The Senate

Standing Senate Committee on Social Affairs, Science and Technology

The Health of Canadians – The Federal Role

Highlights

Final Report on state of the health care system in Canada

Chair:
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Volume Six: Recommendations for Reform

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INTRODUCTION

The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.

Benjamin Disraeli – July 24, 1877

It is to the Canadian people, and their improved health, that the Committee dedicates this report.

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This report is the culmination of a two-year study by the Standing Senate Committee on Social Affairs, Science and Technology. During this period, the Committee heard the views of over 400 witnesses, many of whom were representatives of organizations that have thousands of members. The Committee wishes to express its sincerest thanks for the effort these witnesses made to give us their advice on what needs to be done to reform Canada's health care system and to make it fiscally sustainable.

As one would expect, given the complex, ideological and political nature of health care issues, the advice we received was often conflicting. Nevertheless, the Committee considered seriously the views of all the witnesses in arriving at our recommendations.

The recommendations in this report reflect the *unanimous* view of the eleven Senators on the Committee (seven Liberals, three Progressive Conservatives, and one Independent). The experience of the eleven Committee members in public policy and health related issues is as deep as it is varied. The Committee includes:

- two doctors: Yves Morin, a former Dean of Medicine at Laval University, and Wilbert Keon, the Founder and Director General of the Ottawa Heart Institute;
- two former provincial ministers of health: Brenda Robertson and Catherine Callbeck, who was also a provincial premier;
- two former Members of Parliament: Douglas Roche and Lucie Pépin, who was also a nurse;
- a former federal cabinet minister and former journalist: Joyce Fairbairn;
- two long-time community activists: Joan Cook, who served for many years on various hospital boards, and Jane Cordy, who was also a teacher;

- two former senior members of a Prime Minister's office: Marjory LeBreton and Michael Kirby, who was also a former federal Secretary to the Cabinet for Federal Provincial Relations.

The Committee believes that its recommendations meet the *four objectives* the *Committee set for itself at the outset of its work*:

1. To formulate a detailed, concrete *plan of action.* The recommendations should not focus primarily on governance issues or intergovernmental structures;
2. To attach a *cost* to the Committee's recommendations and propose a specific *revenue raising plan.* For its proposals to be truly useful, the Committee believed that it must not be vague on the question of precisely how its recommendations would be funded;
3. To specify clearly the *changes* that each of the major stakeholders – individual Canadians, health care professionals, provincial and federal governments – would have to make in order for the Committee's reform plan to be successfully implemented.
4. To make clear the *consequences of not changing,* and hence of not reforming, the health care system.

The Committee believes it has worked out a detailed, concrete and realistic plan, which, if implemented integrally, would lead to the strengthening of the publicly funded health care system in Canada and help guarantee its fiscal sustainability for the foreseeable future.

The Committee believes that there is a real window of opportunity at this time for implementing the kind of reform that is needed to ensure the long-term sustainability of Canada's health care system.

The recommendations contained in Volume Six can be grouped into six categories:

- recommendations for restructuring the current hospital and doctor system to make it more efficient and more effective in providing timely and quality patient care;
- recommendations with respect to the "health care guarantee" that would ensure that patients would have to wait no longer then a specific maximum amount of time for major hospital or diagnostic procedures. At the end of the waiting time, the "health care guarantee" would require the insurer/government to pay the cost of the patient receiving the necessary service in another jurisdiction or another country;
- recommendations for expanding public insurance to include coverage for catastrophic prescription drug costs, immediate post-hospital home care costs and costs of providing palliative care for patients who choose to spend the last weeks of their life at home;
- recommendations that strengthen the federal contribution to, and role in, health care infrastructure, including health information systems, health care technology, the evaluation of health care system outcomes, health care human resources

supply, health research, health promotion and protection and the nation's sixteen Academic Health Science Centres;

- recommendations with respect to how additional federal revenue should be raised, and administered in a transparent and accountable manner in order to implement the recommendations in this report;
- observations about the consequences that would arise if the additional federal revenues that the Committee recommends be raised are *not* invested in the health care system.

As some of these recommendations will require the financial participation of the provincial and territorial governments if they are to be implemented, the Committee is keenly aware of the importance of fostering a spirit of cooperation and collaboration amongst the various levels of government in the course of working to reform and renew Canada's health care system.

CHAPTER ONE

THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS

Federal policy in health care should be designed to achieve two objectives:

- ***To ensure that every Canadian has timely access to all medically necessary services regardless of their ability to pay for these services.***
- ***To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.***

The *Canada Health Act*

The Committee supports the five principles of the *Canada Health Act*, namely:

- The principle of universality, which means that public health care insurance must be provided to all Canadians;
- The principle of comprehensiveness, which is meant to guarantee that all medically necessary hospital and doctor services are covered by public health care insurance;
- The principle of accessibility, which means that financial barriers to the provision of publicly funded health services, such as user charges, are discouraged, so that needed care is available to all Canadians regardless of their income;
- The principle of portability, which means that all Canadians are covered under public health care insurance, even when they travel within Canada or move from one province to another.
- The principle of public administration, which means that hospital and doctor services are publicly funded through a single payer insurance system. (This principle refers to the *funding* of hospital and doctor services, not to the *delivery* of those services.)

- *None of the recommendations in this report require any change to the* Canada Health Act.

The Current System is Not Fiscally Sustainable

- The Committee has concluded that Canada's publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels.
- New federal money must be used to buy change, not merely to support the system as it is presently structured.

The Role of a National Health Care Commissioner and National Health Care Council

- It is essential to improve the governance of Canada's health care system.
- The Health Care Commissioner, and the associated National Health Care Council, as recommended by the Committee would:
    - be national, not purely federal in structure
    - be independent of government
    - build on the strengths of existing organizations, such as the Canadian Institute for Health Information (CIHI) and the Canadian Council for Health Services Accreditation (CCHSA)
    - be funded by the federal government at a cost of $10 million annually
- The Health Care Commissioner, and the associated National Health Care Council, would produce an annual report to the Canadian public on the state of the nation's health care system and on the health status of Canadians. Essentially, this report would be a public accounting of how the health care system is evolving and how the health status of Canadians is changing.
- The Commissioner and the Council would also advise the federal government on how new money raised to reform and renew the health care system in the ways recommended in this report should be spent.

CHAPTER TWO

HOSPITAL RESTRUCTURING AND FUNDING IN CANADA

The lack of costing data with respect to hospital services is inconsistent with our vision of what a 21st century service sector ought to be: that is, a sector capable of providing timely and high-quality care on the basis of strong evidence-based decision making and held accountable as a result of governments (and the public) knowing what services, in what hospitals, are provided efficiently and those that are not.

The Need for Service-Based Funding for Hospitals

- Current hospital funding mechanisms, which are based primarily on funding inputs and not on final outcomes, must be changed to a funding mechanism that focuses on paying for the delivery of specific hospital services that meet specific performance criteria.
- A shift from the current lump sum, or global, funding method for hospitals to a *service-based funding* method is essential.
- Service-based funding has numerous advantages over the methods currently used to finance hospitals in Canada including:
    - much improved focus on patient-oriented service delivery
    - significant incentives for institutions to improve operating efficiencies and quality performance
    - creating competition between institutions to provide the best services
    - encouraging the establishment of "centres of excellence"
    - making the funder neutral on the ownership structure of the institution
    - improving transparency and accountability with respect to the performance of individual institutions
    - giving institutions greater operating independence from government
    - leading to a reduction in the size of provincial health departments

Academic Health Sciences Centres

- An Academic Health Sciences Centre consists of a university medical school and its affiliated teaching hospitals and/or regional health authority. There are sixteen Academic Health Sciences Centres in Canada.
- Academic Health Sciences Centres constitute a *national* resource in the Canadian health care system. They are a crucial part of the health care infrastructure in Canada.
- Because of their national character, the federal government should contribute substantially to sustaining capital investment in Academic Health Sciences Centres across the country.
- The federal government should contribute $4 billion over the next ten years (or $400 million annually) to Academic Health Sciences Centres for the purpose of renewing their badly deteriorated physical facilities.

