



Funding the Continuum of Care

The continuum of care may be defined as the array of health services that spans the range over the life course from primary care (including prevention and health promotion) through institutionally based secondary and tertiary care to community and home-based services that promote health maintenance, rehabilitation and palliation at the end of life. Given the ever-increasing diversity of service offerings and providers, and aging populations, governments worldwide face the ongoing challenge of what to fund for whom.

After a lengthy period of examination that began in the 1930s, Canada arrived at a social consensus on universal, first-dollar coverage provision of hospital (1957)¹ and physician (1966)² services. All provinces bought into “Medicare” by the early 1970s and the 1984 *Canada Health Act (CHA)*³ was the capstone of the national hospital and medical insurance program, adding the principle of accessibility, which effectively prohibited user charges for insured hospital and physician services.

Notwithstanding the more recent legislation, the foundation of Medicare was set in the health and health care reality of 1957. Hospital and medical services accounted for two-thirds of health spending (65%).⁴ Prescription drugs accounted for just 6% of spending, less than half of their 14.6% share in 2008. Life expectancy was almost a decade shorter than it is today, hence there was less concern about long-term care. The first knee replacement was not done until a decade later.

The 1957 Hospital and Diagnostic Services Act specifically excluded tuberculosis hospitals, sanatoria and psychiatric hospitals as well as nursing homes/homes for the aged. These exclusions carried forward to the CHA.

By all accounts the *CHA* has taken on an iconic status, but at the same time it is agreed that it is an impediment to modernizing Medicare through its definitions and program criteria and how they are interpreted by the provinces and territories. The *CHA* narrowly defines insured health services as “hospital services, physician services and surgical dental services provided to insured persons.” While the *CHA* recognizes “extended” health services such as home care and ambulatory health care services, these are not subject to the program criteria.

Over the years, the *CHA* has been extremely effective in preserving the publicly funded character of physician and hospital services. As of 2008, the Canadian Institute for Health Information (CIHI) has estimated that 98.4% of physician and 90.7% of hospital expenditures are publicly funded.⁵ The dividing line of the *CHA* may be seen in virtually all other categories of service. Fewer than one-half of prescription drugs (44.5%) and less than one-tenth (6.9%) of the services of other health professionals (e.g., dentistry and vision care) are publicly covered. Canada is unique among industrialized countries in its approach to Medicare. Countries with social insurance (Bismarck) funded systems tend to

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provide a similar total level of public expenditure over a wider range of services.

Over time, as health care has moved from institutions to the community, the *CHA* is diminishing with respect to the share of total health spending it covers. At the time the *CHA* was passed, physician and hospital services represented 57% of total health spending; this has declined to 41% as of 2008. It must be emphasized that there is significant public spending beyond *CHA*-covered services (in excess of 25% of total spending) for programs such as seniors' drug coverage and home care; however, those programs are not subject to the *CHA*'s program criteria. In addition, they can be subject to arbitrary cutback. While a majority of the working age population and their families are covered by private health insurance, those with lower incomes are less likely to have such benefits. Since the late 1990s, notwithstanding the widely shared concern about the sustainability of Canada's Medicare program, several high profile studies have advocated for its expansion, starting with the 1997 *Report of the National Forum on Health*⁶ and latterly with the Kirby⁷ and Romanow⁸ reports in 2002, both of which strongly recommended home care and catastrophic drug coverage. There is also growing concern about the availability of so-called "orphan drugs" that treat rare diseases such as Fabry disease, and can cost hundreds of thousands of dollars per patient for a single year of treatment.

First Ministers have concluded three health accords in 2000⁹, 2003¹⁰ and 2004¹¹, each of which addresses expanding the boundaries of Medicare. To date there are a series of unfulfilled commitments from these accords, including a national basket of home care services and first-dollar coverage for home care and catastrophic drug coverage. In its 2007 report, the Health Council of Canada summarized progress on catastrophic drug costs as "disappointing."¹²

There is no appetite among governments in Canada to implement new universal programs with first-dollar coverage. In fact, recently governments have removed services that had previously been publicly insured, as evidenced by

recent examples such as physiotherapy and chiropractic services in some jurisdictions.

General Principles

The CMA puts forward the following principles for funding the continuum of care in a national context, recognizing that there will continue to be a mix of public-private funding.

