

The Standing Senate Committee on Social Affairs, Science and Technology

Interim Report on  
the state of health care system in Canada

*The Health of Canadians – The Federal Role*  
*Volume One – The Story So Far*

*Chair*

The Honourable Michael J. L. Kirby

*Deputy Chair*

The Honourable Marjory LeBreton

MARCH 2001



# TABLE OF CONTENTS

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<b>ORDER OF REFERENCE.....</b>	<b>iii</b>
<b>MEMBERSHIP.....</b>	<b>iv</b>
<b>FOREWORD.....</b>	<b>v</b>
<b>INTRODUCTION.....</b>	<b>1</b>
<b>CHAPTER ONE: .....</b>	<b>5</b>
Historical Background on Public Health Care Insurance and the Role of the Federal Government in Financing Health Care .....	5
1.1 <i>Federal Role in Health and Health Care</i> .....	5
1.2 <i>Cost-Sharing Arrangements</i> .....	7
1.3 <i>Functioning of the EPF Block Funding</i> .....	11
1.4 <i>The CHST</i> .....	15
1.5 <i>Tax Points versus Cash Transfers</i> .....	20
1.6 <i>The Federal Contribution to Health Care</i> .....	22
1.7 <i>The Need for Stability in Federal Funding</i> .....	24
1.8 <i>Accountability in the Use of Federal Health Care Dollars</i> .....	27
<b>CHAPTER TWO: .....</b>	<b>31</b>
National Principles for Health Care and the Advent of the <i>Canada Health Act</i> .....	31
2.1 <i>The Origins of the Canada Health Act</i> .....	31
2.2 <i>Definition/Interpretation of the National Principles and their Application</i> .....	34
2.3 <i>Enforcement Penalties under the Canada Health Act</i> .....	37
2.4 <i>Is the Canada Health Act Still Relevant?</i> .....	39
2.5 <i>Committee Commentary</i> .....	40
<b>CHAPTER THREE: .....</b>	<b>45</b>
Public Expectations about Health Care.....	45
3.1 <i>Health Care is an Important Public Policy Concern</i> .....	45
3.2 <i>Canadians Are Concerned About Quality, Access and Universality</i> .....	47
3.3 <i>Health Care is a Priority</i> .....	48
3.4 <i>Health Care is a Federal/Provincial Partnership</i> .....	51
3.5 <i>Support for the Principles of the Canada Health Act is High</i> .....	52
3.6 <i>Decreasing Support for User Charges and Private Initiatives</i> .....	53
3.7 <i>Committee Commentary</i> .....	53

<b>CHAPTER FOUR:</b>	<b>57</b>
Trends in Health Care Expenditures	57
4.1 Global Trends – From 1975 to 2000	58
4.2 Public versus Private Spending	61
4.3 Categories of Expenditures	63
4.4 International Comparisons	65
4.5 Health Care is a Priority in the Provinces	70
4.6 Committee Commentary	71
<b>CHAPTER FIVE:</b>	<b>73</b>
Health Status and the Concept of Population Health	73
5.1 Health Status of Canadians	73
5.2 How Does Canada Compare to Other Countries?	77
5.3 Health Care Expenditures and Health Status	80
5.4 The Concept of Population Health	81
5.5 What Makes Canadians Healthy or Unhealthy?	87
5.6 Committee Commentary	89
<b>CHAPTER SIX:</b>	<b>93</b>
Myths and Realities	93
6.1 Myths About Rising Health Care Costs	93
6.2 Myths About Public Financing	95
6.3 Myths About the Canada Health Act	97
6.4 Myths About Privatization	102
6.5 Myths About Health Care Utilization	107
6.6 Myths About the Health Status of the Population	108
6.7 Myths About the Need for Change	111
6.8 Myths About Health Care Providers	113
<b>CONCLUSION</b>	<b>117</b>
The Next Steps	117
<b>APPENDIX A - LIST OF WITNESSES</b>	<b>A-1</b>

## ORDER OF REFERENCE

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Extract from the *Journals of the Senate* of March 1, 2001:

Resuming debate on the motion of the Honourable Senator LeBreton, seconded by the Honourable Senator Kinsella:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:

- (a) The fundamental principles on which Canada's publicly funded health care system is based;
- (b) The historical development of Canada's health care system;
- (c) Health care systems in foreign jurisdictions;
- (d) The pressures on and constraints of Canada's health care system; and
- (e) The role of the federal government in Canada's health care system;

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament be referred to the Committee;

That the Committee submit its final report no later than June 30, 2002; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

After debate,

The question being put on the motion, it was adopted.

ATTEST :

Paul C. Bélisle  
*Clerk of the Senate*

## MEMBERSHIP

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Standing Senate Committee on Social Affairs, Science and Technology

The Honourable Michael J. L. Kirby, Chair

The Honourable Marjory LeBreton, Deputy Chair

The Honourable Senators :

Catherine S. Callbeck

Erminie J. Cohen

Joan Cook

Jane Marie Cordy

Joyce Fairbairn

Alasdair B. Graham

Janis G. Johnson

Lucie Pépin

Douglas Roche

Brenda Robertson

\* Sharon Carstairs (or Fernand Robichaud)

\* John Lynch-Staunton (or Noel A. Kinsella)

Original Members agreed to by Motion of the Senate :

The Honourable Senators :

Callbeck, \*Carstairs (or Robichaud), Cohen, Cook, Cordy, Graham, Fairbairn, Kirby, Johnson, LeBreton, \*Lynch-Staunton (or Kinsella), Pépin, Roche, Robertson

Other Senators who participated in the work of the Committee during the First Session of the Thirty-Seventh Parliament and the Second Session of the Thirty-Sixth Parliament:

The Honourable Senators :

Atkins, Banks, Keon, Losier-Cool, Mahovlich, Meighen, Morin, Murray, Robichaud F. and Wilson

\* *Ex Officio* members

## FOREWORD

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Canada's publicly-funded health care system has always sparked emotional discussion. Providing a forum that allows for the rational debate of issues affecting the federal government's role in Canada's health care system is therefore a significant challenge. It is with this goal in mind that the Standing Senate Committee on Social Affairs, Science and Technology undertook this study.

This Phase 1 report is the product of our work so far and is the first of five reports. In order to plan for the future, we need to understand how we got to where we are today. This report presents the history of Canada's publicly funded health care system, what we have learned about what factors affect the health status of Canadians, and presents some of the myths and realities surrounding the health care debate. It is the story so far.

Phase 2 will examine the pressures that will be exerted on Canada's health care system over the coming years. Phase 3 will describe how other countries have structured their health care systems, including several countries that have universal health care systems that are significantly different from Canada's. Phase 4 will take the lessons from the first three phases (the past, future pressures, and other countries systems) and will present options for renewal and reform of the federal role in the Canadian health care system. This fourth report will form the basis for a broad discussion and debate with Canadians from all backgrounds and regions of the country. Phase 5 will present the results of this discussion along with the Committee's recommendations for change.

This first report would not have been possible without the assistance of many people from across Canada. We would like to thank the many witnesses who appeared or sent submissions to enlighten us on the history of publicly-funded health care in Canada, the changing health status of Canadians, the challenges we face now, and what can be done to improve our health care system in the future. Although this report is being tabled in the 37<sup>th</sup> Parliament, it could not have been written without the dedicated interest and contribution of the members of the Standing Senate Committee on Social Affairs, Science and Technology from the 2<sup>nd</sup> session of the 36<sup>th</sup> Parliament, as well as the many Senators who came to listen to witnesses or to replace one of us temporarily. We look forward to continuing our work in a completely non-partisan, consensus-driven atmosphere.

We hope that you will follow and join in the debate. The sustainability of our most prized social program is at stake. We owe it to ourselves to ensure that its future is debated in a rational, objective way.

The Honourable Michael J.L. Kirby  
Chair

The Honourable Marjory LeBreton  
Deputy Chair

# THE HEALTH OF CANADIANS

## THE FEDERAL ROLE

### VOLUME ONE – THE STORY SO FAR



## INTRODUCTION

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In December 1999, during the Second Session of the Thirty-Sixth Parliament, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the state of the Canadian health care system and to examine the evolving role of the federal government in this area. The Senate renewed the mandate of the Committee in the First Session of the Thirty-Seventh Parliament. The terms of reference adopted by the Senate for the purpose of this study read as follows:

*That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:*

- a) *The fundamental principles on which Canada's publicly funded health care system is based;*
- b) *The historical development of Canada's health care system;*
- c) *Publicly funded health care systems in foreign jurisdictions;*
- d) *The pressures on and constraints of Canada's health care system; and*
- e) *The role of the federal government in Canada's health care system.<sup>1</sup>*

In response to this broad and complex mandate, in March 2001, the Committee re-launched its multi-year and multi-faceted study comprising five major phases. Table 1 provides information on each individual phase and their respective timeframes.

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<sup>1</sup> Debates of the Senate (Hansard), 2nd Session, 36th Parliament, Volume 138, Issue 23, December 16, 1999.



**TABLE 1**  
**HEALTH CARE STUDY:**  
**INDIVIDUAL PHASES AND PROPOSED TIMEFRAMES**

<b>Phases</b>	<b>Content</b>	<b>Timing</b>	<b>Release Of Report</b>
<b>Phase 1</b>	Historical Background and Overview	Winter/Fall 2000	March 2001
<b>Phase 2</b>	Future Trends, Their Causes and Impact on Health Care Costs	Winter/Spring 2001	June 2001
<b>Phase 3</b>	Models and Practices in Other Countries	Winter/Spring 2001	June 2001
<b>Phase 4</b>	Development of Options Paper	Summer 2001	September 2001
<b>Phase 5</b>	Hearings on Options Paper and Development of Final Report and Recommendations	Fall 2001	March 2002

The purpose of this report is to present the evidence obtained in the first phase of the Committee's study on health care. The objectives of Phase One were to:

- retrace the federal government's role in the Canadian health care system, and, more specifically, review the initial federal legislation regarding hospital and medical care;
- reexamine the rationale for the enactment of the *Canada Health Act*;
- look into the evolution of federal funding for health care;
- review the most important facts and trends relating to or affecting the Canadian health care system, in terms of both health care expenditures and health status indicators;
- explore the current thinking about the system, including public opinion and areas of consensus/dissension among recognized Canadian authorities; and
- examine current myths and realities concerning Canada's health care system.

In order to meet the objectives of Phase One, the Committee heard from a wide range of witnesses, including former federal and provincial ministers and deputy ministers, health

economists, experts in Canadian history, public health administration, public policy and health ethics, officials from Health Canada and the Department of Finance, selected health care organizations, Canadian pollsters and representatives from the Canadian Institute for Health Information. We are most grateful for their invaluable contribution.

For the purposes of our study, we defined health care as any activity the primary objective of which is to improve or maintain the health of individuals or to prevent the deterioration of their health. This definition is very broad and encompasses health promotion, disease prevention, health protection, public health and health research, as well as diagnostic services and treatment of disease. It also includes a wide variety of health care delivery sites (hospital, home, community, clinic, etc.) and a broad range of health care providers (physicians, nurses, nurse practitioners, pharmacists, physiotherapists, caregivers, etc.).

Our definition of health care contrasts with the narrow range of health services covered under the *Canada Health Act*, which is limited to hospitals and physician services. Moreover, the shift away from institutional care towards more home care and community care has meant that, increasingly, many important health services are not covered by the Act.

We feel that these two concepts – the broad concept of health care and the narrow application of the *Canada Health Act* – must be put into perspective as solutions for reforming Canada's publicly funded health care system, which is currently centred around the *Canada Health Act*, may lie in adopting a broader vision of health and health care.

This report consists of six chapters. Chapter One provides historical information about public health care insurance in Canada and about the federal government's involvement in health care funding. Chapter Two traces the evolution of nation-wide principles in the Canadian health care system and their implementation and administration by the federal government. Chapter Three discusses past and present public attitudes towards, and public expectations of, the health care system. Chapter Four briefly reviews previous and current trends in health care spending, with comparative data from Canada and other OECD countries. Chapter Five provides information on the health status of Canadians and explains

the concepts of “health determinants” and “population health”. Chapter Six discusses myths and realities in an attempt to clarify many of the misconceptions in order to ensure an informed, fact-based debate on health care.

## CHAPTER ONE:

### HISTORICAL BACKGROUND ON PUBLIC HEALTH CARE INSURANCE AND THE ROLE OF THE FEDERAL GOVERNMENT IN FINANCING HEALTH CARE

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The history of public health care insurance in Canada is a vast, complex and long-standing subject of study. The federal government's role in the context of health care, particularly in terms of financing mechanisms, has changed substantially over the years.<sup>2</sup>

*The delivery and means of financing health services on a universal basis has been a long-standing subject of study. It was the subject of several commissions in the 1930s and 1940s.*

*Abby Hoffman, Senior Policy Advisor, Health Canada (13:1).*

#### 1.1 Federal Role in Health and Health Care

During the Committee's hearings, a few witnesses gave an overview of the basis for the federal role in health and health care. The following is a summary of their observations.

Under the Constitution, the provinces are responsible for delivering health care to the majority of Canadians, but the federal government also has a number of roles and responsibilities in areas that affect health and health care. The first, and most direct, is ensuring access to health care to specific groups of people, including primary care to First Nations and Inuit communities, and other services to the RCMP, Correctional Services, the Armed Forces and veterans.

*While provincial governments have primary responsibility for health care delivery, the field of health is not assigned exclusively to either order of government. There are very well-established and well-developed mechanisms for intergovernmental collaboration in health.*

*Abby Hoffman, Senior Policy Advisor, Health Canada (13:5).*

The second area of responsibility falls under the broad category of health protection. For example, Health Canada regulates the safety and efficacy of pharmaceuticals and medical

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<sup>2</sup> In this report, the testimony received by witnesses printed in the *Minutes of Proceedings and Evidence of the Standing Senate Committee on Social Affairs, Science and Technology* will be hereinafter referred to only by issue number and page number within the text.

devices; the Department of Fisheries and Oceans monitors the safety of the fish and seafood we buy; and Environment Canada watches over our land, air and water quality.

The third federal role in health encompasses health promotion, disease prevention and education strategies. These strategies focus on educating, informing and encouraging individuals to take an active part in enhancing their own health and well-being.

*We currently describe the federal mission in health as being that of helping the people of Canada to maintain and improve their health. We do that through work in three broad areas. One pertains to national health policy and systems, including in particular our publicly funded health care system. The second area pertains to our work in the fields of health promotion and protection, including disease, illness, and injury prevention. The third area pertains to our particular roles with respect to the health and health care services of First Nations and Inuit.*

*Abby Hoffman, Senior Policy Advisor,  
Health Canada (13:5).*

The fourth area of federal involvement is in health research. For 40 years, the federal government provided significant funds to health research through the Medical Research Council (MRC). In 1999, this role was expanded through the creation of the Canadian Institutes of Health Research (CIHR) as MRC's replacement. CIHR is the major federal agency responsible for funding health research in Canada.

The fifth, and perhaps most important, area of federal responsibility is financial support of provincial health care systems. Professor Keith Banting, Director of the School of Policy Studies at Queen's University (Kingston, Ontario), told the Committee that federal involvement in health care delivered by the provinces stems mainly from its constitutional "spending power":

The spending power in our Constitution is assumed to lie with the federal government – to make payments to individuals, to institutions, or to provincial governments, and to make payments even in areas of policy that it does not have the constitutional authority to legislate on or regulate. (...) This authority is not written formally into the Constitution but has been inferred constitutionally from a number of other jurisdictions. This power was core to the development of the welfare state in this country and core to the development of health policy.<sup>3</sup>

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<sup>3</sup> Keith Banting (9:62).

Under its spending power, the federal government can spend money that it has raised through taxation or otherwise and set conditions on the disposition of funds. The Committee was told that the federal spending power is the basis for transferring funds to the provinces to be used for health care, and for administering and enforcing the *Canada Health Act*. As we will see below, the federal government's role in financially supporting provincial health care delivery is important and has a long history.

## **1.2 Cost-Sharing Arrangements**

Canada's publicly funded health care system – or “Medicare” as it is usually called – has evolved into its present form over five decades. Prior to the late 1940s, private medicine and private insurance dominated health care in Canada, and access to care depended on one's ability to pay.

Tom Kent, a former federal deputy minister and senior policy advisor to Lester B. Pearson, explained that the underlying objective of federal health care policy was essentially to ensure timely access to necessary health services without undue financial impediment:

The number of Canadians who knew life before Medicare will very soon be, if it is not already, a minority. Of course, how life was before was the essential reason Medicare developed. As you all know, before that, treatment could be a financial disaster even for well-to-do people, and many poorer people just did not get care when it was needed. The aim of public policy was quite clearly and simply to change that situation to make sure that people could get care when it was needed without regard to other considerations.<sup>4</sup>

The trend toward universal, publicly financed health care insurance began in 1947 when the province of Saskatchewan introduced a public and universal insurance plan for hospital services. Then, in 1957, the federal government introduced the *Hospital Insurance and Diagnostic Services Act* in order to encourage the development of hospital insurance plans in all provinces. Through the provisions of the Act, the federal government offered to share the

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<sup>4</sup> Tom Kent (13:30).

costs of eligible hospital and diagnostic services with the provinces on a roughly 50-50 basis.<sup>5</sup> As a condition for receiving federal money, the provinces agreed to make insured services available to all their residents, under uniform terms and conditions. By 1961, all provinces had signed agreements establishing public insurance plans that provided universal coverage for in-patient hospital care.

In 1962, Saskatchewan once again led the way by extending public health care insurance to physician services provided outside of hospitals. In 1964, the Royal Commission on Health Services, chaired by the Hon. Justice Emmett Hall, recommended that the federal government establish a public medical care insurance plan similar to that available to residents of Saskatchewan. In response to the report of the Hall Commission, the federal government introduced in 1966 the *Medical Care Act*, under which it paid approximately half the costs of eligible physician services.<sup>6</sup> To qualify for federal funding, provincial medical insurance plans were required to satisfy four conditions relating to: public administration, portability, universality and comprehensiveness. By 1972, all provinces had extended their health care insurance plans to include physician services.

*In 1964, the Royal Commission on Health Services reviewed the health system and recommended that the federal government also enter into agreements with the provinces to share the costs of comprehensive, universal medical care for their residents, sustaining the view that pre-paid access to medically necessary physician care for all Canadians was equitable, cost-effective and socially responsible.*

*Abby Hoffman, Senior Policy Advisor,  
Health Canada, (13:10).*

Also in 1966, the federal government introduced the Canada Assistance Plan (CAP). While the main purpose of this federal-provincial program was to cost-share comprehensive welfare services, it also covered the costs of certain health services required by welfare

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<sup>5</sup> Payments due to the provinces under the *Hospital Insurance and Diagnostic Services Act* were calculated as follows: a province's entitlement in a given year was equal to 25% of the average national per capita cost of the insured services, plus 25% of the cost of the insured services per resident of that province multiplied by the population of that province in that year. Overall, the federal government's contribution was equal to about 50% of the cost of insured services in Canada, although it was more in the provinces where the per capita costs were lower than the national average and less in the other provinces.

<sup>6</sup> Under the *Medical Care Act*, a province's entitlement in a given year was equal to 50% of the average national per capita cost of insured services multiplied by the population of that province in that year. As a result, all provinces received equal per capita transfers, although the federal contribution as a proportion of total provincial expenditures varied from one province to another.

recipients but not funded through Medicare or supplementary provincial health care insurance plans including mainly prescription drugs, as well as dental and vision care.

During our hearings, witnesses identified a number of disadvantages associated with the cost-sharing arrangements under both the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*:

- unpredictable for the federal government;
- extremely cumbersome to administer;
- inflexible federal funding, which stifled innovation;
- perceived federal intrusion into an area of provincial jurisdiction.

The Hon. Marc Lalonde, a former federal Minister of Health and Minister of Finance, stated that since federal transfers to provinces were tied to provincial health care spending initiatives, shared-cost programs were proving to be expensive for the federal government, and these costs were unpredictable:

As for the federal government (...), [w]e were stuck with paying 50 per cent of what the provinces wanted to spend in the areas covered, without having any say at all on the allocation of funding by the provincial governments. There was at the time a great desire for predictability of the federal government's obligations.<sup>7</sup>

Tom Kent, who is regarded by some as the father of Canadian Medicare, explained that these cost-sharing arrangements were both cumbersome to administer and perceived as an intrusion into an area of provincial jurisdiction:

(...) how were 50 per cent of the costs reckoned? Hospital insurance had been based on provinces signing agreements that required them to give quite detailed undertakings and be involved in a good deal of federal vetting

*Until then, provinces had come forward to present detailed reports on their programming, and federal officials had to make decisions about whether this particular program – for example, a particular home for the elderly – fell inside or outside the terms of the shared-cost program. Many detailed decisions were being made in Ottawa, which, in effect, was a deeper intervention and deeper administrative control over provincial jurisdiction.*

*Keith Banting  
Queen's University ( 9:64).*

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<sup>7</sup> Hon. Marc Lalonde (15:7).



of what they did. There were objections of principle to that as an intrusion of jurisdiction and a distortion of provincial priorities. Certainly, also very important to both provincial and federal governments, it was very tiresome to administer.<sup>8</sup>

Mr. Lalonde also indicated that the provinces were concerned that funding under the federal legislation was inflexible because it was limited to hospital and physician services. In his view, this generated distortion in the allocation of health care resources and discouraged innovation:

(...) the system in place discouraged innovation and concentrated resources in the most costly areas, namely health, hospital insurance and medical insurance. (...) Over time, we realized that this concept of health care was rather narrow and that there was a less costly alternative to hospitalization for a good many types of treatment. Unfortunately, this alternative was not eligible for cost sharing with the federal government. (...) [For example] the Government of Quebec wanted to set up local community service centres to take the overflow from the hospitals, promote less specialized services and improve accessibility. It however found itself in a situation where it was forced to absorb 100 per cent of the costs.<sup>9</sup>

In 1977-78, the 50-50 federal provincial cost-sharing arrangements were replaced by the Established Programs Financing (EPF), a block funding transfer mechanism that combined federal transfers for hospital services and medical care with transfers for post-secondary education. The same year, the federal government also implemented the Extended Health Care Services Program (EHCSF) to provide financial assistance to provinces for ambulatory care, nursing home intermediate care, adult residential care and home care. Transfers under the EHCSF were tied to the EPF block fund.

*The new system, called block funding, said that the federal government would make a general contribution to the provinces to cover health and post-secondary education. There would no longer be an exact fit between expenditures and transfers – that is, the federal government would make a general transfer that would not be based on what the provinces were spending but would grow over time with the rate of growth in the economy. The amount transferred would be unrelated to how much the province had actually spent.*

*Keith Banting  
Queen's University (9:64).*

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<sup>8</sup> Tom Kent (13:33).

<sup>9</sup> Hon. Marc Lalonde (15:6-7).

### **1.3 Functioning of the EPF Block Funding**

Under the EPF, each province received an equal per capita transfer for health care and post-secondary education. About 70% of all EPF transfers were notionally earmarked for the "health care" component, while the remaining 30% were notionally tied to the "education" component. This breakdown was arbitrary, because EPF was a "block" funding mechanism. Unlike shared-cost programs, EPF transfers were not linked to the provinces' own expenditures on health care and post-secondary education. Furthermore, these percentages did not necessarily reflect equal apportionment at the provincial level, since provinces were able to use EPF transfers according to their own priorities.

EPF entitlements comprised two components, a tax transfer and a cash transfer. Under the tax transfer, the federal government ceded a certain tax room to the provinces through the transfer of tax points. To do this, it reduced its tax rates while the provinces increased their rates by an equivalent amount. This procedure resulted in a reallocation of revenue between the two levels of government: federal revenue was reduced by an amount equivalent to the increase in the provincial governments' revenues. The fiscal burden on taxpayers remained the same because, although they paid more provincial tax, they paid less federal tax.<sup>10</sup> The cash transfer, which was a payment made periodically by cheque, matched the difference between the total EPF entitlement of each province and the value of the tax transfer.

Originally, the basic payment under EPF was calculated on an initial per capita amount, determined in 1975-76, which was then adjusted each year, according to an escalator that reflected the rate of growth in the gross domestic product (GDP)<sup>11</sup> per capita.<sup>12</sup> To

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<sup>10</sup> Under EPF, the federal tax transfer was 13.5 tax points on personal income tax and one tax point on corporate income tax. The provinces whose fiscal strength was lower than a provincial standard received equalization payments to bring their transfer up to that standard (the provinces making up the standard were Quebec, Ontario, Manitoba, Saskatchewan and British Columbia). As part of its opting-out agreements, Quebec received a special abatement of 8.5 additional tax points on personal income. Because of this additional abatement, Quebec received a relatively larger share of its federal contribution than the other provinces in the form of transferred tax points and a smaller share in the form of cash. In total, however, Quebec's per capita entitlement under EPF was exactly the same as those of other provinces.

<sup>11</sup> The GDP measures the value of all goods, services and investment in a country during a defined period of time, usually a year.

<sup>12</sup> The initial per capita entitlement amounted to \$144.34 for hospital and medical care, \$68.31 for post-secondary education and \$20.00 for extended health care.

determine the total value of a province's EPF entitlement, the initial per capita amount was multiplied by the escalator and then by the population of that province.

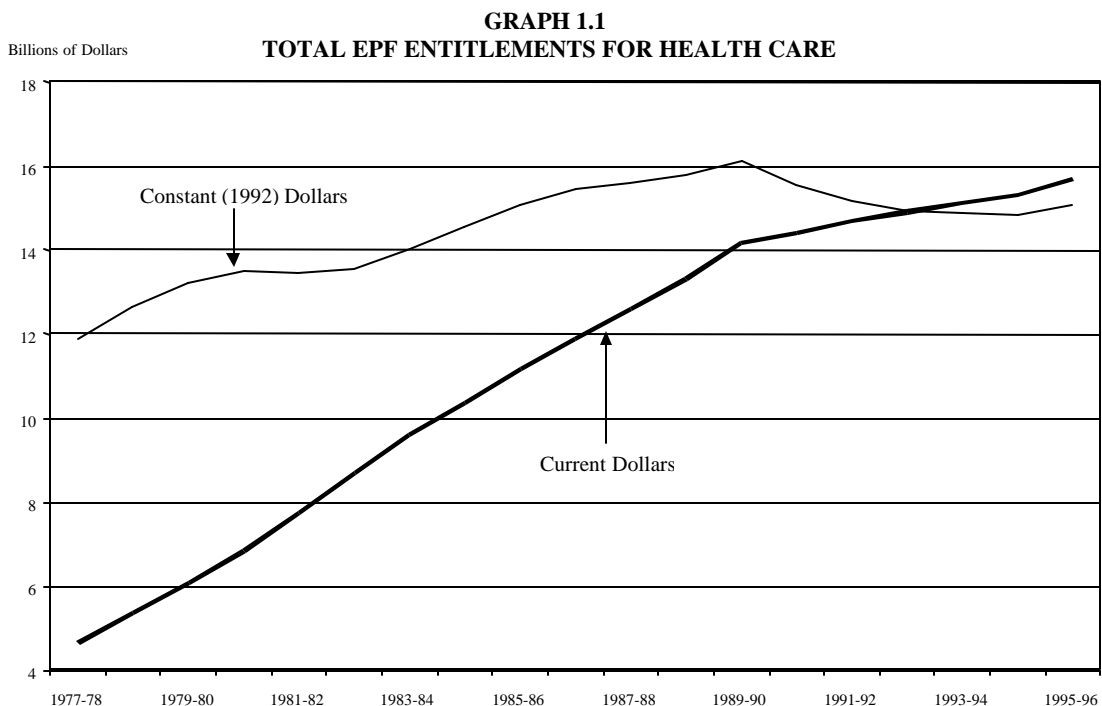
In an effort to reduce the federal deficit, the escalator was modified on several occasions. In 1983-84 and 1984-85, the escalator associated with the education portion of EPF was capped at 6% and 5% respectively (if the formula based on the growth in the GDP per capita had been used, the education component of EPF would have increased by 9% in 1983-84 and by 8% in 1984-85). For all other years, the escalator for post-secondary education was the same as for health care.

From 1986-87 to 1989-90, the escalator used to calculate total EPF entitlements was reduced by 2%. After this period, and until 1994-95, per capita transfers were frozen at their 1989-90 levels, so that increases in transfer payments hinged on population growth in each province (about 1%). For 1995-96, the escalator was decreased by 3% and the result was a negative escalator (almost -1.0%, according to the Federal-Provincial Relations Division of the Department of Finance); this meant a decrease in per capita transfers, given the fact that GDP growth was less than 3%.

Graph 1.1 depicts total EPF entitlements for health care in both current and constant dollars. Expressed in current (nominal) dollars, total EPF transfer payments for health care increased continually, although the growth rate slowed down considerably in the late 1980s. When adjusted for inflation and converted into constant (1992) dollars, however, EPF entitlements for health care began to decline in 1989-90. Because of its deficit and its desire to reduce expenditures, in the late 1980s and early 1990s the federal government gradually levelled off its real contribution to health care to the provinces.

In order to obtain an idea of the magnitude in the reduction of federal funding, we asked the Library of Parliament to estimate the shortfall in provincial revenues due to the constraints on the growth of EPF transfers for health care. Two different ways of computing these losses were used. The first computation results in an estimate of the difference between actual EPF entitlements and the theoretically possible value of federal transfers to provinces

if no changes had ever been made in EPF. The second computation is of a different nature as it compares the legislated changes to the EPF formula from one period to the next one. It yields the difference between actual EPF entitlements for health care and the level of transfers the provinces would have otherwise received if we assume that the formula used in the preceding period had been maintained. The results of these calculations are provided in Table 1.1. While these numbers should be used with caution, it is clear that the provinces incurred continual losses in federal transfers for health care between 1986-87 and 1995-96.



Source: Department of Finance, Special Computation, 21 July 2000, and Library of Parliament.

Some witnesses suggested that, while this might not have been the initial intent of EPF, block funding allowed the federal government to cut its financial commitment to health care. For instance, the Hon. Marc Lalonde commented:

I wish to emphasize that the intent at the time was not to reduce the federal contribution to the services already covered, but it is obvious that subsequent

events proved that it was perhaps easier for the federal government to do this under the 1977 program than previously.<sup>13</sup>

**TABLE 1.1**  
**ESTIMATED SHORTFALLS IN PROVINCIAL REVENUES DUE**  
**TO CONSTRAINTS ON THE GROWTH OF EPF TRANSFERS**  
**FOR HEALTH CARE**

	<b>Results of First Computation (in dollars)</b>	<b>Results of Second Computation (in dollars)</b>
<b>1986-87</b>	226,309,946	226,309,946
<b>1987-88</b>	486,176,584	486,176,584
<b>1988-89</b>	779,908,361	779,908,361
<b>1989-90</b>	1,119,885,311	1,119,885,311
<b>1990-91</b>	2,235,404,086	1,923,289,637
<b>1991-92</b>	3,091,649,580	2,428,407,569
<b>1992-93</b>	3,516,854,362	2,485,271,924
<b>1993-94</b>	3,688,879,572	2,287,699,962
<b>1994-95</b>	3,935,164,742	2,152,824,719
<b>1995-96</b>	4,533,434,766	2,270,889,679
<b>TOTAL</b>	<b>23,613,667,310</b>	<b>16,160,663,692</b>

*Source: Department of Finance and Library of Parliament.*

This, however, was detrimental to the federal government's visibility in the field of health care:

It was obviously more difficult to evaluate the specific federal contribution to each program since you had payments covering a group of programs and since there was no specific allocation, contrary to what had previously been the case (...). Without a doubt this brought a certain reduction of the political visibility of the federal government's contribution.<sup>14</sup>

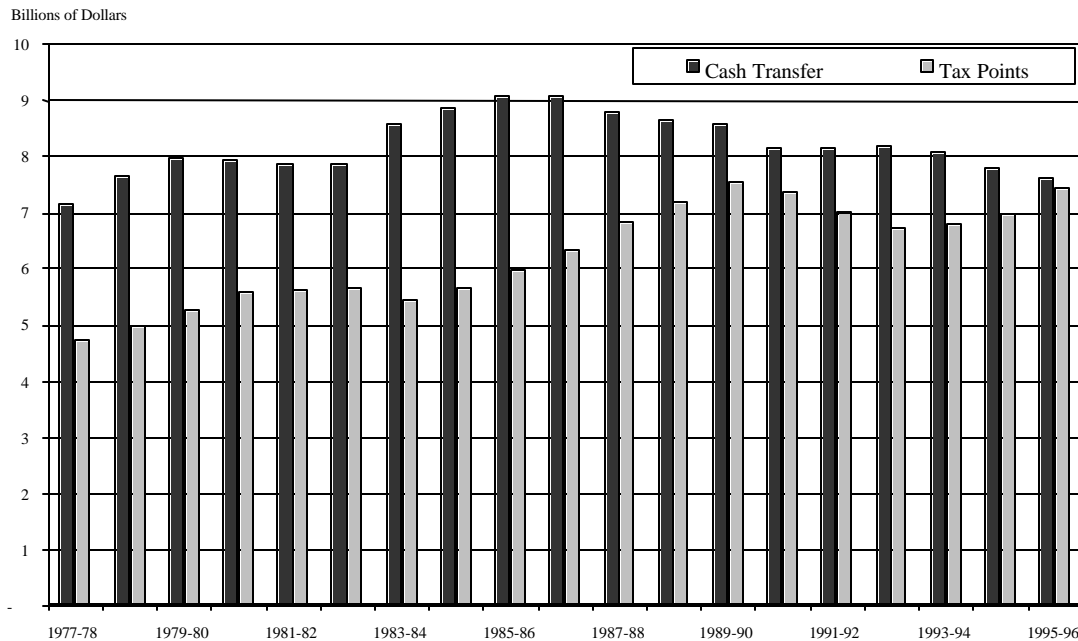
Graph 1.2 shows the diverging paths of transfers in the form of cash and tax points resulting from the limits to the overall rate of growth in EPF entitlements. While the cash transfers for health care declined continually between 1986-87 and 1995-96, the value of the tax transfers increased in real terms in the first half of the 1990s. It became clear that, over the medium term, constraints on the growth rate of EPF entitlements for health care would

<sup>13</sup> Hon. Marc Lalonde (15:7).

<sup>14</sup> *Ibid.*

have caused the cash transfers to some provinces to come to an end. The distinction between cash and tax transfers is discussed in more detail in section 1.5 below.

**GRAPH 1.2**  
**EPF CASH AND TAX TRANSFERS IN CONSTANT (1992) DOLLARS**



Source: Department of Finance. Special Computation. 21 July 2000. and Library of Parliament.

## 1.4 The CHST

In the Budget Speech of February 1995, the federal government announced its intention to merge the EPF with the CAP into a new block funding mechanism called the Canada Health and Social Transfer (CHST) that would cover transfers for health care, post-secondary education and social assistance. The CHST legislation was implemented for the 1996-97 fiscal year with the coming into force of Bill C-76. Since then, the *Federal-Provincial Fiscal Arrangements Act*, which now governs the CHST, has been modified on five different occasions by the following pieces of legislation: Bill C-31 (1996), Bill C-28 (1998), Bill C-71 (1999), Bill C-32 (2000) and Bill C-45 (2000). Table 1.2 provides the details of the various legislative steps for the CHST.

**TABLE 1.2**  
**A BRIEF HISTORY OF THE CHST**

<b>1995</b>	<p>Budget announced that, starting in 1996-97, EPF and CAP programs would be replaced by CHST block fund. Meanwhile, for 1995-96 (<u>Bill C-76</u>):</p> <ul style="list-style-type: none"> <li>• EPF growth set at GDP growth minus 3 percent.</li> <li>• CAP frozen at 1994-95 levels for all provinces.</li> <li>• CHST entitlements set at \$26.9 billion for 1996-97 and \$25.1 billion for 1997-98.</li> <li>• CHST entitlements for 1996-97 to be allocated among provinces in the same proportion as combined EPF and CAP entitlements for 1995-96.</li> <li>• CHST cash transfer to be obtained residually by subtracting the value of the tax transfer from the total CHST entitlement.</li> </ul>
<b>1996</b>	<p>Budget announced a five-year CHST funding arrangement covering the years 1998-99 to 2002-03 (<u>Bill C-31</u>):</p> <ul style="list-style-type: none"> <li>• For 1996-97 and 1997-98, CHST entitlements maintained at \$26.9 and \$25.1 billion respectively. Then, for 1998-99 and 1999-00, CHST entitlements fixed at \$25.1 billion. For each subsequent fiscal year, through 2002-03, total CHST entitlements set to increase according to an escalator equal to the average GDP growth for the three preceding years, less a predetermined coefficient (2% in 2000-01, 1.5% in 2001-02 and 1% in 2002-03).</li> <li>• Guaranteed cash floor of at least \$11 billion per year.</li> <li>• A new allocation formula introduced to reflect differences in provincial population growth and to narrow existing funding disparities, moving half-way to equal per capita entitlements by 2002-03.</li> </ul>
<b>1998</b>	<p>Legislation passed putting in place a \$12.5 billion cash floor under the CHST for the years from 1997-98 to 2002-03 (<u>Bill C-28</u>). As a result, total CHST entitlements varied directly with the value of tax points, and CHST cash transfer no longer determined residually.</p>
<b>1999</b>	<p>Budget announced increased CHST funding of \$11.5 billion over 5 years, and this amount was earmarked specifically for health care (<u>Bill C-71</u>):</p> <ul style="list-style-type: none"> <li>• \$8 billion provided through increases to the CHST and \$3.5 billion provided through a CHST supplement to give provinces and territories the flexibility to draw down funds over three years as they see fit. One-time cash supplement to be allocated to the provinces on an equal per capita basis.</li> <li>• The cash floor provision was abolished as the amended legislation provided a level of cash transfer over and above the \$12.5 billion limit. Similarly, the escalator used to calculate growth in total CHST entitlements was eliminated since the total entitlement was no more fixed in legislation but varied directly with the cash transfer.</li> <li>• Changes to the provincial allocation formula accelerated the move to equal per capita CHST by 2001-02.</li> <li>• CHST legislation extended program to 2003-04.</li> </ul>
<b>2000</b>	<p>Budget announced a \$2.5 billion increase for the CHST to help provinces and territories fund both post-secondary education and health care (<u>Bill C-32</u>). These funds were paid into a CHST Supplement Fund and allocated on an equal per capita basis. Provinces can draw down their respective share at any time over the course of four years (2000-01 to 2003-04).</p>
<b>2000</b>	<p>The CHST legislation was extended by one year to 2005-06 and the total CHST entitlement was increased by \$21.1 billion over a five year period (<u>Bill C-45</u>). The enriched cash transfer is to cover all the three fields supported by the CHST, including early child development, and be allocated to the provinces on an equal per capita basis.</p>

Source: Department of Finance (<http://www.fin.gc.ca/fedprove/hise.html>) and Library of Parliament.

The structure of the CHST is similar to that of the EPF, as the federal transfer of funds involves both cash and tax transfers. Unlike EPF, however, the CHST included a cash floor provision. The cash floor, which was initially set at \$11 billion and then increased to \$12.5 billion in 1997-98, was established to make sure that the growth in the value of tax points would not erode the cash transfer.<sup>15</sup> Many witnesses pointed out that, by bringing in the CHST, the federal government has prevented the erosion of its power to ensure that the provinces comply with the *Canada Health Act*.

The CHST legislation sets out the manner in which the total entitlement is to be allocated among the provinces. Initially, provincial entitlements were not calculated on a per capita basis. Under Bill C-76 (1995), the allocation for fiscal year 1996-97 was based solely on each province's share of the transfers received under the CAP in 1994-95 and under EPF in 1995-96. Then, under Bill C-31 (1996), each province's CHST entitlement for 1997-98 was based on the transfers received under the earlier programs and on the ratio between each province's cumulative population growth and Canada's. From 1998-99 to 2002-03, the allocation formula was to be similar to the one used in 1997-98, but took into account each province's proportion of the country's population, and a weighting coefficient was used in the calculation. This change to the formula was aimed at reducing discrepancies among provinces in the value of per capita transfers but without making equal per capita allocations.<sup>16</sup>

With the enactment of Bill C-71 in 1999, the method of allocating the CHST transfer to the provinces was modified once again. Under the new method, the provincial distribution focuses less on the initial provincial share (based on the former EPF and CAP) and more on the province's demographic weight. As a result, the CHST transfer is moving gradually towards an identical per capita distribution among the provinces. In fact, it is expected that all provinces will receive an equal CHST per capita entitlement by 2001-02.

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<sup>15</sup> The cash floor provision of the CHST was abolished in 1999 as the amended legislation (Bill C-71) provided a level of cash transfer over and above the \$12.5 billion limit.

<sup>16</sup> The main reason for these discrepancies was the funding disparity under the CAP: the provinces that used to receive a greater than average share under the CAP continued to receive a greater than average share under the CHST.



Equal per capita entitlements are to be achieved on a cash and tax basis, not cash alone. The federal cash contribution, per capita, will still vary from province to province. All equalization-receiving provinces obtain, as in the past, a per capita CHST cash contribution that is higher than the all-province average. This is due to the fact that they need more federal cash, per capita, to bring their entitlements to the national average.<sup>17</sup> By contrast, richer provinces will receive more of their federal support from the tax points and less from cash transfers.

Consequently, if the CHST cash component were to be allocated on an equal per capita basis, the total per capita entitlements would be higher for provinces with higher income than for those with lower income because tax points have a higher value in higher income provinces. In the federal government's opinion, equal per capita entitlements ensure that all provinces receive equitable federal support regardless of differences in provincial governments' revenues and economic growth rates.<sup>18</sup>

As Graph 1.3 shows, important reductions in federal transfers to provinces were implemented when Bill C-76 (1995) created the CHST. From 1995-96 to 1996-97, the total CHST entitlement (expressed in current dollars) decreased by \$3.0 billion or 10%. During the same period, the cash transfer declined even more steeply, by some \$3.7 billion or 20%. In the following year, the overall CHST entitlement was reduced again by \$1.1 billion (or 5%), while the cash transfer decreased by \$2.2 billion (or 15%). The changes legislated by Bill C-28 (1998) and Bill C-71 (1999) reversed the downward trends in both the total CHST entitlement and its cash component.

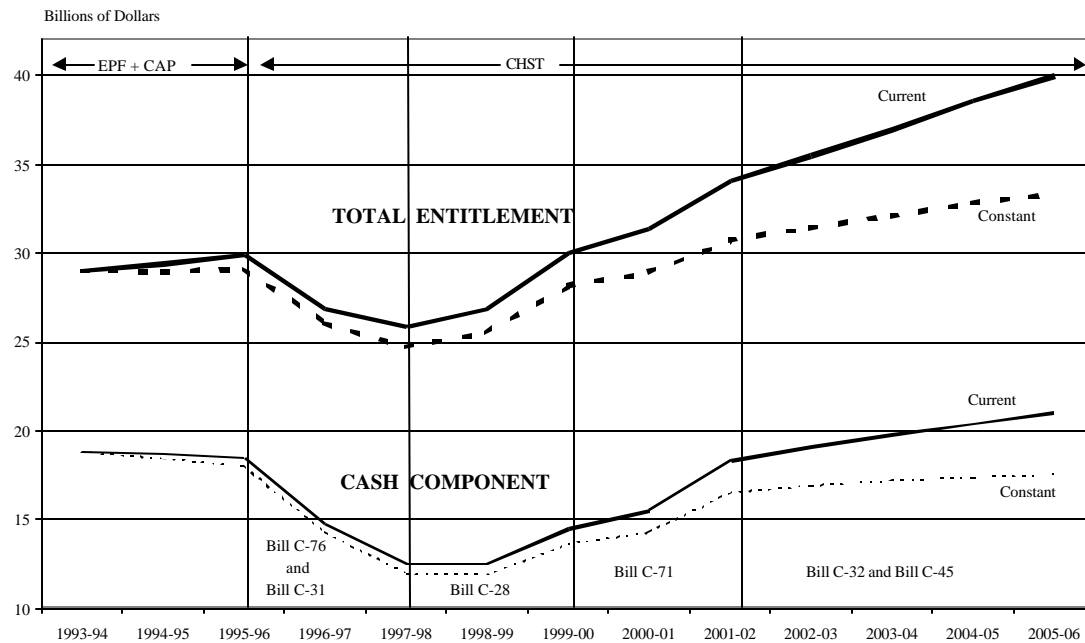
*Clearly, as we all know, the CHST represented a cut in cash transfers at a time of broad cutbacks in federal spending to address the deficit situation. However, the value to the provinces of the tax point portion of the CHST continued to grow as the economy grew.*

*Abby Hoffman, Senior Policy Advisor, Health Canada (13:9).*

<sup>17</sup> Finance Canada, *History of the Canada Health and Social Transfer*, Submission to the Standing Senate Committee on Social Affairs, Science and Technology, 7 June 2000, p. 3.

<sup>18</sup> *Ibid.*, p. 6.

**GRAPH 1.3**  
**TOTAL CHST ENTITLEMENT AND CHST CASH COMPONENT**



Source: Finance Canada and Parliamentary Research Branch, Library of Parliament.  
 Nota: The conversion into constant (1993-94) dollars were made by using the implicit price index for government expenditures; an annual growth of 2% was assumed from 2000-01 to 2005-06.

Bill C-32 (2000) and Bill C-45 (2000) together led to substantial growth in both the total CHST entitlement and the CHST cash transfer. Bill C-32 established a CHST supplement fund of \$2.5 billion to be allocated to provinces on an equal per capita basis. Bill C-45 was enacted in response to the federal-provincial health accord reached on September 11, 2000, following a First Ministers' Meeting; it provides additional federal investment of \$21.1 billion in CHST cash transfers. The health accord also resulted in a further \$2.3 billion in federal targeted funding to help the provinces meet health care challenges in three specific areas: acquisition of medical equipment (\$1 billion), health information technology (\$0.5 billion) and primary care reform (\$0.8 billion).

Total CHST entitlement, expressed in current dollars, is expected to reach a new high of close to \$31 billion in 2000-01, slightly above its position prior to the 1996-97 reduction. The CHST cash transfer will match its peak level in 2002-03. However, when converted into constant (1993-94) dollars, the total CHST entitlement will surpass the 1995-96 level only in 2002-03, while the CHST cash transfer will never achieve its peak level of 1993-94.

Meanwhile, the value of the CHST tax transfer is constantly growing: from 1997-98 to 2000-01, a higher proportion of the CHST was provided in the form of tax transfers.

Although the federal government introduced measures to halt cuts in CHST transfer payments and to ensure growth in transfers (namely through bills C-28, C-71, C-32 and C-45), it failed, according to the provinces, to restore the cash portion to previous levels. On a number of occasions, provincial governments called on the federal government to restore the CHST cash transfer to the 1994-95 levels and to include an escalator to ensure appropriate growth in the CHST. In their view, this would be a major step toward stabilizing and sustaining Canada's health care system.<sup>19</sup>

### **1.5 Tax Points versus Cash Transfers**

The federal government and the provinces do not agree on what constitutes the federal contribution to health care because they hold different views on the tax transfer. The federal government believes that cash and tax transfers should be regarded as the same in that both represent a cost to the federal treasury and both contribute to provincial revenues. Therefore, the federal government includes the tax component in the calculation of the overall CHST entitlement.

The provinces, however, do not consider it legitimate to count the value of tax points as part of the CHST transfer. They maintain that the tax points constitute a one-time permanent transfer that occurred 23 years ago and that they are now firmly embedded in the provincial tax room. Moreover, they contend that over the past two decades the federal government has more than recaptured the tax room it ceded to the provinces in 1977. In the view of the provinces:

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<sup>19</sup> Provincial Premiers and Territorial Leaders, *Letter to the Prime Minister of Canada*, 3 February 2000. A copy of this letter is available on the Canadian Intergovernmental Conference Secretariat's Internet site at [http://www.scics.gc.ca/cinfo00/85007604\\_e.html](http://www.scics.gc.ca/cinfo00/85007604_e.html). Also see the following statement: "Premiers' Commitments to their Citizens", 41<sup>st</sup> Annual Premiers' Conference, *News Release*, 11 August 2000 (available at [http://www.scics.gc.ca/cinfo00/850080017\\_e.html](http://www.scics.gc.ca/cinfo00/850080017_e.html)).

(...) the federal practice of including the tax component has – particularly in recent years – had the effect of making the CHST transfer appear larger than it actually is, and making the CHST cuts appear smaller.<sup>20</sup>

During our hearings, witnesses expressed different views on the tax transfer. In her statement to the Committee, the Hon. Monique Bégin suggested that tax points should be entirely removed from CHST calculations and that only cash should be transferred to the provinces. In her view, this approach would both preserve the federal government's role in establishing and maintaining national principles and enable the provincial governments to rely on a steady contribution. This suggestion could be implemented only if the federal government agreed to forego the cost it incurred when it initially transferred tax points to the provinces.

*I would just take the tax points out of the way. I think it poisons the whole thing and does not help at all. If it was bad politics, so be it. It was bad politics, but I still believe firmly that it was the only thing they could do at the time. Perhaps they should have given fewer tax points and more cash.*

*Hon. Monique Bégin (16:8).*

By contrast, the Hon. Marc Lalonde held the view that the tax transfer was and still is a valid federal contribution:

I also believe that contribution in tax points should not just be written off on the basis of, "It is gone, so it is gone." It is something that the federal government, at a certain stage, has said we will withdraw. That contribution, in my view, is still there. There is a way of evaluating it, certainly in terms of the contribution of the federal Parliament to provincial programs in the field of health or in the general field of the services covered now with the new system, which includes post-secondary education and health and welfare.<sup>21</sup>

Mr. Lalonde also told the Committee that the tax transfer was, and remains, a reasonable compromise in terms of the federal involvement in an area of primarily provincial jurisdiction. Also, in 1977, it appeared to be the only way to reach an agreement with all provinces:

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<sup>20</sup> Provincial and Territorial Ministers of Health, *Understanding Canada's Health Care Costs – Interim Report*, June 2000, p. 10.

<sup>21</sup> Hon. Marc Lalonde (15:13).

Fundamentally, it was a political settlement with the provinces. We bought our peace at a certain cost, no doubt. (...) provinces generally felt that the federal government was spending money in what were recognized as provincial matters or provincial jurisdictions. We argued that, indeed, we were using the constitutional spending power that we had. It was clear that these programs would be in operation, we assumed, for a long time. Some provinces had tax points that brought in more money than others, and the provincial governments were insisting that they would feel much more reassured that they were not at the whim of the federal government if at least part of the transfer was in the form of tax points.<sup>22</sup>

Overall, there is no one answer to the whole question of how to account for tax points. Keith Banting suggested that both the perspective of the federal government and the views of the provinces are right:

There is no single answer to the question as to what is the federal contribution to health care. The provinces have taken the view that the transferred tax points are simply part of the tax base of the provinces and that the federal contribution is therefore the cash contribution. The federal government says that, no, its contribution is both the cash transfer and the value of the tax points transferred in 1977, as escalated by growth in the economy. As a consequence, there are two answers to the question regarding the federal contribution to health care. Both the provinces and the federal government are right. They both define the system differently and, in their terms, they are both correct.<sup>23</sup>

## **1.6 The Federal Contribution to Health Care**

What is, then, the federal contribution to health care? Under the 1957 and 1966 cost-sharing arrangements, the federal share corresponded to approximately 50% of the eligible hospital and physician services covered under provincial health care insurance plans. It did not correspond to 50% of all public health care costs incurred in the provinces.

When EPF was implemented, a notional portion of the transfer payments was attributed to health care. Under the CHST, however, there is no specific allocation for health care, not

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<sup>22</sup> Hon. Marc Lalonde (15:10-11).

<sup>23</sup> Keith Banting (9:65).

even a notional one. Therefore, it is not possible to determine exactly how much the federal government spends on health care.

Health Canada provided an estimate of the federal contribution to health care, calculated on the basis of the same notional apportioning among health care, post-secondary education and social assistance as existed in the pre-CHST days under the combined effects of EPF and CAP. This estimate was used to calculate the federal share of provincial government spending on health care.

This information was used to construct Graph 1.4, which depicts the evolution of public health care spending by source of financing from 1977-78 to 2003-04. These data, as reported by Health Canada, show that spending on health care from provincial funds in 1999-00 is expected to amount to 65% of total health care expenditures

*I wish to say that it is difficult (...) to determine exactly how much the federal government spends on health because of the flexibility under the CHST. When one calculates federal contributions to health using the same notional apportioning among health, post-secondary education and social security as existed in the pre-CHST days under the combined effects of EPF and CAP, the federal government is contributing \$1 out of every \$3 spent on health by public authorities in Canada. That is a subject of debate at the moment, but it is undeniable that it is a one-in-three share of public spending.*

*Abby Hoffman, Senior Policy Advisor,  
Health Canada (13:10).*

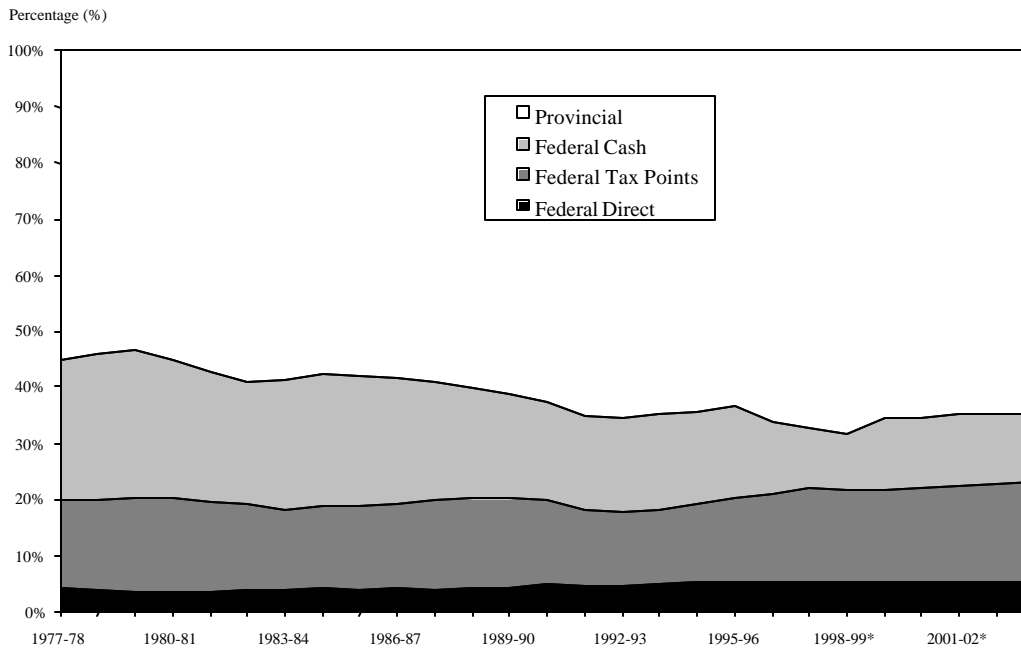
by the public sector. Thus, the federal share for that year is approximately 35%. If tax points are not included as part of the federal contribution, then the proportion of health care spending by provincial governments totals some 82%, while the federal share is 18%.

Health Canada's data also indicate that the provincial governments' share of public health care expenditures has been increasing steadily since the late 1970s, irrespective of the method of calculation used. Concurrently, the estimated federal share has been declining since then. The value of tax transfers and federal direct funds<sup>24</sup> are increasing slightly, but the cash transfer share is largely decreasing. This downward trend could be reversed, however, with the additional federal investment in health care provided in Bill C-45 (2000).

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<sup>24</sup> Federal direct funds refer to direct health care spending by the federal government in relation to health services for specific groups (Aboriginals, the Armed Forces and veterans), as well as for health research, health promotion and health protection.

**GRAPH 1.4**  
**SOURCE OF HEALTH CARE FUNDING BY THE PUBLIC SECTOR**



Source: Health Canada *Health Expenditures in Canada - Sources of Financing*, and Library of Parliament

## 1.7 The Need for Stability in Federal Funding

According to Tom Kent, subsequent federal governments have, over the years, played a major role in diminishing the federal commitment to health care by restraining the growth or reducing transfer payments to provinces. He stated that federal funding for the purpose of health care should be committed in relation to provincial costs and that stable federal financing would insure uniformity and consistency of provincial health care insurance plans:

As yet, the main attack on Medicare has not come from "two-tierdom," from Mr. Klein or from anyone else. It has come over a good many years from federal governments. Medicare was not built on principles for the provinces alone. It was also built on federal principles, and the crucial federal principle was its commitment to share in the costs of the provinces. That commitment has been increasingly dishonoured ever since 1977, and in 1995 it was completely tossed aside. In 1977, as you know, the form of financing was switched in part to a transfer of taxes instead of a cash transfer. That had its merits, but at the same time the opportunity was taken to de-couple the total from provincial health costs and relate it instead to the GNP. Subsequently, by unilateral federal decisions, that relation was increasingly diminished, and finally, with the CHST, the Canada Health and Social Transfer, all vestige of

a formula was removed. The transfer became an arbitrary sum determined entirely according to federal financial and political convention. Political pressure has since led to some restoration of the original cuts, but there has been no restoration of the principle of federal commitment. (...)

For better or worse, delivering health care is provincial business. There will be collaboration and there can be national consistency if there is federal financial help. However, what is significant is not so much the amount of that help but that, if there is to be the planning of efficient, comprehensive health care, it must be based on an assurance of financing. Part of that financing must be federal if we are to have consistent national programs, and it is important that that federal share be committed in relation to provincial costs.<sup>25</sup>

*In my province, I have seen radical and arbitrary cost cutting, and decisions have been taken that were purely looking at the short term. The Minister of Finance wanted to have a smaller deficit next year, and that was it. We ended up with the early retirement of nurses in Quebec. We made them an offer that they could not refuse. Next thing we knew, we were short of nurses. We are rehiring those willing to come back and paying them hefty remuneration. We are in a situation now where we are even sending people to the United States to be treated at public expense. Surely, this could have been foreseen. Surely, we know what the needs of the population will be over the next few years. It is mind boggling to see situations like this, and it is totally unacceptable. I can understand why there is such an outcry amongst the people in Canada about the current situation and the tendency to say, "A plague on both your governments' houses. It is your job to fix it; get going."*

*I hope that there will arise out of your deliberations a recommendation that the federal government at least look at providing a stable base of financing over the next decade.*

*Hon. Marc Lalonde (15 :23-24).*

Most witnesses agreed on the necessity for stable and predictable federal transfers. However, Guillaume Bissonnette, General Director of the Federal-Provincial Relations and Social Policy Branch, Finance Canada, told the Committee that the concept of stability of funding should be balanced with the notions of adequacy, affordability and sustainability:

(..) we are trying to balance a number of competing notions. We obviously want to take into account the notion of affordability, which is important. We also want to take into account the notion of adequacy – which, in a sense, is the flip side. How much is adequate? As well, we want to take into account a notion that is talked about frequently on the environmental side, but which I think applies here, too, and that is the concept of sustainability over time and the notion of stability.

<sup>25</sup> Tom Kent (13:34-35).



Of course, there are conflicts between all those pairs of concepts. You cannot make commitments about a stability. They are so strong that when the world changes – and nobody can control what happens in the world – you find that your commitments are no longer sustainable. You do not want to make commitments, for example, about adequacy and then find that those commitments are not affordable – not just by one order of government but by both orders of government.

Thus, in a sense, we are trying to balance all of these notions. Presumably, we are also trying to balance the fact that there are other spending priorities that are also meritorious. Health is important for the future of the country, but so are post-secondary education, research and innovation. They are viewed as key to the development of our country.<sup>26</sup>

During the Committee's hearings, there was no agreement on the mechanism through which more federal transfers for health care and social programs should be provided. Ms. Bégin, for example, suggested that there should be a specific program for home care and primary care. In her view, this should be done under a new piece of legislation which would parallel the *Canada Health Act*.<sup>27</sup>

By contrast, Tom Kent indicated that separate financial support would not be conducive to an integrated, efficient and coordinated system of health care delivery:

I groan, frankly, when I hear talk, in federal circles in particular, of separate financial support for home care or Pharmacare or whatever is the hot button. That would make a political splash, but that sort of division of the total health care service would be disastrous. Health care of high quality can be efficiently delivered according to need, but only if there is coordinated management in the community of the comprehensive services – the components of the whole health care system. Separate bags of money are certainly not the way to reform health care.<sup>28</sup>

The Hon. Claude Castonguay, a former Quebec health minister in the 1960s, also known as the father of Medicare in that province, believes that the federal government should not designate more funds to specific programs of primary care and home care, but should

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<sup>26</sup> Guillaume Bissonnette (17:12).

<sup>27</sup> Hon. Monique Bégin (16:5).

<sup>28</sup> Tom Kent (13:32).

provide flexible funding that would let provinces allocate money according to their own needs and priorities:

The federal government has proposed to increase the level of its financing through the establishment of a national program of primary care and home care. The provinces find this proposal inappropriate while they are struggling with their existing plans. They know what has to be done and that what they need most is additional funds. Instead of its proposed plan, the federal government could play a much more useful role by bringing to the provinces transitional financial help. The objective would be to give the provinces some room or margin to allow them to develop new approaches and to introduce changes in their plans capable of improving the situation in a durable way. In the middle of the sixties, the federal government created a health resources fund to enable all the provinces to have the human resources and the equipment necessary for the introduction of Medicare. Using that successful initiative as a model, the federal government could create a health transition fund to help the provinces make the necessary changes to their respective plans. The setting up of such a fund, to which it could allocate at least the funds intended for the national primary and home care programs, would give the federal government an essential role fully compatible with its responsibility with respect to health services and the visibility it is seeking in this field. Contrary to a primary and home care national program, this approach had the advantage of not pressuring the provinces into increasing in a permanent way the level of their health expenditures when they are not in a position to finance adequately their existing plans.<sup>29</sup>

## **1.8 Accountability in the Use of Federal Health Care Dollars**

The issue of accountability surfaced on a number of occasions during the hearings. The Committee was told that the notion of accountability for federal dollars has evolved enormously over the years:

(...) there has been an evolution in the notion of accountability. There has been a long, steady evolution away from tracing dollars and tracing inputs to broader, more modern definitions of accountability that have to do with measuring results.

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<sup>29</sup> Hon. Claude Castonguay, *Canada's Health Care System: An Urgent Need for Change*, Brief to the Committee, pp. 3-4.

One could look back at the history of these transfers, since the Second World War. In fact, there has been a constant search for an accountability link with the dollars being spent. If one looks at that evolution, one sees that, in the 1940s, we started with accountability, meaning that the federal government would actually inspect provincial hospitals to find out whether they met certain standards.

In the 1950s, we moved to a slightly more flexible form of accountability, that is, cost-sharing, where we agreed that we would cost-share a certain well-defined basket of doctor services and hospital services.

With the advent of EPF, we moved, yet again, to another notion of accountability, which was less concerned with the use of inputs and the matching of inputs. It was a form of accountability that basically gave a block fund, had some general principles, and then counted upon the provinces to use the money in a way that respected those general principles.

If we carry the evolution of this practice of accountability right up to the social union framework agreement, we are now seeing accountability being defined much more in terms of results achieved and in terms of outcomes.

In a sense, there has been a shift away from inputs to outputs to broader results. There has been a shift, as well, in the doctrine of accountability and what we mean by accountability.<sup>30</sup>

It is clear that the concept of accountability has changed dramatically over the last forty years or so. The recent shift from evaluating inputs to estimating outcomes is of particular importance. For most of the last century, Medicare was evaluated on the basis of inputs. While we know how public health care funding has been allocated among physicians, institutions, hospital beds and so on, it is astonishing how little we know about how effectively the money has been used. We need to start measuring the quality of the health care system by its outputs, not its inputs. This is essential if we are to know how to spend government funds more wisely.

To do this, we need better information. With better information, governments will be able to make more informed decisions about the management, delivery and financing of health care.

Better information will also ensure that governments are accountable to Canadians for the way in which they spend health care dollars. In Phase Two of its study, the Committee will examine the issues related to health information, including evidence-based and outcome-based decision-making and the potential role of the federal government in this area.

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<sup>30</sup> Guillaume Bissonnette (17: 11).



## CHAPTER TWO:

### NATIONAL PRINCIPLES FOR HEALTH CARE AND THE ADVENT OF THE *CANADA HEALTH ACT*

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The fact that the delivery of health care is primarily an area of provincial jurisdiction does not mean that national principles are absent. The federal government has always attached a set of national principles or conditions to its health care contribution, whether cost-shared or block-funded.

#### 2.1 The Origins of the *Canada Health Act*

Both the *Hospital Insurance and Diagnostic Services Act* of 1957 and the *Medical Care Act* of 1966 included four explicit conditions for provincial public health care insurance plans – namely universality, public administration, comprehensiveness and portability. They did not, however, contain specific provisions preventing provinces from demanding a financial contribution from patients. Moreover, since federal contributions under cost-sharing arrangements were proportional to provincial government expenditures, the provincial governments had nothing to gain from permitting direct patient charges; the revenue from such charges would in fact have resulted in a reduction in the federal contribution. This implicit reduction mechanism thus strongly deterred provinces from adopting any form of direct patient charges, such as extra-billing or user fees.

In 1977-78, when EPF replaced the shared-costs formula, the conditions attached to both federal acts on hospital services and medical care were retained. However, the implicit mechanism for reduced federal contributions was eliminated, since federal funding was no longer linked to provincial government expenditures. Michael Bliss, professor of history at the University of Toronto, told the Committee that the late 1970s and early 1980s period were marked by an attempt to control health care costs through constraints in the physicians' fee schedule and in hospital budgets. Overall, this resulted in a proliferation of direct patient charges:

In the 1970s, the problem of paying for health insurance quickly became the most serious thing that ministries of health, both provincial and federal, had to face. Immediately, the question of how to contain health care costs came to the fore, and a whole cadre of experts and health care economists grew up to try to give advice to state insurers on how you could stop the escalation of costs. We remember the 1970s of stagflation, in which the overall costs of Canadian social programs began to be a terrible burden on governments. (...) they began to try to squeeze the providers of health care, the hospital system and the physicians in order to try to hold down costs.

The providers responded the way anyone else does when they are squeezed: They began to look for alternatives. The Medicare system of 1968 was a pluralist system that allowed for the freedom of providers to practise outside the system. You could opt out; you could extra bill. It was not surprising, then, in the 1970s, that, as the provincial governments began to squeeze the Medicare fee schedule, more and more practitioners opted out. By the end of the 1970s and early 1980s, a kind of re-privatization occurred in health care. Many people saw the public system as a penny-pinching system and they wanted to work in the private sector where there was more freedom, more protection of incomes, and more possibilities for innovation.

By the early 1980s, we were seeing across the country serious problems in our Medicare system. So many specialists had opted out that, in large parts of the country, it was impossible to have access to certain specialists under Medicare. That was particularly true in obstetrics and gynaecology. The issue of accessibility became very important.<sup>31</sup>

More precisely, extra-billing by physicians was authorized in New Brunswick, Ontario, Manitoba, Saskatchewan and Alberta. In addition, hospital user fees were levied in New Brunswick, Quebec, Alberta and British Columbia.

In 1980, the Health Services Review by Justice Hall reported that health care in Canada ranked among the best in the world, but warned that direct patient charges were posing a threat to the principle of free and universal access to health care throughout the country. In

*The government ended up tabling and obtaining unanimous passage of the Canada Health Act, to fix a problem, which derives, in my opinion, from EPF.*

*Hon. Monique Bégin (16:3).*

response to these concerns, Parliament unanimously passed the *Canada Health Act* in 1984. Abby Hoffman told the Committee that the new Act combined and updated the conditions

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<sup>31</sup> Michael Bliss (13:37-38).

set out in the two federal acts of 1957 and 1966 and it added accessibility as a fifth criterion. In addition, specific restrictions were added to deter any form of direct patient charges and to provide residents of all provinces with access to health care regardless of their ability to pay:

There were several key points in the *Canada Health Act* worth noting, including the affirmation of universal insurance as the basis for medically necessary hospital and physician services, and the strengthening of the principles of portability, comprehensiveness, and public administration. A fifth criterion, accessibility, was added – that is, reasonable access to medically necessary insured services on uniform terms and conditions. Further, and perhaps most importantly, there was to be an effort to discourage user charges and extra billing. The *Canada Health Act* provided for mandatory dollar-for-dollar deductions from federal transfer payments to any province that permitted user charges or extra billing for insured services.<sup>32</sup>

According to Marc Lalonde, the *Canada Health Act* was adopted in response to the erosion of public health care insurance. Its was not intended as a means of increasing some of the federal visibility that was lost in this field with the advent of EPF block funding:

As to the 1984 Act, I do not think it had anything to do with reasserting our visibility. It had to do with a genuine concern that there was, through the back door, erosion of the basic elements of Medicare generally. Extra billing and additional fees for hospital care were creeping in right and left, and there was a necessity for the federal government to reassert the basic principles that were enshrined in the first legislation and to try to set up regimes that would provide for greater accountability in the way the provinces were using federal funds, in particular, for the public in general and for the federal government.

If you must look for a rationale for the 1984 Act, I do not think you should look for it in terms of trying to recuperate some lost visibility that the federal government did not have or had lost. It was essentially that there was federal legislation that provided for fundamental principles to which the federal Parliament was unanimously attached. We were seeing erosion that, if not stopped at that time, might have led to a dismantling of the whole national system as we knew it.<sup>33</sup>

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<sup>32</sup> Abby Hoffman (13:11).

<sup>33</sup> Hon. Marc Lalonde (15:11).



In essence, Mr. Lalonde reiterated that the main objective of Medicare was, as Tom Kent had said, to remove financial barriers to access to health care:

The aim of public policy was quite clearly and simply to (...) make sure that people could get care when it was needed without regard to other considerations.<sup>34</sup>

## **2.2 Definition/Interpretation of the National Principles and their Application**

The *Canada Health Act* sets out five major criteria or “national principles” – universality, accessibility, comprehensiveness, portability and public administration. Table 2.1 provides details about each criterion.

**TABLE 2.1**  
**THE FIVE CRITERIA OF THE CANADA HEALTH ACT**

**Public Administration:** requires that the administration and operation of the health care insurance plan of a province be carried out on a non-profit basis by a public authority responsible to the provincial government.

**Comprehensiveness:** requires that all medically necessary services provided by hospitals and doctors be covered under the provincial health care insurance plan.

**Universality:** requires that all residents of a province be entitled to public health care insurance coverage.

**Accessibility:** requires reasonable access unimpeded by financial or other barriers to medically necessary hospital and physician services for residents, and reasonable compensation for both physicians and hospitals.

**Portability:** requires that coverage under public health care insurance be maintained when a resident moves or travels within Canada or travels outside the country (coverage outside Canada is restricted to the coverage the resident has in his/her own province).

*Source: Health Canada, Canada Health Act Annual Report – 1998-1999, Ottawa, 1999, pp. 2-3. This document is available on Health Canada’s Internet site at <http://www.hc-sc.gc.ca/medicare/download.htm>.*

<sup>34</sup> Tom Kent (13:30).

During her testimony, Abby Hoffman provided a description of the health services to which the *Canada Health Act* applies and does not apply. She made a distinction among the five categories of health services:

- insured services;
- extended health care services;
- supplementary health care services;
- uninsured health services, and
- de-insured services.

Table 2.2 provides examples for each category of health care services and indicates whether or not they are governed by the five conditions of the *Canada Health Act*. Clearly, the federal legislation is very limited: it is centred on medically necessary services provided by hospitals and doctors.

**TABLE 2.2**  
**CATEGORIES OF HEALTH CARE SERVICES**

<b>Type of Services</b>	<b>Examples of Services</b>	<b>Five criteria of the <i>Canada Health Act</i></b>	<b>Provisions with respect to user charges and extra-billing</b>
<b>Insured Services</b>	Medically necessary hospital and physician services, including some dental care when performed in a hospital	Apply	Apply
<b>Extended Health Care Services</b>	Long term care, adult residential home, some ambulatory care	Do not apply	Do not apply
<b>Supplementary Health Care Services</b>	Prescription drugs outside hospitals, chiropractic services, physiotherapy, dental services	Do not apply	Do not apply
<b>Uninsured Services</b>	Cosmetic surgery, telephone advice by physicians	Do not apply	Do not apply
<b>De-Insured Services</b>	Wart removal, extraction of wisdom teeth	Do not apply	Do not apply

Source: Abby Hoffman (13:11-12).

The application of the Act is so restricted that provinces are not required to insure health promotion/prevention services or non-hospital based services of health care practitioners such as chiropractors, physiotherapists or psychologists. The national principles do not apply to extended health care services – nursing homes, adult residential care, home care and ambulatory health care. Although some provinces do insure some of these additional services, Canadians do not have universal and equal access to them.

Moreover, the *Canada Health Act* applies to a shrinking number of services because fewer services are provided now in hospitals. Thanks to new technologies, health services can be provided on an out-patient basis or at home. Hospital stays are shorter and pharmaceutical products sometimes enable us to avoid surgery altogether. When services and prescription drugs are provided outside the hospital, however, they are outside the ambit of the *Canada Health Act*. As a result, these services are not necessarily provided at no cost to patients, nor are they necessarily provided in accordance with the principles of accessibility, comprehensiveness and universality.

Over the years, provinces have expanded the array of services that are eligible for public coverage, either fully or partially. This includes, for example, dental care, vision care and prescription drugs to selected population groups in some provinces, as well as some community care and some home care. These services, once again, do not fall under the *Canada Health Act*. As a result, the range of publicly funded health services varies greatly from province to province. The Committee was told that our health care system, as defined broadly, is becoming less and less uniform:

It is good that provinces have chosen to extend the array of chosen services. The difficulty is that they have not done so uniformly, and we have ended up with fragmentation and something of a patchwork across the country.<sup>35</sup>

While the *Canada Health Act* has managed to obtain consistent public coverage for hospital and physician services across the country, it is clear that its limited focus has led to a lack of

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<sup>35</sup> Abby Hoffman (13:25).

uniformity in public coverage for the much broader range of health care services which, one suspects, Canadians would like to receive under their publicly funded health care system.

### **2.3 Enforcement Penalties under the *Canada Health Act***

Provinces must comply with the five conditions of the *Canada Health Act* in order to qualify for the entire federal cash contribution. If these conditions are not met, section 15(1)(a) of the Act stipulates that a penalty may be applied to the cash value of federal transfers. The Governor in Council sets the amount of this financial penalty depending on the "gravity" of the default. Sections 18 to 21 of the Act, which set out penalties for extra-billing and user charges, stipulate that the federal government may withhold one dollar of cash transfer for every dollar collected through direct patient charges.

Between 1984-85 and 1991-92, penalties for a failure to comply with the *Canada Health Act* were applied to the portion of EPF cash transfers earmarked for health care. Then, from 1991-92 to 1995-96, financial penalties were extended to cover other transfer payments because of the federal government's continuing restriction on the growth of EPF transfers and its specific impact on cash transfers: it was estimated that the health care portion of the EPF cash transfers to some provinces would have reached zero by the year 2000. Without the cash transfer, the federal government would not have had the power to enforce the conditions of the *Canada Health Act*. The additional withholdings or deductions were not stipulated in the Act, but were specifically set out in the *Federal-Provincial Fiscal Arrangements Act* (paragraphs 23.2(1), 23.2(2) and 23.2(3)). Since 1996-97, penalties under the *Canada Health Act* have applied to the cash portion of the CHST.

Information provided by Health Canada<sup>36</sup> indicates that, on three occasions, the federal government resorted to financial penalties and reduced its contributions to some provinces that were authorizing extra-billing or imposing user charges. First, it deducted over \$246,732,000 from EPF cash transfers to all the provinces from 1984-85 to 1986-87. However, it also complied with section 20(6) of the Act, under which a province was able to

recover these funds if it terminated all forms of direct patient charges in the three years after the Act came into force, that is, before 1 April 1987. Since all provinces complied with the Act within that timeframe, the amounts withheld were all reimbursed.

Second, from 1992-93 to 1995-96, the federal government withheld some \$2,025,000 in EPF cash transfers to British Columbia because a number of physicians in that province had opted out of the province's health care insurance plan and resorted to extra-billing.

Finally, since 1995-96, the federal government has imposed financial penalties on provinces that permit private clinics to demand facility fees from patients for medically required services, having determined that such facility fees constitute user charges. These penalties have applied to four provinces. By the time the deductions from transfers to Alberta ended in July 1996, a total of \$3,585,000 had been deducted from that province (see Table 2.3). Similarly, a total of \$323,000 had been deducted from Newfoundland, which started complying with the Act in January 1998. The penalties imposed on Manitoba (\$2,056,000 in total) were discontinued as of 1 February 1999. Nova Scotia has still not complied with the *Canada Health Act* and is being penalized in the amount of \$4,780 per month (a total of \$247,750 was deducted from transfers to Nova Scotia between October 1996 and January 2000 inclusively).

The Hon. Monique Bégin, the former federal health minister who introduced the *Canada Health Act*, noted that, until now, no discretionary penalty for failure to comply with the five national principles of the Act has ever been applied, despite some complaints regarding portability, comprehensiveness and accessibility.

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<sup>36</sup> Health Canada, *History of Dispute Resolution under the Canada Health Act*, Information binder prepared for the Committee, section 6, 9 February 2000.

**TABLE 2.3**  
**DEDUCTIONS BY PROVINCE UNDER THE**  
**CANADA HEALTH ACT (IN THOUSANDS OF DOLLARS)**

	<b>1992-93</b>	<b>1993-94</b>	<b>1994-95</b>	<b>1995-96</b>	<b>1996-97</b>	<b>1997-98</b>	<b>1998-99</b>	<b>1999-00*</b>
Newfoundland				46	96	128	53	
Prince Edward Island								
Nova Scotia				32	72	57	39	47,8
New Brunswick								
Quebec								
Ontario								
Manitoba				269	588	587	612	
Saskatchewan								
Alberta				2,319	1,266			
British Columbia	83	1,223	676	43				
<b>Total Canada</b>	<b>83</b>	<b>1,223</b>	<b>676</b>	<b>2,709</b>	<b>2,022</b>	<b>772</b>	<b>704</b>	<b>47,8</b>

\* Up to January 2000.

Source: Health Canada, *Deductions by Province Since Passage of the Canada Health Act*, Information binder prepared for the Committee, Section 8, 10 February 2000.

## 2.4 Is the *Canada Health Act* Still Relevant?

A few witnesses discussed the relevancy of the *Canada Health Act*. Some of them were of the view that the Act should remain intact. For example, the Hon. Marc Lalonde stated:

Many people blame the *Canada Health Act* for something it was not trying to do. The Act does not introduce rigidity. The five criteria existed before. The *Canada Health Act* introduces clearer definitions through regulations, or otherwise, to ensure that these rules mean something. In that sense perhaps there is some rigidity. I have no qualms whatsoever about saying that the federal Parliament should maintain the five criteria that were enacted by Parliament in the past. In my view, those criteria remain as valid as they ever were.<sup>37</sup>

The Hon. Monique Bégin indicated that the Act is very important for Canadians and should not be reopened:

The *Canada Health Act* has taken on a life of its own. It has now reached the status of an icon. Because of that, I personally think that no politician can

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<sup>37</sup> Hon. Marc Lalonde (15:21).

reopen the *Canada Health Act*, even to improve it, because it will destabilize people too much.<sup>38</sup>

She suggested, however, that new legislation similar to the *Canada Health Act* be established to govern the use of new federal transfers. The new Act could include additional conditions, such as accountability and sustainability.

By contrast, others argued that the Act should be reviewed. For example, the Hon. Claude Castonguay indicated that the new prescription drug insurance plan initiated by the Quebec government in 1996 would not qualify for federal funding under the *Canada Health Act* because it is made up of a mixture of public and private components. While all citizens are covered, beneficiaries are required to pay a premium and a portion of the cost of their drugs.

## **2.5 Committee Commentary**

In this section, the Committee wishes to outline its thoughts about the national principles underlying Canada's health care system and its questions about these principles.

As mentioned earlier, Tom Kent indicated that the original policy objective of public hospital and medical care insurance was to ensure that all Canadians, regardless of their personal financial circumstances or where they lived in Canada, would have access to all medically necessary services. We believe that this objective explains four of the principles of the *Canada Health Act*:

- The principle of universality, which means that health care services are to be available to all Canadians;
- The principle of portability, which means that all Canadians are covered, even when they move from one province to another;
- The principle of comprehensiveness, which is meant to guarantee that all medically necessary services are covered by public health care insurance;
- The principle of accessibility, which means that barriers to the provision of health care, such as user charges, are discouraged, so that services are available to all Canadians regardless of their income.

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<sup>38</sup> Hon. Monique Bégin (16:5).

The above four principles all focus on individual Canadians – they are patient-centred. This is consistent with the patient-oriented approach in the original public policy objective of Canadian Medicare. However, what began over thirty five years ago as a patient-centred national health care system has become a more narrow national system that is centred more around the delivery mechanism (hospitals and doctors) than around the patient’s entire health care needs. This distinction, even though it is critical to the development of future public policy, is not made in the vast majority of public commentary on the current system.

Moreover, the final principle of the *Canada Health Act* – the principle of public administration – is of a completely different character. It does not focus on the patient but is rather the means of achieving the ends to which the other four principles are directed. In our view, this distinction between ends and means explains much of the current debate about the *Canada Health Act* and Canada’s health care system. People who agree completely on the desired ends of a public policy can nevertheless disagree strongly on the means of achieving those ends.

The recent debate over Alberta’s Bill 11 is a clear example of this. This legislation allows private, for-profit, health care facilities to compete against publicly funded hospitals for the provision of selected minor surgical services. It is the view of the Alberta government that contracting out to these facilities can improve access, reduce waiting times/lists and increase efficiency by reducing the demand on the existing publicly-funded hospitals. Opponents of the new legislation believe that these goals could be better achieved by increasing the level of funding of public hospitals.

In Phase Three of our study, the Committee will examine the means by which other countries have tried to achieve the ends of comprehensive and universally accessible coverage for health care. This exercise will be useful in enhancing our understanding of Canada’s health care system and in evaluating options for building a long-term sustainable system.



The principles of comprehensiveness and accessibility are intertwined. Indeed, they go to the very core of the critically important issue of what services are covered by public health care insurance as “medically necessary” and how these services should be paid for. This, in turn, leads to the debate over affordability and sustainability.

Determining what services ought to be considered “medically necessary” is a difficult task. Most Canadians would agree that life-saving cardiac procedures are medically necessary. Most Canadians would also agree that most cases of cosmetic surgery do not meet the criterion of medical necessity. The difficulty comes with those services that lie between these two extremes. For example, virtually everyone would consider life-sustaining medication as “medically necessary”, even if the medication is not taken in a hospital and therefore not subject to public coverage pursuant to the “medical necessity test” contained in the *Canada Health Act*. However, this does not change the harsh reality that many Canadians are struggling to find the money to pay for their “medically necessary” prescriptions every month.

Obviously, the more services we include in the definition of “medically necessary”, the more costly the health care system is. Yet clearly, as more medically necessary products and services are produced and delivered outside the traditional hospital setting, a broadening of the definition of the concept of medical necessity is essential if Canada is to remain true to the spirit of the *Canada Health Act*. But broadening this definition raises the question of how these services should be paid for, and how excessive costs can be prevented.

For example, would modest user fees be an effective way to reduce unnecessary use of the health care system, as some people have proposed? Or would user fees have a disproportionately negative impact on low-income patients, preventing them from seeking out services when they truly need them ( a violation of the principle of accessibility)? Alternatively, should higher income Canadians pay a portion of the health care costs they are responsible for generating, through, for example, some form of income tax surcharge?

Tom Kent told the Committee that this was in fact the original vision of Medicare the Liberal party adopted:

To look at the history, when the Liberal rally, in 1961, so firmly committed the Liberal Party to health care, it was with a provision. It was that the costs that an individual thereby incurred through the tax system, would indeed become a charge through the tax system directly to the individual. The value of the services that you obtained from public health insurance would become a part of your statement for income tax purposes, within limits, and so on, so that it would never be overwhelming in any one year for any individual or family, and it would mean that people who paid little or no tax would pay nothing for their health care, but people who had relatively large incomes, had a significant tax, would pay something.<sup>39</sup>

If this funding method were ever to be used, the question arises as to whether individual Canadians should be able to purchase private insurance to cover the potential cost to them?

A major problem with health care insurance is that conventional economic principles do not fully apply. Because most bills are picked up by insurance, people pay little attention to the cost of health care. In addition, they have no way to assess the quality of the health services they receive. Beyond that, for most people, good health is priceless; they want to have access to the best available medical technologies and procedures at whatever cost. This creates a conundrum for politicians. On the one hand, their constituents will not accept the rationing of their health services. On the other hand, neither the politicians nor their constituents want to pay the higher taxes required for unlimited health care.

The question of precisely what services should be covered by government and what services should be paid for by individuals out of their own funds, either partially or fully, directly or through private insurance, is one that requires full discussion. Though these crucial questions are difficult ones, and just asking them arouses anxiety in some Canadians, they must be the focus of serious public debate. The Committee, through its subsequent reports of this study, hopes to provide a forum for this debate.

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<sup>39</sup> Tom Kent (13:40).

It is no longer possible for Canadians to gloss over the issues of what services are to be covered by their public health care insurance plan, and how the plan should be paid for, by simply referring to the laudable principles of comprehensiveness and accessibility in the *Canada Health Act*. These terms, even though they represent very important principles to all Canadians, are no longer sufficient to enable the government, and all Canadians, to avoid confronting the difficult practical decisions that must be made with respect to our health care system. In future parts of its study, the Committee will outline options for addressing these issues, and for examining the opinions and expectations of Canadians about their health care system.

## CHAPTER THREE:

### PUBLIC EXPECTATIONS ABOUT HEALTH CARE

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For many Canadians, our health care system is a defining feature of the country and a symbol of our societal values. They cherish their public health care insurance plan for what it is, and for the values it represents: shared risk, compassion, fairness

and common responsibility. However, an increasing number of Canadians are concerned that the health care system will not retain these qualities in the future. Many believe that health care in Canada is not as good now as it was in the past, because of government cuts in health care spending, longer waiting lists for doctors and procedures, and the number of doctors and nurses leaving to work in the United States. These views reflect an understanding that health care costs will continue to grow, especially for prescription drugs and new medical technologies, for instance.

*The universality of the system is certainly linked to strong Canadian values like egalitarianism and generosity...*

*Our health care system is a powerful symbol of our societal values.*

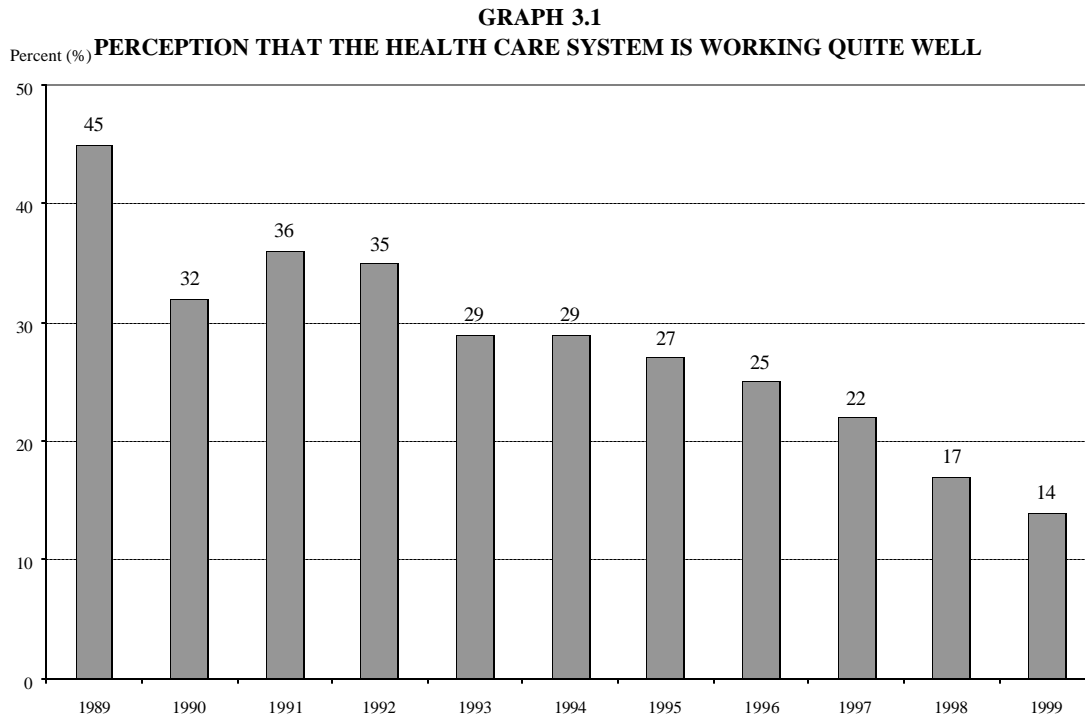
*Chris Baker, V-P, Environics Research Group  
(9:30 and 9:33).*

Knowing more about public values and attitudes is a vital component that can help ensure the development of policy options that are consistent with the views of Canadians. In this perspective, the Committee invited Canadian pollsters to provide more information on historical and current public attitudes towards, and expectations of, the health care system. We acknowledge that different surveys and polls often ask different questions and use different survey methods and that, as a result, findings may not be directly comparable. It is interesting to note, however, that we found great consistency and similar long-term trends in the polling data presented to the Committee.

#### 3.1 Health Care is an Important Public Policy Concern

Canadians' faith in their health care system has declined significantly during the past decade. A survey by Goldfarb Consultants found that 45% of Canadians felt in 1989 that the health care system was working well, compared with only 14% in 1999 (see Graph 3.1). Similarly,

the Environics survey suggests that the level of satisfaction with the Canadian health care system has decreased dramatically during the 1990s. In fact, there is a growing consensus that there is a problem with our health care system.



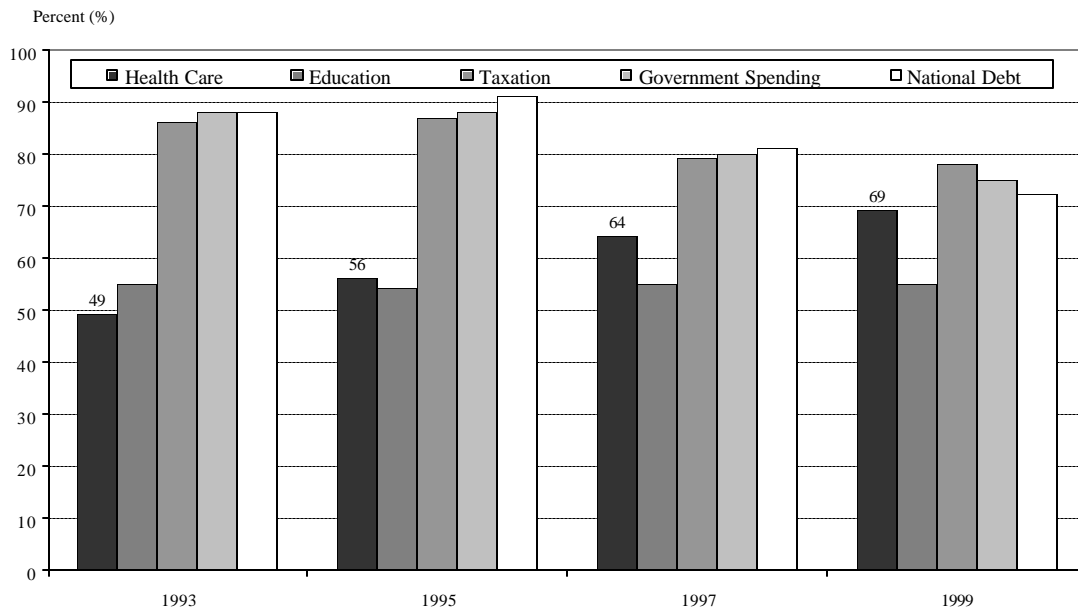
Source: Goldfarb Consultants, Presentation to the Committee, 22 March 2000, Slide 6.

With respect to public policy, data from the Goldfarb survey indicate that Canadians are becoming more and more concerned with health care (see Graph 3.2). In the early 1990s, Canadians were predominantly concerned with government spending, the debt and taxes. While taxation remained a major public policy concern in 1999, health care was perceived as one of the most important problems facing Canada. There were, however, demographic differences on this issue. For example, in 1999, women were more concerned about health care, while men were more concerned about taxes. Similarly, older Canadians were more concerned about the state of the health care system than younger ones.

*It is not that taxation and debt have completely disappeared from the agenda, they are still in the public's mind, but health is grabbing a larger share of that concern.*

*Dr. Scott Evans, Senior Statistical Consultant, Goldfarb ( 9:36).*

**GRAPH 3.2**  
**PUBLIC POLICY: SHIFTING CONCERNS**



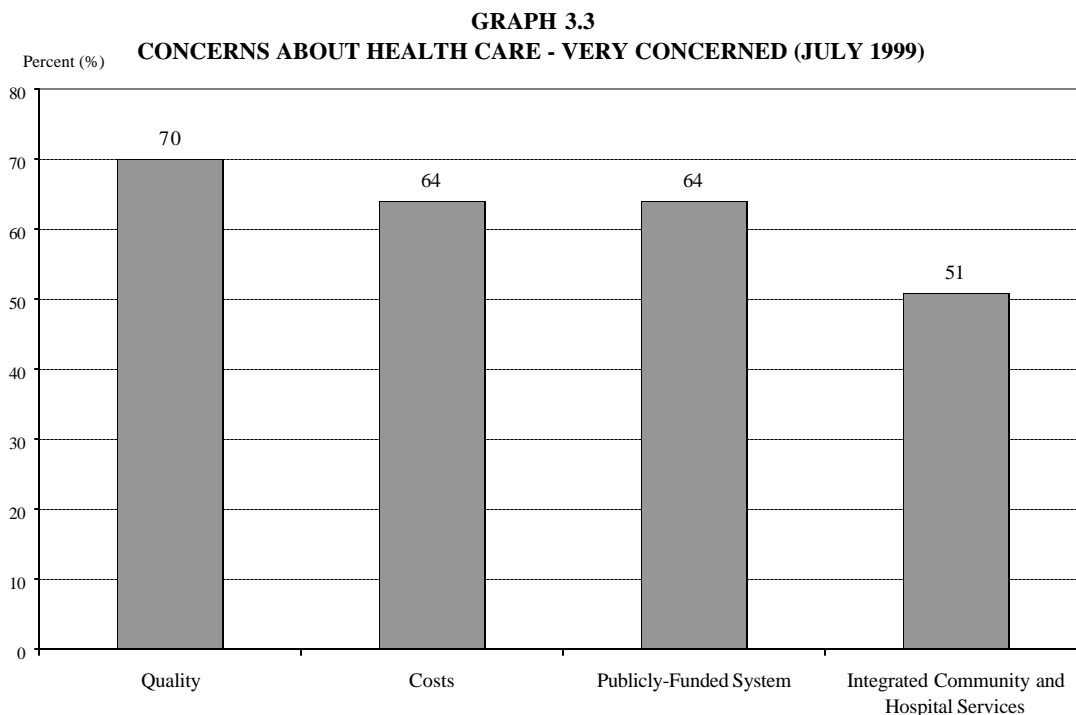
Source: Goldfarb Consultants, Presentation to the Committee, 22 March 2000, Slide 13.

### **3.2 Canadians Are Concerned About Quality, Access and Universality**

According to the Environics survey, quality appears to be the most important health care concern. About 70% of Canadians were very concerned about quality in 1999 (see Graph 3.3). Health care costs and the maintenance of a publicly funded health care system were both seen as very important, but secondary (with 64%). Some 51% of Canadians were very concerned about the integration of community and hospital services. During the hearings, it was noted that concerns about cost and the publicly funded system have decreased since 1994, but the concerns about quality have remained persistently high.<sup>40</sup>

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<sup>40</sup> Chris Baker (9:31-32).



Source: Environics Research Group, Presentation to the Committee, 22 March 2000, Slide 23.

Furthermore, Chris Baker explained that there is a strong link between quality and accessibility in the mind of Canadians (see Graph 3.4). In his view, they would strongly resist any measures that could restrict access to health care.<sup>41</sup>

*Access and availability remain the top areas of concern, and any move to restrict that would be strongly resisted by Canadians.*

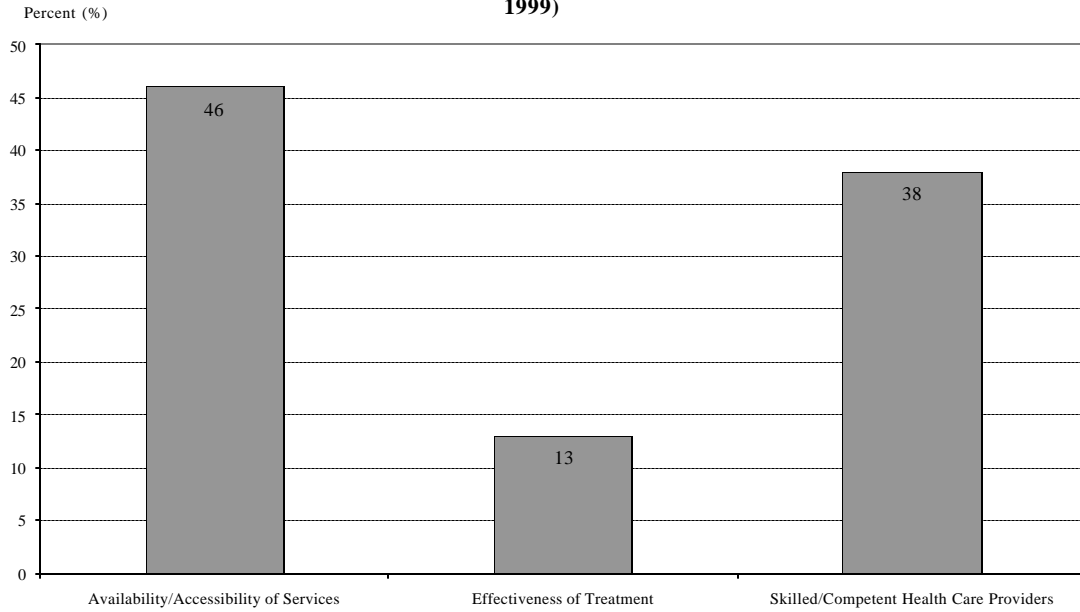
*Chris Baker, V-P, Environics Research Group (9:33).*

### 3.3 Health Care is a Priority

The 1999 Goldfarb survey asked about the most desirable use of the federal budgetary surplus. While cuts to personal income tax were important to Canadians, reinvesting in health care was just as high a priority (Graph 3.5). Universality remains a core value for Canadians. In fact, support for universal health care insurance coverage for all regardless of economic status increased from 81% to 84% between 1991 and 1999 (Graph 3.6).

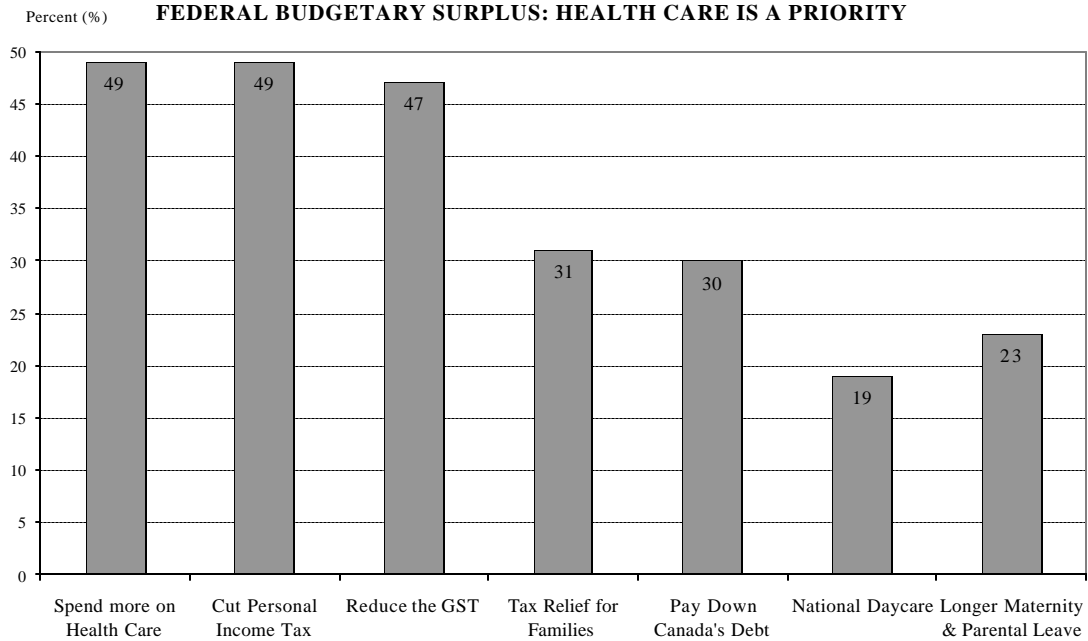
<sup>41</sup> Chris Baker (9:32).

**GRAPH 3.4**  
**MOST IMPORTANT FEATURE OF QUALITY HEALTH CARE SYSTEM (JULY 1999)**



Source: Environics Research Group, Presentation to the Committee, 22 March 2000, Slide 26.

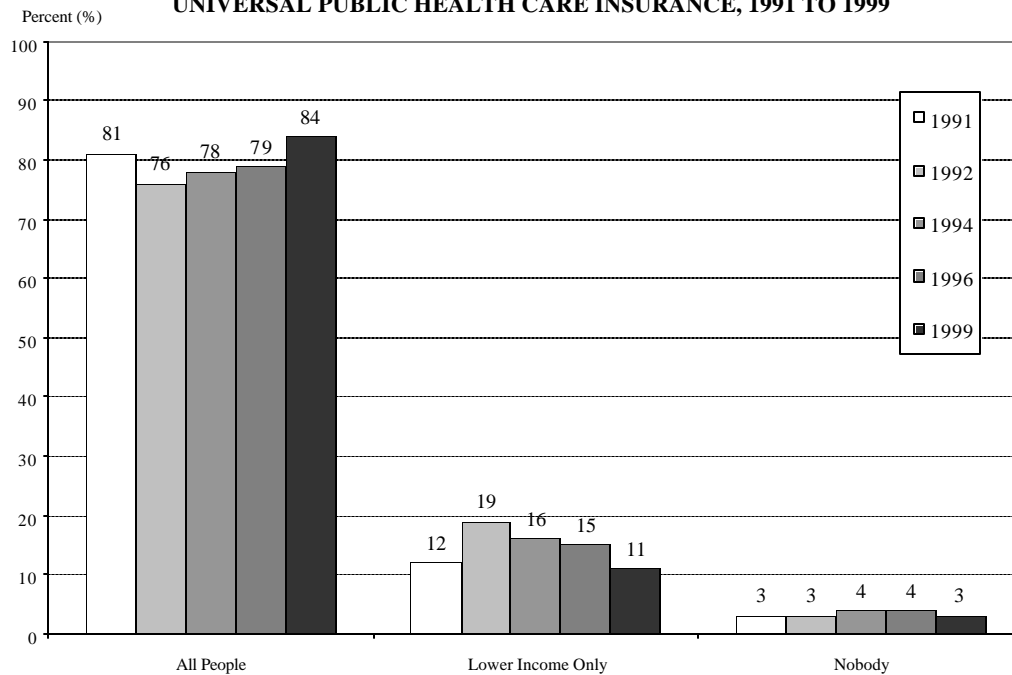
**GRAPH 3.5**  
**FEDERAL BUDGETARY SURPLUS: HEALTH CARE IS A PRIORITY**



Source: Goldfarb Consultants, Presentation to the Committee, 22 March 2000, Slide 22.



**GRAPH 3.6**  
**UNIVERSAL PUBLIC HEALTH CARE INSURANCE, 1991 TO 1999**



Source: Environics Research Group, Presentation to the Committee, 22 March 2000, Slide 27.

When asked about spending priorities in health care, Canadians show a strong preference for “bricks and mortar” infrastructure and research activities. Community-based activities are considered secondary, and activities that are seen as remote from front-line care are assigned the lowest priority for new health care funding.

Some 78% of Canadians believe that maintaining hospital beds is a high priority, followed by funding research for women’s diseases, and medical technology. Population health initiatives, while providing benefits over the long term, cannot match the immediacy of new hospital beds or high-tech diagnostic or therapeutic equipment in the public perception. Baker explained this as follows:

I believe this is because there is a certain immediacy to anxiety about our health care system... Hospital beds and high-tech equipment will deliver immediate benefits, whereas community-based initiatives, population health initiatives, are seen as more long term. Canadians, because of their level of

anxiety, focus on those activities that will deliver benefits immediately rather than down the road.<sup>42</sup>

Abby Hoffman from Health Canada expressed similar views:

(...) when people feel that the care and treatment side is vulnerable, they are somewhat resistant, quite understandably, to seeing more energy, and possibly more resources, being devoted to health prevention and promotion, public health, population health, those kinds of activities.<sup>43</sup>

Graham Scott, a former deputy minister of health in the province of Ontario, cautioned that while short term solutions may help ease the anxiety of Canadians about their health care system, long term solutions could bring more benefits down the road. He provided the following example:

If you spend \$100 million to upgrade the OHIP system in Ontario, in the short term that does not cure one patient. However, if you announce that you are expanding the emergency wings in six community hospitals in southwestern Ontario, that is worth many seats. That is where the trade-off is.<sup>44</sup>

In his view, “it will take a fair amount of political courage at the federal and provincial levels” to invest in those areas that can bring the most benefits in the long term.

### **3.4 Health Care is a Federal/Provincial Partnership**

Both the Environics and Goldfarb surveys indicate that Canadians expect both levels of government to do their part to reinvest in health care. Both surveys also suggest that Canadians give low marks to both the federal and provincial governments on their handling of health care issues. Furthermore,

*There is declining satisfaction with the system and critical assessments of all government performance in this area. There is a strong desire for governments to stop competing on the issue of health care and start cooperating.*

*Chris Baker, V-P, Environics Research Group (Q-33)*

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<sup>42</sup> Chris Baker (9:32).

<sup>43</sup> Abby Hoffman (13:27).

<sup>44</sup> Graham Scott (20:13)

Canadians are impatient with blame-laying, they are more interested in positive results and intergovernmental cooperation. For example, as Dr. Scott Evans pointed out:

Canadians are also becoming impatient with the bickering between the two levels of government. When asked about their understanding of federal-provincial relations, they cannot seem to understand why there is such unwillingness or inability to reach agreement on what needs to be done. There is a sense of losing patience with what governments are doing.<sup>45</sup>

### **3.5 Support for the Principles of the *Canada Health Act* is High**

A review of polls, surveys and reports from the past ten years undertaken by the Conference Board of Canada shows that support for the principles of the *Canada Health Act* has remained high throughout the past decade. The highest supported principles have been universality and accessibility, while public administration has received the lowest support (see Table 3.1).

**TABLE 3.1**  
**THE PRINCIPLES OF THE *CANADA HEALTH ACT* ARE**  
**“VERY IMPORTANT” (PERCENTAGE)**

	<b>1991</b>	<b>1994</b>	<b>1995</b>	<b>1999</b>
Universality	93	85	89	89
Accessibility	85	77	82	81
Portability	89	78	81	79
Comprehensiveness	88	73	80	80
Public Administration	76	63	64	59

*Source: Conference Board of Canada, Canadians' Values and Attitudes on Canada's Health Care System: A Synthesis of Survey Results, 6 October 2000, p. 11.*

Despite this strong support, many Canadians believe that, with the exception of universality, the health care system is not fully living up to the national principles of Medicare. According to the Conference Board, these views “are not entirely surprising, given that many health services that Canadians rely on fall outside the scope of the *Canada Health Act* (...).”<sup>46</sup>

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<sup>45</sup> Dr. Scott Evans (9:38).

<sup>46</sup> Conference Board of Canada, *Canadians' Values and Attitudes on Canada's Health Care System: A Synthesis of Survey Results*, 6 October 2000, p. 12.

### **3.6 Decreasing Support for User Charges and Private Initiatives**

Surveys show an increasing resistance to financial measures that would limit access to health care. According to Goldfarb Consultants, support for patient charges to visit a doctor, which was on the rise between 1989 to 1992, has been on decline since then (see Graph 3.7). Similarly, the Environics survey indicates that only a minority of Canadians (31%) believe that private clinics are a good way to reduce waiting lists. In addition, there is increasing concern that the introduction of privately-run facilities will erode the publicly-funded health care system (Graph 3.8).

In its 2000 survey review, the Conference Board of Canada suggests that support for various privatization options is higher when they are presented as a means for preserving Medicare either through making the system more efficient or ensuring equal access to high quality services. For example, with respect to user charges, it states that “support for user fees is often conditional – support is highest if user fees are presented as a method to improve system efficiency while not prohibiting people from accessing needed services.”<sup>47</sup> Similarly, with regard to private facilities, the Board’s report indicates: “Public support is stronger for people purchasing private services in the event that the public system is unable to provide the necessary services than for allowing people to purchase services for the purposes of receiving faster or better service.”<sup>48</sup>

### **3.7 Committee Commentary**

The reason for the decline in public confidence to the Canadian health care system remains open to debate. According to Dr. Scott Evans:

Certainly much of the financial restructuring in the health care system, and the response of the media and the various advocacy groups to that, have all contributed to this general sense of declining faith.<sup>49</sup>

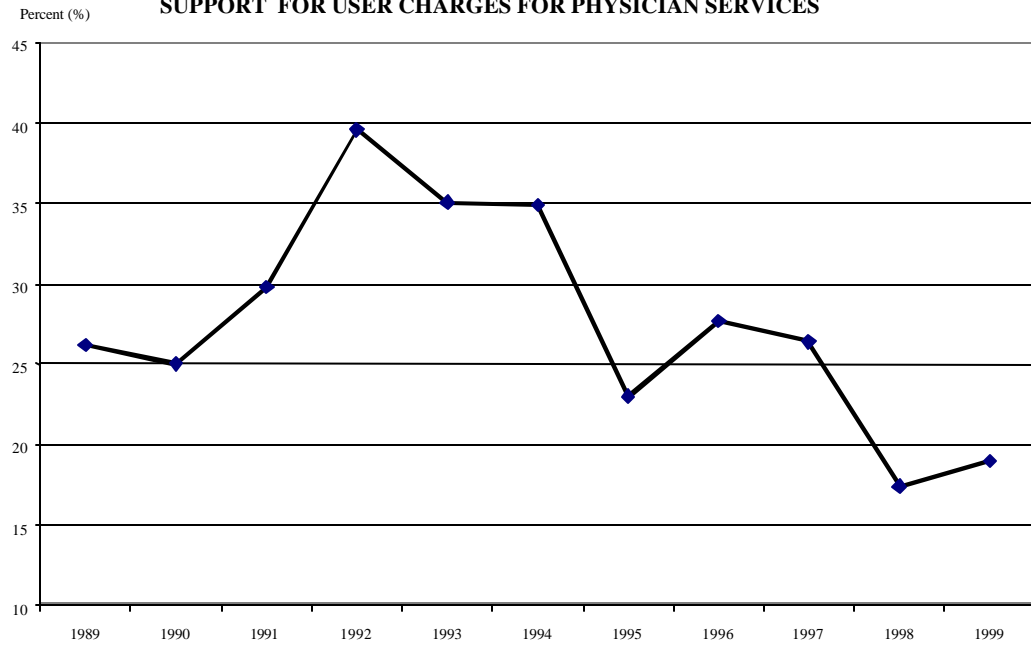
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<sup>47</sup> *Ibid.*, pp. 31-32.

<sup>48</sup> *Ibid.*, p. 2.

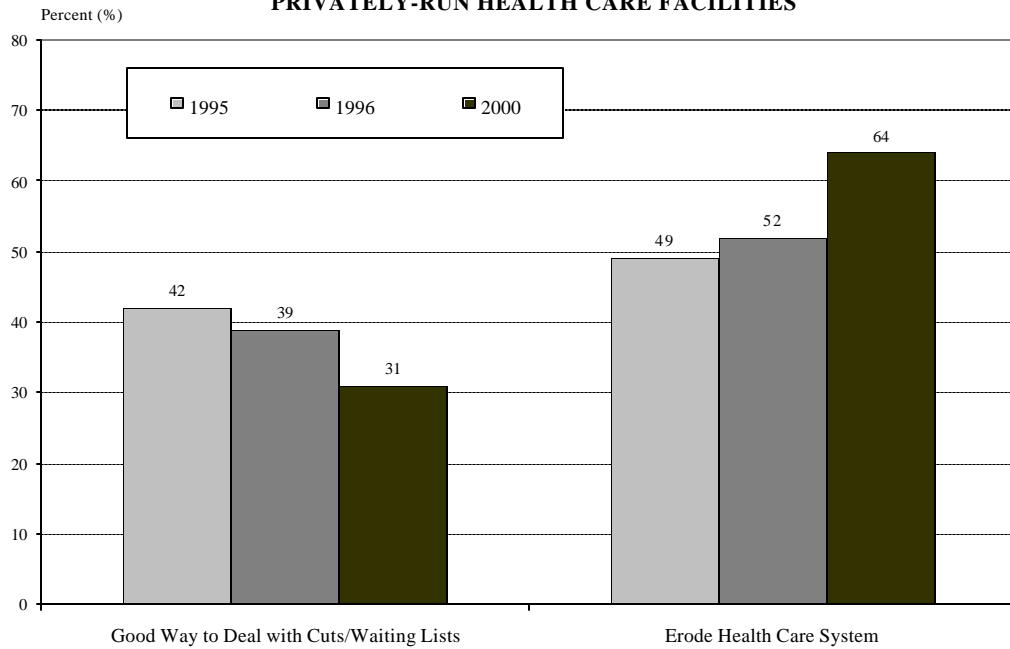
<sup>49</sup> Dr. Scott Evans (9:34-35).

**GRAPH 3.7**  
**SUPPORT FOR USER CHARGES FOR PHYSICIAN SERVICES**



Source: Goldfarb Consultants, Presentation to the Committee, 22 March 2000, Slide

**GRAPH 3.8**  
**PRIVATELY-RUN HEALTH CARE FACILITIES**



Source: Environics Research Group, Presentation to the Committee, 22 March 2000, Slide 45.

Similarly, Dr. John S. Millar, V-P of Research and Analysis at the Canadian Institute for Health Information (CIHI) indicated:

(...) changes in funding and the reductions in funding have clearly created a lot of stresses in the system. (...) One of those is that public confidence has been eroded significantly. We certainly have very well documented in this report that there has been less access to some services, such as emergency rooms and some specialist services and procedures. As a consequence of that and as a result of media attention to it, public confidence has dropped quite considerably.<sup>50</sup>

While reductions in government spending are often pointed as an important factor in declining public support for Medicare, it remains unclear whether or not recent increases in federal CHST transfers through the enactment of Bill C-32 (2000) and Bill C-35 (2000) will be enough to enhance Canadians' confidence in the publicly funded health care system. Moreover, the Committee was told that the lack of confidence in the system should not be confused with the actual performance of the health care system. In fact, when patients are questioned about the health care they have received, they are generally satisfied:

(...), when you ask people who have actually been the recipients of care, they express very high levels of satisfaction. That reflects the fact that the provider groups, that is, doctors and nurses, despite all the stresses, have been struggling to continue to perform to a high level. The performance measures we have show that there are good outcomes. It is an interesting dichotomy, which shows up time and time again when these types of surveys are done.<sup>51</sup>

Sholom Glouberman, Director of the Health Network, Canadian Policy Research Networks, suggested that the major issue therefore is to develop strategies that will enhance public confidence in Canada's health care system:

There is a bit of confusion between the actual performance of the health care system and people's lack of confidence in it. The response to people's lack of confidence in the health care system is often to add more resources to the system. That does not tackle the problem, because the problem is about

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<sup>50</sup> Dr. John S. Millar (14:35).

<sup>51</sup> Dr. John S. Millar (14:35).

confidence. The question is: What strategies can be used to increase confidence in the health care system? Part of it is information. Another part is an assurance that the health care system will be there when people need it. That has been a big part of the struggle.<sup>52</sup>

This is one of the current challenges in our health care system:

I believe that this is an interesting and volatile period with respect to public opinion. There is an opportunity to make great gains on the legitimacy of different kinds of approaches to health care that will be able to restore a sense of faith and confidence in the system.<sup>53</sup>

Public opinion and public expectations are vital to the examination of Canada's health care system. In Phase Two of its study, the Committee will look at the issue of rising expectations, as they may have a significant impact on future government decisions, particularly as regards what health services to cover and who should be eligible for publicly funded health care, as well as how the money to pay for these services should be raised.

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<sup>52</sup> Sholom Glouberman (9:18-19).

<sup>53</sup> Dr. Scott Evans (9:37).

## CHAPTER FOUR:

### TRENDS IN HEALTH CARE EXPENDITURES

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The purpose of this chapter is to provide a factual in-depth review of past and current trends in health care spending in Canada. The chapter is divided into six sections. The first section describes historical trends in total health care expenditures. Section 2 examines trends in public and private spending. Section 3 details trends by category of expenditures. Section 4 gives a brief comparison between Canadian and international spending on health care. Section 5 looks at provincial health care spending. Section 6 summarizes the causes of, and pressures on, health care costs. The chapter builds on data provided by the Canadian Institute for Health Information (CIHI) and the Organization for Economic Cooperation and Development (OECD).<sup>54</sup>

Data on health care spending reported by both CIHI and the OECD include the following: hospitals, other institutions (namely residential care facilities), physicians, other health care professionals (such as chiropractors, physiotherapists, opticians and so on), drugs – both prescribed and non-prescribed, capital, public health (including health promotion and disease prevention), health research and personal health supplies and devices. This definition is consistent with the Committee's broad definition of health care given in the introduction to this report.

As we will see in the following sections, there are different ways of measuring how much Canada spends on health care. The interpretation of the level of health care expenditures and their trends depends upon how we measure spending.

*(...) we are spending less than we think, far less of it from public sources than most other countries, and the federal share of spending for health care is far higher than provincial rhetoric would lead one to believe.*

*Raisa Deber, Professor,  
University of Toronto (8:3).*

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<sup>54</sup> CIHI, *National Health Expenditure – Trends*, Ottawa, 15 December 1999 (1975-1999) and 11 December 2000 (1975-2000); and OECD, *OECD Health Data*, CD-ROM, Paris, 1999 and 2000.



## 4.1 Global Trends – From 1975 to 2000

Graph 4.1 depicts the evolution of total health care spending in Canada over the last 25 years. Expressed in current or nominal dollars (bold line), total health care expenditures grew steadily from \$12.2 billion in 1975 to \$95.1 billion in 2000. In fact, the growth in nominal health care expenditures exhibited double digit rates in the 1970s and early 1980s, but it did slow considerably to single digit growth rates in the latter part of the 1980s and the 1990s.<sup>55</sup> Abby Hoffman from Health Canada told the Committee:

We must be careful how we interpret the extent and the significance of the slowdown because raw numbers are a little misleading. We need to take into account the much higher levels of inflation in the 1970s and early 1980s, compared with single digit inflation in the latter part of the 1980s and the 1990s, and our current very low levels.<sup>56</sup>

The second line in Graph 4.1 represents total health care expenditures adjusted for inflation and converted into constant (1992) dollars.<sup>57</sup> Even after removing the effect of inflation, which makes it possible to measure real growth rates, health care spending rose steadily from 1975 to the early 1990s. However, the real rates of growth throughout the 1975-2000 period were much lower, in the range of less than 1% to about 5%.<sup>58</sup>

According to CIHI, sustained growth in health care spending in the last four years reflects primarily increased investment in health care by governments.

A number of witnesses who appeared before the Committee suggested that, in order to properly interpret trends in health care spending, the data should also be adjusted to the size of the population. Total health care spending per capita is presented in Graph 4.2.

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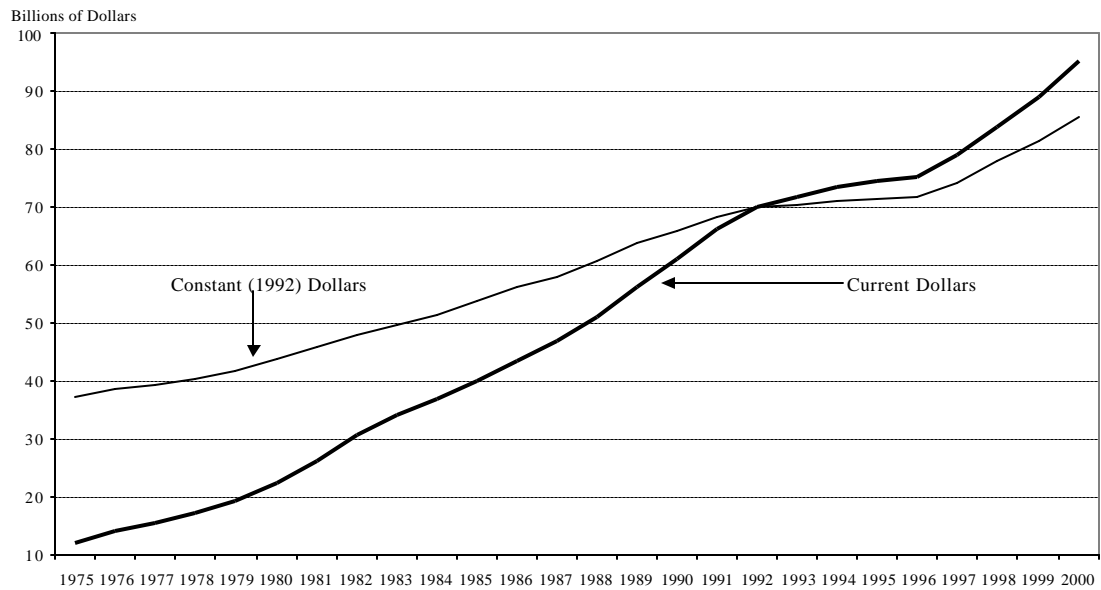
<sup>55</sup> More precisely, total health care spending grew at an average annual rate of 11.1% over the period 1975 to 1991. Then, growth fell substantially to an average annual rate of 2.6% between 1991 and 1996. The average annual rate of growth is expected to have risen to some 6.0% between 1996 to 2000.

<sup>56</sup> Abby Hoffman (13:8).

<sup>57</sup> Data are usually adjusted for inflation by using a GDP implicit price index (the 1992 index equals 100).

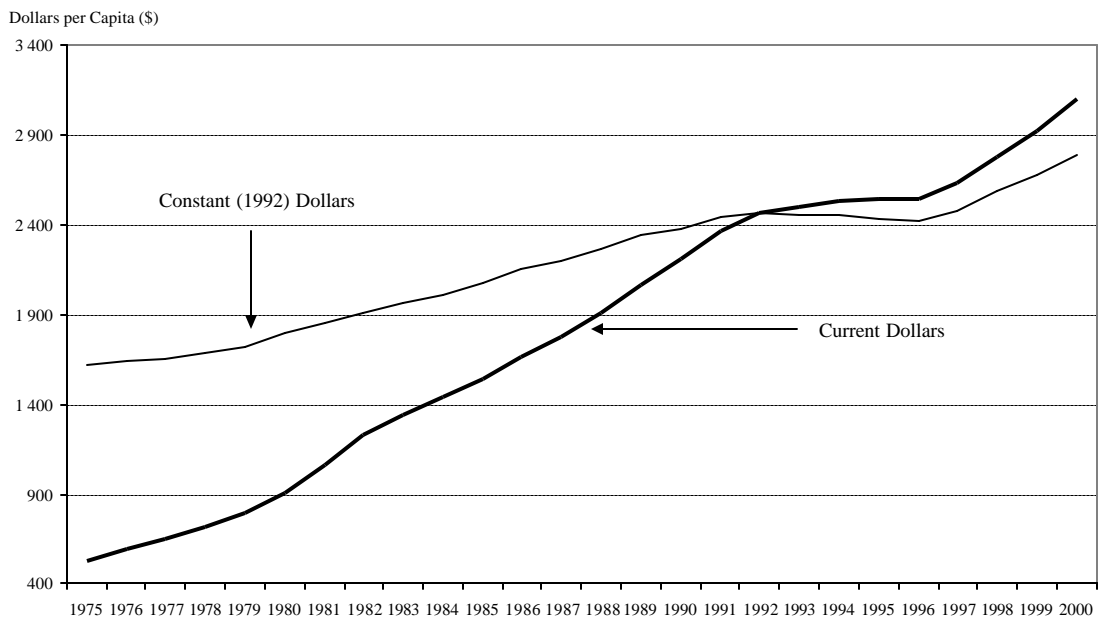
<sup>58</sup> Real rates of growth averaged 3.8% between 1975 and 1991, 1.0% between 1991 and 1996 and 4.6% between 1996 and 2000.

**GRAPH 4.1**  
**TOTAL HEALTH CARE EXPENDITURES IN CANADA**



Source: CIHI(2000) and Library of Parliament.

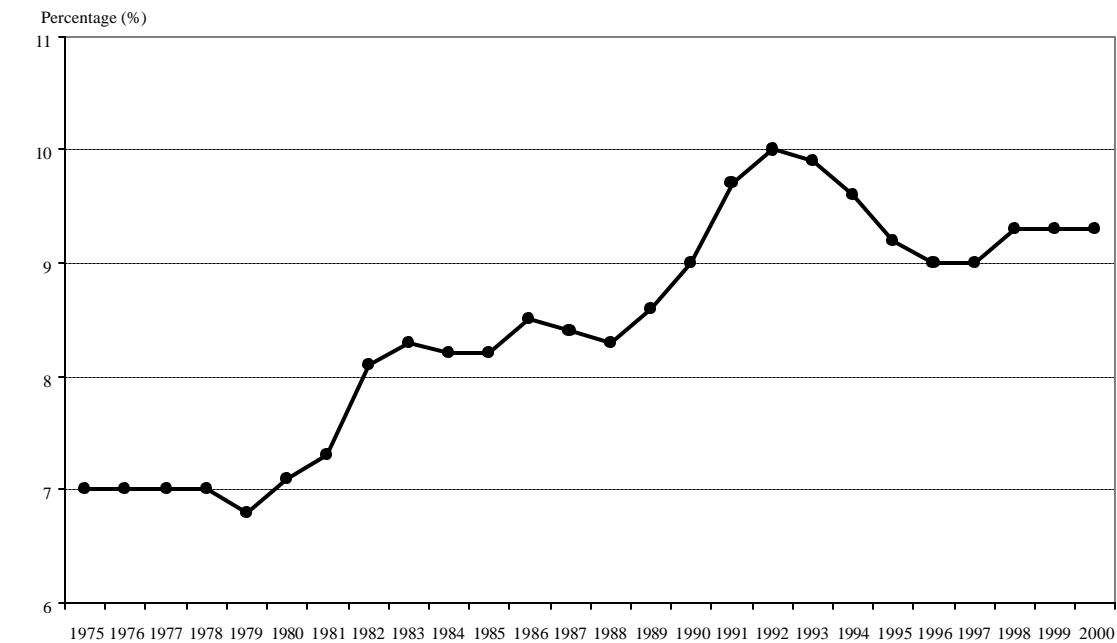
**GRAPH 4.2**  
**TOTAL HEALTH CARE EXPENDITURES IN CANADA**



Source: CIHI(2000) and Library of Parliament.

The fine line, which represents per capita expenditures adjusted for both inflation and population, indicates that health care spending in Canada increased from 1975 to the early 1990s. However, there were small annual declines in real expenditures per capita from 1992 to 1996. This trend was reversed in 1997 and real annual rate of growth in spending per capita is expected to average 3.6% between 1997 and 2000.

**GRAPH 4.3**  
**TOTAL HEALTH CARE SPENDING IN CANADA AS A PERCENTAGE OF GDP**



Source: CIHI(2000) and Library of Parliament.

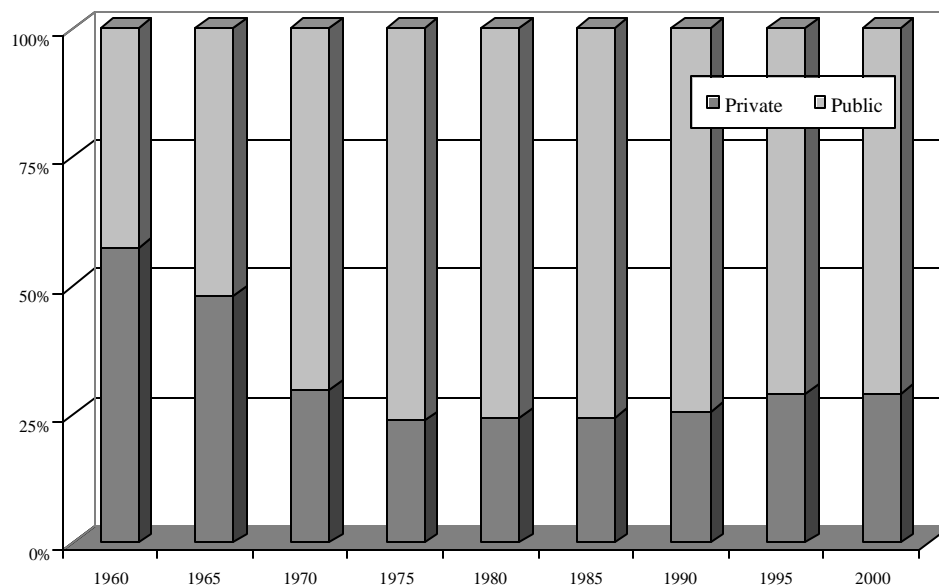
Another way to measure how much Canada spends on health care is to calculate health care expenditures as a percentage of gross domestic product (GDP).<sup>59</sup> This indicator, which is referred to as the “health care to GDP ratio”, reflects the extent to which Canada devotes productive resources to health care. In 1975 (see Graph 4.3), health care expenditures in Canada amounted to 7.0% of GDP. This percentage increased for the most part of the 1970s and the 1980s, and it peaked at 10% in 1992. Then, the health care to GDP ratio decreased continually from 1992 to 1996, when it reached 9.0%. The latest forecast by CIHI suggests that this downward trend has been reversed: the share of the GDP devoted to health care rose to 9.3% in 1998 and it has remained at this level in 1999 and 2000.

<sup>59</sup> As explained in Chapter 1, the GDP measures the value of all goods, services and investments in a country during a year.

## 4.2 Public versus Private Spending

While the public sector is currently the main source of health care funding in Canada, this was not the case forty years ago, when over half of health care spending came from the private sector.<sup>60</sup> Graph 4.4 provides information on the sources of health care financing in Canada. In 1960, private sector funding accounted for over 57% of total health care expenditures. Throughout the next decade, as universal health care insurance was introduced in the provinces, health care expenditures by the public sector grew at rates that were much higher than the growth rates in private sector funding. As a result, the private sector share dropped dramatically. By 1975, the public sector share had increased to over 76%, while the private share accounted for the remaining 24%.

**GRAPH 4.4**  
**PUBLIC AND PRIVATE SHARES OF TOTAL HEALTH CARE EXPENDITURES**

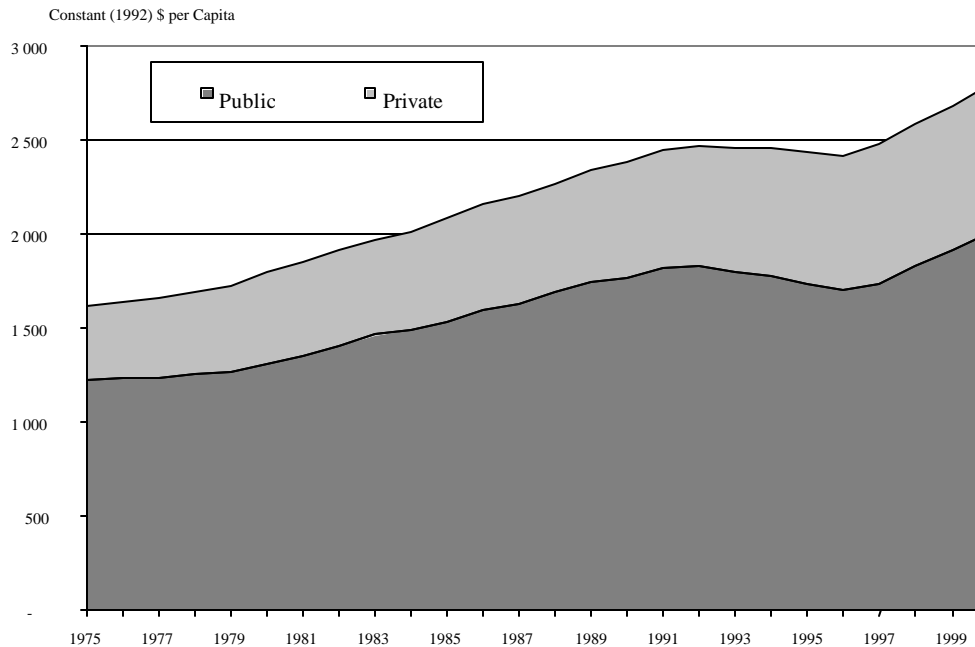


Source: Vern Hicks (1999), CIHI (2000) and Library of Parliament.

Between 1975 and 1985, the private and public shares remained relatively constant. Then, governments initiated restraints in funding for hospitals and physician services and introduced measures to enhance efficiencies in the health care system. This resulted in a

levelling off of public expenditures. As the same time, the private sector share began to increase and, in 1997, it peaked at 30%, higher than at any time since 1970. The private sector share has decreased slightly in recent years, to reach 29% in 2000. In that year, the public sector share amounted to 71% of total of health care spending.

**GRAPH 4.5**  
**PUBLIC AND PRIVATE HEALTH CARE SPENDING**



Source: CIHI (2000) and Library of Parliament.

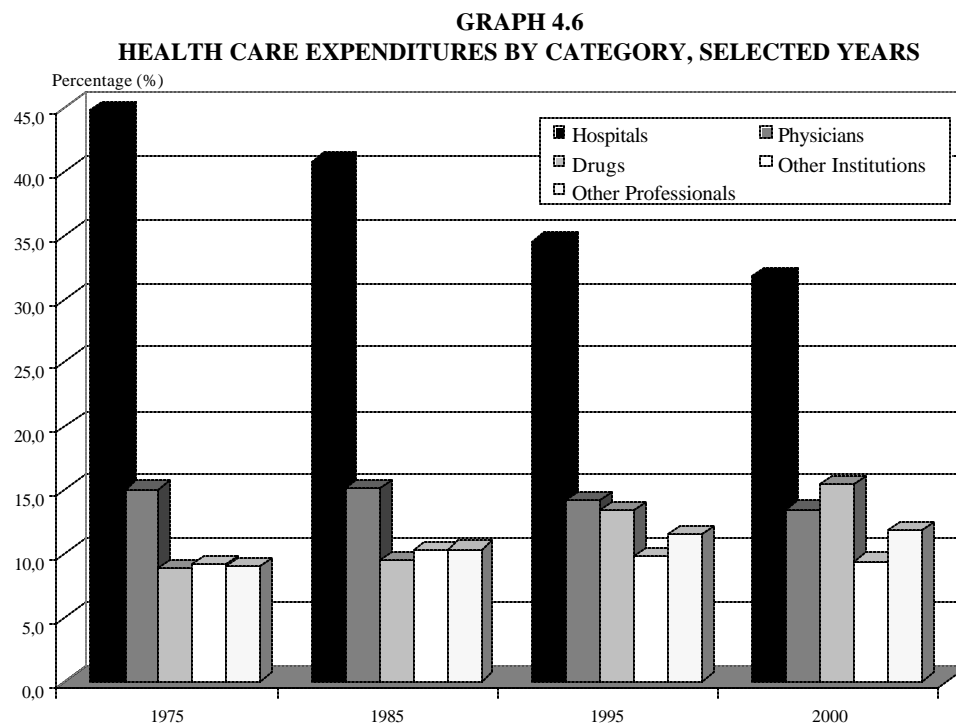
Once again, it is useful to consider trends when expenditures are adjusted for both inflation and population size. Graph 4.5 shows that public sector expenditures per capita in constant dollars increased continuously from 1975 to 1992. Between 1992 and 1996, public sector expenditures on health care on a per capita basis decreased in real terms. In other words, growth in public spending on health care did not keep up with either economic growth or population growth. This downward trend was reversed in 1997 and, in 1998, public spending on health care, per capita, in constant dollars, came back to its 1992 peak. This was followed by a real growth of 4.4% in 1999 and 4.8% in 2000:

<sup>60</sup> The public sector refers to the various levels of government. Private sector spending primarily consists of direct out-of-pocket costs by individuals and expenditures covered by third-party insurers. Expenditures by Workers' Compensation Boards are included in public spending on health care.

When one adjusts spending for overall population growth and general inflation, the slowdown in public spending – indeed the decline in the mid-1990s – becomes more apparent. In other words, the mid 1990s was clearly a period when public health expenditures did not keep pace with overall, albeit low, inflation rates and population growth. However, with the rebound in public health expenditures in the late 1990s, the overall level of public spending regained its peak of the early 1990s in terms of real per capita expenditures, even after adjusting for population growth and the general rise in price levels.<sup>61</sup>

### 4.3 Categories of Expenditures

In 2000, Canada spent \$30.2 billion on hospital care. Hospital care is the largest category of health care expenditures, accounting for 31.8% of total health care spending in 2000. The share of total health care spending allocated to hospitals has seen a downward trend over the last 25 years, from a high of 45.0% of total health care expenditures in 1976 (see Graph 4.6).



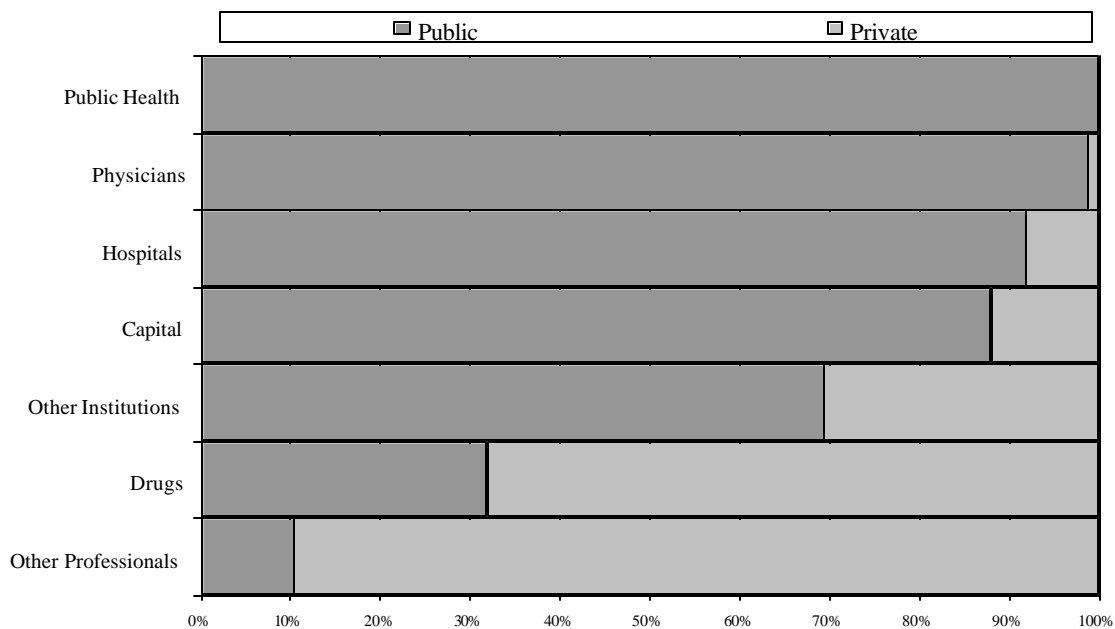
Source: CIHI(2000) and Library of Parliament.

<sup>61</sup> Abby Hoffman (13:8).

Spending on physician services amounted to almost \$12.8 billion in 2000, representing 13.5% of total health care expenditures. Between 1975 and 1985, the share of total health care spending on physician services remained relatively constant. It declined slightly from 1985 to 2000.

Since 1997, expenditures on drugs have been the second largest category of total health care spending, overtaking spending on physician services. The share of total health care spending allocated for drugs has grown continuously over the last 25 years, from 8.8% in 1975 to 9.5% in 1985, 13.4% in 1995 and 15.5% in 2000.

**GRAPH 4.7**  
**SHARE OF PUBLIC\PRIVATE HEALTH CARE SPENDING BY CATEGORY, 2000**



Source: CIHI (2000) and Library of Parliament.

Public spending by category ranges from 100% of expenditures on public health to 10% of expenditures on health care providers other than physicians (see Graph 4.7). More than 70% of total expenditures in all categories, except drugs and other professionals, is publicly funded. Public sector spending on hospitals accounts for some 91% of total spending on hospitals, while just under 99% of total physician services is financed by public sector sources. Private health care spending in Canada is generally concentrated in areas such as

drugs, dental services, vision care and home care, items for the most part not covered under the *Canada Health Act*.

#### **4.4 International Comparisons**

International comparisons are another way of evaluating our health care system. Indeed, in attempting to determine the optimum size of the health care sector, international comparisons are essential to gaining a better understanding of the volume of expenditures and the factors causing them to increase. There is a variety of indicators for health care spending that can be used when comparing countries. As Professor Deber pointed out during her presentation to the Committee, it is important to give a precise definition of what is measured by each indicator because Canada's ranking changes depending upon the indicator used to measure health care spending.

There are three types of indicators that are most commonly used to compare the level of health care expenditures among countries. The most frequently used indicator is the ratio of health care expenditures to GDP, which measures how much of the total economy each country is devoting to health care.

As shown in Table 4.1, in 1998, Canada ranked fourth (9.5%) among the OECD countries, after the United States (13.6%), Germany (10.6%) and Switzerland (10.4%), in terms of the ratio of total health care expenditures to GDP. The United States spent the highest proportion of GDP on health care, while Turkey spent the least. Japan ranked 18<sup>th</sup>, with a relatively low proportion of GDP devoted to health care (7.6%). On average, OECD countries spent 7.9% of GDP on health care. This indicator suggests that Canada spent more on health care than the OECD average in 1998 and is one of the top spenders on health care.



TABLE 4.1

Health Care Expenditures in OECD Countries in 1998						
Country	Expenditures as a % of GDP	Rank	Per Capita Expenditures in US \$	Rank	Per Capita Expenditures In \$ PPP	Rank
Australia	8.5	9	1,691	17	2,036	12
Austria	8.2	15	2,164	11	1,968	13
Belgium	8.8	6	2,169	10	2,081	9
<b>Canada</b>	<b>9.5</b>	<b>4</b>	<b>1,828</b>	<b>14</b>	<b>2,312</b>	<b>5</b>
Czech Republic	7.2	19	393	24	930	24
Denmark	8.3	12	2,736	5	2,133	7
Finland	6.9	21	1,724	15	1,502	17
France	9.5	5	2,333	8	2,055	11
Germany	10.6	2	2,769	4	2,424	3
Greece	8.3	13	957	22	1,167	23
Hungary	6.8	22	319	26	705	26
Iceland	8.3	14	2,468	7	2,103	8
Ireland	6.4	24	1,436	19	1,436	19
Italy	8.4	10	1,720	16	1,783	15
Japan	7.6	18	2,283	9	1,822	14
Korea	5.0	27	351	25	730	25
Luxembourg	5.9	26	2,473*	6*	2,215	6
Mexico	4.7*	28*	202*	28*	356*	28*
Netherlands	8.6	7	2,143	13	2,070	10
New Zealand	8.1	16	1,127	20	1,424	20
Norway	8.6	8	2,836	3	2,330	4
Poland	6.4	25	263	27	496	27
Portugal	7.8	17	859	23	1,237	21
Spain	7.1	20	1,044	21	1,218	22
Sweden	8.4	11	2,146	12	1,746	16
Switzerland	10.4	3	3,834	2	2,794	2
Turkey	4.0*	29*	122*	29*	255*	29*
United Kingdom	6.7	23	1,607	18	1,461	18
<b>United States</b>	<b>13.6</b>	<b>1</b>	<b>4,178</b>	<b>1</b>	<b>4,178</b>	<b>1</b>
OECD Average	7.9	-	1,730	-	1,689	-

\*1997 data.

Source: OECD Health Data 2000.

Another international indicator is “nominal spending per capita”: it involves converting national currency units into a common unit (usually US dollars) and then dividing by its population. This indicator is therefore adjusted for population size. The third column in Table 4.1 indicates that Canadian health care spending in 1998 amounted to \$1,828 US per capita. Using this measure, Canada slipped to 14<sup>th</sup> place, far behind the United States (\$4,178 – 1<sup>st</sup> place), Switzerland (\$3,834 – 2<sup>nd</sup> place), Norway (\$2,836 – 3<sup>d</sup> place) and Germany (\$2,769 – 4<sup>th</sup> place). Canada’s spending on health care was comparable with that

of Sweden, the Netherlands and Finland. By comparison, Japan ranked 9<sup>th</sup>, spending \$2,283 US per capita. Using this indicator, Canadian spending on health care is in line with the average OECD amount and we are not among the countries that spend the most on health care. Japan's showing is not nearly so impressive: while it ranked 18<sup>th</sup> in terms of health care expenditures as a percent of GDP (among the lowest spending levels), Japan's comes in 9<sup>th</sup> place in terms of US dollars per capita (among the highest levels of health care expenditures).

A more sophisticated indicator uses purchasing power parity (PPP) per capita; it is computed by comparing the prices of identical products in various countries and dividing by population.<sup>62</sup> The conversion into PPPs eliminates price disparities between countries. With this indicator, Canada remains among the top, ranking 5<sup>th</sup> (\$2,312 per capita), following the United States (\$4,178), Switzerland (\$2,794), Germany (\$2,424) and Norway (\$2,330). Japan ranked 14<sup>th</sup>, in the middle of all the OECD countries (\$1,822).

Regardless of the measurement used, the United States clearly spent the most on health care in 1997, followed by Germany and Switzerland. Although Canada's spending was high, it was proportional to that of several other countries.

Table 4.2 provides the OECD ranking with respect to public health care spending. In 1998 in almost all countries, the best part of health care spending came from the public sector. In Canada, 69.6% of total health care expenditures were publicly financed, a proportion lower than the average among OECD countries (73.6%). The United States and Korea were the only two OECD countries where more health care spending came from the private sector than from the public sector, with approximately 45% of total health care spending coming from public sources. At the other extreme was Luxembourg, where 92.3% of total health care expenditures were publicly financed. Compared with other OECD countries, Canada

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<sup>62</sup> PPP is an international price index calculated by comparing the prices of identical goods in various countries. It indicates the rate at which one currency must be converted into another currency to be able to purchase an equivalent basket of goods and services in other countries. Dollars adjusted by the PPP make it possible to compare the prices of identical products in various countries. PPP is not, therefore, simply a monetary conversion but an equivalence which takes into consideration a real value assigned to a basket of goods and services.

had the 9<sup>th</sup> highest public health care expenditures measured as a percentage of GDP. Interestingly, Canada's level of public health care spending as a proportion of GDP was close to that of the United States.

**TABLE 4.2**

<b>Public Health Care Expenditures in OECD Countries (1998)</b>				
<b>Country</b>	<b>Public Share of Total Health Care Expenditures (%)</b>	<b>Rank</b>	<b>Public Health Care Expenditures as a % of GDP</b>	<b>Rank</b>
Australia	69.5	22	5.9	15
Austria	70.5	19	5.8	16
Belgium	89.7	3	7.9	1
<b>Canada</b>	<b>69.6</b>	<b>21</b>	<b>6.6</b>	<b>9</b>
Czech Republic	91.9	2	6.6	10
Denmark	81.9	8	6.8	8
Finland	76.3	14	5.3	21
France	76.4	13	7.2	4
Germany	74.6	16	7.9	2
Greece	56.8	27	4.7	25
Hungary	76.5	12	5.2	22
Iceland	84.3	4	7.0	6
Ireland	75.8	15	4.8	24
Italy	67.3	23	5.6	17
Japan	78.3	9	6.0	13
Korea	45.8	28	2.3	29
Luxembourg	92.3	1	5.4	19
Mexico	60.0*	26*	2.8*	28*
Netherlands	70.4	20	6.0	14
New Zealand	77.1	10	6.2	11
Norway	83.1	7	7.1	5
Poland	65.4	25	4.2	26
Portugal	66.9	24	5.2	23
Spain	76.9	11	5.4	20
Sweden	83.8	5	7.0	7
Switzerland	73.4	17	7.7	3
Turkey	72.8*	18*	2.9*	27*
United Kingdom	83.7	6	5.6	18
<b>United States</b>	<b>44.7</b>	<b>29</b>	<b>6.1</b>	<b>12</b>
OECD Average	73.6	-	5.8	-

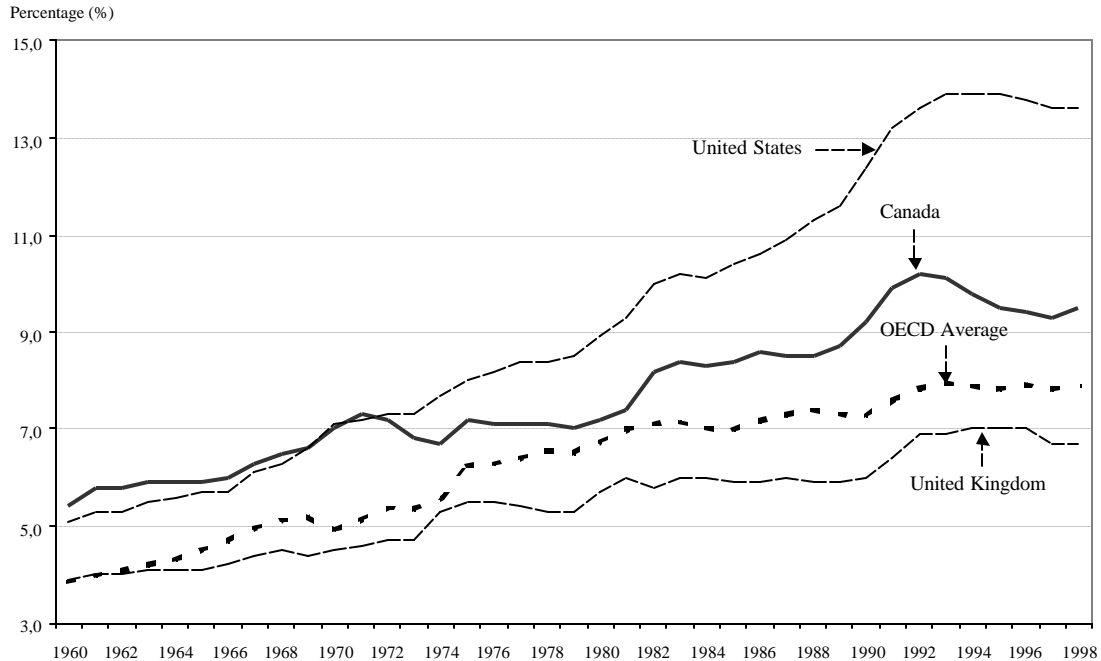
\*1997 data.

Source: OECD Health Data 2000.

Have different countries experienced similar trends in health care expenditures over the last four decades? Graph 4.8 depicts the evolution of health care expenditures as a percentage of GDP in selected OECD countries from 1960 to 1998. It can be seen that the United

Kingdom has consistently devoted far less of its GDP to health care than either Canada or the United States has done. Trends in health care to GDP ratio in Canada and the United States looked virtually identical until about 1971 – when Canada instituted universal health care insurance, while the United States did not.

**GRAPH 4.8**  
**HEALTH CARE SPENDING AS A PERCENTAGE OF GDP**

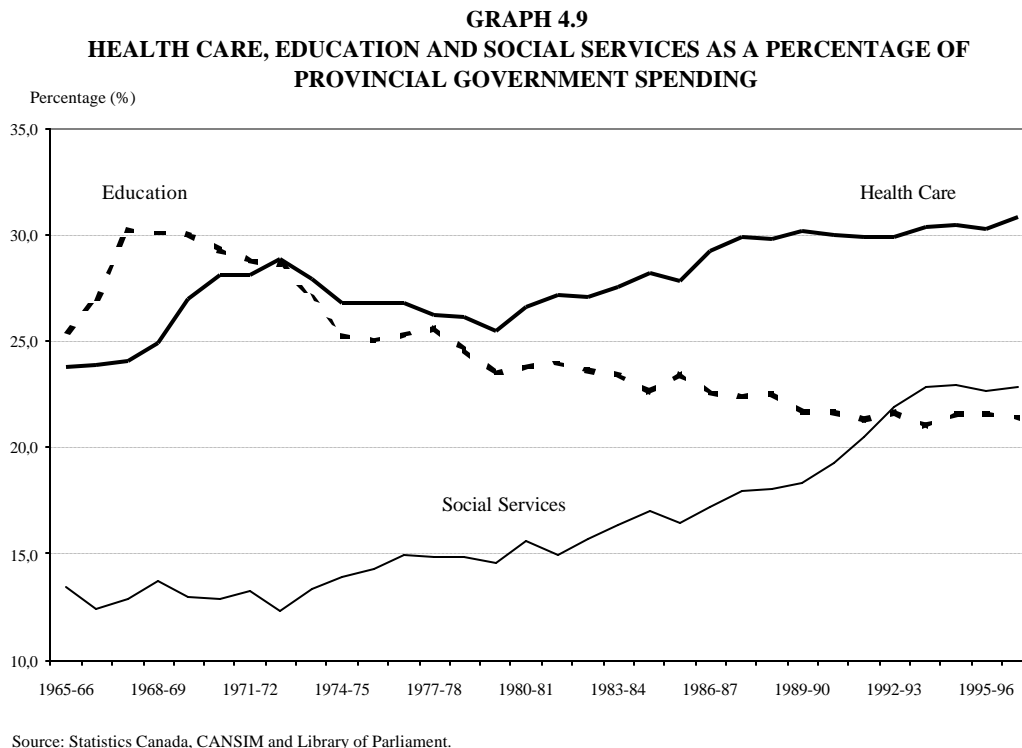


Source: OECD Health Data (2000) and Library of Parliament.

The health care spending to GDP ratio in Canada remained relatively stable throughout the 1970s. Then it peaked at 10.2% in 1992, second only to the United States. Many observers have argued that Canada now had one of the most expensive health care systems among OECD countries. This result was widely discussed and interpreted as meaning that the Canadian model was inherently inflationary. As in Canada, most OECD countries experienced growth in health care expenditures as a percentage of GDP during most of the 1975-1990 period. Increases also occurred in the early 1990s, during periods of low GDP growth and recession, and then were followed by stabilization or slight declines in the ratio of health care spending to GDP. However, Canada is the only country to have experienced a five-year decline (from 1992 to 1997).

## 4.5 Health Care is a Priority in the Provinces

During her testimony, Raisa Deber contended that health care is the priority for provincial governments and that spending on education and social assistance has been cut rather drastically in the provinces. Graph 4.9 depicts provincial government spending on health care, education and social services as a percentage of total program spending; while provincial governments have increased the proportion of public spending devoted to health care and social assistance, spending on education has been declining steadily. The 2000-01 Performance and Potential report of the Conference Board of Canada shows similar trends: in the last three years, 62% of the increase in provincial government spending went to health care, while 25% was devoted to education, 3% to social services, 5% to interest and 5% to general spending.<sup>63</sup>



<sup>63</sup> Conference Board of Canada, *Performance and Potential 2000-2001 – Seeking “Made in Canada” Solutions*, 2000, p. 115.

## 4.6 Committee Commentary

We hope that this chapter will contribute to a better understanding of the past and current trends in health care spending, of the relationship between public and private health care expenditures, and of the Canadian situation in terms of international comparisons. There remain, however, gaps in the information about health care expenditures. In a recent report, CIHI indicates what we do not know about health care spending in Canada:

- How do changes in health care spending affect the health status of the population?
- How does health care spending differ between regions within provinces?
- What are the costs of treating specific diseases?
- What are the costs of rehabilitation, health promotion and other community-based services?
- How much do Canadians spend out-of-pocket on complementary and alternative medicine (e.g. massage therapy, homeopathy, herbs and other similar remedies, etc.)?<sup>64</sup>

Moreover, there are still other difficult questions. For example, how much of its GDP should Canada devote to health care? What would be an appropriate level of public health care spending? What role should the private sector play in the financing of health care? What should be the role of the federal government in health care and, more specifically, how much money should it earmark for health care? What factors could explain the disparities in health care costs among OECD countries? Are there important lessons for future public policy in Canada that can be learned from a close examination of the international experience? These questions and others will be debated when the Committee examines a set of options for the future of Canadian health care system in Phase Four of its study.

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<sup>64</sup> CIHI, *Health Care in Canada – A First Annual Report*, 2000, p. 21.



## CHAPTER FIVE:

### HEALTH STATUS AND THE CONCEPT OF POPULATION HEALTH

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Canadians are extremely interested in health. Personal health status, the health of family members and that of our friends are all important. Good health enables us to lead productive and fulfilling lives. For the country as a whole, a high level of health contributes to increased prosperity and overall social stability. Therefore, the overall level of health enjoyed by Canadians is an important indicator of the success of our society and our quality of life.

#### 5.1 Health Status of Canadians

There is a variety of health status indicators. Life expectancy, for instance, is a widely used, internationally accepted measurement of the health of a population. It is defined as the average number of years an individual of a given age is expected to live if current mortality rates continue.

*Over the past several decades, the health of Canadians has been going up and up and up, surpassing all other countries. We are now second in the world in terms of our life expectancy, second only to Japan. I would anticipate before long that we will be number one. We are increasing at a rate that is even more rapid than that of Japan, and Japan is experiencing some difficulties.*

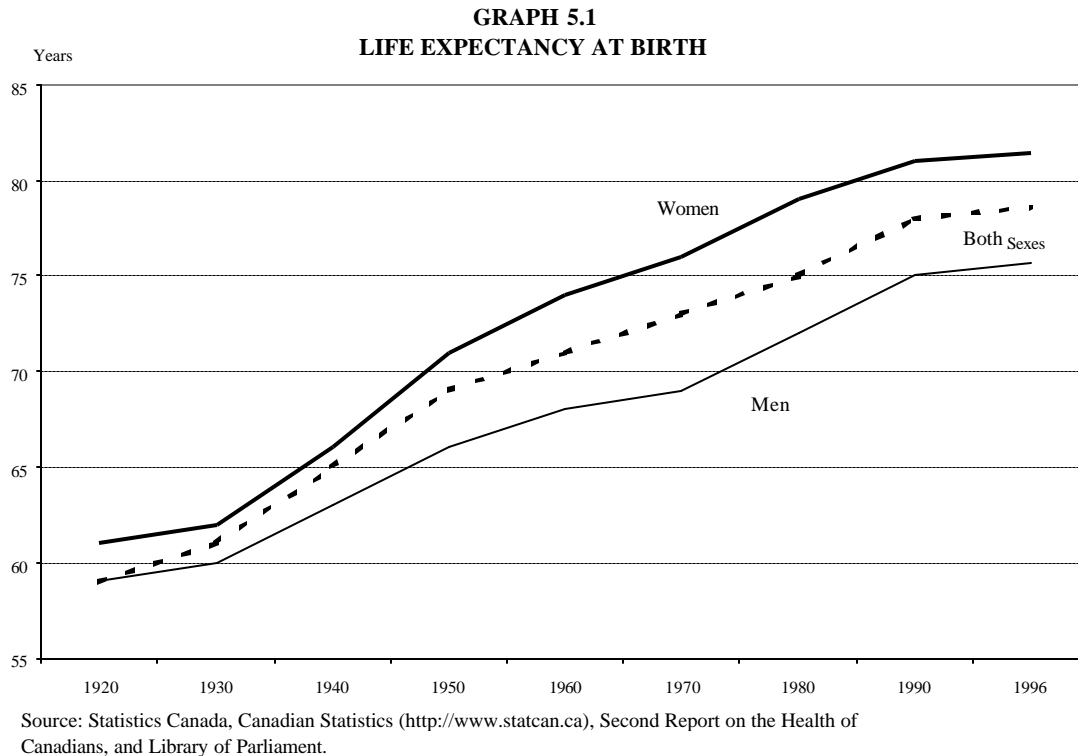
*Dr. John S. Millar, V-P, Research and Analysis, CIHI (14:33).*

Over the past century, life expectancy has increased steadily (see Graph 5.1). Based on current mortality patterns, a baby girl born in Canada in 1996 can expect to live 81 years on average, while a baby boy will live 76 years. This is a new high in Canada. At all ages, women have a greater life expectancy than men. The gap in life expectancy at birth between men and women has been narrowing, however, since the early 1980s.