Community Hospitals in Rapidly Growing Areas

- While community hospitals are a provincial responsibility, the federal government should assist in meeting the capital needs of community hospitals in areas of exceptionally high population growth; that is, areas whose population growth exceeds their provincial average by 50%. Examples of such areas are: Calgary, Abbotsford, Vancouver, Halifax, Oshawa, Toronto, Montreal, and Saskatoon.
- The federal government should provide half of the capital investment needed in community hospitals in exceptionally high-growth areas. This is estimated to be $150 million annually for ten years.

CHAPTER THREE

DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES

Regional health authorities have done a commendable job of integrating and organizing health services for people in their regions during the last decade in Canada. They should now be given more responsibility and authority for delivering and/or contracting for the* full range *of publicly insured health services.

- Now is the time for regional health authorities to be given greater control over the *full range* of health care spending in their region.
- Regional health authorities in major urban centres should be given control over the cost of physician services in addition to their responsibility for hospital services in their regions.
- Authority for prescription drug spending should also be devolved to regional health authorities.
- Regional health authorities should be able to choose between providers (individual or institutional) on the basis of quality and costs, and to reward the best providers with increased volume.
- Regional health authorities should establish clear contracts specifying volume of services and performance targets with various providers, both individuals and institutions.
- Consistent with the recommendations in Chapter Two, regional health authorities should use service-based funding as the method of remunerating health care institutions when they purchase hospital services on behalf of the residents of their region.

CHAPTER FOUR

PRIMARY HEALTH CARE REFORM

The creation of primary health care groups is central to reform of primary health care delivery. Every major provincial report issued in recent years has recommended some version of primary health care reform.

- Primary health care constitutes a patient's first point of contact with the health care system and includes the diagnosis, treatment and management of health problems, prevention and health promotion, and ongoing support.
- The federal government should continue to work with the provinces and territories to reform primary health care delivery.
- The federal government should provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care groups that:
    - are working to provide a broad range of services, 24 hours a day, 7 days a week
    - strive to ensure that services are delivered by the most appropriately qualified health care professional
    - utilise to the fullest the skills and competencies of a diversity of health care professionals, including particularly nurse practitioners
    - adopt alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae
    - seek to integrate health promotion and illness prevention strategies in their day-to-day work
    - fully integrate electronic patient health records into the delivery of care
    - progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.
- The federal government should commit $50 million per year to assist the provinces in setting up primary health care groups. This is in addition to the $800 million that the federal government is contributing to primary health care reform under the September 2000 federal/provincial/territorial health care funding agreement.

CHAPTER FIVE

TIMELY ACCESS TO HEALTH CARE

In the Committee's opinion, the continued failure to deliver health services in the publicly funded system in a timely manner, as evidenced by long waiting lists for services, is likely to lay the foundation for a successful Charter challenge to laws that prevent or impede Canadians from personally paying for medically necessary services in Canada, even if these services are included in the set of publicly insured health services.

- Governments *must* address the waiting time problem.
- Canadians cannot, and should not, be prevented from having access to *timely* health care in Canada.
- Timely access means that service has been provided consistent with clinical practice guidelines, which ensure that the patient's health is not being negatively affected while waiting for care.
- Timely access does *not* mean providing service at the moment the patient wants it.
- Solving the timely access problem is *critical* if Canada is to preserve the single insurer model of the publicly funded hospital and doctor system that Canadians, and the Committee, so strongly support.
- When timely access to appropriate care is not available in the publicly funded health care system, the prohibition of private payment for health services becomes impossible to justify.
- The failure to effectively address the issue of the lack of access to timely care is highly likely to lead, as a result of court decisions, to the establishment of a parallel private hospital and doctor system.
- *Governments should not be passive* and wait for the courts to determine how Canadians will gain timely access to medically necessary care.

CHAPTER SIX

THE HEALTH CARE GUARANTEE

A health care guarantee would ensure that for every type of major procedure or treatment, a maximum waiting time would be established and patients would be entitled to receive service within that time frame.

- For each type of major procedure or treatment, *a maximum needs-based waiting time should be established and made public.*
- When this maximum waiting time is reached, the insurer (government) should pay for the patient to *immediately* receive the procedure or treatment in another jurisdiction including, if necessary, another country (e.g. the United States). This is called the *Health Care Guarantee.*
- The length of waiting time at which this health care guarantee would become operable would be based on an assessment of when a patient's health or quality of life would deteriorate significantly as a result of waiting longer for the procedure.
- Waiting times would be established by scientific bodies using clinical, evidence-based criteria.
- Maximum waiting times should apply nationally.
- *A health care guarantee* should be put in place as a result of a federal-provincial-territorial agreement.
- If such an agreement is not possible, the health care guarantee should be put in place by federal legislation that should include the same type of financial penalties as are contained in the *Canada Health Act.*

CHAPTER SEVEN

EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS

No Canadian should suffer undue financial hardship as a result of having to pay health care bills. It is essential that this principle be applied to prescription drug expenses.

- Many Canadians have no coverage at all for prescription drugs.
- Financial hardship due to high prescription drug expense is increasingly a real risk for many Canadians.
- Under the Committee's proposed plan, no Canadian individual or family would ever be obliged to pay out of pocket more than 3% of total family income for prescription drugs:
    - the first $5000 in prescription drug expenses would be paid for by some combination of (a) provincial/territorial public plans, (b) private supplementary insurance plans, and (c) individual contributions; but individual out-of-pocket expenses would be capped at 3% of family income
    - an individual's prescription drug costs would be deemed to be "catastrophic" if the *total* cost of those drugs exceeds $5000 in any given year (regardless of how they were paid for).
    - The federal government would pay for 90% of prescription drug costs that exceed $5000; the remaining 10% would be paid by either a provincial/territorial or a supplementary private insurance plan
- The Committee's proposed plan builds on, rather than replaces, Canada's extensive current systems of provincial prescription drug coverage and private supplementary drug insurance plans.
- In order to ensure uniformity of coverage throughout the country, and in order to be able to regulate which drugs are eligible to be covered under this program, it will be necessary to establish a *national drug formulary* in which the federal government plays a major role.

- The net result would be a real step forward for those Canadians (roughly 600,000 people) who currently have no protection against catastrophic prescription drug expenses and the 100,000 who currently have annual drug expenses exceeding $5000.
- The plan would also protect all other Canadians as prescription drug costs rise in the future.
- Implementing this federal initiative to protect all Canadians against catastrophic prescription drug costs would cost approximately $500 million per year.

CHAPTER EIGHT

EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE

The need for home care will become a major challenge as the baby boomers age, average life expectancy rises, health care delivery becomes both more de-institutionalized and more technologically complex, and as work and social patterns decrease the availability of informal care-giving by family members.

- Post-acute home care costs should be publicly funded under Medicare because they are incurred as a direct extension of hospital care.
- An episode of post-acute home care is defined as all home care services received between the first date of service provision following hospital discharge, if that date occurs within thirty days of discharge, and up to three months following hospital discharge.
- The funding for post-acute home care should be administered by hospitals.
- Directing the funding for the provision of post-acute home care to hospitals will allow them to benefit from the potential cost-savings associated with shorter lengths of stay, thereby encouraging the uptake of home care and greater use of post-acute home care.
- Hospitals may provide the services themselves; or hospitals may contract with not-for-profit or for-profit home care service providers, or hospitals may contract with third party agencies who in turn sub-contract with home care service providers.
- In order to encourage innovation and service integration, and to enhance the efficient and effective provision of necessary health care irrespective of the setting in which such care is received, a service-based method of reimbursement for post-acute home care should be developed in conjunction with service-based arrangements for each episode of hospital care.
- A National Post-Acute Home Care Program should be jointly financed with the provinces and territories on a fifty-fifty basis.
- The federal government share of a National Post-Acute Home Care Program is estimated to be approximately $550 million per year.

CHAPTER NINE

EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE

There is a clear need to ensure that proper palliative care is universally available, and that it is provided in a manner that respects the wishes of the dying person and his or her loved ones.