- Canadians should take personal responsibility to plan ahead for the contingency that they may eventually require support with their activities of daily living;
- home care and long-term care should be delivered in appropriate and cost-effective settings that respect patient and family preferences;
- there should be quality and accreditation standards for both public and private service delivery;
- there should be uniform approaches to needs assessment for home care and long-term care;
- there should be a uniform means of distinguishing the medically necessary component of home care and long-term care from the accommodation component;
- there should be a means of mitigating against open-ended public coverage of pharmaceutical, home care and long-term care coverage;
- there should be recognition and financial support for informal care givers;
- there should be consideration of risk-pooling, risk adjustment and risk sharing¹ between public and private funders/providers of pharmaceutical, home care and long-term care coverage;
- there should be a uniform approach to individual/household cost-sharing (e.g., copayments and deductibles); and

¹ Risk pooling is defined by the World Health Organization as the practice of bringing several risks together for insurance purposes in order to balance the consequences of the realization of such individual risk. Risk adjustment and risk sharing are means of adjusting or compensating for risk differentials between risk pools.

- provision should be made for pre-funding long-term care from public and private sources.

government to build capacity at the local level.

Prevention and Health Promotion

The continuum of care begins with prevention and this requires a strong public health foundation that includes the core elements of population health assessment, health surveillance, health promotion, disease and injury prevention and health protection.¹³ An investment in public health, including health promotion and disease prevention, is critical to the future health of Canadians.

One important component of effective prevention is immunization. The National Immunization Strategy was implemented in 2001 with the goal of reducing vaccine preventable diseases and improving vaccine coverage rates. The 2004 federal budget allocated \$400 million to support this strategy and in 2007, \$300 million was set aside in the federal budget for a Human Papillomavirus Immunization program. However, permanent funding should be allocated towards immunization programs for all illnesses that are preventable through vaccinations.

The federal government also has a role to play in establishing and promoting partnerships that will enhance prevention and promotion programming down to the local level.

The CMA recommends that:

the federal government continue funding of the national immunization strategy consistent with the original three-year funding program;

governments fund appropriate additions to the vaccination schedule, as new vaccines are developed, within the context of a national immunization strategy; and

the federal government establish a Public Health Infrastructure Renewal Fund (\$350 million annually) to build partnerships between all levels of

Pharmaceuticals

Prescription drugs are the fastest growing item in the health envelope. Over the past two decades, prescription drugs as a proportion of total health spending have doubled from 7% in 1986 to an estimated 14.6% in 2008, and they are now the second largest category of health expenditure. It is estimated that less than one-half (44.5%) of prescription drug costs were paid for publicly in 2008; just over one-third (37.1%) were paid by private insurers and almost one-fifth (18.4%) out-of-pocket.

The studies reported in 2002 by the Senate Standing Committee on Social Affairs, Science and Technology (Kirby) and by the Commission on the Future of Health Care in Canada (Romanow) have forged a consensus on the need for “catastrophic” pharmaceutical coverage, which may be defined as out-of-pocket prescription drug expenditures that exceed a certain threshold of household income.

In the Kirby proposal, in the case of public plans, personal prescription drug expenses for any family would be capped at 3% of total family income. The federal government would then pay 90% of prescription drug expenses in excess of \$5,000. In the case of private plans, sponsors would have to agree to limit out-of-pocket costs to \$1,500 per year, or 3% of family income (whichever is less). The federal government would then agree to pay 90% of drug costs in excess of \$5,000 per year. Both public and private plans would be responsible for the difference between out-of-pocket and \$5,000, and private plans would be encouraged to pool their risk. Kirby estimated that this plan would cost approximately \$500 million per year. For his part, Romanow recommended a Catastrophic Drug Transfer through which the federal government would reimburse 50% of the costs of provincial and territorial drug insurance plans above a threshold of \$1,500 per year. Romanow estimated that this would cost approximately \$1 billion.

