*The Community Voice for Seniors*

Summer 2013

# BULLETIN

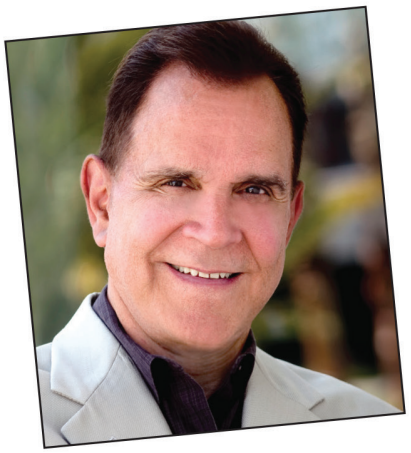
## Health Care

### Let's Talk About it

The Council on Aging of Ottawa

Le Conseil sur le vieillissement d'Ottawa

*1975-2013 Age-Friendly Ottawa*



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# Foreward

Today there are deep seated issues facing Canada's health care system: the population is aging, the institutional structure of the system is considered by many to be inefficient, and cost increases for health care services far outstrip inflation. Recently, Canadians have seen efforts among the provinces to coordinate and collaborate on health care issues and to focus more on health outcomes rather than on inputs and systems.

In 2011 the Federal government withdrew from anything but a financing role in health care. It guaranteed continued 6% annual increases in funding to provinces until 2017, after that increases will be pegged to the GDP with a guarantee base of 3%. The current Federal-Provincial health care agreement will expire in March 2014; at that juncture, Canada will face an important next step in its medicare history - securing a sustainable health system for the future.

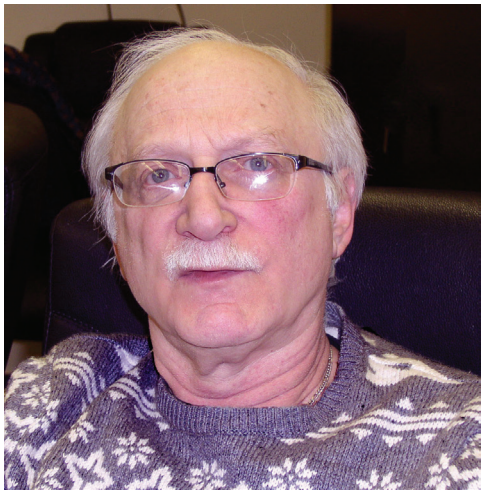
Some articles in this edition focus on the need for private clinics as a way of improving access and services, other articles suggest the need for better funding and organization of the public health care system. Yet others propose a blending of private and public systems.

The Council on Aging of Ottawa welcomes your opinions on this important subject.

**Please direct your letters to Dr. Marjorie Hinds or Dr. Glenn Drover**
**101-1247 Kilborn Place, Ottawa K1H 6K9**

# Federal Health Funding to the Provinces: What is at stake?

## Introduction



Federal transfers of funds to the provinces for health care have a history which predates medicare. However, major changes have taken place in the funding arrangements over the last fifteen years and further changes are planned for the next few years. This article provides a brief overview of the recent history of changes in health care funding and then discusses what is at stake in current discussions aimed at renewing Federal Provincial health care funding beyond 2014 when current arrangements come to an end.

## Recent History

On the 1st of July 1996, a new funding arrangement came into being for health care which combined the funds previously available to the provinces for health care, hospitalization, social services, social assistance and post-secondary education into one Canada Health and Social Transfer.[1] As is evident in the chart on page 4, the value of Federal transfers for these programs fell after 1996-7 and did not return to the same levels until 2002-3.

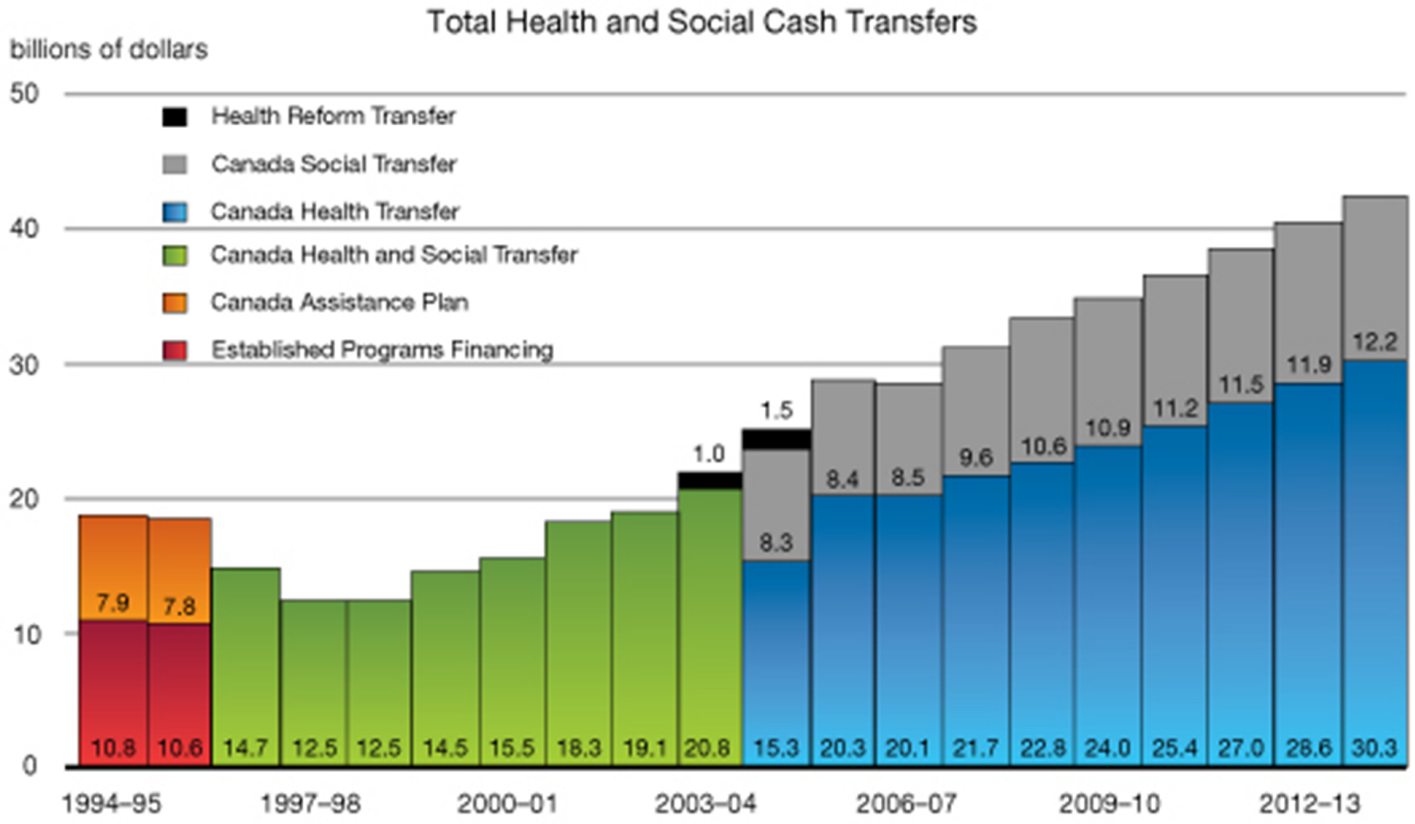
Some $2.3 billion additional funds were added to the total health related transfers as a result of an agreement reached between the Federal government and the provinces in September 2000. Under the Health Action Plan, a $1 billion fund was created to permit the provinces and territories to upgrade hospital and diagnostic equipment; a $800 million was created to fund projects to better provide access to doctors, nurses and frontline health care services, and an additional $500 million was created to fund better use of information technology in the health care system. It was also agreed that the provinces would report on their use of health care dollars. [2]

