National Pensioners Federation | Fédération Nationale des Retraités

Tough Love: Health Care for Seniors in Canada

NPF Health Committee
Chairperson, Kathleen Jamieson

Preface

As seniors, we have a vested interest in ensuring our publicly-funded national health care system, Medicare,[1] is fair, high quality, and accessible to all those who need it regardless of ability to pay.

As Canadians, we are proud of Medicare and the principles that underlie it and see it as an important symbol of Canadian values.[2] However, the reality is that our cherished health care system has not kept up with the times. Indeed, relative to other OECD countries' health care systems in 2016, we are in the middle of the pack and may be losing ground.[3]

A key reason for this state of affairs is that the health care needs of the Canadian population and the way that health care is delivered today have changed radically since Medicare was first introduced as a national insurance program in 1968. At that time, Medicare was designed to meet the needs of a much younger population than today and provided coverage only for hospitals and doctors.

In 1968, prescription drugs played a limited role in most people's lives. Today, the primary focus of Medicare and government funding for health care is still on hospitals and doctors, although, as the Romanow report noted fifteen years ago, "Prescription drugs … have fundamentally changed the face of health care in Canada." [4] Today, in 2017, hospital stays tend to be brief and home care has taken the place of recovery in hospital. However, neither prescription drugs nor home care are covered under Medicare and may be

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[1] Medicare is also the name of a US federal health care program for seniors over age 65 and some people with disabilities

[2] Mendelsohn, Matthew (2002). *Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation.*

[3] The Commonwealth Fund (2014:4). *Mirror, Mirror on the Wall: 2014 Update: How the US Health Care System Compares Internationally*; Health Council of Canada (2014).
Conference Board of Canada (2017:3). *How Canada Performs: Health;*
A. Scott Carson, et al. (2015). *Toward a Healthcare Strategy for Canadians.* McGill-Queen's University Press.

[4] Commission on the Future of Health Care in Canada (2002:189). *Building on Values: The Future of Health Care in Canada – Final Report.*

partially covered or not depending on the province or territory in which an individual lives. Costs have shifted from hospitals funded through Medicare to individuals. Other health care services such as extended care, assisted living, mental health care, hearing aids, dental care and physiotherapy, which are essential for maintaining the health and well-being of an older and diverse population, are not included in Medicare and the cost of accessing any of these services can be an insurmountable barrier for many seniors.

As seniors, we need to understand why our health care system had not moved with the times, as it has in many other developed countries, and to keep ourselves informed about any policy changes that impact on our health and quality of life as we age. We also need to be proactive, to consider what needs to change to ensure high quality health care for all Canadians, and to ask ourselves what we can and need to do to make that change happen.

This Background Paper aims to explore these questions by examining a key area of the Canadian health care system from the perspective of seniors: Medicare and federal/provincial/territorial agreements on funding levels and national standards for health care. The focus also reflects concerns raised by seniors at annual conventions of the National Pensioners Federation.

1. Introduction: Power and Politics: In search of quality health care for seniors

The purpose of this background paper is to explore:

1. How major attempts to reform and modernize our health care system have ground to a halt since the heady days of the 2002 Romanow and Kirby reports on transforming the health care system;

2. How the spirit of collaborative federalism that inspired and guided the First Ministers' pan-Canadian Health Accord of 2003/2004 has eroded over the last 13 years; and

3. Whether the new (2016-2017) bilateral federal/provincial/territorial (F/P/T) agreements that now replace the 2003 *First Ministers' Accord on Health Care Renewal* and the linked First Ministers' 2004 *Ten-Year Plan to Strengthen Health Care* seem likely to lead to "sunny days" and better health care for seniors in Canada.

The paper begins with an outline of how our health care system (Medicare) is structured. It then reviews the two linked federal/provincial/territorial (F/P/T) ten-year health care agreements signed by the First Ministers in February 2003 and 2004. The report describes the optimistic political and historical context that shaped that 2003-04 Health Accord and, after a change of government in 2006, the lack of progress in implementing the goals of the Health Accord and the eventual dissolution of the Accord.

A summary of the events leading up to the new 2016-2017 bi-lateral (F/P/T) agreements that have replaced the Health Accords follows. The report concludes with a discussion of some continuing problems in the health care system that seriously impact seniors' health and well-being. Finally, it provides some National Pensioners Federation

recommendations for change that the federal provincial and territorial governments should implement.

