The NACA Position on Enhancing the Canadian Health Care System

This position was unanimously adopted by NACA members on September 7, 2000 following the 59th Council meeting

NATIONAL ADVISORY COUNCIL ON AGING

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Health Canada's Division of Aging and Seniors provides operational support to the National Advisory Council on Aging.

THE NACA POSITION ON... is a series of policy papers presenting NACA's opinions and recommendations on the needs and concerns of seniors and issues related to the aging of the population. Position papers are available at the website address above.

1st printing, 2000

Cat. No.: H71-2/2-21-2000
ISBN: 0-662-65241-X

Agreement No.: 1754424

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.

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NACA Beliefs

NACA believes that:

- 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.

The NACA Position in Brief

This report examines an insidious threat to both the overall cost and the fairness of health care in Canada: that of the highly variable and growing personal expenditures across the country for services not insured by the Canada Health Act (CHA). NACA touched on this situation in a previous position paper, *The NACA Position on the Privatization of Health Care*. It now reexamines the health and financial burden to seniors in the areas of home care, medication, long-term residential care and other health expenses, and describes the wide variations across Canada in the access seniors have to public coverage and in the level of costs levied for services.

NACA's vision proposes a more equitable system. It builds a case and makes recommendations for the planned and gradual implementation of a health care system offering a complete range of services; it compares the different models of financing health care services; finally, it explores the political and financial feasibility and examines the social justice aspects of the question.

NACA's first recommendation is a reiteration of one put forth in The NACA Position on the Privatization of Health Care:

1. **That publicly funded services be extended to comprise all services necessary to restore and preserve health and functional capacity, including home care, prescription drugs, care provided in long-term care facilities, dental care and vision, hearing and other assistive technologies.**

NACA also makes the following recommendations:

2. **That the federal government increase the CHST and, where warranted, equalization payments, to make it possible for provinces and territories to extend publicly-insured health services to make them more comparable across Canada.**

3. **That the provincial and territorial governments include home care, drug care and institutional long-term care in their regular report to Canadians on health care investments and health system performance.**

4. **That the extension of health care services provided in all jurisdictions be funded through general tax revenues, without requirement for any additional individual private payment.**

5. **That in extending public insurance for health services, priority be placed on home care, then on drug benefits, followed by health and personal care provided to residents of long-term care facilities. Elements to incorporate later include dental care and vision, auditory and other assistive technologies and products.**

   That charges for room and board for residents of long-term care facilities not be set higher than current market rates in the local community for similar lodging and food services.

6. **That the federal government provide an income-tested refundable tax credit for all out-of-pocket medical expenses over $500 which have not been reimbursed by private insurance plans.**

NACA believes that Canada is currently in a favourable economic and fiscal situation to extend and sustain a wider range of health services and that public financing is the most equitable and cost-effective model of health financing.These goals can be achieved through a staged implementation which would allow adjustment by governments and the private market.

The NACA Position on Enhancing the Canadian Health Care System

INTRODUCTION

The national public health care system is an achievement which Canadians value and which must be safeguarded against encroachment. The current debate about the long-term affordability of the national public health care system has eclipsed a more insidious threat to both the overall cost and the fairness of health care: that of the highly variable and growing expenditures across Canada for services not insured by the *Canada Health Act* (CHA). According to the Canadian Institute for Health Information, growth in private expenditures for health services outpaced the growth in public expenditures during the early to mid-1990s; in 1997, all other G7 countries, except the United States, had a higher proportion of publicly covered health costs than did Canada[1]. Partly because of the high level of private health expenditures required by Canadians to supplement the services provided by the public health care system, in 2000, the World Health Organization (WHO) rated Canada 30th out of 191 countries in a comparative analysis of national health care systems. The WHO report repeatedly warned of the dangers of high levels of out-of-pocket health expenses, particularly for individuals with low income[2].

The rising private costs of non-insured — but necessary — health services, such as drugs, home care, long-term care in institutions, dental care, vision and hearing care, affect seniors disproportionately, not only because they are more likely to need health care than other Canadians[3] and have to pay more for it, but also because they have lower incomes[4]. Compared to younger adults, seniors see doctors more frequently, are hospitalized more often, use more home care services and take more drugs[5]. In 1997, senior couple households reported a higher average spending on health care ($1,582) than all households ($1,153). Seniors living alone also reported higher annual health care expenditures ($826) than one-person households in general ($707)[6]. While all provinces and territories have supplemented the hospital and physician services insured under the CHA with some level of coverage for other services, there are wide variations in access to public coverage for seniors and in the level of costs levied for services.