Continuing concern about the state of health care and expenditures in Canada, led to the appointment of

**Funding** *Continued on page 4*

1. History of Health and Social Transfers, http://www.fin.gc.ca/fedprov/his-eng.asp
2. The Health Action Plan, Downloaded from http://canadaonline.about.com/od/healthcarecanada/a/canada-health-care-agreement-2000.htm; Stephen Laurent and François Vaillancourt, Federal-Provincial Transfers for Social Programs in Canada: Their Status in May 2004, IRPP Working Paper Series no. 2004-07. Federal Investments in Health Care, http://www.fin.gc.ca/fedprov/fihc-ifass-eng.asp

**Funding** *from page 3.*




**Source: Government of Canada, Ministry of Finance, History of Health and Social Transfers, http://www.fin.gc.ca/fedprov/his-eng.asp**

the Royal Commission on the Future of Health Care in Canada, headed by Roy Romanow, former Premier of Saskatchewan. [3] The Romanow Commission Report, *Building on Values: The Future of Health Care in Canada*, was tabled on November 28th 2002. In the Report, the Commission recommended more stable cash only funding for medicare with a five year escalator, and the establishment of 5 specialized funds to improve primary care, diagnostic services, home care, rural and remote care, and access to drugs for illnesses requiring expensive therapies. The Commission also recommended establishing a national personal electronic medical data base, and improving timely access to health care. [4]

Ministers of Health Care continued to meet during 2001 and 2002, leading to an agreement reached in February 2003. Funding for health would be separated from the CHST, and a new Federal Canada Health Transfer would be created effective March 31, 2004. The new CHT would include the health related portion of the cash and tax points transferred to the provinces under the previous Canada Health and Social Transfer. The Federal government also agreed to create a $16 billion, 5 year Health Reform Fund which would address several of the recommendations of the Royal Commission: the need for additional funding in primary health care, home care, and to cover catastrophic drug costs. Funding for Health Reform would at a future time be folded into the Canada Health Transfer. The provinces also agreed to report back on their use of these and other funds allocated as a part of the September 2000, agreement. [5]

3. Health Canada, The Health Care System, http://www.hc-sc.gc.ca/hcs-sss/com/fed/romanow/index-eng.php
4. Commission On The Future Of Health Care In Canada , Final Report, 2002, 248-250. http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf
5. History of Health and Social Transfers, http://www.fin.gc.ca/fedprov/his-eng.asp

In September 2004, First Ministers signed the *10-Year Plan to Strengthen Health Care.* In support of this 10-year plan, the Government of Canada committed additional funding to provinces and territories for health that included increases to the CHT through a base adjustment (minimum of $19 billion in health funding) and an annual six per cent escalator effective 2006-07. The 2003 Health Reform Transfer was incorporated into the Canada Health Transfer effective April 1, 2005. The purpose of the agreement was both to secure and to increase health care funding. Under the agreement several pressing issues identified in the Romanow Report were to be addressed: reducing wait times and improving access, Strategic Health Human Resource action plans, Home Care, Primary Care Reform, Access to Care in the North, National Pharmaceuticals Strategy, Prevention, Promotion and Public Health, Health Innovation, and Accountability. Five and a half billion was set aside over 10 years to reduce wait times. [6]

The 2007 Federal budget made some additional changes in the CHT, putting the cash portion of the transfer on a per capita basis for all of the provinces and territories. The cash transfer was to grow by 3 percent per year. It was also announced that the entire Canada Health Transfer would move to a cash only basis for 2014-15.

## Current Discussions on the Future of Health Care Funding

In December 2011, the Federal Government announced its plans for the future of fiscal relations with the provinces and territories. At that time, it was announced that the Federal Government would increase the CHT by 6 percent a year from 2012 to 2017 at which time a new formula would come into place linking increases to a rolling 3 year average of provincial GDP. They also announced limited protection of the provinces from the effects of moving entirely to a cash basis for CHT funding. [7]

*It should not be a surprise to find that expenditure reductions are often a zero sum game.*

In January 2012, the provinces and territories announced the appointment of a Working Group on Fiscal Arrangements to consider the impact of the Federal announcement. In July of 2012, the Working Group on Fiscal Arrangements released its report. The report concluded that were the CHT funding agreement extended for ten years from 2014 and on the basis announced by the Federal government the result would be a cumulative loss of $36 billion in health care funding to the provinces and territories by 2024. [8] In their July 27th press release, the provinces maintain that the reductions planned by the Federal government would eventually bring their portion of health care costs down to 20%. [9]

At a time when the population is aging, and there is likely to be an increased demand for health care and health care related services such as home care, it appears that the Federal government plans to reduce its overall contribution. If the plan is successful, it will place increased pressure on the provinces to either reduce expenditures or increase provincial tax revenues. It should not be a surprise to find that expenditure reductions are often a zero sum game. If the federal government succeeds either the provinces have to pick up the difference or we do in the form of health care reductions. We need to ensure that the Federal government on behalf of us all pays a reasonable share of health costs or we run the risk of that there will be substantially differential health care across the country.

