What is the National Advisory Council on Aging?

The National Advisory Council on Aging (NACA) was created by Order-in-Council on May 1, 1980 to assist and advise the Minister of Health on issues related to the aging of the Canadian population and the quality of life of seniors. NACA reviews the needs and problems of seniors and recommends remedial action, liaises with other groups interested in aging, encourages public discussion and publishes and disseminates information on aging.

The Council has a maximum of 18 members from all parts of Canada. Members are appointed by Order-in-Council for two- or three-year terms and are selected for their expertise and interest in aging. They bring to Council a variety of experiences, concerns and aptitudes. Health Canada's Division of Aging and Seniors provides operational support to the National Advisory Council on Aging.

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Waiting for Romanow...

Recommendations on the Future of Health Care in Canada

Introduction

In the Spring of 2002, the National Advisory Council on Aging (NACA) submitted an abstract to the Romanow Commission on the Future of Health Care in Canada. This abstract presented NACA's views on specific issues related to health care reform – primarily from a seniors' perspective, and responded to some of the important questions posed by the Commission's *Interim Report*. The NACA abstract concluded with a set of specific recommendations to reform the health care system.

Though NACA's views on the future of health care in Canada are now known to the Romanow Commission, NACA has yet to make these views public. The purpose of this document is to describe and explain the Council's views to the public at large, in anticipation of the Romanow Commission's Final report, due to be released in mid-November, 2002.

Patricia Raymaker
Chairperson

How Well Has Canada's Health Care System Served Canadians?

NACA believes that Canadians have been well served by a publicly funded universally accessible health care system. Though Canadians have voiced some concerns in recent years related to specific aspects of the health care system (e.g., access to certain services, waiting lists), survey after survey demonstrates that Canadians who actually need to *use* the health care system, generally report a high level of satisfaction with the care they receive. International comparisons of health care systems across industrialized countries reveal that Canada's health care system provides a high level of care for all its citizens at a relatively low cost to society (i.e., our system is relatively "efficient"). But, NACA also believes reforms do need to be undertaken if Canada's health care system is to be modernized and sustained. More specifically, the Council urges all governments to take action on particular health care issues that disproportionately affect seniors. More often than not, making changes to the health care system to meet the needs of seniors better will simultaneously benefit all age groups.

NACA believes that the five principles of the *Canada Health Act (CHA)* that have guided the delivery of health care in Canada (comprehensiveness, accessibility, universality, portability and public administration) are sound and effective. However, the Council also recognizes that health care has changed dramatically since the 1960s when these principles became the foundation of Medicare and in 1984, when they were enshrined in the *CHA*. It may be time to ask whether we need these principles further clarified to meet the realities of today's health care and/or whether we need to add new principles or programs that reorient the health care system to meet Canadians' evolving health care needs.

Though sustaining and reforming health care in Canada is obviously in the interest of all Canadians, it is of particular importance to seniors: as a person ages, having access to high quality health care has a greater influence on health.

I. Specific issues

Primary Care Reform

NACA sees reforming primary care as a critical part of sustaining and modernizing health care. When policy makers refer to primary care reform, it usually includes changing the way in which health care professionals are organized (e.g., advocating integrated interdisciplinary teams of various practitioners versus individual doctor practices; changing respective roles played by various health professionals) and/or changing the ways in which they are paid. For example, by moving physicians away from what is now a predominantly fee-for-service basis to a mix of payment methods, the incentives for physicians to practice in different and more efficient ways (e.g., preventive medicine, increased counselling) would improve. These payment methods might include salaries, capitation, and contract or fee-for-service.

Primary care reform is important to seniors because they often rely more heavily, relative to other population groups, on timely access to their health care practitioners. Timely access to primary care can "nip a problem in the bud" and reduce the chance of being hospitalized. It is NACA's view that primary care should be changed so that it is more consistent with the principles of geriatric care. Seniors with multiple health problems would benefit from health care settings in which practitioners from various disciplines work in teams. Changing the way physicians are paid (e.g., less fee-for-service) would improve incentives for practitioners to spend more time with each patient. Finally, reforming primary care to create a larger role for health promotion and disease prevention activities within a primary care setting would improve the health of seniors and the entire population.