Life expectancy measures years of life only. Related indicators are being developed to tell us whether those years of life are spent in good health. One example is disability-free life expectancy, which measures the years of life spent in various states of independence. In this regard, a Canadian child born in 1991 could expect to spend on average 69 years – almost 90% of his or her total life span – free from disabling health problems. Other measures



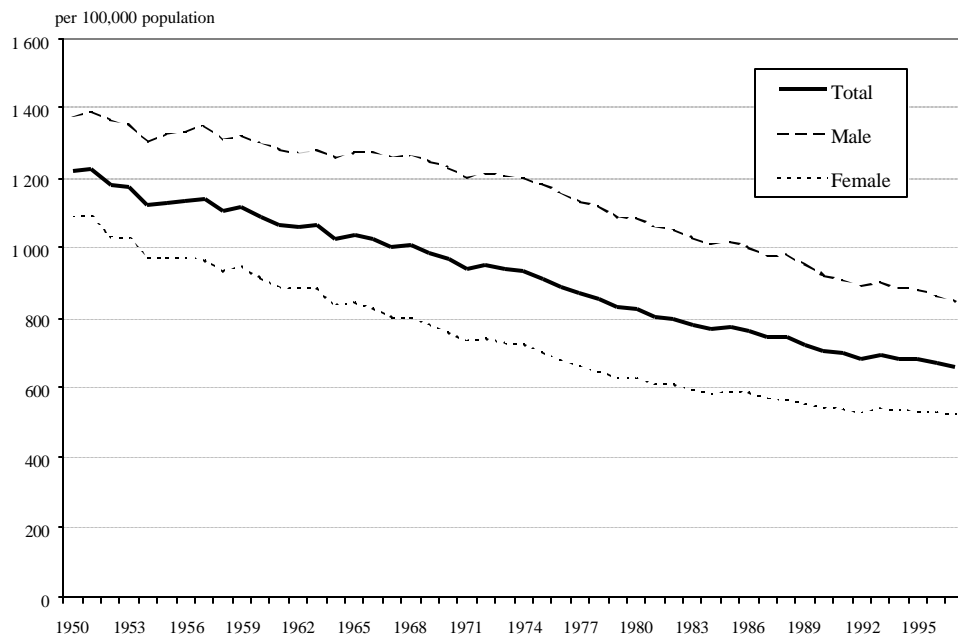
such as quality-adjusted life expectancy and health expectancy are still evolving, and long-term trends are not available.



Life expectancy and related indicators do not evolve very quickly, however, so it is not expected that significant changes will be observed from year to year. For example, between 1986 and 1991, disability-free life expectancy increased by 1.2 years for men and by 0.6 years for women.

The age-standardized mortality rate (ASMR) is another useful health status indicator. The ASMR is a measure of the death rate that is adjusted to take into account the age distribution of the population. Graph 5.2 depicts the evolution of the ASMR for both males and females over some 47 years. It can be seen that the ASMR for both sexes improved continually during this period. Specifically, the ASMR fell from 1,375 deaths per 100,000 males in 1950 to 848 deaths in 1997, and from 1,089 deaths per 100,000 females to 524.

**GRAPH 5.2**  
**AGE-STANDARDIZED MORTALITY RATES, ALL CAUSES**

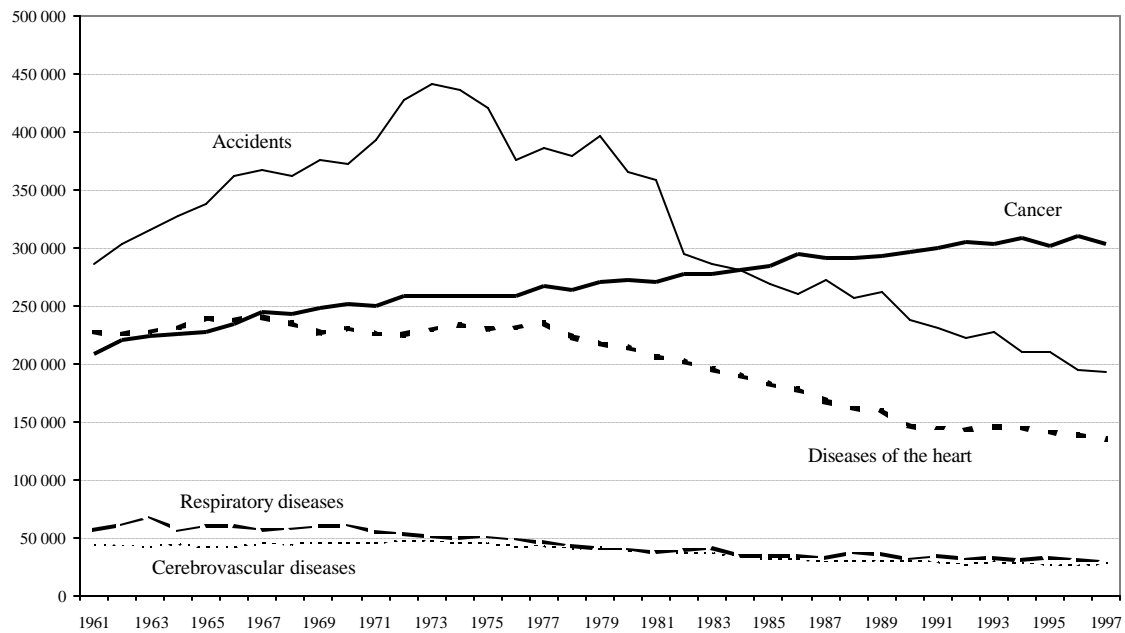


Source: Statistics Canada, *Health Statistics at a Glance*, Publication No. 82F0075XCB, 1999, and Library of Parliament.

Another internationally recognized indicator is called “potential years of life lost” (or PYLL). It refers to the number of years of life lost when a person dies before a specified age, say age 75. A person dying at age 25, for example, has lost 50 years of life. PYLL helps to identify causes of deaths which occur in younger age groups and which could, in theory, be prevented or postponed.

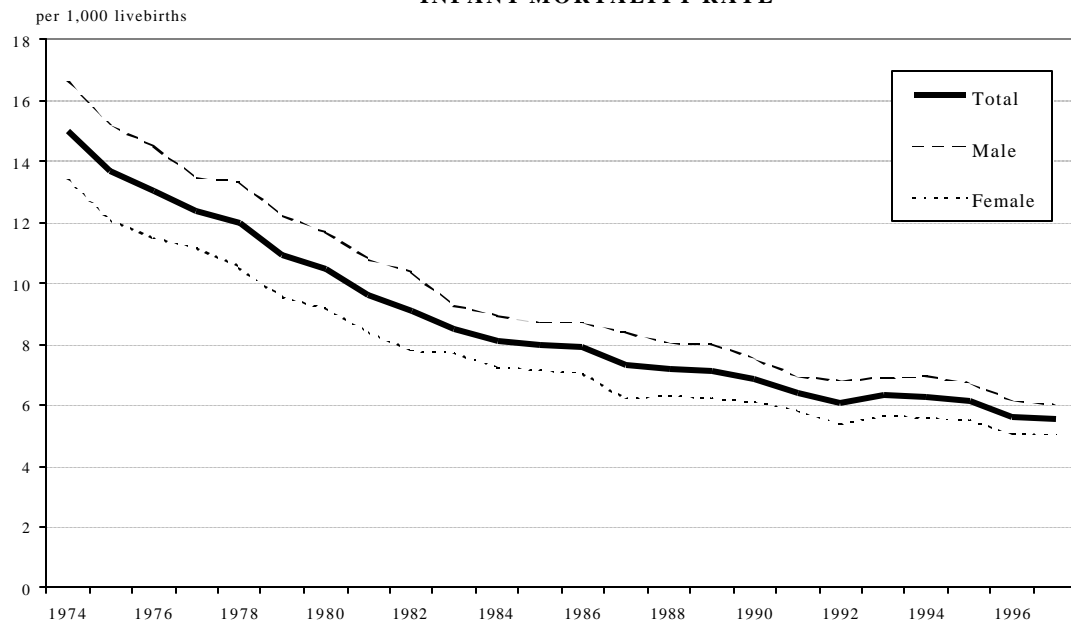
Long term trends in PYLL by major causes of death are presented in Graph 5.3. In 1997, there were over one million PYLL due to all causes, the most important being cancer, accidents and heart disease. As the graph indicates, cancer has been the leading cause of PYLL since 1984, and is the only major cause of PYLL to have continually increased. PYLL due to accidents have declined dramatically since 1979. The PYLL of heart disease, respiratory conditions and strokes has also declined over the past two decades. This suggests that Canada has been successful in reducing premature mortality over the past thirty years.

**GRAPH 5.3**  
**POTENTIAL YEARS OF LIFE LOST BY MAJOR CAUSE**



Source: Statistics Canada, *Health Statistics at a Glance*, Publication No. 82F0075XCB, 1999, and Library of Parliament.

**GRAPH 5.4**  
**INFANT MORTALITY RATE**



Source: Statistics Canada, *Health Statistics at a Glance*, Publication No. 82F0075XCB, 1999, and Library of Parliament.

Infant mortality is often used as a basic indicator of social and economic development. The rate of infant mortality – deaths within the first year of life – has declined substantially over the last 20 years in Canada (see Graph 5.4). In 1997, the rate of infant mortality was about 6 out of every 1,000 newborns, down from 15 deaths per 1,000 births in 1974.

Overall, the health status of Canadians has improved continuously over the past decades. Canadians live longer with fewer disabilities in old age. Fewer babies die in the first year of life and premature deaths from major causes, except cancer, continue to decline. Where does Canada stand internationally in terms of health status?

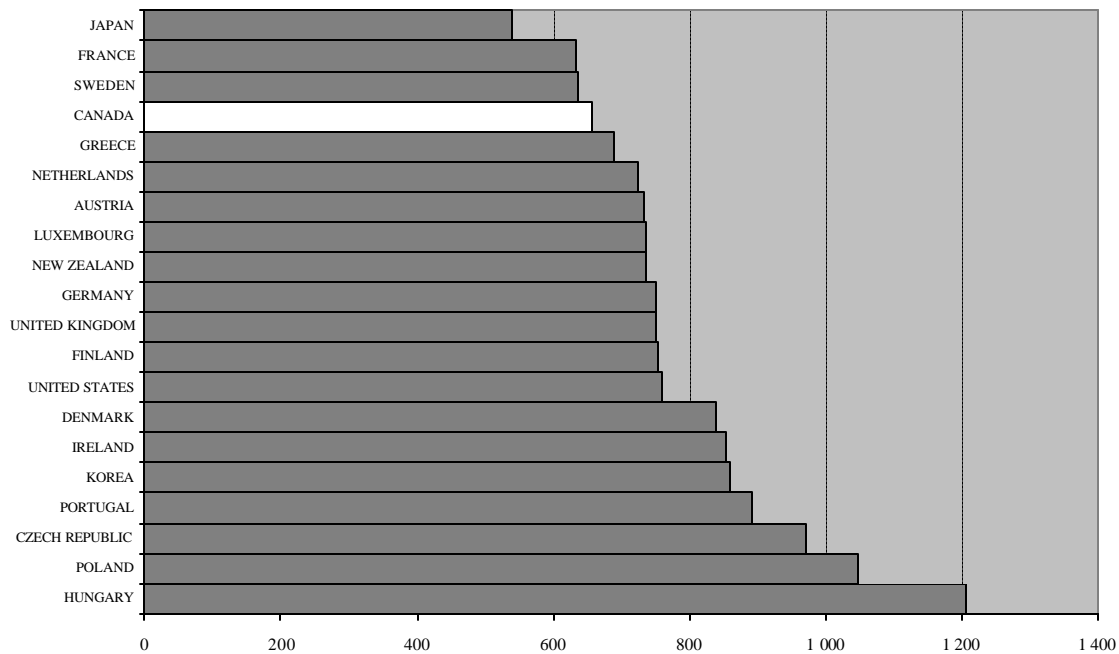
## 5.2 How Does Canada Compare to Other Countries?

In 1998, life expectancy at birth for Canadians was 79 years. Canada ranked second only to Japan (80 years) among the 25 countries with the longest life expectancy (see Graph 5.5). By contrast, the United States ranked the lowest, along with Luxembourg.



Canada ranked fourth in 1996 in terms of age-standardized mortality rates among 20 OECD countries (see Graph 5.6). Japan had the lowest rate, followed by France and Sweden. By comparison, Germany ranked 10<sup>th</sup>, the United Kingdom 11<sup>th</sup> and the United States 13<sup>th</sup>.

**GRAPH 5.6**  
**AGE-STANDARDIZED MORTALITY RATES PER 100,000 POPULATION, 1996**

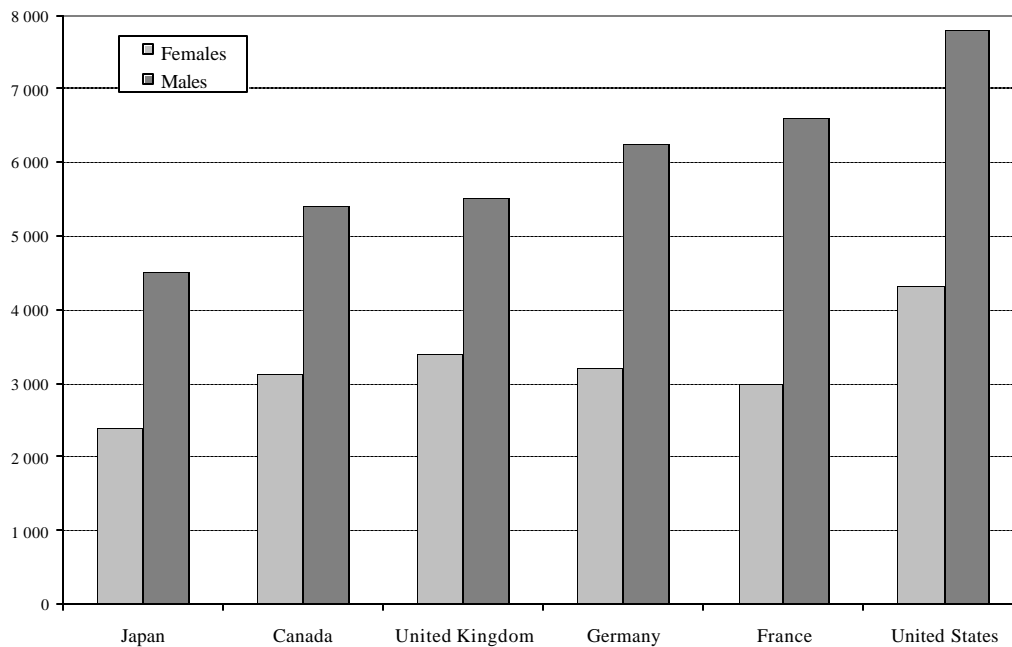


Source: OECD Health Data (2000) and Library of Parliament.

Compared to five other industrialized countries for which figures are available, Canada ranked second lowest in PYLL per 100,000 population for males and third lowest for females (see Graph 5.7).

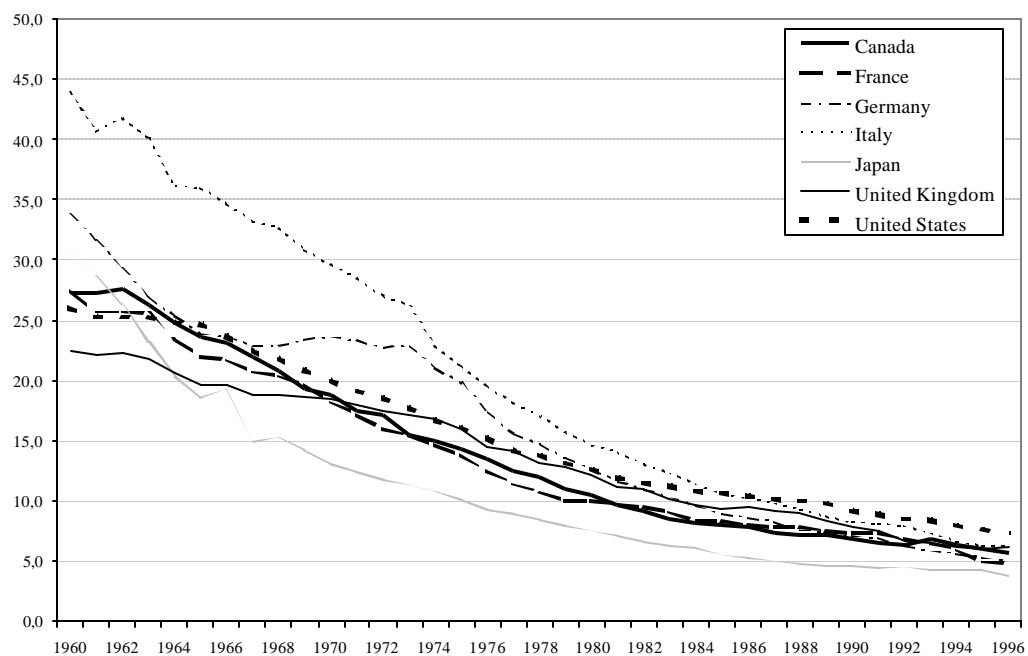
Like Canada, other industrialized countries have seen a decline in their infant mortality rates over the past few decades (see Graph 5.8). In 1960, the rates ranged from a low of 22 per 1,000 in the United Kingdom to a high of 44 per 1,000 in Italy. By 1996, the rates had fallen to a low of 4 in Japan and a high of 7 in the United States. Canada's infant mortality rate remains far above that of Japan which is the lowest in the world.

**GRAPH 5.7**  
**POTENTIAL YEARS OF LIFE LOST, AGE 0-69, 1996**



Source: OECD Health Data (2000) and Library of Parliament.

**GRAPH 5.8**  
**INFANT MORTALITY RATES (DEATHS PER THOUSAND OF LIVE BIRTHS)**

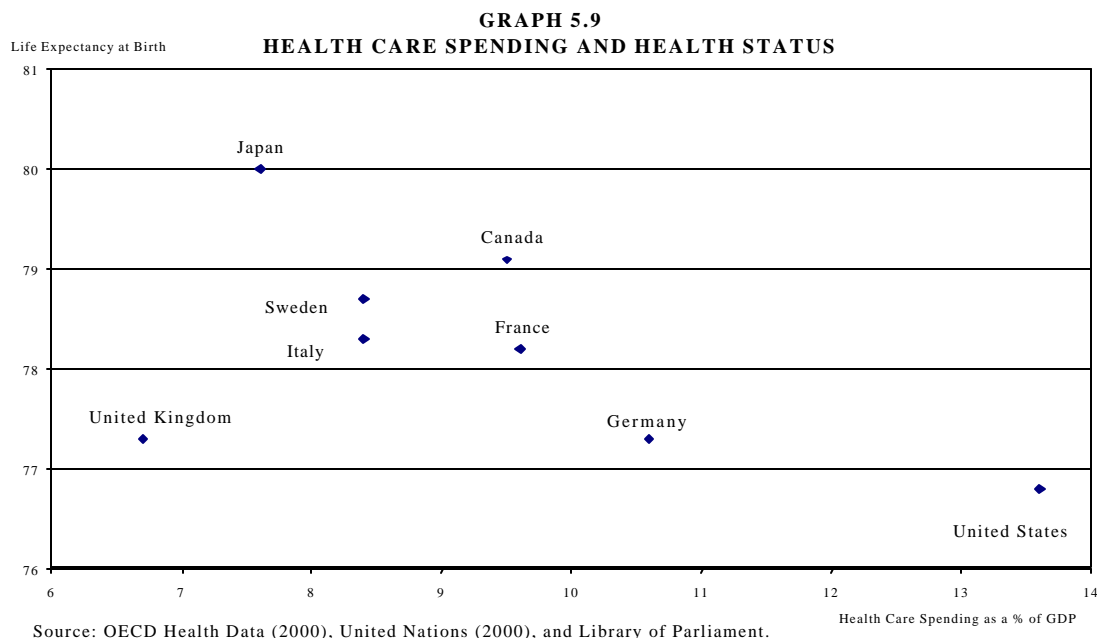


Source: OECD Health Data (2000) and Library of Parliament

Overall, a variety of health indicators show that Canadians enjoy a standard of health that is among the highest in the world. Canada ranks second in life expectancy, behind only Japan. Canadian mortality rates are among the lowest in OECD countries, behind only those of France, Sweden and Australia. And Canada has the second lowest premature mortality rate among industrialized countries. While Canada's infant mortality rate is still higher than Japan's, it is well below the American rate.

### 5.3 Health Care Expenditures and Health Status

Somewhat surprisingly perhaps, there is no definitive relationship between a country's spending on health care and the health status of its population (see Graph 5.9). For example, the Japanese have the longest life expectancy; yet their health care expenditure as a percentage of GDP is the second lowest among the industrialized countries. By contrast, the Americans have the highest ratio of health care spending to GDP, but their life expectancy is one of the lowest and their infant mortality rate one of the highest. While Sweden and Italy have similar levels of health care expenditures, the life expectancy of their respective populations differs. In addition, Canada spends less on health care than the United States, but the overall health status of Canadians is much better.

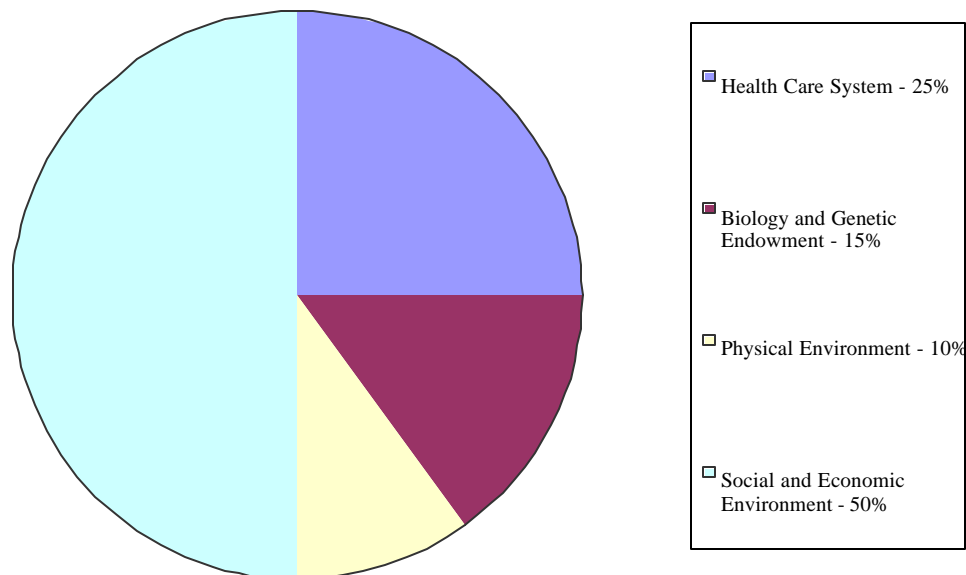


It is obvious that there is no clear relationship between a country's health care spending and the health status of its population. In other words, the health status of a population depends on many factors of which health care is only one.

## 5.4 The Concept of Population Health

It is clear that the state of the health care system affects our health. Services such as childhood immunisation, medications to reduce high blood pressure as well as heart surgery all contribute to health and well-being. But a good health care system is only one of numerous factors that contribute to good health. Graph 5.10 reproduces a chart prepared by the Canadian Institute for Advanced Research available on Health Canada's website. This graph suggests that only 25% of the health of the population is attributable to the health care system, while 75% is dependent on factors such as biology and genetic endowment, the physical environment and socio-economic conditions.

**GRAPH 5.10**  
**ESTIMATED IMPACT OF DETERMINANTS OF HEALTH ON THE HEALTH**  
**STATUS OF THE POPULATION**



Source: Estimation by the Canadian Institute for Advanced Research, Graph available on Health Canada's Website.



The term “population health” is used to describe the multiplicity and range of factors which all contribute to health. “Determinants of health” is the collective label given to the multiple factors which are now thought to contribute to population health. While there is no agreement on a finite set or the relative importance of the determinants of health, a certain degree of consensus has developed over the past decade. The list of health determinants presented in Table 5.1 was provided by Health Canada. It must be pointed out that the population health approach does not detract from the impact of the health care system, but it includes additional factors or determinants of health and takes the interaction between and among the determinants into consideration.

Unlike traditional health care, which deals with individuals one at a time when they become ill, population health strategies aim to improve the health of an entire population through broadly based preventive approaches that take determinants of health into account. Such preventive approaches ward off potential health problems before they have an impact on the health care system.

*Whenever one sees a person in a care situation – I am focusing here on primary care in particular – it is imperative for there to be consideration of the environment from which that person comes: the social, economic, and physical environmental forces that work on and affect that person's life.*

*Robert McMurtry, G.D.W. Cameron Visiting Chair, Health Canada (8:24).*

The concept of population health is not new. In 1974<sup>65</sup>, the then federal Minister of Health, Marc Lalonde, released a working document entitled *A New Perspective on the Health of Canadians*. This report put forward the idea that good health is not the result of medical care alone. For example, it proposed that changes in lifestyles or to social and physical environments would likely improve in the health status of Canadians more than would spending more money on health care delivery. The Lalonde report identified four major health determinants: human biology, environment, lifestyle and health care organization.<sup>66</sup>

<sup>65</sup> This review of the development of population health approach in Canada was based on a document entitled *Population Health Initiatives* provided to the Committee by Health Canada.

<sup>66</sup> Marc Lalonde, Minister of National Health and Welfare, *A New Perspective on the Health of Canadians – A Working Document*, Ottawa, April 1974, p. 31.

**TABLE 5.1**  
**KEY DETERMINANTS OF HEALTH**

<b>KEY DETERMINANTS</b>	<b>UNDERLYING PREMISES</b>
<b>Income and Social Status</b>	<p><b>Health status improves at each step up the income and social hierarchy.</b></p> <p>High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth.</p>
<b>Social Support Networks</b>	<p><b>Support from families, friends and communities is associated with better health.</b></p> <p>The importance of effective responses to stress and having the support of family and friends provides a caring and supportive relationship that seems to act as a buffer against health problems.</p>
<b>Education</b>	<p><b>Health status improves with level of education.</b></p> <p>Education increases opportunities for income and job security, and equips people with a sense of control over life circumstances - key factors that influence health.</p>
<b>Employment/Working Conditions</b>	<p><b>Unemployment, underemployment and stressful work are associated with poorer health.</b></p> <p>People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.</p>
<b>Social Environments</b>	<p><b>The array of values and norms of a society influence in varying ways the health and well-being of individuals and populations.</b></p> <p>In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Studies have shown that low availability of emotional support and low social participation have a negative impact on health and well-being.</p>
<b>Physical Environments</b>	<p><b>Physical factors in the natural environment (e.g., air, water quality) are key influences on health. Factors in the human-built environment such as housing, workplace safety, community and road design are also important influences.</b></p>
<b>Personal Health Practices and Coping Skills</b>	<p><b>Social environments that enable and support healthy choices and lifestyles, as well as people's knowledge, intentions, behaviours and coping skills for dealing with life in healthy ways, are key influences on health.</b></p> <p>Research in areas such as heart disease and disadvantaged childhood indicates that biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.</p>

<b>Healthy Childhood Development</b>	<p><b>The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills and competence is very powerful.</b></p> <p>Children born in low-income families are more likely than those born to high-income families to have low birth weights, to eat less nutritious food and to have more difficulty in school.</p>
<b>Biology and Genetic Endowment</b>	<p><b>The basic biology and organic make-up of the human body are a fundamental determinant of health.</b></p> <p>Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.</p>
<b>Health Care</b>	<p><b>Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health.</b></p>
<b>Gender</b>	<p><b>Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis.</b></p> <p>"Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles. Women, for example, are more vulnerable to gender-based sexual or physical violence, low income, lone parenthood, gender-based causes of exposure to health risks and threats (e.g., accidents, STDs, suicide, smoking, substance abuse, prescription drugs, physical inactivity).</p>
<b>Culture</b>	<p><b>Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.</b></p>

*Source: Health Canada, Towards a Common Understanding: Clarifying the Core Concepts of Population Health, Discussion Paper, December 1996, pp. 15-16; F/P/T Advisory Committee on Population Health, Strategies for Population Health: Investing in the Health of Canadians, Ottawa, 1994, pp. 2-3.*

The Jake Epp report, *Achieving Health for All: A Framework for Health Promotion*, released in 1986 when he was federal minister of health, gave us new insight into the field of population

health by focusing on the broader social, economic and environmental factors affecting health.<sup>67</sup>

The Epp report viewed health promotion as a complement to the health care system and a means to reduce health inequities between the various socio-economic population groups, to prevent the occurrence of injuries, illnesses, chronic conditions and their resulting disabilities, and to enhance people's ability to manage and cope with chronic conditions, disabilities and mental health problems.

In 1989, the Canadian Institute for Advanced Research (CIAR) argued that individual determinants of health do not act in isolation, noting instead that it is the complex interaction among the various determinants that can have a far more significant effect on health. These types of interaction can help explain why some groups of Canadians are healthier than others in spite of the fact that all Canadians have equal access to the health care system.

*This new understanding that is affecting our health beliefs is the increasing appreciation of how the environment in which individuals live and work throughout the life cycle has major effects on physical and mental health problems.*

*Dr. J. Fraser Mustard, Brief to the Committee, 22 March 2000, p. 7.*

In 1994, the population health approach was officially endorsed by the federal, provincial and territorial Ministers of Health in a report entitled *Strategies for Population Health: Investing in the Health of Canadians*.<sup>68</sup> This report summarized what was known at the time about the broad determinants of health and set out a framework to guide the development of policies and strategies to improve population health.

In 1997, the National Forum on Health furthered the discussion of the determinants of health. It stressed the importance of working, not only with health departments, but with various sectors, to take action on the determinants of health. It proposed the establishment of a "Population Health Institute" as an instrument to improve decision-making in the field

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<sup>67</sup> Jake Epp, Minister of Health and Welfare, *Achieving Health for All: A Framework for Health Promotion*, Ottawa, 1986.

<sup>68</sup> Federal/Provincial/Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians*, Ottawa, 1994.

of health by contributing and promoting a population health perspective in health research and policy-making.

In response to the Forum's recommendation, the federal government launched the Canadian Population Health Initiative (CPHI) in 1999. Established within CIHI, the initiative is designed to bring together researchers and analysts from across the country. It builds on existing databases and aims at creating a statistical infrastructure that will form the foundation of population health research. It will aggregate and analyse data, develop data standards and common definitions, report to the public on the national health status and health system performance as well as act as a resource for the development and evaluation of public policy. The first CPHI Council was announced on February 3, 2000. It is now developing a research agenda, and dissemination and communication strategies.

Again in 1999, the Federal/Provincial/Territorial Advisory Committee on Population Health released a report entitled *Intersectoral Action... Towards Population Health* which stressed that improving the health, well-being and quality of life of the population requires the involvement of many sectors.<sup>69</sup> It stated that intersectoral action – cooperation and collaboration within and between organizations and sectors – must involve the public and government sectors, the voluntary sector, the private sector, businesses, professionals and consumers in the fields of health, justice, education, social services, finance, agriculture, environment, and so forth.

Following the release of the *Second Report on the Health of Canadians* (September 2000), all federal, provincial and territorial Ministers of Health have agreed to the following priority areas for action on the broader, underlying conditions that make Canadians healthy or unhealthy in the first place. These are:

- renewing and reorienting the health care sector;
- investing in the health and well-being of key population groups;

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<sup>69</sup> Federal/Provincial/Territorial Advisory Committee on Population Health, *Intersectoral Action... Towards Population Health*, Ottawa, June 1999.

- improving health and reducing disparities in literacy, education and income distribution in Canada.

## 5.5 What Makes Canadians Healthy or Unhealthy?

Health status in Canada does not extend evenly to all Canadians. Our universal health care system has ensured equitable access to insured services, but not necessarily to good health for everybody. There are variances in terms of many different health status indicators between the affluent and the poor, and these cannot only be explained by unequal access to health care services.

*Within that overall good news story about the health of Canadians, there are some more disturbing stories, because certainly not all Canadians enjoy that high level of good health. Aboriginal people, particularly, have a life expectancy that is five, seven or twelve years different, depending on how you measure it. Certainly, people in northern, rural, and low-income, urban areas have a remarkably lower life expectancy than more affluent Canadians; so there are some problems.*

*Dr. John S. Millar, V.P., Research and Analysis, CIHI, 14:33.*

Disparities in health status exist in terms of geographical location, demographic factors, socio-economic conditions, gender differences and so on.

A copy of the *Second Report on the Health of Canadians* was tabled with the Committee.<sup>70</sup> This comprehensive report provides valuable information and comments on the health status of Canadians using a population health approach. Among other things, it points out that:

- Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes;
- Large disparities in income distribution lead to increases in social problems and poorer health among the population as a whole;
- Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy;
- Canadians with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier food;

<sup>70</sup> Federal, Provincial and Territorial Advisory Committee on Population Health, *Toward a Healthy Future – Second Report on the Health of Canadians*, 1999.

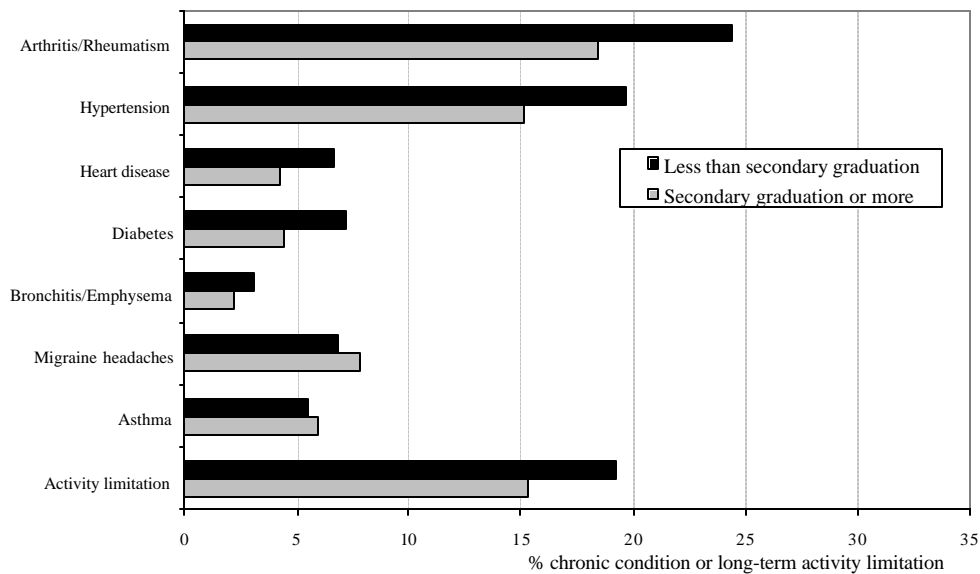
- Studies in neurobiology have confirmed that experiences from conception to age 6 have the largest influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health right into adulthood;
- Ageing is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning may be particularly important for maintaining health and cognitive capacity in old age;
- Despite reductions in infant mortality rates, improvements in education levels, and reductions in substance abuse in many Aboriginal communities, First Nations and Inuit people remain at higher risk than the Canadian population as a whole for illness and early death;
- Men are more likely to die prematurely than women, largely as a result of heart disease, fatal unintentional injuries, cancer and suicide. Women are more likely to suffer from depression, stress overload, chronic conditions, and injuries and deaths resulting from family violence;
- Older Canadians are far more likely than younger Canadians to have physical illnesses, but young people report the lowest levels of psychological well-being.

A recent study by Statistics Canada shows that chronic conditions and activity limitation are more prevalent among individuals aged 45 to 64 with lower education or lower income. In 1998-99, arthritis or rheumatism, high blood pressure, heart disease, diabetes, bronchitis or emphysema and activity limitation were more prevalent among those who had not graduated from high school (see Graph 5.11). These conditions, as well as asthma and migraine headaches, were also more prevalent among those with a low or lower-middle income than among those with a higher income (see Graph 5.12).

There are also great disparities in infant mortality rates between income groups. For example, Statistics Canada reports that infant mortality rates are highest in the poorest urban neighbourhoods, and lowest in the richest urban neighbourhoods. Graph 5.13 shows that, while there has been progress in reducing this disparity, the infant mortality rate in Canada's poorest neighbourhoods (6.5 per 1,000) in 1996 was still two-thirds higher than that of the richest neighbourhoods (3.9 per 1,000). Statistics Canada estimated that if the rate for all

Canada had been as low as that of the richest neighbourhoods, there would have been about 500 fewer infant deaths in 1996.<sup>71</sup>

**GRAPH 5.11**  
**PREVALENCE OF CHRONIC CONDITIONS OR LONG-TERM ACTIVITY**  
**LIMITATION BY EDUCATIONAL ATTAINMENT, POPULATION AGED 45-64**  
**CANADA EXCLUDING TERRITORIES, 1998-99**



Source: "Health in mid-life," In Statistics Canada, *Health Reports*, Publication No. 82-003, Winter 1999, Vol. 11, No. 3.

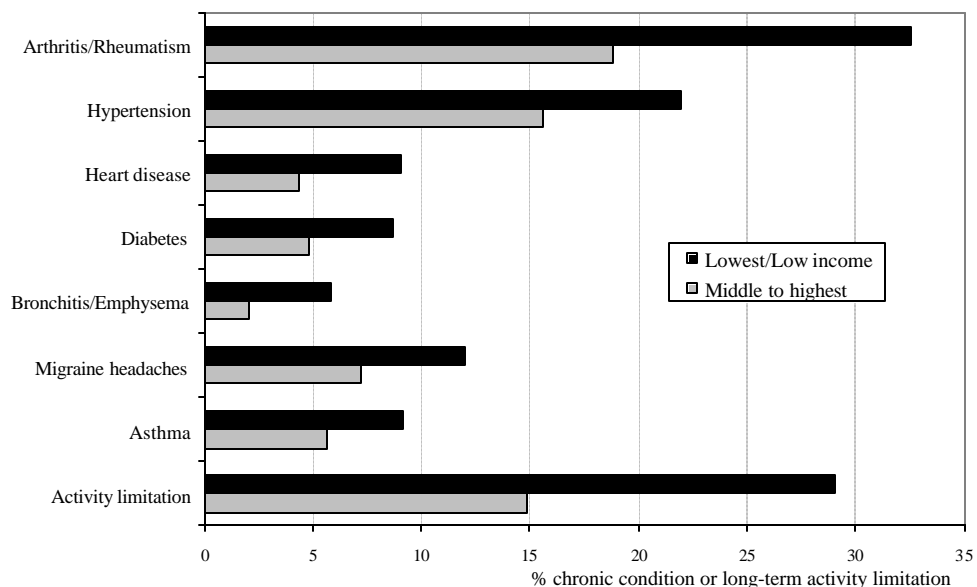
## 5.6 Committee Commentary

While many Canadians enjoy high levels of health and although Canada ranks well above other countries in terms of most of the major health status indicators, there is definitely room for improvement. There are disparities in health associated with age, socio-economic conditions, gender and so on. Many witnesses told the Committee that it is imperative to reduce these disparities if we want to improve the overall health status of Canadians. In their view, this can be best achieved through a comprehensive population health approach.

<sup>71</sup> Statistics Canada, "Health Status of Children", *Health Reports*, Catalogue 82-003, Winter 1999, Vol. 11, No. 3.

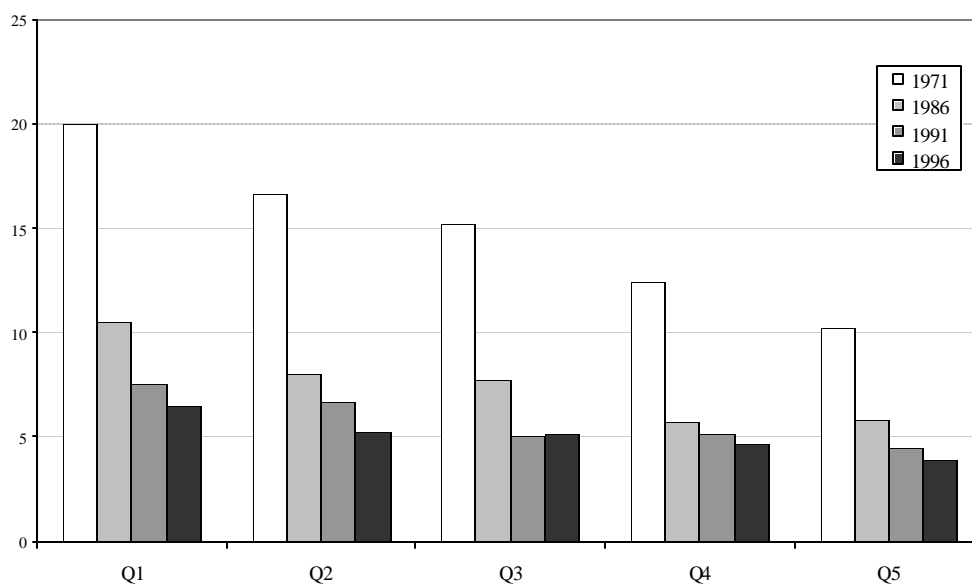


**GRAPH 5.12**  
**PREVALENCE OF CHRONIC CONDITIONS OR LONG-TERM ACTIVITY**  
**LIMITATION BY HOUSEHOLD INCOME, POPULATION AGED 45-64**  
**CANADA EXCLUDING TERRITORIES, 1998-99**



Source: "Health in mid-life," In Statistics Canada, *Health Reports*, Publication No. 82-003, Winter 1999, Vol. 11, No. 3.

**GRAPH 5.13**  
**INFANT MORTALITY RATES BY NEIGHBOURHOOD INCOME QUINTILE,**  
**URBAN CANADA**



Source: "Health Status of Children," In Statistics Canada, *Health Reports*, Publication No. 82-003, Winter 1999, Vol. 11, No. 3.

Witnesses also stressed that there is a need to better understand the links between health status and the various determinants of health. We do not know how changes in health care spending affect the health of a population. We do not know much about the impact of other public policies on health status as a recent report clearly indicated:

We have large gaps in our understanding of the factors affecting individuals' health over the medium to long term. For example, what is the longer-term effectiveness of sometimes competing procedures or interventions – such as coronary bypass surgery and balloon angioplasty? In the case of prostate cancer, what are the relative merits of drug therapy, surgery, or simply waiting and seeing? How do psychological interventions affect outcomes? What are the special health risks of different occupations? What are the long-term effects of many environmental hazards? To what degree, if at all, do people with low incomes or educational levels benefit from “equal access” provisions in the *Canada Health Act*?<sup>72</sup>

During his testimony, Sholom Glouberman raised the following question: given that health care is only one factor among a variety of health determinants, what role can or should the health ministers play in establishing population health strategies? Specifically, he told the Committee:

The Ministry of Health has a problem because the most critical contributors to health are not health-related by this account. They have to do with social status, control over work, level of education, and the Ministry of Health has no authority over these matters. If they take responsibility for this, they risk being viewed by other government departments as “health imperialists”. How do you deal with those kinds of problems?<sup>73</sup>

Since a multiplicity of factors determines the health of a population, there is clearly a need for collaboration and intersectoral action. According to Marc Lalonde, the federal Minister of Health should act as a leader. He also stressed that new initiatives to improve the health of the Canadian population are needed, particularly in the areas of health promotion and disease prevention:

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<sup>72</sup> Advisory Council on Health Infostructure, *Paths to Better Health: Final Report*, Ottawa, February 1999, p. 4-1.

<sup>73</sup> Sholom Glouberman (9:9).

We need the type of action wherein the Minister of Health can be a leader, but he cannot be the only actor. There must be action that will take place on the basis of a collective action by the government, because in almost every instance it involves action by a number of departments of the government. Money is not the problem. A program of public education on obesity, for instance, is insignificant compared to what you spend on the health budget. What we need is a determination to go ahead with programs and do it consistently.<sup>74</sup>

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<sup>74</sup> Hon. Marc Lalonde (15:15).

## CHAPTER SIX:

### MYTHS AND REALITIES

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The current debate over Canada's health care system and its future has generated a great deal of confusion. It mixes large elements of truth with misconceptions and erroneous beliefs about health, health care, health care financing and health care costs. This debate is an important one, however, as it will pave the way for discussions about future reforms. Therefore, the Committee strongly believes that it is

*Based on facts, and in comparison to other countries, our health care system in respect to the health of Canadians is not in a real crisis. Based on perception, it is in crisis... Some of the crisis is related to myths, beliefs and values in respect to health care."*

*Dr. J. Fraser Mustard, Brief to the Committee, p. 1.*

essential to put a series of arguments into perspective in order to have an informed, fact-based debate. In the following sections, several of the most widespread notions are analyzed briefly in order to help separate myth from reality. It is our hope that this discussion will throw some light on the fundamental issues at stake with health care.

#### 6.1 Myths About Rising Health Care Costs

**Myth:** The single biggest increase in health care expenditures is attributable to the needs of older Canadians.

**Reality:** Persons over 65 consume, on average, more health services than those under 65. However, the ageing of the population is only one of many factors contributing to increasing health care costs. In fact, a complex mix of factors – both supply and demand related – has contributed to the increase in health care spending.

Other cost drivers include the use of new technology, the cost of new drugs, changing consumer expectations and needs, and new and changing patterns of disease (e.g. emergence of new strains of bacteria, resistance of old infectious diseases, such as tuberculosis, health effects of global warming, AIDS). These all have a significant influence on the cost of health care.

Although it is difficult to identify or quantify the importance of each factor with precision, some estimates were made available to the Committee. On the one hand, Dr. Robert McMurtry suggested that the annual growth in health care expenditures attributable to ageing is approximately 4.8%. This is expected to rise by 0.6% per year for the next ten years.<sup>75</sup> On the other hand, a 1995 OECD study indicated that probably one-half of the growth in overall health care expenditures in OECD countries between 1960 and 1990 could be attributed to factors such as technological developments, growth in the number of medical personnel and facilities, and real increases in the price of health care inputs.<sup>76</sup>

**Myth:** Health care expenditures have been rising uncontrollably in Canada.

**Reality:** As discussed in Chapter 4, it is important to remove the effect of inflation in order to interpret long-term trends in health care expenditures. A dollar today is not the same as a dollar in 1975. Data should also be adjusted to the size of the population.

Health care expenditures per capita in constant (1992) dollars increased from 1975 to the early 1990s, but then decreased slightly between 1992 and 1996. Similarly, the health care to GDP ratio, which increased throughout most of the 1970s to the early 1990s, declined continuously from 1992 to 1997. Therefore, Canada has been successful in controlling total health care costs over the last decade.

*The notion that she emphasized, which is that the hypothesis that health care costs are out of control was a myth, needs to be reiterated. (...) During the 1990s, we went from expending 10 per cent of our GDP on health care to 8.9 per cent, as per the most recent year for which statistics are available. Estimates and forecasts for 1998 and 1999 would have us rising to 9.1 per cent or thereabouts, well below where we have been.*

*Robert McMurtry,  
( 8:20-21)*

**Myth:** The cost of an ageing society to the health care system will be far in excess of present health care expenditures.

**Reality:** As stated previously, there is no doubt that beyond the age of 65, more money per capita is spent on health care. However, the annual growth in health care spending

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<sup>75</sup> Dr. Robert McMurtry (8:17).

attributable to ageing is estimated at less than 5%. Furthermore, Canadians are living both longer and more healthily. Therefore, the anticipated demographic impact of ageing on the health care system may need to be revised. While the costs associated with ageing must be analyzed and managed, a more significant issue concerns the health care costs that are generally incurred during the last six months of life, regardless of age. The cost of medical care individuals receive skyrockets as they near the end of their life. As a result, it is

*Clearly, we are living longer. The corollary to that is: Are we living healthier or less healthier? If we are living more healthily, then we could anticipate that the costs would not necessarily go up as we age. The early demographic findings published fairly recently by Statistics Canada indicate that we are living both longer and more healthily. Therefore, the anticipated impact on the health care system is not necessarily as severe as we once thought it might be.*

*Dr. John S. Millar, CIHI  
(14:39)*

not the ageing per se of the population which has an impact on health care costs, but rather the overall increase in the population.

## **6.2 Myths About Public Financing**

**Myth:** Canada's health care system is 100 percent publicly funded.

**Reality:** Not true! According to data from CIHI, the public share of health care spending amounted to 71% in 2000, while private spending accounted for 29% of total health care expenditures.

As shown in Graph 4.7, the public sector is the main source of funding for public health (100%), hospital care (91%) and physician services (99%). Private funding is generally concentrated on items not completely covered under the *Canada Health Act* (e.g. prescription drugs, dental services, vision care, home care and so forth.).

**Myth:** The only problem is a shortage of money. If the federal government would restore previous funding levels, then the problems in the current system would be fixed.

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<sup>76</sup> Howard Oxley and Maitland MacFarlan, *Health Care Reform: Controlling Spending and Increasing Efficiency*, Economic Department Working Papers No. 149, OECD Paris, 1995.

**Reality:** Although more public funding will help deal with immediate problems in the system – long waiting lists, crowded emergencies and so on. – witnesses stressed the importance of stability and predictability in federal financing. Following the federal-provincial agreement on health care renewal of 11 September 2000, the federal government enacted Bill C-45 which provides some \$21 billion of additional cash transfers over the next five years. It is the view of the federal government that this new investment will ensure stable, predictable and growing funds in the CHST.

However, in recent years, we have had a series of commissions and special committees across the country that have examined the health care system in Canada and in some provinces. Their conclusions were clear: the problems with our current system would not be resolved even if previous funding levels were restored.

On the contrary, without a new vision of what the future health care system should be, there is a risk that new money will be reinvested only in traditional, publicly funded, sectors of health care (e.g. hospitals and institutional care). Therefore, witnesses stressed that, before devoting additional government dollars in health care, three major questions should be addressed: 1) What would we be willing to give up in other areas to support the increased investment in health care?, 2) What would the return on our increased investment in health care be? and 3) What is the best balance between prevention and treatment? In other words, there are trade-offs to be made in allocating limited public financial resources:

The more money that goes into the health care sector, and as you know that is now up to 40 per cent of some provincial government budgets, the less that is available for other things like early childhood care. There is always that balance that one has to trade off, and that is very important.<sup>77</sup>

(...) throwing increasing amounts of money into the health care system is not sustainable in the absence of economic growth. Putting more and more into it means we spend less and less on other things, such as education, income support, job development, et cetera.<sup>78</sup>

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<sup>77</sup> Dr. John S. Millar (14:49).

<sup>78</sup> Professor Colleen Flood, University of Toronto (14:18-19).

(...) we are trying to balance all of these notions. Presumably, we are also trying to balance the fact that there are other spending priorities that are also meritorious. Health is important for the future of the country, but so are post-secondary education, research and innovation. They are viewed as key to the development of our country.<sup>79</sup>

### 6.3 Myths About the *Canada Health Act*

**Myth:** The *Canada Health Act* ensures the provision of the same set of free health services across the country.

**Reality:** Health services that must be covered under the *Canada Health Act* are determined on the basis of the “medical necessity” concept under the criterion of comprehensiveness. All medically necessary services provided by hospitals and doctors must be insured under provincial health care insurance plans. The determination of what services meet the requirement of medical necessity is made in each province by the provincial government in conjunction with the medical profession.

*(...) under the comprehensiveness criterion of the Canada Health Act, provincial and territorial health insurance plans must insure all medically necessary hospital, physician, and surgical dental services to eligible persons in the particular province. (...) medical necessity is not defined anywhere in legislation, and therefore is a matter of negotiation that may give rise to some differences from province to province.*

*Abby Hoffman, Health Canada  
(13:13).*

During her presentation to the Committee, Professor Raisa Deber explained that the *Canada Health Act* is quite permissive as provinces are free to go beyond its definition of necessary services, but they cannot go below it. In her view, comprehensiveness is a floor, not a ceiling. Over the years, provinces have expanded the array of services insured under their public plan, but they have not done so uniformly. As a result, public coverage for health services vary greatly among provinces. Frank Fedyk, Acting Director of the Canada Health Act Division at Health Canada, stated:

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<sup>79</sup> Guillaume Bissonnette (17:6).



Many provinces do have home and community care programs, but they are very much a patchwork.<sup>80</sup>

(...)The palliative care programs across Canada are at different stages of development, similar to other home care services. Some are very well developed and include home visits by physicians, care nurses and other health professionals. Unfortunately, it does vary across the provinces and is not covered by the federal legislation. Therefore, there is a patchwork and there are no national standards.<sup>81</sup>

Furthermore, most provinces have de-insured some services previously covered under their public health care insurance plans. This has generated further disparities in provincial health care coverage. A list of some of the de-insured services by province is presented in Table 6.1. For example, the removal of warts is no longer covered in Nova Scotia, New Brunswick, Ontario, Manitoba, Alberta, Saskatchewan and British Columbia, but it remains publicly insured in Newfoundland, Quebec and Prince Edward Island. In addition, coverage varies widely across the country in the areas of reproductive services. While stomach stapling is covered in most provinces, it is not insured in New Brunswick, Nova Scotia and the Yukon, and patients in these provinces must pay for this procedure.

**Myth:** The *Canada Health Act* prohibits the private sector from playing a role in the provision of health care services.

**Reality:** The public administration criterion of the *Canada Health Act* relates to the administration of provincial insurance plans for medically necessary services, not to the delivery of insured health services. It stipulates that provincial health care insurance plans must be administered by a public agency on a non-profit basis. As a corollary, private insurance is not allowed for insured services. But the Act does not preclude private insurers from supplementing provincial health care insurance plans. Private plans can and do insure services that are not covered or are only partially covered under public plans (e.g. prescription drugs outside hospitals, semi-private or private rooms, dental care, vision care, assistive devices, ambulance, long-term care, chiropractors, cosmetic surgery and so on.).

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<sup>80</sup> Frank Fedyk (13:14).

<sup>81</sup> Frank Fedyk (13:21).

**TABLE 6.1**  
**DEINSURED HEALTH CARE SERVICES BY PROVINCE**

<b>SERVICE <sup>(1)</sup></b>	<b>PROVINCE</b>
Routine circumcision of newborn	NFLD, PEI, NS, NB, ONT, ALTA, YK
Xanthelasma excision (removal of fatty spots on eyes)	NFLD, NS, ONT
Hypnotherapy	NFLD
Removal of impacted teeth	NFLD
Otoplasty	NFLD, PEI, NB, ONT, ALTA
Gastroplasty (stomach stapling)	NB, NS, YK
Tattoo removal	SASK, MAN, ONT
Reversal of sterilization	PEI, NB, ONT, MAN, SASK, ALTA, YK (uninsured service in NS and BC)
Penile prosthesis	NS, ONT, SASK
Psychoanalysis	MAN, QC
Eye examination (People aged 19 to 64)	PEI, NS, NB, QC, MAN, SASK, ALTA
Wart and benign skin lesion removal	NS, NB, ONT, MAN, ALTA, SASK, BC
Second or subsequent ultrasounds in uncomplicated pregnancies	NS, BC
In-vitro fertilization	ONT, MAN (uninsured service in NFLD, NS, NWT)
Simple sclerotherapy (removal of varicose veins)	QC, ONT, MAN (uninsured service in NS)
Artificial/intrauterine insemination	NS, NB (uninsured service in ALTA)
Ear wax removal	NS
Anaesthesia associated with a non-insured service	NB, SASK, ALTA
Chiropractic services	SASK
Epilation of facial hair	PEI, ONT
Eye refractions	NFLD, SASK
Cosmetic surgery	ALTA (uninsured service in NFLD, NS, PEI, NB, QC, MAN, SASK, BC, YK, NWT)
Breast reduction/augmentation	NS, NB, ONT, BC

*(1) Some exceptions may apply.*

*Source: Health Canada, Insured Services De-insured From 1990 by Province/Territory, Information binder prepared for the Committee, Section 12, February 2000.*

In addition, the *Canada Health Act* does not prevent private providers from delivering, and being reimbursed for, provincially insured health services, so long as extra-billing or user charges are not involved. In fact, most doctors are private practitioners who work in independent or group practices. Private practitioners are generally paid on a fee-for-service basis and submit their service claims directly to the provincial health care insurance plan for payment. Physicians in other practice settings may also be paid on a fee-for-service basis, but are more likely to be salaried or remunerated through an alternative payment scheme.<sup>82</sup>

*All physicians who are on fee-for-service can be seen as private providers of care. As well, there are not-for-profit charitable organizations. Part of the confusion is that in Canada we use the term "public hospital" to refer to private organizations. This becomes confusing because the argument against "public hospitals" gets into the rigidity of government employees. However, these are not government employees; they are people who work for hospitals on a not-for-profit basis. There is not a lot of inherent reason that they could not achieve the same sort of efficiencies that for-profit organizations can achieve and not have to find additional money to return to shareholders.*

*Professor Raisa Deber  
University of Toronto (8:16).*

Similarly, over 95% of Canadian hospitals are operated as private not-for-profit entities run by community boards of trustees, voluntary organizations or municipalities. The for-profit hospital sector comprises mostly long-term care facilities or specialized services such as addiction centres.<sup>83</sup>

We acknowledge that some provinces do have private, for-profit hospitals. For example, the Shouldice hospital in Ontario is a private, for-profit facility whose status was grand fathered when Medicare was enacted in that province. Facilities like this one are regulated on a rate of return basis, to reduce the risk of overcharging patients. However, Alberta's Bill 11, which was enacted earlier this year, allows private, for-profit surgical facilities to charge a fee for "enhanced" services sold in combination with the provision of an insured service.

Overall, the real debate in health care delivery is not about the role of the private sector – it is about the distinction between not-for-profit and for-profit providers.

<sup>82</sup> Health Canada, *Canada's Health Care System*, 1999, p. 2.

<sup>83</sup> *Ibid.*

**Myth:** Canada's health care system – or Medicare – is an insurance plan that could be run either privately or publicly.

**Reality:** Illness is unpredictable. Therefore, the demand for health care is unpredictable. Such uncertainty can be offset by insurance. In Canada, the evolution of health care insurance has been marked by a shift from the private to the public sector. We have favoured public insurance over private insurance in part because of market failures. For example, private insurance companies could refuse to insure high-risk clients or force them to pay a much higher premium to offset the risk (as is happening increasingly in the United States). In addition, in a private insurance market, individuals with a low income would be subject to the same fee structure as high-income individuals and, thus, would have to assume a relatively higher proportion of health care costs. But most importantly, Canadians have opted for universal public health care insurance on the grounds of compassion, equity and social justice.

*All developed countries, with the notable exception of the United States, have a common goal in mind with their health care systems, and that is to ensure that everyone has access to a comprehensive range of high quality services on the basis of need and not on the basis of ability to pay. That is basically the redistributive goal that most developed countries, apart from the United States, have.*

*Professor Colleen Flood  
University of Toronto (14:15)*

By contrast, the United States relies extensively on private health care insurance. The American system, no matter how we measure spending, is the most expensive health care system in the world. The Canadian system, which is publicly financed for the most part, has proven to be less expensive to administer and more cost-effective than the American system. In fact, an article in the *New England Journal of Medicine* some years ago estimated that Canada saved one percentage point of GDP compared to the United States by having a “single payer”.

Moreover, our system of Medicare and the national principles set out in the *Canada Health Act* – universality, accessibility, comprehensiveness, portability and public administration – are strongly supported by Canadians.

**Myth:** The *Canada Health Act* was a monumental change.

**Reality:** The *Canada Health Act* was a consolidation of the prior legislation on hospital insurance (1957) and medical care insurance (1966). The Hon. Monique Bégin told the Committee that, for the most part, the principles and conditions of the Act existed already in the previous pieces of legislation:

(...) the five principles or conditions of the *Canada Health Act* existed in the previous pieces of legislation. (...) There were originally four principles. Accessibility was included as a sort of subtext of universality, but we extracted it and made it a formal fifth condition. The legislation consolidated and did away with the two previous acts, borrowing everything it could from the spirit and the conditions of the previous acts.<sup>84</sup>

What was new in the *Canada Health Act* was the explicit reference to free access and the addition of specific restrictions with respect to direct patient charges in the form of user fees and extra-billing.

## 6.4 Myths About Privatization

**Myth:** “Two-tier” health care means the same thing to everyone.

**Reality:** Almost every day, conflicting and confusing statements are made about “two-tier” health care in Canada. Politicians, health care providers and health experts alike hold differing views about the existence of a two-tier health care system in Canada because they all provide their own definition for the concept of two-tier.

*If there is one statement to which the leaders of all parties in Canada's current federal election would undoubtedly subscribe, it is the one imprinted on Stockwell Day's infamous cue-card: "No 2-tier health care". And yet no issue in the campaign has generated more heat. This irony points out the central problem: "Two-tier health care" is an ambiguous and negatively charged phrase that makes a convenient political weapon but says little about actual policy intentions.*

*Carolyn Hughes Tuohy, "Comment", Globe and Mail, 17 November 2000, p. A-23.*

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<sup>84</sup> Hon. Monique Bégin (16:8).

Most frequently, a two-tier system refers to two co-existing health care systems: a publicly funded system and a privately funded system. This definition of two-tier health care implies differential access to health services based on one's ability to pay, not his or her need. Those who can afford to pay may obtain either access to better quality of care or access to quicker care, while the rest of the population continue to access health care only within the publicly funded system.

However, in the field of health care in Canada, the variant definitions for the concept of two-tier include the following:

- For some, a two-tier system is one that requires patients to pay a user charge to access medically necessary services.
- For some others, a two-tier system is one in which some patients pay out of their own pockets to get to the front of the line to receive faster medically necessary care (this situation is often referred to as “queue jumping”).
- Still, others define two-tier health care as made of two separate or parallel systems that provide medically necessary services. One system is accessible and publicly funded and the other is entirely private and allows patients to pay for faster and preferential treatment. The two systems compete for the provision of publicly insured services. To obtain health services privately, however, patients must pay the full cost, either out-of-pockets or through private insurance.
- For some, a two-tier system is one in which certain health services are available free to some citizens but other services are only available to those who pay for them. By this definition, the current system in Canada definitively could be described as a two-tier system since certain expensive drugs, even though prescribed by a physician as “medically necessary”, are not publicly funded and are only available to those who pay for them, personally or through a private drug insurance plan.

Under the *Canada Health Act*, hospital and physician services deemed “medically necessary” must be made available to all Canadians based on need, and without financial barrier. The Act discourages user charges for these insured health services and is enforced by the federal government via a reduction in cash transfers to the provinces that permit this practice. As such, the Act does not explicitly prohibit two-tier medicine (no matter which of the above definitions of “two-tier” is used); rather, the Act strongly discourages two-tier medicine.

This strong disincentive led the National Forum on Health to conclude in its 1997 report that Canada has a single-tier system for medically necessary hospital and physician services.

The *Canada Health Act*, however, applies only to physician and hospital services. All other health care services lie in a realm of shared public/private or fully private finance. This includes additional benefits such as prescription drugs, optometry services, long-term care and home care, as well as semi-private and private ward accommodation in hospitals, medical examinations required by insurers, and so on.

Some health services traditionally regarded as being under the purview of the publicly funded health care system are now available privately. These services include for example diagnostic services provided in MRI clinics (Magnetic Resonance Imaging) in some cities of some provinces (namely Quebec and Alberta). Patients can obtain a scan at these private MRI clinics by paying the full fee. Queue jumping is one of the dangers of private clinics. Those who can afford to pay are able to get their diagnostic tests done more quickly; they then return to the publicly funded system one step ahead of patients still awaiting diagnostic tests in the public system. Although the number of such private clinics remains limited, some analysts contend that their existence means that a two-tier system exists in Canada. Others say that, at the very least, the existence of these choices constitutes a step towards the gradual erosion of Canada's publicly funded health care system along with the development of a second tier of health service delivery.

A few other private health care facilities are also accessible in Canada without referral or reference to medical necessity. They offer same-day surgery procedures, such as cataract removal, as fully private transactions. The physician performing the operation does not get paid by the provincial health care insurance plan, nor is the patient reimbursed by the public plan. Moreover, patients must pay the full cost out of their own pockets, since in most provinces private insurance is not permitted for health services that are insured publicly. The prohibition on private insurance to cover the kind of services covered by provincial health care insurance plans was designed to discourage the development of private facilities performing services which are also available free under provincial health care insurance

plans. Indeed, some people argue that allowing private insurers to compete with public insurance would open the door to a two-tier system of health care in Canada.

Whether a private tier of health care services can improve the access to and effectiveness of the publicly funded system remains open to question. Another important issue concerns the right of individual Canadians to establish and use a private market alternative to the publicly funded system. These questions are critical and must be debated in discussing the future of Canada's health care system.

**Myth:** A free market system would solve the problem of waiting lists as well as other problems associated with public health care.

**Reality:** Those who support this idea contend that a free market would reduce the number of people on public waiting lists. They explain that wealthier persons, by removing themselves from the public waiting lists and seeking care in the private system, would allow people on the public lists to move up faster and receive care in a more timely fashion.

The Committee was told, however, that a private system might attract an excess of health care providers and this could result in an under-supply of professionals in the public system. This would, in turn, create longer public sector waiting lists for these under-supplied health services.

The Committee was also told that, if we deliver health care services using a free market system, it would likely result in a more expensive system. In his brief, Dr. Mustard stated:

What is more important in this whole debate is that health care does not fit the market concepts of the productive or wealth creating sector of society. (...) privatization of health care does not increase efficiency and lower costs. Recent assessments of the American system have come to some interesting perceptions. The conversion of not-for-profit hospitals to for-profit hospitals



increased health care expenditures in the affected region. Conversion back to not-for-profit institutions decreased per capita health care expenditures.<sup>85</sup>

**Myth:** The American health care system is 100% privately funded.

**Reality:** The latest OECD data indicate that the private share of total health care spending in the United States amounted to 55% in 1998, while the public sector accounted for the remaining 45% of overall expenditures on health care. During his testimony, Professor Mark Stabile from the University of Toronto described Medicare and Medicaid, the major public health care insurance programs in the United States:

While the majority of Americans receive their health insurance through private insurance plans, offered primarily through their place of employment, a substantial number of Americans also qualify for public insurance. The two largest public insurance programs in the United States are the Medicare program, which serves individuals aged 65 and over, as well as the disabled and people with permanent kidney failure, and the Medicaid program, which serves the poor. The Medicare program is a federally run program while the Medicaid program is run by individual states. Twenty-five per cent of Americans claim either Medicare or Medicaid as their primary source of health insurance.<sup>86</sup>

Moreover, the American Medicare and Medicaid systems require user charges and provide less coverage than the Canadian system does.

**Myth:** The real alternative to the current Canadian model of health care is the American model.

**Reality:** On the contrary, many other models exist, particularly in Europe. Health care systems can be classified according to how they are organized, financed, regulated and delivered. At one extreme are the mostly

*It is interesting that being next door to the one nation with the largest proportion of its health care costs funded by the private sector that we have not as consumers listened to what many thoughtful Americans try to tell us about the problems with their health care.*

*Dr. J. Fraser Mustard, Brief to the Committee, p. 3.*

<sup>85</sup> Dr. Fraser Mustard, *Myths, Beliefs, Values, Facts and Health Care*, Brief to the Committee, p. 3.

<sup>86</sup> Mark Stabile (14:12).

publicly financed and publicly managed systems, such as in the United Kingdom, and at the other are the mostly private systems that are predominantly financed and delivered by the private sector, such as in the United States. The health care system of most OECD countries includes a combination of the public and private models. However, there are differences among these countries in the way the public/private split is organized. In some countries, the private sector complements the public sector (for example hospital services in Britain and Australia). In other countries, some population groups are covered by a public health care insurance plan, while the others must rely on private insurance (for example, in the United States and Germany). What lessons Canada can learn from the health care system models in other OECD countries will be the subject of the Committee's report on Phase Three of this study.

## 6.5 Myths About Health Care Utilization

**Myth:** Introducing user fees would help alleviate the problem of too many patients making too many frivolous demands on the health care system.

**Reality:** Some people argue that user charges would limit unnecessary utilization (or abuse) by patients thereby reducing health care expenditures. However, many studies indicate that user charges may delay necessary visits, resulting in complications and higher health care costs. Moreover, studies also suggest that user charges may act as a deterrent for low-income people.

Martin Zelder, Director of the Health Policy Research at the Fraser Institute, who is a proponent of user charges, agreed that such fees act as a deterrent for low-income individuals: "Yes, low-income people are deterred from consuming care that improves their health if they are required to pay user fees."<sup>87</sup> For this reason, he suggested that user charges should apply to all people except those with low income. This,

*In New Zealand, they have user charges just to go to see your doctor. We really have problems with health outcomes. We have worse infant mortality. We have concerns about access to care for people on lower incomes.*

*Professor Colleen Flood,  
University of Toronto  
(14:31).*

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<sup>87</sup> Martin Zelder (12:39).

therefore, would result in a means test: “(...) the means test would have to be used to exempt low-income people from paying user fees. To ensure that they are not harmed financially then, yes, the means test would be necessary.”<sup>88</sup>

However, the imposition of a means test runs counter to Canadians’ expectations and values. With respect to the impact of user charges on total health care expenditures, Professor Evans stated:

despite heavy user charges in the United States and despite heavy user charges for pharmaceuticals in Canada, those costs actually escalate much faster than the costs in a public system.<sup>89</sup>

## 6.6 Myths About the Health Status of the Population

**Myth:** The health of the population is directly proportional to the amount of health care available.

**Reality:** The information provided in Chapter 5 clearly indicates that the health of a population is determined by many other factors outside the delivery of health care services. Investing more and more money in the traditional health care system will

*The United States spends more per capita out of tax dollars on health care than does Canada. They also spend more in terms of private expenditures, privately purchased insurance and out-of-pocket expenditures, than do Canadians. Yet, Canadians are almost the healthiest people in the world, whereas the United States ranks twentieth-fifth in terms of life expectancy.*

*Dr. John S. Millar, V.P., Research and Analysis, CIHI (14:34).*

not lead to commensurate improvements in the health of the population. In fact, it is important to ensure that investments are not overly skewed towards the delivery of traditional health care services as the primary strategy for improving the health of the population.

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<sup>88</sup> Martin Zelder (12:40).

<sup>89</sup> Robert Evans (12:41-42).

More attention needs to be given to the non-medical determinants that promote good health (e.g. adequate income, early childhood development, employment and so on.), to the development of strategies that control health risks and prevent disease and disability, and to the need for an increased focus on evaluating and measuring health outcomes. To highlight the importance that other factors play in the health of Canadians, Dr. McMurtry provided the following examples<sup>90</sup>:

- There are currently 66 million days of workforce absence in Canada annually; 60% of those absences are related to stress. Decreasing work stress could not only act to improve the health of Canadians, but might indirectly improve our productivity and save the health care system money.
- 80% of people who are 65 years and older have the lowest two levels of literacy on the international adult literacy survey. More than half of them will have trouble understanding their prescriptions.

Investment in these areas holds the greatest potential for generating positive returns, and would lead to greater improvements in the health of Canadians than a comparable money degree of spending on health care delivery.

**Myth:** Health care reform has been responsible for a decline in the health of Canadians.

**Reality:** The health status of Canadians, as measured by life expectancy and mortality rates, has continued to improve during the period of health care reform. In his brief to the Committee, Dr. Fraser Mustard referred to a recent OECD report showing that the health status of Canadians remains high, despite the reform that took place in the 1990s:

Whatever the changes in our health care system, we have not, from a population perspective, been placed at a disadvantage in relation to other countries.<sup>91</sup>

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<sup>90</sup> Robert McMurtry (8:25).

<sup>91</sup> Dr. J. Fraser Mustard, Brief to the Committee, 22 March 2000, p. 2.

**Myth:** The closure of hospitals has compromised the health of Canadians.

**Reality:** Over the last decade, the number of hospital beds have dropped year after year in Canada. For example, 53 small hospitals were closed or converted to health centres in rural Saskatchewan and 727 hospital beds were closed in urban Manitoba (Winnipeg). Despite these cuts, the overall health status of these populations (measured by death rates) has continued to improve and the quality of care (measured by indicators such as readmission after discharge and emergency room visits) has not deteriorated.

**Myth:** The Aboriginal population enjoys the same health status as other Canadians.

**Reality:** The life expectancy of Aboriginal peoples in Canada is at least five years below the average for all Canadians. This is an enormous gap. It has been estimated that increasing the life expectancy of the Aboriginal population by five years would require the elimination of all deaths from cardiovascular diseases (the leading cause) and almost all deaths from cancer (the second cause of death).<sup>92</sup> Although this would appear to be an insurmountable obstacle, the Committee was told that progress is being made:

The health status of Aboriginal peoples relative to the non-Aboriginal population is improving on average. The disparities are significant and they persist. There is no question that there is still a great deal to achieve. There is also no question that some significant improvements have been accomplished.<sup>93</sup>

Although the discrepancies in the health status of the Aboriginal population are evident, the underlying causes are not as easily identified. Aboriginal Canadians are less likely to have finished high school, and are twice as likely to be under Statistics Canada's low income cut-offs.<sup>94</sup> This could help explain some of the factors contributing to the Aboriginal population's higher incidence of health problems. In Phase Two of its study, the Committee will examine the health concerns of Aboriginal Canadians with a view toward better

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<sup>92</sup> CIHI, *Health Care in Canada: A First Annual Report*, p. 6.

<sup>93</sup> Abby Hoffman (13:10).

understanding their specific needs, identifying preventive interventions and debating federal responsibility.

## **6.7 Myths About the Need for Change**

**Myth:** Waiting lists and waiting times are unique to the Canadian health care system.

**Reality:** Not true! At the Committee's session on international health care systems, experts told us that the waiting list problem is significantly worse in New Zealand, the United Kingdom and in other countries which permit private insurance to compete with public coverage:

In the U.K. and New Zealand, countries that have this supplementary private insurance system, which I reiterate again is quite different from what happens in the Netherlands, waiting lists are far, far longer. In fact, they are five times as long as a percentage of the population in New Zealand and three times as long in the U.K. Arguably, once there is that kind of private insurance, perhaps the middle class and wealthy lose their incentive to lobby for improvements in the public system.<sup>95</sup>

**Myth:** Canada's health care system is completely broken.

**Reality:** The health care system is not broken, but it is undergoing necessary changes. Witnesses stated that we need to find a way to move beyond our current preoccupation with protecting the status quo and preserving a health care system that was put in place some fifty years ago. We were told that, in spite of all of its merits, that system is no longer equipped to deal with the present or emerging needs of our society.

The reality is that health care can now be provided by a greater variety of health care professionals. Further, health services can be delivered in a wider range of sites – not only in

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<sup>94</sup> Federal/Provincial/Territorial Advisory Committee on Population Health, *Statistical Report on the Health of Canadians*, 1999, pp. 31 and 38.

<sup>95</sup> Colleen Flood (14:19).

the hospital, but also in the home and the community. New health care technologies are now being introduced as a means of reducing, and even preventing, surgery.

The Canadian health care system was designed in the 1960s and early 1970s. Since then, much has changed in the way health care services are administered and delivered. The changes need to be reflected in the conditions on which the Canadian health care system is built. Defending the status quo on the grounds that it worked well more than forty years ago does not stand up to scrutiny.

**Myth:** The health care system needs to be rebuilt from the ground up.

**Reality:** Not true! There is much that is good in the current system, not the least of which is the confidence most people have that when they are sick or injured they will have relatively ready access to services of the range and quality necessary to facilitate their return to health. This confidence is well placed. Canada's well-trained professionals, institutions, and organizations are committed and dedicated to serving in the public interest. We need to build on what is good in the system while embracing the need for a "fresh start". In short, although our health care system needs to be reformed, it does not need to be transformed.

**Myth:** Definitive intervention with a major investment by the federal government is required within the next 12-24 months.

**Reality:** While reinvestment is essential, it is equally important to define a vision for the health care system of the future. The vision will enable reinvestment to facilitate the appropriate trajectory of change rather than simply funding a return to the past. Dr. Robert McMurtry stressed that:

the fundamental founding principles of the Medical Care Act of 1966 as originally pronounced are still real. What is missing, however, is a unifying

vision of the future. That is something that I feel is imperative if we are to move forward with any effect.<sup>96</sup>

The recent federal-provincial agreement on health care renewal represents a major step toward the development of a common vision based on shared principles and a commitment to work in a collaborative manner. Governments have agreed to co-operate in many important areas such as:

- improving the timely access to, and quality of, health services;
- strengthening investments in health education and strategies to prevent illness;
- accelerating primary health care reforms;
- strengthening investment in home care and community care;
- investing in health information and communications technology, as well as in health equipment, new health care technologies and facilities; and
- measuring, tracking and reporting on the performance of health services.<sup>97</sup>

## 6.8 Myths About Health Care Providers

**Myth:** Fee-for-service is the only model that physicians will accept.

**Reality:** Most physicians are currently paid under a fee-for-service scheme in Canada. There is evidence, however, that many physicians would prefer an alternative mode of remuneration. A 1999 survey by the Canadian Medical Association reported that only 33% of respondents would prefer to be paid on a fee-for-service basis. Another 21% would prefer to be salaried, while less than 1% would select capitation. Some 35% indicated a preference for a blend of payments (e.g. mix of fee-for-service and capitation). Data from a recent CIHI report shows that, at present, the proportion of physicians remunerated by non fee-for-service mechanisms ranges from 2% in Alberta to 53% in Manitoba.

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<sup>96</sup> Dr. Robert McMurtry (8:21).

<sup>97</sup> First Ministers' Meeting, *Communiqué on Health*, 11 September 2000 (available at [www.scics.gc.ca](http://www.scics.gc.ca)).



The fee-for-service scheme has some drawbacks. Graham Scott, former Deputy Minister of Health in Ontario, told the Committee:

Fee-for-service family physicians make sufficient income enjoying an office practice from 9 a.m. to 5 p.m. without any need for a hospital relationship and the responsibilities it demands.

The fee codes ensure a good income only if the family physician engages in a high-volume, high-turnover practice. This in turn dictates addressing only the less complex challenges posed by presenting patients. The rest get referred to a specialist or to the hospital emergency. Since they only work 9 to 5, patients after hours must also go to emergency regardless of the severity of their complaint.<sup>98</sup>

**Myth:** Nurses continue to play the same caregiving role that they have always played, assisting individual physicians in a hospital or clinic setting.

**Reality:** The nursing profession has undergone a revolution. Nurses are found at every point in care delivery in the health care system: in hospitals, in private institutions and in the community. At least 12,000 nurses are now certified in a specialty, using specialized knowledge to contribute to the individual needs of patients as members of specialized health care teams.<sup>99</sup> They play a critical integration and communication role in terms of the needs of individual patients and their families.

During his testimony, Graham Scott indicated that nurses have gained higher status in accordance with their qualifications. For example, in some teaching hospitals and in some large community hospitals, nurses are seen as an integral part of the health care team, rather than as adjuncts, or add-ons, to teams. This contrasts with the traditional hierarchy where the physician was in charge.

The Committee was told that, despite the important gains that nurses have made, the nursing profession is facing challenges that could affect the integrity of the health care

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<sup>98</sup> Graham W. S. Scott, Brief to the Committee, June 2000, p. 7.

<sup>99</sup> Dr. Mary Ellen Jeans (8:21).

system as a whole. Of all workforce categories, nurses have more time off, more disability and more back pain.<sup>100</sup> The average age of nurses is about 45, which means that the majority of nurses will be retiring in the next 10-15 years. In addition, 50% of nurses do not have a full-time job and sometimes work for two, three or four different employers.<sup>101</sup>

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<sup>100</sup> Dr. John S. Millar (14:5).

<sup>101</sup> Dr. Mary Ellen Jeans (8:21).



## CONCLUSION

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This report completes Phase One of the Committee's study on health care. It summarizes the evidence we heard from March 2000 to September 2000, and makes reference to documents that were either tabled with the Committee or brought to the attention of the Members.

During Phase One, the Committee learned about the origins and current status of public health care insurance in Canada. We now have a better understanding of the federal government's involvement in health care in terms of funding and enforcement of the *Canada Health Act*. We have a clearer idea of Canadians' opinions about the health care system and health care policy. We have gathered a lot of information on health care expenditures and on health status. We know how Canada's spending on health care compares with that of other countries and how the health status of Canadians contrasts with the health status of other nations.

With all this background information, we attempted to shed light on the current debate over health care in Canada by separating myths from realities. We hope that this report will serve as a useful reference document to anyone who wishes to participate in future phases of the Committee's study on health care.

### **The Next Steps**

Phase Two of the study, which will begin in March 2001, is designed to obtain an overview of existing and foreseeable pressures for change within the health care system. During this phase of the study, Committee members will explore the implications for health care in Canada of:

- the ageing of the population and the increasing demands on the system if past and present patterns of use continue;

- our growing Aboriginal population and its specific health care needs, which include higher incidence of foetal alcohol syndrome, HIV/AIDS, tuberculosis, diabetes, injury and chronic diseases;
- advances in health care technology, including drugs, that affect the organization, delivery and cost of health care and raise issues relating to ethics and effectiveness;
- the appearance of new diseases and the resurgence of “old” ones that may require costly therapy and treatment;
- expectations of both patients and health care providers which may lead to misuse of services and inappropriate service delivery;
- the impact of health research, which is a critical component of the health care system. Canada’s health care system will depend increasingly upon scientific information about biological and social determinants of health, as well as upon objective data on health and health care. For example, the identification of the 30,000 or so genes that determine our susceptibility to disease will mark a revolution that could transform both health research and the health care system;<sup>102</sup>
- the need for sufficient and comparable health-related information to make decisions in allocating resources and in delivering care;
- the growing concern about the workload, stress and ageing of our health care providers. Planning for human resources in health care is a complex exercise that must take into account both the needs of the population and the needs of health care professionals;
- health care issues specific to rural and remote areas;
- the role of preventive intervention in encouraging healthy lifestyles and thereby enhancing the potential for better health;
- the incidence of mental health problems in Canadian society and the implications for health care delivery.

Phase Two of the study will focus on affordability and sustainability and conclude with a report reviewing the key factors that will have an impact on the Canadian health care system over the next 25 years. The planned release date for this report is June 2001.

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<sup>102</sup> Stem cell technology is another good example of the potential impact health research can have on health and health care. Recently, medical researchers in Alberta have made remarkable breakthroughs in what is called “stem cell” technology. They have taken the healthy cells from a properly functioning pancreas and implanted them into an insulin-dependent diabetic. Months after the procedure, the patient still does not require insulin. Not only will this person save the cost of insulin during his life, he will also be at a much lower risk of developing the debilitating complications of diabetes, such as blindness and heart failure, later on. This development would not only improve the quality of life for the individual, it could potentially save the cost of care for the primary disease and secondary complications associated with it.

Phase Three of the study will provide Committee members with a review and discussion of the experiences of other countries, including up-to-date information and analyses obtained through a series of videoconferences. Supplemented by panels of experts and specialists from Canada, these hearings will allow the Committee to:

- explore the health care systems of selected countries, including their objectives and principles, and health care delivery systems;
- compare selected countries both with one another and with Canada; and
- consider the strengths and weaknesses of the prime alternatives.

Phase Three of the study will culminate in a report reviewing developments in other countries, and key comparative findings. The planned release date for this report is June 2001.

In Phase Four of the study, the Committee will draw upon the findings from the first three phases of the study to develop a set of policy options relating to the Canadian health care system. This process will focus on two related aspects:

- a framework of fundamental principles and objectives; and
- a set of alternatives regarding the implementation of the principles and objectives.

The Phase Four report will provide a brief statement of policy options, for the purpose of providing a reference point for public hearings. The planned release date for this report is September 2001.

During Phase Five, the concluding phase of the study, the Committee will hold extensive public hearings on the options paper developed in Phase Four. Witnesses will be invited to comment on:

- the proposed framework of principles and objectives;
- the respective strengths and weaknesses of the options developed by the Committee, along with other suggestions warranting consideration; and
- the preferred option(s).

The report of Phase Five will summarize the key findings obtained during the public hearings and describe the Committee's preferred option(s) and recommendations. The planned release date is March 2002.

## APPENDIX A - LIST OF WITNESSES

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**(2<sup>nd</sup> Session, 36<sup>th</sup> Parliament)**

<b>NAME</b>	<b>ORGANIZATION</b>	<b>DATE OF APPEARANCE</b>
Raisa Deber, <i>Professor</i>	University of Toronto, Department of Health Administration	March 2, 2000
Dr. Robert McMurtry, <i>G.D.W. Cameron Visiting Chair</i>	Health Canada	March 2, 2000
Sharon Sholzberg-Gray, <i>Co-Chair</i>	Health Action Lobby (HEAL)	March 2, 2000
Dr. Mary Ellen Jeans, <i>Co-Chair</i>	Health Action Lobby (HEAL)	March 2, 2000
Sholom Glouberman, <i>Director, Health Network</i>	Canadian Policy Research Network	March 22, 2000
Dr. Fraser Mustard	Founder's Network	March 22, 2000
Dr. Scott Evans, <i>Senior Statistical Consultant</i>	Goldfarb Consultants	March 22, 2000
Chris Baker, <i>Vice-President</i>	Environics Research Group	March 22, 2000
Wendy Watson-Wright, <i>Director General, Policy and Major Projects Directorate, Health Promotion and Programs Branch</i>	Health Canada	March 23, 2000
Sylvain Paradis, <i>Acting Policy Group Manager, Policy and Major Projects Directorate, Quantitative Analysis and Research Section, Health Promotion and Programs Branch</i>	Health Canada	March 23, 2000
Liz Kusey, <i>Policy Analyst, Policy and Major Projects Directorate, Health Promotion and Programs Branch</i>	Health Canada	March 23, 2000
Monique Charon, <i>Acting Director, Program Policy and Planning, Program Policy, Transfer Secretariat and Planning Directorate, Medical Services Branch</i>	Health Canada	March 23, 2000
Robert G. Evans, <i>Director, Population Health Program</i>	University of British Columbia	April 6, 2000



Colleen Fuller, <i>Research Associate</i>	Canadian Centre for Policy Alternatives	April 6, 2000
Martin Zelder, <i>Director of Health Policy Research</i>	Fraser Institute	April 6, 2000
Cliff Halliwell, <i>Director General, Applied Research and Analysis Directorate, Information, Analysis and Connectivity Branch</i>	Health Canada	May 3, 2000
Abby Hoffman, <i>Senior Policy Advisor</i>	Health Canada	May 3, 2000
Frank Fedyk, <i>Acting Director, Canada Health Act Division, Intergovernmental Affairs Directorate, Policy and Consultation Branch</i>	Health Canada	May 3, 2000
Tom Kent	As an individual	May 4, 2000
Michael Bliss, <i>President</i>	University of Toronto	May 4, 2000
Ake Blomqvist, <i>Professor</i>	University of Western Ontario	May 10, 2000
Colleen Flood, <i>Professor</i>	University of Toronto	May 10, 2000
Mark Stabile, <i>Professor</i>	University of Toronto	May 10, 2000
John S. Millar, <i>Vice-President, Research and Analysis</i>	Canadian Institute for Health Information	May 11, 2000
Margaret Somerville, <i>Professor</i>	McGill University	May 11, 2000
Laura Shanner, <i>Professor</i>	University of Alberta	May 11, 2000
The Honourable Marc Lalonde, <i>P.C.</i>	As an individual	May 17, 2000
The Honourable Monique Bégin, <i>P.C.</i>	As an individual	May 31, 2000
Guillaume Bissonnette, <i>General Director, Federal-Provincial Relations and Social Policy Branch</i>	Department of Finance	June 7, 2000
Barbara Anderson, <i>Director, Federal-Provincial Relations and Social Policy Branch</i>	Department of Finance	June 7, 2000
Graham Scott, <i>Former Deputy Minister of Health, Province of Ontario</i>	As an individual	September 21, 2000



The Standing Senate Committee on Social Affairs, Science and Technology

Interim Report on  
the state of the health care system in Canada

*The Health of Canadians – The Federal Role*  
*Volume Two: Current Trends and Future Challenges*

*Chair*

The Honourable Michael J. L. Kirby

*Deputy Chair*

The Honourable Marjory LeBreton

JANUARY 2002



# TABLE OF CONTENTS

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TABLE OF CONTENTS.....	i
ORDER OF REFERENCE .....	v
SENATORS .....	vi
INTRODUCTION .....	1
CHAPTER ONE: .....	5
THE IMPACT OF POPULATION AGING ON THE HEALTH CARE SYSTEM .....	5
1.1 Population Aging .....	5
1.2 The Impact of Population Aging.....	6
1.3 Caring for Canadian Seniors.....	11
1.3.1 <i>Providing a Continuum of Care</i> .....	11
1.3.2 <i>Primary Care Reform</i> .....	13
1.3.3 <i>Wellness Promotion and Illness Prevention</i> .....	13
1.3.4 <i>New Methods of Funding</i> .....	14
1.3.5 <i>Public Policy: Long-Term Horizon</i> .....	15
1.3.6 <i>A Unique Approach to Residential Long-Term Care</i> .....	16
1.4 Committee Commentary .....	16
CHAPTER TWO: .....	19
SPENDING ON DRUGS IN CANADA .....	19
2.1 Trends in Spending on Drugs.....	19
2.2 Cost Drivers.....	22
2.2.1 <i>Trends in Drug Utilization</i> .....	22
2.2.2 <i>Trends in Drug Prices</i> .....	23
2.2.3 <i>Trends in the Types of Drugs Prescribed</i> .....	25
2.2.4 <i>Cost Driver Analysis</i> .....	25
2.3 Appropriate Drug Therapy.....	26
2.4 Who Pays for Drugs in Canada?.....	29
2.5 Do Some Canadians Have Better Coverage for Drug Costs than Others?.....	32
2.6 Committee Commentary .....	35
CHAPTER THREE: .....	37
HEALTH CARE TECHNOLOGY .....	37
3.1 Availability Of Health Care Technology .....	38
3.2 Health Care Technology Assessment .....	42
3.3 Impact On Health Care Costs .....	43
3.4 Committee Commentary .....	44

<b>CHAPTER FOUR:</b>	<b>45</b>
DISEASE TRENDS	45
4.1 Trends In Diseases	45
4.1.1 <i>Infectious Diseases</i>	46
4.1.2 <i>Chronic Diseases</i>	47
4.1.3 <i>Injury</i>	48
4.1.4 <i>Mental Illness</i>	48
4.1.5 <i>The Economic Burden of Disease</i>	49
4.2 Determinants of Poor or Good Health	49
4.3 The Need For Health Promotion And Disease Prevention	50
4.4 Population Health Strategy	52
4.5 Research	53
4.6 Committee Commentary	54
<b>CHAPTER FIVE:</b>	<b>57</b>
THE HEALTH OF ABORIGINAL CANADIANS	57
5.1 Demographic Profile of Canada's Aboriginal Population	57
5.2 Socio-economic Profile and Physical Environment	59
5.3 Health Profile of the Aboriginal Population	60
5.4 Federal Programs Directed to Aboriginal Health	63
5.5 Aboriginal Health Policy at the Federal Level	65
5.6 Barriers to Aboriginal Health and Wellness	68
5.7 Committee Commentary	72
<b>CHAPTER SIX:</b>	<b>75</b>
HUMAN RESOURCES	75
6.1 Physicians	76
6.1.1 <i>Physician Supply</i>	76
6.1.2 <i>Geographic Maldistribution</i>	78
6.1.3 <i>Physician Training and Recruitment</i>	78
6.1.4 <i>The "Brain Drain"</i>	81
6.2 Nurses	82
6.2.1 <i>Supply of Nurses</i>	83
6.2.2 <i>Working Conditions</i>	84
6.2.3 <i>Training and Recruitment in Nursing</i>	86
6.3 Other Health Care Providers	87
6.4 Primary Care Reform	88
6.5 Committee Commentary	91
<b>CHAPTER SEVEN:</b>	<b>93</b>
HEALTH RESEARCH	93
7.1 Federal Role in Health Research	93
7.2 Genetics and Genomics	97
7.3 Benefits and Challenges of Health Research	100
7.4 Committee Commentary	103

<b>CHAPTER EIGHT:</b>	<b>105</b>
HEALTH-RELATED INFORMATION: A CANADIAN HEALTH INFOSTRUCTURE.....	105
8.1 Concepts and Definitions .....	106
8.2 Provincial and Federal Initiatives With Respect to a Pan-Canadian Health Infostructure.....	108
8.3 Costs and Benefits .....	113
8.4 Issues .....	116
8.5 Committee Commentary .....	118
<b>CHAPTER NINE:</b>	<b>121</b>
HOME CARE.....	121
9.1 What is Home Care? .....	121
9.2 Current Demand for Home Care .....	122
9.2.1 Hospital Bed Reductions .....	123
9.2.2 Rapid Population Growth over 65 Years of Age .....	123
9.2.3 Pressures on Informal Caregivers.....	123
9.2.4 Advances in Technology.....	124
9.3 Public and Private Spending.....	124
9.4 Future Actions .....	126
9.4.1 National Standards .....	127
9.4.2 Human Resources.....	128
9.4.3 Organization and Financing.....	130
9.4.4 Informal Caregivers .....	132
9.4.5 Information and Research.....	133
9.4.6 Prescription Drugs.....	134
9.4.7 Telehealth.....	135
9.5 Committee Commentary .....	136
<b>CHAPTER TEN:</b>	<b>137</b>
RURAL HEALTH.....	137
10.1 Health Status Indicators.....	137
10.2 Access to Health Services in Remote and Rural Areas .....	139
10.3 Telehealth .....	143
10.4 Rural Health Research.....	143
10.5 The Federal Role .....	144
10.6 Committee Commentary .....	144
<b>CHAPTER ELEVEN:</b>	<b>147</b>
MYTHS AND REALITIES .....	147
11.1 Demographic Aging.....	147
11.2 Spending on Drugs .....	147
11.3 Health Care Technology .....	148
11.4 Aboriginal Health.....	148
11.5 Human Resources in Health Care .....	149
11.6 Health Information Systems .....	150
11.7 Home Care .....	151
11.8 Rural Health.....	151

<b>CONCLUSION .....</b>	<b>153</b>
<b>APPENDIX: .....</b>	<b>155</b>
LIST OF WITNESSES (MARCH – JUNE 2001) .....	155



## ORDER OF REFERENCE

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Extract from the *Journals of the Senate* of March 1, 2001:

Resuming debate on the motion of the Honourable Senator LeBreton, seconded by the Honourable Senator Kinsella:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:

- (a) The fundamental principles on which Canada's publicly funded health care system is based;
- (b) The historical development of Canada's health care system;
- (c) Health care systems in foreign jurisdictions;
- (d) The pressures on and constraints of Canada's health care system; and
- (e) The role of the federal government in Canada's health care system;

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament be referred to the Committee;

That the Committee submit its final report no later than June 30, 2002; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

After debate,

The question being put on the motion, it was adopted.

ATTEST :

Paul C. Bélisle  
*Clerk of the Senate*

## SENATORS

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The following Senators have participated in the study on the state of the health care system of the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J.L. Kirby, Chair of the Committee

The Honourable Marjory LeBreton, Deputy Chair of the Committee

and

The Honourable Senators:

Catherine S. Callbeck

Joan Cook

Jane Cordy

Joyce Fairbairn, P.C.

Alasdair B. Graham, P.C.

Wilbert Keon

Yves Morin

Lucie Pépin

Douglas Roche

Brenda Robertson

*Ex-officio members of the Committee:*

The Honourable Senators: Sharon Carstairs P.C. (or Fernand Robichaud, P.C.) and John Lynch-Staunton (or Noel A. Kinsella)

*Other Senators who have participated from time to time on this study:*

The Honourable Senators Banks, Beaudoin, Cohen\*, DeWare\*, Ferretti Barth, Grafstein, Hubley, Joyal P.C., Milne, Losier-Cool, Rompkey, and Tunney

\*retired from the Senate

## INTRODUCTION

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In December 1999, during the Second Session of the Thirty-Sixth Parliament, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the state of the Canadian health care system and to examine the evolving role of the federal government in this area. The Senate renewed the mandate of the Committee in the First Session of the Thirty-Seventh Parliament. The terms of reference adopted for the purpose of this study read as follows:

*That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:*

- a) The fundamental principles on which Canada's publicly funded health care system is based;*
- b) The historical development of Canada's health care system;*
- c) Publicly funded health care systems in foreign jurisdictions;*
- d) The pressures on and constraints of Canada's health care system;*
- e) The role of the federal government in Canada's health care system.<sup>1</sup>*

In response to this broad and complex mandate, in March 2001, the Committee re-launched its multi-year and multi-faceted study comprising five major phases. Table 1 provides information on each individual phase and their respective timeframes.

**TABLE 1**  
**HEALTH CARE STUDY:**  
**INDIVIDUAL PHASES AND PROPOSED TIMEFRAMES**

PHASES	CONTENT	TIMING (REPORTS)
One	Historical Background and Overview	March 2001
Two	Future Trends, Their Causes and Impact on Health Care Costs	Winter 2002
Three	Models and Practices in Other Countries	Winter 2002
Four	Development of Issues and Options Paper	September 2001
Five	Hearings on Issues and Options Paper and Development of Final Report and Recommendations	Fall 2001/Winter 2002

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<sup>1</sup> Debates of the Senate (Hansard), 2<sup>nd</sup> Session, 36<sup>th</sup> Parliament, Volume 138, Issue 23, December 16, 1999.

The Phase One report was released in March 2001. The first report recounted the history of how the federal government helped the provinces and territories to fund hospital and physician care. It focused in particular on the initial objectives of the federal government's involvement in health care and raised some questions about the future role of the federal government in light of the changing health care environment (e.g., increased recourse to drug therapy, hospital out-patient services, home care and community care). This first report also traced the evolution of health care spending and health indicators over the past several decades. Finally, it looked at a number of myths that are still current concerning the delivery and financing of health care in Canada and clarified the reality surrounding each of these myths. The objective of the first report was to provide factual information as well as to clarify the major current misconceptions that recur in the health care debate in Canada.

The purpose of this report is to present the evidence obtained in the second phase of the Committee's study on health care. The objectives of Phase Two were to examine the factors that can affect the affordability and sustainability of Medicare such as:

- The aging of the population and the increased demand that will be placed on the system if past and present patterns of use continue;
- Our growing Aboriginal population and its specific health care needs;
- Advances in health care technology, including drugs, that affect the organization, provision and cost of health care;
- The appearance of new diseases and the resurgence of "old" ones that may require costly therapy and treatment;
- The growing concern about the workload, stress and aging of our health care providers;
- Particular health care issues in rural and remote areas;
- The need for sufficient and comparable health-related information to make decisions in allocating resources and in delivering care;
- The role of preventive interventions in encouraging healthy lifestyles and thereby enhancing the potential for better health.

In order to meet the objectives of Phase Two, the Committee heard from a wide range of witnesses, including: officials from Health Canada the Department of Indian and Northern Affairs the Canadian Institutes of Health Research and the Canadian Coordinating Office for Health Technology Assessment; officials from provincial ministries of health; health care organizations; Aboriginal representatives; and health economists (a list of witnesses is provided in Appendix A). We are most grateful for their invaluable contribution.

This report consists of eleven chapters. Chapter One discusses demographic trends and forecasts and examines the various implications of population aging on the health care system. Chapter Two reviews past and current trends in drug costs and provides some information on the problem of inappropriate prescribing and utilization of drugs. Chapter Three summarizes the concerns about the availability, cost-effectiveness and appropriateness of both new and existing health care technologies. Chapter Four examines trends in disease and

injury and discusses their potential impact on the publicly-funded health care system. Chapter Five looks at the specific health and health care needs of Aboriginal Canadians. Chapter Six deals with issues related to the supply, retention and management of human resources in health care. Chapter Seven provides information on the level of funding for health research in Canada and on the future of health research in terms of its implications on health and health care. Chapter Eight provides information on the current stage in the development of the Canadian Health Infostructure. Chapter Nine reviews the provision of home care in Canada. Chapter Ten examines the health care needs of rural Canada. Chapter Eleven discusses myths and realities in an attempt to clarify many of the misconceptions in order to ensure an informed, fact-based debate on health care.



## CHAPTER ONE:

### THE IMPACT OF POPULATION AGING ON THE HEALTH CARE SYSTEM

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#### 1.1 Population Aging

Demographic aging refers to the increasing average age in a society, and is characterized by the emergence of a greater proportion of older people in the overall population. From a historical perspective, the process of population aging in a given country is determined primarily by fertility (birth) rates and secondarily by mortality (death) rates. It can also be affected by the rate of immigration. Over the 20<sup>th</sup> century, various advances – public sanitation, medical breakthroughs such as vaccination, and technological enhancements – have increased life expectancy while fertility rates have declined markedly. The net result has been longer life expectancies and an aging population.

Canada's population is aging. The proportion of Canadians aged 65 and over more than doubled between 1881 and 1981, rising from 4.1 percent to 9.7 percent.<sup>2</sup> Since then, the percentage of the population aged 65 and over has increased steadily, to reach 12.5 percent of the population in 2000.<sup>3</sup>

*I look at the aging of the population as one of the great successes of the health and social services systems.*

*Dr. Michael Gordon, National Advisory  
Council on Aging (2:36)*

Demographic aging is expected to intensify in the coming decades, as the “baby-boomer generation” gets older. The baby-boomers are those Canadians who were born between 1946 and 1965, a period during which the number of births soared. According to recent projections by Statistics Canada, the proportion of seniors (those aged 65 and over) will reach 14.6% of the population by 2010 and then grow more rapidly as increasing numbers of baby-boomers reach retirement age. By 2031 they are expected to represent 23.6 percent of the population.<sup>4</sup> The rate of increase will then subsequently slow down, and seniors should constitute about 25% of the population by 2051.

Witnesses told the Committee that the cut-off point used to identify “seniors” (those over 65) continues to be used exclusively for historical reasons rather than scientific ones. As Abby Hoffman, Director General of the Health Care Directorate at the Health Policy and Communications Branch of Health Canada, said, “We use it because it is the agreed legal age for certain purposes of retirement, but it has no use other than that.”<sup>5</sup> More importantly, the category “over 65” is not at all a homogeneous one. There are many differences amongst seniors that depend on factors such as gender, socio-economic status, place of residence, or ethnic background.

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<sup>2</sup> David Cheal, “Aging and Demographic Change,” *Canadian Public Policy*. Vol. XXVI, supplement 2, August 2000, p. S110.

<sup>3</sup> Statistics Canada, CANSIM, Matrix 6367.

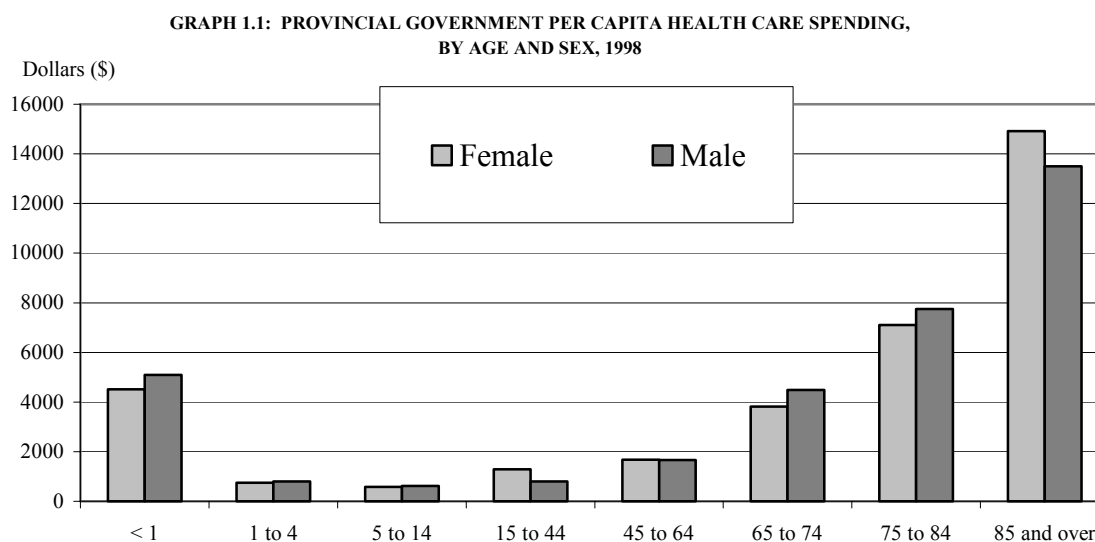
<sup>4</sup> Réjean Lachapelle and Jean-Marie Berthelot, Brief to the Committee, 21 March 2001, p. 2.

<sup>5</sup> Abby Hoffman (7:19).

Many demographers stress the need to distinguish between younger and older seniors, noting, for example, that the prevalence of institutionalization does not really begin to increase until age 75. At the same time, however, according to Professor Byron Spencer of McMaster University, “roughly speaking, the ‘old old’ make somewhat less use per capita of physician services – of specialized services in particular – than do people in the ‘younger old’ ages.”<sup>6</sup> The proportion of people aged 85 and over within the senior population has been increasing over the years. According to Statistics Canada, it will continue to do so, although not uninterruptedly, as the pattern depends on the aging of the baby-boomers. The proportion of those over 85 is expected to reach 21% of all seniors by the time all the baby-boomers have reached that age in 2051.

## 1.2 The Impact of Population Aging

As Graph 1.1 shows, health care costs follow a pattern that varies with age. They tend to be relatively high in the earliest years, fall significantly during youth and young adulthood, rise gradually during middle age and then sharply increase during old age. On average, per capita public spending on health care for those aged 65 and over is almost five times greater than per capita spending on the rest of the population. Growth in health care spending in the older age groups is exponential: spending more than doubles from ages 45-64 to ages 65-74; it doubles again from ages 65-74 to ages 75-84; and it doubles once again from the 75-84 age group to the 85 and over age group.



Source: CIHI 2000 and Library of Parliament.

Given this pattern, both the growing number of seniors and the fact they will make up a larger percentage of the population raise many concerns for the future sustainability of Canada’s health care system. There remains, however, a considerable degree of disagreement

<sup>6</sup> Byron G. Spencer, Brief to the Committee, 22 March 2001, p. 7.



among Canadian experts as to the impact that an aging population will have on overall health care costs. A review of the literature points to at least four different plausible scenarios:<sup>7</sup>

- (a) The **“nightmare high-cost”** scenario. This scenario assumes that, while people live longer, they still get sick or become disabled at the same age as now. Thus, health care costs continue to rise at the same rate as over the past two decades. The combined effects of these two trends (population aging and increased costs) leads to a doubling of the percentage of GDP devoted to health care spending. The “crisis” is further compounded by the fact that a smaller percentage of the population is working and contributing to the public purse.
- (b) The **“compressed morbidity”** scenario. This scenario supposes that people will live longer without disability or disease, meaning that overall health care costs will not rise as sharply as the more pessimistic scenarios envisage.
- (c) The **“manageable costs”** scenario. The onset of disability and disease is postponed to the same extent as death itself, while rising costs in health care are offset by budgetary cuts elsewhere.
- (d) The **“reformed system”** scenario. Significant changes to the delivery of health care result in greater efficiencies that will allow the system to cope with the added pressure of an aging population.

Witnesses who testified before the Committee reflected these various views. For example, the Conference Board of Canada contended that health care will consume an increasing proportion of government expenditures in the coming years as a result of population aging. The Board estimates that, by 2020 in both British Columbia and Ontario health care expenditures will represent about 50 percent of total provincial government spending (compared to 38 and 36 percent, respectively, in 2000).<sup>8</sup> Similarly, William Robson, Vice-President and Director of Research at the C.D. Howe Institute, calculated that if the provinces and territories continue to tax the same share of their gross domestic products as they do at present, health spending in Newfoundland, the Yukon, and the Northwest Territories could require fully 100% of their own-source revenue by 2040.<sup>9</sup>

Dr. Michael Gordon, of the National Advisory Council on Aging (NACA), stressed that, in attempting to gauge the impact of an aging population on health care spending, we should be careful not to make unwarranted assumptions about the state of health of seniors in the future. Nor should we simply assume that the current level of efficiency of the health care system will prevail. To illustrate this point, he stated in his brief to the Committee that, “if we were to extrapolate the length of hospital stays for seniors in 1999 based on data from 1971, the result would be 50% higher than the actual numbers.”<sup>10</sup>

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<sup>7</sup> These four schools of thought are well summarized in: Canadian Medical Association, *In Search of Sustainability: Prospects for Canada's Health Care System*, August 2000.

<sup>8</sup> Conference Board of Canada, Brief to the Committee, 21 March 2001, p. 5.

<sup>9</sup> William Robson, *Will the Boomers Bust the Budget?*, Brief to the Committee, 21 March 2001.

<sup>10</sup> Dr. Michael Gordon, NACA, Brief to the Committee, 21 March 2001, p. 5. In fact, a number of factors influence the average length of stay in hospital including advances in surgical and other procedures, the greater range and efficacy of available drugs, as well as more sophisticated approaches to convalescence.

For his part, Professor Byron Spencer pointed out that population aging takes place slowly; this means that there is still time to develop appropriate public policy responses. He also noted that “the ratio of the total population to the population of working age is low today, by historical standards, and it will not change much for another fifteen or twenty years.”<sup>11</sup> This ratio, known as the “dependency ratio,” is used as a rough indicator of the ability of the population to support itself. It usually compares the number of people who are of working age (20 to 64) to those who have either not yet entered the workforce (0 to 19) or who are no longer working (65 and over). This dependency ratio in Canada reached a peak in the middle of the 1960s, as a result of the high proportion of young dependants (the baby-boomers). Since then, the ratio has declined substantially.

Some analysts suggest that the declining trend in the dependency ratio is misleading since the ‘dependant’ population is now more heavily concentrated amongst seniors, who are heavier users of health care, than amongst the dependent young.<sup>12</sup> For this reason, William Robson told the Committee:

*The broad directions are clear. In the coming decades, the older population, who are more intense users of health services, will grow quickly. The younger working population, who participate in the workforce and generate government tax revenue, will grow relatively slowly or even shrink.*<sup>13</sup>

Professor Spencer presented a strong case to the Committee suggesting that the increases in health care spending that will occur as the population ages could very well be balanced by decreases in other areas of government expenditures that will also come about as a result of population aging. He pointed out to the Committee that:

*It is important to note that if you are concerned about the overall impact of population aging, it makes little sense to focus on one area in which costs will go up and say there is a crisis, without also focusing on other areas in which costs will not go up or may even go down. For example, the residents of penal institutions are mostly young. In that area there would be noticeable cost savings. Older people do not receive Employment Insurance, yet that is a very large component of government expenditures, et cetera.*<sup>14</sup>

And, he concluded that:

*If we consolidate all of the different categories of expenditure, not just the areas where there is an age-related potential crisis, the impact is, in a series of progressions, that government expenditure increases in consequence of population change and the aging*

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<sup>11</sup> Byron Spencer, Brief to the Committee, p. 1.

<sup>12</sup> See, for example, a report by the Office of the Auditor General of Canada, *Population Aging and Information for Parliament: Understanding the Choices*, Chapter 6, 1998 Report.

<sup>13</sup> William Robson (3:5). In this report, the testimony received by witnesses printed in the *Minutes of Proceedings and Evidence of the Standing Senate Committee on Social Affairs, Science and Technology* will be hereafter referred to only by issue number and page number within the text.

<sup>14</sup> Byron Spencer (3:30).

*of the population at very much the same rate as the population as a whole. Government expenditures would increase approximately 50 per cent over that period, while the population increases 50 per cent over that same projection period.*<sup>15</sup>

According to Professor Spencer, the challenge we are facing is therefore one of properly allocating the resources that are available to governments rather than an absolute shortage of resources.

Assessing the impact of an aging population on health care costs also requires an understanding of how best to meet the health and health care needs of that population. Jean-Marie Berthelot from the Health Analysis and Modelling Group of Statistics Canada indicated to the Committee that “the health of the current generation of 45 to 64 year olds is better than that of the same category twenty years ago.”<sup>16</sup> Moreover, this generation “has a higher level of education, has smoked less and is comprised of more individuals with employment income (mainly because of higher labour market participation by women) than the previous generations.”<sup>17</sup>

New indicators to measure how much of our lives are spent in good health have been developed, including *dependence-free life expectancy* (DFLE) and *health-adjusted life expectancy* (HALE). Different levels of dependency (summarized in Table 1.1) have been identified that require different types of assistance and entail varying levels of cost for the health care system. If most of tomorrow’s seniors will spend their additional years of life in relatively good health (the ‘compressed morbidity’ hypothesis), then the impact of aging will be considerably smaller than if longer life expectancy is associated with a correspondingly longer period of illness (the ‘expanded morbidity’ hypothesis). In this regard, Mr. Berthelot explained:

*Between 1986 and 1996, years of dependence-free life expectancy at age 65 increased significantly, from 12.0 to 12.7 and from 12.7 to 13.5 for men and women respectively. By contrast, there was little change in life expectancy with dependence. Thus, the proportion of dependence-free lives increased.*<sup>18</sup>

He also pointed out that there was no clear correlation between the amount different countries spend on health care and the age profile of their population. In their brief, Statistics Canada noted that “the United States spends close to 14% of its GDP on health care but the proportion of seniors in its population is less than 13%, whereas Sweden spends less than 9% of its GDP on health care, even though its proportion of seniors is 17%” of the population, and that, nonetheless, “life expectancy of Swedes at 65 years of age is higher than that of Americans.”<sup>19</sup>

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<sup>15</sup> Byron Spencer (3:16).

<sup>16</sup> Jean-Marie Berthelot (2:11).

<sup>17</sup> *Ibid.*

<sup>18</sup> Jean-Marie Berthelot (2:10).

<sup>19</sup> Lachapelle and Berthelot, Brief to the Committee, p. 4.

**TABLE 1.1**  
**NEW HEALTH STATUS INDICATORS**

Level	Health Status	Definition
1	Dependence-free	No dependency or needs help only with heavy housework
2	Moderately dependent	Needs help for meal preparation or for shopping for groceries or other necessities or for everyday housework
3	Severely dependent	Needs help for personal care or for moving around the house
4	Institutionalized	Lives in a health care institution

Source: Martel, Laurent and Alain Bélanger, "An Analysis of the Change in Dependence-Free Life Expectancy in Canada Between 1986 and 1996," in Statistics Canada, *Report on the Demographic Situation in Canada*, 1999, p. 171.

Another important issue raised to the Committee concerns whether the increased health care costs associated with an aging population are due to aging *per se*, or whether they can be more plausibly attributed to the costs of dying. As Rob Brown, from the Task Force on Health Care Financing of the Canadian Institute of Actuaries, told the Committee:

*We expend something in the order of 50 per cent to 70 per cent of the final year health care costs just prior to death. In fact, there are estimates that up to 50 per cent of our total lifetime health care expenditures may be made just prior to death.*<sup>20</sup>

This was also the general picture painted by Abby Hoffman who noted that, "the extremes of relative expenditure on the old and the young are more attributable to the proximity of death than they are to the simple fact of being older."<sup>21</sup>

While this assessment can help identify more precisely the causes of increased health care spending generated by having more older people, it does not lead to any easy policy prescriptions. Dr. Michael Gordon put this point pithily to the Committee:

*I would like to note that if we could only get rid of the last year of life, we would save a lot of money. The problem is that the last year is only known afterwards. (...) One does not decide to forego surgery, as I went through with my father last week, and who is 89, because one may die from it. It is done because the person is vibrant and needs the surgery. Should he die in three weeks, one might say that that was a waste of money, but that is not the way we provide health care. We do not look from the back; we always look forward, fortunately.*<sup>22</sup>

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<sup>20</sup> Rob Brown (2:15).

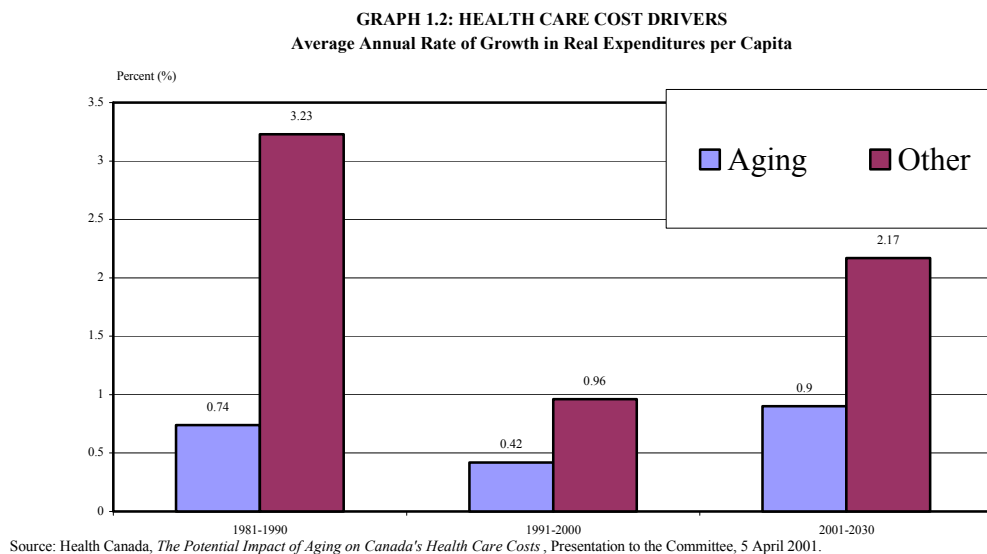
<sup>21</sup> Abby Hoffman (7:7).

<sup>22</sup> Dr. Michael Gordon (2:39).

A number of witnesses stressed that while the aging of the population will be one of the important drivers of cost increases to health care over the coming decades, it is not the only one, and probably is not even the most important one. Health Canada identified the following factors driving changes in health care spending:

- Population aging
- Fiscal capacity
- Technology and innovation
- Factors affecting need and demand for health services (including population health status, preferences and values)
- Changes in the structure of health care delivery systems
- Relative costs of health care compared to general price inflation

Against this background, Health Canada's projections anticipate that although population aging will account for an increasing percentage of the growth in health care expenditures in the period from 2001-2030, it will still represent under 30% of the total projected growth, as shown in Graph 1.2.<sup>23</sup>



## 1.3 Caring for Canadian Seniors

### 1.3.1 Providing a Continuum of Care

According to Dr. Michael Gordon of NACA, a key dimension of meeting the needs of Canadian seniors, now and in the future, is “to develop and more fully integrate”<sup>24</sup> the

<sup>23</sup> Health Canada, Brief to the Committee, slide 6.

<sup>24</sup> Dr. Michael Gordon, Brief to the Committee, p. 2.

various health care components into a continuum of care that would encompass wellness promotion, illness and injury prevention, acute hospital care, medical care, home care, long-term care and palliative care. There are, however, many challenges associated with the development of such a continuum, embracing issues such as what services should be covered by the publicly-funded system, how these should be delivered in an integrated fashion, and how to ensure that there is an adequate supply of health care providers to meet the variety of needs.

Professor Spencer stressed to the Committee the importance of an integrated approach:

*I would like to emphasize the importance of an overall, integrated look at the health care system as a system, so that substitution of one type of personnel for another, or the question of care in hospitals versus in the community, and all the rest of it are also considered. That is very important. There is much scope for saving costs by moving towards best practice, where that is being demonstrated repeatedly in all sorts of studies. There are better ways of doing things, yet we seem to have a system that does not readily accommodate this information as it becomes available.<sup>25</sup>*

The idea of a more integrated approach to health care delivery in order to meet the needs of an aging population brought forward the suggestion from several witnesses that health services provided in the home and prescription drugs should be covered under the *Canada Health Act*. For his part, Dr. Gordon proposed that home care for the elderly be publicly covered:

*...home care should now be part of the health care system. The Canada Health Act, when constructed, had a rather limited view of health care, which at the time was perhaps appropriate. However, much of health care can now be delivered in the home. Many of the problems related to aging and function, rather than requiring high-tech treatments, require relatively low cost, but very important assistance in home care. We believe that this should become part of the health care system.<sup>26</sup>*

With respect to prescription drugs, the Committee was told that, although all provinces provide public coverage to seniors, the nature and scope of this coverage vary widely, as drugs prescribed for use outside the hospital setting are not under the umbrella of the *Canada Health Act*. More importantly, Dr. Gordon stated that despite public coverage for prescription drugs, Canadian seniors may still face financial hardship: “the funding systems in some provinces require that, for a very modest increase in your income, your costs of Pharmacare escalate rapidly.” (The issues regarding prescription drugs and home care are discussed in more detail in chapters Two and Nine respectively.)

Finally, witnesses stressed the importance of providing appropriate palliative care: “it is important to have a comprehensive palliative care system that is institutional or home-

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<sup>25</sup> Byron Spencer (3:36).

<sup>26</sup> Dr. Michael Gordon (2:38).

based – whatever is appropriate for the individual – and that the time has come to ensure that all Canadians who require palliative care have access to it.”<sup>27</sup>

### 1.3.2 Primary Care Reform

It is clear from the testimony presented to the Committee that the current fee-for-service system has serious drawbacks with regard to providing even current levels of care to the elderly. Geriatric practice, as NACA indicated, requires time and health care and professional resources that are less readily provided when physicians’ sole source of income is fee-for-service payment. In this regard, Dr. William Dalziel, of the University of Ottawa, stated:

*If I were a family physician, I would put my office up three flights of stairs with no elevator. They cannot possibly provide good care to the elderly, or they would be making less than the checker at Loblaws.*

*Dr. William Dalziel, University of Ottawa  
(3:19)*

*I can run a middle-aged person through my office, usually with a simple problem, without dealing with a backdrop of five other problems and taking six drugs, in 15 or 20 minutes. The average consultation for a senior would take an hour to an hour and half. In most provinces, you are paid exactly the same amount for each patient.*<sup>28</sup>

These kinds of prospects have a major impact on the recruitment of geriatric specialists. Dr. Dalziel noted that, “I have residents coming to me to ask why they should do two more years’ training in geriatrics so that they can earn 30 to 50 per cent less money.”<sup>29</sup> Only seven physicians are expected to enter programs in Canada to become geriatric specialists this year. Four of these are in Quebec, leaving only three for the rest of the country. Dr. Dalziel estimated that there is already a shortage of approximately 500 specialists in the field.

The issue of physician remuneration is part of the much broader discussion about primary care reform (see Chapter Six). Primary care reform also provides possible avenues for developing a more integrated approach to the provision of the full continuum of care, which is of great relevance to the health care needs of seniors. This implies that a broader range of health services is available at this level, that a wider range of health care providers is available and that services are delivered in the most cost-effective manner. Overall, primary care reform that allows these different skills to be more effectively teamed together allows seniors (and others) to have better access to the health services they need, when they need them.

### 1.3.3 Wellness Promotion and Illness Prevention

The importance of health promotion and disease prevention is another point that was made by several witnesses. Dr. William Dalziel stated categorically that “the key to staying healthy is exercise” and gave the following example:

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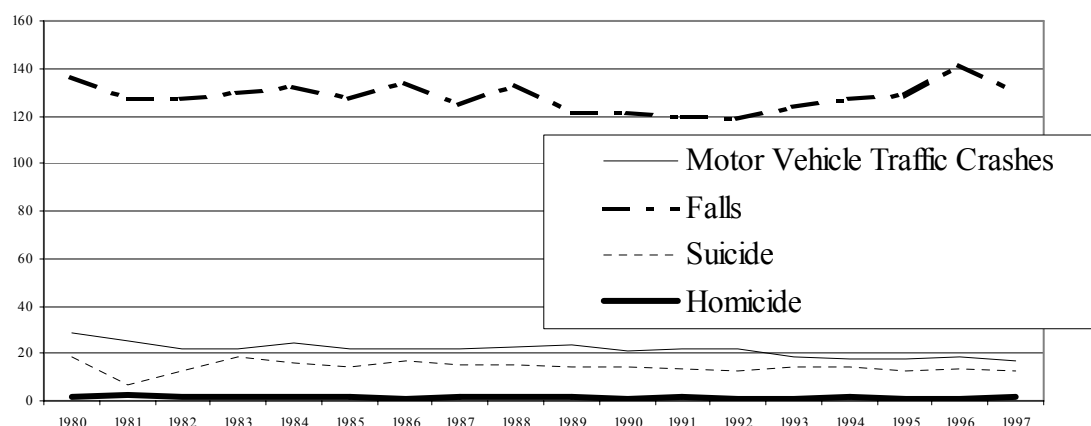
<sup>27</sup> *Ibid.*

<sup>28</sup> Dr. William Dalziel (3:18).

<sup>29</sup> Dr. William Dalziel (3:12).

*Elderly women training two times a week for six months were made five years younger in terms of heart and lung capacity. Over an eight-week strength training program for women in their 90s living in nursing homes, it was found that they increased their quadricep muscle strength by 174 per cent. People stopped falling. They threw away canes and walkers.<sup>30</sup>*

**GRAPH 1.3: INJURY MORTALITY, SELECTED CAUSES**  
Rate/100,000, Over Age 75, Both Sexes, 1980 to 1997



Source: Health Canada, *The Potential Impact of Ageing on Canada's Health Care Costs*, Presentation to the Committee, 5 April 2001.

Data provided by Health Canada (see Graph 1.3) show that falls are amongst the most important preventable causes of death amongst seniors, leading to more than double the rate of mortality per 100,000 population than motor vehicle crashes, homicides and suicides combined. Despite the real possibility that expenditure on health promotion and disease and injury prevention would improve the quality of life for many seniors, and save the system money, NACA expressed concern that federal investments in health promotion programs had dwindled throughout the 1990s.

*Our conclusion is that there are resources to be saved by the application of good prevention and health promotion measures. That is one reason to pursue them, but the most important reason is to have a healthier population for as long as life lasts for the individuals in question.*

*Abby Hoffman  
Health Canada (7:23)*

### 1.3.4 New Methods of Funding

Perhaps the most important issue that specifically touches on the aging population has to do with health care financing. It was generally agreed that, at least until the peak of the baby-boom generation has died, there would be important cost pressures placed on the system that could be directly attributed to the aging of the population. This raises the question as to how any additional costs should be covered.

<sup>30</sup> Dr. William Dalziel (3:10).



Witnesses suggested that there is an issue of inter-generational fairness that needs to be taken into account in this regard. Our health care system is basically funded on a pay-as-you go basis. That is, revenues are collected from people who currently pay taxes, and these pay for government services to everyone, including those who are no longer paying taxes, or paying less than they did while working. As the proportion of seniors increases, however, there will be proportionally fewer people of working age to cover the (growing) costs of health care for the aging population. The burden on the working population could thus be expected to increase, resulting in what some see as an unfair transfer of wealth from one generation to another.

One way of dealing with this problem is to develop a pre-funding mechanism that would allow future expenses to be paid for by the people who would actually make use of them. This was the intent of the proposal put to the Committee by William Robson of the C. D. Howe Institute. More precisely, he suggested that part of the current Canada Health and Social Transfer (CHST) from the federal government to the provinces and territories be converted into a “senior’s health grant.” He explained:

*...we could replace part of the CHST with a new grant, set at \$3,000 per senior, and initially offset the grant with matching decreases elsewhere so that it is cost-neutral in the first year. Over time, we would allow the grant to escalate at the same rate per capita as other grants relative to the general population, but being geared to the seniors' population, it would grow more quickly. In that way, you could accommodate some of the demographic pressure on the federal transfers.<sup>31</sup>*

Another method of pre-funding that was brought to the Committee’s attention was the proposal from the Clair Commission in Quebec for a special “loss-of-autonomy fund” that would be financed through employer and employee contributions. Similar to a dedicated pension fund, it could be managed by an arms-length body that would ensure its financial viability and that its resources be used to help finance a broader range of services for the aging population.

### **1.3.5 Public Policy: Long-Term Horizon**

Finally, several witnesses raised the issue of the need for longer-term overall policy planning with regard to the needs of the aging population. Professor Byron Spencer noted, for example, that at one time the Economic Council of Canada provided medium- to longer-term economic projections and analysis, and that it might be useful to consider setting up an agency that would have as its focus, in particular, “the anticipation of the effects of population aging.”<sup>32</sup> This could strengthen our ability to regularly study the economic implications of demographic change and their fiscal and budgetary consequences for government.

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<sup>31</sup> William Robson (3:7).

<sup>32</sup> Byron Spencer, Brief to the Committee, p. 5.

### **1.3.6 A Unique Approach to Residential Long-Term Care**

During the course of its study, the Committee received interesting information on Laurier House. Situated in Edmonton (Alberta), Laurier House could be described as “condo care”: residents buy their own suites; receive on-site constant medical care; pay a monthly fee for operating costs, food and domestic services; and when they die, their estate receives back most of the capital investment. Laurier House is operated by the Capital Care Group, the largest publicly funded and operated continuing care organization in the country.

Laurier House has 78 suites occupied by 100 people. One-bedroom suites cost \$97,000-\$115,000; two-bedrooms \$118,000-\$136,000; studios \$88,000. The monthly fee for residents, depending on their accommodation, varies from \$950 to \$1,060. Health services are funded by Alberta Health. Laurier House differs from standard nursing homes in that residents buy their suite; the provincial government does not put any money into capital costs.

## **1.4 Committee Commentary**

The Committee acknowledges that there remains a considerable degree of disagreement among experts as to the impact that an aging population will have on the sustainability of the health care system. These differing views can be summarized into four different scenarios: the “nightmare high-cost” scenario, the “compressed morbidity” scenario, the “manageable costs” scenario, and the “reformed system” scenario.

Of these scenarios, the Committee feels that the least likely to be realized is the first one, the “nightmare high-cost” scenario. The evidence it heard suggests that while the aging population, especially during the peak of the baby-boom, will put important pressures on the health care system, these are unlikely to result, in and of themselves, in a full-blown crisis.

Indeed, the aging of the population is only one of a complex mix of factors – related to both supply and demand – that contributes to the increase in health care costs. Other cost drivers include the use of new technology, the cost of new drugs, changing patients’ expectations, and so on.

This does not mean, however, that nothing needs to be done to help cope effectively with the pressures associated with demographic aging. The Committee believes that it is important to study carefully the various proposals for ‘pre-funding’ the costs associated with an aging population, at least until the full effects of the baby-boom generation have been felt. Moreover, we feel that the aging population increases the urgency of addressing a number of other issues, and may require that specific measures be adopted within broader programs of change.

For example, primary care reform that would not be organized exclusively on a fee-for-service basis and would therefore build in incentives for physicians to spend more time consulting with patients, has particular importance for seniors who often represent more complex cases. Primary care reform could also allow a wider range of services to be available at the initial point of contact with the health care system, something that is also of great interest to seniors who require care from a number of health professionals. This implies, however, that the issue of expanding public coverage to include these services also be addressed. And, in this

context, it is necessary to explore whether other services, such as home care and prescription drugs, should also come under the provisions of the *Canada Health Act*.

While primary care reform and expansion of public coverage, as well as issues related to the implementation of an integrated continuum of care, are of great relevance to the health of seniors, they also have many implications for the broader population. In Phase Four of its study, the Committee will examine these issues in more detail.

Finally, the Committee found Laurier House to be a rather unique and striking concept. Of course, the question may be raised as to whether Laurier House is a form of “two-tier” nursing care system. We suggest that it may represent a two-tier housing system for the ill, but that it still remains within a one-tier health care system.



## CHAPTER TWO:

### SPENDING ON DRUGS IN CANADA

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The term “drugs” (or “medicines”) typically includes prescription drugs, non-prescription drugs (over-the-counter or OTC products) and personal health supplies. Prescription drugs are usually prescribed by a physician or dentist, dispensed by pharmacists, and received either in hospital or in the community. OTC products such as cough and cold remedies and pain relievers can be purchased without a prescription through a number of retail outlets. Personal health supplies such as oral hygiene products and home diagnostic kits are also available to the public through retail outlets.

Drugs can be patented or non-patented. A patented drug is one for which a patent has been issued. Non-patented drugs include drugs that are not yet patented, drugs whose patents have expired, drugs for which there has never been a patent and generic copies. Since 1987, the Patented Medicine Prices Review Board (PMPRB) has regulated the prices charged by manufacturers of patented drugs in Canada. There are two components to this price regulation. One is a limit on increases to the costs of patented drugs already on the market; the other is a limit on introductory prices of new patented drugs. The prices of non-patented drugs are not subject to regulation.

Health Canada is responsible for the approval of all drugs that enter the Canadian market. It assesses new drugs to ensure that they are safe to use and are effective in treating what they claim to treat. Authorization to market or distribute a medicine is granted through a Notice of Compliance (NOC). However, a drug may be distributed with specified restrictions before receiving a NOC, as an Investigational New Drug or under the Special Access Program (SAP).

Witnesses pointed out that drug therapy is an integral part of health care. The importance of drugs in treating disease, maintaining health and quality of life, and in preventing and reducing the need for surgery and hospital stays is well recognized. The Committee was told that appropriate drug therapy can optimize health outcomes and avoid other unnecessary costs.

*Drugs continue to consume an increasing share of Canada's health care dollar, accounting for the second largest category of health expenditures next to hospital services. In 2000, spending on drugs is expected to have reached \$14.7 billion, representing 15.5% of total health care spending, following increases of 8.9% and 9% in 1999 and 2000.*

CIHI (2001)

#### 2.1 Trends in Spending on Drugs

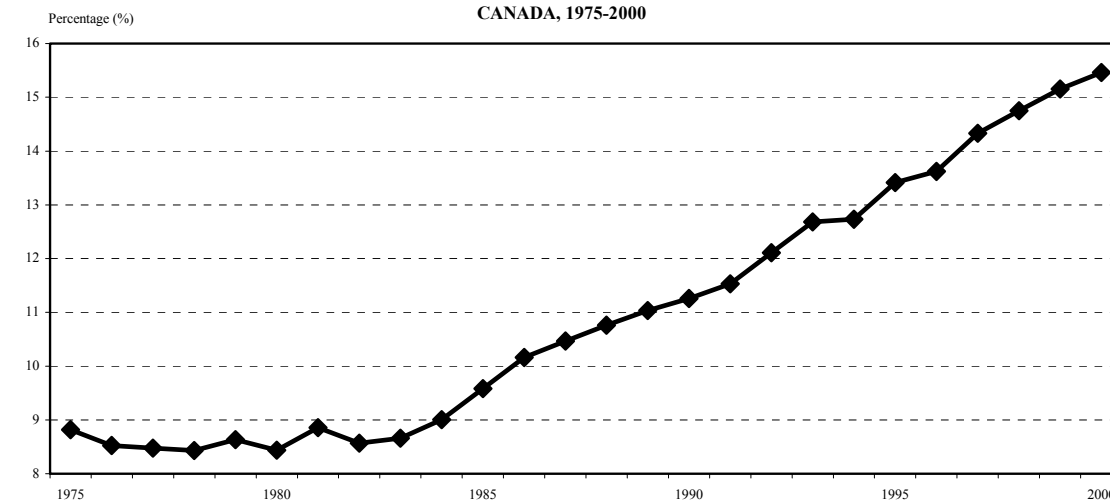
Data reported by the Canadian Institute for Health Information (CIHI) indicate that spending on drugs in Canada has grown continually over the past 25 years, from \$1.1 billion in 1975 to \$14.7 billion in 2000.<sup>33</sup> During this period, drugs accounted for an increasing portion of total health care spending: in 1975,

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<sup>33</sup> Spending on drugs reported by the CIHI includes prescription drugs, OTC products and personal health supplies, but does not include drugs dispensed in hospitals and other institutions.

drugs represented about 9% of total health care expenditures; by 2000, this share had increased to almost 16% (see Graph 2.1). Data from CIHI also suggest that total spending on drugs has been growing at a higher rate than inflation. Furthermore, since 1997, expenditures on drugs have been the second largest category of health care spending in Canada, behind hospitals but ahead of spending on physician services.

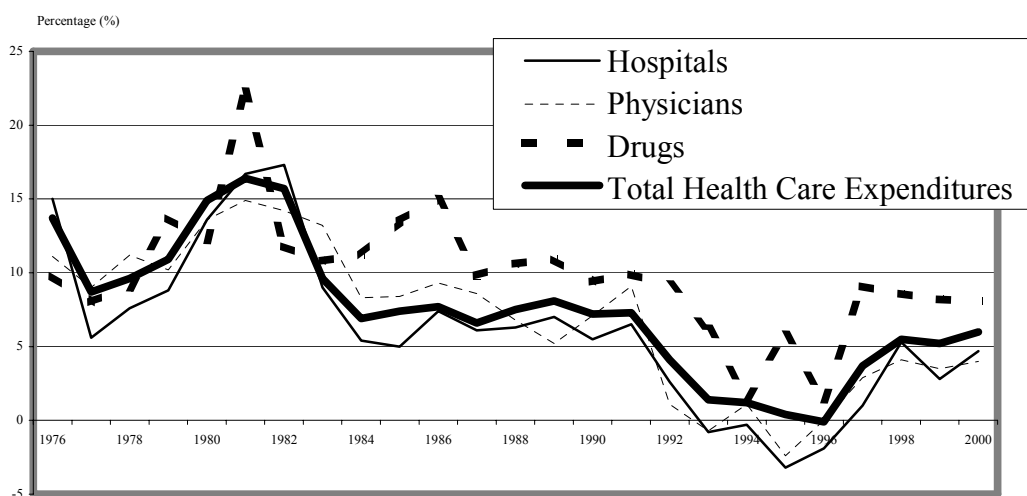
**GRAPH 2.1 : SPENDING ON DRUGS AS A PERCENT OF TOTAL HEALTH CARE EXPENDITURES, CANADA, 1975-2000**



Source: CIHI (2000) and Library of Parliament.

Graph 2.2 shows that spending on drugs in Canada, expressed in dollars per capita, continues to increase at a rate faster than spending in other key health care sectors such as hospitals and physicians. In fact, between 1990 and 2000, drug expenditures per capita increased by almost 93%, more than twice the average for all health care expenditures (40%).

**GRAPH 2.2 : ANNUAL GROWTH IN PER CAPITA SPENDING ON HEALTH CARE, BY CATEGORY OF EXPENDITURES, 1976-2000**



Source: CIHI 2000 and Library of Parliament.

Four components generally make up the cost of prescription drug products. These are: the manufacturer's price, the wholesaler's mark-up, the retailer's mark-up and the pharmacist's dispensing fee. Data from IMS Health (Canada) and the Federal/Provincial/Territorial Task Force on Pharmaceutical Prices estimated that, in 1997, wholesale and retail mark-ups and dispensing fees accounted for just over one-third of the end cost of a prescription drug while distribution costs and the manufacturer's selling price comprised 4% and 63% respectively of the final cost.<sup>34</sup>

Prescription drugs make up the largest component of spending on drugs (77% in 2000, up from 72% in 1975). Non-prescription drugs and personal health supplies accounted for the remaining 23% of drug spending in 2000 (compared to 28% in 1975). For the most part, non-prescription drugs and personal health supplies are purchased directly by consumers and paid for out-of-pocket. By contrast, multiple payers are involved in the financing of prescription drugs. In 1975, the private sector accounted for 80% of prescription drugs expenditures. By 2000, private sector spending had decreased to 57%. During the same period, the share of prescription drugs financed from public sources increased steadily from 20% in 1975 to 43% in 2000.

More drugs are being sold in Canada every year, and patented drugs comprise an ever-growing proportion of drug sales. According to the Patented Medicine Prices Review Board (PMPRB), total sales by manufacturers of pharmaceuticals for human use in 2000 in Canada are estimated at \$10.0 billion. This represents an increase of 12.4% from 1999.<sup>35</sup> The total sales of patented drugs as a proportion of total drug sales have been steadily rising. At 43.9% of sales in 1995, by 2000, patented drugs comprised 63.0% of total sales.<sup>36</sup> From 1990 to 1995, sales of non-patented brand name drugs accounted for nearly 50% of the total drug sales of companies holding drug patents. From 1996 to 2000, however, that proportion declined steadily, reaching 28% in 2000.<sup>37</sup> At the same time, generic drug sales have been increasing. According to information published by IMS Health and reported by the PMPRB, total sales of generic drugs are estimated at approximately \$929 million in 2000, an increase of 15.2% from 1999.<sup>38</sup>

Most patented drugs are sold by prescription. Of the patented drug products reported to the PMPRB for human use, about 96% required a prescription.<sup>39</sup> The quantity of patented drugs sold has also increased. From 1988 to 2000, the average annual increase in quantities of patented medicines sold was 12%. This compares with an average annual increase in their prices of 0.8%.<sup>40</sup>

Overall, increases in spending on drugs in recent years have had an important impact on escalating health care costs. According to witnesses, this trend is likely to continue as

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<sup>34</sup> Report of the Federal/Provincial/Territorial Task Force on Pharmaceutical Prices, *Drug Prices and Cost Drivers 1990-1997*, April 1999, pp. 13-14.

<sup>35</sup> PMPRB, *Annual Report 2000*, p. 15.

<sup>36</sup> *Ibid.*, p. 16.

<sup>37</sup> *Ibid.*, p. 17.

<sup>38</sup> *Ibid.*

<sup>39</sup> *Ibid.*

<sup>40</sup> *Ibid.*, p. 23.

Canada's population ages, new drug therapies become available, and demand for prescription drugs increases:

*Drugs will become more and more effective and will constitute an increasing portion of the therapies utilized and their share of health care costs will continue to rise. New drugs are expensive, but they will be prescribed and access will be demanded by an aging public that is increasingly aware of its options (...).*<sup>41</sup>

## 2.2 Cost Drivers

A number of factors are contributing to increased drug spending including: increased levels of drug utilization, price increases and greater use of costlier, newer drugs. Some of these factors may have a greater impact on spending than others.

### 2.2.1 Trends in Drug Utilization

Drug utilization refers to the quantity of drugs used. Increases in the number of prescriptions can relate to a number of factors including: population increases; changes in the age structure and health status of the population; increases in the number of people being prescribed a particular drug; trends toward using drug therapy instead of other forms of treatment; new diseases and better treatment of existing diseases; and increases in the number of prescriptions per person.

More prescriptions are being written in Canada every year. IMS Health (Canada) reports that approximately 272 million prescriptions were dispensed in 1999, up by 6.3% over 1998. This gives an indication of the magnitude of drug utilization in Canada – an average of 8.9 prescriptions per person per year, up from 8.3 in 1998 (see Table 2.1).

**TABLE 2.1**  
**UTILIZATION OF PRESCRIPTIONS IN 1999**

Average family size	3.1
Prescriptions per person	8.9
Prescriptions per family	28.0
Average prescription price	\$35.48
Consumption per family/year	\$978.89

Source: IMS Health (Canada).

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<sup>41</sup> Canadian Pharmacists Association, *Health Care Delivery, Optimizing Drug Therapy and the Role of the Pharmacist*, Brief to the Committee, March 2001.



There is much to learn and understand about drug utilization in Canada. Utilization is increasing, but at the same time utilization patterns for various drugs can differ across Canada and between Canada and other countries. There are significant variations in the use of some drug therapies across the country. Benzodiazepines are one example. Many more benzodiazepines are dispensed in Eastern Canada than in Western Canada: in 2000, 41.5 tablets and capsules of benzodiazepines were dispensed per capita from retail pharmacies in New Brunswick, a number that is more than three times the per capita rate in Saskatchewan. Significant variations also exist within provinces. Benzodiazepines' usage in northern Alberta, for example, is higher than in southern Alberta.<sup>42</sup>

*There is a significant variation in the utilization of pharmaceuticals that does not correlate to population distribution.*

*Dr Roger A. Korman (4:15)*

Dr. Roger A. Korman, President of IMS Health (Canada), told the Committee that although a causal link has not yet been established between use of benzodiazepines and socio-economic status, there seems to be a correlation – usage is higher in lower socio-economic status areas.<sup>43</sup> Use of benzodiazepines also correlates more closely to the age of the prescribing physician than to the age of the patient – 90% of the top 100 prescribers of benzodiazepines in Alberta, Quebec and Ontario graduated from medical school before 1981.<sup>44</sup>

Utilization of various drugs can vary from country to country. Although utilization of antibiotics is decreasing in Canada, it is still twice as high as utilization in the Netherlands. Ritalin is another example. Canadian prescriptions for Ritalin continue to grow at a rapid pace (9% in 2000), but are down by 5% in the United States.

### 2.2.2 Trends in Drug Prices

Both the federal and provincial governments have roles in controlling Canadian drug prices. At the federal level, the PMPRB reviews prices charged by the manufacturers of patented drugs to ensure that they are not excessive. In addition, provincial and territorial governments have used a number of approaches to manage drug prices in their Pharmacare plans. These include:<sup>45</sup>

- Generic substitution – where a generic drug is available, the lower-priced generic product must be substituted for the equivalent brand name drug, unless a physician otherwise orders.
- Formulary management – this could include not listing drug products on formularies, listing with restrictions or de-listing.
- Reference-based pricing – paying for the lowest price drug in a therapeutic group. The main difference between reference-based pricing and generic

<sup>42</sup> Dr. Roger A. Korman (4:15).

<sup>43</sup> *Ibid.*

<sup>44</sup> *Ibid.*, 4:16.

<sup>45</sup> A description of provincial cost controls can be found in the Institute of Health Economics Working Paper 00-2, *Public Policies Related to Drug Formularies in Canada: Economic Issues* and Devidas Menon, "Pharmaceutical Cost Control in Canada: Does It Work?", *Health Affairs*, Vol. 20, No. 3, May/June 2001.

substitution is that under the former, drugs in a category have only to be therapeutically equivalent, not chemically identical.

- Controls on mark-ups and dispensing fees - provincial governments can limit markups on drugs and dispensing fees paid to pharmacists.
- Risk-sharing – in some cases, governments have negotiated with drug companies to limit total expenditures on specific drugs. If expenditures exceed an agreed-upon level, the company pays the province for expenditures above that amount.
- Price freezes – Ontario introduced a price freeze from 1994 to 1998.

The PMPRB limits annual price increases of patented drugs to the increases in the Consumer Price Index (CPI). With the exception of one year (1992), prices for patented drugs have not increased more than the CPI since 1988. In 2000, the prices of patented drugs rose by an average of 0.4% while consumer prices increased by 2.7%.<sup>46</sup> The PMPRB also reviews the introductory prices of new patented drugs. Generally, prices for most new patented drugs are limited so that the cost of the new drugs will not be greater than the highest cost of therapy for existing drugs used to treat the same disease. The price of a new breakthrough drug is limited to the median price for the drug in seven other countries – France, Germany, Italy, Sweden, Switzerland, the United Kingdom and the United States. Furthermore, the price of a patented drug cannot exceed the highest price in these countries.<sup>47</sup>

In 1987, Canadian prices for patented medicines were some 23% higher than median international prices. By the mid-1990s, Canadian prices were about 10% below such prices; in 2000, they were 8% below median international prices. The PMPRB reported that Canadian prices were slightly lower than prices in Germany, Sweden, Switzerland and the United Kingdom but higher than prices in France and Italy. Prices in the U.S. were higher than all other countries.<sup>48</sup>

The F/P/T Task Force on Pharmaceutical Prices analyzed annual price changes of prescription drug products in six provincial drug plans. The study divided drug products into three categories: patented drugs; non-patented single source drugs; and non-patented multiple source (brand name and generic) drugs. In 1997, spending on patented drugs comprised about 50% of the total prescription spending in the six drug plans. Non-patented single source drugs made up 13% of the total amount spent by the plans on drugs in 1996. The Task Force compared the Canadian and foreign prices of the top-selling non-patented single source drugs reimbursed by the six drug plans and found that Canadian prices were, on average, 30% higher than the median international prices of the seven countries used by the PMPRB for comparative purposes. These prices contrast with Canadian prices for patented medicines, which were about 10% lower than median foreign prices.<sup>49</sup>

Multiple source drugs (brand-name and generic) accounted for 44% of prescription drug plan spending of five of the provincial plans in 1997.<sup>50</sup> Data from the F/P/T

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<sup>46</sup> PMPRB (2000), p. 18.

<sup>47</sup> *Ibid.*, p. 26.

<sup>48</sup> *Ibid.*, p. 21.

<sup>49</sup> *Drug Prices and Cost Drivers 1990-1997* (1999), p. 30.

<sup>50</sup> *Ibid.*, p. 34. Nova Scotia was not included.

Task Force on Pharmaceutical Prices indicate a clear trend toward higher generic drug prices in relation to their brand name equivalents.<sup>51</sup> According to the Task Force, “this trend has occurred despite the fact that overall prices of generic drugs have remained stable or declined, and prices of their brand name equivalents have remained constant or increased during this period.”<sup>52</sup> Two possible explanations for this are: higher relative introductory prices for generic drugs; and differences in price trends for generic drugs with no brand name equivalent than for generics with brand name counterparts.<sup>53</sup> A study by the Fraser Institute (August 2000) also showed that generic drug prices were often higher in Canada than in the United States.<sup>54</sup>

Drug prices vary from province to province. The F/P/T Task Force on Pharmaceutical Prices reported significant differences in the manufacturers’ prices across Canada for the same drug products. In 1993, prices in Ontario, the highest price province, were 8.8% higher than the prices in British Columbia, the lowest price province. By 1997, the last year covered by the report, price differences had been reduced, with Nova Scotia, the highest price province, having prices that were 5% higher than the lowest price province, Manitoba. The Task Force also found that if all provinces in the study had paid the lowest available prices for the same products in 1997, \$60 million would have been saved.<sup>55</sup>

### **2.2.3 Trends in the Types of Drugs Prescribed**

A shift in prescribing patterns away from older therapies toward newer costlier drugs can have a significant impact on drug spending. Data compiled by the F/P/T Task Force on Pharmaceutical Prices reveal that in 1997, newer drugs (introduced since 1990) represented 57% of the total pharmaceutical expenditures in British Columbia. The introduction and use of new drugs was estimated to have been responsible for 32% of the increase in drug spending in British Columbia between 1990 and 1997.

### **2.2.4 Cost Driver Analysis**

Using data from British Columbia, the F/P/T Task Force on Drug Utilization found that changes in prescription drug spending could be attributed to the following cost drivers (see Graph 2.3): price increases of existing drugs (18%), increased utilization of existing drugs (50%), and sales of new drugs in their first full year (32%). In 1997, drugs introduced on the Canadian market since 1990 (newer drugs) accounted for 57% of pharmacare expenditures in British Columbia. As a result of these findings, the Task Force concluded that increased drug utilization and increased consumption of newer drugs were the primary drivers of prescription drug spending.<sup>56</sup>

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<sup>51</sup> *Ibid.*, p. 35.

<sup>52</sup> *Ibid.*

<sup>53</sup> *Ibid.*, p. 36.

<sup>54</sup> The Fraser Institute, “Prescription Drug Prices in Canada and the United States,” *Public Policy Sources*, August 2000.

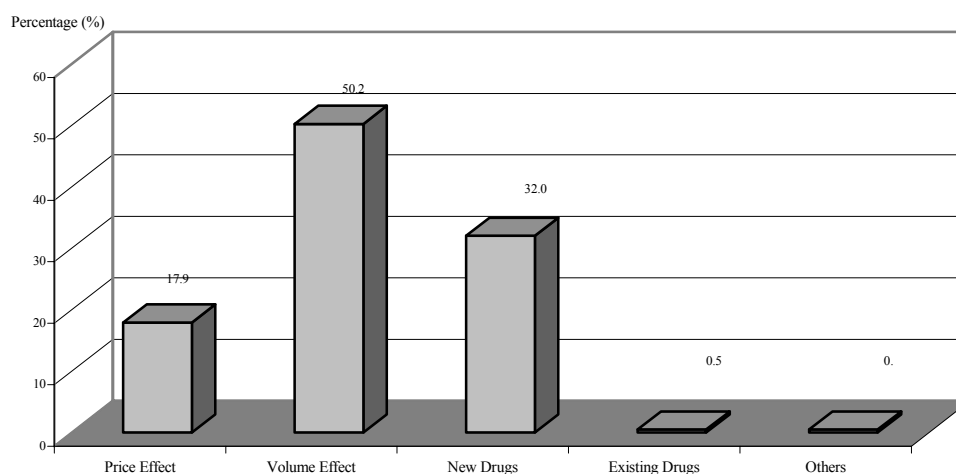
<sup>55</sup> *Drug Prices and Cost Drivers – 1990-1997* (1999), p. iii.

<sup>56</sup> Report of the Federal/Provincial/Territorial Task Force on Drug Utilization, *Drug Utilization in Canada*, April 1999, p. 1.

## 2.3 Appropriate Drug Therapy

Appropriate drug therapy refers to prescribing and utilizing the right drug at the right time. Appropriate and cost-effective utilization of drugs is essential if we are to both optimize health outcomes and avoid unnecessary health care costs. There are, however, two major barriers to appropriate drug therapy: inappropriate use by patients and inappropriate prescribing by physicians. Table 2.2 provides a brief outline of inappropriate use and inappropriate prescribing.

GRAPH 2.3: CONTRIBUTION TO INCREASES IN DRUG COSTS BY MAJOR COMPONENTS, 1990 TO 1997



Source: F/P/T Task Force on Drug Utilization, April 1999.

Inappropriate prescription drug use is a problem of increasing significance. Estimates put patient non-compliance with prescribed drug regimes and early discontinuance of medications for chronic conditions such as high blood pressure and high cholesterol as high as 50%. Using Saskatchewan data with respect to patient use of cholesterol-lowering drugs, Dr. Robert Coombs, President and CEO of Health Promotion Research, pointed out that it takes 18 months to two years before the benefits of such drugs are realized, but only 10 percent of patients are still using their medication after 800 days. Non-compliance can lead to other adverse health situations, as well as increased visits to physicians and hospitals.<sup>57</sup> Patients often fail to take the medication as prescribed, stop taking their medication too soon, or neglect to refill prescriptions.

*Every chronic care medication has severe compliance problems.*

*Dr. Robert Coombs (4:8)*

<sup>57</sup> Dr. Robert Coombs (4:9).

**TABLE 2.2**  
**INAPPROPRIATE DRUG THERAPY: DEFINITION**

INAPPROPRIATE DRUG USE <sup>1</sup>	INAPPROPRIATE PRESCRIBING <sup>2</sup>
<ul style="list-style-type: none"> <li>• Not having a prescription filled or refilled</li> <li>• Taking too much or too little of the drug prescribed</li> <li>• Erratic dosing, such as altering time intervals or omitting doses</li> <li>• Stopping the drug too soon</li> <li>• Taking a drug without a prescription</li> <li>• Combining prescription drugs with OTC products or illicit drugs</li> <li>• Combining prescription drugs with alcohol</li> </ul>	<ul style="list-style-type: none"> <li>• Under-prescribing or not specifying sufficient quantities or correct intervals of doses</li> <li>• Over-prescribing or going beyond the maximum therapeutic dosage</li> <li>• Prolonged use that result in iatrogenic effects and adverse reactions</li> <li>• Prescribing that is contraindicated by the medical condition</li> <li>• Contraindicated combinations that produced an undesirable effect</li> </ul>

<sup>1</sup>Coambs, Robert B., Ph.D. *et al.*, *Review of the Scientific Literature on the Prevalence, Consequences, and Health Costs of Non-Compliance and Inappropriate Use of Prescription Medications in Canada*, PMAC, 1995.

<sup>2</sup>Coambs, Robert B., Ph. D., et al., *A Preliminary Review of the Causes of Inappropriate Prescribing and its Costs in Canada. Health Promotion Research*, February 1997.

Research also reveals that many patients do not understand their drug therapy. The Committee heard that half of all patients who walk out of a physician's office do not understand the drug they were given, why they were given it, or how they were supposed to take it.<sup>58</sup> Low levels of literacy are a major barrier to the appropriate use of prescription drugs.

Inappropriate prescribing of medications is also a problem, particularly in relation to seniors. The Canadian Association of Gerontology discussed the problem in a recent policy statement:

*Seniors are more likely to receive prescriptions for medication that are potentially inappropriate; 11% to 46% of seniors receive at least one inappropriate prescription per year. (...) Prescribing errors account for approximately 19% to 36% of drug-related hospital admissions. The co-existence of multiple prescribing physicians, the number of drugs currently in the market (over 24,000), the number of relative contraindications documented (over 33,000) and deficiencies in physician knowledge related to both age and training are important contributors to the risk of inappropriate prescriptions.*<sup>59</sup>

<sup>58</sup> Dr. Roger A. Korman (4:17).

<sup>59</sup> Canadian Association of Gerontology, *Policy Statement: Seniors and Prescription Drugs*, 1999, (<http://www.cagacg.ca/english/pubs/pol-drugs.htm>).

**TABLE 2.3**  
**ESTIMATED ECONOMIC COSTS**  
**OF INAPPROPRIATE DRUG THERAPY**  
**(IN BILLIONS OF DOLLARS)**

	INAPPROPRIATE USE	INAPPROPRIATE PRESCRIBING
<b>Direct Costs:</b>		
▪ Hospitals	1.78 – 2.74	0.30 – 0.85
▪ Nursing Homes	0.66	–
▪ Ambulatory Care	1.09	0.12 – 0.43
<b>Indirect Costs:</b>		
▪ Lost Productivity and Premature Deaths	3.5 – 4.49	0.42 – 1.28
<b>Total Economic Costs</b>	<b>7.06 – 8.98</b>	<b>0.84 – 2.56</b>

Source: as in Table 2.2.

Inappropriate prescription drug use costs the health care system substantial amounts of money. A 1995 study by Dr. Coombs *et al.* showed that the economic costs of inappropriate prescription drug use in Canada was between \$7 to \$9 billion annually, an amount equivalent to the cost of cancer, from all causes, in Canada.<sup>60</sup> This figure incorporated both direct costs – resulting from increased hospitalization, more medical visits and interventions, and higher nursing home costs; and indirect costs – resulting from lost productivity at work, absenteeism, and premature deaths. In 1997, Coombs and his team evaluated the economic costs of inappropriate prescribing as ranging between \$0.8 and \$2.6 billion annually (see Table 2.3).

Witnesses stressed that improving the quality of drug use would have a positive impact on patient health and on spending. Dr. Coombs suggested that good patient support programs would help ensure that patients were taking medication properly. Dr. Jeffrey Poston, Executive Director of the Canadian Pharmacists Association, emphasized the role of pharmacists in creating value for money in drug use.

*Pharmacists make substantial contributions to primary health care every day by fixing patients' drug-related problems, improving patient compliance – the problem identified in the earlier presentation – managing minor illnesses, and promoting good health. However, it is also a fact that the knowledge and skills of pharmacists are underutilized (...).*

*Dr. Jeff Poston, CPA (4:10)*

*While drug use management strategies such as trial prescription programs can save money, the greatest improvement in value for money comes when pharmacists sit down with patients and critically review their therapy. In a recent study in Ontario, pharmacists reviewed the medication of elderly patients on five drugs or more. Eighty-eight percent of those patients had, on average, 3.23 drug-related problems. The pharmacist informed the physician taking care of the patient about these problems, and*

<sup>60</sup> Coombs, Robert B., Ph.D. *et al.*, *Review of the Scientific Literature on the Prevalence, Consequences, and Health Costs of Non-Compliance and Inappropriate Use of Prescription Medications in Canada*, PMAC, 1995.