- Recent studies have estimated that while over 80% of Canadians die in hospital, fully 80-90% of Canadians would prefer to die at home, close to their families, living as normally as possible.
- Palliative care is designed to meet not only the dying person's physical needs but also his or her psychological, social, cultural, emotional and spiritual needs and those of his or her family as well.
- The federal government should make a substantial contribution to making palliative care available to Canadians in their homes.
- The federal government should contribute $250 million per year towards a national palliative home care program to be designed with the provinces and territories and co-funded by them on a fifty-fifty cost-sharing basis.
- The federal government should also consider other measures in order to alleviate the burden that now falls on the shoulders of thousands of informal caregivers.
- Many working Canadians are faced with stark choices as they try to balance the need to provide for their family with caring for a terminally ill family member.
- Minimizing the amount of lost income during this temporary but very difficult period would be an important first step toward improving the situation facing family caregivers of dying individuals.
- The federal government should examine the feasibility of providing Employment Insurance benefits for a period of six weeks to employed Canadians who choose to take leave to provide palliative care to a dying relative at home.
- The federal government should amend the Canada Labour Code to allow employee leave for family crisis situations, such as care of a dying family member, and should work with the provinces to encourage similar changes to provincial labour codes.

CHAPTER TEN

THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE

Health care technology, electronic health records and the evaluation of quality, performance and outcomes of the health care system are three areas of Canadian health care infrastructure which must be given priority by the federal government.

Electronic Health Records

- A system of electronic health records is an automated provider-based system within an electronic network that provides complete patients' health records in terms of visits to physicians, hospital stays, prescription drugs, laboratory tests, and so on.
- Both Canadians and their publicly funded health care system will benefit greatly if the system of electronic health records is national in scope.
- The federal government committed $500 million in 2000-2001 to a private not-for-profit corporation, known as Canada Health Infoway Inc. (or *Infoway*). *Infoway* is not a federal agency or a crown corporation, nor is it controlled by the federal government.
- The federal government should provide additional financial support of $2 billion over a 5-year period to Canada Health Infoway Inc. so that *Infoway* can develop, in collaboration with the provinces and territories, a national system of electronic health records.

Health Care Technology

- The availability of many new technologies continues to be disproportionately low in Canada in comparison with other OECD countries.
- The federal government should devote $2.5 billion over a five-year period to provide funding to hospitals for the express purpose of purchasing and assessing health care technology. Of this funding, $400 million should be allocated annually to Academic Health Sciences Centres, while $100 million should be provided annually to community hospitals on a 50-50 cost-shared basis. The funding for the Academic Health Sciences Centres should be 100 % federal.
- The institutions benefiting from this program should be required to report to the federal government on their use of such funding in order to ensure that it is used for its intended purposes.

Protection of Personal Health Information

- Health information technology provides a real opportunity for increased privacy protection through more effective security safeguards to restrict access and enhanced tracking features to audit all transactions.
- The following key issues require greater consistency and/or coordination across federal/provincial/territorial jurisdictions:
    - Need-to-know rules restricting access to authorized users based on their purposes;
    - Consent rules governing the form and criteria of consent in order to be valid;
    - Conditions authorizing non-consensual access to personal health information in limited circumstances and for specific purposes;
    - Rules governing the retention and destruction of personal health information; and,
    - Mechanisms for ensuring proper oversight of cross-jurisdictional electronic health record systems.
- The Committee believes that the benefits of an enhanced information technology system in health care can be achieved without jeopardizing the privacy of an individual's personal health information.

CHAPTER ELEVEN

HEALTH CARE HUMAN RESOURCES

Addressing the shortage of professionals in all health care disciplines and finding ways to increase their individual and collective productivity are two of the most pressing, yet complex, problems facing health care policy makers.

- One of the major consequences of the growing world-wide shortage of health care human resources is that Canada must develop a strategy to enable the country to become self-sufficient in this field.
- The federal government must play a much stronger role than it has to date in coordinating efforts to deal with health care human resources shortages.
- The federal government should work with other concerned parties to create a permanent National Coordinating Committee for Health Care Human Resources, to be composed of representatives of key stakeholder groups and of different levels of government.
- The federal government should contribute $160 million per year so that Canadian Medical Colleges can enrol 2,500 first-year students by 2005, which represents an increase of 640 students per year.
- The federal government should commit $90 million per year in order to enable Canadian nursing schools to graduate 12,000 nurses by 2008. This represents an increase of more than 2,600 graduates over the currently anticipated number for that year.
- The federal government should commit $40 million per year in order to assist the provinces in raising the number of allied health professionals who graduate each year.
- In order to facilitate the return of Canadian health care professionals working abroad, the federal government should consider adopting short-term tax incentives for expatriate health care professionals who are prepared to return to Canada, as it did in the 1960s when there was a shortage of qualified university professors.

- The federal government should work with the provinces to establish *national standards* for the evaluation of international medical graduates, and provide ongoing funding to implement an accelerated program for the licensing of qualified international medical graduates and their full integration into the Canadian health care system.
- Improving the productivity of health care professionals would reduce the number required in Canada. It is essential that detailed *productivity studies* of each of the major health care professions be undertaken. This issue should receive high priority for action.
- There is an urgent need for an *independent review* to be undertaken of scope of practice rules and other regulations affecting what individual health care professionals can and cannot do. The purpose of this review is to develop proposals that would enable the skills and competencies of diverse health care professionals to be utilized to the fullest and enable health services to be delivered by the most appropriately qualified professional.

CHAPTER TWELVE

NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH

Canada must increase its investment in health research in order to bring research funding up to the level of other industrialized countries.

Health Research Funding

- Good science will lead to improved health for Canadians and to the development of an efficient health care delivery system.
- Health research will lead to the creation of products and technologies that will improve the health of Canadians:
  - clinical trials supported by the Canadian Institutes of Health Research will lead to effective guidelines in clinical practice
  - population health research will lead to better health promotion and protection
  - health services research will lead to a more efficient health care system
  - the translation of research will lead to evidence-based clinical decision making
- Canada's challenge in health research is to attract and retain outstanding scientists. This requires predictable and multi-year research funding.
- Canada should increase its spending on health research to the level of 1% of total health care spending. This requires an additional investment of $440 million by the federal government.
- The federal government should commit to a five-year budget plan for the Canadian Institutes of Health Research.

The Ethics of Health Research

- The leading stakeholders of health research involving human subjects must work together to develop a governance system for health research involving human subjects.

CHAPTER THIRTEEN

HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE

There are enormous potential benefits to be derived from health and wellness promotion, disease and injury prevention, public health and health protection and population health strategies, measured primarily in terms of improving the health of Canadians, but also in terms of their positive long term financial impact on the health care system.

Healthy Public Policy

- The components of a healthy public policy are:
  - health and wellness promotion
  - illness and injury prevention
  - public health and health protection
  - population health strategies, including efforts to enhance literacy
- Additional funding in these fields is essential in order for Canada to develop healthy public policies that focus on improving the health and wellness of the population, rather than continuing the current policies that concentrate almost solely on curing people after they get sick.
- The federal government can and must play a leadership role in this area.

Chronic Disease Prevention

- About two thirds of total deaths in Canada are due to the following chronic diseases: cardiovascular disease (heart and stroke), cancer, chronic obstructive lung disease (bronchitis and emphysema) and diabetes.
- Poor diet, lack of exercise, smoking, stress and excessive alcohol intake – all lifestyle issues – are the leading social/behavioural risk factors for these diseases.
- Reducing these common lifestyle risk factors would greatly lessen the prevalence of these chronic diseases. This in turn would bring significant economic benefits.
- The federal government should take the lead in implementing a National Chronic Disease Prevention Strategy. This strategy should incorporate a combination of public education efforts, mass media programs and policy interventions.
- The federal government should commit $125 million for chronic disease prevention.

Public Health and Health Promotion

- A major problem with public health programs is that funding is low, and usually unstable or inconsistent.
- As a result, the public health care infrastructure in Canada is under considerable stress and has deteriorated substantially in recent years.
- The federal government should ensure strong leadership and provide additional funding of $200 million to sustain, better coordinate and integrate the public health infrastructure in Canada as well as relevant health promotion efforts.

CHAPTER FOURTEEN

HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED

A fiscally sustainable health care system is one upon which Canadians can rely both today and in the future. When considering the system's fiscal sustainability, two inter-related constraints must be taken into account. The first is the willingness of taxpayers to pay for the system. The second is the need for continued economic growth and the corresponding need for governments to keep tax rates at levels that do not damage Canada's ability to invest, create jobs and keep us relatively competitive with other OECD countries, and particularly with the United States.