The Council has already drawn attention to the problem of the increasing privatization of the health care system. In *The NACA Position on the Privatization of Health Care* (1997), Council recommended the expansion of Canada's publicly-funded national health system to comprise all medically necessary services, including home care, prescription drugs and health technologies[7]. NACA reiterates this recommendation and carries it further in the present report. Beginning with a closer look at the dramatic variations in seniors' access and costs for non-insured health services across Canadian provinces and territories and at the gaps in health services provided, NACA will build a case for the planned and gradual implementation of a comprehensive public health care system based on the impact on health, comparative models of health care financing, political and fiscal feasibility and, finally, social justice.

1. NON-INSURED HEALTH SERVICES: AN UNEVEN PATCHWORK

The examination of variations affecting seniors in provincial and territorial home care, drug benefit and long-term institutional care programs borrows heavily from the detailed analysis presented to Council in 1999 by E. Richard Shillington, of Tristat Resources[8].

1.1 Home Care

Home care prevents and delays institutionalization and promotes the social integration of seniors. It responds to the changing health needs of older Canadians in a flexible, holistic manner and provides support to their informal caregivers. Decreases in the number and in the duration of hospital stays for acute health problems and an increase in the numbers of persons needing care for chronic health problems have made home care a vital component of the health care system. While the costs of services of nurses or other health professionals are usually fully covered by the province or territory, fees are often charged for support services such as homemaking and personal care. The provision of services is limited by the budget of the local home care service provider. With fixed budgets, agencies must often ration services and client income levels can be one of the rationing criteria. Often there is a minimum charge for low-income seniors and, in some

jurisdictions, fees can be waived for seniors with very low incomes. Yet, as income increases, charges also often increase. **Table 1** presents how fees for personal care services are determined in each jurisdiction[9]. There is considerable variation in the charges for service as well as in the income criteria used to determine how charges are set. Two provinces (Newfoundland and New Brunswick) may include assets as well as income in determining fees. Only Manitoba does not charge user fees for home care.

The services provided through public home care agencies may not be sufficient to meet legitimate needs[10] and tighter rationing by home care agencies to meet rising demands with fixed budgets[11] may result in a decrease in the amount of publicly supported services received. Under these circumstances, home care clients may be forced to do without the services needed, rely more heavily on informal caregivers, relinquish their home for a long-term care institution, or pay even more than they are already paying to receive additional care from private agencies — if they can.

1.2 Drug Care

Medication has become an essential element of health care, improving health and replacing or delaying hospitalization or surgical intervention. Despite their importance, drugs prescribed outside of a hospital are not universally publicly covered, but are paid for through a combination of provincial drug benefit plans, private insurance and personal payments. As shown in **Table 2**, provincial and territorial drug benefit plans vary widely in their coverage, eligibility criteria and kinds and levels of user charges (premiums, deductibles and co-payments)[12].

Methods of income-testing for drug benefits can have a dramatic impact on seniors whose income is only slightly higher than the income threshold established in a government plan. The impact can be seen in the following examples from three provinces:

- In Newfoundland, recipients of the Guaranteed Income Supplement (GIS) are covered at no cost but seniors who do not receive GIS have no coverage at all.

- New Brunswick charges a maximum annual co-payment for drugs of $200 for GIS recipients but there is no maximum for seniors not receiving GIS.

- In Saskatchewan, GIS recipients living in the community pay a $200 semi-annual deductible, whereas seniors who do not receive GIS have a semi-annual deductible of $850.

In all of these instances, having an income a few dollars higher than the GIS income threshold can be very costly in terms of lost drug coverage.

An all-or-none approach to entitlements and fee schedules can pose financial hardship for lower-income seniors and options are limited: cut back on other essentials of life or cut back on necessary drugs. There is evidence as well that increases in out-of-pocket payments have negative consequences on seniors who have limited financial maneuverability. A 1996 study by the Government of Alberta reported that lower-income seniors are at risk of financial hardship if they have high health needs or if they have unexpected emergency expenses, such as increased drug costs[13]. In other research, it was found that seniors living on a fixed income who have to suddenly pay more for rent or for medications are likely to decrease their expenses for food[14]. When Quebec introduced a provincial drug plan that provided coverage for all residents, but that required payment of a premium and co-payments and deductibles, there were major consequences for low-income seniors, who were accustomed to receiving their prescriptions virtually free of charge. Reducing or ceasing medication use because the drug costs were unaffordable resulted in a 111% increase in physician visits, a 47% increase in visits to hospital emergency rooms and an increase of 66% in hospitalizations, institutionalizations and deaths[15]. Many seniors were forced to rely on community organizations and churches to help pay for their medications.