*in 69 per cent of cases, the physician accepted recommendations from the pharmacist to make changes.*<sup>61</sup>

Dr. Poston urged that pharmacists be an integral part of primary care reform. This would solve the problem of underutilizing pharmacists and would also enhance overall drug therapy:

*(...) as provinces develop primary health care reform, they should look at ways to integrate pharmacists into the proposed models for primary health care delivery. Such models should be designed to make maximum use of the consultative services pharmacists can provide to optimize drug therapy.*<sup>62</sup>

Witnesses also commented on the importance of using information to reduce waste resulting from inappropriate prescribing and use of drugs. The Committee heard that Canada lacks comprehensive drug use and cost information. Evaluating the quality of drug use was seen as a priority. Ms. Barbara Ouellet, Director, Home Care and Pharmaceuticals Division (Health Canada), pointed out that:

*Canada does not have good, comprehensive drug use and cost information, which in and of itself is a barrier to any analysis, including analysis of some of the policy directions or potential implications of policy directions. Canadians are also seeking authoritative, evidence-based, patient-oriented information provided when their prescriptions are written or dispensed.*<sup>63</sup>

Dr. Poston called for research that critically evaluates the quality of drug use:

*There has been a strong focus on drug costs, but little on the quality of drug use. It is through improving the quality of drug use that true savings will be found, both in costs and human life. Evaluation research should focus on the value of interventions developed to improve the quality of drug use.*<sup>64</sup>

## **2.4 Who Pays for Drugs in Canada?**

Most Canadians have some form of insurance coverage for prescription drugs from one source or another. They receive drug coverage from government programs, private plans through their employers, and individual plans (see Table 2.4). Information provided to the Committee by the Canadian Life and Health Insurance Association (CLHIA) suggests that about 97% of the Canadian population is protected by some form of prescription drug insurance. Estimates by the CLHIA also show that:

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<sup>61</sup> Dr. Jeffrey Poston (4:11-12).

<sup>62</sup> *Ibid.* (4:13).

<sup>63</sup> Ms. Barbara Ouellet (4:20).

<sup>64</sup> Dr. Jeffrey Poston (4:13).

- employer-sponsored group plans are the primary source of insurance for Canadians, providing coverage to 57% of the population;
- individual drug insurance companies cover another 3% of the population;
- the two major public prescription drug insurance plans for seniors and social assistance recipients contribute 12% and 10% respectively to the total;
- provincial programs for the general population (i.e. not limited to seniors or social assistance recipients) cover another 15% of the population;
- programs for status Indians and eligible Inuit and Innu account for about 2% of the coverage;
- various other plans (individual policies, affinity groups, etc.) account for a further 1%;
- some 3% of the Canadian population appear to have no insurance coverage at all for prescription drugs.<sup>65</sup>

**TABLE 2.4**  
**TYPES OF PLANS**

PRIVATE PLANS	GOVERNMENT PLANS
<ul style="list-style-type: none"> <li>▪ Employment benefit plans</li> <li>▪ Individual insurance policies</li> <li>▪ Affinity-related group plans</li> </ul>	<ul style="list-style-type: none"> <li>▪ Registered Indians, eligible Inuit and Innu</li> <li>▪ Veterans</li> <li>▪ Seniors</li> <li>▪ Social assistance recipients</li> <li>▪ Institutionalized individuals (health related and Corrections)</li> <li>▪ Universal programs open to all residents</li> </ul>

Source: *Canadians' Access to Insurance for Prescription Medicines*, Executive Summary, Applied Management in Association with Fraser Group Trisat Resources, Study submitted to Health Canada under the Health Transition Fund, March 2000.

Because the *Canada Health Act* does not include prescription drugs used outside the hospital setting, public coverage varies considerably from province to province. Similarly, private insurance for prescription drugs provided through employer-sponsored plans or individual insurance companies exhibit significant differences in terms of design, eligibility and out-of-pocket costs.

For example, there are wide variations in public prescription drugs insurance plans.<sup>66</sup>

<sup>65</sup> Canadian Life and Health Insurance Association, *Drug Expense Insurance in the Canadian Population*, 1998.

<sup>66</sup> The summary description of government and private plans has been taken from information contained in the study *Canadians' Access to Insurance for Prescription Medicines*, Applied Management in Association with Fraser Group, Trisat Resources, Study submitted to Health Canada under the Health Transition Fund, March 2000.



- The federal government provides drug plan benefits to registered Indians and eligible Inuit and Innu under the Non-Insured Health Benefits program for medication not covered by provincial or territorial government plans.
- Veterans Affairs Canada provides drug plan coverage for certain eligible veterans.
- Members of the armed forces and their families receive drug coverage from the federal government, as do prisoners in federal correctional institutions. Provincial governments provide drugs to prisoners in provincial institutions.
- Some provinces have universal programs (British Columbia, Saskatchewan and Manitoba cover all residents; Quebec covers residents without employer-sponsored drug plans; Ontario has an income-tested program to cover individuals with high drug costs relative to income).
- All provinces and territories cover social assistance recipients and seniors under Pharmacare programs although some provide coverage to low-income seniors only.
- Individuals with certain high-cost diseases are covered in all provinces (for example, people with diabetes, HIV/AIDS, cancer, cystic fibrosis).
- Nursing home and long-term care facility residents obtain drug benefits through provincial drug plans or through funding for the operation of the home or facility.
- Some provincial drug plans charge premiums. Most do not. Others have deductibles (an amount that individuals must pay before being eligible for reimbursement). Most provincial government plans require plan beneficiaries to pay a portion of the prescription costs after the deductible is reached (co-payment). Many plans limit the total amount individuals are required to pay in co-payments and deductibles.
- Provincial and territorial drug plans have adopted formularies – a list of drugs that the plan will pay for.

Most large employers and many small employers offer employee benefit plans that include drug coverage. A number of the larger employers also cover retirees. Self-employed individuals can also purchase individual drug plan coverage. Employers usually pay the premium costs under most employer-sponsored plans but employees may also be required to contribute: the split between plans requiring employees to pay a premium and those that do not is about 50/50. Many private plans do not have deductibles and those that do impose relatively low deductible amounts. Beneficiary co-payments are a feature of many private plans (usually 20%), but a number of plans make no provision for co-payments.

The public/private mix of prescription drug coverage varies widely across Canada. Data from IMS Health (Canada) shows that public insurance covers only 31% of the cost of prescription drugs in Newfoundland and New Brunswick, while governments are responsible for over 60% of prescription drug costs in Saskatchewan, Quebec and Manitoba (see

Table 2.5). Overall, residents of the Atlantic Provinces have less public coverage for prescription drugs than residents of other parts of Canada.

**TABLE 2.5**  
**WHO PAYS FOR PRESCRIPTION DRUGS**

JURISDICTION	GOVERNMENT PERCENTAGE	CASH/PRIVATE SECTOR PERCENTAGE
British Colombia	40.9%	59.1%
Alberta	45.5%	54.5%
Saskatchewan	66.1%	33.9%
Manitoba	62.2%	37.8%
Ontario	42.8%	57.2%
Quebec	62.2%	39.8%
New Brunswick	31.1%	68.9%
Nova Scotia	33.3%	66.7%
Newfoundland	31.1%	68.9%

Source IMS Health (Canada)

## 2.5 Do Some Canadians Have Better Coverage for Drug Costs than Others?

The Health Transition Fund (Health Canada) funded a study to examine the range and extent of government and private prescription drug plans and to assess measures of under-insurance in Canada. A copy of this comprehensive study, which is entitled *Canadians' Access to Insurance for Prescription Medicines*, was provided to the Committee.<sup>67</sup>

Perhaps the most striking conclusions from the study are the substantial regional variations in who is eligible for coverage and the reimbursement levels under government drug plans. The study also reveals that a substantial number of people have inadequate coverage or no coverage at all. Part-time and low-income workers are particularly vulnerable because they do not qualify for government plan coverage and do not have access to an employee benefits plan. Overall, the study came to the following conclusions:<sup>68</sup>

- Ninety-three percent of Canadians have a combination of public and private drug insurance plans to provide protection against serious financial hardship in the event that expensive drug treatment is required. Approximately 4 percent of the population would be considered under-insured because their coverage would reimburse only a portion of their bills while 3 percent are uninsured.

<sup>67</sup> *Canadians' Access to Insurance for Prescription Medicines*, Executive Summary Applied Management in Association with Fraser Group Trisat Resources, Study submitted to Health Canada under the Health Transition Fund, March 2000.

<sup>68</sup> These conclusions are summarized in the study's Executive Summary.

- Residents of the Atlantic Provinces, other than seniors and social assistance recipients and those in employer-sponsored group programs have no protection against catastrophic levels of drug expense.
- In all provinces, except Quebec, workers in part-time or low-wage positions are more likely to be uninsured or underinsured for routine drug expenses compared to the general population under age 65 because there is little to no coverage under employer-sponsored group plans.
- In all provinces, except Quebec, there is reduced coverage in the 55-64 age group.
- Of the Aboriginal population, registered Indians or eligible Inuit and Innu have good coverage under Health Canada's Non-Insured Health Benefits program. Métis and Non Status Indians, on the other hand, are more likely to be under-insured or uninsured than the non-Aboriginal population.
- Therefore, the strongest determinant of whether an individual will have adequate coverage against catastrophic (high) drug expenses is province of residence. While many individuals, especially seniors, have protection against catastrophic expenses under government plans, non-seniors residing in provinces or territories without universal government programs can face a significant financial burden if they do not have private drug plan coverage through their employers.

Another study that was tabled before the Committee assessed the recent changes to the Quebec prescription drug plan and the effect of co-payment on drug consumption.<sup>69</sup> In 1996, Quebec made drug insurance mandatory. As a result, previously uninsured individuals were given access to a prescription drug plan. The new drug plan required beneficiaries to pay a portion of their prescription costs. This differed from the previous plan under which many beneficiaries – particularly social security recipients and seniors entitled to the Guaranteed Income Supplement – received prescription drugs free. The Quebec study found that seniors and social security recipients significantly reduced their drug consumption. This decline in consumption applied to both essential and non-essential drugs. The study also reported increases in the number of adverse events, emergency room visits, and visits to doctors attributable to the reduction in consumption of essential drugs.<sup>70</sup>

A number of witnesses raised concern about patient access to drug therapy especially in light of recent changes to public drugs plans that impose higher co-payments and deductibles. In their view, if certain patients have to bear all or a portion of the cost of their prescriptions, they will forego essential drug therapy. They

*Two-tier health care is alive and well. First estimates vary, but approximately 3 million Canadians have no drug coverage, and probably another 3 million or more have inadequate coverage because of the high deductibles and co-payments that were introduced in many public plans in the 1990s.*

*Dr. Jeffrey Poston (4:12)*

<sup>69</sup> Robyn Tamblyn, *et al.*, *Evaluation Report of the Impact of Prescription Drug Insurance Plan*, Summary, March 1999.

<sup>70</sup> *Ibid.*, p. 22.

stressed that many Canadians have inadequate drug coverage or no coverage at all and cannot afford the drugs prescribed for them. This, of course, has important cost and service implications for other areas of the health care system. For example, Dr. Coombs observed:

*(...) if you raise the price or make the drug less accessible, people will fill scripts less, renew the scripts less, and use other health care resources more. They will drive up your hospitalization charges if you deny them the drugs. ...Economics is a barrier and other access issues are also a barrier.<sup>71</sup>*

A number of witnesses recommended that the federal government develop, in collaboration with the provinces, a national Pharmacare plan. There is no single model for a pan-Canadian Pharmacare, and a number of complex issues can influence their design. These include deciding who should be covered (e.g., everyone, specific groups of the population such as seniors or social assistance recipients, etc.), what is covered (e.g., all prescriptions, specific categories of prescriptions, etc.), and how it should be financed (e.g., public financing only or a mix of public and private funding with deductibles, co-payments, etc.). Witnesses indicated that if user charges were required under Pharmacare, they should be minimal; they should not place an undue burden on patients.

Furthermore, there is considerable controversy concerning the costs of setting up a national Pharmacare program and of ensuring its long-term viability. In 1997, Palmer d'Angelo Consulting Inc. estimated the cost of funding several models of national Pharmacare. Here is a summary of the major findings of this study:

- A fully funded, comprehensive, publicly administered, national Pharmacare plan would increase public expenditures on prescription drugs by an estimated \$4.3 billion.
- Other publicly administered plans would increase public expenditures by \$2.1-\$2.5 billion with patients paying co-payments or the dispensing fee. These plans would in essence “nationalize” current private plans.
- With a national Pharmacare plan similar to the drug plans that exist in Saskatchewan and Manitoba, public expenditures would fall by almost \$0.5 billion. However, expenditures by individuals would increase by \$0.9 billion.
- The impact on the public purse of the mixed public/private plans is considerably less than the public only plans. The incremental increase in expenditures range from \$0.1 billion with a plan similar to that currently in Quebec, to \$1.5 billion for a plan that provides true first dollar coverage.<sup>72</sup>

Clearly, the cost of funding a national Pharmacare program would vary according to how it is designed. A recent study by Dr. Joel Lexchin suggested that although such a system would increase public spending, it would nonetheless save money by reducing administrative

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<sup>71</sup> Dr Robert Coombs (4:21).

<sup>72</sup> Palmer d'Angelo Consulting Inc., *National Pharmacare Cost Impact Study*, September 1997.

costs and dispensing fees.<sup>73</sup> The impact of a national Pharmacare program on drug prices is also unclear. For example, international experience with national Pharmacare programs shows that drug costs continue to grow at a rate of 8% annually.

The Committee was told that the idea of a common drug formulary was being discussed at the provincial and territorial level. More specifically, following their conference in August 2000, Provincial Premiers and Territorial Leaders agreed to work together and “mandated their Health Ministers to develop strategies for assessing and evaluating prescription drugs. These strategies could include the creation of a common inter-provincial/territorial advisory process to assess drugs for potential inclusion in provincial/territorial drug plans.”<sup>74</sup> However, the Committee was told that provinces might resist the development of a national drug formulary:

*With respect to Pharmacare, a fairly broad proposal was made to governments in the early 1990s that included aspects of what we are talking about here, including national formularies. The issue for the provinces is that they are trying to manage their own resources in ways that best meet the needs of their own populations. That may mean, for example, that if they have a high senior population, then there will be certain demands for access to pharmaceuticals for that population. If they have a high proportion of AIDS patients, then they will need to deal with those needs as well. They are desperately trying to ensure that the drugs they list are appropriate for their citizens. In fact, as some drugs lose their effectiveness and better ones become available, can they actually be removed from the formularies? I would say that there is currently no desire or will to talk about one national formulary because of the need to respond flexibly to their own population needs, which they argue would differ.*<sup>75</sup>

## 2.6 Committee Commentary

In recent years, there has been a marked increase in drug spending. The evidence suggests that the growth in drug costs has been driven largely by increased utilization of drugs and a shift from older, less-expensive medications to newer, costlier forms of drug therapy, but less so by price increases. Witnesses told the Committee that they expect drug spending to take up an even larger portion of health care dollars in the future.

There is also increasing evidence of inappropriate prescribing and use of medicines. Patient non-compliance with prescribed drug regimens and early discontinuance of medications for chronic conditions is estimated to be as high as 50%. Inappropriate drug therapy is costly to the Canadian health care system. In the opinion of the Committee, it is critical to address the issue of inappropriate drug therapy. We agree with witnesses that pharmacists can play a crucial role in primary care reform and that better integration of the work

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<sup>73</sup> Dr. Joel Lexchin, *A National Pharmacare Plan: Combining Efficiency and Equity*, Canadian Centre for Policy Alternatives, March 2001.

<sup>74</sup> 41st Annual Premiers' Conference, “Premiers' Commitment to their Citizens,” *News Release*, Winnipeg, 11 August 2000 (also available at [http://www.scics.gc.ca/cinfo00/850080017\\_e.html](http://www.scics.gc.ca/cinfo00/850080017_e.html)).

<sup>75</sup> Barbara Ouellet (4:41).

of physicians with that of pharmacists can greatly reduce the economic burden of inappropriate drug prescribing and use. The Committee also believes that the implementation of health information systems could greatly improve information on prescribing and using medicines. The development of PharmaNet in British Columbia, for example, deserves attention as it provide pharmacists with a complete record of drugs prescribed to each resident of the province.

Furthermore, the Committee received evidence that Canadians do not have uniform coverage for prescription drugs. Some Canadians have no coverage at all, while others are clearly under-insured. Lack of coverage for prescription drugs and under-coverage are of particular concern for residents of the Atlantic provinces. The Committee strongly feels that prescription drugs should be easily available when they are medically necessary.

There is, at the moment, no definite consensus regarding the development of a national Pharmacare program. A variety of models can be envisioned each of which raises multiple issues. For example, should a national Pharmacare plan meet all the conditions of the *Canada Health Act*? Should a national Pharmacare plan be established along with a national drug formulary or with existing individual provincial formularies? How would the plan be financed – public funding only, public/private mix, with co-payments and deductibles? Where would the public funding come from – general taxation, employer/employee premiums, a dedicated health care tax, etc.?

In Phase Four of its study, the Committee will outline options for addressing these various issues.

## CHAPTER THREE:

### HEALTH CARE TECHNOLOGY

“Health care technology” is a very broad concept that can be defined as “the set of techniques, drugs, equipment, and procedures used by health care professionals in delivering medical care to individuals and the systems within which such care is delivered.”<sup>76</sup> David Feeny, professor of Pharmacy and Pharmaceutical Sciences at the University of Alberta, told the Committee that the concept of health care technology includes both embodied and disembodied technologies. An embodied technology is one that is “contained” or captured in the physical artefact itself. In contrast, disembodied technologies are ideas or procedures that do not involve a tangible product or piece of equipment.<sup>77</sup> Table 3.1 provides selected examples of health care technologies.

**TABLE 3.1**  
**EXAMPLES OF HEALTH CARE TECHNOLOGY**

<b>EMBODIED TECHNOLOGY</b>	<i>Devices, Equipment and Supplies:</i> <ul style="list-style-type: none"><li>Cardiac pacemakers, computed tomography (CT) scanners and magnetic resonance imagers (MRIs), surgical gloves, diagnostic test kits, etc.</li></ul>
	<i>Medical and Surgical Techniques:</i> <ul style="list-style-type: none"><li>Coronary angiography, gall bladder removal, etc.</li></ul>
	<i>Drugs:</i> <ul style="list-style-type: none"><li>Aspirin, beta-blockers, penicillin, vaccines, blood products, etc.</li></ul>
	<i>Support Systems:</i> <ul style="list-style-type: none"><li>Electronic patient record systems, telemedicine systems, blood banks, clinical laboratories, etc.</li></ul>
<b>DISEMBODIED TECHNOLOGY</b>	<i>Procedures:</i> <ul style="list-style-type: none"><li>Pap smear test</li></ul>
	<i>Ideas:</i> <ul style="list-style-type: none"><li>Early ambulation following surgery, washing hands between patients, etc.</li></ul>

The Committee heard that health care technologies have lifecycles: some are well-established while others are in the early stages of development; still others have become obsolete. Innovative technologies today move increasingly quickly from the research laboratory to the health care sector. As a result, rapid innovation is contributing to faster obsolescence of health care technologies.

<sup>76</sup> David Feeny, *The Generation, Evaluation and Application of Health Care Technologies in Canada*. Brief to the Committee, 29 March 2001, p. 5.

<sup>77</sup> Experts often include the innovative ways to finance, organize and provide health care under the category of disembodied health care technology.

The Committee was also told that Canada does not play a leading role in the development of health care technology. In fact, 70 percent of health care technologies currently used in Canada were developed abroad.

Everybody agrees that health care technology constitutes an important component of health care delivery in advanced countries. Health care technology can improve the speed and accuracy of diagnosis, cure disease, lengthen survival, alleviate pain, facilitate rehabilitation, and maintain independence. However, many concerns have been raised in Canada about the availability, assessment and cost of both new and existing health care technologies. The Committee was told that these issues need to be addressed if Canadians are to derive the maximum benefits health care technology can provide, while sustaining an affordable health care system.

Although the definition of health care technology does encompass drugs, this chapter will discuss issues related to “hard” technologies only. Issues related to drugs are the subject of the previous chapter.

### 3.1 Availability Of Health Care Technology

A recent study by the Fraser Institute shows that although Canada is the 5<sup>th</sup> highest among OECD (Organization for Economic Cooperation and Development) countries in terms of total spending on health care (as a percentage of GDP), it is generally among the bottom third of OECD countries in the availability of health care technology (see Table 3.2). For example, Canada ranks 21<sup>st</sup> of 28 OECD countries in the availability of CT scanners, 19<sup>th</sup> of 22 in availability of lithotriptors, and 19<sup>th</sup> of 27 in availability of MRIs. Its only favourable ranking is in the availability of radiation equipment, where it ranks 6<sup>th</sup> out of 17. The study also reveals that this technology gap is widening. For example, Canada’s deficit in the availability of MRIs worsened between 1986 and 1995 relative to other leading OECD countries including Australia, France, the Netherlands and the United States. In other words, Canada’s levels of health care technology are disproportionately low given its level of health care spending.

**TABLE 3.2**  
**AVAILABILITY OF HEALTH CARE TECHNOLOGY**  
**INTERNATIONAL COMPARISONS, 1997**  
**(NUMBER PER MILLION POPULATION)**

TECHNOLOGY	CANADA	OECD AVERAGE	CANADIAN RANK	SAMPLE SIZE
<i>CT Scanners</i>	8.1	12.9	21	28
<i>Radiation Equipment</i>	5.3	4.2	6	17
<i>Lithotriptors</i>	0.4	1.4	19	22
<i>MRIs</i>	1.7	3.9	19	27
<i>Health Care Spending as a % of GDP</i>	9.3	7.7	5	29

Note: Data is not available for some countries for some technologies.

Source: David Harriman, William McArthur and Martin Zelder, “The Availability of Medical Technology in Canada: An International Comparative Study.” *Public Policy Sources*, No. 28, 2000.



The Fraser Institute study also indicates that Canada lags behind its competitors in terms of the more advanced health care technology. For example, 18 leading-edge technologies - including intraoperative CT scanners and “open” type MRIs - are available in Washington and Oregon, but unavailable in the province of British Columbia.

According to the study, the low availability of health care technology in Canada has translated into limited access to care and lengthened waiting times. For example, waiting times for CT, MRI and ultrasound scans are relatively long and are growing. In particular, the current waiting time for an MRI is 12 weeks and 5 weeks for a CT scan. Overall, waiting times have grown by more than 40% since 1994.

Availability is not the only issue with respect to health care technology. The “aging” of that technology is also of concern. For example, information provided to the Committee indicates that between 30% to 63% of imaging technology currently used in Canada is outdated (see Table 3.3). The outdated nature of the health care technology depends on both the number of years in usage and the relative effectiveness of the equipment in terms, for example, of the quality of the image or the dose of radiation.

*Many of our standard x-ray machines and other machines in the hospitals are functionally inadequate at this point because they are simply too old to do the job for which they were designed. It has become quite common to see duct tape holding our equipment together. It has become a joke amongst us. You see this in the press, but it is true. I have seen it in my own hospitals and my own area of work.*

*Dr. John Radomsky, president  
CAR (5:7)*

**TABLE 3.3**  
**OUTDATED RADIOLOGY EQUIPMENT**

<b>EQUIPMENT TYPE</b>	<b>PERCENTAGE OF OUTDATED EQUIPMENT</b>
<i>General radiography</i>	63%
<i>Fluoroscopy</i>	63%
<i>Ultrasonography</i>	53%
<i>Angiography</i>	50%
<i>Mobile radiography</i>	50%
<i>CT</i>	39%
<i>Nuclear medicine</i>	34%
<i>Mammography</i>	32%
<i>MRI</i>	30%

Source: Canadian Association of Radiologists, *Timely Access to Quality Care – the Obligation of Government, the Right of Canadians*, Brief to the Committee, March 2001, p. 4.

The Committee was told that the shortage of new technology and the use of outdated equipment impede exact diagnosis and inhibit high quality treatment. This situation, which can negatively impact on the health of a patient, also raises concerns about the liability of the health care providers. When he appeared before the Committee, Dr. John Radomsky, president of the Canadian Association of Radiologists (CAR), provided the following example:

*Several machines in one of our hospitals are approximately eight to ten years old. They were once state-of-the-art machines. They are maintained to that standard. However, when I find a breast cancer with my newer ultrasound machine in the office, I cannot find that same cancer with the eight-year-old machine in the hospital. Therefore, I cannot perform a biopsy on it. We have to use some other test or send the patient to some other facility, thereby increasing the cost, the anxiety, as well as inconvenience of the patient.(...) There is the potential to miss something that will be hazardous to the patient, and that puts us in an untenable position.<sup>78</sup>*

It is not clear why Canada is not introducing and making use of health care technologies at the same pace as other OECD countries and why it does not routinely replace aging equipment. Indeed, many factors seem to contribute to this situation:

- On the one hand, Canada imports most of its health care technology. This contrasts sharply with countries such as Germany, France and the United States which have a strong health care technology industry. It may be easier and less costly to purchase new equipment from a domestic manufacturer than from an offshore supplier.
- On the other hand, investment in health care necessarily implies that trade-offs have to be made between health care technology and other health care goods and services. For example, while Canada is far behind other countries in terms of the availability of “hard” technology, if we include drugs in the definition of technology, then Canada does not do so poorly. Therefore, we might invest relatively less in health care technology, but relatively more in other health care goods and services.
- Moreover, the process for assessing health care technology is separated from the decision-making process for purchasing such technology. It is difficult for assessment agencies to have any influence on the purchase of health care technologies when the decisions are made at other levels of the health care system.
- But most importantly, fiscal pressures faced by all levels of government throughout the 1990s have resulted in low levels of capital investment in Canada’s health care system.

The federal government is well aware of the deficit in health care technology. In September 2000, it announced that it would invest a total of \$1 billion in 2000-01 and 2001-02, to assist provinces and territories in the purchasing of new medical equipment. This funding was made available upon passage of the legislation in October 2000, allowing provinces and territories to start making immediate acquisitions of necessary diagnostic and clinical equipment. Although the medical community has welcomed this injection of new federal funds, a number of concerns remain:

- Some provinces have not applied for their share of this fund, possibly because the federal government requires matching grants.

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<sup>78</sup> Dr. John Radomsky, CAR (5:32).

- There is no apparent accountability within the provinces as to exactly where that money is going to be spent.
- This funding is not distributed equitably among health care facilities. For example, CAR told the Committee that all federal government funding in the province of Ontario is being directed toward hospitals, although approximately 50% of all radiology testing is conducted outside of the hospital sector, by community-based independent health care facilities.
- Additional resources are required to operate the equipment. CAR estimates that a \$1 billion investment in new equipment necessitates some \$700 million to cover operational costs.
- This investment does not address the problem of the old equipment that needs to be upgraded. According to the CAR, this would require an additional \$1 billion investment.
- This new funding does not enable Canada to rank at a level comparable to that of the other OECD countries.
- Finally, this funding is not subject to any requirement for health care technology assessment.

*The recent influx of new health care funding from the federal government has been welcomed by provincial payers, as well as those working in the system. However, it also means that it is important now, perhaps more than ever, to pay attention to how these funds are spent, by using an approach that is based on closely examining the evidence behind the many products and services competing for the public health care dollar.*

CCOHTA, Brief, p. 4.

The Committee was told that the aging of the Canadian population as well as increased public expectations will have a great impact on the future needs for health care technology. Overall, witnesses suggested that the current deficit in health care technology requires a serious re-evaluation of the way in which equipment is supplied, funded and provided in Canada. They also stressed that health care policy-makers must forecast future needs and develop an appropriate plan for action.

Witnesses underlined, however, that providing the health care sector with all the technology it needs would not solve all the problems because there is not an appropriate level of professionals to operate that equipment. In their view, there is a need to increase the number of professionals, retain those that we have and bring back some of the people who went to the United States or other countries. This issue is discussed in more detail in Chapter Six, which deals with the availability and distribution of human resources in health care.

*As the proportion of elderly people increases, the demand for imaging procedures likely will also increase. As many diseases are more prevalent in the elderly, more medical imaging procedures, per capita, are performed on adults than on children; an on older rather than younger adults.*

CAR, Brief, p. 8.

### 3.2 Health Care Technology Assessment

Technology assessment refers to the production and analysis of evidence on the safety, clinical effectiveness and economic efficiency of health care technologies. Health care technology assessment (HTA) often also considers the social, legal and ethical implications of the use of health care technologies. HTA can be undertaken at various stages of a technology's lifecycle. HTA contributes in many ways to the knowledge base for improving the quality of health care: it can ensure that health care technologies are effective, that they are applied in the appropriate cases and conditions, and that the least costly technology is used to achieve a particular outcome. Moreover, HTA can assist in deciding whether a new technology should be introduced or when an existing technology should be replaced.

*Health Technology Assessment (HTA) is the process of evaluating medical technologies (devices, equipment, procedures and drugs) and their use. HTA researchers collect, synthesize and critically evaluate the available research on medical technologies. Based on an interdisciplinary approach, an assessment can encompass analyses of safety, efficacy, effectiveness, quality of life and patient use. Other important factors such as economic, ethical, and social implications and other effects which may be unintended, indirect or delayed, may also be considered.*

CCOHTA, Brief, p. 2.

In recent years, the federal and provincial governments have supported the creation of various health care technology assessment agencies. The first provincial HTA agency in Canada was established in 1988 in Quebec – the *Conseil d'évaluation des technologies de la santé du Québec*. A national agency, the Canadian Coordinating Office for Health Technology Assessment (CCOHTA) was established in 1989. The British Columbia Office of Health Technology Assessment was established in 1990. The Health Technology Assessment unit of the Alberta Heritage Foundation for Medical Research was established in 1996. Health services utilization agencies, with close links to their respective provincial governments, which undertake some HTA activities, have been formed in Manitoba, Ontario and Saskatchewan. At the national level, CCOHTA plays a role of coordination of all HTA activities across jurisdictions, and it attempts to minimize duplication with other national and provincial organizations.

The Committee was told that, despite the work performed by these agencies, not enough attention is devoted to HTA in Canada. On a worldwide basis, Canada spends less in HTA activities than other countries. Dr. Jill Sanders, president and CEO of the CCOHTA, mentioned that while CCOHTA invests some \$4.3 million, with some additional funding from provincial governments (about another \$3 million), the United Kingdom provides some \$100 million. Therefore, health care technologies are often introduced into Canada's health care system with only superficial knowledge of their safety, effectiveness and cost.

David Feeny<sup>79</sup> told the Committee that, while the volume and scope of HTA in Canada has increased in recent years, the reports generated by the HTA agencies rely heavily upon the synthesis of existing evidence. In his view, these agencies have lacked the resources to fund large-scale studies and, in particular, to conduct randomized controlled clinical trials. Furthermore, the social and ethical implications of health care technologies have received relatively little attention in the work of Canadian agencies.

<sup>79</sup> David Feeny, Brief to the Committee, pp. 5-6.

Professor Feeny also argued that if the goal of the health care system is to maintain and improve the health status of Canadians, then more needs to be done in assessing how health care technology can have an impact on health-related quality of life (HRQL). He suggested that the increased use of outcome measures such as HRQL would have the potential to enhance substantially the accountability and transparency of the health care system.

Martin Zelder, Director of Health Policy Research at the Fraser Institute, suggested that Canada should use the results of HTA undertaken offshore. Other witnesses cautioned, however, that we cannot simply translate the results of HTA studies realized elsewhere. The application of foreign research is complicated by certain factors such as differences in demography and patterns of disease, differences in the costs of various health care resources, and differences in patterns of practice.

According to Dr. Radomsky, HTA in Canada remains in the realm of academia and government, and it does not filter down to the grassroots users. In his view, health care providers need to work with experts in HTA to develop clinical practice guidelines that will allow them to use the equipment more efficiently and effectively. Therefore, there is a need for more collaboration and multidisciplinary work. In the same vein, Dr. Sanders suggested that decision-makers be involved in the design, execution, and interpretation of evaluative studies and HTA activities. This would help getting the evidence gained from HTA activity into the formulation of public policy with respect to health and health care.

*If governments are not assisted with information regarding the relative safety and efficacy of competing treatment alternatives that may vary widely in cost, there is a great potential for taxpayer dollars to not be used appropriately.*

CCOHTA, Brief, p. 3.

Overall, witnesses pointed to the importance of investing more in HTA and stressed the need to increase the awareness and thus the use of HTA findings.

### 3.3 Impact On Health Care Costs

In terms of spending and effectiveness, there are four different ways that health care technologies can have an impact on the provision of health care. In general, a technology can be: 1) *more* effective and *more* expensive; 2) *more* effective and *less* expensive; 3) *less* effective and *less* expensive; 4) *less* effective and *more* expensive.<sup>80</sup> Unfortunately, however, the Committee was told that the precise contribution of technology to the costs of health care in Canada is not known. Attempts to quantify the connection between technology and rising health care expenditures have suffered from a lack of reliable data. The majority of studies to date have treated technology as a “residual” item, attributing to technology that portion of the increase in health care spending not accounted for by more easily identifiable factors.<sup>81</sup>

<sup>80</sup> British Columbia Medical Association, *Turning the Tide – Saving Medicare for Canadians*, Part I of II: Laying the Foundation for Sustaining Medicare, Background Paper, July 2000, pp. 31-34.

<sup>81</sup> Konrad Fassbender and Melinda Connolly, *An Empirical Review of Health Expenditures and Technology – Part 2 of 5: Literature Review*, Institute of Health Economics, University of Alberta, Working Paper Series no. 00-08, 2000 (<http://www.ipe.ab.ca>).

Therefore, we do not know how much Canada spends on health care technology nor do we know how health care technology has an impact on the health and quality of life of Canadians. It is not possible to know whether the cost of health care technology represents an “add-on” or whether it is offset by reductions in the actual costs of the treatments they permit. Witnesses unanimously pointed to the need to undertake research in this area.

### **3.4 Committee Commentary**

The Committee is concerned by the shortage in health care technology and the impact this might have on waiting lines. In our view, timely access to diagnosis and treatment is a crucial objective that must be ensured in Canada’s health care system. In this perspective, we applaud the investment by the federal government to help the provinces and territories in the financing of new medical equipment. It is our hope that the various concerns raised during the hearings regarding the use of these new funds be addressed in a timely manner.

Nevertheless, the Committee agrees with witnesses that technology assessment is a critical activity and that more HTA needs to be undertaken when considering the introduction of a new technology or the replacement of existing medical equipment. The Committee is also aware that there is currently an under-production of relevant and timely information on the costs and consequences of the use of health care technologies and that more research in this area would greatly benefit the whole health care system. The federal government, through its role in financing innovative health research, should devote more funding to the assessment of new and existing health care technologies.

## CHAPTER FOUR:

### DISEASE TRENDS

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The 20<sup>th</sup> century revolution in health care has significantly altered the pattern of diseases, with the causes of mortality shifting away from infectious diseases and towards non-communicable diseases. Chronic diseases, such as cancer and cardiovascular disease, are now the leading causes of death and disability in Canada, while accidental injuries are the third most common cause of death. However, some infectious diseases once thought to have been conquered – such as tuberculosis – are re-emerging and antibiotics are becoming increasingly ineffective against them. Rapid international transport of foods and people also increases the opportunities for the spread of infectious diseases.

The incidence of illness and trends in diseases greatly differs between men and women and within sub-populations such as Aboriginal peoples, children and youth, as well as between different socio-economic groups. The economic burden of disease is significant and must be seen to include not only direct health care costs, but also lost productivity and lower quality of life.

There are concerns that new diseases and increasingly prevalent illnesses may have a significant impact on the current and future costs of health care. However, many of the causes of disease, disability and early death are preventable. It has been suggested that increasing efforts in the area of health promotion and disease prevention, with a particular focus on Canadians with low incomes and low levels of education, must remain key areas in public policy if we are to improve overall health status and contain health care costs.

#### 4.1 Trends In Diseases

The leading causes of death have changed dramatically over the 20<sup>th</sup> century (see Table 4.1). In the early 1920s, heart and kidney diseases were the leading causes of death. The next most common causes were influenza, bronchitis and pneumonia, followed by diseases of early infancy. Tuberculosis took more lives than cancer. Intestinal illnesses such as gastritis, enteritis and colitis, and communicable diseases such as diphtheria, measles, whooping cough and scarlet fever, were also among the leading causes of death.

**TABLE 4.1:  
LEADING CAUSES OF DEATH  
(RATE PER 100,000)**

<b>1921-25</b>	
Cardiovascular and renal disease	221.9
Influenza, bronchitis and pneumonia	141.1
Diseases of early infancy	111.0
Tuberculosis	85.1
Cancer	75.9
Gastritis, duodenitis, enteritis and colitis	72.2
Accidents	51.5
Communicable diseases	47.1
<b>ALL CAUSES 1,030.0</b>	
<b>1996-97</b>	
Cardiovascular diseases (heart disease and stroke)	240.2
Cancer	184.8
Chronic obstructive pulmonary diseases	28.4
Unintentional injuries	27.7
Pneumonia and influenza	22.1
Diabetes mellitus	16.7
Hereditary and degenerative diseases of the central nervous system	14.7
Diseases of the arteries, arterioles and capillaries	14.3
<b>ALL CAUSES 654.4</b>	

Nota: Disease categories not identical over time. Rates in 1996-97 are age-standardized. Source: Susan Crompton, "100 Years of Health," *Canadian Social Trends*, Statistics Canada, Catalogue 11-008, No. 59, Winter 2000, p. 13.

Public health programs, combined with the large-scale introduction of vaccines and antibiotics, have led to a major shift in the pattern of diseases. Today, although cardiovascular disease remains the leading cause of death among Canadians, its impact on mortality has declined dramatically over the past 70 years, probably reflecting changes in lifestyles (reduced levels of smoking, lower-fat diets, more exercise) and improvements in treatment (new drugs and improved medical/surgical techniques). In contrast, cancer has become the second cause of death in Canada, compared to fifth in 1921.

#### **4.1.1 Infectious Diseases**

Dr. Paul Gully, Acting Director General at the Centre for Infectious Disease Prevention and Control (Health Canada), told the Committee that although some infectious diseases have been controlled or virtually cured, many infectious diseases persist. Indeed, he stated that: "since 1980, the death rate from infectious diseases in Canada has increased."<sup>82</sup>

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<sup>82</sup> Dr. Paul R. Gully, *Infectious disease trends in Canada*, Brief to the Committee, 4 April 2001, p. 2.



Infectious diseases are a significant economic burden, costing more than \$6 billion annually in 1998.<sup>83</sup> Dr. Gully pointed to seven infectious disease trends that threaten Canadians:

- Many infectious diseases, such as AIDS and hepatitis C, persist;
- There are new and emerging disease threats, including mad cow disease and E. coli, as well as the West Nile Virus infection;
- Global travel and migration can introduce new diseases into the population;
- Environmental changes, such as global warming, deforestation, and tainted water, may cause infections, such as Lyme disease;
- Behavioural changes, particularly high-risk sexual practices and drug use, can spread HIV and other diseases;
- Resistance to immunization could cause a resurgence in polio and measles, for example; and
- Anti-microbial resistance may reduce the effectiveness of traditional curative measures.<sup>84</sup>

#### 4.1.2 Chronic Diseases

According to the National Population Health Survey, in 1998-99, more than half of all Canadians, or 16 million, reported having a chronic condition. The most prevalent conditions were allergies, asthma, arthritis, back problems, and high blood pressure.<sup>85</sup> In a written brief to the Committee, Dr. David MacLean, Department Head, Community and Epidemiology, Dalhousie University, noted:

*Chronic non-communicable diseases are the major health burden today in developed countries like Canada. They are by far the most important cause of all mortality, premature mortality, morbidity, and years of potential life years lost in Canada. They are the leading causes of disability, loss of productivity, and deterioration in the quality of life.*<sup>86</sup>

Cardiovascular disease is the major cause of death in Canada, accounting for 37% of all deaths. Mortality from cardiovascular disease has been declining in Canada since 1970 among both men and women, although more slowly in women. Cancer in its many forms is the second-leading cause of death and the leading cause of potential years of life lost before age 70 (over one-third of all potential years of life lost). Cancer is primarily a disease of older Canadians, with 70% of new cancer cases and 82% of deaths due to cancer occurring among those who are at least 60 years old. Cancer death rates have declined slowly for men since 1990, while they have remained relatively stable among women over the same period. However, lung cancer rates for women are now four times higher than they were in 1971.

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<sup>83</sup> Dr. Paul Gully, Brief, p. 5.

<sup>84</sup> Dr. Paul Gully (6:10-11).

<sup>85</sup> Dr. Christina Mills, *Chronic Diseases and Injuries in Canada*, Brief to the Committee, 4 April 2001, p. 4.

<sup>86</sup> Dr. David MacLean, *Addressing the Burden of Chronic Disease in Canada*, Brief to the Committee, 3 April 2001, p. 1.

Witnesses identified some of the factors that are affecting the incidence of chronic disease. More precisely, poor diet, lack of exercise, smoking, stress, excessive alcohol intake, and obesity were all identified as chronic disease risk factors. Dr. MacLean suggested that most chronic diseases - such as cancers, heart disease, diabetes, and respiratory disease - are “entirely preventable” and, moreover, that the social and biological determinants of chronic diseases “can be manipulated.”<sup>87</sup> In his view, however, there is a tendency to focus on curing chronic diseases, rather than preventing them. He said that the most common chronic disease strategy

“has been to deal with the issue largely as a clinical problem with significant health care resources invested in the development of specialized services utilising sophisticated diagnostic and treatment technologies.”<sup>88</sup> Dr. MacLean noted that there is a limited political will to expend resources on prevention because “the outcomes from preventative work are long term. There are no short payoffs. For some parts of the political process, that is not an attractive issue.”<sup>89</sup>

*Eighty-five per cent of Canadians over 65 have at least one modifiable risk factor for cardiovascular disease, and almost two-thirds of Canadians overall have at least one factor for cardiovascular disease. Two-thirds of Canadians lead sedentary lifestyles, and over half are above a healthy weight.*

*Dr. Christina Mills, Director General, CCDPC,  
Health Canada (6:8)*

#### **4.1.3 Injury**

In 1995-96, there were 217,000 hospital admissions due to injury. By far, the highest rates of hospital admissions due to injuries were among Canadians over the age of 65. The rate was lower among people under the age of 45. Falls remain an important cause of injury among seniors and children under 12. Among children, the next most important cause of injury-related admission to hospital in 1996 was poisoning. For adolescents and adults under the age of 65, the second most important cause was motor vehicle crashes. The vast majority of injuries are accidental (about 66%).<sup>90</sup> In her brief, Dr. Christina Mills, Director General, Centre for Chronic Disease Prevention and Control (CCDPC) at Health Canada, indicated that each year, \$9.5 billion in direct costs are the result of injuries, in addition to \$4.7 billion in compensation costs. Most of these injuries are preventable.<sup>91</sup>

#### **4.1.4 Mental Illness**

The National Population Health Survey of 1994/95 found that approximately 29% of Canadians had a high level of stress; 6% of Canadians felt depressed; 16% of Canadians reported that their lives were adversely affected by stress; and 9% had some cognitive impairment such as difficulties with thinking and remembering. Work prepared for the Federal/ Provincial/ Territorial Advisory Network on Mental Health estimated that about 3% of Canadians suffer from severe and chronic mental disorders that can cause serious functional

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<sup>87</sup> Dr. David MacLean (6:14).

<sup>88</sup> Dr. David MacLean, Brief to the Committee, p. 4.

<sup>89</sup> Dr. David MacLean (6:16).

<sup>90</sup> Federal/Provincial/Territorial Advisory Committee on Population Health, *Toward a Healthy Future – Second Report on the Health of Canadians*, Ottawa, 1999, p. 19.

<sup>91</sup> Dr. Christina Mills, Brief to the Committee, p. 10.

limitations and social and economic impairment such as manic depression and schizophrenia. This translates into approximately one in every 35 Canadians over 15 years of age.<sup>92</sup>

Mental stresses and disorders leading to mental illness can strike at different periods of life. Autism, behavioural problems and attention deficit disorder most commonly affect children. Adolescence is typical for the onset of eating disorders and schizophrenia. Adulthood is a time when depression may manifest more obviously. Seniors years are marred by Alzheimer's and other types of dementia although depression is also being identified more often in the elderly.

#### **4.1.5 The Economic Burden of Disease**

According to data provided to the Committee, the total cost of illness was estimated at \$156.4 billion in 1998. Direct costs (such as hospital care, physician services and health research) amounted to \$81.8 billion, while indirect costs (such as lost productivity) accounted for \$74.6 billion. The diagnostic categories with the highest total costs were cardiovascular diseases, musculoskeletal diseases, cancer, injuries, respiratory diseases, diseases of the nervous system, and mental disorders.

The economic burden of mental health problems were estimated at approximately \$14 billion in 1998. Mental illnesses and disorders were the seventh highest among all diseases in terms of the overall cost of illness. It is estimated that mental illness is the second-leading cause of hospital use among those aged 20 to 44, a period of life normally associated with high productivity.

### **4.2 Determinants of Poor or Good Health**

Disease issues are complex. This complexity is attributable to the fact that poor or good health is dependent on a variety of factors such as biology and genetic endowment, as well as the physical environment and socio-economic conditions in which an individual lives. More importantly, it is the interaction among these various factors that can have a significant impact on one's state of health. For example, Dr. MacLean noted: "Illness generally results from the interaction between an individual's genetic make up and broad environmental factors."<sup>93</sup> This was echoed by Dr. Mills who stated that: "many major conditions share common risk factors" and, moreover, risk factors often "cluster together" in individuals.<sup>94</sup>

According to many experts, the most powerful influence on health is socio-economic status. Whether we look at how people rate their own health, premature mortality, psychological well-being or the incidence of chronic disease, socio-economic status remains strongly related to health status. Differences in health status are readily evident in a comparison of the highest and lowest income groups. Canadians with low incomes and low levels of education (which are often related) are more likely to have poor health status, no matter which

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<sup>92</sup> Kimberly McEwan and Elliot Goldner, *Accountability and Performance Indicators for Mental Health Services and Supports: A Resource Kit*, prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Ottawa, Health Canada, 2000, p. 30.

<sup>93</sup> Dr. David MacLean, Brief to the Committee, p. 3.

<sup>94</sup> Dr. Christina Mills (6:6 and 6:8).

measure of health is used, and people's health improves on virtually all measures and in all of the factors that influence health as levels of income and education increase. Canadians with low incomes are also more likely to die earlier than other Canadians, no matter which cause of death is considered. But an active gradient in health status from low to middle and upper levels of income can also be observed in virtually all measures of both mortality and morbidity. In other words, high-income Canadians are more likely to be healthy than middle-income Canadians, who are in turn healthier than low-income Canadians. Indeed, it is estimated that if the same death rates as for the highest income earners applied to all Canadians, over one-fifth of all potential years of life lost before age 65 could be prevented.

### 4.3 The Need For Health Promotion And Disease Prevention

The common thread woven through the witnesses' presentations was the need to invest more in prevention and promotion strategies. They pointed out that currently, there is a tendency to focus on curing diseases, rather than on preventing them. In their view, clinical treatment has been the most common strategy and there has been only a limited political will to expend resources on health promotion and disease prevention, because outcomes from preventive work are generally visible only over the longer term, and are therefore less attractive politically.

*We certainly do not have what could be called a preventative dose of prevention programming in Canada, and there is unfortunately a history dealing with things on a one-off basis.*

*Dr. Christina Mills, Director General,  
CCDPC, Health Canada (6:9)*

Witnesses stressed that with appropriate disease prevention and health promotion strategies, many chronic and infectious diseases, and most injuries, can be prevented. According to Dr. Mills, investing in promotion and prevention is the only way to reverse disease trends and reduce the burden of illness:

*Our only chance to slow or reverse the rate of increase [in the economic burden of disease] is to invest in effective upstream prevention. It is quite well recognized now that failure to prepare for an increased burden due to the aging population is a threat to the sustainability of our health care system, but it is not widely recognized that our failure to invest upstream is an equally great, and perhaps even greater, threat to sustainability.<sup>95</sup>*

*Dr. MacLean echoed this recommendation, noting, "We have not marketed [the Canada Food Guide] at all. We have not spent what Kellogg's spends in a week, on that guide over the past 10 years. These things will not diffuse by osmosis to people. If you want to change habits, particularly in people after they develop them, there is an effort required.*

*Dr. David MacLean, Dalhousie University  
(6:24)*

Witnesses stressed that it is necessary to encourage people to make smart choices with regard to their own health. They suggested that, to date, strategies that attempted to prescribe "good behaviour" have not been entirely successful, and noted that part of the challenge lies in creating an environment that allows people themselves to make the right choices.

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<sup>95</sup> Dr. Christina Mills (6:7).

Prevention and promotion efforts have to be tailored and flexible. There is no “one size fits all” strategy. For example, sexually transmitted disease trends change as sexual practices change and therefore will always require new prevention and promotion strategies. In this regard it is important to ensure that the marketing of health information be current. Witnesses pointed to the Canada Food Guide as an example of a good initiative, but one that has not been marketed effectively or updated and adapted over time.

Strategies must also recognize the link between healthy communities and healthy citizens. For example, people may be less inclined to bike or jog if the streets are unsafe. Successful community-based programs combine an understanding of the community, with the participation of the public, and the cooperation of community organizations. Approaches that address several risk factors and that can produce multiple benefits include support for families at risk, comprehensive school health promotion programs, and comprehensive work health and safety programs.

*We must create healthier communities in Canada because many of the barriers that prevent us from being healthy are in our communities and at the community level.*

*Dr. David MacLean,  
Dalhousie University (6:15)*

Furthermore, because disease and injury are not uniformly distributed across populations, strategies must also look at the linkages between health status and demographic and environmental factors, such as age, race, region of residence, and gender. Strategies must therefore address disease and injury trends among specific demographic groups, such as youth and Aboriginal peoples. For example, suicides and motor vehicle accidents predominantly affect young men and Aboriginal youth. Adults over age 65 are most affected by falls, and accidents are the leading cause of death in children. Strategies must be tailored to the situations of each affected group, and need to be targeted to the groups that will derive the most benefit from prevention.

Many witnesses pointed to the need for intergovernmental cooperation, in order to implement prevention and promotion programs. They noted that all three levels of government should be involved, given the complexity and multiple dimensions of health issues. Dr. MacLean recommended that:

*(...) the federal government use its time-honoured way of influencing provinces, which is the 50-cent dollars. The federal government could start by making a policy priority of trying to increase the infrastructure for prevention because they have to work with the provinces on these issues.*

...

*We have never had a cost-shared process for public health.*<sup>96</sup>

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<sup>96</sup> Dr. David MacLean, Dalhousie University (6:25).

One difficulty that arises with regard to the elaboration of strategies for health promotion and disease prevention is that many diseases usually have several risk factors associated with them. Comprehensive prevention and promotion strategies must therefore address the linkages between risk factors, as well as between health status and socio-economic, demographic, and environmental factors. Approaches that address several risk factors and which can produce multiple benefits include support for families at risk, comprehensive school health promotion programs, and comprehensive work health and safety programs. Approaches like these can be part of a broader population health strategy.

#### 4.4 Population Health Strategy

Witnesses explained that several key issues with regard to population health strategies largely revolve around the difficulties associated with how to translate research evidence into actual policy that can be implemented. In their view, there can be little doubt that population health strategies would result in improved health outcomes, but there remain significant practical obstacles to moving beyond the expression of pious good wishes to the design of concrete programs that are sustainable over the long haul.

In the first place, the multiplicity of factors that influence health outcomes means that it is exceedingly difficult to associate cause and effect, especially because the effects are often only felt many years after exposure to the cause. The Committee was told that this time lag also means that the timeframe for judging the impact of policy in this area is a long term one. Because political horizons are often of a shorter-term nature, this can constitute a serious disincentive for the elaboration and implementation of population health strategies.

Furthermore, as noted earlier, a massive infrastructure that is already in place to deal with the treatment of illness, and this creates many entrenched interests within the system. Witnesses explained that it is not necessarily that people who treat illness have anything against promoting health — the contrary is no doubt the norm. Rather, it is simply that massive resources must be deployed simply to sustain the existing health care infrastructure, making it difficult to find sufficient time, energy and capital to devote to the preventive, or wellness, side of the system.

Moreover, the Committee heard that because of the diversity of the factors that influence health outcomes, it is very difficult to coordinate government activity in the area of population health. Given that the health care system itself is only responsible for a relatively small percentage of the actual determinants of health, the responsibility for population health cannot reside exclusively with the various ministries of health. Yet the structure of most individual governments does not easily lend itself to inter-ministerial regulation of complex problems, and this difficulty is compounded several times over when the various levels of government, along with the many non-governmental players, are taken into account, as they must be.

*It is important to recognize that the social determinants of health are tied and people who suffer the most from [the] diseases are people who fall into lower socio-economic categories. It is also important to link our economic and social policies to health if we want to make a dent in these issues.*

*Dr. David MacLean, Dalhousie University  
(6:15)*

For example, the evidence concerning the existence of gradients of health that correlate with socio-economic levels is quite conclusive. The implication of this fact is that the promotion of population health requires a strong focus on the reduction of poverty. But there are clearly a great number of government policies that have an impact on the levels of poverty in the country and it would be impossible to ask a ministry of health to take charge of all the policy tools that are involved, if for no other reason than this would be rightly seen as a form of ‘health imperialism’ by other ministries. It is also somewhat perverse, as one witness pointed out, to argue for the reduction of poverty exclusively on the health terrain. Any such initiative would have to come about as a result of the overall social policy orientation of government, something that is considerably broader than health policy alone.

Overall, the evidence suggests that population health strategies in general should be carefully thought through so that they take into account the realities facing specific communities. This implies that rigidly-designed programs applied in a uniform and highly centralized fashion are unlikely to succeed. Some combination of coordination and decentralized implementation therefore would seem to be required.

Although there are many difficulties associated with the development of an effective population health approach, the witnesses contended that it is important for the federal government to continue to try to set an example by exploring innovative ways to turn good theory into sound practice that will contribute to improving health outcomes in Canada.

## **4.5 Research**

Many witnesses told the Committee that greater research is needed, particularly in certain areas. Often, money is spent without sufficient epidemiological research to guide where it is invested. For example, billions of dollars have been spent on breast cancer screening programs, but there has been minimal research on the physiology and biology of the disease, or on the intersection of risk factors that contribute to its development.

Dr. MacLean also told the Committee that more research on prevention strategies is needed. He pointed to the budgetary increases for the Canadian Institutes of Health Research (CIHR), but wondered whether or not those new resources would be directed at health promotion and disease prevention research. Dr. Mills noted that CIHR’s expanded mandate offers an “opportunity to support additional research required to determine what is most effective to create lasting behaviour change.”<sup>97</sup>

In terms of chronic disease research, witnesses told the Committee that the problem, essentially, is not a lack of data or research, but a lack of knowledge on how to use that information in the implementation of preventive strategies. In this respect, research is needed to determine how best to share health information with people and, in particular, how best to target that information to those in lower socio-economic groups or those with poor literacy skills.

In terms of infectious disease research, Dr. Gully noted that although resources are being directed to research initiatives, such as the CIHR and the Health Canada laboratory in

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<sup>97</sup> Christina Mills (6:9).

Winnipeg, “it is always difficult to make a bid for contingency funds for new [infectious disease] threats.”<sup>98</sup> He pointed to the difficulty of balancing resources for immediate threats with those for other, less immediate, issues.

With respect to mental illness, witnesses stressed the need to invest more in applied research. In their view, research into mental illness and mental health is vastly underfunded in relation to the economic burden of mental disease and disorder. It was suggested that the federal government should take the lead in promoting a comprehensive research agenda on the mental health issue.

Witnesses indicated that we need to spend more on the infrastructure for disseminating the evidence generated by health research. According to Dr. Gully, federal funding in this area would allow data to be collected from, and shared among, all of the provinces and territories. He pointed to the Internet as a tool for such an undertaking. This idea was echoed by Dr. MacLean, who told the Committee about the Health Promotion web site developed in Nova Scotia, which provides health-related information to users.

#### **4.6 Committee Commentary**

Although the witnesses addressed a wide range of issues, the primary emphasis was on the need to increase disease prevention and health promotion programs. Witnesses noted that the federal government could play an important role in preventing disease and promoting healthy lifestyles. Moreover, they suggested that appropriate, comprehensive, and targeted disease prevention and health promotion programs would have a significant effect on both the health of Canadians and Canada’s health care system. Such programs would improve quality of life, increase productivity, decrease unintentional disability and premature death, and reduce the economic burden of disease.

Canada is one of the healthiest countries in the world, with high life expectancy, low infant mortality rates, and a good quality of life. These successes, however, should not conceal the challenges that persist. Chronic diseases - such as cancer, heart disease, and respiratory problems - are the leading cause of death in Canada. Diseases that had, at one time, virtually disappeared, such as tuberculosis, are re-emerging, and increased international mobility has accelerated the spread of other diseases. Moreover, in 1997, accidents killed more than 13,000 Canadians. Finally, the prevalence of disease varies among different demographic groups and populations, striking, in particular, Aboriginal peoples, and the poor.

A diversity of factors influences health outcomes. Population health strategies are broadly based policies that take all these determinants of health into account with the aim of improving the health of an entire population. The main objective of population health is to ward off potential health problems before they require treatment within the health care system. These strategies can greatly contain the demand for health services and reduce the economic burden of disease.

The Committee concurs with witnesses that the federal government has a definite role in health promotion and disease prevention. Similarly, the federal government has

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<sup>98</sup> Paul Gully (6:26).



been recognized as a leader worldwide in developing the concept of population health. In our view, the federal government should, once again, show leadership in implementing a population health strategy for all Canadians. This is a feasible task, given its current role in many areas that affect health, such as the environment, economic policy, workplace safety, etc.



## CHAPTER FIVE:

### THE HEALTH OF ABORIGINAL CANADIANS

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There are notable disparities between the health of Canada's Aboriginal population and the health of the general Canadian population. The Aboriginal population experiences poorer health, lower life expectancies, higher infant mortality rates and higher rates of some chronic illness. There are also significant socio-economic disparities between Aboriginal people and the general population – unemployment rates are higher and education and average income levels are lower.

This chapter provides a brief demographic, socio-economic and health profile of Canada's Aboriginal population. It also highlights federal programs directed to Aboriginal health and discusses the Aboriginal health policy of the federal government.

#### 5.1 Demographic Profile of Canada's Aboriginal Population<sup>99</sup>

Aboriginal people constitute approximately 3% of Canada's total population. The *Constitution Act, 1982* recognizes three groups of Aboriginal peoples: Indians, Inuit, and Métis. The Indian population includes both status and non-status Indians. The *Indian Act* sets out the legal definitions that apply to status Indians (First Nations) in Canada, that is, Indians who are registered under the *Indian Act*. Non-Status Indians are those who are not registered under the Act. The Inuit population of Canada lives primarily in communities in the Northwest Territories, Nunavut, Nunavik and Labrador. About 6% of Inuit live in southern Canada. Inuit are not specifically covered by the *Indian Act* but receive certain benefits from the federal government. Métis people are of mixed Indian and European ancestry. The Métis are not covered by the *Indian Act* and do not receive Métis-specific benefits from the federal government.

As Graph 5.1 shows, Canada's total Aboriginal population was estimated at 1,398,400 in 2000 and comprised: 28.5% of Status Indians living on reserve, 30.6% of Non-status Indians, 20.8% of Status Indians off reserve, 15.6% of Métis, and 4.5% of Inuit.<sup>100</sup>

Canada's Aboriginal population is diverse. There are over 600 First Nations communities, comprising over 50 nations or cultural groups and more than 50 languages. Approximately 63% of First Nations communities have fewer than 500 residents — 5% have more than 2,000. Although the Inuit communities share the same language, Inuktitut, they have different dialects from one region to another. Most Inuit communities have fewer than 1,000 persons. The Métis have developed their own distinct language, known as Michif, from a

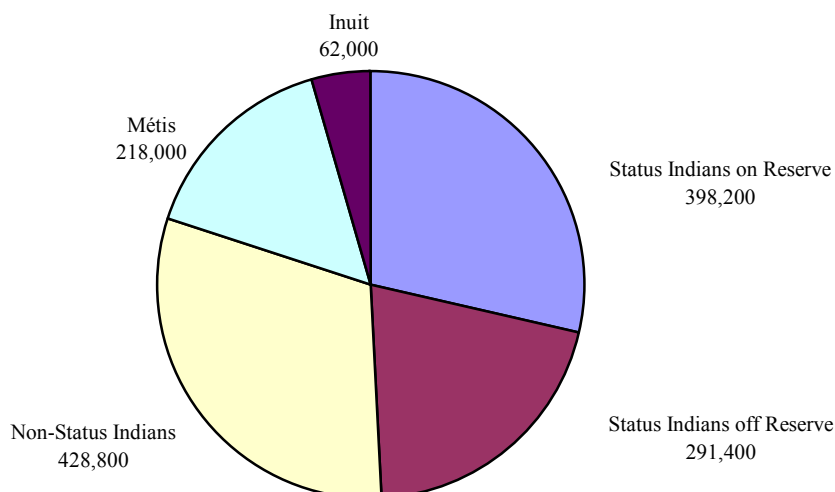
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<sup>99</sup> The demographic information comes from the following three publications: Indian and Northern Affairs Canada and Canadian Polar Commission, *Estimates Part III, 2000-2001*; Statistics Canada, 1996 Census: Aboriginal Data; Health Canada, *A Second Diagnostic on the Health of First Nations and Inuit People in Canada*, November, 1999.

<sup>100</sup> Indian and Northern Affairs Canada and Canadian Polar Commission, *Estimates 2000-2001, Part III, Report on Plans and Priorities*, p. 4.

mixture of French, English, Cree and Ojibway. The Métis population is mainly concentrated in Manitoba, Saskatchewan and Alberta; about 10% of them live in Métis settlement lands.

**GRAPH 5.1:**  
**ESTIMATED ABORIGINAL POPULATION, 2000**



Source: Indian and Northern Affairs Canada and Canadian Polar Commission, *Estimates 2000-2001*, Part III, p. 4.

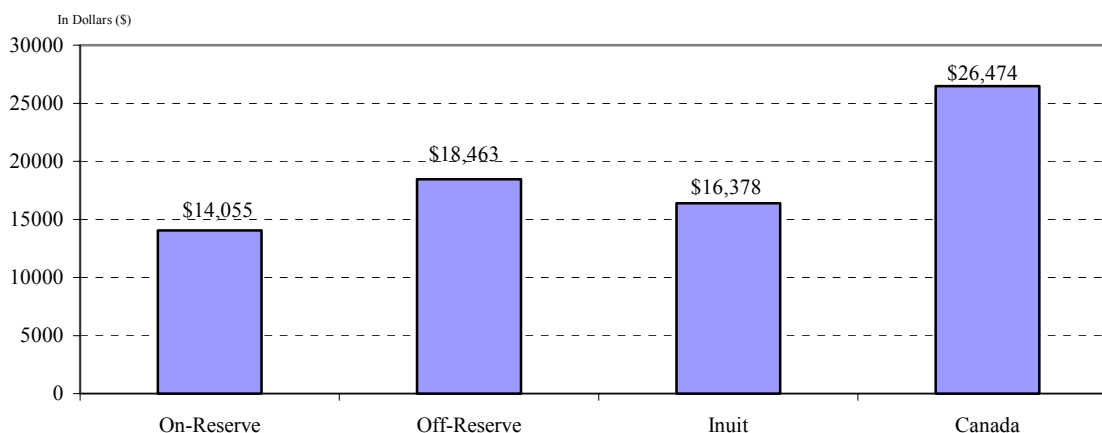
Canada's Aboriginal population is becoming increasingly urbanized. The urban Aboriginal population experienced rapid growth between 1981 and 1991, increasing by 55 percent (compared to an 11 percent increase in urban non-Aboriginal residents). Although its future rate of growth is expected to be slower, the urban Aboriginal population is still anticipated to grow by 43 percent in the next 25 years, from 320,000 in 1991 to 457,000 in 2016. In 1996, about one-fifth of the Aboriginal population lived in seven of the country's 25 largest census metropolitan areas – Winnipeg, Edmonton, Vancouver, Saskatoon, Toronto, Calgary and Regina.

Overall, the Aboriginal population is growing at twice the rate of the Canadian population and is younger on average than Canada's general population. In 1996, the average age of the Aboriginal population was 25.5 years, 10 years younger than the average age of the general population. Children under age 15 comprised 34% of all Aboriginal people, compared to 21% of Canada's total population. Young people in the 15-24 age range constituted a greater portion of the Aboriginal population (18%) compared to the general population at 14%. Seniors currently make up a relatively small proportion of the Aboriginal population in Canada. In 1996, just 4% of people who reported they were North American Indian, Métis, or Inuit were aged 65 and over, compared with 11% of the general population.

## 5.2 Socio-economic Profile and Physical Environment<sup>101</sup>

There are significant socio-economic disparities between Aboriginal peoples and the general Canadian population. Aboriginal peoples are less likely to be in the labour force, and unemployment rates are higher than those of the general population. In 1997-98, the unemployment rate on reserves was almost triple the national rate, and reliance on social assistance was four times the Canadian rate. The Royal Commission on Aboriginal Peoples (1996) reported that the unemployment rate for the urban Aboriginal population was two and a half times greater than that of their non-Aboriginal counterparts. In 1995, the average employment income of the Aboriginal population was \$17,382 compared to the national average of \$26,474. Average annual income from all sources for Aboriginal people in urban areas trailed 33 percent behind that of non-Aboriginal residents.

GRAPH 5.2:  
AVERAGE EARNINGS, 1995



Source: Health Canada, *A Second Diagnostic on the Health of First Nations and Inuit People in Canada*, November 1999, p. 13.

According to the recent report, *Toward a Healthy Future: Second Report on the Health of Canadians*, in 1994 at least 44 percent of the Aboriginal population and 60 percent of Aboriginal children under six years of age lived below Statistics Canada's low income cut off measure.<sup>102</sup> The incidence of poverty among the urban Aboriginal population is high. The 1991 census found that more than 60 percent of Aboriginal households in Winnipeg, Regina and Saskatoon were below the low-income cut-off line. For single-parent households headed by women, the percentage was even higher.

<sup>101</sup> The information relating to the socioeconomic conditions and the physical environment comes from the following publications, unless otherwise indicated. Federal, Provincial and Territorial Advisory Committee on Population Health, *Toward a Healthy Future, Second Report on the Health of Canadians*, 1999, Statistics Canada, 1996 Census: Aboriginal Data; Royal Commission on Aboriginal Peoples, *Final Report*, 1996; Health Canada, *A Second Diagnostic on the Health of First Nations and Inuit People in Canada*, November 1999.

<sup>102</sup> The report also pointed out that these figures likely underestimate the Aboriginal data because some 44,000 people living on reserves and settlements were incompletely enumerated in the 1996 census.

Overall, levels of educational attainment among the Aboriginal population are lower than those of the Canadian population as a whole. In 1996, 54 percent of the Aboriginal population aged 15 years and over did not have a high school diploma. The comparable figure for the non-Aboriginal population was 16 percent. Differences between 1981 and 1996 data show improvement in educational attainment – the proportion of the Aboriginal population with less than a high school education dropped from 59 percent to 45 percent, a greater proportion of the Aboriginal population aged 20 to 29 had obtained a college degree or diploma (23 percent in 1996, 19 percent in 1981) and the proportion of Aboriginal university graduates rose by 1 percent (from 3 percent to 4 percent), but are still below comparable measures for the general Canadian population.

*A Second Diagnostic on the Health of First Nations and Inuit People in Canada* noted that one's “physical environment is an important factor in the exposure to risks such as infectious organisms, chemical and biological contaminants, stress levels, and injury.”<sup>103</sup> The report made the following points about the physical environment of many Aboriginal people:

- Aboriginal people appear to be the largest population sub-group that is the most at risk of becoming homeless in Canada;
- Crowded housing conditions are much more prevalent among the Aboriginal population than among the general Canadian population;
- Significant numbers of Aboriginal people (43%) live in inadequate housing;
- Mold growth is a recently identified issue in aboriginal housing but the full extent and impact on health is not yet known;
- First Nations and Inuit people are more at risk of exposure to environmental contaminants because of their traditional diet of fish and marine mammals;
- Access to clean, safe drinking water and adequate sewage disposal is an issue for a number of Aboriginal communities.<sup>104</sup>

### 5.3 Health Profile of the Aboriginal Population<sup>105</sup>

There are significant differences in health status between the Aboriginal population and the Canadian population. *Toward a Healthy Future: Second Report on the Health of Canadians* noted that the Aboriginal population experiences poorer health than the general

<sup>103</sup> *A Second Diagnostic on the Health of First Nations and Inuit People in Canada*, November, 1999, p, 14.

<sup>104</sup> *Ibid.*, p. 14-18.

<sup>105</sup> Sources include: Federal/Provincial/Territorial Working Group on Aboriginal Peoples and HIV/AIDS, *Making a Difference*, May 1999; Federal, Provincial and Territorial Advisory Committee on Population Health, *Toward a Healthy Future: Second Report on the Health of Canadians*, 1999; Jill Lava and Michael Clark, *Diabetes Among Aboriginal (First Nations, Inuit and Métis) People in Canada: The Evidence*, 10 March 2000; First Nations and Inuit Regional Health Survey National Report 1999; Health Canada, *A Second Diagnostic on the Health of First Nations and Inuit People in Canada*, November, 1999; Assembly of First Nations, Brief to the Committee, 30 May 2001; Inuit Tapirisat of Canada, *Evaluation of Models of Health Care Delivery in Inuit Regions*, 2000; Mr. Gerald Morin, President, Métis National Council, 30 May 2001 (16:29-33).

Canadian population, as evidenced by lower life expectancies, higher infant mortality rates and higher rates of some chronic illness. Many other reports made similar observations:

- Aboriginal people suffer from chronic diseases (hypertension, arthritis, diabetes and heart disease) more so than the general population. Diabetes is one of the leading causes of illness and disability among First Nations. Current evidence indicates that diabetes is more than three times as prevalent in Aboriginal communities as in the general population. The

*(...) the First Nations life expectancy falls somewhere around the 1970 level of all Canadians. (...) To put this in a broader perspective, the life expectancy of First Nations is lower than in all of the 25 countries with the longest life expectancy. Looking at the age-standardized mortality rates, for First Nations men the rate is 1.4 times higher; for First Nations women it is 1.9 times higher. The age-standardized mortality rate for women actually falls somewhere around 1958 levels, when you look at the level for all Canadians. Infant mortality is still two times higher for First Nations relative to all others. We are looking at First Nations women with an infant mortality rate of 11.5, as against the Canadian average of 6. Again, the rates are similar to years in the mid-1970s.*

*Dr. Judith Bartlett (16:58)*

following table of chronic disease rates taken from *A Second Diagnostic on the Health of First Nations and Inuit People in Canada*, illustrates the depth of the chronic disease problem among the Aboriginal population.

**TABLE 5.1**  
**CHRONIC DISEASES**

CHRONIC CONDITION	GENDER	AGE ADJUSTED PREVALENCE (%)		FN&I TO CANADIAN RATIO
		FIRST NATIONS AND INUIT (FN&I)	GENERAL CANADIAN POPULATION	
Heart Problems	Male	13	4	3.3
	Female	10	4	2.5
Hypertension	Male	22	8	2.8
	Female	25	10	2.5
Diabetes	Male	11	3	3.7
	Female	16	3	5.3
Arthritis/Rheumatism	Male	18	10	1.8
	Female	27	18	1.5

Source: Table taken from *A Second Diagnostic on the Health of First Nations and Inuit People in Canada*, November 1999, p. 17.

- First Nations men and women on reserves have approximately three times the rate of heart problems and hypertension compared to the general

Canadian population. (*First Nations and Inuit Regional Health Survey, National Report 1999*).

- Between 1991 and 1996, age-standardized tuberculosis rates were almost seven times higher among First Nations persons living on reserves than the rate for the general Canadian population. The current incidence of TB among First Nations living on reserves is 18 times higher than the rate for the Canadian-born non-Aboriginal population (*A Second Diagnostic on the Health of First Nations and Inuit People in Canada*).
- Despite major improvements since the 1970s, infant mortality rates for First Nations communities continue to be double the rate for Canada as a whole (*Toward a Healthy Future: Second Report on the Health of Canadians*).
- The suicide rate among the Aboriginal population for all age groups is about three times higher than the rate for the population of Canada as a whole (*A Second Diagnostic on the Health of First Nations and Inuit People in Canada*). Among Aboriginal youth, the suicide rate is five to six times higher than the suicide rate of the general Canadian youth population. Data taken from *Evaluation of Models of Health Care Delivery in Inuit Regions* indicate that the suicide rate for Canada's Inuit regions is approximately 6 times higher than the rate for the general Canadian population.
- Alcohol, substance and solvent abuse is common in a number of First Nations and Inuit communities.
- Fetal Alcohol Syndrome/Fetal Alcohol Effects is much higher in some Aboriginal Communities than in other parts of Canada (*A Second Diagnostic on the Health of First Nations and Inuit People in Canada*).
- The rate of deaths due to injuries and poisonings is 6.5 times higher for First Nations and Inuit than for the total Canadian population (*A Second Diagnostic on the Health of First Nations and Inuit People in Canada*).
- A 1999 study reported that the annual number of Aboriginal AIDS cases has increased significantly. In 1996-97, cases had risen to 10% of the total AIDS cases (up from 2% in 1989).<sup>106</sup>
- Smoking is more prevalent in the Aboriginal population. The First Nations and Inuit Regional Health Survey indicates that 62% of adult First Nations peoples living on reserve and in Labrador Inuit communities are smokers and over 70% of all respondents to the survey aged 20-29 were smokers.
- Obesity is a major health problem among the Aboriginal population.
- Approximately 75% of Aboriginal women are victims of family violence and up to 40% of children in some Northern communities have been physically abused by a family member (*A Second Diagnostic on the Health of First Nations and Inuit People in Canada*).

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<sup>106</sup> *Making a Difference*, Report of the Federal/Provincial/Territorial Working Group on Aboriginal Peoples and HIV/AIDS, May 1999.



- Overall, life expectancy rates for Aboriginal peoples are lower by some 6 years than comparable statistics for the general population.
- Many Aboriginal people have reduced access to health care services because of the remote geographical location and small size of several Aboriginal communities. Seventy-seven percent of communities have fewer than 1,000 people and many (44 percent) are found in isolated, semi-isolated or remote-isolated areas of Canada.<sup>107</sup>

## 5.4 Federal Programs Directed to Aboriginal Health

Health care is delivered to Canada's Aboriginal people through a complex array of federal, provincial and Aboriginal-run programs and services. In addition, the framework for the delivery of a number of federal programs is changing as Aboriginal communities, governments and organizations take control over the delivery of health-related programs.

Who delivers what to whom depends on a number of factors such as status under the *Indian Act*, place of residence (on or off-reserve), the location of one's community (non-isolated or remote), and whether Health Canada has signed an agreement to transfer the delivery of certain health services to an Aboriginal community or organization.

In his testimony, Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch at Health Canada, told the Committee that Status Indians (First Nations) under the *Indian Act* are a federal responsibility. The provision of hospital and physician services, however, is a provincial or territorial responsibility. First Nations who reside on reserves are entitled to the general health services provided by the provinces and territories such as hospitals, physician services, and other insured services covered by provincial and territorial health plans. Health Canada, however, provides direct primary care and emergency services on reserves in remote and isolated areas where no provincial services are available. More precisely, the department operates 4 small hospitals, 77 nursing stations and 217 health centres.

Health Canada also provides community-based health promotion and prevention services or funding for such services for First Nations people living on reserves. Regardless of residence (on or off-reserve), First Nations people receive non-insured health benefits (NIHB) funded by the federal government. These benefits include drugs, medical supplies and equipment, dental care, vision care, medical transportation, provincial health care premiums and crisis mental health counselling.<sup>108</sup>

Provincial and territorial governments are responsible for delivering health services to Inuit, but delivery of health services to Canada's Inuit population varies with jurisdiction of residence. In 1988, the federal government transferred responsibility for health administration to the Government of the Northwest Territories. With the creation of Nunavut, the Nunavut government assumed this responsibility for the Nunavut region. The federal

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<sup>107</sup> Health Canada, Brief to the Committee, 30 May 2001; Margaret Horn, National Indian and Inuit Community Health Representatives Organization, Brief to the Committee, 30 May 2001.

<sup>108</sup> National Aboriginal Health Organization, Brief to the Committee, 30 May 2001, p. 1.

government provides funds to the territorial governments to deliver health programs for First Nations and Inuit including non-insured health benefits.<sup>109</sup>

As a result of the James Bay and Northern Quebec Agreement, the federal government transferred responsibility for Inuit health services in northern Quebec to the government of Quebec then to Nunavik. The Nunavik Regional Department of Health and Social Services administers federal and provincial programs in that region.<sup>110</sup>

In Labrador, the province provides health services to all residents and the federal government provides funding to the Labrador Inuit Health Commission through a transfer agreement and contribution agreements for specific projects and for a range of federal programs including non-insured health benefits.<sup>111</sup>

Métis and non-status Indians are not eligible for federal health programs. They receive medical services from provincial and territorial governments on the same basis as other Canadians. Métis and non-status Indians are not included under the *Indian Act* and are not eligible for non-insured health benefits funded by the federal government.

The federal government responsibilities with respect to First Nations and Inuit health services are carried out by Health Canada's First Nations and Inuit Health Branch (FNIHB) (formerly the Medical Services Branch). FNIHB's overall responsibilities include:

- the provision of community-based health promotion and prevention programs to First Nations living on reserves and to Inuit communities (including public health, health education and promotion, as well as strategies to address specific health problems such as alcohol and drug abuse);
- the provision of non-insured health benefits (NIHB) to First Nations and Inuit people regardless of residence in Canada;
- the provision of primary care and emergency services in nearly 200 isolated and semi-isolated areas where no provincial services are readily available;
- public health services in over 400 communities;
- funding addiction services through treatment centres and addiction treatment workers.

Overall, the expenditures of the First Nations and Inuit Health Program for 2000-01 were estimated at \$1.3 billion. About 53 percent or \$677.6 million of this amount was devoted to expenditures on community health services, 45 percent or \$578 million to non-insured health benefits, and 2 percent or \$23.5 million to hospitals.

In his testimony, Mr. Potter outlined several challenges faced by the First Nations and Inuit health programs. These include: an increasing client base; a shortage of doctors and nurses; providing service in remote and isolated communities; maintaining and attracting physicians and nurses to work in isolated communities; difficult access to some

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<sup>109</sup> Inuit Tapirisat of Canada, *Evaluation of Models of Health Care Delivery in Inuit Regions*, 2000, p. 10.

<sup>110</sup> *Ibid.*, pp. 9-10.

<sup>111</sup> *Ibid.*

specialized services; significant cost increases associated with drug benefits, medical technology and transportation; and increases in the rate of chronic diseases that require long-term care and drug therapy.<sup>112</sup>

Working to change the underlying social and economic conditions such as poverty, inadequate housing and low levels of education that are also important determinants of health and achieving better coordination with the provinces were also identified as important challenges.<sup>113</sup>

In addition to Health Canada, eleven other federal government departments offer programs for Aboriginal people. Total expenditures for these programs for 2001-02 are estimated at \$7.3 billion. The vast majority of this money (70 percent) falls under the budget of Indian and Northern Affairs Canada (INAC) followed by Health Canada at 19 percent (\$1.3 billion), Canada Mortgage and Housing Corporation (CMHC) at 4 percent and Human Resources Development Canada (HRDC) at 3 percent. A number of other departments make up the remaining 3 percent.

Indian and Northern Affairs Canada's mandate includes social assistance programs, funding for elementary, secondary and post-secondary education, on-reserve housing, child and family services; and services on reserves such as homemaker services. INAC also funds infrastructure projects in Aboriginal communities. These include water and sewer services, environmental remediation, roads and bridges, fire protection, electrification, education facilities and other community facilities.

Other federal departments are also involved in the funding of a number of Aboriginal business development and workforce participation initiatives.

## **5.5 Aboriginal Health Policy at the Federal Level**

The historic relationship between the federal government and Canada's Aboriginal peoples sets the context for federal policy and initiatives in relation to Aboriginal health. Table 5.2 outlines a number of events in this relationship. In its brief to the Committee, the National Aboriginal Health Organization (NAHO) explained:

*The federal government's policy relationship with Aboriginal groups has seen significant change in the last decade. As little as fifteen years ago, federal Aboriginal resources for health and social programs were directed almost exclusively to First Nations and Inuit communities; non-reserve groups received limited programs from the federal government (examples would be off-reserve housing programs and the Canadian Aboriginal Economic Development Strategy) and indeed these groups were virtually invisible to the Canadian public. Today, the federal government's policy focus remains*

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<sup>112</sup> Ian Potter (16:8-9).

<sup>113</sup> *Ibid.*

*directed to First Nations and Inuit, however, several Aboriginal-wide initiatives have been developed which also involve the non-status, off-reserve and Métis populations.*<sup>114</sup>

**TABLE 5.2**  
**SIGNIFICANT HEALTH POLICY EVENTS:**  
**ABORIGINAL PEOPLES – FEDERAL GOVERNMENT**  
**RELATIONSHIP**

YEAR	EVENT	DESCRIPTION
1867	<i>Constitution Act, 1867</i>	Gave the federal government jurisdiction over “Indians and Land reserved for the Indians”
1876	<i>Indian Act</i>	Enactment of the federal <i>Indian Act</i>
1939	Supreme Court of Canada decision	Recognized that the term “Indian” in the Constitution includes Inuit
1945	Shift in health services	Responsibility for Indian health services was transferred from Indian Affairs to the Department of National Health and Welfare
1962	Medical Services Branch (now the First Nations and Inuit Health Branch)	The Medical Services Branch was created within the Department of National Health and Welfare to amalgamate Indian Health and Northern Health
1979	Indian Health Policy	Goal: “to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves”. Improvements to the health status of the Indian population should be built on three pillars: 1. community development; 2. the traditional relationship between Indian people and the federal government; and 3. the interrelated Canadian health system, with its federal, provincial, municipal, Indian and private sectors.
1980	Berger Report	Recommended methods of consultation that would ensure substantive participation by First Nations and Inuit people in the design, management and control of health care services in their communities.
1982	<i>Constitution Act, 1982</i>	Recognition of First Nations, Inuit and Métis and enshrinement of existing Aboriginal and treaty rights in the Canadian Constitution
1988	Transfer Policy Approval	Federal Cabinet approved the health transfer policy framework for transferring resources for Indian health programs south of the 60th parallel to Indian control.
1990s	Supreme Court of Canada	Various Supreme Court of Canada decisions with respect to the government’s fiduciary responsibility to

<sup>114</sup> National Aboriginal Health Organization, *An Examination of Aboriginal Health Service Issues and Federal Aboriginal Health Policy*, Brief to the Committee, 30 May 2001, pp. 4-5.

		Aboriginal people
1995	Self-Government Policy	The Government of Canada recognizes the inherent right of self-government as an existing right within section 35 of the <i>Constitution Act, 1982</i> . Health is one of the subject matters that could be covered in self-government negotiations.
1996	Report of the Royal Commission on Aboriginal Peoples (RCAP)	Report made a number of recommendations in relation to Aboriginal health. Aboriginal health and healing systems should embody the following characteristics: <ol style="list-style-type: none"> <li>1. equity in access to health and healing services and in health status outcomes;</li> <li>2. holism in approaches to problems and their treatment and prevention;</li> <li>3. Aboriginal authority over health systems and, where feasible, community control over services; and</li> <li>4. diversity in the design of systems and services to accommodate differences in culture and community realities.</li> </ol>
1998	<i>Gathering Strength: Canada's Aboriginal Action Plan</i> -- Federal government response to the RCAP report	<i>Gathering Strength</i> focuses on: Renewing the Partnerships with Aboriginal people; Strengthening Aboriginal Governance; Developing a New Fiscal Relationship; Supporting Strong Communities, People and Economies

The Committee was told that federal Aboriginal health policy has followed a continuum that reflects developments in both the Canadian health care system at large and the evolving relationship between the federal government and Aboriginal people. During the first half of the 20<sup>th</sup> century, federal Aboriginal health initiatives focused on medical care, rather than on providing comprehensive services to the First Nations and Inuit populations. This included the operation of nursing stations, health centres and hospitals. With the introduction of universal Medicare, the provision of public health and preventative measures rather than the delivery of direct health care became the main emphasis of federal Aboriginal health activities, although Health Canada has continued to provide primary health services in remote and isolated areas. For the most part, however, federal Aboriginal health initiatives are limited to First Nations and Inuit. Métis and non-status Indians benefit from only a limited number of federal programs.<sup>115</sup>

The federal Indian Health Policy 1979 established the general policy framework for the provision and payment of health services by the federal government to First Nations and Inuit. The stated goal of the Policy is “to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves”. The Policy provided that improvements to the health status of the Indian population should be built on three pillars:

<sup>115</sup> NAHO, Brief to the Committee, 30 May 2001, p. 5. These initiatives include Aboriginal Diabetes Initiative, Aboriginal Healing Foundation, National Aboriginal Health Organization, Aboriginal Head Start.

1. community development (socio-economic and cultural/spiritual) in order to remove the conditions which limit the attainment of well-being;
2. the traditional trust relationship between Indian people and the federal government; and
3. the Canadian health care system, with its federal, provincial, municipal, Indian and private sectors.

Another important feature of the Policy was the recognition that First Nations and Inuit communities could take over the administration of their own community health programs. To achieve this objective, in the mid-1980s the federal government began to emphasize the transfer of control over health services to First Nations and Inuit communities and organizations.

Table 5.3 shows the status of transferred communities as of March 31, 2000 and the projected transfers to 2005. The total number of eligible First Nations/Inuit communities is 599. As of fiscal year end 1999/2000, a total of 276 (46 percent) of these communities had signed a Health Services Transfer Agreement.

**TABLE 5.3:**  
**HEALTH SERVICES TRANSFERS**

<b>TRANSFERS BY REGIONS/COMMUNITIES</b>					
<b>Region</b>	<b>Total Eligible Communities</b>	<b>Transfers as of March 31, 2000</b>		<b>Projected Transfers to March 31, 2005</b>	
	<b>Number</b>	<b>Number</b>	<b>% Total</b>	<b>Number</b>	<b>% Total</b>
<b>Atlantic</b>	40	20	50	36	90
<b>Quebec</b>	28	23	82	28	100
<b>Ontario</b>	124	38	31	57	46
<b>Manitoba</b>	62	33	53	52	84
<b>Saskatchewan</b>	83	60	72	68	82
<b>Alberta</b>	58	4	7	10	17
<b>Pacific</b>	204	98	49	109	53
<b>TOTAL</b>	<b>599</b>	<b>276</b>	<b>46</b>	<b>360</b>	<b>60</b>

Source: Health Canada, *First Nations and Inuit Control, Annual Report, 1999-2000* (available at [http://www.hc-sc.gc.ca/msb/pptsp/annual\\_e.htm#T3](http://www.hc-sc.gc.ca/msb/pptsp/annual_e.htm#T3)).

## **5.6 Barriers to Aboriginal Health and Wellness**

During the hearings, witnesses outlined a number of jurisdictional and structural

*All of the provinces are at different levels with their involvement in providing health programming to Aboriginal people.*

*Dr. Judith Bartlett, National Aboriginal Health Organization (16:59)*

issues in relation to Aboriginal health services that have the effect of impeding or denying access to appropriate health care services.

Jurisdictional barriers to the provision of health services to Aboriginal people exist on two levels. The first barrier arises from the division of powers between the federal and provincial governments. Provincial governments provide equal access to health care services under the *Canada Health Act* for all residents including First Nations living on reserves and Inuit but take the position that the federal government is responsible for certain health services to Aboriginal persons who are Indians under the *Indian Act* (Status Indians). As a result, witnesses indicated that health services not covered by the *Canada Health Act* but otherwise provided by the provinces may or may not be provided to First Nations and Inuit communities.<sup>116</sup>

Other consequences of having two jurisdictions involved in delivering health services include program fragmentation, problems with coordinating programs and reporting mechanisms, inconsistencies, gaps, possible overlaps in programs, lack of integration, the inability to rationalize services, and impediments to developing a holistic approach to health and wellness.

The second jurisdictional barrier stems from the divisions among Aboriginal peoples that arise as a result of the *Indian Act*. Because Métis and non-status Indians are excluded from the legislation, they are not eligible for most federal programs. The NAHO and the Métis National Council stressed before the Committee that lack of recognition leaves the Métis and non-status populations in a jurisdictional void. For example, Dr. Judith Bartlett noted:

*The division of powers and fragmentation among the various services, service providers and authorities create confusion regarding the services to which Aboriginal people are entitled. It is not just the recipients that suffer, but also the people providing the services and community managers.*

*Michelle Audette, Native Women Association of Quebec (16:38)*

*There are no primary care services specifically targeted to Métis and non-status Indian populations. (...) The Métis and non-status are in a jurisdictional void. They, in fact, are excluded from legislation, and this impacts on their eligibility for programs.*<sup>117</sup>

Similarly, Gerald Morin, President of the Métis National Council, told the Committee:

*Federal and provincial jurisdictional disputes, cultural barriers and geographic isolation ... impede our access to the health care system. Métis communities are facing many of the same health challenges as other Aboriginal communities but the difference is that Métis health issues receive limited and scant attention from the federal government. The fundamental issue at stake for the Métis is the unwillingness of Health Canada to*

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<sup>116</sup> *Ibid.* pp. 7-8.

<sup>117</sup> Dr. Judith Bartlett (16:58-59).

*deal equitably and fairly with the Métis people as one of the indigenous peoples in Canada.*<sup>118</sup>

Witnesses told the Committee about the restrictive nature of the federal health transfer policy that transfers control of federal health programs south of 60° to First Nations and Inuit communities and organizations. It was observed that the NIHB, a program comprising nearly half of Health Canada's funding to First Nations and Inuit, is not eligible for inclusion in the transfer process.<sup>119</sup> Furthermore, the NAHO noted that Health Canada's policy with respect to the transfer of health services to Aboriginal organizations does not include a framework that would "facilitate the integration of federal and provincial services."<sup>120</sup> Again, this creates barriers to program rationalization and the development of a comprehensive approach to Aboriginal health.

Witnessed also pointed out that structural barriers arising from geography, isolation and small community size in rural and remote areas have an impact on access to health services and the comprehensiveness of available services. High turnover rates for health workers, changes in visiting physicians, language, and the lack of integration of traditional and western health systems also constitute barriers. Witnesses stressed that structural barriers are not just confined to rural and remote areas – in urban settings barriers exist as well but may be secondary to issues relating to the cultural appropriateness of care and lack of access due to poverty.<sup>121</sup>

Ron Wakegijig, a healer from the Wikwemikong Health Centre, pointed out that because of the differences between the concerns, issues and requirements of remote, isolated or semi-isolated Aboriginal communities and more urbanized southern Aboriginal communities, national policies developed for all Aboriginal people may not adequately address specific regional concerns.<sup>122</sup>

A number of witnesses emphasized to the Committee that Aboriginal peoples are not a homogeneous group. Inuit witnesses called for this distinctiveness to be recognized in the delivery of health programs and research. Pauktuutit Inuit Women's Association of Canada stressed the importance of meaningful involvement of Inuit in the development of programs and policies that affect Inuit health. Pauktuutit noted that often the terms "Aboriginal health" and "First Nations health" have become one and the same; with the result that programming is not based on the input and needs of Inuit.

*The term "Aboriginal health" is often misunderstood to be synonymous with First Nations Health. That misinterpretation is a reflection of the lack of clear understanding of the Indigenous people of Canada and their three distinct cultures. For Inuit, the impact is most significant in the area of health programming. Aboriginal Health Programming continues to be First Nations focused, too often developed with*

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<sup>118</sup> Mr. Gerald Morin (16:31).

<sup>119</sup> *Ibid.*, p. 9.

<sup>120</sup> NAHO, Brief to the Committee, p. 9.

<sup>121</sup> *Ibid.*, p. 7.

<sup>122</sup> Ron Wakegijig, Brief to the Committee, 30 May 2001, p. 9.



*minimal, if any meaningful Inuit consultation and rarely reflective of the specific linguistic and cultural needs of Inuit. Further, it does not reflect the realities of program delivery in isolated/remote communities nor acknowledge the differences in infrastructure that exist between First Nations and Inuit communities. Programs designed for First Nations are often imposed upon Inuit when, in actuality, alternative, Inuit-specific, community based programming would better meet the needs of Inuit community members.*

<sup>123</sup>

Witnesses involved in the hearings on Aboriginal health stressed that the traditional concepts of health and wellness in all Aboriginal communities are holistic, multifaceted and community focused:

*The First Nations concept of wellness encompasses the four realms of human existence. Some First Nations refer to this concept as “the medicine wheel.” It is believed that well-being and optimum health can only be achieved by addressing not only the physical aspects of health, but also the emotional, mental and spiritual needs of an individual. Those fundamentals make the First Nation view far more holistic than the biomedical model.*

*The medicine wheel illustrates that First Nations people believe that a person is not only a body. If a person is to be healthy or achieve wellness then each of the four aspects of their life must be in balance. Appropriate attention must be given to each of the four aspects of a person. Not only must one be balanced, one must live in a balanced, harmonic community. Harmony must be addressed at all levels of existence and aspects of life. The prevention of illness and the promotion of good health and healthy lifestyles must be addressed through healthy communities and governments.*<sup>124</sup>

Aboriginal people define health and illness in terms of balance, harmony, holism and spirituality rather than in terms of the Western concepts of physical dysfunction and disease within the individual. Aboriginal wellness emphasizes that solutions to health will not be effective until all factors having an impact on a problem are considered. Witnesses suggested that federal Aboriginal health policy must develop a greater focus on prevention, population health and a holistic approach to health that includes health promotion and community-based program planning. For example, the Assembly of First Nations observed:

*Poverty, ill health, educational failure, family violence and other problems reinforce one another. To break this circle, all determinants should be addressed together, in a coordinated strategy, not a piecemeal approach.*<sup>125</sup>

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<sup>123</sup> Pauktuutit Inuit Women’s Association of Canada, Presentation to the Standing Senate Committee on Social Affairs, Science and Technology, May 30, 2001, p. 2.

<sup>124</sup> Elaine Johnson (16:26).

<sup>125</sup> Assembly of First Nations, Brief to the Committee, 30 May, p. 5.

The Committee was told that much of the current research has been focused on First Nations. Dr. Judith Bartlett pointed to the paucity of Métis and Inuit-specific research data. The President of the Métis National Council confirmed that there is a lack of research, data and information with respect to the health conditions and the demographics of Métis people. The Inuit Tapirisat of Canada cited the lack of Inuit-specific health information as a key challenge. Pauktuutit Inuit Women's Association of Canada echoed this concern and noted that problems arise when information from larger data sets is used in the context of another Aboriginal peoples.

*Identifying new and emerging health issues for Inuit is often complicated by a lack of "hard" data and by a reluctance to use innovative anecdotal indicators in research methodology. Inuit-specific health data is spotty at best and often extrapolated from larger pools of Aboriginal data collected mainly in southern Canada. For Inuit to adequately plan and prioritize health issues, for them to identify changing trends in disease, data must be collected by Inuit about Inuit and for Inuit. One prime example is HIV/AIDS surveillance data. Inuit statistics are extrapolations of data collected in two provinces, Alberta and British Columbia, primarily large urban centres. This has resulted in an overwhelming focus on and disproportionate distribution of funding on prevention programs for "Aboriginal" intravenous drug users, which have little, if any, relevance to Arctic Inuit.*<sup>126</sup>

Witnesses also stressed the importance of research on Aboriginal health issues that encompasses Aboriginal-directed and controlled research. Dr. Jeff Reading of the Institute of Aboriginal Health (CIHR) told the Committee:

*Undertaking research can be a significant determinant of health in its own right. It is a determinant of health because people are able to take control over factors affecting their lives. The context of native communities has been one where people outside the community have managed control for a great period of time. Now people have the opportunity to seize control and to start interpreting data about themselves.*

*When people participate in the creation and understanding of knowledge about themselves, they take greater ownership of their health problems and, in so doing, become active in terms of solving those problems. Research is the first step in terms of the drive toward self-determination and improved health status.*<sup>127</sup>

## 5.7 Committee Commentary

The Committee acknowledges that many reports have been written and many suggestions made for changes to benefit Aboriginal people. Repeatedly, this particular

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<sup>126</sup> *Ibid.*, p. 8.

<sup>127</sup> Dr. Jeff Reading (16:61-62).

population of 1.3 million Canadians has been designated by international, national and regional bodies as the most needy in the country. In spite of the breadth of effort being undertaken, the state of health of Aboriginal Canadians and the socio-economic conditions in which they live remain deplorable.

The Committee heard about the various federal health strategies coordinated by Health Canada and the multiple programs managed by Indian and Northern Affairs Canada. Still, an enormous amount remains to be done if we are to reduce disparities in health status and socio-economic disparities between Aboriginal people and the general population. The Committee feels that, given the wide range of programs that the federal government currently manages and given its specific constitutional responsibilities, it must develop population health strategies aimed specifically at Aboriginal Canadians. These strategies must include dealing with economic conditions, environmental issues such as clean and safe drinking water, high-quality and culturally sensitive health care, healthy lifestyle choices, etc. It is also important, as suggested by Ron Wakegijig and others, to consider ways to integrate traditional healing approaches to Aboriginal health with mainstream health care.

Jurisdictional barriers should not be used as an excuse to progress slowly in this field. The Committee believes that these barriers can be overcome rapidly, and that all levels of government – federal, provincial, territorial, municipal, band and settlement – must develop a comprehensive plan that could meet the needs of all Aboriginal people in Canada. The federal Minister of Health should play a leadership role in coordinating such a plan.

The Aboriginal population is young and growing. It is imperative to develop programs that are sustainable in the long-term period. The Aboriginal community is also diverse. Programs must be designed in a way that accommodate differences in culture and community realities.

The Committee believes that undertaking research on the health of Aboriginal people can provide useful information on how to improve service provision and health outcomes. The Committee welcomes the new Institute on Aboriginal Health at the CIHR and believes it is essential that it be provided with a sufficient level of funding.



## CHAPTER SIX:

### HUMAN RESOURCES

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Canada's health care system is a labour-intensive industry. About one in ten employed Canadians work in the health care sector. Many more help to care for their friends and family members. Therefore, our system depends on having a steady supply of appropriately distributed, well-trained and experienced health care providers and committed volunteer caregivers. (The issues concerning volunteer or informal caregivers are presented in more detail in Chapter Nine).

A complex mix of health care providers – comprising more than 30 provincially regulated professional groups – delivers care to Canadians. Table 6.1 shows the total number of licensed health care providers per 100,000 Canadians and the percentage change in these numbers over a 10-year period.

**TABLE 6.1**  
**REGULATED HEALTH CARE PROVIDERS IN CANADA**  
(Number Per 100,000 Canadians and Percentage Change)

	1989	1998	Change
<b>Registered Nurses</b>	809	750	-7.2
<b>Licensed Practical Nurses</b>	301	250	-17.0
<b>Physicians</b>	187	185	-0.5
<b>Pharmacists</b>	67	76	13
<b>Dentists</b>	52	54	4
<b>Physiotherapists</b>	37	49	32
<b>Psychologists</b>	32	40	25
<b>Dental Hygienists</b>	29	46	59
<b>Chiropractors</b>	12	16	33
<b>Optometrists</b>	11	11	0

Source: CIHI, *Health Care in Canada*, 2001.

Nursing is the largest health care profession. In 1998, there were 7% fewer registered nurses and 17% fewer licensed practical nurses than in 1989. Doctors are the third-

largest group of regulated health care providers. The number of physicians per Canadian in 1998 was about the same as ten years before, with only a slight decrease of about a half percent. Other categories of health care providers (except optometrists) substantially expanded their workforce over the same period. Although precise data are not available, an army of informal (volunteer) care providers provide some form of care to someone in their home with a long-term physical or mental illness or who is frail or disabled. Information from CIHI (2001) suggests that the number of informal caregivers has increased over the past decade.

There are no straightforward answers to the question of how many people are currently needed in each field, and there is much less certainty with regard to future requirements. Nevertheless, talk of a ‘crisis’ in health care has a good deal of plausibility in relation to human resource issues. This is particularly true with regard to the situation facing registered nurses (RNs) in Canada. But there are also shortages of other health care providers, in areas ranging from laboratory technologists to pharmacists.

Although it is more difficult to assess the overall situation with regard to physicians, there is nonetheless a long-standing problem of geographical distribution of physicians, with all rural and remote areas having great difficulty recruiting and retaining both general practitioners (GPs) and specialists. The geographic maldistribution of physicians is discussed in more detail in Chapter Ten. As well, certain specialties are experiencing serious shortages.

Without an adequate supply of providers, health care will simply not be available to the extent that Canadians expect and deserve. Questions concerning the supply, retention and management of human resources in health care are complex, broad and often overlapping, but they are of paramount importance in the context of ensuring the sustainability of Canada’s health care system.

Many of the key issues, such as the method and level of remuneration of health care providers, fall largely outside the purview of the federal government. There are nonetheless other concerns - such as inter-provincial mobility, immigration, research funding, and taxation - in which federal policy plays a central role. Because of the interaction between all these factors, it is important to get as complete a picture as possible of human resource issues so that the impact of possible policies at the federal level can be properly understood and assessed.

## **6.1 Physicians**

### **6.1.1 Physician Supply**

The extent to which there is a looming overall shortage of physicians in Canada remains a subject of debate. Figures recently released by CIHI indicate that the number of physicians has increased in Canada over the past five years, from 54,918 in 1996 to 57,803 in 2000.<sup>128</sup> However, while the total number of specialists increased by 7.4 percent, the number of family physicians only grew by 3.2%. Since the Canadian population grew by 3.5 percent over

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<sup>128</sup> CIHI, *Supply, Distribution and Migration of Canadian Physicians, 2000 Report*, Executive Summary, 9 August 2001 (available at <http://www.cihi.ca>).

the same period, the number of family physicians on a per capita basis actually declined slightly (from 95 per 100,000 population in 1996 to 94 in 2000).

Several witnesses stressed the importance of looking beyond the aggregate numbers. Thus, despite the increase in the total number of specialists, witnesses indicated to the Committee that certain specialties are experiencing shortages. For example, Dr. William Dalziel of the University of Ottawa estimated that there is a serious deficit of geriatricians. Similarly, Dr. John Radomsky of the Canadian Association of Radiologists told the Committee that Canada currently has a shortage of about 200 radiologists, and that:

*We simply do not have the manpower to provide the service. In my own practice, we have had to curtail service... to two small institutions because we do not have the manpower to provide them the service on-site. Patients have to travel. They are inconvenienced. In many cases they just do not do it.*<sup>129</sup>

Witnesses told the Committee that physicians are already straining under the workload. Dr. Peter Barrett, President of the Canadian Medical Association (CMA), pointed out that “the average physician in Canada is currently working 53 hours per week and an additional 25 hours per week while on call.”<sup>130</sup> Of even greater concern were the approximately 2,000 physicians who had no shared call, and were therefore “literally on call 24 hours per day, seven days per week, every day, every week, for years at a time.”<sup>131</sup>

Furthermore, the aging of the physician population means that many doctors are no longer willing or able to work the long hours that have become the norm. Dr. Barrett indicated that the average age of physicians rose from 46.4 to 47.5 between 1996 and 2000, and he added that “by 2024, 40 per cent of all active physicians will be over the age of 55.”<sup>132</sup>

At the same time, women have made tremendous strides in changing the profile of the medical profession. Since the mid-1990s women make up over half of the medical students in the country,<sup>133</sup> and the percentage of practising female doctors increased from 25 to over 29 percent of the total between 1993 and 2000. The Task Force on Physician Supply of the Canadian Medical Forum predicts that, by 2015, women will make up 40% of the physician supply. However, data also indicate that female physicians practise fewer hours than their male counterparts, averaging 48.2 hours per week compared to the male average of 55.5 hours per week.<sup>134</sup> As Dr. Barrett pointed out:

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<sup>129</sup> Dr. John Radomsky (5:7).

<sup>130</sup> Dr. Peter Barrett (13:6).

<sup>131</sup> *Ibid.*

<sup>132</sup> Dr. Peter Barrett (13:8).

<sup>133</sup> The Association of Canadian Medical Colleges, *Canadian Medical Education Statistics*, Vol. 22, 2000, Table 8, p. 11.

<sup>134</sup> Canadian Medical Forum, *Task Force on Physician Supply in Canada*, 22 November 1999, p. 11.

*Women traditionally are more caring individuals and have tended to want a better balance in life. We are not seeing that only from the women, though. We are also seeing that from our younger graduates.*<sup>135</sup>

### 6.1.2 Geographic Maldistribution

There was clear agreement during the Committee's hearings on one subject: the persistent geographic maldistribution of physicians across the country. Over the past two decades, studies have repeatedly concluded that this longstanding problem has led to shortages of physicians in rural and remote areas.

*Rural Canada has 9 million people and is growing. It is scattered over 10 million square kilometres. The number of physicians serving this population is proportionately under half of that serving those in the cities.*

*Peter Hutten-Czapski, President, Society of Rural Physicians of Canada (17:12)*

The problem seems to be getting worse, as an increasing number of smaller and medium-sized communities are finding it difficult to ensure a proper supply of physicians. As of October 1999, for example, 99 communities in Ontario had been designated as underserved and were looking for a total of 534 physicians.<sup>136</sup> Many factors have been identified as contributing to the difficulties in encouraging physicians to locate in underserved areas, including the heavy workload, the lack of training in skills needed for rural medicine, professional isolation and lack of interest in rural lifestyle.

The Committee heard evidence suggesting that physicians setting up their practices are more likely to choose rural or remote areas if they come from those backgrounds or if their training has exposed them to the positive challenges associated with locating in these areas. Dr. Thomas Ward, chair of the Federal/Provincial/Territorial Advisory Committee on Health Human Resources, noted that "the single most important determinant as to whether an individual will work in a small community is if they are from a small community."<sup>137</sup>

The supply of physician resources in rural Canada is discussed in more detail in Chapter Ten.

### 6.1.3 Physician Training and Recruitment

During the Committee's hearings, witnesses discussed the issue of whether enough students are being admitted to Canada's medical schools.

In 1991, a report by Barer and Stoddart recommended that enrolment in Canadian medical schools, along with positions in postgraduate training positions, be decreased by 10% in order to deal with a perceived unwarranted increase in physician supply.<sup>138</sup> Despite the report's admonishments that this recommendation not be implemented in isolation from the

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<sup>135</sup> Dr. Peter Barrett (13:8).

<sup>136</sup> Dr Robert McKendry, *Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond*, p. vii.

<sup>137</sup> Dr. Thomas Ward (13:37).

<sup>138</sup> Morris L. Barer and Greg L. Stoddart, *Toward Integrated Medical Resource Policies for Canada*, Prepared for the F/P/T Conference of Deputy Ministers of Health, June 1991.



others it proposed<sup>139</sup> (53 in all), policy-makers did precisely that. As a result, according to data from the Association of Canadian Medical Colleges, the size of first year classes in medical colleges has declined by 16 percent since 1991.

The first-year enrolment in 1997-98 of 1,577 students, or approximately 1 per 19,000 citizens, put Canada well behind other industrialized countries such as the United Kingdom (1 per 12,200 citizens) or Australia (1 per 13,500). According to Dr. Hugh Scully, President of the Task Force on Physician Supply, Canadian Medical Forum: “by 1997, there was less opportunity for a Canadian to go to medical school than for any person in any other developed country in the world for its population.”<sup>140</sup> Although by early 2001 announced increases to undergraduate enrolment totalled 228 new places (a 14 percent increase over 1998) this is still below the entry level of 1983 (the peak year).<sup>141</sup>

While recognizing that “that there has been more movement on the part of the medical schools and the establishment in the last 18 months than in the last 20 years,”<sup>142</sup> Dr. Scully insisted that more progress cannot be made unless additional resources are put into the system, telling the Committee that:

*If we are to have the teachers to do the work and the resources, both capital and physical, that we need, there needs to be some infusion. We think that the federal government can play a significant role in partnership with the provinces and the territories.*<sup>143</sup>

Canada also does not offer as many postgraduate training positions as other countries, with 100 provincially-funded positions for each 100 graduates (compared to 129/100 in the United States and 140/100 in Britain). Dr. Scully pointed out that “we once had a much better capacity than we have at the present time to validate the international graduates who were qualified.”<sup>144</sup>

In the past, Canada has been able to rely on recruitment from abroad to fill some of the gaps. International medical graduates (IMGs) have made significant contributions to Canadian health care. Currently, almost 25 percent of Canada’s physicians received their undergraduate (MD) training outside Canada. IMGs are unevenly distributed geographically and by specialty, accounting for only 12 percent of supply in Quebec but about 50 percent in Saskatchewan. One third of pediatricians, but only 22% of family practitioners are IMGs.

The United Kingdom has been the major source of IMGs. However, other countries now face many of the same shortages that confront our health care system, and there

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<sup>139</sup> The report stated: “isolated policies on undergraduate medical school enrolment may do more harm than good if they are not combined with appropriate companion policies concerning graduates of foreign medical schools, financing of academic medical centres, residency training, and quality assurance, to name only a few.” See p. 6.

<sup>140</sup> Dr. Hugh Scully (13:11).

<sup>141</sup> Canadian Medical Forum, Brief to the Committee, 16 May 2001, p. 3.

<sup>142</sup> Dr. Hugh Scully (13:19).

<sup>143</sup> Dr. Hugh Scully (13:14).

<sup>144</sup> Dr. Hugh Scully (13:12).

does not seem to be much sense to countries endlessly poaching each other's highly trained health care professionals. Dr. Scully insisted on this point:

*Canada traditionally would draw upon the U.K., South Africa, and some of the European countries for its medical graduates. That source has in large part stopped, not all together. Those countries are working earnestly to try to retain their own physicians and make it attractive for them to stay. The sources that we have had are not there.*<sup>145</sup>

Rising tuition fees constitute a major barrier to medical enrolment. Dr. Barrett stated that:

*(...) tuition deregulation has meant that tuition for our students is becoming prohibitive. If we do not do something soon, it will only be the sons and daughters of wealthy Canadians who will be able to go to medical school and choose a career in medicine.*<sup>146</sup>

The Committee was told that rising tuition fees are of great concern for students from rural Canada. For example, Dr. Thomas Ward, Chair of the F/P/T Advisory Committee on Health Human Resources, stated:

*We have seen a dramatic swing in the past four years, in our province, in the distribution of people coming into the medical school. As university tuition has gradually risen, university medical schools are a cash cow for most universities, quite frankly. We have seen that the percentage of students coming from rural Nova Scotia is dropping steadily.*<sup>147</sup>

Dr. Barrett expressed similar concerns in relation to the recruitment of medical students from Canada's Aboriginal populations:

*I will give you an example from my province of Saskatchewan, where we have a huge Aboriginal population. The best way to deliver health care to them would be, especially in consideration of their culture, to have First Nation's health care providers. However, right now our system has barriers that hinder their receiving the necessary education. That is why we need to look at the whole area of post-secondary education. In particular in consideration of tuition deregulation, we must examine who we are educating today.*<sup>148</sup>

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<sup>145</sup> Dr. Hugh Scully (13:17).

<sup>146</sup> Dr. Peter Barrett (13:9).

<sup>147</sup> Dr. Thomas Ward (13:36-37).

<sup>148</sup> Dr. Peter Barrett (13:41).

#### 6.1.4 The “Brain Drain”

Another controversial issue concerns the ‘brain drain’ of physicians, particularly to the United States. Table 6.2 gives figures for the departure and return of physicians. During the period between 1996 and 2000, the number of physicians leaving the country declined significantly, from 1.3 percent of the total physician supply in 1996 to 0.7% in 2000. Of these physicians, the majority were male, specialist physicians. Almost half received their M.D. within the past 10 years. The number of physicians who returned from abroad increased somewhat over the 1996-2000 period. Overall, fewer doctors are leaving and more are entering Canada (except for 2000). However, Canada still experiences a net loss year after year.

The international migration of physicians remains a major concern for many witnesses. Dr. Barrett said that “for every 19 physicians that go south, one comes north,”<sup>149</sup> while Dr. Scully pointed out that “we continue to lose two medical class school equivalents a year as a net loss to the United States.”<sup>150</sup>

**TABLE 6.2**  
**PHYSICIANS MOVING ABROAD AND RETURNING TO CANADA, 1996-2000**

	Moving Abroad	Returning	Net Loss
1996	726	218	508
1997	658	227	431
1998	568	319	249
1999	584	340	244
2000	420	256	164

Source: CIHI, *Supply, Distribution and Migration of Canadian Physicians, 2000 Report*, Executive Summary, 9 August 2001 (available at <http://www.cihi.ca>).

While clearly many factors clearly influence decisions by Canadians to relocate elsewhere, it has sometimes been contended that Canada’s more onerous tax regime drives high-earners to seek more favourable circumstances south of the border. Surveys among doctors, however, indicate that income is usually not the prime motivator for leaving Canada, and that the conditions under which they are able to practise their profession rank higher as a factor. Dr. Scully argued very much along these lines:

*The money is no different in Alberta than North Dakota. It is not a question of money. It is the facility to take care of your patients’ welfare. If we want to attract and retain physicians, we need to work together to ensure that the facilities are there so that*

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<sup>149</sup> Dr. Peter Barrett (13:7).

<sup>150</sup> Dr. Hugh Scully (13:12).

*physicians, nurses and others can work to provide the services that are needed by people.*<sup>151</sup>

In the same vein, Dr. Barrett stated:

*Like other sectors of the economy, if we are going to compete and succeed, we must provide an attractive environment to not only retain but repatriate the physicians who have left. If we are serious about a world class health care system in Canada, we must provide an environment that will attract world-class people and retain the world class people that we train.*<sup>152</sup>

Overall, all witnesses agreed that what was needed was a comprehensive human resources plan. As Dr. Scully pointed out, “there are no quick answers or quick fixes.”<sup>153</sup> In Dr. Barrett’s words:

*We could start with a national strategy because it is a national problem. I realize a lot of health care is delivered provincially and territorially. First and foremost, we need a national plan.*<sup>154</sup>

## 6.2 Nurses

Nurses constitute the largest group of health care providers in Canada, making up almost two-thirds of the total. There are three regulated nursing groups: registered nurses (RNs), licensed practical nurses (LPNs – also known as Registered Nursing Assistants and Registered Practical Nurses), and Registered Psychiatric Nurses (RPNs). Most of the available data refers to the situation of RNs. There are two routes to qualification as an RN: (i) diploma programs offered at community colleges, and (ii) baccalaureates of Science in Nursing at the university level. Around 90% of nurses employed in nursing have a basic diploma education. Some provinces recognize an additional extended classification of nurses, usually referred to as nurse practitioners, but there are no national standards in place, and the term is not a protected designation.

Nurses work in a great variety of settings and perform a wide array of tasks requiring a considerable diversity of skills, ranging from assisting in the treatment of acutely ill patients in a hospital setting, to planning and monitoring home care programs, to organizing and delegating workloads. Recent changes in the organization and delivery of health care have had a significant impact on the types of work being done by nurses and on the numbers of nurses available to perform them.

With the shift towards shorter hospital stays, nurses are treating more acutely ill patients as well as being asked to perform many tasks that might have been done previously by

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<sup>151</sup> Dr. Hugh Scully (13:40).

<sup>152</sup> Dr. Peter Barrett (13:9).

<sup>153</sup> Dr. Hugh Scully (13:14).

<sup>154</sup> Dr. Peter Barrett (13:17).

other hospital staff. For example, a recent study indicates that in Canada over 42% of nurses report performing housekeeping duties, while a similar number (43.6%) report that such essential nursing tasks as comforting or talking with patients are being left undone.<sup>155</sup> Trends in health care technology also mean that nurses must accomplish more complex tasks, under great stress and with shrinking resources. In this regard, Kathleen Connors, President of the Canadian Federation of Nurses Unions, told the Committee that nurses:

*(...) want to nurse in the way that they were educated to nurse. Not only do they want to perform the physical parts of the care, they also want to teach and take the time to sit on the side of the bed of someone who needs to be supported and comforted. They want to counsel, nurture and do all those things on which it is difficult to place a monetary value.*<sup>156</sup>

### 6.2.1 Supply of Nurses

CIHI reports a decline of 7.2% in the number of RNs (per 100,000 Canadians) employed in nursing between 1989 and 1998, while the number of LPNs declined by 17% over the same period (see Table 6.1). According to the Canadian Nurses' Association, there is looming crisis in the supply of qualified nursing personnel. The Association forecasts a shortfall of at least 59,000 nurses in Canada by 2011, but that this shortfall could be as high as 113,000 if all the needs of an aging population are taken into account (Table 6.3).

*The importance and focus of addressing the nursing health human resource issue is imperative. We ignore it at the peril of our health care system. That is the message that we cannot state any more passionately to you as a committee looking at the future of our health care system.*

*Kathleen Connors, Canadian Federation of Nurses Unions (13:79)*

**TABLE 6.3**  
**NUMBER OF EMPLOYED REGISTERED NURSES NEEDED**  
**TO ADEQUATELY MEET DEMANDS IN 2011**

Projected level of demand	Needed	Available	Deficit
Low	290,000	231,000	59,000
Medium	317,000	231,000	86,000
High	344,000	231,000	113,000

Source: Statistical picture of the past, present and future of RNs in Canada, CNA, 1997.

While witnesses acknowledged that the nursing shortage is worldwide in nature (with only Hong Kong registering a surplus of nurses<sup>157</sup>), they also indicated that the severity of

<sup>155</sup> Aiken, Linda et. al., "Nurses Reports on Hospital Care in Five Countries" in *Health Affairs*, May-June 2001.

<sup>156</sup> Kathleen Connors (13:65).

<sup>157</sup> Canadian Federation of Nurses Unions, Brief to the Committee, 16 May 2001, p. 5.

the situation facing nursing in Canada had its origins in the cost containment strategies that were initiated by all governments across the country in the early 1990s. For this reason, they unanimously recommended that more funds be invested in the health care system so that the shortage in nursing resources could be redressed. For example, Régis Paradis, President of the Ordre des infirmières et infirmiers auxiliaires du Québec, argued that “even if the federal government had to take various steps to put its fiscal house in order, we believe that the cuts have been too drastic, carried out without meaningful consultation and also without taking into account the real needs of the public.”<sup>158</sup> Similarly, Sandra MacDonald-Remecz, Director of Policy, Regulation and Research at the Canadian Nurses Association (CAN), affirmed to the Committee:

*If I were to leave with you any message, it is that I believe that investing is extremely important. We need to invest so that we can have the kind of qualified, competent worker within our health system. If you do not have that competent, qualified person, you do not have a health system.*<sup>159</sup>

### 6.2.2 Working Conditions

The shortage of nurses has important consequences both for the delivery of health care and for the working conditions faced by health care providers who have to try to cope with fewer available people. Kathleen Connors noted that “Canada is suffering a nursing shortage that regularly closes emergency rooms and shuts operating rooms,”<sup>160</sup> and added:

*Shifts piling on top of each other take their toll on nurses who might be taking care of your mom or your child. In some cases, we are doing so having worked more than 60 hours in the week... Flight attendants have mandatory time off, but nurses do not. In the end, that is not good for nurses and it definitely is not good for those for whom we care.*<sup>161</sup>

Despite the overall shortage of nursing personnel, full-time employment for nurses has become less common. Sandra MacDonald-Remecz told the Committee that “the period that we have gone through saw a significant move to part-time and casual status.”<sup>162</sup> In fact, the number of nurses working part-time increased by almost 10% between 1990 and 1997 while those in full-time positions declined by about 8.5%. There was also a 37.5% increase in the number of nurses working as casuals over the same period. While it is no doubt true that some nurses prefer part-time work, nonetheless about 19% of nurses employed part-time in 1998 held down more than one job, and very few nurses voluntarily choose casual work.<sup>163</sup>

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<sup>158</sup> Régis Paradis (13:50).

<sup>159</sup> Sandra MacDonald-Remecz (13:63).

<sup>160</sup> Kathleen Connors (13:54).

<sup>161</sup> *Ibid*

<sup>162</sup> Sandra MacDonald-Remecz (13:61).

<sup>163</sup> Dussault, Gilles *et. al.*, *The Nursing Labour Market in Canada: Review of the Literature*, December 1999, p. 25.

The “casualization” of the workforce has also meant that it is increasingly difficult for new nursing graduates to secure permanent positions. This tends to reduce the attractiveness of nursing as a career choice and to prolong the apprenticeship period of new graduates. In this regard, Kathleen Connors pointed out that:

*The situation facing those younger nurses is that of casual or part-time employment opportunities – working for several employers, instead of working full-time for one employer. In 1998, 48 per cent of all nurses in Canada were working part-time. It just should not be.*<sup>164</sup>

According to witnesses, this contributes to a situation where 3 in 10 nurses leave the profession in the first five years after graduation.<sup>165</sup>

This combination of an overall shortage of nursing personnel and under-utilization of trained nurses is also evident with regard to other categories of nursing personnel. For example, Linda Jones from the Nurse Practitioners Association of Ontario told the Committee that “of our 401 graduates, 200 of them are under- or poorly employed as nurse practitioners.”<sup>166</sup> Similarly, Régis Paradis indicated that, “we (...) consider that the skills of Quebec auxiliary nurses are not being fully used,”<sup>167</sup> and that “the solution to the problem of work overload, in addition to putting more money into the system, lies partly in making more use of auxiliary nurses.”<sup>168</sup>

But the deterioration in working conditions for nurses extends beyond the full utilization of the different categories of nursing personnel. According to CIHI, nurses account for over 75% of workplace injuries in health care, stemming mainly from lifting and moving patients. During her testimony, Kathleen Connors indicated that:

*(...) nurses are sicker than any other worker in the country. In fact, 8.4 percent of nurses are absent from work due to illness each week. That is twice the national average.*<sup>169</sup>

Witnesses also raised concerns that there are many ways in which nurses are not being accorded the respect they deserved for their essential contribution to the health care system. Amongst the issues that have been raised as critical to retaining nurses in the profession are appropriate workload, adequate continuing education, career mobility, flexible scheduling and deployment, professional respect and good wages. Witnesses argued that what is needed to retain nurses in the profession in Canada is a comprehensive approach to ensuring a healthy work environment that also allows nurses sufficient autonomy in carrying out their duties and room for ongoing professional development. The Canadian Nurses Association identified seven areas of action needed to retain nurses:

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<sup>164</sup> Kathleen Connors (13:55).

<sup>165</sup> Canadian Nurses Association, Brief to the Committee, 16 May 2001, p.4.

<sup>166</sup> Linda Jones (13:46).

<sup>167</sup> Régis Paradis (13:51).

<sup>168</sup> Régis Paradis (13:65).

<sup>169</sup> Kathleen Connors (13:54).

- Improve work design
- Facilitate use of full scope of practice
- Provide support for professional development and continuous learning via taxes, training and time
- Identify career opportunities and offer career planning
- Support flexible scheduling
- Provide accessible professional supports
- Improve access to research on clinical disease issues and provide time to review and stay up-to-date.

### 6.2.3 Training and Recruitment in Nursing

The Committee was told that there are many difficulties in recruiting enough young people to train as nurses. Witnesses contended that nursing, which remains an overwhelmingly female profession,<sup>170</sup> is no longer as attractive a career option for young women entering university as it was for the previous generations. Sandra MacDonald-Remecz noted that “we have seen a 50 per cent reduction in the number of graduates in nursing over the last 10 years.”<sup>171</sup>

Figures indicate that not only are fewer new nurses entering the profession each year, but those that do are older than previously. The number of new nurses graduating each year was in the 10,000 per year range in the 1970s and in the 8,000 per year range in the 1980s. Since then, each class has become increasingly smaller and only 5,500 nurses graduated in 1995. Witnesses pointed to the solution adopted in the Republic of Ireland, where they waived all tuition fees for nursing students, as being worthy of emulation.

The issue of continuing education for nursing was also raised at the Committee’s hearings. The lack of opportunity for ongoing education was pointed to as part of the problem explaining the attraction of new graduates in nursing to the United States. While no exact figures are available, some media reports have suggested that as many as 20,000 Canadian nurses have been recruited by American hospitals. According to Sandra MacDonald-Remecz:

*(...) when we look at why the Americans are so successful in recruiting our new graduates, we see that it is because they promise continuing education opportunities right from the time they sign on.”<sup>172</sup>*

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<sup>170</sup> According to Kathleen Connors , 96 per cent of nurses are women (13:65).

<sup>171</sup> Sandra MacDonald-Remecz (13:61).

<sup>172</sup> Sandra MacDonald Remecz (13:61-62).



One way of facilitating ongoing education was suggested by Kathleen Connors:

*(...) one of the issues that we continue to promote and hope that there will be support for, is the use of employment insurance dollars. There is a surplus. If skilled trades can access EI dollars to continue to advance their education, why can nurses not do the same thing? We need to look at that. Why does EI prevent access of dollars for post-secondary education?*<sup>173</sup>

Another solution was proposed by Ms. MacDonald-Remecz:

*Signing bonuses are another incentive - which, in a field like health care it sounds almost heretical to be taking on that kind of orientation. However, it is something that many organizations are realizing that they may need to do. In other words, we need to be more aggressive and recognize that people will not just naturally come into the profession.*<sup>174</sup>

### 6.3 Other Health Care Providers

Many other health care providers, from pharmacists to laboratory technologists to ultrasound technicians, have voiced similar complaints to the ones expressed by physicians and nurses over human resource shortages and deteriorating working conditions throughout Canada's health care system.

For example, the Canadian Society for Medical Laboratory Science (CSMLS) predicts a nation-wide shortage of general medical laboratory technologists within the next 5 to 15 years. Moreover, medical laboratory technologists are aging: 12% of the current workforce will be eligible to retire in 5 years, 15.8% in 10 years and another 16.6% in 15 years. By the year 2015, 44.4% of the medical laboratory workforce will either have retired or will be eligible to retire.<sup>175</sup> In its brief, the Society stressed that the number of training positions would have to be increased significantly to avert the shortage of technologists. Medical laboratory technologists also stressed the need for ongoing training to enable them to operate new high-tech equipment. Moreover, the medical laboratory workforce is also experiencing high levels of burnout and fatigue. Finally, the establishment of a national data base was recommended to develop accurate projections of future human resource requirements in health care.

*Chiropractors are mostly neuro-musculoskeletal physicians. They are currently unable to utilize all the tools of the profession and are hampered clinically. We are denied hospital access, sometimes unable to treat lifelong patients who become institutionalized. We are denied x-ray access and access to blood and urine analysis.*

*Dr. Tim St. Denis, President, Canadian Chiropractic Association (13:85)*

<sup>173</sup> Kathleen Connors (13:78).

<sup>174</sup> Sandra MacDonald Remecz (13:61).

<sup>175</sup> Canadian Society for Medical Laboratory Science, Brief to the Committee, 26 April 2001, p. 2.

The Canadian Pharmacists Association also pointed to a current shortage of pharmacists. This shortage is not unique to Canada, but is a problem faced in many countries including the United Kingdom and the United States. The low supply of pharmacists translates into increased numbers of vacancies, longer times to fill vacancies, increases in overtime hours, and wages rising in excess of the cost of living. A recent study suggests that well over 2,000 additional pharmacists could readily find work in Canada.<sup>176</sup> In the context of the growing evidence of drug-related complications, an aging population, and rising public expectations, it is anticipated that pharmacists will be increasingly valued and demanded for their knowledge, skills, and cost-effective contribution to the health care system. The study also mentions that currently available information offers an incomplete picture of the labour market for pharmacists.

Chiropractors' representatives told the Committee about their particular situation. Chiropractic services are not considered as medically necessary under the *Canada Health Act*. Only a few provinces provide public insurance for chiropractic services. The Committee was told that there are over 5,000 practising chiropractors in Canada and that approximately 4.5 million Canadians use their services every year. In its brief, the Canadian Chiropractic Association stated that chiropractors are not being utilized by Canada's health care system in the most effective way. There are policy and legislative barriers to chiropractic services which result in inequitable resource allocation irrespective of patient choice, efficacy or cost-effectiveness. For example, chiropractors do not have hospital privileges, they cannot refer their patients to publicly supported X-ray facilities or diagnostic laboratories, or render services to their patients who may require hospitalization.

## 6.4 Primary Care Reform

Testimony before the Committee by health care providers, particularly physicians and nurses, clearly indicated that a more rational and efficient use of human resources requires a rethinking of the organization and the funding of primary health care delivery in Canada.

"Primary health care" refers to the first level of care, and is usually the first point of contact that people have with the health care system. Primary health care settings support individuals and families to make the best decisions for their health. Primary health care services need to be:

- coordinated;
- accessible to all consumers;
- provided by health care professionals who have the right skills to meet the needs of individuals and communities being served; and
- accountable to local citizens through community governance.

Multidisciplinary teamwork must therefore be a vital part of primary health care. The goal of this teamwork is not to displace one health care provider with another, but rather to look at the unique skills each one brings to the team and to coordinate the deployment of these

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<sup>176</sup> Peartree Solutions Inc., *A Situational Analysis of Human Resource Issues in the Pharmacy Profession in Canada*, Canadian Pharmacists Association, May 2001 (available at <http://www.cdnpharm.ca/>).

skills. Clients need to see the health care provider who is most appropriate to deal with their problem.

The way in which health care is currently delivered in Canada does not normally reflect a primary health care philosophy (although Community Health Centres are an example of organizations that do deliver health services using such a philosophy). Health services are often not coordinated, nor are they being provided by the most appropriate practitioner; as well, the knowledge and skills of many practitioners are not being fully utilized.

The need for significant changes to the way primary health care is delivered has been the principal thrust of the recommendations of a number of provincial health care reviews, notably the Sinclair Commission Report in Ontario, the Clair Commission Report in Quebec and the Fyke Commission Report in Saskatchewan. In fact, the importance of changing the way primary health care is delivered is so widely established that, in September 2000, provincial and territorial governments all agreed to accelerate primary health care renewal.

The federal government is actively supporting the efforts of provinces and territories in primary health care reform and renewal. More precisely, it has established a Primary Health Care Fund of \$800 million over four years (2000-2004) to support the transitional costs of implementing systemic, large-scale, primary health care initiatives. Some 70% of the funds are to be devoted to major provincial and territorial reforms, while the remaining 30% is going to support national and multi-jurisdictional initiatives related to advancing primary health care reform.

Dr. Thomas Ward indicated that Canadians and physicians support the idea of moving towards multidisciplinary primary care teams:

*There was a survey last fall in which, when Canadians were asked if they would rather receive their care from a family physician or from a primary care team that included a family physician, their response was 4 to 1 in favour of the team. They would much rather have a team of health care providers. Our vision for the future is full integration wherever primary health care is provided through practising within interdisciplinary teams.<sup>177</sup>*

The Committee was also told that reform of primary care is clearly central to the possibility for the full deployment of the additional skills possessed by nurse practitioners. Primary health care nurse practitioners are experienced registered nurses with additional nursing education that enables them to provide individuals, families and communities with health services in the areas of health promotion, disease and injury prevention, cure, rehabilitation and support. Their skills include the ability to: provide health screening activities such as PAP smears; to diagnose and treat minor illnesses such as ear and bladder infections or minor injuries such as sprains; to screen for the presence of chronic disease such as diabetes; and to monitor people with stable chronic disease such as hypertension. They function within the full scope of nursing practice and are neither second-level physicians nor doctor's assistants. As Linda Jones, from the Nurse Practitioners Association of Ontario, said:

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<sup>177</sup> Dr. Thomas Ward (13:21).

*A very important...point is the lack of public understanding of the role, impacts and utilization of nurse practitioners. If we are seen as physician replacements – you cannot see your family doctor, you must see your nurse practitioner instead – that will not enhance or increase public acceptance of us.*<sup>178</sup>

While nurse practitioners are an important part of primary health care reform, there remain considerable barriers to their full integration into the system of primary health care delivery. Ms. Jones pointed out that, in Ontario:

*The existing legislation, although we are incredibly excited about the fact that we now have our own autonomy to do our role, leaves us with barriers. For example, the public hospitals act does not allow us to perform our role in hospitals.*<sup>179</sup>

The Committee was told that the barriers are not exclusively legislative or organizational, however. They are also created by the way that money is distributed throughout the health care system, and, in particular, by the overwhelming reliance on fee-for-service payment as the main method for remunerating physicians. Fee-for-service tends to actively discourage physicians from promoting teamwork, as their individual remuneration depends on the number of patients they see. In her testimony, Linda Jones pointed to another way that fee-for-service payment prevents full collaboration amongst health care providers:

*(...), although we have skills and knowledge to refer to medical specialists, the current payment system under OHIP does not give a specialist the full consulting fee if the referral comes from nurse practitioners. Therefore, they decline our referrals.*<sup>180</sup>

The main alternatives to fee-for-service payment are salary- and capitation-based systems, where physician practices are remunerated based on the number of registered patients. William Tholl, Secretary General and Chief Executive Officer of the Canadian Medical Association (CMA), told the Committee that physicians are willing to consider other forms of remuneration:

*The CMA would suggest, as I would also suggest, that the form of payment should follow the functions that you identify for the physician in the system. Clearly, physicians and other health professionals working in rural and remote areas have a different function in the system as compared to those that work in downtown Toronto.*<sup>181</sup>

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<sup>178</sup> Linda Jones (13:47).

<sup>179</sup> Linda Jones (13:46).

<sup>180</sup> Linda Jones (13:47).

<sup>181</sup> William Tholl (17:18).

## **6.5 Committee Commentary**

The Committee is convinced that addressing the issues relating to human resources in health care must be amongst the top health care policy priorities for all levels of government. What is needed is a country-wide, long-term, made-in-Canada, human resources strategy. The federal government could play an important role in coordinating and implementing such a strategy. Of course, not only do the provinces and territories have the responsibility for the delivery of health care to their populations, they are also responsible for education and training. The challenge is therefore to find a way to develop such a strategy in a manner that is acceptable to the provinces and territories.

In the past, the federal government has contributed capital funds toward the creation of new health services training programs, notably in the 1960s when it was involved in the expansion of a number of medical schools. The federal government has also contributed to training programs for some health professionals under the various federal training programs which have existed over the years. Moreover, the federal government, through its support for such institutions as the Medical Research Council and now the Canadian Institutes for Health Research, has helped support graduate students pursuing health research for more than 40 years.

It is important that the federal government continue this involvement in order to help resolve the many health care human resource challenges facing the country. This includes assisting the provinces in their efforts to reform primary health care, because ways of effectively deploying human resources are intimately tied to the reorganization of primary health care.



## CHAPTER SEVEN:

### HEALTH RESEARCH

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**H**ealth research is about creating new knowledge with respect to health and health care. Health research can lead to the development of new or improved drug therapy, treatment, medical equipment and devices; as well, its results provide information on new ways of organizing and delivering health care. Health research contributes to a better understanding of the complex interplay of the determinants that affect our health and susceptibility to disease.

With the creation of the Canadian Institutes for Health Research (CIHR), the federal government expanded its definition of health research. More precisely, it moved beyond its previous emphasis on basic and applied research – mostly biomedical and clinical research activities – to encompass a wider range of disciplines and components. This shift was part of the general movement toward a population health approach that acknowledges that health is broader than health care, as well as a response to the increasing need to obtain evidence-based information to allow for effective health care reform and renewal. Table 7.1 summarizes the four main research components now financed by the CIHR.

**TABLE 7.1**  
**CIHR – THE FOUR COMPONENTS OF HEALTH RESEARCH**

<b>Biomedical research</b>	<i>Pertaining to biological organisms, organs, and organ systems</i>
<b>Clinical research</b>	<i>Involving direct observation of people undergoing medical care</i>
<b>Health services research</b>	<i>Embracing health care delivery, administration, organization and financing</i>
<b>Population health research</b>	<i>Focusing on the broad factors that influence health status (socio-economic conditions, gender, culture, education, etc.)</i>

Research plays a vital role in the field of health and health care. The Committee held two sets of hearings on health research. Testimony was heard with respect to: 1) the role of the federal government in health research; 2) genetics and genomics research as the burgeoning research areas and their implications on health and health care; and 3) the benefits and challenges of health research.

#### 7.1 Federal Role in Health Research

The federal government plays a major role in supporting health research carried out in universities, teaching hospitals and research institutes (extramural research), as well as in its own laboratories (intramural research). According to Kimberly Elmslie, Acting Executive

Director, Health Research Secretariat, Health Canada, the federal government's role in health research and health care research is multi-faceted and includes:

- Setting research priorities;
- Undertaking research in areas related to direct federal responsibilities (e.g., health protection, risk management, Aboriginal health);
- Funding extramural research and related science and engineering research;
- Supporting the training and development of researchers (e.g., through the Canada Research Chairs Program, the CIHR and the other granting councils);
- Funding research infrastructure (through the Canadian Foundation of Innovation);
- Supporting information and systems management (CIHI and Statistics Canada);
- Funding Networks of Centres of Excellence (Industry Canada and Health Canada).<sup>182</sup>

Only a relatively small proportion of federally funded health research is conducted in federal government facilities (less than 20%). Federal facilities in which health research is performed include Health Canada, Statistics Canada, the National Research Council, Human Resources Development Canada and Environment Canada (in partnership with Health Canada). For the most part, health research funded by the federal government is extramural and takes place in universities and hospitals (72%), private non-profit organizations (6%), and business enterprises (1%).<sup>183</sup>

The principal federal funding body for health research is the CIHR (see Table 7.2). In fact, the CIHR is the only federal entity whose budget is entirely devoted to health research. Its creation in 1998 involved the merging of the Medical Research Council of Canada with the National Health Research and Development Program (NHRDP), Health Canada's main financing instrument for extramural health research. Health Canada is also involved in multiple internal research activities, as well as in extramural research, which are all devoted to the health field. There are, however, other research-oriented bodies supported by the federal government along with other partners where the focus is entirely health-related. These include the Canadian Health Services Research Foundation (CHSRF), the Canadian Institute for Health Information (CIHI), and the Canadian Coordinating Office for Health Technology Assessment (CCOHTA).

In addition, several secondary sources of federal health research funding are available. The federal government is responsible for a number of research councils, agencies and programs where only a portion of their budget goes to health-related research. These include the Natural Sciences and Engineering Research Council of Canada, the Social Sciences and Humanities Research Council, the Canada Foundation for Innovation, the Canada Research Chairs, and the Networks of Centres of Excellence (it is worth noting that seven networks, of

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<sup>182</sup> Kimberly Elmslie, Health Research Secretariat (Health Canada), Brief to the Committee, 26 April 2001, p. 1

<sup>183</sup> Sonya Norris, Nancy Miller-Chenier and Odette Madore, *Federal Funding for Health Research*, TIPS 56E, Parliamentary Research Branch, Library of Parliament, 11 December, 2000.



the currently-funded 18 NCEs, conduct health research in the fields of: arthritis, bacterial diseases, vaccines and immunotherapeutics for cancer and viral diseases, stroke, health evidence application, genetic diseases, and protein engineering).

**TABLE 7.2**  
**Primary Sources of Federal Health Research Funding in 2000**

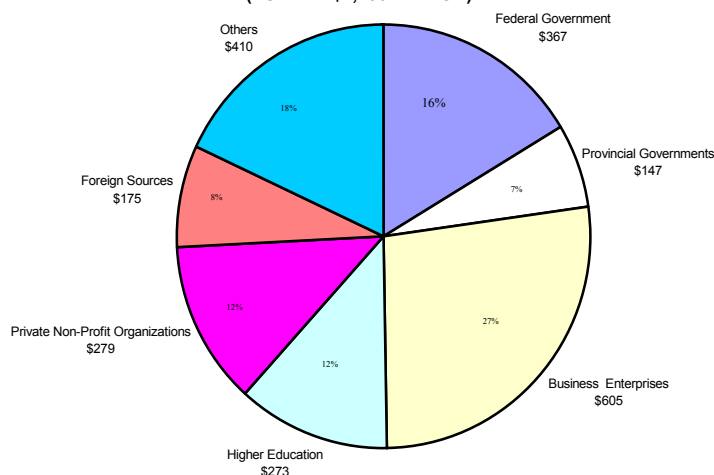
<b>Primary Federal Funding Source</b>	<b>Date Established</b>	<b>Federal Contribution in or around 2000</b>
Canadian Institutes of Health Research	2000	\$402 annual
Health Canada Health Transition Fund	1997	\$150 million for 3 years
Health Canada Population Health Fund	1999	\$14 million annual
Health Canada Canadian Health Infostructure Partnerships program (CHIPP)	2000	\$80 million over 2 years
Health Canada Centres of Excellence for Children's Health	2000	\$20 million over 5 years
Health Canada Centres of Excellence for Women's Health	1996	\$12 million over 6 years
Canadian Health Services Research Foundation (CHSRF)	1996	\$65 million over 5 years
CHSRF Nursing Research Fund	2000	\$2.5 million annual (for 10 years)
Canadian Institute for Health Information (CIHI)	1994	\$328 million over 3-4 years (1999-03)
CIHI Canadian Population Health Initiative	1999	\$20 million over 4 years (1999-03)
Canadian Coordinating Office for Health Technology Assessment	1989	\$3.7 million (2000) - \$4.34 million per year (2001-04)

Source: Sonya Norris, Nancy Miller-Chenier and Odette Madore, *Federal Funding for Health Research*, TIPS 56E, Parliamentary Research Branch, Library of Parliament, 11 December 2000.

Overall, the federal government plays an important role in funding health research in Canada. Graph 7.1 indicates that, in 1998, almost \$370 million of federal funding was allocated to health research. This was prior to the establishment of the CIHR. However, the proportion of health research funding provided by the federal government declined steadily from a high of 28% in 1992 to 16% in 1998. Since 1994, the pharmaceutical industry has been

the leading source of funds for health research. The federal government believes that its position in terms of health research funding will greatly improve as a result of the establishment of the CIHR along with additional investment announced in both the February 2000 budget and the October 2000 Economic Statement and Budget Update. The federal government also provided an additional grant of \$140 million in February 2001 to Genome Canada bringing their total budget to \$300M.

**GRAPH 7.1: SOURCES OF FUNDING FOR HEALTH RESEARCH IN CANADA, 1998**  
(TOTAL = \$2,256 MILLION)



Source: Statistics Canada, "Estimates of Gross Expenditures on Research and Development in the Health Field in Canada, 1970 to 1998". In Science Statistics, Service Bulletin, Vol. 23, No. 4, July 1999.

The whole health research community welcomed the new infusion of federal funds. For example, Dr. Barry D. McLennan, Chair of the Coalition for Biomedical and Health Research (CBHR), stated:

*The [federal government] has done its part recently. During the past few years, it has created a modern, new health research funding agency, introduced a broad range of new funding programs for health researchers, announced funding for infrastructure support to ensure that research facilities are conducive to innovation and developed policies that will attract world class research and researchers in Canada. These initiatives deserve praise for far-sightedness and for the important momentum that they have created with the health research community in Canada.*<sup>184</sup>

The Committee was told that, while the increase in federal funding represents significant support for health research, it does not bring Canada to a favourable position worldwide. In 1997, Canada devoted only 1% of its total health care spending to health research and ranked 6<sup>th</sup> behind the United Kingdom (6.5%), France (3.7%), Japan (2.4%), the United States (1.7) and Australia (1.4%). The same year, Canada ranked 5<sup>th</sup> among 8 OECD countries in terms of overall spending on health research expressed in PPP per capita.<sup>185</sup> Furthermore, the

<sup>184</sup> Dr. McLennan, *The Improving Climate for Health Research in Canada*, Brief to the Committee, 9 May 2001, p. 2.

<sup>185</sup> The conversion into purchasing power parity (PPP) per capita eliminates price disparities between countries and evaluates spending that is adjusted to population size.

role of the central government in financing health research, expressed in PPP per capita, was far more important in the United States, the United Kingdom, France and Australia than in Canada. For example, the American government provided four times more funding per capita to health research than did the Canadian government. This was prior to the establishment of the CIHR.

Witnesses unanimously recommended that the federal government's share of total spending on health research should be increased to 1% of total health care spending from its current level of approximately 0.5%. In their view, this would bring the level of the federal contribution to health research more in line with that of central governments in other countries. According to Dr. Alan Bernstein, President of the CIHR, such federal investment is essential to maintain a vibrant, innovative and leading-edge health research enterprise:

*However, despite the significant research funding increases represented by the 1999 budget commitment, Canada does not compare favourably with its major competitors in terms of the amounts government-sponsored agencies dedicate to health research. In many ways, Canada is simply playing catch-up with the United Kingdom, France and the United States, which have increased funding to health research between 30% and 50% during the past decade. Canada's cumulative increase, even taking into account the CIHR commitment, was slightly more than 10% during the same period. In this fiscal year, the U.S. National Institutes of Health has received five times the funding enjoyed by the former Medical Research Council (MRC) on a per capita basis. Even after the CIHR commitment is fully realized in 2002, it is estimated that the U.S. will be providing as much as four times the funding per capita than will Canada.*

*Murray Elston, President, Rx&D, Brief, p. 7.*

*(...) health care is Canada's largest knowledge-based industry. If I were a CEO of Health Canada Inc. and said that we are going to double our spending to 1 per cent of our total budget on research, you would fire me if you were on the board. You would say that 1 per cent is ridiculously low for a knowledge-based industry. Despite Nortel's problems, Nortel and all the high-tech companies down the road here in Ottawa spend between 20 per cent and 40 per cent of their revenues on research. How else can they be at the leading edge?*<sup>186</sup>

## 7.2 Genetics and Genomics

Witnesses told the Committee that health research in Canada and throughout the world is currently undergoing a scientific revolution. They explained that this revolution in health research is fuelled by the ongoing advances in genetics and genomics (see Table 7.3 for some definitions).

In the view of witnesses, the revolution in health research can be seen as a significant driver of change in Canada's health care system. For example:

- Genetic research offers a new capability to predict, decades in advance, who is susceptible to a given disease. This new capability is based on the

<sup>186</sup> Dr. Alan Bernstein (9:17).

identification of the gene(s) that cause or predispose an individual to certain diseases. Dr. Bernstein told the Committee that we already have this capability now for about 5-10% of all breast and colon cancers, Alzheimer's Disease, and other less common diseases. Because early diagnosis can often lead to better health outcomes at lower cost, experts in health research predict that the next 10-20 years will be marked by a significant shift in health care delivery from disease treatment to prevention strategies.

*Ten to 20 years from now, our health care system will undoubtedly be vastly different than it is today. These profound tectonic shifts will be largely driven by science. The health care sector is truly Canada's largest knowledge-based industry, and to contribute to this global health revolution for the health and wealth of all Canadians our country needs a robust, innovative and evidence-based health care system. We require a culture that can respond to change, that can innovate and originate change, a culture that recognizes and awards excellence and evidence-based decision making.*

*Dr. Alan Bernstein, CIHR (9:10)*

**TABLE 7.3: BASIC GENETIC LEXICON**

TABLE 7.3: BASIC GENETIC LEXICON	
<b>Human Cells</b>	All living organisms are composed of one or more cells. They are the individual units from which tissues of the body are formed. The human body is composed of some 100 trillion cells.
<b>DNA</b>	Abbreviation for “deoxyribonucleic acid,” the chemical building blocks of which genes are constructed.
<b>Chromosome</b>	Discrete unit of the genome that carries many genes and consists of histone proteins and a very long molecule of DNA that is tightly coiled. Human cells (except the reproductive and red blood cells) carry 23 pairs of chromosomes, one chromosome of each pair having originated from either genetic parent.
<b>Genes</b>	The unit of hereditary material, which is the physical basis for the transmission of the characteristics of living organisms from one generation to another. Genes are made of DNA and occupy a specific place on a chromosome.
<b>Genome</b>	The entire hereditary or genetic material contained in a cell, including both the nuclear and mitochondrial DNA. The human genome project involves research and development activities aimed at mapping and sequencing the entire human genome.
<b>Stem Cells</b>	The primitive undifferentiated cells that have the potential to differentiate into any cell type. Stem cells have been identified in embryonic, foetal, child and adult sources but embryonic stem cells are believed to have the greatest potential in terms of differentiating into virtually any cell or tissue type.
<b>Genetics</b>	Genetics is the study of traits (genes) that are passed on from parents to offspring and the variation of those traits in individuals.
<b>Genomics</b>	The study of genes and their role in an organism's structure, growth, health and disease. Genomics is distinct from genetics in that it acknowledges that rarely is the manifestation of a disease dependent solely on the presence of a single gene. More often disease will involve multiple genes, compounded perhaps by the absence of another, and influenced by seemingly random environmental factors that are difficult to define.

<b>Biotechnology</b>	The means of manipulating other organisms to provide desirable products for human use. Biotechnology in the field of health and health care is used for disease surveillance, diagnosis, treatment and prevention. It permits the identification of disease agents where conventional means do not succeed, allows better tracking of pathogens, facilitates earlier detection of disease and provides therapeutic products and processes. Biotechnology is also used as a product base in the health industrial sector, and as an enabling technology in health sciences.
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Source: Library of Parliament. Adapted from the National Human Genome Research Institute, National Institute of Health (US), *Genetics – The Future of Medicine* ([www.nhgri.nih.gov](http://www.nhgri.nih.gov)); Industry Canada, *The Biotechnology Gateway* (<http://strategis.ic.gc.ca/SSG/bo01376e.html>), and Kimball R. Nill, *Glossary of Biotechnology Terms*, (<http://biotechterms.org>).

- New insights into the molecular mechanisms that underlie most illnesses will enhance our understanding of the basic biology of disease. This will change how disease is diagnosed and how it can be treated. It will also change how drugs are designed. An entirely new generation of drugs, which is likely to be more effective, with fewer side-effects but more expensive, will be designed according to the molecular pathology of disease. These changes will have a significant impact on Canada's health care system.

*We know already that early diagnosis provides a better and cheaper therapy than anything after-the-fact. If genomics research can help us identify the conditions to which we are most susceptible, then it will be possible to take preventative measures early in the process. As a result, during the coming decades, it is likely that disease management will shift from treatment of contracted conditions to prevention strategies.*

*Dr. McLennan, Brief, p. 4.*

- Genetic research will change the focus of the practice of medicine from a generalized to a highly targeted, individualized approach. Currently, clinical practice guidelines and provincial drug formularies are developed on the basis of disease uniformity. With advances in health research, however, we will move towards tailored care, based on patient variability.
- Stem cell technology is another good example of the potential impact health research can have on health and health care. Currently the research community is very enthusiastic about the potential of stem cells, particularly embryonic stem cells. It is anticipated that research on these cells will lead to treatments for serious diseases such as Parkinson's and Alzheimer's. It is also widely believed that these cells can ultimately be manipulated to grow into virtually any tissue or organ thus providing much needed organs for transplant. Recent research has been successful in 're-programming' undifferentiated stem cells into producing insulin. This is a function only performed by pancreatic islet cells. Should this treatment prove to be successful in the treatment of diabetes (a cure really) it will not only improve the quality of life for the individual, but will save the cost of care for the primary disease and its secondary complications as well. The federal government has unveiled, under its Proposals for Legislation Governing

Assisted Human Reproduction, draft legislation that would allow for embryo research, including stem cell research. The proposals, which include regulation of such research, is currently under review by the House of Commons Standing Committee on Health.

The genetics and genomics revolution is raising ethical, legal and social issues. As Dr. Bernstein clearly pointed out:

*The ability to predict disease, decades in advance, has profound implications for how we view our lives and make life decisions. How will this new genetic information affect our decisions about whether to have children – and what should we tell them? What should they tell us? Do our employers and insurance agents have the right to access our genetic information?*<sup>187</sup>

In the same vein, Ms. Elmslie noted:

*We are seeing rapid advances in science and technology. They are very exciting. However, we cannot forget the social and ethical issues that they raise for us as a society and as a population. Research that moves us forward, for instance, in genetics and genomics, needs to be accompanied by a vigorous research agenda in the ethical and social aspects and implications of that research. The purpose of the agenda is not in any way to prevent bringing the benefits of that research to the population. Its purpose is to understand the impacts on what we value as a society and what we need to do to put the pieces together in a way that Canadians can understand and make informed choices concerning the options that become available to them.*<sup>188</sup>

With respect to stem cells, the CBHR stressed in its brief the need to protect basic human rights and guard against long-term damage to life and the environment. The Coalition suggested that a national oversight body should be established to provide ethical review of all publicly and privately funded research using human embryo or foetal tissue, including embryonic stem cell research. Full ethical review should include review by both the local research ethics board and the national oversight body.

### **7.3 Benefits and Challenges of Health Research**

The benefits of health research are significant. Health research leads to improved drug therapy and diagnosis, enhanced prevention, and targeted treatment. Health research fosters the creation of knowledge-based employment and it contributes to stemming the brain drain. The Committee heard that it improves the personal and economic health of Canadians:

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<sup>187</sup> Dr. Alan Bernstein, Brief to the Committee, p. 5.

<sup>188</sup> Kimberly Elmslie, Health Canada (9:24).

*Health research provides enormous economic, social and health care rewards to society. The jobs that are created by these investments are high quality, well-paying, knowledge-based positions that generate worldwide recognition for Canadians. These investments also support the rejuvenation of academic institutions across the country. They help train new health professionals in the latest technologies and techniques and they provide important support for the health care delivery system in Canada. Most importantly, the results of these activities lead directly to better ways to treat patients, which ensures a healthier and more productive population.*<sup>189</sup>

Dr. Pat Armstrong from the Centre for Excellence in Women's Health told the Committee that health research is important not only to discover new treatments and drug therapies; it is also essential to chart the future of the Canadian health care system and the impact of changes on women, men and children in their different physical, economic, social and cultural locations across the country. In her view, sex and gender differences should be taken into account in health research.<sup>190</sup> Failure to do so makes health research partial at best and greatly incomplete at most:

*For example, it has become increasingly clear that some forms of medical intervention in the natural events of women's lives, such as pregnancy, childbirth and menopause, are costly and unnecessary. Other significant issues, such as the extent and impact of violence and stress on women's health, have been overlooked or ignored.*

*Women are often under-represented in clinical trials of new medical treatments and drugs. This can be true even when the product or therapy under review is intended to treat ailments like heart disease – the number one killer of Canadian women. New therapies are often approved without a clear understanding of how they will affect women and men differently.*<sup>191</sup>

Ms. Elmslie told the Committee that: "Research is a critical element and important tool, but the tool is only as good as the use we make of it. Without investing in the transfer [of knowledge] (...), we are really missing the opportunity to be able to see positive outcomes in the health of the population."<sup>192</sup> The outcomes of health research must be made available to policy-makers, health care providers as well as to the public.

Dr. Bernstein told the Committee that the CIHR will be developing a multi-faceted "knowledge translation" initiative. He explained that a website called "Research Net" will be available for the use of all Canadians, be they researchers, health care providers, consumers, etc. The site will contain information for everyone, from students in grade 6 doing a science project on health, to health professionals learning the very latest in the field, to researchers who want to know how to apply for funding, to policy-makers across the country

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<sup>189</sup> Dr. McLennan, Brief to the Committee, p. 2.

<sup>190</sup> While sex refers to the biological differences between men and women, gender refers to the social or cultural roles and characteristics that define them.

<sup>191</sup> Centre for Excellence in Women's Health, *Champions of Research Innovation*, p. 2.

<sup>192</sup> Kimberly Elmslie (9:23).

who are interested in the latest evidence-based decision-making issues with which they must deal. It is expected to be ready in late 2002.

One organization, the Canadian Health Services Research Foundation (CHSRF), is dedicated to knowledge transfer. The CHSRF is a not-for-profit organization established with federal funding whose mission is to sponsor and promote applied research on the health care system to enhance its quality and relevance, and to facilitate its use in evidence-based decision-making by policy-makers and health care managers. Similarly, CIHI is another entity that brings data into the decision-making process.

With respect to the lack of information to the general public, Murray J. Elston, President of Canada's Research-Based Pharmaceutical Companies (Rx&D), told the Committee:

*The issue of public awareness and public education is also very important. This is an area of which the public is well-aware, but not necessarily well-informed. Today concerns about genetic research in medicine, animal cloning, embryo research and genetically modified foods are mixed in the public consciousness. It is vital that the level of public understanding is increased, so that the role of genetics in medical research is separated from the sensationalism of the newspaper headlines.*<sup>193</sup>

Another major challenge in health research is the low level of training capacity. The Committee heard that academic health centres are currently under-funded and unable to respond to the challenges of contributing to Canada's success in developing a globally competitive health research sector. There is also great regional disparity in terms of health research capacity. For example, certain medical faculties and academic health centres in the Atlantic Provinces and in the Prairies lack the capacity to sustain and nurture growth. Dr. McLennan told the Committee:

*Given the paucity of well-trained and talented clinical faculty in many specialities across the country, those provinces with healthy budgets are able to offer salaries and resources that attract away these critical faculty from the under funded centres. The less-well resourced provinces then face a double jeopardy – the inability to recruit replacement faculty and the added stress and workload that fall upon those who are left behind. This scenario curtails teaching and research time, which eventually entices the remaining group to look for better opportunities in more financially endowed centres. This internal competition for talented people is counter-productive. It is an urgent matter that requires rapid attention at the federal level.*<sup>194</sup>

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<sup>193</sup> Murray J. Elston, The Implications of the Revolution in Genetics Research on Public Policy Development, Brief to the Committee, 9 May 2001, p. 4.

<sup>194</sup> McLennan, Brief to the Committee, pp. 8-9.



## 7.4 Committee Commentary

The Committee acknowledges that the federal government has, in recent years, contributed to the strengthening and better integration of the health research infrastructure. In particular, the creation of the CIHR in April 2000 – a model unique in the world – is a key element in ensuring that Canada is at the leading edge of the knowledge-based economy.

The Committee also agrees with the witnesses that Canada needs a robust, integrated and proactive health research sector. However, OECD data clearly show that Canada does not compare favourably with its major competitors in terms of public funding for health research. The role of central governments in many countries in financing health research is far more important than it is in Canada. It is imperative that the federal government addresses this concern.

Health research and innovation will be a major driver of change in Canada's health care system in the coming years. The knowledge gained as a result of health research translates directly into better diagnosis, treatment, cure and prevention of many diseases. The federal government's strategic investments in programs such as CFI, CHSRF, CIHR, Genome Canada and the Canada Research Chairs today will pay huge dividends for our health care system tomorrow.

We also agree that rapid advances in genetics and genomics will revolutionize health care delivery in unprecedented ways. This highlights the need for multi-disciplinary research that will examine the societal costs and benefits, the ethical considerations and potential unintended impact of advances in genetic and genomic research.

The Committee also concurs with the witnesses in regard to the transfer of knowledge generated by health research. The dissemination of health research results should reach everyone – government officials and policy-makers, health care providers and the general public. In our view, this will greatly enhance evidence-based decision-making with respect to health and health care to the benefit of all Canadians.



## CHAPTER EIGHT:

### HEALTH-RELATED INFORMATION: A CANADIAN HEALTH INFOSTRUCTURE

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**H**ealth and health care are, and have always been, two fields that rely intensively on information. With the right information, a health care provider can order the right treatment, prescribe the most appropriate medication, or recommend the best preventive approach. With the right information, an individual is better able to take good decisions with respect to his/her health and lifestyle. With the right information, health care policy-makers and managers can decide on how to allocate financial, physical and human resources in the most cost-effective and efficient way.

Getting the right information, however, is not an easy task. For example, the Committee was told that doctors would currently need to read 19 scientific articles a day, 365 day a year, just to keep abreast of progress in medicine.<sup>195</sup> Obviously, it is almost impossible to keep pace with such overwhelming information. Similarly, individuals and patients are faced with an abundance of health-related information, with an estimated 40,000 health websites accessible to the general public.<sup>196</sup> It can be very difficult for them to discern between the good and the bad information.

And yet, despite the volume of information available, there is still a lot that we do not know about health and health care. According to witnesses, this is mainly because Canada's health care system is not integrated: physicians and other health care providers, hospitals, laboratories and pharmacies all operate as independent entities, with limited linkages to allow for the sharing of information about patients. While each entity holds a vast amount of current, relevant and valuable information on the health of individuals, such information is not standardized, it is stored in inconsistent means and, thus, it cannot be shared efficiently. This lack of integration impedes the establishment of a direct relationship between the inputs we use in the health care system and the resulting outputs or outcomes. This creates a significant barrier in evidence-based decision-making by both health care managers and policy-makers.

