

**Paying for Healthcare for the Elderly in Ontario Canada:
Challenges to Consider**

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Paper prepared for the
International Conference on the Politics and Regulations Governing the Costs of Health
Care and Long Term Care of the Elderly
Organized by the Institute of Economic Research of Hitotsubashi University
January 14-15, 2009
Tokyo, Japan

Abstract

Population aging is common throughout the industrialized world. The population of Canada and each of its provinces are rapidly aging too. While there might be differences in the pace of aging between the provinces this difference is very small. The aging of the population has far reaching economic implications including of course for the health care system. There is a feeling that the rapid growth in the elderly population threatens to bankrupt the health care system. In Canada health care is the responsibility of the provincial government. In this paper I describe the Medicare program in Canada and the implications in terms of the funding of services available for the elderly in Ontario (the largest province in Canada where about 40% of the population reside). It is clear that not all aspects of care for the elderly are equally dealt with. Some (e.g., physicians and hospital services) are better defined and funded as they are covered by the Canada Health Act. Other services are left to the discretion of the provinces and are more fragmented and their coverage is not as comprehensive and in many cases is absent for most of the elderly. The question of whether the health care system of Ontario (and of Canada) is ready to meet the challenges of the future is discussed.

Introduction:

Population aging is common throughout the industrialized world. In only few countries are total fertility rates close to the natural replacement level (about 2.1 children per woman) and in most they are well below that level thus inhibiting the growth of the population and causing long-term changes in age distribution. The proportions of individuals over 60 or 65 are rising, the proportions individuals under 15 are falling, and these trends are projected to continue far into the future. Circumstances vary from country to country, but virtually all share this one demographic characteristic: their populations are growing older.

The aging of a population has far-reaching economic implications. It has implications for patterns of consumption, saving and investment in the economy, for the level and rates of growth of the national product and for per capita national income. It has implications for the rates of flow of young workers into the labor force and the rate of retirement, for pensions at one end of the age spectrum and for enrollment in schools and universities at the other, for the levels and composition of government budgets and of course for the health care system (Denton and Spencer, 2000).

Every aspect of the health care system is affected in one way or another by changes in the population including the requirements for physicians, nurses and other skilled personnel, the demand for hospital beds and equipment, the mix of services consumed and the need for long-term institutional care facilities and for home care services for the elderly. The cost implications of such changes are prominent in discussions of public policy, in light of the now widely recognized aging trend. But such discussions often go not much further than emphasizing aging as a source of future increases in health care costs; they frequently display little understanding of the likely timing and magnitude of aging effects.

Questions of “when” and “how much” seem not to have received the attention they deserve. At least this is my impression based, on policy discussions in Canada.

A typical argument is that the rapid growth in the elderly populations threatens to bankrupt the health care system of every industrialized country. However, as already explained by Barer et al (1987), “the rhetoric supporting this belief is much stronger than the evidence”. They explain that demographic trends do not imply that health care costs will increase in excess of what is supportable by normal economic growth. A ‘cost crisis’ will only occur if per capita rates of utilization among the elderly will increase faster than for the general population. Barer et al separate the impending ‘crisis’ of the aging population into three distinct component – the increasing numbers of the elderly, their actual level of health or morbidity and the intensity of the services delivered to them by the health care system. They argue that if there is an impending ‘crisis’ it stems from the rise in the relative intensity with which the health care system is treating the elderly, overlaid on the increasing number of elderly.

The feeling of ‘impending crisis’ is the context, I presume, of the three questions to be discussed in this seminar: (i) How do different countries, who are facing an aging population, is paying for the health care costs of the elderly? (ii) Are there any signs of increased tension between the elderly and the rest of the population? (iii) How does each country deals with the health care of the very old population? In this paper I will attempt to discuss this issues as applied to the Canadian health care system. As will be explained later, health care is the responsibility of the different provinces, hence in practice there are 10 different systems which correspond to the ten provinces. I shall thus concentrate on one such system, that of the province of the Ontario which the largest province where about 40% of the Canadian population reside.