More Money is Needed for Health Care

- There are real, continuing upward pressures on Canada's health care costs:
  - Drug costs
  - New technologies
  - Aging population
  - Cost of health care human resources
  - Growing public expectations
  - Health care restructuring
  - Gaps in the health care safety net

Increased Funding Must Come from New Sources

- Given all the competing demands for federal government expenditures, most additional health care funding from the federal government will have to come from *new* money, not from revenue transferred into the health care envelope from existing sources.

How New Federal Funding Should be Managed

- The federal government should not just give money to the provinces and territories without having a say in how that money is spent.
- Most new money should not be used to fund the publicly funded health care system as it is presently structured. New federal money given to the provinces and territories *must* buy change or reform.
- New federal funding for health care should not be given to the provinces and territories under the mechanism of the Canada Health and Social Transfer.
- Increased federal revenue for health care must go into an *earmarked fund* that is separate and distinct from the Consolidated Revenue Fund.
- The Health Care Commissioner, and the associated National Health Care Council, should advise the federal government on the priorities that should be attached to expenditures out of the earmarked fund. Their advice should be made public.
- An annual audit by the Auditor General of Canada of the earmarked fund should detail how the money in the fund has been spent; the results of the audit should be made public.

CHAPTER FIFTEEN

HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED

If the publicly funded health care system is to become fiscally sustainable, the people of Canada must be prepared to fund it collectively.

ADDITIONAL ANNUAL FEDERAL INVESTMENT NEEDED TO IMPLEMENT THE RECOMMENDATIONS IN THIS REPORT

Expansion and Restructuring	Federal Share (in Millions $)	Additional Information
Expansion of Coverage:		
▪ Post-Hospital Home Care[b]	550	Annually
▪ Catastrophic Drugs[a]	500	Annually
▪ Palliative Care[b]	250	Annually
Improving Efficiency and Effectiveness:		
▪ Health Care Technology (AHSCs)[c]	400	$2 billion over 5 years
▪ Capital Costs (AHSCs)[c]	400	$4 billion over 10 years
▪ Infoway (EHRs)[c]	400	$2 billion over 5 years
▪ Capital Costs (Community Hospitals)[b]	150	$1.5 billion over 10 years
▪ Equipment for Community Hospitals[b]	100	$500 million over 5 years
▪ Primary Health Care Reform[c]	50	$250 million over 5 years
▪ CIHI[c]	50	Annually
Promotion and Prevention:		
▪ Health Promotion and Protection[c]	200	Annually
▪ Prevention of Chronic Diseases[c]	125	Annually
Health Care Human Resources:		
▪ Medical Schools[c]	160	Annually
▪ Nursing Schools and Allied Professions[c]	130	Annually
▪ AHSCs (Post-Graduate Training)[c]	70	Annually
Research, Evaluation and Reporting:		
▪ Research Funded by CIHR[c]	440	Annually
▪ Health Care Commissioner[c]	15	Annually
▪ National System (CCHSA)[c]	10	Annually
Contingency (20%)	1,000	Annually
TOTAL	**5,000**	**Annually**

(a) 90% federal funding.
(b) 50/50 federal and provincial/territorial cost-sharing program.
(c) 100% federal funding.
(See list of abbreviations at the end of this chapter.)

The Amount of New Federal Funding Required

- About 30% of the proposed new federal funding will be spent on expanding public health care coverage and on health promotion and disease prevention.
- About 40% will enhance effectiveness and efficiency of the doctor and hospital system and support increased enrolment in the various health care professions.
- Another 10% of the proposed expenditures will be invested in health research, outcome evaluation and performance reporting.
- There is a 20% annual contingency to provide the necessary flexibility in federal investment.
- The Committee believes that an additional $5 billion is an amount that Canadians should be willing to invest annually in a health care system that meets the principles of the *Canada Health Act* and the objectives of Canadian health care policy.
- The additional $5 billion should *not* come from any existing or anticipated federal surplus. Since surpluses rise and fall with the state of the economy, it would be irresponsible for government to base the future of the Canadian health care system on the vagaries of the economic cycle.

Potential Sources of Increased Federal Funding

- The revenue raising source chosen should meet the following objectives:
  - it should be apportioned fairly and reasonably over the groups that will be called upon to pay it;
  - it should have the least possible adverse effect on economic activity and growth in relation to the revenues raised;
  - it should involve modest administrative costs of compliance for taxpayers and collection costs to government;
  - its justification should be clearly apparent to the public, by associating the revenue with the benefits of the spending;
  - it should have revenues that are stable and robust (in the sense that they will grow at about the rate of GDP), enabling the funds raised to meet increasing costs in the future;
  - it should be perceived to result in tangible improvements to the system and to health care coverage, so as to justify its collection.
- The full range of potential sources of increased federal revenue was evaluated according to the above objectives and the criteria of equity, efficiency, intergenerational fairness, stability and visibility.

- The Committee rejected many potential sources of increased federal revenue for reasons related to the need to keep Canadian tax rates competitive with other OECD countries, and the need for the new source of federal revenue to meet the objectives listed above and the tests of social equity and intergenerational fairness.
- The Committee concluded that there are two ways in which $5 billion could be raised annually from Canadians.
    - The first option is a *National Health Care Sales Tax*. Under this option, Canadians would pay a national sales tax of 8.5%, which would consist of a 7% GST and a 1.5% National Health Care Sales Tax. The GST tax credit rebate program would be expanded to parallel the increase in the rate to 8.5%.
    - The second option involves a *Variable National Health Care Insurance Premium*. Under this option, Canadians would pay, through the tax system, a national health care insurance premium, the amount of which would vary with the income of individuals. This option is progressive across the entire income spectrum, but it is virtually flat within each income bracket.
    - To ensure that individuals with taxable income only slightly in excess of the bottom of their bracket are not subject to a significant increase in their premiums, a "notch relief" provision has been incorporated into the calculation of premiums. This notch relief provides that the premiums of taxpayers will not be more than the premium of the income bracket below theirs plus 10% of income exceeding the income threshold for the bracket.
    - Under the *Variable National Health Care Insurance Premium,* Canadians in the lowest income tax bracket would pay $0.50 per day. Those in the next income tax bracket - that is, taxable income between approximately $31,000 and $63,000 - would pay $1.00 per day. Those in the third income tax bracket would pay $2.00 per day. Those in highest income tax bracket - that is, taxable income over $103,000 - would pay $4.00 per day.
    - In the Committee's opinion, these are not unreasonable amounts to ask Canadians to pay to restructure a health care system, and to begin to close gaps in the health care safety net, while at the same time preserving the fundamental health care values that Canadians, and the Committee, hold dear.

ANNUAL FEDERAL REVENUE GENERATED FROM A VARIABLE NATIONAL HEALTH CARE INSURANCE PREMIUM

Taxable Income Bracket (Federal Personal Income Tax Rate)	Number of Taxfilers Paying Premiums (Millions)	Level of Premium (Dollars)	Estimated Annual Federal Revenue ($ Billion)
Up to $31,677 (16%)	7.9	**$0.50 / day (or $185 / year)**	1.341
$31,678 to $63,354 (22%)	5.8	**$1 / day (or $370 / year)**	2.096
$63,355 to $103,000 (26%)	1.4	**$2 / day (or $740 / year)**	0.968
Over $103,000 (29%)	0.5	**$4 / day (or $1,400 / year)**	0.622
ESTIMATED TOTAL FEDERAL REVENUE			**5.027**

- Both the National Health Care Sales Tax and the Variable National Health Care Premium raise $5 billion annually in new federal health care revenue.
- Each option has advantages and disadvantages:
    - The *National Health Care Sales Tax* would be simple to administer, have a built in growth factor, not be significantly regressive, but is almost certain to encounter major public opposition.
    - The *Variable National Health Care Insurance Premium* is progressive, consistent with the way that individuals usually buy insurance, is familiar to Canadians living in provinces that now have, or have had in the past, health care premiums, but has the disadvantage of being somewhat similar to an income tax increase. The Committee rejected the option of a "pure" income tax increase because of the need to keep Canadian income tax rates competitive with other OECD countries.
- The most important issue is for Canadians to agree to contribute $5 billion annually in new federal revenue for health care. This is the issue Canadians need to seriously consider, debate and then decide.
- Which of the two options is eventually chosen as the revenue raising mechanism is less important than the agreement to raise the $5 billion. *However, the Committee recommends that the federal government establish the Variable National Health Care Insurance Premium.*