**Allan Moscovitch, professor of Social Work, Carleton University.**

6. First Minister's Meeting on the Future of Health Care 2004, A 10-year plan to strengthen health care, Government of Canada, September 16, 2004, Available at http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

7. Government of Canada, Ministry of Finance, History of Health and Social Transfers, http://www.fin.gc.ca/fedprov/his-eng.asp

8. Report of The Council of The Federation Working Group On Fiscal Arrangements, Assessment Of The Fiscal Impact Of The Current Federal Fiscal Proposals, July 2012, http://www.councilofthefederation.ca/meetings/meetings2012.html

9. Council of the Federation, Fiscal Arrangements, July 27th, 2012, http://www.councilofthefederation.ca/meetings/meetings2012.html

# The Earlier the Better

Increasingly, governments are turning to spending cuts and fee increases to help put their financial books in order. One such measure, introduced by the Ontario Government, raises the cost of accommodation in provincially run long-term care facilities. Effective July 1 of this year, the monthly rate for basic accommodation in a long-term care facility rose to $1,674.14, up from $1,619.08 in 2010. For a private room, the cost is now $2,166.58.

This increase comes at a time when fewer of us have defined benefit pension plans. As a result, planning for the potential of long term care has never been more important. Ideally, your long term care plan should be in place and funding identified before retirement—the earlier the better.

What many people do not realize is that Medicare will not cover the full suite of expenses associated with quality long term care. In particular, expenses outside very basic care (for example enhanced physiotherapy or companion services) are either not covered or would be subject to very strict rationing on the part of government agencies.

Returning back to the "basic accommodation cost" mentioned above, it is important to note that the province expects you to be able to pay this cost from your own funds. While you cannot be denied admittance to basic accommodation at a provincial facility, the province will effectively garnish your available income in a situation where it is insufficient to pay the cost. They would afterwards provide you with a small monthly allowance for extras.

While we may debate the desirability of the current state of affairs regarding long term care and seek more equitable and effective legislative solutions, there is a more immediate course of action which will point the way towards what will be most practical for our individual situations. That is, to make long term care planning an integral part of your financial plan. If you do not have a financial plan, then that is the first step to take!

A long term care plan would take place within the context of your overall retirement planning. As such, it would assess the ability of your income and assets to cover long term care costs whether by way of home or facility care. You will want your plan to reflect the costs associated with the quality of care you desire. What would such care cost today? The plan should take inflation into consideration when projecting these costs.

Family involvement will be a key component in the long term care planning process. This reflects not only the central role played by the family in providing care, but also the importance of clear communication to family members about your wishes for quality care and their impact on your overall estate planning.

It is possible – subject to insurability – to transfer some of the risk of long term care to an insurance company through "long term care (LTC) insurance". An LTC policy will pay you a monthly benefit should you be unable to perform two tasks of daily life, such as eating or dressing. The benefits could be for facility care alone or for facility care and home care.

Like most insurance policies, the size of your premium will depend on your age when you apply, the type of benefit, and the period for which you want that benefit applied. Of course, your insurability will also affect your premium. The maximum issue age for these policies is age 80 with most carriers.

Some carriers offer policies in which you pay the premium for a set number of years—20 to 25 years is typical. In a perfect world, you would purchase one of these "limited pay" policies so that it was fully paid before you retired. Having an LTC policy as part of your long term care plan will place less stress upon your income and investment assets in the funding of these costs.

The bottom line is having a plan, and communicating it to your family and significant others. Work with your trusted advisors in developing the plan, as well as a strategy for its implementation. At the same time, advocate to the applicable governmental authorities for what you feel a societal strategy on long term care should be. In this way you are striving for the best of both worlds.

**Ken Browness, Financial Planner, Scrivens Family of Companies Ottawa**

# The Doctor Will See You Now

The Ontario government has promised to reduce its $16-billion deficit substantially over the next few years, and tackling health-care cost growth has to be part of the solution. When the Minister of Health ended discussions with the Ontario Medical Association and imposed fee cuts and freezes for Ontario physicians, she signalled where reducing Ontario's health-care costs needs to begin.

Now (former) Premier Dalton McGuinty asked other provinces to consider following Ontario's lead, and they are watching Ontario to see whether reducing health care costs in this way is politically possible. In response, the Canadian Medical Association has speculated that doctors may move to jurisdictions where physician earnings are on the rise, and that wait times in Ontario may increase as a result of the cuts.

While there has been considerable discussion of a cap on spending on physician remuneration, the government has not actually implemented a cap on the OHIP budget and is not looking to reduce the number of services provided. It has simply reduced, or in most cases, not increased the fees paid for those services. The $338-million of targeted cuts (which the province notes is likely to be reinvested in primary care in the next few years) is based on a reduction in fees and little change in the quantity of physician services supplied. The government targeted large cuts on a small number of medical specialists, with smaller changes to the fees charged by most doctors.

The health economics literature offers some insight into what we can expect from such a change. How does anyone respond to a decline in his or her wage? There are competing effects of a wage cut.

On the one hand, it has just become less costly in terms of lost income to see one less patient. Reducing the number of hours worked results in a smaller hit on the doctor's income. However, the fixed costs for most doctors (rent, salaried employees, equipment) haven't changed so the cost of not working has not dropped by as much as it might if all these costs didn't need to be paid. On the other hand, there is an income loss associated with a fee cut (or even a fee freeze when the cost of everything else rises) so doctors also have an incentive to work more hours, not fewer, in order to recover this income. So overall, with a relatively small change in remuneration for most physicians, it seems unlikely that we will see a big decline in the number of hours worked by our family doctors.

There are some economic models that predict that when the price for each service a doctor performs falls, doctors might respond by increasing marginal treatments, such as follow-up visits or more tests, to make up this income. However, four factors make such a response unlikely to happen among primary care physicians.

First, one can safely assume that doctors don't really want to do this. Doctors have little interest (other than a monetary one) in having their patients go through care they don't really need. Second, there is no shortage of patients looking to see a family doctor and lots of important work for doctors to do without increasing the number of follow-up visits. Third, an increasing number of doctors are moving away from fee-for-service payment, where they are paid for each service provided, and toward group practices, where they are either on salary or receive a per-capita payment for each patient. In this case, there is little incentive for doctors to increase unnecessary treatments. Those with a per-patient funding arrangement may even have an incentive to take more patients into their roster if they can manage it, as more patients increase the dollars coming in, whereas more follow-up treatments do not.