Growth and aging of the Canadian and Ontario populations:

The data presented in this section is taken from two sources: (i) a report by Statistics Canada: Population projections for Canada, the provinces and territories (2005-2031) (ii) a projection in Denton et al (2002) of the growth of the Ontario population (2005 – 2040). The reasons for using the Denton et al projection as well are (i) it is done using a different projection model than the one used by Statistics Canada but which is highly regarded (for more details about the model see Denton et al (1994)) (ii) It provides projections under different growth scenarios than those provided by Statistics Canada.

Statistics Canada projection however is based on a more recent population estimate (July 1, 2005) as a starting point. I felt that it will be interesting to compare the two projections. However, while the numbers may differ between the different projections the message is the same.

In 2005 the report by Statistics Canada concluded that Canada population is aging fast and senior citizens (> 65 years old) will outnumber children (< 15 years old) in about a decade. In 2005, Canada's population is younger than most of the populations of G8 countries. However, it is expected to age more rapidly in the coming years as the pronounced baby boom following the Second World War and the rapid decline in fertility that followed. The aging of the baby boomers will combine with continuing low fertility levels and increasing longevity to age the population rapidly. Statistics Canada projection show that population aging, which has already begun, would accelerate in the year 2011 when the first baby boom cohort (born in 1946) reaches the age 65.

The rapid aging is projected to last until 2031, when seniors would account between 23-25% of the total population. This would be almost double their current proportion of 13%.

Their share would continue to grow following 2031 but at a slower pace, and by 2056 it would range between 25-30%. According to Statistics Canada projection the median age of Canada's population would continue to rise. In 2005 it was 39 years. By 2031 it would reach between 43 and 46 years. In 2056 it would be between 45 and 50 years. In addition, the proportion of older seniors, people aged 80 years and over, would increase sharply. By 2056 an estimated 1 out of 10 Canadians would be 80 years or over, compared with 1 in 30 in 2005.

The Denton et al (2002) projection for the province of Ontario dates the "baby boom" in Canada to be from the mid 1940s to the mid 1960. It considers people who are over 55 years old to be subject to the health care requirements associated with an older population. People aged 75 years and over are considered to be the "old -old". They offer three projections covering the period 2005 to 2040. Projection A, which is referred to as "standard", assumes the most recent available fertility rate (i.e., about 1.5 children per woman) will continue throughout the projection period, that mortality rate will change in such a way as to increase life expectancy at birth by about 5 years for male by the end of the period and 2.5 years for females, that immigration to Canada will be 225,000 per year (consistent with announced government targets), that provincial net migration to Ontario will be in adherence with recent average levels, and that emigration to other countries will also be in accordance with recent levels. This may be regarded as "best guess" prediction, given recent information.

Projections B is a "younger population" projection: it assumes that by 2020 the total fertility rate will rise to 2.1 (the natural replacement level), that life expectancy will rise somewhat more slowly and that immigration to Canada will be at a level of 275,000 per year. Projection C is an "older population" projection: by 2020, the total fertility rate falls 1.2 (the lowest recent observed rate in any of the European Union countries), life expectancy rise somewhat more rapidly than in projection A, and immigration to Canada is reduced to 175,000 per year.

Following these projections it is also clear that the population of Ontario is aging rapidly. According to this projection the median age in Ontario is about 38 in all projections. It will rise to 42.2 (Projection A), 39.9 (Projection B) and 45.7 (Projection C) in 2030. The age distribution of the population in 2030 (i.e., proportion of people under 15 years, between 55 and 74 and 75 and older respectively) in the three projections is as follows: 15.3%, 24.6%, 9.7% in projection A; 19.5%, 22.3%, 8.4% in projection B, 12.4%, 26.4%, 11.0% in projection C. In 2040 it is projected that under the “best guess” scenario (projection A), 1 in 8 people living in Ontario will be 75 years or over.