Arguments that provinces and territories have generous drug plans protecting seniors from catastrophic drug costs and that seniors also have access to supplementary private drug insurance are not strong. In comparison with public drug plans in the United Kingdom and the Netherlands which covered 90% of drug costs in 1995, Canadian programs covered only 45%. Moreover, Canada fell near the bottom of OECD countries in the public share

of drug costs[16]. With respect to supplementary private insurance, only 52% of seniors aged 65-74 and 50% of seniors aged 75 and older were insured in 1999[17].

1.3 Long-term Residential Care

Long-term care facilities are places of residence for persons whose degree of functional impairment makes it very difficult or impossible to live at home. These facilities provide room and board as well as services such as nursing, drugs and personal care. Given the health status of the residents, most of these services are medically necessary and would be fully covered in a hospital.

As with home care and drugs, provincial and territorial charges for long-term care residences are similar for low-income seniors but vary widely for seniors with incomes above the bare minimum assured by public pensions. Charges for seniors receiving only Old Age Security (OAS) and GIS benefits are set so that these seniors are left with a personal allowance of $100 - $200 dollars per month. As seen in **Table 3**, rates and rate-setting methods for seniors with more income differ in each jurisdiction. In the Yukon, Northwest Territories and Alberta, there is a flat rate not subject to income testing. British Columbia, Saskatchewan and Manitoba set rates on the basis of income, and Ontario sets standard room rates, but uses income-testing to permit some residents to pay a lower rate. East of Ontario, the assessment of financial resources includes asset tests. The rules vary, but in essence the maximum fee is charged for long-term care until the person's assets are reduced to a minimum. The costs of long-term care for seniors with incomes of $10,000, $15,000 and $30,000 are displayed in **Figure 1** for each jurisdiction.

Clearly, seniors in some jurisdictions are paying for medically necessary services and not only for room and board. Because long-term care facilities are not technically hospitals, the letter of the *Canada Health Act* is not violated, although the spirit of it is. Furthermore, as in the case of drug charges, long-term care institutional fees in many jurisdictions are a disincentive to retirement saving, since seniors with personal income above public pension entitlements are charged more for the same benefits and standard of care as seniors with only public pension income.

1.4 Other Health Services

Many other services and products that are important in maintaining good health, independence and quality of life, particularly for seniors, are often not included among supplementary health benefits. These include dental health services, vision and hearing aids and other assistive devices.

In older adulthood, poorly fitted dentures, illness, some medications and poor oral hygiene can lead to pain and gum disease, which in turn may contribute to poor nutrition. Yet only 25% of seniors aged 65-70 and 20% of seniors aged 75+ have dental insurance, and seniors are half as likely as younger Canadians to have visited a dentist within the past year[18].

In addition to the normal decline in close vision that accompanies aging, older eyes are more susceptible to problems such as cataracts, glaucoma and macular degeneration. Most provinces and territories cover annual eye examinations to monitor vision changes and eye health, but they do not provide complete coverage of corrective eyewear for seniors, even for low-income seniors. Only 28% of seniors aged 65-74 and 26% of seniors aged 75+ have private supplementary insurance to pay for prescription glasses.

Hearing loss is the third most prevalent chronic disability among older adults and the incidence of hearing loss increases with age. An estimated 25% to 48% of seniors aged 75-79 have some degree of measured hearing loss[19]. However, some provincial health care plans do not fully cover hearing aids or other assistive devices that help reduce the effects of hearing loss.

More and more assistive technology is available to allow persons with disabilities to function independently and safely. Again, seniors comprise a large proportion of the disabled population; in 1996-97, 25% of seniors living at home reported having a long-term disability, compared to 20% of persons aged 55-64 and less than 10% of those aged 25-54[20]. Some provinces include the provision of assistive devices as a supplementary health benefit, but in others, the responsibility for providing these supports falls upon community service groups and charitable organizations[21].

2. AN ENHANCED NATIONAL HEALTH CARE SYSTEM: NACA'S VISION

The Council believes that all Canadians have the right to expect the same level of health care regardless of where they live in the country. A person's level of income should not be a factor in determining access to health services or products which — evidence shows — are important to preserving health and well-being. People should not be forced to choose between health services and other amenities of life.

NACA repeats a recommendation made previously in The NACA Position on the Privatization of Health Care (1997), that:

Publicly funded services be extended to comprise all services necessary to restore and preserve health and functional capacity, including home care, prescription drugs, care provided in long-term care facilities, dental care and vision, hearing and other assistive technologies.

Extension of insured health services will require additional federal transfers to the provinces and territories, both in payments made under the Canada Health and Social Transfer (CHST) and, for less prosperous jurisdictions, in federal equalization payments. Equalization payments allow less prosperous jurisdictions to provide public services to their residents that are comparable to those offered in richer jurisdictions.

NACA recommends that:

The federal government increase the CHST and, where warranted, equalization payments, to make it possible for provinces and territories to extend publicly-insured health services to make them more comparable across Canada.