Finally, should we expect to see doctors leave Ontario for another jurisdiction? Pay is certainly one factor that helps determine where physicians work, but it isn't the only one. Hospital privileges, professional networks and a number of non-work-related factors also contribute. It is costly to relocate, and small changes in relative pay make this unlikely. Larger changes may tip the balance, but Canada's physicians remain very well paid, and those in Ontario are not an exception.

**Doctor** *Continued on page 15*

# The Future of Our Health System

As a society, we chose, four decades ago, to cover 100 per cent of hospital and doctors' care, and not to cover (or only marginally) other health services such as dental care, eye care, physiotherapy and prescription drugs. We also chose to prohibit private insurance for those services covered at 100 per cent, but to allow it for the other services. This is why many employers offer group insurance for drugs, dental care and eye care.

Other societies made different choices, for example providing larger coverage for drugs and less for hospital or doctors, and allowing private insurance to cover the gaps in all areas. In France, for example, prescription drugs are covered, but you have to pay a user's fee for doctors' visits and hospital stays. In turn, this user's fee may be covered by private insurance.

They also allow private hospitals and private, or mixed, medical practice. In turn, if you choose to go to a private hospital or to see a physician in 'private' practice, the public system will reimburse you for what it would have cost in the public system. You, or your insurance pays the difference (exceptions exist for low income citizens).

This has facilitated the creation of services such as SOS médecins, with one number to call throughout almost the whole country, where you can get a physician in your home within one hour, 24 hours a day, 7 days a week. This is a private service, operated by physicians, that I have used several times when I lived in France. You pay them after the visit, and then the public system reimburses you for part of the cost, which makes sense since you pay your taxes and it may avoid a visit to the emergency room.

Generally speaking, these societies spend overall about the same as we do and have similar results in terms of health indicators. But they have more physicians, more hospital beds, and basically no wait for tests and treatment. Among developed countries, Canada is at the very bottom when it comes to the number of physicians per population, but at the top when it comes to wait time.

Ontario lost a very good opportunity to think outside the Medicare box this year in its negotiations with the Ontario Medical Association. Because the government wanted to freeze the total amount it spends on physician remuneration, and since the number of physicians is going up, the only solution they found was to actually reduce the average revenue of individual physicians.

But there was another way. They could have said: we will maintain the current amount paid from the public purse, but will allow certain groups of physicians to charge an additional fee to their patients. In turn, Ontario citizens could be allowed to purchase private insurance to cover this additional charge. In time, this would gradually allow for more physicians to practice in Ontario without hurting the provincial budget, and would be a first step towards moving our system in the direction taken by the best systems in the world.

According to most analyses, a good number of societies have a better system than ours. For example, the World Health Organization ranked France first in the world and Canada thirtieth. Are we satisfied with having one of the five most expensive systems in the world, but be ranked thirtieth?

Maybe it is time we stop comparing ourselves to the United States, whose costs are higher and health indicators much worse, and start looking at other societies and see if there are lessons we can learn from them.

**Michel Bilodeau is Vice-President of Public Governance International (www.pgionline.com ) and a former CEO of Bruyere Continuing Care and Children's Hospital of Eastern Ontario**

# Time to Fight for Universal Pharmacare

A universal program would save Canadians up to $10 billion a year, some estimate.

When Prime Minister Stephen Harper, along with the health and immigration ministers, tried to justify cutting refugee health coverage in Canada they argued it was about fairness. Providing prescription drug coverage to refugees was unfair, they claimed, because other Canadians do not have such coverage. They were at least partly right.

As a country, we provide universal access to medically necessary hospital care, diagnostic tests and physician services based solely on need. It's a point of national pride. But Canadian "medicare" — as it is affectionately known — ends as soon as a patient is given a prescription to fill.

Provincial drug plans cover only limited populations, such as seniors or social assistance recipients, or limited costs (such as costs exceeding "catastrophic" deductibles). Private drug insurance is a perk not easily obtained by Canadians who are retired, self-employed or employees of small companies.

The patchwork of drug coverage in Canada has consequences that cost us all.

A recent study found that one in 10 Canadians can't afford to fill their prescriptions as directed. Such financial barriers often increase costs elsewhere in the health care system — from the public purse. For example, if parents cannot afford the necessary drugs for a child's asthma, they may be forced to visit the emergency department when the asthma gets out of control.

Thus, the question is not whether it is fair to provide refugees with prescription drug coverage; the question is whether it is fair — and even fiscally responsible — not to provide such coverage to all Canadians.

In a recent essay in Healthcare Policy journal, we show how the omission of Pharmacare from Canadian medicare came about as an accident of history, the correction of which is long overdue.

Canada's health insurance system was developed in stages, starting with the components of health care that were the most important at the time. Coverage for hospital care and diagnostic tests was established in the 1950s, followed by coverage for medical care in the 1960s. The fathers of our medicare system intended that Pharmacare and homecare be established next.

Pharmacare never happened, but the need for it is stronger than ever.

The range, use and availability of pharmaceuticals has increased dramatically over the past 30 years. As a result, prescription drugs are one of the most important components of contemporary health care. They are also one of the most costly forms of care.

Canadians now spend more money on prescription drugs than they do on all of the services provided by physicians in this country. And, while many drugs are available at modest cost, a new wave of biological drugs is coming to market with price tags of thousands of dollars a year; in some cases, thousands of dollars a month.

The need for Pharmacare has not gone unnoticed. In 1997, the National Forum on Health recommended expanding Pharmacare across Canada, but the pharmaceutical industry lobbied against such reforms, arguing that Canada could not "afford" the cost of a national Pharmacare system. Such arguments are repeated today.

In truth, a universal Pharmacare program would save Canadians billions of dollars; some estimate up to $10 billion per year.

The proof is found in virtually all countries comparable to Canada, countries like Australia, Denmark, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the United Kingdom. In comparison to Canada, pharmaceutical spending is lower and has been growing more slowly in all of these countries. Yet they all provide better, more equitable access to prescription drugs than Canada through universal Pharmacare systems of one form or another.

In the 2012 Emmett Hall Memorial Lecture, Dr. Michael Rachlis said that medicare was one of the best expressions of Canadian democracy because Canadian citizens wanted it and had to fight for it.

**Universal** *Continued on page 11*

# The Next Generation of Health Care

Across our country, no other public social service is cherished as much as our healthcare system and its underlying principles set in the Canada Health Act. Canadians appreciate the peace of mind of knowing that whatever health problem they have, help is available to them, regardless of their ability to pay.