Since the texts of the new bi-lateral health agreements are not currently in the public domain, it is not clear how or if spending and standards under these agreements will be monitored or how transparency and accountability will be ensured. The information currently available concerns only the amount and adequacy of the CHT to the provinces and territories. The federal government has unilaterally decided on these amounts.

Media attention and public concern are currently focused on the annual increases in the CHT which will go from the 6% that was established in 2006-2007 to 3% for the next ten years. The fear is that, as a result, federal CHT funding will gradually reduce over the next ten years and become insufficient to ensure even the same level of health care that Canadians have now.

However, any calculation about future CHT funding levels is complex and complicated further by the federal offer of an additional ten-year funding transfer for home care and mental health and a bonus of extra funding for specific provincial concerns such as the opiate crisis in BC.

This paper argues that both the First Ministers' vision of a new high quality Canadian health care system and drive for change that prevailed for a few short years in the 2000s have both been severely undermined to the detriment of all Canadians. Seniors. in particular, need to be able to access a quality health care system and to have all levels of government working cooperatively to achieve that goal. It's not just about living longer; it is about the quality of these years. However, it is clear that the health care system is not working well enough for many Canadian seniors and that many seniors are now receiving sub-optimal heath care.

2.0. Medicare and the Canada Health Act

Under our health care system, Medicare, the federal government transfers funding for health care to the provinces and territories (P/T) which are then responsible for the administration and delivery of health services to their residents.[5] Health care is therefore a shared responsibility but in this division of powers, the federal government holds the purse strings and also has the right and obligation to impose conditions on the transfer of these funds to ensure conformity with the five principles of the Canada Health Act (1984) that form the foundation of the Canadian health care system:[6] These principles are:

- "*Universality*: all eligible residents are entitled to public health insurance coverage on uniform terms and conditions;

[5] The federal government retains responsibility for the health care of registered Indians, members of the armed forces, and federal prisoners.

[6] Health Canada (2015). *Canada Health Act Annual Report 2014-2015. What is the Canada Health Act? http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs-2015-cha-lcs-ar-ra/index-eng.php#c1*

- *Portability*: coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country;
- *Public administration*: the health insurance plan of a province or territory must be administered on a non-profit basis by a public authority;
- *Accessibility:* reasonable access by insured persons to medically necessary hospital and physician services must not be impeded by financial or other barriers, and
- *Comprehensiveness:* all medically necessary services provided by hospitals and doctors must be insured." [7]

Under Medicare, health care as it is currently defined is publicly funded but, for the most part, it is privately provided by doctors and other medical specialists.

3.0. The 2003 Pan-Canadian Consensus on Health Care Renewal

At the beginning of the new millennium, after years of major cutbacks in federal health and social programs and "corrosive and divisive debates" [8] between both orders of government on health care and the growth of regional disparities in health care provision, "Canadians began to name health care as the single most important problem facing the country, overtaking concerns about the economy, which had dominated public opinion surveys throughout the 1990s."[9]

Momentum for change built as several provinces commissioned studies on how to address health care issues.[10] In response, First Ministers met in September 2000 and agreed on a vision, principles, and action plan for health system renewal.[11]

A few months earlier, in December 1999, the Senate had asked the Standing Senate Committee on Social Affairs, Science and Technology "to examine and report on the state of the Canadian health care system and on the federal government's role in that system."[12] The final recommendations of that report, known as the *Kirby Report,* were issued in October 2002.

The Kirby report recommends the continuance of a universal, publicly funded health care system and calls for greater public accountability. Kirby is in favour of private-public partnerships in hospitals and public funds being used for some privately provided health care services.

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[7] University of Ottawa (2014). *The 1984 Canada Health Act.* *https://www.med.uottawa.ca/sim/Canada_Health_Act.htm*
[8] Romanow op cit. p.46-47
[9] Health Council of Canada (2008:np). Rekindling Reform: Health Care Renewal in Canada, 2003-2008.
[10] Ibid. P.1.
[11] Canada, *2003 First Ministers' Accord on Health Care Renewal* (2003:1).
[12] Standing Senate Committee on Social Affairs, Science and Technology (2003:1). *The Health of Canadians – The Federal Role.*

Kirby's first recommendation is about the need to establish a National Health Care Council and the appointment of a National Health Care Commissioner, the Council to be composed of five P/T and five federal representatives to advise governments on how to implement the recommendations of the report.

