CARE WATCH
Advocating Quality Home & Community Care

Backgrounder

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APPLYING *CANADA HEALTH ACT* PRINCIPLES TO HOME CARE AND COMMUNITY SUPPORT SERVICES

Starting the Discussion

Care Watch has long supported the principles underlying the *Canada Health Act (CHA)*. We also believe these principles are fundamental to any system for in-home and community support services.

Constitutionally, our provincial/territorial governments are responsible for health services and programming. The federal government is responsible for leadership, coordination, funding, and maintaining nationwide equity. National frameworks such as the *Canada Health Act*[1] provide a foundation and guidance for consistent and coordinated provincial/territorial action. This action creates public goods that benefit us all. Such frameworks can guide not only health care, but also other national initiatives and programmes.

As of this writing, Ontario is restructuring the delivery and funding of health services, including home care and community support services. The CHA's five legislated principles (***public administration, comprehensiveness, universality, portability, and accessibility***), as well as the implicit principles of ***equity*** **and** ***solidarity***, provide a lens for viewing and assessing current and pending changes.

The *Canada Health Act*

The *Canada Health Act* establishes a national policy framework for publicly funded health insurance plans (generally called Medicare), which cover (or insure) necessary medical,[2] surgical dentistry, and hospital services by authorized providers. Medicare is not, however, a single unified programme; each province and territory establishes its own insurance plan, with its own terms and conditions. To qualify for federal funding (transfer payments), these plans must conform to the CHA's legislated principles. Although most providers operate as private, for-profit businesses,[3] their medically necessary services are publicly funded, so users don't pay directly for them and don't pay at the point of service. Some people, in Canada and elsewhere, think of Canada's Medicare system as free. It is not, however, any more "free" than any other insurance system. Insured people pay (through their taxes) into a common pooled fund, from which they withdraw as needed.

Sect. 3 of the CHA states that Canadian health care policy's primary objective "… is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

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[1] The CHA has no funding provisions. Funding is provided under the Canada Health Transfer provisions of the *Federal-Provincial Fiscal Arrangements Act.*

[2] Includes a number of therapeutic services, such as nursing and physiotherapy.

[3] Deber, R.B. (2009). Public funded, not-for-profit health care: Clarifying Canada's complex reality. https://www.cna-aiic.ca/*/media/cna/files/en/re-examining-public-funding-not-for-profit-healthcare_e.pdf?la=en.

Health Canada also affirms that ''framed by the Canada Health Act, the principles governing our health care system are symbols of the underlying Canadian values of equity and solidarity"[4] based on the shared goals and interests of maintaining and improving individual health, population health, and the public health system.

Home Care and Community Support Services

Historically, home care and community support services were provided on a voluntary basis by charitable organizations. Today, they are provided by a mix of for-profit and not-for-profit organizations and municipalities and funded through public funds, user co-payments and fees, and charitable donations.

The CHA does not mandate that in-home care or community support services be insured, but it does give each province and territory the discretion to insure medically-related "extended health care" services.[5] Examples include nursing home intermediate services, adult residential care services, home care services,[6] and ambulatory health care services. Provinces and territories may also provide "additional benefits," which they fund and deliver according to their own terms and conditions.[7]

In 1994, Ontario's *Home Care and Community Services Act (HCCSA)*, and associated regulations, established a legislative foundation for the province's home and community care sector. HCCSA's stated goals included: (a) providing a wide range of community services to people in their own homes and communities, thus offering alternatives to institutional care; (b) supporting family caregivers; (c) improving the quality of community services; and (d) promoting the health and well-being of those who need these services. It outlines administrative responsibilities, accountability, and oversight; sets rules and standards; and creates funding structures and requirements. It also includes a patient bill of rights along with requirements for complaints and appeal processes.[8]

On February 25, 2020, Ontario's government tabled *Bill 175 – Connecting People to Home and Community Care Act, 2020,* which is intended to modernize Ontario's home and community care services system. If passed,[9] the Bill will repeal and replace the HCCSA, formally transferring responsibility for planning, coordinating, and delivering home and community care[10] (HCC) to the new Ontario Health Teams. Health teams are essentially not-for profit corporations or interlocking corporate partnerships,