But that's not to say that our system is perfect. There are still many improvements that need to be made to ensure Canadians get proper value for money from our healthcare system, and at the rate at which costs are increasing, the current status quo just won't do.

This is why we need to start building the next generation of health care in our country. We need to look at the areas where we can control costs and move forward on many of the reforms included in the Romanow Report and the 2003-2004 Health Accords.

While many of the tools for improving service delivery are under provincial and territorial jurisdiction, the federal government has also a key role to play in providing proper leadership. Unfortunately, this is not the direction this government is taking. After failing miserably at implementing the commitments in the 2003-2004 Health Accords, Stephen Harper recently put forward a plan to unilaterally reduce the federal contribution to healthcare. At a time when the differences between provincial health care systems in Canada is growing, federal leadership is required now more than ever to ensure Canadians have access to quality health care across the country.

I was in Victoria during a recent Premier's conference on health care sustainability, where the NDP held its own event to hear from key health care advocates and researchers and met with many interested Canadians. We received the same message from the premiers and citizens alike: don't privatize healthcare; continue to expand it in innovative ways.

While some people spread the word that more privatization is needed to control costs in healthcare, evidence points to the contrary. While total spending on health care has grown from about 7% of GDP to around 12% today, that number hides the fact that the components covered by Medicare have remained between 4 and 5% of GDP since the mid '70s, while the other components not covered by Medicare have grown from 3% to 7% of GDP. Public delivery has been an important cost container. Therefore, a sustainable health care system delivering quality healthcare services should rely on more, not less, public coverage.

To move away from the status quo, there are three key areas outlined in the Health Accords that we should immediately start with: better drug coverage, home care, and primary care reform.

First, we need to address the ever-increasing costs of prescription medication. Over the past 10 years, they have increased at a rate of 10% per year. The 2004 Health Accord included a pharmaceutical strategy aimed at reducing the cost of medications. Unfortunately, this plan, which is mostly of federal jurisdiction, has gone nowhere. Such a plan would not only save our health care system billions of dollars each year, it would also help Canadians have better access to more effective drugs.

We also need to adjust to the 21st century reality of offering more services in the community. New healthcare delivery models such as home care and palliative care have proven to be less expensive than hospital beds, while keeping the patient in a much more familiar environment. In the 2004 Health Accord, First Ministers agreed to provide first dollar coverage for certain home care services. While some progress has been made, there is no reporting as to what services are covered in each province. It is impossible to know if there is a baseline of services offered. Establishing a comprehensive care strategy will save costs in the long-run and improve the health of millions of Canadians.

Finally, primary health care reform is considered the key to a more efficient and cost-effective use of health care resources. A better coordination of healthcare resources in the community has been shown to provide better access and better health outcomes for patients. Primary care reform would lower costs while supporting more timely access to health care services, particularly for the delivery of healthcare services to Canadians who live in rural and remote areas and Aboriginal people.

What our healthcare system needs today is leadership. Leadership to put in place the much needed reforms that have been in talks for over a decade. The provinces want a federal partner that's committed to improving Medicare, who seeks accountability by linking spending to clear health care improvements. The hands-off approach of the Conservative government simply doesn't work for the provinces, and it won't work for Canadians.

**Libby Davies, MP Vancouver East**

# Canada Favours Mixed Model System

Given the choice between a private and a public health care system, Canadians overwhelmingly choose the latter. But insert a third option – a mixed public/private system – and the country is less certain.

A poll by Ipsos-Reid for Postmedia News and Global News finds that 80 per cent of Canadians prefer the "not-for-profit" health care model, where services are delivered by the public sector. Only 20 per cent would rather have a "for-profit" system delivered by the private sector.

Not surprisingly, support for the public system is higher among the poorest Canadians (83 per cent) and lowest among the richest people in the country (75 per cent). Nevertheless, that even three-quarters of those most able to afford a private system still prefer public health care is a strong indication of how much Canadians believe in our model.

But that faith in Canadian health care is not unconditional. When given the choice between a fully private system, a completely public system, and a mixed model that would provide a public option as well as the choice to seek and pay for medical services in the private sector, a majority of Canadians (53 per cent) prefer the "mixed" model. Support for such a system is highest in British Columbia and Atlantic Canada and lowest in Alberta, while 39 per cent nationwide still choose the public system.

Here again, the wealthiest Canadians (64 per cent) are most likely to prefer the mixed system, while only 48 per cent of Canadians who earn $40,000/year or less feel the same.

Interestingly, however, university graduates are the most split demographic on the issue: 47 per cent prefer the public model while 49 per cent want a mixed model. These Canadians (being the most educated are also likely to be among the wealthiest) could be weighing the pros and cons of a publicly-funded system open to all versus giving Canadians a choice to seek out private health care -- something which could potentially weaken the public system.

> *80 percent of Canadians prefer the "non-for-profit" health care model, where services are delivered by public sector.*
>
> **Ipsos-Reid**

But while 76 per cent of Canadians think people in this country should be able to buy private health insurance to cover treatments outside the current public system, 54 per cent oppose allowing doctors to work in the private sector.

This is not the case in Quebec, however, where 56 per cent support allowing doctors to work outside the public system. Generally speaking, the Ipsos poll shows that Quebecers are the most ambivalent about publicly-funded health care. For instance, Quebec scored the highest on support for a fully private system both with and without the option of a mixed model.

But overall, the survey suggests that while Canadians want a public option, they also believe in being given a choice. At the same time, they appear wary of the consequences of changing the way health care is delivered in this country, wanting the option of seeking private treatments but uncomfortable with Canadian doctors transitioning from the public to the private sector. Will any provincial government try to square this circle?

**Éric Grenier, The Huffington Post Canada, 06/29/2012.**

**Universal** *from page 9 concluded.*

If Canadians take pride in their medicare system, and want to achieve better access to medicines at lower costs than they pay today, then maybe it is time for the original vision of medicare, which included Pharmacare, to be completed as planned.

Perhaps it is time to fight for Pharmacare. Not just for refugees, but for all Canadians.

**Steve Morgan, expert adviser with EvidenceNetwork.ca; associate professor/ associate director, Centre for Health Services and Policy Research, University of British Columbia. Jamie Daw, policy analyst, Centre for Health Services and Policy Research. The Vancouver Sun, 08/20/12.**

# Planning to Age at Home?

Regardless of your age, you have likely started to feel the strain that Canada's Public Health Care system is under. Whether you have found yourself waiting for a drive from Para Transpo, a surgery at the Ottawa Hospital or an appointment to see a specialist, it is undeniable that the wait times in Canada have increased rapidly over the past 15- 20 years.