Home Care

NACA believes that maintaining and expanding the provision of home care is critical to a reformed health care system, to meet both the needs of today's seniors (and other age groups that depend on home care) and those of an aging population. Home care prevents and delays institutionalization and improves seniors' quality of life by allowing them to remain in their community. Yet, despite the advantages of home care – and the increasing need for it – expansion of home care has not kept pace with

hospital cut-backs. Despite the goal of moving health care delivery away from physical institutions such as hospitals and back into communities, spending on home care accounts for only 4% of all health care expenditures. Between 80 to 90% of home care is unpaid. Publicly funded home care and home support vary widely across the country, even within provinces.

Prescription Drugs

Prescription drugs have become a much more important part of Canada's health care system. In fact, prescription drugs are the fastest growing cost component of the nation's health care system. The cost of prescription drugs has risen 170% per household over the last 20 years. Canada's publicly insured health care system has not kept pace with this changing reality of health care. Prescription drugs are publicly insured only if they are prescribed in a hospital even though most prescribing occurs in a physician's office. Public insurance for prescription drugs for seniors varies widely across Canada. The issue of prescription drug coverage affects seniors disproportionately because seniors use more prescriptions drugs than other population groups. Some seniors – and younger Canadians as well – are still vulnerable to undue financial hardship from high drug prices.

Population Health/Health Promotion/Disease Prevention

Seniors are not a monolithic group; some seniors are aging in better health than others. This means there is significant potential for investments in health promotion/disease prevention strategies to maintain the health of those who are aging well and to improve the health of those with diseases, or at risk for serious problems. There is solid evidence that shows that health promotion and disease prevention strategies (e.g., falls prevention, physical activity, healthy eating) can improve the health of seniors – even very late in life. Many chronic diseases that shorten life and/or decrease quality of life for seniors (diabetes, heart disease, osteoarthritis) are modifiable by health promotion, health education and disease prevention programs. NACA believes that, in designing and delivering such health promotion and disease prevention programs, particular attention should be given to marginalized groups such as those with low-incomes, poor housing conditions, or those lacking in social support from family or friends.

II. NACA responds to questions posed by the Romanow Commission's *Interim Report*

The Commission's *Interim Report* asked Canadians for their views with respect to a series of questions concerning the future of health care in our country.

"*Should the Canada Health Act (CHA) be revisited?*"

To this question, NACA responds with a qualified **Yes**: revisited, but not reopened. By this, the Council means that the *CHA* has *historically* served Canadians well. The five principles contained in the *Act* (accessibility, universality, comprehensiveness, portability and public administration) continue to be relevant and consistent with Canadian values. The principles have provided each province with a great deal of flexibility in the design and delivery of health care.

On the other hand, the Council thinks that the definition of these principles is too vague. The lack of clarity on what these principles truly mean has, many would argue, allowed some aspects of the health care system to erode. Because there is no consensus on how these principles should apply to real-life health care scenarios, critics have argued that provincial governments have had too much latitude in the interpretation of the principles while the federal government has lacked the authority to challenge these interpretations.

Should the CHA be reopened to put something in, something might equally be taken out. That would pose an unwarranted risk. One option suggested by NACA is to leave the principles as they currently exist in the *CHA* untouched but introduce a compendium Act that would provide greater clarity to the five principles. NACA believes that the term "medically necessary" as contained in the Act – though not itself one of the five principles – needs to be clearly defined and agreed upon by all levels of government. This new Act could also provide two additional principles to guide Canada's health care system: quality and accountability. These two new principles would mean that governments would be required – on a regular basis – to report to their electorates on the quality and performance of their respective health care systems. All

governments should be audited by a third party, independent of the governement, to ensure as much as is possible, that health care is delivered in an efficient, cost-effective manner. This would make governments, providers, insurers, etc., accountable to taxpayers and citizens for the health care they provide and the taxpayers dollars they use in doing so.