*I believe that we do a wonderful job of creating data in the system, a mediocre job of turning it into information, a lousy job of turning it into knowledge, and an even worse job of sharing that knowledge. It is not because people do not want to do it. It is because people are so hard pressed by what they are doing that it is hard to step back and do broad-system thinking.*

*William J. Pascal, Director General, OHIH, Health Canada (12:6)*

The Committee was told that the availability of, the accessibility to, and the sharing of the "right information" on health and health care could be greatly enhanced through the use of information and communications technology (ICT). Many witnesses stressed that the health care sector is far behind other information-intensive sectors – such as the banking

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<sup>195</sup> William J. Pascal, Office of Health and the Information Highway (Health Canada), *A Health Infrastructure for Canada*, Brief to the Committee, 10 May 2001, p. 1.

<sup>196</sup> Dr. Jill Sanders, CCOHTA (5:16).

industry, insurance companies and the airlines – in terms of investing in ICT for collecting, managing and analysing data. Dr. John S. Millar, Vice-President of Research and Analysis at the Canadian Institute for Health Information, described Canada’s health care system as a “cottage industry”:

*Hospitals, agencies and providers have long been used to working (...) as “cottage industry,” looking after themselves and their own quality processes but not wanting to share that publicly. There has to be an increased stress on accountability and informing consumers who (...) are largely uninformed.*<sup>197</sup>

In the same vein, David Cowperthwaite, Director of Information Systems at the New Brunswick Department of Health and Wellness, stated:

*By any measure, private sector or public, we are far behind an appropriate level of investment in infostructure for health care. We are behind government norms for good management compared to other programs, and we are certainly behind private sector norms for any information intensive industry.*<sup>198</sup>

## 8.1 Concepts and Definitions

The use of ICT in the field of health care is often referred to as “telehealth”. The purpose of telehealth is twofold: to share health-related information among various health care providers and health care settings; and to deliver health services over large and small distances. Telehealth applications can improve quality of care and enhance health care system management.

*What advanced information and communications technologies (ICTs) have to offer to the health sector is timely access to the most current information where it is needed, when it is needed for those who need it to take action.*

*William J. Pascal, OHIH,  
Brief, p. 3.*

Dr. Robert Filler, President of the Canadian Society of TeleHealth (CST), told the Committee that telehealth encompasses five broad applications: electronic health record; health information networks; telemedicine; tele-homecare; and distance continuing education and training. Each of these applications is described briefly in Table 8.1.

The telehealth applications that are envisioned in Canada for the purpose of sharing the right information and integrating health care delivery include a system of EHR and an Internet-based health information system:

- The foundation of an EHR is electronic patient records (EPR) which represent the results of a series of encounters between an individual and a

<sup>197</sup> Dr. John S. Millar, CIHI (12:13).

<sup>198</sup> David Cowperthwaite, Director, Information Systems, New Brunswick Department of Health and Wellness, *A Provincial Perspective on Health Related Information*, Brief to the Committee, 10 May 2001, p. 1.

health care provider. EHR systems are composed of all lifelong EPR records for that individual incorporating data from all sources: health care providers (e.g., physicians, hospitals, community and home care), as well as support and feeder systems (e.g., pharmacies and laboratories). An EHR system can make the data available to health care providers anywhere on a need-to-know basis by connecting interoperable databases that have adopted the required data and technical standards.

**TABLE 8.1**

<b>TELEHEALTH APPLICATIONS</b>	
<b>Electronic Health Record (EHR)</b>	The EHR is an automated provider-based system within an electronic network that provides complete patients' health records in terms of visits to physicians, hospital stays, prescribed drugs, lab tests, and so on.
<b>Health Information Networks</b>	These networks refer to Internet-based health information with the purpose of empowering individuals to make informed choices about their own health and well-being, their health care system and health care policy.
<b>Telemedicine</b>	Telemedicine makes use of video conferencing equipment to provide health care at a distance. The video conferencing, which uses a relatively high bandwidth, is live and interactive. A large bandwidth can simultaneously accommodate television, voice, data and many other services.
<b>Tele-homecare</b>	Tele-homecare uses ICT to deliver and manage health care at a patient's residence from a health care facility. This includes, for example, triage call centres and telemonitoring.
<b>Distance Continuing Education and Training</b>	Video conferencing equipment is also used for providing continuing education and training. This is of particular interest to health care providers located in remote communities.

Source: *Glossary of Terms*, OHIH's Website ([http://www.hc-sc.gc.ca/ohih-bis/menu\\_e.html](http://www.hc-sc.gc.ca/ohih-bis/menu_e.html)) and Library of Parliament.

- An Internet-based health information network is a system that empowers individuals to make informed choices about their own health and well-being, their health care and about health policy. Health information to the general public could include for example: 1) general health information (health promotion and disease prevention); 2) information on treatment options and drugs, as well as on illness management (e.g. blood pressure, diabetes or obesity); 3) information on public health issues (e.g. quality of air, water and food); 4) information on the effects of health determinants; 5) health and health care policies at the federal, provincial and territorial levels as well as

the policies in other countries; 6) data on health outcomes of public policies; 7) accountability data (such as report cards on the performance of the health services and providers).

Not only can telehealth applications improve the sharing of the right information, but they also offer the possibility to deliver care over large and small distances. For example, “telemedicine” is used in Canada in the areas of teleconsultations, teleradiology, telepsychiatry, telepathology, teledermatology and telecardiology. Similarly, tele-homecare allows individuals to obtain medical information 24 hours a day by calling a nurse call centre, which can advise them on whether their condition requires immediate medical attention.

Dr. Feller told the Committee that, while each of the main five telehealth applications stands as an individual component, they must act together to create the seamless technology system that will be able to deliver the right information at the right time and at the right place. He stressed that the EHR is the central piece that ties all the components together.

## **8.2 Provincial and Federal Initiatives With Respect to a Pan-Canadian Health Infostructure**

Telehealth is the foundation of what many people in Canada call the health information infrastructure or “health infostructure”<sup>199</sup> Various components of a health infostructure are currently being implemented at all levels of government. For example:

- The provincial ministry of health in British Columbia operates HealthNet/BC, an electronic network that connects virtually all hospitals, health agencies and health authority offices across the province.
- In Newfoundland, the government is currently launching Phase 1 of an eight-phase, five-year implementation EHR system that will enable exchange of information between the health boards, health care providers and the provincial ministry of health.
- In Saskatchewan, the Saskatchewan Health Information Network (SHIN) is linking all health care providers and health care settings across the province.
- Nova Scotia has installed one of the most comprehensive and active telemedicine networks in Canada, reaching 42 health care facilities throughout the province. Approximately 53 videoconferencing systems provide for educational and medical consultations. There are 36 teleradiology sending stations and 11 reading stations.
- The health ministry in Quebec has implemented the Réseaux de télécommunications sociosanitaire (RTSS) which enables the secure exchange of clinical and administrative information between health care facilities.

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<sup>199</sup> The concepts of “health infoway” or “health information highway” can also be used interchangeably.

- The Alberta We//net is currently developing a telephone triage service, available 24 hours a day, seven days a week, that will give people advice about how best to treat minor ailments or where to seek appropriate treatment.
- The federal government, through Health Canada, provides telemedicine services into 5 First Nations communities located in different provinces (British Columbia, Alberta, Saskatchewan, Manitoba and Quebec).
- The Canadian Institute for Health Information (CIHI) - which was established in 1994 as a national, independent, not-for-profit organization - is doing a great job at collecting and analysing the currently available information on the health of Canadians and on the state of the Canadian health care system.

These initiatives are all at different stages of development. Moreover, they are isolated within organizations, institutions and provinces and are considered as “a patchwork of unconnected projects, whose value would increase immensely if part of a coherent whole.”<sup>200</sup> The key element is how to bring all those infostructures together. It is a great challenge to integrate 14 jurisdictions (10 provinces, 3 territories and the federal government). It is obviously an ambitious, costly and long-term undertaking which will take years to bring into being. Most experts believe, however, that it is essential to do so if we wish to acquire sound information on the health of Canadians, the state of our health care system, and on the efficiency and effectiveness of health services delivery and distribution, and most importantly, if we want to improve the quality of health care Canadians receive, particularly if they live in rural or remote communities.<sup>201</sup>

The federal government wants to champion the development of a Canadian Health Infostructure that it defines as “an integrated network of computer and communication networks that virtually connects physical infrastructure, health professionals, facilities, communities and patients to enhance health care delivery and the sharing of health-related knowledge for the better health of Canadians.”<sup>202</sup> The envisioned Canadian Health Infostructure will not be a single massive structure, but a network of networks, building on the initiatives that are already in place or under development at the federal, provincial and territorial levels.

*[Provincial and territorial] respective initiatives toward building health information systems constitute the base for a pan-Canadian health infostructure. Each of them face the same issues and must find solutions to similar problems. Their responsibility for the management and delivery of health services make them key actors on the scene of health information, but also confines them to looking at their own needs and delivery mechanisms. Understandably, the need for inter-jurisdictional linkages is not at the forefront of their concerns.*

*William J. Pascal, OHIH,  
Brief, p. 6.*

As Table 8.2 shows, many reports have recommended the development of a pan-Canadian health information infrastructure and have stressed the need for federal leadership and

<sup>200</sup> Report of the National Conference on Health Info-Structure, February 1998, p. 19.

<sup>201</sup> Michel Léger, *The Canadian Health Infoway: A Vital Link to the Future*, May 2000.

<sup>202</sup> Office of Health and the Information Highway (Health Canada), *Virtual Integration for Better Health: from Concept to Reality*, September 1998, p. 1.

a cohesive national vision for the health infostructure. The federal government has been making financial contributions to the Canadian Health Infostructure since 1997. The Office of Health and the Information Highway (OHIH), established within Health Canada in the summer of 1997, is the focal point for all matters concerning the use of ICT in the field of health and health care.

**TABLE 8.2: CANADIAN HEALTH INFOSTRUCTURE:  
CHRONOLOGY OF FEDERAL GOVERNMENT INITIATIVES**

April 1994	The federal government mandated the Information Highway Advisory Council to investigate the development and use of the information highway for the economic, cultural and social advantage of all Canadians.
October 1994	The Prime Minister of Canada launched the National Forum on Health to advise the federal government on innovative ways to improve the health care system.
September 1995	The Information Highway Advisory Council released its report entitled <i>Connection Community Content: The Challenge of the Information Highway</i> . One of its 300 recommendations called for the creation of an advisory council to identify new information technology applications specifically for the health care sector.
February 1997	In its final report entitled <i>Canada Health Action: Building on the Legacy</i> , the National Forum on Health recommended that the federal Minister of Health take a leadership role in the development of a nationwide health information system. Such a system would serve as the foundation of an “evidence-based” health care system.
February 1997	The 1997 Budget provided \$50 million over three years for a Canada Health Information System.
August 1997	The federal Minister of Health established the Advisory Council on Health Info-Structure to provide strategic advice on the development of a national strategy for a Canadian health info-structure.
August 1997	The federal government created the Office of Health and the Information Highway (OHIH) to assist in addressing new and evolving issues and develop a longer term strategy regarding the Canadian Health Info-structure. OHIH is now the federal government’s focal point for all health info-structure-related activities.
September 1997	The Canadian Network for the Advancement of Research, Industry and Education (now CANARIE Inc. – Canada’s Advanced Internet Development Organization) issued a paper entitled <i>Towards a Canadian Health Iway: Vision, Opportunities and Future Steps</i> . This paper envisioned the Canadian Health Iway as “a virtual “information centre” open and accessible, yet confidential, system to assist decision-making by health professionals, patients, researchers and policy-makers.



February 1998	Health Canada sponsored a two-day National Conference on Health Infostructure to discuss impediments to the application of information management and information technology within Canada's health care system. Participants stressed the need to develop a consensus regarding the vision of Canada's Health Infostructure and called on Health Canada to play a leadership role in engaging all stakeholders.
March 1998	Health Canada launched the Health Infostructure Support Program (HISP). HISP was a shared-cost contribution program supporting pilot projects using new information technologies and applications in areas such as public health, health surveillance, Pharmacare, First Nations health, homecare and telehealth.
February 1999	The Advisory Council on Health Info-Structure released its final report, <i>Canada Health Infoway: Paths to Better Health</i> . It affirmed that setting up a nationwide health information highway could significantly improve the quality, accessibility and efficiency of health services across the entire spectrum of care in Canada. The Council's four objectives include: developing a Canadian vision of a health information highway and identifying the essential needs it should meet; generating a federal action agenda to implement the most vital components of the system; suggesting collaborative mechanisms to achieve a Canadian consensus on an integrated health information system; and identifying issues, challenges and barriers to the effective use of information and communications technologies, and recommending possible solutions.
February 1999	The 1999 Budget provided \$328 million to further develop health information systems in Canada (Canadian Health Network, National Health Surveillance Network, Federal Accountability Initiative, and a \$95 million grant to CIHI) and \$190 million for the First Nations Health Information System.
June 1999	The F/P/T Deputy Ministers of Health established an Advisory Committee on Health Info-structure with working groups to examine key issues regarding the development and implementation of the Canadian Health Infostructure.
October 1999	The F/P/T Deputy Ministers' Advisory Committee on Health Infostructure released a strategic blueprint to identify the technology components required to achieve a cohesive national health infostructure. Entitled <i>National Health Technical Infostructure: Blueprint and Preliminary Tactical Plan</i> , the report stressed that the Canadian Health Infostructure must be guided by the following set of values: strengthening Medicare, protecting personal health information, including all stakeholders, being based on collective and personal responsibility.
November 1999	The federal government launched three different initiatives: Canadian Health Network; National Health Surveillance Infostructure; First Nations Health Information System.
February 2000	The 2000 Budget provided \$366 million over four years for health information and information technologies.

June 2000	Health Canada launched the Canada Health Infostructure Partnerships Program (CHIPP). CHIPP is a two-year, \$80 million, shared-cost incentive program aimed at supporting the implementation of innovative applications of ICT in health care (namely telehealth and electronic health records). The deadline for applications for funding was 31 August 2000.
October 2000	The federal government enacted Bill C-45, the <i>Canada Health Care, Early Childhood Development and Other Social Services Funding Act</i> . This Act provides \$500 million in 2001-02 for the purpose of developing and supporting the adoption of Canada-wide information standards and compatible communications technologies for health care.

Source: Information on Health Canada's website summarized by the Library of Parliament.

The provinces and territories also want to be involved in the development of the Canadian Health Infostructure. On September 11, 2000, the First Ministers agreed to work together to: 1) strengthen a Canada-wide health infostructure to improve quality, access and timeliness of health care for Canadians; 2) develop an electronic health record system and enhance technologies such as telehealth over the next few years; 3) work collaboratively to develop common data standards to ensure compatibility of health information networks; 4) ensure stringent protection of privacy, confidentiality and security of personal health information; and 5) report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services.<sup>203</sup> In support of the agreement reached by First Ministers, the federal government committed \$500 million to accelerate the adoption of modern information technologies to provide better health care.<sup>204</sup> The Committee was told that this money will be invested in a not-for-profit organization, known as Canada Health Infoway Inc., which will work with provinces and territories to create the necessary common components of an EHR over the next three to five years. This will be a major step towards the full integration of the health infostructures being developed.

Witnesses welcomed this collaboration between the federal government and the provinces and territories. For example, David Cowperthwaite told the Committee:

*We are currently enjoying a wave of collaboration between the federal government and the provinces and territories, as well as among the provinces and territories. This cooperative attitude provides a significant opportunity to advance the development of the health infostructure in a more cost-effective manner than any of us could do individually.*

*This wave of cooperation has developed, in part, because of a genuine interest to do the best job we can with the resources available. But there is another significant issue driving collaboration and that is a sense of desperation. Our infostructure needs in provinces and territories are great, and the resources available to meet the needs are*

<sup>203</sup> First Ministers Meeting, *Communiqué on Health*, News Release, 11 September 2000.

<sup>204</sup> First Ministers Meeting, *Funding Commitment of the Government of Canada*, News Release, 11 September 2000.

*woefully insufficient. The result is a willingness to collaborate, albeit a somewhat forced willingness. This situation does provide a window of opportunity for change, and we must take advantage of it.*<sup>205</sup>

The Committee agrees with the witnesses that the federal government has a definite role to play in the area of health-related information:

*Considerable agreement exists among provinces and territories and other stakeholders that the federal government should foster collaboration in this area. Indeed, without a federal effort to ensure compatibility among these health information initiatives, little exchange between jurisdictions would have happened, and expenditures by all orders of governments within their respective jurisdictions could be significantly less productive.*<sup>206</sup>

Federal investment should also help reduce the current disparities between provinces and territories in the field of health-related information. However, the Committee was told that current federal programs may be encouraging more disparity. For example, under CHIPP, federal funding requires matching funds from the applicant. The relative needs for service improvements, or health service deficiencies in one region over another, were not considered in the project selection. According to Cowperthwaite, those who had the money got more money, and those in great financial need did not have an opportunity to apply. He pointed out that, while the opportunity to change the design of CHIPP has passed, the federal government should ensure that the investment strategy of Canada Health Infoway Inc. should not be as it was in the CHIPP program. Rather, it should place greater emphasis on projects in locations that have the greatest need, the willingness to act, and the commitment to implement system change.

### **8.3 Costs and Benefits**

The implementation and deployment of the pan-Canadian Health Infostructure is a costly undertaking involving a vast array of patients, health care providers and institutions. For example:

- Over 800 hospitals across the country provide 132,000 in-patient beds;
- Approximately 28,000 family doctors and 27,000 specialists provide care;
- Approximately 228,000 registered nurses are working in the health care system.

Given the complexity of our health care system and the variety of stakeholders, it is difficult to evaluate the total costs associated with the deployment of a pan-Canadian Health Infostructure. William J. Pascal suggested that between \$6 and \$10 billion would be needed to achieve full implementation:

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<sup>205</sup> David Cowperthwaite, Brief to the Committee, p. 1.

<sup>206</sup> William J. Pascal, OHIH, Brief to the Committee, p. 7.

*(...) over a horizon of seven to eight years, based on some current expenditures related to implementation and operation of information systems in different settings, it is estimated that somewhere between six to ten billion dollars will be needed to achieve full implementation. Decisions on such things as the rate of replacement of current systems used in the health care sector or the type of connections needed – low or broad bandwidth – and our success at pooling resources, or at least sharing best practices and successful applications, at the pan-Canadian level will determine the true level of investment needed. But it is clear that this will not come at a small price for any of those involved, and we should not underestimate the task ahead.*<sup>207</sup>

Nonetheless, there is a wide consensus that the benefits of a pan-Canadian Health Infostructure will be numerous.<sup>208</sup>

- The health infostructure will enable effective medical care at patients' homes and in remote rural areas. This will also improve accessibility of specialized care. Patients will be able to perform specialized tests at homes and transmit data from electronic sensors via telecommunication networks. Post-surgical patients would wear wireless sensors, continuously transmitting physiological information to their physician's office. This information would be continuously analyzed by a computer, which would alert a physician to significant deviations. Using telehealth links with two-way audio and video capabilities, major medical centres will be connected with general practitioners and nurse practitioners in remote communities, assisting them in appropriate diagnosis and treatment of patients.
- The quality of medical care will be improved dramatically by bringing reliable information to physicians, through national data on treatment outcomes and extended information on the effectiveness of previous treatment received by a patient. The patient file will provide medical professionals not only with descriptive information, but also with most of the previous X-rays, MRIs and detailed biochemical analyses. This information will prove to be life saving in emergencies, when survival, often determined by minutes, depends on availability of essential data (e.g., blood type or known allergies).
- A pan-Canadian Health Infostructure based on the electronic transfer of health information between jurisdictions would result from a macroeconomic effect on the development of the information and communication industries, health care industries and educational institutions.
- Many people work on contract and visit their client companies in different provinces. Many people travel. Ability to transfer health information would enable local physicians and nurses to access the visiting patient's records on an as-needed basis.
- Information exchange is the core of public health and epidemiology. It is crucial for the well-being of the population that reliable public health

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<sup>207</sup> William J. Pascal, OHIH, Brief to the Committee, p. 8.

<sup>208</sup> OHIH (Health Canada), *Virtual Integration for Better Health: from Concept to Reality*, September 1998.

surveillance information be communicated among different countries, provinces and territories. Diseases do not abide by jurisdictions, nor should the information about them.

- The ability to transfer health information between jurisdictions also holds vast potential for facilitating research by groups of biomedical scientists working in different parts of the country. The results of such research would benefit all people of Canada.
- The Canadian federal government is a major provider and purchaser of health care services through its health care responsibilities for military personnel, public service, veterans, immigrants and First Nations. Implementation of interoperable health records systems across the country could enable both the federal government and the local providers of health care to decrease expenditures through decreasing duplication of records and eliminating excessive paperwork.
- Unrestricted flow of health information between jurisdictions, enhanced by unique identification of patients and providers, would enable fraud detection, and therefore save considerable costs.
- The economic benefits of inter-jurisdictional transfer of health information could be realized mainly through the replacement of existing paper flow between the provinces and territories by electronic technology. In addition, should provinces decide to jointly participate in the design and implementation of the pan-Canadian Health Infostructure, economy of scope could be realized.
- In terms of technological benefits, federal/provincial/territorial collaboration in the development of the pan-Canadian Health Infostructure would facilitate diffusion of new technologies and result in comparable technological capacity for transmitting multimedia health information between jurisdictions. It would also contribute to the faster development of interoperability standards between federal/provincial/territorial information system platforms.
- A pan-Canadian Health Infostructure could contribute to the elimination of sharp differences in social and health care infrastructures of rural and urban areas of different provinces and territories. Inter-jurisdictional transfers of health information could drastically improve access to health information by patients and health professionals.
- A pan-Canadian Health Infostructure could facilitate the development of the virtual health care environment extending over provincial and territorial borders and enable true portability of health care. This environment would make possible the effective maintenance of virtual networks of health specialists across the country, thus resolving the issue of relative professional isolation in rural areas. This could have a positive effect on human resource issues in remote communities of different provinces and territories.

- Sharing health and economic outcomes information across the country could enable continuous cost-effectiveness analysis and analysis of quality of life indicators on a national scale, thus facilitating the sharing of best practices.
- Health care management issues posed by the increasing rate of change, demographic shifts, technological revolution, etc., are roughly the same across the country. The capacity to exchange hard data on organizational levels between similar facilities in different jurisdictions and discuss management issues and solutions would enhance the quality of health care management.
- The information generated by the health infostructure would provide the basis for preparing regular reports on health outcomes, health care providers and on the performance of health services delivery. This is very important as a tool to improve the health care system.
- The development of the pan-Canadian health infostructure could consolidate and virtually integrate provincial and territorial health care systems into a new, more efficient and streamlined national health care system, without actually interfering with the management and delivery of services by provincial/territorial health care systems.

Overall, a pan-Canadian Health Infostructure that virtually connects physical infrastructure, health professionals, facilities, communities and patients will enhance health care delivery and the sharing of health-related knowledge for the better health of Canadians. This will lead to a truly patient-oriented health care system:

*(...) the return on investment will be tremendous for all stakeholders. But the real winners will be Canadians, because they will gain better and easier access to continued quality health services, because they will profit from the knowledge that they will be able to acquire themselves, because they will gain improved understanding of how their health care system fares and meets their needs.*<sup>209</sup>

## 8.4 Issues

According to witnesses, the implementation and full deployment of the pan-Canadian Health Infostructure faces three major barriers: the protection of personal information, legal and ethical issues, and the interoperability of the various systems.

The issue of privacy, confidentiality and security related to personal health information in the electronic world is certainly the most crucial one. The *privacy* issue refers to the extent of authorized access to personal health information. The subject of *confidentiality* is the extent of permissible distribution of available personal health information. *Security* refers to the set of standards in and around information systems that protect access to the system and the information it contains.

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<sup>209</sup> William J. Pascal, OHIH, Brief to the Committee, pp. 8-9.

Protection of privacy in Canada is a shared responsibility between the federal and provincial/territorial governments. Current legal protection of privacy represents a patchwork of various laws, policies, regulations and voluntary codes of practice. The Committee was told that the first step is certainly to attempt to gain support for the harmonization of legislation and regulation across Canada that will protect the privacy of Canadians in matters of health. Witnesses stressed that Canadians need to be assured that governments are taking all the necessary steps to implement stringent rules in these matters. Already, a resolution for the harmonization of legislation is being examined by all jurisdictions and agreement is expected in the coming weeks. At the technological level, it has been demonstrated that confidentiality and security of personal health data can be achieved currently at a level that is not achievable in a paper world. The problems that we face right now concern mostly the architecture of the systems that would be put in place, and their governance from a pan-Canadian perspective.

*How can we as Governments expect the other stakeholders who hold the information to participate with us in building the EHR if we cannot demonstrate the ability to manage our own information well? How can we expect an individual to grant us permission to share information through an EHR if we cannot show that we are competent and efficient managers of the data we currently hold? Governments must lead by example in the effective management of information to demonstrate the value of an EHR and to draw the rest of the stakeholders into the EHR process.*

*David Cowperthwaite,  
New Brunswick Department of Health and  
Wellness, Brief, p.3.*

The Committee was concerned by the evident lack of progress among stakeholders with respect to Bill C-6, *Personal Information Protection and Electronic Documents Act*. In November and December 1999, the Committee held hearings on this bill. The hearings focused largely on concerns regarding the application of Part 1 of the bill to the collection, use and disclosure of personal information. The Committee was of the view that, while Part 1 may be adequate in setting minimum legal standards for protecting the personal information of Canadians in the commercial arena, the adequacy of these standards for the health care sector was open to question. It amended the bill so that its application to personal health information be delayed for one year following the coming into force of the legislation. The purpose of this amendment was to provide health care stakeholders with an opportunity to formulate legislative measures appropriate to the special nature of personal health information. The amendment was accepted by the House of Commons, and the bill received Royal Assent on 13 April 2000.

When the Committee met on the issue of health-related information in May 2001, witnesses indicated that no consensus had been reached yet among them on the changes that are required to Bill C-6 to ensure the flow of data between health care stakeholders involved in the health infostructure. The application of Bill C-6 to organizations involved in health information systems as well as in health research must be clarified in order that they may continue to provide critical information to improve the health of all Canadians. It is the hope of the Committee that solutions will be found to this problem before the end of the one-year moratorium in December 2001.

Legal and ethical concerns relate mostly to the licensure, reimbursement and liability of health care providers in delivering services from a distance. Clearly, there will need to be some form of incentive to foster the use of these new technologies in health care settings. These technologies will bring changes in work processes that will need to be carefully monitored

to ensure success, and supported by the necessary skills and knowledge training programs, whether in academic or work settings.

Another major obstacle, and not the least, is the issue of standardization which is at the heart of interoperability of the various health information systems. When people refer to *standards* in the health infostructure domain, they refer as much to the technology, hardware and software, as to nomenclatures or to patient or provider identification. Currently, none of those are fully compatible and readily interoperable across Canada. The Committee was told that even within the same institution, information systems often cannot connect with each other to exchange data. This situation can be multiplied over and over again across the country. A lot of work remains to be done to ensure full compatibility at all levels from coast to coast. A proposal is currently being developed for the Advisory Committee on Health Infostructure to improve the way in which standards related to health information are dealt with in Canada in order to harmonize standards used in the different jurisdictions, the federal government included.

Finally, the Committee was told that a balance is needed between development and deployment. Witnesses indicated that many of the components needed for a pan-Canadian Health Infostructure exist today and we should start its deployment now:

*Development without deployment creates expensive “white elephants” that do not deliver improvements to the health of Canadians. We will be far better served by limited systems that are fully implemented and used for everyday service delivery than to develop a technology showcase system that never makes it out to the real world.*<sup>210</sup>

## 8.5 Committee Commentary

Overall, the use of telehealth applications in implementing the Canadian Health Infostructure can support and enable the development of a true patient-oriented health care system by providing the base for vertical and horizontal integration of services. The health infostructure can help create the information pools that will facilitate evidence-based decision-making throughout the system by all the users, be they patients, health care providers, managers, researchers, or policy-makers.

The Committee agrees that to remain sustainable in the long term, the health care system must move from its current model of an array of disjointed entities to a fully integrated continuum of services that can be accessed by people at any of the points of service, whether at home, at a private clinic, at the hospital, etc., wherever they live in Canada. Therefore, good health-related information and the need to ensure its accessibility for all those concerned with health and health care is key to the successful renewal of Canada’s health care system. Many benefits will come simply by standardizing, connecting and sharing what we have.

The Committee also believes that the federal government has a critical role to play in fostering collaboration, developing common standards, and encouraging the harmonization of legislation. More importantly, the federal government must maintain its

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<sup>210</sup> David Cowperthwaite, Brief to the Committee, p. 4.



leadership role and provide a level of funding that can sustain the deployment of the Canadian Health Infostructure.



## CHAPTER NINE:

### HOME CARE

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#### 9.1 What is Home Care?

Home care is generally defined in terms of services provided to individuals in their homes. Home care does not include care provided privately or publicly in a residential facility for long-term or continuing care purposes.

Home care services can extend along a continuum that incorporates medical interventions as well as societal supports. It can also include assistance needed for family and volunteer caregivers. Home care can thus encompass an array of health, social or educational services that enable an individual requiring support to live and participate in society outside an acute or long-term care setting.

*Home care is the program that plans in-home supports. It monitors and evaluates clients' needs, provides nursing services, helps with activities of daily living and provides homemaking or offers assistance to enable independent living. Home care programs work with other services, including community support services such as meals on wheels, day centres, respite care and volunteer services. Home care also works with acute care hospitals, palliative care and respite facilities, long-term care services, mental health services and independent living programs - all to assist the client in the home and community.*

*Nadine Henningsen, Executive Director, Canadian Home Care Association (14:7)*

However, there is no single, universal agreement about what services should be included in the definition. Home care services can cover acute care such as intravenous therapy and dialysis, long-term care provided for individuals with progressive diseases such as Alzheimer's or chronic physical or mental disabilities, end-of-life care for people with terminal conditions, or personal support services such as attendant services and technical aids. Formal home care can include both health care and social support services such as monitoring, assessment, coordination, nursing, homemaking, nutritional counselling and meal preparation, occupational and physical therapies, pain control, emotional support and self-care instruction.

Home care can be provided by formal providers who are predominately nurses, therapists, homemakers, and personal support workers. These formal providers can be part of a community organization or a quick response team. They can provide care in person or via communication technology. While these formal services have evolved steadily over the past three decades, informal home care provided by friends and family has a long history. These informal providers - often mothers, wives and sisters - also need to be considered as recipients of home care programming to prevent the often costly crisis created by caregiver burnout. In particular, there is an identified need for respite care offering two types of services: caregiver replacement and direct services to caregivers.

Witnesses saw home care as part of the continuum of care related to health and well-being. They stressed the need to include it in considerations relating across the health and

social spectrum of primary care, acute care, long-term residential care, end-of-life care, community support programs, and personal support. They emphasized that effective home care contributes to lower long-term costs for the health care system through its three primary functions of:

- substitution for services provided by institutions, either acute care hospitals, long-term care institutions or palliative care facilities;
- maintenance enabling individuals to remain in their current environment; and
- prevention through ongoing monitoring and assessment.

Focusing particularly on the health care system, the Canadian Home Care Association stressed that home care is not facility based and requires no major capital investment or overhead. It does not depend on physicians for access. It can go beyond physical health care to engage social supports for comprehensive client care.<sup>211</sup>

**TABLE 9.1**

BENEFITS OF HOME CARE
<ul style="list-style-type: none"> <li>▪ Enables the health care system as a whole to operate more cost-efficiently;</li> <li>▪ Reduces the pressure on acute care beds and emergency rooms by providing medical interventions in alternate settings and using hospital resources only when they are needed;</li> <li>▪ Reduces the demand for long-term beds by providing a viable choice for aging Canadians to maintain their independence and dignity in their own homes and community;</li> <li>▪ Helps support family caregivers and sustain their commitment.</li> </ul>

Source: Nadine Henningsen (14:8).

## 9.2 Current Demand for Home Care

The 1998/99 National Population Health Survey provided some data relevant to the use of publicly funded home care.<sup>212</sup> It found that publicly funded home care use increased with: age; disability; and diminished income. Thus:

- While less than 1 percent of adults under 65 years of age received care, 37 percent of those over age 85 years did so.
- People needing help with activities of daily living were six times more likely to receive care than those who did not need this help.

<sup>211</sup> Nadine Henningsen (14:8).

<sup>212</sup> Canadian Institute for Health Information, *Health Care in Canada: A First Annual Report*, Ottawa: 2000, p. 58.

- People in the lowest two income brackets were much more likely to receive care than those in the highest income bracket.

Witnesses also identified various forces that reinforce the demand for further growth. In their view, four key variables must be considered:

### **9.2.1 Hospital Bed Reductions**

The current trend is towards shorter hospital stays, early discharge and the use of outpatient procedures; all of which places more reliance upon community services. While home care is critical to sustaining a hospital system with fewer beds, it needs dedicated resources. With the substantially reduced capacity within the acute care hospital sector in the 1990s, shorter periods of hospitalization became the norm and people were sent home to the community without the subsequent investment in the home care side of the provision of health care services.<sup>213</sup> Concerns about “bed blocking” in acute care hospitals focused on situations where an acute episode of treatment was completed but inadequate home support services prevented discharge, leaving a person in an acute care bed at a phenomenal cost to the system.<sup>214</sup> When the hospital sector downsized, there was no funding put in place for the transition to the community and no investment in the community.<sup>215</sup>

### **9.2.2 Rapid Population Growth over 65 Years of Age**

Available data indicates that while many seniors live at home, their home care use increases with age and disability. Projections suggest that, where the percentage of the population aged 65 years and over reached 12.5 percent in 2000, by 2025, this population will have increased to over 21 percent of the general population. Statistics Canada noted that in 1996, approximately 95 per cent of seniors aged 65 and over lived at home.<sup>216</sup> According to the 1998/99 National Population Health Survey, about 400,000, or 12 percent of seniors received care through provincial home care programs.<sup>217</sup> The highest use of home care occurred in the senior population aged 85 years and up at 37 percent, compared to 20 percent for the age group 80 to 84 years.<sup>218</sup> The likelihood of a person having a disability increases with age and in 1991, 35 percent of people with disabilities were over age 65.<sup>219</sup>

### **9.2.3 Pressures on Informal Caregivers**

The majority of informal caregivers are women who support their family members and who must often manage simultaneously responsibility for aging parents, for their own children and full-time paid work.<sup>220</sup> More than three million Canadians - mostly women -

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<sup>213</sup> Kathleen Connors (13:70).

<sup>214</sup> Dr. Taylor Alexander (14:24).

<sup>215</sup> Dr. Thomas Ward (13:24).

<sup>216</sup> Jean-Marie Berthelot (2:10).

<sup>217</sup> Dr. Taylor Alexander (14:10).

<sup>218</sup> Canadian Institute for Health Information, *Health Care in Canada: A First Annual Report*, Ottawa: 2000, p. 58.

<sup>219</sup> Federal, Provincial and Territorial Ministers Responsible for Social Services, *In Unison: Persons with Disabilities in Canada*, Ottawa: 2000, p. 5.

<sup>220</sup> Nadine Hennigsen (14:8).

provide unpaid care to ill family members in the home.<sup>221</sup> A survey in Alberta indicated that, up to age 75, women were more likely than men to have provided health care support to a family member.<sup>222</sup> More than 60 percent of family and friend caregivers for seniors were women.<sup>223</sup> More women are being conscripted into unpaid health care work and do so without training and with few supports.<sup>224</sup> The combination of pressures can lead to not only stress-related illness and loss of work time for the caregiver, but can also increase the risk of neglect and mistreatment of the care recipient.

#### **9.2.4 Advances in Technology**

Medical advances have increased life expectancy, decreased the length of hospital stays and resulted in more outpatient services. Conditions that previously required hospitalization - e.g. pain control - can now be managed at home. Advances in treatment protocols and accessibility to high-tech equipment make palliative care in the home a real option for Canadians.<sup>225</sup> Telehealth offers increased possibilities for diagnosis, monitoring, assessment, and maintenance. With tele-homecare, care can be provided using video conferencing in people's homes whereby data is received from the home and people are kept away from hospitals.<sup>226</sup>

### **9.3 Public and Private Spending**

Witnesses suggested that public home care spending in Canada has grown from 1.2 percent of public health care expenditures in 1980-81 to approximately 4 percent in 1997-98. This 4 percent of all public expenditures on health care devoted to home care amounted to about \$2.1 billion per year.

Health Canada's data on public home care expenditures show that such expenditures more than doubled from 1990-91 to 1997-98, with an average annual rate of increase of almost 11.0 percent (see Graph 9.1). At the same time, public home care spending accounted for a small but increasing percentage of total public health care spending in Canada: 4.0 percent in 1997-1998, up from 2.3 percent at the beginning of the decade (1990-91).

Existing analysis of private home care costs is more limited. For example, assessments of how much Canadians pay out-of-pocket for services and costs associated with care, drugs, equipment and supplies appear occasionally in newspapers.<sup>227</sup> Thus, *The Toronto Star* (27 November 1999) reported on a cross-Canada survey that showed home care clients spending an average of \$283 a week for in-home nursing care and other home support services such as personal care, bathing and meal preparation. This cost was estimated to cover about 25% of nursing services and 60% of home support services. Shortly afterward, the *Globe and Mail*

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<sup>221</sup> Dr. Taylor Alexander (14:10).

<sup>222</sup> CIHI, *Health Care in Canada 2001*, Ottawa: 2001, p. 54.

<sup>223</sup> CIHI, *Health Care in Canada, A First Annual Report*, Ottawa: 2000, p. 60.

<sup>224</sup> Dr. Patricia Armstrong (11:22).

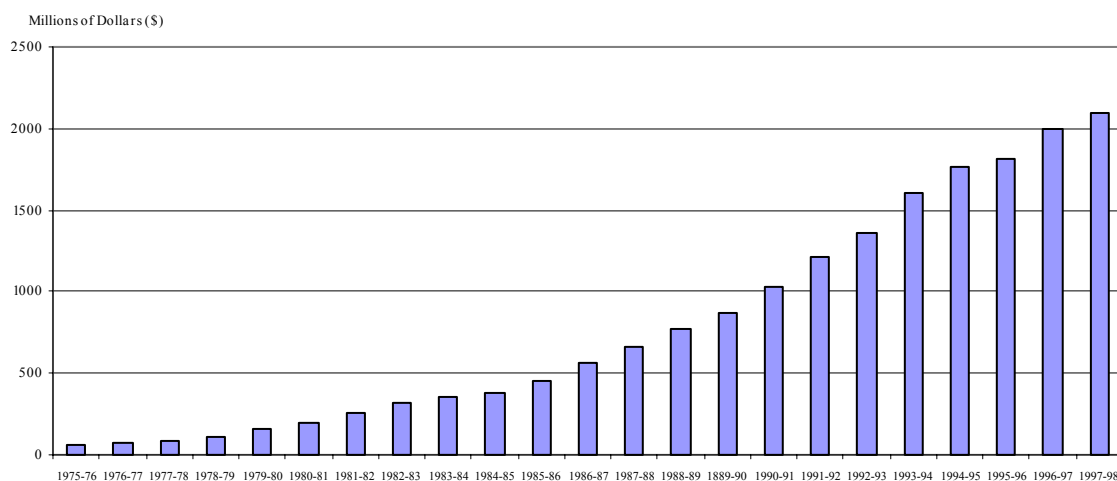
<sup>225</sup> Nadine Hennigsen (14:8).

<sup>226</sup> Dr. Robert Filler (12:15).

<sup>227</sup> Nancy Miller Chenier, *Home Care: A Federal Perspective*, Ottawa: Parliamentary Research Branch, Library of Parliament, TIP 77-E December 19, 2000.

(6 December 1999) also found that home care clients incurred significant costs for post-acute nursing services at about \$202 a week. General home care was estimated at \$407 a month with another \$138 for prescription drugs.

**GRAPH 9.1:**  
**PUBLIC HOME CARE EXPENDITURES IN CANADA, 1975-76 TO 1997-98**



Source: Health Canada, *Public Home Care Expenditures in Canada, 1975-76 to 1997-98*.

Witnesses emphasized that, while home care provision has increased in most provinces, spending on home care is still a small portion of the overall provincial health care budgets. In addition, there are wide variations among the provinces and territories regarding the proportion of public spending on home care. This leads to disparities in the provision and scope of services across the country with differences from province to province and from region to region. Also, some noted that financial expenditure data may omit paraprofessionals who provide most of the care in the home.

Witnesses were especially concerned that many individuals who need home care services may do without them because they cannot afford the costs. Dr. Taylor Alexander, President and CEO of the Canadian Association for Community Care, cited a Health Canada study indicating that “20 per cent of family caregivers reported that their loved ones did without services because they could not afford them.”<sup>228</sup> Currently, most provinces have a system where individuals pay according to ability; however, the rules for what is established as a baseline for payment is different in every province. Some noted that whereas some provincial governments support almost the full cost of home care, in other jurisdictions, people may be drained of their assets in order to receive the same care.

Evidence presented to the Committee provided specific data relevant to cost-effectiveness evaluations. Preliminary results from a cost-effectiveness study of home care at the Centre of Aging at the University of Victoria indicated an average of \$12,504 per year to provide lowest-level care for a client in a facility compared to \$5,413 at home. For clients with the highest-level needs, requiring nursing coverage 24 hours a day, the average cost was \$41,023 in

<sup>228</sup> Dr. Taylor Alexander (14: 11).

an institution and \$33,579 at home.<sup>229</sup> The Manitoba Centre for Health Policy and Evaluation at the University of Manitoba provided an example suggesting that the average case cost of providing care in hospital would be \$2,652 compared with the cost of \$1,882 for providing home care as well as drug therapy.<sup>230</sup> A study on home care in Saskatchewan indicated that, while outcomes are the same, it cost \$830 more overall to provide a patient with non-acute care in hospital than to discharge them home with alternate follow-up care.<sup>231</sup>

## 9.4 Future Actions

Witnesses strongly supported changes to the way that home care is currently organized, delivered and financed. They were consistent in calling for actions related to national standards and human resources. They did not, however, have a single perspective on the methods of financing home care, whether through public funds or private non-profit or for-profit organizations. Most witnesses focussed attention on informal caregiver needs, while others touched on information, research, prescription drugs, and technology issues. Several key areas for future action emerged during the Committee study.

**TABLE 9.2**  
**CHRONOLOGY OF RECENT FEDERAL INVOLVEMENT**  
**IN HOME CARE**

Date and Activity	Outcomes
February 1997: National Forum on Health	The National Forum report noted the shift toward non-institutionalized care with a resulting increase in home care and other community-based services. It called for increased data collection and assessment and for greater integration of home care with other health services.
February 1997: Federal Budget	The federal government announced the Health Transition Fund (HTF) in its 1997 Federal Budget. This three-year \$150 million fund supported innovations leading to a more integrated health care system. Home care was one of the priority areas included in national, provincial and territorial evaluation and pilot projects.
March 1998: National Conference on Home Care	Conference participants emphasized the need for: common principles framing a national approach to home care; clear standards; and agreement on program scope and content of coverage.

<sup>229</sup> Centre of Aging, University of Victoria, "The National Evaluation of the Cost Effectiveness of Home Care", *Newsletter*, 1(1), March 2000.

<sup>230</sup> Manitoba Centre for Health Policy and Evaluation, "A New Tool for Costing Health Care in Canada," Cost List example comparing the cost of providing care in hospital with the cost of providing home care plus drug therapy, April 1999.

<sup>231</sup> Health Services Utilization and Research Commission, *Hospital and Home Care Study*, Summary Report No. 10, March 1998.



February 1999: National Roundtable on Home and Community Care	Consensus positions highlighted the development of common standards, information systems, integrated human resources, strong research, knowledge and dissemination, and technological innovations.
February 1999: Federal Budget	The federal government allocated \$1.4 billion over three years for health initiatives with relevance for home care. These included: \$50 million over three years to develop innovative approaches to home and community care and access to quality health services, particularly in rural communities; an enhanced First Nations and Inuit home care and community care program and a First Nations health information system; increased funding for health research; and improving information technology for health care delivery, system accountability and citizen access.
June 1999: Working Group on Continuing Care of the F/P/T Advisory Committee on Health Services	The Working Group document, <i>Provincial and Territorial Home Care Programs: A Synthesis for Canada</i> provided analysis of home care programs by descriptive factors including: organization and governance, legislation, services and providers, eligibility, assessment and case management, coverage and co-payment charges, funding and utilization data.
March 2000: National Advisory Council on Aging	NACA advised the Minister of Health that the federal government should act as a role model and leader in home care development. In its Position Paper on Home Care, NACA presented 15 recommendations to advance the development of home care.
September 2000: First Ministers' Meeting	First Ministers, in their <i>Communiqué on Health</i> , directed Health Ministers to report on home and community services as part of the larger commitment to measuring, tracking and reporting on the performance of health services and programs.
2000: F/P/T Ministers Responsible for Social Services	The report titled <i>In Unison 2000: Persons with Disabilities in Canada</i> highlights the need for accessible, portable and individualized disability supports (human, technical, and other) in the home and community to facilitate the inclusion of the disabled.

Source: Parliamentary Research Branch, Library of Parliament.

#### 9.4.1 National Standards

Discussion over national standards for home care referred to organization, service delivery and training. The emphasis was on quality of care and equity in access. Nadine Henningsen saw national standards as a way of ensuring “both an effective Canadian health care system and equitable treatment of Canadians in all parts of our country.”<sup>232</sup> Dr. Taylor Alexander believed that “Canadians living in the so-called “have-not” provinces should not be

<sup>232</sup> Nadine Henningsen (14:8).

further disadvantaged and put at risk if their province lacks the funds to provide home and community services that are comparable to more affluent jurisdictions.”<sup>233</sup> Diane McLeod, Vice-President, Policy, Planning and Government Relations, at the Victoria Order of Nurses for Canada (VON) asserted that “without these standards, there is really no hope of having a unified health care program in the community sector.”<sup>234</sup>

While witnesses were clear that services and training should be comparable across the country, they did not specify one way to achieve this goal. With regard to national standards, Dr. Taylor Alexander believed that standards developed around the provision of core services should weave together the principles from the *Canada Health Act*.<sup>235</sup> He called for a federal/provincial/territorial

*There are many kinds of national standards. There are, for example, the standards that have been developed by the Canadian Council on Health Services on accreditation for home care and long-term care. Long-term care facilities and home care programs across the country are being accredited. Those standards relate primarily to program administration and organization of the program, et cetera. There are standards with regard to training. Those standards are not in place across the country. There are no national training standards for home care workers. They will occur within individual provinces; each province is different. Some provinces financially support them; some do not. Sometimes home care certificate workers must pay for their own training out of their wages.*

*Dr. Taylor Alexander, President and CEO, Canadian Association for Community Care (14:17)*

agreement on a “core basket” of essential home and community care services to which the principles of the *Canada Health Act* would apply. These insured services would include paraprofessional home support, nursing, social work, physiotherapy, occupational therapy, palliative care, prescription drugs, respite and case management. Nadine Henningsen stressed that while “the method by which these standards are incorporated into national legislation may be debated, the time for debate about the importance of the standards has passed.”<sup>236</sup>

#### 9.4.2 Human Resources

Witnesses saw a growing national crisis in the supply, distribution, recruitment and retention of staff in home and community care programs. They argued that years of health care cuts, nursing layoffs, low wages, difficult working conditions, poor training and greater complexity of care have made the sector an increasingly unattractive work environment. Their human resources concerns generally focused on training, compensation, work conditions, and retention for those involved in home care. The issue of substitution or crossover among professionals and between professionals and paraprofessionals was also raised.

With regard to training, there was an emphasis on education and training as part of the standard curricula for all individuals connected to home care. Without adequate numbers of trained staff, home care programs were unable to fulfil their mandates, thereby threatening the independence of clients and adding pressures on the acute care system. Some witnesses noted that more time and investment would be needed in helping to teach physicians about the

<sup>233</sup> Dr. Taylor Alexander (14:12).

<sup>234</sup> Diane McLeod (14:16).

<sup>235</sup> Dr. Taylor Alexander (14:12).

<sup>236</sup> Nadine Henningsen (14:8).

concept of home care and how to discuss it with their patients. Others pointed out that training requirements depend on the policy of each province.

For example, Ontario was noted for its stringent training program - a three-year program for a home support worker. In Nova Scotia, a training curriculum is currently being designed but is not instituted yet. In Saskatchewan, there is no training program for home support workers; it is managed by the service agency. Another witness explored provincial differences related to the proportion of registered nurses to auxiliary nurses. Régis Paradis, President, Ordre des infirmières et infirmiers auxiliaires du Québec, pointed out that, in Quebec, auxiliary nurses are almost absent from health care. However, in Ontario and the United States, where the proportion of registered nurses to auxiliary nurses is three to one, auxiliary nurses are heavily involved in home support services.<sup>237</sup> According to this witness, if Quebec had the same proportion as Ontario, it would now have almost 4,500 more auxiliary nurses, which would lead to savings of approximately \$50 million annually.

*Improved training and retention strategies are needed to counter the shortage of nurses, home support workers and therapists in some regions across Canada. While these personnel shortages are part of a larger picture of scarcity of health workers, they are often exacerbated in home care by lower wages and benefits than those paid to workers in hospital and care facilities. Both the wages and supply of community workers are a serious challenge. We must provide compensation that is competitive with care facilities and hospitals. Ongoing professional training must become a priority to ensure that the highest standards of care are maintained. We must continue to investigate the most effective working relationships with the health care team, including the primary care physician and other components of the health care system.*

*Nadine Henningsen, Executive Director,  
Canadian Home Care Association (14:8)*

Deficiencies in wages and benefits for home care workers is another key issue. In particular, the fact that they are paid lower wages than institutional providers was cited as one reason for shortages. Dr. Taylor Alexander noted that, in Ontario, there are some circumstances where community nurses are being paid as much as 25 per cent less than their counterparts who work in institutions.

The home care sector is characterized by lower wages and benefits than provided by hospitals, especially for paraprofessionals who, in some provinces, earn roughly minimum wages. It was also noted that virtually all of the paraprofessionals are female and that many are recent immigrants with low education who speak English as a second language. Many home care workers are subject to various forms of abuse in client's homes. Also, many provide service after hours without pay to assure that the clients receive the support that they need.

The wide disparities in wages and benefits across the country draw workers to areas of higher pay, thereby creating even worse shortages in areas with low wages, such as some Atlantic provinces. Reference was made to work by Human Resources Development Canada and Health Canada on home care human resources. Working with relevant organizations, this study will involve research and analysis of the issue of wage disparity for nurses and home

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<sup>237</sup> Régis Paradis (13:52).

support workers, workplace conditions for all staff who work in the community, as well as training needs for the community.<sup>238</sup>

Overall, witnesses called for close cooperation between the federal government and the provinces and territories in developing a national home and community care human resources strategy that will help ensure an adequate supply and distribution of appropriately trained home and community care workers across Canada. They saw the strategy including provisions to enable: the provinces to support the training and skill development, particularly of paraprofessionals; and agencies to offer adequate wages and benefits that will allow them to recruit and retain staff and prevent their loss to the institutional care sector or to other sectors.

### 9.4.3 Organization and Financing

Emerging evidence indicates that home care is more cost effective than care in acute care hospitals and that it presents a cost-effective alternative to premature use of long-term care facilities.<sup>239</sup> In relation to long-term residential care, preliminary work found that savings of 50 percent could be obtained if home care replaced residential care for elderly clients who were stable in their type and level of care. The more unstable the client's health, and the more he or she moved through increasing levels of care, the more home care costs approached, and ultimately exceeded, the costs of residential care. Researchers also suggest that savings result from the way service delivery systems are structured in some parts of Canada and argue that policy-makers could consider mandating a "best practices" approach to organizing the home care delivery system.

*We cannot simply pour new health care resources into the same old silos in the same proportions. Health care renewal should aim for a sustainable health care system for all Canadians, no matter where their care is provided. Often home supports can be provided at fewer costs than new hospital beds. It is imperative that we build the basic infrastructure of home and community care so that services are accessible, properly managed and available. We must invest to increase the quality and quantity of home care services. We must also ensure that there is a capacity to support people of all ages with many different needs.*

*Nadine Henningsen, Executive Director  
Canadian Home Care Association (14:9)*

Palliative care or end-of-life care was mentioned as one area where home care could substitute for hospital beds. End-of-life care is different from acute care and from long-term care but can involve both high and low intensity of care. Witnesses noted the lack of studies on the costs of palliative care and were unsure about the merits of initiating a

*About 225,000 persons die in Canada each year. In 1997, an Angus Reid poll found that about 80 per cent of Canadians prefer to die at home. However, this is often not possible because of the lack of home-based palliative care services. Such services vary across the country; rural and remote areas are particularly under serviced. Overall, only about 10 per cent of Canadians have access to palliative care services.*

*Dr Taylor Alexander, President and CEO  
Canadian Association for Community Care (14:14)*

<sup>238</sup> See Canadian Home Care Human Resources Study website at [www.homecarestudy.ca](http://www.homecarestudy.ca)

<sup>239</sup> Hollander Analytic Services *et al.*, *The National Evaluation of the Cost Effectiveness of Home Care*, ongoing studies, website: <http://www.homecarestudy.com>

national home care program targeted only at people requiring end-of-life care. They noted that provinces have often expressed concerns about targeted programs that intrude into their sphere and that most of the available data suggests that acute care substitution is the quickest and easiest way to see the value of home care, because you could compare it to the cost of keeping the patient in a hospital bed.<sup>240</sup>

Bonnie Pape from the Canadian Mental Health Association touched on home care in relation to mental illness and indicated that, in general, it is not working for mentally ill people. She pointed out that: “People with mental illness often are not eligible for home care unless they have another primary diagnosis. When they do get home care, the services are often not appropriate to mental illness, which has very specific needs. That is tragic because we know from small pilot studies that home care can make a big difference in the lives of people with mental illness, particularly those with complex needs. Home care can even prevent the need for institutionalization.”<sup>241</sup>

One of the unsettled issues around both organization and financing concerned the appropriate place for the public sector and the private sector. Currently, home care in Canada is provided through a mixture of public and private involvement. Aside from the limited role of the federal government in home care for specific groups such as First Nations and veterans, the budgets and public spending for home care are controlled primarily by provincial and territorial governments.

However, when it comes to delivery of services, both the public and private sectors have a role. In the private sphere, service delivery can be through not-for-profit agencies such as the Victorian Order of Nurses and for-profit companies such as ComCare. For most witnesses, the key concern was to eliminate financial barriers for people seeking care at a vulnerable time in their lives. Several witnesses noted studies showing that when people are aware that they have to pay for care, they tend not to access that care.

Some witnesses noted that the private factor in home care is not divergent from the rest of the organization of health care. Dr. Taylor Alexander pointed out that “physicians in our country are virtually private practitioners paid by public funding. Hospitals are private institutions paid by public funding.”<sup>242</sup> By extension, home care could be dealt with in the same manner as physicians and hospitals, as private services paid by public funding but with the four patient-oriented principles of the *Canada Health Act* applying.

For Nadine Henningsen, one of the key variables in the profit versus the not-for-profit debate around home care was that the case management function should be a government, publicly administered role. According to her, home and community care is unique in its case management function and almost all jurisdictions now have single entry, standardized assessment and placement to home care services with ongoing case management. She noted that, unlike hospitals, in the area of home care, the case managers are the drivers or the

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<sup>240</sup> Dr. Alexander Taylor (14:32) and Nadine Henningsen (14:33).

<sup>241</sup> Bonnie Pape (19:41).

<sup>242</sup> Dr. Taylor Alexander (14:20).

controllers while the service providers, whether equipment or personnel, follow a pre-established and controlled case management plan.<sup>243</sup>

Other witnesses had concerns about private for-profit provision of home care. Kathleen Connors, President of the Canadian Federation of Nurses Unions observed that, in Manitoba, the government's experiment with private-for-profit home care was a failure. They could not obtain bids that were more cost effective in the delivery of quality home care services and so they reverted to the publicly funded and publicly delivered system.<sup>244</sup>

Witnesses generally felt that the federal government had a role, both in terms of research support to establish best practices and also with respect to an appropriate level of federal financial support. In relation to best practices, they pointed to a model in Manitoba where the home care programs are permitted to spend for home care services up to the amount that it would cost to have someone in a long-term care institution. On federal funding, they called for immediate allocation of funds targeted to home care by the provinces and territories with accountability for their appropriate allocation.

#### 9.4.4 Informal Caregivers

Witnesses expressed concerns that the reduction in inpatient hospital services has increased the burden of care on families and friends. This shifting of the care from the public to the formal and informal private sector is occurring at the same time that family size is diminishing and the older population is increasing.

The financial burden for family members and close friends who assume care of a person discharged from acute care or released into home palliative care can be high. In the 1996 General Social Survey on social and community support, 86 percent of caregivers provided unpaid informal care. Overall, about 15 percent indicated that their informal caregiver duties were taking an economic toll on them and their families. Women aged 45 to 65 years were most likely to provide care.<sup>245</sup> The National Advisory Committee on Aging, in its advisory role to the federal Minister of Health, recommended that the Canada Pension Plan and Employment Insurance be adjusted to accommodate individuals who leave the workforce temporarily to provide informal care.<sup>246</sup>

*We see over and over again, informal caregivers being pressured by the lack of services in the community and no support for them. It is a critical situation that needs to be addressed for chronically ill, disabled or dying patients.*

*Diane McLeod, VON, (14:17)*

With the process of deinstitutionalization, both for acute care and with mental health, witnesses observed that the dollars did not follow the patients into the community but were used for other purposes. As a result, individuals needing care turned to family members and close friends for support. These informal caregivers in turn spend hours of their time as well as money arranging needed supports and services for the family member or friend shifted from the institution to the community. According to the Roeher Institute - a national research

<sup>243</sup> Nadine Henningsen (14:20).

<sup>244</sup> Kathleen Connors (13:71).

<sup>245</sup> Kelly Cranswick, "Canada's Caregivers," *Canadian Social Trends*, Winter 1997, Statistics Canada, No. 11-008-XPE.

<sup>246</sup> National Advisory Council on Aging, *Position on Home Care*, No. 20, Ottawa: March 2000.

organization focusing on public policy concerns of persons with intellectual and other disabilities - the time-consuming process of finding funding, working with several agencies, managing schedules for several therapists, and obtaining respite services can lead to serious physical and mental burnout for informal caregivers.<sup>247</sup>

The need to prevent physical and mental burnout of informal caregivers is an issue for all families caring for someone at home. Witnesses argued that when home care is considered, the financial cost of respite programs for the unpaid caregiver must be part of health costs. They advocated for low-cost interventions that included: information and advice, time for themselves, psychosocial support through self-help and other groups and advocacy on their behalf.

Witnesses called for the federal government to work closely with the provinces and territories in the development of a national respite strategy to give people time off from their care-giving so that they can recuperate and have a personal life and some recreation. The strategy could include a wide variety of financial mechanisms to support caregivers such as the tax system, employment policies, employment insurance and pension systems as well as direct payments.

#### 9.4.5 Information and Research

Witnesses pointed to the large number of unanswered questions in relation to home care and called for enhanced information systems and increased research. Like other witnesses in the Committee study, those talking specifically about home care emphasized that more evidence is needed in order to make responsible decisions. In their view, all aspects of care delivery need to be documented and evaluated including looking at who would be the best-qualified, trained and supported home care workers and whether the organization providing services is utilizing the “best practices” in all aspects from worker training to care delivery.

Witnesses on health information generally pointed out that the area is currently hospital- and physician-dominated. This was reiterated by witnesses on home care generally and those addressing mental health concerns. It was noted that, although most mental disorders are treated in the community, rather than in hospital, data on mental illness come primarily from hospital data with a growing body of knowledge based on national health surveys.<sup>248</sup>

In relation to home care information systems, witnesses envisioned needs that included: a common assessment system oriented to client outcomes; a common service classification system; and a clinical information

*There is little statistical information in the community sector to help in decision making critical to the effect of delivery of care. At the present time, we basically have a paper-based system. This not only causes enormous inefficiencies and extra cost but also, perhaps more importantly leads, to an inadequate capacity to assess quality of services. Unlike the institutional sector, governments across Canada have not made a significant investment in development of an information system for home care.*

*Diane MacLeod, VON (14:16)*

<sup>247</sup> Roeher Institute, *When Kids Belong: Supporting Children with Complex Needs – At Home and In the Community*, North York (Ont.) Roeher Institute, 2000.

<sup>248</sup> Tom Lips (19:20).

system to support multi-disciplinary teams. Régis Paradis, from the Ordre des infirmières et infirmiers auxiliaires du Québec, stressed the need for uniform data collection after standardized surveillance:

*(...) we need reliable and well-documented interprovincial data on the performance and effectiveness of the health care system, particularly as regards home support services. The Canadian Institute for Health Information is an example of what can be done. The work done by Human Resources Development Canada is also important as it provides an overall assessment of the problem of human resources in a given area.*<sup>249</sup>

On home care research, witnesses advocated shifting research funding away from its current channel through established organizations such as hospitals and universities to targeted research funding for the community sector. Research questions included broad ones about the role of government and the role of private for profit and private not-for-profit organizations; the role of family and friends and community; and more specific ones about the level of per capita spending on home care compared to hospitals and residential care and quantitative data about the effect of the change from CAP to CHST on home care.

For those closely involved in home care, little is known about ways that home care can be incorporated as part of hospital downsizing exercises or into primary care innovations. They want to know the effectiveness and efficiency of offering incentives to physicians to collaborate with home care nurses and case managers, of developing professional and paraprofessional teams, of organizing physical, technical and human resources differently. In particular, they want to develop common outcome-oriented assessments and common classification that will permit wider application of research results.

#### **9.4.6 Prescription Drugs**

For many witnesses, the impact on the home care sector of discharging sicker patients earlier into the community has significance for the drug costs as well as other costs that must be paid for by an in-home care patient. As Dr. Taylor Alexander emphasized: “Home care, which was designed to support people not only in an acute phase but over a long period of time, is being required to shift increasing resources into what is called “acute care substitution.” In other words, it is like the hospital at home with all of the accompanying high-tech and high-cost resources.”<sup>250</sup> Prescription drugs are among the high-cost resources that are covered by medicare while persons are in hospital, but not when they return home.

There is a fear that the lack of coverage for prescription drug costs can place the health of a person at risk, especially for those who cannot afford to buy all the drugs they require. One at-risk group is the de-institutionalized mentally ill who may lack both financial and other resources for appropriate drug treatment at home.

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<sup>249</sup> Régis Paradis (13:53).

<sup>250</sup> Dr. Taylor Alexander (14:25).



In relation to palliative care, witnesses emphasized that one critical element of an effective palliative care is for the patient to be pain free. Dr. Taylor Alexander referred to palliative care situations where there is a widespread lack of adequate pain management, often because patients and families simply cannot afford the drugs to control the pain. This tragic situation results in unnecessary suffering for persons who are ill.<sup>251</sup>

The Senate report on end-of-life care provided an overview of provincial responses to questions about the removal of financial barriers to community palliative care caused by the cost of drugs and other medical supplies. It indicated that many provinces had already taken steps or were in the process of providing drugs to people designated as palliative by physicians or case management assessments.<sup>252</sup>

#### 9.4.7 Telehealth

Technology in various telehealth applications is seen as vital to the home care discussion. The ability to connect a patient's in-home monitoring equipment to local health facilities over telephone lines is already a reality. Other possibilities are close to realization. Various telehealth applications relevant to home care include: telemedicine involving medical consultations, diagnosis, rehabilitation for the home care patient from a distance; tele-education for information exchange between professionals and the home care patient; telemonitoring where patients undergoing hemodialysis, cardiac, oncological treatments can be monitored or elderly persons can be assisted at home; and tele-networking for linkages of home care patient records with pharmacies and laboratories.

*In about 10 years, you will have a communication device in your home. It will not be a television. It will be a flat screen TV, probably a plasma screen, on your wall. It will be voice-activated. You will talk to it. You will say, "Connect me to my doctor." It will dial automatically for you. You will have a discussion. You will have a slot to put your finger in; it will do a blood test and take your pulse. This technology exists now. This is not dreaming.*

*William Pascal, Office of Health and the Information Highway, Health Canada (12:24)*

Various provinces are trying different approaches to link home care and professionals. Ontario and New Brunswick have recently established centres with 24-hour nurse call centres for people to phone for medical information and advice. Health Canada has worked with Ontario to set up projects where a monitoring station within a hospital links nurses and physicians to home care health workers operating through community care access centres.<sup>253</sup>

As witnesses noted, the efficiencies of telehealth in relation to home care still need to be assessed. Current cost analysis suggests that links to a person's home can save money in several ways. From the health professional's perspective, one nurse could see many more people in their homes if the nurse was not required to drive long distances by car each day. From the health care system perspective, information from the United States suggests that the management of children with asthma using computer systems in schools could result in a

<sup>251</sup> Dr. Taylor Alexander (14:14).

<sup>252</sup> Senate Subcommittee to Update of Life and Death, *Quality End-of-Life Care: The Right of Every Canadian*, June 2000, Appendix I: Update 2000.

<sup>253</sup> William Pascal (12:24).

decrease in hospitalization and an improvement in wellness. From the family perspective, it could save money on travel costs. For example, the cost of transporting a child and the family from Thunder Bay to Toronto could be \$1,300 per family.<sup>254</sup>

The Committee also heard that another benefit of telehealth in the home as well as elsewhere is that such technology can reduce language and literacy problems for people interacting with the health care system. Dr. Thomas Ward of the F/P/T Advisory Committee on Health Human Resources pointed out that: “In the Maritimes we have a significant problem with literacy, particularly in the adult population. Most people leave school at a young age to work on the fishing boats or in the mines. That population can be maintained at home through the opportunity for some sort of interactive link through television sets. The technology is there such that someone at the other end - a face - can answer a question, and it does not require someone to sit down and read through some technical document.”<sup>255</sup>

## 9.5 Committee Commentary

The Committee agrees with witnesses that the home care issues related to national standards, human resources, organizing and financing, informal caregivers, information and research, prescription drugs, and technology must be addressed quickly. It favours increased public policy being given to home care and alternative care provision. The mounting evidence of cost effectiveness in home care delivery is encouraging, as is the extensive participation by community organizations in articulating the needs of those members of the Canadian population who could most benefit from increased home care services.

The Committee also recognizes that while extensive discussion has ensued around the issue of home care as a substitute for acute care, insufficient attention has been given to home care as a substitution for services in long-term and residential facilities. There is also a lack of data and research about home care in relation to palliative care and home care with respect to prevention of incapacity through social and other supports.

The Committee also acknowledges that the federal government currently has several avenues for influencing home care outcomes in Canada.<sup>256</sup> To further the development of home care as a national program, the federal government could continue and expand its funding for direct home care programs and services for specific groups under its jurisdiction. It could increase federal transfers under the CHST to assist provinces in developing home care programs in their respective jurisdictions or design a targeted program for specific aspects of home care. It could offer additional financial assistance to home care consumers through tax credits and deductions. It could collect and analyze home care data and increase research funding in the area. It could promote telehealth projects in the area of home care. It could enlarge the scope of the *Canada Health Act* so that necessary health care services are provided in care settings other than hospitals and physician’s offices. And finally, to accomplish all this, it could ensure that there is extensive federal, provincial and territorial consultation.

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<sup>254</sup> *Ibid.*

<sup>255</sup> Dr. Thomas Ward (13:26).

<sup>256</sup> Nancy Miller Chenier, *Home Care: A Federal Perspective*, Ottawa: Parliamentary Research Branch, Library of Parliament, TIP 77-E 19 December 2000.

## CHAPTER TEN:

### RURAL HEALTH

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Rural Canada occupies 9.5 million square kilometres, or about 95 percent of Canada's territory. Approximately nine million Canadians, or about 30 percent of the total population, live in rural and remote areas of the country. Rural and remote areas in Canada embrace varied terrain and economic activities spanning resource, manufacturing and service industries. Observations about rural Canada suggest some defining characteristics:

- Rural Canada includes rural and remote communities as well as small towns outside major urban centres.
- Rural populations that are more distanced from urban centres continue to decline, particularly as young people leave for educational and employment opportunities and as seniors leave to seek greater access to long-term care.
- Rural populations in closer proximity to cities or in recreational areas are increasing.
- Across Canada, more than half of the Aboriginal peoples (whether on reserves or in Inuit or Métis communities) live in rural areas.
- Ontario and British Columbia have the lowest percentage of rural residents while the territories and Atlantic provinces have the highest. Almost half of the population in Atlantic Canada live in rural areas.
- Seniors, children and youth under the age of 20 are over-represented in rural regions of Canada. More precisely, the 1996 Census shows that, compared with the national average, rural Canada has a higher percentage of children between the ages of 5 and 19, a lower percentage of males between 20 and 39 and females between 20 and 49, and a higher percentage of males over 55 and females between 60 and 69.
- Rural areas have generally higher unemployment rates and lower formal education levels.
- Rural people living in the Prairie provinces have a lower unemployment rate than do people living in Atlantic Canada.<sup>257</sup>

#### 10.1 Health Status Indicators

A recent report, entitled *Rural, Remote and Northern Health Research: The Quest for Equitable Health Status for All Canadians*, points out that there is not a great deal of information

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<sup>257</sup> Canada, Canadian Rural Partnership, *Questions for Rural Canadians: Rural Dialogue Workbook*, Ottawa, 1998; Canada, Rural Secretariat, *Working Together in Rural Canada: Annual Report to Parliament*, Agriculture and Agri-Food Canada, May 2000.

available on the health of rural Canadians, although data on life expectancy, death rates and infant mortality rates give some broad indicators of health. Overall, compared to urban areas, life expectancy in rural regions is shorter while death rates and infant mortality rates are higher. In 1996, life expectancy for rural females was 80.82 years as opposed to 81.31 years for urban females. The comparable figures for rural and urban males were 74.67 years and 75.67 years, respectively.<sup>258</sup>

Overall, the health status of rural and remote residents is lower than that of their urban counterparts. Dr. Peter Hutten-Czapski, President of the Society of Rural Physicians of Canada, noted:

*There is a trend towards a progressive deterioration in health as one moves from an area bordering urban centres into the very remote hinterland.*

*Dr. Peter Hutten-Czapski, President, Society of Rural Physicians of Canada (17:13)*

*Health status decreases as one travels to more rural and remote regions. As an example, heart disease is common in northern Ontario. Certain types of cancer are found among miners and farmers. There are substantially higher rates of diabetes, respiratory and infectious diseases, as well as violence-related deaths, in some aboriginal communities. Combined, there is an increase in mortality in rural regions as evidenced by life span.*

*The lower life expectancies are not associated with just a few specific causes; rather, the mortality rates in these regions are higher for most causes of death. Consistent with other measures of the health of the population, there is an association with socio-economic factors: life expectancy decreases as the rate of unemployment increases and the level of education decreases.*<sup>259</sup>

The health and health care needs of rural Canadians are different from those of Canadians living in urban areas. As Health Canada's Office of Rural Health pointed out:

*Rural realities and health needs differ from those of urban areas. These needs may be particular to the environment (e.g., the need for education on tractor roll-over prevention), changing demographics (e.g., an increase in the seniors' population in some rural areas), a common health need present in a rural environment (e.g., the health status of First Nations' communities), or the need for health concerns to be expressed in a 'rurally sensitive' way (e.g., obstetrical services that do not generate an excessive 'travel burden' on rural women).*<sup>260</sup>

This statement highlights some of the particular populations in rural Canada that may have special needs based on factors such as age, gender, ethnicity, and occupation. For example, various studies have shown that:

<sup>258</sup> M. Watanabe with A. Casebeer, *Rural, Remote and Northern Health Research: The Quest for Equitable Health Status for All Canadians*, A Report of the Rural Health Research Summit, January 2000, p. 21.

<sup>259</sup> Peter Hutten-Czapski, *State of Rural Health Care*, Brief to the Committee, 31 May 2001, p. 3.

<sup>260</sup> Health Canada, *Rural Health* (<http://www.hc-sc.gc.ca/ruralhealth/>).

- Seniors in Canada are over-represented in rural regions, as are children and youth under the age of 20. There are particular issues for seniors needing assisted home care or long-term care and for children and youth with special medical needs or who are in abusive situations.
- Farmers, fishers, foresters, and miners can face serious health hazards in their jobs. In addition to accidents related to the increasingly complex machinery used in these occupations, there are hazardous exposures to chemicals, noise, long working hours, temperature extremes, infectious diseases, and stress.
- While Aboriginal peoples face an array of health problems related to their socio-economic status, they also experience some of the cultural insensitivity experienced by new immigrants such as lack of services in their own language, health care personnel who are unaware of cultural practices, and problems associated with services designed for a mainstream population.<sup>261</sup>

## 10.2 Access to Health Services in Remote and Rural Areas

The accessibility criterion of the *Canada Health Act* requires that reasonable access to insured health services be provided to all Canadians on uniform terms and conditions and without financial or other barriers. Dr. John Wootton, former Executive Director of the Office of Rural Health (now Special Advisor on Rural Health, Population and Public Health Branch, Health Canada) raised the problem of accessibility for rural residents, when he stated: “If there is two-tiered medicine in Canada, it’s not rich and poor, it’s urban versus rural.”<sup>262</sup>

*If there is two-tiered medicine in Canada, it’s not rich and poor, it’s urban versus rural.*

*Dr. John Wootton, quoted in Farm Family Health.*

Canadians living in rural and remote areas are limited to a smaller range of health care providers when seeking care than are their urban counterparts. Rural hospital closures and centralization of health services have had an impact on rural residents. Rural physicians explained that, when the insured health services are not available from local providers in local health care facilities, rural residents must travel long distances and incur additional costs for transportation and other needs such as hotels. This can also negatively affect their health:

*We must understand that if rural people are forced to travel for care, some will not travel. If they do not travel, they cannot achieve the health outcomes of people who are able or willing to travel. Some will travel, but the delay caused by the travelling or the need to travel will be costly to them. Others will be subject to the hazards of transport or inclement weather. Collectively forcing people to travel long distances for health care, even to a centre of the highest standards, will adversely affect health outcomes.*

<sup>261</sup> For an overview of these factors, see Therese Jennissen, *Health Issues in Rural Canada*, Parliamentary Research Branch, BP-235E, 1993.

<sup>262</sup> Interview with Dr. John Wootton, “New Office to Focus on Rural Health Issues,” *Farm Family Health*, 7(1) Spring 1999.

*This is a particular concern for women's health. Studies show that women do poorly if they must travel long distance to give birth. In Saskatchewan, it should be noted, the 1993 closure of 53 rural hospitals was followed by an increase in its perinatal mortality rate. We cannot say that these things are causal, but it is certainly concerning.*<sup>263</sup>

The recruitment and retention of health care personnel including physicians, specialists, nurses, technicians, social workers, physiologists and nutritionists, in remote and rural areas of Canada have been ongoing concerns. Access to physician services is a particular problem. For example, Dr. Hutten-Czapski stated:

*Doctors are concentrated where the most healthy people in the country live, and the sickest populations have the least access to health care, so the gap between urban and rural grows.*<sup>264</sup>

Physician shortages in rural and remote communities have been persistent and are expected to continue. According to the Canadian Medical Association:

- While approximately 30% of Canadians live in rural or remote areas, only 10% of Canadian physicians practise outside Census Metropolitan Areas or Census Agglomerations;
- Of the approximately 5,700 rural physicians, 87% are family physicians;
- While the majority of rural physicians (72%) graduate from Canadian medical schools, the number of Canadian graduates varies from region to region. In Newfoundland, one-third of the rural physicians are Canadian graduates; in Saskatchewan, one-fifth of rural doctors have graduated from Canadian medical schools. In Quebec, 95% of rural physicians have been trained in Canada.<sup>265</sup>

*Statistical modeling predicted a decrease of rural physicians from 5,531 in 1998 to 4,529 in 2021. The ratio of physicians per 1000 population will decrease from an already low 0.79 physicians per 1000 population in 1999 to 0.53 by 2021 (a 33% decrease).*

*Society of Rural Physicians of Canada, Brief, p. 1*

*(...) the rural physician currently is produced by accident and not by design. In fact, the largest source of medical school that is more pertinent to rural Canada is the University of Johannesburg. We have 1,500 physicians from South Africa in Saskatchewan.*

*Dr. Hutten-Czapski (17:29)*

In the early 1990s, the federal and provincial/territorial Ministers of Health considered strategies for physician resource management and by the end of the decade were examining options for both physicians and nurses through the Federal/Provincial/Territorial Advisory Committee on Health Human Resources. A discussion paper prepared for this Committee in 1999, entitled *Improving Access to Needed Medical Services in Rural and Remote Canadian*

<sup>263</sup> Dr. Peter Hutten-Czapski (17:13).

<sup>264</sup> *Ibid.*

<sup>265</sup> Canadian Medical Association, *Rural and Remote Health in Canada*, Brief to the Committee, 31 May 2001.

*Communities: Recruitment and Retention Revisited* (Barer and Stoddart, 1999), attributed the lack of access to physicians services in remote and rural areas compared to urban settings to “a fundamental mismatch between the needs of rural and remote communities ... and the needs and choices of (and influences on) those who become physicians.”<sup>266</sup> Barer and Stoddart also pointed out:

*There are many communities across the country that are simply too small to support a general practitioner, or that are large enough to support one but too small to support two or three, let alone the full range of specialists found in large urban centres. For their part, most Canadians who are accepted into the medical schools across the country have grown up in urban settings; the bulk of their medical training occurs in urban settings; that training takes place largely in tertiary hospitals which are only found in urban settings; much of the training is provided by physician-educators who work in urban settings; there are (given in per capita terms) more practice opportunities in urban settings; access to specialist colleagues and other complementary treatment and diagnostic resources are more plentiful in urban settings; hours of work are more likely to be ‘regular’ in urban settings and, in particular, call schedules are less onerous; and there are many more social, educational, recreational, employment and cultural opportunities for physicians and their families in urban settings.*<sup>267</sup>

Experts suggest that, while policy approaches to dealing with physician shortages in rural and remote areas have been economic or financial, most of the determinants of practice location involve a complex mix of factors involving far more than financial considerations.<sup>268</sup> Personal background, professional education and practice factors, personal considerations (e.g., children’s education, recreation, spousal job opportunities) and community size and are also important influences in practice locations. Financial considerations, however, are not as important as personal factors. The physicians who moved for professional reasons also indicated that the presence of certain factors such as additional colleagues, *locum tenens* (physicians who temporarily carry on the practice for an absent colleague), opportunities for group practice, specialist services and alternative compensation would have influenced them to remain in rural practice.<sup>269</sup>

Unfortunately, there is very little data on registered nurses or other health care providers in similar settings.

A variety of measures have been proposed to help alleviate the shortage of physicians in under-serviced areas. For example, these include:

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<sup>266</sup> Morris L. Barer and Greg L. Stoddart, *Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited*, Discussion paper prepared for the Federal/Provincial/Territorial Advisory Committee on Health Human Resources, June 1999, p. 3 (available on the Internet at <http://www.srpc.ca/librarydocs/BarSto99.htm>).

<sup>267</sup> *Ibid.*

<sup>268</sup> Morris L. Barer, Laura Wood, and David G. Schneider, *Toward Improved Access to Medical Services for Relatively Underserved Populations: Canadian Approaches, Foreign Lessons*, Centre for Health Services and Policy Research, The University of British Columbia, May 1999, p. 7.

<sup>269</sup> William Tholl, Secretary General and Chief Executive Officer, Canadian Medical Association (17:8).

- Reserving undergraduate medical school places for qualified applicants willing to commit to rural area practice;
- Revising admission criteria for medical schools to favour qualified rural applicants;
- Enhancing rural area exposure in both undergraduate and post-MD training;
- Developing new residency training programs designed explicitly to prepare specialists to serve as rural regional consultants; and
- Introducing or increasing financial incentives to encourage choices of specialties in short rural supply.

Provincial and territorial governments have used a number of incentive programs to attract physicians to practice in rural and remote areas. Most of these are financial in nature, but some focus on working conditions, some seek to direct where physicians can establish practices, others recruit foreign medical graduates and others focus on attracting rural residents to attend medical school and providing rural exposure in the course of medical training.

Research demonstrates that a greater proportion of trainees from rural settings will return to rural areas because they are already comfortable with the rural culture. As governments acknowledge that it may be easier to retain physicians in rural and remote areas if they have grown up there, programs to attract rural residents to become doctors are becoming more common. One such program will be the creation of a rural medical school in northern Ontario – the “Thunder-Barrie Medical School”. Rural physicians challenged the federal government to commit half of the funding for the establishment of rural medical schools in Canada.

*Many doctors do come to rural communities as a result of (...) incentive programs. The problem is that doctors are not staying.*

*Dr. Peter Hutten-Czapski (17:13)*

Barer, Wood and Schneider (1999) also pointed out that while all provinces and territories face similar issues and problems in relation to the distribution of health services and personnel, there has not been a great deal of cooperation among them in attempting to solve these problems.

*The failure to develop any pan-Canadian initiatives has meant a history of destructive competition rather than co-operation.*

*Barer, Woods and Schneider (1999)*

William Tholl, Secretary General and CEO of the Canadian Medical Association (CMA), attributes this lack of success to the fact that these financial programs have little to do with the major factors involved in a physician’s decision to locate and stay in a rural or remote area – those that are non-financial in nature.<sup>270</sup> Moreover, the lack of cooperation among the provinces suggests that the federal government could play a useful role in fostering inter-provincial collaboration.

It is important to note that Canada is not alone in experiencing problems in providing health services to rural and remote locations. Significant variations in the geographic supply of health services occur in virtually every industrialized country. The United States, Australia and New Zealand, for example, are experiencing health care personnel distribution

<sup>270</sup> William Tholl (17:9).



problems similar to those found in Canada. Like Canada, these countries have adopted a number of policy approaches to deal with these problems.

### 10.3 Telehealth

Many experts see telehealth as an important vehicle for delivering health services to rural and remote areas. Supporters of telehealth believe that it holds significant promise in this regard. The Office of Health and the Information Highway at Health Canada is promoting telehealth as a way to offer fairer distribution of health resources and to connect patients and health care providers separated by geographic distance. The Society of Rural Physicians of Canada sees both potential and risks in telehealth. The potential lies in its ability to supplement the skills and abilities of existing rural health care workers to deal with problems that would otherwise require patients to travel out of the community to access needed care. The risks, on the other hand, lie in its potential to divert resources away from the local community with the result that needed care can be accessed only from outside sources.<sup>271</sup>

*Telehealth is a very positive step of providing health care to rural residents of our country.*

*Dr. Judith Kulig, Consortium for Rural Health Research (17:6)*

### 10.4 Rural Health Research

Witnesses confirmed that many gaps exist in information on the health status of individuals and communities in rural Canada. Similarly, there is not a substantial body of research on rural health issues. In the view of witnesses, rural health issues tend to be eclipsed by those in urban areas. Policy solutions often are based on experiences in urban areas and rely on urban data and research. A position paper prepared for the Canadian Health Services Research Foundation and the Social Science and Humanities Research Council pointed out:

*Because the health problems confronting rural Canada are serious, complex, interrelated and evolving, research should have a critical role to play in examining the nature of these problems, monitor their progress or deterioration, identifying their causes, finding solutions and evaluating the effectiveness of various interventions. However, to date, rural health research has not received substantial or sustained support from major health research granting agencies in Canada. Generally speaking, within the health research community, rural health issues are either overlooked or dealt within a “generic” manner. In “generic” studies, even when rural is mentioned, it is commonly used as a convenient comparison category to illustrate urban-rural differences. Rural is rarely the focus of attention, yet findings and recommendations from urban-based research are often considered universally applicable or are extrapolated to rural settings.<sup>272</sup>*

<sup>271</sup> Society of Rural Physicians of Canada, Brief, p. 4.

<sup>272</sup> Raymond W. Pong, Anne Marie Atkinson, Andrew Irvine, Martha MacLeod, Bruce Minore, Ann Pegoraro, J. Roger Pitblado, Michael Stones, and Geoff Tesson, *Rural Health Research in the Canadian Institutes of Health*

One of the weaknesses identified in rural health research is lack of coordination and planning. A 1999 Rural Health Research Summit was held to develop a “Blueprint” for future action in rural health research. Other initiatives such as the development of the Canadian Institutes of Health Research (CIHR), increases in health research budgets and the appointment of a special advisor on rural health to CIHR’s President have been important developments in rural health research. In addition, a Rural Health Research Consortium was formed in 1999 to build capacity in research endeavours related to health in rural and remote areas.

## **10.5 The Federal Role**

The federal government has responded to the concerns of rural Canadians in a number of ways. For example, the Office of Rural Health was established in September 1998 to ensure that the views and concerns of rural Canadians are better reflected in national health policy and health care system renewal strategies. In February 1999, the federal government announced funding of \$50 million over three years (from 1999-00 to 2001-02) to support pilot projects under the “Innovations in Rural and Community Health Initiative.”

In June 2000, the federal government announced a National Strategy on Rural Health that it sees as an important milestone on the road to ensuring that all Canadians have reliable access to quality health care. Then, in July 2001, the federal government announced the establishment of a Ministerial Advisory Committee on Rural Health to provide advice to the federal Minister of Health on how the federal government can improve the health of rural communities and individuals.

## **10.6 Committee Commentary**

The Canadian health care system faces many challenges, some of the greatest of which are providing for the health care needs of those who live in rural and remote areas of the country. We know that, generally, rural Canadians have: higher death rates; higher infant mortality rates; and shorter life expectancies than do urban Canadians. We also know that certain types of diseases and conditions are more prevalent in rural areas and among occupations associated with a rural environment. But witnesses pointed out that little is known about the overall health status of rural Canadians. Dr. Judith Kulig, Consortium for Rural Health Research, characterized the adequacy of information on the health status of rural residents as very poor.<sup>273</sup> She attributed this to the limited number of individuals pursuing rural health topics and the limited number of dollars to support research in this field.

Providing equal access to health care is a challenge in rural and remote areas of Canada. The Committee was told that systemic trends such as inadequate numbers of rural doctors and increasing centralization of medical services have the effect of impeding access. The current medical education system is not geared to producing sufficient numbers of doctors who are interested in committing to rural practices; as well, provincial financial incentive programs to attract and retain rural physicians have not had high success rates. Telehealth

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*Research*, A position paper prepared for Canadian Health Services Research Foundation and Social Sciences and Humanities Research Council, p.3.

<sup>273</sup> Dr. Judith Kulig (17:4).

applications can help solve some of these problems, but they constitute only one part of the solution.

Witnesses emphasized the importance of federal, provincial, and territorial cooperation in developing national strategies to deal with rural health issues whether in the areas of planning, research, health human resources or reducing structural barriers to national rural health policy advancement. They argued for a federal presence in areas such as funding, immigration, planning, evaluation, information-sharing and co-ordination, technology, facilitating consensus, promoting innovative solutions to rural health issues, and an expansion of the mandate of the Health Canada's Office of Rural Health.<sup>274</sup>

The Committee hopes that the recently established Ministerial Advisory Committee on Rural Health will lead to concrete policies and programs that will effectively contribute to enhancing the health of rural Canadians.

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<sup>274</sup> In September 1998, the Office of Rural Health was established in Health Canada to apply a “rural lens” to the federal government’s policies, programs and services. The Office’s mandate is to:

- Provide policy advice on rural health issues;
- Identify rural health issues in relation to broad federal, departmental and regional priorities;
- Foster understanding about rural health issues of national concern and build consensus on how to address them;
- Identify emerging trends;
- Work with others to promote, encourage or influence action on rural health issues; and
- Promote the involvement of rural citizens, communities and health care providers.



## CHAPTER ELEVEN:

### MYTHS AND REALITIES

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**A**s mentioned in the Phase One report, the debate about Canada's health care system and its future has generated a great deal of confusion. In this chapter, the Committee briefly analyzes a series of arguments in order to help separate myth from reality. We hope that this information will contribute to an informed, fact-based debate on health and health care.

#### 11.1 Demographic Aging

**Myth:** The single biggest increase in health care spending is attributable to the needs of older Canadians.

**Reality:** Persons over 65 consume, on average, more health services than those under 65. However, the aging of the population is only one of the many factors – related to both supply and demand – contributing to increasing health care costs. Other cost drivers include the use of new technology, the cost of new drugs, changing public expectations, and new and changing patterns of diseases. These all have a significant influence on the cost of health care.

Canadians are living both longer and more healthily. Therefore, the anticipated demographic impact of aging on the health care system needs to be revisited. Moreover, while the costs associated with aging must be analyzed and managed, a more significant issue concerns the health care costs that are generally incurred during the last six months of life, regardless of age. The cost of medical care that individuals receive skyrockets as they near the end of their life. As a result, it is not the aging per se of the population which has an impact on health care costs, but rather the overall increase in the population.

#### 11.2 Spending on Drugs

**Myth:** Spending on drugs is increasing because of higher drug prices.

**Reality:** A number of factors are responsible for increased spending on drugs such as increased utilization, a shift in prescribing patterns away from older less expensive drugs to newer costlier medications, and price increases. Using data from British Columbia, the Federal/Provincial/Territorial Task Force on Drug Utilization (see Chapter Two) found that changes in prescription drug spending could be attributed to the following cost drivers: increased utilization of existing drugs (50%), sales of new drugs in their first full year (32%) and price increases of existing drugs (18%). Thus, increased utilization and a shift to newer drugs, not price increases have been largely responsible for recent increases in spending on drugs.

**Myth:** Canadians in all parts of Canada have equal access to prescription drugs under provincial government Pharmacare plans.

**Reality:** There are significant regional variations in who is eligible for coverage and the reimbursement levels under government drug insurance plans. Residents of Atlantic Canada do not fare as well as residents in other parts of Canada. Also, substantial numbers of people have inadequate coverage or no coverage at all. Part-time and low-income workers are particularly vulnerable because they often do not qualify for government plan coverage and do not have access to employee benefits plans with drug coverage.

**Myth:** Drugs prices are the same throughout Canada.

**Reality:** Drug prices vary from province to province. The Federal/Provincial/Territorial Task Force on Pharmaceutical Prices reported significant differences in the manufacturers' prices across Canada for the same drug products. In 1993, prices in Ontario (the highest-price province) were 8.8% higher than the prices in British Columbia (the lowest-price province). By 1997, the last year covered by the report, price differences had been reduced, with Nova Scotia (the highest-price province) having prices that were 5% higher than the lowest-price province, Manitoba. The Task Force also found that if all provinces in the study had paid the lowest available prices for the same products in 1997, \$60 million would have been saved.

Despite various efforts to control prices, drug spending is expected to continue to escalate largely because of increased utilization and increased consumption of newer more expensive drugs.

### 11.3 Health Care Technology

**Myth:** All health care technologies currently used within the Canadian health care system have been evaluated in term of their safety, clinical efficacy and cost-effectiveness.

**Reality:** Unfortunately, this is not the case. As mentioned in Chapter Three, Canada does not devote a great deal of money to health care technology assessment (HTA). On a worldwide basis, Canada spends less on HTA activities than do other countries. For example, all levels of government invest less than \$8 million in Canada, whereas the United Kingdom provides some \$100 million to its national HTA body – the National Institute for Clinical Excellence (NICE). As a result, health care technologies are often introduced into the Canadian health care system with only superficial knowledge of their safety, effectiveness and cost.

### 11.4 Aboriginal Health

**Myth:** The federal government pays for the health services for all Aboriginal people in Canada.

**Reality:** Health care to Aboriginal Canadians is delivered through a complex array of federal, provincial and Aboriginal-run programs and services. Métis and non-status Indians are not eligible for most federal health-related programs. Health Canada provides services to First Nations (status Indians) and Inuit. These include:

- community-based health promotion and prevention programs to status Indians living on reserves and in Inuit communities;
- non-insured health benefits (NIHB) to status Indians and Inuit peoples regardless of residence in Canada. (As explained in Chapter Five, the NIHB program provides a range of health-related services to eligible beneficiaries who are status Indians, recognized Inuit or Labrador Innu. Benefits include drugs, medical supplies and equipment, dental care, vision care, medical transportation, provincial health care premiums, and crisis mental health counselling.);
- primary care and emergency services in nearly 200 isolated and semi-isolated areas where no provincial services are available;
- public health services in over 400 communities;
- funding for addiction services through treatment centres and addiction treatment workers.

**Myth:** The Aboriginal population enjoys the same health status as other Canadians.

**Reality:** The life expectancy of Aboriginal peoples in Canada is at least five years below the average for all Canadians. This is an enormous gap. It has been estimated that increasing the life expectancy of the Aboriginal population by five years would require the elimination of all deaths from cardiovascular diseases (the leading cause) and almost all deaths from cancer (the second cause of death). Although this would appear to be an insurmountable obstacle, the Committee was told that some progress is being made.

Although the discrepancies in the health status of the Aboriginal population are evident, the underlying causes are not easily identified. Aboriginal Canadians are less likely to have finished high school, and are twice as likely to be under Statistics Canada's low income cut-offs. This could help explain some of the factors contributing to the Aboriginal population's higher incidence of health problems.

Overall, a variety of determinants affect the health of Aboriginal Canadians. Witnesses told the Committee that, because many federal departments are currently responsible for delivering a wide range of programs that can have an impact on Aboriginal health, the federal government is, therefore, well positioned to develop and implement population health strategy designed specifically for Aboriginal Canadians.

## 11.5 Human Resources in Health Care

**Myth:** Fee-for-service is the only model that physicians will accept.

**Reality:** Most physicians are currently paid under a fee-for-service scheme in Canada. There is evidence, however, that many physicians would prefer an alternative mode of remuneration. A 1999 survey by the Canadian Medical Association reported that only 33% of respondents would prefer to be paid on a fee-for-service basis. Another 21% would prefer to be

salaried, while less than 1% would select capitation. Approximately 35% indicated a preference for a blend of payments (e.g. mix of fee-for-service and capitation). Data from CIHI (2000) shows that, at present, the proportion of physicians remunerated by non fee-for-service mechanisms ranges from 2% in Alberta to 53% in Manitoba.

The fee-for-service scheme has some drawbacks. First, fee-for-service actively discourages physicians from promoting teamwork, as their individual remuneration depends on the number of patients they see. Second, fee-for-service encourages family physicians to refer as a matter of course many of the more complex cases to specialists because they have no incentive to spend more time with “difficult” cases. Finally, fee-for-service reinforces the public’s perception of the current “hierarchy” within the health care system, and can only serve to accentuate demand on the part of individual patients to always consult the most “highly” qualified provider, regardless of whether or not they are the one best-suited to meeting the patient’s needs.

## 11.6 Health Information Systems

**Myth:** Canada’s health care system is structured like a 21<sup>st</sup> century service industry.

**Reality:** On the contrary, witnesses stressed that a major weakness in our current health care system is that it still operates as a “cottage industry”, despite the fact that the health care sector is an extremely information-intensive industry. Indeed, the most important single ingredient in any diagnosis, treatment and prevention is information. As mentioned in Chapter 8, the health care sector in Canada is not making use of information and communications technology to the same extent as do other information-intensive industries. Moreover, the health care system is not integrated: physicians and other health care providers, hospitals, laboratories and pharmacies all operate as independent entities with limited access to electronic linkages that would enable a better sharing of information.

Greater use of information and communications technology along with better integration of health care providers and institutions would facilitate the determination of causal relationships between the various inputs typical of the health care system and the resulting outputs or outcomes. This would greatly improve evidence-based decision-making by health care providers, health care managers and health care policy-makers. This would allow us to answer such questions as: Are we investing enough, too much, or too little in health care technology? Are there too many, too few, or just enough physicians, nurses, or other health care professionals? Are we getting our money’s worth? Currently, we simply do not know the answers to these questions.

The Committee believes that many of the problems facing the health care sector can be successfully addressed only if the industry is prepared to transform itself into a 21<sup>st</sup> century service industry, rather than remaining mired in a 19<sup>th</sup> century structure and outlook. In our view, the federal government could provide assistance to encourage this transformation.



## 11.7 Home Care

**Myth:** Home care is only for people who are old.

**Reality:** Although many home care services are aimed at the frail elderly, there are no upper or lower age or other limits for home care requirements. Home care may be appropriate for people with minor health problems and disabilities as well as for those who are acutely ill requiring intensive and sophisticated services and equipment. Services are available to children recovering from acute illness, adults with chronic diseases such as diabetes, persons with physical or mental disabilities, and individuals needing end-of-life care.

## 11.8 Rural Health

**Myth:** The health and health care needs of rural Canadians are the same as those of Canadians living in urban settings.

**Reality:** Health Canada's Office of Rural Health points out that rural health needs differ from those of urban areas. These needs stem from the particular environment, such as the hazards associated with rural occupations including mining, fishing and farming; demographic trends such as an increase in the seniors' population in some rural areas; and the common health needs associated with the presence of a significant number of Aboriginal communities. In addition, there are more problems associated with delivering health services in rural and remote environments compared to an urban setting – distances are greater, the numbers of health care providers are smaller and specialist services may not be readily available.

**Myth:** The rural health issues faced by Canada are unique to this country.

**Reality:** Rural health issues tend to be similar throughout the world. Significant variations in the geographic supply of health services occur in virtually every industrialized country. The United States, Australia and New Zealand, for example, are experiencing health care personnel distribution problems similar to those found in Canada.



## CONCLUSION

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This report completes Phase Two of the Committee's study on health care. It summarizes the evidence we heard from March 2001 to June 2001, and makes reference to documents that were either tabled with the Committee or brought to the attention of the Members.

During Phase Two, the Committee learned a great deal about the major trends that are having an impact on the cost and the method of delivery of health services and the implications of these trends for future public policy and funding. We have heard that issues with respect to demographic aging, the growing cost of new drugs and technologies, shortages of health care providers, the burden of illness, and the particular needs of rural Canadians and Aboriginal peoples all need to be addressed if Canada is to sustain its health care system. The Committee now has a better understanding of how health research and the deployment of a pan-Canadian health info-structure can help improve both the quality of care and the effectiveness of health services delivery in the future. We also understand that health and wellness promotion, disease prevention and population health strategies can contribute to curbing the costs of health care by enhancing the overall health status of Canadians.

With all this background information, we attempted, as in the Phase One report, to shed some light on the current debate over health care in Canada by separating myths from realities. We hope that this report will serve as a useful reference document to anyone who wishes to participate in future phases of the Committee's study on health care.



## APPENDIX:

### LIST OF WITNESSES (MARCH – JUNE 2001)

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#### Wednesday, March 21, 2001

*Statistics Canada:*

Réjean Lachapelle, Director, Demography Division

Jean-Marie Berthelot, Manager, Health Analysis and Modeling Group, Social and Economic Studies Division

Brian Murphy, Senior Research Analyst, Socio-Economic Modeling Group

*Canadian Institute of Actuaries:*

David Oakden, President

Rob Brown, Manager of Task Force on Health Care Financing

Daryl Leech, Chair, Committee on Health Care

*National Advisory Council on Aging:*

Dr. Michael Gordon, Member

*Conference Board of Canada:*

James G. Frank, Ph.D., Chief Economist and Vice-President

Glenn Brimacombe, Director of Health Program

#### Thursday, March 22, 2001

*C.D. Howe Institute:*

William B.P. Robson, Vice-President and Director of Research

*McMaster University:*

Byron G. Spencer, Professor

*University of Ottawa:*

Dr. William Dalziel

#### Wednesday, March 28, 2001

*IMS Health Canada:*

Dr. Roger A. Korman, President

*Canadian Association of Pharmacists:*

Dr. Jeff Poston, Executive Director

*Health Promotion Research:*

Dr. Robert Coombs, President and CEO

*Health Canada:*

Barbara Ouellet, Director of Home Care and Pharmaceuticals, Health Care Directorate, Policy and Consultation Branch

#### Thursday, March 29, 2001

*Canadian Association of Radiologists:*

Dr. John Radomsky

**Thursday, March 29, 2001 (cont'd)**

*Canadian Coordinating Office for Health Technology Assessment (CCHOTA):*  
Dr. Jill Sanders, President and CEO

*The Fraser Institute:*  
Martin Zelder, Director of Health Policy Research

*As an individual:*  
Professor David Feeny

**Wednesday, April 4, 2001**

*Health Canada:*  
Dr. Christina Mills, Director General, Centre for Chronic Disease Prevention and Control – Population Public Health Branch  
Dr. Paul Gully, Acting Director General, Centre for Infectious Disease Prevention and Control  
Dr. Clarence Clottey, Acting Director, Diabetes Division, Bureau of Cardio-Respiratory Diseases and Diabetes, Centre for Chronic Disease prevention and Control  
Nancy Garrard, Director, Division of Aging and Seniors

*Dalhousie University:*  
Dr. David MacLean, Departmental Head, Community Health and Epidemiology

**Thursday, April 5, 2001**

*Health Canada:*  
Abby Hoffman, Director General, Health Care Directorate – Health Policy and Communications Branch  
Cliff Halliwell, Director General, Applied Research & Analysis Directorate, Information, Analysis and Connectivity Branch  
Nancy Garrard, Director, Division of Aging and Seniors

**Thursday, April 26, 2001**

*Canadian Institute of Health Research:*  
Dr. Alan Bernstein, President

*Health Canada:*  
Kimberly Elmslie, Acting Executive Director, Health Research Secretariat

*Statistics Canada:*  
T. Scott Murray, Director General, Institutions and Social Statistics Branch

**Wednesday, May 9, 2001**

*Canada's Research-Based Pharmaceutical Companies:*  
Murray Elston, President

*Coalition for Biomedical and Health Research:*  
Dr. Barry McLennan, Chairman  
Charles Pitts, Executive Director

*Centre for Excellence for Women's Health:*  
Dr. Pat Armstrong

**Wednesday, May 9, 2001 (cont'd)**

*Canadian Genetic Diseases Network:*

Dr. Ronald Worton, CEO & Scientific Director

**Thursday, May 10, 2001**

*Health Canada:*

William J. Pascal, Director General, Office of Health and Information Highway, Information, Analysis and Connectivity Branch

*Canadian Institute for Health Information:*

Dr. John S. Millar, Vice-President, Research and Analysis

*Canadian Society of Telehealth:*

Dr. Robert Filler, President

*Department of Health and Wellness of New Brunswick*

David Cowperthwaite, Director of Information System

**Wednesday, May 16, 2001**

*Canadian Medical Association:*

Dr. Peter Barrett, President

*Canadian Medical Forum Task Force 1:*

Dr. Hugh Scully, President

*Federal Provincial Territorial Advisory Committee on Health Human Resources:*

Dr. Thomas Ward, Chair

*Canadian Nurses Association:*

Sandra MacDonald-Remecz, Director of Policy, Regulation and Research

*Canadian Federation of Nurses Unions:*

Kathleen Connors, President

*Ordre des infirmières et infirmiers auxiliaires du Québec:*

Régis Paradis, President

*Nurse Practitioners Association of Ontario:*

Linda Jones

*Canadian Radiation and Imaging Societies in Medicine (CRISM):*

Dr. Paul C. Johns, Past Chair

*The Canadian Chiropractic Association:*

Dr. Tim St. Dennis, President

*Canadian Society for Medical Laboratory Science:*

Kurt Davis, Executive Director

**Thursday, May 17, 2001**

*Canadian Home Care Association (CHCA):*  
Nadine Henningsen, Executive Director

*Canadian Association for Community Care (CACC):*  
Dr. Taylor Alexander, President

*Victorian Order of Nurses for Canada (VON Canada):*  
Diane McLeod, Vice-President, Policy, Planning and Government Relations, Central Region

**Wednesday, May 30, 2001**

*Health Canada:*  
Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch  
Jerome Berthelette, Special Advisor, Office of the Special Advisor Aboriginal Health, First Nations Inuit Health Branch  
Dr. Peter Cooney, Acting Director General, Non-Insured Health Benefits, First Nations and Inuit Health

*Indian and Northern Affairs Canada:*  
Chantal Bernier, Assistant Deputy Minister, Socio-economic Development Policy and Programs  
Terry Harrison, Director, Social Services and Justice

*Assembly of First Nations:*  
Elaine Johnston, Director of Health

*Métis National Council:*  
Gerald Morin, President

*Native Women's Association of Canada:*  
Michelle Audette, Interim Speaker and President of the Native Women Association of Quebec

*Congress of Aboriginal Peoples:*  
Scott Clark, President, United Native Nations

*Inuit Tapirisat of Canada:*  
Larry Gordon, Member ITC, Health Committee

*Panktutit Inuit Women's Association:*  
Veronica N. Dewar, President

*National Aboriginal Health Organization:*  
Dr. Judith Bartlett, Chair  
Richard Jock, Executive Director

*Canadian Institutes of Health Research:*  
Dr. Jeff Reading, Scientific Director, Institute of Aboriginal People's Health

*Wkwemikong Health Centre:*  
Ron Wakegijig, Healer

*National Indian and Inuit Community Health Representatives Organization:*  
Margaret Horn, Executive Director



**Thursday, May 31, 2001**

*Health Canada:*

Dr. John Wooton, Special Advisor on Rural Health, Population and Public Health Branch

*Canadian Medical Association:*

William Tholl, Secretary General and Chief Executive Officer

*Society of Rural Physicians of Canada:*

Dr. Peter-Hutten-Czapski, President

*Consortium for Rural Health Research:*

Dr. Judith Kulig

**Wednesday, June 6, 2001**

*University of Ottawa:*

Professor Martha Jackman, Faculty of Law

*University of Calgary: (by videoconference)*

Professor Sheila Martin, Faculty of Law

**Thursday, June 7, 2001 (11:00 a.m.)**

*Health Canada:*

Nancy Garrard, Acting Director General, Centre for Healthy Human Development, Population and Public Health Branch

Tom Lips, Senior Policy Advisor for Mental Health, Population and Public Health Branch

Carl Lakaski, Senior Analyst, Mental Health, Health Human Resources Strategies Division, Health Policy and Communications Branch

*Canadian Psychological Association:*

Dr. John Service, Executive Director

*Canadian Alliance on Mental Illness and Mental Health:*

Phil Upshall, Coordinator

*Canadian Mental Health Association:*

Bonnie Pape

*Department of Health and Wellness of New Brunswick:*

Ken Ross, Assistant Deputy Minister, Mental Health Services

The Standing Senate Committee on Social Affairs, Science and Technology

Interim Report on  
the state of the health care system in Canada

*The Health of Canadians – The Federal Role*  
*Volume Three – Health Care Systems in Other Countries*

*Chair*

The Honourable Michael J. L. Kirby

*Deputy Chair*

The Honourable Marjory LeBreton

JANUARY 2002



# TABLE OF CONTENTS

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TABLE OF CONTENTS.....	i
ORDER OF REFERENCE .....	iv
SENATORS .....	v
INTRODUCTION.....	1
<b>CHAPTER ONE: .....</b>	<b>5</b>
HEALTH CARE IN AUSTRALIA.....	5
1.1 Government Responsibility.....	5
1.2 Health Care Insurance and Coverage .....	5
1.3 Funding for Health Care .....	8
1.4 Management and Provision .....	8
1.5 Particularities.....	9
<b>CHAPTER TWO: .....</b>	<b>13</b>
HEALTH CARE IN GERMANY.....	13
2.1 Government Responsibility.....	13
2.2 Health Care Insurance and Coverage .....	13
2.3 Funding for Health Care.....	15
2.4 Management and Provision.....	16
2.5 Particularities.....	17
2.5.1 <i>Competition Among Sickness Funds</i> .....	18
2.5.2 <i>Lack of Integration</i> .....	18
2.5.3 <i>Long-Term Care</i> .....	18
<b>CHAPTER THREE: .....</b>	<b>21</b>
HEALTH CARE IN THE NETHERLANDS.....	21
3.1 Government Responsibility.....	21
3.2 Health Care Insurance and Coverage .....	21
3.2.1 <i>Insurance for Normal Medical Care</i> .....	22
3.2.2 <i>Insurance for Exceptional Medical Care</i> .....	23
3.2.3 <i>Voluntary Supplementary Insurance</i> .....	23
3.3 Funding for Health Care .....	24
3.4 Management and Provision .....	24
3.5 Particularities.....	25

<b>CHAPTER FOUR:</b>	<b>29</b>
HEALTH CARE IN SWEDEN	29
4.1 Government Responsibility	29
4.2 Health Care Insurance and Coverage	29
4.3 Funding for Health Care	30
4.4 Management and Provision	32
4.5 Particularities	33
<b>CHAPTER FIVE:</b>	<b>37</b>
HEALTH CARE IN THE UNITED KINGDOM	37
5.1 Government Responsibility	37
5.2 Health Care Insurance and Coverage	37
5.3 Financing for Health Care	39
5.4 Management and Provision	39
5.4.1 Hospital Services	39
5.4.2 Physician Services	40
5.5 Private Health Care Delivery	42
5.6 Particularities	43
<b>CHAPTER SIX:</b>	<b>45</b>
HEALTH CARE IN THE UNITED STATES	45
6.1 Government Responsibility	45
6.2 Health Care Insurance and Coverage	46
6.2.1 Medicare	46
6.2.2 Medicaid and SCHIP	47
6.2.3 Public and Private Health Care Coverage	48
6.3 Funding for Health Care	50
6.4 Management and Provision	50
6.5 Particularities	51
<b>CHAPTER SEVEN:</b>	<b>53</b>
MEDICAL SAVINGS ACCOUNTS (MSAS)	53
7.1 MSAs in Singapore	53
7.2 MSAs in South Africa	55
7.3 MSAs in the United States	56
7.3.1 Private Sector MSAs	57
7.3.2 Medicare Plus Choice	59
7.4 Proposals for MSAs in Hong Kong	61
7.5 MSAS: the Debate	62
<b>CHAPTER EIGHT:</b>	<b>65</b>
COMPARATIVE ANALYSIS	65
8.1 Financing And Coverage	65
8.2 Primary Care	68
8.3 Integration of Health Services	69
8.4 Role of Government	71

<b>CONCLUSION .....</b>	<b>73</b>
<b>APPENDIX A: .....</b>	<b>75</b>
LIST OF WITNESSES .....	75
<b>APPENDIX B: .....</b>	<b>77</b>
HEALTH CARE SPENDING, HEALTH CARE RESOURCES AND HEALTH STATUS :	
COMPARATIVE DATA, 1998.....	77

## ORDER OF REFERENCE

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Extract from the *Journals of the Senate* of March 1, 2001:

Resuming debate on the motion of the Honourable Senator LeBreton, seconded by the Honourable Senator Kinsella:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:

- (a) The fundamental principles on which Canada's publicly funded health care system is based;
- (b) The historical development of Canada's health care system;
- (c) Health care systems in foreign jurisdictions;
- (d) The pressures on and constraints of Canada's health care system; and
- (e) The role of the federal government in Canada's health care system;

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament be referred to the Committee;

That the Committee submit its final report no later than June 30, 2002; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

After debate,

The question being put on the motion, it was adopted.

ATTEST :

Paul C. Bélisle  
*Clerk of the Senate*

## SENATORS

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The following Senators have participated in the study on the state of the health care system of the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee

The Honourable Marjory LeBreton, Deputy Chair of the Committee

and

The Honourable Senators:

Catherine S. Callbeck

Joan Cook

Jane Cordy

Joyce Fairbairn, P.C.

Alasdair B. Graham, P.C.

Wilbert Keon

Yves Morin

Lucie Pépin

Douglas Roche

Brenda Robertson

*Ex-officio members of the Committee:*

The Honourable Senators: Sharon Carstairs P.C. (or Fernand Robichaud, P.C.) and John Lynch-Staunton (or Noel A. Kinsella)

*Other Senators who have participated from time to time on this study:*

The Honourable Senators Banks, Beaudoin, Cohen\*, DeWare\*, Ferretti Barth, Grafstein, Hubley, Joyal P.C., Milne, Losier-Cool, Rompkey, and Tunney

\*retired from the Senate





## INTRODUCTION

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In December 1999, during the Second Session of the Thirty-Sixth Parliament, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the state of the Canadian health care system and to examine the evolving role of the federal government in this area. The Senate renewed the mandate of the Committee in the First Session of the Thirty-Seventh Parliament. The terms of reference adopted for the purpose of this study read as follows:

*That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:*

- a) The fundamental principles on which Canada's publicly funded health care system is based;*
- b) The historical development of Canada's health care system;*
- c) Publicly funded health care systems in foreign jurisdictions;*
- d) The pressures on and constraints of Canada's health care system;*
- e) The role of the federal government in Canada's health care system.<sup>1</sup>*

In response to this broad and complex mandate, in March 2001, the Committee re-launched its multi-year and multi-faceted study comprising five major phases. Table 1 provides information on each individual phase and their respective timeframes.

This document constitutes the Phase Three report of the Committee's study on health care. In accordance with the Committee's mandate, this report examines "publicly funded health care systems in foreign jurisdictions". More precisely, it describes and compares the way that health care is financed and delivered in several other countries and the objectives of national government health care policy in those countries. It highlights those policies from which Canada could learn.

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<sup>1</sup> Debates of the Senate (Hansard), 2<sup>nd</sup> Session, 36<sup>th</sup> Parliament, Volume 138, Issue 23, December 16, 1999.

**TABLE 1**  
**HEALTH CARE STUDY:**  
**INDIVIDUAL PHASES AND PROPOSED TIMEFRAMES**

PHASES	CONTENT	TIMING (REPORTS)
<b>One</b>	Historical Background and Overview	March 2001
<b>Two</b>	Future Trends, Their Causes and Impact on Health Care Costs	Winter 2002
<b>Three</b>	Models and Practices in Other Countries	Winter 2002
<b>Four</b>	Development of Issues and Options Paper	September 2001
<b>Five</b>	Hearings on Issues and Options Paper and Development of Final Report and Recommendations	Fall 2001/Winter 2002

The findings and observations contained in this report are based on a review of the relevant literature by the Committee's research staff, comparative studies commissioned with the assistance of Health Canada<sup>2</sup>, videoconferences with health care officials, organizations and experts from the surveyed countries, and public hearings with Canadians experts in comparative international analysis in the field of health care.

In selecting countries to be examined, the Committee did not want to limit its study to health care systems that are similar to the Canadian model. We wanted to look at a variety of models, including those systems which are quite different from Canada's health care system but from which we could learn a great deal given that these countries have been actively involved in various health care reforms. Given the limited time and resources at its disposal, the Committee decided to review the health care system of the following countries: Australia, Germany, the Netherlands, Sweden, the United Kingdom and the United States. The Committee also reviewed the operation of medical savings accounts systems (MSAs) in various countries.

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<sup>2</sup> Two studies were commissioned by the Committee. Ake Blomqvist, Professor of Economics at the University of Western Ontario, prepared a paper describing the Swedish health care system and entitled International Health Care Models: Sweden. Colleen Flood, Mark Stabile and Carolyn Hughes Tuohy, respectively professors at the Faculty of Law, Department of Economics and Department of Political Science, at the University of Toronto, prepared a document entitled Lessons From Away: What Canada Can Learn From Other Health Care Systems. Their paper provides a thorough review of the health care systems in place in Australia, the Netherlands, New Zealand, the United Kingdom and the United States. These two studies are available on the Committee's Website at the following address: [http://www.parl.gc.ca/common/Committee\\_SenHome.asp?Language=E&Parl=37&Ses=1&comm\\_id=47](http://www.parl.gc.ca/common/Committee_SenHome.asp?Language=E&Parl=37&Ses=1&comm_id=47).

This report consists of eight chapters.<sup>3</sup> Chapter One through Chapter Six describe the main characteristics and particularities of the health care systems in Australia, Germany, the Netherlands, Sweden, the United Kingdom and the United States respectively. These chapters all have the same structure and address the following issues: government responsibility for health care; health care insurance and coverage; funding for health care; management and provision; and, particularities. The information provided in these six chapters is presented in comparative terms with respect to the Canadian experience. Chapter Seven reviews the system of MSAs established in Singapore, South Africa and the United States, as well as the proposals put forward in Hong Kong. Finally, Chapter Eight provides a comparative review of the experience gained elsewhere.

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<sup>3</sup> In this report, the testimony received by witnesses and printed in the Minutes of Proceedings and Evidence of the Standing Senate Committee on Social Affairs, Science and Technology will be hereinafter referred to only by issue number and page number within the text.



## CHAPTER ONE:

### HEALTH CARE IN AUSTRALIA

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#### 1.1 Government Responsibility

Like Canada, Australia has a federal system of government. As in Canada, health care in Australia is a shared responsibility between the national (or Commonwealth) government and sub-national governments (six States and two Territories). In Australia, however, the Commonwealth government has a stronger role in health care than is the case in Canada. While provincial governments in Canada have far greater fiscal leverage in health care than does the federal government, States and Territories in Australia are largely dependent on the Commonwealth government for health care funding. As in Canada, local governments (municipalities) in Australia play a relatively small role in health care.

- The **Commonwealth government** is responsible for public policy making at the national level in the fields of public health, research and national health information management. The Commonwealth government operates “Medicare”, the national, publicly-funded health care insurance plan in Australia, and regulates the private health care insurance industry. It also finances and regulates residential aged care (nursing homes) and, jointly with States and Territories, it funds and administers some community-based care and home care. Commonwealth funding for health care is derived from general taxation plus a dedicated health care levy of 1.5% on taxable income.
- The **State and Territory governments** have primary responsibility for the management and delivery of publicly insured health services within their jurisdiction. As such, they deliver public acute and psychiatric hospital services and a wide range of community and public health services including school health, dental care, maternal and child health. State and Territory governments are also responsible for the regulation of health care providers as well as for the licensing and approval of private hospitals. Health care funding by States and Territories is derived mostly from grants from the Commonwealth government, as well as from general taxation and user charges.
- **Local governments** are responsible for health promotion and disease prevention programs (such as immunization), and environmental health services (such as sanitation and hygiene).

#### 1.2 Health Care Insurance and Coverage

Medicare in Australia, which is operated by the Commonwealth government, is a compulsory regime that provides universal coverage to all citizens. Public health care

insurance is broader in Australia than in Canada as it covers physicians, hospitals, prescription drugs and some community-based care and home care. In contrast to Canada, user charges and extra-billing may be required for publicly insured health services. More specifically, Australian Medicare is made of three main components:

- The Medical Benefits Scheme (MBS) ensures access to physician services (outside of hospitals). The MBS lists a wide range of physician services and stipulates the fee applicable to each item (the “scheduled fee”). The MBS reimburses only 85% of the doctors’ scheduled fee. In other words, Australian physicians may extra-bill. When doctors bill Medicare directly (“bulk bill”), they accept the 85% level as full payment and the patient pays nothing. When doctors charge more than the scheduled fee, the patient must pay the difference between the Medicare benefit and the scheduled fee and then claim reimbursement from Medicare or alternatively obtain from Medicare a cheque made out to the physician. However, a safety net provision applies to MBS: once patients have paid A\$276 in physician fees in a given year (about \$229CAN), they are exempt from further charges. Private insurance is not allowed to provide coverage for physician services that are publicly insured or for the gap between Medicare and the fee charged by the doctor. Relatively few physicians bill patients more than 85% of the MBS schedule.<sup>4</sup> Concessional patients (mostly social security recipients and veterans) are not required to pay any extra-billing.
- The Australian Health Care Arrangements (AHCAs) provide the basis for funding by the Commonwealth government to the States and Territories for hospital services. Funding by the Commonwealth government takes the form of annual block grants whose amounts are negotiated in five-year agreements with the States and Territories, who in return agree not to allow user charges for public hospital services. The extent of public coverage for hospital care depends on whether a patient elects to be a public patient or a private patient. Full coverage for hospital care is provided to public patients in State and Territory owned hospitals or in private non-profit hospitals. Public patients are also entitled to free hospital care in for-profit hospitals which have made arrangements with governments to care for public patients. However, when an individual chooses to be a private patient in a public hospital (in which case he/she has the ability to choose his/her own doctor) or goes to a private hospital, the Commonwealth government pays only 75% of the scheduled hospital-based physician fee. All other costs are the responsibility of the patient. The safety net that applies to physician services under the MBS and which limits the amount paid by the patient in a one-year period does not apply to Medicare benefits for hospital services. Private health care insurance is allowed to cover the difference between 75% of the scheduled fee and the actual fee charged. Private

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<sup>4</sup> It is estimated that 70% of all physician services are billed directly.

insurers can also provide additional benefits for hospital accommodation and other hospital charges.

- The Pharmaceutical Benefits Scheme (PBS), which is based on a national drug formulary, provides free access to drugs prescribed outside of hospital, subject to annual thresholds.<sup>5</sup> Under the PBS, eligible people fall into two categories: general patients and concessional patients. General patients are required to pay a maximum of A\$20.60 per prescription (\$17.10CAN) up to a total of A\$612 per year (about \$508CAN); beyond that limit, they are required to pay only A\$3.30 per prescription (\$2.80CAN). Concessional card holders pay A\$3.30 per prescription. Once the safety net threshold is reached for concessional patients (A\$166), drugs are fully paid by the Commonwealth. If the prescription involves a more costly but equivalent brand, the subsidy may be limited to the lower cost brand (this is called the minimum pricing policy). Individuals must pay for drugs not listed on the national formulary in full and, also in full, for drugs that are priced below the co-payment amount. It is estimated that about 75% of all prescriptions issued in Australia are subsidized under the PBS.

As in Canada, some services are not covered under Australian Medicare, such as cosmetic surgery and services provided under workers' compensation insurance and private insurance can cover allied health/paramedical services (such as physiotherapists' and podiatrists' services), as well as some aids and devices. However, in contrast to Canada, private health care insurance in Australia both complements and competes with Medicare since private insurers may cover the same benefits as under the public plan. Australians can supplement their Medicare benefits through private health care insurance, but they cannot opt out of the publicly-funded system since they continue to pay their taxes.

The Commonwealth government is responsible for regulating private health care insurance and it requires that premiums be community rated. This means that private insurers must establish a common premium structure for all enrollees regardless of their health status. In other words, they cannot charge higher rates for high risk individuals such as the aged or the chronically ill. Community rating ensures that private insurance is available to a wide range of people in the community. This in turn necessitates a system of reinsurance, designed to ensure that insurers with high proportions of aged and chronically ill customers do not suffer competitive disadvantage. The Commonwealth government has also introduced a number

*(...) health insurance in Australia is fully community rated, which I think reflects its social role as far as governments are concerned. By "fully community rated" I mean that there is no premium discrimination against people by virtue of age, sex, state of health or potential health risk. The only restriction is a 12-month waiting period after joining for pre-existing ailments. At the end of 12 months, benefits are fully payable for pre-existing conditions as well as for conditions that occur after joining. I think you can see from that that there is a very strong social component of the private sector in Australia, and it does link in quite well with the public sector.*

*Russell Schneider, Chief Executive Officer, Australian Health Insurance Association (21:5)*

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<sup>5</sup> Like in Canada, prescription drugs dispensed in public hospitals are free of charge.



of tax-based measures to encourage people to purchase private health care insurance in order to counteract a long-term trend of decreasing take up of private insurance. Overall, there are about 40 private health care insurance funds registered in Australia.

### **1.3 Funding for Health Care**

As in Canada, some 70% of health care spending is financed by the public sector (46% by the Commonwealth government and 24% by State and Territory governments) and 30% by the private sector (see Appendix). The Commonwealth government finances a greater proportion of Australian health care than does the federal government in Canada. The Commonwealth government in Australia is the primary public insurer of prescription drugs and physician services. It also funds some 50% of hospital expenditures.

Medicare is financed largely by general taxation revenue, some of which is raised by an income-related Medicare levy at the national level. This Medicare levy is paid by individuals at a basic rate of 1.5% of taxable income above certain income thresholds. Individuals who do not pay any income tax do not pay the Medicare levy (but they are entitled to full coverage under Australian Medicare). Taxpayers with high incomes who do not have private health care insurance pay an additional 1% of taxable income as part of the levy. The Medicare levy accounts for approximately 27% of Commonwealth funding for Medicare and for about 8% of total health care spending in Australia.

The Commonwealth government provides funding for Medicare in three ways: 1) through subsidies for prescription drugs and private medical and optometric services; 2) grants to States and Territories for the purpose of health care; 3) specific grants to State and Territory governments and other bodies. State and Territory governments supplement Commonwealth grants by raising their own revenue through taxation.

Residential aged care is financed by the Commonwealth government by means of subsidies paid to service providers, based on the level and type of care needed by the individual. Community care services for the frail aged and the disabled are jointly funded by both the Commonwealth and State/Territory governments.

About 25% of State and Territory government budgets are allocated to health care and about 69% of those funds go to public hospitals.

### **1.4 Management and Provision**

As in Canada, the majority of doctors are self-employed. Most primary care provided by general practitioners in private practice is reimbursed on a fee-for-service basis. A small proportion of physicians are salaried employees of Commonwealth, State/Territory or local governments. General practitioners in primary care act as gatekeepers, with access to specialist medical services being available only on their referral.

Hospital care is provided by a mix of public and private institutions. Public hospitals remain the major providers of care. Public hospitals include hospitals established by State/Territory governments and hospitals established by religious or charitable bodies but now directly funded by government (private non-profit hospitals). Specialists in public hospitals are either salaried or paid on a per-session basis. Salaried specialist doctors in public hospitals can treat some patients in these hospitals as private patients, charging fees to those patients and usually contributing some of their fee income to the hospital.

There are a small number of private for-profit hospitals built and managed by private firms providing public hospital services under arrangements with State/Territory governments. However, most acute care beds and emergency outpatient clinics are in public hospitals.

Private hospitals tend to provide less complex non-emergency care, such as simple elective surgery. However, some private hospitals are increasingly providing complex, high technology services. Like public hospitals, some private facilities provide same-day surgery and other non-inpatient operating room procedures. Public and private hospitals are not perfect substitutes for each other, however, as accident and emergency facilities, as well as technologically complex and highly specialized services, remain concentrated in the public sector.

A significant proportion of other health care providers are self-employed. In addition, there are many independent pathology and diagnostic imaging services operated by doctors.

## 1.5 Particularities

Australia shares many similarities with Canada: both countries have the same political system of government, they have similar geography and they enjoy similar health outcomes. The public share of total health care spending is the same in Canada as in Australia (around 70% - see Appendix). However, Australia manages to spend much less on health care as a percentage of GDP (8.5%) than does Canada (9.5%). Australian Medicare is a single

*By analogy to Canada, we are similar. We have a somewhat smaller percentage of GDP spent on health. It is 8.5 per cent. We have a system that is much more complex in its federal state relation between federal government and state governments, with the federal government running directly reimbursements for medical services and pharmaceuticals and with the states running the hospitals, as in the Canadian provinces. There are large transfers of money from commonwealth government to state governments, unlike your arrangements where the provinces raise their own. We have a much bigger private sector than in Canada, with a strong private health insurance system that has strong government support – both financial and political – underpinning that health insurance system. It finances a wide network of private hospitals in particular.*

*I think the similarities between us are probably greater than the differences compared with other countries.*

*Dr. Richard Madden, Director, Australian Institute of Health and Welfare  
(21:4)*

national program, whereas Canadian Medicare is an amalgam of separate provincial and territorial health care insurance plans. In Australia, the national government plays a stronger role in health care than does its Canadian counterpart and it is more able to take unilateral action when reforms are undertaken.

Australia's health care system differs from the Canadian in the following main ways: 1) public coverage is much broader in Australia; 2) user charges and extra-billing for publicly insured services provide non-tax sources of revenue to the health care sector; 3) private insurance both complements and competes with public coverage. One factor that may have contributed to the ability of the Australian health care system to provide broader coverage is the willingness to employ user charges and extra-billing and to allow private insurance.

In Australia, the Commonwealth government operates a national Pharmacare program, the PBS. It is the view of the Commonwealth government that the PBS has succeeded in containing the cost of prescription drugs for a number of reasons. First, since 1993, the PBS does not list a drug on its formulary unless it receives a positive assessment with respect to safety, quality, effectiveness and cost-effectiveness. Second, higher user charges are required for brand-name drugs when generic copies are available. And third, a "reference pricing" mechanism ensures that the government subsidizes only up to the price of a lower-priced drug that is therapeutically interchangeable with, or equivalent to, the prescribed drug.

Overall, the PBS subsidizes about 75% of all prescriptions in Australia, and the average subsidy is 57% of the prescription cost. According to Colleen Flood, Professor of Law at the University of Toronto, although this is a significant contribution by patients, it is in the context of a coherent national system that ensures access for those to whom cost would be a barrier.<sup>6</sup>

Physicians in Australia may extra-bill. Therefore, they are not wholly dependent on the government for remuneration. They can bill patients at rates of their own choosing above the scheduled fee. As a result, they have accepted a considerably lower level of public remuneration than is the case in Canada.

It is legal in Australia to obtain private health care insurance to cover: 1) part of the cost of physician services provided in public and private hospitals to private patients and that is not covered under Medicare; 2) all other hospital costs incurred by private patients in public or private hospitals. However, private insurance is prohibited for physician services rendered outside of hospitals. It has been suggested that this prohibition has created some "perverse" side-effects (see below).

The Commonwealth government strongly encourages Australian residents to acquire private health care insurance. More specifically, it offers holders of private health care insurance a subsidy of 30% of the cost of that insurance. This rebate for private insurance premiums is available to all, regardless of income, as a 30% refundable tax credit. This rebate represents an average of A\$800 in savings annually (or about \$600CAN). The

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<sup>6</sup> Colleen Flood, Profiles of Six Health Care Systems: Canada, Australia, the Netherlands, New Zealand, the UK, and the US, 30 April 2001, p. 12.

objective of the Commonwealth government is to have about one-third of the population participate in private insurance schemes.

Since July 2000, the 30% rebate legislation stipulates that the private insurance company must offer policies with no gaps between the medical scheduled fee and the fee charged by doctors. This provision, called the “no gap/known gap”, is intended to reduce the gaps and to make the extra charges known to patients. Prior to that reform, private insurance covered only scheduled medical fees, and actual fees charges could be much higher: two patients could be given exactly the same treatment for which the private patient received a large bill not reimbursed by private insurance, while the publicly insured patient never saw a bill.”<sup>7</sup>

A “Lifetime Health Cover” was also introduced in July 2000. Under this system, individuals aged 30 years or less who purchase private health care insurance pay lower premiums throughout their life compared with someone who joins later in life. Over the age of 30, a 2% increase in premiums over the base rate is tacked on for every year a person delays in joining. This initiative is expected to reduce premium rates by encouraging more younger and healthier people to take out private insurance and by discouraging people from joining prior to treatment and leaving following the treatment.

According to Carolyn Hughes Tuohy, Professor, Department of Political Science at the University of Toronto, it remains unclear whether a very large public subsidy for private health care insurance is an effective use of public funds. She suggests that directing an equivalent expenditure toward public treatment in public hospitals would be more effective.<sup>8</sup>

During the Committee’s hearings, Dr. Roger Kilham, from the Australian Medical Association, suggested that private insurance for hospital services in Australia has resulted in rationing in the public system (in the form of longer waiting times) and in queue jumping:

*(...) there is more rationing in the public sector. People do not get access. It is very common to meet someone who has waited five years to get a hip replacement or even longer for a knee replacement. There is a lot of rationing in the public sector. We call private health insurance "queue-jumping insurance." Basically, it buys a place further up the queue. That is the reality and that is why people like it. They can jump queues if they have the money to do so.*<sup>9</sup>

More public funding was provided to deal with to longer waiting lists. According to Russel Schneider, CEO of the Australian Health Insurance Association, this did not solve the problem:

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<sup>7</sup> Jane Hall, “Incremental Change in the Australian Health Care System,” Health Affairs, May/June 1999, p. 95-110.

<sup>8</sup> Carolyn Hughes Tuohy, The Political Economy of Health Care Reform: A Cross-National Analysis, 30 April 2001.

<sup>9</sup> Dr. Roger Kilham (21:8).

*Waiting lists at public hospitals are a political problem that varies from time to time. Governments have tried to solve the problem by putting more financial resources into the public sector, but the tendency seems to be the same as it is anywhere else in the world. More money does not reduce waiting lists. All it does is allow those people who were not on the waiting list before to get put on to it.*<sup>10</sup>

This was echoed by Dr. Roger Kilham who noted:

*Our experience is every time the state government announces a program to deal with waiting times, the waiting times get longer. Because we have this ability within the system to switch from the public to the private and back again, each time the government says it will spend more money to reduce the waiting lists, expectations of service in the public sector increase and people then rejoin the public sector lists. In reality, programs to reduce waiting times do not work; they only relocate the business in the public sector.*<sup>11</sup>

Russel Schneider also indicated that restricting private insurance to in-hospital services has created “perverse incentives”:

*One of the difficulties is that all non-hospital medical treatment is funded by a single source, which is the government, and possibly a patient care payment. Health insurance does not apply to non-hospital medical treatment.*

*That leads to some perverse incentives within the system, because from both the doctor's point of view and the patient's point of view, the level of rebate for a particular service will be greater if that service is performed in an in-hospital setting, than if that same service were performed outside the hospital. That could probably be a criticism of our system.*

*It also makes it difficult for insurers to exercise effective cost-containment by the support of primary care interventions, or primary care treatment, for their populations. Consequently, there is a defect in the system. This is a very politically controversial statement, but we would achieve a better health care system if we were able to redirect the energies of the private sector and the public sector into primary care interventions, rather than funding high-cost, high-tech hospitalization, which is where insurers are confined at the moment.*<sup>12</sup>

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<sup>10</sup> Russel Schneider (21:33).

<sup>11</sup> Dr. Roger Kilham (21:33).

<sup>12</sup> Russel Schneider (21:10).

## CHAPTER TWO:

### HEALTH CARE IN GERMANY

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#### 2.1 Government Responsibility

Germany is a federal republic consisting of a national (federal) government and 16 state governments (known in Germany as *Länder*). Decision-making powers with respect to health care are shared between the two levels of government<sup>13</sup>:

The **federal government** provides the regulatory framework for health care at the national level. National health care policy rests essentially on the principles of statutory social insurance (often referred to in Germany as the “Bismarck model”). The federal government has the authority to regulate Sickness Funds (described below) and private health care insurance. It is also responsible for long term care policy as well as for reference pricing policy with respect to prescription drugs.

The **Länder** are responsible for the delivery of health care. They own many hospitals, along with local governments and charitable organizations. They are responsible for maintaining all hospital infrastructure in their jurisdiction, independently of actual ownership. *Länder* have the authority to finance medical education and supervise health care professionals. They are also responsible for public health, health promotion and disease prevention.

#### 2.2 Health Care Insurance and Coverage

Health care insurance in Germany is organized into three different schemes: 1) Sickness Funds; 2) private health care insurance; 3) public coverage by the federal government for military personnel, police officers and social welfare recipients.

Public health care insurance in Germany is administered by some 453 Sickness Funds. These Sickness Funds are private non-profit organizations that are structured on a regional and/or occupational basis. Sickness Fund membership is compulsory for employees with gross income lower than DM 77 400 (data for 2000) or around \$63,000 CAN and is voluntary for those above that level. Sickness Funds provide health care coverage both to members and to their spouses/dependants. Although all Sickness Funds are regulated at the federal level through what is known as the “Social Code Book,” they are essentially run by representatives of the employees and employers.<sup>14</sup>

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<sup>13</sup> Following unification in 1990, the health care system of the former German Democratic Republic was reformed to match that of the Federal Republic of Germany.

<sup>14</sup> While Sickness Funds are private non-profit organizations, they are regulated by government to a point that they can be more accurately described as quasi-public entities.

Under national legislation, Sickness Funds have the right to raise contributions from their members and to determine their own contribution rate. Contributions are based on taxable income and are shared equally between the employee and his/her employer. In 2000, members of the Sickness Funds and their employers were required to contribute jointly an average of 13.5% of monthly gross income (or 6.75% each). For employees with an income below a certain threshold, only employers make contributions.<sup>15</sup>

Public health care coverage is much broader in Germany than in Canada. In fact, the German health care system is among the most comprehensive in the world. Sickness Funds are required under the Social Code Book to provide coverage for: physician services, hospitals, prescription drugs, diagnostic services, dental care, rehabilitative care, medical devices, psychotherapists, nursing care at home, medical services by non-physicians (physiotherapists, speech therapists, occupational therapists, etc.) and income support during sick leave.<sup>16</sup>

*(...) the German statutory health care system is part of the German social security system. It works on the same principle as the pension system and the unemployment system. This means that the financing of the system works on the basis of contributions. Contribution rates are carried by employees and employers, each carrying half of the contribution. When people retire, the contribution is paid from the pension system.*

*We have a system that is financed without taxes. It is financed on a contribution base. This is very important. It is a system that is organized by law but is not run by the government. Our system is different from the typical national health care system.*

*This system is carried by the sickness funds. The sickness funds are not government parts. They are not private companies. I would describe them as non-profit institutions which work on the basis of federal law but have their own contribution rates.*

*Georg Baum, Director General, Head of Directorate, Health Care, German Health Ministry (20:5).*

In Contrast to Canada, user charges may be required for publicly-insured health services. In 2000, user charges, whose levels are determined in national legislation, applied to the following:

- prescription drugs (between DM 8 to 10 or \$7-8 CAN depending on pack size or 100% of price above the reference price);
- dental care (a coinsurance payment that varies from 35% for some services to 50% on crown and denture treatment, depending on the case);
- hospital services (DM 17 per day or \$14 CAN);
- rehabilitation services (DM 17 per day or \$14 CAN), and
- ambulance transportation (DM 25 per trip or \$20 CAN).

<sup>15</sup> In the case of retired and unemployed people, the retirement and unemployment funds take over the financing role of the employer.

<sup>16</sup> Psychologists specialized as psychotherapists have become members of the physicians' associations and therefore no longer have the status of non-physicians.

User charges are subject to an annual threshold: once they have reached this limit, Sickness Fund members are exempt from further charges. Some individuals are exempted from paying any user charges, such as people with low income, those receiving unemployment benefits or on social welfare, children and the chronically ill.

Private health care insurance is available to individuals whose annual gross income is superior to DM 77 400 (\$63,000 CAN) and who have voluntarily opted out of their Sickness Fund. Private coverage is currently offered by 52 private insurance companies. Since re-entry of privately insured people into Sickness Funds is not permitted under ordinary circumstances, private insurers are obliged to offer an insurance policy with the same benefits as the Sickness Funds at a premium that is no higher than the average maximum contribution in the Sickness Funds. However, premiums in the private health care insurance sector are risk-related and reflect the medical history of the insured individual (this contrasts with Australia where premiums charged by private insurers are community-rated). Further, unlike Sickness Funds, private health care insurers require that separate premiums be paid for spouses and dependants.

Private health care coverage is also available to self-employed people who are excluded from the Sickness Funds. Private insurers also provide coverage to public servants who are also excluded *de facto* from participating in Sickness Funds as their health care bills are reimbursed at 50% by the federal government (private insurance covers the remainder). Finally, private health care insurance can offer supplementary benefits to members of the Sickness Funds (Sickness Funds are not legally allowed to offer these extra benefits).

Overall, 88% of the German population is covered under Sickness Funds: 74% are mandatory members and their dependants, while 14% are voluntary members and their dependants. Some 9% of the German population are covered under private health care insurance, mostly high-income earners; another 2% are insured by governmental insurance (police officers, military members, etc.). Less than 1% of the population has no health care insurance at all (according to testimony, they are usually self-employed people who have decided not to purchase private insurance).

## 2.3 Funding for Health Care

The public share of overall health care spending is higher in Germany (75%) than in Canada (70%). Private sector funding in Germany accounts for the remaining 25% (see Appendix).

Contributions to the Sickness Funds constitute the main source of financing health care in Germany (70%). User charges by patients fund the next largest share (12%), while the balance of funding comes from general taxation (7%), private health care insurance (7%) and other sources (4%).<sup>17</sup> General taxation is used to reimburse some of the health care expenditures incurred by public employees, persons on welfare, subsidies for the farmers' funds.

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<sup>17</sup> OECD Health Data (2000).



## 2.4 Management and Provision

In Germany, a national body, called the “Advisory Council for Concerted Action in Health Care,” is responsible for setting guidelines with respect to the rate of growth of health care spending. These guidelines must be taken into account in the determination of physician remuneration and of hospital budgets.

Primary care is organized almost exclusively on the basis of office-based physicians. The majority of physicians have solo practices – only 25% share a practice. Patients are free to select a Sickness-Fund-affiliated doctor of their choice. German doctors do not act as gatekeepers of the system and patients can go directly to specialists practising outside hospitals. As a result, both general practitioners and specialists carry out primary care. Primary care doctors, however, do control access to hospital care.

Primary care physicians are paid on a fee-for-service basis. At the beginning of each year, in each Länd, the Sickness Funds and the regional medical associations negotiate an overall remuneration package. Then, the medical associations distribute this total allotment according to a Uniform Value Scale (UVS). This scale lists all medical services that can be provided by physicians and allocates a point value to each service. At the end of each quarter, every office-based physician invoices his/her association for the services delivered. Physicians, however, do not know exactly how much they will earn since the monetary value of a single service may decline if physicians are performing too many services in any one category. As in Canada, physicians cannot extra-bill patients insured under Sickness Funds.

Although Sickness Funds and private insurers use the same scale for remunerating primary care physicians, they each assign different point values. Private insurers generally provide a higher remuneration for the same services compared to the Sickness Funds. Moreover, physicians treating privately insured patients are not subject to budget caps as occurs with Sickness Funds. Therefore, physicians obtain a higher remuneration when treating privately insured individuals in Germany. Further, it is permissible for physicians to extra-bill privately insured patients.

There are about 2030 general hospitals in Germany: around 790 (39%) are publicly-owned, 820 (40%) have private non-profit status and 420 (21%) are private for-profit hospitals. The Länder are responsible for developing all “hospital plans.” These plans determine how many hospitals are required in each region. They also list for every hospital the specialities that are necessary, and the number of beds per specialty.

While the Länder are responsible for the flow of capital investment into the hospital sector, the Sickness Funds/private insurers are responsible for funding hospitals’ operating costs. Prior to the 1990s, hospital remuneration by Sickness Funds was done through a per diem rate which was uniform within a hospital and independent of actual diagnosis, amount of care, or length of stay. Rates varied among hospitals depending on their size and structure and thus on the spectrum of services available. As a result, the general per-diem rate led to wide cross-subsidization across medical departments in hospitals.

In the 1990s, the federal government introduced several changes to hospital financing. Remuneration of hospitals now consists of three parts: 1) a general per diem typically covering food and lodging; 2) a ward specific compensation for additional resources spent in a given hospital department; and 3) a lump-sum remuneration for specialized treatment services (such as cancer treatment and organ transplants).<sup>18</sup>

Doctors employed in public hospitals are paid on a salary basis. Non-profit hospitals and the doctors working in them receive payment in the same fashion as their public hospital counterparts. Arrangements in the private for-profit hospitals are somewhat different. There, doctors are paid on a fee-for-service basis according to a schedule that is laid out by the federal government. A part of each fee received by doctors working in private for-profit hospitals is given to the hospital.

As in Australia, national legislation in Germany enforces therapeutic reference-based pricing for prescription drugs as the reimbursement method under the Sickness Funds. Reference prices are set through an ordinance issued by the federal minister of health. To contain drug costs further, in 1996 the federal government introduced a list of drugs which were not entitled to public reimbursement. There are plans to develop a positive list of reimbursable prescription drugs (national formulary).

## **2.5 Particularities**

The health care system in Germany shares many similarities with the system in the Netherlands (see Chapter 3), but it is very different from that of Canada. First, social insurance (based on employee and employer contributions which vary with income) is the main source of health care funding in Germany and not general taxation revenue as in Canada. Second, the revenue generated from these income-related contributions is not managed by government but by the Sickness Funds themselves. Third, public health care coverage is more comprehensive in Germany than in Canada. Fourth, user charges are permitted for a variety of publicly-funded health services in Germany, while they are prohibited in Canada. Finally, private health care insurance plays a more important role in Germany than in Canada.

Privatization is another important feature of the German health care system. As in Canada, physicians have their own private practice and community pharmacies operate privately. The hospital sector in Germany is a mixture of public, private non-profit and private for-profit hospitals. Like Australia, but unlike Canada, private health care insurance in Germany coexists alongside the statutory Sickness Funds.

Three elements of the German health care system are of particular interest. The first concerns competition among Sickness Funds. The second relates to the lack of integration between the primary care sector and the hospital sector. The third element is the introduction of statutory long-term care insurance in 1994.

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<sup>18</sup> This system is similar to the Diagnostic Related Groups currently in place in the United States (see Chapter 6).

### 2.5.1 Competition Among Sickness Funds

Traditionally, individuals had no choice over their Sickness Funds and were assigned to the appropriate fund based on geographical and/or job characteristics. This mandatory distribution of fund members led to great variation in contribution rates due to different income and risk profiles. Since 1996, however, individuals enrolled in a regional or employment-based Sickness Fund have had the right to choose another Sickness Fund. To ensure a level playing field, the federal government also established in the same year a “risk structure compensation scheme” that requires all Sickness Funds to equalize differences in contribution rates (due to different income levels) and expenditures (due to age and sex). The free choice of fund and the risk structure compensation scheme have led to members moving between funds,

from those funds with higher than average contribution rates to those with lower than average rates, as well as to a narrowing of the gap between the various contribution rates.

*We have an equalizing financial distribution system between the sickness funds. With this instrument, we are able to balance the contributions so they are more equal. At the moment, we are making additional efforts to create a more sophisticated money distribution system between the sickness funds.*

*We have four factors. They are income, which is one aspect of money distribution; sex: male or female; the number of people insured by one contribution payer - we have the family system, and age. Those are the four relevant factors for one sickness fund to pay into another sickness fund.*

*Georg Baum, Director General, German Health Ministry (20:18)*

### 2.5.2 Lack of Integration

Before 1993, primary care physicians were not allowed to treat patients in hospitals and hospitals could not provide outpatient surgery and services, which were provided by general practitioners, specialists or dentists. German hospitals had to concentrate on inpatient care. This led to many inefficiencies, including duplication of technical equipment and repetition of diagnostic tests.

Hospitals in Germany have been allowed to offer surgery on an ambulatory or day-case basis only since 1993. As well, general practitioners and specialists have been given access to a certain number of hospital beds to perform treatment inside hospitals. It has now become easier for doctors involved in providing ambulatory services to be involved in inpatient care and there are also greater possibilities for the joint acquisition of high cost technical equipment.

### 2.5.3 Long-Term Care

Historically, long term care in Germany was only available in hospitals. Therefore, at times people were admitted for non-medical reasons. To rectify this situation, in 1994 the federal government introduced a separate piece of legislation regarding statutory long-term care insurance. All members of Sickness Funds as well as people with full-cover private health care insurance were declared mandatory members of the long-term care insurance scheme, which is administered by both the Sickness Funds and the private

insurers. Members and their employers must contribute jointly 1.7% of monthly gross income (or 0.85% each).

Everybody with an entitlement to nursing care is given the choice between monetary support for home care delivered by family members or professional services as in-kind benefits. In addition, caregivers who care for family members at home can attend training courses free-of-charge and are insured against accidents, invalidity and old age. For persons needing long-term, institutionalized nursing care, benefits are available for day or night clinics, as well as for institutionalized care in old age or special nursing care home.



## CHAPTER THREE:

### HEALTH CARE IN THE NETHERLANDS

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#### 3.1 Government Responsibility

The Netherlands has a unitary system of government.<sup>19</sup> It is, however, a highly decentralized country with 12 provinces and 646 municipalities. Each province has its own representative body and its own responsibilities in many fields of jurisdiction. However, their role in health care is rather limited. Health care policy-making in the Netherlands has to a great extent been monopolized by the national government.<sup>20</sup> This contrasts to Canada, where health care is a shared responsibility between the federal government and the provinces.

The national government of the Netherlands has responsibility for, and financial control over, most aspects of the health services. In contrast to Canada, the government's financial contribution to health care through general taxation is relatively low, accounting for less than 10% of total health care spending.<sup>21</sup> Like in Germany, most of the public funds allocated to health care in the Netherlands are raised by the social insurance system through employers' and employees' contributions.

The role of the Dutch government in regulating the health care system is a significant one. Amongst other things, it requires certain groups to buy insurance, closely regulates insurers for fiscal stability, monitors negotiations between purchasers and providers, and sets a target budget that signals its wishes to all parties concerning health care expenditures.

*The Dutch have a unitary state, yet they do not have direct provision of services. What they have - and it is not only in the health sector but also across other policy sectors - is something called steering or guiding. In fact, even when one uses the word "control," it certainly guides behaviour, and there can be penalties, it does not have that same feeling of lockstep control because there is so much persuasion involved in the system.(...), if the government notices a pattern shifting, it will think about the impact of that and then tinker with ways to raise or lower that pattern.*

*Dr. James Björkman, International Institute of Social Studies of the Netherlands (15:19)*

#### 3.2 Health Care Insurance and Coverage

The health care system of the Netherlands is similar to the German system, but very different from that of Canada. There is no single public health care insurance plan

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<sup>19</sup> The Netherlands is a constitutional monarchy with a written constitution (last revised in 1983). Executive power lies with the Crown and legislative power rests with both the Crown and the bicameral Parliament.

<sup>20</sup> Maarse, J. A. M. (Hans), "The Health System of the Netherlands" in *Health Care and Reform in Industrialized Countries* (University Park, Penn.: The Pennsylvania State University Press, 1997), pp. 135-36.

<sup>21</sup> Ministry of Health, Welfare and Sport, *Health Care Insurance in the Netherlands*, July 2000, p. 7.

covering everyone as there is in Canada, but a mixture of public, social and private health care insurance schemes. Every Dutch citizen is guaranteed access to health care insurance, although certain categories of people (high income earners) are not obliged to purchase it (yet just about all of them do). Unlike the situation prevailing in Canada, user charges in the Dutch health care system are not perceived as impeding access to health care and may be required at the point of service.

In the Netherlands, a distinction is made between what is seen as “normal medical care” and the “exceptional costs” associated with long-term care or high-cost treatment, where the risk is such that it cannot be borne by individuals or adequately covered by private insurance. More specifically, there are three different categories of health care insurance:

### **3.2.1 Insurance for Normal Medical Care**

The first category of health care insurance deals with “normal medical care.” Normal medical care includes all medical and surgical treatment by general practitioners and specialists, some dental care, and prescription drugs. Coverage for normal medical expenses is available through a variety of health care insurance plans, some of which are public and some of which are private (and voluntary). More specifically, there are three forms of insurance covering normal medical expenses:

1. Public coverage is governed by national legislation, the Health Insurance Act, and is provided through social health care insurance or “Sickness Funds.” Sickness Funds are private non-profit institutions that cover everyone who earns below a designated income level (for 2000 this was set at 64,600 Dutch guilders, or about \$42,000CAN). Sickness Fund membership for this group of the population is mandatory, and more than 64% of the Dutch population currently belong to these funds. The employee and his/her employer must pay a premium whose maximum level is fixed by regulation. Patients may also incur user charges for health services covered by their Sickness Funds, subject to an annual threshold (200 Dutch guilders or about \$130CAN). There are over two dozen Sickness Funds. They used to be regionally based, but as a result of reforms undertaken over the past 15 years each Sickness Fund now serves the entire country. People can select which fund they wish to join and the funds compete with one another for members. As in Germany, the funds pay health care providers directly the agreed fee for a given service, so for Sickness Fund members no exchange of money takes place between patients and doctors (other than user charges, where applicable).
2. People earning over the prescribed income limit are entitled to purchase voluntary private health care insurance, and most of them do (31% of the Dutch population). Those who have private

insurance do not have to pay the income-related contribution that finances the Sickness Funds. Private insurers are both non-profit and for profit. Some of the non-profit insurers are owned by the Sickness Funds while others are “mutual” insurers, owned by their shareholders, or run by large multinational corporations. The for-profit insurers are mostly large, multi-line insurers whose activity is not limited to health care, but also include life, home and automobile insurance. People with private health care insurance pay providers for the cost of care and are subsequently reimbursed by their insurer. Private insurers must accept all those who apply for coverage that is equivalent to that offered under the Sickness Funds. User charges and premiums required in private health care insurance schemes are subject to national legislation.

3. The third form of coverage for normal medical expenses applies to civil servants employed at all levels of government, who make up the remaining 5% of the Dutch population. The scheme is mandatory and patients are generally reimbursed for 80-90% of their medical expenses. Coverage is slightly broader than that offered by the Sickness Funds (partial reimbursement is offered for dental crowns and bridges, contact lenses, chiropractic treatment, etc.) and is administered by 12 special private insurance arrangements.

### **3.2.2 Insurance for Exceptional Medical Care**

The second category of health care insurance is provided under the *Exceptional Medical Expenses Act*. This is the only national, mandatory health care insurance plan, that covers the entire Dutch population. This scheme, which is often referred by its Dutch acronym “AWBZ,” covers exceptional expenses such as long term care (nursing homes), mental illness, physical disability, etc. Anyone who is insured for normal risks by any other insurer is automatically entitled to benefits under the exceptional expenses scheme. In this way, people only deal with a single insurer who administers all their benefits regardless of the source of the funding. The entire population must pay into these funds regardless of whether or not they use the services that they cover. The premium is set at a percentage of the employee’s wage and is paid by the employer. Patients may be required to pay user charges for some services. The national government also provides grants to insured people under certain conditions to cover some services and treatments (such as abortion clinics, intensive care at home, prenatal and perinatal tests, etc.).

### **3.2.3 Voluntary Supplementary Insurance**

The third category is voluntary supplementary insurance for forms of care regarded as less necessary, and which are not included in either of the other two categories. This resembles supplementary health care benefits that are provided by private insurers in Canada and that cover health services not insured publicly.



### **3.3 Funding for Health Care**

The table presented in the Appendix to this report provides some information on health care spending in selected OECD countries. The OECD records the public share of total health care spending in the Netherlands at 70.4% for 1998.<sup>22</sup> It is important to remember, however, that unlike Canada but as in Germany, the Dutch system for public health care funding is a form of social insurance. More precisely, the funds for the purpose of health care are raised through employers' and employees' contributions, not by general taxation. Social insurance funds are not managed by the Dutch government but by the Sickness Funds themselves. Less than 10% of total health care spending is generated through general taxation raised by the national government. The other sources of health care funding consist of private health care insurance premiums and user charges.

Sickness Funds are financed by three main sources. First, insured people and their employer must pay an income-related contribution whose maximum is set in national legislation. These income-related contributions are collected in a central pool which then distributes them to the various Sickness Funds. Second, since 1991, Sickness Fund members must also pay a nominal (flat-rate) contribution. This nominal contribution is set by each Sickness Fund and can therefore vary from fund to fund. This measure obliges the Sickness Funds to compete with one another. Finally, Sickness Funds receive an annual grant from the national government to cover the costs of some groups, primarily the elderly.

Health care for civil servants is funded through contributions from participants and employers. The participant pays both a nominal contribution and a percentage of the salary.

Private health care insurance premiums are voluntary, except when the policyholder is a pensioner or a person in a high-risk group. People in these groups are entitled to a standardized policy that is subsidized by the national government. Premiums required in private health care insurance schemes, as well as co-payments and deductibles, are based on the level of coverage that is purchased, subject to the limits established by national legislation.

The resources to cover the costs of the second category of insurance, the AWBZ scheme, are obtained from contributions and payments from the people insured. Contributions are collected together with income tax and represent a percentage of taxable income. The employer withholds the employees' contributions from their wages and pays them to the tax authorities. Insured people under the age of 15 are not liable for contributions. Funding for the AWBZ also includes direct national government grants, and user charges.

### **3.4 Management and Provision**

As in Canada, most hospitals in the Netherlands are privately owned and operate on a non-profit basis. Many are affiliated with Protestant, Catholic or non-

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<sup>22</sup> OECD Health Data (2000).

denominational religious orders. The budget for hospital and other institutional services and the fees for health care providers are set during centralized negotiations between representatives of insurers and providers.<sup>23</sup> Since 1983, Dutch hospitals have been funded using prospective annual global budgets negotiated with representatives of private insurers and the Sickness Funds. Prospective budgets are not linked to the volume of services provided, but depend on the size of the service area, the number of authorized beds and specialists and the number of contracts between the hospital and the insurers. These budgets apply to both public and private patients and cover nearly all costs incurred by a hospital apart from specialists' fees.<sup>24</sup> Although the Dutch government is not involved in the negotiations surrounding hospital budgets, it must give its approval before construction of new hospitals or other major hospital investments may be undertaken.

As in Canada, most general practitioners in Netherlands operate a private practice. Each Sickness Fund member must choose a family doctor to register with from the list of those that the fund has contracted with, and cannot change for a year. Family doctors then act as gatekeepers to the rest of the system. Sickness Funds pay family doctors on a capitation basis (an annual fee per person), the fee being uniformly set for the whole of the Netherlands by regulated negotiations between representatives of practitioners and insurers.<sup>25</sup> This contrasts with the situation in Canada, where general practitioners are remunerated on a fee-for-service basis and where the negotiations over physicians' remuneration also involve the government. Patients with private insurance pay their physician on a fee-for-service basis and are reimbursed by their insurer.

As in Canada, both the Sickness Funds and private insurers pay specialists on a fee-for-service basis. There are two fee schedules for specialists, one for services provided to Sickness Fund members and another for privately insured patients. Specialists who are employed by university hospitals and by psychiatric institutions are compensated on a salary basis. Pharmacists are paid on a fee-for-service basis by both public and private insurers.

### 3.5 Particularities

The most striking feature of the Dutch health care system is its reliance on private financing and delivery. Among the OECD countries, the Netherlands is second only to the United States in the share of private health care insurance, yet everyone has some form of insurance and user charges remain a relatively small fraction of the costs of health care (7% in 2000). It was not until the Second World War that the Dutch government became involved with health care on a major scale, and even then the long tradition of private ownership and provision of health services was never overturned, despite the introduction of extensive government regulation.

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<sup>23</sup> Akved & H.E.G.M. Hermans, "The Netherlands" in *Medical Law – Suppl.* (Deventer and Boston: Kluwer Law and Taxation Publishers, 1995) at 25.

<sup>24</sup> OECD, *Health Policy Studies No. 2, The Reform of Health Care: A Comparative Analysis of Seven OECD Countries* (Paris: OECD, 1992), p. 92.

<sup>25</sup> Colleen Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2000), p. 107.

According to Colleen Flood, the health care system in the Netherlands is characterized, as in Canada, by a strong commitment to ensuring access to health care on the basis of need and not ability to pay. However, she also indicated that the Dutch are much more open to using the regulation of private insurance to attain this objective than exists in Canada. Thus, while the Dutch are committed to the progressive

funding of health care, in the sense of having people contribute according to their means, they are not committed to public funding for its own sake.<sup>26</sup>

*We [the Netherlands] are the only country in the European Union that has private insurance for over 30 per cent of its population for acute health care. We had to start regulating that private health care sector about 15 years ago. The only reason it still works - and this is a personal opinion - is that we had heavy regulation for all bad health risks within the private market and as such the rest of the market was able to survive.*

*Dr. Hugo Hurts, Deputy Director, Health Insurance Division,  
Ministry of Health of the Netherlands (15:7)*

According to Professor Flood, the Dutch system for the provision of “normal” health care would appear to be susceptible to becoming a “two-tier system,” the sort of system feared by many in Canada. However, she noted that two factors help prevent this from happening. First, those who purchase private health care insurance cannot fall back on the public system for some of their health care needs. Private insurers must cover all needs and not just skim off the easier kinds of care like elective surgery (as happens in the United Kingdom). Second, having private insurance does not enable Dutch citizens to jump queues in the public system. It is seen as against a physician’s ethical code to prefer a patient with private insurance to other patients, and both kinds of patients are treated side-by-side in the same hospitals.

The health care system in the Netherlands has been the subject of many proposals for reform over the last 15 years. In 1987, the Dekker Commission, set up by the national government, released a report containing a full set of recommendations. Had these been fully implemented, they would have reduced the degree of government control and introduced more market-oriented elements, changing the Dutch health care system in two fundamental ways.