While there are differences between the projections of Statistics Canada (2005) and in Denton et al (2002) the message is the same. The population of Canada and each of its provinces are aging rapidly. While there might be a difference in the pace of aging between the provinces this difference is very small. From the information presented here it is easy to see that the pace of aging in Ontario is very similar to the one experienced in Canada as a whole. Furthermore, the rapid projected growth of the proportion of people who are defined as “old-old” (regardless of the definition) justifies the urgency of rethinking the way we provide and fund services to this segment of the population. This is due to the fact that structural changes in the health care system (e.g., increasing the supply of physicians and changing the mix of specialties; building of institutions) do not occur overnight. The health care system can be compared to a huge boat. When it needs to change course, it should be done slowly. Otherwise we risk sinking the ship.

The Medicare program in Canada:

Funding of services can only be understood in a policy context. Hence a little bit of historical perspective is always helpful. Under the 1867 British North America Act that

formed Canada, health care in Canada was one of several “low-cost” items deemed to be a responsibility of the provinces. As the cost of health care rose over time, provincial governments turned increasingly to the federal government for financial support. Following World War II, concerns with unequal access to health care led several provinces to introduce public hospital insurance. This led to increasing pressure on the federal government to get involved in health care, but the articles of confederation restricted what role it could play (Vayda and Deber, 1992). Thus federal action concentrated on setting explicit conditions to be met by provincial governments to qualify for federal cost sharing of provincial health care programs. In 1957, the Hospital and Diagnostic Services Act laid down conditions for federal funding of hospital insurance programs. This was extended to physician services under the 1965 Medical Care Act. In 1984 these acts were consolidated under the Canada Health Act (Canada House of Commons, 1984).

The Canada Health Act (CHA) is thus the foundation of the Canadian public health care system (Baker and Bhabha, 2004). It sets out explicit objectives for health care policy – “The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers”. Under the act, policy levers remain confined to the conditions that provinces are obliged to meet to qualify for federal financial support. The five conditions require that the entire population of the province be covered by the provincial plan; that the plan cover a comprehensive range of hospital and physician services; that coverage will be portable between provinces; that the plan of each province be administered by a public authority; that the terms of access to services be the same for all in the province and based on the notion of medical necessity. The level and form of cost sharing, however, is not specified in the Act. At the time of legislations, provinces received approximately 50 percent of the cost of the programs from the federal government once the qualifying conditions were satisfied (Taylor, 1986). This incentive was sufficient for each province to introduce its own legislation to ensure that the conditions were met.

This Medicare program arose from concerns over the prohibitive cost of health care and the importance of insurance against the costs of care being made available to all members of the populations (Vayda and Deber, 1992; Taylor M, 1986). The price barrier to medical care was removed by creating provincial monopolies for buying hospital and physician services (what are referred to under the Act as insured services). Federal cost sharing was the lever to get each province to outlaw all aspects of private payment for these “insured” services. For example, physicians must opt out of billing a province plan entirely in order to charge patients for services covered by the Act. In this way, physicians cannot bill patients for insured services.

Little attention was paid to the role of supply factors in determining the distribution of services. The levels and distribution of supply, as well as the mechanisms for the planning, management and delivery of services were inherited from the pre-Medicare era. Public payment of private providers was based on physicians’ fee schedules set by provincial ministries in negotiations with medical associations and cost reimbursement of hospitals determined by each hospital activity. The funding provided for the services delivered free at the point of delivery (in Canada referred to as “first dollar coverage” for health care) through publicly administered insurance, are collected by the general taxation system.

Ability to pay was proscribed as the mechanism by which services were shared among competing demands. Nothing was put in place to serve this important economic role. It was implicitly assumed that, in the absence of prices at the point of consumption, the increased demand for care would be served in ways that did most to protect, promote and restore the health of the population. In other words, available health care resources would in some way follow needs for care. Those with poor health or at greater risk of health problems would receive priority in the allocation of health care resources. Conventional wisdom indicated that the Medicare program was achieving the objectives set out in the Canada Health Act. For example, the former federal minister of health, Monique Begin,

claimed that under the Medicare program in Canada “everyone has equal access to quality health care” (Begin M, 1988). Bob Ray, then premier of Ontario, the country’s largest province, went further claiming that under his government stewardship “people will continue to have access to the best medical care system in the world” (Papp, 1993).