The National Pharmaceuticals Strategy (NPS) has continued to explore cost projections of catastrophic pharmaceutical coverage, leaning toward a variable percentage threshold linked to income but there has been no public reporting on progress since 2006.¹⁴ At their September 2008 meeting, provincial/territorial health ministers called for the federal government to be an equal partner (50/50) to support a national standard of pharmacare coverage so that prescription drug costs will not exceed 5% (on average) of the net income base of provincial/territorial populations. The total estimated cost of such a program for 2006 was estimated at \$5.03 billion.¹⁵

Data from Statistics Canada indicate that there is wide variation in levels of household spending on prescription drugs in Canada. In 2006 almost one in twenty (3.8%) households in Canada spent more than 5% of net income on prescription drugs; there was almost a five-fold variation across the provinces, ranging from 2.2% in Ontario to 10.1% in Prince Edward Island.¹⁶

Canada does not have a nationally coordinated policy in the area of very costly drugs that are used to treat rare diseases. Moreover, there is also an issue of expensive drugs that may be used for common diseases (wide variation has been documented across provinces/territories).

Thus far the term “catastrophic” has been used by First Ministers and the NPS to describe their vision of national pharmaceutical coverage. As defined by the World Health Organization catastrophic expenditure reflects a level of out-of-pocket health expenditures so high that households have to cut down on necessities such as food and clothing and items related to children’s education.¹⁷ From the CMA’s perspective, this does not go far enough and what must be strived for is “comprehensive” coverage that covers the whole population and effectively pools risk across individuals and public and private plans in various jurisdictions.

The CMA recommends that:

governments, in consultation with the life and health insurance industry and the

public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial/territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies;

such a program should include the following elements:

- *a mandate for all Canadians to have either private or public coverage for prescription drugs;*
- *a uniform income-based ceiling (between public and private plans and across provinces/territories) on out-of-pocket expenditures on drug plan premiums and/or prescription drugs (e.g., 5% of after-tax income);*
- *FPT cost-sharing of prescription drug expenditures above a household income ceiling, subject to capping the total federal and/or provincial/territorial contributions either by adjusting the federal share of reimbursement or by scaling the household income ceiling or both;*
- *group insurance plans and administrators of employee benefit plans to pool risk above a threshold linked to group size; and,*
- *a continued strong role for private supplementary insurance plans and public drug plans on a level playing field (i.e., premiums and co-payments to cover plan costs);*

the federal government establish a program for access to expensive drugs for rare diseases where those drugs have been demonstrated to be effective;

the federal government assess the options for risk pooling to cover the inclusion of

expensive drugs in public and private drug plan formularies;

the federal government provide adequate financial compensation to the provincial and territorial governments that have developed, implemented and funded their own public prescription drug insurance plans;

governments provide comprehensive coverage of prescription drugs and immunization for all children in Canada; and

the Canadian Institute for Health Information and Statistics Canada conduct a detailed study of the socio-economic profile of Canadians who have out-of-pocket prescription drug expenses to assess barriers to access and to design strategies that could be built into a comprehensive prescription drug coverage program.

Home Care

Home care began in Canada in the late 19th century as a charitable enterprise delivered by non-profit groups such as the Victorian Order of Nurses. In the expansionary period of the 1960s and 1970s, governments moved increasingly into this area. The New Brunswick Extra-Mural Program, arguably Canada's most successful/ambitious home care program, accepted its first clients in 1981. The *Established Programs Financing Act* of 1977 recognized home care as one of several extended health services and included a fund initially set at \$20 per capita to cover such services. These extended services are also recognized in the *CHA* but are not subject to the five program criteria (principles). The 1997 *Report of the National Forum on Health* recommended that home care be added to Medicare (along with pharmacare). The \$150 million Health Transition Fund supported several demonstration projects in the home care area. Both the Kirby and Romanow reports recommended expanded home care funding. In February 2003, First Ministers concluded an

accord in which they committed to determine a basket of home care services by 30 Sept. 2003, covering short-term acute home care, community mental health and end-of-life care. To date this has not happened. The federal government implemented a Compassionate Care Benefit in 2003 to support family caregivers; however, this only applies to those who are in the paid labour force.¹⁸

According to the Canadian Institute for Health Information, there is almost a five-fold variation in the use of home care across provinces/territories.¹⁹ The extent of private expenditure on home care services is not presently known. However, Statistics Canada has reported that the proportion of Canadians living in the community who require assistance with their personal activities of eating, bathing and dressing who are receiving government-subsidized home care declined from 46% in 1994-1995 to 35% in 2003; the suggestion is that some of the burden may have shifted to home care agencies or family and friends.²⁰ Statistics Canada has reported that in 2002, over 1.7 million adults aged 45 to 64 provided informal care to almost 2.3 million seniors with long-term disabilities or physical limitations.²¹