Current Federal Funding for Health Care

- To substantially improve transparency and accountability in federal health care spending, the federal cash contribution to the existing hospital and doctor system should be paid through an *earmarked* tax source.
- In addition to improving transparency and accountability, such earmarking would also strengthen the predictability and stability of federal funding for health care, which is very important to provincial and territorial governments.
- Currently, 62% of federal Canada Health and Social Transfers are notionally attributed to health care. This is equivalent to 3.1 of the 7 percentage points of GST (or around 45% of the revenue generated through the GST).
- Given the need for a modest increase in the federal contribution to the *existing* health care system, as a transition measure until the changes recommended in this report are fully in effect, if the federal government decides to use an earmarked tax source for current health care expenditure, and if the GST is chosen as the tax source, then 50 % of the current GST or 3.5 percentage points (rather than 45% or 3.1 percentage points) should be earmarked for health care. This would increase current federal funding by $1.5 billion.
- If half of the GST is earmarked for health care costs for the *existing* health care system, then the federal government would be contributing *at least* an additional $3 billion per year. $1.5 billion would come from the 3.5 percentage points of GST earmarked for health care, while another $1.5 billion would come from money the provinces are now spending and which they would no longer have to spend once the recommendations in this report are implemented.
- If the federal government also decided to invest the $1 billion contingency as a transitional payment into the existing hospital and doctor system while the efficiency measures proposed in this report are being put into effect, the total additional contribution of the federal government to the *existing* system would be *at least* $4 billion.

List of Abbreviations:

AHSC	Academic Health Sciences Centre
CCHSA	Canadian Council on Health Services Accreditation
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
EHR	Electronic Health Record

CHAPTER SIXTEEN

THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE

If the people of Canada are not prepared to collectively fund a fiscally sustainable public health care system, court decisions are likely to lead to a parallel private system.

- If Canadians are not prepared to pay the additional $5 billion in federal revenue recommended in this report, the proposed expansions of public health care insurance coverage will not occur, the efficiency reforms of the hospital and doctor system will not take place, the needed investments in health care infrastructure will not be made, and the health care guarantee will not be implemented.
- Consequently, waiting times will continue to grow and timely access to the publicly funded health care system will become increasingly harder to obtain.
- Under these circumstances, it seems highly probable that the courts would decide that, under the *Charter of Rights and Freedoms,* government could no longer deny Canadians the right to purchase private health care insurance to enable them to pay for and receive in Canada health services that are also part of the publicly insured set of services. Thus, a parallel private health care system would emerge.
- *Such a development would be highly regrettable.*
- The Committee categorically rejects the position that the problems of Canada's health care system can be solved in a way that is cost-free to individual Canadians.
- The Committee believes that Canadians, through their federal government, must confront head-on the choice between putting considerably more money into the health care system or have the courts rule in favour of the emergence of a parallel private system.

CHAPTER SEVENTEEN

THE *CANADA HEALTH ACT*

All recommendations put forward in this report are designed to make progress in achieving the two overarching public objectives of federal health care policy in a manner consistent with the principles of the Canada Health Act.

- All of the Committee's recommendations can be implemented without any changes to the *Canada Health Act.*
- A National Health Care Guarantee Act should be passed by Parliament in order to ensure that Canadians are entitled to receive timely access to medically necessary health services.
- The federal government should also enact legislation instituting coverage for catastrophic prescription drugs, post-hospital home care and palliative care in the home as recommended in this report.
- A Committee on Public Health Care Insurance Coverage, made up of citizens, ethicists, health care providers and scientists should be established and given the mandate to review and make recommendations on the set of services which should be covered under public health care insurance.

CONCLUSION

There is no perfect solution. Everyone involved will have to be prepared to compromise in order to make health care reform work for the benefit of all Canadians. Insisting on perfection, or attempting to obtain everything one wants, will doom reform to failure.

- The Committee's recommendations take into account the following requirements:
  - The efficiency of the health care system needs to be substantially improved.
  - Investment in infrastructure is essential, particularly with respect to Academic Health Science Centres, health information systems and health care technology.
  - Steps must be taken now to begin to close the major gaps in the health care safety net.
  - Anyone proposing a plan of reform for the health care system has an obligation to show how their plan will be paid for.
- The Committee understands that its set of recommendations requires considerable behavioral change on the part of all participants in the health care system:
  - The change to service based funding will cause hospitals to alter the way in which they are managed.
  - The changes involved in primary health care reform will require family practitioners to accept changes to the way they practice and are remunerated.
  - These changes will also require that modifications be made to the scope of practice rules for all health care professionals in order to ensure that such rules are not barriers to health care professionals being able to use their skills to the fullest extent for which they have been trained.
  - The changes involved in primary health care reform will also require that patients agree to stay with their choice of family physician for a year, unless they move to a different community.
  - The recommendation to set up a system of Electronic Health Records will require that patients agree to give the necessary approval to enable an efficient system to be developed.
  - Provincial governments will need to change a significant aspect of their approach to the health care system by agreeing to a health care guarantee, thus accepting responsibility for the consequences of their past decisions to cut budgets and ration the supply of health care services.

- Provincial governments will also have to move away from their current command-and-control approach to health care by giving regional health authorities sufficient autonomy and allowing the system of incentives, with its associated behavioural change, to generate the desired result.
- The federal government will have to agree to the creation of an earmarked fund, overseen by a Health Care Commissioner and a National Health Care Council who will advise the government on how money in the fund should be spent. This advice should be made public, and there should also be an annual public accounting of how funds earmarked for health care are actually spent.
- The federal government will also have to accept that it has a major leadership role to play in financially sustaining the infrastructure that is essential to a successful national health care system.
- The federal government will also have to accept that it has a major role to play in financing, and marketing, programs of health promotion and the prevention of chronic diseases.

Finally, it is important to stress how critical the objectives of greater accountability and transparency are to the Committee's views on the kinds of reform that are needed in the health care system, and the critical role that improved information, at all levels of the system, must play in implementing these objectives.

We ask readers to keep in mind that no major reform of any large system, particularly one as complex as the health care system, is ever perfect. There is no perfect solution. Everyone involved will have to be prepared to compromise in order to make reform work for the benefit of all Canadians. Insisting on perfection, or attempting to obtain everything one wants, will doom reform to failure.

Reform will fail if people insist on addressing all health care problems before beginning to make progress on some of them, particularly on the hospital and doctor system. These tendencies, along with a focus on self-interest by those employed in the system, explain why reform has failed in the past.

Recognizing these dangers, we have worked hard to develop a set of recommendations we believe to be pragmatic, middle-of-the-road in ideological terms, workable and that will lead to substantial improvements in the hospital and doctor sectors of the health care system. We believe that a steady pace of reform is the way to make the restructuring and renewal of Canada's health care system possible.

We trust that those involved in all aspects of the country's health care system, and indeed all Canadians, will consider the recommendations with the same pragmatic approach as the Committee and that everyone will be prepared to make some compromises in order to meet our common goal: having a fiscally sustainable health care system of which Canadians can be truly proud.

APPENDIX

LIST OF RECOMMENDATIONS BY CHAPTER

The Committee recommends that:

CHAPTER ONE:

THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS

A National Health Care Commissioner and National Health Care Council

New federal/provincial/territorial committee made up of five provincial/territorial and five federal representatives be struck. Its mandate would be to appoint a National Health Care Commissioner and the other eight members of a National Health Care Council from among the Commissioner's nominees;

The National Health Care Commissioner be charged with the following responsibilities:

- To put nominations for members to a National Health Care Council before the F/P/T committee and to chair the Council once the nominees have been ratified;
- To oversee the production of an annual report on the state of the health care system and the health status of Canadians. The report would include findings and recommendations on improving health care delivery and health outcomes in Canada, as well as on how the federal government should allocate new money raised to reform and renew the health care system;
- To work with the National Health Care Council to advise the federal government on how it should allocate new money raised to reform and renew the health care system in the ways recommended in this report;
- To hire such staff as is necessary to accomplish this objective and to work closely with existing independent bodies to minimize duplication of functions.