First, the Dekker Commission recommended that all health care insurers (both Sickness Funds and private insurers) be integrated and that a basic benefits package be defined. Under the proposed plan, consumers would continue to have a choice among competing insurance plans, but the distinction between Sickness Funds and private insurance would essentially disappear. Instead, every insurance plan would be obliged to offer at least a minimum degree of coverage specified in regulation by the national government. This was supposed to give consumers a wider range of choice, allowing them to select from amongst all the available health care insurance plans the one that offered the insurance features and premium levels that best corresponded to their individual situations.

Second, the Dekker Commission recommended that all health care insurers be given the freedom to contract with health care providers (general practitioners, specialists,

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<sup>26</sup> Colleen M. Flood, *Profile of Six Health Care Systems: Canada, Australia, the Netherlands, New Zealand, the United Kingdom and the US*, 30 April 2001, p. 13.

hospitals). The idea was that this would allow insurers to compete with one another in order to attract members based on the level and kind of care that their particular mix of providers was able to supply. The two new kinds of competition – amongst the insurers to attract members to their plans and among providers to obtain contracts with health care insurers – were to be introduced in the hope that this would help contain costs and lead to a more cost-effective health care delivery.

Only a limited number of the Dekker proposals were introduced between 1989 and 1993. In particular, the Sickness Funds were allowed to expand across the country and people who were insured by them were given the right to freely choose their insurer. As well, people insured under the Sickness Funds must now pay a nominal contribution, in addition to their income-related contribution. However, since 1994, successive national governments have decided to scrap further implementation of the Dekker reforms and to opt for gradual change within the existing system made up of three separate health care insurance schemes.



## CHAPTER FOUR:

### HEALTH CARE IN SWEDEN

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#### 4.1 Government Responsibility

Although Sweden has a unitary political system, it has, in practice, a high degree of decentralization – so much so that in many ways it resembles a federal system. As in Canada, health care in Sweden is a shared responsibility between the national and sub-national governments. In Sweden, these are the 26 county councils and 288 municipalities.

- The **national government** is responsible for public policy matters and legislation related to health care and health care insurance.<sup>27</sup> In addition, the national government transfers funds for the purpose of health care to the county councils and municipalities.
- The **county councils**<sup>28</sup> have full responsibility for the management and delivery of health care to their residents, subject to national legislation. This responsibility includes primary care, hospital care, prescription drugs, public health and preventive care. County councils provide most funding for health care through taxation applied within their boundaries.
- **Municipalities** are responsible for financing and operating home care and nursing homes for the elderly, the disabled and long term psychiatric patients. Like county councils, municipalities have the right to levy taxes on their population.

#### 4.2 Health Care Insurance and Coverage

As in Canada, access to public health care insurance in Sweden is universal. However, in Sweden user charges are not seen as endangering access to publicly-funded health care and the county councils are free to require user charges, subject to certain limits established by the national government.

Public health care coverage in Sweden is considerably broader than in Canada, encompassing physicians, hospital services, drugs and dental care.<sup>29</sup> Long term care and

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<sup>27</sup> The most important national legislation is the Health and Medical Services Act of 1982 which establishes the division of jurisdiction between the national government and county councils. The Act also imposes certain restrictions that apply to both the delivery and financing of health care by county councils. The national legislation does not define basic or essential health care or drug package.

<sup>28</sup> County councils are independent regional government bodies whose members are elected every fourth year concurrently with national and municipal elections. As of today, there are 23 county councils; 3 large municipalities (Gotland, Gothenburg and Malmo) have chosen not to belong to any county council and therefore have the same health care responsibilities as the county councils.

<sup>29</sup> Long term care in nursing homes and home care are not managed or funded by county councils, but by municipalities.

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elderly, the disabled and long term psychiatric patients).

*[User] fees are somewhat higher in the hospitals [than in primary care centres]. This is because the aim is to make the patient choose a less expensive and acceptable level of care in the individual situation.*

*(...)*

*The idea of this different fees is that you should make a judgement as to whether you need a hospital or if you you can seek the service or the care at the local health centre instead.*

*Lars Elinderson, Deputy Member, Swedish Parliament (19:6 and 19:7)*

care are also  
publicly insured  
specific groups  
population (the

Contrary to Canada, private health care insurance that covers the same benefits as public insurance is legal in Sweden, but it is only used by a very small minority of the population.

### 4.3 Funding for Health Care

As in Canada, health care in Sweden is financed predominantly by the public sector through a combination of general taxation and social insurance (ie. employer/employee contributions). Taxes are levied at the national, county and municipal levels.<sup>30</sup>

The national government contributes to health care funding in two ways: through direct grants to the county councils (for physician and hospital services) and through the flow of funds from the broader social insurance system to designated health services delivered at both the county and municipal levels (doctors in private practice, prescription drugs, dental care, long term care and home care). The contribution by the national government to county councils is population-based, with certain additional adjustments to take account of the population's socio-economic status and other factors. This contribution represents about 10% of the county councils' total revenue. Funds from the national social insurance system are transferred to county councils and municipalities on a per capita basis.<sup>31</sup>

Most public resources that are used to pay for health care in Sweden are raised through income tax levied by the county councils. Each county council is free to set its own tax rate, at a level that is sufficient to cover its expenditures. The national government has, at times, imposed restrictions on the tax rates that county councils could levy. For example, during the late 1980s and early 1990s, the national government unilaterally froze the county council tax rates. Currently, the national government still exercises some control over the county council tax rate: those county councils that generate additional revenue by raising their tax rate suffer a reduction in the national government contribution equal to 50% of the additional revenue they raise themselves.

Municipalities are responsible for financing long term care and home care for specific groups of the Swedish population. They must reimburse county councils for nursing-home patients who have been hospitalized for acute care if these patients have been

<sup>30</sup> The national income tax is progressive (with a higher tax rate applying to higher taxable income). County councils and municipalities levy a proportional income tax (a flat rate on each person's taxable income). The base on which the county councils and municipalities levy their income tax is the basic national tax.

<sup>31</sup> The social insurance system is headed by the National Social Insurance Board, Rickforsakringsverket. The system is compulsory for all individuals over the age of 16 and is funded mainly by payroll contributions, with the remainder made up of national grants.

fully treated and could be discharged. The per diem fee level that municipalities must pay to county councils for these patients is set in regulations by the national government.

Private health care expenditures in Sweden are of two kinds: user charges paid by patients at the point of service and spending by private insurance companies. Spending by private health care insurance is minimal (only 2% of total health care expenditures), but user charges are more important. In contrast to Canada, user charges are required for publicly funded health services and they are levied on both physician and hospital services, as well as on drugs and dental care. Each county council determines its own user charge structure for out-patient care use.

Fees for in-patient care and prescription drugs are decided by the national government. The national government also specifies “stop-loss provisions” that limit the maximum amount any individual has to pay out-of-pocket for health services and drugs in any one-year period. Above this limit, there are no further user charges. Special provisions apply to persons with low income and persons under age 20 are exempt from user charges.

User charges required for hospital stays amount to about \$12 per day, and fees for primary care consultation with nurses and doctors range between \$15 to \$20. The stop-loss provision set by the national government specifies that user charges for physician and hospital services per person cannot exceed \$135 in a given year. For prescription drugs, patients must pay the first \$135 per year and part of any additional cost up to a maximum of \$270 per year (for a total of \$405 annually).

In Sweden, user charges are regarded as “essential in order to make people choose the most economical service.” In Sweden, user charges are not perceived as impeding access. Nor are they designed to raise money. In fact, the cost of administering the user charge scheme (collecting the fees and keeping track of how much an individuals has paid so that the cap is not exceeded) is almost as much as the total amount collected in user charges.

The Committee was told that the purchase of private health care insurance, although still limited to a small proportion of the Swedish population, is now growing at a fast rate due to waiting lists. This has resulted in the problem of queue jumping:

*We have a very short tradition of private insurance in the health care system because the public health care system is supposed to cover everything for all individuals. Because of difficulties with accessibility, waiting lists and things like that, some people (...) have bought private insurance to have quick access to hospitals when they need it. (...) The growing rate of the number of insured, or people on private health care insurance, is some 80% or something like that now. It is growing very fast due to the normal waiting lists and the problems within the system today.<sup>32</sup>*

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<sup>32</sup> Lars Elinderson (19:8).



## 4.4 Management and Provision

Responsibility for health care management and delivery rests primarily with the county councils. There are, however, national laws that oblige each county to offer all types of necessary care to all citizens, regardless of their ability to pay or where they live.

County councils own the local primary care centres, where patients are seen by doctors or nurses. Most doctors and nurses are salaried employees of the county council. Only a limited number of doctors (less than 10%) run a private practice. This contrasts to Canada where most doctors operate their own practice privately and are remunerated on a fee-for-service basis under the public health care insurance plan. Publicly employed doctors in Sweden are not allowed to practice privately on a part-time basis.

County councils in Sweden have the authority to negotiate the establishment of private physician practices and the number of patients they can see during a year.<sup>33</sup> Since the private physician must have an agreement with the county council in order to be reimbursed by public health care insurance, the county councils are able to regulate the private health care market. As a matter of fact, almost all doctors that practice privately on a full time basis do so within the public system. If the private physician has not signed an agreement with a county council, then the patient has to pay the full cost to the provider.<sup>34</sup>

The vast majority of hospitals are also owned by the county councils and their personnel, including doctors, are salaried employees of the county councils.<sup>35</sup> In comparison, most hospitals in Canada are private, not-for-profit organizations, and only a small minority of doctors are paid by salary. There are nine private hospitals in Sweden, most of them being located in the largest cities.<sup>36</sup> Public health care insurance does not reimburse patients for care received at these hospitals. It is only the well-to-do patients who can afford private hospital care.<sup>37</sup> According to Mr. Elinderson, Deputy Member of the Swedish Parliament, public hospitals are less productive and less efficient than privately-run hospitals:

*We have a long tradition in Sweden of publicly run or operated facilities. Also, boards are populated by politicians, not professional doctors or lawyers and other people who normally staff boards. I think that this has created a culture that is not very moderating for raising the productivity. That is the first point.*

*Second, the individual hospitals are not paid for performance. They have a fixed-budget system. All the staff, the medical professionals, are paid within the*

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<sup>33</sup> Funds to pay for private doctors are transferred to the county councils on a per capita basis by the national government through its social security insurance system.

<sup>34</sup> World Health Organization (WHO), *Health Care Systems in Transition – Sweden*. 1996, p.8.

<sup>35</sup> Depending of the county council, a patient may or may not need a referral in order to see a hospital-based specialist.

<sup>36</sup> “Swedish Health Care System Robust, Despite Regional Disparities,” *Ocular Surgery News – International Edition*, May 1997.

<sup>37</sup> Margit Gennser, *Sweden’s Health Care System*, The Fraser Institute, 1999.

*fixed salary system. This would not give any incentive for high productivity. These are two of the explanations.*<sup>38</sup>

Overall, privatization of health service delivery has been very limited in Sweden. With the exception of general ancillary services, most health services are still provided by facilities owned by the county councils.<sup>39</sup>

In contrast to Canada, county councils in Sweden pay for all prescription drugs. Part of this payment is covered by a grant from the national government. All drugs prescribed by doctors and hospitals are purchased by a single national agency, *Apoteksbolaget*, a state-owned company which owns all community pharmacies and hospital pharmacies in Sweden. All pharmacists therefore are public employees. *Apoteksbolaget*, which operates its pharmacies under one-year contracts with the county councils, is required by national legislation to supply drugs at uniform prices throughout the country and at the lowest possible cost to both individual and society. Patients must defray the cost of their prescription drugs up to the maximum payable (\$405). They then receive a card entitling them to free prescription drugs for the remainder of the year.

## **4.5 Particularities**

In 1992, the national government introduced the “care guarantee” which established a maximum waiting time not exceeding three months for diagnostic tests, hearing aid tests and certain types of elective surgery (treatment for coronary artery disease, hip and knee replacements, cataract surgery, gallstone surgery, inguinal hernia surgery, surgery for prolapse and incontinence). Subsequently, maximum waiting time guarantees were introduced for consultations with primary care doctors (8 days) and specialists (3 months).

The national government provided the county councils with additional funding specifically intended to shorten waiting times. In some cases, the county councils distributed these funds only to those hospitals that were able to guarantee that patients would be treated within the specified period of time.

It appears that the care guarantee led to a substantial reduction in waiting times, to the point where waiting lists “ceased to be a political issue.”<sup>40</sup> The care guarantee was abandoned when a new government was elected. This has resulted in a resurgence of long waiting lines.

The national government has also enacted legislation providing patients the right to freely choose the hospital in which they would receive treatment. Prior to that reform, patients requiring hospital treatment could only receive it in the hospital to which they were assigned, that is the hospital serving the area in which the patient resided. When a patient elects to receive care in a hospital other than the one to which he/she was originally assigned, a specified sum of money can be transferred from the budget of the latter to that of the former. County councils thus have to pay for services provided to their residents by

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<sup>38</sup> Lars Elinderson (19:9).

<sup>39</sup> WHO, p. 13.

<sup>40</sup> Ake Blomqvist, *International Health Care Models: Sweden*, May 2001, p. 19.

another county council. The public at large have put considerable value on the increased freedom of choice this legislation offers. Many observers also claim it has produced a major change in the way patients scheduled for surgery are treated, as an incentive is created for each hospital to attract patients from other ones, or to prevent patients from going elsewhere.

In the 1990s, many county councils in Sweden embarked on an approach called the “purchaser-provider split.” This split simply consists in separating the purchasing of health care from its provision. The goal is to improve efficiency in the publicly funded health care system through greater management by purchasers (the county councils) and greater competition among providers (hospitals, primary care centres, private doctors). Under such a scheme, the purchaser seeks to contract with or employ only those providers that are more likely to enhance cost-effectiveness and efficiency. The contract between the purchaser and the provider specifies what services that are to be rendered to what part of the population and how the provider will be paid. However, it does not specify how the services are to be provided. A fundamental principle of the purchaser/provider split is that the provider will only be paid the amounts specified in the contracts. Any deficits incurred should be the provider’s responsibility or should result in some form of future sanctions. Purchasers are also free to choose among competing providers in contracting for their population’s care. According to experts, the experience with the purchaser-provider split in Sweden has been mixed.<sup>41</sup>

*In Sweden, the 20 county councils (...) implemented internal market reforms throughout the 1990s by removing hospitals from county council control.*

*This arrangement frees health authorities from becoming bogged down with the minutiae of running facilities such as hospitals. Instead, they can focus on assessing the needs of their population and establishing contracts with various health care providers in line with their assessments of where the priorities lie. It also removes the perverse incentives of a system where health authorities pay their bills without being able to direct priorities, and are unable to reward efficient providers. The balance of power is realigned as at least one body takes a population perspective rather than having service provision driven by the existing bricks and mortar and the providers (mainly doctors) who work therein. With an internal market, health authorities hold the purse strings and choose between providers on the basis of quality and cost, rather than simply funding the decisions of those using the resources.*

*Donaldson, Currie and Mitton, April 2001, pp. 7-8.*

With its 26 county councils, the health care system in Sweden is highly decentralized, but the national government plays a significant role in regulating health care at the regional level. According to Professor Blomqvist, the division of responsibility for health care has not generated any major tension between the Swedish government and county councils.<sup>42</sup> He concludes that “a study of the interplay between the county councils

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<sup>41</sup> Blomqvist, p. 16.

<sup>42</sup> Blomqvist, p. 12.

and Sweden's national government may contain useful lessons in assessing the methods we use in Canada to regulate federal-provincial relations."<sup>43</sup>

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<sup>43</sup> Blomqvist, p. 1.



## CHAPTER FIVE:

### HEALTH CARE IN THE UNITED KINGDOM

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#### 5.1 Government Responsibility

While it has the same Parliamentary system as Canada, the United Kingdom is a unitary state comprising Great Britain (England, Scotland and Wales) and Northern Ireland. Since 1999, however, there are National Assemblies in Scotland and Wales and the legislative assembly in Northern Ireland was also re-established as a consequence of the negotiations there between the concerned parties.<sup>44</sup> Even before devolution, each nation was responsible for managing its health care system, but the principles and functioning were basically the same throughout the United Kingdom.

The centralized nature of the United Kingdom state is reflected in the structure of its public health care system – the National Health Service (NHS). The NHS, which was established in 1948, still stands out as the most centrally managed and financed health care system in the world. The central government is not only involved in the financing of health services but is also heavily involved in the management and delivery of services. This contrasts sharply with Canada, Germany and Sweden where the responsibility for health care is shared between the different levels of government.

Responsibility for social care, such as long-term residential nursing care, is shared between local government, various social services departments and the NHS, which has led to long-standing problems of poor coordination.

#### 5.2 Health Care Insurance and Coverage

As in Canada, all people normally resident in the United Kingdom are eligible for health care insurance coverage under the NHS. The NHS does not specify an explicit list of services to be covered. However, unlike Canadian Medicare, the NHS is more comprehensive as it covers physicians, hospitals, prescription drugs, dental care and optical services.

As in Canada, there are no user charges for physician services in the United Kingdom and hospital and specialist services are to be provided free-of-charge. However, user charges apply to prescription drugs, dental and optical services.

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<sup>44</sup> As part of the process of devolution, the Scottish and Welsh Assemblies are now responsible for health care, leading to some differences with the prevailing system in England. This chapter concentrates on the common history of the health care system in the United Kingdom as a whole, and on recent changes in England, unless otherwise specified.

In the case of drugs, there is a flat charge (£6 or about C\$13.50<sup>45</sup>) for each prescription written on the NHS. However, about 60% of the population benefit from exemptions, and around 80% of prescriptions are written for people who are exempt. The Committee was told that, despite these exemptions, changes in the user charges can have a noticeable impact both on government revenue and on the number of prescriptions dispensed.

Within the NHS, general dental services are subject to a considerable amount of co-insurance, with individuals paying 80% of the cost of their treatment up to a maximum charge set at £348 (C\$780) in 1999-2000. Here as well, certain groups, such as children, are exempt.

Unlike Canada, the United Kingdom does allow people to purchase private health care insurance that covers the same benefits as the NHS if these services are supplied by providers working outside of the NHS. Private insurance takes two main forms: employer-sponsored insurance (59% of the total) and individual insurance policies. In just under one third of the company schemes employees meet all or part of the premium costs. In 1996 there were 25 private health care insurers offering coverage in the United Kingdom. Seven of these were non-profit, provident insurers while the remaining 18 were commercial insurers. Two large insurers (PPP Healthcare and British United Provident Association [BUPA]) cover more than two thirds of those covered by private health care insurance. There is some degree of vertical integration in the private health care sector, as several of the large insurers are also amongst the major owners of the 230 medical/surgical hospitals that comprise the independent sector.

The proportion of people who purchase private health care insurance in the United Kingdom has historically been low, but has steadily grown in recent years to 11.5% of the population. Examination of the socio-economic status of people with private insurance indicates that it is heavily skewed towards higher socio-economic groups. The percentage of people with private insurance varies considerably across the country, approaching 20% in London, whereas in Scotland it is as low as 5%.

The lines between public and private can be fuzzy, as private patients can be treated in an NHS facility (in what is called a “pay bed”<sup>46</sup>) as well as in private hospitals. Overall, surveys indicate that the most common reason people take out private health care insurance is to avoid waiting for elective surgery. The Committee was told that patients can begin their course of treatment in the private sector but end up in the NHS if

*In terms of jumping queues, yes it happens. One of the major reasons given by people who take private insurance is they want the peace of mind of being able to have elective operations for themselves or their families more quickly or at more convenient times than if they must depend on the National Health Service. That is seen, of course, as a cause of unfairness, which is one of the reasons that the government is committed to bringing down waiting times for National Health Service patients as rapidly as it can.*

*Clive Smee, Chief Economic Advisor, Economic and Operational Research Division of the United Kingdom (20:35)*

<sup>45</sup> The flat charge represented about 57% of the average prescription charge in 1998.

<sup>46</sup> There were an estimated 1400 dedicated pay beds in HNS private units in 1997, of which 39% were in London.

there are complications, if treatment beyond the scope of services that are available in the private sector is warranted, or if their insurance will not cover their treatment.

### **5.3 Financing for Health Care**

In the United Kingdom, a larger proportion of health care spending is financed by the public sector (84%) than in Canada (70%). Like the public health care insurance scheme of Australia, the NHS is financed mainly through central government general taxation together with an element of national insurance contributions made by employers and employees. User charges account for less than 3% of total NHS financing.

The various waves of reform that swept across the health care system in the United Kingdom in the course of the 1990s have not significantly altered the ratio between public and private spending, as they have concentrated on introducing reforms within the publicly-funded system.

Because NHS spending dominates overall expenditures on health care in the United Kingdom, and because public spending is subject to tight cash limits, the level of spending on health care is the subject of intense political debate. One advantage that is often cited for the kind of centralized system that exists in the United Kingdom is that it permits a greater degree of overall cost control. This is illustrated by the fact that spending on health care in the United Kingdom in 1998 only represented 6.7% of GDP, compared to 9.5% for Canada, 10.6% for Germany and 13.6% for the United States.

### **5.4 Management and Provision**

It is in the area of the management and provision of health services that many significant reforms of the health care system in the United Kingdom have been undertaken over the past decade. These reforms, which were established during the tenure of Prime Minister Margaret Thatcher, created an ‘internal market,’ meaning that certain market-oriented principles were introduced into the publicly-funded health care system. More precisely, the reforms referred to as the “purchaser-provider split” affected the relationships between the regional health authorities and the hospitals, while the establishment of “GP Fundholding” modified the organization and shape of general family practices. The Labour government of Tony Blair, elected in 1997, was critical of the internal market; it has since modified a number of significant features of the system, but has not sought to return it to its original form.

#### **5.4.1 Hospital Services**

Until 1990, NHS hospitals were state-owned and operated by the NHS through its regional health authorities. The budget of each regional health authority was determined by the central government by means of a weighted capitation formula based on the health care needs of the regional population. Each hospital’s budget was then determined regionally through an administrative process involving negotiations between its management and the relevant regional health authority. Hospital specialists were salaried



employees of the NHS (but were also permitted to operate a private practice in parallel to the NHS).

A major critique of such a system was that regional health authorities were contracting, or purchasing, services on behalf of their local populations, but at the same time they were running the local hospitals. Thus, they had a pronounced conflict of interest aimed at protecting those hospitals.

In 1991, under the reforms of the Thatcher government, regional health authorities ceased to manage hospitals and became responsible, as purchasing organizations, for contracting with NHS hospitals and private providers to deliver the services required by their resident populations. Hospitals, for their part, were transformed into NHS Trusts; that is, not-for-profit organizations within the NHS but outside the control of the regional health authorities.

NHS trusts were expected to compete for contracts from health authorities and general practitioners for the provision of clinical services. Each trust was expected to generate income through service contracts with purchasers and had to meet centrally specified financial objectives such as making a 6% return on its capital assets. Payments to hospitals thus depended on the contract signed with the purchasers. Typically, contracts specified what services were to be provided and the terms on which they were to be supplied.

Despite its commitment to abolish the internal market, the Blair government has announced no plans to radically change the status of NHS Trusts. Trusts remain independent organizations within the NHS. However, their relationship with the regional health authorities has shifted from the previous emphasis on competition and financial performance toward a collaborative approach to quality of care.<sup>47</sup>

As in the past, hospital doctors remain directly employed by the NHS on a salaried basis. Their actual salary scales are determined by the government each year, taking into account the recommendations of the Review Body on Doctors' and Dentists' Remuneration. In addition to their NHS earnings, full-time NHS hospital specialists are permitted to earn up to 10% of their gross income from private practice.

#### **5.4.2 Physician Services**

When the NHS was established, general practitioners (family physicians) were allowed to operate as independent contractors within the NHS (like most family physicians currently practicing in Canada). They were also permitted the right to private practice alongside their NHS work. According to experts, the independent contractor status of general practitioners meant that “services had developed piecemeal and coordination with hospital based health services was poor.”<sup>48</sup> For these reasons, the provision of care by general practitioners was brought into a “rostering system”; this system required patients to

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<sup>47</sup> More precisely, the national government set up a regulatory agency, called the Commission for Health Improvement, the task of which is to visit every NHS institution – hospitals, health authorities, primary care groups – to monitor their activities.

<sup>48</sup> European Observatory, *Health Care Systems in Transition – United Kingdom*, 1999, p. 9.

register with one general practitioner, who then acted as a “gatekeeper” to the rest of the health care system. Patients could only be admitted to hospital, see a specialist or have their prescription drugs paid for if they had a referral from their general practitioner. Within such a system, individual general practitioners remained under contract with the NHS and were remunerated through a mixed system that combined a salary with capitation based simply on the number of patients on a doctor’s list.

Then, with the 1991 reform, the concept of GP Fundholding was introduced. The purpose of this system was to give incentives to general practitioners to provide the most cost-effective form of care. Under the system of fundholdings, general practitioners were given a “fund” made of two spending categories: the cost of drugs they prescribed to their patients and the cost of certain kinds of specialist and hospital treatment for their patients. If, during a given period, the actual expenditures were less than the budgeted fund, the general practitioner was allowed to spend the surplus on improvements to his/her practice. Conversely, general practitioners who exceeded their budgeted fund faced a penalty corresponding to a portion of their deficit.

One criticism of the fundholding system was that it tended to produce inequality in the standard of care that different patients groups were receiving. More precisely, general practitioners in poorer regions had patients with greater health care needs than those practising in more affluent areas, making it harder for the former to generate a surplus. Another critique of the GP Fundholding was its very high administrative costs: general practitioners found that negotiating with hospitals and specialists for health services was both cumbersome and time consuming. In 1999, the Blair government reformed the GP Fundholding system by creating Primary Care Groups (PCGs). PCGs are group practices made of the merging of former GP Fundholders. Thus, PCGs are far larger than previous GP Fundholders, covering between 50,000 to 250,000 people in designated geographic areas. They are expected to develop through a number of stages until they are able to assume responsibility for commissioning care and for the provision of community health services for their population.

The various reforms enacted throughout the 1990s, such as GP Fundholding and more recently the creation of PCGs, did not affect the ways that general practitioners received their personal incomes. Fundholding budgets were for the purchase of hospital and community services and could not be used to supplement general practitioners’ incomes. Currently, general practitioners are paid by the NHS as independent, self-employed professionals under a ‘cost-plus’ principle – the payments they receive cover their expenses in delivering services (the ‘cost’) and a net income for doing so (the ‘plus’). The basic elements of the current payment system include:

- *Capitation fees* – annual fees payable for each patient registered on their list (with three levels of payment depending on the age of the patient). These amount to just over one half of general practitioners’ gross income from all fees and allowances.
- *Allowances* – are the next largest element for the average general practitioner and include a basic practice allowance that covers the basic

costs incurred in setting up and maintaining a practice. The level of this allowance can vary in order to encourage practitioners to locate in underserved areas.

- *Health promotion payments* – comprise payments for running health promotion and chronic disease management programs.
- *Item of service payments* – paid every time a general practitioner provides certain, usually preventive, services (e.g. contraception).

Overall, this combination of types of payment means that the income of individual general practitioners will depend on the number of patients on their list, the fees and allowances for which they qualify, the number and level of activities undertaken and the performance achieved.

## 5.5 Private Health Care Delivery

There are approximately 230 independent medical/surgical facilities and hospitals in the United Kingdom. In these private settings, doctors are paid fee-for-service either directly by the patient who may be then reimbursed by a private insurance company if he/she is a policyholder, or by the private hospital/clinic at which the services are provided. Private sector care is specialized and is mainly used for such elective (non-emergency) surgical procedures as hernias, varicose vein surgery and hip replacements. Abortions are the most common procedure (13.2% of the total). In recent years, there has been substantial growth in rather more complex procedures such as coronary bypass grafts and other heart operations.

By contrast, there is very little privately financed primary care in the United Kingdom. Only 3% of general practitioner consultations are estimated to be in the private sector. The main reason for the lack of development in this area is that general practitioners are not allowed to see patients

*The NHS has always made some use of privately run hospitals, but during the recent election campaign - this may be what you are referring to - the Blair government made a commitment to be pragmatic after the election as to whether private or public hospitals should be used to treat National Health Service patients. Those patients would be treated free at the point of use of those services, whether public or private. That is to try to bring down the waiting lists and waiting times, particularly for non-urgent medical treatments, and to help achieve the targets set by the government. That is quite a shift compared to, traditionally, how Labour governments have seen these issues. The Blair government claims to be new Labour, not old Labour, being much more pragmatic about where the care is provided, as long as it is free for the patients.*

*Professor Chris Ham, University of Birmingham  
(20:27)*

on their NHS list privately or to issue NHS prescriptions and there are currently few insurance products to cover primary care services.

## 5.6 Particularities

As in Canada, all residents in the United Kingdom are covered through a universal, tax-financed health care insurance plan, the NHS. As in Canada, there are no user charges for hospital and physician services. However, coverage under the NHS is broader than in Canada, in the sense that prescription drugs and basic dental and vision care are included. User charges do apply to these additional publicly-insured services. By contrast to Canada, it is legal in the United Kingdom to purchase private insurance that covers the same kinds of services that are provided under the NHS.

From a Canadian perspective, two points stand out with regard to the unprecedented reform process undertaken in the United Kingdom over the past decade. In the first place, because of the relatively centralized nature of both the political system in the United Kingdom and of the health care system that was built in its image, it was possible to enact a ‘big bang’ reform that transformed key aspects of health care, probably forever.

In the second place, however, as Professor Julian LeGrand noted, “perhaps the most striking conclusion to arise from the evidence is how little overall measurable change there seems to have been” that can be attributed to the core mechanisms of the reforms designed to introduce elements of market-oriented competition into the publicly-funded system.<sup>49</sup>

*I would say "internal market" was always a bit of a misnomer in our case. I would say, it was a managed market and it turned out to be a heavily politically-managed market. (...) They did not actually implement the internal market as it was intended from the beginning, so in practice I would say there was not ever a great deal of competition between hospitals and other health care providers and to that extent the so-called internal market experiment was never tested in the way that was intended at the outset.*

*Chris Ham, Director, Health Services Management Centre, United Kingdom (20:29)*

Why did the purchaser-provider split not function as originally envisaged? According to Ake Blomqvist the most likely explanation “was that there was a lack of incentive to make it work, on both sides of the market.”<sup>50</sup> As he points out, on the provider side, hospitals that are already operating near capacity have little incentive to seek more patients, even if these will bring in greater revenues. On the purchaser side the health authorities were caught in a situation where they could have a major impact on individual hospitals if they shifted their purchasing elsewhere. They could have provoked layoffs and even closures, which would have destroyed relationships of trust that had been built up over many years and upon which the system still depended in order to function.

At the same time, however, it is important to note that the GP fundholding system quickly became more popular than anyone had anticipated. At the beginning of the 1990s it was seen as a small part of the overall reform process, but a variety of factors contributed to the unexpected growth of the scheme. There was evidence early on that fundholders could improve the services their patients received, and this created a bandwagon effect, with many physicians not wanting to be left behind. The Thatcher government

<sup>49</sup> Le Grand, Julian, “Competition, Cooperation, or Control? Tales from the British National Health Service,” Health Affairs, May-June 1999, p. 31.

<sup>50</sup> Blomqvist, Ake, Health Care Reform in Canada: Lessons from the U.K, Japan and Holland, unpublished paper, p. 44.

reinforced this trend by offering further benefits (e.g. computers) to GP fundholding practices that were not available to other doctors. Moreover, fundholding gave general practitioners a greater role in the overall health care system than they had previously. Hospital specialists have been forced to become more responsive and accountable to general practitioners who could now opt to take their business elsewhere.

However, experts are still divided over how to assess the overall balance sheet. Some feel that the “internal market” was never given a fair chance, that insufficient incentives were provided and too many constraints retained. Others argue that it is impossible to introduce a fully-functioning market system into a largely publicly-funded health care system. For the time being, the Blair government has opted for a system that attempts to engineer a shift towards greater cooperation amongst the various players, while retaining many aspects of the purchaser-provider split that was initiated under the previous Thatcher government.

## CHAPTER SIX:

### HEALTH CARE IN THE UNITED STATES

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#### 6.1 Government Responsibility<sup>51</sup>

The United States is a republic with a federal system of government consisting of a national (federal) government and fifty state governments. Each State and the national government have written constitutions that spell out what each government can and cannot do. While private insurance is the dominant player in the health care field, each level of government also plays a role with respect to health care:

- As in Canada, the **national government** of the United States provides health services to specific groups of the population, including military personnel, veterans with service-related disabilities, Native Americans (American Indians and Alaskan Natives), and inmates of federal prisons. More importantly, the US national government has the authority to raise taxes and appropriate funds for the purpose of the general welfare of the population, including health care.<sup>52</sup> Responsibility for administering the health care insurance programs Medicare and Medicaid and the recently enacted State Children's Health Insurance Program (SCHIP) is entrusted to the Health Care Financing Administration (HCFA) of the federal Department of Health and Human Services (DHHS). The federal government of the United States is also responsible for regulating health care insurance provided by employers and managed care organizations participating in federally subsidized health care.
- The responsibilities of **State governments** with respect to health care include the licensing of hospitals and health care personnel, public health (sanitation, water quality, etc.) and mental health. States can raise their own revenue by various types of taxes and there is no federal limit on their taxing powers. State governments must conform to federal regulations when receiving funds from the national government under Medicaid and SCHIP. State governments are also responsible for regulating private health care insurance, including managed care organizations, as well as Blue Cross/Blue Shield.

Although the federal and State governments of the United States do provide public coverage for health care, the American health care system remains unique around the world as it strongly relies on the private sector to both provide health care coverage and

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<sup>51</sup> The information contained in this section has been mostly derived from M.W. Raffel and N.K. Raffel, "The Health System of the United States," in *Health Care and Reform in Industrialized Countries*, The Pennsylvania State University Press, 1997, pp. 263-289.

<sup>52</sup> This constitutional power has been interpreted as encompassing funding for health care delivery, health research and medical/nursing education.

deliver health services. This chapter focuses primarily on public health care insurance in the United States.

## 6.2 Health Care Insurance and Coverage

The national government of the United States is responsible for administering and operating Medicare, which provides health care insurance for the elderly. Jointly with the States, it finances Medicaid for the poor and the State Children's Health Insurance Program (SCHIP) for children.

### 6.2.1 Medicare

Medicare is a federal health care insurance plan for people 65 years of age and over, some people with disabilities under 65, and people with end-stage renal disease. Medicare is not means-tested and has two parts:

- *Part A* provides coverage for hospital services, skilled nursing facility care for the purpose of rehabilitation, hospice care, and some home care.<sup>53</sup> Most people get *Part A* automatically when they turn age 65.<sup>54</sup> They do not have to pay a monthly payment or premium to be entitled to *Part A* Medicare benefits. People, however, must pay user charges. For 2001 each beneficiary must pay a deductible of \$792US. With respect to skilled nursing facility care, *Part A* pays all charges for the first 20 days, then a co-insurance requirement kicks in for days 21 through 100. All costs beyond the 100<sup>th</sup> day must be paid by the patient. A 20% coinsurance payment also applies to medical equipment (such as wheelchair or walker) for home care. People who select hospice care must pay some of the costs for drugs and inpatient respite care. People with low income may have their Medicare costs (user charges) paid by the State under Medicaid (described below).
- *Part B* covers physician services, outpatient hospital care (including emergency room visits), ambulance transportation, diagnostic tests, laboratory services, some preventive care (such as mammography and Pap smear screening), services of physical and occupational therapists, and some home care for which *Part A* does not pay. *Part B* does not cover prescription drugs, routine physical examination, dental care, cosmetic surgery, hearing aids, vision care. Enrolment in *Part B* is optional. People must pay a monthly premium (\$50US in 2001) if they

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<sup>53</sup> Hospital care includes semi-private rooms and meals, general nursing services, operating and recovery room costs, intensive care, drugs, laboratory tests, X-rays, and all other necessary medical services and supplies (up to 90 days for each benefit period). Coverage for skilled nursing facility care is mainly for the purpose of rehabilitation and includes semi-private room and meals, skilled nursing services, rehabilitation services, drugs, and medical supplies (up to 100 days for each benefit period). Home care only refers to part-time or intermittent nursing services prescribed by a physician for treatment or rehabilitation services, and it does not include custodial services (help with daily living activities like bathing, eating or getting dressed).

<sup>54</sup> Coverage for Part A may be purchased by individuals who do not have insured status through the payment of monthly premiums.

enrol before they turn 65. The monthly premium is higher for people who sign up at a later stage (and they then pay this higher premium for the rest of their life). *Part B* pays 80% of the cost of insured services. In addition to covering the remaining 20% (coinsurance) people must also pay a deductible of \$100US per year. People with low income may have their premium paid by the State where they reside (under Medicaid).

Medicare is delivered through two different mechanisms. First, under the original Medicare plan, the federal government contracts with private insurance companies (there are about 55 of them) to process and pay claims. Many of these insurers offer their clients “Medigap,” a supplemental insurance policy that helps to fill the gaps in the plan (coinsurance, deductibles and other out-of-pocket costs). Some Medigap policies will also cover services not covered by Medicare, such as prescription drugs. Some 80% of Medicare beneficiaries are enrolled in the original plan.

Second, since 1997, Medicare can be provided through “Medicare+Choice.” This option offers access to managed care plans – such as Health Maintenance Organizations (HMOs), and Preferred Provider Organizations (PPOs) – as well as to medical savings accounts, or other private health care insurance options.<sup>55</sup> Medicare managed care plans have the following characteristics:

- They must provide all of the services that are offered under the original Medicare plan;
- They can offer a variety of additional benefits, like preventive care, prescription drugs, dental care, hearing aids, eyeglasses and other items not covered by the original Medicare plan. Costs for these extra benefits vary greatly among plans.
- They usually impose restrictions on the choice of providers. For example, clients enrolled in an HMO will only be able to seek care from doctors and hospitals employed or owned by the HMO.
- Given these restrictions on the freedom to choose, these plans permit savings in comparison to the average cost of the original Medicare coverage. Those who enroll in the HMO option are charged a lower premium to belong to Medicare *Part B*.

### **6.2.2 Medicaid and SCHIP**

Medicaid is a joint federal and State health care insurance plan available to people with low income. It is means-tested, but low income is only one of the criteria for Medicaid eligibility. Assets and resources can also be tested against established thresholds. Basic coverage includes physicians, hospitals, laboratory and x-ray services, etc. The federal government pays half of the cost incurred by individual States in providing coverage for the

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<sup>55</sup> An HMO is an organization that offers health services provided by selected doctors and hospitals. In exchange for a monthly fee, enrollees receive care as needed. PPOs are a simplified form of HMOs in the sense that they provide incentives to their enrollees to use a limited number of selected providers at a reduced cost. Medical savings accounts are currently being offered on a trial basis.



poor and establishes broad national guidelines. However, each State 1) administers its own program; 2) establishes its own eligibility standards; 3) determines the type, amount, duration and scope of services, and 4) sets the rate of payment for services. Medicaid programs therefore vary from State to State.

Medicaid does not make health care coverage available to all people who can be considered poor. Coverage is provided to those considered either “categorically needy” or “medically needy.” The categorically needy population includes persons receiving federally assisted income maintenance payments (mostly children, the aged, the blind and disabled). The medically needy population includes those in the welfare category who do not receive federal cash assistance but whose net income falls below State standards. Most States have additional state-only programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program, but no federal funds are provided for state-only programs. States may require user charges from some Medicaid recipients for certain services. User charges, however, are not required for emergency services, pregnant women and children under age 18.

SCHIP is a program initiated in 1997 by the federal government to expand public health care coverage to otherwise uninsured children. Under this program, each State receives enhanced federal matching payments up to a fixed allotment. SCHIP may be provided either as an expansion of Medicaid, or through separate State programs. It enables States to provide coverage to children from working families with income too high to qualify for Medicaid but too low to afford private health care insurance.

Like Medicare, Medicaid is provided through various payment arrangements to eligible beneficiaries.

### 6.2.3 Public and Private Health Care Coverage

Overall, public health care insurance covers about 24% of the population in the United States. Private insurance, either purchased directly or obtained through employment, is predominant in the health care field. The majority of Americans with private insurance receive coverage through an employer-sponsored plan.

*The U.S. is unique in the source of health insurance, as employer health insurance is the dominant form of health insurance coverage in the United States. (...) Health insurance, in a way, is part of a total compensation package for workers. (...) 63 per cent of those who are covered get their coverage through employer-sponsored programs.*

*Christine Schmidt, U.S Department of Health and Human Services (23:5)*

American employers may provide their employees with self-insurance plans or insurance plans contracted out with third-party insurers. Self-insured employers usually operate and administer their own plans; a few of them even run their own health care facilities. In addition to commercial plans, third-party insurers include HMOs and PPOs, which both insure and deliver health services. It is recognized that HMOs, PPOs and employer-sponsored plans somewhat restrict patient’s choice among health care providers. Individuals who do not have access to

employer-based coverage may obtain health care insurance by purchasing it directly from commercial insurers or HMOs.

A report by Health Canada points out that, although employer-sponsored insurance is voluntary (except in Hawaii), it is nonetheless encouraged by tax policy. As in Canada, employer-paid contributions to employee health care costs in the United States are deducted from the employer's taxable income and are, in the end, basically a substitute for cash wages.<sup>56</sup>

Despite the availability of public and private health care insurance, it is estimated that some 43 million Americans, or 15.5% of the population, have no coverage at all (see table below). Moreover, a significant proportion of Americans remain underinsured (that is they have some coverage but there is no limit on out-of-pocket costs).

**TYPE OF HEALTH CARE INSURANCE AND COVERAGE  
STATUS  
IN THE UNITED STATES, 1999**

	NUMBER OF PERSONS (‘000)	PERCENT OF POPULATION (%)
Private	194,599	71.0
Employment-based	172,023	62.8
Government	66,176	24.1
Medicare	36,066	13.2
Medicaid	27,890	10.2
Military	8,530	3.1
<b><i>Total Covered</i></b>	<b>231,533</b>	<b>84.5</b>
<b><i>Not Covered</i></b>	<b>42,554</b>	<b>15.5</b>
<b><i>Total</i></b>	<b>274,087</b>	<b>100.0</b>

Note: The estimates by type of coverage are not mutually exclusive: people can be covered by more than one type of health care insurance.

Source: US Census Bureau and Library of Parliament.

<sup>56</sup> Health Policy and Communications Branch, International Affairs Directorate (Health Canada), US Health Care System, 15 January 2001.

### 6.3 Funding for Health Care

In the United States, health care is financed predominantly by private sources (55%), with the balance (45%) coming from public sources. Private spending includes private health care insurance (33%), out-of-pocket payments made by individuals under both public and private plans (17%), and other sources (5%). The federal government contributes approximately 33% of total health care spending, with State and local governments paying the remaining 12%.

Medicare *Part A* is financed primarily from the social security payroll tax: contributions are mandatory and are set at 1.45% for employers and 1.45% for employees. Medicare *Part B* is financed by a combination of premiums and general tax revenue (from both federal and State governments). As indicated above, Medicare funding is also derived from a variety of user charges.

The portion of the Medicaid program that is paid by the federal government is derived from general revenue. The federal share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each State according to a formula that compares the State's average per capita income level with the national average. By law, the FMAP cannot be lower than 50% or greater than 83%. Wealthier States have a smaller share of their costs reimbursed. The federal government also shares in the State's expenditures for administration of the Medicaid program, covering 50% of most administrative costs for all States.

### 6.4 Management and Provision

As in Canada, most physicians in the United States practice privately. Under Medicare, payments for physician services are made on a fee-for-service basis. However, since 1997, with the advent of managed care organizations, other methods of remuneration, such as capitation, are becoming more popular.

Under Medicaid, payments are made directly to physicians. Each State has relatively broad discretion in determining its method of reimbursement. These include paying physicians on a fee-for-service basis and the use of various prepayment arrangements, such as the capitation system used by HMOs. Physicians participating in Medicaid must accept the Medicaid reimbursement level as payment in full; that is, no extra-billing is allowed.

According to Colleen Flood, about 15% of hospitals in the United States are private for-profit institutions, 60% are private non-profit, and the remaining 25% are owned by States or local governments.<sup>57</sup> Under Medicare, hospital-based specialists are remunerated on a fee-for-service scheme.

Medicare reimburses hospital services according to a system of "Diagnosis Related Groups" (DRGs). This system is based on a list of some 500 services, each of

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<sup>57</sup> Colleen Flood, Profiles of Six Health Care Systems, 30 April 2001, pp. 3-5.

which is assigned an average national cost. When admitted, patients are classified into one of the 500 categories. At the end of the treatment episode, the hospital receives the amount shown on the list. It does not depend on the length of stay, or the volume of services actually provided. The DRG system is intended to encourage efficiency by rewarding those hospitals that can treat patients at a lower than average cost. Some States also use this method to fund hospitals delivering Medicaid services.

## **6.5 Particularities**

Unlike Canada, the United States does not have a public system of health care insurance that offers coverage to all its citizens. However, its Medicare system does offer universal coverage for all Americans over age 65 and its Medicaid program does guarantee health care coverage to a definite group of the population, particularly those with low incomes.

In the 1990s, during the debate about constructing a system of universal health care insurance plan in the United States, one proposal put forward was to adopt the Canadian system. Another quite different proposal was that universal coverage could be accomplished simply by expanding Medicare to cover every American. In many ways, these two proposals are relatively similar. As in the Canadian system, conventional Medicare gives patients unrestricted choice among providers, and doctors – both general practitioners and specialists – are paid on the basis of a regulated fee for service schedule.

There are, however, significant differences. One is that there are some user charges in American Medicare, and the possibility exists for those individuals who so desire to hold supplementary private health care insurance which covers all or part of these user charges. Another difference is that under American Medicare, patients do have the choice between the conventional public plan and the HMO option, and, in addition, they have some degree of financial incentive to choose the latter, which is less costly to the plan. Finally, a very important difference is in the way hospitals are funded, with the Americans using the DRG system.

Overall, there is widespread agreement in Canada among both health care experts and the general public that, on the whole, the Canadian health care system is vastly superior to the American system. A large proportion of the population in the United States has no health care coverage at all and a great number of Americans remain clearly under-insured.



## CHAPTER SEVEN:

### MEDICAL SAVINGS ACCOUNTS (MSAS)

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A number of proposals for Medical Savings Accounts (MSAs) have been put forward in recent years in Canada.<sup>58</sup> MSAs are health care accounts, similar to bank accounts, set up to pay for the health care expenses of an individual (or family). They are often established in conjunction with high-deductible (or catastrophic) health care insurance. Money contributed to an MSA belongs to, and is controlled by, the account holder, accumulates on a tax-free basis and is not taxed if used for health care purposes.

MSAs usually involve three levels of payment. First, money in the account is used for normal medical expenses. Next, if the account is exhausted and the deductible has not been reached, the expenses are paid out of pocket. Third, the insurance policy covers expenses beyond the deductible.

The general theory is that consumers would make more judicious and cost-effective decisions if they were spending their own money, rather than relying on the public purse. There are several different ways of structuring these accounts. MSA systems have been operating in a few countries. This chapter briefly examines the operation of MSAs in Singapore, South Africa and the United States and reviews the proposal for MSAs put forward in Hong Kong.<sup>59</sup>

#### 7.1 MSAs in Singapore

The Singapore government's philosophy of health care delivery can be summed up in the following words – individual responsibility coexisting with government subsidies to keep health care affordable. An overview of the Singapore health care system describes the system this way:

*Patients are expected to pay part of the cost of medical services which they use, and pay more when they demand a higher level of services. The principle of co-payment applies even to the most heavily subsidized wards to avoid the pitfalls of providing "free" medical services.*<sup>60</sup>

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<sup>58</sup> See the following documents: 1) William McArthur, Cynthia Ramsay and Michael Walker ed., *Healthy Incentives: Canadian Health Reform in a Canadian Context*, The Fraser Institute, 1996; 2) Cynthia Ramsay, "Medical Savings Accounts", *Critical Issues Bulletin*, The Fraser Institute, 1998; 3) David Gratzner, *Code Blue – Reviving Canada's Health Care System*, ECW Press, 1999; 4) Dennis Owens and Peter Holle, *Universal Medical Savings Accounts*, Frontier Centre for Public Policy, Policy Series No. 5, July 2000.

<sup>59</sup> This chapter is a summary of a more exhaustive paper on MSAs prepared by Margaret Smith from the Parliamentary Research Branch, Library of Parliament. Her paper is available on the Committee's Website.

<sup>60</sup> Ministry of Health, Singapore, *Overview of the Singapore Healthcare System*, February 2001, [http://www.gov.sg/moh/mohinfo/mohinfo\\_a.html](http://www.gov.sg/moh/mohinfo/mohinfo_a.html)

Therefore, health care financing in Singapore is a combination of public and private sources encompassing general tax revenue, employer/employee contributions, compulsory savings, private insurance and out-of-pocket payments.<sup>61</sup> Because individual responsibility for health care expenses is one of the tenets of the Singapore health care system, the government has made saving money for health care expenses compulsory. There are currently three government programs that operate to assist individuals in this regard:

- **Medisave** is a compulsory savings program for certain health care expenses. Under this program, which was established in 1984, every employee is required to contribute a certain percentage of his/her income, with a matching contribution from the employer. These contributions are collected in a central fund managed by the national government. There is an upper limit on the total contributions to Medisave. According to the Ministry of Health of Singapore, the limit is imposed “to prevent an excessive build-up of Medisave balance which could result in unnecessary use of medical services.”<sup>62</sup> Medisave accounts can be used to pay for hospital and certain other medical expenses for the individual account holder and his or her family. Withdrawals from Medisave are subject to limits that require some cash co-payment from patients, particularly those who choose private hospitals or more expensive ward accommodation in public hospitals. Medisave also covers certain expensive outpatient treatments such as, radiotherapy, chemotherapy, renal dialysis and HIV anti-retroviral drugs. Subject to a requirement to maintain a balance, account holders are permitted to withdraw their Medisave accounts at age 55. In addition, any remaining Medisave balance can be transferred as part of the account holder’s estate on death.
- **MediShield** is a non-compulsory, low-cost catastrophic illness insurance scheme designed to cover medical expenses from major and prolonged illnesses. It was introduced in 1990 as a supplement to Medisave. Medisave account holders under 75 years of age are eligible to participate in the MediShield scheme. MediShield premiums are paid from Medisave contributions. Premiums vary depending on age. MediShield covers most hospital expenses including intensive care, surgical operations and implants. It also covers outpatient kidney dialysis, outpatient chemotherapy, radiotherapy for cancer treatment and certain drugs for transplant patients and pre-dialysis and dialysis patients. Patients are required to pay user charges under MediShield, subject to an annual threshold.<sup>63</sup>

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<sup>61</sup>Information about the Medisave program comes from a document prepared by the Ministry of Health, Singapore, Health Care Financing in Singapore, June 2000. Available on the Internet at [http://www.gov.sg/moh/mohinfo/mohinfo\\_b.html](http://www.gov.sg/moh/mohinfo/mohinfo_b.html).

<sup>62</sup> Health Care Financing in Singapore, June 2000.

<sup>63</sup> Much of the information about MediShield comes from Singapore Ministry of Health at [http://www.gov.sg/moh/mohinfo/mohinfo\\_b\(B\).html](http://www.gov.sg/moh/mohinfo/mohinfo_b(B).html).

- **Medifund** is a government endowment fund that operates as a safety net to help the poor and needy pay for hospital care. At the time the fund was created, the government made an initial capital injection which has then been followed by other capital injections. The interest income (but not capital) from the fund is distributed on a case-by-case basis to public sector hospitals.

A 1996 study prepared for the American-based National Center for Policy Analysis on the Singapore experience with MSAs stated that the Singapore program provides incentives “to reduce consumption and offer protection against extraordinary events and free-rider abuses.”<sup>64</sup> Because individuals must start saving at an early age, savings accumulate to cover costs later in life when medical care needs will be greater. The study concluded that Medisave and MediShield have worked well as part of a system that balances personal savings for medical care and government management of the health care system that has kept overall costs relatively low.<sup>65</sup> Another study, however, mentioned in a recent C. D. Howe Institute Commentary (April 2001) reports that hospitals in Singapore did not begin to compete on price and the per capita cost of health care rose faster after the introduction of the health care model that included MSAs than it had prior to that time.<sup>66</sup>

## 7.2 MSAs in South Africa

The private health care insurance market in South Africa offers a wide range of insurance plans to residents that elect to be treated in private facilities. Since their introduction in 1994, MSAs have grown to half of the private insurance market.<sup>67</sup>

In South Africa, MSAs allow individuals to do essentially two things: (1) to pay for medical expenses that are covered by insurance but are less than the deductible amount specified in their medical insurance policies; and (2) to pay for certain types of health care that are not covered by insurance (for example, corrective eye surgery). MSAs are set up as insurance plans that typically have the following features:

- first dollar coverage for non-discretionary services, such as heart bypass operations and other inpatient hospital services;
- a deductible of about \$1,200 for discretionary expenses, such as visits to a doctor and other outpatient services;
- first-dollar coverage for medications required to treat certain chronic conditions.<sup>68</sup>

<sup>64</sup> Thomas A. Massaro and Yu-Ning Wong, *Medical Savings Accounts: The Singapore Experience*, NCPA Policy Report No. 203, April 1996, p. 2. Document available on the Internet at <http://www.ncpa.org/studies/s203/s203.html>.

<sup>65</sup> *Ibid.*, pp. 11-12.

<sup>66</sup> Cam Donaldson, Gillian Currie, Craig Mitton, C.D. Howe Institute Commentary, *Integrating Canada's Dis-Integrated Health Care System, Lessons from Abroad*, No. 151, April 2001, p. 18 (see [www.cdhowe.org](http://www.cdhowe.org)).

<sup>67</sup> Much of the information on Medical Savings Accounts in South Africa comes from a policy report entitled, *Medical Savings Accounts in South Africa*, prepared by Shaun Matisonn for the U. S.-based National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000. (See <http://www.ncpa.org/studies/s234/s234.html>).



MSA contributions are given favourable tax treatment. Two-thirds of any employer contribution to an MSA for employees is excluded from the employee's taxable income and two-thirds of employee contributions can be made with pre-tax dollars.<sup>69</sup>

For the most part, there is a considerable amount of flexibility in the various MSA plans offered in South Africa. There would appear to be few limits on the amount that an individual can contribute to his or her MSA to cover expenses below the insurance deductible. An individual, an employer or both can make MSA contributions and unspent balances in an account can be distributed back to the account holder annually.<sup>70</sup>

A study prepared for the National Center for Policy Analysis (NCPA), a long-time proponent of MSAs, concluded that the South African experience with MSAs has been a positive one. MSAs have become a popular health care vehicle due in no small part to a flexible regulatory environment that allows insurers to tailor plans to the needs of the private market and offer incentives to encourage a healthy lifestyle and wellness.<sup>71</sup> More precisely, the study reported that:

- MSAs save money – on average MSA holders spend about half as much on outpatient services plus drugs as do people in traditional plans.
- there is no evidence that MSA holders substituted care with no deductible for care with a high deductible.
- similarly, there is no evidence that MSA holders forgo appropriate care – a comparison of catastrophic claims under MSA and traditional plans did not reveal a higher level of such claims by MSA holders.
- although MSA plans appeal to people who are healthy, MSA plans can be attractive to those who are sick and have high health care costs.<sup>72</sup>

### 7.3 MSAs in the United States

Much of the discussion and literature and most of the controversy and debate relating to MSAs originates in the United States where, in the wake of rising health care costs and increasing criticism of the system of managed care by HMOs and other providers, MSAs have been proposed as means of reducing health care spending and empowering health care consumers.

MSAs are authorized favourable tax treatment under both federal and State legislation. MSAs are currently offered by employer-sponsored insurance plans as well as under the Medicare Plus Choice.

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<sup>68</sup> *Ibid.*, p. 9.

<sup>69</sup> *Ibid.*, p. 10.

<sup>70</sup> *Ibid.*

<sup>71</sup> For example, the Policy Report notes that one plan offers a point system for having preventative tests such as pap smears and mammograms and participating in an exercise program. Accumulated points can be redeemed for benefits such as airline tickets.

<sup>72</sup> *Ibid.*, p. 15-17.

### 7.3.1 Private Sector MSAs

The first federal program in the United States to authorize favourable tax treatment for MSAs became effective on January 1, 1997. The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established a four-year medical savings account demonstration project ending in 2000 and set out the requirements for the tax treatment of MSAs at the federal level. The demonstration project has since been extended for two additional years.

The federal MSA demonstration is limited to 750,000 MSA account holders.<sup>73</sup> Those eligible to participate in the federal MSA program include self-employed individuals and businesses with 50 or fewer employees. (Unlike the federal MSA scheme, state MSA programs do not cap the number of employees.) While employers with more than 50 employees are restricted from offering the federal MSA tax benefit to employees, they can still offer MSA-style programs, although with limited tax benefits.

In order to participate in the program, participants must have a qualified high-deductible (catastrophic) health insurance plan to cover large health care expenses. A high deductible health plan is a comprehensive health insurance plan with a higher annual deductible than typical health plans and a maximum limit on annual out-of-pocket medical expenses. For individuals, the deductible must be between \$1,550 and \$2,350 (with a total out-of-pocket maximum of \$3,100), and for families, the deductible must fall between \$3,100 and \$4,650 (with a total out-of-pocket maximum of \$5,700.) The MSA is set up through a trustee who can be a bank, insurance company or any other entity approved by the Internal Revenue Service.

Contributions to an MSA can be made by the employer or the employee, but not by both during the same year. For individuals, contributions up to 65 percent and for families up to 75 percent of the annual health plan deductible can be contributed. There are also upper limits on contributions based upon the individual's wages or compensation. The MSA is portable; it is owned by the account holder and follows the account holder when the person changes jobs.

MSAs offer a number of tax advantages. Employer deposits into an MSA plan are not classified as taxable benefits for employees, employee contributions qualify for a tax deduction and funds accumulate in the MSA tax-free. Contributions in excess of annual limits, however, are subject to a 6% excise tax. MSA funds are typically used for routine health care expenses. Withdrawals from MSA plans are tax free if used for medical expenses that would qualify as a medical deduction for income tax purposes. Non-medical spending from an MSA is subject to taxation and additional tax penalties. Money remaining in the MSA account at the end of the year can be rolled over to the next year without penalty.

A beneficiary can be designated for an MSA account. If a spouse is designated, on death the account is treated as the spouse's plan. If someone other than the spouse is designated, on death the account loses its MSA status and its fair market value is taxable to

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<sup>73</sup> Internal Revenue Service, Publication 969 gives a detailed description of the requirements for federal medical savings accounts. This publication is the source of the information about the federal MSA program. ([http://www.irs.ustreas.gov/prod/forms\\_pubs/pubs/p96901.htm](http://www.irs.ustreas.gov/prod/forms_pubs/pubs/p96901.htm)).

the designated beneficiary. Where there is no designated beneficiary, the fair market value of the plan is included in the deceased's final income tax return.

The proponents of the 1997 legislation thought that insurers would be quick to enter the MSA market and many individuals would opt for MSAs. However, the market has developed slowly with some 100,000 MSAs having been set up.<sup>74</sup>

A report to Congress by the Medicare Payment Advisory Commission (MedPac) on Medical Savings Accounts in the context of Medicare (November 2000) cited four main reasons for the slow development of MSAs.<sup>75</sup> These are: limited supply, lack of broker interest, limited demand and program design problems.

- *Limited Supply:* The federal law establishing MSAs limited eligibility to self-employed people and those employed in firms with 50 or fewer employees. According to the MedPac report, these eligibility requirements had the effect of limiting suppliers of MSAs to insurance companies that participate in or want to enter the individual and small group insurance markets. Companies entered the MSA market to have a market presence should the plans become popular but many did not enthusiastically pursue MSAs when they found that the level of interest in the plans was low. Insurers were also reluctant to enter the market because MSAs were established as a four-year demonstration project.<sup>76</sup> Similarly, a United States General Accounting Office (GAO) Report to Congressional Committees on MSAs (December 1998) found that while a wide range of insurers were offering MSA plans, only a minority of them were marketing them aggressively.<sup>77</sup>
- *Lack of broker interest:* The MedPac report points out that agents have not displayed a great deal of interest in selling MSAs. Because MSA policies tend to have lower premiums than other policies, agents receive lower commissions for sales. Furthermore, the public's lack of familiarity with MSAs and the somewhat complicated nature of the accounts required agents to devote a considerable amount of time to selling the product. As a result, agents have been reluctant to commit the time necessary to learn about and sell the product.<sup>78</sup>
- *Limited demand:* The MedPac report points out that self-employed individuals could constitute a potentially large market for MSAs. Many of the self-employed, though, continue to prefer the certainty of traditional

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<sup>74</sup> Linda Klinger, "Few Takers for Medical Savings Accounts, Washington Business Journal, April 2, 2001. (<http://washington.bcentral.com/washington/stories/2001/04.02/focus4.html>).

<sup>75</sup> Medicare Payment Advisory Commission (MedPac), Report to Congress, Medical Savings Accounts and the Medicare Program, November 2000, pp. 6-7 (<http://www.medpac.gov/>).

<sup>76</sup> *Ibid.*, p. 6.

<sup>77</sup> United States General Accounting Office (GAO), Report to Congressional Committees, Medical Savings Accounts Results from Surveys of Insurers, December 1998, GAO/HEHS-99-34. p. 11 (<http://www.gao.gov/archive/1999/he99034.pdf>).

<sup>78</sup> MedPac, Medical Savings Accounts and the Medicare Program, p. 6.

comprehensive medical insurance plans with relatively low deductibles.<sup>79</sup> The GAO report confirmed that sales were lower than expected. Some insurers participating in the GAO survey felt that the low sales numbers were not surprising in light of the complexity of the MSA product and the limitations of the demonstration project.<sup>80</sup>

- *Program design problems:* The MedPac report also notes that the restrictions applying to federal MSAs have impeded their growth. These restrictions, which were put in place in part to allay concerns about possible negative effects on tax revenues and the health insurance market if MSAs were taken up in large numbers by healthy and relatively wealthy individuals, have had a dampening effect on the MSA market. Consequently, the number of policies was limited to 750,000 and no new policies could be issued after December 31, 2000, minimum and maximum deductibles were established, a limit on out-of-pocket amounts was imposed, the amount that could be contributed to an MSA was set at between 65 percent and 75 percent of the deductible, and only the employee or the employer could contribute to the account, but not both.<sup>81</sup>

A 1998 Policy Report by the National Center for Policy Analysis looked at obstacles to the growth of the U.S. MSA market.<sup>82</sup> Among other things, the NCPA suggested that the range of permitted deductibles was too narrow and the limit on the amount that could be deposited to an MSA account could expose MSA holders to substantial out-of-pocket health care expenses before their insurance took over. Concluding that the MSA legislation was “the result of a number of political compromises that had little to do with health policy, economic research or market demand”,<sup>83</sup> the NCPA made a number of recommendations for MSA reform, including the following:

- allowing a wider range of deductibles to give insurers more flexibility to design MSAs to meet consumer needs;
- allowing the market to determine the out-of-pocket exposure under MSA plans;
- permitting employer and employee contributions to MSA plans; and
- removing the enrollment cap of 750,000.<sup>84</sup>

### **7.3.2 Medicare Plus Choice**

The Medicare+Choice MSA plan combines a high deductible health insurance plan (in the order of \$6,000) and a medical savings account. Under this program, Medicare pays the insurance premium, which because of the high deductible is lower than a typical

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<sup>79</sup> *Ibid.*, p. 7.

<sup>80</sup> GAO, Medical Savings Accounts Results from Surveys of Insurers, p. 12.

<sup>81</sup> MedPac, Medical Savings Accounts and the Medicare Program, p. 7.

<sup>82</sup> National Center for Policy Analysis, Medical Savings Accounts: Obstacles to Their Growth and Ways to Improve Them, NCPA Policy Report No. 216, July 1998. (<http://www.ncpa.org/studies/s216.html>).

<sup>83</sup> *Ibid.*

<sup>84</sup> *Ibid.*, pp. 2-4.

health insurance premium, and deposits the difference between the cost of the premium and the normal Medicare capitation amount in an MSA. Plan contributions are the same for all beneficiaries but payments are adjusted for demographic and health status.

The Medicare+Choice MSA was intended to give Medicare beneficiaries more control over their health care by allowing them to choose their health care providers under financial arrangements that they would negotiate. One benefit it was hoped that this approach would achieve was reduced spending on discretionary health care as beneficiaries became more conscious of the costs involved.

Under the program, only the Medicare authority is permitted to make deposits to MSAs; Medicare beneficiaries cannot contribute to the account. Deposits and interest earned are free of federal income tax and qualified spending from the account is tax-free. Beneficiaries who do not have major health expenses can take the MSA payment as additional income over time. The savings account can be used for medical expenses that qualify for income tax deductions and for payment of certain insurance premiums such as long-term care. If the amount in the account accumulates to more than 60 percent of the annual deductible level, the amounts above 60 percent can be withdrawn penalty-free for any purpose (although these amounts would be treated as taxable income). On death, the MSA can be transferred to a spouse who is designated as a beneficiary and will be treated as the spouse's MSA. Otherwise, the MSA loses its MSA status and the fair market value becomes taxable.

As of November 2000, no organization had applied to offer an MSA plan to beneficiaries under Medicare+Choice. Consequently, Congress asked the Medicare Payment Advisory Commission (MedPac) to report on how the program could be changed to make it a viable option for organizations and Medicare beneficiaries.

MedPac's November 2000 report, *Medical Savings Accounts and the Medicare Program*, concluded that the private sector would not offer Medicare MSAs for two reasons:

1. little demand from the risk-averse Medicare beneficiary population, and
2. the expense and difficulty of marketing a complex product such as Medicare MSAs to a fragmented and scarce set of customers.<sup>85</sup>

MedPac noted that as premiums under the traditional Medicare plan are relatively low and plan coverage is broad there is little incentive for Medicare beneficiaries to move to MSAs. While MedPac observed that some of the conditions applying to the program that discouraged participation could be changed, it concluded that institutional changes would probably not encourage much participation because of the underlying market characteristics. In addition, the report noted that most of the steps intended to increase

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<sup>85</sup> Medicare Payment Advisory Commission, Report to Congress, *Medical Savings Accounts and the Medicare Program*, November 2000, p. 19.(<http://www.medpac.gov/>).

participation would “decrease beneficiary protection or increase the financial risk to the Medicare program.”<sup>86</sup>

## 7.4 Proposals for MSAs in Hong Kong

In December 2000, the Hong Kong government released a consultation document on health care reform entitled *Lifelong Investment in Health*.<sup>87</sup> Acknowledging that the sustainability of Hong Kong’s health care system is “highly questionable”, the document puts forward a three-pronged strategy for ensuring the system’s long-term financial sustainability. The third prong, after reducing costs/enhancing productivity and revamping the fee structure, is the introduction of MSAs called “Health Protection Accounts”.<sup>88</sup> Health Protection Accounts will have the following key features:

- the creation of a personal account for the individual and the spouse comprised of mandatory contributions by the individual of one to two per cent of earnings from age 40 to 64;
- savings cannot normally be withdrawn from the account until the person reaches 65;
- on withdrawal, the savings can only be used for the person’s or spouse’s medical and dental care, based on public sector rates, or to purchase medical and dental insurance from private insurers;
- if a person chooses services in the private sector, he or she will be reimbursed at public sector rates from the accumulated savings, any price difference will have to be met from the person’s resources outside the savings accounts or from private insurance;
- on death, unspent savings left in the account will be passed on to the surviving family.<sup>89</sup>

The purpose of the Health Protection Account is to assist “individuals to pay for heavily subsidized medical services after retirement, and not to shift the burden to the next generations”.<sup>90</sup> To keep the savings rate at an affordable level, the proposal limits withdrawals from the account until age 65 and after and provides for reimbursement of costs at public sector rates. The government estimates that for a family at a median income level, based on the average utilization rate, a couple will be able pay for medical expenditures at public sector rates up to the average life expectancy age.<sup>91</sup> The Hong Kong government intends to conduct a further study of the merits and feasibility of Health Protection Accounts in 2001-2002.

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<sup>86</sup> *Ibid.*

<sup>87</sup> Hong Kong, *Lifelong Investment in Health*, Consultation Document on Health Care Reform, December 2000. (<http://www.info.gov.hk/hwb/english/CONSULT/HCR/HCR2.HTM#Contents>).

<sup>88</sup> *Ibid.*, p. 51.

<sup>89</sup> *Ibid.*, p. 57.

<sup>90</sup> *Ibid.*, p. 58.

<sup>91</sup> *Ibid.*

For individuals who have saved very little or who have exhausted their savings because of frequent illness, the paper makes brief reference to (but does not detail) a second “safety net” provided by the government.

To deal with individuals requiring long term nursing care, however, the consultation document mentions a proposal for a separate personal savings account, “Medisage”, with contributions from the individual at the rate of 1% of salary to purchase long-term care insurance upon retirement. Because long-term care insurance is not well developed in Hong Kong, the government proposes to conduct more in-depth studies of options for long-term care and the features of the scheme.<sup>92</sup>

## 7.5 MSAs: the Debate

There is no consensus among experts on the impact of MSAs on health status and on health care costs. On the one hand, proponents maintain that MSAs increase consumer choice, encourage patients to make more prudent use of health services and reduce health care spending. MSA opponents, on the other hand, contend that MSAs can realize only small health care savings at best, segment the risk in the insurance market, drive up insurance costs for those remaining in comprehensive plans and have an adverse impact on health as people, particularly the poor and unhealthy, cut back on necessary health care.

Could a system of MSAs be implemented in Canada? A study authored by University of Calgary health economists, Cam Donaldson, Gillian Currie and Craig Mitton, pointed out that the task in Canada would not be particularly easy. In their view, there are practical problems associated with implementation and other structural issues that would have to be addressed before any benefits associated with MSAs could be realized. First, the advantages of consumer choice associated with MSAs might be limited in the Canadian context because Canadians already have considerable leeway in choosing their doctors and specialists. Similarly, MSAs might have a limited impact on encouraging Canadians to invest in their own health choices because Canadians can already make many of these investments.

<sup>93</sup>

Donaldson, Currie and Mitton mentioned the problem of “asymmetrical information” as another limit on the possibility for gain from MSAs. Many consumers may have difficulty making informed decisions about their health care because they lack the appropriate information. In addition, the ability of consumers to become active health care consumers may vary across age and socioeconomic groups.<sup>94</sup> Finally, they stressed that if governments were to allocate their health care dollars to MSAs, health care spending would remain the same. With money in MSAs, however, consumers may demand more and better access to services but the system may not be able to accommodate those increased demands and expectations. Their study concluded by suggesting that “valid and reliable piloting of

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<sup>92</sup> *Ibid.*, pp. 58-59.

<sup>93</sup> *Ibid.*

<sup>94</sup> *Ibid.*, p. 20.

the medical savings account model in a Canadian setting would certainly be required before fully informed judgments about its impact can be made.”<sup>95</sup>

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<sup>95</sup> Ibid.





## CHAPTER EIGHT:

### COMPARATIVE ANALYSIS

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During Phase Three, the Committee was made aware of substantial differences among countries in what they each cover under their public health care insurance programs and how these programs are funded. Health care systems also differ in terms of the role of private insurance and patient responsibility for paying part of their health care expenses. We learned that all health care systems are hybrids: they have a combination of public and private involvement in financing and delivering health care. The characteristics of each health care system also vary from country to country depending on their political economy and structure of government, as well as on the values of their respective society.

Despite these differences, most countries want similar things from their health care system: effective services that improve the health and quality of life of their citizens, equitable access to those services, and efficient use of health care resources. In pursuing those goals, however, different countries have taken very different paths. Moreover, choosing one direction over another has always entailed trade-offs. As Dr. James Björkman from the International Institute of Social Studies of the Netherlands eloquently put it:

*(...) there are three criteria sought by all health care systems that I know of. These criteria are summed up in the quest for the highest quality care at the lowest reasonable cost for as many people as possible. In other words, policy-makers seek to improve access and to assure quality at the same time as ensuring cost-effectiveness.*

*Problematically, however, these three pull in different directions – that is, to get more of one usually entails getting less of others. The search is for the right combination appropriate for a particular country at a point in time.<sup>96</sup>*

#### 8.1 Financing And Coverage

As stated above, there are substantial differences among the countries considered in the Committee's study in terms of what is covered under their publicly funded health care system and how it is financed.

Our international comparative study indicated that the most comprehensive publicly financed health care systems are found in Germany, Sweden and the United Kingdom. The public share of total health care spending is greater in these three countries (with 84% in Sweden and the United Kingdom and 75% in Germany) than in Canada (70%).

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<sup>96</sup> Dr. James Björkman (15:4).

Many countries with a similar share of public health care spending to Canada – such as Australia and the Netherlands – also provide coverage that is much broader than is available in Canada. This has usually been achieved with the participation of the private sector either through the imposition of user charges or the involvement of private health care insurance.

In contrast to Canada, however, user charges for publicly insured health services are required in Australia, Germany, the Netherlands and the United Kingdom. Even in Sweden, which is generally recognized as being amongst the most socialized

of the European countries, user charges are required for publicly funded services. Furthermore, private health care insurance that covers the same benefits as public insurance is available in many countries, while it is not in Canada.<sup>97</sup> For example, in Germany and the Netherlands, private health care insurance is voluntary for those people with an annual income over a certain level (public health care coverage is mandatory for those with low incomes). In those countries private insurers must accept all those who apply for coverage and must provide benefits equivalent to those offered under the public plan. In Australia and Sweden, government legislation requires that premiums charged by private health care insurers be community-rated (i.e. a single premium structure applies to everyone regardless of their health status). The Australian government actively encourages residents to acquire private health care insurance by subsidizing 30% of its cost. In the United Kingdom, as in Australia, residents can purchase private insurance to cover services provided in private hospitals as well as in public hospitals.

The evidence suggests that a contribution of direct payments by patients, allowing private insurance to cover some services, even in publicly funded hospitals, and an expanded role for the private sector in the delivery of health services are the factors which have enabled countries to achieve broader coverage of health services for all their citizens. Some countries like Australia and Singapore openly encourage private sector participation as a means to ensure affordable and sustainable health services.

*[One] difference relates to what is covered publicly. In Canada, the public financing of the system is focused on hospitals and doctors. In many other countries, public financing extends much more into pharmaceuticals. I am not sure what the implications of that are for efficiency, but there are certainly implications of that with respect to equity and access to needed care.*

*Cam Donaldson, Professor, Department of Economics, University of Calgary (22:17)*

*Differences also arise with respect to the extent to the two-tier system in different countries. In the U.K., everyone is locked into paying for the system. In Canada we pay through our taxes. However, unlike Canada, the U.K. has no restrictions on private purchase of publicly insured services. That is always portrayed as a great thing about the Canadian system, but one of the paradoxes is that in the U.K. only 10 per cent to 15 per cent of expenditures come from the private purse: in Canada that figure is 25 per cent. Therefore, what you have here is a different form of the two-tier system. It just covers a different set of services.*

*Cam Donaldson, Professor, Department of Economics, University of Calgary (22:17)*

<sup>97</sup> No single country relies exclusively on private insurance to provide health care coverage to its citizens. Even in the United States, where the private sector is a dominant player in the field of health care insurance, public funding accounts for 45% of total health care spending. The fact is that health care is different from other marketable goods and services.

With respect to user charges, Ake Blomqvist suggested that, while it would be difficult to start requiring direct partial payments from patients for physician and hospital services in Canada, these charges could help raise revenue to pay for an expanded basket of publicly-funded health services:

*(...) I have come to the conclusion that we will never have a rational debate about user fees in Canada. The concept of user fees has become a symbol in the federal-provincial jostling over power in health care policy. We are all better off giving up on the idea of user fees for physician services and hospital services.*

*If, however, we expand the concept of Medicare to include publicly funded Pharmacare, and perhaps long-term care and home care as well, then I believe that the issue of user fees must be re-examined. I do not think that there is an example of a country that covers pharmaceuticals and long-term care that does not have some degree of patient co-payment.<sup>98</sup>*

By contrast, Mark Stabile stressed that while Canada has the opportunity to improve access to care and equity by expanding coverage to include other areas of health services not previously publicly funded, this will come at a trade off, probably in terms of Canada no longer offering first dollar coverage for all hospital and doctor services.<sup>99</sup>

In addition to the variations in public coverage, the health care insurance plans in the comparison countries also differ greatly in the sources of government revenue that are used to fund the public share of total health care spending. In Australia, Canada and the United Kingdom, public funding is largely derived from general tax revenue, while in Germany and the Netherlands most of the public funds allocated to health care are raised by the social insurance system through employers' and employees' contributions. In Sweden and Singapore, public funding for health care is generated from a combination of both general taxation and social insurance.

Are there particular lessons for Canada in the experience with the different approaches to health care funding in other countries? According to Ake Blomqvist, countries with a single payer health care system seem to better contain overall health care costs. In his view, it is worth considering the possibility of extending public health care coverage in Canada, while maintaining the single-payer principle:

*(...) those countries whose systems most closely approach the principle of single-payer public funding, (...), also are those that devote the lowest share of GDP to health care costs. While Canada strictly respects the single-payer principle with respect to the services covered under the Canada Health Act, the fact that the range of benefits that is covered is relatively narrow means that, in reality, we have a mixed system with a relatively high degree of reliance on private funding. Thus if cost containment is a main objective,*

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<sup>98</sup> Ake Blomqvist (22:22-23).

<sup>99</sup> Mark Stabile, E-mail to the Committee, June 2001.

there would seem to be a *prima facie* case for extending public sector coverage to encompass a broader range of benefits, for example, by introducing a system of publicly funded Pharmacare, as suggested by the National Forum on Health.<sup>100</sup>

## 8.2 Primary Care

Perhaps the most interesting differences among the health care systems of industrialized countries reviewed by the Committee pertain to the way primary care is supplied and, in particular, the incentives to which primary care providers are subject.

In Canada, Australia and Germany, as well as in the original Medicare plan in the United States, the predominant form of delivery remains through general practitioners (family doctors) who operate as solo practitioners, and are paid through a fee-for-service scheme. From the viewpoint of patients, a valued feature of the fee-for-service remuneration scheme is that it places no significant restrictions on their choice of doctors. Critics of such a system say that it gives doctors incentives to provide many short visits, but no incentives – in fact disincentives – to fix multiple problems in one visit, or to provide education or counselling activities at the same time. Put simply, doctors who choose to have longer visits, and hence treat fewer patients daily, see in effect their remuneration reduced.

In contrast, primary care in the Netherlands and in many managed-care plans under American Medicare, is provided by general practitioners whose income is based on capitation, working in solo or group practices. Capitation funding, as the name suggests, is a per capita method of compensation. The amount of revenue a general practitioner receives is based on the amount of patients he/she treats, regardless of the number of visits. One advantage of capitation funding is that it encourages doctors to devote more time to their patients. Capitation, however, carries an incentive to under-serve because payment is unrelated to the quantity of services provided. Moreover, a system of capitation that requires individuals to enrol with one particular general practitioner or group of health care providers reduces a patient's freedom to choose his/her own health care provider.

One of the attractive properties of a capitation system is that it can be modified to incorporate incentives for primary care physicians to make cost-effective decisions with respect to the use of a wide range of health care inputs (drugs, specialists, hospital services, diagnostic testing). The experience with GP Fundholding in the United Kingdom, and their recent transformation into Primary Care Groups, provides useful guidance in this regard. General practitioners involved in Primary Care Groups receive a mixture of remuneration including capitation, salary and fee-for-service (for selected items). It has been suggested that this combination of types of payment ensures an effective provision and utilization of health services.

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<sup>100</sup> Ake Blomqvist, *International Health System Comparisons: Lessons for Canada*, Brief to the Committee, June 2001, p. 4.

According to Ake Blomqvist<sup>101</sup>, the fact that capitation has been widely used for a long time in the Netherlands means that its workability in providing cost-effective care is well established. The increasing importance of managed-care plans with capitated primary care providers in the United States, not only under the Medicare plan but in the general population as well, is further evidence in favour of its potential attractiveness. In Blomqvist's view, the capitation alternative should be given serious consideration as a central element in primary care reform in Canada. He also stressed that the United Kingdom experience clearly illustrates that it is possible to have a system in which capitation, salary and fee-for-service exist side by side, as alternative ways of paying for primary care.

Sweden is an outlier among the countries reviewed by the Committee in that most of its general practitioners are salaried. Under this salary mechanism, Swedish doctors are paid an annual income unrelated to their workload. The most common argument against salary remuneration is that providers tend to be unresponsive to their patients' needs. The main advantage of salary remuneration is that it does not encourage doctors to over-service patients by providing unnecessary care. The Committee was told that general practitioners in Sweden receive an overall level of remuneration that is lower than many other industrialized countries.

Overall, it seems that all remuneration methods create both desirable behaviour and undesirable behaviour. In this perspective, a number of Canadian experts believe that a blended system for remunerating family doctors, incorporating elements of fee-for-service and capitation and/or salary, would be more appropriate than one single payment mechanism.

However, the Committee was told that fee-for-service is a major impediment to primary care reform in Canada. According to Cam Donaldson:

*The big difference here compared to many other countries is the remuneration of physicians. To me, this is a great barrier to reforming the system. I personally think that maintaining a fee-for-service form of remuneration is inconsistent with moving to a purchaser-provider model. I do not think that a purchaser-provider model will work with a fee-for-service form of remuneration.*<sup>102</sup>

### 8.3 Integration of Health Services

In contrast to a number of countries, the different elements of Canada's health care system are not well integrated financially. Separate financing means that the various health care providers and institutions tend not to take account of the costs and benefits of their actions to the system as a whole. According to Donaldson, Currie and Mitton, this lack

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<sup>101</sup> Ake Blomqvist, *International Health System Comparisons: Lessons for Canada*, Brief to the Committee, June 2001, p. 5.

<sup>102</sup> Cam Donaldson (22:18).

of financial integration has led to «perverse incentives» within the Canadian health care system.<sup>103</sup>

For example, regional health authorities and health care providers (hospitals, hospital doctors, and primary care doctors) in Canada very often act independently from each other and are remunerated separately. Consequently, they do not face the same incentives with respect to achieving common goals for the publicly financed health care system.

Regional health authorities do not have enough control of health care resources within their jurisdictions. First, doctors are remunerated independently of health authorities. Second, it is doctors who direct much of what happens in health care, but health authorities must pick up the tab. For example, when a physician orders a lab test or an X-ray, it is the health authority that carries the financial burden. If health authorities had control over the budget currently used to pay for doctors, the behaviour of both doctors and authorities would be more in line with each other. According to Donaldson, Currie and Mitton, some form of internal market or purchaser/provider split, as adopted in Sweden and the United Kingdom, could do this.

In Canada, the separation of the purchaser and provider function in the hospital sector already exists. In the past, purchasers have been the provincial ministries of health, with whom hospitals have negotiated their annual funding. In many provinces, the purchasing function is now being decentralized to regional health authorities which, in many ways, are in a position similar to the District Health Authorities in the United Kingdom in the 1990s (or to the county councils in the Swedish health care system).

International experience shows that accepting the principle of a purchaser-provider split would not imply significant change in Canada. The key is to be careful about the way the contracts between purchasers and providers are written and enforced, to whom the purchasers are accountable, and the incentives to which they are subject.

One element of such a reform would be to include the cost of physician services in the regional authorities' budgets, as has been done in Sweden. According to Ake Blomqvist, giving regional health authorities control over the aggregate cost of both hospitals and physician services would greatly strengthen their ability to make rational decisions about how to allocate their resources most effectively to promote population health.<sup>104</sup>

Could greater financial integration of Canada's health care system be achieved by putting health care money in the hands of patients themselves through a system of MSAs? As Chapter 7 indicated, MSAs would make health care consumers more active participants in health care spending decisions. However, Donaldson, Currie and Mitton cautioned that: "Valid and reliable piloting of the medical savings account model in a

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<sup>103</sup> Cam Donaldson, Gillian Currie, Craig Mitton, C.D. Howe Institute Commentary, *Integrating Canada's Dis-Integrated Health Care System, Lessons from Abroad*, No. 151, April 2001.

<sup>104</sup> Ake Blomqvist, Brief to the Committee, p. 9.

Canadian setting would certainly be required before fully informed judgements about its impact can be made.”<sup>105</sup>

## 8.4 Role of Government

Among the countries reviewed by the Committee, Canada is unique in that the central level of government plays a very small direct role in the delivery of health care. Under the Canadian Constitution, health care is a matter of provincial/territorial jurisdiction except in the case of some groups of people, the most important being the First Nations and the Inuit. Historically, the federal government, at a time when its share of overall health care spending was more important than it is now, had a controlling influence on the development of the Canadian health care delivery system which culminated in the *Canada Health Act*.

Given Canada’s political structure, most analysts agreed that it would be difficult to adopt the approach taken by other countries to reform their health care system. Carolyn Hughes Tuohy pointed to three strategies for enacting and implementing health care reform:

*A big bang approach to health care reform is very politically risky and it is rare that any government will take that chance. It requires a confluence or convergence of political developments that is very rare. You must be able to consolidate political authority on a fairly massive scale and you must have the political will to take the risk. To the extent that you consolidate authority, you also consolidate accountability, which then makes it more difficult to shift the blame to someone else.*

*We have seen big bang reforms on rare occasions. We saw it in Britain after the Second World War with the establishment of the NHS. We saw it in 1980s in Britain with the Thatcher government in its third successive majority mandate. These are rare events.*

*Blueprint-type reforms are more likely in coalition circumstances where bipartisan compromise is necessary. I have not mentioned certain U.S. states where we also saw blueprint approaches because of the need for bipartisan compromise - with a similar result as that in the Netherlands. Things tended to stall or get rolled back as the complexion of the political coalition changed over time.*

*In Australia and Canada we have seen incremental reforms where federal-provincial consensus cannot be mobilized for something broader. That, also, is a*

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<sup>105</sup> Donaldson, Currie and Mitton, p. 20.



*result of factors in the broad political arena and not in the health care arena itself.*  
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Overall, proposals for a “big bang” overhaul of Canada’s health care system would be difficult. Nonetheless, major changes are needed if the hopes and aspirations of Canadians are to be met.

Claude Forget, a former health minister in Quebec and an acknowledged expert on comparative health care systems, told the Committee that international experience should alert us to the dangers of a public system that is held hostage to the vagaries of political life, and that therefore fails to sustain a pragmatic, managerial approach to health care reform:

*It appears that there are many instances of practical solutions being attempted [in Western Europe]. However, those systems are closely related with the political lives of their respective country means that the attempts are fragile. These experiments are not sustained, even when successful.*

*I would not condemn any system for attempting new solutions and changing its mind when new solutions are not effective. However, this has not been the case. The closeness of the system to the political life of the country means that ideological reasons are the cause of the system’s failure.*

*We [in Canada] share that habit to some extent. It should alert us to the danger of a public system that is held hostage by the vagaries of political life. When the health care system is tied to the political system it fails to sustain a pragmatic, managerial approach to problem solving.<sup>107</sup>*

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<sup>106</sup> Carolyn Tuohy (22:28).

<sup>107</sup> Claude Forget (22:14)

## CONCLUSION

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This report completes Phase Three of the Committee's study on health care. It summarizes the evidence we heard and makes reference to documents that were either commissioned by the Committee or brought to the attention of the Members.

Canadians may find some consolation in the fact that Canada is not alone in confronting complex health care issues. Everywhere in the industrialized world health care policy is thoroughly intertwined with the political, social, and even cultural life of each country. As such, every health care system is unique. Therefore, no single international model constitutes a blueprint for solving the challenges confronted by the Canadian health care system. However, experts told the Committee that careful consideration must be given to the repercussions in Canada of introducing, on a piecemeal basis, changes undertaken in other countries.

In its Phase Four report released recently, the Committee stressed the importance of adopting an open-minded approach to health care reform, and of considering the full range of available options, including those gleaned from the experience gained elsewhere in the world. We hope that this report will serve as a useful document to anyone who wishes to participate in the fifth and final phase of the Committee's study on health care – the set of public hearings which will lead to the Committee's final recommendations.



## APPENDIX A:

### LIST OF WITNESSES

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#### **Monday, May 28, 2001**

*(By videoconference)*

*From the Ministry of Health, Welfare and Sports of the Netherlands:*

Dr. Hugo Hurts, Deputy Director, Health Insurance Division, Ministry of Health, Welfare and Sports of the Netherlands

*From the International Institute of Social Studies of the Netherlands:*

Professor James Bjorkman

#### **Thursday, June 7, 2001 (9:00 a.m.)**

*(by videoconference)*

*Swedish Parliament (Riksdag):*

Lars Elinderson, Deputy member, Committee on Health and Welfare

#### **Monday, June 11, 2001**

*(By videoconference)*

*German Health Ministry:*

Georg Baum, Director General, Head of Directorate Health Care

Dr. Margot Faelker, Deputy-Director, Section Financial Issues of Statutory Health Insurance

Dr. Rudolf Vollmer, Director-General, Head of Directorate Long-Term Nursing Care Insurance

*Department of Health – Economic and Operational Research Division of the United Kingdom:*

Clive Smee, Chief Economic Adviser

*University of Birmingham:*

Professor Chris Ham, Director, Health Services Management Centre

*London School of Economics:*

Professor Julien LeGrand, Richard Titmuss Professor of Social Policy, LSE Health & Social Care

#### **Tuesday, June 12, 2001**

*(By videoconference)*

*Australian Institute of Health and Welfare:*

Dr. Richard Madden, Director

*Australian Health Insurance Association:*

Russel Schneider, CEO

*National Centre for Epidemiology and Population Health – Australian National University*

Dr. Tony Adams, Professor of Public Health

*Health Insurance Commission:*

Dr. Brian Richards

**Tuesday, June 12, 2001 (cont'd)**

*Australian Medical Association:*

Dr. Carmel Martin, Director

Dr. Roger Kilham

**Wednesday, June 13, 2001**

*Health Canada:*

Ake Blomqvist, Visiting Academic, Applied Research and Analysis Directorate, Information, Analysis and Connectivity Branch and Professor, University of Western Ontario

*University of Calgary:*

Professor Cam Donaldson, Department of Economics

*University of Toronto (by videoconference):*

Professor Colleen Flood, Faculty of Law

*As an individual:*

Claude Forget

*University of Toronto:*

Professor Mark Stabile, Department of Economics

Professor Carolyn Tuohy, Department of Political Science

**Thursday, June 14, 2001**

*(by videoconference)*

*U.S. Department of Health and Human Services:*

Christine Schmidt, Deputy to the Deputy Assistant Secretary for Health Policy, Office of the Assistant Secretary for Planning and Evaluation

Ariel Winter, Analyst

Tanya Alteras, Analyst

## APPENDIX B:

### HEALTH CARE SPENDING, HEALTH CARE RESOURCES AND HEALTH STATUS : COMPARATIVE DATA, 1998

	SPENDING ON HEALTH CARE		PUBLIC HEALTH CARE SPENDING		HEALTH CARE RESOURCES		HEALTH STATUS INDICATORS	
	As a % of Gross Domestic Product	Dollars per Capita at Purchasing Power Parity	As a % of Total Health Care Spending	As a % of Gross Domestic Product	Acute Care Beds (per 1,000 population)	Practising Physicians (per 1,000 population)	Life Expectancy at Birth (in years)	Infant Mortality Rate (per 1,000 of live births)
<i>Australia</i>	8.5	2,043	69.3	5.9	4.0 <sup>1</sup>	2.5 <sup>1</sup>	78.3	5.0
<i>Canada</i>	9.5	2,312	69.6	6.6	2.9 <sup>1</sup>	2.1	79.1	5.5 <sup>1</sup>
<i>Germany</i>	10.6	2,424	74.6	7.9	7.1	3.5	77.3	4.7
<i>Netherlands</i>	8.6	2,070	70.4	6.0	3.7	n.a.	78.0	5.2
<i>Sweden</i>	8.4	1,746	83.8	7.0	2.7	3.1 <sup>2</sup>	78.7	3.6 <sup>1</sup>
<i>United Kingdom</i>	6.7	1,461	83.7	5.6	2.4	1.7	77.3	5.7
<i>United States</i>	13.6	4,178	44.7	6.1	3.2	2.7	76.8	7.2 <sup>1</sup>

PPP: Purchasing power parity.

n.a.: Non available.

1) 1997 data.

2) 1996 data.

Source : OECD Health Data (2000), United Nations (for life expectancy), and Library of Parliament.

The Standing Senate Committee on Social Affairs, Science and Technology

*The Health of Canadians – The Federal Role  
Volume Four – Issues and Options*

*Chair*

The Honourable Michael J. L. Kirby

*Deputy Chair*

The Honourable Marjory LeBreton

SEPTEMBER 2001





## TABLE OF CONTENTS

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<b>TABLE OF CONTENTS</b> .....	<b>i</b>
<b>ORDER OF REFERENCE</b> .....	<b>vi</b>
<b>SENATORS</b> .....	<b>vii</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>ix</b>
<i>Chapters 1, 2 and 6</i> .....	<i>ix</i>
<i>Chapters 3 and 4</i> .....	<i>ix</i>
<i>Chapter 5</i> .....	<i>xii</i>
<i>Chapter 7</i> .....	<i>xiii</i>
<i>Chapter 8</i> .....	<i>xvi</i>
<i>Chapter 9</i> .....	<i>xxiii</i>
<i>Chapter 10</i> .....	<i>xxv</i>
<i>Chapter 11</i> .....	<i>xxix</i>
<i>Chapter 12</i> .....	<i>xxxiii</i>
<i>Chapter 13</i> .....	<i>xxxv</i>
<i>Chapter 14</i> .....	<i>xxxviii</i>
 <b>CHAPTER ONE:</b> .....	<b>1</b>
<b>Introduction</b> .....	<b>1</b>
 <b>CHAPTER TWO:</b> .....	<b>5</b>
<b>Summary of Main Findings and Observations from Phases One, Two and Three</b> .....	<b>5</b>
<i>2.1 Main Findings and Observations from Phase One</i> .....	<i>5</i>
<i>2.2 Main Findings and Observations from Phase Two</i> .....	<i>6</i>
<i>2.3 Main Findings and Observations from Phase Three</i> .....	<i>8</i>
 <b>CHAPTER THREE:</b> .....	<b>9</b>
<b>The Role of the Federal Government: An Overview</b> .....	<b>9</b>
<i>3.1 The Transfer of Funds for the Provision of Health Services Administered by Other Jurisdictions: The Financing Role</i> .....	<i>9</i>
<i>3.2 Funding Innovative Health Research and the Evaluation of Pilot Projects: The Research and Evaluation Role</i> .....	<i>10</i>
<i>3.3 Support for the Health Care Infrastructure and the Health Infostructure: The Infrastructure Role...</i> .....	<i>11</i>
<i>3.4 Health Protection, Health and Wellness Promotion and Disease Prevention: The Population Health Role</i> .....	<i>12</i>
<i>3.5 The Direct Provision of Health Services to Specific Population Groups: The Service Delivery Role</i>	<i>13</i>

<b>CHAPTER FOUR:</b>	<b>15</b>
<b><u>The Role of the Federal Government: Objectives and Constraints</u></b>	<b>15</b>
4.1 <i><u>Objectives for the Financing Role of the Federal Government</u></i>	15
4.2 <i><u>Objectives of the Research and Evaluation Role for the Federal Government</u></i>	19
4.3 <i><u>Objectives of the Infrastructure Role for the Federal Government</u></i>	20
4.4 <i><u>Objectives for the Population Health Role of the Federal Government</u></i>	22
4.5 <i><u>Objectives for the Service Delivery Role of the Federal Government</u></i>	23
4.6 <i><u>Constraints on the Role of the Federal Government</u></i>	24
 <b>CHAPTER FIVE:</b>	 <b>27</b>
<b><u>A 21<sup>st</sup> Century Context for Health Care Policy</u></b>	<b>27</b>
5.1 <i><u>Reforming Primary Care: A Step Toward a 21<sup>st</sup> Century Structure</u></i>	28
5.2 <i><u>Health Care: Different from Other Goods and Services</u></i>	30
 <b>CHAPTER SIX:</b>	 <b>33</b>
<b><u>Observations on Choosing Among Options</u></b>	<b>33</b>
6.1 <i><u>The Need to be Financially Realistic in Choosing Options</u></i>	33
6.2 <i><u>The Desirability of a Non-Ideological Debate</u></i>	33
6.3 <i><u>The Value of Understanding the Experience of Other Countries</u></i>	35
 <b>CHAPTER SEVEN:</b>	 <b>37</b>
<b><u>The Canada Health Act, Timely Access to Treatment, and Fairness</u></b>	<b>37</b>
7.1 <i><u>Introduction</u></i>	37
7.2 <i><u>Do Canadians Have a Right to Health Care?</u></i>	38
7.3 <i><u>To What Extent, if any, is Private Health Care Provision and Private Health Care Insurance Permissible under the Canada Health Act?</u></i>	38
7.4 <i><u>Timely Access and Waiting Times</u></i>	40
7.5 <i><u>How Can “Timely Access” to Health Care Be Ensured?</u></i>	43
7.5.1 <i><u>“Care Guarantee”</u></i>	44
7.5.2 <i><u>Patient’s Bill of Rights</u></i>	45
 <b>CHAPTER EIGHT:</b>	 <b>49</b>
<b><u>Issues and Options for the Financing Role</u></b>	<b>49</b>
8.1 <i><u>Introduction</u></i>	49
8.2 <i><u>What Changes Can be Made to the Way Health Care is Delivered that Could Have an Impact on the Level of Funding Required?</u></i>	50
8.2.1 <i><u>Improving Efficiency and Effectiveness</u></i>	50
8.2.2 <i><u>Reforming Primary Care</u></i>	52
8.2.3 <i><u>Regionalization of Health Services</u></i>	53
8.2.4 <i><u>Contracting Private For-Profit Health Care Facilities</u></i>	54
8.2.5 <i><u>Devoting More Resources to Health Promotion, Disease Prevention and Population Health</u></i>	55

8.3	<u>What Should be the Form of Federal Funding for Health Care?</u>	55
8.3.1	<u>Return to Cost-Sharing Arrangements</u>	57
8.3.2	<u>Retain Current Block Funding</u>	58
8.3.3	<u>Improved CHST Block Funding</u>	58
8.3.4	<u>Medical Savings Accounts (MSAs)</u>	59
8.3.5	<u>Convert all CHST Cash Transfers into Tax Point Transfers</u>	60
8.4	<u>How Should Government Raise Revenue for the Purpose of Health Care?</u>	60
8.4.1	<u>Spend More of Existing Tax Dollars on Health Care</u>	61
8.4.2	<u>Increase General Revenue (through income tax or sales taxes) and Devote the Additional Revenue to Health Care</u>	61
8.4.3	<u>User Charges</u>	62
8.4.4	<u>Income Tax on Health Care</u>	63
8.4.5	<u>Annual Health Care Premiums</u>	64
8.4.6	<u>Private Health Care Insurance is Allowed to Compete with Public Coverage</u>	64
8.5	<u>The Impact of Financing Options on Behavioural Change</u>	65
8.6	<u>Two-Tier Health Care</u>	67
8.7	<u>What Services Should be Covered and Who Should be Covered Under Public Health Care Insurance?</u>	68
8.7.1	<u>De-Listing Some Services</u>	69
8.7.2	<u>Expanding Coverage</u>	69
8.8	<u>Prescription Drugs: Reducing Their Cost</u>	69
8.8.1	<u>A National Drug Formulary</u>	70
8.8.2	<u>Requiring the Use of the Lowest Cost Therapeutically Effective Drug</u>	72
8.8.3	<u>The Advertising of Prescription Drugs</u>	73
8.9	<u>Prescription Drugs: Expanding Coverage</u>	74
8.9.1	<u>A National Pharmacare Initiative</u>	77
8.9.2	<u>A Comprehensive Public Program</u>	78
8.9.3	<u>A Comprehensive Public/Private Initiative</u>	78
8.9.4	<u>Public/Private Initiative to Protect Against High Drug Expenses</u>	79
8.9.5	<u>Tax Initiative to Protect against High Drug Expenses</u>	80
8.10	<u>Home Care</u>	80
8.10.1	<u>A National Home Care Program</u>	82
8.10.2	<u>Tax Credit and Tax Deduction to Home Care Consumers</u>	83
8.10.3	<u>Creating a Dedicated Insurance Fund to Cover the Need for Home Care</u>	84
8.10.4	<u>Specific Measures aimed at Informal Caregivers</u>	84
8.11	<u>Summary</u>	85

## **CHAPTER NINE:..... 89**

### **Issues and Options for the Research and Evaluation Role..... 89**

9.1	<u>Innovative Health Research</u>	90
9.1.1	<u>Increasing the Federal Share of Health Research Funding</u>	91
9.1.2	<u>Sustaining the Transfer of Knowledge</u>	92
9.1.3	<u>Reducing Regional Disparities</u>	92
9.1.4	<u>A National Human Research Ethics Oversight Body</u>	93

9.2	<i>Financing and Evaluation of Innovative Pilot Projects</i>	93
9.2.1	<i>Federal Investment in the Evaluation of Pilot Projects Aimed at Improving Health Care Delivery</i>	94
9.2.2	<i>Reducing Regional Disparities in the Funding of Pilot Projects</i>	94
<b>CHAPTER TEN:</b>		<b>95</b>
<b>Issues and Options for the Infrastructure Role: Technology and Information Systems</b>		<b>95</b>
10.1	<i>Health Care Technology</i>	96
10.1.1	<i>Funding the Acquisition and Upgrading of Health Care Technology</i>	97
10.1.2	<i>Investing More in Health Care Technology Assessment</i>	97
10.2	<i>Health Information Systems</i>	98
10.2.1	<i>Deployment of a Pan-Canadian Health Infostructure</i>	100
10.2.2	<i>Investing in Telehealth in Rural and Remote Communities</i>	101
10.2.3	<i>Ensuring Confidentiality and Privacy of Personal Health Information</i>	102
10.3	<i>Accountability and Quality</i>	103
10.3.1	<i>An Annual Report on the Health Status of Canadians and on the State of the Health Care System</i>	104
10.3.2	<i>A National Health Care Quality Council</i>	104
10.3.3	<i>Ensuring Greater Government Accountability</i>	104
<b>CHAPTER ELEVEN:</b>		<b>107</b>
<b>Issues and Options for the Infrastructure Role: Health Human Resources</b>		<b>107</b>
11.1	<i>Introduction</i>	107
11.2	<i>The Need for a National Human Resources Strategy</i>	108
11.3	<i>Towards a Spectrum Approach</i>	109
11.4	<i>Primary Care Reform and Human Resources</i>	111
11.5	<i>Incentives for Individuals</i>	113
11.6	<i>Recruitment, Training, Retention</i>	113
11.6.1	<i>Financing</i>	114
11.6.2	<i>Research</i>	114
11.6.3	<i>Dealing with the 'Brain Drain'</i>	114
11.7	<i>Physicians</i>	115
11.7.1	<i>Training</i>	115
11.7.2	<i>Geographic Maldistribution</i>	116
11.8	<i>Nurses</i>	116
11.9	<i>Other Health Care Professionals</i>	118
11.10	<i>Summary</i>	118
<b>CHAPTER TWELVE:</b>		<b>119</b>
<b>Issues and Options for the Population Health Role</b>		<b>119</b>
12.1	<i>Trends in Diseases</i>	120
12.2	<i>Some Disturbing Trends</i>	120
12.3	<i>Determinants of Health: Some Evidence</i>	122

<u>12.4</u>	<u><i>The Role of the Federal Government</i></u>	123
<u>12.4.1</u>	<u><i>Health Promotion and Disease Prevention</i></u>	124
<u>12.4.2</u>	<u><i>Population Health Strategies</i></u>	125
<u>12.4.3</u>	<u><i>Research</i></u>	127

**CHAPTER THIRTEEN:.....129**

**Issues and Options for the Service Delivery Role: Aboriginal Health.....129**

<u>13.1</u>	<u><i>Health and Socio-Economic Profile of Canada's Aboriginal Population</i></u>	130
<u>13.2</u>	<u><i>Health Service Delivery to Aboriginal Canadians</i></u>	131
<u>13.2.1</u>	<u><i>A National Action Plan on Aboriginal Health Services</i></u>	132
<u>13.3</u>	<u><i>Ensuring Adequate Access to Culturally Appropriate Health Services</i></u>	133
<u>13.3.1</u>	<u><i>Aboriginal Health Care Providers</i></u>	133
<u>13.3.2</u>	<u><i>Telehealth</i></u>	133
<u>13.3.3</u>	<u><i>Culturally Appropriate Health Services</i></u>	133
<u>13.4</u>	<u><i>Population Health</i></u>	134
<u>13.4.1</u>	<u><i>A Population Health Strategy for Aboriginal Canadians</i></u>	134
<u>13.4.2</u>	<u><i>Federal Accountability for Programs aimed at Aboriginal Health</i></u>	134
<u>13.5</u>	<u><i>Aboriginal Health Research</i></u>	135
<u>13.6</u>	<u><i>Involvement of Aboriginal Communities</i></u>	135

**CHAPTER FOURTEEN:.....137**

**Conclusion.....137**

## ORDER OF REFERENCE

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Extract from the *Journals of the Senate* of March 1, 2001:

Resuming debate on the motion of the Honourable Senator LeBreton, seconded by the Honourable Senator Kinsella:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:

- (a) The fundamental principles on which Canada's publicly funded health care system is based;
- (b) The historical development of Canada's health care system;
- (c) Health care systems in foreign jurisdictions;
- (d) The pressures on and constraints of Canada's health care system; and
- (e) The role of the federal government in Canada's health care system;

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament be referred to the Committee;

That the Committee submit its final report no later than June 30, 2002; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

After debate,

The question being put on the motion, it was adopted.

ATTEST :

Paul C. Bélisle  
*Clerk of the Senate*

## SENATORS

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The following Senators have participated in the study on the state of the health care system of the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee  
The Honourable Marjory LeBreton, Deputy Chair of the Committee

and

The Honourable Senators:

Catherine S. Callbeck  
Joan Cook  
Jane Cordy  
Joyce Fairbairn, P.C.  
Alasdair B. Graham, P.C.  
Wilbert Keon  
Yves Morin  
Lucie Pépin  
Douglas Roche  
Brenda Robertson

*Ex-officio members of the Committee:*

The Honourable Senators: Sharon Carstairs P.C. (or Fernand Robichaud, P.C.) and John Lynch-Staunton (or Noel A. Kinsella)

*Other Senators who have participated from time to time on this study:*

The Honourable Senators Banks, Beaudoin, Cohen\*, DeWare\*, Ferretti Barth, Grafstein, Hubley, Joyal P.C., Milne, Losier-Cool, Rompkey, and Tunney

\*retired from the Senate





## EXECUTIVE SUMMARY

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### **Chapters 1, 2 and 6**

#### **Introduction**

#### **Summary of Main Findings and Observations from Phases One, Two and Three**

#### **Observations on Choosing Among Options**

The purpose of this paper is to outline the role of the federal government in the major issues facing Canada's health care system and to present a set of potential policy options for addressing each of these issues. In developing the set of options, the Committee has tried to be factual and non-ideological. We have deliberately not foreclosed discussion of any option a priori.

The Committee's objective in writing this paper is to launch a public debate. We believe that Canadian citizens, health care stakeholders, and federal and provincial policy makers need to become engaged in a national debate on the changes which must be made to our nation's health care system if it is to be sustainable in the long-term. We also believe that such a debate needs to include options which are often rejected out-of-hand by various individuals, organizations, political parties and segments of Canadian society.

While this paper does not reiterate information that is contained in other reports which the Committee has previously released, or which the Committee will be releasing shortly, Chapter 2 does highlight a number of conclusions that the Committee has drawn from its hearings. These conclusions are useful background information, but they do not indicate the Committee's position on the issues raised in this report. The Committee's recommendations on the issues will be contained in our fifth and final report, which will be released very early in 2002, following a set of public hearings this fall across the country.

### **Chapters 3 and 4**

#### **The Role of the Federal Government: An Overview**

#### **The Role of the Federal Government: Objectives and Constraints**

In order to consider the merits of an option for addressing a public policy issue, one must have a clear statement of the objective of the public policy. Only once an objective has been clearly articulated can one understand the impact a particular option will have on achieving the stated objective and hence whether the option should be adopted or rejected. Therefore, the Committee began its work by articulating, in Chapter 3, five distinct roles for the federal government in health and health care. Then, in Chapter 4, we list the specific objectives that we believe should be the focus of public policies related to each of these five roles. These roles, and their associated objectives, are as follows:

## **FIVE DISTINCT FEDERAL ROLES IN HEALTH AND HEALTH CARE**

1. **FINANCING ROLE:** *the transfer of funds for the provision of health services administered by other jurisdictions*
2. **RESEARCH AND EVALUATION ROLE:** *funding innovative health research and evaluation of innovative pilot projects*
3. **INFRASTRUCTURE ROLE:** *support for the health care infrastructure and the health infrastructure, including human resources*
4. **POPULATION HEALTH ROLE:** *health protection, health and wellness promotion, illness prevention, and population health*
5. **SERVICE DELIVERY ROLE:** *the direct provision of health services to specific population groups*

The specific objectives related to the financing role are as follows:

### **THE TRANSFER OF FUNDS FOR THE PROVISION OF HEALTH SERVICES ADMINISTERED BY OTHER JURISDICTIONS**

*The Committee proposes that the objectives of the federal government's financing role in health and health care should be:*

- *To provide a stable level of funding that ensures the sustainability of Canada's health care system and that fosters reform and renewal;*
- *To ensure that every Canadian has timely access to all medically necessary services regardless of their ability to pay for those services;*
- *To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills;*
- *To ensure that the four patient-oriented principles of the Canada Health Act (universality, comprehensiveness, accessibility, and portability) are applied.*

With respect to the research and evaluation role, the Committee's specific objectives for the federal government are given in the following table:

## **FUNDING INNOVATIVE HEALTH RESEARCH AND EVALUATION OF INNOVATIVE PILOT PROJECTS**

*The Committee proposes that the following objectives should apply to the second role of the federal government:*

- *To foster the development of a solid base of innovative health research in Canada that compares favourably with that of other countries;*
- *To encourage the foundation of a knowledge-based health care sector by facilitating the transfer of knowledge from the research community to public policy makers, health care providers and the general public;*
- *To provide appropriate financial support for joint federal/provincial/territorial initiatives that will encourage and facilitate innovation and advancement in health care delivery through evaluation of pilot projects.*

The infrastructure role of the federal government involves these elements: human resource planning, health-related information systems, such as telehealth and electronic patient records, and physical infrastructure. The Committee's objectives for this role are:

## **SUPPORT FOR THE HEALTH CARE INFRASTRUCTURE AND THE HEALTH INFOSTRUCTURE**

*The Committee believes that the following five objectives should apply to the federal government's third role :*

- *To lay the foundation for evidence-based decision-making in areas that affect both wellness and the delivery of health care, while ensuring the protection of privacy, confidentiality and security of personal health information;*
- *To monitor the health of the population and the state of the health care system and to report these findings to Canadian stakeholders;*
- *To develop, in collaboration with the provinces and territories, an appropriate structure and process to ensure greater accountability in the system;*
- *To assist provinces and territories in financing needed health care infrastructure, such as new medical technologies and the costs related to their ongoing operation;*
- *To co-ordinate, in collaboration with the provinces and territories, the planning of human resources in health care.*

The population health role of the federal government focuses on illness prevention rather than treating people once they are sick. The objectives proposed for this role are:

## **HEALTH PROTECTION, HEALTH AND WELLNESS PROMOTION AND ILLNESS PREVENTION**

*The Committee proposes that the following objectives should apply to the federal government's population health role:*

- *With respect to health protection: to strengthen our national capacity to identify and reduce risk factors which can cause injury, illness, and disease, and to reduce the economic burden of disease in Canada;*
- *With respect to health promotion and disease prevention: to develop, implement and assess programs and policies whose specific objective is to encourage Canadians to live a healthier lifestyle;*
- *With respect to wellness: to encourage population health strategies by studying and discussing the health outcomes of the full range of determinants of health, encompassing social, environmental, cultural and economic factors.*

The federal government delivers health services to more Canadians than do five provincial governments (the Atlantic provinces and Saskatchewan). Thus, the federal government is a major player in service delivery. As such, its objectives should be, in regard to Aboriginal health:

## **THE DIRECT PROVISION OF HEALTH SERVICES TO ABORIGINAL CANADIANS**

*The Committee proposes that the following objectives should apply to the federal government's service delivery role:*

- *To take a leadership role in ensuring inter-jurisdictional co-ordination of health care delivery to all Aboriginal peoples;*
- *To ensure adequate access to culturally appropriate health services;*
- *To implement and sustain population health strategies specifically designed for Aboriginal peoples.*

## **Chapter 5**

### **A 21<sup>st</sup> Century Context for Health Care Policy**

Before examining the policy issues related to each of the five federal government roles, it is useful to step back and review the health care industry in the context of what other 21<sup>st</sup> century service sector industries look like. When we do this, we note that none of the major characteristics of a modern service industry exist in the health care sector. This observation clearly points to the need for a major organizational overhaul in the delivery of health services, even if other issues, such as rising costs, were not also driving change. A modern service sector industry has three main characteristics:

1. The development of larger organizational units that allow for economies of scale, along with the ability to provide customers with 7/24 service;

2. The emergence of specialized organizational units that focus on delivering a limited range of higher quality services more efficiently than units that provide a wider range of services;
3. A strong focus on consumers who are more demanding than ever before: they want both timely and high-quality service.

The primary care sector is structured like a 19<sup>th</sup> century cottage industry rather than a 21<sup>st</sup> century service industry, consisting as it does largely of individual physician practices which are not clustered together into group practices, making 7/24 service impossible.

Specialization of the health care industry into service units delivering a narrow range of services has generally not occurred. There are, of course, some exceptions, such as laser eye clinics, and a very few specialized hospitals have emerged, such as the Shouldice Hospital in the Toronto area that only performs hernia operations. The major delivery system in the health care sector in Canada remains the unspecialized general hospital. While these will always be needed, it is important to investigate the benefits of making specialized delivery units a larger part of a modernized health service delivery system.

Little has been done in terms of the third characteristic of a 21<sup>st</sup> century service sector industry – a strong focus on timely and high-quality customer service. In fact, long waits for certain kinds of treatment is the complaint most often voiced by Canadians with regard to the health care system. This is clearly not timely service.

The Committee believes that many of the difficulties facing the health care sector can be successfully resolved only if the industry is prepared to transform itself into a 21<sup>st</sup> century service industry, instead of remaining an industry mired in a 19<sup>th</sup> century structure.

The first and essential step in organizational change must be primary care reform. This has been recognized by the Sinclair Commission in Ontario, the Clair Commission in Quebec and the Fyke Commission in Saskatchewan. It is also why the federal government agreed to contribute \$800 million to primary care reform following the federal, provincial and territorial agreement of September 2000. Primary care reform would create larger organizational units with a strong focus on 7/24 service; it would also create a structure with two of the three characteristics of a 21<sup>st</sup> century service organization referred to above.

## **Chapter 7**

### **The *Canada Health Act*, Timely Access to Treatment, and Fairness**

The *Canada Health Act* is pivotal in the health care debate in Canada, not only because it sets forth the conditions to be met by the provinces and territories in order to receive federal cash contributions under the Canada Health and Social Transfer (CHST), but also

because the Act has taken on mythical proportions as the only thing which prevents the Americanisation of the Canadian health care system.

The four patient-oriented conditions or principles of universality, accessibility, comprehensiveness and portability are strongly supported by the Committee, although we recognize that the principles are not nearly as strictly adhered to as many Canadians would like. Contrary to popular belief, the fifth principle – public administration – does not mean that there should be no private sector delivery of health care. The public administration principle refers to the requirement that, for the purposes of administrative efficiency, the system should be a single payer model, with the payer being a provincial government.

With respect to the *Canada Health Act*, the Committee asked three questions: First, do Canadians have a right to health care, and if such a right exists, can it be found in the *Charter of Rights and Freedoms*? Second, to what extent, if any, are private health care provision and private health care insurance permissible under the *Canada Health Act*? And third, is “reasonable access” under the *Canada Health Act* meant to ensure that Canadians have timely access to needed health services?

First, health care is not explicitly mentioned in the Charter. Thus, such a right, if it exists, would have to be found by the courts to be implied from the interpretation of one of the Charter rights. However, because a case can be made that the Charter guarantees Canadians an implicit right to health care, experts told the Committee that they expected cases on the right to health care to arise in the next few years.

Second, the *Canada Health Act* does not prohibit the provision of private health care. Rather, it discourages the provinces, under threat of losing federal funds, from permitting health care providers to bill patients directly for amounts over and above what they receive for such services under provincial health care insurance plans, known as extra-billing. Similarly, in order to obtain their full CHST cash contribution, provinces and territories must not allow hospitals to impose user charges on patients for insured hospital services. The *Act* only dictates the terms under which federal cash transfers to the provinces will occur.

The legislation does not prevent private, for-profit health care providers and institutions from delivering and being reimbursed for provincially insured health services, so long as extra-billing and user charges are not involved. Also, health care providers and facilities may opt out of the provincial plan and bill patients directly for the full cost of services provided, without any penalty being imposed on the province under the *Canada Health Act*. In these cases, patients are not eligible for reimbursement under provincial plans. Moreover, the *Canada Health Act* effectively prevents individuals from purchasing private health care insurance to cover the cost they would incur in receiving services from a provider who had opted out of a provincial health care plan.

Overall, the *Canada Health Act*, along with provincial/territorial legislation, has prevented the emergence of a private health care system that would compete directly with the publicly funded one. It is simply not economically feasible for patients, physicians or health care institutions to be part of a parallel system.

This raises the following question: if access to publicly funded health services is not timely, can governments continue to discourage the provision of private health care through the prohibition of private insurance? To paraphrase Section 1 of the *Charter of Rights and Freedoms*: is it just and reasonable in a free and democratic society that government ration the supply of health care (through budgetary allocations to health care) and at the same time effectively prevent individuals from purchasing the service in Canada?

This issue is not just a legal matter. It is, above all, a question of fairness. Whether the current situation is fair is something the readers of this report must decide for themselves.

It is clear, however, that any option for the reform of current arrangements that involves a private sector competing effectively with the publicly funded sector would require substantial modifications to the *Canada Health Act*.

The third question raised at the beginning of this section is whether “reasonable access” under the *Canada Health Act* is meant to ensure that Canadians have timely access to needed health services. Again, the legal answer to this question is unclear.

What is clear, however, is that waiting times for tests and treatment are perceived to be a major problem by the Canadian public. The question then becomes: what can be done, if anything, to guarantee Canadians that the amount of time they have to wait for a test or procedure has a fixed upper limit; that they will never have to wait more than a specified maximum period (which may be different for different tests or procedures).

Two options for dealing with this problem are presented in Chapter 7. Section 7.5.1 describes the “care guarantee” approach which was developed in Sweden. Section 7.5.2 explains how the United Kingdom has tried to deal with long waiting lines through its Patient’s Charter. Both of these approaches use a combination of incentives and penalties to make health care facilities more productive and efficient.

These approaches also raise the question of whether the Canadian health care system should be modified to allow, or even encourage, competition between hospitals. Moreover, if competition is allowed, should patients be allowed to pay for the cost of a procedure (and be allowed to buy insurance to cover the cost of a procedure) in order to receive expedited service, as they can in most other industrialized countries? This question raises the issue of a so-called “two-tier” system.

Advocates of a single payer system invoke the “fairness” argument. They argue that health services should be provided exclusively on the basis of need, and that the introduction of a second tier of care, available only to a minority of the population with the personal resources to pay for them, goes against the principles of equity and fairness. This is the converse of the question asked earlier-- is it fair to deny people who can afford to buy health services the right to buy those services? The criticism of a “two-tier” system suggests that Canada does not have any elements of a “two-tier” system at the present time. Is this true?

People who can afford it can, and do, go out of Canada (usually to the United States) to receive the medical services they require if their only alternative is a long waiting line in Canada. There is also strong anecdotal evidence that suggests that the situation in Canada is similar to that in Australia where, in the words of one of the Australian witnesses who testified before the Committee: “access to public (health) services is usually more easily obtained by wealthier and more powerful individuals who understand how the system works and have appropriate contacts in hospital service delivery and administration”. In addition, provincial Worker’s Compensation boards in most provinces manage to have faster access to treatment for their clients because, they argue, they need to ensure the client goes back to work quickly (not just, incidentally, to save the WCB money).

The Canadian health care system does not comprise “one tier”, as most Canadians believe, and as most government spokespersons claim. Whether this constitutes an argument for a more open “two-tier” system is an issue for readers of this report to decide.

## **Chapter 8**

### **Issues and Options for the Financing Role**

The health care issue that receives the most media attention is how much money each level of government should pay to support the health care system as it is presently structured. The question, when it is posed in this way, overlooks two critical factors:

- first, how much money can be saved through efficiency measures such as primary care reform, regionalization of health services, contracting-out to private for-profit health care facilities and devoting more resources to health promotion, disease prevention and population health measures. (These efficiency measures are explored in section 8.2.)
- second, if new sources of financing are required, should the money come from taxpayers to government to the health care sector or should it come from individual Canadians directly to the health care sector. (A variety of options both for government funding and for payments directly from individuals are discussed in sections 8.3 and 8.4.)

There are two schools of thought on the question of whether new financing sources are needed to make the health care system sustainable. Proponents of the first school contend that operating the health care system more efficiently will save enough money that no



new sources of funding will be required. This view is reflected in the recent Fyke report on health care in Saskatchewan and in reports and newspaper articles by many writers, including Dr. Michael Rachlis.

While many observers recognize that the effectiveness and efficiency of Canada's health care system must be improved, there is no agreement on the level of savings such improvements would generate. Those who believe new funding sources are required agree that, in a \$90 billion health care system, some economies are certainly possible and that every effort must be made to implement such efficiency-driven changes, but they argue that it will be difficult to implement changes to enhance efficiency and effectiveness because both the attitude and the behaviour of those with vested interests in the health care system – including patients, service providers, and drug companies – have over the years proven to be very difficult to change. In fact, if the proposed changes were as easy to put into place as proponents of the first school of thought imply, then the question is why have they not already been implemented.

The Committee believes it is important to be prudent and to develop plans and policies that will be effective, in case the savings arising from changes made to the way the system currently works are insufficient. Any other approach would be the same as putting all our eggs in one basket, and betting the future of the sustainability of the health care system on making system changes when there is not yet enough evidence to demonstrate that these changes are actually feasible, and when there is no reliable indication of the savings that can be made by such changes.

The Committee realizes that there is a significant advantage in the approach put forward by supporters of the first school of thought – it makes it possible to avoid most of the tough financing questions, as outlined in the rest of this chapter. While it is tempting to adopt their point of view, and thereby skirt the most controversial health care issues, the Committee believes that responsible public policy planning requires that the views of the second group should prevail, and that Canadians should now explore ways of raising additional funds, at the same time as efforts are being made to organize health care delivery more efficiently.

The question, then, is what new sources of funding should be used. In section 8.3, several options are outlined, most of which are variations of current, or previous, federal financing mechanisms:

- return to cost-sharing (8.3.1), retain block funding (section 8.3.2), or improved CHST block funding (section 8.3.3), or converting all CHST cash transfers into tax point transfers (section 8.3.5)
- medical savings accounts in which part or all of the “health portion” of the CHST is transferred into a health account for each individual Canadian (section 8.3.4)

In section 8.4, we review a variety of methods by which individuals could pay themselves a portion of the health care costs which are now paid out of public funds. Specifically, we look at the following options:

- user charges (section 8.4.3), where a patient makes a cash payment to cover a portion of the cost of the service, at the time the service is received.
- income tax payments on the value of health services an individual receives from the public health care system during the year (8.4.4).
- annual health care premiums paid to the government (section 8.4.5).
- private health care insurance premiums which compete with public health insurance so that individuals with private insurance can purchase the services they need from either public or private health care facilities (section 8.4.6).

There are three forms of user charges which are used in various industrialized countries. These are:

- Co-insurance, the simplest form of user charge, requires the patient to pay a fixed percentage (say 5%) of the cost of services received. Thus, the higher the cost of the service, the larger the fee. Many private sector drug insurance plans operate using this method of payment.
- Co-payment is an alternative to co-insurance. Instead of having to pay a share of costs, the patient is required to pay a flat fee per service (for example, \$5) which does not necessarily bear any relation to the cost of the service. The same amount is charged, no matter what the cost of the health care provided. This form of user charge exists in many countries, such as Sweden.
- In the “deductible” system, the patient is required to pay the total cost of services received over a given period up to a certain ceiling, called the “deductible”. Above this ceiling, costs of services to the patient are covered by the insurance plan. All users must pay a standard minimum deductible, which is independent of the number of services received. Again, this form of insurance-based user charge is required in some countries.

With respect to treating the value of health services received during the year as taxable income, the option presented in Section 8.4.4 includes a cap on the increase in income tax an individual would pay in any given year.

The annual health care premium option (Section 8.4.5) could be a flat fee, or it could be linked to an individual’s income. However, in contrast to the user charges and income tax options, an annual premium would not vary according to the number of health care services received during the year.

Some of the options presented – namely user charges for publicly funded health services, medical savings accounts and private health care insurance – may raise concerns about the possible impact of two-tier health care. Three suggestions have been made as a means of avoiding the negative aspects of a two-tier health care system, while maintaining the quality of the publicly funded system:

- all doctors would be required to work a certain number of hours in the publicly funded system, meaning that they would not be permitted to work exclusively in the privately funded system;
- the publicly funded health care system would provide a guarantee that waiting times for various procedures would not exceed a certain period and, if the maximum time was exceeded, the government would be obliged to pay for the required treatment to be performed in the private sector system;
- an independent body would be mandated to ensure that health care technology in the public sector was as good as in the private sector.

The Committee looks forward to receiving the views of Canadians on the issue of two-tier health care based on the assumption that the three conditions outlined above could be met.

In considering various financing options, it is important to keep in mind that each will have an impact on behaviour. Examples from several countries with a universal health care system illustrate that the way a health care system is financed can help in achieving the overarching public policy objective of delivering the best health care possible at the lowest cost.

Unfortunately, as many witnesses pointed out, the current system in Canada contains few incentives for health care providers to reduce costs or to strive for better integration (through, for example, primary care reform). Similarly, the Canadian system has no incentives for consumers of health care to use the system in a responsible manner.

User charges can be valuable in diverting demand from high cost services to those which are less expensive without diminishing access to medically necessary services. But this is only possible if a less expensive service is available and covered by insurance.

The following questions must be asked about the structure of health care financing in Canada:

- Should the financial structure be such that all those involved in the system – health care consumers, providers, facilities administrators and so forth – have an incentive to use the system as efficiently as possible?

- Should incentives be used to help patients understand that their perceived right to universal health care is accompanied by a responsibility to use that right reasonably and judiciously?

Responses to these questions will determine our health care financing system for the future.

Following the description of options for addressing future financing issues, the next part of Chapter 8 looks into the services that should be covered and who should be covered by public health care insurance, since these issues have a direct impact on the cost of publicly funded health care.

In section 8.8, options are put forward for reducing the cost of prescription drugs, which are the most rapidly increasing component of health care costs. These options are not mutually exclusive: all of them could be adopted:

- a national drug formulary (section 8.8.1)
- requiring the use of lowest cost therapeutically effective drug (section 8.8.2)
- maintaining the current prohibition on the advertising of prescription drugs (section 8.8.3)

The establishment of a national drug formulary could lead the way to the creation of a single national buying agency – one which covers all provincial and territorial governments as well as the federal government. The buying power of such an agency would be enormous, and would likely strengthen the ability of public drug insurance plans to receive the lowest possible purchase price from the drug companies.

The need for aggressive drug cost-benefit management, particularly in terms of listing only the most cost-effective prescription drugs on formularies, is a reality that must be faced in light of limited public health care resources. In recent years, provincial drug insurance plans have begun to use their reimbursement policies to encourage doctors to make substitutions among alternative drug therapies. In some cases, a drug is simply not listed on a formulary if it is more expensive than others that are equally effective in treating particular medical conditions. In other cases, a drug benefit plan (for example, the Ontario Drug Benefit Plan) will only pay for a more expensive drug on special authorization in a case where it is chosen over a less expensive alternative because of one, but not all, its indications. British Columbia's reference-based pricing policy has been used for this same purpose: the province only reimburses up to the price of a reference drug in a particular therapeutic category, unless the physician demonstrates a specific need for the more expensive product and it is approved, in advance, by the drug plan.

The difficult policy questions are: to what extent should governments adopt a program of mandatory therapeutic substitution to the lowest priced therapeutically equivalent drug? And how aggressively should such a substitution policy be followed?

A third issue related to prescription drug costs is whether pharmaceutical companies should be allowed to advertise prescription drugs. Currently, Health Canada bans direct advertising to consumers and limits the advertising of prescription drugs to health care providers. Direct-to-consumer advertising of prescription drugs is not permitted in most industrialized countries. In the United States, where the advertising of prescription drugs is allowed (the industry spends hundreds of millions of dollars a year on advertising in the U.S.), studies have shown that a very significant proportion of prescriptions are issued by physicians, particularly family practitioners, to patients who ask for a specific drug because they have seen it advertised. This is hardly surprising since the purpose of advertising is to increase demand. It has been suggested that in order to avoid an increase in demand for prescription drugs in Canada, the federal government should maintain its current ban on prescription drug advertising.

In section 8.9, a range of options are presented for expanding coverage for publicly funded prescription drugs. The options presented range from various forms of a national Pharmacare program (section 8.9.1 through 8.9.3) to a program targeted at protecting Canadians against catastrophic drug costs. Two ways of funding such a program are presented. One is a public/private sector insurance program (section 8.9.4) and the other is a tax-based program (section 8.9.5). Focussing on a targeted catastrophic program is based on evidence which shows that this is where there is the biggest gap in coverage of “medically necessary” drug therapy. Also, such programs fill the traditional role of government in Canada, in that they provide a safety net in case a catastrophic event occurs.

Some 3% of the Canadian population have no insurance coverage at all for prescription drugs. The Committee learned that most of these people are working age adults. Qualitative data also suggests those in this group may be unskilled, low-paid employees, part-time workers, seasonal employees, or the short-term unemployed. In the event of illness, these individuals are not sheltered from catastrophic drug costs, or high prescription drug costs.

Low-income families, particularly in jurisdictions that do not have public drug insurance plans for the general public, are often in a difficult position. Although their income may be too high for them to qualify for social assistance, they generally do not have regular employment or group insurance. Drug costs can place them in a financial situation in which their income after drug costs is less than that of someone on social assistance.

Moreover, in the four Atlantic provinces, there is no generally available public program to limit exposure of individuals and families to high prescription drug costs. As a matter of fact, a recent study funded by Health Canada’s Health Transition Fund found that over 25% of the population of the Maritimes are without catastrophic coverage for prescription drugs and that another 25% might be considered under-insured.

Finally, section 8.10 has a discussion of home care, the other form of care that, along with prescription drugs, is most frequently mentioned as a possible candidate for coverage expansion in the publicly funded system.

Effective home care can contribute to lower long-term costs for the health care system for a number of reasons:

- it reduces the pressure on acute care beds by providing medical interventions in a lower-cost setting and by making use of hospital resources only when they are really needed (that is, home care is a substitute for keeping the patient in an acute-care hospital);
- it reduces demand for long-term beds by providing a viable choice for aging Canadians to maintain their independence and dignity in their own homes (that is, home care acts as a substitute for nursing-home care);
- it enables palliative care patients to spend their final days in the comfort of familiar surroundings (that is, home care acts as a substitute for palliative-care institutions).

Many witnesses contended that when home care substitutes for acute care, it should be treated in the same way as acute care delivered in other settings and, accordingly, should fall under the parameters of the *Canada Health Act*.

With respect to home care that substitutes for long-term and palliative care, the issue was raised as to whether patients should be required to contribute a larger co-payment to help cover the cost of these services as long as they have the necessary financial resources. A larger co-payment is already required in some provinces, but not in others, and where it is required, many long-term care patients are obliged to exhaust most of their personal resources before their care is paid for by the government. This raises the question of whether individuals who have the financial resources to pay the cost of long-term care should do so, or whether their care should be paid for by the government, as is the case of those with low incomes, enabling them to leave a larger legacy to their children.

In considering the home care issue, a range of options are presented:

- a full national home care program (section 8.10.1)
- a tax credit and tax deduction to consumers of home care services (section 8.10.2)
- creating a dedicated insurance fund to protect individuals against future home care costs (section 8.10.3)
- a series of measures designed to give financial support to family members, usually women, who are providing unpaid care to a member of their family.

The following table summarises all the options presented in Chapter 8:

<b>OPTIONS FOR THE FINANCING ROLE OF THE FEDERAL GOVERNMENT</b>	
<b>Changes in Health Care Delivery (8.2)</b>	Improving Efficiency and Effectiveness (8.2.1)
	Primary Care Reform (8.2.2)
	Regionalization of Health Services (8.2.3)
	Contracting Private For-Profit Facilities (8.2.4)
	Promotion, Prevention and Population Health (8.2.5)
<b>Form of Federal Funding for Health Care (8.3)</b>	Cost-Sharing (8.3.1)
	Current Block-Funding (8.3.2)
	Improved CHST (8.3.3)
	Medical Savings Accounts (8.3.4)
	Tax Transfers (8.3.5)
<b>Raising Government Revenue for Health Care (8.4)</b>	Through General Revenue: Reallocating Existing Revenue to Health Care (8.4.1) Increased Taxation (8.4.2)
	Through Direct Payments: User Charges (8.4.3) Income Tax on Health Care (8.4.4) Health Care Premiums (8.4.5)
<b>Private Health Care Insurance (8.4.6)</b>	For Health Services Delivered both Publicly and Privately
<b>Public Health Care Coverage (8.7)</b>	De-listing Services (8.7.1)
	Expanding Coverage (8.7.2)
<b>Reducing the Cost of Prescription Drugs (8.8)</b>	National Drug Formulary (8.8.1)
	Use of Lowest Cost Effective Drug (8.8.2)
	Advertising of Prescription Drugs to the Public (8.8.3)
<b>Expanding Coverage for Prescription Drugs (8.9)</b>	National Pharmacare Initiative (8.9.1)
	A Comprehensive Public Program (8.9.2)
	A Comprehensive Public/Private Initiative (8.9.3)
	Public/Private Initiative to Protect Against High Drug Expenses (8.9.4)
	Tax Initiative to Protect Against High Drug Expenses (8.9.5)
<b>Home Care (8.10)</b>	National Home Care Program (8.10.1)
	Tax Credit and Tax Deduction (8.10.2)
	Dedicated Insurance Fund for Home Care (8.10.3)
	Specific Measures for Informal Caregivers (8.10.4)

## **Chapter 9**

### **Issues and Options for the Research and Evaluation Role**

The role of the federal government in the field of research and evaluation is twofold, as it encompasses both funding health research and financial support for the evaluation of pilot projects. Throughout the hearings, there was unanimous consent among witnesses that

funding innovative research and project evaluation should in the future remain a major responsibility of the federal government.

The federal government has had a long tradition – over 40 years – in financing health research. In fact, up until 1994, the federal government was the main source of funding for health research in Canada. The Canadian Institutes of Health Research (CIHR) is currently the principal federal funding body for health research. The main concern raised by witnesses during the hearings on health research was that Canada's expenditures were low in comparison with other industrialized countries and that the federal government should devote more funding to health research. Other issues related to the transfer of knowledge, regional disparities and ethics.

Everybody agrees that health research will be one of the major drivers of change in Canada's health care system in the coming years (Section 9.1). The knowledge that is gained as a result of health research translates directly into better diagnosis, treatment, cure and prevention of many diseases. This, in turn, leads to reduced health care costs through:

- reducing the cost of illness, both social and economic, through the development of new drugs, products, technologies, and advances that shorten hospital stays, speed healing, and prolong good health;
- improving the efficiency and effectiveness of health care delivery; and,
- curing disease.

The first option would be to raise the federal share of total spending on health research to 1% of total health care spending from its current level of approximately 0.5% (Section 9.1.1). This would mean at least doubling CIHR's current budget to \$1 billion. This would also bring the level of the federal contribution to health research more in line with that of central governments in other countries. More importantly, such federal investment would help maintain a vibrant, innovative and leading-edge health research industry.

The transfer of knowledge generated by health research would greatly enhance evidence-based decision-making with respect to health and health care to the benefits of all Canadians (9.1.2). The Committee was told that there is a need to disseminate the results of health research to health care providers and policy makers. There is also a need to establish a public awareness campaign to inform Canadians about, for example, genetic research, animal cloning, and embryo research. The proposed option is to establish an organization to disseminate the results of biomedical and clinical research. Such an organization could be created within the CIHR or within Health Canada. Another option could be to create a separate federal agency devoted to this task.

The Committee heard that there is great regional disparity in terms of health research capacity across the country (9.1.3). For example, some medical facilities and academic health centres, particularly in the Atlantic provinces and in the Prairies, are currently under-



funded and unable to respond to the challenges of contributing to Canada's success in developing a globally competitive health research. The Committee would like to hear about possible options on how the federal government can contribute to reducing provincial disparities in health research capacity.

The Committee heard that a Panel on Research Ethics was recently created by the CIHR in collaboration with SSHRC and NSERC (Section 9.1.4). This panel will govern the federal policy related to the ethical conduct of research involving human subjects. The Committee was told that while this policy has high standards, effective oversight is required to ensure compliance with those standards. Moreover, the Panel on Research Ethics will be reviewing only research funded by the CIHR, SSHRC and NSERC, and not all health research conducted in Canada. It was suggested that a national oversight body independent from the CIHR should be established to provide ethics review functions for all publicly and privately funded health research, and in particular research using human embryo or foetal tissue, including embryonic stem cell research.

In recent years, the federal government has provided funding to evaluate innovative pilot projects aimed at improving the delivery of health care (Section 9.2). An important component of these pilot projects is the requirement to provide an evaluation of outcomes, including a report on the impact of the project on health status and on health services utilization, its cost-effectiveness, improvements made in the provision of care, health systems security and privacy of personal information, and so forth. All witnesses agreed that the federal government should maintain or increase its level of funding in this field (Section 9.2.1), while addressing the issue of regional disparities (Section 9.2.2).

## **Chapter 10**

### **Issues and Options for the Infrastructure Role: Technology and Information Systems**

The concept of “health care infrastructure” encompasses the broad mix of resources – both physical and human – that sustain the delivery of health care. In this sense, infrastructure includes not only bricks and mortar and medical equipment and technology, but also human resources, the educational sector and the information and communication systems that support health care providers.

Although Canada ranks fifth among OECD countries in terms of total spending on health care (as a percentage of GDP), Canada is generally among the bottom third of OECD countries as regards the availability of health care technology. The “aging” of health care technology is another issue of concern.

The restricted availability of health care technology has often translated into limited access to care and longer waiting times. Timely access to diagnosis and treatment is a

crucial objective and must be guaranteed in Canada's health care system (see Chapter 7 for more details about of waiting times).

Although the federal government announced that it would invest a total of \$1 billion in 2000-01 and 2001-02 to assist the provinces and territories in purchasing new diagnostic and clinical medical equipment, a number of concerns remain. First, some provinces have not applied for their share of this fund, possibly because the federal government requires matching grants. Second, there are apparently no mechanisms for ensuring accountability on the part of the provinces as to exactly where that money is going to be spent. Third, additional resources are required to operate the equipment. Estimates suggest that a \$1 billion investment in new equipment necessitates an additional \$700 million to cover operational costs. And fourth, this investment does not address the matter of the old equipment that needs to be upgraded. A further \$1 billion investment would be required for the upgrading of existing equipment.

All this suggests that the federal government should seriously consider committing to a longer term program of financing for health care technology (section 10.1.1). Such federal funding would encompass both the acquisition of new health care technology and the operation and upgrading of existing equipment. As part of this program, provincial and territorial governments could be required to report to Canadians on how they have invested these federal funds; otherwise, the federal government has no way of knowing whether its money has been spent on the things it was intended for.

Health care technology assessment (HTA) (Section 10.1.2) provides information on safety, clinical effectiveness and economic efficiency. HTA can assist in deciding whether a new technology should be introduced and when an existing technology should be replaced. More importantly, HTA ensures that health care technologies are effective, that they are applied in the appropriate cases and under the proper conditions, and that the technology used to achieve a particular outcome is the least costly.

Not enough attention has been paid to HTA in Canada. For example, all levels of government invest less than \$8 million to HTA in Canada, whereas the United Kingdom provides some \$100 million to its national HTA body – the National Institute for Clinical Excellence (NICE). As a result, health care technologies are often introduced into the Canadian health care system with only superficial knowledge of their safety, effectiveness and cost.

A major weakness in our current health care system is that it still operates as a “cottage industry” (see also the discussion of the primary care sector in Chapter 5). On the one hand, the health care sector in Canada is not making use of information and communications technology as much as the other information-intensive industries are. On the other, the health care system is not integrated: physicians and other health care providers, hospitals, laboratories and pharmacies all operate as independent entities with limited access to linkages that would lead to more effective sharing of information.

Greater use of information and communications technology (Section 10.2) along with better integration of health care providers and institutions would greatly improve evidence-based decision-making by health care providers, health care managers and health care policy makers.

Many witnesses pointed to the urgency of improving our capacity to manage health information, and suggested that this be done even if it means that in the short term waiting lists become somewhat longer, less health care technology is purchased, and other expenditures are postponed. In the view of many witnesses, enhancing our ability to manage health information is essential to the survival of Medicare.

The use of information and communications technology in the field of health care is often referred to as “telehealth”. The telehealth applications that are envisioned in Canada for the purposes of sharing information and integrating health care delivery include a system of Electronic Health Records (EHR) and an Internet-based health information system.

The key issue is to bring together all the diverse infostructures which are now being developed in isolation by various institutions and provinces. This is what the proposed Canadian Health Infostructure will do (10.2.1). It will not be a single massive structure, but a network of networks, building on the initiatives that are already in place or under development at the federal, provincial and territorial levels. This is an ambitious, expensive and long-term undertaking which will take years to realize. However, it is essential to do so if we wish to acquire reliable information on the health of Canadians, the state of our health care system, and on the efficiency and effectiveness of health services delivery and distribution.

In implementing this option, priority should be given to electronic patient records, since the electronic patient record system is the cornerstone of an efficient and responsive health care delivery system that is able to improve quality and accountability. Without this kind of infostructure, the prospects for a truly patient-oriented health care system and for enhancing efficiency in health care delivery are dim. In fact, an EHR is essential if primary health care reform is to be realized.

Telemedicine (Section 10.2.2) is one form of the telehealth applications that can greatly improve quality and timely access to care, particularly in rural and remote Canada. Accessibility to health care is one of the four patient-oriented principles of the *Canada Health Act*. However, rural Canadians are increasingly voicing concerns about disparities between the services available in rural and remote areas and those in urban areas.

Tele-medicine is an important component of the overall rural health policy of the federal government. In the context of rural health, telemedicine offers the following advantages: it addresses the shortage of rural health care providers and medical training; it improves rural health infrastructure; it conforms with the accessibility principle of the *Canada Health Act*; and it ensures more equitable development of health information systems across the country.

An important outcome of the Canadian Health Infostructure will be the generation of a massive amount of health information. It is the view of all levels of government as well as all health care stakeholders that an evidence-based health care system can provide greater accountability and ensure continuous improvement to health status and health care delivery, in addition to providing a better understanding of the determinants of health. (Section 10.3)

The federal government, along with the provinces and territories, made a clear commitment to moving toward greater accountability in the area of health care with the signing of the First Ministers' Agreement in September 2000. A Performance Indicators Reporting Committee (PIRC), chaired by Alberta, with Newfoundland, Quebec, Ontario and Health Canada as members, is working to address issues and make recommendations on a list of indicators. Similarly, the report by the Canadian Institute for Health Information (CIHI), entitled *Health Care in Canada*, is a step towards a national accounting process for the health care system. One option would be to expand CIHI's information analysis and its capacity to report annually to Canadians on the health status of the population and on the state of the health care system (Section 10.3.1).

Similar to the recommendation by the Fyke Commission in Saskatchewan, a National Health Care Quality Council (Section 10.3.2) would be an independent, evidence-based organization, at arm's length from government. Its purpose would be to provide the most objective assessment and evaluation possible of health service delivery and it would report to both government and the general public. The Council would undertake an analysis of the performance of the health care system, develop benchmarks and standards, undertake a cost-benefit analysis of programs and services, assess trends in health status, and so on.

The performance indicators developed by the National Health Care Quality Council would lay the foundation for quality improvement and serve as a guide for resource allocation. The Council would pinpoint areas in need of support and allow the public to make better informed judgements on individual sectors and services, as well as on the overall system. This would greatly improve the prospects for optimizing the use of available public resources.

There are two aspects of government accountability (Section 10.3.3). The first involves the federal government reporting to Canadians on its policies and programs with respect to health care (public accountability). The second involves provincial/territorial reporting to the federal government on the use of federal transfer payments (government-to-government accountability).

The federal government could set a valuable example by establishing a permanent mechanism for reporting to the Canadian public on the impact of all its policies affecting health and health care. One possibility could be to create a Health Commissioner charged with this task. The initiative called "Healthy People" by the Surgeon General of the United States, with the collaboration of the US Department of Health and Human Services, could be considered as a possible model.

The second form of accountability – government-to-government – may appear problematic for those who feel that there should be no role for the federal government in establishing the accountability of provincially delivered programs. But, given the substantial amount of money the federal government contributes to the provinces/territories for health care delivery, accountability to federal taxpayers requires that the federal government understand how well, or how poorly, their contributions are being spent. The affirmation of a role for the federal government with respect to government-to-government accountability is not meant to infringe on provincial prerogatives, but rather to allow all Canadians to judge how their federal tax dollars are being spent, including those spent by the federal government in its role of provider of services to specific population groups, particularly Aboriginal Canadians.

## **Chapter 11**

### **Issues and Options for the Infrastructure Role: Health Human Resources**

Talk of a ‘crisis’ in health care has a good deal of plausibility in relation to human resource issues, particularly with regard to the situation facing registered nurses (RNs) in Canada. The Canadian Nurses’ Association forecasts that by 2011 there will be a shortfall of at least 59,000 nurses in Canada, but the shortfall could be as high as 113,000 if the needs of our aging population are taken into account. There are also shortages of other health care professionals, ranging from laboratory technologists to pharmacists.

Assessing the situation with regard to physicians is more difficult. While the total number of physicians has increased, the physician-to-population ratio has, despite fluctuations, remained relatively constant over the years. Yet the aggregate numbers do not tell the whole story. Availability of physician services varies widely depending on what kind of doctor one is dealing with and where one lives.

There is unlikely to be a quick fix to the human resource problems faced by the health care sector. All national organizations representing health care providers insisted that what is needed is a country-wide, long-term, made-in-Canada, human resources strategy co-ordinated by the federal government (Section 11.2). Of course, not only do the provinces and territories have the responsibility for the delivery of health care to their populations, they are also responsible for education and training. The challenge is therefore to find a way to develop such a strategy in a manner that is acceptable to the provinces and territories.

Provincial and territorial governments may resist the involvement of the federal government in the development of such a national human resources strategy. For example, when they met in August 2001, the provincial and territorial premiers and leaders agreed to develop ongoing inter-provincial co-operation to ensure that there is an adequate supply of health care providers, without the involvement of the federal government. Nevertheless, the Committee believes that a national (as opposed to a federal) strategy involving all governments, including the federal government, is needed.

There are two other human resource issues that clearly require the attention of all governments (Section 11.3):

- How to make the best use of the full spectrum of differently qualified health professionals, so that the full range of abilities of each type of professional is productively employed;
- How to recruit, train and retain an adequate supply of health care professionals who can adapt to the changing health and health care needs of the Canadian population.

Today there is a largely hierarchical structure to the 'ranking' of health care professionals and other caregivers. Specialist doctors are generally perceived to be at the top, followed by family physicians, various categories of nurses, from those with advanced training (nurse practitioners) through to auxiliaries (licensed practical nurses). Other professionals, from pharmacists to laboratory technologists, receive less attention but are no less important to the smooth running of the system. Then there are the practitioners of various kinds of alternative medicines who continually struggle for full recognition of their contribution to the health and well-being of Canadians. And finally there is an army of informal caregivers and volunteers whose essential work often goes completely unrecognized.

We need therefore to ask explicitly whether it is time to move away from this hierarchical way of thinking and attempt to adopt a 'spectrum' approach to human resources. The 'spectrum' concept would challenge the idea that 'specialist' physicians are somehow 'higher' up the ladder by virtue of their in-depth knowledge of a particular area than their family practitioner colleagues, or that doctors, in general, are necessarily more 'highly' qualified than nurses. This concept is based on the assumption that each profession has its particular strengths and these all need to be properly valued and deployed.

The major obstacles to the development of a plan to deal with these issues are the existing rules, which define what the various health professions can, and cannot do (called the scope of practice rules). Primary care reform is essential if we are to rationalize the use of human health resources (Section 11.4). Primary care is the first level of care, and usually the first point of contact that people have with the health care system. Primary care supports individuals and families to make the best decisions for their health. Primary care services need to be:

- co-ordinated
- accessible to all consumers
- provided by health care professionals who have the right skills to meet the needs of individuals and communities being served, and
- accountable to local citizens through community governance.

Multidisciplinary team work must therefore be a vital part of primary care. However, the goal of this team work should not be to replace one health care provider with another, but rather to look at the unique skills each one brings to the team and to co-ordinate the deployment of these skills. Clients need to see the health care worker who is the best qualified to deal with their ailment.

The way in which health care is now delivered in Canada does not normally reflect a primary care philosophy (although Community Health Centres are an example of organizations that do deliver health services using a primary care philosophy). Health services are often not co-ordinated, nor are they being provided by the most appropriate practitioner and the knowledge and skills of many practitioners are not being fully utilized.

The implementation of a primary care strategy, as noted earlier in this report (see Chapter 5), also entails rethinking the current reliance on fee-for-service payments as the main way of remunerating physicians. A fee-for-service actively discourages physicians from promoting teamwork, as their individual salaries depend on the number of patients they see. Moreover, it encourages family physicians to refer as a matter of course many of the more complex cases to specialists since there is no incentive for them to spend more time with 'difficult' cases. Finally, a fee-for-service reinforces the public's perception of the current 'hierarchy' within the health care system, and can only serve to accentuate demand on the part of individual patients to always consult the most 'highly' qualified practitioner, regardless of whether or not they are the one best-suited to meeting the patient's needs.

The main alternatives to a fee-for-service payment are salary- and capitation-based systems, where physician services are remunerated according to the number of registered patients. Currently, some physicians with substantial teaching or administrative duties are on salary, and there have been a number of initiatives aimed at organizing group practices in various provinces that utilize forms of capitation. It is also possible to combine these forms of payment (as is done in Great Britain).

Finding alternative means of remuneration for physicians is not the only obstacle to be overcome in reforming the current system so that better use can be made of all types of human resources in the health care sector. Reform in this area necessarily challenges the current distribution of decision-making power, and is therefore likely to be resisted by those who are presently perceived to be in the most powerful position. Primary care reform would have the effect of increasing the number of people sharing the top of the hill, and means will have to be found to persuade those who are now in a dominant position to share some of their power.

Finally, it is important to consider various ways of encouraging individuals themselves to seek the most appropriate form of care (Section 11.5). Canadians have been led to believe that they must see a doctor when they could well consult a nurse or a nurse practitioner, and that a specialist is needed when a general practitioner might well be able to provide care of comparable quality. The health care delivery system needs to be organized so that it is possible for patients to consult the most appropriate health care professional, and there must be

incentives that reward patients for making the best choice and consequences that penalize them when they behave in a way that is unnecessarily costly to the system.

Among the options that could be considered to accomplish this goal are user fees that would kick in if (and only if) a patient insisted on seeing a particular health care professional when it was not considered necessary at the initial point of contact between the patient and the system. Referrals that were made on the advice of a health care professional (triage nurse, general practitioner) would be free of charge, but if patients requested a further consultation of their own volition, they would be required to pay a user fee that could vary according to the type of professional consulted. These fees could be made refundable if the consultation proved necessary, so as to avoid overly discouraging those who wish to obtain a second opinion on their case. It might also be possible to guarantee shorter waiting times for consulting some categories of professionals, and to use this as an additional incentive to promote cost-conscious behaviour on the part of health care consumers.

There are four broad issues which are intertwined in the human resource planning problem:

- What role should the federal government play in the development of a national human resources plan for all health services sector personnel?
- What role should the federal government play in helping to implement such a plan (e.g. through infrastructure funding or financial contributions to training programs)?
- How can individual Canadians be “trained” or given incentives which will help them to differentiate and discriminate between their true needs for health services and their desired demand?; and
- How can those who are currently perceived to be at the top of the health care power structure be persuaded to relinquish some of their power and to change the scope of practice rules so that a more efficient use of health services personnel can be achieved (where efficient means that a patient is always seen by a health care worker who is qualified to address the patient’s needs, and who will refer the patient when necessary to a differently qualified service provider if that is what the patient genuinely requires)?

The difficulty in addressing these issues is that the first two depend critically on the assumptions one makes about the timing and the precise nature of the progress which can be made on the last two issues.



## **Chapter 12**

### **Issues and Options for the Population Health Role**

A good health care system is only one of numerous factors that help keep people healthy. Some experts have suggested that only 25% of the health of the population is attributable to the health care system, while 75% is dependent on factors such as biology and genetic endowment, the physical environment and socio-economic conditions.

There is broad agreement that multiple factors – called “determinants of health” – influence health status. These include such things as income and social support; education; employment and working conditions; social and physical environments; personal health practices and coping skills.

The term “population health” is used to refer to the overall state of health of a population that is brought about by all these determinants of health. The objective of a population health approach is to ward off potential health problems before they require treatment within the health care system.

One of the key attractions of a population health approach is that it widens the framework for an understanding of why health status in Canada does not extend evenly to all Canadians. A wide range of health status indicators show significant disparities among Canadians in terms of geographical location, demographic factors, socio-economic conditions, gender differences and so on.

The 20<sup>th</sup> century revolution in health care significantly altered the pattern of diseases, with the causes of mortality shifting away from infectious diseases and towards non-communicable diseases (Section 12.1). Chronic diseases, such as cancer and cardiovascular disease, are now the leading causes of death and disability in Canada, while unintentional injuries are the third most important cause of death.

A number of health trends that affect young people in Canada are of great concern. These include, for example, overweight and obesity, eating disorders, incidence of smoking, illiteracy and low levels of psychological well-being (Section 12.2).

Disease issues are complex, but many chronic and infectious diseases, and most injuries, can be prevented. However, there has been a tendency to focus on curing diseases, rather than on preventing them, largely because of a lack of political will.

According to many experts, the most powerful influence on health is socio-economic status (section 12.3). Canadians with low incomes and low levels of education are more likely to have poor health, no matter which measurement of health is used, and, as levels

of income and education increase, people's health improves on virtually all scales of measurement and in terms of all of the factors that influence health.

The federal government's role with regard to health promotion and disease prevention is a well established one (section 12.4). Similarly, the federal government has been recognized as a leader worldwide in developing the concept of population health. It could, once again, show leadership in implementing a population health strategy for all Canadians.

Prevention efforts have to be tailored and flexible. There is no 'one size fits all' strategy (section 12.4.1). Comprehensive prevention and promotion strategies must therefore address the linkages between risk factors, as well as between health status and socio-economic, demographic, and environmental factors.

Strategies must also recognize the link between healthy communities and healthy citizens. Approaches that address several risk factors and that can produce multiple benefits include support for families at risk, comprehensive school health promotion programs, and comprehensive work health and safety programs.

The Committee is of the view that there are several key issues with regard to population health strategies that largely revolve around the difficulties associated with how to translate research evidence concerning the importance of these population health strategies into actual policy that can be implemented. In the first place, the multiplicity of factors that influence health outcomes means that it is exceedingly difficult to associate cause and effect, especially since the effects are often only felt many years after exposure to the cause.

Moreover, because of the diversity of the factors that influence health outcomes, it is very difficult to co-ordinate government activity in this regard. Given that the health care system itself is only responsible for a relatively small percentage of the actual determinants of health, responsibility for population health cannot reside exclusively with the various ministries of health. Yet the structure of most individual governments does not easily lend itself to inter-ministerial regulation of complex issues.

Although there are many difficulties associated with the development of an effective population health approach, the Committee believes that it is important for the federal government to continue to try to set an example by exploring innovative ways to turn good theory into sound practice that will contribute to improving health outcomes in Canada. There are two broad options the Committee would like to put on the table and to solicit comments from readers on them (section 12.4.2).

The first of these options concerns the federal responsibility for the delivery of health care services to Aboriginal Canadians (see also Chapter 13). The key idea is that in an area of clear federal responsibility it should be possible for the government to adopt an explicit

population health approach that would recognize the many factors that contribute to the deplorable health outcomes that are still the norm in many Aboriginal communities.

The second option would involve an even wider federal undertaking. Because of the very broad focus required to implement population health strategies, it is essential that a way be found to break down the ministerial silos that compartmentalize responsibility for policy outcomes and to screen all policy through a population health lens. One way of doing this would be to give responsibility to a 'Health Commissioner' (see also Chapter 10) for monitoring and reporting on the health impact of all federal government policy.

Finally, greater research is needed (section 12.4.3), particularly in certain areas. Often, money is spent without sufficient epidemiological research to guide where it is invested. In terms of chronic disease research, there is a lack of knowledge on how to use that information in the implementation of preventive strategies. In this respect, research is needed to determine how best to share health information with both providers and individual Canadians and, in particular, how best to target that information to those in lower socio-economic groups or those with poor literacy skills.

## **Chapter 13**

### **Issues and Options for the Service Delivery Role: Aboriginal Health**

There are significant health and socio-economic disparities between Aboriginal peoples and the general Canadian population (Section 13.1). In the view of the Committee, the health of Aboriginal Canadians is a national disgrace. If the Aboriginal population was enjoying a state of health similar to that of the overall Canadian population, Canada would probably stand as the healthiest country in the world. We certainly need to do a better job. The federal government must take a leadership role in working to immediately redress this situation.

Health care to Canada's Aboriginal people is delivered through a complex array of federal, provincial and Aboriginal-run programs and services (Section 13.2). Who delivers what to whom depends on a number of factors such as status under the *Indian Act*, place of residence (on or off-reserve), the location of one's community (non-isolated or remote) and whether Health Canada has signed an agreement to transfer the delivery of certain health services to an Aboriginal community or organization.

During Phase Two of its study, the Committee was told that status Indians under the *Indian Act* are a federal responsibility. The provision of hospital and physician services, however, is a provincial or territorial responsibility. Status Indians who reside on reserves are entitled to the general health services provided by the provinces and territories such as hospitals, physician services, and other insured services covered by provincial and territorial health plans. Health Canada, however, provides direct primary care and emergency services on reserves in remote and isolated areas where no provincial services are available. Regardless of residence (on or off-reserve), status Indians receive non-insured health benefits (NIHB) funded by the federal

government. These benefits include drugs, medical supplies and equipment, dental care, vision care, medical transportation, provincial health care premiums and crisis mental health counselling.

Provincial and territorial governments are responsible for delivering health services to the Inuit, but delivery of health services to Canada's Inuit population varies with jurisdiction of residence. In 1988, the federal government transferred responsibility for health administration to the Government of the Northwest Territories. With the creation of Nunavut, the Nunavut government assumed this responsibility for the Nunavut region. The federal government provides funds to the territorial governments to deliver health programs for status Indians and the Inuit including non-insured health benefits.

Métis and non-status Indians are not eligible for federal health programs. They receive medical services from provincial and territorial governments on the same basis as other Canadians. Métis and non-status Indians are not included under the *Indian Act*, nor are they eligible for non-insured health benefits funded by the federal government.

Overall, jurisdictional barriers to the provision of health services to Aboriginal people exist on two levels. The first barrier arises from the division of powers between the federal and provincial governments. The consequences of having two jurisdictions involved in delivering health services include program fragmentation, difficulties co-ordinating programs and reporting mechanisms, inconsistencies, gaps, possible overlaps in programs, lack of integration, the inability to rationalize services and impediments to developing a holistic approach to health and well-being.