A potentially promising first step in this direction has been made with the announcement of new federal investments of $21 billion over 5 years into the CHST for health care in the context of a federal/provincial/territorial (F/P/T) Health Action Plan, as well as with the agreement to consider enhancing equalization payments. However, NACA is concerned that the opportunity to use these funds to improve home care, drug care and institutional long-term care will be lost as provinces respond to immediate public pressures within their jurisdictions to increase hospital-based services and primary care. The commitment of First Ministers to continue collaborative action to integrate home care within the health system and to address issues around drug care is only partly reassuring. At a minimum, provinces should be accountable to the public for improving home, drug and institutional long-term care until these areas come to the forefront of the F/P/T health agenda.

NACA recommends that:

Provincial and territorial governments include home care, drug care and institutional long-term care in their regular report to Canadians on health care investments and health system performance.

To be a viable goal, the Council's initial recommendation must address some key issues:

- Is it fiscally realistic to consider extending publicly-funded health care benefits, especially at a time when the financial sustainability of the current, limited public health system is questioned?

- Is public financing of health care the best policy option in terms of equity, efficiency, and cost-effectiveness?

- Should public coverage be provided for all of these services at the same time, or should they be phased-in, and in what order of priority?

- How can disparities in private health costs be alleviated pending full inclusion of services within publicly insured plans?

2.1 Can Canada Afford to Extend Health Care?

The argument against the affordability of new health care programs — as are most arguments against the long-term sustainability of the Canadian health care system — is based on projections of program costs. However, the availability of revenues to sustain cost increases is often forgotten. The federal government and many provincial governments are projecting large surpluses in the years to come. The federal government alone has recorded a financial surplus in each of the last three years — $1.3 billion in 1996-97, $12.7 billion in 1997-98 and $11.5 billion in 1998-99. Based on financial results to date this fiscal year, a financial surplus of $12 billion is expected in 1999-2000[22]. Costs of a national home care program are not yet available, although a rough cost of about $ 5 - 6 billion can be established on the basis of the value of services currently being provided by informal caregivers[23].

The cost of implementing a fully funded, comprehensive, national pharmacare program would increase public expenditures on prescription drugs by an estimated $4.3 billion[24]. These figures strongly suggest that governments can expect to have sufficient revenues to sustain and extend the health care system. Denton and Spencer have demonstrated that while program costs for pensions and health will rise as society ages, these increases will largely be offset by decreases in other programs more heavily used by a younger population, such as education and correctional services. Re-allocation of program resources will be more important in the future than controlling an overall increase in program costs[25].

Furthermore, proposed new publicly-funded health care programs are not simple additions to the existing health care system. There is a substitution effect where the new health care program reduces some of the demand for (and cost of) existing services; for example, under certain conditions, home care reduces the need for extended hospital care or for institutionalization in a long-term care facility and many drugs and new technologies decrease the need for hospitalization or surgery.

Some would argue that Canadians must make a choice between tax cuts and expansion of social and health programs. Yet both these choices have similar results. Tax cuts obviously increase the disposable income of individuals. Enhanced health care programs reduce individual out-of-pocket

health expenses, thus also increasing disposable income. The difference is that individuals with high incomes benefit most from tax cuts whereas enhanced public coverage of health services provides broader relief and has a greater positive impact on Canadians with lower incomes, in particular, seniors.

2.2 Is Public Financing the Best Policy Option?

Different types of funding mechanisms have been proposed for providing extended coverage of health products and services outside the CHA-insured system which is funded by general government revenues collected through income taxes[26]. It is important to examine the potential advantages and drawbacks of each of these proposals. Criteria to consider in this assessment include: social equity, that is, how fairly the benefits are distributed across the population; impact on overall health costs; and impact on health care utilization and on health outcomes.

One financing option is the creation of a national extended health care insurance program, similar to the provincial drug insurance plan introduced in Quebec in 1997[27]. This program would provide insurance coverage for health services not insured under the CHA for Canadians who are not covered by private plans. The national public plan would operate much like its counterparts in the private sector in that it would be self-funded by charging members income-tested premiums, and there would be deductibles and co-payments for services.

The chief advantages of this plan are that it would be self-funding and not pose a potential burden on public revenues and improve access to health services by persons of all ages with low income. It would not compete with the private sector and it would allow the government insurer to control the costs of services provided. Yet the drawbacks are serious. First, the risk pool is too small and too selective, as Quebec has discovered in the operation of its drug insurance plan. The pool of contributors to the national plan would be largely composed of people who cannot contribute to employment-based or other private insurance plans, that is, people who are unemployed, disabled or seniors. These people are more likely to have health problems and make more demands on the health services than their pooled premiums would

cover. Secondly, there would still be out-of-pocket costs for services that could be prohibitive to individuals.