[4] Health Canada Health Care System. http://hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/index-eng.php.
[5] Section 2 of the *Canada Health Act;* Monique Lanoix (2016).
[6] All provinces and territories have publicly funded home care programmes, although service delivery models vary substantially across Canada. Services may be delivered by public agencies or by private establishments (either not-for-profit or for-profit) or a mix (Statistics Canada, 2017).
[7] These additional benefits are often directed to specific groups, such as seniors, children, and social assistance recipients, and they may be partially or fully covered. Examples include prescription drugs, general dental care, and optometric, chiropractic, and ambulance services.
[8] Wellesley Institute. Nazeefah Laher, Lauren Bates & Seong-gee Um. *The Changing Face of Home and Community Care* (2019).
[9] The legislative review process for Bill 175 has been fast-tracked, but public review opportunities are currently unknown.
[10] Under Bill 175, "home and community care" is the umbrella term for home care and community support services.

some of which may be for-profit service providers. Beyond this information, however, we know little about their structures, partnerships, governance, funding, and operating methods.

Some HCCSA provisions appeared to align with CHA principles, though the HCCSA had no clear statutory provisions for them. Bill 175, however, contains no reference to either the HCCSA's purposes or goals, and it includes no new public interest purposes or service goals. Home and community care services are thus unprotected and prey to erosion in the name of modernization and cost-cutting.

Applying the *Canada Health Act* to Home Care and Community Support: Examining the Principles

CHA Principle – Public Administration (Sect 8)**:**
• Public health insurance must be administered by a public authority on a non-profit basis, accountable to the province or territory, and with records and accounts subject to audits.

Medicare is publicly funded via general and specific taxes administered by each provincial/territorial government and its designated crown agencies, which are publicly accountable for expenditures and performance. Each government determines the extent and amount of services covered. To foster Canada-wide equity, programming, and standards, the federal government also gives some provinces equalization funds.

In Ontario, the *Ontario Health Insurance Plan Act (OHIP)* and associated regulations outline insured services. The Ontario Medical Association negotiates physician fees and the Ontario Hospital Association negotiates hospital fees; the resulting fees, reflected in OHIP's Schedule of Benefits and Fees, are deemed regulations.

In 2006, Ontario's government delegated health service planning and funding to 14 regional health authorities[11] (local health integration networks, or LHINs), which allocated funds and managed provider contracts within geographic regions. In addition to planning and funding institutional services (except for physician services), LHINs were responsible for funding HCC through Community Care Access Centres (CCACs). However, a 2015 Auditor General of Ontario report[12] identified some 1,500 different service agreements with HCC delivery agencies, with a multitude of financial arrangements for the same or similar services. Understandably, the report questioned how, and how effectively, public resources were being used.

Under Ontario's restructured health system and Bill 175, Ontario Health will assume responsibility for overall system planning and funding home and community care services. Coordination and delivery of these services will become the responsibility of interim service providers called Home and Community Support Services (formerly LHINs) for a transitional period and, eventually, the sole purview of local Ontario Health Teams.

[11] Although the legislation was passed in 2006, LHINs officially came into effect in 2007 as crown agencies accountable to both the Minister of Health and the public.
[12] Auditor General of Ontario, 2015. Annual Report Value-For-Money Audits – Community Care Access Centres. Subsequently, CCACs were disbanded and their functions were folded into the associated LHIN.

Funding for home and community care will be allocated to and through the health teams. It isn't yet clear how these health teams will be accountable for their use of public funds or for the performance of services they choose to deliver, and especially how they will plan, allocate, protect, or sustain funding for home care and community support services. It is also not clear how they will negotiate fees and payments.

Accountability for and public reporting of system expenditures currently rest with Ontario's government,[13] and expenditures are subject to audit by the provincial auditor general. Crown agencies, such as Ontario Health,[14] which deliver and manage insured services, are similarly accountable for their use of public funds. Other providers, such as health teams, health service organizations, and/or contracted service providers, however, have limited public accountability.[15] For example, for-profit home care and community care providers receiving public funding don't have to provide detailed public financial or service performance reports. The auditor general has had limited authority. The principle of public administration and accountability could be at risk, leaving the question of who is minding the store.