Although many initiatives are being implemented to try and offset and reduce the long "line ups", I would have to say that it is up to each individual to decide whether or not those initiatives are working for them. I say this due to a recent experience of which I was made aware regarding one lady's trip to an Ottawa emergency room. From start to finish she was there for seven and a half hours, fifteen minutes of which she was actually having interaction with a medical professional. This recent account of ER wait times leaves me wondering how effective government efforts are in improving the health care system.

I believe the answer in working toward a more efficient health care system lies in creating a unified system bringing together the private and public sector, allowing the private industry to support and compliment what is already offered by the public system. This being said, I do not think we can expect to see a system like this being put in place tomorrow, so, in the meantime, I recommend people be proactive rather than reactive when it comes to their health.

The first thing I would suggest people do is to sit down with their caregivers to make a plan as to how they can continue to age successfully in the comfort of their own home by utilizing available resources from both the public and private sectors. As a starting point, aspects that should be considered when analyzing one's needs are things like: transportation to attend medical appointments and complete necessary errands; current layout and renovation needs (e.g., stairs, bathrooms, ramps); home maintenance (take care of the upkeep of the interior and exterior); and personal care.

Many people try to manage on their own by relying on family members to take time off work to provide them with transportation and accommodate their in-home needs. However, when work leave is running out or family schedules start overlapping, people are often left wondering what their options for respite are.

Recently a directory of Aging at Home Services was developed that can be accessed for free by seniors and caregivers Monday to Friday from 9am to 5pm. Simply calling 613 914 HOME (4663). Every time you call you can speak with a friendly representative who is there specifically to get you pointed in the right direction in providing solutions to your current and future needs.

This directory consists of established and reputable organizations that will do everything from providing transportation and accompanying people to their doctor's appointment, to having a heath care specialist come into the home to assess needs and help you and your family finalize a care plan that works for everyone (while taking into account your budget). This plan will analyze what you or your loved one is entitled to from the public sector, what volunteer services in your area are able to provide, and what private services can be accessed to create a comprehensive plan that suits the needs of you and your family.

If your goal is to age gracefully in your own home, I cannot stress enough that it is never too soon to start thinking ahead and prepare a plan of action. I hear story after story of people who wish they had a plan in place before losing some or all of their physical mobility and were left scrambling.

If you are ready or someone you know is ready to take the next step in planning for the future, I encourage you to call and speak with one of the representatives at Aging at Home Services. It is completely free and confidential. When deciding if this may be of assistance to you, ask yourself one question: what do you have to lose?

**Jana Mitchell, BPR – Founder, Wheels for the Wise Inc.**

# Better Value Trends in Spending on Healthcare

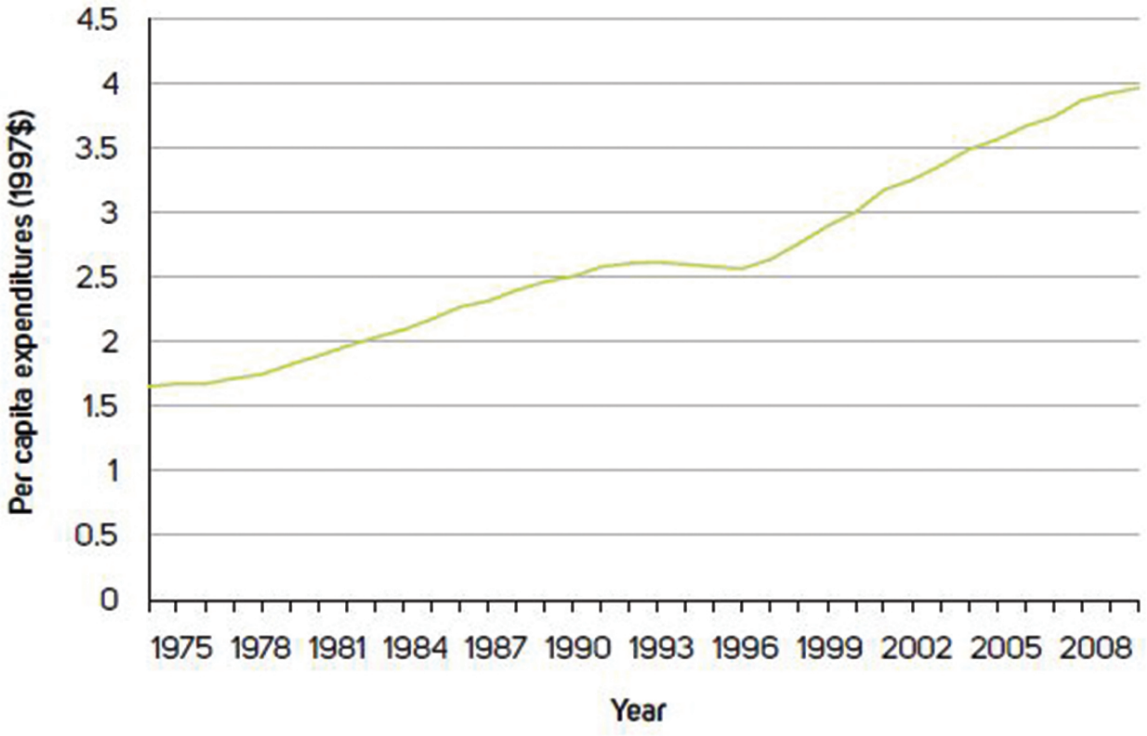
Let us begin with an overview of recent trends in spending on healthcare in Canada. Figure 1 sets the stage, showing per capita spending on healthcare in Canada from 1975 to 2010. Data are drawn from the NHEX database and are presented in (thousands of) 1997 dollars to control for inflation.[iii]

The figure shows a clear and steady increase in spending on healthcare over almost the entire period, save for the mid-1990s, a period of fiscal restraint in which the federal government reduced spending on healthcare (mainly through reduced transfers to provinces). But starting in the late 1990s, there has been a striking increase in spending on healthcare. Per capita spending as of 2010 – even controlling for inflation – was more than 50% higher than in 1996.