In light of the foregoing, the CMA believes that:

optimal management of the continuum of care requires that patients take an active part in developing their care and treatment plan, and in monitoring their health status;

the issue of the continuum of care must go beyond the question of financing and address questions related to the organization of the delivery of care and to the shared and joint responsibilities of individuals, communities and governments in matters of health care and promotion, prevention and rehabilitation;

support systems should be established to allow elderly and disabled Canadians to optimize their ability to live in the community;

strategies should be implemented to reduce wait times for accessing publicly funded home and community care services;

integrated service delivery systems should be created for home and community care services; and

any request for expanding the public plan coverage of health services, in particular for home care services and the cost of prescription drugs, must include a comprehensive analysis of the projected cost and potential sources of financing for this expansion.

The CMA recommends that:

governments adopt a policy framework and design principles for access to publicly funded medically necessary services in the home and community setting that can become the basis of a “Canada Extended Health Services Act;”

governments initiate a national dialogue on the Canada Health Act in relation to the continuum of care;

governments and provincial/territorial medical associations review physician remuneration for home and community-based services; and

governments undertake pilot studies to support informal caregivers and long-term care patients, including those that:

- a) explore tax credits and/or direct compensation to compensate informal caregivers for their work,*
- b) expand relief programs for informal caregivers that provide guaranteed access to respite services in emergency situations,*
- c) expand income and asset testing for residents requiring assisted living and long-term care, and*

- d) promote information on advance directives and representation agreements for patients.*

Mental Health Care

In 2000 mental illness was the fourth-ranking contributor to the total economic burden of illness in Canada.²² The exclusion of psychiatric hospitals from the CHA means that they are not subject to the five principles and were not included in the original basis of the federal transfer payments. While a major Senate Committee report has pointed out that the closure of psychiatric facilities means that this exclusion is no longer pertinent, the Committee also noted that many essential services for persons with mental illness such as psychological services or out-of-hospital drug therapies are not covered under provincial health insurance plans.²³ Moreover, there remain 53 psychiatric hospitals in Canada.²⁴

The CMA recommends that:

the federal government make the legislative and/or regulatory amendments necessary to ensure that psychiatric hospital services are subject to the five program criteria of the Canada Health Act;

in conjunction with legislative and/or regulatory changes, funding to the provinces/territories through the Canada Health Transfer be adjusted to provide for federal cost sharing in both one-time investment and ongoing cost of these additional insured services; and

Canadian physicians and their organizations advocate for parity of allocation of resources (relative to other diseases) toward the continuum of mental health care and research.

Long-term Care

According to Statistics Canada’s most recent population projections, the proportion of seniors in the population (65+) is expected to almost

double from its present level of 13% to between 23% and 25% by 2031.²⁵ The Organization for Economic Cooperation and Development has projected that the share of Gross Domestic Product devoted to long-term care will at least double from its 2005 level of 1.2% to 2.4% by 2050, and could almost triple to (3.2%) depending on the success of efforts to contain cost.²⁶

The potential need for long-term care is not confined to the senior population. Based on the results of its 2006 Participation and Activity Limitation Survey, Statistics Canada estimated that there were 2 million adults aged 15-64 with disabilities, of whom 40% were severely disabled; in addition there were 202,000 children with disabilities, of whom 42% were severely disabled.²⁷

A lack of appropriate long term care is imposing a bottleneck in the acute care system. The term Alternate Level of Care (ALC) is used to describe a situation when a patient is occupying a bed in a hospital and does not require the acute care provided in this setting. According to a 2009 CIHI report, in 2007-08, there were more than 74,000 ALC patients and more than 1.7 million ALC hospital days in Canada (excluding Manitoba and Quebec), accounting for 5% of hospitalizations and 14% of hospital days. In other words, every day almost 5,200 beds in acute care hospitals were occupied by ALC patients²⁸.

This has significant consequences; emergency departments are being used as holding stations while admitted patients wait for a bed to become available, surgeries are being postponed, and the care for ALC patients may not be as good as it might be in an alternate site that is better equipped to suit their specific needs. Insufficient access to long term care at all ages is an obstacle to improving the health care system. Major investment is required in community and institutionally based care.

Most of the discussion in Canada since the mid-1990s has focused on the sustainability of the current Medicare program and the prospect for enhancements such as pharmacare. There has been little attention since the early 1980s on the

future funding of long-term care. Internationally, in contrast, the United Kingdom has had a Royal Commission on long-term care, and Germany has moved to put in place a contributory social insurance fund.