CHA Principle – Comprehensiveness (Sect 9):

- Provincial health insurance programmes must include all necessary medical services, including hospitals, physicians, and surgical dentistry services.
- The CHA defines comprehensiveness, broadly, to include … ***medically necessary services*** ***"for the purpose of maintaining health, preventing disease, or diagnosing or treating an injury, illness or disability".*** However, the Act doesn't define what constitutes "medical necessity", which is determined by the province or territory in consultation with professional colleges and groups.[16]
- The CHA also provides for insurance of extended health care services, which include medically necessary home care and ambulatory services, at the province's or territory's discretion.

Comprehensiveness means that all insured persons have access to a wide array of critical services - relatively straightforward for medical and hospital services. Comprehensiveness of home care and community support services, however, often depends on where a resident lives. In general, rural, northern, and First Nations residents[17] don't enjoy access to the same range of services as those in southern or major urban areas.[18]

[13] Accountability rested primarily with the Ministry of Health and Long-Term Care. This previous ministry's functions are now divided among three ministries: Health; Long-Term Care; and Mental Health and Addictions.
[14] Ontario Health, a new crown agency, amalgamates 20 provincial health agencies, including Local Health Integration Networks (LHINs) and assumes the LHINs' system planning and integration functions.
[15] Canadian health services are provided primarily by private businesses, accountable only to their owners/operators or boards of directors. Public accountability for use of public funds and alignment with publicly-established goals are limited. David Naylor terms this "public payment for private practice". Ontario has the largest proportion of private sector home care delivery agents (Statistics Canada, 2017).
[16] For example, Ontario's College of Physicians and Surgeons, the Ontario Medical Association, and several associations representing medical specialists.
[17] First Nations members also receive some federal health benefits, but comprehensiveness and availability still depend on location.
[18] For example, Ontario's secondary and tertiary care (i.e., highly specialized) hospitals tend to be located in major urban centres, such as Toronto, Ottawa, Hamilton, and London.

A province or territory may include home care services under the CHA as "extended health care services". Community support services, in contrast, have not been considered insured health services, largely because they were viewed as aligned with the social determinants of health and therefore not medically necessary. This historical view of community support services as simply "nice to have" is changing, however, as:

- The connections between social determinants and physical health become more apparent.
- The makeup of the population evolves. People live longer, and the large and vocal Baby Boomer generation is a force. The health needs of older, ageing adults are increasingly linked to chronic conditions, multiple diagnoses, and dementia rather than strictly to acute episodes.
- Care moves from hospitals to the home and community to mitigate institutional costs. Community support services are therefore increasingly viewed as necessary to keep older adults living safely in their homes and communities and, more importantly, as alternatives to institutional care.

These changes could warrant expanding the range of insured services to include non-medical services that maintain health, prevent or mitigate injury and ill-health, and facilitate treatment of injury, illness, or disability within the context of continuing care (or continuity of care). Manitoba, for example, includes supports for activities of daily living as well as some professional services within extended health care.[19]

Under Ontario's restructured health system, each health team will determine the range of home care and community support services to be provided within a range of broad expectations articulated by the government. However, since there are no specific provincial or national standards, the comprehensiveness of services to be offered is unclear.

CHA Principle – Universality (Sect 10):
• The provincial health insurance plan must entitle 100% of insured persons to the insured health services provided on uniform terms and conditions.

Medicare coverage has two basic eligibility criteria: (a) provincial/territorial residency; and (b) medical necessity as determined by authorized practitioners. The insured person does not have to pay for insured services when receiving them; the public insurance plan pays providers directly on the person's behalf.[20]

Provision of service on ***uniform terms and conditions*** means that all insured persons are equally entitled to needed insured services,[21] without discrimination. No one is either privileged or disadvantaged based on non-medical characteristics, such as ability to pay, socio-economic status, age, sex, or race.[22]

[19] Manitoba's programme also takes into account the availability of other resources, such as family care and local community services, in determining service provision.
[20] Also, private insurance plans are generally prohibited from covering medically necessary services provided by the public plan, although they can top up services (e.g., semi-private or private hospital rooms) beyond the basic public service.
[21] Note that ***Universality*** does **not** mean no-charge coverage for all possible health interventions, regardless of the cost, since no government can provide all services without charge on a sustainable basis. In Canada, everyone who pays taxes contributes to Medicare costs, which are pooled and distributed across the insured population.