The second jurisdictional barrier stems from the divisions among Aboriginal peoples that arise as a result of the *Indian Act*. Because Métis and non-status Indians are excluded from the legislation, they are not eligible for most federal programs. In the view of witnesses, this lack of recognition leaves the Métis and non-status populations in a jurisdictional void.

The option proposed in Section 13.2.1 is for the federal government to undertake, in collaboration with the provinces, territories and Aboriginal representatives of all groups, the development of a National Action Plan on Aboriginal Health to improve inter-jurisdictional co-ordination of health care delivery. A unique contribution of the federal Minister of Health could be to facilitate such co-ordination.

Section 13.3 discusses ways of ensuring adequate access to culturally appropriate health services for Aboriginal Canadians. A long-term strategy to increase the number of Aboriginal health care providers could be established by federal, provincial and territorial governments (Section 13.3.1). As part of this strategy, the federal government could provide the necessary resources to train Aboriginal Canadians across a wide range of disciplines.

A long-term strategy should also address training, recruitment and retention issues of emerging health career categories such as home care workers, early childhood educators, diabetes prevention workers, telehealth and systems development technicians, etc.

Tele-medicine could also play an important role in improving access to health services in Aboriginal communities (Section 13.3.2). In the context of remote and isolated Aboriginal communities, telemedicine offers the following advantages: it addresses the shortage of health care providers and medical training; it improves the health care infrastructure; it enables conformity with the accessibility principle of the *Canada Health Act*; and it ensures a more equitable development of health information systems across all regions of the country. The Committee welcomes opinions on how adequate access to culturally appropriate health services can be best achieved for all Aboriginal Canadians (Section 13.3.3).

Aboriginal peoples of all groups do not simply define health as the absence of disease (Section 13.4). They adopt a broader view of the concept of health (they talk about “wellness”) that encompasses the spiritual, physical, mental and emotional aspects of the individual. They explain that the various components of the overall state of health may be influenced by the social, cultural, physical, economical and political environments of a person. Aboriginal wellness emphasizes that solutions to health will not be effective until all factors having an impact on a problem are considered. Witnesses suggested that federal Aboriginal health policy must develop a greater focus on illness prevention, health promotion and a holistic approach to population health.

The federal government has been recognized as a leader worldwide in developing the concept of population health. Under the option discussed in Section 13.4.1, it would, once again, show leadership in implementing a population health strategy designed specifically for Aboriginal Canadians. Such a strategy should include dealing with economic conditions, environmental issues such as clean and safe drinking water, high quality and culturally appropriate health care, healthy lifestyle choices, etc. Investing in such activities will improve the health status of Aboriginal peoples and reduce the suffering and costs that result from poor health. This option would require extensive and ongoing inter-departmental collaboration. The federal Minister of Health could act as a leader.

The federal government should also set a valuable example by establishing a permanent mechanism for reporting to the Canadian public on the impact of all its policies and programs aimed at Aboriginal health. This could be the first step towards federal accountability for its overall health policy. We welcome any suggested options for an effective federal accountability mechanism with respect to Aboriginal health (Section 13.4.2).

During the hearings on Aboriginal health, witnesses pointed out the importance of undertaking research on the health of Aboriginal peoples as a means to provide useful information on how to improve health services delivery and health outcomes (Section 13.5). They welcomed the new Institute on Aboriginal Health within the CIHR and stressed that it is essential that it be provided with a sufficient level of funding. In their view, the diversity of the

various groups within the Aboriginal population must be reflected in health research activities. In addition, funding should be allocated to research activities that explore various models to obtain evidence-based information on how to design and deliver programs that affect Aboriginal health.

Given the diversity of Aboriginal peoples and given their unique health and health care needs, it is essential to involve their communities in the renewal of federal policies and programs affecting Aboriginal health (Section 13.6). We heard that the most successful programs leading to healthier outcomes are those based on significant input from the members of the involved community. The Committee would like to obtain suggestions on the most appropriate process to involve Aboriginal Canadians in designing, developing, implementing and assessing federal programs and policies aimed at Aboriginal health.

## **Chapter 14**

### **Conclusion**

For Canadians, our publicly funded health care system is a key distinguishing characteristic of our country. In fact, it has achieved iconic status. It is perceived to reflect Canadian values and these are seen to stand in sharp contrast to the values of our American neighbours.

Medicare is based on the belief that Canadian society should collectively share the risks, and the consequences, of illness and injury to individual Canadians. Before Medicare, these were largely borne by the sick or injured themselves, their families, or various charitable organizations. Canadians' attachment to a sense of collective responsibility for the provision of health care has remained largely intact despite a shift towards more individualistic values that has, in recent years, led to broader changes in society.

Health care is also seen in Canada as very much a public good, in spite of the fact that more than 30% of total health care costs are paid out of private funds. It is a public good also in the sense that Canadians look to government, both federal and provincial, to guarantee the services to which they feel entitled.

One might expect that given the importance of the health care issue in the collective psyche of Canadians, and in the political life of the country more generally, that an ongoing, thoughtful, discussion of health care issues would be the norm. Unfortunately, the opposite is true.

Faced with this situation the Committee decided from the outset that it would provide a useful public service if it could produce a report that outlined the major issues facing Canada's health care system and presented a set of potential options for addressing them. Moreover, it envisaged this report as being factual and non-ideological. Also, the Committee strongly believes that it was essential not to foreclose discussion of any option *a priori*. This is what the Committee hopes it has achieved with this report.

We recognize that our set of issues is not exhaustive, and that many readers of this report will want to add to the issues list. Similarly, there are those who will feel that our set of options is not complete, and they will want to add new options of their own. We very much welcome these additions to our work. We believe that they will help to further the Committee's objective of being a catalyst for informed public debate on health care issues.

Above all, we hope that individual Canadians – the people who most benefit from Canada's Medicare system and the people who will be most affected by any changes that are made to it – will take the time to write to the Committee, and give us their views on which options they prefer, and why. We very much look forward to receiving the guidance of Canadians as we prepare our final report and our own set of recommendations.

Please write to:

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# CHAPTER ONE:

## INTRODUCTION

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In December 1999, during the Second Session of the Thirty-Sixth Parliament, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the state of the Canadian health care system and to examine the evolving role of the federal government in this area. The Senate renewed the mandate of the Committee in the First Session of the Thirty-Seventh Parliament. The terms of reference adopted for the purpose of this study read as follows:

*That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:*

- (a) The fundamental principles on which Canada's publicly funded health care system is based;*
- (b) The historical development of Canada's health care system;*
- (c) Publicly funded health care systems in foreign jurisdictions;*
- (d) The pressures on and constraints of Canada's health care system;*
- (e) The role of the federal government in Canada's health care system.<sup>1</sup>*

In response to this broad and complex mandate, in March 2001, the Committee re-launched its multi-year and multi-faceted study comprising five major phases. Table 1 provides information on each individual phase and their respective timeframes.

**TABLE 1**  
**HEALTH CARE STUDY:**  
**INDIVIDUAL PHASES AND PROPOSED TIMEFRAMES**

Phase	Content	Timing
One	Historical Background and Overview	Winter/Fall 2000
Two	Future Trends, Their Causes and Impact on Health Care Costs	Fall 2001
Three	Models and Practices in Other Countries	Fall 2001
Four	Development of Issues and Options Paper	Fall 2001
Five	Hearings on Issues and Options Paper and Development of Final Report and Recommendations	Fall 2001/Winter 2002

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<sup>1</sup> Debates of the Senate (Hansard), 2<sup>nd</sup> Session, 36<sup>th</sup> Parliament, Volume 138, Issue 23, December 16, 1999.

This report constitutes volume four of a series of five reports by the Committee on the health of Canadians and on the federal role in health and health care. In this report, the Committee identifies key public policy issues with respect to the role of the federal government and presents a set of potential options for addressing these issues. In the Committee's opinion, federal and provincial policy makers, health care stakeholders, and the Canadian public should all consider these issues and options, given that they relate to the long-term sustainability of Canada's health care system.

During October and November 2001, the Committee intends to hold extensive public hearings across the country on the issues and options presented in this report. More precisely, the Committee will hold hearings in Vancouver, Edmonton, Regina, Winnipeg, Toronto, Montreal, Fredericton, Charlottetown, Halifax and St. John's. Then, in January 2002, the Committee will present its fifth and final report in which it will summarize the key findings obtained during these public hearings and present the Committee's recommendations for addressing the public policy issues presented in this report.

The issues and options discussed here have been developed on the basis of the evidence presented to the Committee during the first three phases of its study on health care. The evidence garnered from hearings with expert witnesses has been presented in great detail in the Committee's first three reports on the role of the federal government in health and health care:

- The first report recounts the history of how the federal government helped the provinces to fund hospital and physician care. It focuses in particular on the initial objectives of the federal government's involvement in health care and raises some questions about the future role of the federal government in light of the changing health care environment (e.g. increased recourse to drug therapy, hospital out-patient services, home care and community care). This first report also traces the evolution of health care spending and health indicators over the past several decades. Finally, it looks at a number of the myths that are still current concerning the delivery and financing of health care in Canada and clarifies the reality surrounding each of these myths. The objective of the first report was to provide factual information as well as to clarify the major current misconceptions that recur in the health care debate in Canada.
- The second report reviews the major trends that are having an impact on the cost and the method of delivery of health services, and the implications of these trends for future public funding. In particular, the report focuses on the pressures associated with the changing demographics of the Canadian population, the increasing use and growing cost of drugs and technology, and developments in the delivery of health services (e.g. the increased use of out-patient, home care, telehealth). This report also considers issues surrounding health research, health human resource planning (including the shortage of health care providers), rural health, disease trends and the health of Canada's Aboriginal population. Finally, it examines how a health info-structure could help improve the delivery of health services in the future.

- The third report describes and compares the way that health care is financed and delivered in several other countries (Australia, Germany, the Netherlands, Sweden, the United Kingdom and the United States), and the objectives of national government health care policy in those countries. It highlights those policies and reforms from which Canada could learn. The report also examines briefly the operation of medical savings accounts systems (MSAs) in Singapore, South Africa, the United States and Hong Kong.

The Committee learned a great deal in the course of the first three phases of its study and it has shared its findings in the three reports referred to above. The Committee hopes that people will consult the first three reports as background to the discussion of the policy options that are the focus of this fourth report.

However, the Committee feels it is useful to highlight a number of the conclusions it has drawn from its study to date, as these help set the stage for the next phase of the Committee's work. The following section summarizes some of the main findings and observations from the first three phases of its study.



## CHAPTER TWO:

### SUMMARY OF MAIN FINDINGS AND OBSERVATIONS FROM PHASES ONE, TWO AND THREE

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#### 2.1 Main Findings and Observations from Phase One

- The definition of “medically necessary services” that guarantees Canadians access only to health services provided by doctors or in hospitals, no longer allows health services to be delivered in a way that corresponds to the reality of the 21<sup>st</sup> century health and wellness needs of the Canadian population, nor does it even fully reflect the range of services that are actually covered under the different provincial health care insurance plans.
- The more services we include in the definition of “medically necessary”, the more costly the public health care system becomes. Broadening this definition raises the question of how these services should be paid for, and how excessive costs can be prevented. The question of precisely what services should be covered by government, what services should be paid for by employers, and what services should be paid for by individuals out of their own funds, either partially or fully, directly or through private insurance, is one that requires full public debate.
- Canadians have opted for universal public health care insurance on the grounds of compassion, equity and fairness. The patient-centred principles of the *Canada Health Act* continue to express fundamental values of Canadian society. In fact, the Act has now attained iconic status.
- The mechanism of a single payer to achieve the four patient-oriented principles of the *Canada Health Act* appears to be sound. The underlying principle of “public administration,” however, is not as well understood and may need to be revisited in light of developments in the delivery of health services.
- Only on three occasions has the federal government resorted to financial penalties and reduced its transfers to some provinces that were permitting extra-billing or imposing user charges. However, the federal government has never applied the discretionary penalties for failure to comply with the five principles of the *Canada Health Act*, despite periodic complaints regarding portability, comprehensiveness and accessibility.
- Private spending already accounts for a significant and increasing proportion (approximately 30%) of total health care spending in Canada. The structure of the Canadian Medicare

system, with its focus on physician and hospital costs only, has contributed noticeably to this situation.

- Provincial governments are already devoting on average over one-third of their overall budget to health care; hence, the provinces have insisted on the necessity for stable and predictable federal transfers. Experts, however, agree that the need for a more stable formula for federal funding must be balanced against concerns of adequacy, affordability and sustainability as they affect both levels of government. Moreover, spending more public money on health care could mean that less was available for investment in non-medical areas that also greatly affect health.
- Canadians remain deeply attached to their health care system, and want governments at all levels to address their growing concerns about its long-term viability and sustainability, and in particular, they want government to ensure more timely access to health services.
- The federal government has played, and continues to play, a crucial role in promoting the health of Canadians and in financing the health care system. The issue is not whether there is a role for the federal government, but rather how the current federal role should change to adapt to contemporary realities in order to help guarantee the long-term sustainability of a high quality health care system.
- Changing public expectations have already had a major impact on the shape of Canada's publicly funded health care system, moving it away from its origins as public insurance against catastrophic medical costs towards a system that is under constant pressure to continuously expand the set of services that are expected to be provided "free" to the consumer. Dealing with expanding public expectations is thus a major challenge facing anyone who wants to reform the system.

## **2.2 Main Findings and Observations from Phase Two**

- Cost pressures on the system are real and multidimensional. They are likely to continue to grow with the introduction of new and more expensive drugs and technology, and especially over the next 20-30 years as the peak of the baby boom generation ages. It is therefore important to focus on these cost pressures as we think about how to sustain and renew Canada's health care system.
- The economic burden of illness has been estimated at \$156 billion for Canada in 1998 (both direct and indirect costs). Trends in diseases and injuries can therefore have a significant impact on current and future costs of health care. It has been strongly suggested that increasing efforts in the area of health promotion and disease prevention, with a particular focus on Canadians with low incomes and low levels of education and literacy, should be key areas in public policy if we are to improve overall health status and contain health care costs.



- While many Canadians enjoy high levels of health, and although Canada ranks well above most other countries in terms of the majority of health status indicators, there is definitely room for improvement. There remain disparities in health associated with age, socio-economic conditions, gender, geographic location, and so on. The health status and the socio-economic conditions of the Aboriginal population in Canada is particularly deplorable.
- Enhancing the health of Canadians involves more than just curing illness. There are many complex determinants of health that interact with one another, and fostering well-being means finding ways to take them all into account. Since a multiplicity of factors determines the health of a population, there is clearly a need for collaboration and intersectoral action.
- While women provide more than 80% of the paid and unpaid health care, they are only a minority of the policy and management decision makers. This means that there is a particular need to assess the consequences of health care reforms on women.
- Canada's health care system is already having difficulty attracting and training the personnel it needs in many disciplines (in the context of a growing world-wide shortage of health care human resources). Given the relative labour intensity of the health care sector, the human resource problem is more critical than any other single problem facing the system. As well, we are experiencing real problems in keeping up with the introduction of new, but very expensive, drugs and technologies that Canadians rightly expect to be made available to meet their health care needs.
- Canada needs a robust, integrated and proactive health research sector. However, Canada does not compare favourably with its major competitors in terms of the amount of public funding devoted to health research. The role of central governments in the United States, the United Kingdom, France and Australia in financing health research, expressed in purchasing power parity (PPP) per capita, is much greater than it is in Canada.
- It is generally agreed that rapid advances in genetics and genomics will revolutionize health care delivery in unprecedented ways. This points to the need for multidisciplinary research that will examine the societal costs, benefits, ethical considerations and potential unintended impact of advances in genetic and genomic research.
- We must move away from only tracing dollars and inputs in health care and move towards linking these inputs to health outcomes. We need to start measuring the quality and effectiveness of the health care system by its outputs, not exclusively by its inputs. This is essential if we are to know how to spend government funds more wisely in the future.
- The development of a pan-Canadian health infostructure would lay the foundation for evidence-based decision-making in areas that affect the delivery of health care and the well-

being of the population. An infostructure would also enhance the accountability of all players involved in the health care system – governments, providers, and patients. Canada is currently seriously deficient in this area and it is imperative to foster and maintain our capacity to manage health information.

### **2.3 Main Findings and Observations from Phase Three**

- Proposals for a “big bang” overhaul of Canada’s health care system are unlikely to achieve widespread consensus. Nonetheless, major changes may be needed if the hopes and aspirations of Canadians are to be met.
- No single international model constitutes a blueprint for solving the challenges confronted by the Canadian health care system. Moreover, experts told the Committee that careful consideration must be given to the repercussions in Canada of introducing, on a piecemeal basis, changes undertaken in other countries. However, health care systems do share common features and face similar problems and pressures. Canada can learn a great deal from the experience gained elsewhere.
- Many countries with a similar share of public health care spending provide coverage that is much broader than Canada, encompassing such items as prescription drugs, home care, and long-term care. This has usually been achieved with the participation of the private sector either through the imposition of user charges or the involvement of private insurance.
- No single OECD country relies exclusively on private insurance to provide health care coverage to its citizens. Even in the United States, where the private sector is a dominant player in the field of health care insurance, public funding accounts for 45% of total health care spending. The fact is that health care is different from other marketable goods and services.

## CHAPTER THREE:

### THE ROLE OF THE FEDERAL GOVERNMENT: AN OVERVIEW

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Before proceeding to the discussion of issues and options with respect to the role of the federal government in health and health care, it is important to understand what the role of the federal government is, and equally what it is not. As pointed out in the Committee's first report, a considerable mythology has developed around the federal government's role. The Committee believes that, currently, there are five distinct federal government roles in health and health care. These are outlined in the table below:

FIVE DISTINCT FEDERAL ROLES IN HEALTH AND HEALTH CARE
<b>FINANCING ROLE:</b> <i>the transfer of funds for the provision of health services administered by other jurisdictions</i>
<b>RESEARCH AND EVALUATION ROLE:</b> <i>funding innovative health research and evaluation of innovative pilot projects</i>
<b>INFRASTRUCTURE ROLE:</b> <i>support for the health care infrastructure and the health infostructure, including human resources</i>
<b>POPULATION HEALTH ROLE:</b> <i>health protection, health and wellness promotion, illness prevention, and population health</i>
<b>SERVICE DELIVERY ROLE:</b> <i>the direct provision of health services to specific population groups</i>

#### 3.1 The Transfer of Funds for the Provision of Health Services Administered by Other Jurisdictions: The Financing Role

By far, the most well known role for the federal government involves the funding it provides to the provinces and territories to help them carry out their responsibilities with respect to health care delivery. Federal involvement in health care delivered by the provinces stems essentially from its constitutional spending power. This power is the basis for the transfer of funds under the Canada Health and Social Transfer (CHST) and for the enforcement of the conditions of the *Canada Health Act*.

Strictly speaking, the federal government cannot establish and maintain a national health care insurance plan because it cannot regulate the delivery of health care to individuals: under the Canadian Constitution, as interpreted by the courts, health care delivery and management is a field primarily under provincial jurisdiction. The federal government is responsible for the actual delivery of health services only to groups that fall under its jurisdiction, such as Aboriginal peoples, the Canadian Forces, veterans, and inmates in federal penitentiaries. This leaves provincial and territorial governments with the responsibility for determining such central matters as how the overall system will be organized, the administration of their public

health-care insurance plans, determining how many hospital beds will be available, and what categories of health care providers will be hired. It is also the responsibility of provincial and territorial governments to approve hospital budgets and to negotiate fee scales with the medical associations.

Although the federal government is not responsible for health care administration, organization or delivery, it exerts considerable influence on provincial/territorial health care policies by using the political and financial leverage afforded by its constitutional spending power. In fact, many analysts believe that by setting the requirements for providing federal funding, the *Canada Health Act*, and its precursors, have to a large extent shaped provincial health care insurance plans throughout the country.

The issues relating to the federal role in financing health care concern the level of federal transfers for health care, the mechanisms used to execute them and the sources of the revenue that are used to generate them. Other related issues touch on what conditions, if any, the federal government should impose on the provinces in return for federal contributions to health care delivery.

Note that, contrary to popular perception, the *Canada Health Act* does not cover all health services. It only covers services provided by two health care delivery systems – hospitals and doctors – from among a number of other delivery systems. In particular, it does not cover two other delivery systems, namely drug therapy outside hospitals and home care, that have grown enormously in importance since Medicare began. Although provinces and territories have expanded the array of services insured under their public health care plans, they have not done so uniformly. As a result, public coverage for services not included under the *Canada Health Act* varies greatly among provinces and territories.

Although long-term care and nursing-home care are mentioned in the *Canada Health Act* under the definition of “extended health care services”, the five principles of the Act do not apply to them. This has contributed to a lack of uniform access to these services across the country.

This situation prompted the important observation made in the Committee’s Phase One report that the concept of “medical necessity” as defined in the *Canada Health Act* no longer reflects the reality of the variety of delivery systems that provide health care to Canadians.

### **3.2 Funding Innovative Health Research and the Evaluation of Pilot Projects: The Research and Evaluation Role**

This second role for the federal government has two dimensions. It involves funding all areas of health research (basic biomedical research, clinical research, health services research, and population health research) as well as the financing of pilot projects designed to

test and evaluate new models of health care delivery and approaches designed to improve Canada's health care system.

For over 40 years the federal government has contributed to the financing of health research. In fact, up until 1994, the federal government was the main source of funding for health research in Canada. The Canadian Institutes of Health Research (CIHR) is currently the principal federal funding body for health research.

From time to time, the federal government also fulfils its role in health research by giving financial support for initiatives, or pilot projects, that are designed to encourage innovation in health care delivery. The \$800 million the federal government agreed to contribute to primary care reform, as part of the federal/provincial agreement of September 2000, illustrates this role. Other examples include grants under the Health Transition Fund (1997-2001), which supports pilot projects undertaken jointly with provincial and territorial governments in the fields of Pharmacare, home care, primary care and integrated service delivery, as well as the Canada Health Infostructure Partnerships Program (2000-2002) which supports provincial and territorial projects using new information technology in health care.

### **3.3 Support for the Health Care Infrastructure and the Health Infostructure: The Infrastructure Role**

A third federal role involves contributions to the health care infrastructure. This involves financing improvements to the health care system as a whole, as opposed to helping fund physicians and hospitals whose services are directed to individual patients.

The Hospital Construction Grants Program of 1948 provides an early but significant example of this role. Under this program, the federal government paid the full cost of building hospitals in every province and territory. As a result, from 1948 to 1960, the number of hospital beds in Canada increased at a rate that was twice that of population growth.

Another important example of federal support to health care infrastructure is provided by federal funding for health information systems designed to enable health care providers to make better informed decisions (through, for example, the development of electronic patient record systems). Support given to the provinces through funding that is targeted towards specific goals, such as the acquisition of health care technology provided under Bill C-45 (October 2000), is another example of federal funding aimed at health care infrastructure.

If the federal government were to decide to develop (or help to develop in co-operation with the provinces) structures and processes to ensure greater accountability in the health care system, this too would fall under the federal government's role in health care infrastructure. Similarly, the publication of an annual report by the federal government on the

health of Canadians and on the quality and efficiency of the health care delivery system, along with recommendations for improvements, would be a federal contribution to improving the accountability of the system.

### **3.4 Health Protection, Health and Wellness Promotion and Disease Prevention: The Population Health Role**

A fourth role for the federal government encompasses health protection, health and wellness promotion and disease prevention. Health protection includes activities such as food legislation, the approval of drugs and devices, environmental protection, the regulation of biotechnology, and disease surveillance. Health and wellness promotion as well as disease prevention stand in contrast to the first federal role which focuses on the treatment of illness. This role involves encouraging Canadians to adopt healthier lifestyles, and takes into account the impact of the broader determinants of health on the health of the population.

The best known examples of the federal role in the fields of promotion and prevention include campaigns to reduce tobacco consumption; the Canada food guide which promotes healthy eating habits; campaigns that target youth with information about the danger of sexually transmitted diseases; Heart Health, a multi-level and multi-year strategy for the prevention of cardiovascular disease; and Active Living, a program designed to encourage Canadians to lead a more active, less sedentary, lifestyle.

The federal role related to the promotion of good health and well-being also encompasses consideration of the broader determinants of health which lie mainly outside the realm of health care delivery, using what are often called “population health strategies”. These strategies are based on the fact that health status can be improved by investing in a variety of fields – including the environment, economic policy, income support, education, literacy, etc. – where the federal government plays a role.

There are many critical trade-offs that must be made between the population health and the financing roles. For example, studies suggest that health promotion and disease prevention programs can bring substantial long-term benefits, in terms of reduced cost for the health care system and improved quality of life for Canadians. Thus, experts argue that it might be possible to achieve a better return on the health care dollar by promoting healthier lifestyles for Canadians than by spending the same amount of money on the treatment of illness.

Similarly, evidence suggests that investing in population health strategies, such as early childhood development, improved housing conditions and enhanced literacy capabilities, can generate more benefits in the long run in terms of overall health status than would spending more on health care delivery. Yet, for a variety of reasons, there is significant public pressure on the federal government to focus overwhelmingly on its first role, often to the neglect of its population health role.

### **3.5 The Direct Provision of Health Services to Specific Population Groups: The Service Delivery Role**

A fifth role played by the federal government lies in the direct provision of a variety of health services to particular population groups. The federal government is responsible for the provision of health care, including primary care, to First Nations and the Inuit communities, and some health services to the RCMP, Correctional Services, the Armed Forces and veterans. Indeed, the federal government delivers health services to more Canadians (approximately three quarters of a million) than several provinces do. Later in this report the Committee raises specific issues with respect to the delivery of health care to Aboriginal Canadians and suggests potential public policy options for addressing those issues.

Beginning with Chapter 7 of this report, a series of public policy issues and options for addressing them are presented. Each issue stems from one or more of the five federal roles outlined above. First, however, we turn to a discussion of what the public policy objectives with respect to each of the above five federal roles ought to be.





## **CHAPTER FOUR:**

### **THE ROLE OF THE FEDERAL GOVERNMENT: OBJECTIVES AND CONSTRAINTS**

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It is important to develop a coherent vision for the role of the federal government in fostering the health and well-being of Canadians and in financing the health care system. The continued involvement of the federal government is essential to the renewal of public policy in this area. The Committee's third report on comparative health care systems suggests that it is very unlikely that a "big bang" approach to health care renewal would work in Canada. Therefore, the focus of any vision for the federal government's role in health and health care needs to include a set of public policies and programs that could be implemented incrementally in collaboration with the provinces, territories and all stakeholders.

The broad objectives for the federal role in health care and wellness promotion form the necessary backdrop to choosing which option is best suited to addressing each of the policy issues presented in later sections of this report. The choice of one option over another necessarily implies that one is "better" than the other. "Better" in this context can only be evaluated in relation to outcomes measured against a specific public policy objective.

Therefore, the Committee believes that it would be useful to articulate the set of proposed objectives for each of the roles for the federal government that were described in the previous section. The Committee recognizes that some people may prefer a different set of objectives, and that is as it should be. There are many differing views on what federal policy objectives, and hence federal policy, should be.

The Committee welcomes opinions on its set of public policy objectives, issues and options and wants to hear about other options and their related objectives. Nevertheless, by proposing its own set of public policy objectives, the Committee hopes that it will encourage everyone who wants to argue for specific policy options also to state as clearly as they can what they believe the objectives of federal health policy should be. This will help the Committee to better understand the linkages between the various proposed policy options and specific sets of policy objectives as it formulates its final recommendations.

#### **4.1 Objectives for the Financing Role of the Federal Government**

The federal government's involvement in the financing of health care has a long history. It is clear that without federal funding Canada's health care system would not be what it is today. Federal transfers to the provinces and territories have been essential to the development of a system of public health care insurance plans across the country that offer comparable benefits, and many Canadians believe that federal funding is essential to the

maintenance and renewal of our health care system. Therefore, the Committee proposes that the first objective of the federal financing role be to provide a level of funding that ensures the sustainability of Canada's health care system and that fosters health care reform and renewal.

During the initial phase of its study, Tom Kent pointed out to the Committee that the original objectives of the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1966) were the following:

“To ensure that every Canadian had access to all medically necessary services regardless of their ability to pay for those services.”

and

“To ensure that no Canadian suffered undue financial hardship as a result of having to pay health care bills.”

These public policy objectives were reaffirmed in the *Canada Health Act* of 1984 through its four patient-oriented principles: universality, comprehensiveness, accessibility, and portability, where:

1. Universality means every Canadian;
2. Comprehensiveness means all medically necessary services;
3. Accessibility means regardless of the patient's ability to pay;
4. Portability means that patients can move from one province to another without facing a gap in coverage.

The Committee proposes that the two statements given above continue to be the primary policy objectives for the financing role of the federal government, and that the four patient-oriented principles remain the foundation of federal involvement with respect to the first role of the federal government. This does not necessarily mean that the principles cannot in any way be modified – some may require further refinement through a more precise definition and a clearer articulation of their scope and limits.

The final principle of the *Canada Health Act* – the principle of public administration – is of a completely different character. It does not focus on the patient but is rather the means of achieving the ends to which the other four principles are directed. In the view of the Committee, this distinction between ends and means explains much of the current debate about the *Canada Health Act* and Canada's health care system. People who agree completely with the desired ends of a public policy can nevertheless disagree strongly on the means of achieving those ends. The principle of public administration is not well understood and, in our view, might need to be revisited.

Since the inception of the *Canada Health Act*, on a number of occasions the federal government has imposed financial penalties to discourage provinces from allowing extra-

billing and user charges, but it has never penalized provinces for non-compliance with the five principles. According to the November 1999 report of the Auditor General of Canada, there are outstanding cases of non-compliance, involving the patient-oriented principles of portability, comprehensiveness and accessibility.<sup>2</sup> Clearly, then, there are problems in interpreting those principles and in enforcing them. These issues must be resolved if we are to have a system that is focussed on the patient and that is uniform across the country.

In considering health care policy issues, it is important to keep in mind that federal legislation restricts the universality of coverage to health services provided in hospitals and by doctors. This was a logical way to meet patients' needs in the late 1950s and 1960s since nearly hospitals and doctors then provided 70% of the cost of the entire health care system. Today, however, less than 45% of total health care spending is attributable to hospital care and physician services.

During the late 1950s and 1960s, the only major channel for the delivery of health care services, other than doctors and hospitals, was nursing homes. Since the federal government was already contributing to senior citizen incomes through the Canada Pension Plan (CPP), the Old Age Security program (OAS), and the Guaranteed Income Supplement (GIS), it was felt that access to these services was being adequately ensured through those programs.

Today, home care, drug therapy, and treatment by other health care professionals (e.g. physiotherapists, diagnostic technicians, midwives, nurse practitioners, occupational therapists, etc.) have become commonplace, yet when they are delivered outside the walls of a hospital, these services are not eligible for coverage under the *Canada Health Act*. This has created a situation where publicly funded access to these services, many of which are frequently medically necessary, is not offered in a uniform way across the country, when it is offered at all.

In short, a number of trends, combined with public expectations, have overtaken the original design of the system. Making the distinction between that which is formally covered under the *Canada Health Act* and the actual array of services that are required to meet the total health care needs of Canadians is critical to the development of future public policy. However, this distinction is not made in the vast majority of public commentary on the current system. Most commentators still speak as if patients are assured uniform publicly funded access to *all* health services under the *Canada Health Act*.

In addition, the *Canada Health Act* is misunderstood to mean that there should be no role for the private sector in delivering health care. This is clearly not prohibited, nor was it intended to be prohibited, by the *Canada Health Act*. The clearest possible illustration of this fact is that over 95% of Canadian hospitals are operated as private not-for-profit entities and that doctors operate, in effect, as private businesses.

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<sup>2</sup> Auditor General of Canada, *Federal Support of Health Care Delivery*, Chapter 29, November 1999.

When the hospital care and medical insurance plans were started, two significant decisions were made with respect to the method by which these programs would be funded and delivered:

1. No means test would be required of patients *before* they received medical services. This decision was made because it was felt that a means test would discourage low income patients from seeking medical assistance, since they would feel it was demeaning to have to say they were “poor” in order to receive full medical care.
2. A central provincial department or agency would administer the program in each province. This decision was made in order to have the hospital care and medical insurance plans gain the efficiencies of a “single payer” model. (This “single payer” aspect is reflected in the principle of public administration enshrined in the *Canada Health Act*). Public administration as a principle is often misunderstood to mean that in the current system a role for the private sector in the delivery of health care is prohibited. That is not the case.

One final point is worth observing. When public funding for hospital and physician services began, the underlying principle was that they would be insurance plans in which individuals might be expected to pay part of the cost of the health services they received. However, as explained in point 1 above, no such payment could be required up front, at the point of service, since it might discourage low income Canadians from seeking medical care.

This is why the 1957 Act was called the *Hospital Insurance and Diagnostic Services Act* and why some provinces (e.g. Alberta and British Columbia) have for many years charged their residents annual health care premiums. It is also why the original Liberal Party policy resolution at its 1961 convention proposed that the cost imposed on the health care system by receiving treatment would be added to everyone’s taxable income at the end of each year, and income tax would be paid on part of that amount (subject to a maximum in order to avoid undue financial hardship).

The Committee makes these observations in order to encourage Canadians to “think outside the box.” For example, if one concludes that additional funds are needed to provide health care, particularly to people who otherwise do not receive services such as drug therapy and home care, then it might be important to consider such options as a health care premium, or some form of post-service income graduated payment.

## **THE TRANSFER OF FUNDS FOR THE PROVISION OF HEALTH SERVICES ADMINISTERED BY OTHER JURISDICTIONS**

*The Committee proposes that the objectives of the federal government's financing role in health and health care should be:*

- *To provide a stable level of funding that ensures the sustainability of Canada's health care system and that fosters reform and renewal;*
- *To ensure that every Canadian has timely access to all medically necessary services regardless of their ability to pay for those services;*
- *To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills;*
- *To ensure that the four patient-oriented principles of the Canada Health Act (universality, comprehensiveness, accessibility, and portability) are applied.*

### **4.2 Objectives of the Research and Evaluation Role for the Federal Government**

The Committee believes that the following three objectives ought to apply to the research and evaluation role of the federal government:

- To foster the development of a solid base of innovative health research in Canada that compares favourably with that of other countries in terms of both health research funding levels and health research outcomes;
- To encourage the foundation of a knowledge-based health care sector by facilitating the transfer of knowledge from the research community to public policy makers, health care providers and the general public;
- To provide appropriate financial support for joint federal, provincial and territorial initiatives that will encourage and facilitate innovation and advancement in health care delivery through pilot and evaluation projects.

In proposing these objectives the Committee recognizes that they are relatively non-controversial. Indeed, the federal role in health research has existed for over four decades. The main concern raised in this regard during the Committee hearings was that Canada's expenditures on health research were low in comparison with other industrialized countries. It was recommended that the federal share of total spending on health research should be increased to 1% of total health care spending from its current level of 0.5%. In the view of several witnesses who testified before the Committee, this would bring the level of the federal contribution to health research more in line with that of central governments in other countries.

Similarly, federal support for reform of the primary care sector that was announced as part of the federal/provincial agreement in September 2000, is an excellent

example of action being taken in relation to the second objective listed above. The Health Transition Fund (1997-2001), a federal initiative supporting provincial and territorial pilot projects in fields such as integrated service delivery, is another good example of federal government intervention as part of its research and evaluation role. These programs are well accepted by provincial governments and enhance our understanding of the impact of reform in health care delivery.

#### **FUNDING INNOVATIVE HEALTH RESEARCH AND EVALUATION OF INNOVATIVE PILOT PROJECTS**

*The Committee proposes that the following objectives should apply to the second role of the federal government:*

- *To foster the development of a solid base of innovative health research in Canada that compares favourably with that of other countries;*
- *To encourage the foundation of a knowledge-based health care sector by facilitating the transfer of knowledge from the research community to public policy makers, health care providers and the general public;*
- *To provide appropriate financial support for joint federal/provincial/territorial initiatives that will encourage and facilitate innovation and advancement in health care delivery through evaluation of pilot projects.*

### **4.3 Objectives of the Infrastructure Role for the Federal Government**

The Committee proposes the following objectives for the third federal role in health and health care:

- To lay the foundation for evidence-based decision-making in areas that affect both well-being and the delivery of health care, while ensuring the protection of privacy, confidentiality and security of personal health information;
- To monitor the health of the population and the state of the health care system and to report these findings to Canadians;
- To develop, in collaboration with the provinces and territories, an appropriate structure and process to ensure greater accountability in the system;
- To assist provinces and territories in financing needed health care infrastructure, such as new medical technologies and the costs related to their ongoing operation;
- To co-ordinate, in collaboration with the provinces and territories, the planning of human resources in health care.

The first objective under this federal role relates to the development of a health infostructure. The health infostructure that has already been envisioned by the federal government will enhance health care delivery and allow for the sharing of health-related information by connecting health care providers, facilities, communities and patients across the country to. Telehealth, electronic health records and Internet-based health information will be the main building blocks of the pan-Canadian health infostructure. This is certainly an ambitious and costly undertaking which will take years to bring into being. Most experts believe, however, that it is essential to do so if we wish to acquire sound information on the health of Canadians, the state of our health care system, and on the efficiency and effectiveness of health service delivery and distribution. Privacy, confidentiality and security issues are of paramount importance in the development of a Canadian health infostructure.

The second and third objectives given above may well be more problematic for some people who feel that there should be no role for the federal government with regard to establishing the accountability of provincially delivered programs. The Committee rejects this view. We believe that, given the substantial amount of money the federal government contributes to the provinces for health care delivery, accountability to federal taxpayers requires that the government understands how well, or how poorly, their contributions are being spent.

In addition, the Committee believes that making available to Canadians the information that is necessary to enable them to compare the performance of the health care delivery systems across the country can only contribute to enhancing the overall quality of Canada's health care system. The affirmation of a role for the federal government in this regard is not meant to tread on provincial prerogatives, but rather to allow all Canadians to judge how their tax dollars are being spent, including by the federal government in its role of provider of services to specific population groups.

The last objective the Committee wants to propose for the infrastructure federal role would help ensure that Canadians have timely access to medical equipment and that sufficient resources are provided to cover operation and maintenance costs.

#### **SUPPORT FOR THE HEALTH CARE INFRASTRUCTURE AND THE HEALTH INFOSTRUCTURE**

*The Committee proposes that the following five objectives should apply to the third role of the federal government:*

- *To lay the foundation for evidence-based decision-making in areas that affect both well-being and the delivery of health care, while ensuring the protection of privacy, confidentiality and security of personal health information;*
- *To monitor the health of the population and the state of the health care system and to report these findings to Canadian stakeholders;*
- *To develop, in collaboration with the provinces and territories, an appropriate structure and process to ensure greater accountability in the system;*
- *To assist provinces and territories in financing needed health care infrastructure, such as new medical technologies and the costs related to their ongoing operation;*
- *To co-ordinate, in collaboration with the provinces and territories, the planning of human resources in health care.*

#### **4.4 Objectives for the Population Health Role of the Federal Government**

During Phase Two of its study, the Committee held specific hearings on disease trends and was told that the pattern of diseases had changed significantly during the 20<sup>th</sup> century, shifting away from infectious diseases and towards non-communicable diseases. Chronic diseases such as cancer and cardiovascular disease are now the leading causes of death and disability in Canada, while unintentional injuries are the third most important cause of death. The overall economic burden of illness is significant in Canada: it was estimated at \$156 billion in 1998.

The Committee was told that many of the causes of disease, disability and early death are preventable, or at least deferrable, and that people should not only be able to live longer lives, but also to spend more of their lives disability free. It has been suggested that increasing efforts in the area of health promotion and disease prevention, with a particular focus on Canadians with low incomes and low levels of education and literacy, should become key areas of public policy if we are to improve the overall health status and contain health care costs.

The Committee believes that the federal government has an important role to play in the fields of health protection, health and wellness promotion and disease prevention. Accordingly, we believe that the following objectives ought to apply to the population health role of the federal government:

- With respect to health protection: to strengthen our national capacity to identify and reduce risk factors which can cause injury, illness, and disease, and to reduce the economic burden of disease in Canada;
- With respect to health promotion and disease prevention: to develop, implement and assess programs and policies whose specific objective is to encourage Canadians to live a healthier lifestyle;
- With respect to wellness: to encourage population health strategies by studying and discussing the health outcomes of the full range of determinants of health, encompassing social, environmental, cultural and economic factors.

The Committee recognizes that there are important difficulties associated with the evaluation of health outcomes, because many factors, and not only the quality of the available health services, affect an individual's state of health. These factors often take many years to manifest themselves, and it is well known that the political world responds much more readily to shorter-term than to longer-term concerns. It is also a very complex matter to locate the precise factors that lead to specific health outcomes, since these are often the result of the interaction of multiple causes.

But there is also considerable evidence that health promotion, illness prevention and policies that are concerned with the overall well-being of the population improve health



outcomes, and may also contribute to a more effective deployment of health and health care resources. While the fiscal constraints (see below) under which the health care system operates make it essential that the programs selected be those which give the greatest return for each dollar spent, the Committee believes it is essential that the federal government invest heavily in this area.

#### **HEALTH PROTECTION, HEALTH AND WELLNESS PROMOTION AND ILLNESS PREVENTION**

*The Committee proposes that the following objectives ought to apply to the population health role of the federal government:*

- *With respect to health protection: to strengthen our national capacity to identify and reduce risk factors which can cause injury, illness, and disease, and to reduce the economic burden of disease in Canada;*
- *With respect to health promotion and disease prevention: to develop, implement and assess programs and policies whose specific objective is to encourage Canadians to live a healthier lifestyle;*
- *With respect to wellness: to encourage population health strategies by studying and discussing the health outcomes of the full range of determinants of health, encompassing social, environmental, cultural and economic factors.*

#### **4.5 Objectives for the Service Delivery Role of the Federal Government**

The *Constitution Act, 1982* recognizes three groups of Aboriginal peoples – Indians, the Inuit and Métis. The Indian population includes both status and non-status Indians. The *Indian Act* sets out the legal definitions that apply to status Indians in Canada: status Indians are those registered under the Act, while non-status Indians are not registered under the Act. The Métis are of mixed Indian and European ancestry. The Inuit live primarily in Nunavut, the Northwest Territories and northern parts of Labrador and Quebec. The Inuit are not covered by the *Indian Act*, but, following a 1939 decision of the Supreme Court of Canada, they do receive certain benefits from the federal government.

The responsibilities of the federal government with respect to Aboriginal peoples are to status Indians living on reserve and the Inuit. The federal government provides health services to status Indians living on reserve and the Inuit, while the health care needs of the other Aboriginal peoples are seen as the responsibility of the particular province or territory where they reside. Other services and programs provided by the federal government to status Indians living on reserve and the Inuit include social assistance, schools, infrastructure (such as water and sewer services), housing, public health, etc.

Canada's total Aboriginal population was estimated at 1,399,500 in 2000. Currently, 12 federal government departments offer programs for Aboriginal peoples. Total expenditures for these programs are estimated at \$7.3 billion for 2001-2002. Despite a large

federal investment targeted at improving the health and well-being of Aboriginal peoples, very significant health and socio-economic disparities persist between the Aboriginal population and the broader Canadian population. Furthermore, during the Committee hearings, status Indians off-reserve, non-status Indians and the Métis stressed that their unique health care needs often fall between the cracks of public policy.

The health of Aboriginal Canadians is a national disgrace. The Committee believes that, given its constitutional responsibilities, the federal government must take leadership and act immediately to reverse the poor health and socio-economic conditions that plague many Aboriginal communities. Therefore, we propose the following objectives with respect to the direct provision of health services:

<b>THE DIRECT PROVISION OF HEALTH SERVICES TO ABORIGINAL CANADIANS</b>
<p><i>The Committee proposes that the following objectives ought to apply to the service delivery role of the federal government:</i></p> <ul style="list-style-type: none"> <li><i>• To take a leadership role in ensuring inter-jurisdictional co-ordination of health care delivery to all Aboriginal peoples;</i></li> <li><i>• To ensure adequate access to culturally appropriate health services and ensure the full participation of the Aboriginal population in the design and implementation of these services;</i></li> <li><i>• To implement and sustain population health strategies specifically designed for Aboriginal peoples.</i></li> </ul>

#### **4.6 Constraints on the Role of the Federal Government**

There are two major constraints on the federal government with respect to how it can meet the set of objectives outlined above – one is constitutional, the other is fiscal.

With respect to the constitutional constraint, it is generally accepted that the delivery of health care to Canadians at large is a matter of provincial/territorial jurisdiction. The federal government is not responsible for the administration and delivery of health care except in the case of specific groups of people, such as the First Nations and the Inuit. This constraint clearly has an impact on the scope of future federal interventions and means that much federal, provincial and territorial negotiation will have to accompany any new initiatives.

In terms of the fiscal constraint, a few brief points are worth noting. First, the selection of one federal health care strategy over another will be influenced by the capacity and political willingness of governments at all levels to raise additional revenue and on the willingness of taxpayers to pay to generate this extra revenue. Government fiscal capacity combined with taxpayers' willingness to pay will determine the types of program that can be

launched, and whether such programs will be broad universal ones or more narrowly targeted programs. Public opinion polls suggest that Canadians have mixed views on whether they are prepared to pay higher taxes to improve the health care system. While cuts to personal income tax are important to Canadians, reinvesting in health care is also rated as a high priority.

Related issues concern the most appropriate means for generating additional revenue if it does not come from the general tax base: should it come from health care premiums, user charges, a surtax on income? Should the health care costs incurred by an individual be added to his/her taxable income? These options will be addressed in more detail in Chapter 8.

It is also important to recognize that additional investment in the field of health and health care will involve significant trade-offs between competing objectives. How much should we spend on health care versus how much should be devoted to wellness promotion and illness prevention? Should we spend less on treating illness and more on population health strategies such as early childhood development, literacy, housing, environment, income distribution, etc.?

What new programs should be developed (if any) and how they should be financed are some of the policy issues raised in the options sections of this report. However, when considering these issues it is worth remembering that other countries, and not just the United States, already spend a higher proportion of their GDP on health care than does Canada. For example, while health care expenditures in Canada account for 9.5% of GDP, this is below both Switzerland (10.4%) and Germany (10.6%). It is also worth noting that many countries with a similar share of public health care spending provide coverage that is much broader than Canada. This has usually been achieved with the participation of the private sector in a variety of ways that have included the imposition of user charges or the involvement of private insurance.

Moreover, health care spending as a percentage of GDP in Canada has declined since its peak of 10% in 1992. This downward trend has since been reversed and, from 1998 on, the share of the GDP devoted to health care has been stable at 9.3%. However, some witnesses (including the Honourable Marc Lalonde, former federal Minister of Health and of Finance) argued before the Committee that it may be necessary for Canadian expenditures on health care to return to the 10% level if the objectives of the first federal role in health care are to be met. Others have suggested that the share of public health care funding be set at a predetermined level. The desirability of implementing suggestions such as these is discussed in greater detail in the options chapters of this report.



## **CHAPTER FIVE:**

### **A 21<sup>ST</sup> CENTURY CONTEXT FOR HEALTH CARE POLICY**

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The constitutional and fiscal constraints discussed in section 4.6 are not the only contextual factors that must be taken into account as we examine the options for health care reform in Canada. Health care is a service sector industry, and the very shape and form of many such industries have undergone significant changes in the closing years of the 20<sup>th</sup> century.

Indeed, it is possible to trace the outlines of what a 21<sup>st</sup> century service sector looks like. Three main characteristics stand out for our purposes:

- The development of larger organizational units that allow for economies of scale, along with the ability to provide customers with the 7/24/365 service which they are increasingly demanding (service seven days a week, 24 hours a day, every day of the year).
- The emergence of specialized organizational units, that focus on providing a limited range of services, but deliver them very efficiently and with higher quality than units that provide a wider range of services.
- A strong focus on the consumer, since repeated market research studies have shown that consumers are demanding more than ever before: they want both timely service and high quality service.

The current organizational structure of the health care industry in Canada does not reflect any of these three characteristics. Indeed, one of the witnesses at the Committee hearings described the primary care sector as structured like a 19<sup>th</sup> century cottage industry rather than a 21<sup>st</sup> century service industry because it consists largely of individual businesses (physician practices). The fact that these are not clustered together into group practices means that providing more extensive services, such as making care available 7/24/365, is impossible.

Also, specialization of the health care industry into service units that can deliver a narrow range of services has generally not occurred. There are, of course, a number of exceptions, including laser eye clinics and a very limited number of specialized hospitals, such as the Shouldice Hospital in the Toronto area which only performs hernia operations (and is reimbursed at the regular provincially insured rate).

The major delivery system in the health care sector in Canada remains the unspecialized general hospital. While these will always be needed, it is also important to investigate the benefits that could arise by making specialized delivery units a more important part of a modernized health service delivery system. This, of course, requires a major trade-off between quality of care and accessibility to health services.

With respect to the third characteristic of a 21<sup>st</sup> century service sector industry – a strong focus on timely and high-quality customer service – little has been done. In fact, long waits for certain kinds of treatment is the complaint most often voiced by Canadians with regard to the health care system. This is obviously not timely service.

By remaining fixed largely on the quantity of inputs (particularly on the amount of public money going into the system, and on the number of physicians and nurses) rather than on quality measures of system outputs, attempts at evaluating the functioning of the health care sector remain at odds with the customer service orientation of a modern service industry. Yet, using money spent as a measure of the quality of a health care system is clearly erroneous. The United States has the highest per capita spending on health care, but, when measured in terms of many health indicators such as infant mortality, life expectancy and potential years of life lost, it can be seen to have one of the lowest quality systems of any OECD country.

Measurement of system outputs or outcomes are just being developed, and inter-provincial comparisons of system performance are only now starting to be published by the Canadian Institute for Health Information. The whole field of outcome measurements is in its infancy, not only in Canada but elsewhere as well. Much remains to be done.

The Committee believes that many of the problems facing the health care sector can be successfully addressed only if the industry is prepared to transform itself into a 21<sup>st</sup> century service industry, rather than remaining mired in a 19<sup>th</sup> century structure and outlook. As part of its role dealing with the health care infrastructure (see Chapters 10 and 11), the federal government could provide assistance to encourage this transformation.

## **5.1 Reforming Primary Care: A Step Toward a 21<sup>st</sup> Century Structure**

Although not a direct federal responsibility, the way in which health services are organized for delivery within each province has a direct impact on the overall efficiency and effectiveness of the health services Canadians receive. For this reason, the Committee believes that it is important to take into account the changes that are expected to occur in the near term with regard to primary care reform. Furthermore, changing the way primary care is delivered opens up other potential changes to the health care system and hence other options for reform. (More information on primary care reform is provided in sections 8.2.2, 8.5 and 11.4.)

The need for significant changes to the way primary health care is delivered has been the principal thrust of the recommendations of a number of provincial health care reviews, notably the Sinclair Commission Report in Ontario, the Clair Commission Report on health care delivery in Quebec and the Fyke Report on health care delivery in Saskatchewan. In fact, the importance of changing the way primary care is delivered is so widely established that the federal government agreed, in September 2000, to contribute \$800 million to help the provinces achieve reform of the primary care sector.

For the federal government, the issues relating to primary care fall mainly under its role in contributing to innovative health research and enhancing the health care infrastructure, but they also touch on its other roles as well.

In the first place, decisions concerning the optimum use of public resources have important implications for the overall level of funding required to sustain our health care system. For example, if the organization of group medical practices allowed patients to access their family physician's group practice seven days a week (as recommended in both the Clair and Fyke reports), this could lead to a decline in the use of expensive emergency wards in hospitals, with potential savings for the system as a whole.

Similarly, many of the reforms being mooted for the primary care sector touch on the extent to which health promotion and disease prevention (the population health federal role) should be integrated into the delivery of health services.

Moreover, if primary care reform includes moving physicians from a fee-for-service payment system to a capitation payment system, or to a mixture of capitation and fee-for-service, then more options for modernizing the health care system would become possible,<sup>3</sup> including the expansion of the number of services that are covered by public health care insurance. For example, physiotherapy services, chiropractic services and potentially even drug therapy could be supplied by a health care unit remunerated under a capitation or a combined capitation and fee-for-service scheme.

Such a system would also help ensure that everyone receives treatment in the most efficient way possible. Primary care reform involves not only changing the way in which physician services are provided, but also altering the way in which an individual's initial contact with the health care system is handled. For example, under a capitation remuneration scheme, it becomes possible for a nurse practitioner to handle certain cases that would otherwise have to be handled by a physician under fee-for-service payment systems.

For all the reasons outlined above, the Committee feels it is important that the federal government continue to play a role in assisting the provinces and territories in the restructuring of primary care delivery. In fact, we believe that primary care reform is one of the most critical steps that need to be taken in order to modernize Canada's health care system.

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<sup>3</sup> Capitation refers to a payment system in which a health care unit receives an annual payment for each individual for which the unit is responsible for providing service. The amount of the payment may depend on the age and medical history of the individual, but not on the number of service calls the individual makes to the unit during the year.

## **5.2 Health Care: Different from Other Goods and Services**

It is important to note that, while the health care industry must adapt to the reality of a 21<sup>st</sup> century service sector industry, one fact remains: health care does not respond to market incentives as do other goods and services. In the terms used by economists, health care is subject to a number of “market failures”. In a free marketplace, resources are allocated according to the law of supply and demand. The resulting price levels ensure optimal allocation of resources when certain conditions related to supply and demand are met. However, these conditions are largely absent in the area of health care.

More precisely, there are three key differences between health care and other goods and services. The first market failure in health care relates to the lack of “consumer sovereignty”. While individuals initiate the first contact with the health care system, it is providers who then determine the volume of diagnostic tests, visits to specialists and the needed prescription drugs. In other words, an individual cannot obtain hospital surgery or radiation therapy without the recommendation of a licensed provider. Thus, resource allocation in health care is not a simple function of the interaction between supply and demand as it is in a free marketplace. In fact, health care providers can affect demand in a way that is impossible in just about any other industry.

Second, there is a problem of “asymmetry of information” between the health care provider and the consumer because consumers are generally unable to determine for themselves the type of health services they need. Health care providers have a very large advantage over consumers in that they have the professional knowledge to determine what is best for their patients. Therefore, in a free health care market, this asymmetry of information leaves open the possibility of exploitation of consumers by providers. Health care providers can be placed in a situation of conflict of interest if they recommend care at the same time as they make their own living from it.

The third market failure relates to the “uncertainty of illness”. Marketable goods – such as food and shelter or TVs and VCRs – can be properly budgeted for. This contrasts sharply with health care. Because illness is unpredictable, the demand for health care is likewise uncertain. Individuals cannot easily determine in advance an optimal pattern of health care use in a given year as they might do for food. More importantly, health care costs can also be enormous. Very few people can manage health care costs on their own.

Health care insurance, either public or private, is the response to such uncertainty. In Canada, as in many other OECD countries, governments have favoured public health care insurance over private insurance. The reason is that private insurance is also subject to market imperfection. The sources of failures in private health care insurance markets include adverse selection, moral hazard, and economies of scale.



Moral hazard and adverse selection are somewhat distinct, but they have similar implications for private insurers in that they both relate to a private insurer only agreeing to insure “good risks”. “Moral hazard” refers to the fact that individuals are more likely to purchase insurance if they think they are more likely to use services. “Adverse selection” refers to the fact that insurers seek to avoid individuals most likely to cost them money. In response to both situations, private insurers may either refuse to provide coverage or charge higher premiums. Therefore, in a private insurance market, individuals with health problems may face higher premiums or reduced coverage. Similarly, economically disadvantaged individuals would have to assume a relatively higher proportion of health care costs for an equivalent set of premiums. This contrasts with public health care insurance, which guarantees access to insurance, regardless of the individual’s state of health and ability to pay.

In addition, there are inherent economies of scale in the field of insurance. While some costs (such as the payment of claims) depend on volume of business done, others (such as rate setting) are the same regardless of the number of people insured. In general, large insurers will face relatively lower costs than small carriers. A single insurer (or single payer), for whom claims payments and data handling are centralized, greatly benefits from these economies of scale through relatively low administrative costs. When the single payer is public, even more administrative costs may be eliminated if no premiums are collected and the required funds are drawn from general government revenue.

Overall, market failures and considerations of equity and fairness explain much government involvement in health care. As stated above, many countries including Canada have preferred a stronger role for the public sector in the field of health care insurance. Countries that permit private health care insurance, such as Australia, the Netherlands and Sweden, also control the private market to a great extent by regulating the level of premiums, co-payments and deductibles that can be charged by private insurers.



## **CHAPTER SIX:**

### **OBSERVATIONS ON CHOOSING AMONG OPTIONS**

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#### **6.1 The Need to be Financially Realistic in Choosing Options**

The Committee's primary objective in undertaking a study of the role of the federal government in the health and health care fields was to help launch a public debate on the policy options that the federal government should choose in order to effectively address the challenges it faces in these areas. This report is the Committee's vehicle for launching this debate.

In the remaining sections of this report we outline a series of options that are available for responding to the challenges confronting the health care system in Canada. These options are based on the evidence gleaned from the Committee's hearings as well as from the documentation made available to the Committee. While we do not claim to have produced an exhaustive inventory of options, the Committee did hear from a wide range of stakeholders and experts and was able to canvas a broad range of opinions. Hence, we believe that our range of options covers the spectrum of opinions reasonably well.

As we have already said, we hope that when choosing their preferred option, readers of this report will be explicit about the public policy objective their preferred option is designed to help achieve. We also hope that readers will take into account the linkages among options. In some instances choosing one option may make the choice of other options impossible, or at least very difficult, while other options, in contrast, might in fact achieve the desired objective only when selected together.

In addition, the fiscal constraints described previously clearly have an impact on the set of options which, when taken together, are feasible (unless, that is, the set of options also envisages new sources of funding). Therefore, if readers of this report foresee any expansion of services in the health care field, it is incumbent on them to also state a preference for how such an expansion should be funded.

#### **6.2 The Desirability of a Non-Ideological Debate**

It is the Committee's hope that the way in which it has set out these options will help to focus the debate on reforming Canada's health and health care policies and programs around realistic options for change. In this spirit, it is worth highlighting a few general observations about the state of this debate in the country today.

It is clear to the Committee that it is absolutely essential that the debate progress beyond political rhetoric. In considering options with respect to the current system, we raise some issues that are usually dismissed out-of-hand in any discussion of reform of the Canadian health care system. We raise them not to be deliberately provocative, but because we believe that Canadians can no longer avoid tough choices by resorting to simplistic statements about how the current system works, many of which are only partially true. We believe that maintaining a long-term sustainable health care system is too important for issues affecting that system not to be discussed openly and rationally. Of course, individual positions on these issues will very much depend on everyone's personal set of values. Indeed, it is precisely because these issues are value-laden that they provoke emotional and ideological responses.

It is important to look at experience acquired elsewhere in the world, since many other health care systems share similar characteristics to Canada's. International comparisons show that there are many feasible ways of balancing public and private involvement in the health care field that respond not only to the health care needs of people at large, but also make sense from an overall economic point of view. Clearly, this debate over how to balance public and private sector participation in health care is central to the future shape of the health care system in the coming years.

A second overarching dimension to the health care debate that overlaps with the public/private one concerns the overall level of spending that Canadians feel is appropriate. We currently devote about 9.5% of GDP to health care from both public and private sources. A few countries (Germany, Switzerland and the United States) spend more, while many spend less. Deciding on an appropriate level of spending as a percentage of GDP, setting it as a goal, and then figuring out how to divide that total amount between public and private sources are among the issues that Canadians need to resolve.

There are a number of competing imperatives, however. On the one hand, the cracks and strains inflicting our system are increasingly evident along two important fault lines: concerns over timely access to treatment and issues relating to the training, recruitment and retention of human resources in the health care field. Neither of these is a simple issue on its own, and the fact that they are inter-related and overlap with other complex issues make them extremely difficult to address. But there is an urgency to addressing them: health care providers are increasingly refusing to assume the brunt of responsibility for shoring up the system, and individual Canadians are becoming frustrated and angry as stories of unnecessary suffering caused by delays in getting care regularly appear in the press.

On the other hand, however, Canadians are rightly wary of further restructuring of the system simply to deal with the immediate pressures. The cost-cutting measures undertaken by every level of government in the 1990s succeeded in reigning in the escalation of health care spending (at least until the end of the decade). But it is arguable that the various stresses these cost-cutting measures placed upon the system are an indication that we are now living with the consequences of these decisions. Furthermore, Canadians are right to remain

proud of the system that has been built over nearly four decades, and prudence therefore dictates that reform be thoroughly debated and, only then, implemented carefully.

### **6.3 The Value of Understanding the Experience of Other Countries**

Readers may find some consolation in the fact that Canadians are not alone in confronting complex health care issues. Everywhere in the world health care policy is thoroughly intertwined with the political, social, and even cultural life of each country. In Sweden and the United Kingdom, for example, major health care reforms were undone when another party with a considerably different political ideology replaced the government that put the reforms in place. As a result, many experiments in reforming health care systems have been abandoned before adequate time has been given to see how effective the reform would be. Others have been abandoned for ideological reasons even though they were successful!

Canadian experience has not been quite the same, largely because all major political parties support the current system and, as a result, have been unwilling (some would say fearful) of experimenting with changes to it. Nevertheless, as Claude Forget, a former Minister of Health in Quebec and an acknowledged expert on comparative health care systems, told the Committee that international experience should alert us to the dangers of a public system that is held hostage to the vagaries of political life, and that therefore fails to sustain a pragmatic, managerial approach to problem solving. It is safe to say that we have not yet found a way to encourage these kinds of approaches, and even that some aspects of our current legislative framework actively inhibit the type of experimentation that is required.

There are also many unknowns that could influence the shape of Canadian health care in the future. One of these is the eventual impact of various international and regional trade agreements. In Europe, for example, competition law that applies to all members of the European Union forbids monopolies, even in the health care and services sectors. This has put pressure on national legislatures to 'open up' their health care systems, and there are numerous experiments with forms of market incentives and competition that have been introduced into systems that remain predominantly publicly financed. It would therefore seem to be important for Canadians to adopt an open-minded approach to health care reform, and to consider the full range of available options, rather than to reject some of them out-of-hand.



## CHAPTER SEVEN:

### THE CANADA HEALTH ACT, TIMELY ACCESS TO TREATMENT, AND FAIRNESS

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#### 7.1 Introduction

It is a constitutional fact that, generally, health care is a matter of provincial/territorial jurisdiction. The federal government is not responsible for the administration and delivery of health care except to specific sub-groups of the population. In point of fact, Canada does not have a national health care insurance plan, but an interlocking set of 10 provincial and 3 territorial health care insurance plans.

However, through its financial contribution to provincial and territorial health care systems and its enforcement of the *Canada Health Act*, the federal government has helped shape public health care insurance plans across the country. To a great extent, the Act ensures that Canadians, no matter where they live, receive a reasonably comparable level of health care with relatively uniform terms and conditions.

The conditions imposed by the *Canada Health Act* are linked to the funds that are transferred by the federal government to the provinces and territories to assist them in providing public health care insurance. The Act dictates the terms upon which these federal cash transfers will occur. It does not regulate health care delivery.

There seems to be a consensus among experts consulted by the Committee that the *Canada Health Act* is constitutional, in that it does not interfere with the every day business of managing health care delivery and administering public health care insurance plans. It is worth noting that the constitutionality of the Act has never been challenged since its inception, some seventeen years ago. Nevertheless, the Committee's expert witnesses agreed that test cases on the constitutionality of the Act are likely to arise in the next few years.

Some implications of the *Canada Health Act*, however, remain difficult to assess. It is not always clear what the Act does, and more importantly, what it does not do. More specifically, three main issues have been raised about the Act. First, do Canadians have a right to health care, and if such a right exists, can it be found in the *Canada Health Act*? Second, to what extent, if any, are private health care provision and private health care insurance permissible under the *Canada Health Act*? And third, is "reasonable access" under the *Canada Health Act* meant to ensure that Canadians have timely access to needed health care services?

To examine these questions, the Committee convened a panel of constitutional lawyers, supplemented by the excellent constitutional expertise of some members of the Senate

who do not normally sit on the Committee. The results of the panel discussion, which are summarized below, have provided the Committee with some guidance in the development of proposals to address the three issues mentioned above.

## **7.2 Do Canadians Have a Right to Health Care?**

As indicated above, the *Canada Health Act* specifies the conditions under which federal transfers are channelled to provinces and territories that comply with a set of terms and conditions. The Act does not make any mention, either explicitly or implicitly, of a right to health care. However, repeated public opinion polls have shown that there is a general perception among the Canadian public that there is a right to health care. So, when all is said and done, is there a legislated right to health care in Canada?

The *Charter of Rights and Freedoms*, as part of the Constitution of Canada, sets out those rights which are considered fundamental to Canadian society. The most likely sources of a Charter right to health care are to be found in sections 7 and 15 of the Charter. These sections state:

*7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*

*15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*

Health care is not explicitly mentioned in the Charter. Thus, such a right, if it exists, would have to be found by the courts to be implied from the interpretation of one of the Charter rights. Experts told the Committee that the right to life necessarily implies the right to health and, therefore, the right to health care. Thus, a case can be made that the Charter guarantees Canadians an implicit right to health care. Justice Bertha Wilson also expressed this view when she stated: “(...) government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members.”<sup>4</sup> This is why experts told the Committee that they expected cases on the right to health care to arise in the next few years.

## **7.3 To What Extent, if any, is Private Health Care Provision and Private Health Care Insurance Permissible under the *Canada Health Act*?**

Information provided to the Committee by Professor Martha Jackman suggests that the *Canada Health Act* does not prohibit the provision of private health care. Rather, it discourages the provinces, under threat of losing federal funds, from permitting health care

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<sup>4</sup> Quoted in Martha Jackman, “The Application of the Canadian Charter in the Health Care Context”, in *Health Law Review*, Vol. 9, No. 2, 2000, pp. 22-26.



providers to bill patients directly for amounts over and above what they receive for such services under provincial health care insurance plans. That is, it discourages so-called extra-billing.

Similarly, in order to obtain their full CHST cash contribution, provinces and territories must not allow hospitals to impose user charges on patients for insured hospital services. Thus, the Act only dictates the terms upon which federal cash transfers to the provinces will occur.

As such, the legislation does not prevent private, or for-profit, health care providers and institutions from delivering and being reimbursed for provincially insured health services, so long as extra-billing and user charges are not involved. The Act does not prevent the provinces from allowing private health care providers, whether individual or institutional, to operate completely outside the publicly funded health care system. Health care providers and facilities may opt out of the provincial plan and bill patients directly for the full cost of services provided, without any penalty being imposed on the province under the *Canada Health Act*. In these cases, patients are not eligible for reimbursement under provincial plans. Moreover, the *Canada Health Act* also effectively prevents individuals from purchasing private health care insurance to cover the cost they would incur in receiving service from a provider who had opted out of a provincial health care plan.

The *Canada Health Act* is intended to discourage the cross-subsidization of health care providers and facilities that provide medically necessary services funded partially by public health care insurance and partially by the patient. According to the federal government, this discourages the growth of a second tier of health care, which, it claims, could pose a significant threat to Canada's publicly funded health care system. (It should be noted, however, that parallel public and private health care systems exist in most other industrialized countries.)

Currently, some private clinics appear to be operating in a manner which is arguably quite close to the edge of the letter, and certainly to the spirit, of the *Canada Health Act*. A private MRI clinic, which treats both publicly funded and private patients, is viewed by the federal government as being consistent with the letter of the Act apparently because the government does not consider the person who performs the MRI to be a "doctor". Indeed, in some cases a technician, based on a recommendation from a physician carries out the MRI and the results subsequently go to a physician. Thus, the MRI service is not subject to the Act.

However, some would insist that this arrangement nonetheless confers an unfair advantage on patients who are able to pay for a private MRI. Once the physician has the results of the diagnostic test, according to this argument, patients are able to join the waiting list for the next procedure required by their treatment much faster than if they had waited in line for the public MRI. This situation, which is called "queue jumping", may undermine the principle of accessibility of the *Canada Health Act* which states that access to medically necessary health services should be based on need – not on means – and on uniform terms and conditions.

The federal government is monitoring this issue. In September and October 2000, Allan Rock, the Minister of Health, sent letters to the Alberta and Quebec governments in order to obtain more information with respect to MRI clinics operating in these two provinces. No decision has been made yet with respect to the compliance of both provinces with federal legislation.

The *Canada Health Act* requires provincial health-care insurance plans to be accountable to the provincial government and to be non-profit, thereby effectively preventing private health care insurance plans from covering services that are included under the publicly insured plan in the province. Private insurers are limited to providing supplementary health care benefits only, such as semi-private or private accommodation during hospital stays, prescription drugs, dental care and eyeglasses.

Overall, the *Canada Health Act*, along with provincial/territorial legislation, has prevented the emergence of a private health care system that would compete directly with the publicly funded one. It is simply not economically feasible for patients, physicians or health care institutions to be part of a parallel system.

This raises the following question: if a right to health care is recognized under section 7 of the Charter, and if access to publicly funded health services is not timely, can governments continue to discourage the provision of private health care through the prohibition of private insurance? To paraphrase Section 1 of the *Charter of Rights and Freedoms*, is it just and reasonable in a free and democratic society that government ration the supply of health care services (through budgetary allocations to health care) and, simultaneously, effectively prevent individuals from purchasing the service in Canada?

The answers given to this question by the panel of constitutional experts were mixed. They stressed that this issue is not only a legal question. It is, above all, a question of fairness. Is it fair to deny someone, who could afford to purchase a health service, the right to make such a purchase? Conversely, is it fair to those Canadians who do not have the means to purchase health care to allow others to do so? Where one considers fair in this matter is something for readers of this report to decide for themselves.

What is clear, however, is that any option for the reform of current arrangements that includes a private sector that is able to compete effectively with the publicly funded sector would require substantial modifications to the *Canada Health Act*.

## **7.4 Timely Access and Waiting Times**

The principle of accessibility of the *Canada Health Act* stipulates that Canadians should have "reasonable access" to insured health services. However, the Act does not provide a clear definition as to what constitutes reasonable access. Lately, the issue over access to health care has been associated with the problem of waiting lists and waiting times – that is, the

problem is one of *timely* access. “Timely” is, of course, a subjective word. What is timely to one person may be an eternity for another, particularly where illness is involved. Nevertheless, the Committee believes that “timely access” describes more accurately what the public expects from the health care system than “reasonable access”.

The problem of waiting lists is not unique to Canada. In the course of its international comparative study, the Committee learned that many countries – including Australia, Sweden and the United Kingdom – experience waiting line problems, and that in several countries people wait somewhat longer than they do in Canada.

Although there is no doubt that some Canadians wait too long, the lack of accurate information on waiting lists remains a major problem. In fact, there is no standardized data on waiting lists. Nor is there a uniform method for establishing and maintaining waiting lists in Canada or any agreed “scientific” rules for when patients should be placed on a list, or a definitive consensus on how long patients should be allowed to remain on waiting lists.

Obviously, there is an urgent need to implement an appropriate process for developing and managing waiting list information. In the meantime, however, Canadians are quite unhappy with the amount of time they have to wait to see a specialist, obtain a diagnosis or to receive treatment as an in patient or out patient. This unhappiness grows as both perceived and real waiting lines grow.

Since we do not have consistent and coherent data across the country, we cannot paint a precise picture of all of the factors that contribute to the lengthening of waiting lists. We do know, however, that some waiting lines are better managed than others. The Cardiac Care Network of Ontario, for example, manages its waiting lines well. For other illnesses, waiting lines are not managed nearly as well. In addition, the length of waiting time depends on where a patient lives in the province.

Throughout the Committee’s hearings, a number of questions were raised with respect to this problem:

- What can be done about the lack of reliable information on waiting lists?
- Could renewing outdated diagnostic and clinical equipment shorten waiting lists?
- How do shortages of health care personnel affect the length of waiting lists?
- Does the absence of competition among health care providers exacerbate the problem of waiting lists?
- Does the absence of firm commitments to guarantee treatment within a specified time frame mean that waiting lists are allowed to grow unchecked?

- Could waiting times for publicly funded services be shortened by introducing or increasing access to private care for those who wish to pay?

Clearly, the problem of waiting times and waiting lists is a complex one, touching many other issues. The shortage of human resources, the lack of medical equipment, and the insufficiency of information will be addressed in subsequent parts of this report. However, at this point it is worth noting some of the observations that are often made about the problem of timely access.

First, if waiting lines are caused by a shortage of physicians and other health care providers, as evidence before the Committee strongly suggests they are,<sup>5</sup> at least in part, then allowing a private parallel system will not reduce the total waiting time between the two lines, and may even make the public waiting lines worse. This is because, in this case, the bottleneck is the number of service providers and not the number of medical facilities, such as equipment or hospital beds, so increasing the latter will have no effect on the total length of the waiting line, and siphoning off a finite number of health care personnel to service private patients will mean that fewer are available to care for the public ones.

Second, even if the supply of human resources is not the problem, experience from other countries shows that allowing the creation of a parallel private system does not shorten the waiting lines in the public system. Among the reasons for this is the fact that health care providers (e.g. physicians) and/or patients use the waiting lists for somewhat less urgent cases than they might otherwise have done.

Suppose, for example, that the current rule for deciding that a patient goes on the waiting list for a cataract operation is that the patient has lost 50% or more of the sight in an eye. Experience in other countries has shown that introducing a parallel system could cause ophthalmologists to start putting people on the waiting list for a cataract operation when they have, for example, lost only 30% of their sight. Therefore the publicly funded waiting list actually grows with the establishment of a parallel private system.

Third, opponents of the creation of a parallel system reject what they usually call “a two tier” system, that is, a system in which patients in the private system receive expedited service or qualitatively superior care. Here it is advocates of a single system who invoke the “fairness” argument. They argue that health services should be provided exclusively on the basis of need, and that the introduction of a second-tier of care that would only be available to the minority of the population with the personal resources to pay for them, goes against the principles of equity and fairness. This criticism suggests that Canada does not have any elements of “a two tier” system at the present time. Is this true?

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<sup>5</sup> See the Committee’s Phase Two report for a more detailed discussion of health human resource issues.

People who can afford it can, and do, already go out of Canada (usually to the United States) to receive the medical services they require if their only alternative is a long waiting line in Canada. There is also, strong anecdotal evidence that suggests that the situation in Canada is similar to that in Australia where, in the words of one of the Australian witnesses who testified before the Committee: “access to public (health) services is usually more easily obtained by wealthier and more powerful individuals who understand how the system works and have appropriate contacts in hospital service delivery and administration”.

In addition, provincial Worker’s Compensation Boards in most provinces receive preferred access to treatment for their clients on the argument that they need to ensure the client goes back to work quickly (and not, incidentally, to save the WCB money). In some provinces, the Boards have contracts with hospitals for a specified number of beds and diagnostic procedures ensuring quick access. They also make direct payments to physicians for the services performed and these payments do not count toward any cap on a physician’s income which may exist in the province.

All this suggests that the Canadian system is not nearly as “one tier” as most Canadians believe, or as most government spokespersons claim. Whether this constitutes an argument for a more open “two tier” system is an issue for readers of this report to decide. (See sections 7.5.1 and 8.6 for further comments on a two-tier system.)

## **7.5 How Can “Timely Access” to Health Care Be Ensured?**

There are many ways in which the problem of timely access might be tackled, ranging from changes that do not alter the structure of the current health care system to those that entail substantial structural modifications.

The changes that might be made without changing the structure of the current system include:

- Increasing the quality of screening by family physicians to ensure that referrals for specialized services, including diagnostic tests, are given only to patients who really need them;
- Providing information to family doctors and their patients about the specialists with the shortest waiting periods;
- Establishing specialist group practices to share the workload and increase the hours during which service is available.

Another option, which involves a certain amount of systemic change, and which has been used very effectively in Sweden, is to introduce incentives into the system to encourage greater efficiency, particularly in the hospital sector.

### 7.5.1 “Care Guarantee”

In Sweden, in 1992, the national government introduced the “care guarantee”, which established a maximum waiting time not exceeding three months for diagnostic tests, certain types of elective surgery (treatment for coronary artery disease, hip and knee replacements, cataract surgery, gallstone surgery, inguinal hernia surgery, surgery for prolapse and incontinence). Subsequently, maximum waiting line guarantees were introduced for consultations with primary care doctors (8 days) and specialists (3 months). If the maximum waiting time was reached, the patient was given the money to go elsewhere in Sweden, or to another country, to obtain the required medical service. The money to pay for this treatment came from the county government (roughly equivalent to a provincial government as far as health care is concerned) which in turn took it out of the money that would otherwise have gone to the offending hospital. The care guarantee was responsible for a substantial reduction in waiting, to the point where waiting lists “ceased to be a political issue”.<sup>6</sup>

Note also that in the Swedish model there is no second tier of patients. Everyone is treated the same with regard to the “care guarantee.”

The national government has also enacted legislation giving patients the right to choose their family doctor and the hospital in which they receive treatment. Prior to this reform, patients requiring hospital treatment could only receive it in the hospital to which they were assigned, that is, the hospital serving the area where the patient resided. When a patient elects to receive care in a hospital other than the one to which he/she was originally assigned, a specified sum of money can be transferred from the budget of the assigned hospital to the treating hospital. County councils thus have to pay for services provided to their residents by another county council. The general public attach great importance to the enhanced freedom of choice under the new legislation. Many observers also claim it has produced a major change in the way patients scheduled for surgery are treated, as an incentive is created for each hospital to attract patients from other ones, or to prevent patients from going elsewhere.

An in-depth assessment of the results of Sweden’s experience with the “care guarantee” would have to take into account all the dynamics that are particular to that country and its culture, but it is nonetheless interesting to note that when there was a change in government and the newcomers eliminated the “care guarantee”, waiting periods lengthened.

Clearly, people respond to certain types of incentives by being more productive and operating organizations more efficiently, and this has nothing to do with whether the organization is in the public or the private sector. Virtually all hospitals in Sweden are public sector institutions.

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<sup>6</sup> Quoted in Ake Blomqvist, “International Health Care Models: Sweden.” Document prepared for the Committee, May 2001, p.19.

The Swedish example thus raises the issue of whether the Canadian system should be modified to allow, or even encourage, competition between hospitals. And, if so, should all hospitals continue to be public institutions (or more precisely private not-for-profit institutions) or should private, for-profit hospitals or clinics be allowed to compete with public ones? (It must be noted that the conditions of the *Canada Health Act* would still be met even if all hospitals in a province were private institutions, as long as it remained a single payer system.)

If private, for-profit medical institutions are allowed, standards would have to be put in place to ensure the quality and safety of patient care received at the institution. This is clearly not an insurmountable task, since private hospitals exist in every major industrialized country. (Canada is the only major country with a 100% publicly funded hospital system.)

Also, conditions might have to be placed on the types of procedures such private sector institutions could carry out (for instance, joint replacement would probably be acceptable but heart bypass surgery might not). Thus, these private institutions would most likely be highly specialized clinics (like the Shouldice Hospital or laser eye clinics), each offering a very limited range of services, but doing so efficiently precisely because they are specialized.

One potential option would be the Swedish “care guarantee” model with private clinics competing with each other and with public hospitals when the maximum waiting period for a procedure has expired.

A second option, which would involve more systemic change, would be to allow patients to go to the private clinic before the expiry of the maximum waiting time allowed under the “care guarantee”. In such a situation, patients would have to pay the entire cost of the procedure out of their own pockets (unlike the Swedish “care guarantee” option in which public funding would pay the cost at the end of the maximum waiting period.). Presumably, as well, people would be allowed to purchase insurance to cover the cost of paying for the service in a private clinic. Thus, one would have what is usually called a “two tier” system – similar to the two tier systems that exist in virtually all other industrialized countries (see Section 8.6 for further observations on a two tier system).

### **7.5.2 Patient’s Bill of Rights**

A final option to address the problem of timely access would be to introduce a Patient’s Bill of Rights.

In recent years, the patient’s bill of rights or the patient’s charter, as it is known in some jurisdictions, has been introduced in response to increasing concerns about the quality and timeliness of health care. New Zealand, for example, has developed a Code of Health and Disability Services Consumers’ Rights. Australia also has a form of patient’s charter. As part of the agreements under which Australian Commonwealth government funds are transferred to State and Territorial governments for publicly funded hospital services, the latter have developed

Public Patients' Hospital Charters that outline a number of rights in relation to hospital services, including the right to:

- receive treatment on the basis of health needs, regardless of financial or health insurance status;
- have access to public hospital services regardless of place of residence in Australia;
- be treated with respect, compassion and consideration of privacy, taking into account the patient's background, needs and wishes;
- participate fully in health care decisions including admission, discharge and arrangements for continuing care;
- have a clear explanation of proposed treatment including risks and alternatives, before agreeing to the treatment;
- give informed consent (except in exceptional circumstances) before a procedure is carried out, including consent to participation in undergraduate health professional teaching or medical research;
- withdraw consent or refuse further treatment;
- have access to personal medical records;
- confidentiality of personal information, unless otherwise provided by law;
- receive interpreter services where there is difficulty communicating with staff;
- comment or complain about health care and to be advised of the procedure for expressing concerns.

In some American states, laws also provide for patients' bills of rights in relation to the provision of health care services and cover many of these same issues.

In the United Kingdom, in an effort to reduce the number of complaints about long waiting periods for medical services, to alleviate concerns about the quality of care and the manner in which patients were being treated under the National Health Service (NHS), the government introduced the NHS Patient's Charter in the early 1990s. Comprised of individual rights and service standards (known as expectations), the NHS Patient's Charter dealt with access to health services and medical records, patient privacy, participation in medical research and the provision of information to patients.

The Charter standards (expectations) related to the manner in which services were provided and covered matters such as maximum waiting times for certain types of surgery, outpatient appointments, transfers to a hospital bed upon admission through an emergency department, ambulances and assessment upon arrival at an emergency department.

The NHS Patient's Charter was criticized on a number of fronts, however, and a review in the late 1990s concluded that a national charter should be replaced by local charters developed in hospital trusts, primary care groups and other community health services dealing directly with patients. Although the notion of a new national charter was rejected in the review, the concept of minimum standards for waiting times to provide timely access to health care was



not. Such standards (for example, two weeks for referral to a specialist for a first time referral for chest pain for suspected angina, no more than a 26 week wait for outpatient treatment) are now contained in a new document – an NHS Guide – that replaced the NHS Patient’s Charter.

Even though there are issues surrounding the effectiveness of patients’ charters, it is widely accepted that such bills of rights/charters promote the rights of health care consumers. It has been suggested that a patient’s bill of rights/charter that includes standards or entitlements for timely access to appropriate diagnosis, treatment and hospital care could introduce a measure of accountability to consumers into the Canadian health care system, and make sure that the focus for the delivery of health services was on the patient. Patients would know what they could expect from the system. Armed with this information, they can make health care decisions about what is acceptable or unacceptable in their particular situation.

Adopting a bill of rights/charter at the provincial level would allow the standards or entitlements to be adapted to provincial circumstances and might even inject a degree of competition into health care delivery. Regional health authorities could even adopt their own version of such standards. This being said, however, given the national nature of Canada’s health care system, many Canadians would not want to see wide discrepancies among provincial standards. It may therefore be appropriate for the federal and provincial/territorial governments to participate in the development of minimum standards for timely access to health care that would serve as the basis for provincial patients’ bills of rights/charters.

There still remains the issue of how to overcome concerns about the effectiveness of patients’ bills of rights/charters. Some type of monitoring and complaints intake and review process would be required.

As a further incentive to ensure that patients’ bills of rights/charters are adopted, the federal government could make federal transfer payments to provinces and territories conditional upon the creation of provincial/territorial patient’s bills of rights/charters along with appropriate monitoring and enforcement mechanisms.



## CHAPTER EIGHT:

### ISSUES AND OPTIONS FOR THE FINANCING ROLE

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#### 8.1 Introduction

Funding for health care in Canada, and indeed in all OECD countries, is the subject of intense debate around a number of questions. What is the appropriate level of public health care funding? What role should the private sector play in the financing of health care? What would be the best public/private mix for funding health care? In countries with federal political systems like Canada, there is also the question of how to balance the spending on health care between the various levels of government.

All health care systems are hybrids: they have a combination of public and private financing. During phase three of its study, the Committee was made aware of the substantial differences among OECD countries in terms of what they each cover under their public health care insurance schemes and how these are funded.

Our international comparative study indicated that the most comprehensive publicly financed systems are currently found in Germany, Sweden and the United Kingdom. The public share of total health care spending is greater in these three countries (with 84% in Sweden and the United Kingdom and 75% in Germany) than in Canada (70%). Many countries with a similar share of public health care spending to Canada – such as Australia and the Netherlands – also provide coverage that is much broader than is available in Canada.

In contrast to Canada, however, user charges for publicly insured services are required in Australia, Germany, the Netherlands, Sweden and the United Kingdom. Furthermore, private health care insurance that covers the same benefits as public insurance is available in these countries, while it is not in Canada. This raises the possibility that it is the way the participation of the private sector is organized in these countries that has enabled them to achieve broader levels of public coverage for health care.

In Canada, the debate over the affordability and sustainability of the publicly funded health care system is intertwined with the broader issues of which services should be deemed “medically necessary” and therefore subject to public coverage, who should be entitled to publicly funded health care and how these services should be paid for. The federal role in transferring funds for the provision of health care to the provinces and territories and in administering the *Canada Health Act* is central to this debate.

With respect to health care financing, the Committee has identified the following four broad issues:

- i. What changes can be made to the way health care is delivered that could have an impact on the level of funding required?
- ii. What should be the form of federal funding for health care?
- iii. How should government raise revenue for the purpose of health care?
- iv. What services should be covered and who should be covered under public health care insurance?

The options presented in this chapter are not intended to be exhaustive. Nor are they to be seen as mutually exclusive; elements from the various options can each be reconfigured in many different ways.

## **8.2 What Changes Can be Made to the Way Health Care is Delivered that Could Have an Impact on the Level of Funding Required?**

In considering the future financing structure of health care, it is important for readers to reflect on the question of whether new financing sources are needed to make the system economically sustainable in the long run, or whether sufficient changes to the system can be made so that the resulting efficiencies will generate enough money to pay for future cost increases (caused by, among other things, demographic aging and increasing drug costs).

Many options for change were presented throughout the Committee's hearings during the first three phases of its study. While these options do not necessarily relate directly to the federal financing role, they may nonetheless enable savings that would have an impact on the overall level of funding required to sustain the system.

Several options for improving the efficiency of the current system are outlined in sections 8.2.2 through 8.2.5 below. The Committee believes that most, and probably all, of these changes ought to be made in the near future.

### **8.2.1 Improving Efficiency and Effectiveness**

There are two schools of thought on the question of whether new financing sources are needed to make the health care system sustainable. Proponents of the first school contend that operating the health care system more efficiently will save enough money so that no new sources of funding are required. This view is reflected in the recent Fyke report on health care in Saskatchewan, and in reports and newspaper articles by many observers, including Dr. Michael Rachlis.

For example, the Fyke Commission concludes that, "changing the delivery of primary health services, carefully planning the delivery of specialized care, continuing to invest in wellness, and making a commitment to quality improvement are the keys to an effective and

sustainable health system.”<sup>7</sup> For his part, Dr. Rachlis has suggested that it is by generalizing best practices, in particular in the area of primary care reform, that the system can best be sustained. Among the examples he has cited are group practices in Beechy, Saskatchewan, and Sault Ste. Marie, Ontario, that have allowed the number of patients served per physician to increase dramatically, by integrating nurse practitioners and others into a comprehensive primary care group.<sup>8</sup>

While many analysts recognize that the effectiveness and efficiency of Canada’s health care system must be improved, there is no agreement on the extent of the savings that this would generate. Moreover, there are currently two major barriers that hamper our ability to improve effectiveness and efficiency. One relates to the lack of performance indicators, while the other concerns the difficulties involved in bringing about behavioural change.

The scarcity of indicators for measuring improvements in health status and the lack of information on the effects of medical treatments make it difficult to assess the effectiveness of care and the overall performance of the health care system. Hence, there is, at present, insufficient evidence to demonstrate that improved efficiencies alone would be enough to bridge the gap between increasing health care costs and government funding.

This leads to the second school of thought on the issue of the need for new funding sources. This school agrees that in a \$90 billion health care system some economies are certainly possible and that every effort must be made to implement such efficiency-driven changes.

Proponents of this argument contend that it will be difficult to implement changes to enhance efficiency and effectiveness because both the attitude and the behaviour of a variety of vested interests in the health care system – ranging from patients, to service providers, to drug companies and so on – have, over the years, proven to be very difficult to change. Indeed, if many of the proposed changes were as easy to put in place as proponents of the first school imply, then one has to ask why they have not already been implemented.

The Committee therefore believes that it is important to be prudent and to develop policies and plans that will be effective, should sufficient efficiencies not be gained from changes to the way the system works. To do otherwise is to put all our eggs in one basket. This would mean betting the future sustainability of the health care system on making changes when there is not yet enough evidence to demonstrate that they are actually achievable, and there is no reliable indication of the amount of money that can be saved through such changes.

In saying this, the Committee realizes that there is an important advantage inherent in the approach advocated by the first school of thought – it allows most of the tough

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<sup>7</sup> *Caring for Medicare*, the Commission on Medicare, Saskatchewan, April 2001, p. 79.

<sup>8</sup> See Michael Rachlis, “We can do better with what we’ve got”, *National Post*, July 5, 2001, A14.

financing questions, outlined in the rest of this chapter, to be avoided. While it is tempting to adopt the first school's point of view, and thereby duck the most controversial health care issues, the Committee believes that responsible public policy planning requires that the view of the second school prevail, and that Canadians should now pursue the discussion on how to raise additional funds, at the same time as efforts are made to organize health care delivery more efficiently.

We look forward to hearing the views of readers on the critical issue of which school's approach should be the basis of health care policy.

### **8.2.2 Reforming Primary Care**

The way in which primary care reform can be used to make health care delivery more efficient was described in section 5.1. As noted earlier, primary care refers to the initial point of contact that people have with the health care system. Currently, primary care physicians are the "gatekeepers" of the system, and are the ones who must refer patients elsewhere in the system for further treatment. There is unanimity among provincial and territorial governments that primary care reform needs to be undertaken. Reforming primary care means encouraging the use of the most appropriate health care providers (not necessarily physicians), having providers work in multidisciplinary teams, and adopting new ways of remunerating physicians – either through some form of capitation or salary or a blended payment system such as mixed capitation and fee-for-service. Many experts believe that primary care reform can generate substantial benefits for the following reasons:

- First, since physicians would not be paid solely on the basis of fee-for-service, the current incentive for physicians to want to see every patient who comes into their practice is eliminated. It therefore becomes possible for a patient to receive service from a health care professional who is qualified, but not necessarily over qualified. Thus, in many cases in which a doctor now furnishes care, service could instead be provided by a triage nurse, a nurse practitioner or another health care provider.
- Second, under a primary care capitation system, the doctor who is responsible for a patient gets a fixed amount of money to provide the patient's care for a year. Thus, for example, there is an incentive for a doctor only to order tests which are genuinely required, since the payment for the tests comes out of the fixed amount of money the doctor has received for the patient's care. When tests are no longer "free" to the physician, as they are now, behavioural change in the way tests are ordered occurs.
- Third, the multidisciplinary teamwork which forms the basis of primary care reform allows for more appropriate and efficient use of human resources in health care.
- Fourth, a reformed primary care system could also allow more time and effort to be devoted to wellness promotion and illness prevention, thereby helping to reduce the quantity of health services that would need to be provided in the longer term.

Primary care reform could therefore potentially generate considerable savings for the health care system. It would, in all likelihood, bring about a decline in the rate of increase of health care expenditures, if not an absolute decrease in expenditures. Such “savings” could be ploughed back into the system by providing additional services which are not now included under the public health care system in some or all of the provinces.

For example, health services by non-physicians, such as physiotherapists, speech therapists, occupational therapists could be covered (at least for those patients who do not now have these services covered under a private health care insurance plan). In addition, some diagnostic services (e.g. a PSA test for screening for prostate cancer) could be added to the list of covered services, as could rehabilitative care and certain medical devices. Again, presumably, these services would be added only for those people for whom they are not now covered.

The two service areas for which there appears to be the greatest public demand for coverage expansion in Canada are drug therapy and home care. Given their significance and potential cost we have treated them separately in Sections 8.9 and 8.10.

### **8.2.3 Regionalization of Health Services**

Regionalization has been an important part of the restructuring of health care that has taken place since the beginning of the 1990s. Regionalization usually encompasses both decentralizing and centralizing elements. Decentralization usually entails moving planning, budgeting and decision-making authority from the provincial or territorial level to regional bodies. Centralization involves moving the planning and governance of health care and medical services from individual institutions or agencies to the regional level.

All provinces and territories, except Ontario and the Yukon Territory, have implemented some form of regionalization. The objectives of regionalization include streamlining the provision of health services and providing care according to the needs of the community. Regionalization also offers the flexibility to bring responsibility and accountability for health care delivery closer to the people who depend on these services.

A major advantage of regionalization is that it enables planning to be done, and money to be moved, across the traditional silos of the health care system. The cross-silo governance, management and planning which regionalization makes possible has allowed considerable savings to be made in several provinces. For example, in Calgary, by spending money for flu vaccination for the elderly, curtailing the number of flu patients who came to the emergency ward generated considerable savings. This kind of juggling of funds across silos was usually not done before regionalization.

Many experts believe that regionalization has provided the opportunity to integrate and better co-ordinate the delivery of the full spectrum of health services, ranging from health protection and prevention, through primary care, to acute care, and finally incorporating

rehabilitation and chronic care services. They also point out that significant benefits can be gained by integrating, at the regional level, hospital and medical budgets which otherwise would remain separately funded. For example, the Edmonton Regional Health Authority integrated all the budgets devoted to the provision of laboratory services. Estimates suggest that this enabled lab costs to be reduced by almost 40%, as regional managers (using the capacity of their hospital labs as a bargaining lever) drove much harder bargains with private labs than had been possible for the provincial health care insurance plan.

Regionalization, like primary health care reform, is a key element in improving the integration of health services, even if it is not the whole answer.

### **8.2.4 Contracting Private For-Profit Health Care Facilities**

In order to save the public sector from having to pay the capital cost of specialized delivery units (often called clinics), one option might be to have such clinics built and operated by the private sector, but have the medically necessary health services they perform paid for by the public health care insurance plan, in the same way that the Shouldice Hospital in Toronto (which specializes in the treatment of hernias) is remunerated.

The Alberta government (under Bill 11, 2000) allows regional health authorities to contract out to private for-profit facilities for the provision of some publicly insured health services (non-major surgical procedures). Other countries, notably the United Kingdom, allow private health care insurance that enables patients to be treated in private for-profit health care facilities.

Advocates suggest that contracting out to the private, for-profit sector offers a number of advantages over investing the same amount of money in the existing public or private not-for-profit sector. In their view, contracting out leads to improved access, declines in waiting times/lists and increases in efficiency by reducing the demand on public or private not-for-profit hospitals. They also suggest that the prospect of facing competition could encourage the public hospitals to become more efficient in managing their resources and that the resulting cost savings could be used to improve quality and access to care.

Opponents contend that contracting out to private facilities reduces the funding allocated to existing public hospitals, thereby possibly lowering the quality of care they provide. Public hospitals could also lose some of the other revenue they currently earn through the provision of uninsured services (cosmetic surgery, Workers' Compensation Board, etc.) if their private for-profit competitors decided to deliver these services.

If specialized privately owned delivery clinics are permitted, it is widely acknowledged that they would have to be closely supervised in order to ensure that adequate quality standards were maintained, much as they are in other countries with parallel public and private systems.



### **8.2.5 Devoting More Resources to Health Promotion, Disease Prevention and Population Health**

A number of experts contend that no additional public funding should be devoted to health care delivery. In their view, some of the funding from health care delivery should rather be redirected towards health promotion, disease prevention and to implementing population health strategies.

During Phase Two of its study, the Committee was told that health promotion and disease prevention can generate substantial long-term benefits, both by reducing costs to the health care system overall and by improving quality of life for Canadians. Experts in this field argue that it might be possible to achieve a better return on the health care dollar by promoting healthier lifestyles than by spending the same amount of money on the treatment of illness.

Similarly, evidence suggests that investing in population health strategies, such as early childhood development, improving levels of education and ensuring a fairer distribution of income, can bring greater benefits in the long run than does spending more on health care delivery. In the longer term, this could significantly reduce pressures on health care costs.

It is clear that decisions concerning the allocation of public resources necessarily involve important trade-offs and the balancing of competing interests. In the final analysis, Canadians must decide what portion of public resources should be devoted to health promotion and prevention and how much on the treatment of illness. Similarly, we must determine whether government resources should be directed towards other health-related uses, such as electronic patient records, the health infrastructure, health research and so on, rather than on the direct delivery of health care services. These issues and options will be further developed in Chapter 11 that deals with the population health role of the federal government.

## **8.3 What Should be the Form of Federal Funding for Health Care?**

As explained in the first report of the Committee, federal funding to the provinces and territories for the purpose of health care has a long history, and federal transfers have taken many different forms since the first health care insurance program was negotiated in the late 1950s.

Early federal transfers were cost-shared. Federal contributions matched provincial/territorial levels of health care expenditures and these transfers were to be used specifically for health care. As indicated in the Committee's Phase One report, cost-sharing arrangements had a number of disadvantages. They were unpredictable for the federal government, cumbersome to administer and perceived as a federal intrusion into an area of provincial jurisdiction. They were also considered inflexible, as they tended to stifle innovation in the delivery of health care by the provinces.

The introduction of Established Programs Financing (EPF) in 1977 converted the form of federal transfers to a block funding program for health care and post-secondary education. EPF had four major characteristics. First, the federal contribution was no longer tied to provincial/territorial spending and the federal government alone determined the amount of EPF funding to be transferred. This solved the problems related to the unpredictability of federal costs and of cumbersome administrative procedures. Second, a notional proportion was allocated to the two EPF components (about 70% for health care and 30% for education). Third, EPF was split between cash transfers and tax transfers.<sup>9</sup> The second and third measures resolved the problems of perceived federal intrusion and the discouragement of provincial innovation. At the same time, however, they also contributed to reducing federal visibility in health care financing. And fourth, EPF transfers were to grow in line with an escalator that took into account both GDP and population growth. This escalator proved difficult to sustain, particularly in periods of fiscal restraint, and was modified on several occasions in the 1980s and 1990s in order to reduce and even freeze the rate of growth of EPF transfers.

In 1996, the federal government merged EPF and the Canada Assistance Plan (CAP) in order to create the Canada Health and Social Transfer (CHST). Like EPF, the CHST is a block funding mechanism; it provides federal transfers for health care, post-secondary education and social assistance. Unlike EPF, the legislation governing the CHST does not designate, either specifically or notionally, what proportion of the total entitlement is to be allocated to each of these fields. Nor does it indicate how the provinces should make use of the federal funding. Unlike EPF, there is no escalator associated with the CHST transfer.

As in the past, the five principles of the *Canada Health Act* apply only to the cash portion of the CHST. The federal government has the authority to withhold the cash transfers to provinces/territories that do not comply with these principles. However, the federal government cannot decrease the tax transfers because it does not have the power to require the provinces/territories to reduce their income tax rates. For this reason, it has often been observed that federal cash transfers would have to be retained if there are to be national principles guiding public health care insurance in Canada. Otherwise the federal government would have no leverage for persuading the provinces to abide by the national principles.

The current funding arrangement suffers from three major weaknesses: a lack of federal visibility, a lack of federal and provincial accountability, and a lack of stability in federal funding. Federal visibility is weak under the CHST because it is no longer possible to identify, even notionally, the actual level of the federal contribution to health care. Moreover, since the amount of the federal contribution to health care is unknown, it is not possible to trace how the provinces and territories use federal funds, which leads to a lack of accountability.

Finally, federal transfers have been subject to a great deal of variation over the past 40 years. From the late 1950s to the mid-1970s, under the cost-sharing arrangements, the

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<sup>9</sup> As explained in the Committee's first report, a cash transfer is simply a deposit of federal funds into the provinces' and territories' consolidated revenue. A tax transfer is a reduction in federal income tax in concert with an offsetting increase in provincial/territorial income tax.

federal contribution was 50 percent of eligible provincial/territorial spending on health care. During the EPF era, the federal government unilaterally restricted the rate of growth of EPF transfers. When the CHST was introduced in 1996-97, federal transfers were systematically reduced. Since then, the federal government has halted cuts to the CHST transfers and even allowed them to grow once again. However, according to the provinces/territories, the federal government has failed to restore the cash portion to its previous levels.

Provincial and territorial governments claim that the overall impact of federal measures to restrain the growth of transfers and then to reduce them has been to generate a “funding gap”. This gap represents the increasing difference over time between what the federal government has contributed to the health care system by way of its transfers to the provinces and territories, and what these jurisdictions have had to spend in order to meet rising costs.

Provincial and territorial governments have repeatedly called on the federal government to restore the CHST cash transfer to its 1994-95 peak level and to include an escalator in order to ensure appropriate growth in the CHST. In their view, this additional investment is necessary just to maintain the current health care system, while extending public coverage to other health services would require even more federal funding.

More recently, some provinces have suggested that more tax transfers be provided as a means of increasing the provincial/territorial share of growing government expenditures on health care. Moreover, in a recent news release, the provincial/territorial Finance Ministers stressed that “Canadians cannot wait 18 months until Commissioner Romanow presents his report to the Prime Minister. The health care system requires urgent and immediate action towards a more equal sharing of increasing costs.”<sup>10</sup>

Against this background, a number of options for the design of federal transfers have been suggested in recent years.

### **8.3.1 Return to Cost-Sharing Arrangements**

Under this option the federal contribution to health care would be specifically designated as a fixed proportion of provincial/territorial government spending on health care, which would have the effect of increasing federal visibility in health care and enhancing federal accounting and accountability. It would also bring more predictability and stability to federal funding and improve accountability at the provincial/territorial level. Moreover, it could enable the “funding gap” to be reduced, which would assist the provinces/territories in dealing with increasing cost pressures. However, as explained in Section 8.3, when cost-sharing was used in the 1960s and 1970s, it had such significant disadvantages that it was abandoned.

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<sup>10</sup> Provincial/Territorial Meeting of Ministers of Finance, *News Release*, Montreal, 15 June 2001. This news release is available on the Internet at [http://www.scics.gc.ca/cinfo01/860430004\\_e.html](http://www.scics.gc.ca/cinfo01/860430004_e.html).

Tom Kent made one variant of this proposal. He suggested that cost-sharing not be restored to its original form (a 50/50 split), but rather that a form of “cost-sharing with a difference” be implemented that would have a ceiling of 25% for the federal contribution.<sup>11</sup> The advantage of this ceiling is that, by placing a limit on the overall federal contribution to health care, it gets round the issue of unpredictable costs.

### **8.3.2 Retain Current Block Funding**

Other analysts argue that all forms of cost-sharing represent a step backward. They claim that the benefits gained by block-funding federal transfers, namely enhanced provincial flexibility, must be maintained, even to the detriment of federal visibility. In their view, the explicit tracking of the use of federal dollars is unnecessary, since conformity with the *Canada Health Act* is sufficient to ensure provincial accountability.

However, it is difficult for the public to understand why the federal government is unable to determine whether the funds transferred to the provinces and territories for specific objectives (such as the \$800 million for primary care reform, and \$1 billion for new medical equipment, such as MRI machines) are actually spent on those objectives. This lack of provincial/territorial accountability for targeted federal transfers leads many people to question their value.

### **8.3.3 Improved CHST Block Funding**

A major issue with regard to the CHST relates to the impossibility of determining the exact federal contribution to health care. This problem could be solved by designating a notional portion of the CHST for the purpose of health care as was done under EPF. This would ensure recognition of federal funding, while not affecting provincial flexibility.

Another concern often raised by the provinces and territories is the absence of an appropriate escalator under the CHST to ensure continual growth in federal transfers. While some mechanism that allows for annual growth appears desirable, it is still necessary to design an appropriate escalator. There are a number of possibilities.

The original EPF escalator was a compound three-year moving average of nominal GDP per capita applied to per capita cash contributions and cumulated year after year. Others have suggested that the total CHST cash transfer be indexed to reflect not only an expanding population and economic growth, but also the incidence of disease and the cost of new drugs and health care technologies. However, while all these considerations are certainly relevant, the complexity of such a proposal would make it difficult to operationalize.

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<sup>11</sup> Tom Kent, *What Should Be Done About Medicare?*, Caledon Institute of Social Policy; August 2000.

Another alternative proposed by the C.D. Howe Institute in response to demographic aging is to convert part of the CHST into a grant per person age 65 and over (the “seniors’ health grant”). This grant would escalate at the rate of GDP growth (real growth plus inflation) per person. The extra money the seniors’ health grant would provide to each province would, by construction, be proportional to the growth in its elderly population. For those provinces whose elderly populations grow relatively quickly, the grant would have an appreciable impact on their finances.

### **8.3.4 Medical Savings Accounts (MSAs)**

A number of proposals for MSAs have been put forward in recent years in Canada.<sup>12</sup> MSAs are health care accounts, similar to bank accounts, set up to pay for the health care expenses of an individual (or family). Under a system of MSAs, some part or even the totality of the current CHST transfer would be transformed into separate individual health care accounts. Each account would be set up by depositing an amount equivalent to the average amount the federal government now spends per capita on health care, and everyone would control their own account.

MSAs usually incorporate aspects of private finance – each individual is responsible for covering a portion of their health care costs up to a ceiling. In addition, MSAs are usually set up to cover those health care costs that are amenable to individual control (such as routine or minor medical expenses). They must be combined with a high-deductible, catastrophic insurance plan to ensure payment of extraordinary, high-cost care.

The general theory is that consumers would make more judicious and cost-effective decisions if they were spending their own money, rather than relying on the public purse. There are several different ways of structuring these accounts, and each approach must be assessed on its merits.

However, in general, the arguments supporting the introduction of MSAs include their potential to promote personal responsibility and accountability, to help reduce “unnecessary” use of services, to stimulate price competition and to encourage forward-looking financial planning. Those in opposition to the idea caution that these accounts are unlikely to control expenditures or utilization effectively, and insist that they would disadvantage the poor relative to the wealthy.

It is generally acknowledged that any MSA proposal would require careful scrutiny. However, it is not unreasonable to expect that a plan could be developed that avoids the possible pitfalls. Such a plan might first be contemplated for application in a limited sphere,

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<sup>12</sup> See the following documents: 1) William McArthur, Cynthia Ramsay and Michael Walker ed., *Healthy Incentives: Canadian Health Reform in a Canadian Context*, The Fraser Institute, 1996; 2) Cynthia Ramsay, “Medical Savings Accounts”, *Critical Issues Bulletin*, The Fraser Institute, 1998; 3) David Gratzner, *Code Blue – Reviving Canada’s Health Care System*, ECW Press, 1999; 4) Dennis Owens and Peter Holle, *Universal Medical Savings Accounts*, Frontier Centre for Public Policy, Policy Series No. 5, July 2000.

such as paying for long-term care facilities, where there are already significant private out-of-pocket charges.

### **8.3.5 Convert all CHST Cash Transfers into Tax Point Transfers**

Another option suggested by some experts would be for the federal government to abandon entirely its first role of transferring funds to the provinces and territories for the purpose of health care. This could be achieved by transforming the whole of the CHST into tax transfers.

Such a complete withdrawal of the federal government from financing health care would eliminate the uncertainty and instability relating to the level of cash transfers to the provinces. This option would provide a clearer division of responsibilities and would probably reduce the likelihood of friction between the federal and provincial/territorial governments. It would also provide provinces with greater flexibility in allocating health care funds and in reforming and renewing their systems. Provinces would establish the type of health care delivery system that is best suited to their population. With time, Canada would have a diversity of health care systems.

However, since tax points are less valuable in the poorer provinces, these provinces would likely encounter difficulties in maintaining their current level of health services. Furthermore, the *Canada Health Act* would become irrelevant as its enforcement mechanism is tied to federal cash transfers. Overall, this option would exacerbate discrepancies between the provinces in the level, quality and accessibility of health services. It would therefore not appear to be consistent with the objectives the Committee has enunciated for the financing role of the federal government.

## **8.4 How Should Government Raise Revenue for the Purpose of Health Care?**

There are two basic sources for revenues collected by government to pay for health care: (1) general revenue and (2) various forms of direct payments.

With respect to general taxation, there are two possible ways of increasing the amount of money that is spent on health and health care: spending more of existing dollars on health care or increasing general revenue and devoting the additional revenue to health care.

The second route that is available for raising additional government revenue is to introduce some form of payment by consumers for health services. This could be done in a variety of ways, all of which fall into three broad categories: user charges, income tax on the value of health care received, and annual health care premiums.

In considering the options of user charges and premiums, one must also decide if individual Canadians should be allowed to purchase private health care insurance to protect themselves against the risk of having to make these payments. Moreover, the option of purchasing private health care insurance can be extended to having such insurance pay the cost of receiving health services in private facilities, and even for health care that is also insured by public health care insurance. This introduces a further option: private health care insurance for services delivered in private institutions that competes with public insurance for services received in public institutions.

All these options are discussed in further detail below.

#### **8.4.1 Spend More of Existing Tax Dollars on Health Care**

This means increasing the share of federal and provincial budgets that are devoted to health care and decreasing public spending in other areas. This option has two main defects. First, it is clear that, on the one hand, governments have other important spending priorities (such as roads, the environment, etc.) and that, on the other, the amount spent directly on health care is only one of the determinants of an individual's health status.<sup>13</sup> Second, health care expenditures are rising at a substantially faster rate than the rate of growth of government revenues. Indeed, it is projected that provincial spending on health care will increase by an average of 5% annually if current trends with respect to population growth, aging and inflation continue.<sup>14</sup> Thus, there are limits to how much of a contribution this option can make to bridging the funding gap.

#### **8.4.2 Increase General Revenue (through income tax or sales taxes) and Devote the Additional Revenue to Health Care**

This option is influenced by the capacity and political willingness of governments at all levels to raise additional revenue and on the willingness of taxpayers to pay to generate this extra revenue. The review of public opinion polls conducted in Phase One of the Committee's study showed that Canadians have mixed views on whether they are prepared to pay higher taxes for the purpose of health care. While cuts to personal income tax are important to Canadians, reinvesting in health care is also rated as a very high priority. However, regardless of what public opinion polls say, this option runs counter to the tax reduction strategies undertaken at both provincial and federal government levels in recent years.

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<sup>13</sup> These include such factors as education, income distribution, housing, etc. In its *Performance and Potential Report* (2000-01), the Conference Board of Canada pointed out that "health care spending is 'crowding out' education funding. For the first time, public health care spending has outstripped public education expenditures. Yet Canada's long-term success depends on developing the workforce through life-long learning."

<sup>14</sup> Provincial and Territorial Ministers of Health, *Understanding Canada's Health Care Costs – Final Report*, August 2000.

### 8.4.3 User Charges

User charges are usually defined as a form of payment made by a consumer of a health service at the time the service is rendered. That is, they represent an up-front charge to the patient. There are different forms of user charges:

- Co-insurance, the simplest form of user charge, requires the patient to pay a fixed percentage (say 5%) of the cost of services received. Thus, the higher the cost of the service, the larger the fee. Many private sector drug insurance plans require this method of payment.
- Co-payment is an alternative to co-insurance. Instead of having to pay a share of costs, the patient is required to pay a flat fee per service (for example \$5) which does not necessarily bear any relation to the cost of the service. The same amount is charged, no matter what the cost of the health care provided. This form of user charge exists in many countries, such as Sweden.
- Under a system of deductibles, the patient is required to pay the total costs of services received over a certain period up to a certain ceiling, the deductible. Above this ceiling, costs of services to the patient are covered by the insurance plan. All users must pay a standard minimum deductible, which is independent of the quantity of services received. Again, this form of insurance based user charge is required in some countries.

In Canada, the literature with respect to user charges tends to conclude that these charges deter some individuals from seeking necessary as well as unnecessary care, and do so in a way that falls disproportionately on the poor. In view of these studies, experts told the Committee that user charges raise issues of access and equity and, depending on how they are implemented, they could violate some of the patient-oriented principles of the *Canada Health Act*. Part of these problems related to user charges could be circumvented if the level of the user charge varied according to income, or if low income groups were exempted from paying these charges.

It is worth noting that Canada is the only industrialized country in the world that prohibits user charges for publicly funded health services. Even in Sweden, which is generally recognized as being among the most socialized of the European countries, user charges are regarded as “essential in order to make people choose the most economical service”. Swedes pay between \$15-20 for each visit to the doctor and about \$12 a day for hospital stays. The total amount which an individual can pay in any one year is capped at around \$135 per year.

In Sweden, user charges are not perceived as impeding access. Nor are they designed to raise money. In fact, the cost of administering the user charge scheme (collecting the fees and keeping track of how much an individual has paid so that the cap is not exceeded) is almost as much as the total amount collected in user fees. The system of user charges in Sweden is designed to change consumer behaviour. Swedish public policy is based on the principle that



individuals should be aware that a decision to use the health care system costs the government, and hence all taxpayers, money and that, therefore, they should use the system only when they genuinely need it.

Thus, if user charges were to be implemented in Canada, they could be applied in a manner that minimizes the risk of impeding an individual's access to care, while at the same time encouraging an individual to make appropriate use of the system. One important issue would be to decide whether user charges should apply to existing publicly insured health services (physicians and hospitals) or if they should be considered only for services that would expand public coverage.

#### **8.4.4 Income Tax on Health Care**

In this option, patients are required to add the cost of the health services which they receive each year to their taxable income. This proposal has been presented both as a means of raising revenue and as a means of promoting individual accountability for the use of health care. This type of payment was proposed in 1961, at the start of the debate on a publicly funded health care program, and subsequently was revived in 1991 by the government of Quebec<sup>15</sup> and in 2000 by Tom Kent.<sup>16</sup>

This system has a number of advantages over the application of user charges. First, an income tax on health care is progressive: for equal use of services, a patient with a higher income pays relatively more than one with a lower income. Second, such a payment does not apply to those who do not pay income tax. And third, it avoids the problem of an up-front means test, thereby addressing the issues of access and equity referred to in section 8.4.3.

It has also been suggested that a cap could be applied to the amount of increased income tax an individual would have to pay in any one year and over a lifetime. This would be in line with the third objective that the Committee identified for the financing role of the federal government (the avoidance of undue financial hardship). However, such an option is not currently possible because the health care system is not structured to enable the tracking of the costs incurred by the system for each individual patient. This problem could possibly be solved with a system of electronic patient records (see Chapter 10).

One of the arguments against an income tax on health care is that some people will contend that they are paying for health care twice, once through general taxes and once through the additional income tax they would pay for the health services which they received during the year. One way around this problem would be to have a tax which everyone pays, such as the GST, earmarked for health care, with the income tax element being essentially a top up to the core GST generated amount. It should be recalled that when Medicare began it was

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<sup>15</sup> Ministère de la santé et des services sociaux, *Un financement équitable à la mesure de nos moyens*, Government of Quebec, 1991, pp. 78-82.

<sup>16</sup> Tom Kent, *What Should Be Done About Medicare*, The Caledon Institute of Social Policy, August 2000.

funded in some provinces (e.g. Nova Scotia) through a provincial sales tax which was called a hospital tax.

#### **8.4.5 Annual Health Care Premiums**

A health care premium is a payment by residents that helps government defray the costs of publicly financed health care. In essence, it is an insurance premium paid by everyone for the right to be covered under a public health care insurance plan. Health care premiums are currently required in two provinces, Alberta and British Columbia. Current monthly rates in Alberta amount to \$34 for single coverage and \$68 for family coverage (two or more people). In British Columbia, premiums are set at \$36 for a person without dependants, \$64 for a family of two and \$72 for a family of three or more. In both provinces, there are subsidies that reduce the amount of the premium for some low income people and eliminate them for the very poor.

In contrast to user charges or the income tax on health care, premiums are not related to the amount of health services consumed by individuals during a year. Nor are premiums in Alberta and British Columbia related to income. As a result, most lower-income individuals pay the same flat amount as higher income people. Health care premiums are not prohibited under the *Canada Health Act*.

#### **8.4.6 Private Health Care Insurance is Allowed to Compete with Public Coverage**

Currently, the *Canada Health Act* requires provincial health care insurance plans to be accountable to the provincial government and to be non-profit, thereby effectively preventing private health care insurance plans from covering medically required services. Moreover, the majority of provinces (British Columbia, Alberta, Manitoba, Ontario, Quebec, and Prince Edward Island) prohibit private insurance companies from covering services that are also guaranteed under public health care insurance plans. Private insurers are limited to providing supplementary health care benefits only, such as semi-private or private accommodation during hospital stays, prescription drugs, dental care and eyeglasses.<sup>17</sup>

This contrasts sharply with a variety of practices in other industrialized countries. For example, in Germany and the Netherlands, private health care insurance is voluntary for

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<sup>17</sup> Four provinces permit private health care insurance (New Brunswick, Newfoundland, Nova Scotia and Saskatchewan). In Nova Scotia, opted-out physicians cannot bill privately in excess of the scheduled fee. This creates a disincentive, as physicians cannot be paid more than if they worked in the public plan. As a result, the need for private insurance remains limited. In Newfoundland, patients of opted-out physicians are entitled to public coverage up to the amount set out in the fee schedule. Out-of-pocket spending thus is limited to the difference between the fee charged and the scheduled fee. In New Brunswick and Saskatchewan, patients of opted-out physicians cannot be subsidized by the public plan, but we still have not seen the development of a significant private sector in health care insurance. For more detail, see Colleen Flood and Tom Archibald, *Legal Constraints on Privately Financed Health Care in Canada: A Review of the Ten Provinces*, April 2000, Dialogue on Health Reform, Atkinson Foundation.

those people with an annual income over a certain level. In those countries private insurers must accept all those who apply for coverage and must provide benefits equivalent to those offered under the public plan. In Australia and Sweden, government legislation requires that premiums charged by private health care insurers be community-rated (i.e. a single premium structure applies to everyone regardless of their health status). The Australian government actively encourages residents to acquire private health care insurance by subsidizing 30% of its cost. In the United Kingdom, as in Australia, residents can purchase private insurance to cover services provided in private hospitals as well as in public hospitals.

The evidence from the Committee's international review of health care systems highlighted the fact that a number of benefits can be generated by allowing private insurance in health care, including enhanced patient choice, increased competition, and improved efficiencies in the public sector.

Permitting private insurers to provide coverage similar to that offered under public health care insurance in Canada would require amending federal and provincial legislation that currently prohibit them. With respect to federal legislation, this would necessitate a revision of the public administration (or single payer) principle of the *Canada Health Act*.

Advocates of private health care insurance suggest that safeguards could be put in place in order to ensure that: 1) private insurance is administered on a non-exclusionary basis (take all comers, not only the healthiest ones); 2) queue jumping is avoided by treating all patients side by side; and, 3) private insurance does not "skim off" the easier kinds of care and falls back on the publicly funded system for the more difficult cases.

## **8.5 The Impact of Financing Options on Behavioural Change**

In considering various financing options, it is important to keep in mind that each option has a behavioural impact as well as a financial impact. Three examples will illustrate this.

First, as explained above in the section on the Swedish care guarantee (section 7.4), when hospital administrators were faced with a financial penalty if patients exceeded the maximum time on the waiting list, changes were made in the way the hospital was run and waiting lines dropped dramatically. Conversely, when the care guarantee was dropped, waiting lines increased again. Clearly, the behaviour of hospital administrators and staff was affected by concern about their institution suffering a financial penalty if waiting lines became too long.

Second, evidence suggests that a switch from a fee-for-service remuneration scheme to a population-based payment system changes the incentive structure for physicians. They are no longer pushed to maximize services delivered but are instead encouraged to provide only the amount of care their patients actually need. For example, there is an incentive for a doctor working under a capitation system to only order tests which are genuinely required, since

the payment for these tests comes out of the fixed amount of money the doctor has received for the patient's care. When tests are no longer "free" to the physician, as they are now, behavioural change in the ordering of tests occurs.

Third, consider the requirement of user charges in Sweden. As mentioned above, Swedes pay some \$15-20 for each visit to the doctor and \$12 a day for hospital stays, with an annual threshold of \$135. According to witnesses who appeared before the Committee, the cost of administering the system of user charges is almost as much as the total amount collected in user charges. In Sweden, user charges are not designed to generate revenue but to change consumer behaviour. Swedish public policy is based on the principle that individuals must be aware that a decision to use the health care system costs the government, and hence all taxpayers, money, and that, therefore, they should use the system only when they genuinely need it.

Unfortunately, as many witnesses stressed, the current system in Canada contains few incentives for health care providers to reduce costs or to strive for better integration (through, for example, primary care reform). Similarly, the Canadian system has no incentives for consumers of the health care system to use the system in a responsible manner.

Not only does the Canadian system not provide incentives for providers to achieve cost savings through integration, it actually contains an incentive for providers to use what is often the most expensive service. The *Canada Health Act* requires that medically necessary physician and hospital services be provided without patient charge, but the Act does not contain any similar obligation with regard to the provision of cheaper (and often more effective) alternate ways of treating a patient, such as drugs administered outside hospitals, home care, or assisted living services. Most provinces do provide some payment for these kinds of services. Nevertheless, the incentive for the provider, who is acting in the best interest of the patient, is to overuse high cost, but government paid, hospital and medical services, rather than resort to lower cost, but relatively unsubsidized, alternative services.

With regard to incentives designed to encourage users to reduce costs, a number of facts are clear. First, it is essential to remember that in any given year 80% to 90% of health care costs (depending on age/sex group) are attributable to catastrophic (acute or chronic) illness. Thus, under any insurance system, public or private, modest annual user charges do little or nothing to offset costs.

Second, there does not seem to be an administratively simple way to deal with the problem of overuse of health services by patients other than by excluding certain services from coverage (or limiting the number of times a service can be used by a specific patient in a given time period).

Of course, the other way to control overuse of services is to levy relatively large user charges. User charges can generally be set at higher levels for those services thought to be

subject to overuse rather than for those services dealing with uncontrollable or catastrophic illness. The problem with significant user charges for medically necessary services is that they reduce claims on the public system by pricing poorer sick people out of the system rather than by curtailing “abuses”. No doubt “abuse” exists; all insurance systems are subject to moral hazard. But what is equally clear is that any insurance system which relies on large user charges to ration medically necessary services will be a system that denies access to the less well-off who have the misfortune to require expensive services.

However, user charges can play a very useful role in diverting demand from high cost to less costly health services without impairing access to medically necessary services. But this is only possible if less costly service is available and is an insured service.

The examples and comments given above, along with the experience from other countries with universal health care systems, illustrate the fact that the way a health care system is financed can help to achieve the overarching public policy objective of delivering the best health care possible at the lowest cost. This raises the following questions concerning the structure of health care financing in Canada:

- Should the financial structure be such that everyone involved in the system – consumers, providers, health care facilities administrators and so on – has an incentive to use the system as efficiently as possible?
- Should incentives be used to help patients understand that along with their perceived right of universal health care there is also the responsibility to use that right reasonably and judiciously?

Readers’ responses to these questions will have a direct impact on their choice of system for financing health care in the future.

## **8.6 Two-Tier Health Care**

In its Phase One report, the Committee defined the various meanings of the concept of two tier health care. In the broad sense, a two-tier system refers to two co-existing health care systems: a publicly funded system and a privately funded system. This definition implies that there is a differential access to health services based on one’s ability to pay, rather than according to need. In other words, those who can afford it may either obtain access to better quality care or to quicker care in the privately funded system, while the rest of the population continues to access health care only through the publicly funded system.

Some of the options presented above – namely user charges for publicly funded health services, MSAs and private health care insurance – may raise concerns over the possible impact of two-tier health care. Three suggestions have been put forward as ways of circumventing the negative aspects of two-tier health care systems, while maintaining the quality of publicly funded ones:

- all doctors would be required to work a certain number of hours in the publicly funded system, meaning that they would not be permitted to work exclusively in the privately funded system;
- the publicly funded health care system would provide a guarantee that waiting times for various procedures would not exceed a certain level and, if the maximum time was exceeded, the government would be obliged to pay for the required treatment to be performed in the private sector system;
- an independent body would be mandated to ensure that health care technology in the public sector is as good as in the private sector.

The Committee would like to obtain the views of Canadians on the issue of two-tier health care based on the assumption that the three conditions just outlined could be met.

### **8.7 What Services Should be Covered and Who Should be Covered Under Public Health Care Insurance?**

The *Canada Health Act* covers hospital and physician services that are deemed to be “medically necessary.” The concept of medical necessity, however, is not defined in the Act. Moreover, the Act does not set out a process for determining which health services are medically necessary. Therefore, each province and territory (in collaboration with their respective medical associations) is responsible for determining what specific services are to be insured under the public health care insurance plan. Because provinces/territories do not use a uniform method for determining the provision of comprehensive health care, there is uneven public coverage for certain health services across the country.

Furthermore, the Act remains focused on hospitals and physician services. When the Act was put in place in 1984, many additional services – such as drugs, rehabilitation, convalescence and palliative care – were provided in hospitals. However, this is no longer the case. Increasingly, these services are being delivered in the home or in the community by a broader range of health-care providers (such as nurses, nurse practitioners, physiotherapists, occupational therapists, etc.). They therefore fall outside the scope of the *Canada Health Act*. As a result, there are wide variations among provinces in terms of public coverage for home care, prescription drugs, palliative care, institutional long-term care, dental and vision care, etc.

Given this shift toward less institutional care, the 1997 National Forum on Health suggested that public coverage should be refocused to “follow the care and not the site.” Others have also explicitly recommended that the federal government expand coverage under the *Canada Health Act* to include additional services, mostly home care and prescription drugs.

Overall, there are two broad options that are available with regard to the services that can be included in the publicly funded basket:

### **8.7.1 De-Listing Some Services**

Some people argue that, if it is to be sustainable, the publicly funded health care system cannot be all things to all people. In their view, it is not realistic to expect unlimited service provision, even for only hospitals and doctors, in a context of constrained government budgets. It has therefore been suggested that some health services that are currently publicly financed be de-listed as a means of saving money.

There is, however, little agreement on the process that could be used to select the services to be de-insured. Moreover, there is evidence from Oregon, where attempts were made along these lines, that suggests that de-listing does not generate substantial savings. There are also studies that have concluded that there is a real danger that this option would lead to making decisions about what services should be covered based more on economic considerations than on medical necessity.

Nevertheless, in light of the Committee's view on the need for new financing sources, it follows that if Canadians do not agree to explore new sources of financing, then some reduction in services is inevitable, either by continuing with rationing via waiting lines (the approach currently being used by governments), or by moving to explicitly de-list some services.

### **8.7.2 Expanding Coverage**

Other analysts, by contrast, stress the need to expand public health care coverage. As stated previously, the *Canada Health Act* is applied mostly to medical and hospital services. Many Canadians believe that the scope of the Act should be broadened to encompass more services. The two service areas into which there appears to be the greatest public demand for coverage expansion are prescription drugs and home care. Given their significance and potential costs, the issues and options that relate to these areas are discussed in more detail in Sections 8.9 and 8.10 below.

## **8.8 Prescription Drugs: Reducing Their Cost**

In recent years, prescription drugs have exhibited the most rapidly escalating costs in the health care system. During Phase Two of its study, the Committee learned that:

- Data reported by Canadian Institute for Health Information (CIHI) indicate that spending on drugs in Canada has grown continually over the last 25 years, from \$1.1 billion in 1975 to \$14.7 billion in 2000.
- During this period, drugs accounted for an increasing portion of total health care spending; in 1975, drugs represented about 9% of total health care expenditures; by 2000 this share had increased to almost 16%.

- Since 1997, expenditures on drugs have been the second largest category of health care spending in Canada, behind hospitals but ahead of spending on physician services.
- Spending on drugs in Canada, expressed in dollars per capita, continues to increase at a rate faster than spending in other key health care sectors such as hospitals and physicians. In fact, between 1990 and 2000, drug expenditures per capita increased by almost 93%, more than twice the average for all health care expenditures (40%).

Prescription drugs make up the largest component of spending on drugs (77% in 2000, up from 72% in 1975). In 1975, the private sector (employer-sponsored drug insurance plans, individual private insurance companies and out-of-pocket spending by consumers) accounted for 80% of prescription drug expenditures. By 2000, private sector spending had decreased to 57%. During the same period, the share of prescription drugs financed from public sources (provincial and territorial governments and the federal government) increased steadily from 20% in 1975 to 43% in 2000.

The question therefore arises as to what steps, if any, can be taken to contain the rate of increase of prescription drug costs on publicly funded health care programs. The following options were presented to the Committee:

### **8.8.1 A National Drug Formulary**

The idea of a national drug formulary surfaced on a number of occasions during the Committee's study. A drug formulary usually refers to a list of drugs that are supplied under public drug insurance plans. A "national" drug formulary, as advocated by experts, does not mean that the federal government would be the only party responsible for determining which prescription drugs would be on the formulary. Rather, the concept of a national formulary is best conceived in terms of federal, provincial and territorial collaboration along with the participation of interested stakeholders.

In considering this question, it is important first to understand the process for including a new drug on the list of drugs that will be paid for, whether by provincial drug plans, or by the federal drug plan for those for whom the federal government has the responsibility for providing health care services (the service delivery role of the federal government as described in section 3.5).

Whenever a new drug comes on the market, the officials responsible for a government's formulary receive a request to put the new drug on the approved list. These officials must then evaluate the new drug and determine whether or not the drug will be listed. Getting the drug on a formulary is critical for pharmaceutical companies, since without it, sales of the drug in the jurisdiction covered by the formulary will be very limited. Therefore, not unreasonably, drug companies lobby hard to have their new drugs added to the formulary.



The Committee was told that two situations arise with this system. First, once a drug is approved for the formulary in one province, it is difficult (indeed almost impossible) for another province to refuse to add the drug to its formulary. Second, many provinces, particularly the smaller ones, lack the staff to be able to assess in detail whether new drugs have sufficient new benefits to warrant being added to the formulary (with the possible consequence that an existing drug on the formulary would have to be removed).

A potential solution to this problem would be to have a single national (as opposed to federal) formulary, an idea that was advocated by many witnesses who testified before the Committee. In general, the benefits of a national drug formulary include the following:

- The elimination of the potential for log-rolling, or pressuring one province to add a drug to its formulary because another has already done so;
- An enhanced ability to do the research needed to understand whether the benefits of a new (and costlier) drug genuinely represent a significant improvement on existing (and cheaper) drugs, since such research would be done at the national level, rather than by different provincial governments.

The establishment of a national drug formulary could lead the way to the creation of a single national buying agency – one which covers all provincial and territorial governments as well as the federal government. The buying power of such an agency would be enormous. This would likely strengthen the ability of public drug insurance plans to receive the lowest possible purchase price from the drug companies.

During its Phase Two hearings, the Committee was told that the idea of a common drug formulary was being discussed at the provincial and territorial level. More specifically, following their conference in August 2000, Provincial Premiers and Territorial Leaders agreed to work together and “mandated their Health Ministers to develop strategies for assessing and evaluating prescription drugs. These strategies could include the creation of a common inter-provincial/territorial advisory process to assess drugs for potential inclusion in provincial/territorial drug plans.”<sup>18</sup>

The Committee welcomes opinions on the feasibility of a national drug formulary as well as on its potential impact. It is particularly interested in ideas on how the administration of a national formulary could be organized so as to ensure its independence from government (note that federal participation would be by virtue of its responsibility for the delivery of health care services to specific groups, and not as a result of any federal constitutional role). Moreover, in the course of discussions about a national drug formulary, the Committee is interested in asking whether consideration should be given to a national drug purchasing agency and, if so, how such a purchasing agency would work?

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<sup>18</sup> 41st Annual Premiers' Conference, “Premiers' Commitment to their Citizens,” *News Release*, Winnipeg, 11 August 2000 (also available at [http://www.scics.gc.ca/cinfo00/850080017\\_e.html](http://www.scics.gc.ca/cinfo00/850080017_e.html)).

### **8.8.2 Requiring the Use of the Lowest Cost Therapeutically Effective Drug**

Faced with limited public health care resources it is necessary to consider the need for aggressive drug cost-benefit management, particularly in terms of listing only the most cost-effective prescription drugs on formularies. For many years, hospitals that have operated with global budgets have had to make difficult choices about what drugs to make available on their internal formularies. Hospital Pharmacy and Therapeutics (P&T) Committees have made these decisions, and physicians have accepted them because they were made by their peers. Some have suggested that extending this concept of a P&T review to limit prescription drug listings for all drugs would be difficult for physicians to accept.

Nonetheless, in recent years, provincial drug insurance plans have begun to use their reimbursement policies to encourage doctors to make substitutions among alternative drug therapies. In some cases a drug is simply not listed on a formulary when it is more expensive than alternatives that are equally effective in treating particular medical conditions. In other cases, a drug benefit plan (for example the Ontario Drug Benefit Plan) requires special authorization before it will pay for more expensive drugs if these drugs are chosen over less expensive alternatives because they are uniquely required for one, but not all, of their indications. British Columbia's reference based pricing policy has been used for this same purpose. Under that policy, the province only reimburses up to the price of a reference drug in a particular therapeutic category, unless there is a specific need for the more expensive product demonstrated by the physician and it is approved, in advance, by the drug plan.

In short, reimbursement policies that encourage physicians to make therapeutic substitutions already exist in some provincial drug insurance plans. The difficult policy questions are:

- to what extent should governments adopt a program of mandatory therapeutic substitution to the lowest priced therapeutically equivalent drug?
- and, how aggressively should such a substitution policy be used?

The better and more accepted the process of scientific/clinical advice supporting decisions about which drugs are therapeutic alternatives for each other, the more likely they are to be accepted by physicians and tolerated by the public.

This raises the further question of whether all the key players, including public and private drug insurance plan managers, doctors and pharmacists, Health Canada (as the federal regulator of drug safety), patients and the pharmaceutical industry, should be required to work together to generate consensus advice that would be used both by insurers and by prescribers to determine which drugs can be therapeutically substituted for each other. The goals of this kind of the collaboration would include not only more cost effective prescribing and drug benefit management, but also improved quality of patient care through better

identification of the best treatments, the elimination of inefficient treatments or those with avoidable risks of adverse reactions.

The overall objective of such collaboration would be to achieve: i) effective, timely, national guidance to formularies (or a national formulary); and ii) timely, relevant, accepted national prescribing guidance that could be adapted to local requirements.

The proposed collaboration could be supported by, and integrated with, a strengthened system of post-market surveillance of prescription drugs run by Health Canada and by a national drug utilization information system that would provide a detailed analysis of drug prices, how they are utilized and what the cost drivers are for each of the various classes of drug therapies needed to make better formulary management, prescribing, and regulatory (drug safety) decisions.

### **8.8.3 The Advertising of Prescription Drugs**

A third issue related to prescription drug costs concerns the ways in which pharmaceutical companies should be allowed to advertise prescription drugs. Currently, Health Canada bans direct advertising to consumers and limits the advertising of prescription drugs to health care providers. Direct-to-consumer advertising of prescription drugs is not permitted in most industrialized countries. In the United States, where the advertising of prescription drugs is allowed (the industry spends hundreds of millions dollars a year on advertising in the U.S.), studies have shown that a very significant percentage of prescriptions issued by physicians, particularly family practitioners, arise because patients ask for a specific drug because they have seen it advertised. This is hardly surprising since the purpose of advertising is to increase demand.

It has been suggested that in order to avoid a corresponding increase in demand for prescription drugs in Canada, the federal government should maintain its current ban on prescription drug advertising. However, three arguments against continuing the advertising ban are usually made:

- (a) Consumers have a right to know what prescription drugs are available;
- (b) Under the *Charter of Rights and Freedoms*, companies have the right to communicate with their consumers; and
- (c) Since drugs can be advertised in the United States, and since Canadians can see such ads when watching U.S. channels on cable television or on the Internet, a Canadian ban is meaningless and therefore the current ban should be lifted.

With respect to (a), the question is the extent to which a consumer's right to know should be traded off against the increased cost of drugs, which will be the inevitable result of allowing the advertising of prescription drugs in Canada.

With respect to (b), constitutional lawyers have expressed mixed opinions on whether the current advertising ban is constitutional. However, it has been suggested that if a decision is made to establish a national formulary, then the constitutional issue could be avoided by having the national formulary adopt as a policy that any drug which is advertised in Canada, other than to physicians, would not be included in the formulary.

With respect to (c), the leakage at the border through U.S. cable television stations can be eliminated by having the federal government use its directive powers to order the CRTC to require that Canadian cable companies use mandatory advertising substitutions wherever a U.S. station they are carrying puts on an ad for a prescription drug.

An emerging issue is the widespread health-related information that is now available on the Internet. By all accounts, it would seem to be virtually impossible to stop the flow of such advertising across the boarder.

These are important federal policy issues on which the Committee seeks the opinions of readers of this report.

## **8.9 Prescription Drugs: Expanding Coverage**

Most Canadians have some form of insurance coverage for prescription drugs from one source or another, including government programs, private plans through their employers and individual plans. However, since the *Canada Health Act* does not deal with prescription drugs used outside the hospital setting, public coverage varies considerably from province to province. Similarly, private insurance plans for prescription drugs provided through employer-sponsored plans or individual insurance policies are significantly different in terms of design, eligibility and out-of-pocket costs.

Information provided to the Committee by the Canadian Life and Health Insurance Association suggests that some form of prescription drug insurance protects about 97% of the Canadian population:

- employer-sponsored group plans are the primary source of insurance for Canadians providing coverage to 57% of the population;
- provincial drug insurance plans for seniors and social assistance recipients account for 12% and 10% of the population respectively;
- provincial programs for the general population (i.e. not limited to seniors or social assistance recipients) cover another 15% of the population;
- Various other plans (individual policies, affinity groups, etc.) account for a further 1%.

- programs for status Indians and eligible Inuit and Innu account for about 2%.<sup>19</sup>

Some 3% of the Canadian population appear to have no insurance coverage at all for prescription drugs. The Committee learned that most of these people are working age adults. Qualitative data also suggests that people in this group have the following employment profile: they are primarily unskilled workers, low paid employees, part time employees, seasonal employees, and short term unemployed. Moreover, among those with some form of coverage, there are substantial variations in the nature and quality of coverage.

The Committee learned that there are significant inter-provincial disparities in the level of drug insurance coverage. Table 1 shows that five provinces (British Columbia, Saskatchewan, Manitoba, Ontario and Quebec) achieve 100% coverage for prescription drugs in the sense that provincial government programs provide a minimum level of coverage for all residents. In Alberta, the provincial government offers a premium-funded public drug insurance program – the Alberta Blue Cross – to all residents. The 17% of Albertans who do not have drug coverage do have a public plan available to them but have decided not to join it and hence do not pay the premium. The Atlantic provinces stand out as having much lower levels of coverage than the rest of Canada. In fact, there are no public drug insurance programs available that cover all residents in the Atlantic provinces.

**Table 1**  
**Proportion of Population with Drug Coverage**

	<i>% Covered</i>
<b>Canada</b>	<b>97</b>
Newfoundland	65
PEI	73
Nova Scotia	76
New Brunswick	67
Quebec	100
Ontario	100
Manitoba	100
Saskatchewan	100
Alberta	83
B.C.	100

These inter-provincial differences in drug insurance coverage rates reflect significant differences in provincial drug programs, particularly with respect to what is available to groups other than low-income seniors and social assistance recipients, who are virtually entirely covered in every jurisdiction. The inter-provincial differences also reflect different levels of coverage from private plans. The Committee learned that all provinces currently levy taxes on premiums and, in the case of Ontario and Quebec, retail sales taxes on private health insurance plans. The resulting tax burden of \$1 billion a year is an important disincentive to gaining coverage under private plans, which are the major vehicle for drug insurance coverage.

<sup>19</sup> Canadian Life and Health Insurance Association, *Drug Expense Insurance in the Canadian Population*, 1998.

Such inter-provincial differences clearly raise public policy issues in and of themselves, as do the tax provisions noted above. However, their public policy significance comes into sharper focus when seen against the goal of avoiding “undue financial hardship” which has played such a fundamental role in forging Canadian health care policy. Despite the generally high levels of drug insurance coverage that prevail throughout Canada, many Canadians are not protected against the possibility of “undue financial hardship” due to high drug expenses.

Modern drug-based therapies can – and with increasing frequency do – require extremely high expenditures on drugs. Only those drug costs incurred in a hospital setting are covered by the *Canada Health Act*. As a result, financial hardship due to high drug expenses outside the hospital context is increasingly a real risk – indeed, it is a reality – for many Canadians.

Information provided to the Committee suggests that those currently protected from such financial hardship generally include:

1. Canadians who belong to private drug insurance plans which protect plan members against high drug expenses by effectively limiting the maximum amount a plan member must pay;
2. Canadians on social assistance and low income seniors, as these groups are eligible for public coverage which protects them against high prescription drug expenses in all provinces;
3. Canadians residing in provinces where public drug benefit plans are available to limit the overall amount any plan member must pay for prescription drug costs (Alberta, British Columbia, Manitoba, Ontario, Quebec and Saskatchewan).

The protection available from the various plans noted above is, however, by no means uniform or absolute. For example, access to the kind of provincial plan coverage described above is not automatic in all of the provinces noted above and, only a small minority of private plans caps the financial exposure of plan members.

In the four Atlantic provinces, there is no generally available public program to limit exposure of individuals and families to high prescription drug costs. Moreover, private plan coverage of any kind is less common in the Atlantic region. In fact, a recent study funded by Health Canada’s Health Transition Fund found that over 25% of the population of the Atlantic region are without catastrophic coverage for prescription drugs and that another 25% might be considered under-insured.<sup>20</sup> It is clear that the residents of Atlantic provinces require substantial improvement in their drug insurance coverage.

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<sup>20</sup> Applied Management in association with Fraser Group Tristat Resources, *Canadians’ Access to Insurance for Prescription Medicines: Volume 2 – The Un-Insured and Under-Insured*, Submitted to Health Canada’s Health Transition Fund, March 2000.

These general findings were put into a specific human context through the real-life experience of one Atlantic Canadian whose circumstances became known to the Committee. Although a professional librarian and a member of a good quality employer-sponsored plan, the individual in question faces personal out-of pocket costs of \$17,000 annually due to his wife's requirement for prescription drugs costing \$50,000 a year. This example clearly illustrates that even people with excellent drug insurance plans are not fully protected against the risk of undue financial hardship arising from catastrophic drug costs.

### **8.9.1 A National Pharmacare Initiative**

The issue therefore is how to improve coverage for prescription drugs. In recent years, a number of experts have recommended that the federal government develop, in collaboration with the provinces and territories, a national Pharmacare initiative as a means of broadening insurance coverage to medically necessary drug therapy. A national Pharmacare initiative would expand coverage to those who are uninsured or under-insured and provide more uniform prescription drug benefits for the entire population.

There is no single model for a pan-Canadian Pharmacare initiative and a number of complex issues can influence the design of such a program. These include deciding:

- who should be covered (e.g., everyone, or specific groups of the population such as seniors or social assistance recipients, etc.);
- what is covered (e.g., all prescriptions, or specific categories of prescriptions, etc.);
- whether the focus should be on paying for all drug costs or on protecting against high drug expenses;
- how it should be financed (e.g., public financing only or a mix of public and private funding with deductibles, co-payments, etc.); and,
- how it should be delivered (e.g. through provincial drug programs and/or private plans and/or a new federal program).

Different experts offer different answers to each of these questions. There is also considerable controversy concerning the costs of setting up a national Pharmacare program and ensuring its long-term viability. In 1997, Palmer d'Angelo Consulting Inc. estimated the cost of funding several models of a national and universal Pharmacare program. Here is a summary of the major findings of this study:

- A fully funded, comprehensive, publicly administered, national Pharmacare plan that conforms with the principles of the *Canada Health Act* would increase public expenditures on prescription drugs by an estimated \$4.3 billion.
- Other publicly administered and funded plans that require patients to pay user charges (15.9%) and dispensing fees would increase public expenditures

by \$2.1-\$2.5 billion. These plans would in essence “nationalize” current private plans.

- With a national Pharmacare plan similar to the drug plans that exist in Saskatchewan and Manitoba (which require very high user charges), public expenditures would fall by almost \$0.5 billion. However, expenditures by individuals would increase by \$0.9 billion.
- The impact on the public purse of a mixed public/private plan is considerably less than that of a public-only plan. The incremental increase in expenditures range from \$0.1 billion with a plan similar to that currently in Quebec, to \$1.5 billion for a plan that provides true first dollar coverage.<sup>21</sup>

Clearly, the cost of funding a national Pharmacare program would vary according to how it is designed. A recent study by Dr. Joel Lexchin suggested that although such a system would increase public spending, it would nonetheless save money by reducing administrative costs.<sup>22</sup>

As a basis for Committee consultation and dialogue, four possible options for a national Pharmacare initiative are set out below, each offering a different focus and design.

### **8.9.2 A Comprehensive Public Program**

A fully public national Pharmacare program could be financed by both the federal government and the provinces/territories either through increased CHST transfers or through a new cost-shared funding arrangement involving 25%, 50% or more in federal money. Such a program could provide first dollar coverage and therefore comply with the *Canada Health Act*. Or it could require user charges, in which case federal funding could be subject to a “revised” *Canada Health Act* or to a set of new conditions. This would be a “greenfield initiative”, replacing all current federal and provincial public drug insurance programs and would also likely make current private drug insurance plans largely redundant.

### **8.9.3 A Comprehensive Public/Private Initiative**

Like Option 8.9.2, this initiative would focus on providing universal access to coverage for all drug expenses. However, it would do so through a partnership effort among the federal government, provincial governments and the private sector in order to expand the coverage that is currently offered under both public and private plans.

Federal cost-sharing could be provided to the provinces for the expansion of provincial drug program coverage. A special focus in this regard would be the Atlantic provinces, where there are currently no drug plans that are universally accessible. At the same

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<sup>21</sup> Palmer d’Angelo Consulting Inc., *National Pharmacare Cost Impact Study*, September 1997.

<sup>22</sup> Dr. Joel Lexchin, *A National Pharmacare Plan: Combining Efficiency and Equity*, Canadian Centre for Policy Alternatives, March 2001.



time, however, equity would require providing federal assistance to those provinces which have already put in place broadly accessible programs. Such assistance could serve to encourage these latter provinces to maintain and even expand their coverage.

Recognizing that some provinces might not respond well to the cost-sharing incentives, and that therefore such programs might not reach the entire population, federal financial incentives could also be made available to private plans to encourage expansion of coverage to those who are currently un-insured and under-insured but still have some connection to the world of work (e.g. part-time workers, workers in transition between jobs, etc.).

Federal assistance to the provinces could be made subject to a number of conditions, including elimination of the major disincentives to private drug coverage posed by current provincial taxes on insurance premiums and retail sales taxes on supplementary health insurance premiums. It should be noted that Quebec used a hybrid public/private model to implement its Universal Drug Program, which has been in effect since 1997.

#### **8.9.4 Public/Private Initiative to Protect Against High Drug Expenses**

Unlike Options 8.9.2 and 8.9.3, which seek to pay for all or virtually all prescription drug costs, this option would focus on ensuring that all Canadians are protected against undue financial hardship arising from high drug expenses. This option would focus on protecting Canadians, including those who now have private drug insurance coverage, from the type of catastrophic situations described in the example in the last paragraph of Section 8.9. As such, this option is a safety net option.

Like Option 8.9.3, this option would involve a shared effort among the federal government, provincial governments and the private sector to build upon and expand protection under provincial public plans and private plans against high drug expenses. Substantial federal cost-sharing would be available to universally accessible provincial programs that capped individual exposure to high drug costs at an appropriate limit. Such a limit might be a specified percentage of income (e.g. 4% or lower, as in some current programs) or a dollar amount (e.g. \$1000 per year).

As in the previous option, a special priority would be placed on inducing the Atlantic provinces to introduce provincial programs of this nature. However, cost-sharing would also be available for existing provincial drug insurance plans which already have this kind of protection.

Moreover, as in Option 8.9.3, recognizing that some provinces might not respond to the cost-sharing incentives and that hence such provincial public programs might not reach the entire population, federal financial assistance could be made available to private plans to induce them to cap the out-of-pocket expenses of individual plan members at a specified limit

(e.g. \$1000/year). As under Option 8.9.3, the federal-provincial dimension could include conditions, such as the removal of the provincial tax disincentives on private drug insurance coverage.

Option 8.9.4 is likely to become increasingly important as drug costs rise and as high priced biotech drugs become an increasing part of drug utilization. There is a risk that such rising costs could cause some employers to discontinue prescription drug insurance plans. However, if employers knew that financial assistance would be made available from government once their plan had reached the limit of an employee's drug coverage, this might well persuade them to keep their existing drug plans.

### **8.9.5 Tax Initiative to Protect against High Drug Expenses**

Like Option 8.9.4, this option would focus on capping an individual's exposure to high drug expenses. However, the tax system, rather than public and private drug insurance plans, would be the delivery mechanism.

Under this option, Canadians with expenses for "medically necessary" prescription drugs above some threshold (e.g. a percentage of income, probably in the range of 2% to 4%) would receive a tax credit for the excess amount. This credit would reduce taxes otherwise payable (for higher income taxpayers) or be paid out as a refundable tax credit (for lower income earners owing no tax). It could be designed by modifying the current Medical Expenses Tax Credit or by introducing a new, separate tax credit. Such an option would require the development of an official drug formulary listing all the "medically necessary" drugs.

One drawback to this approach is the retrospective nature of tax filing – it only helps with last year's high drug expense. This coverage could be rendered virtually irrelevant due to the prior death and/or prior personal insolvency of the intended beneficiary. This option would be more readily adaptable to meeting the needs of those with chronic high drug cost problems.

## **8.10 Home Care**

Home care is generally defined in terms of services provided to individuals in their homes. Home care does not include care provided privately or publicly in a residential facility for long-term or continuing care purposes. There is no agreement about what services should be included in the definition of home care. Home care services can cover some types of acute care such as intravenous therapy and dialysis, long-term care provided for individuals with degenerative diseases such as Alzheimer's or chronic physical or mental disabilities, as well as end of life care for people with terminal conditions, or personal support services such as attendant services and technical aids. Home care can include both health care and social support services such as monitoring, assessment, co-ordination, nursing, homemaking, nutritional

counselling and meal preparation, occupational and physical therapies, pain control, emotional support and self-care instruction.

Thus, home care services can extend along a continuum that incorporates medical interventions as well as societal supports. Home care can be provided by formal providers who are predominately nurses, therapists, and personal support workers, or by informal caregivers who are usually family members or friends.

The 1998/99 Population Health Survey found that the majority of those who report needing care in the home due to aging, chronic illness or disability, received no formal, publicly funded care whatsoever. Between 80% and 90% of all home care in this group is unpaid. The survey did not report to what extent needs that were not being met publicly are met by private payment, by informal caregivers, or simply go unmet.

During its Phase Two hearings, the Committee heard that 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.

Currently, each province and territory offers some form of home care program. But because home care is not considered a “medically necessary” service under the *Canada Health Act*, publicly funded home care programs vary greatly across the country in terms of eligibility, scope of coverage and applicable user charges. All jurisdictions cover services such as assessment and case management, nursing care, and home support for eligible clients. But only some provinces include various types of therapy (such as physiotherapy, speech therapy, respiratory therapy) in their publicly funded home care programs. If home care clients want services beyond those covered, they typically have to pay for them. Although home care provision has increased in most provinces in recent years, public spending on home care still represents a small proportion of overall provincial health care budgets.

Recent studies suggest that home care is cost-effective in some cases, although it seems clear that in many cases institutionalized care remains more efficient, particularly for the frail elderly. In addition, institutionalized care is always easier for service providers. However, cost and the ease of service delivery are not the only factors to be taken into account – many people want to be able to receive care in their homes, rather than in institutions. At the same time, this does not mean they want to be at home without the benefit of adequate care.

Effective home care can contribute to lower long-term costs for the health care system for a number of reasons:

- it reduces the pressure on acute-care beds by providing medical interventions in a lower-cost setting and making use of hospital resources only when really

needed (that is, home care acts as a substitute for keeping the patient in an acute-care hospital);

- it reduces demand for long-term beds by providing a viable choice for aging Canadians to maintain their independence and dignity in their own homes (that is, home care acts as a substitute for nursing-home care);
- it enables palliative care patients to spend their final days in the comfort of familial surroundings (that is, home care acts as a substitute for palliative care institutions).

Many witnesses contended that when home care substitutes for acute care, it should be treated in the same way as acute care delivered in other settings and, accordingly, it should fall under the parameters of the *Canada Health Act*.

With respect to home care that substitutes for long-term and palliative care, the issue was raised as to whether patients should be required to contribute a larger co-payment to help cover the cost of these services as long as they have the necessary financial resources. Such a larger co-payment is already required in some provinces but not in others. Where it is applied, many long-term care patients are obliged to exhaust most of their personal resources before their care is fully paid for by the government.

This issue can be summed up in the following question: is it reasonable for tax dollars to be used to pay the cost of long-term and palliative care for an individual who has the personal resources to be able to pay for their care, even if that care is provided in a long-term care institution, such as a nursing home? In other words, should individuals be subsidized by government so that they can leave a larger legacy to their children? The Committee welcomes the views of readers on this question.

Many witnesses suggested that the federal government presently has several financial avenues for influencing home care outcomes in Canada. These are outlined below:

### **8.10.1 A National Home Care Program**

Under this option, the federal government would increase its transfers to assist the provinces and territories in developing home care programs in their respective jurisdictions. This could be done either through the CHST or through a new cost-sharing arrangement.

The program could provide first dollar coverage and therefore comply with the *Canada Health Act*, or it could require user charges, in which case federal funding could be subject to a “revised” *Canada Health Act* or to a set of new conditions.

This program could be either universal or targeted to selected population groups (e.g. the elderly or the mentally ill) or to some types of home care services (e.g. palliative care).

The federal government would have to work closely with the provinces and territories to develop national home care standards, including agreement about core services and human resource supply. The elaboration of national standards is a critical issue if home care is ever to become an integrated part of Canada's health care delivery system. The question of human resource supply is also front and centre, given the shortage of trained home care service providers, and is discussed in more detail in Chapter 11.

### **8.10.2 Tax Credit and Tax Deduction to Home Care Consumers**

The federal government could offer enhanced financial assistance to home care consumers through tax changes. Presently, such assistance is offered through a variety of measures:

1. The Medical Expense Tax Credit (METC) is available to all taxpayers with above average medical costs. For the year 2000, the METC reduced the federal tax of an individual by 17% of qualifying medical expenses in excess of the lesser \$1,637 or 3% of net income. There is no upper limit on the amount of expenses that may be claimed.
2. The Refundable Medical Expense Supplement provides increased tax assistance for low-income individuals in the paid labour force with higher-than-average medical expenses. The supplement is calculated as 25% of the allowable portion of eligible medical expenses determined under the METC, up to a maximum of \$500. It is available only to individuals with at least \$2,535 in earned income and is reduced by 5% of net family income above \$17,663 to ensure that only low- and modest-income individuals receive benefits.
3. The Disability Tax Credit (DTC) recognizes the effect of a severe and prolonged mental or physical impairment on an individual's ability to pay tax. For 2000, the DTC equalled about \$730. It should be noted that this is unlikely to be of much help considering the real costs of home care;
4. The Attendant Care Expense Deduction (ACED) is intended to reduce barriers to work. The ACED permits a patient or disabled person to deduct up to two-third of earned income for the costs of attendant care expenses that are required to enable the individual to participate in the labour force.

Suggestions for tax changes could include increasing the Medical Expenses Tax Credit on federal income tax and expanding the Attendant Care Expenses Deduction to include a deduction from the caregiver's income and to allow a deduction from all income sources, not just earned income.

In addition, consideration should be given to potential tax incentives to encourage people to put money aside for their long-term care needs. Such incentives could be

structured in a fashion similar to RRSP and RESP incentives. However, individuals with low income would either be unable to contribute or would receive a smaller tax deduction than higher income Canadians.

### **8.10.3 Creating a Dedicated Insurance Fund to Cover the Need for Home Care**

An insurance fund approach has been suggested by the Clair Commission in Quebec to cover long-term loss of autonomy. Such a fund would be separated from general government revenue and be administered on a non-profit basis by a financial institution like the CPP or QPP pension boards. The plan would be funded through a mandatory contribution based on personal income from all sources (or it could be financed through both employer and employee contributions). The plan would be capitalized (at a rate to be determined) in order to decrease the foreseeable financial impact linked to the cost of these services for the younger generation.

Home care could be offered through benefits in kind or monetary benefits. Monetary benefits for home care would be determined, as needed, through the care plan. They would be non-taxable in the hands of the beneficiary or recognized caregivers, depending on levels and circumstances to be determined.

### **8.10.4 Specific Measures aimed at Informal Caregivers**

In Phase Two of our study, witnesses expressed concern that the reduction in in-patient hospital services has increased the burden of care on families and friends of patients. The Committee was told that the majority of informal caregivers are women who support their family members and who must often simultaneously manage responsibility for aging parents, for their own children while holding down full-time paid work.

Currently, more than 3 million Canadians – mostly women – provide unpaid care to ill family members in the home. The Committee's Phase Two report indicates that, up to age 75, women are much more likely than men to have provided health care support to a family member. In addition, more women are being conscripted into unpaid health care work and do so without training and with little support. This combination of pressures can lead not only to stress-related illness and loss of work time for the caregiver, but can also increase the risk of neglect and mistreatment of the care recipient.

In the view of the Committee, it is very important to consider the support given to informal caregivers. The recent introduction of the caregiver tax credit (in 1998) is an encouraging sign of the federal government's awareness of the important role played by informal caregivers. Under this tax credit, Canadian taxpayers providing care to an elderly parent or a family member can reduce federal tax by up to \$400 annually. However, it must be recognized that the current limit of \$400 is inadequate to compensate informal caregivers for the time and resources that they provide.

Therefore, there is a need for further financing support for Canada's informal caregivers. The National Advisory Committee on Aging has recommended that the Canada Pension Plan (CPP) and Employment Insurance be adjusted to accommodate individuals who leave the workforce temporarily to provide informal care:

- The CPP currently allows people who have left the workforce temporarily to care for their children to drop these periods of little or no income from the calculation of CPP benefits. These CPP drop-out provisions could be extended to support informal caregivers who have left the workforce to care for ailing relatives.
- The EI system covers temporary disruptions of an individual's participation in the workforce. Providing EI benefits to persons leaving the workforce to care for an ailing relative would ease the financial burden of informal caregiving. It has been estimated that this option would increase the overall cost of the EI system by about \$670 million per year.

The Committee was also told that the current respite needs of informal caregivers in Canada are significant. However, informal caregivers face a number of challenges in accessing respite care:

- Respite care is targeted for situations where the caregiver is seen to be on the verge of burn-out, rather than being offered early and on an ongoing basis to enable caregivers to take on the extra work of care-giving. In other words, respite care is often used as a service to address burn-out and not as a way to prevent burn-out or illness.
- When a respite program is put in place, the services offered usually focus on replacing the caregiver while he/she has time away, rather than providing a good menu of respite choices.
- Respite programs are set up and funded separately from other community/home care and long-term care services. There is a need to better integrate respite care with the range of existing services available through institutional long-term care, hospital care, home care and community agencies.

The Committee would like to hear from readers on these options and welcomes any other options not mentioned in the report.

## **8.11 Summary**

The issues and options related to the financing role of the federal government in health care are complex, multiple and interrelated. The table below lists the options presented in this chapter.

Decisions must be made about the form and the size of federal funding for health care. If the level of federal funding is to be maintained or expanded, we must consider whether the government should continue to generate revenue through general taxation or whether other revenue could be raised through some form of direct payments by consumers. If direct consumer payments are permitted, it needs to be decided whether they should apply to all publicly funded health services, including physicians and hospitals, or only to an expanded scope of services. Allowing direct payment of publicly funded health services would require that the accessibility principle of the *Canada Health Act* be revisited.

