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

Amiram Gafni Ph.D., Professor
Centre for Health Economics and Policy Analysis
Department of Clinical Epidemiology and Biostatistics
McMaster University
Hamilton, Ontario, CANADA

Population aging

- Population aging is common throughout the industrialized world.
- Total fertility rate is less than the natural replacement level (2.1 children per woman).
- The proportions of individuals over 60 or 65 are rising.
- The proportions of individuals under 15 are falling.
- Theses trends are projected to continue far into the future.
- Circumstances vary from country to country, but all share this one demographic characteristic: Their populations are growing older!

Economic Implications of Population Aging

Far reaching economic implications. For example:

- Patterns of consumption, savings and investment
- Level and rates of growth of GNP and per capita national income
- Labor force (rate of flow of young workers, retirement and pensions)
- Enrollment in schools and universities
- The health care system

Population aging and healthcare

Every aspect of the healthcare system is affected. E.g.,

- Requirements for services and mix of services
- Need for long-term institutional care, home care services
- Hospital beds: number and mix
- Requirements for and mix of physicians, nurses and other skilled personnel
- There are major costs implications
- The need for planning

Three questions:

- How do we currently pay for the healthcare of the elderly?
- Are there any signs of increased tension between the elderly and the rest of the population?
- How do we deal with the healthcare of the old-old?

BAFFIN SEA
BEAUFORT SEA
NUNAVUT TERRITORY
YUKON
TERRITORY
NORTHWEST
TERRITORIES
Foxe
Basin
Iqaluit
Yellowknife
Whitehorse
Hudson Bay
Labrador
Sea
BRITISH
COLUMBIA
ALBERTA
MANITOBA
Gulf of
Alaska
SASKATCHEWAN
Edmonton
ONTARIO
QUEBEC
NEWFOUNDLAND
Regina
Winnipeg
Victoria
PRINCE
EDWARD
ISLAND
St-John's
PACIFIC
OCEAN
Quebec
Charlottetown
OTTAWA
Fredericton
NOVA SCOTIA
Halifax
UNITED STATES
CANADA Political Map
0 km 300 600 900
© Trail Canada www.trailcanada.com
ATLANTIC
OCEAN

Yukon Territory
Whitehorse
Northwest Territories
Yellowknife
Nunavut
Iqaluit
British Columbia
Victoria
Alberta
Edmonton
Saskatchewan
Regina
Manitoba
Winnipeg
Ontario
Ottawa
Toronto
Quebec
Québec
Newfoundland and Labrador
St. John's
Prince Edward Island
Charlottetown
New Brunswick
Fredericton
Nova Scotia
Halifax
CANADA – Political
International boundary
Provincial/territorial boundary
Alberta Province/territory
Ottawa National capital
Regina Provincial/territorial capital
Scale
0 250 500 750 1 000 km

Growth and Aging in Canada

CANADA:

- Canada population is growing slowly but aging fast
- Senior citizens (>65) will outnumber children (<15) before 2015
- Rapid growth projected to last until 2031 when seniors will account between 23-25% of population
- Median age 39 (2005); 43-46 (2031); 45-50 (2056)
- Proportion of old-old (>80) would increase sharply; 1 in 30 (2005) to 1 in 10 (2056)

…..and Ontario

- Median age 38 (2002); 42.2 (39.9-45.7) (2030)
- Age distribution in 2030 (“best guess” scenario)

< 15 years	15.3%
Between 55 and 74 years	24.6%
> 75 years	9.7%

- In 2040 it is projected that under the “best guess” scenario, 1 in 8 people living in Ontario will be 75 years or over.

Aging in Canada (cont.)

- The population of Canada and each of its provinces are aging rapidly
- There is a difference in the pace of aging between the provinces, this difference is very small
- The rapid growth of the proportion of people who are defined as “old-old” justify the urgency of rethinking how we provide and fund services to this segment of the population.

The Medicare Program in Canada

- Under the 1867 British North America Act health care was deemed to be a responsibility of the provinces
- Following WWII, concerns with unequal access to healthcare led several provinces to introduce public hospital insurance
- This led to increased pressure on the federal government to get involved in health care. But the articles of confederation restricted what role it could play
- Thus federal action concentrated on setting explicit conditions to be met by the provinces to receive federal financial support
- 1957: Hospital and Diagnostic Service Act
- 1965: extended to physician services (Medical Care Act)
- 1984: These acts were consolidated under the Canada Health Act

The Canada Health Act (CHA)

- CHA is the foundation of the current Canadian Health Care system
- 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

CHA: The five conditions are…

- The entire population be covered by the provincial plan
- The plan cover a comprehensive range of hospital and physician services
- Coverage will be portable between provinces
- The plan will be administered by a public authority
- The terms of access to services will be the same for all in the province and based on the notion of medical necessity

CHA (cont)

- At the time of legislations, provinces could receive 50% of the cost of the programs from the federal government once the qualifying conditions were met
- This incentive was sufficient for each province to introduce its own legislation to ensure that the conditions were met
- The Medicare program arose from concerns over the prohibitive cost of healthcare
- The price barrier was removed by creating (i) provincial insurance plans with (ii) monopoly power for buying hospital and physician services
- Federal cost sharing was used to outlaw all aspects of private payment for "insured" services

CHA (Cont)

- Little attention was paid to the role of supply factors in determining the distribution of services
- The levels and distribution of supply, mechanisms for planning management and delivery of services were inherited from the pre-Medicare era
- It was implicitly assumed that, in 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”
- It was assumed that available resources will follow needs
- Conventional wisdom (but non necessarily evidence) indicated that Medicare was achieving the objectives set out in the CHA

So…who pays for the care of the elderly in Ontario?