Research consistently finds that when people must pay out-of-pocket fees, deductibles, and co-payments for medically necessary services and prescription medications, they tend to use those services less and therefore not to follow medical advice. The Advisory Council on the Implementation of National Pharmacare found, for example, that the struggle with affordability caused some people to not take their prescription drugs as directed; others had to cut back on food or home heating to pay for their medication. Failing to take prescribed medication, as it is prescribed, can have serious health consequences; sacrificing food or heating makes those consequences even worse. For people with low and/or fixed incomes, and now for those whose health and livelihoods are affected by a pandemic, the consequences can be disastrous.

When the medically necessary home care services provided can't fully address the identified need, recipients and families must cover the remaining costs. Paying for supplementary services, which are generally quite expensive, can pose a significant financial barrier to service and therefore to continued independence.

Research by the Wellesley Institute identified that many Ontario seniors could not supplement the shortfalls in publicly funded home and community care from their own resources. Theoretically, private insurance could bridge this gap. However, current private insurance plans aren't available to the vast majority of seniors because of age or health restrictions (such as pre-existing or unstable health conditions or recent emergency department visits) or because current seniors lacked the time or financial resources to contribute to them.

CHA Principle – Portability (Sect 11)
• While temporarily absent from their home province, insured persons retain their insured status respecting receipt of medically necessary services. • Waiting period for coverage is limited to a maximum of 3 months (because of immigration/migration; refugees are covered by other legislation).

Medicare benefits are portable because both the service and individual are deemed to be insured. Also, most medically necessary services are fairly standard and therefore readily available in most Canadian jurisdictions.[23] However, since amounts payable are based on fees established in one's home province, amounts above those fees charged by another jurisdiction may become the recipient's responsibility.

Historically, Ontarians were covered for medically necessary services incurred while travelling out of the country. As of December 31, 2019, the Ford government deemed out-of-country absences to be ineligible for any coverage, viewing administration as not cost-effective.[24] Ontarians are now considered insured persons only within Canada, negatively affecting many seniors who cannot afford private travel insurance.

The principle of portability is tricky to apply literally to home and community care services, because:

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[22] It is acknowledged that while OHIP is essentially "status blind", some individual medical decisions may be influenced by non-medical considerations (such as ageism). LGBTQ communities also face structural discrimination as well as biased practitioners and care practices.

[23] Except for a few, highly specialized services (for example, tertiary hospitals) where availability is limited.

[24] The federal government and, more recently, the Canadian Snowbird Association have challenged this decision as a breach of the CHA, but the matter is still unresolved.

- There is no unified or publicly-funded insurance plan, comparable to Medicare, for home care and community support services.
- There is no consistent definition of which persons and which services are covered, and under which circumstances**.** In Ontario, the basic eligibility for publicly-funded home care requires that an individual be insured under Ontario's *Health Insurance Plan*. A service coordinator then uses assessment tools to determine the actual types and amounts of services a client receives.[25]
- Services vary considerably both within and across provinces/territories. Although Ontario's legislation prohibits geographic location as a criterion for denying home and community care, services are planned, funded, and delivered regionally. Responsibilities for planning, funding, and delivering local home and community care services are scheduled to transfer to individual health teams with smaller geographic catchment areas than the LHINs (and their transitional successors, Home and Community Support Services agencies). Despite recent attempts to assign specific resource amounts to individuals (in effect, creating a voucher system), trying to transfer such resources across regional, community, or health team boundaries would cause serious inequities for both individuals and communities.