<b>OPTIONS FOR THE FINANCING ROLE OF THE FEDERAL GOVERNMENT</b>	
<b>Changes in Health Care Delivery (8.2)</b>	Improving Efficiency and Effectiveness (8.2.1)
	Primary Care Reform (8.2.2)
	Regionalization of Health Services (8.2.3)
	Contracting Private For-Profit Facilities (8.2.4)
	Promotion, Prevention and Population Health (8.2.5)
<b>Form of Federal Funding for Health Care (8.3)</b>	Cost-Sharing (8.3.1)
	Current Block-Funding (8.3.2)
	Improved CHST (8.3.3)
	Medical Savings Accounts (8.3.4)
	Tax Transfers (8.3.5)
<b>Raising Government Revenue for Health Care (8.4)</b>	<i>Through General Revenue</i>
	Reallocating Existing Revenue to Health Care (8.4.1)
	Increased Taxation (8.4.2)
	<i>Through Direct Payments</i>
	User Charges (8.4.3) Income Tax on Health Care (8.4.4) Health Care Premiums (8.4.5)
<b>Private Health Care Insurance (8.4.6)</b>	For Health Services Delivered both Publicly and Privately
<b>Public Health Care Coverage (8.7)</b>	De-listing Services (8.7.1)
	Expanding Coverage (8.7.2)



<b>Reducing the Cost of Prescription Drugs (8.8)</b>	National Drug Formulary (8.8.1)
	Use of Lowest Cost Effective Drug (8.8.2)
	Advertising of Prescription Drugs to the Public (8.8.3)
<b>Expanding Coverage for Prescription Drugs (8.9)</b>	National Pharmacare Initiative (8.9.1)
	A Comprehensive Public Program (8.9.2)
	A Comprehensive Public/Private Initiative (8.9.3)
	Public/Private Initiative to Protect Against High Drug Expenses (8.9.4)
	Tax Initiative to Protect Against High Drug Expenses (8.9.5)
<b>Home Care (8.10)</b>	National Home Care Program (8.10.1)
	Tax Credit and Tax Deduction (8.10.2)
	Dedicated Insurance Fund for Home Care (8.10.3)
	Specific Measures for Informal Caregivers (8.10.4)

In order to relieve some of the pressures on public financing, it could be decided to allow private health care insurance to compete directly with public plans. Permitting private insurers to provide coverage similar to that offered under public health care insurance plans would necessitate a revision of the public administration principle of the *Canada Health Act*.

Canadians must also decide whether additional health services should be financed publicly and, if so, which services should be subject to public funding. There have been many discussions in recent years about broadening the scope of public financing to include prescription drugs and home care. Many options need to be considered here, ranging from federal and provincial/territorial collaboration in establishing national Pharmacare and Home Care programs to the creation or enhancement of tax credits and deductions for drug and home care costs. If the federal government is to provide funding for prescription drugs and home care, should this funding be subject to the principles of the *Canada Health Act*? Or do we need another set of principles?

Finally, it is important to remember that the renewal of the federal role in financing health care must be examined at the same time as that we consider other activities aimed at improving health care delivery, such as enhancing our ability to conduct research, developing a health infostructure and implementing population health projects and programs. It is to these issues that we now turn.



## **CHAPTER NINE:**

### **ISSUES AND OPTIONS FOR THE RESEARCH AND EVALUATION ROLE**

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The role of the federal government in the field of research and evaluation is twofold: it encompasses both funding for health research and financial support for the evaluation of pilot projects.

The federal government has had a long tradition – over 40 years – in financing health research. In fact, up until 1994, the federal government was the main source of funding for health research in Canada. The Canadian Institutes of Health Research (CIHR) is currently the principal federal funding body for health research.

From time to time, the federal government also fulfils its role in health research by giving financial support for establishing and evaluating pilot projects that are designed to encourage innovation in health care delivery. Examples of such federal involvement include the Health Transition Fund (HTF, 1997 to 2001), which supports pilot projects undertaken jointly with provincial and territorial governments in the fields of Pharmacare, home care, primary care and integrated service delivery, as well as the Canada Health Infostructure Partnerships Program (CHIPP, 2000 to 2002), which supports provincial and territorial projects using new information technology in health care.

Throughout the Committee's hearings on health research, there was unanimous consent among witnesses that funding innovative research and project evaluation should remain a major responsibility of the federal government. With respect to health research, the main concern raised by witnesses was that Canada's funding level is low in comparison with other industrialized countries and that the federal government should devote more funding to health research. Other issues raised in the hearings related to the transfer of knowledge, regional disparities and ethics.

With regard to the evaluation of pilot projects designed to test new ways of delivering health care, all witnesses agreed that the federal government should maintain or increase its level of funding, while simultaneously addressing the issue of regional disparities. The latter issue arises because federal funding for pilot projects usually requires that a provincial government match the federal financial contribution. For Canada's poorer provinces, this is often not financially possible. Thus, most of the pilot projects supported by the federal government are in the richer provinces, and the poorer provinces which most need the help receive very little.

## 9.1 Innovative Health Research

Canada has an international reputation for excellence in health research. Going back to the days of Banting and Best and the discovery of insulin more than 75 years ago, Canadian researchers have made discoveries that make a difference in the lives of people around the globe. For example:

- Canadian research pointed out that one dollar spent on early childhood intervention saves, on average, seven dollars in education, social services, justice system and health care costs;
- Canadian researchers discovered and developed 3TC, a drug that helps extend lives for many people living with HIV and AIDS.

Everybody agrees that health research will be one of the major drivers of change in Canada's health care system in the coming years. The knowledge that is gained as a result of health research translates directly into better diagnosis, treatment, cure and prevention of many diseases. This, in turn, leads to reduced health care costs by:

- reducing both the social and economic cost of illness, through the development of new drugs, products, and technologies that shorten hospital stays, speed healing, and prolong good health;
- improving the efficiency and effectiveness of health care delivery; and,
- curing disease.

The federal government plays a major role in supporting health research carried out in universities, teaching hospitals and research institutes ("extramural" research), as well as in its own laboratories ("intramural" research). During Phase Two of its study, the Committee was told that strategic investment today by the federal government in programs and initiatives like the Canadian Institutes for Health Research (CIHR), the Canadian Foundation of Innovation (CFI), the Canadian Health Services Research Foundation (CHSRF), Genome Canada and the Canada Research Chairs (CRCs) will pay huge dividends for our health care system tomorrow.

Ongoing advances in genetics and genomics are of particular interest. For example, the ability to identify people whose genes make them susceptible to a given disease will enable a profound shift to take place in health care – moving the emphasis from disease treatment to disease prevention and health promotion. The better we understand the molecular mechanisms that underlie disease, the sooner we will be able to develop an entirely new generation of drugs that can combat the alterations made by disease to our molecular machinery. This knowledge, coupled with our growing appreciation of the complex interplay between genetic, social, and environmental factors that determine our susceptibility to disease, will transform our health care system over the next 10-20 years.

The creation of the CIHR by the federal government in April 2000 recognizes the critical link between a cost-effective and innovative health care system and a vibrant, internationally competitive health research industry. The CIHR brings together all four pillars of health research – biomedical, clinical, health services and systems, and population health research. It encourages Canadian researchers to take an integrated approach to the health issues that concern Canadians.

### **9.1.1 Increasing the Federal Share of Health Research Funding**

The federal government plays an important role in funding health research in Canada. For example, in 1998, almost \$370 million of federal funding was allocated to health research. This was prior to the establishment of the CIHR. However, the proportion of health research funding provided by the federal government declined steadily from a high of 28% in 1992 to 16% in 1998. Since 1994, the pharmaceutical industry has been the leading source of funds for health research in Canada.

The federal government believes that its position in terms of health research funding will greatly improve as a result of the establishment of the CIHR along with additional investment announced in both the February 2000 budget and the October 2000 Economic Statement and Budget Update. The federal government also provided an additional grant of \$140 million in February 2001 to Genome Canada bringing its total budget to \$300 million.

During its Phase Two hearings, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other countries in this regard. In fact, the role of the national government in financing health research, expressed in purchasing power parity (PPP) per capita, is far more important in the United States, the United Kingdom, France and Australia than in Canada. For example, the American government provides four times more funding per capita to health research than does the Canadian government.

Witnesses unanimously recommended that the federal government's share of total spending on health research should be increased to 1% of total health care spending from its current level of approximately 0.5%. This would mean at least doubling CIHR's current budget to \$1 billion. In the view of several witnesses who testified before the Committee, this would bring the level of the federal contribution to health research more in line with that of national governments in other countries. More importantly, such federal investment would help maintain a vibrant, innovative and leading edge health research industry.

The Committee welcomes opinions on the option of raising the federal share of total spending on health research to 1% of total health care spending. We are particularly interested in obtaining views on how this greatly expanded federal funding for health research should be invested: should it be strategically targeted to the development of a number of areas (such as Aboriginal health, rural health, mental health, gender analysis, determinants of health,

home care, etc.), or should it be distributed more evenly across the full range of health research areas?

### **9.1.2 Sustaining the Transfer of Knowledge**

The Committee was told that the outcomes of health research must be made available, notably to policy-makers and health care providers, but also to the general public. There is a need to establish a public awareness campaign to inform Canadians about, among other things, genetic research, animal cloning, and embryo research. There is also a need to disseminate the results of health research to health care providers and policy makers. The timely transfer of knowledge generated by health research to policy makers and health care providers would greatly enhance evidence-based decision-making to the benefit of all Canadians.

One organization, the Canadian Health Services Research Foundation (CHSRF), is dedicated to knowledge transfer. The CHSRF is a not-for-profit organization established with federal funding whose mission is to sponsor and promote applied research on the health care system in order to enhance its quality, and to facilitate the use of research results in evidence-based decision-making by policy-makers and health care managers.

The CHSRF is devoted to health services research. What is needed, therefore, is an organization whose task would be to disseminate the results of biomedical and clinical research. One option could be to establish such an organization within the CIHR or within Health Canada. Another option could be to create a separate federal agency devoted to this task.

### **9.1.3 Reducing Regional Disparities**

The Committee heard that there is great regional disparity in terms of health research capacity across the country. For example, some medical facilities and academic health centres, particularly in the Atlantic provinces and in the Prairies, are currently under-funded and unable to respond to the challenges of contributing to Canada's success in developing a globally competitive health research industry.

Provinces that do not have a critical mass of expertise and proven excellence are at a severe advantage both in grant competitions and in the recruitment and retention of talented personnel. Provinces with larger budgets are able to offer salaries and resources that lure away well-trained and talented researchers from provinces with smaller budgets. Witnesses told the Committee that this internal competition for talented people is counter-productive and that this matter requires rapid attention from the federal government.

The Committee was glad to hear that the CIHR currently manages the Regional Partnerships Program (RPP) which provides health research funding dedicated to reduce regional disparities. Six provinces are eligible for funding under the RPP: Saskatchewan, Nova

Scotia, Newfoundland, Manitoba, Prince Edward Island and New Brunswick. In addition to funding health research, the RPP supports local strategic planning processes to establish research priorities and partnerships, emphasizing the recruitment and retention of promising and/or excellent researchers, building on local strengths and priority interests of the research institutions.

The Committee would like to hear comments about the RPP programs as well as about other potential options on how the federal government can contribute to reducing provincial disparities in health research capacity.

#### **9.1.4 A National Human Research Ethics Oversight Body**

The Committee was told that health research must be undertaken in a way that ensures that the highest ethical standards are respected. Witnesses stressed that health research requires transparent and credible ethical procedures, primarily so that human subjects involved in research can be protected. Ethical principles must apply to all health research activities. It is also important to monitor, analyze and evaluate ethical issues pertaining to health research.

Recently, the CIHR, along with two other federal agencies funding research, the Social Sciences and Humanities Research Council (SSHRC) and the Natural Sciences and Engineering Research Council (NSERC), announced the creation of a new governance structure, the “Panel on Research Ethics,” which will govern federal policy relating to the ethical conduct of research involving human subjects. This policy is entitled *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS). The Committee was told that while the current policy has high standards, effective oversight is required to ensure compliance with those standards. Moreover, the Panel on Research Ethics will review research funded by the CIHR, the SSHRC and NSERC, not all health research performed in Canada.

It was suggested that a national oversight body independent from the CIHR be established to provide ethics review functions for all publicly and privately funded health research, and in particular research using human embryo or foetal tissue, including embryonic stem cell research. We welcome your views on such a national oversight body.

## **9.2 Financing and Evaluation of Innovative Pilot Projects**

In recent years, the federal government has been involved in the financing of pilot projects aimed at improving the delivery of health care. An important component of these pilot projects is the requirement to provide an evaluation of outcomes, including reporting on the impact of the project on health status and on health services utilization, its cost effectiveness, and improvements made in the provision of care.

For example, in 1997, the federal government announced the Health Transition Fund (HTF). This \$150 million Fund supported 141 projects and numerous sub-studies across

Canada in four priority areas: home care; Pharmacare/pharmaceutical issues; primary health care; and integrated service delivery. These projects were intended to generate evidence that governments, health authorities, hospitals and others could use in making informed decisions on how to provide better, more effective health services to Canadians. An overall evaluation of all these projects will be made public by Health Canada in March 2002.

Another example is the Canada Health Infostructure Partnerships Program (CHIPP), a two-year, \$80 million, shared-cost incentive program, which was announced in June 2000. The objective of CHIPP is to support the implementation of innovative applications of information and communications technologies in the field of health care. The overall goal is to help improve accessibility and quality of care for all Canadians, while enhancing the efficiency and long-term sustainability of the health care system. CHIPP supports projects in the areas of telemedicine, tele-homecare and electronic health records. Like HTF, an evaluation plan is required for all CHIPP projects.

### **9.2.1 Federal Investment in the Evaluation of Pilot Projects Aimed at Improving Health Care Delivery**

The Committee was told that pilot projects and evaluative research are expensive operations; however, there is no alternative to carrying them out if we are to obtain information on cost-effectiveness and health outcomes. The option here is therefore for the federal government to maintain, and even increase, the financial support it provides to the establishment and evaluation of pilot projects in the field of health care delivery.

### **9.2.2 Reducing Regional Disparities in the Funding of Pilot Projects**

A major concern, however, was raised with respect to federal programs which involve federal/provincial cost-sharing. The Committee was told that federal investment in pilot projects sometimes widens regional disparities.

For example, under CHIPP, federal funding requires matching funds from the applicant. The relative needs of the different regions for service improvements, or health service deficiencies in particular regions, were not considered to be relevant in the project selection. According to witnesses, those provinces that already had money got more money, and those in great financial need were not able to apply because they could not afford the matching funds. Witnesses stressed that, while the opportunity to change the design of CHIPP has passed, the federal government should ensure that other federal programs supporting the evaluation of pilot projects should not replicate this aspect of the CHIPP program. Program conditions should place greater emphasis on projects in locations that have the greatest need, the willingness to act, and the commitment to implement system change, and less emphasis on provincial financial contribution.



## **CHAPTER TEN:**

### **ISSUES AND OPTIONS FOR THE INFRASTRUCTURE ROLE: TECHNOLOGY AND INFORMATION SYSTEMS**

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The Committee understands the concept of “health care infrastructure” to encompass the broad mix of resources – both physical and human – that sustain the delivery of health care. In this sense, infrastructure includes not only bricks and mortar and medical equipment and technology, but also human resources, the educational sector and the information and communication systems that support health care providers.

As stated previously, the federal government is not responsible for the administration, organization and delivery of health care, except to specific subgroups of the Canadian population. It is thus the responsibility of the provinces and territories to determine how many beds will be available in their jurisdictions, what categories of health care providers will be hired and how the system will serve the population. However, the federal government has a long tradition of assisting the provinces and territories to fulfil these responsibilities.

A prime example of this role is the Hospital Construction Grants Program of 1948. Under this program, the federal government paid the full cost of building hospitals in every province and territory. As a result, from 1948 to 1960 the number of hospital beds in Canada increased at a rate that was twice that of population growth. Similarly, in the 1960s, the federal government contributed capital funds towards the expansion of a number of medical schools. These federal funds made it possible for most of the health science centres in this country to be built, helping to ensure the provision of high quality education for health professionals, research and patient care.

More recently, the federal government has provided funding to the provinces and territories for the acquisition of health care technology, the development of health information systems and the establishment of a public reporting mechanism on the state of health of Canadians and on the performance of the health care system.

In addition to targeted programs, federal transfers provided under the CHST are also available for use by the provinces and territories for investment in the health care infrastructure to improve both health care delivery and the education of health care providers.

During the Committee’s study, all the witnesses who participated in the hearings on health-related information pointed to the critical role of the federal government in the health care infrastructure. They all agreed that this role must be maintained, and even expanded. Two options can be proposed: 1) that the federal government maintain its current level of funding for health care infrastructure or 2) that this level of funding be increased. These options necessarily

involve trade-offs between the various components of the health care infrastructure (e.g. medical equipment versus human resources versus health information systems) as well as between the various components of the overall health care system (infrastructure versus hospital services versus home care.)

The options related to the federal role in the health care infrastructure are multi-faceted. For this reason, they will be dealt separately in the following sections. As well, given the broad range of issues pertaining to human resources in health care, the human resources options are covered in the next chapter.

## **10.1 Health Care Technology**

It is generally agreed that health care technology constitutes an important component of health care delivery in industrialized countries. Health care technology can improve the speed and accuracy of diagnosis, cure disease, lengthen survival, alleviate pain, facilitate rehabilitation and maintain patient independence. However, many issues were raised before the Committee about the availability, assessment and cost of both new and existing health care technologies in Canada. Witnesses stressed that these issues need to be addressed if Canadians are to derive the maximum benefits health care technology can provide, while still maintaining an affordable health care system.

The Committee was told that although Canada ranks 5<sup>th</sup> among OECD countries in terms of total spending on health care (as a percentage of GDP), it is generally among the bottom third of OECD countries in the availability of health care technology. For example, Canada lags behind many other countries in terms of access to CT scanners, MRIs and lithotriptors.

Availability is not the only issue with respect to health care technology. The “aging” of that technology is also of concern. For example, information provided to the Committee indicates that between 30% to 63% of imaging technology currently used in Canada is outdated. The Committee was told that the shortage of new technology and the use of outdated equipment impede accurate diagnoses and limit the quality of treatment that can be provided. This situation, which can have a negative impact on the health of patients, also raises concerns about the legal liability of health care providers.

During the Committee’s Phase Two hearings, witnesses contended that the aging of the Canadian population as well as increased public expectations will greatly influence future needs for health care technology. Many experts told the Committee that the current deficit in health care technology requires a serious re-evaluation of the way in which equipment is supplied, funded and distributed in Canada.

Witnesses also argued that the restricted availability of health care technology has often been translated into limited access to care and lengthened waiting times. The Committee

is concerned by the shortage of health care technology and the impact this might have on waiting times. In its view, timely access to diagnosis and treatment is a crucial objective that must be ensured in Canada's health care system (see Section 7.4).

### **10.1.1 Funding the Acquisition and Upgrading of Health Care Technology**

The federal government has recently responded to the deficit in health care technology. In September 2000, it announced that it would invest a total of \$1 billion in 2000-01 and 2001-02, to assist the provinces and territories in the purchasing of new medical equipment. This funding was made available upon passage of legislation in October 2000, and it allows provinces and territories to start making immediate acquisitions of necessary diagnostic and clinical equipment.

Although the medical community has welcomed this injection of new federal funds, a number of concerns remain. First, some provinces have not applied for their share of this fund, possibly because the federal government requires matching grants. Second, the Committee heard that there are apparently no mechanisms for ensuring accountability on the part of the provinces as to exactly where money targeted towards purchasing new equipment is actually spent. Third, additional resources are required to operate the equipment. Estimates suggest that a \$1 billion investment in new equipment necessitates an additional \$700 million to cover operational costs. And fourth, this investment does not address the problem of the old equipment that needs to be upgraded. It was estimated that a further \$1 billion investment would be required for the upgrading of existing equipment.

One option could therefore be to have the federal government commit to a longer term program of financing for health care technology. Such federal funding would encompass both the acquisition of new health care technology and the operation and upgrading of existing equipment. As part of this program, provincial and territorial governments could be required to report to Canadians on how they have invested these federal funds; otherwise, the federal government has no way of knowing if its money is spent on the things it is intended to be used for.

The decision to acquire new health care technology should also be based on the appropriate assessment of its efficacy and cost-effectiveness. This issue is discussed in more detail below.

### **10.1.2 Investing More in Health Care Technology Assessment**

Health care technology assessment (HTA) provides information on safety, clinical effectiveness and economic efficiency. HTA can assist in deciding whether a new technology should be introduced and when an existing technology should be replaced. More importantly, HTA contributes in many ways to improving the quality of health care: it ensures that health care technologies are effective, that they are applied in the appropriate cases and conditions, and that the least costly technology is used to achieve the desired outcome.

Both federal and provincial/territorial governments support various HTA agencies. At the federal level, the Canadian Co-ordinating Office for Health Technology Assessment (CCOHTA) plays three major roles: it co-ordinates all HTA activities across the different jurisdictions; it attempts to minimize duplication by other national or provincial/territorial organizations; and it performs HTA activities on its own.

The Committee was told that not enough attention is devoted to HTA in Canada. For example, all levels of government invest less than \$8 million in Canada, whereas the United Kingdom provides some \$100 million to its national HTA body – the National Institute for Clinical Excellence (NICE). As a result, health care technologies are often introduced into the Canadian health care system with only superficial knowledge of their safety, effectiveness and cost.

Another important issue relates to the poor dissemination of the evidence generated by HTA activities to health care providers and managers. An improvement in this regard would certainly raise the quality of health care delivery and strengthen the formulation of public health care policy.

The main option therefore is for the federal government to invest more in health care technology assessment and to enhance the awareness and use of HTA findings. Raising the level of funding provided to the CCOHTA would help fulfil this option.

## **10.2 Health Information Systems**

During Phase Two of the Committee's study, witnesses stressed that a major weakness in our current health care system is that it still operates as a "cottage industry" (see the first part of Chapter 5), despite the fact that the health care sector is an extremely information intensive industry. Indeed, the most important single ingredient in any diagnosis or treatment is information. The health care sector in Canada is not making use of information and communications technology to the same extent as do other information intensive industries. Moreover, the health care system is not integrated: physicians and other health care providers, hospitals, laboratories and pharmacies all operate as independent entities with limited access to linkages that would enable a better sharing of information.

Greater use of information and communications technology along with better integration of health care providers and institutions would facilitate the determination of causal relationships between the various inputs typical of the health care system and the resulting outputs or outcomes. This would greatly improve evidence-based decision-making by health care providers, health care managers and health care policy makers. This would allow us to answer such questions as: Are we investing enough, too much, or too little in health care technology? Are there too many, too few, or just enough physicians, nurses, or other health care professionals? Are we getting our money's worth? Currently, we simply do not know the answers to these questions.

Many witnesses pointed to the urgency of improving our capacity to manage health information, and suggested that this be done even if it means that in the short term waiting lists become somewhat longer, less health care technology is purchased, and other expenditures are postponed. In the view of many witnesses, enhancing our ability to manage health information is essential to the survival of Medicare.

The use of information and communications technology in the field of health care is often referred to as “telehealth”. As discussed in the Committee’s Phase Two report, the telehealth applications that are envisioned in Canada for the purpose of sharing information and integrating health care delivery include a system of Electronic Health Records (EHR) and an Internet-based health information system:

- The EHR is an automated provider-based system within an electronic network that provides complete patients’ health records, including their visits to physicians, hospital stays, prescribed drugs, lab tests, and so on.
- An Internet-based health information network is a system that provides accurate, evidence-based health information to the general public on: health promotion and disease prevention; information on treatment options and drugs, as well as on illness management (e.g. blood pressure, diabetes or obesity); information on public health issues (e.g. quality of air, water and food); information on the effects of health determinants; and so on.

Telehealth is the foundation of what many people in Canada call the “health infostructure”. Various components of a health infostructure are currently being implemented at all levels of government. However, these initiatives are all at different stages of development. In addition, they are isolated within organizations, institutions and provinces and currently constitute “a patchwork of unconnected projects, whose value would increase immensely if part of a coherent whole.”<sup>23</sup> The key issue is how to bring all these diverse infostructures together.

This is what the federal government is seeking to achieve through the development of a Canadian Health Infostructure. The proposed Canadian Health Infostructure will not be a single massive structure, but a network of networks, building on the initiatives that are already in place or under development at the federal, provincial and territorial levels.

It is a great challenge to integrate the information systems of 14 jurisdictions (10 provinces, 3 territories and the federal government). It is also an ambitious, costly and long-term undertaking which will take years to bring into being. It will require that careful attention be paid to ensuring the privacy and confidentiality of patient information which will form the basis of the information systems. Most experts believe, however, that it is essential to do so if we wish to acquire reliable information on the health of Canadians, the state of our health care system, and on the efficiency and effectiveness of health services delivery and distribution. Most

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<sup>23</sup> Report of the National Conference on Health Info-Structure, February 1998, p. 19.

importantly, it appears imperative to do so if we want to improve the quality of health care Canadians receive.

### **10.2.1 Deployment of a Pan-Canadian Health Infostructure**

The federal government has been making financial contributions to the Canadian Health Infostructure since 1997. The provinces and territories have also expressed their desire to be involved in deploying a Canadian Health Infostructure. On September 11, 2000, the First Ministers agreed to work together to: 1) strengthen a Canada-wide health infostructure to improve quality, access and timeliness of health care for Canadians; 2) develop an electronic health record system and enhance technologies like telehealth over the next few years; 3) work collaboratively to develop common data standards to ensure compatibility of health information networks; 4) ensure stringent protection of privacy, confidentiality and security of personal health information; and 5) report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services.<sup>24</sup>

In support of the agreement reached by First Ministers, the federal government committed \$500 million in 2000-01 to accelerate the adoption of modern information technologies to provide better health care.<sup>25</sup> The Committee was told that this money will be invested in a not-for-profit organization, known as Canada Health Infoway Inc., that will work with provinces and territories to create the necessary common components of an EHR over the next three to five years. This will represent a major step towards the full integration of the health infostructures.

Considerable agreement exists among the provinces and territories and other stakeholders that the federal government should foster collaboration in this area. The Committee welcomes this collaboration between the federal government and the provinces and territories.

Estimates suggest that between \$6 and \$10 billion would be needed to achieve full implementation of the Canadian Health-Infostructure. Nonetheless, there is a wide consensus that the benefits of a pan-Canadian Health Infostructure will be enormous.

The only real option, therefore, is for the federal government to continue its leadership role, pursue its collaborative approach and provide increased funding to assure the full deployment of the Canadian Health Infostructure. Once again, provincial and territorial governments and health care stakeholders receiving federal funding should be required to report to the federal government on their utilization of these federal funds.

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<sup>24</sup> First Ministers Meeting, *Communiqué on Health*, News Release, 11 September 2000.

<sup>25</sup> First Ministers Meeting, *Funding Commitment of the Government of Canada*, News Release, 11 September 2000.

In implementing this option, priority should be given to electronic patient records, since this kind of system is the cornerstone of an efficient and responsive health care delivery system that is able to improve quality and accountability. Without this kind of infrastructure, the prospects for a truly patient-oriented health care system, and for enhancing efficiency in health care delivery, are dim. In fact, an EHR is essential if primary health care reform is to be realized.

### **10.2.2 Investing in Telehealth in Rural and Remote Communities**

Not only can telehealth applications enhance the sharing of information among the various health care providers and health care settings, but they also offer the possibility of delivering care over large distances. Telemedicine is a form of telehealth applications that can greatly improve quality and timely access to care, particularly in rural and remote Canada.

Up to 30% of Canada's population lives in rural, remote and northern areas of the country. Accessibility to health care is one of the four patient-oriented principles of the *Canada Health Act*. However, rural Canadians are increasingly voicing concern regarding disparities between services available in rural and remote areas and those in urban areas.

The federal government has responded to the concerns of rural Canadians in a number of ways. For example, the Office of Rural Health was established in September 1998 to ensure that the views and concerns of rural Canadians are better reflected in national health policy and health care system renewal strategies. In February 1999, the federal government announced funding of \$50 million over three years (from 1999-00 to 2001-02) to support pilot projects under the "Innovations in Rural and Community Health Initiative".

In June 2000, the federal government announced a National Strategy on Rural Health that it sees as an important milestone on the road to ensuring that all Canadians have reliable access to quality health care. Then, in July 2001, the federal government announced the establishment of a Ministerial Advisory Committee on Rural Health to provide advice to the federal Minister of Health on how the federal government can improve the health of rural communities and individuals.

Tele-medicine is an important component of the overall rural health policy of the federal government. In the context of rural health, telemedicine offers the following advantages: it addresses the shortage of rural health care providers and medical training; it improves rural health infrastructure; it enables conformity with the accessibility principle of the *Canada Health Act*; and it ensures a more equitable development of health information systems across the country.

The option suggested here is for the federal government to sustain its efforts in rural health and tele-medicine.

### **10.2.3 Ensuring Confidentiality and Privacy of Personal Health Information**

The issue of privacy, confidentiality and security related to personal health information in the context of the Health-Infostructure was perhaps the most sensitive one raised during the Committee's hearings on this question. While these three terms are sometimes used interchangeably, they are, in fact, entirely separate issues:

- *Privacy* refers to the right of individuals to control their personal health information – including the collection, use, and disclosure of that information.
- *Confidentiality* deals with the obligation of health care providers to protect the personal health information of their patients, to maintain its secrecy and not misuse or wrongfully disclose it.
- *Security* refers to the set of standards in and around information systems that protect access to the system and the information it contains.

In other words, privacy drives the duty of confidentiality and the responsibility for security. Protection of privacy in Canada is a shared responsibility between the federal and provincial/territorial governments. Currently, the legal framework for protecting individual privacy is composed of a patchwork of various laws, policies, regulations and voluntary codes of practice. The Committee was told that the first step that needs to be made is to gain support for the harmonization of legislation and regulation across Canada so that the privacy of Canadians will be protected in matters of health. Witnesses stressed that Canadians need to be assured that governments are taking all the necessary steps to implement stringent rules in this regard.

The Committee was pleased to learn that a resolution for the harmonization of legislation is being examined by all jurisdictions and that an agreement is expected soon. At the technological level, it has already been demonstrated that a greater level of confidentiality and security of personal health data can be achieved electronically than is possible in a paper world. The problems that must still be overcome concern mostly the architecture of the systems that are to be put in place, and their governance from a pan-Canadian perspective.

However, the Committee is concerned by the noticeable lack of progress among stakeholders with respect to Bill C-6, the *Personal Information Protection and Electronic Documents Act*. In November and December 1999, the Committee held hearings on this Bill. The hearings focused largely on concerns regarding the application of Part 1 of the Bill to the collection, use and disclosure of personal information. The Committee was of the view that, while Part 1 is adequate in setting minimum legal standards for protecting the personal information of Canadians in the commercial arena, the appropriateness of these standards for the health care sector was open to question. Therefore, the Committee amended the Bill so that its application to personal health information would be delayed for one year following the coming into force of the legislation (January 1<sup>st</sup>, 2001). The purpose of this amendment was to provide health care stakeholders with an opportunity to formulate legislative measures appropriate to the special



nature of personal health information and to put these changes in place by January 1<sup>st</sup>, 2002. The amendment was accepted by the House of Commons, and the Bill received Royal Assent on 13 April 2000.

When the Committee met on the issue of health-related information in May 2001, witnesses indicated that no consensus had yet been reached on the changes that are required to Bill C-6 to ensure the flow of data between health care stakeholders involved in the health infostructure. The application of Bill C-6 to organizations involved in health information systems as well as in health research must be clarified in order that they may continue to provide information that is critical for the improvement of the health of all Canadians. It is the hope of the Committee that solutions will be found to this problem before the end of the one-year moratorium on December 31<sup>st</sup>, 2001.

### **10.3 Accountability and Quality**

An important outcome of the Canadian Health Infostructure will be the generation of a massive amount of health information. In fact, the Canadian Health Infostructure will “enable the creation, analysis and dissemination of the best possible evidence as a basis for informed decisions by patients, informal caregivers, health care providers, health care managers and policymakers.”<sup>26</sup> It is the view of all levels of government, as well as of all health care stakeholders, that an evidence-based health care system can provide greater accountability and ensure continuous improvement to health status and health care delivery as well as a better understanding of the determinants of health.

The federal government, along with the provinces and territories, clearly made a commitment to move towards greater accountability in the area of health care with the signing of the First Ministers’ Agreement in September 2000. The Committee was told that a Performance Indicators Reporting Committee (PIRC), chaired by Alberta, with Newfoundland, Quebec, Ontario and Health Canada as members, is working to address issues and make recommendations on a list of indicators. Similarly, the report by the Canadian Institute for Health Information (CIHI), entitled *Health Care in Canada*, is a step towards a national accounting process for the health care system.

Recently, Minister Rock stated that the federal government is committed to creating a “Citizens’ Council on Quality Care. Decisions about how that council will be appointed and how it will function will be made in collaboration with provincial and territorial ministers of health.

The Committee strongly supports the ongoing development of performance indicators. Performance indicators should be developed according to a set of outcome-oriented goals, and will serve as useful tools in improving the quality of health care delivery. They will

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<sup>26</sup> Advisory Council on Health Infostructure, *Canada Health Infoway: Paths to Better Health*, Final Report, February 1999.

also provide the basis for enhancing accountability of government to the Canadian public as well as accountability between governments. The Committee also believes that a Citizens' Council on Quality Care could provide useful guidance in the development of outcome-oriented goals.

### **10.3.1 An Annual Report on the Health Status of Canadians and on the State of the Health Care System**

Currently, the Canadian Institute for Health Information (CIHI), which receives funding from the federal government and most provinces, is responsible for co-ordinating the development and maintenance of an integrated health information system. To this end, CIHI provides a series of indicators on the health status of Canadians and on the health care system. The option suggested here is to expand CIHI's information analysis and its capacity to report publicly.

### **10.3.2 A National Health Care Quality Council**

This option would be similar to the recommendation by the Fyke Commission in Saskatchewan, in that it suggests the creation of a National Health Care Quality Council that would be an independent, evidence-based organization, at arm's length from government. Its purpose would be to provide the most objective assessment and evaluation possible of health service delivery and it would report to both government and the general public. The Council would undertake analysis of the performance of the health care system, develop benchmarks and standards, undertake cost and benefit analysis of programs and services, and assess trends in health status, etc.

The performance indicators developed by the National Health Care Quality Council would lay the foundation for quality improvement and serve as a guide to resource allocation. The Council would pinpoint areas in need of support and allow the public to make more informed judgements on individual sectors and services, as well as on the overall system. This would greatly improve the prospects for optimizing the use of available public resources.

### **10.3.3 Ensuring Greater Government Accountability**

There are two directions to government accountability. The first involves the federal government reporting to Canadians on its policies and programs with respect to health care (public accountability). The second involves provincial/territorial reporting to the federal government on the use of federal transfer payments (government to government accountability).

The federal government could set a valuable example by establishing a permanent mechanism for reporting to the Canadian public on the impact of all its policies affecting health and health care. One possibility could be to create a Health Commissioner charged with this task. The initiative called "Healthy People" headed by the Surgeon General of the United States, with the collaboration of the US. Department of Health and Human Services, could be considered as a possible model. "Healthy People" establishes a set of health objectives to be

achieved over a decade, and these then serve as the basis for developing activities and programs at the community level. Leading health indicators are tracked for the purpose of evaluating progress in public policies in 10 broad areas: physical activity; overweight and obesity; tobacco use; substance abuse; responsible sexual behaviour; mental health; injury and violence; environmental quality; immunization; and access to health care.

The second form of accountability – government to government – may appear problematic for some people who feel that there should be no role for the federal government with regard to establishing the accountability of provincially delivered programs. Many witnesses rejected this view. Given the substantial amount of money the federal government contributes to the provinces for health care delivery, accountability to federal taxpayers requires that the government understands how well, or how poorly, its contributions are being spent. The affirmation of a role for the federal government with respect to government to government accountability is not meant to tread on provincial prerogatives, but rather to allow all Canadians to judge how their tax dollars are being spent, including by the federal government in its role of provider of services to specific population groups. The Committee looks forward to receiving ideas on how this form of accountability can be most effectively carried out.



## **CHAPTER ELEVEN:**

### **ISSUES AND OPTIONS FOR THE INFRASTRUCTURE ROLE: HEALTH HUMAN RESOURCES**

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#### **11.1 Introduction**

Talk of a 'crisis' in health care has a good deal of plausibility in relation to human resource issues, particularly with regard to the situation facing registered nurses (RNs) in Canada. The Canadian Institute for Health Information (CIHI) reports a decline of 7.2% in the number of RNs employed in nursing since 1989,<sup>27</sup> while the ratio of practising registered nurses to the Canadian population dropped from one nurse for every 120 Canadians in 1989 to one for every 133 Canadians in 1999. According to the Canadian Nurses' Association, there is looming crisis in the supply of qualified nursing personnel. The Association forecasts that by 2011 there will be a shortfall of at least 59,000 nurses in Canada, but that this shortfall could be as high as 113,000 if all the needs of an aging population are taken into account.

There are also shortages of other health care professionals, in areas ranging from laboratory technologists to pharmacists. Assessing the situation with regard to physicians is more difficult. While the total number of physicians has increased, the physician-to-population ratio has, despite fluctuations, remained relatively constant over the years. Between 1986 and 1991, the physician-to-population ratio in fact improved somewhat, going from 1 physician for every 555 Canadians to 1 for every 516 people. It then declined to 1 in 524 in 1996. By 1999, this ratio had further deteriorated to 1 physician for every 546 people, a level that was, however, still lower than the 1986 ratio. Recent projections by the Canadian Medical Association (CMA) suggest that we have not yet seen the end of this trend. They anticipate that by 2021, if current trends remain stable, the ratio will drop to 1 physician for every 718 people.

Yet the aggregate numbers do not tell the whole story. Availability of physician services varies widely depending on what kind of doctor one is dealing with and where one lives. There is little doubt that there is a long-standing problem of geographical distribution of physicians, with all rural and remote areas having great difficulty recruiting and retaining both GPs and specialists. The gap between rural and urban Canada in this regard is growing. There are also certain specialities that are experiencing serious shortages, including radiology and geriatrics. Moreover, there is evidence that many younger doctors and female doctors<sup>28</sup> are not prepared to work the long hours that were once considered normal, meaning that more physicians could be needed in the future.

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<sup>27</sup> CIHI, *Health Care in Canada*, 2001.

<sup>28</sup> Data indicates that female physicians practise fewer hours than their male counterparts, averaging 48.2 hours per week compared to the male average of 55.5 hours per week. Female physicians will make up 40% of the physician supply by 2015 according to projections by The Task Force on Physician Supply in Canada. Canadian Medical Forum Task Force, p. 11

However, many experts caution that there are complex and overlapping factors that influence the availability and deployment of human resources. Shortages are not necessarily due to an absolute lack of numbers of qualified personnel. Many nurses, for example, have left the profession because of frustration with lack of career opportunities or with working conditions. Moreover, nurses feel that their training would allow them to contribute more to patient care than the system currently allows.

Should we be concentrating on encouraging nurses to return to active practice, should we be training greater numbers of new nurses, or should we be doing both? Others have suggested that reforming the organisation of primary care services to make better use of the differentiated skills of all health care professionals could ease the real or perceived shortage of physicians, although it could also have the effect of increasing the demand for nurses, exacerbating the existing shortage.

It does appear certain, however, that there is unlikely to be a quick fix to human resource problems faced by the health care sector. On the one hand, even if the priorities for training were easily agreed to, it takes years to educate and train most health care professionals. But more importantly, it is not necessarily simply a matter of opening up new training places and hoping that they will be filled. Declines in the number of younger people studying to become nurses, for example, can be partly attributed to a greater range of career opportunities now available to young university-educated women and to the widespread perception that, because of fiscal constraint in the health care sector, nursing is not as attractive a career option as it might once have been.

In the past, Canada has been able to rely on recruitment from abroad to fill some of the gaps. For example, over 50% of doctors practising in Saskatchewan are international medical graduates (IMGs), that is, they have been trained elsewhere and moved to Saskatchewan later in their careers. However, other countries now face many of the same shortages that confront our system, and there does not seem to be much sense to countries endlessly poaching each other's highly trained health care professionals.

## **11.2 The Need for a National Human Resources Strategy**

All national organizations representing health care professionals that appeared before the Committee during its Phase Two hearings insisted that what is needed is a country-wide, long-term, made-in-Canada, human resources strategy co-ordinated by the federal government. Of course, not only do the provinces and territories have the responsibility for the delivery of health care services to their populations, they are also responsible for education and training. The challenge is therefore to find a way to develop such a strategy in a manner that is acceptable to the provinces and territories.

The federal government needs to be actively involved in helping to devise such a strategy for several reasons. In the first place, the federal government, as the government

responsible for the delivery of health services to Canada's aboriginal population and military personnel, must ensure that its needs are considered together with those of the provinces and territories in a national human resources plan.

Second, any plan must take into account the mobility of Canadians, particularly those with professional education and training. Its elaboration should therefore be the result of federal/provincial/territorial collaboration, so that the complex problems relating to the supply and geographical distribution of human health resources can be adequately addressed.

Provincial and territorial governments may resist the involvement of the federal government in the development of such a national human resources strategy. For example, when they met in August 2001, the provincial and territorial premiers and leaders agreed to develop ongoing inter-provincial co-operation to ensure that there is an adequate supply of health care providers, without the involvement of the federal government. However, the Committee believes that a national strategy (not a federal only strategy) involving all governments is needed.

The Committee welcomes comments on how best to co-ordinate the activities of the different levels of government in this area.

### **11.3 Towards a Spectrum Approach**

There are two other human resource issues that clearly require the attention of all governments:

- How to make the best use of the full spectrum of differently qualified health professionals, so that the full range of abilities of each type of professional is productively employed;
- How to recruit, train and retain an adequate supply of health care professionals who can adapt to the changing health and health care needs of the Canadian population.

The overlap between these two issues is a further illustration of the complexity of the issues involved in human resource planning. The demand for different health care professionals will depend in part on how one conceives of the health and health care needs of the population, and it is the strength of the demand for each kind of professional that should determine priorities for education and training. Moreover, the attractiveness of embarking on different careers in the health and health care fields will also depend in part on how the different professions interact on the job.

Today there is a largely hierarchical structure to the 'ranking' of health care professionals and other caregivers. Specialist doctors are generally perceived to be at the top,

followed by family physicians, various categories of nurses, from those with advanced training (nurse practitioners) through to auxiliaries (licensed practical nurses). Other professionals, from pharmacists to laboratory technologists, receive less attention but are no less important to the smooth running of the system. Then there are the practitioners of various kinds of complementary medicine who continually struggle for full recognition of their contribution to the health and well-being of Canadians. And finally there is an army of informal caregivers and volunteers whose essential work often goes completely unrecognized.

We need therefore to ask explicitly whether it is time to move away from this hierarchical way of thinking and attempt to adopt a 'spectrum' approach to health human resources. Such a 'spectrum' concept would challenge the idea that 'specialist' physicians are somehow 'higher' up the ladder by virtue of their more in-depth knowledge of a particular area than their family practitioner colleagues, or that doctors, in general, are necessarily more 'highly' qualified than nurses. Rather, it is based on the assumption that each profession has its particular strengths and these all need to be properly valued and deployed.

Consider the following facts from a 1999 report of the Ontario Health Services Restructuring Commission :

- One third of billings by specialists in Ontario in 1997 (at a total cost of \$1.4 billion) was work that could have been done by family doctors;
- The five most frequently used billing codes by Ontario family doctors in 1997, which account for about 69% of the total amount billed by these doctors (at a cost of \$1.2 billion), were for: intermediate assessments (well baby care), general assessments, minor assessments, individual psychotherapy, and counselling. The clinical consultants to the Ontario Health Services Restructuring Commission were of the opinion that most, if not all of the services these bills represent could well be provided by nurse practitioners, nurses and many well-trained health professionals.

Dr. Duncan Sinclair, the Chair of the Commission, went on to say:

“Throughout Canada we are not using our well and expensively trained, highly qualified health professionals – specialists, family doctors, nurses, pharmacists, rehabilitation therapists, the lot – to anything like the full extent of their capabilities.

Having a doctor do work that a nurse practitioner or nurse could do is like calling an electrician to change a light bulb or a licensed mechanic out of the garage to fill your tank and check the oil and tire pressure – would they do a good job? They would do an excellent job! But would it be a good use of their time, training and expertise? It would not! It would constitute an expensive and



inefficient use of scarce resources, both of money and the expertise of very talented people.”

#### **11.4 Primary Care Reform and Human Resources**

One of the major obstacles to the development of a plan that could help deal with these issues are the existing rules which define what the various health professions can, and cannot do (called the scope of practice rules). This points to the importance of considering the impact of primary care reform on our ability to rationalize the use of human health resources. Primary Health Care (PHC) is the first level of care, and usually the first point of contact that people have with the health care system. PHC supports individuals and families to make the best decisions for their health. PHC services need to be:

- co-ordinated
- accessible to all consumers
- provided by health care professionals who have the right skills to meet the needs of individuals and communities being served, and
- accountable to local citizens through community governance.

Multidisciplinary team work must therefore be a vital part of PHC. However, the goal of this team work should not be to displace one health care provider with another, but rather to look at the unique skills each one brings to the team and to co-ordinate the deployment of these skills. Clients need to see the health worker who is most appropriate to deal with their problem.

The way in which health care is now delivered in Canada does not normally reflect a PHC philosophy (although Community Health Centres are an example of organizations that do deliver health services using a PHC philosophy). Health services are often not co-ordinated, nor are they being provided by the most appropriate practitioner and the knowledge and skills of many practitioners are not being fully utilized.

Primary health care reform has become a high priority in all provinces and territories. In September 2000, provincial and territorial governments all agreed to accelerate primary health care renewal. They all agreed to promote the establishment of multidisciplinary primary health care teams that provide Canadians first contact with the health care system.

The federal government is actively supporting the efforts of provinces and territories in primary health care reform and renewal. More precisely, it has established a Primary Health Care Fund of \$800 million over four years (2000-2004) to support the transitional costs of implementing systemic, large-scale, primary health care initiatives. Some 70% of the funds are to be devoted to major provincial and territorial reforms, while the

remaining 30% is going to support national and multi-jurisdictional initiatives related to advancing primary health care reform.

The implementation of a PHC strategy, as noted earlier in this report, also entails rethinking the current reliance on fee-for-service payments as the main way of remunerating physicians. A fee-for-service actively discourages physicians from promoting teamwork, as their individual salaries depend on the number of patients they see. Moreover, it encourages family physicians to refer as a matter of course many of the more complex cases to specialists since they have no incentive to spend more time with 'difficult' cases. Finally, a fee-for-service reinforces the public's perception of the current 'hierarchy' within the health care system, and can only serve to accentuate demand on the part of individual patients to always consult the most 'highly' qualified practitioner, regardless of whether or not they are the one best-suited to meeting the patient's needs.

The main alternatives to a fee-for-service payment are salary and capitation based systems, where physician practices are remunerated based on the number of registered patients. Currently, some physicians with important teaching or administrative duties are on salary, while there have been a number of initiatives aimed at organising group practices in various provinces that utilise forms of capitation. It is also possible to combine these various forms of payment (as they do in Great Britain).

Finding alternative means of remuneration for physicians is not the only obstacle to be overcome in reforming the current system so that better use can be made of all types of human resources in the health care sector. Reform in this area necessarily challenges the current distribution of decision-making power, and is therefore likely to be resisted by those who are presently perceived to be in the most powerful position. Primary care reform would have the effect of expanding the number of people sharing the top of the pyramid, and means will have to be found to persuade those who are now in the dominant position to share some of their power.

In summary then, the options that would allow for a more efficient use to be made of the full range of human resources in the health care sector by operationalizing a 'spectrum' approach are intimately related to primary care reform that would ensure that patients have access to a continuum of care provided by differently skilled health care professionals. It should be noted that this is something that is of particular importance in the context of an aging population that will be making increasingly diversified demands on the health delivery system. As well, attention will need to be paid to ensuring that the training of health care professionals enables them to cope with the constant evolution of the system, and, in particular, fosters an ability to cooperate productively in multi-disciplinary teams.

## **11.5 Incentives for Individuals**

Finally, it is important to consider various ways of encouraging individuals themselves to seek the most appropriate form of care. Canadians have been led to believe that they must see a doctor when consulting a nurse, or a nurse practitioner, may suffice, or that a specialist is needed when a general practitioner might easily provide care of comparable quality. The health care delivery system needs to be organized so that it is possible for patients to consult the most appropriate health care professional, and there need to be incentives that either reward patients for making the best choice or penalize them when they behave in a way that is unnecessarily costly to the system.

Among the options that could be considered to accomplish this goal are user fees that would kick in if (and only if) a patient insisted on seeing a particular health care professional when it was not considered necessary at the initial point of contact between the patient and the system. Referrals that were made on the advice of a health care professional (triage nurse, general practitioner) would be free of charge, but if patients requested a further consultation of their own volition, they would be required to pay a user fee that could vary according to the type of professional consulted. These fees could be made refundable if the consultation proved necessary, so as to avoid overly discouraging those who wish to obtain a second opinion on their case. It might also be possible to guarantee shorter waiting times for consulting some categories of professionals, and to use this as an additional incentive to promote cost-conscious behaviour on the part of health care consumers.

The Committee seeks the views of readers on what forms of rewards and penalties would be the most effective in encouraging behavioural change on the part of patients - change that would help patients to distinguish between real need and desired demand, and help make the health care system less costly while still retaining the same level of medical effectiveness.

## **11.6 Recruitment, Training, Retention**

On most estimates, however, simply reforming the delivery of primary care will not solve all the foreseeable human resource problems. Moreover, implementing primary care reform will take time, if for no other reason than it will have to overcome many entrenched prejudices and behaviours among professionals and the public alike, as well as having slowly to break down the hierarchies that still characterise the structure of our health care system.

Some human resource issues cut across all the health care professions, while others are more specific to each discipline. For example, a whole range of decisions that were implemented in the course of the 1990s with the aim of controlling the growth in health care expenditures led to hospital closures, reductions in the availability of medical school places, the casualisation of many positions throughout the health care system, etc. Fewer people were increasingly being asked to do more with less. Doctors and nurses alike have complained that they are no longer able to provide the kind of care they would like, that they were trained to

deliver, and that their patients request and require. Moreover, heavy workloads and the explosion of new research means that it is a serious challenge for all health care professionals to remain current in their fields.

### **11.6.1 Financing**

Most of these broader human resource issues relate to the level of resources that are available to the health care system. That is, they are strongly influenced by the overall level of funding. If more resources are required, where are they to come from and how are they to be paid for? The options that relate to these kinds of questions were raised in Chapter 8, the financing chapter of this report.

### **11.6.2 Research**

But there are also some general issues that are directly related to human resources. The first of these concerns the availability of data to enable effective human resource planning. There continue to be large gaps in what is known about the state of the existing workforce and in our ability to forecast future needs. In this regard, the federal government must continue to play an important role in ensuring that accurate data is collected and made available to all governments and to all stakeholders in the health care system.

### **11.6.3 Dealing with the ‘Brain Drain’**

Over the years there has been considerable media attention paid to the ‘brain drain’ in the health care sector. The extent and the causes of the migration of skilled professionals southward is a subject of controversy. But there does seem to be sufficient evidence to conclude that in this regard, as with most health human resource issues, simplistic analyses are not helpful.

It has sometimes been contended that it is a more onerous tax regime in Canada that drives high-earners to seek more favourable circumstances elsewhere. Surveys among doctors, however, indicate that income is usually not the prime motivator for leaving Canada, and that the conditions under which they are able to practice their profession ranks higher. Similarly, for nurses who move southward, it is often things such as the possibility for continuing education that attracts them rather than only higher salaries (although it has to be said that for nurses the possibility of obtaining full-time, rather than part-time or casual, employment is also a major attraction).

The point is that it is the overall set of working conditions that face health care professionals that need to be addressed if we are to retain as many of them as possible in this country, rather than just concentrating on any single factor, such as reducing the levels of taxation.

Moreover, it is this same comprehensive package of working conditions that might be able to persuade health care professionals who have left the country to return. A report written for the Provincial First Ministers recently suggested that the federal government take on the co-ordination of a 'return-to-Canada' campaign to lure health care professionals back from the United States.<sup>29</sup> It is certain that a co-ordinated effort involving both levels of government would have a better chance of success, given the complex network of issues that have contributed to the departure of many health care professionals from Canada.

We will now look briefly at some of the issues that relate to the particular professions and types of care.

## **11.7 Physicians**

### **11.7.1 Training**

As a result of attempts to contain growing costs, the number of places in medical schools was reduced over the course of the past decade. In particular, the Barer-Stoddart Report recommended in 1991 that enrolment in Canadian medical schools, along with positions in postgraduate training positions, be decreased by 10% in order to deal with a perceived unwarranted increase in physician supply.

Despite the report's admonishments that this recommendation not be implemented in isolation from the others it proposed<sup>30</sup> (53 in all), policymakers did precisely that. As a result, according to data from the Association of Canadian Medical Colleges, the size of first year classes in medical colleges has declined by 16% since 1991. Canada is now one of the most difficult countries for a student to gain entrance to medical school. The current first year enrolment of 1570, or 1 per 19,000 citizens, puts Canada well behind other industrialized countries such as the United Kingdom (1 per 12,200 citizens) or Australia (1 per 13,500).

A second dimension to the issue of enrolments has to do with rising tuition costs at medical schools across the country. There are concerns that it will soon only be possible for the most well-to-do to afford the costs of medical training.

Options that need to be considered include:

- Federal assistance via student loans
- Federal funding for medical school expansion

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<sup>29</sup> As reported in the *Globe and Mail*, Saturday, July 28, 2001, p. A1.

<sup>30</sup> The report stated: "...isolated policies on undergraduate medical school enrolment may do more harm than good if they are not combined with appropriate companion policies concerning graduates of foreign medical schools, financing of academic medical centres, residency training, and quality assurance, to name only a few." P. 6

### **11.7.2 Geographic Maldistribution**

As already noted, there is little disagreement that there is a worsening problem of geographic maldistribution of physicians that leads to reduced access to needed health care services in Canada's remote and rural regions. There is evidence to suggest that physicians setting up their practices are more likely to choose rural or remote areas if they come from those backgrounds or if their training has exposed them to the positive challenges associated with locating in these areas.

As early as the Barer-Stoddart report in 1991, various measures were proposed to help alleviate the shortage of physicians in under-serviced areas. Many of these, including the following, remain worth considering today:

- Reserving undergraduate medical school places for qualified applicants willing to commit to rural area practice;
- Revising admissions criteria for medical school to favour qualified rural applicants;
- Enhance rural area exposure in both undergraduate and post-MD training;
- Developing new residency training programs designed explicitly to prepare specialists to serve as rural regional consultants;
- Introducing or increasing financial incentives to encourage choices of specialties in short rural supply.

While these kinds of measures do not fall directly under the purview of the federal government, it may nonetheless be possible for it to contribute financially to fostering these kinds of initiatives in the context of a comprehensive national health resources strategy that would be negotiated at the federal/provincial/territorial level. What is certainly clear is that a program of incentives, dealing both with issues of remuneration and other working conditions, is required in order to address the increasingly serious problem of physician shortages in rural and remote areas.

## **11.8 Nurses**

The factors contributing to the global discontent in the nursing profession in the 21<sup>st</sup> century are complex, multi-faceted, and interwoven with issues of gender, power and economics - not to mention broad employee and societal discontent that goes far beyond nursing. Ten years of downsizing the health care system have only exacerbated the situation by producing unhappy patients, horrific workloads for nurses across the system, destruction of organizational loyalty, and decaying morale among all healthcare workers. There *is* no easy *fix*, and no single strategy will turn the situation around. That being said, there are some short term strategies that likely would relieve some of the daily irritants lived by nurses, and in concert with longer term, system-wide workforce planning, would go a long way to improving working lives of nurses. Most important among these:

- the place where the work takes place must itself be healthy, safe and secure
- the tools required to do the job must be in place
- the work being done must be interesting and attractive enough to offer its own intrinsic rewards to those who carry it out - and at the same time must be adequately rewarded, recognized and respected externally
- working hours and the interplay of home life and work life must be addressed, particularly in a workforce largely staffed by women

The federal government is already collaborating with the provinces and territories in developing strategies to improve the working conditions for nurses across the country and in helping ensure an adequate supply of nurses in the future. These strategies need to specifically address the following issues:

- **Workload.** Patient care is a labour-intensive product that requires a full support team that includes environmental services, food services, clerical services, movement of materials, patients and equipment. Nurses are an expensive and shrinking resource and we cannot afford to be using them to carry out those non-nursing tasks. *If nothing else is done, workload must be addressed* in all settings across the system.
- **Lifestyle Needs.** Child care in or near the work setting, safe convenient parking, flexible scheduling systems (new scheduling software), creative scheduling, union contracts will need to look at innovative scheduling options (e.g. different lengths of shifts, permanent shifts, etc.), food should be accessible to workers in all settings on all shifts.
- **Work Status.** Create permanent full time work. Studies show that the least secure jobs produce the most anxiety, burnout, absenteeism, and poorer health
- **Professional Practice & Leadership.** Nursing suffers from poor morale and a systemic lack of work excitement. Nurses want to feel that they are regarded as true professionals who can make valuable contributions to decisions concerning patient care. Nurses want the space to provide quality care. They want freedom, innovation, as well as safe and secure environments. Qualified executive and head-nurse *nursing* leadership are essential. One nursing leader position in an agency is *not* nursing leadership. Capacity building needs to happen at all levels and must be supported nationally to improve the professional practice aspect of the nursing workplaces.
- **Equipment & Supplies.** We need immediately to conduct an inventory in every unit across the country, take note of absent, broken or dangerous equipment, and replace it immediately. This is a *quick hit* that could pay off significantly within weeks. We need to pay attention to the basics as equipment is funded; what nurses need to provide care is not MRI

scanners - they need thermometers and wheelchairs, towels and scissors, patient lifts and IV poles, computers and books and even cars in community settings

- **Education.** Nursing culture is one of life long learning. We need to put the system supports in place to support that need (employer-based *in-services* as well as formal education, plus the need for replacement staff, tuition, nurse educators in the workplace)

## 11.9 Other Health Care Professionals

Many other health care professionals, from pharmacists to laboratory technologists to ultrasound technicians, have voiced similar complaints to the ones expressed by doctors and nurses over deteriorating working conditions throughout the health care delivery system. As well, these other professional groups often have a lower profile than either doctors or nurses which means their particular concerns are often less visible. For example during its hearings the Committee was told that because medical technology is a field that appeals to technically oriented people, many training programs are having difficulty filling their available places despite the existence of jobs for graduates. With regard to other health care professionals as well there is an ongoing problem with a lack of accurate data on the evolving situation.

### 11.10 Summary

There are four broad issues which are intertwined in the human resource planning problem:

- What role should the federal government play in the development of a national human resources plan for all health services sector personnel?
- What role should the federal government play in helping to implement such a plan (e.g. through infrastructure funding or financial contributions to training programs)?
- How can individual Canadians be “trained” or given incentives which will help them to differentiate and discriminate between their true needs for health services and their desired demand?; and
- How can those who are currently perceived to be at the top of the health care power structure be persuaded to relinquish some of their power and to change the scope of practice rules so that a more efficient use of health services personnel can be achieved (where efficient means that a patient is always seen by a health care worker who is qualified to address the patient’s needs, and who will refer the patient when necessary to a differently qualified service provider if that is what the patient genuinely requires)?

The difficulty in addressing these issues is that the first two depend critically on the assumptions one makes about the timing and the precise nature of the progress which can be made on the last two issues.



## CHAPTER TWELVE:

### ISSUES AND OPTIONS FOR THE POPULATION HEALTH ROLE

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In 1974, the then federal Minister of Health, Marc Lalonde, released a working document entitled *A New Perspective on the Health of Canadians*. This report was extremely influential in shaping approaches to health both in Canada and internationally. The report recognized the impact of individual behaviour on health outcomes, and stressed that individual Canadians should assume greater responsibility for their health. But more importantly, the Lalonde report put forward the idea that a good health care system is only one of numerous factors that help keep people healthy. In recent years, some experts have suggested that 25% of the health of the population is attributable to the health care system, while 75% is dependent on factors such as biology and genetic endowment, the physical environment and socio-economic conditions.

In fact, as mentioned in the Phase One report of the Committee, there is agreement that multiple factors – called “determinants of health” – influence individual health status. These include: income and social support; education; employment and working conditions; social environment; physical environment; personal health practices and coping skills; early childhood development; health care; gender; and culture.

The term “population health” is used to refer to the overall state of health of a population that is brought about by all these determinants of health. Unlike traditional health care, which deals with individuals one at a time when they become ill, population health strategies aim to improve the health of an entire population through broadly based policies and programs that focus on these broader determinants of health.

The objective of a population health approach is to ward off potential health problems before they require treatment within the health care system. It is therefore oriented toward preventing a problem from arising as opposed to the health care system which focuses on fixing a problem once illness or injury has occurred.

At the same time, it is important to recognise that a population health approach does not advocate the replacement of traditional health care — rather, in working out how best to improve health outcomes, a population health approach attempts to take into account all determinants of health, as well as their interaction. Population health advocates believe that investing more human and financial resources in a population health approach would improve the health outcomes for a given population, and, in the end, reduce demand for the services required to treat illness.

One of the key attractions of a population health approach is that it widens the framework for understanding why health status is not uniform for all Canadians. Our universal

health care system has ensured equitable access to insured services, but not necessarily to good health for everybody. A wide range of health status indicators show significant disparities among Canadians in terms of geographical location, demographic factors, socio-economic conditions, gender differences and so on.

Therefore, population health strategies encompass a broad range of activities, ranging from health promotion and disease prevention to overall policies and programs that influence income distribution, access to education, housing, water quality, workplace safety, and so on, which all have an impact on health status.

## **12.1 Trends in Diseases**

The 20<sup>th</sup> century revolution in health care has significantly altered the pattern of diseases, with the causes of mortality shifting away from infectious diseases and towards non-communicable diseases. Chronic diseases, such as cancer and cardiovascular disease, are now the leading causes of death and disability in Canada, while unintentional injuries are the third most important cause of death. However, some infectious diseases once thought to have been conquered – like tuberculosis – are re-emerging and antibiotics are becoming increasingly ineffective against them. Rapid international transport of foods and people also increases the opportunities for infectious diseases to spread.

During Phase Two of its study, the Committee was informed that the total cost of illness was estimated at \$156.4 billion in 1998. Direct costs (such as hospital care, physician services and health research) amounted to \$81.8 billion, while indirect costs (such as lost productivity and lower quality of life) accounted for \$74.6 billion. The diagnostic categories with the highest total costs were cardiovascular diseases, musculoskeletal diseases, cancer, injuries, respiratory diseases, diseases of the nervous system, and mental disorders.

According to witnesses, many diseases, and most injuries, can be prevented. In their view, the only way to reverse disease trends and reduce the burden of illness is by investing more in health promotion, disease prevention and population health. More importantly, however, they pointed to a strong tendency for government to focus on curing diseases, rather than on preventing them. For example, clinical treatment has been the most common chronic disease strategy and there has been only a limited political will to expend resources on health promotion and disease prevention. Outcomes from such programs are generally visible only over the longer term, and are therefore less attractive politically than money invested in health care facilities, such as hospitals.

## **12.2 Some Disturbing Trends**

While it is perhaps trite to observe that today's youth represent the future of the country, a number of health trends that affect Canadian young people in particular are of great concern.

A recent study has raised the alarm with regard to overweight and obese children in Canada. Researchers found that the body mass index of Canadian children between the ages of 7 and 13 has increased dramatically in recent years. In 1981, 15% of boys and girls were overweight, but by 1996 the percentages of overweight children had grown to almost 29% of boys and 23% of girls. Childhood obesity also more than doubled over the same period and research suggests that children and adolescents with excessive body mass are more likely to experience health problems as adults.

Eating disorders such as bulimia and anorexia nervosa remain a serious problem, especially among young women. Approximately 90% of those with eating disorders are women, and these disorders usually develop between ages 14 to 25. In Canada, over 38,000 women suffer from anorexia nervosa, and more than 114,000 women suffer from bulimia. While the majority of physical complications in adolescents with eating disorders can be remedied over time, some may be irreversible. Although the full extent of the long-term consequences remain unclear, among the medical complications that are potentially irreversible are pubertal delay or arrest, impaired acquisition of peak bone mass later in life, and increased risk of osteoporosis in adulthood.

According to Statistics Canada, the vast majority of Canadians are aware of the risks associated with smoking – only 4% of Canadians 12 and over in 1996-97 felt that there were no smoking-related health risks for those who light up. Despite the widespread knowledge of the dangers of smoking, over a quarter of Canadians age 12 and up still smoke daily or occasionally, putting them at risk for lung cancer, heart disease and other health problems, and significant numbers of young Canadians start smoking each year.

A number of other broad trends among the Canadian population are also worth noting. Work prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health estimated that about 3% of Canadians suffer from severe and chronic mental disorders, such as manic depression and schizophrenia, that can cause serious functional limitations and social or economic impairment. This translates into approximately one in every 35 Canadians over 15 years of age. The National Population Health Survey of 1994/95 found that some 29% of Canadians had high levels of stress; 6% of Canadians felt depressed; 16% of Canadians reported that their lives was adversely affected by stress; and 9% had some cognitive impairment such as difficulties with thinking and remembering. Canadian youth, in particular, report the lowest levels of psychological well-being.

Approximately 42% of adult Canadians do not possess sufficient literacy skills to allow them to deal with everyday reading tasks, including reading about health matters. Canada is rather unique in that there is a rapid deterioration in literacy skills in mid-life, rather than in later life, as is the case in Sweden, for example. The Committee was told that a number of factors could help explain this difference. Swedes read twice as much in the workplace as Canadians do and they also tend to read more at home. Swedes participate in adult education at a level that is twice the average for Canadians, and they do so throughout their working lives, whereas we see the same kind of reduction in adult education participation in midlife as we see

in literacy levels in Canada. The Committee was also told that, despite increasing education, literacy levels in Canada over the coming decades are likely to remain stable, unless there is an extraordinarily large investment in enhancing literacy skills. This is a major concern, given that about 15% of today's literacy is determined by the previous generation's literacy. Since literacy is an important determinant of health, there is a vector for the intergenerational transmission of inappropriate health behaviours.

### **12.3 Determinants of Health: Some Evidence**

Disease issues are complex, in large part on account of the immense diversity of determinants of health, and this complexity is further compounded by the interaction among these various factors.

According to many experts, socio-economic status constitutes the most powerful influence on health. Whether we look at how people rate their own health, at premature mortality, at psychological well-being or at the incidence of chronic disease, socio-economic status remains strongly correlated with health status. Differences in health status are readily evident in a comparison of the highest and lowest income groups. Canadians with low incomes and low levels of education (which are often related) are more likely to have poor health status, no matter which measure of health is used, and people's health improves on virtually all measures and in all of the factors that influence health as levels of income and education increase.

In other words, high-income Canadians are more likely to be healthy than middle-income Canadians, who are in turn healthier than low-income Canadians. Indeed, it is estimated that if the same death rates as for the highest income earners applied to all Canadians, over one-fifth of all potential years of life lost before age 65 could be prevented. The Committee was also told that:

- Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy;
- Canadians with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier food;
- Despite reductions in infant mortality rates, improvements in education levels, and reductions in substance abuse in many Aboriginal communities, Aboriginal Canadians remain at higher risk than the Canadian population as a whole for illness and early death.

## 12.4 The Role of the Federal Government

The federal government's role with regard to health promotion, disease prevention and population health is a well established one. Following the public release of the Lalonde report in 1974, the federal department of health created community programs and issued specific social marketing campaigns aimed at health promotion (such as ParticipAction, "Dialogue on Drinking" and the Canada Food Guide).

The report, *Achieving Health for All*, released in 1986 by the then federal Minister of Health, Jake Epp, broadened federal policy to encompass both health promotion and disease prevention. The Epp report also placed a particular emphasis on the determinants of health. Programs that were initiated during that period include Canada's Drug Strategy, the Heart Health Initiative, Healthy Communities, a National AIDS strategy, etc.

In the 1990s, the concept of population health was officially endorsed by the federal, provincial and territorial Ministers of Health. This prompted the publication of three major reports that provided data on the determinants that affect the health status of Canadians and set out frameworks to guide the development of population health policies and strategies.<sup>31</sup>

The findings of all these reports offered the federal government a way of participating in the elaboration and implementation of policies and programs that affect the health of Canadians from outside the traditional health care sector (which is, essentially, a provincial/territorial responsibility). In 1997-98, Health Canada formally adopted a population health framework for its programs and initiatives. Other federal department and agencies are also involved in population health strategies. For example:

- Population health is one of the four pillars of health research at the Canadian Institutes of Health Research (CIHR). Moreover, the CIHR Institute of Population and Public Health specifically supports research into the complex interactions (biological, social, cultural, environmental) which determine the health of individuals, communities, and global populations.
- The Canadian Institute for Health Information (CIHI) is responsible for the Canadian Population Health Initiative. This initiative also provides support to research oriented towards advancing our understanding of the determinants of health that affect the Canadian population, and towards the formulation of policies that will improve population health and reduce health inequities.
- The National Children's Agenda involves a variety of healthy child development initiatives, including the Canada Prenatal Nutrition Program, Aboriginal Head Start, the Community Action Program for Children, the National Child Benefit, as well as maternity and parental leave benefits that are covered under Employment Insurance.

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<sup>31</sup> A summary of these reports is provided in Chapter 5 of the Committee's Phase One report.

It is clear that the longstanding federal role in health promotion and disease prevention should be maintained and strengthened. Moreover, the federal government has been recognized as a leader worldwide in elaborating the concept of population health. It could, once again, show leadership in implementing a population health strategy for all Canadians. This is a feasible task, given the federal government's role in many areas that affect health, such as the environment, economic policy, health research, workplace safety, etc.

#### **12.4.1 Health Promotion and Disease Prevention**

Witnesses stressed that it is necessary to continue encouraging people to make smarter choices with regard to their own health. Eating healthy food, exercising regularly and not smoking are certainly important messages that must be reiterated on an ongoing basis.

Although there was some initial resistance to a number of preventive campaigns, many nonetheless proved to be very successful. A good example is the law requiring people to wear seatbelts. Prior to the passage of legislation, only an estimated 15% to 30% of Canadians wore seatbelts, whereas, the rate of seatbelt use is currently about 92% among drivers. This has resulted in an impressive reduction in motor vehicle fatalities in Canada.

However, witnesses suggested that, to date, a number of other strategies that attempted to prescribe 'good behaviour' have not been very successful, and noted that part of the challenge lies in creating an environment that allows people themselves to make the right choices.

Prevention efforts have to be tailored and flexible. There is no 'one size fits all' strategy. For example, sexually transmitted disease trends change as sexual practices change and therefore will always require new prevention and promotion strategies. In this regard, it is important to ensure that health information is always up-to-date. Witnesses pointed to the Canada Food Guide as an example of a good initiative, but one that has not been marketed effectively or updated and adapted over time.

One difficulty that arises with regard to the elaboration of strategies for health promotion and disease prevention is that many diseases usually have several risk factors associated with them. Comprehensive prevention and promotion strategies must therefore address the linkages between risk factors, as well as between health status and socio-economic, demographic, and environmental factors.

Strategies must also recognize the link between healthy communities and healthy citizens. For example, people may be less inclined to bike or jog if the streets are unsafe. Successful community-based programs combine an understanding of the community, with the participation of the public, and the co-operation of community organizations. Approaches that address several risk factors can produce multiple benefits. These include support for families at

risk, comprehensive school health promotion programs, and comprehensive work health and safety programs.

Furthermore, since disease and injury are not uniformly distributed across populations, strategies must also look at the linkages between health status and demographic and environmental factors, such as age, race, region of residence, and gender. Strategies must therefore address disease and injury trends among specific demographic groups, such as youth and Aboriginal peoples. For example, motor vehicle accidents predominantly affect young men, and Aboriginal youth have high rates of suicide. Adults over 65 are most affected by falls, and injuries are the leading cause of death in children. Strategies must be tailored to the situations of each affected group, and need to be targeted to the groups that will derive the most benefit from prevention.

#### **12.4.2 Population Health Strategies**

The Committee is of the view that there are several key issues with regard to population health strategies that largely revolve around the difficulties associated with how to translate research evidence concerning the importance of population health strategies into policies and programs that can be implemented. There can be little doubt that these strategies could result in improved health outcomes, but there remain significant practical obstacles to moving beyond the expression of pious good wishes to the design of concrete programs that are sustainable over the long haul.

In the first place, the multiplicity of factors that influence health outcomes means that it is exceedingly difficult to associate cause and effect, especially since the effects are often only felt many years after exposure to the cause. This time lag also means that the timeframe for judging the impact of policy in this area is a long-term one. Because political horizons are often of a shorter term nature, this can constitute a serious disincentive for the elaboration and implementation of population health strategies.

Furthermore, as noted earlier, there is already a massive infrastructure that is in place to deal with the treatment of illness, and this creates many entrenched interests within the system. It is not necessarily that people who treat illness have anything against promoting population health strategies — the contrary is no doubt the norm. Rather, it is simply that massive resources must be deployed simply to sustain the existing health care infrastructure, making it difficult to find sufficient time, energy and capital to devote to the preventive side of the equation.

Moreover, because of the diversity of the factors that influence health outcomes, it is very difficult to co-ordinate government activity in this regard. Given that the health care system itself is only responsible for a relatively small percentage of the actual determinants of health, the responsibility for population health cannot reside exclusively with the various ministries of health. Yet the structure of most individual governments does not easily lend itself to inter-ministerial responsibility for addressing complex problems, and this difficulty is

compounded several times over when the various levels of government, along with the many non-governmental players, are taken into account, as they must be if population health strategies are to be truly effective.

For example, the evidence concerning the existence of gradients of health that correlate with socio-economic levels is quite conclusive. The implication of this fact is that the promotion of population health requires a strong focus on the reduction of poverty. But there are clearly a great number of government policies that have an impact on the levels of poverty in Canada and it would be impossible to ask a ministry of health to take charge of all the policy tools that are involved, if for no other reason than this would be rightly seen as a form of 'health imperialism' by other ministries. It is also somewhat perverse, as one witness pointed out, to argue for the reduction of poverty exclusively because of the impact which poverty has on the health status on individuals. Any such initiative would have to come about as a result of the overall social policy orientation of government, something that is considerably broader than health policy alone.

The evidence suggests that population health strategies in general must be carefully thought through so that they take into account the realities facing specific communities. This implies that rigidly designed programs applied in a uniform and highly centralized fashion are unlikely to succeed. Some combination of co-ordination and decentralized implementation therefore would seem to be required.

Although there are many difficulties associated with the development of an effective population health approach, the Committee believes that it is important for the federal government to continue to try to set an example by exploring innovative ways to turn good theory into sound practice that will contribute to improving health outcomes in Canada. There are two broad options the Committee would like to put on the table and to solicit comments from readers on them.

The first of these options is developed in more detail in the following chapter, as it concerns the federal responsibility for the delivery of health care services to Aboriginal Canadians. The key idea, however, is that in an area of clear federal responsibility it should be possible for the government to adopt an explicit population health approach that would recognize the many factors that contribute to the deplorable health outcomes that are still the norm in many Aboriginal communities. There would have to be close co-ordination of the activity of the different departments that each have some responsibility in this area (Health, Indian and Northern Affairs, Finance, etc.). Ways would also have to be found to work effectively with the Aboriginal communities themselves, as well as with other levels of government that also deliver services to these communities. This approach would also provide an opportunity for the development of effective accounting mechanisms with regard to measurable health outcomes. This is an important, and often neglected, element of population health programs.



The second option would involve an even wider federal undertaking. Because of the very broad focus required to implement population health strategies, it is essential that a way be found to break down the ministerial silos that compartmentalize responsibility for policy outcomes. One way of doing this, as was already suggested in Chapter 10 of this report, would be to give responsibility to a 'Health Commissioner' for monitoring and reporting on the health impact of all government policy.

Regardless of the exact nature of the office that assumes this responsibility, the important point, however, is to devise a mechanism that enables all government policy to be screened through a population health lens. This would permit an ongoing analysis of health outcomes and provide some measure of overall public accountability. An annual report from such an office that focused on the broad determinants of health could complement the work already being done by CIHI, but also include prescriptions for how to ensure that all government policies have as positive an effect as possible on the health of Canadians.

### **12.4.3 Research**

Many witnesses told the Committee that greater research is needed, particularly in certain areas. Often, money is spent without sufficient epidemiological research to guide where it is invested. In terms of chronic disease research, witnesses told the Committee that there is a lack of knowledge on how to use that information in the implementation of preventive strategies. In this respect, research is needed to determine how best to share health information with both providers and individual Canadians and, in particular, how best to target that information to those in lower socio-economic groups or those with poor literacy skills.



## CHAPTER THIRTEEN:

### ISSUES AND OPTIONS FOR THE SERVICE DELIVERY ROLE: ABORIGINAL HEALTH

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A major role played by the federal government is its direct provision of a variety of health services to particular population groups. The federal government is responsible for the provision of health care, including primary care, to First Nations and Inuit communities, and some health services to the RCMP, Correctional Services, the Armed Forces and veterans. Indeed, the federal government delivers health services to more Canadians than several provinces do. In this chapter, the Committee raises specific issues with respect to the delivery of health care to Aboriginal Canadians and suggests potential public policy options for addressing those issues.

The *Constitution Act, 1982* recognizes three groups of Aboriginal peoples: Indians, Inuit, and Métis. The Indian population includes both status and non-status Indians. The *Indian Act* sets out the legal definitions that apply to status Indians (First Nations) in Canada; that is, Indians who are registered under the *Indian Act*. Non-status Indians are those who are not registered under the Act. The Inuit population of Canada lives primarily in communities in the Northwest Territories, Nunavut, Nunavik and Labrador. About 6% of the Inuit live in southern Canada. The Inuit are not specifically covered by the *Indian Act* but still receive certain benefits from the federal government. Métis people are of mixed Indian and European ancestry. The Métis are not covered by the *Indian Act* and do not receive Métis-specific benefits from the federal government.

The Aboriginal population was estimated at 1,399,300 in 2000, or about 3% of Canada's overall population. Of this total, 28.5% were status Indians living on reserve, 30.6% were non-status Indians, 20.8% were status Indians off reserve, 15.6% were Métis, and 4.5% were Inuit.

Currently, 12 federal government departments offer programs and services for Aboriginal peoples. These programs and services are numerous and include health care and social services; elementary, secondary and post-secondary education; water and sewer services; housing; environmental remediation; business development, etc. Total expenditures for these programs are estimated at \$7.3 billion for 2001-2002.

Despite this large federal investment toward the health and well-being of Aboriginal peoples, very significant health and socio-economic disparities persist between the Aboriginal population and the general Canadian population. In fact, the state of health of Aboriginal Canadians and the socio-economic conditions in which they live remain deplorable. Furthermore, during the Committee hearings, status Indians living off-reserve, non-status

Indians and the Métis stressed that they often fall between the cracks of public policy with respect to meeting their unique health and health care needs.

### **13.1 Health and Socio-Economic Profile of Canada's Aboriginal Population**

There are significant health and socio-economic disparities between Aboriginal peoples and the general Canadian population. During Phase Two of its study, the Committee heard some very disturbing testimony.

Aboriginal peoples suffer from chronic diseases to a much greater degree than do other Canadians. For example, current evidence suggests that heart problems, hypertension and diabetes are over three times as prevalent in Aboriginal communities as in the general population. The prevalence of tuberculosis and HIV/AIDS is much higher among Aboriginal peoples than among other Canadians. The rate of deaths due to injuries and poisoning is 6.5 times higher for First Nations and the Inuit than for the total Canadian population. The suicide rate among Aboriginal youth is five to six times higher than the suicide rate of the general Canadian youth population. Alcohol, substance and solvent abuse is a major problem in Aboriginal communities. Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Effects (FAE) are much more prevalent in some Aboriginal communities than in other parts of Canada. Approximately 75% of Aboriginal women are victims of family violence and up to 40% of children in some Northern communities have been physically abused by a family member.

Aboriginal peoples are less likely to be in the labour force and unemployment rates are higher than for the general population. Average annual income from all sources for Aboriginal Canadians is far behind that of non-Aboriginal peoples. Some 44% of the Aboriginal population and 60% of Aboriginal children under six years of age live below Statistics Canada's low income cut-off line. Some 54% of the Aboriginal population do not have a high school diploma, compared to only 16% for the general population.

Crowded housing conditions are found much more frequently among the Aboriginal population than among Canadians in general. Mold growth has recently been identified as a critical issue in Aboriginal housing, but its full impact on health is not yet known. Access to clean, safe drinking water and adequate sewage disposal is an issue for many Aboriginal communities.

In the view of the Committee, the health of our Aboriginal peoples is a national disgrace. If the Aboriginal population was enjoying a state of health similar to that of the overall Canadian population, Canada would probably stand as the healthiest country in the world. We certainly need to do a better job. The federal government must take a leadership role in working to immediately redress this situation.

### **13.2 Health Service Delivery to Aboriginal Canadians**

Health care to Canada's Aboriginal peoples is delivered through a complex array of federal, provincial and Aboriginal-run programs and services. Who delivers what to whom depends on a number of factors such as status under the *Indian Act*, place of residence (on or off-reserve), the location of one's community (non-isolated or remote) and whether Health Canada has signed an agreement to transfer the delivery of certain health services to an Aboriginal community or organization.

During Phase Two of its study, the Committee was told that the federal government has particular and special responsibilities for status Indians under the *Indian Act*. The provision of hospital and physician services, however, is a provincial or territorial responsibility. Status Indians who reside on reserves are entitled to the general health services provided by the provinces and territories that fall under the *Canada Health Act* such as hospitals, physician services, and other insured services covered by provincial and territorial health plans. Health Canada, however, provides direct primary care and emergency services on reserves in remote and isolated areas where no provincial services are available. More precisely, the department operates 4 small hospitals, 77 nursing stations and 217 health centres.

Health Canada also provides community-based health promotion and prevention services or funding for such services for status Indians living on reserves. Regardless of residence (on or off-reserve), status Indians receive non-insured health benefits (NIHB) funded by the federal government. These benefits include drugs, medical supplies and equipment, dental care, vision care, medical transportation, provincial health care premiums and crisis mental health counselling.

Provincial and territorial governments are responsible for delivering health services to the Inuit; thus, delivery of health services to Canada's Inuit population varies with jurisdiction of residence. In 1988, the federal government transferred responsibility for health administration to the Government of the Northwest Territories. With the creation of Nunavut, the Nunavut government assumed this responsibility for the Nunavut region. The federal government provides funds to the territorial governments to deliver health programs for status Indians and the Inuit. The federal government continues to fund non-insured health benefits for status Indians and the Inuit.

As a result of the James Bay and Northern Quebec Agreement, the federal government transferred responsibility for Inuit health services in northern Quebec to the government of Quebec then to Nunavik. The Nunavik Regional Department of Health and Social Services administers federal and provincial programs in that region.

In Labrador, the province provides health services to all residents and the federal government provides funding to the Labrador Inuit Health Commission through a transfer

agreement and contribution agreements for specific projects and for a range of federal programs including non-insured health benefits.

Métis and non-status Indians are not eligible for federal health programs. They receive medical services from provincial and territorial governments on the same basis as other Canadians.

### **13.2.1 A National Action Plan on Aboriginal Health Services**

Overall, jurisdictional barriers to the provision of health services to Aboriginal peoples exist on two levels. The first barrier arises from the division of powers between the federal and provincial governments. Provincial governments provide equitable access to health care under the *Canada Health Act* for all residents including status Indians living on reserves and the Inuit, but take the position that the federal government is responsible for certain health services (e.g. prescription drugs or home care) to Aboriginal persons who are Indians under the *Indian Act* (status Indians). As a result, witnesses told the Committee that health services not covered by the *Canada Health Act* but otherwise provided by the provinces may or may not be provided to status Indians and Inuit communities.

Other consequences of having two jurisdictions involved in delivering health services include program fragmentation, problems with co-ordinating programs and reporting mechanisms, inconsistencies, gaps, or possible overlaps in programs that prevent the rationalization of services and block the development of a holistic approach to health and well-being.

The second jurisdictional barrier stems from the divisions among Aboriginal peoples that arise as a result of the *Indian Act*. Because Métis and non-status Indians are excluded from the legislation, they are not eligible for most federal programs. In the view of witnesses, this lack of recognition leaves the Métis and non-status populations in a jurisdictional void.

The Committee agrees with the witnesses that these barriers must be overcome rapidly and that all levels of government – federal, provincial, territorial, municipal, band and settlement – should develop a comprehensive plan that could meet the health care needs of all Aboriginal peoples in Canada. The federal Minister of Health should play a leadership role in co-ordinating such a plan.

Therefore, the proposed option is for the federal government to undertake, in collaboration with the provinces, territories and Aboriginal representatives of all groups, the development of a National Action Plan on Aboriginal Health to improve inter-jurisdictional co-ordination of health care delivery. The special contribution of the federal Minister of Health would be to facilitate such co-ordination.

### **13.3 Ensuring Adequate Access to Culturally Appropriate Health Services**

Accessibility to health care is one of the four patient-oriented principles of the *Canada Health Act*. However, access to adequate health services remains a challenge in remote and isolated Aboriginal communities. Most health care is provided by community health clinics or nursing stations staffed by nurses and only offering basic services. Patients with serious health problems are treated in the major urban centres. A lack of appropriate infrastructure and shortages in key health care providers contribute to this problem.

#### **13.3.1 Aboriginal Health Care Providers**

Witnesses suggested that the federal, provincial and territorial governments should address the shortage of health care providers in Aboriginal communities by developing a long-term strategy to increase the number of Aboriginal health care providers. As part of this strategy, the federal government could provide the necessary resources to train Aboriginal Canadians across a wide range of health sector disciplines. In 1996, the Royal Commission on Aboriginal Peoples made a similar recommendation. More precisely, the Commission called upon the federal and provincial/territorial governments, along with the academic community and health professional groups, to implement a program to train 10,000 Aboriginal health care workers. A long-term strategy should also address issues that relate to the training, recruitment and retention of qualified personnel in emerging areas of importance such as home care workers, early childhood educators, diabetes prevention workers, telehealth and systems development technicians, etc.

#### **13.3.2 Telehealth**

Tele-medicine can also play an important role in improving access to health services in Aboriginal communities. In the context of remote and isolated Aboriginal communities, telemedicine offers the following advantages: it addresses the shortage of health care providers and the lack of medical training; it improves the health care infrastructure; it enables conformity with the accessibility principle of the *Canada Health Act*; and it ensures a more equitable development of health information systems across all regions of the country.

#### **13.3.3 Culturally Appropriate Health Services**

Perhaps most importantly, witnesses stressed the need to provide Aboriginal peoples with “culturally appropriate” health services. This means that their cultural experience and traditions must be taken into account when designing and implementing services. For some witnesses, culturally appropriate services are those that can be accessed through the use of an interpreter or provided by Aboriginal workers. For others, culturally appropriate care involves the combination of both western medicine and traditional healing approaches. Witnesses also emphasized to the Committee that Aboriginal peoples are not a homogeneous group. They called for this distinctiveness to be recognized in the delivery of health programs and services.

The Committee welcomes opinions on how adequate access to culturally appropriate health services can be best achieved for all Aboriginal Canadians.

### **13.4 Population Health**

People from all of Canada's Aboriginal groups do not simply define health as the absence of disease. They talk about "wellness" and adopt a broader view of the concept of health that encompasses the spiritual, physical, mental and emotional aspects of the individual. For them, the various components of the overall state of health may be influenced by the social, cultural, physical, economical and political environments in which a person lives. Aboriginal wellness emphasizes that solutions to health will not be effective until all factors having an impact on a problem are considered. Witnesses suggested that federal Aboriginal health policy must develop a greater focus on illness prevention, health promotion and a holistic approach to population health.

#### **13.4.1 A Population Health Strategy for Aboriginal Canadians**

During its Phase Two hearings, the Committee heard about the various federal health strategies co-ordinated by Health Canada and the multiple programs managed by Indian and Northern Affairs Canada and other federal departments. Still, an enormous amount remains to be done if Canada is to reduce disparities in health status and socio-economic disparities between Aboriginal peoples and the general population. Given the wide range of programs that the federal government currently manages and given its specific constitutional responsibilities, it is in a unique position to develop population health strategies aimed specifically at Aboriginal Canadians.

The federal government has been recognized as a leader worldwide in developing the concept of population health, and this option urges it to once again show leadership in implementing a population health strategy designed specifically for Aboriginal Canadians. Such a strategy should include dealing with economic conditions, environmental issues such as clean and safe drinking water, high quality and culturally appropriate health care, healthy lifestyle choices, etc. Investing in such activities will improve the health status of Aboriginal peoples and reduce the suffering and costs that result from poor health. This option would require extensive and ongoing inter-departmental collaboration. The federal Minister of Health could, once again, assume a role of leadership and co-ordination.

#### **13.4.2 Federal Accountability for Programs aimed at Aboriginal Health**

As discussed in Chapter 10, the federal government could set a valuable example by establishing a permanent mechanism for reporting to the Canadian public on the impact of all its policies affecting health and health care. Federal accountability for programs aimed at Aboriginal health is of paramount importance and could be the first step towards federal accountability for its overall health policy. We welcome any suggested options for an effective federal accountability mechanism with respect to Aboriginal health.



### **13.5 Aboriginal Health Research**

During the hearings on Aboriginal health, witnesses pointed out the importance of undertaking research on the health of Aboriginal peoples as a means to improve health service delivery and health outcomes. They welcomed the new Institute on Aboriginal Health within the Canadian Institutes for Health Research (CIHR) and stressed that it is essential that it be provided with a sufficient level of funding.

Witnesses underlined the importance of recognizing the diversity of the various groups within the Aboriginal population. In their view, this diversity must be reflected in health research activities. It was also recommended that more funding be allocated to health research that explores a range of models in order to assist with the design and delivery of programs that affect Aboriginal health.

### **13.6 Involvement of Aboriginal Communities**

Witnesses stressed that, given the diversity of Aboriginal peoples and given their unique health and health care needs, it is essential to involve them directly in the renewal of federal policies and programs that affect Aboriginal health. In their view, it is only with significant input from the members of the concerned community that successful programs leading to healthier outcomes can be implemented. The Committee would like to obtain suggestions on the best way to involve Aboriginal Canadians in designing, developing, implementing and assessing federal programs and policies aimed at Aboriginal health.



## CHAPTER FOURTEEN:

### CONCLUSION

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For Canadians, our publicly funded health care system is a key distinguishing characteristic of our country. In fact, it has achieved iconic status. It is perceived to reflect Canadian values and these are seen to stand in sharp contrast to the values of our American neighbours.

Medicare is based on the belief that Canadian society should collectively share the risks, and the consequences, of illness and injury to individual Canadians. Before Medicare, these were largely borne by the sick or injured themselves, their families, or various charitable organizations. Canadians' attachment to a sense of collective responsibility for the provision of health care has remained largely intact despite a shift towards more individualistic values that has, in recent years, led to broader changes in society.

Health care is also seen in Canada as very much a public good, in spite of the fact that more than 30% of total health care costs are paid out of private funds. It is a public good also in the sense that Canadians look to government, both federal and provincial, to guarantee the services to which they feel entitled.

One might expect that given the importance of the health care issue in the collective psyche of Canadians, and in the political life of the country more generally, that an ongoing, thoughtful, discussion of health care issues would be the norm. Unfortunately, the opposite is true. The health care debate in Canada is characterized by :

- The repetition of myths (as documented in the Committee's first and second reports). The most common of these are the notion that the *Canada Health Act* prohibits the delivery of health care services by the private sector, and the assertion that all medically necessary *health care* services are publicly funded in Canada;
- Ideological statements by the right and the left. The right claims that *all* our health care woes would be solved by introducing competition and private sector delivery into the system and by having patients pay for part of the service they receive. The left claims that the introduction of *any* element of competition, private sector delivery or having patients pay for part of the service they receive, would destroy our current system;
- Politicians of all parties and all levels of government passing the buck for the current troubles in the system. The federal government blames the provinces; the provinces blame the federal government; and all opposition parties, both federal and provincial, blame their respective governments;

- A reluctance on the part of the various organizations representing health care professionals to embrace systemic change. They tend, rather, to argue for more money to be put into the system (presumably on the assumption that money alone will solve the system's problems).

Faced with this situation, the Committee decided from the outset that it would provide a useful public service if it could produce a report that outlined the major issues facing Canada's health care system and presented a set of potential options for addressing them. Moreover, it envisaged this report as being factual and non-ideological. Also, the Committee strongly believes that it was essential not to foreclose discussion of any option *a priori*. This is what the Committee hopes it has achieved with this report.

We recognize that our set of issues is not exhaustive, and that many readers of this report will want to add to the issues list. Similarly, there are those who will feel that our set of options is not complete, and they will want to add new options of their own. We very much welcome these additions to our work. We believe that they will help to further the Committee's objective of being a catalyst for informed public debate on health care issues.

Above all, we hope that individual Canadians – the people who most benefit from Canada's Medicare system and the people who will be most affected by any changes made to it – will take the time to write to the Committee, and give us their views on which options they prefer, and why. We very much look forward to receiving the guidance of Canadians as we prepare our final report and our own set of recommendations.

Please write to:

The Standing Senate Committee on Social Affairs, Science and Technology  
The Senate  
Ottawa, Ontario  
K1A 0A4  
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The Senate

Standing Senate Committee on Social Affairs,  
Science and Technology

# The Health of Canadians - The Federal Role

One in a series of reports on the state of the  
health care system in Canada

*Chair:*

The Honourable Michael J.L. Kirby

*Deputy Chair:*

The Honourable Marjory LeBreton

April 2002

**Volume Five:  
Principles and  
Recommendations  
for Reform  
- Part I**

*Ce document est disponible en français.*



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(Committee Business – Senate – Recent Reports)

The Standing Senate Committee on Social Affairs, Science and Technology

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APRIL 2002





# TABLE OF CONTENTS

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<b>TABLE OF CONTENTS.....</b>	<b>i</b>
<b>ORDER OF REFERENCE.....</b>	<b>iii</b>
<b>SENATORS.....</b>	<b>iv</b>
<b>INTRODUCTION.....</b>	<b>1</b>
<b>CHAPTER ONE:.....</b>	<b>5</b>
A REFORM BASED ON FUNDAMENTAL REALITIES.....	5
1.1 Canada's Publicly Funded Health Care System is Not Fiscally Sustainable Given Current Funding Levels.....	6
1.2 Canadians Want a Strong Role for the Federal Government in Facilitating Health Care Restructuring and Renewal.....	12
1.3 There is a Need to Introduce Incentives for all Participants in the Publicly Funded Hospital and Doctor System – Providers, Institutions, Governments and Patients – to Deliver, Manage and Use Health Services More Efficiently.....	14
1.4 Principles to Guide the Restructuring and Financing of Canada's Health Care System.....	20
<b>CHAPTER TWO: .....</b>	<b>23</b>
PRINCIPLES TO GUIDE THE RESTRUCTURING AND FINANCING OF CANADA'S HEALTH CARE SYSTEM.....	23
2.1 Financing (or Insuring) Health Care.....	23
2.2 Delivering Health Care.....	36
2.3 Evaluating Health Care .....	48
2.4 Achieving a Patient-Oriented Health Care System.....	52
2.5 The Health Care Contract Between Canadians and their Governments.....	59
2.6 Concluding Remarks.....	61
<b>CHAPTER THREE: .....</b>	<b>69</b>
FINANCING AND ASSESSING HEALTH CARE TECHNOLOGY.....	69
3.1 Availability of Health Care Technology.....	69
3.2 Financing the Acquisition and Upgrading of Health Care Technology.....	71
3.3 Investing More in Health Care Technology Assessment.....	72
<b>CHAPTER FOUR.....</b>	<b>77</b>
DEPLOYING A NATIONAL HEALTH INFOSTRUCTURE .....	77
4.1 Establishing a System of Electronic Health Records.....	78
4.2 Evaluating Quality, Performance and Outcomes: the Need for Independent Assessment .....	80
4.3 Fostering Accountability .....	83
4.4 Ensuring Confidentiality and Protection of Personal Health Information.....	84
4.5 Investing in Telehealth in Rural and Remote Communities .....	86
4.6 Investing in Tele-Homecare.....	87

4.7 Investing in Internet-Based Health Information.....	88
<b>CHAPTER FIVE.....</b>	<b>91</b>
NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH.....	91
5.1 Assuming Leadership in Canadian Health Research.....	92
5.2 Engaging the Scientific Revolution.....	95
5.3 Securing a Predictable Environment for Health Research.....	97
5.3.1 Federal Funding for Health Research.....	98
5.3.2 Federal In-House Health Research.....	100
5.4 Enhancing Quality in Health Services and in Health Care Delivery.....	102
5.5 Improving the Health Status of Vulnerable Populations.....	104
5.6 Commercializing the Outcomes of Health Research.....	106
5.7 Applying the Highest Standards of Ethics to Health Research.....	110
5.7.1 Research Involving Human Subjects.....	111
5.7.2 Issues With Respect to Research Involving Human Subjects.....	113
5.7.3 Animals in Research.....	116
5.7.4 Privacy of Personal Health Information.....	118
5.7.5 Genetic Privacy.....	123
5.7.6 Potential Situations of Conflict of Interest.....	123
<b>CHAPTER SIX.....</b>	<b>127</b>
PLANNING FOR HUMAN RESOURCES IN HEALTH CARE.....	127
6.1 Towards a national strategy for attaining self-sufficiency in health human resources.....	127
6.1.1 Shortages of health care professionals.....	127
6.1.2 Towards self-sufficiency in health human resources.....	129
6.1.3 Increasing the supply of health care providers from Canada's Aboriginal peoples.....	132
6.1.4 Dealing with 'The Brain Drain'.....	134
6.1.5 The need for a national health human resources strategy.....	136
6.2 Health Human Resources and Primary Care Reform.....	141
6.2.1 Support for Primary Care Reform.....	142
6.2.2 Inter-Disciplinary Education.....	146
6.2.3 What model for primary care reform?.....	147
<b>CHAPTER SEVEN.....</b>	<b>153</b>
TOWARDS A POPULATION HEALTH STRATEGY.....	153
<b>APPENDIX A.....</b>	<b>A-1</b>
LIST OF PRINCIPLES AND RECOMMENDATIONS BY CHAPTER.....	A-1
<b>APPENDIX B.....</b>	<b>A-11</b>
LIST OF WITNESSES.....	A-11

## ORDER OF REFERENCE

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Extract from the Journals of the Senate of March 1, 2001:

Resuming debate on the motion of the Honourable Senator LeBreton, seconded by the Honourable Senator Kinsella:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:

- a) The fundamental principles on which Canada's publicly funded health care system is based;
- b) The historical development of Canada's health care system;
- c) Health care systems in foreign jurisdictions;
- d) The pressures on and constraints of Canada's health care system; and
- e) The role of the federal government in Canada's health care system;

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament be referred to the Committee;

That the Committee submit its final report no later than June 30, 2002; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

After debate,

The question being put on the motion, it was adopted.



Extract from the Journals of the Senate of Tuesday, December 11, 2001:

The Honourable Senator Kirby moved, seconded by the Honourable Senator Pépin:

That, notwithstanding the Order of the Senate adopted on March 1, 2001, the Standing Senate Committee on Social Affairs, Science and Technology, which was authorized to examine and report upon the state of the health care system in Canada, be empowered to present its final report no later than June 30, 2003.

The question being put on the motion, it was adopted.

ATTEST :

Paul C. Bélisle  
*Clerk of the Senate*

## SENATORS

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The following Senators have participated in the study on the state of the health care system of the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J.L. Kirby, Chair of the Committee

The Honourable Marjory LeBreton, Deputy Chair of the Committee

and

The Honourable Senators:

Catherine S. Callbeck

Joan Cook

Jane Cordy

Joyce Fairbairn, P.C.

Wilbert Keon

Yves Morin

Lucie Pépin

Douglas Roche

Brenda Robertson

*Ex-officio members of the Committee:*

The Honourable Senators: Sharon Carstairs P.C. (or Fernand Robichaud, P.C.) and John Lynch-Staunton (or Noel A. Kinsella)

*Other Senators who have participated from time to time on this study:*

The Honourable Senators Carney, Cochrane, Lawson, Léger, Maheu, St. Germain, Sibbeston and Stratton.

## INTRODUCTION

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In December 1999, during the Second Session of the Thirty-Sixth Parliament, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the state of the Canadian health care system and to examine the evolving role of the federal government in health care. The Senate renewed the mandate of the Committee in the First Session of the Thirty-Seventh Parliament. The terms of reference adopted for the purpose of this study read as follows:

*That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:*

- (a) *The fundamental principles on which Canada's publicly funded health care system is based;*
- (b) *The historical development of Canada's health care system;*
- (c) *Publicly-funded health care system in foreign jurisdictions;*
- (d) *The pressures on and constraints of Canada's health care system;*
- (e) *The role of the federal government in Canada's health care system.<sup>1</sup>*

In response to this broad and complex mandate, in March 2001, the Committee re-launched its multi-year and multi-faceted study. Initially, the study was to comprise five major phases. Given the huge amount of testimony it received and the complexity of many of the issues it confronted, the Committee has decided to add an additional phase to its work plan. The report of this sixth phase (Volume Six) will present the Committee's recommendations on the financing and restructuring of health care. Volume Six will also address issues surrounding the growing gaps in coverage for medically necessary drugs and home care services.

Following completion of Volume Six, the Committee intends to examine several specific health-related issues. These studies will result in a series of thematic reports. These thematic reports will deal with: 1) Aboriginal health; 2) women's health; 3) mental health; 4) rural health; 5) population health; 6) home care and 7) palliative care. The following table provides information on the individual phases and their respective timeframes:

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<sup>1</sup> *Debates of the Senate (Hansard)*, 2<sup>nd</sup> Session, 36<sup>th</sup> Parliament, Volume 138, Issue 23, 16 December 1999.

**HEALTH CARE STUDY  
INDIVIDUAL PHASES AND PROPOSED TIMEFRAMES**

<b>Phases</b>	<b>Content</b>	<b>Timing of Report</b>
<b>One</b>	Historical Background and Overview	March 2001
<b>Two</b>	Future Trends, Their Causes and Impact on Health Care Costs	January 2002
<b>Three</b>	Models and Practices in Other Countries	January 2002
<b>Four</b>	Development of Issues and Options Paper	September 2001
<b>Five</b>	Principles for Restructuring the Hospital and Doctor System and Recommendations on Several Health Care Issues	April 2002
<b>Six</b>	Recommendations with respect to Financing and Restructuring the Hospital and Doctor System and Closing the Gaps in Drug and Home Care Coverage	October 2002
<b>Thematic Studies</b>	Aboriginal Health, Women's Health, Mental Health, Rural Health, Population Health, Home Care and Palliative Care	To be determined

The first report of the Committee, released in March 2001, recounted the history of how the federal government helped the provinces to fund hospital and physician care. It focused in particular on the initial objectives of the federal government's involvement in health care and raised some questions about the future role of the federal government in light of the changing health care environment (e.g. increased recourse to drug therapy, hospital out-patient services, home care and community care). This first report also traced the evolution of health care spending and health indicators over the past several decades. Finally, it looked at a number of the myths that are still current concerning the delivery and financing of health care in Canada and clarified the reality surrounding each of these myths. The objective of the first report was to provide factual information as well as to clarify the major current misconceptions that recur in the health care debate in Canada.

The Committee's second report reviewed the major trends that are having an impact on the cost and the method of delivery of health services, and the implications of these trends for future public funding. In particular, the report focused on the pressures associated with the changing demographics of the Canadian population, the increasing use and growing cost of drugs and technology, and developments in the delivery of health services (e.g. the increased use of out-patient, home care and telehealth). The second report also considered issues surrounding health research, health human resource planning (including the shortage of health care providers), rural health, disease trends and the health of Canada's Aboriginal

population. Finally, it examined how a health info-structure could help improve the delivery of health services in the future.

The third report of the Committee described and compared the way that health care is financed and delivered in several other countries (Australia, Germany, the Netherlands, Sweden, the United Kingdom and the United States), and the objectives of national government health care policy in those countries. It highlighted those policies and reforms from which Canada could learn. The third report also examined briefly the operation of medical savings account systems (MSAs) in Singapore, South Africa, the United States and Hong Kong.

The Committee's fourth report outlined five distinct roles for the federal government in health and health care. These five roles are: 1) financing, 2) research and evaluation, 3) infrastructure, 4) population health and 5) service delivery. For each federal role, a list of objectives was enumerated, some constraints were identified and a wide range of potential policy options for reform and renewal were proposed. The Committee's fourth report served to launch a public debate on the challenges and options facing Canada's health care system.

The current report is based on the testimony gathered during hearings held in the fall of 2001, as well as on evidence received during the earlier phases. In total, nearly 300 individuals and organizations told the Committee which of the options presented in the Phase Four report they liked or disliked, and why.

This fifth report consists of seven chapters. Chapter One identifies three fundamental realities in Canada's health care system. At the end of Chapter One are listed twenty principles which the Committee believes should guide the restructuring and financing of the health care delivery system. Chapter Two provides the Committee's rationale for each of the principles enunciated in Chapter One. Chapter Three summarizes the findings and gives the recommendations of the Committee with respect to the financing and assessment of health care technology. Chapter Four presents the views of the Committee regarding health information systems and details its recommendations for deploying a health infostructure in Canada. Chapter Five provides the perspectives of the Committee with respect to health research. Chapter Six presents the Committee's observations and recommendations with respect to the planning of human resources in health care. Chapter Seven enumerates a number of principles which the Committee believes should apply to the population health role of the federal government, with a particular emphasis on Aboriginal health.

The Committee's sixth report, to be released in October 2002, will focus primarily on presenting a set of recommendations on how to move from the principles outlined in Chapters One and Two of this report to a concrete plan of action for restructuring the hospital and doctor system. The sixth report will also include a specific proposal for increasing federal revenue, so that it will be possible to finance the increased federal responsibilities recommended in this report and to help fund the restructuring of the hospital and doctor system.





## **CHAPTER ONE:**

### **A REFORM BASED ON FUNDAMENTAL REALITIES**

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The purpose of this Chapter and Chapter Two is to present a set of principles which will guide the Committee's recommendations on the restructuring and financing of the health care delivery system<sup>2</sup> and on the role of the federal government in health care renewal. These recommendations will be presented in October 2002 in Volume Six of the Committee's study, following hearings during which witnesses will give the Committee their views on how the principles should be applied in practice.

Some of the principles presented in Chapters One and Two serve as the basis for the Committee's recommendations presented in chapters 3 through 6, which deal respectively with health care technology, health infostructure, health research and human resources planning in health care.

The set of principles reflect key findings from the first three reports of the Committee's study on health care together with the evidence presented to the Committee during extensive public hearings held across the country in the fall of 2001. The rationale for each of the principles listed at the end of this chapter is provided in Chapter Two. It is worthwhile to note that many of these principles bear a strong similarity to some of the observations and recommendations made by recent provincial task forces and commissions on health care.

Overall, the set of principles is based on the recognition of three fundamental realities:

- Canada's publicly funded health care system is not fiscally sustainable given current funding levels;
- Canadians want a strong role for the federal government in facilitating health care restructuring and renewal;
- There is a need to introduce incentives for all participants in the publicly funded hospital and doctor system – providers, institutions, governments and patients – to deliver, manage and use health care more efficiently.

The Committee hopes that the principles presented in this Chapter and Chapter Two will enhance the public's ability to understand and give thoughtful consideration to the various challenges faced by Canada's health care system. We also hope that the principles will help move us away from the uniquely Canadian debate about the role of the private sector in health care and the appropriate public/private mix. It is the Committee's view that the debate is being conducted in a counterproductive fashion, and is often responsible for diverting attempts at reforming the health care system.

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<sup>2</sup> While the Committee usually refers to the "health care system", we acknowledge the fact that Canada currently has 13 similar, but not identical, interconnected systems, one in each province and territory.

Canadians must recognize that every Canadian province and territory has mixed public/private sector involvement in health care, as does every other major industrialized country. Physicians, for example, are private in the sense that only a tiny minority are employed by government or its agencies. In addition, most hospitals are owned and governed by boards representing the communities they serve (and some by religious orders) and they operate on a private, not-for-profit, basis. Moreover, diagnostic laboratories operate in most provinces as private, for-profit, entities delivering their services to the publicly funded system, and the great majority of pharmacies are also privately owned.

The Committee wants to stress, once again, the importance for Canadians to be willing to consider new approaches to delivering health services. It is only through such consideration that we will be able to develop options that offer opportunities to sustain Canada's publicly funded health care system. In his interim report, Roy Romanow stressed this point very well when he stated:

*We need to be clear on what values Canadians want their health system to reflect in its policies and programs. In the past, progress on these issues has been extremely difficult with intransigent positions taken at both ends of the spectrum. This kind of acrimonious debate does nothing to move us forward to a broader consensus on the direction we want to take or the steps needed to put our health care system on a sustainable footing for the future. We need to be open to new options and ideas, be willing to engage in open and honest debate about the pros and cons of each new idea, then be prepared to act.<sup>3</sup>*

We now turn to a discussion of the three fundamental realities listed above.

## **1.1 Canada's Publicly Funded Health Care System is Not Fiscally Sustainable Given Current Funding Levels**

The debate over health care financing in Canada revolves around the issue of sustainability. This concept has taken on several meanings in health care in recent years. The Committee wishes to stress that ensuring sustainability does not mean maintaining the status quo in the structure of health care delivery. Nor does it mean giving every Canadian every health service right when they want it; sustainability does not mean a perfect system. We believe that a sustainable health care system is one that provides an appropriate level of care in response to population needs today and, in the longer term, it is also one that has the capability to adapt or adjust to new and evolving realities.

***It is the view of the Committee that a fiscally sustainable health care system is a system upon which Canadians can rely both today and in the future, given government fiscal capacity and taxpayers' willingness to pay. It does not mean giving every Canadian every health service right when they want it. Neither does it mean a perfect system.***

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<sup>3</sup> Commission on the Future of Health Care in Canada (Roy J. Romanow, Commissioner), *Shape the Future of Health Care*, Interim Report, February 2002, p. 4.

Given the current structure of Canada's publicly funded health care system, questions relating to the sustainability and affordability of the system are closely intertwined. This means that the central issue is one of fiscal sustainability. It is the view of the Committee that a fiscally sustainable health care system is a system upon which Canadians can rely both today and in the future, given government fiscal capacity and taxpayers' willingness to pay. That is, in considering whether the current system is fiscally sustainable, one must take into account two constraints. The first is the willingness of taxpayers to pay for the system. The second is the need for all governments, for economic development purposes, to keep tax rates relatively competitive with the OECD countries, and particularly with the United States.

Is Canada's publicly funded health care system fiscally sustainable? To answer this question, it is necessary to assess whether more money is needed, and whether it is possible to raise it from current sources, given the two constraints identified above. To begin, then, we need to examine current and projected trends in health care spending.

According to data from the Canadian Institute for Health Information (CIHI), public and private health care spending in Canada topped \$95 billion in 2000, 6.9% more than the previous year. Even after adjusting for inflation and population growth, there was a 4.1% real increase in spending between 1999 and 2000.

The pace of growth in health care spending is speeding up. In fact, real spending per capita is rising faster today than at any time since the 1980s. Moreover, projections suggest that there are real, continuing upward pressures on Canada's health care costs:

- **Drug Costs:** Drug costs currently account for over 15% of total (public and private) health care spending. They are expected to climb to \$14.7 billion in 2000, up 9% from the year before. The Committee noted in Volume Two that, between 1990 and 2000, drug spending per capita increased by almost 93%, more than twice the average for all health care spending (40%).<sup>4</sup> Original, effective but very costly drugs will be entering the Canadian market in the next decade (including a possible vaccine against AIDS, a new immunological cure for juvenile diabetes, etc.) exacerbating pressures on overall drug costs.
- **New Technology:** Canada needs to invest more in health care technology and health information systems. The Committee's Phase Two report indicated that each \$1 billion investment in new medical equipment requires an additional \$700 million to cover operating and maintenance costs. In fact, a further \$5 billion would be required to bring Canada's investment in health care technology to a level equivalent to that of other OECD countries. Similarly, estimates suggest that between \$6 and \$10 billion would be required to achieve full implementation of a Canadian health-infostructure (or between \$1 to \$1.25 billion annually).<sup>5</sup>
- **Aging Population:** In 1998, 12% of Canadians were 65 or older and more than 43% of what provincial and territorial governments spent on health care

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<sup>4</sup> Volume Two, p. 20.

<sup>5</sup> Volume Two, p. 41 and p. 114.

went to services for seniors. According to Statistics Canada, by 2010, seniors will represent 14.6% of the population, a percentage that rises to 23.6% as the peak of the baby boom generation enters retirement by 2031. Expensive procedures, which were not previously performed on elderly patients, are increasingly being made available to them.<sup>6</sup> Estimates suggest that the impact of population aging will account for an additional 1% of total health care costs each year. Although this percentage appears to be quite small, in dollar terms it amounts to approximately \$1 billion annually in increased health care costs due to an aging population.

- **Cost of Health Care Human Resources:** Labour costs amount to about 75% of spending on health care. According to the Premier's Advisory Council on Health in Alberta (usually referred to as "the Mazankowski report"), in 2001-02 over half the budget increase for health care in Alberta went to salary increases. Competition for scarce human resources in health care is likely to maintain this trend, not only in Alberta but across Canada.
- **Health Research:** Unprecedented support for health research will lead to an explosion of new technologies and drugs. This year, some \$US 40 billion will be spent on health research in the G-7 countries leading to effective but costly technologies in the fields of genomics, proteomics,<sup>7</sup> nanotechnology,<sup>8</sup> etc.
- **Growing Public Expectations:** Many observers have noted that public demand for health care will have a major impact on future costs. In his interim report, Roy Romanow made this point clearly: "One of the most significant cost drivers is how our own expectations have grown over the past few decades. We expect the best in terms of technology, treatments, facilities, research and drugs, and as a consequence, we may be placing demands on our governments that are not sustainable over time."<sup>9</sup> In fact, Canadians appear to be North American and not European in their viewpoints when it comes to public expectations. More precisely, 64% of Canadians are very interested in new medical discoveries, compared to 66% of Americans and 44% of Europeans.
- **Health Care Restructuring:** Restructuring and renewing health care will cost a considerable amount of money. For example, it has been estimated

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<sup>6</sup> For example, cardiac procedures (e.g. PTCA) performed on the elderly are increasing by 12% annually; joint surgery (e.g. knee replacement) is increasing at an annual rate of 8%; renal dialysis is increasing by 14% a year (at a cost of \$50,000 annually per patient).

<sup>7</sup> Proteomics is the systematic analysis of all protein sequences and protein expression patterns in tissues. Genes encode proteins that perform all of the fundamental activities within cells. Proteins are the molecular machines that carry out genetic instructions. Abnormalities in protein production or function have been connected to many diseases and health conditions.

<sup>8</sup> Nanotechnology is molecular manufacturing or, more simply, building things one atom or molecule at a time. A nanometer is one billionth of a meter (3 - 4 atoms wide). Nanotechnology proposes the construction of novel molecular devices possessing extraordinary properties. The possibilities include microscopic computers, billions of times faster than today's, that could control machines patrolling our bodies as artificial immune systems, and machines that could repair cells on a molecular scale, perhaps stopping or reversing the aging process.

<sup>9</sup> Commission on the Future of Health Care in Canada (Roy J. Romanow Commissioner), *Shape the Future of Health Care*, Interim Report, February 2002, p. 25.

that establishing primary health care teams in Quebec would cost, on average, \$1 million per team.

- **Gaps in the Health Care Safety Net:** As pointed out in the Committee's fourth report, there are presently serious gaps in our health care safety net, particularly with respect to drugs and home care. For example, a number of Canadians are not protected against the consequences of having to pay catastrophic drug costs. Similarly, a significant number of Canadians have limited access to necessary home care services. If Canada is to have national standards in health care, and not only in hospital and doctor care as we do now, more money will clearly be required in the form of additional government funding in order to expand public coverage and reduce or close gaps in the health care safety net.

Given the publicly funded nature of Canada's hospital and doctor system, these multidimensional pressures put considerable strain on governments' budgets, both in the shorter and in the longer terms. This reality was well documented by provincial and territorial ministers of health in their 2000 report on cost drivers<sup>10</sup> as well as by many reports tabled with the Committee.

For example, a report prepared for the Ontario Hospital Association estimated that close to 38% of total provincial program spending went to health care in 2000-01, up from 33% in 1992-93.<sup>11</sup> For its part, the Canadian Taxpayers Federation projected that this proportion will hit 50% as early as 2007 in British Columbia and New Brunswick.<sup>12</sup> Similarly, the Conference Board of Canada estimated that over the period from 2000-2020, public per capita spending on health care (adjusted for inflation) will increase by 58%, while public per capita spending on all other government services and programs will increase by only 17% over the forecast period.<sup>13</sup>

The percentage of government spending that is devoted to health care provides the clearest indication of the short-term pressures felt by governments charged with funding health care. During the Committee's cross-country hearings, a wide range of witnesses, including health care managers, health care providers and health care consumers, expressed deep concerns about rising health care costs and their impact on governments' budgets and on patient care. Based on this testimony as well as on numerous reports, the Committee believes that rising costs strongly suggest that Canada's publicly funded health care system is not fiscally sustainable given current funding levels.

A number of individuals and organizations have suggested that operating the health care system more efficiently would save enough money so that no new sources of funding are required. The Committee has repeatedly acknowledged the critical importance of improving effectiveness and efficiency in the management and delivery of health services. In a similar vein,

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<sup>10</sup> Provincial and Territorial Ministers of Health, *Understanding Canada's Health Care Costs – Final Report*, August 2000.

<sup>11</sup> TEAQ Associates, *Getting the Right Balance: A Review of Federal-Provincial Fiscal Relations and the Funding of Public Services*, prepared for the Ontario Hospital Association, December 2001, p. 21.

<sup>12</sup> Walter Robinson, *The Patient, The Condition, The Treatment – A CTF Research and Position Paper on Health Care*, Canadian Taxpayers Federation, September 2001, p. 59.

<sup>13</sup> Glenn G. Brimacombe, Pedro Antunes and Jane McIntyre, *The Future Cost of Health Care in Canada, 2000 to 2020 – Balancing Affordability and Sustainability*, The Conference Board of Canada, 2001, p. 21.

the Fyke Commission in Saskatchewan remarked that “spending more on the current health care system without addressing its underlying problems would be irresponsible.”<sup>14</sup> Indeed, many of the principles presented in the next chapter are designed to achieve a more efficient system than the one we now have.

At the same time, though, we have also argued that there is not convincing evidence to support the hypothesis that efficiency gains will be sufficient to avoid confronting the issue of the need for new funding sources. The Committee has stated that responsible public policy planning therefore requires the exploration of additional sources of funding for health care.

In the Committee’s view, to do otherwise would be to put all our eggs in one basket. This would mean betting the future fiscal sustainability of the health care system on making changes when there is not yet evidence to demonstrate that such changes are actually achievable, and there is no reliable indication of the amount of money that can be saved through restructuring and efficiency changes. In the Committee’s view, to make such a bet would be irresponsible.

We do, however, understand why some people prefer to gamble on efficiency changes being sufficient to make the system fiscally sustainable. Such an assumption evades most of the tough financing questions, and thereby ducks the most controversial health care issues.<sup>15</sup>

In short, prudence, combined with a careful consideration of the evidence, obliges us to confront the most difficult health care issue facing policy makers and indeed all Canadians: how should additional funds for health care be raised? Should they come from individuals or businesses to government (by way of taxes or health care insurance premiums) or should they come from individuals or businesses directly into the health care sector? The Committee will present its answers to these questions in its October report.

Both the report of the Clair Commission in Quebec and the Mazankowski report insisted that there are limits to government general revenues and that it will be necessary to diversify the revenue stream in order to sustain the health care system and respond to the future health care needs of the population.

The Clair Commission stated:

*To ensure the sustainability of our system, it must first of all be accepted that (...) the resources that (...) society can devote to health and social services are limited. This acceptance leads to two indisputable and inextricably linked obligations: the obligation to make choices and to perform.*

*(...) Leaders must make choices about the limits of financial resources and about medical technologies and insured drugs. Administrators and clinicians must also make*

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<sup>14</sup> *Caring For Medicare*, p. 73.

<sup>15</sup> Volume Four, pp. 51-52.

*choices or, if not, accept the choices made by others. Finally, each citizen must choose between solidarity, equity and the risk inherent in the philosophy of “everyone for himself.”<sup>16</sup>*

Similarly, the Mazankowski report stressed:

*If we continue to depend only on provincial and federal revenues to support health care, we have few options other than rationing health services. On the other hand, if we are able to diversify the revenue sources used to support health care, we have the opportunity of improving access, expanding health services, and realizing the potential of new techniques and treatments to improve health.*

*(...)Rather than rationing health services, we need to look at a variety of options for generating additional revenue and using that revenue to expand opportunities for Albertans to access the health services they want and need on a timely basis.<sup>17</sup>*

The Committee wishes to underline the fact that the federal government has significantly increased its financial support to health care in recent years and, consistent with the view expressed by many witnesses, welcomes this new infusion of funds. However, it is also important to recognize that the health care needs of Canadians are great and that their expectations are continually growing. In addition, the costs of running the hospital and doctor system will continue to increase for the reasons given earlier.

**Therefore, Canadians are confronted with the need to balance their desire for publicly funded health services against their willingness to pay for them.**

Given all the competing demands for federal expenditures, the Committee is of the view that any additional funding from federal sources will have to come from “new” money, and not from revenue transferred into the health envelope from existing sources.

Also, in considering how such additional funding ought to be raised, we must keep in mind that Canada’s personal taxes are the highest of the G-7 countries and among the highest in the OECD.<sup>18</sup> This is why the Committee believes that Canadians are confronted with the need to balance their desire for publicly funded health services against both their willingness to pay for them and the need for Canadian tax levels to be reasonably competitive with those of other OECD countries.

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<sup>16</sup> Commission d’étude sur les services de santé et les services sociaux (Michel Clair, Commissioner), *Emerging Solutions – Report and Recommendations*, January 2001, p. v.

<sup>17</sup> Premier’s Advisory Council on Health (Right Hon. Don Mazankowski, Chair), *A Framework for Reform*, report to the Premier of Alberta, December 2001, pp. 52-53. This report is also referred to as “the Mazankowski report”.

<sup>18</sup> This fact is well documented in a report by Statistics Canada, “Recent Trends in Taxes Internationally”, in *Perspectives on Labour and Income*, Catalogue No. 75-001-XIE, Vol. 2, No. 1, January 2001, pp. 36-40.

Once it is recognized that the publicly funded health care system does not currently have sufficient resources to respond to all the demands that are being placed upon it, Canadians must decide what trade-offs they find acceptable. There are three basic options:

- The continued rationing of publicly funded health services, either by consciously deciding to make some services available and not others (that is, by delisting some services), or by allowing waiting lists to continue to grow;
- Increasing government revenue, either by raising taxes directly or through other means such as health care insurance premiums, so that the rationing of services can be reduced or eliminated and waiting lines shortened;
- Making some services available to those who can afford to pay for them by allowing a parallel privately funded tier of health services, while maintaining a publicly funded system for all other Canadians.

The Committee believes that these are the realistic choices facing Canadians. There are arguments in favour of each option. And each option evokes an emotional response from various groups and individuals. Nevertheless, the three options given above must be addressed if Canada is to sustain a health care system of which Canadians can be truly proud. Section 2.5 shows how each of these options is affected by the principles for restructuring and refinancing presented in Chapter Two.

The testimony from witnesses who argued that health care spending is rising much more rapidly than government revenues reinforces the conclusion that Canadians must make choices. Unless health care spending is to be allowed to crowd out other equally important spending, Canadians must confront, on an ongoing basis, the trade-offs inherent in the three options listed above. The challenge of sustaining Canada's health care system thus entails deciding what aspects of health care delivery are to be publicly funded and how funds are to be raised. In Volume Six, the Committee will present its recommendations with respect to federal funding of health care.

## **1.2 Canadians Want a Strong Role for the Federal Government in Facilitating Health Care Restructuring and Renewal**

Many witnesses underlined the fact that the federal government has historically played a major role in financing the health services covered under the *Canada Health Act*. The Committee believes that, given the serious challenges facing our health care system, the federal government must play a major role in order to preserve the spirit of the Medicare program that it pioneered several decades ago. In fact, Canadians overwhelmingly feel that the publicly funded health care system has served them well and they do not want "big bang" or revolutionary changes to the system. Public attitude

***The Committee believes that the federal government has a critical role to play in facilitating, encouraging and accommodating the provinces and territories in their efforts to restructuring and reconfiguring their health care system. The Committee is convinced that the vast majority of Canadians are looking to the federal government for collaborative support and partnerships in effecting needed changes in the health care system.***



surveys repeatedly show that Canadians expect the federal government to continue to be a major player in Canada's publicly funded health care system.

Although the delivery of health care in Canada is primarily a provincial and territorial responsibility, the Committee believes that the federal government has a critical role to play in facilitating, encouraging and accommodating the provinces and territories in their efforts to restructure and reconfigure their health care systems. The Committee is convinced that the vast majority of Canadians are looking to the federal government for collaborative support and partnership in effecting needed changes in the health care system. In fact, there are a number of reasons why the federal government's role is important.

First, Canadians strongly support national principles in health care, and they look to the federal government to play a strong role in maintaining them. As it now stands, the capacity of the federal government to enforce acceptable standards and to recommend appropriate policies to provincial and territorial governments depends in large part on the size of its cash contribution.

Second, federal funding for health care is particularly critical during this period of reform and renewal: changes to the way the health care system operates and is structured will likely result in more rather than less money being required, at least in the short term. The Fyke Commission in Saskatchewan made a similar point, noting that "new funding must buy change, not time, and must buy quality not merely more volume."<sup>19</sup>

Third, and some would say most importantly, only the federal government is in a position to make sure that all provinces and territories, regardless of the size of their economies, have at their disposal the financial resources to meet the health care needs of their citizens. This redistributive role of the federal government is a fundamental part of what many call "the Canadian way".

Fourth, if fundamental changes are to be made to the health care system, they should not be made in only one or two provinces. Inter-provincial harmonization with respect to what services are insured (and ideally with respect to scope of practice rules as well) are important elements of a truly national system. There is an important federal role in encouraging such harmonization, for example by using financial incentives or penalties to persuade provincial or territorial governments to accept national standards.

Finally, the Committee wants to emphasize its strong belief that the amount of money that the federal government transfers to the provinces for health care ought to ensure that it has a seat at the table when the restructuring of the health care system is discussed. The federal government should not just give money without having a say on how that money is spent.

Canadians also want the federal government to work with the provinces and territories in a spirit of collaboration and partnership in facilitating health care renewal. They are impatient with blame-laying; they are more interested in positive results and intergovernmental cooperation. In this perspective, the Committee totally agrees with the observation made in the

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<sup>19</sup> *Caring for Medicare*, p. 79.

Romanow report that now is the time for all levels of governments to collaborate in health care restructuring:

*(...) Canadians want both levels of governments to stop the corrosive and unproductive long-distance hollering and finger-pointing that currently passes for debate on how to renew the health care system. They see both levels of government as bearing responsibility for the problems affecting the system and for finding solutions to them.<sup>20</sup>*

### **1.3 There is a Need to Introduce Incentives for all Participants in the Publicly Funded Hospital and Doctor System – Providers, Institutions, Governments and Patients – to Deliver, Manage and Use Health Services More Efficiently.**

There is a need to introduce incentives for all participants in the publicly funded hospital and doctor system – providers, institutions, governments and patients – to deliver, manage and use health services more efficiently. The Committee strongly believes that significant change in a system as complex as the hospital and doctor system cannot be achieved through top-down, centralized, micro-management. The required changes can only be achieved by establishing an appropriate system of incentives which will:

***The Committee strongly believes that significant change in a system as complex as the hospital and doctor system cannot be achieved through top-down, centralized, micro-management. The required changes can only be achieved by establishing an appropriate system of incentives.***

- Introduce constructive competition among health care institutions;
- Encourage more effective use of all health care providers;
- Encourage more appropriate utilization of health care technology;
- Put in place structures that will result in a better ongoing evaluation of the system as a whole, and of health care outcomes in particular;
- Ensure that patients receive timely as well as quality care, and
- Encourage patients to make cost-effective use of publicly funded health services.

It is the view of the Committee that the key to developing an appropriate set of incentives is the separation of the three functions of financing (or insuring), delivering and evaluating health care. We are convinced that such a split is a necessary condition for being able to introduce the kinds of incentives that will foster a truly patient-oriented health care system – a system in which the patient receives the most appropriate care, in a timely fashion, by a qualified provider.

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<sup>20</sup> *Shape the Future of Health Care*, p. 4.

Moreover, separating the functions of financing, delivering and evaluating health care will introduce a much greater degree of transparency into the system and enhance the accountability of all parts of the system, including government. It will also lay the groundwork for greater competition among health

care institutions. The rationale for such a split, which we believe is critical to any meaningful reform of Canada's health care system, was discussed in the Committee's hearings as well as in recent reports.

***It is the view of the Committee that the key to developing an appropriate set of incentives is the separation of the three functions of financing (or insuring), delivering and evaluating health care. We are convinced that such a split is a necessary condition for being able to introduce the kinds of incentives that will foster a truly patient-oriented health care system – a system in which the patient receives the most appropriate care, in a timely fashion, by a qualified provider.***

In the Atlantic provinces and Western Canada, as well as in central Canada, the Committee was told that health care in this country operates in many ways as a “monopoly”, with the government acting as the sole funder and the sole provider of many health services, without independent evaluation or competition. The Right Hon. Don Mazankowski, Chairman of the Premier's Advisory Council on Health in Alberta, explained:

*Alberta's health care system, like other systems across the country, operates as an unregulated monopoly. Government...*

- *Defines what constitutes “medically necessary services”*
- *Pays for all insured services provided*
- *Provides public insurance and forbids, by law, the provision of private insurance for these services*
- *Prevents, by law, people from obtaining insured services outside the public system except where there are contracts with the public system*
- *Directly or indirectly administers and governs care*
- *Defines, collects and reviews information on its own performance.<sup>21</sup>*

The Committee heard that such government control over health care makes for an inefficient system that lacks transparency and accountability:

*Governments in Canada are seriously conflicted with respect to health care. Governments do not only collect health insurance premiums (through taxes or by special premiums), and maintain responsibility for the delivery of health services, but also report to themselves on their own effectiveness and efficiency based on information they have decided to collect. Furthermore, the same governments then decide what information will*

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<sup>21</sup>Premier's Advisory Council on Health (Alberta), p. 21.

*be provided to the public. Governments must also decide on the interpretation of results – so health services organizations may regard 80% satisfaction rates as acceptable, when many industries would fire the management of an organization which regularly reported that 20% of customers were dissatisfied or that over half of the employees believe the organization is not a good place to work.*

*The conflict can be reduced or eliminated by separating the insurance function from the health care delivery function. (...) Conflict would also be reduced by distinguishing those responsible for health care system evaluation from those responsible for health services delivery, and from those responsible for collecting insurance premiums.*

*Eliminating the conflict that arises from government acting simultaneously as a regulator, insurer, provider and evaluator will produce an environment which encourages each sector seek appropriate information about health care system performance.<sup>22</sup>*

In Volume Three of its study, the Committee reported that many countries faced with costly, inefficient or unresponsive health care systems have already embarked on reforms aimed at getting rid of the monopoly characteristics described above by separating the various health care functions while maintaining universal access to publicly insured health services. Examples include Sweden, the United Kingdom and the Netherlands.

**...many countries faced with costly, inefficient or unresponsive health care systems, have already embarked on reforms aimed at getting rid of the monopoly characteristics described above by separating the various health care functions while maintaining universal access to publicly insured health services. Examples include Sweden, the United Kingdom and the Netherlands.**

International evidence suggests that separating the role of the funder from that of the provider can contribute to making the health care system more efficient by:

- decentralizing the decision-making process;
- introducing more competition;
- better integrating health services;
- making possible more effective use of all health care providers;
- making possible more appropriate use of health care technology;
- putting the patient first, since the funding follows the patient;
- ensuring that patients receive timely as well as quality care.

Moreover, separating the role of the funder from that of the evaluator will help put in place structures that will result in better ongoing evaluation of the system as a whole, and

<sup>22</sup> Atlantic Institute for Market Studies, Brief to the Committee, 6 November 2001, p. 5.

of treatment outcomes in particular. This will enhance transparency and foster accountability in the use of public funds.

For all these reasons, the Committee believes that the roles of funder (or insurer), provider, and evaluator in the Canadian health care delivery system should be split from one another. The set of principles developed in this report is premised on such a split.

***The Committee believes that the roles of funder (or insurer), provider, and evaluator in the Canadian health care delivery system should be split from one another. The set of principles developed in this report is premised on such a split.***

The Committee recognizes that a number of these principles will have to be applied differently in various parts of the country in order to take into account important regional variations (such as the size of the population and the number of health care providers and institutions that exist within each region) and that they will have to be applied differently for different types of institutions (e.g. community hospitals and teaching hospitals). Indeed, much of our next report will focus on how to go from principle to action, and how to take into account such regional and institutional variations. Nonetheless, the Committee strongly believes that the set of principles, taken as a whole, clearly indicate how the hospital and doctor system ought to be restructured.

It is the view of the Committee that the overall impact of these principles on the health care system will be to effect a two-stage transformation. More precisely, the first stage of reform would involve the following changes:

1. **Split between the funder (or insurer) and the provider:** While government would continue to be the funder/insurer (as it is now), the institutions providing publicly funded health services (hospitals and clinics) would become more independent of government since they would no longer be subjected to the same degree of government control as they are now. To achieve this, the method for remunerating hospital services would have to be modified: global annual budgets for hospitals, which are currently determined by government, would disappear and institutions would be reimbursed under a service-based funding scheme (which assigns a dollar value to each type of hospital service and reimburses hospitals for the specific number and type of services they provide).

By having government fund hospitals for each service, and by having the amounts paid for each service publicly known, the public would be able to see, for the first time, the direct connection between the level of funding and the number and types of procedures that are performed. This would allow the consequences of decisions about the level of health care funding to become more open to public scrutiny, as it would become evident what specific services were affected by various levels of government funding.

This has the potential to change the nature of the health care debate dramatically by having it focus on the number of patients served and the number and variety

of medical procedures carried out (that is, the outputs and outcomes of the hospital and doctor system), rather than focussing only on dollars (or inputs) as the debate does now. Thus, the funding debate would be broadened and become patient-focussed and service-focussed, rather than only dollar-focussed as it is now.

***The Committee believes it is essential that the funding debate become patient-focussed and service-focussed, rather than only being dollar-focussed as it is now.***

2. **Split between the funder/insurer and evaluator:** Government would continue to have overall responsibility for the quality of health care delivery, and providers would ultimately be accountable to government, but the evaluator role would be considerably strengthened. Although it would continue to be funded by government, the evaluator role would be performed at arm's length from government. Much greater emphasis would be placed on measuring the quality of treatments and services, gauging the health outcomes of various procedures and assessing system and institutional performance. A system of independent evaluation, performed by agencies working at arm's length from government, would provide much more accurate and objective evidence-based information about access, outcomes and costs than is currently available.
3. **"Internal market"<sup>23</sup> for hospital services:** Once the service-based funding scheme for hospitals and other institutions is well in place and the independent evaluation function is being well performed, regional health authorities would become responsible for the purchasing of services on behalf of their residents by entering into contracts with hospitals and other institutions. (If a province so wished, regional health authorities could also become responsible for purchasing primary care services). This type of "internal market" reform, which has already been implemented to varying degrees in a number of countries, including Sweden, was also recently proposed in the Mazankowski report in Alberta<sup>24</sup>. Such an "internal market" would foster competition between institutions for the provision of hospital services and encourage both cost-effectiveness and efficiency in service delivery. The Committee is aware that reforms of this type will have to be adapted to the particular circumstances that prevail in different parts of the country in order to take into account the number of providers that operate in each region, as well as factors such as the urban/rural mix.

**The second stage of reform** would result in devolution of the purchasing function from regional health authorities (or from government in provinces where there are no

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<sup>23</sup> The term "internal market" was first used in reference to reforms undertaken in New Zealand and Great Britain during the 1990s that sought to introduce greater competition among health care providers (both public and private) in the context of a system that retained a single insurer.

<sup>24</sup> Premier's Advisory Council on Health (Alberta), see footnote 1.

such regional entities) to primary health care teams.<sup>25</sup> This would mean that primary health care teams would assume the responsibility for purchasing health services from institutional providers on behalf of their patients. An “internal market” among institutional providers who would compete to sell their services to the various primary health care teams would thus be established. This would result in a situation similar to the GP Fundholding scheme in the United Kingdom (for more information, see the Committee’s Volume Three<sup>26</sup>).

In Canada, this form of “internal market” was recommended by the Health Services Restructuring Commission chaired by Duncan Sinclair in Ontario<sup>27</sup>, as well as by Jérôme-Forget and Forget<sup>28</sup>. This second stage of reform would also require moving away from the current fee-for-service remuneration method for physicians toward some form of blended remuneration involving capitation as well as fee-for-service. This would also involve the development of multi-disciplinary group practices and the revision of current scope of practice rules.

Devolving the purchasing function to primary health care teams would also require patients to register on an annual basis with the primary care group of their choice. A number of studies suggest that, while this could limit somewhat a patient’s freedom to choose a provider (primary care provider or specialist)<sup>29</sup>, it would provide for a better integration of health services to the overall benefit of patients. According to several witnesses, this would lead to a more patient-oriented health care system.

The Committee heard evidence that under “internal market” reforms, the overwhelming majority of institutional providers would continue to be, as they are now, privately-owned, not-for-profit institutions. However, nothing would prevent for-profit providers from competing to supply services, including hospital services, as long as they were subjected to the same quality control regulations and evaluations as public sector institutions. Such a structure is entirely consistent with the *Canada Health Act* (and is discussed more fully under Principle Eight in Chapter Two), which does not prohibit private, for-profit institutions. Having noted this, the Committee wishes to make it perfectly clear that it is not pushing for the creation of private for-profit facilities.

It is important to understand that the first stage of reform (the separation of funder/insurer, provider and evaluator) would have to be done before embarking on the second stage, because the second stage (the separation of purchaser and provider) requires that health care institutions know the cost of providing a given service to a patient. At present, the

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<sup>25</sup> A recent review of the various possible types of “internal market” reform can be found in Cam Donaldson, Gillian Currie and Craig Mitton, “Integrating Canada’s Dis-Integrated Health Care System – Lessons from Abroad”, *C.D. Howe Institute Commentary*, April 2001.

<sup>26</sup> Volume Three, pp. 37-44.

<sup>27</sup> Health Services Restructuring Commission (Duncan Sinclair, Chair), *Primary Health Care Strategy – Advice and Recommendations to the Honourable Elizabeth Witmer, Minister of Health*, Government of Ontario, December 1999.

<sup>28</sup> Monique Jérôme-Forget and Claude E. Forget, *Who is the Master? – A Blueprint for Canadian Health Care Reform*, Institute for Research on Public Policy, 1998.

<sup>29</sup> Once enrolled, patients would have to remain with their designated primary health care team for a specific period, usually a year, unless they changed their place of residence. Similarly, enrolled patients do not have direct access to a medical specialist; they must be referred to the specialist (gynaecologists, paediatricians, etc.) participating in the group practice. The primary care physician or team acts as the gatekeeper to the rest of the system.

information systems that are required to do this are not available in most institutions, and the current practice of global budgeting is a major factor that discourages their development.

The Committee is convinced that the separation of the three functions of financing (or insuring), delivering and evaluating health care is an essential step toward a truly patient-oriented health care system in Canada – a system whereby the patient receives the most appropriate care, in a timely fashion, by a qualified provider. Such a split will also introduce a much greater degree of transparency and accountability by government. More importantly, the separation makes it possible for a number of incentives to be introduced into the system – incentives which are intended to improve efficiency in the use, provision and management of health care services. While the Committee has not taken a final position on “internal market” reforms, its current inclination would be to have primary health care teams act as purchasers of all health services on behalf of their patients. We intend to review this proposal carefully and present our final recommendations in Volume Six.

#### **1.4 Principles to Guide the Restructuring and Financing of Canada’s Health Care System**

Chapter Two develops the rationale for, and the implications of, the principles for reform supported by the Committee. These principles, which form an integrated whole, are listed below.

##### **THE INSURER:**

1. There should be a single funder (insurer) – the government either directly or through an arm’s length agency – for hospital and doctor services covered under the *Canada Health Act*.
2. There should be stability of, and predictability in, government funding for public health care insurance.
3. The federal government should play a major role in sustaining a national health care insurance system.
4. The determination of what should be covered under public health care insurance should be done through an open and transparent process. Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.
5. The federal government should contribute on an ongoing basis to fund health care technology.



6. The federal government should increase its investment in those areas of health and health care for which it already has a major responsibility.
7. The consequences arising from changes in the level or amount of government funding for hospital and medical care should be clearly understood by government and explained to the public, in as much detail as possible, at the time such changes are made and announced.

#### **THE PROVIDER:**

8. In the first stage of health care reform, the method for remunerating hospitals should be changed from the current annual global budget to service-based funding.
9. Regional health authorities should have the responsibility for purchasing hospital services provided by institutions within their region.
10. Primary care renewal should lead to the provision of primary care by group practices, or clinics, which operate twenty-four hours a day, seven days a week.
11. To facilitate primary care reform, the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards.
12. New scope of practice rules and other measures need to be developed in order to enable all health care providers in the primary care sector to provide the full range of services for which they have been trained.
13. In the second stage of health care reform, an “internal market” should probably be created in which primary health care teams would purchase health services provided by hospitals and other health care institutions on behalf of their patients.
14. A national (not exclusively federal) strategy must be developed to achieve both an adequate supply and optimal use of health care providers.

## **THE EVALUATOR:**

15. Accountability and transparency in health care financing and delivery require the deployment of a system of electronic health records (EHR) that can capture and translate information on system performance and outcomes.
16. Measuring treatment outcomes and system performance must become an essential part of the health information system. Such monitoring and evaluation of the health care delivery system should be performed independently at the national (not federal) level and be funded by government.

## **THE PATIENT:**

17. Canada's publicly funded health care system should be patient-oriented.
18. Incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees for services that are deemed to be medically necessary.
19. Programs that enable people to be responsible for their own health and to stay healthy must be given high priority. The federal government can play a leadership role in this regard.
20. For each type of major procedure or treatment a maximum waiting time should be established, and made public. When this maximum time is reached, the insurer (government) shall pay for the patient to receive immediately the procedure or treatment in another jurisdiction including, if necessary, another country.

## CHAPTER TWO:

### PRINCIPLES TO GUIDE THE RESTRUCTURING AND FINANCING OF CANADA'S HEALTH CARE SYSTEM

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#### 2.1 Financing (or Insuring) Health Care

#### *Principle One*

**There should be a single funder (insurer) – the government directly or through an arm's length agency – for hospital and doctor services covered under the *Canada Health Act*.**

The most compelling argument for a single public funder or insurer is that a publicly funded hospital and doctor system is the essence of the health care system which Canadians strongly support. The Committee agrees that this central element of our system must be maintained, provided that the system meets appropriate standards for quality services delivered in a timely manner.

That is, the Committee believes that there should be a single funder – the government directly or through an arm's length agency – for medically necessary hospital and doctor services. A single-funder system yields considerable efficiencies over any form of multi-funder arrangement, including administrative,

***The Committee believes that there should be a single funder – the government directly or through an arm's length agency - for hospital and doctor services. A single-funder system yields considerable efficiencies, including administrative, economic and informational economies of scale, over any form of multi-funder arrangement. (...) As a corollary, there should not be private insurance for publicly insured hospital and doctor services.***

economic and informational economies of scale. Furthermore, since a publicly funded hospital and doctor system has become a fundamental element of Canadian society, the Committee believes that the single funder should be government, either directly or indirectly (e.g. through a third party, such as a regional health authority or other arm's length agency). As a corollary, there should not be private insurance for publicly insured hospital and doctor services.

In addition, numerous witnesses told the Committee that by concentrating primary financial responsibility in a single funder, the Canadian health care system would lead to more efficient administration of health care insurance. They suggested that Canada's publicly financed single-insurer system for medically necessary services delivered under the *Canada Health Act* eliminates the costs associated with the marketing of competitive health care insurance policies, billing for and collecting premiums, and evaluating insurance risks.

Lee Soderstrom, professor at the Department of Economics, McGill University, described the advantages of a public, single funder for health care as follows:

*Available evidence indicates that the cost of the public insurance would be lower because administrative costs would be lower with that public plan. These costs would be lower because the public plan would take maximum advantage of the economies of scale possible in plan administration. There would be no need for advertising costs.*

*(...)The evidence understates the efficiency gains from having a single payer plan. With the public plan, users avoid administrative hassles when seeking care. They also avoid a second major problem all too familiar to Americans with private insurance: the inevitable, countless administrative difficulties involved in obtaining reimbursement for bills they have incurred.<sup>30</sup>*

Similarly, a document tabled to the Committee by the Atlantic Institute for Market Studies stated:

*Under a private insurance-based model, such as predominates in the USA, the possibility of adverse selection involves high costs that contribute little to the quality of medical care provided. Pooling all citizens into a universal health insurance plan can dramatically lower such costs. The per capita cost of insurance overhead under the Canadian system, wherein the provinces operate “single payer” insurance systems, is approximately one-fifth the per capita cost in the United States where private health insurance is the norm.<sup>31</sup>*

Another strong argument in favour of public health care insurance is the fact that very few Canadians can afford not to be covered. It therefore makes sense to have everyone covered by a single plan. A single-insurer system providing universal coverage also means that no one will deny themselves needed health care because they have a more pressing use for their money (perhaps for food, shelter, clothing, etc.). Nor will anyone be denied necessary care due to inability to pay.

***A single-funder model also implies that there will not be, within Canada, a parallel, private insurance sector that competes with public insurance for the funding of hospital and doctor services covered under the Canada Health Act, at those hospitals and with those doctors that care for publicly funded patients.***

A single-funder model also implies that there will not be, within Canada, a parallel, private insurance sector that competes with public insurance for the funding of hospital and doctor services covered under the *Canada Health Act*, at those hospitals and with those doctors that care for publicly funded patients. The public funding of the Canadian health care

<sup>30</sup> Professor Lee Soderstrom, Brief to the Committee, 31 October 2001, p. 4.

<sup>31</sup> Brian Lee Crowley and David Zitner, *Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System*, Atlantic Institute for Market Studies, November 1999, p. 9.

system would still be done using revenue raised through general taxes, earmarked taxes or public health care insurance premiums, as is currently the case. Canadians should, however, still be permitted to purchase private insurance for non-publicly insured health services and to buy insurance abroad for services delivered abroad as they do now. Health care institutions would also continue to receive the additional revenue they currently derive from non-insured benefits and services.

Under the current Canadian health care system, a provider can be paid from private sources for the delivery of services that are publicly insured as long as the provider opts out completely from the public system, taking no publicly funded patients. Research brought to the attention of the Committee shows that allowing doctors to function in both the public and parallel private systems

***Therefore, the Committee feels it is important that the current restrictions which prevent doctors from operating in both parallel public and private systems be maintained.***

disadvantages patients in the publicly funded system, both in terms of quality and timeliness of care. Therefore, the Committee feels it is important that the current restrictions which prevent doctors from operating simultaneously in parallel public and private systems be maintained.

Moreover, the Committee agrees with witnesses that no one should face excessive financial hardship or possible bankruptcy because of illness, disease, injury or disability. Access to timely and medically necessary health services should be available to all, regardless of income. This does not mean, however, that Canadians should not bear some responsibility to keep healthy or to contribute to the future sustainability of the health care system. Rather, it means that any funding mechanism or financial involvement by individual Canadians should be equitable and fairly distributed. Incentives designed to encourage responsible use of the publicly funded health care system by patients are discussed in Section 2.4 below.

## *Principle Two*

**There should be stability of, and predictability in, government funding for public health care insurance.**

The Committee heard repeatedly that there is a major lack of stability and predictability in the policies and the financing of the Canadian health care system. For example, Lawrence Nestman, professor at the School of Health Services Administration, Dalhousie University, stated that the high turnover of ministers of health and their deputies, as well as that of senior civil servants, has created an atmosphere of unpredictability in federal and provincial/territorial relationships and in health care policies, particularly with regard to those policies that are related to funding.<sup>32</sup> This view was echoed by Jeff Lozon, President of St Michael's Hospital in Toronto and former deputy minister of health in Ontario, who said:

<sup>32</sup> Professor Lawrence Nestman, *Three Proposals to Improve Federal-Provincial Relations in the Health Services Field*, Brief to the Committee, p. 1.

*My first point is perhaps my most strongly held. It is premised on the urgent need for predictability and stability of direction in the health care system, it is driven by the need to shelter the system from the daily parry and thrust of the political fabric. One of the least desirable, most difficult and important jobs is the leadership of the health care system at a provincial level. Without more stability and certainty, the best reform policies will fail. Consider the following. In Ontario, there have been 7 Ministers of Health in the last 10 years, and 7 Deputy Ministers in that same timeframe. Based on personal experience, I know that 3 months as Deputy Minister gives you seniority over half you colleagues, and going beyond one year constitutes long service! The job expectancy of a Minister of Health is 15 months, and a Deputy Minister about the same. It is impossible to take the system forward with that type of turnover, and long range system planning is impractical.<sup>33</sup>*

Both Professor Nestman and Mr. Lozon recommended the creation of provincial non-profit organizations to run the health care system. In their models, these bodies would consist of a board of directors appointed by the government and supported by a staff of experts. They would exist at arm's length from the political process and would replace the current departments of health. According to Mr. Lozon:

*In this way, a sense of stability and direction could emerge distanced from the day-to-day pressures of electoral politics and would continue to be responsible for high level goals established by the legislature.<sup>34</sup>*

Similarly, the Committee was told that health care funding is heavily dependent on annual revenues to the government and can fluctuate significantly with changes in the economy. In his brief to the Committee, Claude Forget stated:

*Governments have used the health care sector as their main deficit-fighting tool, and yet the need of those services is not sensitive to economic cycles. (...) It is difficult to manage a budget which changes unpredictably in time, largely beyond the control of managerial intervention.<sup>35</sup>*

Witnesses also complained about the lack of strategic and long-term planning to deal with the anticipated and growing health care cost pressures resulting from an aging population, rising expectations and costly technology and drugs (see section 1.1 above). They stressed that stability and predictability in health care funding, for example in the form of multi-year funding arrangements, is a prerequisite to undertaking any systemic reform and sustaining public confidence. This observation was also made in the Romanow report:

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<sup>33</sup>Jeffrey C. Lozon, Brief to the Committee, 29 October 2001, p. 4.

<sup>34</sup> *Ibid.*, p. 5.

<sup>35</sup> Claude Forget, *Canadians' Health: The Role of Government*, Brief to the Committee, 31 October 2001, pp. 7-8.

*(...) our health care system has in recent years suffered from inconsistent and erratic funding. Many key health care decisions – from building new facilities, to creating new capacity and delivering certain types of services to targeted populations – require a long planning cycle. When health care decision makers are obliged to cope with constantly shifting priorities, or when anticipated resources are reduced or eliminated, great uncertainty is the first result quickly followed by reductions in services. This lack of stable, long-term, predictable funding is jeopardizing long-term planning and, in turn, eroding public confidence in the system's future.<sup>36</sup>*

Many witnesses underlined the important role the federal government could play in ensuring such stability. For example, the British Columbia Health Association stressed:

*A stable funding contribution from the federal government is essential in order to ensure that our provincial health care systems can function in an environment that is conducive to undertaking fundamental changes and implementing required innovations.<sup>37</sup>*

Similarly, Bill Bryant, Chair of the Southwestern regional health authority in Manitoba stated:

*Before we can undertake dramatic and sustainable reconfiguration of the system, which we believe is needed, a stable and on-going funding framework must be assured. Some of the basic infrastructures of our health care system have suffered serious erosion over the past decade as a result of “stop-and-go” funding methodologies by both federal and provincial governments. Therefore, one of the first priorities must be a significant and sustained federal cash commitment to restore stability to the existing health care system and ultimately renew confidence in the health care system.<sup>38</sup>*

The Committee concurs with the witnesses that there should be stability of, and predictability in, government funding. It is our view that no industry can be expected to effectively operate if, from year to year, its revenue is subject to significant fluctuations over which it has no control. In fact, effective planning, which is an essential element of an efficiently operated industry, is impossible unless stability and predictability of funding is assured. In other words, multi-year funding is essential to running the publicly funded health care system efficiently.

***The Committee concurs with the witnesses that there should be stability of, and predictability in, government funding. It is our view that no industry can be expected to effectively operate if, from year to year, its revenue is subject to significant fluctuations over which it has no control. Multi-year funding is essential to running the publicly funded health care system efficiently.***

<sup>36</sup> *Shape the Future of Health Care, Interim Report*, pp. 4-5.

<sup>37</sup> Health Association of British Columbia, Brief to the Committee, October 2001, p. 3.

<sup>38</sup> Bill Bryant, Brief to the Committee, 15 October 2001, p. 1.

Stability and predictability require that governments are capable of providing sufficient funding in order to meet health care needs at all times, including times of fiscal restraint. This is, of course, easier said than done, given that health care needs do not vary with economic cycles as government revenues do. The challenge, therefore, will be to ensure that spending on health care does not crowd out other vital forms of public spending, including education, infrastructure, security, and various other social services:

*Spending on health care cannot be allowed to crowd out other vital forms of public spending, including education, infrastructure and other social services. Our future prosperity and health depend on all of these, and to the extent that it is crowding out these other forms of spending, tax-financed health care in its current form is not sustainable.*<sup>39</sup>

This principle does not, in itself, prescribe what sources of revenue are to be used by government in order to guarantee stability and predictability. It does, however, raise two important questions:

- First, should earmarked taxes or health care insurance premiums be used to pay for health care in order to help ensure the predictability and stability of funding?
- Second, should some form of arm's length agency, as suggested by several witnesses, including Professor Nestman and Mr. Lozon, be given the responsibility for managing the health care system, in order to shelter the system from the daily parry and thrust of elected politics?

The Committee will seek views on these questions before giving the Committee's answers to them in our October report.

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<sup>39</sup> Premier Advisory Council on Health (Alberta), p. 31.



## *Principle Three*

### **The federal government should play a major role in sustaining a national health care insurance system.**

Many witnesses underlined the crucial role of the federal government in financing the hospital and doctor system and in ensuring stability in funding. Although the provision of health care is under provincial and territorial responsibility, the federal government has historically played a major role in financing the health services covered under the *Canada Health Act*. Witnesses told the Committee that a number of reasons explain why it is important that this major role be continued. These reasons were explained in Section 1.2.

On a number of occasions, provincial and territorial governments have called on the federal government to increase CHST transfer payments in order to help stabilize and sustain Canada's health care insurance system. Increasing the federal contribution to health care would likely require raising the level of federal taxation. As stated in Chapter One under Section 1.1, this could prove difficult to implement, as Canada's personal taxes are the highest of the G-7 countries and among the highest in the OECD.<sup>40</sup> Accordingly, Canadians need to balance their desire for publicly funded health services with their willingness to pay taxes to support the financing of those services.

***...a number of witnesses suggested we should diversify the revenue sources used to support health care. This would serve to improve timely access to health care and/or to expand the basket of publicly insured health services. A national health care insurance premium would be an example of an earmarked revenue source which could be used to support health care.***

A major concern that was raised during the Committee's cross-country hearings was that if we continue to depend solely on the general tax base of provincial/territorial and federal governments to support health care, we may end up having to increase the rationing of publicly funded health care services. For this reason, a number of witnesses suggested we should diversify the revenue sources used to support health care. This would serve to improve timely access to health care and/or to expand the basket of publicly insured health services. A national health care insurance premium would be an example of an earmarked revenue source which could be used to support health care.

***...a number of witnesses suggested that it would be essential to establish a mechanism that would allow federal funding to be targeted to specific purposes, its usefulness and efficacy to be evaluated and those who spend it to be held accountable.***

<sup>40</sup> Statistics Canada, "Recent Trends in Taxes Internationally", in *Perspectives on Labour and Income*, Catalogue No. 75-001-XIE, Vol. 2, No. 1, January 2001, pp. 36-40.

A further issue has to do with whether provinces and territories should have to account for their use of new or additional federal funds. The evidence provided in the Committee's Phase One report showed that block transfers inhibit government accountability.<sup>41</sup> For this reason, a number of witnesses suggested that it would be essential to establish a mechanism that would allow federal funding to be targeted to specific purposes, its usefulness and efficacy to be evaluated and those who spend it to be held accountable. One such mechanism, recommended by Claude Forget, was that a portion of personal income taxes be allocated permanently to health care in order to ensure stability of the financial health care system and that this proportion be integrated into federal-provincial fiscal arrangements. The Committee's recommendations on the funding issue will be presented in our October 2002 report.

## *Principle Four*

**The determination of what should be covered under public health care insurance should be done through an open and transparent process. Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.**

The Committee is of the view that health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.

***The Committee is of the view that health services covered under the Canada Health Act should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.***

The Committee concurs with the Canadian HealthCare Association that now is the time to examine the public private mix in health care if the federal and provincial governments are to develop sound public policies. The Association, which represents provincial and territorial hospital and health organizations across Canada, stated:

*It is time for governments, managers, trustees, providers, researchers and the public to develop and implement sound public policies to ensure that we achieve the appropriate private-public mix in our health care system.<sup>42</sup>*

<sup>41</sup> Volume One, pp. 5-30

<sup>42</sup> Canadian Health Care Association, *The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities*, Policy Brief, 2001, p. 3.

In this perspective, the Committee agrees with the report of the Clair Commission in Quebec and the Mazankowski report in Alberta that consideration should be given to reviewing the principle of comprehensiveness of the *Canada Health Act*. Both reports recommended the establishment of a

***The Committee supports the establishment of a permanent committee, made of citizens, ethicists, doctors and scientists, to review and make decisions on services that should be publicly insured.***

permanent committee, made up of citizens, ethicists, doctors and scientists, to review and make decisions on services that should be publicly insured. Such a review would lead to evidence-based decision making for public health care coverage. Such a review would also set the boundaries between publicly insured and privately funded health services:

*On an initial basis, the expert panel should review the broad categories of services currently provided and decide whether all existing services should be “grandfathered” for continued public funding. Services that are not publicly insured could be provided by the public or private health care provider but would not be paid for by public health care funds.<sup>43</sup>*

The Committee agrees with the intent of the above quotation, but disagrees that the panel should be composed only of experts. We strongly believe that input from those who would be directly affected by the panel’s decisions – namely citizens – is essential if the process is to be truly open and is to have public credibility and acceptability. Moreover, only such an open process will make possible the essential debate of what health services Canadians are prepared to pay for through their taxes.

Thus, the Committee concurs with the Romanow Commission that the public must be involved in the process for determining publicly funded health services:

*Canadians need a greater say in determining what health services should or should not be publicly covered. Although elected governments must always retain accountability, the ways in which decisions are currently made, and who is making them are difficult to understand and often even more difficult to justify.<sup>44</sup>*

Determining which services should be paid for publicly and which ones should not – that is, deciding what services are to be listed and delisted – has always been part of the way that Canadian Medicare has functioned. That is why there are some differences in what is covered in different provinces/territories. As indicated in Volume One of the Committee’s study, for example, the removal of warts is no longer covered in Nova Scotia, New Brunswick, Ontario, Manitoba, Alberta, Saskatchewan and British Columbia, but it remains publicly insured in Newfoundland, Quebec and Prince Edward Island. Similarly, stomach stapling is covered in

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<sup>43</sup> Premier’s Advisory Council on Health (Alberta), p. 45.