Who pays for the care of elderly in Ontario?

As explained above all services “insured” by the province, under the Canada Health Act, are paid by the province. The Ontario Health Insurance Plan (OHIP) is the government-run health plan for the province of Ontario. Every Ontario resident, whose primary and permanent home is in Ontario, is entitled to free of charge access to services, which are insured by OHIP, at the point of delivery. OHIP covers a wide range of services which are deemed “*medically necessary*”. Services that are not deemed “*medically necessary*” may or may not be covered. OHIP is funded by taxes paid by the residents of Ontario and by transfer payment from the federal government. In its 2008-9 budget the province of Ontario states that health care spending will consume nearly 42% of every dollar in revenue, up from 36.3 cents from every dollar in fiscal year 2001-2. It also states that the health care sector will continue to consume all available resources and crowds out other priority areas. Spending on health care is set to rise by 6% in fiscal year 2008-9 (compared with projected nominal GDP growth of 2.9% in 2008) forcing the Ontario government to reduce non-health care spending by 4.1%. I shall return to these figures later.

The condition required by the Health Canada Act that the terms of access to services be the same to *all* in the province and based on the notion of *medical necessity* can create the impression that all needed services will be provided to the elderly (as well as the rest of the residents of the province). However, as explained earlier the Act only demands that

the health care insurance plan of a province pay for hospital, physician and inpatient surgical dental services. This is seen as “core services” with funding for non-core services (e.g., prescriptions drugs, dental care, nursing home, and physiotherapy) left to the province discretion. Furthermore, insured services are only those which deem to be medically necessary. However, the concept of “medical necessity”, which has been a cornerstone of Canadian federal legislation regarding publicly funded health service coverage, was not defined in the Act or in federal policy.

Charles et al (1997) provide a comprehensive inquiry into the meaning of the concept “medical necessity”. In search for the meaning they reviewed many relevant documents. The focus was limited to the policy context of defining what should (or should not) be included in as publicly funded insured health benefits, using as a criterion some notion of medical necessity (although the term itself may not have been used). This (restricted) focus was taken to provide clear direction on the scope of relevant data to collect, to keep data collection within manageable limits, and to focus on a policy context that applied to current debates (at the time of the study). They found that four meanings of medical necessity predominated across time and stakeholders in framing discussions about the appropriate scope of publicly funded health care. Each of them is likely to result in a different package of publicly funded services.

The four meanings of medical necessity, their intended use as a policy tool and the policy objective respectively are:

(1) Medical necessity means what physicians and hospital do. The intended use as a policy tool is to establish entitlement to a minimum federal floor of publicly funded service. The policy goal is to broaden access to publicly funded health services to all Canadians.

(2) Medical necessity means the maximum we can afford. The intended use as a policy tool is to make the federal floor the provincial ceiling of publicly funded services. The policy goal is to control costs.

(3) Medically necessity means what is scientifically justified. The intended use as a policy tool is to limit public health service coverage to services/procedures justified by scientific evidence. The policy goal is to improve the quality of care.

(4) Medical necessity means what is consistently publicly funded by provinces. The intended use as a policy tool is to establish (and later negotiate) a consistent package of publicly funded services across provinces. The policy goal is to promote equity in entitlement and access to publicly funded services across provinces.

The authors argue that the concept of medical necessity has taken on different meanings over time, depending on the perceived policy needs of the day. The result is confusion over the array of meanings and how these are used in current health policy debates. They conclude that “currently, the concept of medical necessity carries a heavy policy load for which it is ill equipped. The focus on developing screening tools to differentiate between medically necessary and unnecessary services creates the illusion that a more rational process for making such decisions will resolve long-standing health care issues like cost control and access to health care according to need. This is unlikely to be the case”. Yet without the ability of resolving these issues we are left with the question – are even all medically necessary physician and hospital based services being provided, free of charge at the point of delivery to the elderly (and others) in Ontario?