Another financing model that has gained attention considers extended health services as taxable benefits[28]. Everyone would receive the services whenever they were needed without making a direct payment. However, they would get a receipt for a taxable benefit. At the end of each year, the cost of all the services used would be added to taxable income.

The advantages are that the system would be funded through additional tax revenues; all Canadians would have access to the same services and would pay according to their income level. The system would be progressive because persons with lower income would be taxed at lower tax rates and there would be a ceiling on the amount that could be charged as tax, not to place undue hardship on people with high health needs. However, the burden of cost would be disproportionately borne by the sick, who would be the heaviest users. While those who are too poor to pay income tax would be protected, those who have modest incomes would still be faced with additional costs that they cannot afford at the end of the year. The requirement to pay out-of-pocket could create disincentives to the use of needed services, thus increasing the risk of more serious health problems later and added public costs for physician and hospital services. If these individuals were to decide not to pay the tax owing on health services to avoid reducing other necessary living expenses, the government would have to choose between pursuing the sick for taxes owed or absorbing the tax loss. The system would be administratively complex and expensive, requiring methods for tracking health expenditures for each citizen and for auditing. Finally, the government would not exercise any control over the costs of health services.

A third approach involves the creation of health care savings accounts, in which workers without supplementary health insurance would be required to contribute a portion of their wages to a saving account earmarked for extended health care benefits[29]. The account would accumulate tax-free, similar to a Registered Retirement Savings Plan, and would be debited whenever a health service were used.

The one advantage of this method is that it would be self-financed by contributors. There are several shortcomings. There would be no pooling of risk as every individual would assume all personal health costs, with the potential for depleting the entire account in the event of a serious, long-term illness. Presumably, individuals who are not employed would not be insured because they could not make contributions. If the unemployed were insured at public expense, government would be assuming the highest cost burden. Because contributors would want to maintain a cushion for serious illness, they might eschew spending on preventive or on early remedial services. As well, in this entirely private system, the costs of health services would be entirely driven by market forces as they are in the USA, which has by far the highest health care costs of any industrialized country.

An alternative method is to fund extended health services in the same way that the CHA-insured services are funded, that is, through general tax revenues. The advantages are numerous: administrative simplicity and efficiency; progressivity in the sharing of costs; maximum pooling of risk; absence of disincentives to use of services when needed; and finally, maximum capacity of the government funder to control service costs. Tax-based health systems typically absorb two-to-three percentage points less of Gross Domestic Product than do social insurance models[30]. Strong support for funding health services through general tax revenues is given by the WHO, that presents detailed evidence that prepayment (through general taxation) is the best form of revenue collection, while out-of-pocket payment tends to be quite regressive and often impedes access to care[31].

NACA recommends that:

Extension of health care services provided in all jurisdictions be funded through general tax revenues, without requirement for any additional individual private payment.

2.3 How Should a Program of Extended Health Services be Implemented?

Obviously, the scope of the changes recommended by Council cannot be accomplished overnight. There will need to be a period of transition to have an orderly adjustment of public health care expenditures and revenues and to permit adaptation by private sector insurers. NACA suggests a phase-in of services based on the criteria of population need and of equity.

The extension of the publicly-funded Canadian health system should begin with home care services, followed as soon as possible by a universal pharmacare program. Both home care and drug care are now essential health services needed by Canadians of all ages. Next, all health and personal care services provided to residents of long-term care should be fully covered so they enjoy the same benefits as persons receiving care in the community. Room and board can be charged legitimately, as these are normal costs of living assumed by individuals. Nevertheless, these charges should, at a maximum, reflect current market rates in the local community for similar lodging and food services. Finally, other health services, including dental care and vision, auditory and other assistive technologies should be included.

NACA recommends that:

In extending public insurance for health services, priority be placed on home care, then on drug benefits, followed by health and personal care provided to residents of long-term care facilities. Elements to incorporate later include dental care and vision, auditory and other assistive technologies and products.

Charges for room and board for residents of long-term care facilities not be set higher than current market rates in the local community for similar lodging and food services.

To help alleviate out-of-pocket expenses for health services and products pending their inclusion in a publicly-funded plan, the federal government could enhance the tax relief for medical expenses. The medical expenses

tax credit, as it now stands, is inadequate to help Canadians cope with the financial burden of long term health expenses. Currently, total medical expenses have to be more than either $1,614, or 3% of individual net income and the tax credit is not refundable for individuals who are not in the work force. Provision should be made to increase access to the tax credit for low- and modest-income Canadians and to make it refundable for persons who are not in the work force, such as seniors.

NACA recommends that:

The federal government provide an income-tested refundable tax credit for all out-of-pocket medical expenses over $500 which have not been reimbursed by private insurance plans.