A cursory assessment of the literature would suggest that there is a consensus that long-term care cannot/should not be financed on the same pay-as-you-go basis (i.e., current expenditures funded out of current contributions) as medical/hospital insurance programs.

The federal government has several options available to promote the pre-funding of long-term care:

Long-term care insurance: Policies are offered in Canada and are of fairly recent origin. There has been little take-up of such policies to date. At the end of 2005, about 52,700 Canadians were covered under long-term care insurance. One option could be to make long-term care insurance premiums deductible through a tax credit, similar to what Australia has done for private health insurance.

Tax-deferred savings: The Registered Retirement Savings Plan (RRSP) has been a very popular method for Canadians to save for retirement. As of 2007, an estimated 7 out of 10 (68%) of Canadians reported having an RRSP. However, in 2002, just 27% of all tax returns filed in Canada reported deductions for RRSP contributions. In 1998, Segal proposed a Registered Long-term Care Plan that would allow Canadians to save against the possibility of their need for a lengthy period of care. Another option to consider would be to add a provision to RRSPs similar to the Lifelong Learning Plan and the Home Buyer's Plan. This would be referred to as the Long-term Care Plan and would allow tax-free withdrawals from RRSPs to fund long-term care expenses for either the RRSP investor's own care or their family members' care.

Tax-prepaid saving: In Canada, the Registered Education Savings Plan (RESP) is an example of a plan whereby after-tax earnings are invested and allowed to grow tax-free until they are distributed

and included in the recipient's income. In the 2007 federal budget, the government announced the introduction of a Registered Disability Savings Plan. Parents and guardians will be able to contribute to a lifetime maximum of \$200,000 and similar to the RESP program there will be a related program of disability grants and bonds, scaled to income. This approach could have more general applicability to long-term care. The 2008 federal budget has introduced a tax-free savings account (TFSA) that, starting in 2009, enables those 18 and over to contribute up to \$5,000 per year in after-tax income to a TFSA, whose investment growth will not be taxed; however, funds can be withdrawn at any time for any purpose²⁹.

Payroll deduction (Social Insurance): A compulsory payroll tax that would accumulate in a separate fund along the lines of the Canada Pension Plan has been recommended in provincial reports in Quebec and Alberta.

In summary, whatever vehicle might be chosen, governments need to impress upon younger Canadians the need to exercise personal responsibility in planning for their elder years, given continuing gains in longevity.

The CMA recommends that:

governments study the options for pre-funding long-term care, including private insurance, tax-deferred and tax-prepaid savings approaches, and contribution-based social insurance; and

the federal government review the variability in models of delivery of community and institutionally based long-term care across the provinces and territories as well as the standards against which they are regulated and accredited.

End-of-life Care

The Senate of Canada, and the Honourable Sharon Carstairs in particular, have provided leadership over the last decade in highlighting both the

progress and the persistent variability across Canada in access to quality end-of-life care. In the latest (2005) of three reports issued since 1995, the Senate again calls for the development of and support for a national strategy for palliative and end-of-life care.³⁰ In that report *Still Not There* it is noted that it is commonly estimated that no more than 15% of Canadians have access to hospice palliative care, and that for children, the figure drops further to just over 3%. To date, palliative care in Canada has primarily centred on services for those dying with cancer. However, cancer accounts for less than one-third (30%) of deaths in Canada. Diseases at the end of life such as dementia and multiple chronic conditions are expected to become much more prevalent in the years ahead. The demand for quality end-of-life care is certain to increase as the baby boom generation ages. By 2020 it is estimated that there will be 40% more deaths per year. While there has been a decreasing proportion of Canadians dying in hospital over the past decade, many more Canadians would prefer to have the option of hospice palliative care at the end of life than current capacity will permit. In its April 2009 report, the Special Senate Committee on Aging recommended a federally funded national partnership with provinces, territories and community organizations to promote integrated quality end-of-life care for all Canadians, the application of gold standards in palliative home care to veterans, First Nations and Inuit and federal inmates, and renewed research funding for palliative care.³¹

The CMA recommends that:

governments work toward a common end-of-life care strategy that will ensure all Canadians have equitable access to and adequate standards of quality end-of-life care.

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