The federal government provide $10 million annually for the work of the National Health Care Commissioner and the National Health Care Council that relates to producing an annual report on the state of the health care system and the health status of Canadians, and to advising the federal government on the allocation of new money raised to reform and renew the health care system.

CHAPTER TWO:

HOSPITAL RESTRUCTURING AND FUNDING IN CANADA

Service Based Funding

Hospitals should be funded under a service-based remuneration scheme. This method of funding is particularly well suited for community hospitals located in large urban centres. In order to achieve this, a number of steps must be undertaken:

- A sufficient number of hospitals should be required to submit information on case rates and costing data to the Canadian Institute for Health Information;
- The Canadian Institute for Health Information, in collaboration with the provinces and territories, should establish a detailed set of case rates to reduce incentives to up-code.
- The federal government should devote ongoing funding to the Canadian Institute for Health Information for the purpose of collecting and estimating the data needed to establish service-based funding.
- The shift to service-based funding should occur as quickly as possible. The Committee considers a five-year period to be a reasonable timeframe for the full implementation of the new hospital funding.

Service-based funding should be augmented by an additional funding method that would take into account the unique services provided by Academic Health Sciences Centres, including teaching and research.

In developing a service-based remuneration scheme for financing of community hospitals, consideration be given to the following factors:

- Isolation: hospitals located in rural and remote areas are expected to incur higher costs than those in large urban centres. An adjustment should reflect this fact.
- Size: small hospitals are expected to incur higher costs per weighted case than larger hospitals. An adjustment should recognize this fact.

Capital Support for Hospitals

The federal government provide capital financial support for the expansion of hospitals located in areas of exceptionally high population growth; that is, areas in which the population growth exceeds the average rate of growth in the province by 50% or more. Such federal financial support should account for 50% of the total capital investment needed. In total, the federal government should devote $1.5 billion to this initiative over a 10-year period, or $150 million annually.

The federal government should encourage the provinces and territories to explore public-private partnerships as a means of obtaining additional investment in hospital capacity.

The federal government contribute $4 billion over the next 10 years (or $400 million annually) to Academic Health Sciences Centres for the purpose of capital investment.

Academic Health Sciences Centres be required to report on their use of this federal funding.

CHAPTER THREE

DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES

Regional health authorities in major urban centres be given control over the cost of physician services in addition to their responsibility for hospital services in their regions. Authority for prescription drug spending should also be devolved to RHAs.

Regional health authorities should be able to choose between providers (individual or institutional) on the basis of quality and costs, and to reward the best providers with increased volume. As such, RHAs should establish clear contracts specifying volume of services and performance targets.

The federal government should encourage the devolution of responsibility from provincial/territorial governments to regional health authorities, and participate in evaluating the impact of internal market reforms undertaken at the regional level.

CHAPTER FOUR

PRIMARY HEALTH CARE REFORM

The federal government continue to work with the provinces and territories to reform primary care delivery, and that it provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care teams that:

- are working to provide a broad range of services, 24 hours a day, 7 days a week;
- strive to ensure that services are delivered by the most appropriately qualified health care professional;
- utilise to the fullest the skills and competencies of a diversity of health care professionals;
- adopt alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae;
- seek to integrate health promotion and illness prevention strategies in their day-to-day work;
- progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.

The federal government commit $50 million per year of the new revenue the Committee has recommended it raise to assist the provinces in setting up primary care groups.

CHAPTER FIVE

TIMELY ACCESS TO HEALTH CARE

There are no recommendations in this chapter.

CHAPTER SIX

THE HEALTH CARE GUARANTEE

For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public.

When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country (e.g., the United States). This is called the Health Care Guarantee.

The process to establish standard definitions for waiting times be national in scope.

An independent body be created to consider the relevant scientific and clinical evidence.

Standard definitions focus on four key waiting periods – waiting time for primary health care consultation; waiting time for initial specialist consultation; waiting time for diagnostic tests; waiting time for surgery.

CHAPTER SEVEN

EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS

The federal government introduce a program to protect Canadians against catastrophic prescription drug expenses.

For all eligible plans, the government would agree to pay:

- 90% of all prescription drug expenses over $5,000 for those individuals for whom the combined total of their out-of-pocket expenses and the contribution that a province/territory incurs on their behalf exceeds $5000 in a single year;
- 90% of prescription drug expenses in excess of $5,000 for individual private supplementary prescription drug insurance plan members for whom the combined total of their out-of-pocket expenses and the contribution that the private insurance plan incurs on their behalf exceeds $5,000 in a single year.
- the remaining 10 % would be paid by either a provincial/territorial plan or a private supplementary plan.

In order to be eligible to participate in this federal program:

- provinces/territories would have to put in place a program that would ensure that no family of the province/territory would be obliged to pay more than 3% of family income for prescription drugs;
- sponsors of existing private supplementary drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out-of-pocket expenses that exceed $1,500 per year; this would cap each individual plan member's out-of-pocket costs at either 3% of family income or $1,500, whichever is less.

The federal government work closely with the provinces and territories to establish a single national drug formulary.

CHAPTER EIGHT

EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE (PAHC)

When Does PAHC Coverage Begin and End

An episode of PAHC should be defined as all home care services received between the first date of service provision following hospital discharge, if that date occurs within 30 days of discharge, and up to three months following hospital discharge.

PAHC Financing Directed to Hospitals

Financing for post-acute home care should be first directed to hospitals.

In order to encourage innovation and service integration, and to enhance the efficient and effective provision of necessary health care irrespective of the setting in which such care is received, a service-based method of reimbursement for PAHC should be developed in conjunction with service-based arrangements for each episode of hospital care.

Range of Services Covered

The range of services, products and technologies (including prescription drugs) that may be used to facilitate the use of home care following hospital care not be restricted.

PAHC Funded Through Service Based Funding

Hospitals have the option to develop contractual relationships directly with home care service providers or with transfer agencies that may provide case management and service provision arrangements.

Contracts formed with home care service providers should include, in addition to service-based reimbursement arrangements, mechanisms to monitor service quality, performance and outcome.

PAHC Programs Should Be Cost-Shared

The federal government establish a new National Post-Acute Home Care Program, to be jointly financed with the provinces and territories on a 50:50 basis.

The PAHC program be treated as an extension of medically necessary coverage already provided under the Canada Health Act, and that therefore the full cost of the program should be borne by government (shared equally by the provincial/territorial and federal levels).

CHAPTER NINE

EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE

The federal government agree to contribute $250 million per year towards a National Palliative Home Care Program to be designed with the provinces and territories and co-funded by them on a 50:50 basis.

The federal government examine the feasibility of allowing Employment Insurance benefits to be provided for a period of six weeks to employed Canadians who choose to take leave to provide palliative care services to a dying relative at home.

The federal government examine the feasibility of expanding the tax measures already available to people providing care to dying family members or to those who purchase such services on their behalf.

The federal government amend the Canada Labour Code to allow employee leave for family crisis situations, such as care of a dying family member, and that the federal government work with the provinces to encourage similar changes to provincial labour codes.

The federal government take a leadership role as an employer and enact changes to Treasury Board legislation to ensure job protection for its own employees caring for a dying family member.

CHAPTER TEN

THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE

Health Care Technology

The federal government provide funding to hospitals for the express purpose of purchasing and assessing health care technology. The federal government should devote a total of $2.5 billion over a five-year period (or $500 million annually) to this initiative. Of this funding, $400 million should be allocated annually to Academic Health Sciences Centres, while $100 million should be provided annually to community hospitals. The community hospital funding should be cost-shared on a fifty-fifty basis with the provinces, while the Academic Health Sciences Centre funding should be 100% federal.

The institutions benefiting from this program be required to report on their use of such funding.

Electronic Health Records

The federal government provide additional financial support to Canada Health Infoway Inc. so that Infoway develop, in collaboration with the provinces and territories, a national system of electronic health records.

Additional federal funding to Infoway amount to $2 billion over a five-year period, or an annual allocation of $400 million.