More specific recommendations are that wait lists needed to be monitored and that patients who had waited for treatment beyond a previously decided time limit should be able to receive treatment at government cost outside the jurisdiction they live in. Kirby makes specific recommendations on how doctors and hospitals should be funded to improve efficiency and accountability. He also recommends that primary care doctors move away from fee-for-service practice to capitation[13] and group practice. On home care, he proposes that new federal funds be made available for "post-acute" or after hospital care and palliative care.[14]

Just one month later, in November 2002, the federal government released another health care report, *The Commission on the Future of Health Care in Canada. Building on Values: The Future of Health Care in Canada,* popularly known as the Romanow report.[15] This report covers much of the same ground as the Kirby report but it is more comprehensive and proceeds from a somewhat different premise about the role of privatized health care services within a universal, publicly funded system. The Romanow report rejects private provision of publicly funded health care services. The Kirby report does not.

Key recommendations of the Romanow report were the need to support home care and a national drug program. Both Kirby and Romanow stressed the need for measures to ensure the accountability of the provinces for their health care decisions. Romanow, like Kirby, recommended primary care doctors move away from fee-for-service.

The first of the Romanow report's forty-seven recommendations is: "A new Canadian Health Covenant should be established as a common declaration of Canadians' and their governments' commitment to a universally accessible, publicly funded health care system. To this end, First Ministers should meet at the earliest opportunity to agree on this Covenant."[16]

The First Ministers met again in February 2003, as Romanow had recommended. They agreed to the terms of a *Health Accord on Health Care Renewal* that states that it

[13] Capitation is a fixed payment that is determined by the number of patients that are enrolled with the doctor.
[14] ibid.
[15] Commission on the Future of Health Care in Canada (2002). *Building on Values: The Future of Health Care in Canada – Final Report.*
Publications.gc.ca/collections/collection/CP32 -85-2002E.pdf
[16] Ibid.

"focuses on federal/ provincial/territorial (F/P/T) collaboration in the area of health-care reform."[17]

They reaffirm their commitment to the principles of Medicare as the foundation of the Accord which they "view as a covenant" which will help to ensure that:

- "all Canadians have timely access to health services on the basis of need, not ability to pay, regardless of where they live in Canada;
- the health care services available to Canadians are of high quality, effective and patient-centred and safe; and
- our health care system is sustainable and affordable and will be here for Canadians and their children in the future."[18]

Their main goals for change --- primary health care, home care, and catastrophic drug coverage echo many of the recommendations of the Romanow and Kirby reports. The premiers agreed to report annually to the public on their progress in implementing the goals beginning in 2004. They also emphasized the need to address Aboriginal health care challenges and consultation issues, to make significant new investments in diagnostic care and treatment services, to prioritize the accessibility and quality of information technology and to build a national system of electronic health records.

The First Ministers agreed to the establishment of an independent Health Council of Canada to monitor progress in the in meeting the goals of the Accord and to ensure transparency and public accountability as Romanow had recommended. In an Annex to the Accord, they include performance indicators on timely access, quality, sustainability, and health status and wellness. The federal government agreed to replace the existing combined Canada Health and Social Transfer (CHST) funding with a separate long-term health funding transfer (CHT) by March 31, 2004 to ensure accountability and transparency for the new funding.

The Canadian Patient Safety Institute was established in 2003 and the Public Health Agency of Canada was established in 2004.[19]

All of these measures reflect a major commitment by the First Ministers to reforming the public health care system.

[17] Canada, 2003 First Ministers' Accord on Health Care Renewal (2003:1). www.scics.gc.ca/CMFiles/800039004_e1GTC-352011-6102.pdf
[18] Ibid.
[19] Health Canada (2010*). Canada's Health Care System*.

4.0. The Ten-Year Plan to Strengthen Health Care

It must have seemed that all the stars were aligned when the Canadian premiers met and together founded the *Council of the Federation* in December 2003. In the *Preamble* to the *Council of the Federation Founding Agreement,* the premiers set out their understanding of power-sharing with the federal government underpinning the Health Accord: "Under the Constitution, Canada's two orders of government are of equal status, neither subordinate to the other, sovereign within their own areas of jurisdiction and accordingly, they should have adequate resources to meet their responsibilities." [20]

The issues the Premiers were most concerned about were timely access to quality care, creating benchmarks for managing and reducing wait times, and increasing the participation of patients and health care providers. [21]

The sleeping dog in the F/P/T continuing cooperative relationship and the concerted effort for health care reform was the 2003 assertion of equality with the federal government by the premiers of the Council of the Federation.