CONCLUSION

Health care delivery and population needs have changed significantly since the Canadian health care system was put in place. Now and in the future, home care, pharmacare and other health services and products that are only partly, or not at all insured are becoming as essential to health as physician and hospital services. Coverage of these services for seniors varies widely across the country, sometimes forcing hard choices between health care and other necessities of life for persons with low and modest incomes, and creating strong disincentives to retirement savings for middle-income Canadians. The Council believes that all Canadians have the right to expect the same level of health care regardless of where they live in the country and that income should not be a factor in determining access to health services or products which are important to preserving health and well-being.

Canada is in a favourable economic and fiscal situation to extend the range of health services provided and evidence suggests that the overall costs of the health system are sustainable. Moreover, public financing is the most equitable and cost-effective model of health financing. NACA believes that the goal of a national, comprehensive and publicly-insured health system can be achieved and that a staged implementation is a sound approach to meet immediate needs while permitting adjustment by governments and the private market.

Table 1. Fee Setting for Home Care

Province	Cost of personal services	Income below which services are free	Minimum charge	Maximum charge
Nfld	Contribution through means test and asset test			
N.S.	Fees assessed on sliding scale determined by income and family size. Will vary according to income and # of hours of services needed. There is a $6/hr charge (with a maximum of $60 to $360).	Free services for people earning less than $1,310/month ($2,620/couple).	At an income of $1,310, the maximum a client could be charged per month is $60.	For individuals earning over $3,272/month ($6,544/couple), the maximum limit is $360/month.
N.B.	Need to calculate.	Individuals with a net family income of less than $6,564 will pay $0.	Those with a net family income of over $25,000 will pay 100% of the cost of the services provided. An individual with net family income of $32,454 will pay a maximum of $12,000. Calculations are done using the income scale.	
P.E.I	Fees assessed on sliding scale determined by net income and family size.	Single seniors with a net income of less than $1,004/month (or <12,059/yr) are not required to pay for any services. Nor are couples with monthly net income under $1,404. Costs for palliative care clients are often waived. Costs for "adult protection" clients are waived.	Single persons with net monthly income of $1,005-1,404 pay $1/hr of service. A couple with a net monthly income of $1,405-$1,604 will be charged $1/hr of service.	Single persons with a net monthly income over $3,805 pay $13/hr of service (the maximum). A couple with $3,605+ pays the max. of $13/hr for service.
Que.	In some circumstances free, but priority is given to lower-income clients. It will depend where they live ($5-7/hr of service). There is a case by case review by the CLSC (no set policy).			
Ont.	Free as long as (i) person is assessed as requiring services and (ii) person lives alone or with a caregiver who is not capable of providing such support. If client needs special services from the community, the client may be charged the cost.			
Man.	Free (although if community is providing the service, such as meals on wheels, a fee may be asked but is often waived when a person claims s/he cannot afford to pay.)			
Sask.	All clients are charged a flat fee of $5.45/unit (e.g. 1 meal) for first 10 units per month. The monthly maximum is $331. After 10 units, client is charged a unit rate corresponding to the client's monthly adjusted income.	Those receiving benefits from the Saskatchewan Assistance Plan or the Saskatchewan Income Plan (not including War Veterans Allowance) are fully subsidized . They pay a max. of $54.50/month. They pay $0 for each unit charged after the first 10 (i.e. max. monthly charge = $54.50).	Clients with adjusted monthly incomes below $54.50 are charged $0 for each additional unit of service after the first 10 units (i.e. max. monthly charge = $54.50).	Clients earning over $600 receive no subsidy. Their unit charge after 10 units is $5.90/hr with a maximum of $331.

Province	Cost of personal services	Income below which services are free	Minimum charge	Maximum charge
Alta.	Clients are charged a flat rate of $5.00/hr for home support services such as homemaking and handyman services. They pay a maximum monthly charge based on an income test which takes both net income and family size into account.	Seniors receiving GIS are exempt from fees for home support services. Single persons with a net income under $15,757 pay $0. A couple with under $31,513 will pay a maximum monthly charge of $0.	A single person with a net income between $15,757-$31,512 will pay a max. monthly monthly charge of $50. A couple with a net income between $31,513-36,768 will pay a max. monthly charge of $50.	A single person with a net income over $52,537 will pay the max. monthly charge of $300. A couple with net income over $57,793 will pay the max. monthly charge of $300.
B.C.	User fees apply to home support services and are based on an income test that is standard across the province.	There is no charge for services to clients in receipt of government financial supplements (GIS, Spouse's Allowance, War Veteran's Allowance or GAIN support).	Clients not on an income supplement pay a daily charge based upon Net Income. **Formula = net income (line 236 income tax form) deduct income tax paid, deduct annual basic income (single= $10,284; couple = $16,752), deduct earned income (up to a max of $15,000 each) to get your remaining income. Divide remaining income by 720 to get your home support rate.	While service is always provided, it may sometimes may be more cost effective for the client to get services elsewhere. For example if the client's per diem was $100 but the client only required 1 hr of services, this would not be beneficial for the client.
Y.T.	Free.			
N.W.T.	Free.			