CHA Principle – Accessibility (Sect 12)

- Insured health services must be provided on uniform terms and conditions and not impede or preclude, either directly or indirectly … ***reasonable access*** to those services by an insured person.
- In addition, all physicians, hospitals, etc., must be provided reasonable compensation for the services they provide.

The CHA removes a critical <u>systemic</u> barrier to general accessibility, namely the requirement to pay at point of service. It doesn't specifically define "reasonable access", but leaves that to provinces/territories. In the absence of a comprehensive definition, some jurisdictions have established distance to be travelled[26] or time lines from date of diagnosis to effective access[27] as a proxy for accessibility to high priority services.

Discussion of accessibility to home and community care services tends to focus largely on factors such as the client's ability to navigate the system, availability of qualified service workers (for example, personal support workers), geography and population density, client finances (affordability), wait times, and distribution of service providers. Accessibility has depended largely on one's residential location and local service availability. However, the concept of accessibility can also be broadened to reflect accommodation of a client's diverse needs and preferences resulting from additional factors, such as physical capacity, ethno-cultural background, language, creed, marital and family status, and/or sexual and gender orientation or identity.

Care Watch advocates for ***equitable accessibility*** to services. All Ontarians (and Canadians) should be equally eligible for service, and the actual services provided should depend on individual need. Specifically, service assessment should be even-handed and standard, taking into account key recipient

[25] In addition to the basic eligibility, each service includes specific "qualifiers", which recipients must also meet to receive service.
[26] Most often used for primary care, childbirth, or general emergency (non-trauma) services.
[27] For example, for hip/knee replacements and cancer care.

needs and preferences. Without specifying the priorities of such needs or preferences, we recognize that Ontario's duty to accommodate[28] individuals, or to avoid discrimination, could also apply to home and community care services.

Applying the *Canada Health Act* Principles

The *Canada Health Act* functions on several levels. The most specific is the range of insured services. Next are the legislated principles to which provincial/territorial insurance plans must conform. Finally, are the even broader concepts and values that underlie these principles.

Following are some of these fundamental concepts and values along with the *Canada Health Act* principles reflecting each one.

Underlying Concepts/Values	*Canada Health Act* Legislated Principle(s)
• The physical and mental well-being of residents of Canada are protected, promoted, and restored • Residents have reasonable access to needed health services without financial or other barriers	• Public administration • Comprehensiveness • Universality • Portability • Accessibility
• All individuals have reasonable and equitable access to services ○ There are no financial or other barriers to reasonable access	• Accessibility (Equity) • Portability

• Service is provided on uniform terms and conditions
  ○ Everyone has the same opportunity to access needed services without financial hardship
  ○ No individual or group is either privileged or disadvantaged
	• Universality

• All necessary services are insured	• Comprehensiveness

• Members of the public/taxpayers know how their money is used
  ○ Agencies are accountable for expenditures
  ○ Processes are transparent
	• Public administration

Getting Some Answers

Care Watch asserts that home and community care services are necessary components of our broader Medicare system. Like medical and hospital services, they maintain individual and population health and contribute to a sustainable public health system.

The current restructuring of Ontario's health care system is not the first, and it won't be the last. Structures change and evolve, but values and principles remain constant. When decisions are made that significantly affect our health and well-being, all of us need to know where our decision makers (and candidates seeking decision-making roles) stand and what they are prepared to do.

[28] *Accessibility for Ontarians with Disabilities Act*.

When new structures or policies are proposed, it's useful to ask ourselves and others:

- ***How will home and community care services policies and actions serve the public interest – the welfare of the general public? How will we know the public interest is being effectively addressed?***
- ***Will home and community care services be treated as essential components of the health system? How will this be achieved?***
- ***Will home and community care be available to everyone who needs it on uniform terms and conditions, without financial or other systemic barriers?***
- ***How will the pubic/private mix of service providers be managed so that services are accessible and front-line staff are adequately compensated?***
- ***How will service providers be accountable to their clients and to the public?***
- ***How can I determine the service I need and how can I access it?***
- ***Who (which entity or professional) will be responsible for coordinating my care?***

The answers to these and other questions can tell us which policies and which decisions deserve our support and which need further work.