Some of the increase apparent in Figure 1 is a product not of public spending on healthcare, but of private spending. Figure 2 separates the two, presenting the trend in each over time. This separation shows an obvious retrenchment in government spending on healthcare in the mid-1990s. The figure also makes evident that, as with public healthcare spending, the past decade has seen a steeper increase in private spending. To be clear, the rate of increase post-1996 is higher than the rate of increase pre-1992, for both public and private healthcare spending.

**Spending** *Continued on page 14*

Figure 1: Total per capita health expenditures ($000's), Canada, 1975-2010

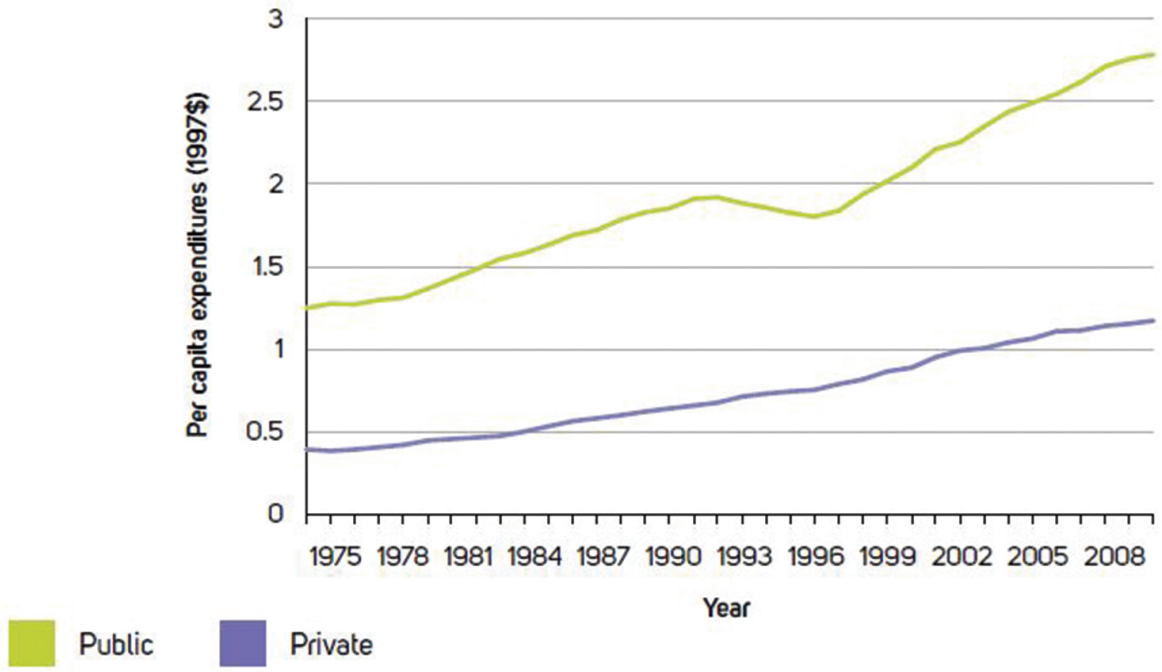



Source: National Health Expenditures Database, Canadian Institute for Health Information
Note: Projected spending estimates are used for 2009 and 2010

iii NHEX data are available from CIHI at www.cihi.ca. Inflation-controlled measures used here are based on the implicit price indices available in the NHEX database; per capita measures are based on population figures in the same database.

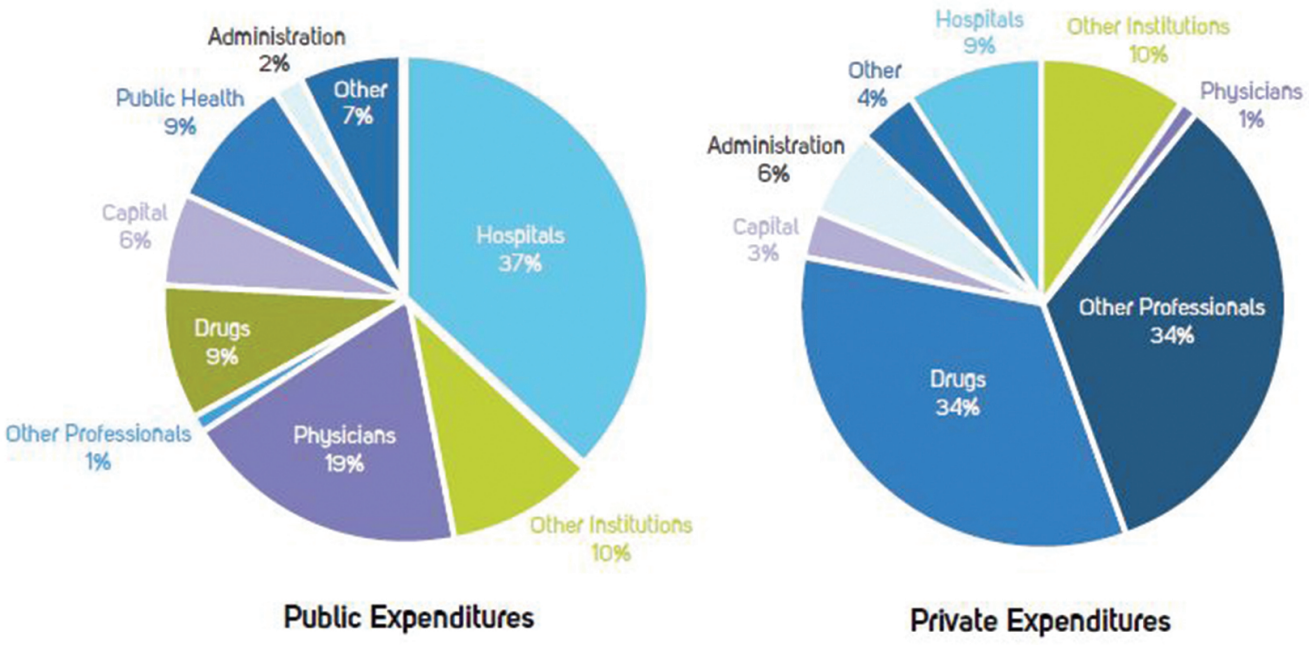
**Spending** *Continued from page 13*

## Figure 2: Public and private per capita health expenditures ($000's), Canada, 1975–2010




Source: National Health Expenditures Database, Canadian Institute for Health Information
Note: Projected spending estimates are used for 2009 and 2010

## Figure 3: Public and private health expenditures, by domain of use, Canada, 2008




Source: National Health Expenditures Database, Canadian Institute for Health Information

Private spending has seen a greater increase, proportionally speaking, than has public spending. Projected per capita public spending in 2010 was roughly 2.2 times greater than in 1975; projected per capita private spending was nearly 3 times greater. The proportion of total healthcare spending that is private has been shifting accordingly over the past 30 years. In 1975, private spending accounted for roughly 23% of total healthcare spending in Canada; by 2010, that figure was nearly 30%.