Table 2. Fee Setting for Public Prescription Drug Plans

Province	Eligibility	Premiums	Deductible	Co-payments
Nfld.	Only GIS recipients are eligible.	None.	None.	Seniors pay professional fee plus 10% of ingredient cost if greater than $30.
N.S.	Coverage is available to all seniors.	Seniors pay annual premium of $215. A credit of $300 is available depending on level of income.	None.	20% (minimum of $3 per prescription) to a maximum of $200 per year.
N.B.	Seniors are offered Blue Cross with an income tested premium.	GIS recipients pay no premium; other seniors are offered Blue Cross. The premium is income tested but is a maximum of $58 per month per person. Most seniors will not need to pay the premium.	None.	$9.05/prescription (for GIS recipients an annual maximum of $250).
P.E.I.	All seniors are covered.	None.	None.	Seniors pay professional fee plus $7 for drug cost.
Que.	All seniors are covered.	Payable to Régie d'assurance maladie du Québec (RAMQ) of $0 to $175 per adult annually depending on income.	Deductible is $25 per 3 months.	Co-payment is 25% of prescription price to a maximum per adult per 3 months; (Max. GIS - $50/Partial GIS - $125/No GIS- $187.50).
Ont.	All seniors are covered.	None.	Lower income seniors do not pay a deductible. Seniors with incomes over $16,018 ($24,017 for couples) pay $100/year.	Lower income seniors up to $2/prescription; other seniors pay the first $100 each year and then up to a maximum of $6.11 dispensing fee.
Man.	All seniors are covered.	None.	Deductible is 3% of adjusted family income over $15,000 or 2% of adjusted family income under $15,000.	None.
Sask.	All seniors are covered.	None.	GIS recipients in nursing home - $100 semi-annually; other GIS recipients - $200 semi-annually, other seniors' deductible is $850 semi-annually.	A 35% co-payment beyond the deductible.
Alta.	All seniors are covered.	None.	None.	Co-payment is 30% of drug cost to a maximum of $25 per prescription.

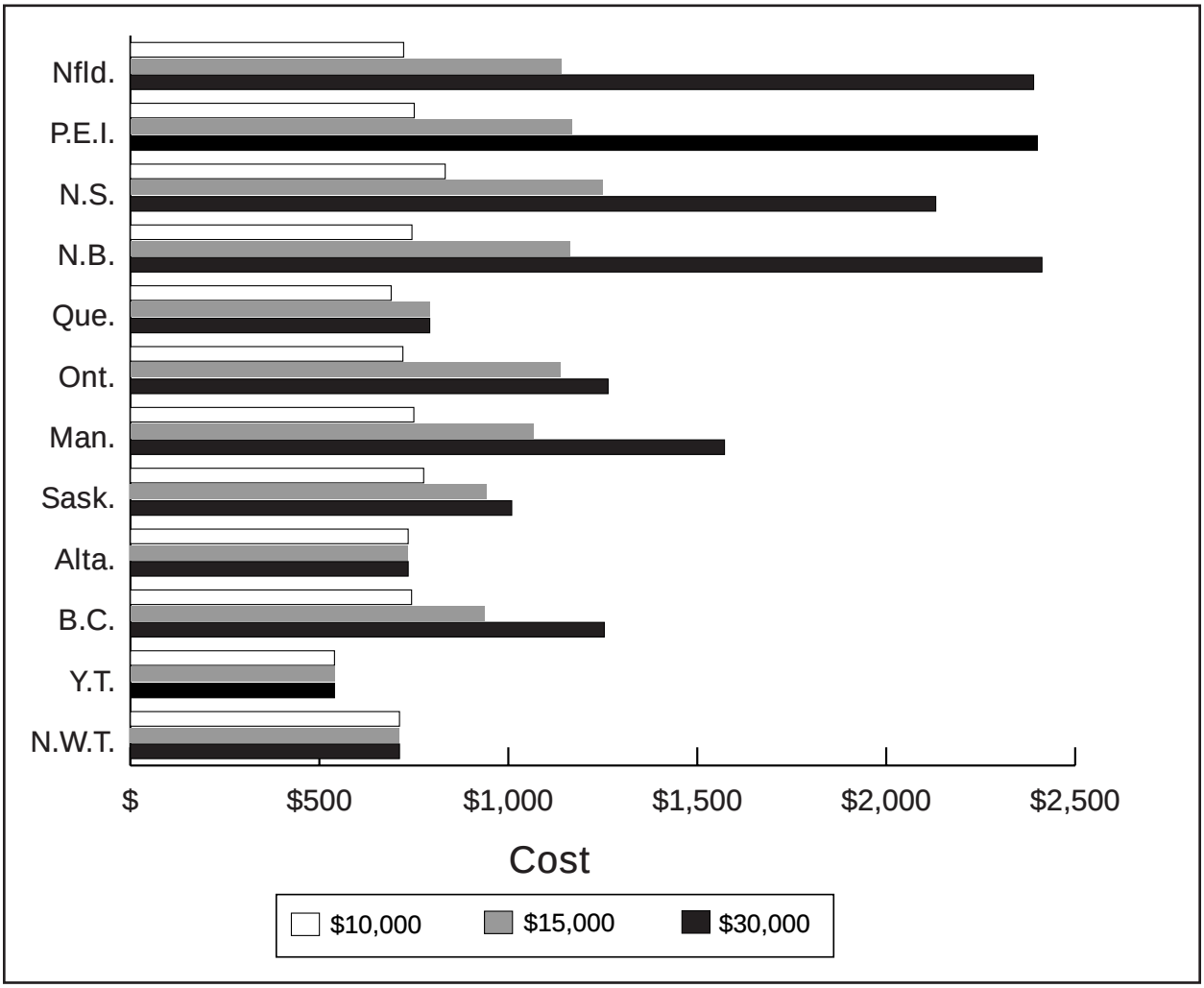
Province	Eligibility	Premiums	Deductible	Co-payments
B.C.	All seniors are covered.	None.	None.	Co-payment of 100% of dispensing fee up to $200 annual ceiling.
Y.T.	All seniors are covered.	None.	None.	None.
N.W.T.	All seniors are covered.	None.	None.	None.