Who pays for “non core” services for the elderly in Ontario?

As explained earlier, under the Act, to qualify for transfer payments from the federal government, only (“medically necessary”) hospital, physician and inpatient surgical

dental services should be covered by the province health insurance plan (“core services”). Other services (“non-core services”) are left to the discretion of the province. These non-core services include, for example, prescription drugs, different home care services, nursing home, physiotherapy, occupational therapy. As a result the heterogeneity in the approaches taken by the different provinces in dealing with this issue is much greater than the heterogeneity between provinces in the coverage of hospital, physician and inpatient surgical dental services. Even within a province there is heterogeneity with respect to the coverage of non-core services. Below I describe how some of the non-core services for the elderly are being paid for in Ontario.

Prescription drugs:

The Ontario Drug Benefit (ODB) program provides coverage for over 3200 drug products, including nutrition products and diabetic testing agents. The ODB does not cover the following products: syringes and other diabetic supplies such as lancets and glucometers, eyeglasses, dentures, hearing aids or compression stockings. Drugs that are not listed in the Ontario Drug Benefit Formulary/Comparative Drug Index (known as the “Formulary”) are also considered for coverage through the Ministry’s Exceptional Access program on a case-by-case basis. Every resident of the province over the age of 65, regardless of where they reside within the province, is eligible for coverage by the program. The program used to be free of charge but a co-pay mechanism which is income based was introduced several years ago. Seniors (i.e., individuals who are 65 years and older) and senior in couple (i.e., where both spouses exceed 65) whose income exceeds a certain amount as specified by the program pay an annual amount deductible before they are eligible for coverage. After these senior pay the deductible they pay up to a certain amount toward the dispensing fee each time they fill a prescription for a covered drug product in the benefit year. Seniors and seniors in couple whose income are below the threshold set by the program are exempted from the annual deductible amount and pay a much smaller amount toward the dispensing fee each time they feel a prescription.

It is interesting to note that the introduction of co-payment for prescription drugs is a deviation from the underlying notion of Canada Health Act that payment for services at the point of delivery is a barrier to access to medically necessary services. Economic theory suggests that the own-price elasticity of demand is typically negative. It is not surprising that a study conducted in the province of British Columbia who also has a publicly funded drug insurance program and senior also face a co-pay for the dispensing fees found that when cost sharing for prescription drugs increased the demand for prescription drugs decreased (Li et al, 2007). Unfortunately it is very difficult to assess if the reduction in demand was mainly in unnecessary (or less necessary) drugs or in those drugs that are important for the protection, promotion and restoration of the physical and mental well-being of these patients which is the objective of the Canada Health Act. In other words, determining the health consequences of the reduction in the demand is not an easy task.

While economic theory suggests that the own-price elasticity of demand is typically negative, the cross-price of elasticity of demand can be either positive or negative. Positive cross-price elasticity of demand indicates that the two goods/services are substitutes in the sense that when the price of one good/service increases the quantity demanded from the other good/service increases as well. Negative cross-price elasticity on the other hands implies that the two goods/services are complementary such that the increase in the price of one good/service leads to a decrease in the quantity demanded from the other good/service. Li et al (2007) found that when cost sharing for prescription drugs increased the demand for physician visits increased. The authors provide several potential explanations to this finding. First, it might be that reduction in drug consumption due to increase in cost sharing might have resulted in worsening of seniors' health and therefore trigger them to see physicians more frequently. Second, in Canada physicians visit, emergency room visits, hospital admissions are free as are drug therapies provided in hospital. Hence, when prescription drugs become more expensive patients are

more likely to seek substitute treatment modalities. Furthermore, some of these treatment modalities will end up being more expensive than the saving in costs due the introduction of cost sharing policy.

