**Funding to Improve Access by Canadians to Home and Community Services**

As associations advocating for seniors, we call for better access to health care services that would enable older Canadians to remain in their homes and communities, as is their usual wish, and to reduce reliance on more expensive hospital infrastructure.

After the demise of the 10-year federal, provincial, and territorial (FPT) Health Accord in 2014, and with no new national accord on the horizon, the newly-elected federal government (October, 2015) decided to adhere to the previous government’s decision to lower the annual escalator governing the Canadian Health Care (CHC)Transfer. Whereas the previous CHC Transfer was based on an annual escalator of 6%, the government in March, 2017 implemented a new escalator with a basis of 3%, which meant that provinces and territories would in fact be receiving less funding for health care. Then in August 2017 the federal government proposed to invest an additional $11 billion over a 10-year period. The new funding would target two aspects of the Canadian health care system: access to mental health and addiction (MHA) services and access to home and community care (HCC).

In a move to qualify for the additional funding, the provinces and territories, one by one, signed 10-year, bi-lateral agreements with the federal government, declaring their intention to work to improve mental health and addiction services and home and community care in their jurisdictions. By August 2017, all provinces and territories had formally accepted their share of the $11 billion in federal health funding, and endorsed a [Common Statement of Principles on Shared Health Priorities](https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/principles-shared-health-priorities.html), which outlines common priorities for action in home and community care, and in mental health and addiction services.

The priorities within the Statement would inform more detailed bi-lateral agreements to be developed between the federal government and the individual provinces and territories.[[1]](#footnote-1) The comprehensive agreements would outline specifically how each jurisdiction intended to use the funding to achieve the objectives articulated in the Statement. Each FPT jurisdiction would be expected to have its own priorities based on its unique circumstances, such as health delivery models for remote areas, limitations in data availability and infrastructure needs. Provincial and territorial governments agreed to have their progress monitored annually in accordance with the common objectives articulated in the Statement.

It was agreed that actions related to the objectives would be guided by these principles: the FPT Health Ministers would work together to achieve the stated objectives; they would develop best practices in the targeted areas, evaluate them and share them to stimulate improvement across health systems; and they would report data, relevant to the stated priorities and objectives, which would allow progress to be measured by the Canadian Institute for Health Information and reported annually and transparently to Canadians.

To date, eight detailed agreements between the federal government and provinces and territories have been posted at www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities.html.

The Common Statement of Principles on Shared Health Priorities makes little specific reference to the provision of mental health care access for seniors. Instead the priorities emphasize services for children and youth (age 10 to 25), and general mental health care interventions as they integrate with “primary health care services . . . and community-based mental health and addiction services for people with complex health needs.”

Given that the new bilateral agreements are not charged with addressing mental health services usually specific to older persons, this review will examine the bilateral agreements as they focus upon services that may affect older Canadians directly: the ways in which provinces and territories plan to improve access to home and community care and to end-of-life and palliative care services. The bi-lateral FPT agreements are of particular significance to us as they promise greater access to the kind of care that increases our chances of independence in later years and enhances our quality of life.

In January 2018 work groups and key sector and measurement experts decided that improved access to services will be demonstrated by the following actions:

1. Selecting models that integrate and connect home and community care with primary health care, and spreading and scaling those models throughout the health care system.
2. Enhancing access to palliative and end-of-life care at home or in hospices
3. Increasing support for caregivers
4. Enhancing home care infrastructure through digital connectivity, remote monitoring technology and facilities for community-based service delivery

The work groups decided that access to home and community care, including palliative and end-of-life care across Canadian jurisdictions, could be measured by focusing on client outcomes, client and caregiver experiences, community palliative care, coordination of care, multiple contacts with the health system, unmet needs and wait times.

It is expected that these priorities and actions will be reflected in the detailed agreements between the FPT governments.

A Summary of the Bi-lateral Agreements (Appendix 1)

1. a report by the Canadian Institute for Health Information. 2018 [↑](#footnote-ref-1)