Nevertheless, this constellation of auspicious events set the stage for the next First Ministers' meeting in September 2004 and the announcement by Prime Minister Paul Martin of the First Ministers' *10-Year Plan to Strengthen Health Care* that incorporated and expanded on the items in the 2003 Health Accord.

Until 2004, the federal funding transfer for health care to the provinces and territories was combined with the funding transfer for social services and social assistance as the Canadian Health and Social Transfer (CHST). In 2004, the CHST was replaced by the new separate Canada Health Transfer (CHT). A CHT base of $19 billion was agreed on and among other funding allocations, was an additional $500 million in 2005-2006 for home care and catastrophic drug coverage, $4.5 billion over 6 years beginning in 2004-5 to reduce wait times, $500 million for medical equipment, and $700 million over 5 years to improve Aboriginal health.[22] Four other areas identified for action in the plan were: 1) Health human resources, 2) Home care 3) Primary care reform and 4) A national pharmaceuticals strategy.[23]

The agreement provides a set of 18 comparable indicators that provinces and territories (P/T) should use to track progress and report to Canadians.

It seemed that Canada was on the cusp of transformative change in the health care system. The Health Council of Canada later noted, "It represented the first pan-Canadian

[20] Council of the Federation (2003:1). *Founding Agreement.*
[21] Ibid.
[22] Canada Department of Finance (2012). Federal Investments in health care. http://www.fin.gc.ca/fedprov/fihc-ifass-eng.asp
[23] Ibid.

consensus to extend universal coverage to services (namely, Ten-year Plan to Strengthen Health Care prescription drugs and homecare) beyond the insured services described in the *Canada Health Act."* [24]

The F/P/T collaborative momentum for change continued through 2006 when the Senate Standing Committee on Social Affairs, Science, and Technology completed the "first-ever national study of mental health, mental illness, and addiction."[25] That study recommended the establishment of a Mental Health Commission. The Commission was set up in 2007 with a ten-year mandate to develop a mental health strategy, advance knowledge exchange, and examine how to help homeless people living with mental health problems. Senator Michael Kirby was appointed as its chairperson. The creation of the Commission was endorsed by all P/T except Quebec and all federal parties voted in favour of it.

After the change from a Liberal to a Conservative government in 2006, both the commitment to the Accord and the delicate F/P/T relationship began to crumble.

The 2007 Budget re-committed to the 2003 Health Accord and the Ten-Year Health Plan but a hint of simmering discord is evident in the comment in the Budget that "Canadians have grown tired of the intergovernmental bickering over fiscal balance issues, and want them resolved." [26] The budget promised "to restore fiscal balance through a principles-based plan and by fostering a new spirit of federalism."[27]

5.0. The Unmaking of the Health Accord

A 2008 report of the Health Council of Canada titled *Rekindling Reform: Health Care Renewal in Canada 2003-2008,* notes the lack of progress after five years in the implementation the 2003 Accord and the 10-Year Plan, commenting: "we find much to celebrate and yet much that falls short of what could – and should—have been achieved by this time." [28]

One issue for the Council was that progress in the implementation of the Accord could not be measured or monitored because the P/T governments were not using the agreed on 2004 eighteen measures "to share information about their progress in any meaningful way."[29] Unable to monitor progress and ensure public accountability, as was its mandate, the Council then focused on producing regular reports on government health care policies and any innovative practices the P/T reported on.

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[24] Health Council of Canada (2008:2). *Rekindling Reform: Health Care Renewal in Canada, 2003-2008.*
[25] Senate Standing Committee on Social Affairs, Science and Technology (2006).
[26] Canada, House of Commons (2007:109). *The Budget Plan 2007. Aspire to a Stronger, Safer, Better Canada.*
[27] Ibid.
[28] Health Council of Canada (2008). *Rekindling Reform: Health Care Renewal in Canada 2003-2008.*
[29] Ibid.