In addition to the above, the new compendium Act needs to reflect the fact that health care delivery has changed tremendously since Medicare was introduced in the 1960s and the CHA, 1984. The compendium Act should stipulate how "new core services", relevant to emerging health issues and changing realities of Canadian society, should be addressed through legislation. In addition to health care services already publicly insured, NACA recommends that additional "new core services" be publicly insured with priority being given (in descending order) to home care, prescription drug coverage and long-term care.

Another question contained in the *Interim Report* dealt with the four perspectives on the future of health care. The Commission found in their presentations to date, that Canadians' views on how to address the challenges facing the health care system seemed to coalesce around four major perspectives. These perspectives were: more public investment; share cost and responsibilities; increase private choice; and, reorganize service delivery.

"Which of the four perspectives does NACA favour? "

NACA endorses some aspects of three perspectives, with qualification:

- **more public investment:** NACA believes increased public investment is **part** of the answer to sustaining and modernizing Canada's health care system, especially in areas related to home care, prescription drugs, and increased Canada Health and Social Transfers (CHST);
- **increased private choice:** NACA is open to innovations in delivery that may increase private choice, and/or improve efficiency or effectiveness, providing these changes *do not* decrease accessibility, universality (e.g., privately delivered but publicly-insured services) or increase costs unnecessarily; and

- **reorganized service delivery**: NACA believes significant improvements can be made by reorganizing service delivery, whether it be through primary care reform, shifting of resources to health promotion/disease prevention models or recognizing that prescription drug coverage and home care should be part of Medicare.

NACA does **not** support the direction of **sharing costs and responsibilities**. NACA is very concerned that use of co-payments, user fees, etc. will result in decreased access without improved efficiency. International evidence from the European Economic Commission suggests that containing costs is better accomplished by reforming how the system delivers services rather than by increasing costs for the patient.

"*What options should we pursue to ensure the funding and fiscal sustainability of the Canadian health care system?* "

NACA believes that:

- there is no "magic" figure that dictates what amount of spending on health care is appropriate;
- health care funding levels need to be more predictable and more transparent; and
- the federal share of health care funding should increase.

III. NACA recommends to the Romanow Commission and Canadians

To address some of the major questions posed by the Commission on the Future of Health Care in Canada's Interim Report, NACA recommends that:

The *CHA* retain the five existing principles that have been the underpinning of the Canadian health care system. That a compendium Act to the *CHA* be introduced to clarify the meaning of the existing five principles, to add two new

principles of quality and accountability, and to provide for publicly-insured home care and more comprehensive prescription drug coverage programs.

All governments collaborate to modernize and sustain Canada's health care system through:

- more public investments;
- increased private choice as described by NACA; and
- reorganized service delivery.

Health care funding levels be more predictable and transparent and that the federal government's share of health care funding be increased.

To address health care system issues that particularly affect seniors, NACA recommends that:

The number of physicians with geriatric training be increased.

All governments explore methods of physician remuneration and improved incentives for various forms of health care practitioner organization (e.g., inter-disciplinary group practices) that are more compatible with the principles of geriatric care. These principles should take into consideration the multi-dimensional approach required to care for this population.

All levels of government collaborate to reform primary health care to make it more accessible (e.g., 24 hours/7days per week), and more integrated across disciplines.

A national, publicly-insured home care program be established (preferably as part of a compendium Act to the *CHA*) that provides, at a minimum, a "core" set of services for everyone.

A national, comprehensive publicly-insured or publicly/privately-insured prescription drug plan be established (preferably as part of a compendium Act to the *CHA*).

Increased priority be given to health promotion/disease prevention by enhancing public funding for health promotion/disease prevention initiatives that have been demonstrated to be effective.

Long-term care be an integral part of the health care system.

NACA believes:

- Canada must guarantee the same rights and privileges to all its citizens, regardless of their age.
- Seniors have the right to be autonomous while benefitting from interdependence and the right to make their own decisions even if it means “living at risk”.
- Seniors must be involved in the development of policies and programs and these policies and programs must take into account their individuality and cultural diversity.
- Seniors must be assured in all regions of Canada of adequate income protection, universal access to health care, and the availability of a range of programs and services that support their autonomy.