It is important to mention that not all available drugs (i.e., drugs approved by Health Canada) are covered by the Ontario Drug Benefit Program. Other drugs might have restrictions attached to their coverage (e.g., the patient has to try first a cheaper drug. If she cannot tolerate the side effect they will be eligible to coverage of a more expensive but with less side effects drug). Also drugs that can be purchased over the counter are typically not covered. Seniors can have supplementary insurance which covers things which are not covered by the ODB and having such insurance does not disqualifies them from being eligible for ODB coverage. Such additional coverage can be part of coverage that they used to have from their work place before becoming eligible for ODB coverage of it can be bought by individuals from different insurance companies. Such policies may cover more than just drugs (e.g., eyeglasses, dental services and dentures). The existence of such insurance policies however represents a situation of a two-tire system where access to services is determined by willingness and ability to pay.

Home care and community support services:

Home care and community support services provide many services to elderly people and people with disabilities (who do not have to be over the age of 65 years old) including Meals on Wheels, assistant with home making, volunteer drivers, day programs to people with Alzheimer and respite care for family care givers needing time to “recharge their batteries”. The services are managed by regional Community Care Access Centres (CCAC) across the province. The budget for these activities is provided by the provincial government but can be supplemented by local sources. In spite of the fact that the type of services provided was similar in the different regions the ability of the elderly to access those services varied. This was partly related to the fact that the budget allocated to each

Community Care Access Centre was not needs –based. Like the case of prescription drugs, private insurance program are available and being purchased by the elderly to complement the public service.

In March 2006 the government of Ontario passed a new health care legislation act. The Local Health System Integration Act 2006 which changed the delivery of health care services in Ontario. The legislation places significant decision-making power at the community level and focuses the local health system planning and resource allocation on the community needs. The Local Health Integration Networks (LHIN) will facilitate the effective and efficient integration of health care services and make it easier to get the best care in the most appropriate setting, when they need it. With this legislation the management of local health services has been devolved to the 14 LHINs created in the province. In fulfilling their mandates, the LHINs have taken on local health system planning and community engagement. As of April 2007 the LHINs have also assume responsibility of funding a wide range of health services providers and for managing the majority of agreements with health care providers. The government of Ontario continues to provide stewardship of the province health system, setting directions and strategic policies.

More specifically the LHINs will have responsibility over the following providers: hospitals, divested psychiatric hospitals, community care access centres, community support service organizations, community mental health and addiction agencies, community health centres, long term homes. In other words in the new system CCACs fall under the “jurisdiction” of the LHIN where they are located. On one hand, this might enable better planning of the services provided by the local CCACs to better meet the community needs. On the other hand, the competition for local resources might be fiercer. As this is a new initiative it is difficult to assess it’s performance at this point in time. Time however will tell.

Long-term care facilities in Ontario:

Long-term care services for the elderly in Canada and in Ontario have evolved into a vast array of types of facilities, levels and type of care and organizational arrangements that vary between provinces. Below I shall describe (briefly) the different “institutions” in Ontario which are there to provide different levels of care and the financial arrangements associated with their funding.

Long-term care homes (Nursing homes and home for the aged):

Long-term care homes are designed for people who require the availability of 24 hours nursing care and supervision within a secured setting. In general, long-term care homes offer higher level of personal care and support than those typically offered by either retirement homes or supportive housing (see below). Long-term care homes are owned and operated by different organizations:

- Nursing homes are usually owned and operated by private corporations.
- Municipal homes for the aged are owned by municipal councils. Many municipalities are required to build home for the aged in their areas either on their own or in partnership with neighboring municipality.
- Charitable homes are usually owned by non profit corporations, such as faith, community, ethnic or cultural groups.

Long term homes offer a variety of accommodation options. People living in the home pay a fee for accommodation that is based on the type or style of accommodation. “Preferred accommodation” is the term used to describe private or semi private rooms with special features. “Basic or standard accommodation” refers to the style of rooms that the home offers in this category. There are three pieces of provincial legislation governing long-term care homes. Following these Acts the Ministry of Health and long Term Care (MOHLTC) sets standards of care and inspects long term care homes annually.

It also set the rules governing eligibility and waiting lists. Homes have to follow these rules if they want to receive funding from the Ministry. The Ministry also encourages the homes to get accredited by the Canadian Council on Health Services Accreditation by providing financial incentives to accredited homes.