Evaluation of System Performance

The federal government provide additional annual funding of $50 million to the Canadian Institute for Health Information. In addition, an annual investment of $10 million should be provided to the Canadian Council on Health Services Accreditation. This new federal investment will help establish a national system of evaluation of health care system performance and outcomes, and hence facilitate the work of the National Health Care Commissioner.

Protection of Personal Health Information

The federal government work to achieve greater consistency and/or coordination across federal/provincial/territorial jurisdictions on the following key issues:

- Need-to-know rules restricting access to authorized users based on their purposes;
- Consent rules governing the form and criteria of consent in order to be valid;
- Conditions authorizing non-consensual access to personal health information in limited circumstances and for specific purposes;
- Rules governing the retention and destruction of personal health information;
- Mechanisms for ensuring proper oversight of cross-jurisdictional electronic health record systems.

Canada Health Infoway Inc. and other key investors structure their investment criteria in such a way as to create incentives for developers of EHR systems to ensure practical and pragmatic privacy solutions for implementing the following:

- State-of-the-art security safeguards for protecting personal health information and auditing transactions;
- Shared accountability among various custodians accessing and using EHRs;
- Coordination among custodians to give meaningful effect to patients' rights to access their EHR, rectify any inaccuracy and challenge non-compliance.

Key stakeholders, including the federal, provincial and territorial Ministries of Health, Canada Health Infoway Inc., the Canadian Institute for Health Information and Canadian Institutes of Health Research, undertake the following:

- Rigorous research into the determinants affecting Canadian attitudes regarding acceptable and unacceptable uses of their personal health information;
- Informed and meaningful dialogue with key stakeholders, including patient groups and consumer representatives;
- An open, transparent and iterative public communication strategy about the benefits of EHRs.

CHAPTER ELEVEN

HEALTH CARE HUMAN RESOURCES

The Need for Productivity Studies

Studies be done to determine how the productivity of health care professionals can be improved. These studies should be either undertaken or commissioned by the National Coordinating Committee on Health Human Resources that the Committee recommends be created.

The National Coordinating Committee for Health Human Resources

The federal government work with other concerned parties to create a permanent National Coordinating Committee for Health Human Resources, to be composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include:

- disseminating up-to-date data on human resource needs;
- coordinating initiatives to ensure that adequate numbers of graduates are being trained to meet the goal of self-sufficiency in health human resources;
- sharing and promoting best practices with regard to strategies for retaining skilled health care professionals and coordinating efforts to repatriate Canadian health care professionals who have emigrated to other countries;
- recommending strategies for increasing the supply of health care professionals from under-represented groups, such as Canada's Aboriginal peoples, and in under-serviced regions, particularly the rural and remote areas of the country;

- examining the possibilities for greater coordination of licensing and immigration requirements between the various levels of government.

Increasing the Supply of Health Human Resources

The federal government:

- Work with provincial governments to ensure that all medical schools and schools of nursing receive the funding increments required to permit necessary enrolment expansion;
- Put in place mechanisms by which direct federal funding could be provided to support expanded enrolment in medical and nursing education, and ensure the stability of funding for the training and education of allied health professionals;
- Review federal student loan programs available to health care professionals and make modifications to ensure that the impact of inevitable increases in tuition fees does not lead to denial of opportunity to students in lower socio-economic circumstances;
- Work with provincial governments to ensure that the relative wage levels paid to different categories of health professionals reflect the real level of education and training required of them.

The federal government work with the provinces and medical and nursing faculties to finance places for students from Aboriginal backgrounds over and above those available to the general population.

In order to facilitate the return to Canada of Canadian health care professionals who are working abroad, the federal government should work with the provinces and professional associations to inform expatriate Canadian health professionals of emerging job opportunities in Canada, and explore the possibility of adopting short-term tax incentives for those prepared to return to Canada.

The federal government contribute $160 million per year, starting immediately, so that Canadian medical colleges can enrol 2,500 first-year students by 2005.

The proposed National Coordinating Committee for Health Human Resources be charged with monitoring the levels of enrolment in Canadian medical schools and make recommendations to the federal government on whether these are appropriate.

The federal government should contribute financially to increasing the number of post-graduate residency positions in medicine to a ratio of 120 per 100 graduates of Canadian medical schools.

The federal government work with the provinces to establish national standards for the evaluation of international medical graduates, and provide ongoing funding to implement an accelerated program for the licensing of qualified IMGs and their full integration into the Canadian health care delivery system.

The federal government phase in funding over the next five years so that by 2008 there are 12,000 graduates from nursing programs across the country, and that the federal government continue to provide full additional funding to the provinces for all nursing school places over and above 10,000, for as long as is necessary to eliminate the shortage of nurses in the country.

The federal government commit $90 million per year from the additional revenue the Committee recommends that it raise in order to enable Canadian nursing schools to graduate 12,000 nurses by 2008.

The federal government commit $40 million per year from the new revenues that the Committee has recommended it raise in order to assist the provinces in raising the number of allied health professionals who graduate each year.

The exact allocation of these funds be determined by the proposed National Coordinating Committee for Health Human Resources.

The federal government devote $75 million per year of the new money the Committee recommends be raised to assisting Academic Health Sciences Centres to pay the costs associated with expanding the number of training slots for the full range of health care professionals.

Review Scope of Practice Rules

An independent review of scope of practice rules and other regulations affecting what individual health professionals can and cannot do be undertaken for the purpose of developing proposals that would enable the skills and competencies of diverse health care professionals to be utilized to the fullest and enable health care services to be delivered by the most appropriately qualified professionals.

CHAPTER TWELVE

NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH

Assuming Leadership in Health Research

Health research and its translation into the health care system be routinely on the agendas of meetings of federal and provincial/territorial Ministers and Deputy Ministers of Health, and that the Canadian Institute of Health Research be represented and be involved in setting the agendas for health research at those meetings. This would greatly help to sustain a culture that supports the creation and use of knowledge generated by health research throughout Canada.

The federal government set, on a regular basis, national goals and priorities for health research in collaboration with all stakeholders.

The federal government foster multi-stakeholder collaborations when performing, funding and using health research. This should contribute to capitalizing on the best available resources while minimizing overlap and duplication.

The federal government take a leadership role, through the Canadian Institutes of Health Research and Health Canada, in developing a strategy to encourage the interchange of research scientists between government, academia and the private sector, including national voluntary organizations.

Funding Health Research

The federal government, through both Health Canada and the Canadian Institutes of Health Research, coordinate and provide resources to ensure that Canada contributes to and benefits from the scientific revolution to maximize the economic, health and social gains for Canadians.

The Canadian Institutes of Health Research and Genome Canada fund research that positions Canada as a world leader in the new area of genomics and human genetics so that the health care system can take appropriate advantage of this new technology to improve the health of Canadians.

The Canadian Institutes of Health Research play a leadership role in establishing best practices for addressing the complex ethical issues raised by the use of this new technology in health research and health care.

The federal government:

- Increase, within a reasonable timeframe, its financial contribution to extramural health research to achieve the level of 1% of total Canadian health care spending. This requires an additional investment of $440 million by the federal government;
- Recognize that health research is a long term proposition, and therefore set and adhere to clear long-term plans for funding health research, particularly through the Canadian Institutes of Health Research. More precisely, the federal government should commit to a five-year planning horizon for the CIHR budget;
- Provide predictable and appropriate investment for in-house health research.

Health Canada:

- Be provided with the financial and human resources in health research that are required to fulfill its mandate and obligations;
- Engage actively in the establishment of linkages and partnerships with other health research stakeholders.

The federal government, through the Canadian Institutes of Health Research, Health Canada and the Canadian Health Services Research Foundation, devote additional funding to health services research and clinical research and that it collaborate with the provinces and territories to ensure that the outcomes of such research are broadly diffused to health care providers, managers and policy-makers.

Health Research on Vulnerable Populations

The federal government, through the Canadian Institutes of Health Research and Health Canada, provide additional funding to health research aimed at the health of particularly vulnerable segments of Canadian society.

The federal government provide additional funding to CIHR in order to increase participation of Canadian health researchers, including Aboriginal peoples themselves, in research that will improve the health of Aboriginal Canadians.