- The Ontario Health Insurance Plan (OHIP) is the (provincial) government run health plan
- Every Ontario resident, whose primary and permanent home is in Ontario, is entitled for free of charge (at the point of delivery) access to services insured by OHIP
- OHIP covers wide range of services which are deemed *“medically necessary”*
- OHIP is covered by taxes paid by the residence of Ontario and by transfer payment from the federal government

Budget implications

- In the 2008/9 budget it is estimated that healthcare expenditures will consume 42% of the budget
- In 2001/2 it was 36.3%
- Spending on HC is set to rise by 6% in fiscal 2008/9 compared to projected GDP growth of 2.9% in 2008
- It is anticipated that the HC sector will continue to consume all available resources and crowds out other priority areas
- Planned spending to all other areas were reduced by 4.1% in the 2008/9 budget

Payment for the elderly in Ontario (cont)

- CHA requires that the terms of access to services be the same to *all* in the province based on the notion of *medical necessity*
- However, the CHA only demand that the provincial plan covers hospital, physician and inpatient surgical dental services ("core services")
- Who pays for non-core services (e.g., prescription drugs, dental care, nursing home, home care, physiotherapy)?
- What are *medically necessary* services?

Medical necessity: 4 meanings and…a funeral

Meaning	Policy goal	Intended use as policy tool
What physicians and hospitals do	Broaden access to publicly funded HC services	Establish entitlement to a minimum federal floor
The maximum we can afford	Control costs	Make the federal floor the provincial ceiling of publicly funded services
What is scientifically justified	Improve the quality of care	Limit public funding to services justified by scientific evidence
What is consistently publicly funded by provinces	Promote equity in entitlement and access across provinces to publicly funded services	Establish (and later negotiate) a consistent package of publicly funded services across provinces

Medical necessity (cont)

- The concept has taken different meanings over time, depending on the perceived policy needs of the day
- The result is a confusion over the array of meanings and how they are used in policy debates
- We are not sure that all “medically necessary” physicians and hospital based services are being provided, free of charge at the point of delivery
- FUNERAL?

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

- This is left to the discretion of each province
- As a result, the heterogeneity in the approaches taken by the different provinces in funding “non-core” services is much greater than the heterogeneity in the coverage of hospital and physician services.
- Even within a province there heterogeneity in the coverage of “non-core” services

Prescription drugs

- The Ontario Drug Benefit (ODB) program provides coverage for over 3200 drug products, including nutrition products and diabetic testing agents
- Drugs are added to the “formulary” based on CE and other considerations
- Drugs not covered by ODB can also be covered through the Ministry’s Exceptional Access program on a case-by-case basis
- Every residence of the province over the age of 65 is eligible for coverage
- The program used to be free of charge but a co-pay mechanism which is income based was introduced several years ago
- This is a deviation from the underlying notion of the CHA – payment at the point of consumption is a barrier to access

Home care and community support services (HCCSS)

- HCCSS provide many services to elderly people and people with disability
- Services include: Meals on wheels, assistant with home making, volunteer drivers, day programs to patients and respite services for family care givers
- 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
- Type of services offered in various regions is similar but access varies (partly due to budget allocation to each CCAC was not need based).
- Complementary private insurance is available

Long Term Care Facilities

- LTC services for the elderly in Canada and Ontario have evolved into a vast array of types of facilities, levels and types of care and organizational agreements that vary between provinces
- Government funding varies – depending on the type and level of facility
- There is always requirement for co-payment
- Co-payment are substantial (in my opinion) and can only be waved (or reduced) based on income considerations
- Government supervision of the facility varies.

Local Health Integration Networks (LHIN)

- The Local Health System Act 2006 changed the delivery of HCS
- The management (including the power to allocate the budget) was devolved to the 14 LHINs created in the province
- LHINs will have responsibility over the following providers: hospitals, psychiatric hospitals, CCAC, LTC homes
- The goal is to improve the planning and integration of existing services to better meet the needs of the (local) population
- But, the competition for local resources might be fiercer
- As this is a new initiative it is difficult to assess it's performance
- My opinion (☺)

Food for thoughts…..

- Canada and Ontario populations are aging rapidly and this is projected to continue at least in the coming decades
- I have described the services that are available today for the elderly in Ontario and who pays for what

But -

- No research on whether existing services meet the HC needs of the elderly
- No research on the financial burden on the elderly and their care givers related to their HC

Food for thoughts (cont.)

- Is the Ontario HC system ready to meet the challenges of the future?

I do not think so

- The aging of the population will require a change in the mix of services, providers, type of institutions etc.
- These changes take a long time, require careful planning and large investment
- It requires comprehensive needs assessment to determine where we are and where we want to be
- A transparent and comprehensive process, that will enable accountability, to deal with the above does not exist

Food for thoughts (cont.)

- One explanation might be that the current system is dealing with a cost crisis that does not seem to be resolved
- The federal government ability to influence provincial decisions has diminished due to the dramatic reductions in its contributions to provincial plans
- But when long term considerations take the back seat, it does not mean that the problems disappear
- This will result in provinces attempt to reduce the number of publicly insured services (core services)
- This can lead to tension and “discrimination” against the elderly and even more likely toward the old-old (i.e., an “attempt” to cancel ODB)
- Without a fundamental change Canada risk loosing the battle of achieving the goals of CHA

CANADA HEALTH ACT (1984)

"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"