The government funding to homes is based on approved and filled beds. In other word, the government pays a fee to the home for every (government) approved bed in the home which is occupied by a government approved client. Home can have non approved beds and can charge according to “market forces”. The government fee for approved beds is not sufficient to cover the costs hence the accommodation fees paid by the clients (described above). However, these fees are regulated by the government who determines the maximum amount that the home can charge. Individuals who can prove that their income (and assets) does not allow them to pay the “basic accommodation fee” can apply for a government subsidy.

Supportive housing:

Supportive housing is designed for people who need minimal to moderate care – such as homemaking or personal care and support – to live independently. Accommodation usually consists of rental units within an apartment building. In a few cases, the accommodation is a small group residence. Supportive housing buildings are owned and operated by municipal governments or non-profit groups including faith groups, seniors’ organizations, service clubs and cultural groups. Accommodations, on-site services, costs and the availability of government subsidies varies with each building. The care arrangements between a tenant and a service provider are usually defined through a contract between the two parties. Services typically include on site personal care and support such as routine hygiene, dressing and washings, daily visits or phone check-ins and can include services like shopping, meals and transportation. Residents can also apply for visiting health professional services through the Community Care Access Centre if required. In some cases the care provided in the house is by the Ministry of Health and long term Care. In such cases quality is monitored by the regional office of the Ministry.

Retirement homes:

Retirement homes are privately owned rental accommodations for seniors who are able to manage and pay for their own care. Generally retirement homes are designed for senior who need minimally to moderate support with their daily living activities. This setting enables residents to live as independent as possible, while providing certain services and social activities. Anyone can apply to a retirement home. The tenant does not need to provide medical evidence that she needs minimum level of care. The retirement home, however, may assess the applicant needs to ensure that it can provide them with appropriate support or that they do not need more support than it can provide. Most retirement homes offer meals, housekeeping, laundry and recreational and social programs. The types and levels of homemaking help, personal care and health services offered by retirement homes vary significantly, and so do their costs. Retirement homes are not subsidized by the government. Except for public health issues, retirement homes are not regulated by the Ministry of Health and Long Term Care.

The challenges for the provision of health care to the elderly in the new millennium

Canada and Ontario populations are aging rapidly and this is projected to continue at least in the coming decades. As explained, every aspect of the health care system is affected in one way or another by these changes in the population. Are Canada and the different provinces well prepared to meet the challenges? In this paper I explained the nature of the Canadian health care system which in fact consists of ten different systems as health is the responsibility of each province. I described the services available today to the elderly in Ontario (the largest province in Canada) and explained how they are funded. It is clear that not all aspects of care for the elderly are equally dealt with. Some (e.g., physicians and hospital services) are better defined and funded as they are covered by the Canada Health Act. Other services that are left to the discretion of the provinces are more

fragmented and their coverage is not as comprehensive and many cases is absent for most of the elderly (e.g., dental care, dentures, eyeglasses).

Is health care system of Ontario ready to meet the challenges of the future? The aging of the population will require probably more doctors, nurses and other health care professions in the future as well as more long term institutions and hospital beds. Also the mix of health care professionals and types of institutional beds required will be different than what we have now due to the increase in diseases of the elderly and reduction in the diseases of younger people. These changes take a long time, require careful planning and large investment as some of this resources are very expensive (e.g., educating more doctors, building of more hospitals). Unfortunately it does not seem to me that this type of planning and investment in the future of health care is occurring. At least what needs to be done is not discussed in public. As a result a transparent and comprehensive process of decision making that will enable accountability does not seem to exist.

One reason might be the fact the current system has been dealing now with a cost crisis that it does not seem to be able to resolve. As mentioned earlier in it's fiscal 2008-9 budget the province of Ontario estimated that health care spending will consume nearly 42% of every dollar in revenue. This is a huge burden that forces the government to reduce spending on non health care programs. Further more, health care costs are set to rise by 6% which is twice the projected rate of growth of the nominal GDP. This projection did not take into account the recent slump in the economy which is likely to result in a much smaller growth in GDP, much smaller revenue base for the government in this fiscal year and even gloomier prospect for next year. In this situation it is easier to understand why longer term considerations take the back seat. However, ignoring what seems to be the longer term is misleading. As the different demographic projections tell us, what we think is a longer term problem is in fact a current problem in terms of the inadequacy of services provided to the elderly population of Ontario.

