject, only 2 articles) • Case Study: Sammen om Rodovre – Together with Older Citizens, Denmark (Canadian website) • Healthcare in Denmark – An Overview (Ministry of Health) • DENMARK Country case study on the integrated delivery of long-term care (WHO)	5	**0**
July 21, 2025	UK	**Search**: "United kingdom ministry of health home care" • NHS @home (not much info, not very relevant) • Help at home from a paid carer (NHS) • Domiciliary care (North Ireland) – links to publications, includes home care experience survey • Home care in England (The King's Fund)	4	**0**
July 21, 2025	Australia	**Search:** "australia ministry of health home care" • Home Care Packages Program (Aus Govt – links to click through) • Support at Home program (Aus Govt) • My Aged Care – click through "we're improving Australia's aged care system" • Home Care Services – Healthcare Australia • Home Care Packages – My Aged Care • Aged care services – healthdirect.gov.au	6	**0**

July 21, 2025	New Zealand	**Search:** "new zealand ministry of health home care" • Help in your home – NZ Govt • Home support services for older people and others – Health NZ • Help at home with housework or personal care – A Guide for Carers – Ministry of Social Development • Nursing and medical help at home – NZ Govt	4	**0**

Appendix II: Data Extraction Tool

Title	Article title as it appears in the source.
Author(s)	Include authors in order listed in the source.
Publication year	The year in which the source was published (retrieved from source).
Citation information	APA citation (use PubMed cite feature).
Country	Include the country in which the study/home care evaluation took place.
Type of literature	Select the most appropriate source type: ○ Research (peer-reviewed) ○ Gray literature
Study aims, purpose, or objectives	Include the study aim, purpose, or objectives (usually identified in introduction or abstract).
Study design	Include the study design, for example: RCTs, non-randomized experimental, cohort studies, cross sectional study, case control study, systematic review, qualitative research, prevalence study, mixed methods, and qualitative study designs including but not limited to phenomenology, grounded theory, ethnography, qualitative description, action research and feminist research. Gray literature (e.g., dissertations, text and opinion papers, organizational reports, or policy documents).
Methods	Describe methods used: surveys, interviews, focus groups, etc.
Study population	Describe the study population, including gender/sex, age range, and population size (n=?). Include information about living situation (e.g. community dwelling, living with a caregiver, etc.).
Theory or framework	If stated, list any theory(ies) or framework(s) used to guide the research.
Home care model	If stated, specify the home care model/framework/program described in the source.
Characteristics of home care model/framework/program	List and describe any key characteristics of the home care model or program mentioned in the source; for example: ○ Continuity (client sees the same person consistently) ○ Accessibility ○ Extent of autonomy ○ Respite care ○ Caregiver benefit(s) ○ Patient and family satisfaction ○ Level of integration into health and/or social care system ○ Support worker resources match with client needs

Reported study outcomes (health and social)	Include any reported outcomes of the study, whether health or social.
Assessments or evaluations of home care model/program	If stated, describe any evaluations or assessments of the home care model or program.

Appendix III: Characteristics of Included Studies

[table attached as separate document due to size]

Appendix IV: Characteristics of Home Care Models

Country	Model	Characteristics
Canada	No national home care model – predominantly Integrated Care	• Not part of Canada Health Act or insured services – provincial/territorial ministries of health and health authorities pan, fund, and manage programs and services • "Home is Best" strategy – facilitation of people recovering in their own homes • Integrated care characterized by continuity, communication and client-care worker compatibility, autonomy • Accessibility can be limited - costs put onto clients or family caregiver (some reimbursement) • Rural settings need solutions specific to their communities
Sweden and Denmark	Nordic Welfare Model	• Public-sector responsibility for basic welfare tasks, high degree of universalism. • Funded by taxes, local and regional authorities provide services directly • Policies preserve well-being, independence, dignity of older person; preventative approach keeps people in their homes for as long as possible • Continuity, caregiver benefits, coverage likelihood is high, accessibility, equity, trust, well-integrated system, provides autonomy, respect, and satisfaction • Strong interpersonal aspect of care; person-centered, needs-driven, knowing the client, meeting their needs with respect is quality • Restrictive access in Sweden, broader in Denmark, accessibility dependent on educational level, de-familisation emphasized (DK) • Challenges with too many or unclear choices, services standardized rather than flexible
Australia	Consumer-Directed Care, Home Care Packages	• Financial autonomy and choice through allocating funds to individuals • Self-management – consumers know their budget, select services • Increased choice, control, and autonomy result in improved personal outcomes; self-management less stressful than negotiating with providers but difficult to make decisions without adequate information • Effective coordination and communications • Continuity of care, self-identity retention, teamwork, service responsiveness, interpersonal relationships, trust – some lack of flexibility and timing of services
New Zealand	Health Care Home, Continuum of Care	• CoC model integrates care options, improves efficiencies, provides residents with choice and control • CoC model reduces stigma associated with aged care – clients choose retirement village living earlier • HCH four main characteristics[59] – improved sustainability, access to urgent and unplanned care, proactive care for complex needs, routine and preventative care
United	Cash for Care –	• Provide clients with choice, control, personalized support, and

Kingdom	Direct Payments	continuity of support worker(s) • Requires sufficient resources to purchase more care and advice in planning and managing budget

Appendix V: Funding of Included Sources

Funding Source Type	**Not sponsored**	5 (35.7%)
	Publicly sponsored	9 (64.3%)

Figure I: PRISMA Flow Diagram

[attached as separate file due to formatting]