Table 3. Fee Setting for Long-Term Care

Province	How does charge vary with income	Asset test
Nfld.		Includes liquid assets but not RRSPs; excludes $5,000 for singles and $10,000 for married couples.
N.S.	All forms of monies received are assessed.	Includes cash, investments, liquid assets, proceeds from sale of fixed assets. Primary residence is excluded if designated to another person.
N.B.	All income in excess of personal allowance is assessed for singles. For couples: first $11,558 is exempt, then next $21,005 is included, then 30% of amount from $21,005 to $35,502, then all of excess over $35,502.	Single: all liquid assets except: principal residence, $500 personal allowance and $5,500 pre-paid funeral expenses. Couple: exception for real property, a vehicle, $500 personal allowance, a trust fund to $75,000 and $5,500 of prepaid funeral expenses.
P.E.I.		Excludes $500 if there is a pre-paid funeral; $2,000 if not. Excludes principal residence and $300 in bank account.
Que.		Liquid and tangible assets are evaluated. Up to $40,000 can be exempted for principal residence.
Ont.	Income testing can reduce the fee to $862.	
Man.	Minimum charged on incomes below $11,419 (single) and $30,745 (couple). Daily rate increases by 10 cents for each $36.50 of income. Maximum charged when incomes over $23,299 (single) or $42,902 (couple); about 30%.	
Sask.	After monthly income of $916, charge increases by $1 for each increase in income of $2 to a maximum charge when income is $1,381; 50%.	
Alta.	N/a	
B.C.	Minimum charged below $7,000 of income and maximum charged on incomes over $30,000. Marginal tax rate of 50% to 30% based on after tax income.	
Y.T.	N/a	
NWT	N/a	

Figure 1.

Cost of Standard Long-Term Care to Seniors by Province and by Income



(1998 data)

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No.	Title
7.	The NACA Position on the Goods and Services Tax, February 1990.
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9.	The NACA Position on Informal Caregiving: Support and Enhancement, September 1990.
10.	The NACA Position on Lifelong Learning, October 1990.
11.	The NACA Position on Gerontology Education, December 1991.
12.	The NACA Position on Managing an Aging Labour Force, February 1992.
13.	The NACA Position on Canada's Oldest Seniors: Maintaining the Quality of their Lives, January 1993.
14.	The NACA Position on the Image of Aging, February 1993.
15.	The NACA Position on Women's Life-Course Events, September 1993.
16.	The NACA Position on Community Services in Health Care for Seniors: Progress and Challenges, February 1995.
17.	The NACA Position on Determining Priorities in Health Care: The Seniors' Perspective, February 1995.
18.	The NACA Position on Health Care Technology and Aging, May 1995.
19.	The NACA Position on the Privatization of Health Care, October 1997.
20.	The NACA Position on Home Care, March 2000.
21.	The NACA Position on Enhancing the Canadian Health Care System, October 2000.