Is the current fiscal crisis likely to result in a tension between the elderly and the rest of the population who is paying (via taxation) the bill on one hand and might also feel that in spite of the higher pay is getting less health services to meet it's needs. To the best of my knowledge this does not seem to be the situation at this point in time. But there are no guarantees that things are not going to change. It is important to remember that most Canadians support the Canada Health Act that requires that the terms of access to services be the same for **all** in the province and based on the notion of medical necessity. This requirement seems to guarantee that no one (including the elderly) will be discriminated against in terms of access to health care services. However, the lack of clarity of the meaning of "medical necessity" might create a possibility of "discriminating" (for lack of a better word) against the elderly. One of the potential meanings of "medical necessity" identified by Charles et al (1997) is the maximum we can afford. This interpretation is consistent with a policy goal of costs control. Furthermore, because the needs and hence some time services required for the elderly population are different than the general population they can be deemed "medically unnecessary" because we cannot afford them. Such decision is likely to result in substantial cost savings, as the proportion of the elderly population increases, but with little or no effect on the services provided to the rest of the population.

The paper by Laupacis (2002) describes the decision making process regarding the approval of drugs to be covered by the Ontario Drug Benefit Program (which was described earlier in this paper). Laupacis, who was the chair of the Drug Quality and Therapeutic Committee, which makes those decisions, argued that the committee was making "reasonable decisions" under very difficult circumstances. In making its decisions and making its recommendations the committee uses cost-effectiveness information. Despite basing the recommendation on cost effectiveness information, program expenditures rose by almost 50% over a period of four years (fiscal 1996/7 to 2000/1). Laupacis admits that this growth in expenditure has lead both the premier of Ontario and the minister of health to question to question the program's affordability and consider to abandon it. Unfortunately Laupacis failed to see that it the use of the cost

effectiveness methodology that was responsible for the uncontrolled growth in expenditures (Gafni and Birch, 2003). However, this event demonstrates that decision makers can interpret “medical necessity” as the maximum that we can afford and will not hesitate to abandon important programs (like a program that provides drug coverage to the elderly) if they deem that are not affordable. In Ontario, the program was “saved by the bell” as the conservative government lost power before it was able to abandon the program.

It seems that Canada Health Act and the conditions are obliged to meet in order to qualify for federal financial support are sufficient to guarantee that the health care needs of the elderly population will be met by the provincial health insurance plans. However, as explained by Birch and Gafni (2005) the changes in the health care environment over the past decade and a half have been associated with a reduction in the effectiveness of the federal cost sharing as a mean to promote the objectives of the Canada Health Act. Under the Act, the federal government’s role and influence is restricted to its contribution to the cost of provincial programs (which health care falls under their jurisdiction). Over time, the level and share of the federal government contributions has diminished. For example, in Ontario it fell from close to 50% when the act was introduced to about 17% in fiscal year 2005/6. The pressure to reduce budget deficits that lay behind the federal cutbacks are not confined to the federal government, however. Provincial government resources are squeezed by their own deficit reduction plans and by the increasing cost to the provinces of their health insurance programs. The double edge sword has caused provinces to look to reduce the demand on insured programs as well as to find other funding sources for health care programs not covered by the federal legislation. The diminishing contribution of federal government to the cost of insured programs also reduced the opportunity cost to provinces of not meeting the conditions of the Canada Health act. Birch and Gafni document in their paper the deterioration in performance of the Canadian model of health care funding. They argue that in the current levels of federal contributions the current provisions of the Act are unlikely to sufficient to enable

the federal government promote the goals of the Act. Without a fundamental change
Canada risk loosing the battle of achieving the goals of the Canada Health Act.

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