What exactly are public and private funds used for? Figure 3 shows the distribution of spending in 2008 across the eight categories tracked in the database.[iv] The main expenditure streams, and the differences between the use of public and private funds, are very clear. Approximately 37% of public funds go to hospitals; another 19% go to physicians.[v]

Where private spending is concerned, the focus is on other professionals (34%, including dentists, chiropractors, optometrists, physiotherapists, etc.[vi] and drugs (34%, including both prescription and non-prescription drugs purchased in retail stores). Past research points toward strong public support for increased government coverage of both other professional services and drugs, and these data serve to illustrate why – these are the areas in which most private spending on healthcare is focused. Clearly, private funds have been taking on a greater role in the Canadian healthcare system. Does public or private spending tend to yield better value? This is an important but difficult issue to deal with, in part because—as we have seen above—private spending is directed at different categories than is public spending. There is some overlap, of course, and it is in the areas in which we see a considerable degree of both public and private funding, aimed at the same objectives, where an analysis of value for each type of spending seems most plausible.

A comparison of value in public versus private spending is an important piece of the Canadian healthcare puzzle, but one that will be left for future work for the time being. However, we continue the process of exploring value in healthcare by focusing on variations in public spending across provinces.

**Stuart N. Soroka and Adam N. Mahon, June 2012. Better Value Report. Canadian Health Service Research Foundation and Canadian Nurses Association.**

iv The current NHEX data at the time of writing included data up to 2010, but the final two years were
spending estimates rather than final figures. We accordingly used data for 2008 here, the last year for which final figures were available.

v Full definitions for the spending categories are available in National Health Expenditure Trends, 1975 to 2010, by the Canadian Institute for Health Information, 2010, Ottawa: Author, available at www.cihi.ca

vi According to the CIHI documentation, nurses are included in hospital expenditures.

**Doctor** *Continued from page 7*

Recent reviews of physician salaries across the OECD place Canada among the top. Depending on how physician incomes are measured (converting currencies so that a dollar basically buys the same amount of goods in each country or comparing doctors' salaries to the average wage earned in that country), Canada's physicians do fairly well. When comparing incomes using purchasing power, they are paid less than their U.S. counterparts and slightly less than those in Britain or Germany but above most other OECD countries. When comparing incomes using the ratio of their salaries to the average in the population they are exceeded only by the United States. Our specialists fare even better, although still behind their U.S. counterparts.

Finally, while Ontario may have been one of the first movers in Canada to try to contain physician costs (and deserves credit for taking concrete steps to do so), concern over health care spending is a national issue, and it is likely that other provinces will wish to follow Ontario's lead in substance, if not style.

**Mark Stabile is the director of the School of Public Policy and Governance and professor at the Rotman School of Management, University of Toronto. The Globe and Mail, 05/29/12.**

## COA Address

The Council on Aging of Ottawa
101-1247 Kilborn Place
Ottawa, ON. K1H 6K9

## Office Hours

Monday to Friday
8:30 a.m. to 4:30 p.m.
Tel: 613-789-3577
Fax: 613-789-4406
www.coaottawa.ca
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June 4 1:30-3:30

**YET KEEN SENIOR CENTRE**
211 Bronson Centre
June 5 9:30-11:30

**CHINESE SENIOR CENTRE**
381 Kent
June 5 1:30-3:30

**1455 CLEMENTINE***
June 6 1:30-3:30

**540 THOMSON***
June 7 9:30-11:30

**800 ST. LAURENT***
June 7 1:30-3:30

**395 SOMERSET***
June 10 9:30-11:30

**110 COBOURG****
June 10 1:30-3:30

**616 KIRKWOOD***
June 11 9:30-11:30

**1041 WELLINGTON***
June 11 1:30-3:30

**LE PATRO SENIOR CENTRE**
40 Cobourg
June 12 9:30-11:30

**PAULINE-CHARRON SENIOR CENTRE**
164 Jeanne-Mance
June 12 1:30-3:30

**KANATA CHINESE SENIOR SOCIAL CLUB**
400 Goldridge
June 13 9:30-11:30

**KANATA SENIOR CENTRE**
2500 Campeau
June 13 1:30-3:30

**CORNERSTONE**
314 Booth Street
June 14 9:30-11:30

**OTTAWA WEST COMMUNITY SENIOR SUPPORT**
1137 Wellington
June 14 1:30-3:30

**CHURCHILL SENIOR CENTRE**
345 Richmond Road
June 17 9:30-11:30

**380 MURRAY****
June 17 1:30-3:30

**THE GOOD COMPANIONS SENIOR CENTRE**
670 Albert
June 18 9:30-11:30

**1041 WELLINGTON***
June 18 1:30-3:30

**CENTRE GUIGUES SENIOR CENTRE**
159 Murray
June 19 9:30-11:30

**ABBOTSFORD/GLEBE SENIOR CENTRE**
950 Bank
June 19 1:30-3:30

**445 RICHMOND***
June 20 9:30-11:30

**300 LACASSE VANIER****
June 20 1:30-3:30

**SÉRAPHIN-MARION SENIOR CENTRE**
6600 Carriere
June 21 9:30-11:30

**OTTAWA COMMUNITY HOUSING**
1909 Russell
June 24 9:30-11:30

**280 ROCHESTER & 865 GLADSTONE***
June 25 9:30-11:30
1:30-3:30

**VILLA MARCONI SENIOR CENTRE**
1026 Baseline
June 26 9:30-11:30

**GLOUCESTER SENIOR CENTRE**
2020 Ogilvie
June 26 1:30-3:30

**ROYAL OTTAWA HOSPITAL**
1145 Carling
June 27 9:30-11:30
June 28 9:30-11:30

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The Council on Aging of Ottawa has a 38 year history of serving the interests of Ottawa's seniors. It is our ambition to make Ottawa an internationally recognized model and standard of age-friendliness. **We need your help to do so.**

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  - o A complete and constantly evolving ecosystem of services, programs, events, research, communications and education tools.
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