Health Canada be provided with additional resources to expand its research capacity and to strengthen its research translation capacity in the field of Aboriginal health.

The federal government provide increased resources to the Global Health Research Initiative.

Commercializing the Results of Health Research

The federal government require an explicit commitment from all recipients of federally funded health research that they will obtain the greatest possible benefit to Canada, whenever the results of their federally funded research are used for commercial gain.

The Canadian Institutes of Health Research, while not ignoring the social value of health research that does not result in commercial gain, seek to facilitate appropriate economic returns within Canada from the investments it makes in Canadian health research, whenever the results of investments in Canadian health research are used for commercial gain. In doing so, CIHR should develop an innovation strategy aimed at accelerating and facilitating the commercialization of health research outcomes.

The federal government invest additional resources to enhance the output of Canadian health researchers and strengthen the commercialization capacity of performers of federally funded health research through CIHR's innovation strategy. This new funding would be additional to the current health research investment. In particular, the funding of the indirect costs of research by the Canadian granting agencies should be made permanent. Health research performers should be made accountable for the use of these commercialization funds.

Ethics in Health Research

Health Canada initiate, in collaboration with stakeholders, the development of a joint governance system for health research involving human subjects for all research that the federal government performs, that it funds, and that it uses in its regulatory activities.

Health Canada, in the development of this ethics governance system, regard the following components as essential to progress:

- Work initially on all (health) research that the federal government performs, funds, or uses in its regulatory activities, to develop an effective and efficient system of governance that will become accepted as the standard of care across Canada;
- Give prime importance in the governance system to effective education and training mechanisms for all who are involved in research and research ethics, with certification appropriate to their different responsibilities;
- Develop standards, based on the Tri-Council Policy Statement, the International Conference on Harmonization guidelines applying to clinical trials involving human subjects, and other relevant Canadian and foreign standards, against which research ethics functions or Research Ethics Boards can be accredited or certified as meeting the levels of function that are consistent with the expectations of Canadians and with those in other countries;
- Ensure that the Tri-Council Policy Statement is updated and is maintained at the forefront of international policies for the ethics or research involving humans;
- Remove inconsistencies between the various policies under which research involving humans is now governed, and make Canadian standards consistent with those of other countries that affect Canadian research;
- Establish an accreditation or certification process for research ethics functions that is at arm's length from government, but clearly accountable to government;
- Develop the governance system through open, transparent and meaningful consultation with stakeholders.

All federal departments and agencies require compliance with the standards of the Canadian Council on Animal Care for:

- All research that is carried out in federal facilities, and
- All research that is funded by federal departments or agencies but performed outside federal facilities, and
- All research that is carried out without federal funding or facilities, but that is submitted to or used by the federal government for purposes of exercising its legislated functions.

The Protection of Personal Health Information

Regulations such as those proposed by the Canadian Institutes of Health Research receive their fullest and fairest consideration in discussions about providing greater clarity and certainty of the law with the view to ensure that its objectives will be met without preventing important research to continue to better the health of Canadians and improve their health services.

Discussions continue among stakeholders, the Privacy Commissioner, and those federal and provincial government departments involved with the provision, management, evaluation and quality assurance of health services.

The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, design and implement a program of public awareness to foster in Canadians a broad understanding of:

- the nature of, and reasons for, the extensive databases containing personal health information that must be maintained to operate a publicly financed health care system, and
- the critical need to make secondary use of such databases for health research and health care management purposes.

The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, be responsible for promoting:

- thoughtful discussion and consideration of the ethical issues, particularly informed consent issues, involved in the secondary use of personal health information for health care management and health research purposes;
- thorough examination of the control and review mechanisms needed for ensuring that databases containing personal health information are effectively created, maintained and safeguarded and that their use for health care management and health research purposes is conducted in an open, transparent and accountable manner.

The Canadian Institutes of Health Research, in partnership with industry and other stakeholders, continue to explore the ethical aspects of the interface between the sectors with a view to ensuring that the collaborations and partnerships function in the best interests of all Canadians.

CHAPTER THIRTEEN

HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE

National Chronic Disease Prevention Strategies

The federal government, in collaboration with the provinces and territories and in consultation with major stakeholders (including the Chronic Disease Prevention Alliance of Canada), implement a National Chronic Disease Prevention Strategy.

The National Chronic Disease Prevention Strategy build on current initiatives through better integration and coordination.

The federal government contribute $125 million annually to the National Chronic Disease Prevention Strategy.

Specific goals and objectives should be set under the National Chronic Disease Prevention Strategy. The outcomes of the strategy should be evaluated against these goals and objectives on a regular basis.

Public Health Infrastructure

The federal government ensure strong leadership and provide additional funding to sustain, better coordinate and integrate the public health infrastructure in Canada as well as relevant health promotion efforts. An amount of $200 million in additional federal funding should be devoted to this very important undertaking.

CHAPTER FOURTEEN

HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED

The federal government establish an Earmarked Fund for Health Care that is distinct and separate from the Consolidated Revenue Fund. The Earmarked Fund will contain the additional revenue raised by the federal government for investment in health care.

Money from the Earmarked Fund for Health Care be used solely for the purpose of health care. Moreover, such money must be used to buy change or reform: it must be utilized exclusively for expanding public health care coverage and for restructuring and renewal of the publicly funded hospital and doctor system.

The National Health Care Council be charged with the mandate of advising the federal government on how the money in the Earmarked Fund for Health Care should be spent. The Council's advice to the government should be made public through an annual report.

The federal government subject the Earmarked Fund for Health Care to an annual audit by the Auditor General of Canada. The result of such an audit should be made public.

The federal government require the provinces and territories to report annually to the Canadian public on their utilization of federal money from the Earmarked Fund for Health Care.

CHAPTER FIFTEEN

HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED

Funding the Recommendations in this Report

The federal government establish a National Variable Health Care Insurance Premium in order to raise the necessary federal revenue to finance implementation of the Committee's recommendations.

Funding Current Federal Expenditures on Health Care

The federal government determine an earmarked revenue source which would fund the approximately 62% of CHST currently regarded as being the federal annual cash contribution to Canada's national health care insurance program.

If the GST is chosen as the earmarked revenue source for the current federal cash contribution to the national hospital and doctor insurance plan, then in order for the federal government to make a significant additional contribution to funding to the current hospital and doctor system, half of all GST revenue (or 3.5 of the 7 percentage points) should be earmarked for health care. (This would be in addition to the increased federal funding required to implement the recommendations in this report.)

The share of the federal annual contribution to which a province/territory is entitled for the purpose of the existing national hospital and doctor program be not only based on the proportion of its population relative to Canada as a whole, but also weighted in some way by the percentage of its population aged 70 years and over.

CHAPTER SIXTEEN

THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE

There are no recommendations in this chapter.

CHAPTER SEVENTEEN

THE *CANADA HEALTH ACT*

The federal government, in collaboration with the provinces and territories, establish a permanent committee – the Committee on Public Health Care Insurance Coverage – made up of citizens, ethicists, health care providers and scientists.

The Committee on Public Health Care Insurance Coverage be given the mandate to review and make recommendations on the set of services that should be covered under public health care insurance.

The Committee on Public Health Care Insurance Coverage report its findings and recommendations to the National Health Care Council.

As its first task, the Committee on Public Health Care Insurance Coverage be charged with developing national standards upon which decisions for public health care coverage will be made.

The Committee on Public Health Care Insurance Coverage be charged with determining the national parameters applicable to post-hospital home care and palliative care delivered in the home.

The federal government enact new legislation establishing the National Health Care Guarantee. The new legislation should include a definition of the concept of "timely access" that will relate to such a guarantee.

The principle of public administration of the *Canada Health Act* be maintained for publicly insured hospital and doctor services. That is, there should be a single insurer – the government – for publicly insured hospital and doctor services delivered by either public or private health care providers and institutions.

The federal government, through Health Canada, clarify the meaning of the concept of public administration under the *Canada Health Act* so as to recognize explicitly that this principle applies to the administration of public health care insurance, not to the delivery of publicly insured health services.

The federal government enact new legislation instituting health care coverage for catastrophic prescription drugs, post-hospital home care and some palliative care in the home. This new legislation should explicitly spell out conditions relating to transparency of decision making and accountability.