In December 2011, the federal Finance Minister, Jim Flaherty, "landed a bombshell" according to news reports, when he announced in December 2011 at a meeting of P/T finance ministers that the 6% annual increase in the CHT would end in 2016/17 and be tied to nominal GDP or 3% a year, whichever was higher. Minister Flaherty argued that the change was reasonable since provincial health spending was increasing on average by 3.2% per year not 6%. Several P/T finance ministers immediately complained saying they had expected to be initiating discussions on the ending of the ten-year Health Accord in 2014 instead of being suddenly informed by the federal government about unilateral changes.[30]

In early 2012, the Standing Senate Committee on Social Affairs, Science and Technology released a review of the 2004 Ten-Year Plan that was requested by the federal Minister of Health. The Senate review describes the 10-Year Plan as "an agreement that focuses on collaboration in the area of health care reform." It reported that some reforms were occurring on the front lines but that the Committee had heard from witnesses that "systemic change had stalled." When compared internationally the Committee noted, "Canada is no longer seen as a model of innovation in health care delivery and financing." The Senate review concluded that there was "sufficient funding in the system to meet the reasonable expectations of Canadians but that has yet to occur." [31]

The federal government shut down the Health Council in 2014. The Chair, Dr. Jack Kitts writing in late 2013 about the impacts of the Heath Accords as drivers for health care reform across Canada comments: "The outcomes have been modest and Canada's overall performance is lagging behind that of many other high-income countries. The status quo is not working. We need to do the business of health reform differently."[32] The report outlines what worked well and what didn't and "sets out an approach for achieving a higher–performing health system."[33]

In 2015, the terms of the 10-year 2004 agreement legally expired except for the annual increase in the funding transfer that had started later, in 2006-2007. The then Conservative federal government confirmed that it would impose a new health care transfer on the provinces and territories without prior consultation with them. Health transfer amounts were henceforth to be based only on population numbers and the annual increase in the CHT was to be reduced to 3 per cent from 6 per cent beginning in April 2017.

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[30] CBC News December 19, 2011. *Premiers split over Flaherty health-funding bombshell*. http://cbc/news/politics/premiers-split-over-flaherty-funding-bombshell-1.1014496

[31] Standing Senate Committee on Social Affairs, Science and Technology (2012:vi). *Time for Transformative Change: A Review of the 2004 Health Accord.* *http://senat/senat-senat.ca/repo7mar12-e.pdf*

[32] Health Council of Canada (2013). *Better health, better care, better value for all: Refocusing health care reform in Canada.*

[33] Ibid.

The collaborative role of the provinces and territories envisaged by the Council of the Federation and the Accord was no longer operative although the Health Accord funding escalator of 6% annually continued until its ten-year expiry (from 2007) in March 2017.

Between 2014 and 2016, in the lead-up to a federal election in October 2015, the future terms of a new F/P/T health care agreement were clouded in uncertainty. A major focus of the premiers, the media, and the public was on the amount of the federal health care funding transfer and the annual increase in that amount.

The Conservative government lost the October 2015 election and was replaced by a Liberal government.

6.0. Sunny Days

The new Liberal government promised to "bring real change – in both what we do and how we do it."[34] Some people understood that statement to mean a change from the increasingly authoritarian approach of the previous Conservative government to a new more collaborative, transparent, and publicly accountable style of government. So, when the Liberals replaced the Conservative government in October 2015, it seemed the stars were once more aligned for the creation of an enhanced F/P/T and a national Health Care Accord. Indeed, the Liberal election platform included a promise to negotiate a renewed Health Accord with the provinces and territories.

The 2016 mandate letter from Prime Minister Trudeau to the new Minister of Health, Dr. Jane Philpott, emphasized the importance of negotiating a new Health Accord. It states:

"In particular, I will expect you … to deliver on your top priorities:

- Engage provinces and territories in the development of a new multi-year Health Accord. This Accord should include a long-term funding agreement. It should also:
    - support the delivery of more and better home care services. This includes more access to high quality in-home care**,** financial supports for family care, and, where necessary palliative care."[35]

Two other health priorities specifically mentioned in that 2016 letter related to health innovation to encourage the adoption of digital technology and the expansion of Nutrition Program North.

Negotiations between the federal government and the provinces and territories for a new Health Accord began in 2016. In preparation, the Council of the Federation met in the

[34] Prime Minister of Canada (2016: 1-4). *Minister of Health Mandate Letter.*
[35] Ibid.

summer of 2016 to discuss their expectations and to prepare for collaborating to renew the Health Care Accord after more than a decade.[36]

However, after a tense mid-October meeting between the federal Health Minister, Jane Philpott, and the P/T, all parties got to the table again on December 19, 2016 to find the terms offered by the federal government fell far below the P/T expectations. The federal government offered to maintain the 2016-17 base funding, targeted funding for health care and mental health, and an annual increase of 3.5 % or nominal GDP, whichever was higher, to replace the previous 2004-2017 annual increases of 6%. Apart from the offer of targeted funding for home care and mental health care that would come with accountability measures, the offer seemed not that different from that of the previous Conservative government.

The terms offered by the federal government were initially rejected outright as unacceptable by the premiers of all the provinces and territories. The premiers countered that an annual increase of 5.2% was needed. The federal government then quickly reduced its offer of the 3.5% annual increase to 3%. There was strong initial resistance from the P/T. Harsh words were exchanged. The Premiers calculated that their share of federal funding would fall to 19.8% in 2026-27 from 23.1 percent in 2017.[37] They demanded a new pan-Canadian Health Accord.

Then, unexpectedly, the federal government announced on December 22, 2016 that it had signed a new and separate 10-year health care funding agreement with the province of New Brunswick. In the agreement, the core health transfer funding of 2016-17 would be increased annually by 3% and separate funding would be provided for home care and mental health. Premier Gallant of New Brunswick commented that if he had not acted quickly he understood that the promise of funding for home care and mental health would have been off the table. The agreement also said that if any other P/T negotiated a better deal New Brunswick would get the same deal. The other premiers expressed outrage that New Brunswick had broken ranks. [38]

However, this agreement was quickly followed by an agreement three days later with the other three Atlantic provinces and it became clear that the federal government intended to negotiate separately with all the provinces and territories. [39]

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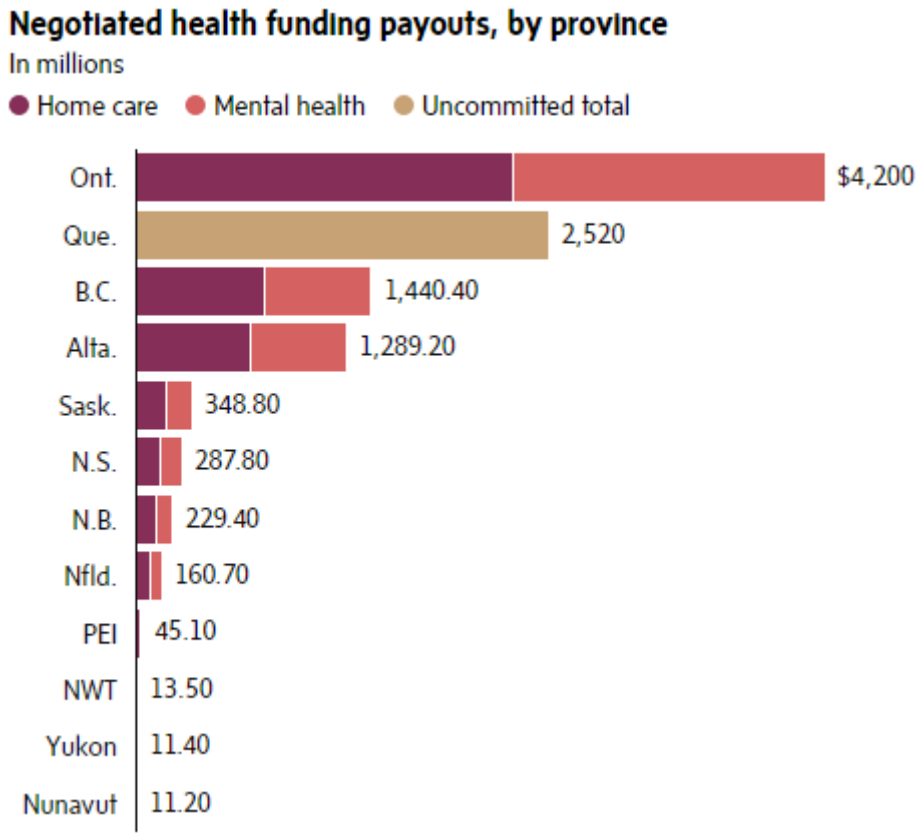
[36] The information in the following paragraphs are compiled from a number of media sources.
[37] National Observer 2016/12/19. *Provinces and territories refuse federal government's offer on health care funding.*
[38] The Toronto Star 2016/12/22. *New Brunswick denounced for cutting a side deal with Ottawa. Call it the night of the long scalpels.*
https://www.thestar.com/news/queenspark/2016/12/22/new-brunswick-denounced-for-cutting-side-deal-with-ottawa-on-health.html
[39] The Hill Times, 2017/02/01.
https://www.hilltimes.com/2017/0201/feds-prepared-health-talk-failures-last-chance-meeting/94177

By March 2017, all the remaining provinces and territories except Manitoba had signed similar bilateral agreements with the federal government. All received additional funding for home care and mental health that is to be separately monitored. The Saskatchewan government was allowed to retain private MRI services running alongside the public system without penalty for one year, contrary to the provisions of the Canada Health Act. B.C. and Alberta received separate five-year funding to deal with the opioid crisis.

Although neither the texts of the agreements nor the promised accountability measures for home care and mental health care are currently publicly available, it seems clear that the visionary Pan-Canadian 2003-04 Health Accord has now been replaced by a series of agreements focused primarily on funding.

Andre Picard, the long-time health reporter for the Globe and Mail, usefully summarized the funding elements of the various agreements to date (see figure 1, below).[40] Picard concludes from his analysis that, despite the reduction in the annual increase, the P/T are no worse off than if they had been offered and accepted their proposed 5.2% increase.[41] This may be true but Picard bases his analysis on the ten-year funding total for the eight provinces and three territories. However, without knowing what Manitoba will be offered, the analysis is incomplete and is also not based on the difference between the new increase and the six per cent annual increases that existed from 2006-2007 until March 2017.

[40] Globe and Mail 2017/03/13. *Provinces get cash but do we get better health care?* https://www.theglobeandmail.com/opinion/provinces-get-cash- but- do- we- get-better- health-care/article342837337



Now, as the public struggles to understand the implications of the new and various health care funding agreements between the F/T/P that replace the 2004 Health Accord, and with the texts of the various agreements still not in the public domain, many matters are unclear.

7.0. Discussion: A Health Care System in Crisis

One thing is very clear, the collaborative federalism and impetus for transformative change that Romanow and Kirby envisioned for the health care system appear to have completely vanished. The legitimacy the 2003/04 Accord conferred on Medicare as a unifying system that represents Canadian values has been eroded. Federal leadership on health care appears to have returned to pre-2000 paternalism, inertia, and the prospect of significant underfunding.

A major drawback of our current Medicare system is that, since its inception as a federal program in 1968, federal funding transfers for health care have covered only hospital care and primary care. Despite, the recommendations of the Romanow commission and the commitment to transformational change envisioned by the F/P/T First Ministers who signed the 2003 Health Accord, positive change had been very slow to come. Now our health care system lags behind that of many other developed countries. Even countries with much older populations than Canada's, such as Japan and Sweden, have better

health outcomes and spend less on health care.[42] And, despite Canada's expensive health care system, many seniors have to rely on private insurance for essential health care services or pay out of their own pocket, if they can afford to do so. About 30 percent of health care expenditures by Canadians are paid through private insurance plans or out of pocket. Compared with many other developed countries this private-pay requirement is very high. Low-income seniors, often women living on their own, are likely to be particularly hard hit. Some studies estimate that one in ten Canadians cannot afford to take their medications as prescribed because of cost.[43]

Although funding in Canada for scientific research has declined by about 35% in the last 15 years, according to the Naylor report,[44] advances in scientific research internationally mean, among other things, that prescription drugs may now replace hospital interventions and many illnesses are being managed at home that might formerly have required hospital stays. Even so funding cutbacks mean that hospitals are overcrowded, there is an acute shortage of beds in most, and long wait lists for medically necessary surgery. Canada has fewer hospital beds per capita than many other developed countries (the 30th least beds out of 33 countries) in 2011.[45] We have now come to accept that some treatment in hospital will be in a hospital corridor where any right to privacy has to be discarded at the entrance door.

Adding to this risky situation is the increasing privatization of hospital services such as cleaning, laundry, food services, and staffing levels that are too low for the acutely ill patients that hospitals now serve. Indeed, patients are encouraged to feel glad that they are being discharged early because of the risk of acquiring an infection in hospital even if they are very unwell and have nowhere else to go to recover. Complaints about inappropriate hospital discharges are among the

top areas of concern that the new Ontario patient Ombudsman is monitoring.[46] A staff lawyer for the Ontario Advocacy Centre for the Elderly said concerns about how frail seniors are discharged from hospitals are the top reason people contact her. She noted the problem has been increasing and said it is now at a crisis point.[47]

Since hospital stays tend to be very brief and people are therefore expected to recover at home, there is an urgent need for better home care. Currently, seniors may need to have a caregiver or pay for aftercare, and also pay for some prescription drugs or necessary health care items that are provided free in hospital. Some seniors do not have a family doctor to provide medical aftercare and coordination of their treatment. Some fragile

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[42] Conference Board of Canada (2017:5). *Health Performance/health outcomes/Canada health ranking.* http://ww.conferenceboard.ca/hcp/detailshealth.aspx

[43] Morgan, Steve et al.(2015). *Pharmacare 2020.The Future of Drug Coverage in Canada.* Pharmacare2020.ca/assets/pdf/The-Future-of-Drug-Coverage-in-Canada.pdf

[44] Globe and Mail 2017/6/8. *Starving Research means less innovation: scientists.* ; Naylor, David (2017). *Investing in Canada's future: Strengthening the future of Canadian Research.*

[45] http://stats.oecd.org/indexaspx?DataSetCode=HEATH_STAT#

[46] Globe and Mail. 2017/5/12. *Bad hospital discharges among top complaints, Ontario watchdog finds.*

[47] Globe and Mail. 2017/5/09. *Health care.*

seniors, on wait lists for extended care for many months, may then have nowhere else to go and languish in a hospital bed needed for acute care patients.

One consequence of this situation, whether it is a deliberate or accidental result of government policies over the last two decades, is an ever-increasing reliance on privately provided services for those who can afford to pay. The practice of medical specialists offering expedited medically-necessary care in private clinics to those people who are willing to pay, though illegal, has gone unchecked and expanded greatly in the past few years.[48] The fundamental principle of equitable access to medically necessary health care is long gone.

The outcome of all these deep fissures in the system is illustrated in recent news reports about the 88-year old man with heart failure, vertigo, and a recently diagnosed fracture in his spine who was being discharged by an Ontario hospital into the care of family members who did not have the resources to care for him. He had been waiting for a bed in a long-term care facility for a year. When the family said they did not have the ability to care for him in such a fragile condition, the hospital notified the family that they were sending the senior to a homeless shelter. When the family arrived at the hospital, they were met with three policemen. The Ontario Ombudsperson intervened and suggested that the elderly man should be temporarily housed in a private pay facility.[49]

In Delta, BC in 2013, a ninety-year-old legally blind woman was discharged and sent home in a taxi at 2:30 am in the rain, wrapped in a sheet, wearing pyjamas and socks. Her family could not be reached. The regional health authority initially said the hospital was complying with Ministry of Health policy, but the Ministry of Health has devolved virtually all accountability to the health regions. An apology from the health region authority was a long time forth coming. [50]

What has happened to respect for human dignity?

This state of affairs is a very far cry from what seniors need and want as a human right in a developed country like Canada and it certainly does not make for “sunny days” for most seniors.

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[48] Globe and Mail. 2017/06/17. *Health Minister vows action on illegal billing*.
[49] Globe and Mail. Tuesday, May 9, 2017. *News. Health Care.* http://www.cbc.ca/news/canada/british-columbia/90-year-old-patient-receives-an-apology-for-late-night-discharge 2017-06-25
[50] http://www.cbc.ca/news/canada/british-columbia/90-year-old-patient-receives-an-apology-for-late-night-discharge 2017-06-25

Recommendations for Action:

The National Pensioners Federation urge the federal, provincial and territorial governments to:

1) Build a new collaborative relationship and work together to improve our faltering health care system;
2) Prepare and sign a new pan-Canadian Health Accord that has a clear vision, goals, nation-wide standards, measures, and timelines for improving the Canadian Health Care system so as to bring it up to par with that of most other developed countries with national health care systems;
3) Establish a new independent national agency to monitor and enforce compliance with the new Health Accord;
4) Establish accountability measures for reporting to Canadians on plans for change to the health care system;
5) Develop and implement a national seniors' health care strategy;
6) Establish and enforce new ethical standards for the treatment of seniors in hospitals and care homes;
7) Work to remove regional disparities in access to medically necessary care for seniors;
8) Eliminate regional disparities in access to hearing aids, vision care and physical therapy for seniors;
9) Develop a campaign to ensure the human right of seniors are respected;
10) Appoint a Minister for Seniors;
11) Appoint a federal Ombudsperson for seniors;
12) Expand the coverage of Medicare to include a national drug/ pharmacare program;
13) Expand the coverage of Medicare to include a national dental care program;
14) Establish a national agency to control and monitor the privatization of assisted living residences and nursing homes;
15) Develop, implement and monitor national standards for home care for seniors.

Glossary

CHT	Canada Health Transfer
CHST	Canada Health and Social Transfer
F/P/T	Federal/ Provincial/Territorial governments
GDP	Gross Domestic Product
OECD	Organization for Economic Cooperation and Development
P/T	Provincial and Territorial governments