<sup>44</sup> *Shaping the Future of Health Care*, p. 18.

most provinces, but it is not insured in New Brunswick, Nova Scotia or the Yukon, and patients in these provinces must pay for this procedure.<sup>45</sup>

Revising the comprehensive basket of publicly insured health services is not intended to reduce costs but to improve evidence-based decisions with respect to public funding. However, it is important to stress that there are limits to what the publicly funded health care system can provide. To put this simply, public health care insurance cannot do all things for all people. What is critical, however, is that the determination of what is to be covered publicly should be done through an open and transparent process, rather than the current process in which decisions about what is covered are made in secret by governments with no public input.

This point was emphasized by the Honourable Monique Bégin, who was the federal Minister of Health at the time the Canada Health Act was enacted, in a recent speech:

*...choices are being made every day without citizens knowing. ... the de-listing of services, a completely secretive process, must be made explicit as a matter of accountability.*<sup>46</sup>

The Committee believes that such an open process would create the possibility for there to be a public debate over whether the population would be prepared to pay more to government in order to have more services covered under the public insurance plan. We also believe that there should be national standards that define those services which are to be covered publicly in each province/territory.

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<sup>45</sup> Volume One, pp. 98-99.

<sup>46</sup> The Hon. Monique Bégin, "Revisiting the Canada Health Act (1984): What Are the Impediments to Change?" delivered at The Institute for Research on Public Policy 30th Anniversary Conference, February 20, 2002, p. 6.

## Principle Five

### **The federal government should contribute on an ongoing basis to fund health care technology.**

During Phase Two of its health care study, the Committee was told that although Canada ranks 5<sup>th</sup> among OECD countries in terms of total spending on health care (as a percentage of GDP), it is generally among the bottom third of OECD countries in the availability of health care technology. For example, Canada lags behind many other countries in terms of access to CT scanners, MRIs and lithotriptors.<sup>47</sup>

Availability is not the only issue with respect to health care technology. The “aging” of that technology is also of concern. For example, information provided to the Committee indicates that between 30% and 63% of imaging technology currently used in Canada is outdated. The Committee was told that the shortage of new technology and the use of outdated equipment impede accurate diagnoses and limit the quality of treatment that can be provided.<sup>48</sup>

The federal government has responded to the deficit in health care technology. In September 2000, it announced that it would invest a total of \$1 billion in 2000-01 and 2001-02 to assist the provinces and territories in purchasing new medical equipment. The Committee welcomes this injection of new federal funds as an important step toward the acquisition of needed health care technology.

However, the Committee is concerned that there are apparently no mechanisms for ensuring accountability on the part of the provinces and territories as to exactly where money targeted towards purchasing new equipment is actually spent. This is why we strongly believe, as stated under Principle Three, that a much better accountability mechanism is needed for targeted federal funds.

***...the Committee is concerned that there are apparently no mechanisms for ensuring accountability on the part of the provinces and territories as to exactly where money targeted towards purchasing new equipment is actually spent. This is why we strongly believe, as stated under Principle Three, that a much better accountability mechanism is needed for targeted federal funds.***

Overall, the Committee believes that the federal government should commit to a long-term program of financing for health care technology. In our view, such a program should incorporate clear accountability mechanisms on the part of the provinces/territories on their use of these targeted federal funds. Chapter 3 of this report provides our findings and recommendations in this regard.

<sup>47</sup> Volume Two, p. 38.

<sup>48</sup> Volume Two, p. 39.

**The federal government should increase its investment in those areas of health and health care for which it already has a major responsibility.**

The Committee believes that the federal government should demonstrate its commitment to improving the health of Canadians and provide further investment in those important areas for which it has a major responsibility, such as health promotion, health protection, health research, and health information systems and health care technology assessment. In Volume Four of its study, the Committee<sup>49</sup> identified a number of objectives for the federal government in these areas that it feels should be actively pursued. These include:

- Fostering the development of a solid base of innovative health research in Canada that compares favourably with that in other countries;
- Laying the foundation for evidence-based decision-making in areas that affect both well-being and the delivery of health care, while ensuring the protection of privacy, confidentiality and security of personal health information;
- With respect to health protection: strengthen our national capacity to identify and reduce risk factors which can cause injury, illness, and disease, and to reduce the economic burden of disease in Canada;
- With respect to health promotion and disease prevention: develop, implement and assess programs and policies whose specific objective is to encourage Canadians to live a healthier lifestyle;
- With respect to wellness: encourage population health strategies that work on the full range of health determinants.

Aboriginal health must be a priority for the federal government. The Committee has already stated unequivocally that the health of Aboriginal Canadians is a national disgrace. The Committee believes that, given its constitutional responsibilities, the federal government must act immediately to attack the poor health and socio-economic conditions that plague many Aboriginal communities.

Specific recommendations on health care technology assessment are presented in Chapter 3. Our recommendations with respect to health information systems are provided in Chapter 4, while those pertaining to health research are detailed in Chapter 5. The issues related to Aboriginal health and health promotion are discussed in Chapter 7.

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<sup>49</sup> See Volume Four, pp. 19-24.

## Principle Seven

**The consequences arising from changes in the level or amount of government funding for hospital and medical care should be clearly understood by government and explained to the public, in as much detail as possible, at the time such changes are made and announced.**

The Committee believes that the consequences arising from changes to government funding for hospital and medical care should be clearly understood by government and explained to the public, in as much detail as possible, at the time such changes are made and announced. Transparency and accountability in government decision-making require that the implications of funding changes be clearly understood by both decision-makers and the public. The lack of transparency was also raised in the Romanow report which stated: “There should be more transparency in terms of how much money is being spent, by whom, on what basis and with what results.”<sup>50</sup>

This principle would apply both to increases and to decreases in government funding. Cuts in government funding translate into the rationing of the supply of hospital and doctor services. In this case, government must explain what services will be rationed. In the event that increases in health care spending are necessary, government must clearly indicate how such increases will be funded and what impact these increases will have on the supply of health care services.

Currently, resources appear to be largely allocated by negotiation among various groups working in the health care system. The allocation is not based on systematic knowledge of either the outcomes of care or access to care or testable predictions of the consequences of changes in funding. Up to now, health care organizations and Departments of Health have been unable to inform Canadians if previous changes in health services delivery have improved, or harmed, access to and quality of health care. The deployment of an electronic patient record system, discussed in more detail in Section 2.4, is the first step towards an evidence-based decision-making process.

The most important reason for enabling the public to understand the health service consequences of changes in the amount of funding for hospitals and doctors is that it will move the debate away from being based strictly on financial data to a debate about services to be covered, the length of waiting lines, the quality of outcomes, and so on. This would move the public debate to where it ought to be – a debate about levels and standards of services to patients. At the present time,

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<sup>50</sup> *Shape the Future of Health Care*, p. 27.

such a debate is not possible because there is no way in which the public can translate statements about health care funding into the one thing which really matters to them, namely what is the impact of various levels of funding on the health services the public receives, their quality, and the amount of time they have to wait to receive them.

## 2.2 Delivering Health Care

*(Note: Readers will find three diagrams at the end of this chapter that illustrate the reforms discussed by the Committee in Principles Eight through Thirteen.)*

### *Principle Eight*

**In the first stage of health care reform, the method for remunerating hospitals should be changed from the current annual global budget to service-based funding.**

In Canada, the global budget has been the dominant funding mechanism for virtually all acute care hospitals for about 30 years. There is good reason for this, because global budgets have some attractive features. They offer simplified accounting for both hospitals and the provincial health departments. Perhaps more importantly for government, they offer a method of cost control.

Global budgets, however, have a number of disadvantages. The first one is a progressive and permanent loss of information about what things cost. The Committee was told that it is shameful that in a system as sophisticated as the health care system, not even senior managers know, for example, what a simple appendectomy costs.

The lack of financial feedback means that there are no yardsticks to compare performance on any basis, financial or otherwise. This allows those hospitals or regions with less efficient practices to imbed those practices and continue doing what they are doing without any focus on performance. Second, the Committee heard that global budgets tend to place patients at the bottom of the list of priorities.

Les Vertesi, Chief of the Department of Emergency Medicine at the Royal Columbian Hospital (Vancouver), suggested an alternative to global budgets: the Service Based Funding (SBF).<sup>51</sup> SBF is a form of activity-based remuneration under which a monetary value is assigned to each type of hospital service and the institution receives payment only once it has actually provided that service. According to Dr. Vertesi, SBF would have a number of immediate advantages, apparent right away after the new mode of remuneration is implemented:

- Since it fundamentally changes the incentives, the vicious cycle of cost escalation would stop;

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<sup>51</sup> See his *Broken Promises: Why Canadian Medicare is in Trouble and What Can Be Done to Save It* (unpublished manuscript).



- It provides a yardstick that would uncover less efficient hospitals and regions, so they can be helped;
- Health departments could develop standards and monitor hospitals;
- Waiting lists would decrease;
- Patient-centred, and patients' choices carry weight;
- Hospitals that know how to provide service at a competitive price would see some hope again and be able to offer assistance to others.

The health department or regional health authority would be responsible for setting the value of each hospital service. The fact that such value determination remains under government control means that government influence over the direction of change would be enhanced, not decreased. Instead of overall funding ceilings, targeted controls would be possible. Even small changes in the relative values could have a large impact on the direction and pace of change. Ultimately, as long as values remain under the control of the government, total funding cannot exceed what government wants to spend.

The Committee heard that such a method for remunerating hospital services would lead to the development of centres of specialization for the provision of certain surgeries or treatment of certain conditions, particularly in large urban centres. Such a change in the delivery of hospital services should be encouraged because of the efficiencies it brings. This would also contribute to improving the quality of services.

Hospitals or regions with special expertise should be able to “market” those services to other regions and enter into contracts with other regions to deliver services. In this way, regions would generate a sufficient volume of services to allow them to achieve better outcomes.

The advantages of specialization for selected hospital services were acknowledged by Provincial Premiers and Territorial Leaders who agreed, at their January 2002 meeting, to share human resources and equipment by developing “Sites of Excellence” in a number of complex surgical procedures.<sup>52</sup>

The Committee believes that, as much as possible, hospitals should be funded for the specific services they provide (that is, according to service-based funding) rather than on the basis of an annual global budget. Service-based funding appears to be an appropriate form of remuneration, particularly for community hospitals. We acknowledge that another form of payment may need to be considered for teaching hospitals where clinical activities are intermingled with teaching and research and services are frequently one-of-a-kind. We are also aware of the concern that remunerating hospitals for each service

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<sup>52</sup> Specialized hospital services include for example paediatric cardiac surgery and gamma knife neurosurgery.

performed may lead to over-servicing. The Committee will discuss these issues in more detail in Volume Six.

It is the view of the Committee that remunerating hospitals according to a pre-established value for each service provided is essential if the government and the public are to understand the implications of funding changes on the numbers and types of services that are feasible under a fixed government health care budget. It is also an essential first step in moving toward a system in which purchasers and providers are split as described under Principle Thirteen below.

Some might wonder whether it is contradictory for the Committee to recommend shifting to service-based funding for hospitals while at the same time advocating moving away from fee-for-service payments to individual doctors (as we do in Principle 11 below). In other words, why does the Committee propose the adoption of a form of funding for hospitals that is roughly equivalent to a method of payment for doctors that it feels should be abandoned?

The answer, in the Committee's view, lies in understanding the impact that a payment system has under various circumstances. Both fee-for-service and service based funding encourage providers (doctors or hospitals) to increase the volume of services that they deliver. In the case of doctors, this can lead to placing greater emphasis on numbers of patients seen rather than on the quality of care. This is why alternate forms of payment must be introduced for primary care physicians. In the case of hospitals, however, an incentive to provide more services is precisely what is needed, given the current waiting lists. Thus, a shift towards service based funding would prove beneficial. Principles 8 and 11 offer a good illustration of the Committee's efforts to find the appropriate incentives to stimulate the types of behavioural changes that the Committee believes are necessary.

The Committee wishes to stress that service based funding for hospitals, and the separation of the funder function from that of the institutional provider of services, means that ownership of the institutional service provider would not be a matter of concern. We believe that the patient and the funder will be equally well served no matter what the corporate ownership structure of a health care institution is, as long as the two following conditions are met:

1. All institutions in a province are paid the same amount of money for performing any given medical procedure or service.
2. All institutions, no matter what their ownership structure is, are subjected to the same rigorous and independent quality control and evaluation system (see Principles Fifteen and Sixteen).

The first condition ensures that the funder is indifferent to the ownership structure. The second ensures that the patient is indifferent, since it ensures that no institution can put profit above quality of care.

The Committee wants to make it clear that it is not pushing for the creation of private, for-profit, facilities. Neither do we believe that they should be prohibited, just as they are not now prohibited under the *Canada Health Act*.<sup>53</sup> Moreover, as we said in Chapter One (see Section 1.4), we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, privately owned, not-for-profit, institutions.

During the cross-country hearings, a number of witnesses raised the concern that introducing private sector participation through contracting out might expose Canada's publicly funded health care system to trade challenges. The report of the Romanow Commission also stated that "our ability to reform and innovate within the health care system may be affected by the rules of international trade agreements."<sup>54</sup>

The Committee requested information from Health Canada and the Department of Foreign Affairs and International Trade on this issue. Senior departmental personnel informed the Committee that the federal government has always maintained the same position with respect to health care and international trade agreements: Canada's health care sector is not negotiable.

A provision in the North American Free Trade Agreement (NAFTA) stipulates that Canada preserves its ability to maintain or establish any measures for a public purpose, including health care. Similarly, under the WTO General Agreement on Trade in Services (GATS), the exclusion of "services supplied in the exercise of governmental authority" from the scope of the Agreement, combined with the absence of commitments by Canada with regards to health services, provides the policy flexibility required to preserve our publicly insured hospital and doctor system. The same longstanding position is being adopted by Canada in the context of the negotiations under the Free Trade Area of the Americas (FTAA).

Overall, the Committee believes that it has obtained sufficient assurance from both Health Canada and the Department of Foreign Affairs and International Trade and is convinced that international trade agreements do not, and will not, pose a threat to Canada's publicly funded health care system.

## *Principle Nine*

**Regional health authorities should have the responsibility for purchasing hospital services provided by institutions within their region.**

During the last decades, most provinces (other than Ontario) have established regional health authorities. Regional health authorities are responsible for assessing the needs of the population in a certain geographic area and for setting health care priorities and assigning

<sup>53</sup> As the Honourable Monique Bégin and others have pointed out, there are many misconceptions surrounding the 'public administration' provision of the *Canada Health Act* (see footnote 77 below). On this point see as well the Myths and Realities section of Vol. 1 of the Committee's study, p. 98.

<sup>54</sup> *Shape the Future of Health Care*, p. 44.

resources in line with those needs. Currently, hospitals and many other health care providers are overseen by these regional health authorities.

One important criticism of regional health authorities is that their control over spending is limited. For the most part, regional health authorities receive a budget from the provincial government which they simply pass to hospitals and other providers of care. In doing so, they are not able to direct the priorities and spending for which they are, in theory, responsible. Neither are they able to reward efficient providers. In particular, regional health authorities do not have control over the cost of doctor services, a control that they must have if they are to manage effectively the health services in their region.

The Committee learned that this problem can be corrected by establishing an “internal market” in which the regional health authorities are responsible for purchasing health services on behalf of the residents of their region:

***...regional health authorities do not have control over the cost of doctor services, a control that they must have if they are to manage effectively the health services in their region.***

*With an “internal market”, regional health authorities hold the purse strings and choose between providers on the basis of quality and cost, rather than simply funding the decisions of those using the resources.<sup>55</sup>*

Such a form of “internal market” has the potential to introduce competition based on both cost and quality among hospitals and other institutions. This also provides the incentives for providers to become more cost conscious and to make decisions about what to provide, to whom, and at what standard. Furthermore, such reform has the potential to reconfigure services in a way that is more in line with population needs.

The Committee believes that devolution of the purchasing function to regional health authorities is part of the first step in reforming health care in Canada. In fact, regional health authorities exist in most provinces and a large percentage of health care spending occurs in and around large cities, creating the potential for competition among providers. At the same time, the Committee is aware that this principle will have to be applied with flexibility so as to take into account the many differences in the size of the regions, as well as the rural/urban mix they contain and the number of health care providers and institutions within their jurisdiction.

***The Committee believes that the devolution of the purchasing function to regional health authorities is part of the first step in reforming health care in Canada.***

We believe, however, that, over time, the purchasing function should be devolved even further – to primary health care teams – as a way of decentralizing decision-making and providing care that is more responsive to patients’ needs (see Principle Thirteen). This would be part of the second stage of reform, as discussed in Section 1.4.

<sup>55</sup> Cam Donaldson, Gillian Currie and Craig Mitton, “Integrating Canada’s Dis-Integrated Health Care System – Lessons from Abroad”, *C.D. Howe Institute Commentary*, April 2001, p. 8.

### **Primary care renewal should lead to the provision of primary care by group practices, or clinics, which operate twenty-four hours a day seven days a week.**

All recent provincial reports have recommended the creation of a network of primary care groups. These proposals all share some common features:

- access 7/24/365 to comprehensive primary care;
- “rostering” or enrolment of patients in the primary care group of their choice on an annual basis;
- better utilization of the spectrum of health care providers through interdisciplinary team work;
- integration and coordination of all health services through the function of “gatekeeping”;
- potential for expansion of public health care coverage;
- change in the method of remuneration of physicians (from fee-for-service to either capitation or blended payment).

Consistent with the recommendations of various provincial health care commissions, the Committee believes that primary care reform should lead to comprehensive primary care being provided by group practices, or clinics, which operate twenty-four hours a day, seven days a week. This will enable patients to have access to primary care always as their initial point of contact with the health care system. This will permit a more efficient operation of the primary care sector, and will take considerable pressure off hospitals’ emergency rooms.

The recommendations of these provincial reports, however, diverged on the extent to which primary care groups should be responsible for purchasing health services on behalf of their patients. The Health Services Restructuring Commission in Ontario suggested that, in addition to providing primary care, primary care groups should also assume the responsibility for purchasing a wide range of health services on behalf of their patients including: hospitals, specialists, public health, rehabilitation centres, long-term care facilities, home care, community care.<sup>56</sup>

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<sup>56</sup> The Mazankowski report acknowledged and supported the movement towards primary care reform along with a change to primary care physician remuneration, but was of the view that the purchasing function should remain within regional health authorities. Accordingly, the report recommended that a portion of the budget for physicians be allocated to regional health authorities which would then contract with them for primary care services. Similarly, both the Clair Commission in Quebec and the Fyke Commission in Saskatchewan stressed that regional health authorities should organize and manage primary care group practices, contracting with or otherwise employing all providers including physicians

Although numerous provincial commissions have all recommended reforming primary care, no single model has been proposed that could be universally implemented. This observation was also made by the Romanow Commission:

*There are an endless variety of potential models and approaches [to primary care reform], but a common element in most is that governments would fund these organizations based on some combination of the number of registered patients, population served, and the health outcomes achieved. While steps have been taken in every province to initiate primary care pilot projects, many argue that, because primary care is the key catalyst to real change in the health care system, it is time to move past the rhetoric and pilot projects and into true action.<sup>57</sup>*

Therefore, flexibility will be required in deciding how to apply this principle. In addition, the experience of a number of provinces and territories has shown that setting up primary care groups is neither easy nor cheap. Indeed, as explained in Section 1.1, the cost of restructuring is one of the reasons why the Committee has concluded that the current system is not fiscally sustainable. Other findings with respect to primary care reform are discussed in more detail in Chapter Six of this report.

## ***P**inciple ***E***leven*

**To facilitate primary care reform, the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards.**

Fee-for-service payment is the dominant form of primary care physician remuneration in Canada. Almost 90% of family physicians surveyed by the Canadian College of Family Physicians in 2001 said that they received some proportion of their earnings in the form of fee-for-service payments,<sup>58</sup> and that these payments accounted for an average of 88 percent of their total income.<sup>59</sup> Although in 1999-00, over 20% of Canadian physicians received some payments for clinical care through alternate forms of payment, such as salaries or capitation, in most provinces these alternate sources were the main form of remuneration for less than 10% of physicians.<sup>60</sup>

Under a fee-for-service payment scheme, primary care physicians are paid a fee for each service they provide to patients according to a preset schedule of tariffs. Fee-for-service is a relatively simple and transparent payment method. It is also fairly easy to administer.

<sup>57</sup> *Share the Future of Health Care*, p. 34.

<sup>58</sup> Canadian Institute for Health Information (CIHI), *Canada's Health Care Providers*, 2001, p. 73.

<sup>59</sup> Hutchison, Brian and Julia Abelson and John Lavis, "Primary Care in Canada: So Much Innovation, So Little Change," in *Health Affairs*, Vol. 20 No. 3, May-June 2001, p. 117.

<sup>60</sup> CIHI, *op. cit.*, p. 74.

It has the benefit of familiarity in Canada as patients and doctors alike are aware of how it works.

Fee-for-service, however, has a number of drawbacks. According to many witnesses, fee-for-service provides the wrong signal or incentive to primary care physicians, that of “over-servicing”: the more health services physicians provide, the more income they receive, irrespective of the needs of the patient receiving the service, the outcomes produced or the cost of providing the service. Moreover, because the remuneration is attached to the service, there is no financial reward for physicians to locate in areas with greater needs as long as they can satisfy their workload and income expectations by serving lesser needs in their preferred locations.

For these reasons, many provincial commissions and task forces have identified fee-for-service as incompatible with promoting the best productive use of the time and skills of primary care physicians. In addition, provincial reports pointed out that fee-for-service is also incompatible with primary care reform. Since doctors are paid for every service they provide, they have an incentive to bill for treatments that could be provided more cost-effectively by other health care professionals. This has effectively discouraged collaborative and multidisciplinary practices.

Health care commissions and task forces at the provincial level, namely the Health Services Restructuring Commission in Ontario, the Clair Commission in Quebec and the Mazankowski report in Alberta, all recommended a system of blended remuneration for primary care physicians incorporating elements of capitation<sup>61</sup>, fee-for-service and other rewards. This recognizes the fact that “one size” does not fit all situations:

*Research to date has not identified one funding system as ideal; every model has advantages and disadvantages. Policy makers need to assess their own situation, understand the risks and benefits of each payment model, and decide for themselves what model best address the needs of the funders, providers, and the community.<sup>62</sup>*

The Committee agrees with provincial commissions and task forces that the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards. Blended remuneration provides incentives for general practitioners both to work hard and to care for a large number of patients as they do now (through fee-for-service

***The Committee agrees with provincial commissions and task forces that the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards.***

<sup>61</sup> Capitation refers to a payment system in which a health care unit receives an annual payment for each individual to whom the unit is responsible for providing service. The amount of the payment may depend on the age and medical history of the individual, but not on the number of service calls the individual makes to the unit during the year.

<sup>62</sup> Canadian Health Services Research Foundation, *Integrated Health Systems in Canada: Three Policy Syntheses – Questions and Answers*, July 1999, p. 2.

funding) and to emphasize preventive care and population health (through capitation funding). However, since physicians are not all alike in their financial expectations or in their reaction to various types of incentive, there must be flexibility in the remuneration system that is used for different group practices. Nonetheless, the Committee acknowledges that, in order to implement primary care reform, a move away from current fee-for-service is essential, otherwise there will be no motivation for family physicians to allow patients to be seen by other clinic staff members.

Most models of primary care reform require that patients enroll with a specific doctor or group practice for a pre-determined period of time, usually a year. Implementation of this kind of reform must therefore confront the perceptions that it limits patients' freedom of choice and, from a doctor's perspective, that it restricts their freedom to practice medicine as they choose.

***Nonetheless, the Committee acknowledges that in order to implement primary care reform, a move away from current fee-for-service is essential, otherwise there will be no motivation for family physicians to allow patients to be seen by other clinic staff members.***

Since a patient need only sign up with a family physician for a year (unless the patient moves his/her residence), this is hardly a significant constraint on patients. Similarly, encouraging doctors to make full use of the skills of all the members of their health care team (e.g. by changing the scope of practice rules so that nurse practitioners can use their full range of skills) is hardly a serious infringement on physicians' freedom to practise as they choose.

As well, the Committee is aware that the issues of how the specialists and physicians employed in teaching hospitals should be remunerated need to be addressed, and the Committee will do so in Volume 6 of its study.

## *Principle Twelve*

**New scope of practice rules and other measures need to be developed in order to enable all health care providers in the primary care sector to provide the full range of services for which they have been trained.**

Issues concerning the scope of practice of various health care providers are discussed in Chapter 6. The Committee believes that new scope of practice rules and other measures need to be developed in order to enable all primary health care providers to deliver the full range of services for which they have been trained. It is also the Committee's view that there would be significant advantages to these measures being as standardized as possible across the country. National standards would also help reinforce Canadians' belief that their health care system is national, not provincial, in character.

In general, the primary care sector would function more efficiently, without loss of medical efficacy, if providers such as nurse practitioners were able to provide the full range of services for which they have been trained. This would then free up more time for general



practitioners to look after those patients who require their particular set of skills, experience and qualifications.

In addition, achieving a better mix of health care providers requires more than just changing the way they currently practice; it may also require changes to the way in which they are trained and educated.

The Committee understands that changes to the regulatory approach adopted by self-governing professions is essential to implement this principle successfully.

***The Committee believes that new scope of practice rules and other measures need to be developed in order to enable all health care providers in the primary care sector to provide the full range of services for which they have been trained.***

## *Principle Thirteen*

**In the second stage of health care reform, an “internal market” should probably be created in which primary health care teams would purchase health services provided by hospitals and other health care institutions on behalf of their patients.**

During Phase Three of its study, the Committee learned a great deal about GP fundholding practices in place in the United Kingdom. In Volume Three, we explained that under such Fundholder practices GPs were given a budget from which to purchase care for their patients, including hospital services, specialist services, and prescription drugs.<sup>63</sup>

The Committee was told that the objective of establishing such an “internal market” in the United Kingdom was to overcome a major disincentive, whereby physicians directed a lot of health care activity and spending but without any financial repercussions for themselves and without any financial incentive to be concerned about the cost their decisions imposed on the health care system as a whole. It was also believed that general practitioners (GPs) would be more effective purchasers for their patients than a regional health authority:

*The GP was closer to patients and thus presumably could effectively meet their needs; the GP was also more able to negotiate with local hospitals. The theory was that the need for GPs to keep within budget and patients’ ability to change doctors would lead to greater fiscal responsibility and improvement in quality.*

*(...) Fundholding introduced a financial incentive for those who joined the scheme to be more efficient: they were able to invest any savings from their budgets in improvements in patient care or practice improvement. Fundholders could also move funds between*

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<sup>63</sup> Volume Three, pp. 37-44.

*components of the budget, allocating resources as they saw fit. Any fundholders that repeatedly failed to meet the budget risked losing fundholding status.*<sup>64</sup>

The Committee was told that an “internal market” reform along the lines of the GP Fundholding scheme could have great potential for implementation in Canada. More specifically, in their 1998 book, Jérôme-Forget and Forget proposed the creation of group practices (referred to as “targeted medical agencies” or TMAs), made up of family physicians, specialists and other health care providers, which would be financially responsible for all the health care needs of their patients. Jérôme-Forget and Forget believe that TMAs as purchaser agents may be more cost-effective and efficient than having this role performed by regional health authorities:

*The goal of establishing physicians as the key decision makers in health care delivery is to decentralize medical decisions and financial responsibility to a level much closer to the patient. (...), many internal market reforms fall short of this objective by giving purchasing responsibility to fairly large organizations. Regional health authorities, (...), are primarily bureaucratic structures whose size makes it difficult to undertake the negotiation of contracts with providers on an individual basis. (...) The [international] experience with large purchasers indicates that they are unable to effectively promote efficient use of resources without resorting to tight regulation of physicians' behaviour – a technique at odds with Canada's tradition of physician autonomy. At the other extreme, a minimum size is necessary to take advantage of professional interaction among physicians as well as defray the additional administrative and management costs.*<sup>65</sup>

The Health Services Restructuring Commission in Ontario made a similar recommendation.<sup>66</sup> In their proposal, interdisciplinary health care teams remunerated mainly through funding by capitation would be given permanent and exclusive responsibility for all the health care needs of a given population. In addition, in their role as gatekeepers, these teams would establish contracts with other institutional providers in the region. Eventually, they would be given control over the entire health care budget pertaining to the population on their roster.

It must be acknowledged that, although this network of primary health care teams could be strongly recommended to the population, it would be impossible to force Canadians to adopt it. The Committee was told that one way to make it worthwhile for patients to agree to signing up with a primary health care team would be to introduce a negative financial incentive that would apply to patients who chose to consult with doctors who were outside the network of their chosen primary health care team.

Overall, the Committee believes that an “internal market” in which financial responsibility rests on primary health care teams should probably be established. We do,

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<sup>64</sup> “Integrating Canada’s Dis-Integrated Health Care System”, p. 13.

<sup>65</sup> *Who is the Master?*, p. 111.

<sup>66</sup> See its report, *Primary Health Care Strategy*, op. cit., pp. 34-40.

however, understand that some provinces/territories may prefer delegating the purchasing responsibility to regional health authorities.

Once again, the Committee wishes to stress that flexibility will be required in applying this principle so as to take into account differences between the regions in terms of the size of their population, the rural/urban mix they contain and the number of health care providers and institutions within their jurisdiction. It is our intention to devote more attention to the second stage of reform in Volume Six.

## ***Principle Fourteen***

**A national (not exclusively federal) strategy must be developed to achieve both an adequate supply and optimal use of health care providers.**

All national and provincial/territorial organizations representing health care providers that appeared before the Committee since the beginning of its health care study insisted that what is needed is a country-wide, long-term, made-in-Canada, human resource strategy coordinated by the federal government. Competition between the different jurisdictions for scarce human resources in health care is detrimental to the country.

It is important to stress that such a strategy must not be exclusively a federal one, with input only, or even primarily, from the federal level of government. It must involve all stakeholders, recognizing that the education and training of health care providers is a provincial/territorial responsibility.

The Committee welcomes the announcement last fall by the Minister of Human Resources Development about the funding of two important sectoral studies on the precise human resources needs for physicians and nurses. We believe that this is an important step towards the development of a national approach. Each of these studies will systematically analyze the labour market and culminate in the elaboration of a strategy designed to ensure an adequate supply of appropriately trained professionals.

The Committee strongly supports the involvement of all the key stakeholders in producing these studies. In Chapter 6, we present specific recommendations with respect to human resources in health care, including the creation of a permanent national coordinating body on health care human resources.

## 2.3 Evaluating Health Care

### *Principle Fifteen*

**Accountability and transparency in health care financing and delivery require the deployment of a system of electronic health records (EHR) that can capture and translate information on system performance and outcomes.**

A system of electronic health records (EHR) is an automated provider-based system within an electronic network that provides complete patients' health records, including their visits to physicians, hospital stays, prescribed drugs, lab tests, and so on, all collected in accordance with a system of common standards applying to the data. Many witnesses viewed the EHR system as the cornerstone of an efficient and responsive health care delivery system that is able to improve both quality and accountability. Such a system is a necessary prerequisite to a truly patient-oriented health care system. A system of EHR is also essential if primary care reform is to be realized.

*The electronic health record (EHR) is the cornerstone of an efficient and responsive health care delivery system, quality improvement and accountability. Without it, the prospects for a patient-friendly health care system, optimal teamwork, and efficiency are dim.<sup>67</sup>*

All levels of government in Canada have recognized the importance of deploying a system of EHR. In fact, on September 11, 2000, the First Ministers agreed to work together to develop an EHR system over the next three years and to work collaboratively to develop common data standards to ensure compatibility of provincial health information networks and to ensure stringent protection of personal health information. The full deployment of a system of EHR was also endorsed by various provincial task forces and commissions on health care, including the Health Services Restructuring Commission report in Ontario, the Clair Commission in Quebec, the Fyke Commission in Saskatchewan and the Mazankowski report in Alberta.

In support of the agreement reached by First Ministers, the federal government committed \$500 million in 2000-01 to accelerate the adoption of modern information technologies in the health care system. The Committee was informed that this money has been invested in a not-for-profit corporation, known as Canada Health Infoway Inc., that will work with provinces and territories to create the necessary common components of an EHR over the next three to five years. We believe that this has the potential to constitute a major step towards the full integration of the various health federal/provincial/territorial infostructures.

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<sup>67</sup> Saskatchewan Commission on Medicare (Kenneth Fyke, commissioner), *Caring for Medicare – Sustaining a Quality System*, April 2001, p. 68.

Considerable agreement exists among the provinces and territories and other stakeholders that the federal government should foster collaboration in this area. The Committee welcomes this collaboration between the federal government and the provinces and territories and encourages the federal government to play a leadership role in promoting a system of electronic health records that is consistent across the country, to the benefit of all Canadians.

Generally, patients want to tell their medical history only once, to have their tests and care coordinated and made available to the different health care providers they consult, and to have a more seamless integration of the health services they need. This can be achieved with an EHR. However, Canadians need to have confidence that protective mechanisms are in place that give access to patient records only to those people authorized by patients themselves. The EHR system needs to be developed in a manner that balances the needs of patients for privacy with respect to their personal health information against the needs of the system to be able to provide patients with the care that they require.

Perhaps the most important benefit to be gained from the deployment of EHR across the country is access to evidence-based information that will be used to assess quality of care, system performance, treatment outcomes and patient satisfaction. This will foster accountability and transparency in decision-making regarding health care delivery and policy and promote improvement in the quality of care.

Along with numerous witnesses, the Committee believes that accountability and transparency in health care financing and delivery require the deployment of a system of EHR that will capture and translate information on system performance and outcomes. It is our view that measuring outcomes must become an essential part of the health information system. Despite advances in recent years, we still do not have nearly enough knowledge about which procedures and treatments work most effectively, or, indeed, even how best to measure health outcomes. Moving towards a uniform EHR system will facilitate the monitoring and comparison of treatment outcomes across the country.

***The Committee believes that accountability and transparency in health care financing and delivery require the deployment of a system of EHR that will capture and translate information on system performance and outcomes. It is our view that measuring outcomes must become an essential part of the health information system.***

The Committee acknowledges that national standards are needed, both at the level of information gathering and processing and for guaranteeing confidentiality and privacy of patient health information, and reiterates its belief that the federal government can play a leading role in helping to bring this about. Our observations and recommendations with respect to health information systems are detailed in Chapter 4.

## Principle Sixteen

**Measuring treatment outcomes and system performance must become an essential part of the health information system. Such monitoring and evaluation of the health care delivery system should be performed independently at the national (not federal) level and be funded by government.**

As stated above, better information on access to care, quality delivery, system performance and patients' outcomes cannot be achieved without an expanded, long-term investment in information technology, including an EHR. During the Committee's hearings, witnesses stressed that partnerships among the provinces and territories, and the leverage of federal government funding for accelerated development, should be pursued.

Similarly, a recent report to the British Columbia Legislative Assembly stated:

*The federal government should be lobbied for designated funds to deal with this significant, Canada-wide need that if properly addressed will improve the functioning of the whole health care system and the health of all Canadians. The need is urgent.*<sup>68</sup>

While witnesses agreed that governments should finance the health information system, many of them were of the view that governments should not be responsible for assessing health data and evaluating quality and outcomes. They explained that, currently, evaluation is done by the same people responsible for paying for, and for providing, health services. There is no independent assessment of the outcomes and no external audit of the impact of the results. In this regard, the Premier's Advisory Council on Health (Alberta) stated:

*Tracking and monitoring outcomes and providing regular reports to the public is an essential way of improving quality in health care. However, when government and health authorities measure and assess their own outcomes and results, it can put them in a conflict of interest.*<sup>69</sup>

This Advisory Council recommended the establishment of a permanent, independent "Outcomes Commission" to track results, assess outcomes and report regularly to the population.

Similarly, in Saskatchewan, the Fyke Commission recommended the establishment of a "Quality Council", an evidence-based organization, working at arm's length from government. The mandate of this Quality Council would involve reporting regularly to the provincial legislature, as well as to the public on a variety of issues, including: trends in health

<sup>68</sup> Select Standing Committee on Health, *Patients First: Renewal and Reform of British Columbia's Health Care System*, Report to the British Columbia Legislative Assembly, December 2001, p. 29.

<sup>69</sup> Premier's Advisory Council on Health (Alberta), p. 68.

status, costs/benefits of health care interventions, clinical practices and clinical errors, evaluation of technology, equipment and drugs, etc. The Fyke report stressed that:

*(...) the Quality Council has the potential to depoliticize decisions, find creative solutions to long-standing problems, free the public from the tyranny of anecdote and ill-informed opinion about the state of care, and reveal where the system provides value for money and where it does not.*<sup>70</sup>

The Committee believes that it is essential to greatly improve the evaluation of our health care delivery system in order to provide care that is evidence-based and corresponds to the needs of patients. We strongly support the view of witnesses and provincial reports that the roles of the funder and provider should be separated from that of the evaluator in order to obtain independent assessment of health care system performance and outcomes. While such evaluation should be performed at arm's length from the funder/insurer, it should be financed by public funds.

***The Committee believes that it is essential to greatly improve the evaluation of our health care delivery system in order to provide care that is evidence-based and corresponds to the needs of patients. We strongly support the view...that the roles of the funder and provider should be separated from that of the evaluator in order to obtain independent assessment of health care system performance and outcomes.***

Moreover, it is the view of the Committee that such independent evaluation should be performed at the national (not federal) level. This would allow for the pooling of expertise, thereby making the most effective use of the limited human resources that are currently available in Canada, and result in major economies of scale. In addition, the smaller provinces, which would not otherwise be able to sustain a truly effective monitoring and evaluation system, would clearly benefit from the results of a national evaluation process.

The Committee believes that a national process for evaluating health care system performance and outcomes should be built on those national organizations that are currently devoted to the task of performing independent evaluation. More precisely, this type of evaluation should be carried out at three levels:

- First, the role of the Canadian Institute for Health Information should be strengthened. In addition to its responsibilities in the public health field, it should take the task of reporting – preferably publicly – on the performance of all regions and of all institutional providers.
- Second, the Canadian Council for Health Services Accreditation would recommend on a regular basis how to correct deficiencies that were identified in institutions delivering health services. At present, this review is voluntary but it should be made mandatory.

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<sup>70</sup> Saskatchewan Commission on Medicare, p. 81.

- Finally, the Citizens' Council on Health Care Quality would be responsible for advising on the development of quality standards and policy to promote improving the quality of health care institutions.

The extent of the authority devolved to each of the three organizations described above would have to be specified. For example, does each organization rely exclusively on public pressure and moral suasion, or should they be able to compel providers who do not meet agreed quality standards to implement changes? There are clearly many jurisdictional issues to be resolved, regardless of the exact mandate of such national evaluative bodies. But this is an issue that must be tackled – it can no longer be ignored.

***The Committee believes that a national process for evaluating health care system performance and outcomes should be built on those national organizations that are currently devoted to the task of performing independent evaluation... There are clearly many jurisdictional issues to be resolved, regardless of the exact mandate of such national evaluative bodies. But this is an issue that must be tackled – it can no longer be ignored.***

## **2.4 Achieving a Patient-Oriented Health Care System**

### ***Principle Seventeen***

**Canada's publicly funded health care system should be patient-oriented.**

In a quality-focussed system, the first priority should be to ensure that individuals get the kind of health care they need and that they be given the tools and support they need to stay healthy.

In Canada currently, the health care system is organized around facilities and providers, not individual Canadians. People are expected to fit into the system and get service when and where the system can provide it.

In other countries, changes have been made to put more focus on patients. This includes introducing health charters or care guarantees to ensure that people get the care they need within a certain period of time and of acceptable quality. This also includes establishing a system in which funding follows the patient.

It is the view of the Committee that patients, at all times, must be at the centre of the health care system. Services should be coordinated around their needs for safe, timely and effective care. Ideally, the goal should be an integrated, cost-effective system characterized by closer working relationships between hospitals, long-term care facilities, primary care, home care, public health, etc.



However, putting patient needs at the centre of the health care system does not mean that anything the patient wants, the patient should get. Services provided by the health care system must be based on evidence that they are safe, effective, necessary and affordable.

The Committee believes that Canadians are entitled to health care that is safe, effective, patient-oriented, timely, efficient, equitable and affordable. In our view, the set of principles we have developed will lead to a better integration of the whole range of health services into a continuum of care in which the focus is really on the needs of patients.

***The Committee believes that Canadians are entitled to health care that is safe, effective, patient-oriented, timely, efficient, equitable and affordable.***

## *Principle Eighteen*

**Incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees for services that are deemed to be medically necessary.**

In Volume Four of its health care study, the Committee recalled that, when a national Medicare program was first debated, there was a suggestion that there should be an element of patient pay in health care. The term “patient pay” was used to mean that patients ought to pay something somewhere in the system.

Volume Four identified different forms of patient payment including user charges, premiums, medical savings accounts, income tax on health care, etc.<sup>71</sup> During its cross-country hearings, the Committee heard many concerns about establishing user charges paid at the point of service. On the one hand, we were told that user charges for publicly insured health care at the point of service reduce demand, and that they do so in a way that disadvantages those with low income.

On the other hand, witnesses stressed that the most expensive decisions that are made about patient care are those made by physicians, and are therefore not the responsibility of the patient.

In fact, most of the spending in the health care system and most of the waste in the system are beyond patient control; the major expenses, and the decisions which give rise to these expenses, are incurred by health care providers on behalf of their patients. These decisions are not made by the patients themselves.

Finally, witnesses pointed out that implementing modest user charges could incur such administrative costs that these costs would nearly equal the revenue generated from such charges.

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<sup>71</sup> Volume Four, pp. 61-65.

The Committee believes that incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees that discourage access to medically necessary health services. Nor should such incentives discourage patients from receiving the treatment that health care providers believe they require. Access to hospitals and doctors should not depend on the income or wealth of individual Canadians. Studies have shown that the application of universal user fees does this and they should therefore not be used in Canada.

***The Committee believes that incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees that discourage access to medically necessary health services.***

Nevertheless, ways need to be found to encourage patients to use the health care system responsibly. One such way that has been proposed many times in the past is to provide each Canadian with an annual accounting of the amount of money that has been paid, on their behalf, for the health services they have received during the year. Other potential incentives need to be explored.

Making the patient aware of the costs of health services or removing the impression that they are all free is the logic behind many proposals. The philosophical principle behind these proposals is that if patients are knowledgeable about health care costs, they will understand the inherent pressures in the system and access it only when it is genuinely needed.

***The Committee believes that the key point in creating a cost-effective, sustainable health care system is not to discourage the use of the system, but to encourage appropriate use.***

They will also have a better understanding of the issue of fiscal sustainability in health care. The Committee believes that the key point in creating a cost-effective, sustainable health care system is not to discourage the use of the system, but to encourage appropriate use and to encourage people to take better care of their health.

## ***Principle Nineteen***

**Programs that enable people to be responsible for their own health and to stay healthy must be given high priority. The federal government can play a leadership role in this regard.**

In 1974, the then federal Minister of Health, Marc Lalonde, released a working document entitled *A New Perspective on the Health of Canadians*. This report recognized the impact of individual behaviour on health outcomes, and stressed that individual Canadians should assume greater responsibility for their health.

Since then, many other reports have underscored the importance of encouraging Canadians to stay healthy. According to the report by the Premier's Advisory Council on Health in Alberta, this is the first step towards sustaining Canada's publicly funded health care system:

*It sounds like just good common sense, but perhaps the best way to sustain [the] health care system over the longer term is to take steps to enable people and communities to stay healthy.<sup>72</sup>*

During Phase Two of its study, the Committee was informed that the total cost of illness was estimated at \$156.4 billion in 1998<sup>73</sup>. Witnesses suggested that the economic burden of illness could be reduced by investing more in health promotion, disease prevention and population health. They stressed that many diseases, and most injuries, can be prevented.

However, they pointed out a strong tendency for government to focus on curing diseases, rather than on their prevention. For example, clinical treatment has been the most common chronic disease strategy and there has been only a limited will on the part of government to expend resources on health promotion and disease prevention. Outcomes of such programs are generally visible only over the longer term, and are therefore less attractive politically than money invested in health care facilities, such as hospitals.

Witnesses indicated that the federal government's role with respect to health promotion, disease prevention and population health is a well established one. Moreover, the federal government has been recognized as a leader worldwide in elaborating the concept of population health. The role of the federal government in the fields of health promotion, disease prevention and population health is addressed in Chapter 7.

## *Principle Twenty*

**For each type of major procedure or treatment, a maximum waiting time should be established, and made public. When this maximum time is reached, the insurer (government) shall pay for the patient to receive immediately the procedure or treatment in another jurisdiction including, if necessary, another country.**

A report tabled with the Committee suggested that a monopolistic, non-competitive environment, combined with no cost of service at the point of service, contributes to growing waiting times for publicly insured health services:

*(...) in a system in which health services are free at the point of consumption, queuing is the most common form of rationing scarce health care resources. And since patient satisfaction plays no part in determining incomes or other economic rewards for health care providers and administrators in the public system, patient's time is treated as if it has no value. There are no penalties in the system for making people wait.<sup>74</sup>*

<sup>72</sup> Premier's Advisory Council on Health (Alberta), p. 14.

<sup>73</sup> Volume Two, p. 49.

<sup>74</sup> *Operating in the Dark*, p.8.

The following case was recently brought to the Committee's attention. An MRI done on April 19<sup>th</sup>, 2001, revealed that a patient had two herniated discs in his neck. As his condition was not improving, on May 24<sup>th</sup> of the same year he was placed on a waiting list for surgery. His condition was classified as 'elective but urgent', a category that includes most of the hospital's cancer surgery, with a guideline of surgery within 2 weeks. As of January 18<sup>th</sup>, 2002, that is, 8 months after being placed on the waiting list, the patient still had not undergone his surgery, and still does not know when it will be performed.

The Committee was told that this case illustrated what is called a 'static queue.' It is a waiting list that does not move because the people who are on it are always being bumped by more urgent cases. These higher priority cases occur at a faster rate than the queue is able to handle. The surgeon who was to treat the patient in question had 96 patients on his waiting list (about average for the four neurosurgeons on staff at the hospital), of whom 74 were graded elective but urgent, and could not guarantee a firm date for surgery for any of them.

It appeared that the only way for the patient in question to move to the top of the list was for his condition to deteriorate. It was not enough for him to be in constant pain and unable to work. Were he to experience actual paralysis, he could then be admitted through the emergency ward, and have his surgery within a few days. Otherwise there was no way to accelerate his surgery without denying someone else with an even more urgent case.

In spite of significant investments in the health care system in the past few years by all levels of government, public perception is that waiting times for selected services are continuing to grow. There is sufficient anecdotal evidence in support of that impression to lead to increasing worry on the part of Canadians that the health care system may not be there when they need it. On many occasions witnesses told the Committee that, if there is one thing Canadians should be able to expect from their publicly funded health care system, it is access to health services when they need them. Clearly, a truly patient-oriented health care system is one in which needed care is provided in a timely fashion.

In Sweden, the government enacted a "care guarantee" to ensure timely access to necessary health care. This guarantee established a maximum waiting time for diagnostic tests (90 days), certain types of elective surgery (90 days), and consultations with primary care doctors (8 days) and specialists (90 days). Sweden has also put in place a system where waiting times for major procedures are posted daily on a website. People can check the website and choose to go to the hospital with the shortest waiting times as long as they are prepared to travel and to use the next available physician.

Based on a review of the Swedish experience, the report of the Premier's Advisory Council on Health in Alberta recommended the establishment of a care guarantee of 90 days for selected services. According to the Advisory Council, this guarantee would provide an incentive for health care providers and regional health authorities to take appropriate action to manage and shorten waiting lists. Their report stressed that patients may need to give up their preference for a specific physician or hospital if they want to be treated within the 90-day period. In addition, if regional health authorities are unable to provide service within this period, they would have to consider other options, such as getting the service from another region. Services could be arranged from either a public or a private provider.

The Committee was told that the current lack of accurate information on waiting lists is a major impediment to the development of a care guarantee in Canada. There is, in fact, no standardized data on waiting lists in Canada. However, the Committee was told about a pilot project funded by Health Canada (through its Health Transition Fund) which, according to many witnesses, provides potential for effective management of waiting lists for elective health care. This pilot project – called the “Western Canada Waiting List Project” or WCWL – led to significant progress in the development of valid and reliable tools for evaluating and managing waiting lists in five clinical specialty areas: cataract surgery; general surgery (including breast cancer, colorectal cancer, inguinal hernia, and laparoscopic cholecystectomy); hip and knee replacement; MRI scanning; and children’s mental health.

The standardized waiting list developed by the WCWL is based on an assessment of a patient’s overall urgency (pain, suffering), clinical findings (x-rays, co-morbidity, psychopathology), as well as on an assessment of the impact of the disease on the patient’s quality of life. The Committee was told that this approach represents a fair and consistent way to rank-order patients waiting for needed elective care. It both promotes better use of health care resources and is patient-oriented.

The Cardiac Care Network in Ontario uses a similar methodology in the management of access to cardiac surgery in that province. The use of such priority scoring systems has the potential to yield a significant improvement to the health care system, as it has with heart patient cases in Ontario.

In the Committee’s view there are two main causes to the growing waiting list problem in Canada. First and foremost are the shortages of all types of human resources as well as of many types of diagnostic equipment. Second, there is a need to improve the management of waiting lists.

With regard to this second cause, it is clear to the Committee that more needs to be done to ensure the effective management of waiting lists. In the same spirit that it supports all efforts to improve the efficiency of the system, the Committee welcomes attempts to find better ways to manage waiting lists so that patients in the greatest need are tended to first and that wherever possible waiting times are kept to a minimum.

However, the Committee feels it is extremely important to recognize that better management of waiting lists will not, on its own, suffice to resolve the waiting line problem. This is because the more significant cause of the problem is a lack of human, technological and infrastructural resources, that has resulted from a series of decisions on the part of governments who have attempted to control costs over the past decade by reducing expenditure in these areas.

Beginning in the early 1990s, funding for the education and training of many categories of health care professionals was cut, as a way of reducing future as well as current health care expenditures. More generally, massive cuts in public spending on health care were made, especially during the first half of the decade. As a consequence, there is today a severe shortage of both people and equipment to meet the growing health care needs of the population.

One reason that this kind of cost-cutting has been attractive to government, and that they have been able to implement it relatively easily, is that, to date, government has not had to bear the costs that result from its decisions. Instead, these costs have been largely borne by patients who face longer waiting times and by the front-line professionals who have seen their conditions of work deteriorate and their ability to provide care diminish.

The Committee believes that, for each type of major procedure or treatment a maximum waiting time must be established, and made public. When this maximum time is reached, the insurer (government) shall pay for the patient to immediately receive the procedure or treatment in another jurisdiction including, if necessary, another country (the United States). The point at which the waiting time guarantee would kick in for each procedure would be based on an assessment of when a patient's health would deteriorate irreversibly as a result of waiting for the procedure. Waiting times would be established by scientific bodies using evidence-based criteria.

***The Committee believes that, for each type of major procedure or treatment a maximum waiting time must be established, and made public. When this maximum time is reached, the insurer (government) shall pay for the patient to immediately receive the procedure or treatment in another jurisdiction including, if necessary, another country (the United States).***

Since government has responsibility for ensuring the adequate supply of the essential service of hospitals and doctors, this responsibility carries with it the obligation to meet reasonable standards of patient service. This is the essence of a patient-oriented system and of the health care contract between Canadians and their governments.<sup>75</sup> A maximum waiting time guarantee of the type described in Principle Twenty would meet this obligation. Were it implemented, this guarantee would mean that government would have to shoulder the responsibility for not delivering needed care in a timely fashion. Increased waiting times would no longer represent a cost-free option for government, since they would be required to pay to have patients be treated in other jurisdictions.

The Committee feels that this would introduce a powerful incentive for government to deal with waiting times that exceed the agreed upon limits. It would also constitute a major step in re-establishing the health care contract between citizens and their government. (The exact nature of this contract is discussed in the next section.)

In closing the discussion of Principle Twenty, it is worth making the observation that using diagnostic and hospital facilities in the United States may be the most economical way of meeting the care guarantee. To meet maximum waiting times within Canada, it will be necessary for the health care system to have some excess capacity or redundancy in order to cover peak periods of demand for service. Whether it is cheaper to build such excess capacity in Canada or purchase it from the United States is an issue that will need to be studied if a care guarantee is implemented.

The Committee acknowledges that a care guarantee can only be implemented and enforced once consensus is reached on the definition, estimation and management of

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<sup>75</sup> See section 2.5, below.

waiting times/lists. We believe that it is absolutely imperative that Canada move forward immediately with the setting of maximum waiting times for major categories of treatment. It is the next critical piece of work that needs to be addressed.

The Committee acknowledges that the care guarantee will cost money, particularly if many patients have to be sent to the United States for treatment because they have exceeded the maximum waiting time for the treatment they require. We have already noted in Section 1.1 that the current hospital and doctor system is not fiscally sustainable, and it is clear that it will be even less so when the costs of the care guarantee are added on to existing costs. Nonetheless, The Committee regards the care guarantee as an essential component of the health care contract between Canadians and their governments.

The Committee recognizes, as it has said several times in Chapters 1 and 2, that new sources of federal and provincial/territorial funding will be needed in order to implement the changes the Committee proposes. The Committee will discuss its specific federal funding proposals in its October report.

## **2.5 The Health Care Contract Between Canadians and their Governments**

In Volume Four, the “Issues and Options Paper”, the Committee endorsed two major public policy objectives for Canada’s publicly funded hospital and doctor system:

- *To ensure that every Canadian has timely access to all medically necessary services regardless of their ability to pay for those services, and*
- *To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.*<sup>76</sup>

The pursuit of these objectives has involved a “contract” between Canadians and their governments – federal, provincial and territorial. The nature of this contract is that Canadians have agreed to pay taxes to their governments who have then used the money to fund a universal, comprehensive, portable and accessible hospital and doctor insurance plan. Since the funder of the plan is government, the plan is described as being publicly administered.<sup>77</sup> (The principles of universality, comprehensiveness, accessibility, portability and public administration are the five principles of the *Canada Health Act*.)

The contract requires governments, acting as insurers, to meet the two policy objectives stated above. In particular, the contract requires governments – federal and provincial/territorial – to provide Canadians with access to publicly insured, medically necessary, hospital and doctor services in a timely fashion.

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<sup>76</sup> Volume Four, p. 16.

<sup>77</sup> In a recent speech, the Honourable Monique Bégin, who was the federal Minister of Health when the *Canada Health Act* was introduced, said the following about the public administration conditions of the *Canada Health Act*: “Public administration” does not mean what the public believes it means. It is most misleading...[I]n Canada, the funding/financing is public but ... the delivery of services is private, in that physicians are not civil servants and hospitals have boards, not deputy ministers. The program criterion of the legislation reads as follows: “(...) the health care insurance plan (hospitals and doctors) of a province must be administered and operated on a non-profit basis by a public authority (...) responsible to the provincial government (...)” ... *Op. cit.* p. 6.

The problem Canadians face today is that, increasingly, timely access to all medically necessary services is not provided. Principle Twenty is designed to address this problem by forcing governments to meet reasonable standards of patient (customer) service, either in their own jurisdiction, elsewhere in Canada or, if necessary, in the United States. Meeting reasonable patient service standards is an essential part of the health care contract between Canadians and their governments. It is part of the bargain.

Another possible approach to making governments fulfill their part of the contract would be to use a patient's charter of rights as the means of enforcing maximum waiting time standards. Such an approach would be consistent with the Charter of Rights and Freedoms in that it would use the courts to enforce rights, in this case the right to timely treatment. Such an approach has been used with mixed success in Australia, New Zealand and the United Kingdom (see Section 7.5 of Volume Four of the Committee's study).

However, the Committee prefers the simpler and less legalistic approach of Principle Twenty. In choosing this approach, we acknowledge (as indicated in our discussion following Principle Twenty) that this would require that Canadians agree to pay for the improved, and more timely, access to service. If they so agree, then Canadians would, in effect, be choosing the second of the three options the Committee outlined at the end of Section 1.1.<sup>78</sup>

If, after public discussion, Canadians decide that they are not willing to pay more for hospital and doctor services, or if the insurer (government) decides not to implement the care guarantee as described in Principle Twenty, then the result would be that the first of the three options in Section 1.1<sup>79</sup> would have been selected, with continued rationing of services and continued lengthening of waiting times.

Under this circumstance, where there is no maximum waiting time guaranteed by the public insurer, the question must be asked: should Canadians who may find that their health is deteriorating while waiting for medically necessary care, have the right to buy private health care insurance to protect themselves against excessive waiting times, and to receive treatment in Canada? That is, should Canadians who can afford to do so have the right to purchase privately a care guarantee for service delivery in Canada? (Canadians already have the option of buying insurance to cover the costs of treatment provided outside Canada, namely in the United States. Such insurance products are now on the market in Canada.)

While the Committee hopes that this issue will never arise because the insurer will fulfill its part of the health care contract by meeting the policy objective of "timely access to all medically necessary services", it is important to recognize that the question raised at the start of the preceding paragraph will have to be addressed if Principle Twenty is not fully

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<sup>78</sup> At the end of Section 1.1, having established that the current health care system is not fiscally sustainable, this report said that there are three basic options from which Canadians must choose as they deliberate about the future of our health care system. These are: (1) the continued rationing of publicly funded health services, either by consciously deciding to make some services available and not others (that is, by delisting some services), or by allowing waiting lists to continue to grow; (2) increasing government revenue, either by raising taxes directly or through other means such as health care insurance premiums, so that the rationing of services can be reduced and waiting lines shortened; (3) making services available to those who can afford to pay for them by allowing a parallel privately funded tier of health services, while maintaining a publicly funded system for all other Canadians.

<sup>79</sup> See preceding footnote.



implemented. If this question is answered in the affirmative, then the third of the options presented in Section 1.1<sup>80</sup> would have been selected.

## **2.6 Concluding Remarks**

There are two themes which run through the set of principles presented in this chapter. The first is the need to restructure hospital and doctor care in order to make it operate more efficiently. The second is to make information about the system, its costs, its waiting times, its performance and its outcomes, available to the public in order to improve transparency and make decision-makers – funders and providers – more accountable to the public.

Both these themes are designed to re-establish the health care contract between Canadians and their federal, provincial and territorial governments. This involves, on the one hand, having Canadians understand where their health care dollars are being spent and why more money is needed in order to make the system fiscally sustainable. On the other hand, it involves pushing government to operate the system more efficiently than it is now and to improve service delivery under the contract by, among other things, putting a cap on the length of waiting time for various procedures.

These themes are driven, in part, by an important observation about Canadians' attitudes towards the health care system, made by Darrell Bricker and Edward Greenspon in their recent book, *Searching for Certainty*.<sup>81</sup> Based on extensive public opinion polling by Ipsos-Reid, Bricker and Greenspon conclude that Canadians will not support additional spending to close the gaps in the health care safety net until they see compelling evidence that the current health care contract with their governments is being honoured. In other words, the current system must be perceived by the public to be working reasonably well – that is, public confidence in the system must be restored – before Canadians will support its expansion.

The two themes of improved efficiency and increased transparency and accountability are designed to restore the confidence of Canadians in the health care system. Only once the twenty principles the Committee has outlined in this chapter have been implemented can Canada proceed to expand public coverage of health care services. The Committee believes that any such expansion will have to be done not by launching new universal programs, but by closing the gaps in the safety net, in particular with respect to drug therapy and home care.

The need to close these gaps is clearly illustrated by the fact that hospitals and doctors now account for only 46% of total health care expenditures.<sup>82</sup> Contrary to popular belief, and unfortunately contrary to most political rhetoric, Canada does not have a national health care system. Rather, it has a national hospital and doctor system, which now accounts for less than half of all health care expenditures.

Given the objectives of health care policy, as stated at the beginning of Section 2.5, the phrase “all medically necessary services” should be applicable to the full range of

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<sup>80</sup> See footnote 78.

<sup>81</sup> *Searching for Certainty*, Inside the New Canadian Mindset, by Darrell Bricker and Edward Greenspon, Doubleday Canada, 2002.

<sup>82</sup> CIHI, December 2001.

health care services and not just to hospital and doctor services. This implies that some expansion of coverage – to close gaps in the health care safety net – is required if the objective of Canada's health care policy is to be met.

The Committee believes that restructuring Canada's publicly funded health care system in order to make it more efficient is necessary to ensure its long-term fiscal sustainability. It is our view that the experience of other countries with respect to internal markets in health care can be instructive in deciding what the elements of this restructuring should be. We believe that restructuring health care in Canada must be based on devising a set of incentives that will lead all participants to change their behaviour in ways which will benefit the system as a whole and patients in particular. Our list of twenty principles is intended to achieve this.

For example, implementation of Principle Seven<sup>83</sup> would give government an incentive to think carefully about the health care consequences of making changes to budgets for funding hospital and doctor services. Once Canadians are able to translate budget dollar amounts into service levels and numbers of procedures to be paid for, they will then be able to evaluate more clearly the appropriateness of the size of the health care budget and to engage their government in a meaningful discussion, including a discussion on whether they were willing to pay more taxes (or health care insurance premiums) in order to improve levels of services. Currently, such a discussion is not possible because Canadians do not have the information that would enable them to translate budget levels into levels of services delivered to patients.

Similarly, Principle Eight<sup>84</sup> gives institutions incentives to operate more efficiently by putting them in competition with one another. There may be a need to develop a specific set of incentives which are targeted at the managers of health care institutions (and perhaps even at their trustees or directors) and another set of incentives for the health care providers they employ. These questions will be further explored in the Committee's October 2002 report.

Principle Eleven<sup>85</sup> introduces incentives for behavioural change on the part of primary care providers that would lead to a more efficient primary care sector. In fact, experience suggests that when providers/institutions are given responsibility for decisions on health care spending, they tend to provide the right treatment in the most cost-effective manner.

Finally, Principle Eighteen<sup>86</sup> provides incentives for patients to use the health care system efficiently. This principle could, for example, require the imposition of a surcharge

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<sup>83</sup> Principle Seven reads: The consequences arising from changes in the level or amount of government funding for hospital and medical care should be clearly understood by government and explained to the public, in as much detail as possible, at the time such changes are made and announced.

<sup>84</sup> Principle Eight reads: In the first stage of health care reform, the method for remunerating hospitals should be changed from the current annual global budget to service based funding.

<sup>85</sup> Principle Eleven reads: To facilitate primary care reform, the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards.

<sup>86</sup> Principle Eighteen reads: Incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees for services that are deemed to be medically necessary.

on patients who choose to seek treatment from providers outside of their chosen primary health care team.

In every part of our system of incentives, there is a critical need for appropriate and timely information. Principle Fifteen ensures that a system of electronic health records, linking all health care providers, will make the “right information” available in a timely fashion to the appropriate provider and provide a better way of allocating resources to the benefit of patients.

As was stated in the introduction to this section, and as was illustrated above, the theme of providing more information to the public also runs through our twenty principles. This information is needed for three reasons:

- first, to make more transparent the processes by which resource allocation decisions – principally with regard to money, but including human resources as well – are made;
- second, to enhance accountability on the part of the people, institutions and governments who make decisions about what types of services will be covered by public insurance and how much of any service will be provided;
- third, and perhaps most importantly, to change the public debate from a debate about dollars to a debate about services and service levels. Canadians have a right to debate the question of whether they are willing to pay more for improved levels of service. Canadians have a right to understand the linkages between funding levels and service levels. Changing the nature of the public debate about health care will be a significant step towards gaining public support for restructuring the publicly funded hospital and doctor system. Ultimately, this will lead to restoring public confidence in the system so that we can move on to closing the gaps that remain in the publicly funded health insurance system.

There is also a need for improved accountability throughout the system. Under Principle Thirteen, the introduction of an “internal market” in Canada’s publicly funded health care system would enhance the accountability both of health care providers/institutions and of governments.

Principle Twenty – the care guarantee principle – would make government accountable for meeting the timely access to treatment condition of its health care contract with Canadians.

The Committee has developed its twenty principles in recognition of the fact that Canadians want health care to be delivered equitably to all, based on need, not on income. In addition, consistent with our patient-oriented view (Principle Seventeen), our list of principles has been designed to address the primary concerns of Canadians with respect to the quality (Principle Sixteen) and timely provision of health services (Principle Twenty).

It is important to stress that the set of principles that the Committee has outlined in this chapter form an integrated whole. If one of these principles is rejected, then it may make the implementation of other principles in the set impossible.

A clear example is provided by the relationship between the first (single funder) and the last (care guarantee) principles. Should government refuse to introduce a waiting time guarantee (or should the public not wish to pay the additional funding that would be required to make the care guarantee a reality), it then becomes necessary to ask whether individuals should be allowed to buy private insurance that would enable them to have access to treatment by using a privately funded care guarantee. However, to allow people to purchase private insurance that would be used to pay for medically necessary services once the pre-defined waiting period has been exceeded would contradict Principle One which stipulates that there should be a single funder or insurer for all medically necessary hospital and doctor services.

The Committee does not advocate the introduction of private insurance and its preferred option is for all its principles to be accepted and applied. But it is necessary to be aware of the fact that if the set of principles is not embraced as a whole, then the rejection of one principle could very well lead to the undermining of others. In this case, the rejection of Principle Twenty could lead to Principle One being abrogated as well.

The Committee fully recognizes that its set of principles will be subject to close critical scrutiny. That is entirely understandable in such a value-laden public policy issue as health care. In fact, it is likely that each reader of this report will support his/her own unique subset of the principles.

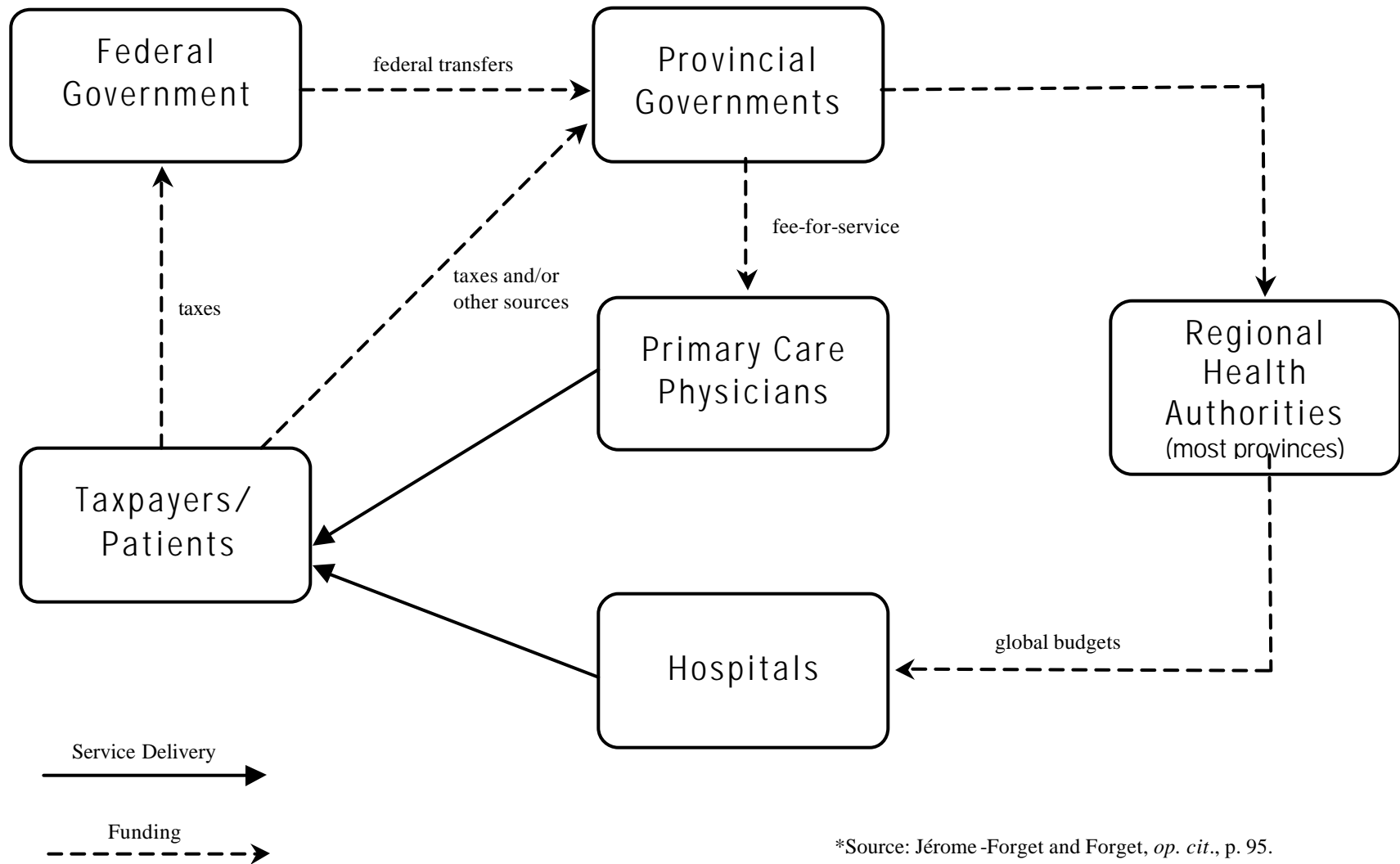
We ask readers, however, to keep in mind that no major reform of any large system, particularly one as complex and deeply personal as the hospital and doctor system, is ever perfect. There is no perfect solution. Everyone involved will have to be prepared to compromise in order to make reform work for the benefit of all Canadians, and reforms will have to be tailored to the specific circumstances that prevail in the different regions of the country.

Insisting on perfection, or attempting to obtain everything one wants, will doom reform to failure. Similarly, reform will fail if people insist on addressing all health care problems before beginning to make progress on the hospital and doctor system. These tendencies, along with an excessive focus on self-interest by those employed in the system, explain why reform has failed in the past.

Recognizing the dangers, we have worked hard to develop a set of principles which we believe are 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 the sector will consider the principles with the same pragmatic approach as the Committee and that everyone will be prepared to make some sacrifices in order to meet our common goal: having a fiscally sustainable health care system of which Canadians can be truly proud.

Figure 1  
*Current Structure of Publicly  
Funded Health Care  
Insurance\**



\*Source: Jérôme-Forget and Forget, *op. cit.*, p. 95.

Figure 2  
*Phase One Reform – The Introduction  
of Service Based Funding for Hospitals*

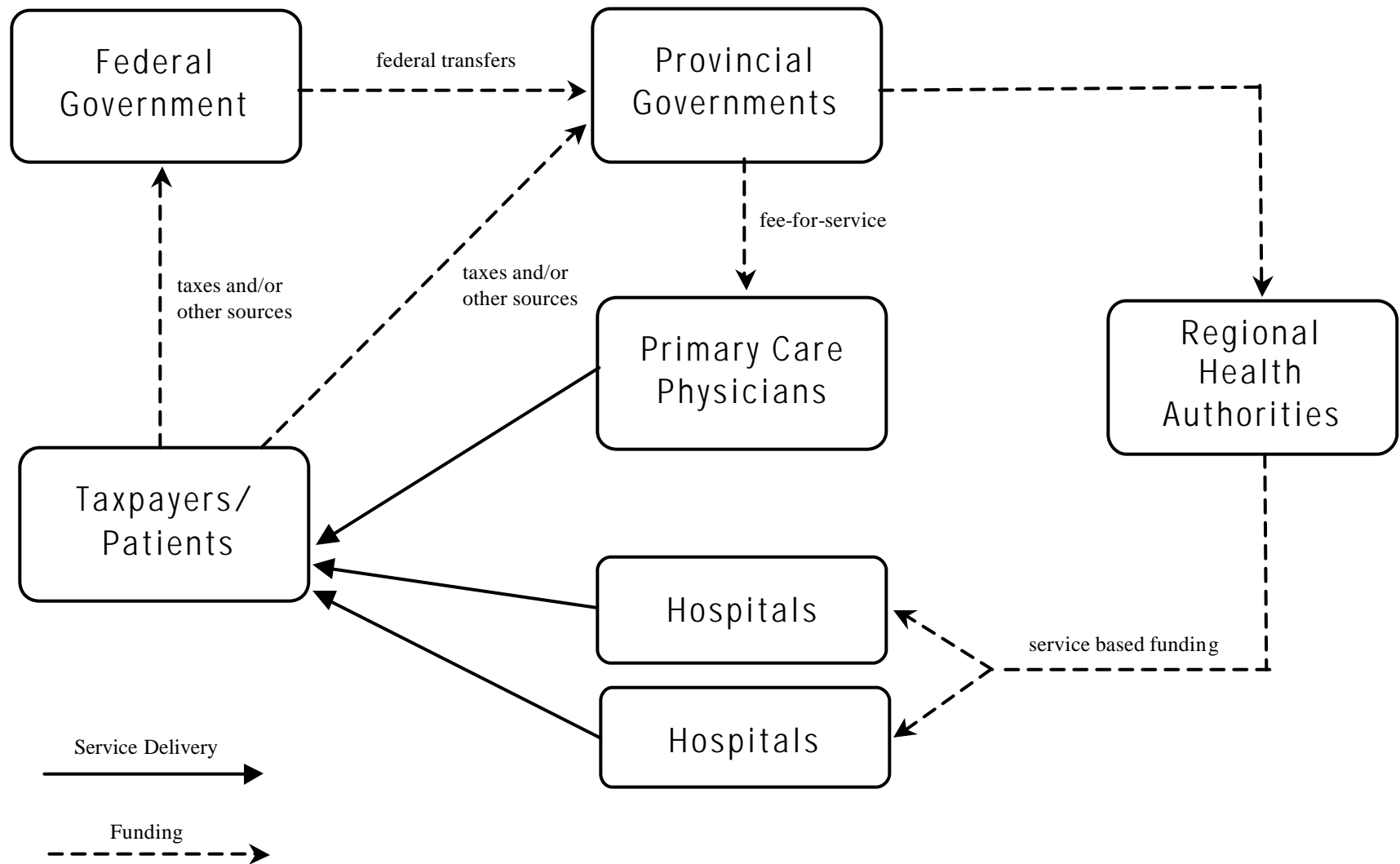
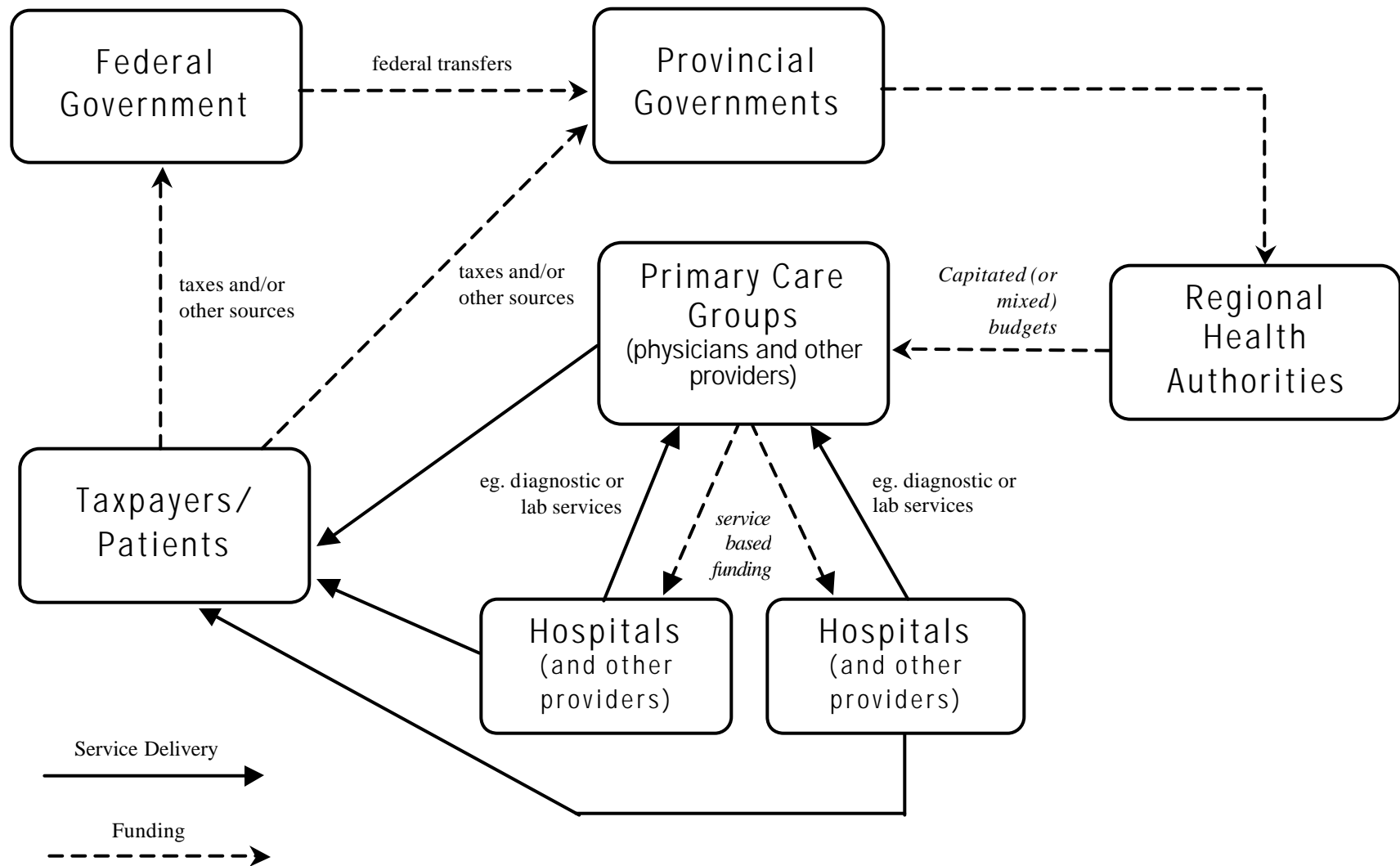


Figure 3  
*Phase Two Reform – Primary Care  
 Groups Purchase Services on Behalf of  
 their Patients*







## CHAPTER THREE

### FINANCING AND ASSESSING HEALTH CARE TECHNOLOGY

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Health care technology is a very broad concept that can be defined as “the set of techniques, drugs, equipment, and procedures used by health care professionals in delivering medical care to individuals and the systems within which such care is delivered.”<sup>87</sup> Although this definition encompasses drugs, this chapter will discuss issues related to “hard” technologies only. Issues related to drugs will be addressed in the Committee’s Volume Six (October 2002).

Everybody agrees that health care technology constitutes an important component of health care delivery in advanced countries. Health care technology can improve the speed and accuracy of diagnosis, cure disease, lengthen survival, alleviate pain, facilitate rehabilitation, and maintain independence. For example, a brief tabled with the Committee by Medical Devices Canada (MEDEC) stated:

*Modern medical devices and technologies have not only improved the health outcomes for Canadian patients, but by enabling less invasive procedures and shorter hospital stays, have also supported cost-effectiveness in the health care system.*<sup>88</sup>

However, many concerns were raised during Committee hearings about the availability, financing and assessment of both new and existing health care technologies. The Committee believes that these issues need to be addressed if Canadians are to derive the maximum benefits health care technology can provide, while sustaining an affordable health care system.

***The Committee believes that the issues over the availability, financing and assessment of health care technology need to be addressed if Canadians are to derive the maximum benefits health care technology can provide, while sustaining an affordable health care system.***

#### 3.1 Availability of Health Care Technology

Despite the importance of health care technology in delivering quality health services, the availability of many new technologies is disproportionately low in Canada given its level of health care spending. In its Phase Two report, the Committee provided data that showed that, although Canada is the 5<sup>th</sup> highest among OECD countries in terms of total spending on health care (as a percentage of GDP), it is generally among the bottom third of OECD countries in the availability of health care technology. For example, Canada ranks 21<sup>st</sup> of 28 OECD countries in the availability of CT scanners, 19<sup>th</sup> of 22 in availability of lithotriptors,

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<sup>87</sup> David Feeny, *The Generation, Evaluation and Application of Health Care Technologies in Canada*, Brief to the Committee, 29 March 2001, p. 5.

<sup>88</sup> Medical Devices Canada, *The Role of Medical Devices and Technologies in the Canadian Health Care System*, Brief to the Committee, 29 October 2001, p. 4.

and 19<sup>th</sup> of 27 in availability of MRIs. Its only favourable ranking is in the availability of radiation equipment, where it ranks 6<sup>th</sup> out of 17.<sup>89</sup>

Data also showed that this technology gap is widening. For example, Canada's deficit in the availability of MRIs worsened between 1986 and 1995 relative to other leading OECD countries including Australia, France, the Netherlands and the United States.<sup>90</sup>

***The availability of many of new technologies is disproportionately low in Canada given its level of health care spending. Data also showed that this technology gap is widening.***

The Phase Two report also stressed that availability is not the only issue with respect to health care technology. The "aging" of that technology is also of concern. For example, information provided to the Committee indicates that between 30% and 63% of imaging technology currently used in Canada is outdated. The outdated nature of health care technology depends on both the number of years of usage and the relative effectiveness of the equipment in terms, for example, of the quality of the image or the dose of radiation.<sup>91</sup>

It is not clear why Canada is not introducing and making use of health care technology at the same pace as other OECD countries and why it does not routinely replace aging equipment. Indeed, two factors seem to contribute to this situation. First, Canada imports most of its health care technology. This contrasts sharply with countries such as Germany, France and the United States which have a strong health care technology industry. This "trade deficit" in health care technology might be explained in part by low levels of government incentives towards the development of this industry in Canada. Second, fiscal pressures faced by all levels of government throughout the 1990s have resulted in low levels of capital investment in Canada's health care system.

Along with numerous witnesses, the Committee is concerned that the shortage of health care technology and the use of outdated equipment impede exact diagnosis and inhibit high-quality treatment. As stated in our Phase Two report, not only can this situation negatively impact on the health of a patient, but it also raises concerns about the liability of health care providers.<sup>92</sup>

***The Committee is concerned that the shortage of health care technology and the use of outdated equipment impedes exact diagnosis, inhibits high quality treatment and limits access to needed health care. Enhancing the availability of new health care technologies and the appropriate replacement of outdated equipment can serve to reduce waiting times and ensure timely access to the best available diagnoses and treatments.***

Moreover, the Committee is concerned that the deficit in health care technology has translated into limited access to needed care and lengthened waiting times. In our view, and in accordance with Principle Twenty enunciated in Chapter 2, timely access to

<sup>89</sup> Data are for 1997. See Volume Two, p. 38.

<sup>90</sup> Volume Two, p. 38.

<sup>91</sup> Volume Two, p. 39.

<sup>92</sup> Volume Two, p. 39-40.

diagnosis and treatment is a crucial objective that must be ensured in Canada's publicly funded health care system.

Overall, the Committee believes that health care technologies are key to providing Canadians with an optimal level of quality health care. Enhancing the availability of new health care technologies and the appropriate replacement of outdated equipment can serve to reduce waiting times and ensure timely access to the best available diagnoses and treatments. Faster and more effective services in turn have the potential to alleviate some of the cost pressures on the health care system in general.

### **3.2 Financing the Acquisition and Upgrading of Health Care Technology**

As mentioned above, many witnesses stressed that fiscal pressures faced by all levels of government throughout the 1990s have resulted in low levels of capital investment in Canada's health care system. They suggested that the current deficit in health care technology requires a serious re-evaluation of the

way in which equipment is acquired and funded in Canada. Moreover, witnesses contended that the aging of the Canadian population as well as increased public expectations will greatly influence future needs for health care technology. Accordingly, in addition to increased investment by governments, witnesses recommended that health care policy-makers should forecast future technology needs and develop an appropriate investment plan for action.

***Health care policy-makers should forecast future technology needs and develop an appropriate investment plan for action.***

The federal government has recently responded to the deficit in health care technology. In September 2000, it announced that it would invest a total of \$1 billion in 2002-01 and 2001-02, to assist provinces and territories in the purchasing of new medical equipment. This funding was made available upon passage of the legislation in October 2000, allowing provincial and territorial governments to start making immediate acquisitions of necessary diagnostic and clinical equipment.

Although witnesses have welcomed this injection of new federal funds, a number of concerns remain. First, witnesses indicated that some provinces have not applied for their share of this fund, possibly because the federal government requires matching grants and some of the smaller provinces have difficulty financing the provincial share of the matching funds. Second, additional resources are required to operate the equipment. Even if provinces can afford their share of the capital investment, they may have difficulty funding the ongoing operating costs.<sup>93</sup> Estimates provided to the Committee suggest that a \$1 billion investment in new equipment necessitates an additional \$700 million to cover operational costs.<sup>94</sup> Third, the investment does not address the problem of the old equipment that needs to be upgraded. It was estimated that a further \$1 billion investment would be required for the upgrading of

<sup>93</sup> Moreover, even if provinces can purchase health care technology, a shortage of technologists may hamper the full utilization of the new equipment. Similarly, once new technology is acquired, there is a need for training to enable technologists to operate new high-tech equipment. These issues are examined in more detail in Chapter Six.

<sup>94</sup> Canadian Association of Radiologists, *Timely Access to Quality Care – The Obligation of Government, the Right of Canadians*, Brief to the Committee, March 2001, p. 2.

existing equipment.<sup>95</sup> Fourth, even with this new funding, Canada would still not rank at a level comparable to that of other OECD countries. Lastly, the Committee heard that there are apparently no mechanisms for ensuring accountability on the part of the provinces and territories as to exactly where money targeted towards purchasing new equipment is actually spent.

Along with witnesses, the Committee welcomes the injection of new federal funds as an important step towards the acquisition of needed health care technology. We do, however, believe that additional funding is required. Such additional federal investment should be structured in such a way as to make the grant more attractive to the provinces and territories. We believe that, at the same time, the federal government should ensure that any new funding for health care technology be spent on incremental purchases of medical equipment and not be used to subsidize already planned expenditures.

***The Committee welcomes the injection of new federal funds as an important step towards the acquisition of needed health care technology. We do, however, believe that additional funding is required.***

***(...)***

***Furthermore, we are concerned about the lack of accountability mechanism for ensuring that provinces and territories use federal funds in accordance with the intended purpose.***

Furthermore, the Committee is concerned about the lack of accountability mechanisms for ensuring that provinces and territories use federal funds in accordance with the intended purpose. This is why we feel, as stated under Principle Three (Chapter 2), that a better accountability mechanism is needed for targeted federal funds. Therefore, the Committee recommends:

**That the federal government initiate a long-term program to assist provinces and territories in financing both the acquisition and ongoing operation of health care technology. Such a program should incorporate clear accountability mechanisms on the part of the provinces and territories on their use of these targeted federal funds.**

Finally, it is the view of the Committee that the decision to acquire new health care technology should also be based on the appropriate assessment of its efficacy and cost-effectiveness. This issue is discussed in more detail below.

### **3.3 Investing More in Health Care Technology Assessment**

During Phase Two of its study, the Committee learned that health care technology assessment (HTA) provides information on safety, clinical effectiveness and economic efficiency. HTA often also considers the social, legal and ethical implications of the use of existing or new health care technologies. A brief tabled with the Committee explained:

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<sup>95</sup> *Ibid.*

*Health Technology Assessment (HTA) is the process of evaluating medical technologies (devices, equipment, procedures and drugs) and their use. HTA researchers collect, synthesize and critically evaluate the available research on medical technologies. Based on an interdisciplinary approach, an assessment can encompass analyses of safety, efficacy, effectiveness, quality of life and patient use. Other important factors such as economic, ethical, and social implications and other effects which may be unintended, indirect or delayed, may also be considered.*<sup>96</sup>

HTA can assist in deciding whether a new technology should be introduced and when an existing technology should be replaced. More importantly, HTA contributes in many ways to improving the quality of health care: it ensures that health care technologies are effective, that they are applied in the appropriate cases and conditions, and that the least costly technology is used to achieve the desired outcome.

In recent years, the federal and provincial governments have supported the creation of various health care technology assessment agencies. The first provincial HTA agency in Canada was established in 1988 in Quebec – the *Conseil d'évaluation des technologies de la santé du Québec*. A national agency, the Canadian Coordinating Office for Health Technology Assessment (CCOHTA) was established in 1989. The British Columbia Office of Health Technology Assessment was established in 1990. The Health Technology Assessment unit of the Alberta Heritage Foundation for Medical Research was established in 1996. Health services utilization agencies, with close links to their respective provincial governments, which undertake some HTA activities, have been formed in Manitoba, Ontario and Saskatchewan. At the national level, CCOHTA plays three major roles: it co-ordinates all HTA activities across the different jurisdictions; it attempts to minimize duplication by other national or provincial/territorial organizations; and it performs HTA activities on its own.

The Committee was told that, despite the work performed by these agencies, not enough attention is devoted to HTA in Canada. On a worldwide basis, Canada spends less in HTA activities than other countries with which Canada ought to at least be on a par. For example, all levels of government invest less than \$8 million in Canada (some \$4.3 million by CCOHTA and about another \$3 million by provincial agencies), whereas the United Kingdom provides some \$100 million to its national HTA body – the National Institute for Clinical Evidence (NICE). As a result, health care technologies are often introduced into Canada's health care system with only superficial knowledge of their safety, effectiveness and cost.

Martin Zelder, Director of Health Policy Research at the Fraser Institute, suggested that Canada should use the results of HTA undertaken offshore.<sup>97</sup> Other witnesses cautioned, however, that we cannot simply translate the results of HTA studies realized elsewhere. The application of foreign research is complicated by certain factors such as differences in demography and patterns of disease, differences in the costs of various health care resources, and differences in patterns of practice. Although CCOHTA shares information on health care technology with similar organizations in other countries, there are limits to the overlap in international technology assessments:

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<sup>96</sup> Canadian Coordinating Office For Health Technology Assessment, Brief to the Committee, 29 March 2001, p. 2.

<sup>97</sup> Martin Zelder, *Evidence on Canada's Medical Technology Gap*, Brief to the Committee, 29 March 2001.

*The efficacy of the technology may generalize, the effectiveness may not, and definitely cost will not. A US cost effectiveness analysis is not a Canadian one. There are different relative prices embodied in those cost figures than exist in Canada.<sup>98</sup>*

Another important issue raised before the Committee relates to the poor dissemination of the evidence generated by HTA activities to health care providers and managers. An improvement in this regard would certainly raise the quality of health care delivery and strengthen the formulation of public health care policy.

Overall, the Committee agrees with witnesses that health care technology assessment is a critical activity and that more HTA needs to be undertaken when considering the introduction of a new technology or the replacement of existing medical equipment. We also agree that, given the rapid advancement in health care technology, the capacity to disseminate the outcomes of HTA activities should be enhanced. It is the view of the Committee that the federal government, through its role in financing innovative health research, should devote more funding to the assessment of new and existing health care technologies. Therefore, the Committee recommends:

***The Committee agrees with witnesses that health care technology assessment is a critical activity and that more HTA needs to be undertaken when considering the introduction of a new technology or the replacement of existing medical equipment. We also agree that, given the rapid advancement in health care technology, the capacity to disseminate the outcomes of HTA activities should be enhanced.***

**That the federal government increase the funding it provides to CCOHTA and other HTA agencies.**

**That this additional funding be used to strengthen HTA capacity in Canada as well as to improve the dissemination and promotion of HTA findings to health care providers and managers.**

Finally, the Committee was told that little information exists in Canada about the precise contribution of technology to the costs of health care. Attempts to quantify the connection between technology and rising health care expenditures have suffered from a lack of reliable data. The majority of studies to date have treated technology as a “residual”, attributing to technology that portion of the increase in health care spending not accounted for by more easily identifiable factors.

Therefore, we do not know how much Canada spends on health care technology nor do we know the extent to which health care technology has an impact on the health and quality of life of Canadians. It is not possible to know whether the cost of health care technology represents an “add-on” or whether it is offset by reductions in the actual costs of the

<sup>98</sup> Committee Proceedings, 2<sup>nd</sup> Session, 37<sup>th</sup> Parliament, 29 March 2001 (5:20).

treatments they permit. Witnesses unanimously pointed to the need to undertake research in this area.

The Committee concurs with witnesses that there is currently an under-production of relevant and timely information on the costs and consequences of the use of health care technologies and that more research in this area would greatly benefit the whole health care system. Therefore, the Committee recommends:

**That the federal government provide additional funding to the Canadian Institutes for Health Research and the Canadian Health Services Research Foundation to support research into the potential impact of health care technology on health care costs.**





## CHAPTER FOUR

### DEPLOYING A NATIONAL HEALTH INFOSTRUCTURE

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Health care is a sector that relies intensively on information. With the “right information”, a health care provider can order the right treatment, prescribe the most appropriate medication or recommend the best preventive approach. With the right information, an individual is better able to make good decisions with respect to his/her health and lifestyle. With the right information, health care policy makers and managers can decide on how to allocate financial, physical and human resources in the most cost-effective and efficient way.

Currently, in Canada, it is often not possible to access the right information in order to deliver, manage and use health care. During the Phase Two hearings, the Committee was told that Canada’s health care system is not making use of modern information and communications technology to the same extent as do other information intensive industries. Witnesses suggested that greater use of information and communications technology would enhance the availability of, the accessibility to, and the sharing of the “right information”. This would significantly improve evidence-based decision making by health care providers, health care managers and health care policy makers, as well as by patients.

The use of information and communications technology in the field of health care is often referred to as “telehealth”. As explained in Volume Two of the Committee’s study, the telehealth applications that are envisioned in Canada for improving the sharing of the “right information” and enhancing health care quality include the following:

- a system of electronic health records (EHR). The EHR is an automated provider-based system within an electronic network that provides complete patients’ health records in terms of visits to physicians, hospital stays, prescribed drugs, lab tests, and so on.
- Tele-medicine and tele-homecare. These telehealth applications offer the possibility of delivering care over large and small distances.
- An internet-based health information network. The purpose of this network is to empower individuals to make informed choices about their own health and well-being, their health care system and health care policy.<sup>99</sup>

Telehealth is the foundation of what many Canadians call the “health infostructure”. Various components of a health infostructure are currently being implemented at all levels of government. However, these initiatives are all at different stages of development. In addition, they are isolated within organizations, institutions and provinces and currently constitute “a patchwork of unconnected projects, whose value would increase immensely if part of a coherent whole.”<sup>100</sup> The key challenge is to bring all these diverse infostructures together into a uniform and comprehensive information system. This challenge clearly requires federal

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<sup>99</sup> Volume Two, pp. 106-108.

<sup>100</sup> Report of the National Conference on Health Info-Structure, February 1998, p. 19.

and provincial/territorial collaboration. As a first step, Canada needs to move towards the development of electronic health records.

#### **4.1 Establishing a System of Electronic Health Records**

A system of electronic health records (EHR) is certainly the first step in gathering health-related information that will allow for evidence-based decision making throughout the whole health care system:

*With sound and timely information on health determinants and outcomes of previous decisions, health care providers will be able to make informed decisions in their patients' interests. With better understanding of health impacts and costs of previous actions, policy makers and managers will be able to make the evidence-based decisions needed to carry forward reform and sustain the health care system. Better health information will allow the general public to engage more fully in the health care policy debate and hold the health care system to account. As consumers, they will be able to shop around knowledgeably for the health care providers and services that meet their needs.<sup>101</sup>*

An important characteristic of an EHR system is that it can make patient data available to health care providers anywhere on a need-to-know basis by connecting interoperable databases that have adopted the required data and technical standards. The Committee believes that a system of EHR offers tremendous opportunities to integrate the various components of Canada's health care system which currently work in silos. We believe that, at the present time, the lack of integration impedes the establishment of a direct relationship between the inputs used in the health care system and the resulting outputs or outcomes. This creates a significant barrier in evidence-based decision-making with respect to health and health care.

***The Committee believes that a system of EHR offers tremendous opportunities to integrate the various components of Canada's health care system which currently work in silos. We believe that, at the present time, the lack of integration impedes the establishment of a direct relationship between the inputs used in the health care system and the resulting outputs or outcomes.***

During the Committee's hearings, many witnesses described the EHR system as the cornerstone of an efficient and responsive health care delivery system that is able to improve both quality and accountability. Such a system, they stated, is a necessary prerequisite to a truly patient-oriented health care system. The Fyke report in Saskatchewan expressed similar views:

*The electronic health record (EHR) is the cornerstone of an efficient and responsive health care delivery system, quality improvement and accountability. Without it, the*

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<sup>101</sup> Advisory Council on Health Info-structure, *Connecting for Better Health: Strategic Issues*, Interim Report, September 1998, p. 2.

*prospects for a patient-friendly health care system, optimal teamwork, and efficiency are dim.*<sup>102</sup>

In addition to the Fyke Commission, the full deployment of a system of EHR was also endorsed by other provincial commissions on health care, including the Health Services Restructuring Commission in Ontario, the Clair Commission in Quebec, and the Mazankowski report in Alberta.<sup>103</sup>

All levels of government in Canada have recognized the importance of deploying a system of EHR. In fact, on September 11, 2000, the First Ministers agreed to work together to develop an EHR system over the next three years and to work collaboratively to develop common data standards to ensure compatibility and interoperability of provincial health information networks and to ensure stringent protection of personal health information.

In support of the agreement reached by First Ministers, the federal government committed \$500 million in 2000-01 to accelerate the adoption of modern information technologies in the health care system. The Committee was informed that this money has been invested in a not-for-profit corporation, known as Canada Health Infoway Inc. (or *Infoway*), that will work with provinces and territories to create the necessary common components of an EHR over the next three to five years. Currently, *Infoway* is working on two different initiatives:

- First, it has created a National Registry of EHR that will document – organizationally, regionally, provincially and nationally – the state of developments in building EHR.
- Second, and jointly with CIHI and other stakeholders, it is developing coordinated and consistent standards for collecting, exchanging and sharing information in the pharmacy arena.<sup>104</sup>

The Committee believes that the work undertaken by *Infoway* represents a major step towards the full integration of the various health infostructures. We welcome this collaboration between the federal government and the provinces and territories. In our view, such collaboration should foster the development of a unique model of EHR. We believe that both Canadians and their publicly funded health care system will benefit most greatly if the system of electronic health records is national in scope. To achieve this, the federal government must provide leadership and the necessary resources. Therefore, the Committee recommends:

***We believe that both Canadians and their publicly funded health care system will benefit most greatly if the system of electronic health records is national in scope. To achieve this, the federal government must provide leadership and the necessary resources.***

<sup>102</sup> Saskatchewan Commission on Medicare (Kenneth Fyke, commissioner), *Caring for Medicare – Sustaining a Quality System*, April 2001, p. 68.

<sup>103</sup> Health Services Restructuring Commission (Duncan Sinclair, Commissioner), *Primary Health Care Strategy – Advice and Recommendations to the Honourable Elizabeth Witmer, Minister of Health*, Government of Ontario, December 1999; Commission d'étude sur les services de santé et les services sociaux (Michel Clair, Commissioner), *Les Solutions Émergentes – Rapport et recommandations*, January 2001; Premier's Advisory Council on Health (Right Hon. Don Mazankowski, Chair), *A Framework for Reform*, report to the Premier of Alberta, December 2001.

<sup>104</sup> According to information provided on Infoway's Website at <http://www.canadahealthinfoway.ca/>.

**That, once the three- to five-year period is over, the federal government provide additional financial support to Canada Infoway Inc. so that Infoway develop, in collaboration with the provinces and territories, a national system of electronic health records.**

The Committee is aware that the public has certain misgivings about the computerization and networking of personal health records, and more particularly in regard to the nature of the information gathered and how it is collected, stored and used. We concur with the Advisory Committee on Health Infostructure that guidelines for the collection, storage and use of information must be developed to ensure a harmonious integration. Therefore, the Committee recommends:

**That the federal government, in collaboration with all stakeholders involved in the computerization of health records, define standards and rules for the collection, storage and use of such information.**

Perhaps the most important benefit to be gained from the deployment of EHR across the country is access to evidence-based information that will be used to assess quality of care, system performance and patient satisfaction. The EHR will also enable the evaluation of outcomes of various procedures. This will foster accountability and transparency in decision-making regarding health care delivery and policy and promote improvement in the quality of care.

#### **4.2 Evaluating Quality, Performance and Outcomes: the Need for Independent Assessment**

The Committee is convinced that long-term investment in information and communications technology, including an EHR, will allow the collection of better and more timely information on access to care, quality delivery, system performance and patients' outcomes. We also agree with witnesses that governments should finance the deployment of a EHR system and the development of a broader, health infostructure that is national in scope.

Moreover, we acknowledge the concern raised by many witnesses that, while governments must finance the EHR, they should not be responsible for assessing health data and evaluating quality and outcomes. These witnesses explained that, currently, collection and evaluation of health-related information is done by the same people who are responsible for paying for, and for providing, health services – that is governments. There is no independent assessment of outcomes and no external audit of the impact of various procedures on patients.

This concern was also raised in recent reports by provincial commissions on health care. For example, the Premier's Advisory Council on Health (Alberta) stated:

*Tracking and monitoring outcomes and providing regular reports to the public is an essential way of improving quality in health care. However, when government and health authorities measure and assess their own outcomes and results, it can put them in a conflict of interest.*<sup>105</sup>

This Advisory Council recommended the establishment of a permanent, independent “Outcomes Commission” to track results, assess outcomes and report regularly to the population.

Similarly, in Saskatchewan, the Fyke Commission recommended the establishment of a “Quality Council”, an evidence-based organization, working at arm’s length from government. The mandate of this Quality Council would involve reporting regularly to the provincial legislature, as well as to the public on a variety of issues, including: trends in health status, costs/benefits of health care interventions, clinical practices and clinical errors, evaluation of technology, equipment and drugs, etc. The Fyke report stressed that:

*(...) the Quality Council has the potential to depoliticize decisions, find creative solutions to long-standing problems, free the public from the tyranny of anecdote and ill-informed opinion about the state of care, and reveal where the system provides value for money and where it does not.*<sup>106</sup>

In other words, these provincial reports recommended that the role of the evaluator of the health care system be separated from that of the insurer and provider. This was also suggested in a recent report, which stated:

*(...) unbundling the functions – insurer, service provider, and evaluator of health care quality – that governments now play in the health care system (...) will improve incentives to collect information and make it widely available, allow consumers to hold providers accountable by abandoning those with unacceptable waiting times or treatment outcomes, and allow governments to exercise a more vigorous and demanding standard or regulatory oversight.*<sup>107</sup>

The Committee believes that the evaluation of our health care delivery system is essential in order to provide care that is evidence-based and corresponds to the needs of patients. We strongly support the view of witnesses

***The Committee believes that the evaluation of our health care delivery system is essential in order to provide care that is evidence-based and corresponds to the needs of patients. We strongly support the view of witnesses and provincial reports that the roles of the funder and provider should be separated from that of the evaluator in order to obtain independent assessment of health care system performance and outcomes.***

<sup>105</sup> Premier’s Advisory Council on Health (Alberta), p. 68.

<sup>106</sup> Saskatchewan Commission on Medicare, p. 81.

<sup>107</sup> Dr. David Zitner and Brian Lee Crowley, *Public Health, Private Secret*, Research Report, the Atlantic Institute for Market Studies, January 2002, p. ix.

and provincial reports that the roles of the funder and provider should be separated from that of the evaluator in order to obtain independent assessment of health care system performance and outcomes. While such evaluation should be performed at arm's length from the insurer and the provider, it should be financed by public funds.

Moreover, and as stated under Principle 16 (Chapter Two), it is the view of the Committee that such independent evaluation should be performed at the national (not federal) level. This would allow for the pooling of the expertise, thereby making the most effective use of the limited human resources that are currently available in Canada, and result in major economies of scale. In addition, the smaller provinces, which would not otherwise be able to sustain a truly effective monitoring and evaluation system, would clearly benefit from the results of a national evaluation process.

The Committee believes that such a national process for evaluating health care system performance and outcomes should be built on those national organizations that are currently devoted to the task of performing independent health care system evaluation. More precisely, evaluation of this type should be carried out at three levels:

***The Committee believes that such a national process for evaluating health care system performance and outcomes should be built on those national organizations that are currently devoted to the task of performing independent health care system evaluation.***

- First, the role of the Canadian Institute for Health Information (CIHI) should be strengthened. In addition to its responsibilities in the public health field, it should take the task of reporting – publicly or confidentially – on the performance of all regions and all institutional providers.
- Second, the Canadian Council on Health Services Accreditation should on a regular basis recommend how to correct deficiencies that it has identified in institutions delivering health services. At present, this review is voluntary; it should be made mandatory.
- Finally, the Citizens' Council on Health Care Quality should be responsible for advising on the development of standards and policy with respect to health care system performance and outcome evaluation.<sup>108</sup>

The extent of the authority devolved to each organization would have to be specified. Do they rely exclusively on public pressure and moral suasion, or would they be able to compel providers who do not meet agreed quality standards to implement changes? There are clearly many jurisdictional issues to be resolved, regardless of the exact mandate of such national evaluative bodies. But as a first step, the Committee recommends:

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<sup>108</sup> The creation of a Citizens' Council on Health Care Quality was announced in the January 2001 Speech of the Throne. More precisely, the federal government stated that it will work with the provinces and territories to create this council whose objective will be to ensure that the public's perspective is considered in developing meaningful indicators of health system performance.

**That the federal government, in collaboration with the provinces and territories, undertake the establishment of a national system of evaluation on health care system performance and outcomes. Such a national system of evaluation should: 1) be built on existing expertise and institutions; 2) remain independent from governments; and 3) receive appropriate funding from the public purse. The federal government should devote substantial funding to this very important undertaking.**

### **4.3 Fostering Accountability**

Numerous witnesses acknowledged that the deployment of a system of EHR, that will capture and translate information on system performance and treatment outcomes, will enhance transparency in health care financing and delivery. Moving towards a uniform EHR system will also facilitate the monitoring and tracking of the use of public health care funds. This, overall, will foster accountability throughout the health care system.

But what does “accountability” mean exactly? In the view of the Committee, accountability refers to the obligation to demonstrate and take responsibility for system performance when measured against a set of agreed targets or goals. As mentioned in our Volume Four, there are two directions to government accountability. The first involves governments reporting to Canadians on their policies and programs with respect to health and health care (public accountability). The second involves provincial/territorial reporting to the federal government on the use of federal funding (government to government accountability).<sup>109</sup>

A major step towards greater public accountability was accomplished in February 1999 with the signing of the Social Union Framework Agreement (SUFA) by federal and provincial/territorial governments (excluding Quebec).<sup>110</sup> Under SUFA, federal and provincial/territorial governments are committed to increasing transparency and accountability to the Canadian public on social policy outcomes – including health care policy – so that Canadians can assess the performance of social programs. More specifically, SUFA states that each level of government agrees to:

- Monitor and measure outcomes of its social programs and report regularly to its constituents on the performance of these programs;
- Share information and best practices to support the development of outcome measures, and work with other governments to develop, over time, comparable indicators to measure progress on agreed objectives;
- Publicly recognize and explain the respective roles and contributions of governments.<sup>111</sup>

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<sup>109</sup> Volume Four, p. 104.

<sup>110</sup> *A Framework to Improve the Social Union for Canadians*, An Agreement between the Government of Canada and the Governments of the Provinces and Territories, 4 February 1999.

<sup>111</sup> *Ibid*

In addition to recognizing the need to strengthen public accountability, governments signatory to SUFA agreed to “use funds transferred from another order of government for the purposes agreed and pass on increases to its residents”.<sup>112</sup> In the view of the Committee, developing such information on the use of public funds would significantly contribute to government-to-government accountability.

Currently, provinces and territories are not required to report explicitly on their utilization of federal transfer payments provided under the Canada Health and Social Transfer (CHST). The government-to-government accountability mechanism rests, at this moment, on compliance with the five principles of the *Canada Health Act*. This legislation also requires provincial and territorial governments to voluntarily provide an annual statement describing the operation of their health care insurance plans as they relate to the principles of the Act. The information provided by the provinces/territories serves as a basis for the *Canada Health Act* annual report.

***In the view of the Committee, developing information on the use of federal funds would significantly contribute to government to government accountability.***

SUFA also provides for greater transparency and public accountability with respect to disputes related to the *Canada Health Act*. With respect to transparency, SUFA establishes a process for dispute avoidance and resolution that will apply to the interpretation of the principles of the Act and that “should be simple, timely, efficient, effective and transparent”.<sup>113</sup> With respect to public accountability, the Agreement states that “governments will report publicly on an annual basis on the nature of intergovernmental disputes and their resolution.”<sup>114</sup>

Such a dispute resolution mechanism for the interpretation of the *Canada Health Act* has not been developed yet. When they met in January 2002, provincial Premiers and territorial Leaders asked Premier Klein to take the lead in working with the federal government to finalize, by April 30, 2002, the process for resolution of disputes under the *Canada Health Act*. It is the hope of the Committee that such a dispute resolution mechanism will be available soon and that, as a result, progress will be made to enhance transparency and accountability in the interpretation and enforcement of the *Canada Health Act*. We believe that such progress would significantly contribute to the renewal and restructuring of health care in Canada.

#### **4.4 Ensuring Confidentiality and Protection of Personal Health Information**

The issue of privacy, confidentiality and security related to personal health information in the context of an EHR system, as well as in the broader context of a national health infostructure, was perhaps the most sensitive one raised during the Committee’s hearings on this question. While these three terms are sometimes used interchangeably, they are, in fact, entirely separate issues:

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<sup>112</sup> *Ibid.*

<sup>113</sup> *Ibid.*

<sup>114</sup> *Ibid.*



- *Privacy* refers to the right of individuals to control their personal health information – including the collection, use and disclosure of that information.
- *Confidentiality* deals with the obligation of health care providers to protect the personal health information of their patients, to maintain secrecy and not misuse or wrongfully disclose it.
- *Security* refers to the set of standards in and around information systems that protect access to the system and the information it contains.

In other words, privacy drives the duty of confidentiality and the responsibility for security. Protection of privacy in Canada is a shared responsibility between the federal and provincial/territorial governments. Currently, the legal framework for protecting individual privacy is composed of a patchwork of various laws, policies, regulations and voluntary codes of practice. The Committee was told that the first step that needs to be made is to gain support for the harmonization of legislation and regulation across Canada so that the privacy of Canadians will be protected in a reasonably uniform way in matters of health across the country.

The Committee was pleased to learn that a resolution for the harmonization of legislation is being examined by all jurisdictions and that an agreement is expected soon. We also fully support *Infoway* in promoting a common position on information privacy, confidentiality and security relating to the deployment of EHR systems across the country.

Moreover, the Committee acknowledges that the *Personal Information Protection and Electronic Documents Act* or PIPEDA, promulgated in June 2000, has stimulated intensive debate and study of this question in the past two years. We are pleased that several groups in the health sector have seriously addressed many of the concerns raised by PIPEDA, and in particular, the need to protect personal health information, while at the same time allowing restricted use of such information for essential purposes such as health care management – which includes the provision, management, evaluation and quality assurance of health services – and health research.

Like other Canadians, the members of the Committee place a very high priority on the protection of personal health information. Though protection of personal health information is understandably of very high importance, we must recognize what else is at risk if access is summarily rejected because of perceived threats to privacy and confidentiality. This being said, the Committee believes that if Canadians are to allow restricted access to personal health information for essential functions, such as health research and health care management, it is imperative that their personal health information be adequately protected. Our main observations and recommendations with respect to privacy of personal health information are detailed in Chapter Five, under Section 5.7.4.

***Like other Canadians, the members of the Committee place a very high priority on the protection of personal health information. Though protection of personal health information is understandably of very high importance, we must recognize what else is at risk if access is summarily rejected because of perceived threats to privacy and confidentiality.***

## 4.5 Investing in Telehealth in Rural and Remote Communities

Not only can telehealth applications enhance the sharing of the right information among various health care providers and health care settings, but they also offer the possibility of delivering care over large distances. Telemedicine is a form of telehealth application that can greatly improve quality and timely access to care, particularly in rural and remote Canada.

As indicated in the Committee's Phase Two report, up to 30% of Canada's population lives in rural, remote and northern areas of the country.<sup>115</sup> Accessibility to health care is one of the four patient-oriented principles of the *Canada Health Act*. However, rural Canadians are increasingly voicing concern regarding disparities between services available in rural and remote areas and those in urban areas.

The federal government has responded to the concerns of rural Canadians in a number of ways. For example, the Office of Rural Health was established in September 1998 to ensure that the views and concerns of rural Canadians are better reflected in national health policy and health care system renewal strategies. In February 1999, the federal government announced funding of \$50 million over three years (from 1999-00 to 2001-02) to support pilot projects under the "Innovations in Rural and Community Health Initiative".

In June 2000, the federal government announced a National Strategy on Rural Health that it sees as an important milestone on the road to ensuring that all Canadians have reliable access to quality health care. Then, in July 2001, the federal government announced the establishment of a Ministerial Advisory Committee on Rural Health to provide advice to the federal Minister of Health on how the federal government can improve the health of rural communities and individuals.

The Committee believes that telemedicine is a critical component of the overall rural health policy of the federal government. In the context of rural health, telemedicine offers the following advantages: it addresses the shortage of rural health care providers and medical training; it improves rural health infrastructure; it allows for conformity with the accessibility principle of the *Canada Health Act*; and it ensures a more equitable development of health information systems across the country. Therefore, the Committee recommends:

***The Committee believes that telemedicine is a critical component of the overall rural health policy of the federal government.***

**That the federal government maintain its support to rural health and invest in telehealth applications that will enhance access to care and improve the quality of health services in rural and remote communities.**

Given the unique health and health care needs of rural and remote communities, the Committee has decided to devote specific hearings on this subject and to release a thematic report with detailed recommendations in the coming year.

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<sup>115</sup> Volume Two, p. 137.

## 4.6 Investing in Tele-Homecare

Technology in various telehealth applications is seen as vital to the timely delivery of quality home care services. Tele-homecare offers numerous benefits by:

- Reducing unnecessary visits to emergency rooms;
- Reducing unscheduled visits to primary care physicians;
- Providing early intervention or prevention of repeat hospitalizations;
- Teaching the patient how to manage early symptoms, thus avoiding the development of an acute pathological condition, and
- Gathering information on vital signs' data fluctuations within a 24-hour period, an important component of differential diagnosis and early prevention.<sup>116</sup>

Witnesses told the Committee that tele-homecare is not a substitute for any of the already available health services. Rather, it complements and reinforces the health care infrastructure by providing a continuum of care with a particular focus on patient's needs.

As indicated in the Committee's Phase Two report, the ability to connect a patient's in-home monitoring equipment to local health care facilities over telephone lines is already a reality.<sup>117</sup> Other possibilities are close to realization. In fact, tele-homecare applications are numerous and include for example: telemedicine involving medical consultations, diagnosis, rehabilitation for the home care patient from a distance; tele-education for information exchange between health care providers and the home care patient; telemonitoring where patients undergoing hemodialysis, cardiac, oncological treatments can be monitored or elderly persons can be assisted at home.

According to the Office of Health and the Information Highway (Health Canada), Canadian tele-homecare is in its early stages of development. Several existing projects are utilizing a range of applications from a telephone information line equipped with high performance diagnostic software to a tele-monitoring device that can transmit vital signs data over the telephone line. Currently, tele-homecare projects in Canada are primarily directed at tele-monitoring and tele-consultation following a visit to the hospital or as a replacement for a visit. A number of large home care organizations are using information and communication technologies to transmit administrative and case management information by qualified personnel from the point-of-care to central databases and to community health information networks.<sup>118</sup>

Many witnesses pointed out the need to develop a national vision of home care in which tele-homecare plays a significant role. Once a national vision is clearly developed, specific tele-homecare activities, national in scope, should be developed. The success of such a national undertaking requires, according to witnesses, strong federal leadership along with

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<sup>116</sup> Office of Health and the Information Highway, *Tele-homecare: An Overview*, Background Paper for Discussion, Health Canada, May 1998, p. 3.

<sup>117</sup> Volume Two, p. 107.

<sup>118</sup> See their website at [http://www.hc-sc.gc.ca/ohih-bsi/tele/hmcare\\_e.html](http://www.hc-sc.gc.ca/ohih-bsi/tele/hmcare_e.html).

collective and immediate action on the part of all stakeholders. The Committee will detail its final recommendations on tele-homecare in its thematic report on home care.

#### **4.7 Investing in Internet-Based Health Information**

An Internet-based health information network is a system that empowers individuals to make informed choices about their own health and well-being, their health care and about health policy. Health information to the general public via the Internet could include for example: 1) general health information (health promotion and disease prevention); 2) information on treatment options and drugs, as well as on illness management (e.g. blood pressure, diabetes or obesity); information on public health issues (e.g. quality of air, water and food); 4) information on the effects of health determinants; 5) health and health care policies at the federal, provincial and territorial levels as well as the policies of other countries; 6) data on health outcomes of public policies; 7) accountability data (such as report cards on the performance of the health services and providers).

A recent report by the Federal/Provincial/Territorial Advisory Committee on Health Infostructure<sup>119</sup> stated that the public sector has a limited presence in providing health information to the public in an electronic form. According to the report, the most notable effort in Canada is the Canadian Health Network. The Canadian Health Network, which is a collaborative effort by the federal government and some health organizations across Canada, is considered by many as among the best in the world. The Network provides health promotion and disease prevention information to Canadians. The private sector, on the other hand, especially American firms, have entered this end of the market with highly specialized ventures providing dynamic, graphic information content. The criticism levelled at these private sector initiatives is whether their health-related information is objective and can be trusted, especially if the content is sponsored.

The report of the F/P/T Advisory Committee on Health Infostructure stressed that, despite public and private sector initiatives, there is still significant amounts of information missing that the public would like to access, for example for certain population groups.

The F/P/T Advisory Committee recommended the creation of a national portal for the Canadian public that would provide comprehensive and trusted health-related information to support self-care decision making. This portal should build on the success of the Canadian Health Network and be strategically linked to provincial and territorial website services to ensure consistency of health-related information across Canada.<sup>120</sup> The national portal should allow better access by specific populations, which currently have restricted access to quality health-related information (e.g. Aboriginal Canadians, rural and remote communities, etc.).

The Committee believes that providing access to objective, trusted, health-related information can significantly improve the ability of Canadians to make health and health care

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<sup>119</sup> F/P/T Advisory Committee on Health Infostructure, *Tactical Plan for a Pan-Canadian Health Infostructure – 2001 Update*, Office of Health and the Information Highway, Health Canada, November 2001.

<sup>120</sup> Examples of provincial websites include BC's HealthGuide, Calgary Health Region's "Your Health", and CapitalHEALTHLink.

decisions. Consistent with Principle Nineteen (Chapter 2), it is our view that initiatives enabling people to be responsible for their own health and to stay healthy must be given the highest priority. Based on this principle and on the observations by the F/P/T Advisory Committee on Health Infostructure, the Committee recommends:

**That the federal government, in collaboration with the provinces/territories and stakeholders, develop a national health information portal, building on the success of the Canadian Health Network and the integration of provincial/regional portals.**

- **As a matter of priority, investments into this national portal should be made in locations where the basic systems infrastructure is inadequate, especially in rural, remote and Aboriginal communities. This would greatly enhance the capacity of all Canadians to access timely and objective electronic health information.**



## CHAPTER FIVE

### **NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH**

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Health research is about creating and applying new knowledge with respect to health and health care. Health research encompasses a full spectrum of activities that range from biomedical research, to clinical research, to health services research, and to population health research:

- **Biomedical research** pertains to biological organisms, organs, and organ systems. For example, this type of research would use animal or human tissues or cell culture to understand how the body controls the production of blood cells in the bone marrow, how those controls break down in leukemia, and how normal controls might be re-instated by treatment with drugs.
- **Clinical research** relates to studies involving human participants, healthy or ill. An example would include clinical trials on humans to test the toxicity and effectiveness of a possible new treatment for leukemia that has shown promising results in basic biomedical research, and then to compare the new drug with other drugs in terms of their net benefit to patients.
- **Health services research** embraces health care delivery, administration, organization and financing. An example might be research into the mechanisms for handling patients with leukemia, from the means for diagnosis, through their treatment in hospital, on an outpatient basis, or at home, to their long-term follow-up through hospital or community care.
- **Population health research** focuses on the broad factors that influence health status (socio-economic conditions, gender, culture, literacy, etc.). An example might be a study using large databases of personal health information gained from a number of sources to learn whether the incidence of leukemia is associated with environmental or other factors.

Health research is the source of new knowledge about human health, how to maintain optimal health, how to prevent, diagnose and treat disease, and how to manage our health care system. Health research leads to the development of new or improved drug therapy, treatment, medical equipment and devices and new ways of organizing and delivering health care. Health research also contributes to a better understanding of the complex interplay of the social, economic, environmental, biological and genetic determinants that affect our health and our susceptibility to disease.

The Committee was told that health research fosters the creation of knowledge-based employment, which in turn contributes to reversing the brain drain observed in the country. Overall, witnesses stressed that health research improves the personal and economic health of Canadians and enhances our international competitiveness:

*Health research provides enormous economic, social and health care rewards to society. The jobs that are created by these investments are high-quality, well-paying, knowledge-based positions that generate worldwide recognition for Canadians. These investments also support the rejuvenation of academic institutions across the country. They help train new health professionals in the latest technologies and techniques and they provide important support for the health care delivery system in Canada. Most importantly, the results of these activities lead directly to better ways to treat patients, which ensures a healthier and more productive population.*<sup>121</sup>

The Committee also heard that health research could serve as a catalyst to regional economic development and that the health services innovations generated through health research activities could greatly contribute to enhancing the quality and sustainability of Canada's health care system. As health research activity spreads out from the academic health science centres and government and into more community-based settings, we can anticipate that standards of care will improve, as health care providers engaged in health research will be better connected with the most recent information. Overall, health research provides tremendous opportunities for both economic and health care progress.

The Committee believes that Canada must actively engage in health research to capture its share of benefits. The Committee also strongly believes that the federal government has a critical role to play as a facilitator, catalyst, performer, consensus builder and co-ordinator in the overall effort to nurture excellence in health research. This chapter addresses a series of issues, including funding, partnerships and ethics, which we believe deserve close attention if Canada is to achieve the highest standard of excellence in health research.<sup>122</sup>

***The Committee believes that Canada must actively engage in health research to capture its share of benefits.***

## **5.1 Assuming Leadership in Canadian Health Research**

As Table 1 shows, health research in Canada is characterized by a complex network that involves a wide range of disciplines and a multiplicity of performers carrying out their research activities in a variety of locations. In Canada, health research is performed by universities, teaching hospitals, business enterprises, government, and non-profit organizations. This research is financed from a variety of public, private, Canadian and foreign sources.

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<sup>121</sup> Dr. Barry D. McLennan, Chair of the Coalition for Biomedical and Health Research (CBHR), *The Improving Climate for Health Research in Canada*, Brief to the Committee, 9 May 2001, p. 2.

<sup>122</sup> The Committee wishes to say that sections 5.1 and 5.2 of this chapter were inspired by a speech given by Dr. Kevin Keough, Chief Scientist at Health Canada, at the third annual Amyot Lecture organized by Health Canada. We found his lecture very useful in highlighting some of the challenges and opportunities facing health research.



**TABLE 1**  
**THE CANADIAN HEALTH RESEARCH NETWORK**

DISCIPLINES	LOCATIONS	SOURCES OF FUNDING
<ul style="list-style-type: none"> <li>▪ Clinical Disciplines</li> <li>▪ Social Sciences and Humanities</li> <li>▪ Epidemiology</li> <li>▪ Life Sciences</li> <li>▪ Cellular and Molecular Biology</li> <li>▪ Chemistry</li> <li>▪ Engineering</li> <li>▪ Computing and Mathematical Sciences</li> <li>▪ Health Services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Academe (Universities, Teaching Hospitals, Research Institutes)</li> <li>▪ Industry</li> <li>▪ Government</li> <li>▪ Physicians' Practices</li> <li>▪ Community Organizations</li> <li>▪ Community Hospitals</li> <li>▪ Others</li> </ul>	<ul style="list-style-type: none"> <li>▪ Governments (Federal, Provincial, Departments, Funding Agencies)</li> <li>▪ Non-Government Organizations and National Voluntary Organizations</li> <li>▪ International Sources</li> <li>▪ Industry</li> <li>▪ Universities</li> <li>▪ Others</li> </ul>

The different stakeholders in health research collaborate with each other in various ways: government-university, university-industry, government-industry. In fact, the Committee was told that science is a continuum and the multiple components of health research cannot exist independently of the others. Each component has an important, albeit changing, research role to play in ensuring maximum health benefits for Canadians.

The federal government has always played an important role in health research as a funder, performer and user of research. The federal government financially supports health research carried out in universities, teaching hospitals and research institutes (extramural research); it performs health research in its own laboratories (intramural or in-house research); and, it utilizes the outcomes of health research carried out elsewhere. Moreover, the federal government has an important role to play in setting national priorities for health research.

The Committee agrees with a 1999 report of the Council of Science and Technology Advisors that health research performed, funded and used by the federal government must be of the highest quality. It must be demonstrated to meet or exceed international standards of excellence in science, technology and ethics.<sup>123</sup>

***The Committee agrees that health research performed, funded and used by the federal government must be of the highest quality. It must be demonstrated to meet or exceed international standards of excellence in science, technology and ethics.***

The Committee was informed that, as the cost, complexity and pace of advancement in health research accelerate, individual organizations no longer have the resources or expertise to work in a vacuum:

<sup>123</sup> Council of Science and Technology Advisors, *Building Excellence in Science and Technology (BEST): The Federal Roles in Performing Science and Technology*, December 1999, p. 5.

*Traditionally, investigators have worked in isolation, pursuing their own research agendas and living grant-to-grant. This scattered, ad hoc approach simply won't work in today's world when the complexity of science requires the pooling of resources.*<sup>124</sup>

At the third annual Amyot Lecture organized by Health Canada, Dr. Kevin Keough, Chief Scientist at Health Canada, stated that it is necessary to adopt an inclusive (or horizontal) approach to health research and to find new ways to partner – that is, to bring together multi-disciplinary teams of scientists from across the whole health research system to combine their intellectual, financial and physical resources in conducting the research required to better understand the complex and highly interconnected world in which we live.<sup>125</sup>

The Committee agrees with Dr. Keough that it is critical to sustain effective partnerships and to distribute the effort of individual partners in a manner that will maximize the output of Canadian health research. In our view, complementary and collaborative approaches to health research are not only feasible and cost-effective, but they also contribute to better research outcomes for all stakeholders. This overarching goal can only be met if the role of the federal government continues to adapt to the changing health research environment. In addition to being a performer, funder and user of health research, the federal government must become more active as a catalyst and a facilitator.

***The Committee agrees that it is critical to sustain effective partnerships and to distribute the effort of individual partners in a manner that will maximize the output of Canadian health research.***

The Committee strongly believes that the federal government should assume leadership in Canadian health research and, therefore, we recommend:

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

**That 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.**

Dr. Keough stressed that, as a starting point, the federal government should encourage interchange of health research scientists between government, academia and the private sector. A freer flow of scientists would enhance the quality of Canadian health research, improve science and research advice to government, maximize the contribution of Canadian

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<sup>124</sup> The Western Canadian Task Force on Health Research and Economic Development, *Seizing the Future – Health as an Engine of Economic Growth for Western Canada*, Summary of the Report, August 2001, p. 2.

<sup>125</sup> Dr. Kevin Keough, Amyot Lecture, October 2001.

scientists to the whole health research community, and contribute to the renewal of the science base in all sectors. The Committee shares similar views and, therefore, we recommend:

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

The Committee wishes to acknowledge the important role played by national voluntary organizations in health research. These organizations act as a key bridge at the national level between health research and its application through knowledge transfer of information to researchers, health care providers and the general public. It is the view of the Committee that, given the knowledge and experience these national voluntary organizations bring, as well as the significant proportion of the health research enterprise which they support, they must be included in the multi-stakeholders collaboration in health research.

## **5.2 Engaging the Scientific Revolution**

Witnesses told the Committee that health research in Canada and throughout the world is currently undergoing a scientific revolution. They explained that this revolution in health research is fuelled by the ongoing advances in genomics, engineering and cell biology. Research in these scientific disciplines will have a profound effect on the detection, diagnosis and treatment of various genetically linked diseases. Elucidation of the physiological processes associated with various conditions will require years of efforts to identify the relevant genes and to determine how they interact.

*We are in the midst of a profound global revolution being driven by our rapidly emerging understanding of the molecular basis of life, of human biology and of disease. Like prior revolutions in science, this revolution is being driven by the collision of diverse disciplines and approaches: genetics, molecular biology, the broader bio-sciences, [information technology] and computational methodologies, small molecules and surface chemistry, bioethics, epidemiology, health economics, and the social sciences and humanities. The pace of this health research revolution is still accelerating, driven by significant global investments by governments, industry and philanthropy.*<sup>126</sup>

As the human genome project approaches completion, the next challenge is to understand the function of the 30,000-40,000 genes that humans appear to possess. These genes encode the entire protein set or proteome estimated at 2 million. Thus, the next frontier in biology appears to be proteomics, the cataloging and functional description of all proteins in living organisms, which is far more complex and promising than genomics.

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<sup>126</sup> Dr. Alan Bernstein, president of the CIHR, *Health Research Revolution – Innovation Will Shape This Century*.

Similarly, advances in biomedical engineering and miniaturization on the molecular scale will push development of more sophisticated devices for diagnosis and therapy – targeted delivery of drugs, biological testing, molecular imaging, and tissue and organ repair. Canada has a real opportunity to become a world leader in this field of “nanotechnology” or “nanomedicine”.

The study and use of stem cells is another good example of the potential impact that health research can have on health and health care. Stem cells have the unique property, whatever their origin, of becoming specialized cells. Currently, both the research community and related stakeholders are very enthusiastic about the potential of stem cells, both from embryonic and adult sources. It is anticipated that research on these cells will lead to treatments for serious diseases such as Parkinson’s, Alzheimer’s, diabetes and spinal cord injuries. It is also widely believed that these cells can ultimately be manipulated to grow into virtually any tissue or organ thus providing much needed organs for transplant.

Recent research has been successful in programming human embryonic stem cells into producing insulin. Normally, this function is performed by specialized pancreatic islet cells. Should this treatment prove to be able to provide a cure for diabetes, which is presently being treated by regular injection of insulin, it will not only improve the quality of life for the individual, but will also ease the economic burden of disease. In a different study, stem cells isolated from the skin of animals were coaxed into becoming neural, muscular and fat cells.

Other areas where the scientific revolution has a definite impact are chemistry and computer science where advances in molecular modelling combined with synthetic chemistry change the way novel drugs are discovered. Bioinformatics and robotics are also areas that will benefit health research.

The scientific revolution in health research is not limited to basic and biomedical research; it is also creating tremendous opportunities for research into health services and population health. More than ever before, research is undertaken in Canada and abroad to find new ways of delivering quality care and to understand the implications of the interaction of the determinants that affect the health of a population.

At the third Amyot Lecture, Dr. Keough stressed that advances in health research, and the need for governments and individuals to accommodate them, will continue to accelerate. This means that governments must be able to both perform and rely on good science, which is based on sound research harnessed for the public good. The government’s effectiveness in integrating progresses from emerging areas such as biotechnology and nanotechnology depends on this principle.

The Committee agrees with Dr. Keough that it is imperative for Canada to take up the challenges wrought by the scientific revolution. We are convinced that countries with a strong health research network are more capable of translating advances and innovations into cost-effective health services, modern and internationally competitive policy and regulatory frameworks, new or adaptive products, and new health promotion activities. An energetic health research environment contributes to improved health, higher quality of life, and an efficient health care system. This in turn engenders public confidence, a vibrant business environment and strong economy.

Along with Dr. Keough, the Committee believes that good science is good economics and that the government has a crucial role in maximizing the gains for Canada and its citizens. Clearly, the costs of doing good science are high; but the costs of not doing it are even higher. These scientific developments are rapidly expanding and there is fierce competition in the field. Along with numerous witnesses, the Committee is convinced that Canada cannot afford to fall behind. The potential pay-off is a fast and economically beneficial transfer of knowledge and its conversion into tangible benefits for the Canadian population.

***The Committee believes that good science is good economics and that the government has a crucial role in maximizing the gains for Canada and its citizens.***

It is the opinion of the Committee that such a formidable challenge can be met only through a concerted effort by government, industry, academia, non-governmental organizations and international organizations. Each of these partners has its own specific role. However, coordination and support should be provided by the federal government, through its agencies and departments, especially CIHR and Health Canada. Therefore, the Committee recommends:

**That 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.**

### **5.3 Securing a Predictable Environment for Health Research**

The Phase Two report of the Committee showed that the federal government has had a long tradition in financing health research.<sup>127</sup> The most recent estimates by Statistics Canada indicate that the majority (some 79%) of federally funded health research is “extramural” as it takes place in universities and hospitals (68%), private non-profit organizations (6%), and business enterprises (4%).<sup>128</sup>

The principal federal funding body for health research is the Canadian Institutes of Health Research or CIHR. In fact, CIHR is the only federal entity whose budget is entirely devoted to health research. Its creation in 2000 involved a major evolution of the mandate of the Medical Research Council of Canada (MRC) and incorporation of the National Health Research and Development Program (NHRDP), formerly Health Canada’s main financing instrument for extramural health research. Despite the creation of CIHR, Health Canada is still involved in the financing of some extramural health research in a wide range of fields (children’s health, women’s health, Aboriginal health, etc.).

<sup>127</sup> Volume Two, pp. 93-104.

<sup>128</sup> Statistics Canada, *Estimates of Total Expenditures on Research and Development in the Health Field in Canada, 1988 to 2000*, Catalogue No. 88F0006XIE01006, April 2001.

There are, also, a number of federal research-oriented bodies whose funding focuses entirely on health-related research. These include namely the Canadian Health Services Research Foundation (CHSRF) and the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). Many feel that for a country of the size of Canada, there are too many federal funding organizations.

In addition, there are several secondary sources of extramural federal health research funding. More precisely, the federal government is responsible for a number of research councils, agencies and programs that devote (to various extents) a portion of their budget for health-related research. These include the Natural Sciences and Engineering Research Council (NSERC), the Social Sciences and Humanities Research Council (SSHRC), the Canada Foundation for Innovation (CFI), the Canada Research Chairs (CRCs), and the Networks of Centres of Excellence.<sup>129</sup> The federal government has also funded Genome Canada, a not-for-profit corporation dedicated to develop and implement a national strategy in genomic research.

The remainder of the federally funded health research (some 21%) is “intramural” or “in-house” research, that is research conducted in federal government facilities. Federal facilities in which health-related research is performed include Health Canada, Statistics Canada, the National Research Council, Human Resources Development Canada, Agriculture Canada, Environment Canada (in partnership with Health Canada) and the Canadian Food Inspection Agency.

### **5.3.1 Federal Funding for Health Research**

The federal government has, on many occasions, demonstrated its commitment to health research. The Committee applauds the high priority for research given in the 2001 Speech from the Throne and particularly its announcement to increase funding for health research:

*Our government's overriding goal is nothing less than branding Canada as the most innovative country in the world – as the place to be for knowledge creation; where our best and brightest can make their discoveries; where the global research stars of today and tomorrow are born; becoming the magnet for new investments and new ventures.*

*(...) The Government of Canada will (...) provide a further major increase in funding to the Canadian Institutes of Health Research, to enhance their research into disease prevention and treatment, the determinants of health, and the effectiveness of the health care system.<sup>130</sup>*

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<sup>129</sup> The NCEs are supported and overseen by the three Canadian granting agencies (CIHR, NSERC and SSHRC). It is worth noting that eight networks, of the currently funded 22 NCEs, conduct health research in the fields of: arthritis, bacterial diseases, vaccines and immunotherapeutics for cancer and viral diseases, stroke, health evidence application, genetic diseases, stem cells and protein engineering. Some of the other NCEs may have impact on health and health care (e.g. Institute for Robotics and Intelligent Systems or Canadian Water Network).

<sup>130</sup> Government of Canada, *Speech from the Throne*, First Session of the 37<sup>th</sup> Parliament, 30 January 2001.

The Committee also recognizes the creation of CIHR as a major achievement in health research. We laud the increased funding for CIHR announced in the December 2001 Budget Speech, despite the severe financial pressures the federal government faces. In addition, the creation of, and funding for, the Canada Foundation for Innovation in 1997, followed by the Millennium Scholarships, the Canada Research Chairs, and Genome Canada, are clear indications that health research and innovation are integral to public health-related policy in Canada.

Throughout the hearings, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other industrialized countries in this regard. In fact, the role of national government in financing health research, expressed in purchasing power parity (PPP) per capita, is much higher in the United States, the United Kingdom, France and Australia than in Canada. For example, as stated in the Committee's Phase Two report, the American government provided in 1998 four times more funding per capita to health research than did the Canadian government.<sup>131</sup>

***Throughout the hearings, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other industrialized countries in this regard.***

Witnesses unanimously recommended that the federal government's share of total spending on extramural health research be increased to 1% of total health care spending in Canada, from its current level of approximately 0.5%. This could involve increasing CIHR's current budget to \$1 billion from the current level of \$560 million. Additional resources should also be devoted to federally performed health research (discussed in the following section). Overall, increased investment in extramural and in-house health research would bring the level of the federal contribution to health research more in line with that of national governments in other OECD countries. More importantly, this would help maintain a vibrant, innovative and leading edge health research industry.

Another concern brought to the attention of the Committee related to the long-term nature of research in contrast to existing budgetary program planning. High quality research is very competitive internationally and requires long-term commitments. Young researchers, on whom Canada's future in research depends, commit their careers on the basis of their perceptions of the long-term environment for research. Canada will not attract or keep excellent people without providing an excellent environment for research. Research pays little attention to national borders. The world recognizes excellence, and competes vigorously for it.

***The Committee strongly supports the view that health research money is money to support the best and brightest minds(...). Ultimately, Canada's challenge in health research is a challenge to attract and retain outstanding people.***

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<sup>131</sup> Volume Two, p. 97.

The Committee strongly supports the view that health research money is money to support the best and the brightest minds. At least two-thirds of funds for health research go to salaries and training stipends for highly qualified and motivated researchers, research assistants, technicians, research trainees, etc. Ultimately, Canada's challenge in health research is a challenge to attract and retain outstanding people.

The role of the federal government is central to this competition for excellent researchers. In particular, CIHR is the long-term source of research funds for the health research activities stimulated by the Research Chairs, the Canadian Foundation for Innovation, and Genome Canada, all of which are adding greatly to Canada's capacity for excellence in research. CIHR is also an essential partner for research stimulated by the many health research charities.

Overall, the Committee believes that the federal government must establish and maintain long-term stability in the Canadian health research environment. Providing an adequate and predictable level of funding is a necessary prerequisite. Health research is a long-term investment; many research projects span a researcher's whole career, and grants are usually awarded for three- to five-year terms, which are simply not consistent with the one-year-at-a-time budget allocation to CIHR. Therefore, the Committee recommends

**That the federal government:**

- **Increase, within a reasonable timeframe, its financial contribution to extra-mural health research to achieve the level of 1% of total Canadian health care spending.**
- **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.**

### **5.3.2 Federal In-House Health Research**

A report by the Council of Science and Technology Advisors identified a clear need for the federal government to perform in-house research. This report stressed that the federal government must have the an adequate research capacity to deliver the following key roles:

- Support for decision making, policy development and regulations.
- Development and management of standards.



- Support for public health, safety, environment and/or defence needs.
- Enabling economic and social development.<sup>132</sup>

In other words, the ability of the federal government to set policy and enforce regulations requires it to have an appropriate in-house research capacity. In addition, the government needs to have access to the highest possible quality scientific and technological information in a time frame that meets its needs. Failure to use the best available data and analysis could expose the government to liabilities for damages caused by those decisions.

The major key player in federal intramural health research is Health Canada, for which this function is critical to the fulfillment of its mandate. The department is mandated to help the people of Canada maintain and improve their health and to ensure their safety. Thus, in addition to access to top-quality scientific and technological information, Health Canada must obtain advice to set policy and enforce regulations. The required in-house research capacity includes expertise in:

- the state and spread of disease;
- ensuring the safety of food, water and health products, including pharmaceuticals;
- air quality issues; and,
- fulfilling health promotion obligations.

To undertake these responsibilities, Health Canada's researchers must possess independent knowledge and skills over a wide range of scientific disciplines, ranging from the behavioural sciences to cellular and molecular biology. In addition, Health Canada must have an adequate in-house capacity to assimilate, interpret and extrapolate the knowledge obtained from other health research partners. Finally, the department must be able to draw widely on expertise and facilities that are not available in-house.

Overall, the Committee learned that Health Canada has a unique role. In order to meet its mandate, the department must be able to provide the best possible independent science advice related to its legislated responsibilities, to undertake a wide range of scientific activities related to its role as regulator and policy advisor, and to provide evidence-based health services and programs. This unique obligation requires Health Canada to have the necessary science and research capacity to fulfill these three functions.

The Committee feels it is important to acknowledge that Health Canada has taken an important step in ensuring, through the appointment in 2001 of a Chief Scientist, that it possess the ability to meet its mandate. The Chief Scientist and his office play a pivotal role in bringing leadership and coherence to Health Canada's scientific responsibilities and activities by championing the principles of alignment, linkages and excellence espoused by the Council of Science and Technology Advisors.

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<sup>132</sup> Council of Science and Technology Advisors (CSTA), *Building Excellence in Science and Technology (BEST): The Federal Role in Performing Science and Technology*, 16 December 1999, p. 12. The CSTA consists of a group of external experts providing the federal government with on science and technology issues.

The Committee strongly believes that there is a clear need for the federal government to perform health research and that it must have the capacity to deliver its mandate. The Committee also acknowledges the importance for Health Canada of partnering with stakeholders outside of government when necessary. Therefore, the Committee recommends

***The Committee strongly believes that there is a clear need for the federal government to perform health research and that it must have the capacity to deliver its mandate.***

#### **That 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.**

### **5.4 Enhancing Quality in Health Services and in Health Care Delivery**

As indicated in Chapter One of this report, the Canadian health care delivery system is facing a very serious situation, marked by rising costs, a high degree of dissatisfaction and high expectations. While many recommendations for change to the publicly funded health care system have been made over the years, most of them have not been based on scientific evidence, but rather have been grounded on anecdotal evidence or political posturing. For these reasons, research on all aspects of Canada's publicly funded health care system is, at the present time, very critical for health care policy makers and managers.

Areas in need of more research are varied and include:

- health promotion policies
- disease and disability prevention strategies (at both the individual and population levels)
- determinants of health
- approaches to primary care management
- new modes of remuneration for health care providers and institutions
- decision-making by health care providers and users
- organizational care delivery models
- health care policy management
- health care resources allocation

- impact of selected areas of privatized health care
- pharmaco-economics, and
- assessment and utilization of health care technology and equipment.

Clinical research and the involvement of health care providers themselves in health research are key elements in ensuring that fundamental research is translated into better health and health care. Clinical trials and large-cohort population health research studies are under-supported in Canada, in part due to the large, long-term financial commitment that is required before such studies can be launched. Urgent investment in training and subsequent career support is needed for clinician investigators in Canada. Harassed by ever increasing demands for clinical service, they find it increasingly difficult to remain competitive in competitions for grants and awards.

In Canada, a wide range of organizations are involved in health services research. It is the view of the Committee that, at this critical time for our health care delivery system, it is essential that this type of research be well funded and that these research centres and their investigators take part in the present debate about the future structure of the Canadian hospital and doctor system and about how the growing gaps in health care coverage can be closed.

Moreover, many studies have shown that there is a major gap between new knowledge and its application in every day medicine. For example, only 46% of elderly patients were given pneumococcal vaccine, though it is the group most at risk for suffering from such infections. Aspirin, although recommended for all adult diabetic patients, was prescribed in only 20% of cases, and counselling on HIV transmission was given to less than 3% of adolescents during physician's office visits.<sup>133</sup>

In addition, wide variations in practice patterns and outcomes persist across regions as well as across provinces. The Committee believes that the federal government, given its unique role in health research, should commit a significant investment to promoting, in partnership with the provinces and territories, the adoption of research findings in clinical practice. This must be done while continuing to support new research on priority health issues and the development of new tools, so that in the future this knowledge and the new tools can be translated into and implemented to produce improved health and enhanced health care.

***The Committee believes that the federal government, given its unique role in health research, should commit a significant investment in promoting, in partnership with the provinces and territories, the adoption of research findings in clinical practice.***

Overall, the Committee acknowledges that more health research should be undertaken in order to enhance quality in health services and in health care delivery. Therefore, we recommend:

**That 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**

<sup>133</sup> JAMA, vol. 286, p. 1834 (2001).

**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.**

## **5.5 Improving the Health Status of Vulnerable Populations**

There are many groups in Canadian society that have, for numerous reasons, less immediate access to health services appropriate to their specific needs. Examples include individuals with mental health problems, individuals with addiction problems, people with physical disabilities, some ethnic minorities, women in difficult circumstances, people living in rural and remote communities, the homeless and the poor. The Committee acknowledges that there is an urgent need in Canada to support cross-disciplinary health research that will provide new evidence on the diverse factors that influence health status, and on approaches to improving access to needed health care for vulnerable groups. CIHR has recently set up a strategic plan through three of its Institutes to study this crucial problem, but more resources are needed. Therefore, the Committee recommends:

**That 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.**

In Volume Four of its health care study, the Committee stated that the health of Aboriginal Canadians is a national disgrace. There is a disproportionately, and completely unacceptable, large gap in health indicators between Aboriginal and non-Aboriginal Canadians. Aboriginal peoples experience much higher incidence of many health problems, including: significantly higher rates of cancer, diabetes and arthritis; heart disease among men; suicide among young men; HIV/AIDS; and morbidity and mortality related to injuries. Infant mortality rates are twice to three times the national average, with high rates of foetal alcohol syndrome and foetal alcohol effects (FAS/FAE), and poor nutrition. Approximately 12% of Aboriginal children have asthma, in comparison with 5% of all Canadian children. This last trend is attributable, at least in part, to environmental health issues, such as the presence of moulds in houses.<sup>134</sup>

The Committee believes that research is perhaps the most important element that will help improve the health status of Aboriginal Canadians. In our view, the creation of CIHR's Institute of Aboriginal Peoples' Health is an important step in this direction. Health Canada, which delivers numerous programs and services to

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<sup>134</sup> Volume Four, pp. 129-135.

First Nations and Inuit communities, needs to strengthen its research capacity as well as its capacity to translate health research into effective public policy. In particular, Health Canada requires a strong research capacity to:

- compile and analyze available population-based information to identify trends, emerging issues, and differences across geographic regions or communities;
- review programs and services to identify the most effective practices in First Nations and Inuit communities and to assess timely progress in addressing key health issues; and
- maintain and augment the capacity to analyze research both nationally and internationally, and integrate best practice into policy and program development, implementation and evaluation.

Therefore, the Committee recommends as a matter of urgency:

**That 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.**

**That 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.**

Research into the field of health in developing countries is also of concern. The Committee learned that very little research activity is directed towards health problems that affect developing countries. In fact, data suggest that less than 10% of health research is devoted to diseases or conditions that account for 90% of the global disease burden.

The primary causes of morbidity and mortality in developing countries can be grouped under four general areas: malnutrition, poor sexual and reproductive health, communicable diseases, and non-communicable diseases including injuries. A recent report by the World Health Organization shows that long-term economic growth is impossible where large numbers of people are malnourished, sick or dying.

It is the view of the Committee that, given its expertise and excellence in health research, Canada should assume a leadership role in this area. The federal government has taken a step in the right direction. In a first-ever collaborative effort, four Canadian government organizations have joined their forces to formalize a shared commitment to address the problems of global health through research. The Canadian International Development Agency (CIDA), CIHR, the International Development Research Centre (IDRC) and Health Canada have formed the Global Health Research Initiative. Not only will this joint undertaking allow

the four partners to operate their programs and research more effectively, it will also contribute to a great humanitarian cause – the health protection of citizens of all countries, including Canadians. This is the beginning; much more needs to be done. Therefore, the Committee recommends:

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

## **5.6 Commercializing the Outcomes of Health Research**

One outcome of health research is the creation of new knowledge. New knowledge is in itself of great value to society but the overall impact of health research is maximized when new knowledge is translated into social and economic benefits. Commercialization of health research outcomes represents one way to achieve this knowledge translation.

***New knowledge is in itself of great value to society but the overall impact of health research is maximized when new knowledge is translated into social and economic benefits. Commercialization of health research outcomes represents one way to achieve this knowledge translation.***

Commercialization of health research can happen at many different stages of research and each stage faces different challenges. For example, one of the main challenges facing commercialization of academic health research (occurring in universities and hospitals) is that their early stage of development makes the investment of capital by private sector very risky, thus speculative. By contrast, once a product is marketable, such as the late stage clinical trials (mainly performed by large research-based pharmaceutical firms), the main challenges relate to intellectual property and the patent regime, as well as to approval and monitoring of drugs. Commercialization of health research outcomes brings numerous benefits including:

- improved health, resulting in a more productive workforce;
- enhanced health services quality;
- increased efficiency in health care system delivery;
- expanded research funding leveraged from commercialization and research partnerships;
- enhanced job creation with newly formed companies;
- and greater economic activity from the manufacturing, marketing and sales of new health care products and services.

In its brief to the Committee, the Council for Health Research in Canada indicated that spin-off biotechnology companies formed by CIHR-funded scientists are an important by-product of public investment in health research:

*For instance, 23 companies have been formed at the University of British Columbia employing 732 people. At McGill, 18 companies have been formed employing 392 people. At the University of Ottawa, 10 companies have been formed employing 459 people. Such companies cannot flourish without public investments to fund a steady discovery pipeline.*<sup>135</sup>

Visudyne is one example of Canadian health research that has produced some powerful advances in health care. The drug, which is approved for use in over 30 countries, is the only approved treatment for age-related macular degeneration, the leading cause of age-related blindness. This treatment was developed at the University of British Columbia (UBC) and was funded, in part, by the federal government. UBC assisted in the start-up of QLT Inc. to commercialize this product that has head offices in Vancouver, employs over 350 people and has a market capitalization of \$1.5US billion.

Another example is 3TC, the only inhibitor of HIV reverse transcriptase with few or no side effects and a common component of treatment for HIV/AIDS, which also arose out of federally funded research performed in Montreal. BioChem Pharma Inc., prior to its acquisition by Shire Pharmaceuticals plc. (based in the United Kingdom), had head offices in Montreal, employed 278 people, and had a market capitalization of \$3.7US billion.

These examples illustrate the potential of health research to treat disease, create employment and generate economic benefits for Canada. While many academic technologies are licensed to foreign companies, it is reasonable to expect that value should be created and retained in Canada wherever possible and appropriate when the federal government has made investments in health research.

As stated in Section 5.2, “good science is good economics”. However, during his testimony, Dr. Henry Friesen, Team Leader of the Western Canadian Task Force on Health Research and Economic Development, told the Committee that the conditions are not presently in place to enable publicly funded health research to maximize the returns to Canadian taxpayers.<sup>136</sup> In the opinion of this Task Force, the capacity for research commercialization is sub-optimal and clearly unacceptable.<sup>137</sup>

Similar findings were presented in a 1999 report published by the Advisory Council on Science and Technology (ACST) and prepared by its Expert Panel on the Commercialization of University Research.<sup>138</sup> The Expert Panel made the case that research results from federal funding of university research, where there is commercialization potential, should be managed as an asset that can return benefits to the Canadian economy and Canadian taxpayers. The Expert Panel also showed that the United States has a much better track record in commercialization of university-based research than Canada, despite a growing private sector involvement in funding research at Canadian universities.

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<sup>135</sup> Council for Health Research in Canada, *Health Research: The Engine of Innovation*, Brief to the Committee, 30 December 2001, p. 2.

<sup>136</sup> See Committee Proceedings, Issue No. 30.

<sup>137</sup> Western Canadian Task Force on Health Research and Development, *Shaping the Future of Health Research and Economic Development in Western Canada*, August 2001, pp. 19-20.

<sup>138</sup> Expert Panel on the Commercialization of University Research, *Public Investments in University Research: Reaping the Benefits*, Advisory Council on Science and Technology, 4 May 1999.

Most major research institutions (universities and research hospitals) in Canada have in-house technology commercialization offices that are funded by university sources and, in cases of successful offices, by revenue derived from operation. Currently, the expenses associated with commercialization activities are not covered by direct federal research funding. The Committee learned that the vast majority of these technology commercialization offices have costs that exceed their revenue. They are operated as a cost centre and not as a profit centre for the institution. However, while their function is not critical to the research enterprise (creation of new knowledge), an argument could be made to include costs of operating these offices in the calculation of indirect research costs since technology commercialization is a research-related activity.

The question of funding indirect costs in Canadian research by the federal granting agencies has been one of contention in recent years. It has been recognized as one element to explain the lower level of competitiveness of Canadian researchers. Indirect costs are those expenses associated with administration, maintenance, commercialization and the salary of the principal investigator that is attributable to the research project. The ACST in its 1999 report<sup>139</sup> and subsequent publications has made the recommendation that the federal government increase its investment by supporting the indirect costs of sponsored research. Similarly, the brief of the Council for Health Research in Canada stressed:

*[The] indirect costs of research must be funded in order to provide a cutting-edge research environment that will fully realize the benefits of the government's Innovation Agenda. (...) The Council believes it should be a priority for the government to develop a specific, long-term plan to address this issue as soon as possible.*<sup>140</sup>

The Committee acknowledges that, in its December 2001 Budget, the federal government provided a one-time investment of \$200 million through the granting councils to help alleviate the financial pressures that are associated with the rising indirect costs of research activities, including commercialization. We both hope that universities and research hospitals will use some of these funds to improve their commercialization abilities, and that the federal government will make this investment permanently recurrent.

The Committee agrees with witnesses and recent reports that there is a need to find ways to maximize the returns to Canadians from the commercialization of federally funded health research. We believe that the federal government should establish the necessary conditions to enable researchers and those technology commercialization offices providing

***The Committee agrees with witnesses and recent reports that there is a need to find ways to maximize the returns to Canadians from the commercialization of federally funded health research. We believe that the federal government should establish the necessary conditions to enable researchers and those technology commercialization offices providing support and services to researchers to perform to their full potential in commercializing the results of federally funded health research.***

<sup>139</sup> *Ibid.*

<sup>140</sup> Council for Health Research in Canada, Brief to the Committee, p. 5.



support and services to researchers to perform to their full potential in commercializing the results of federally funded health research.

Further, the Committee believes that CIHR, Canada's premier vehicle for funding health research with a legislated mandate to translate knowledge into improved health, is uniquely positioned to assess the recommendations made by the Western Canadian Task Force, the ACST's Expert Panel and other studies on technology commercialization as they apply to health research. We believe that CIHR should use these reports as the basis for developing and delivering on an innovation strategy that considers programs, policies and people. In our view, such a strategy would see CIHR support and strengthen the capacity of academic technology commercialization offices to maximize the transfer of technologies to market, thereby creating of Canadian companies and jobs and enhancing Canada's innovation capacity. In addition, we believe that this innovation strategy must be developed within a framework that includes governing principles of public good and benefit to Canada so that any strategy to maximize the social and economic impact does not threaten academic freedom or influence the direction of research or the delivery of health care. Therefore, the Committee recommends:

**That 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.**

**That 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.**

**That 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.**

One aspect of the commercialization of health research outcomes that generated controversy recently is the issuance of patents for higher life forms. This subject goes deeply into ethical, intellectual property, and economical issues. Although these questions are highly relevant to Canadian health research and the work of this Committee, they are debated elsewhere. Indeed, the Canadian Biotechnology Advisory Committee (CBAC) has been mandated by the federal government to provide advice on this crucial issue. The CBAC published an interim report on the subject at the end of 2001 where it recommended that human beings at all stages of development, are not patentable.<sup>141</sup> Further, the report recommended that a systematic research program be undertaken to assess the impact of biotechnology patents on various aspects of health services. It is clearly an issue that deserves serious consideration, but is beyond the scope of this report.

## **5.7 Applying the Highest Standards of Ethics to Health Research**

The preceding sections have demonstrated Canada's growing excellence in, and high priority for, health research. However, history has shown that the pursuit of new knowledge in health research can lead, for example, to abuse of the people who are involved as the subjects of research, to invasions of privacy, and to abuse of animals. In various ways, numerous reports have emphasized that new knowledge must not be gained at the expense of abuse of humans and other life forms, and that excellence in health research requires excellence in ethics.

But what is ethics? Laura Shanner, Professor at the University of Alberta, told the Committee that "ethics" is a "systematic, reasoned attempt to understand and make the best possible decisions about matters of fundamental human importance."<sup>142</sup> When we refer to ethical issues informed by biological knowledge in medicine, we refer to "bioethics". Dr. Nuala Kenny, Professor of Pediatrics at Dalhousie University (Nova Scotia), defined bioethics as follows:

*Bioethics is a particular understanding of ethics that brings the discipline of philosophy to assist in making value-laden decisions. It is about the right and the good. It is a practical discipline. Bioethics is ethics in the realm of the biosphere, human biology. It is actually broader than human health, but most people use it in that context.*

*It asks how, in a pluralistic society, do you lay out the values, the issues and the interests at stake when making a decision about the right and the good, generally about an individual patient situation. Then, how do you assist the relevant parties in establishing*

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<sup>141</sup> Canadian Biotechnology Advisory Committee, *Biotechnology and intellectual property: patenting of higher life forms and related issues*, Interim report to the Government of Canada Biotechnology Ministerial Coordinating Committee, Ottawa, November 2001.

<sup>142</sup> Laura Shanner, *Ethical Theories in Bioethics and Health Law*, University of Alberta, Brief to the Committee, 2000, p. 1.

*some kind of priority, so that if there are competing goods or competing harms, you make your choices in a responsible way.*<sup>143</sup>

In many fields, difficult decisions often involve consideration of numerous factors, each implicating different – and often conflicting – values, principles, viewpoints, beliefs, expectations, fears, hopes, etc. When facing such difficult decisions, people may reach different conclusions not only because they consider different factors, but also because they weigh them against each other in different ways. The practical effect of the discipline of ethics is to help those who face complex decisions to identify the inherent values and principles, to weigh them against each other, and to come to the best possible decision. Though based on strong theoretical foundations, ethics in health care and health research deals with real life situations.

Because research seeks constantly to expand the forefront of knowledge, it poses the most challenging questions of ethics. The purpose of this section is to survey some of the major areas of research ethics in terms of the policies and mechanisms now present and/or needed in Canada, to ensure that health research is carried out in a manner that meets the ethical standards of Canadians.

### **5.7.1 Research Involving Human Subjects**

Health research must involve humans as research subjects. While research with other life forms can provide much essential knowledge, in the end only research directly on human beings can tell us, for example, whether a potential new approach to prevention, diagnosis or treatment of disease is safe enough to use in humans, whether it actually helps patients, what its side effects are, and whether it is better than a treatment that is already available.

Research subjects, often patients with diseases whose treatment is under study, bear the risks of the research so that others may gain from the knowledge that research is intended to provide. Research involving humans poses many risks: abuse of people, misuse, exploitation, breaches of privacy, confidentiality, etc. Because health research raises such a wide range of issues, an international consensus has developed over the last 50 years or so. This international consensus, which started with the Nuremberg Code (1947) and the Declaration of Helsinki (1964, revised in 2000), requires that the ethical aspects of any research project involving humans be reviewed and approved, with modifications if needed, by an appropriately constituted ethics committee (in Canada called “Research Ethics Board” or REB) before the research project is started.

***Research subjects, often patients with diseases whose treatment is under study, bear the risks of the research so that others may gain from the knowledge that research is intended to provide.***

The Research Ethics Board “is a societal mechanism to ensure the protection of research participants.”<sup>144</sup> REBs are multidisciplinary local institution-based boards, independent of the investigator and research sponsor, established to review the ethical standards of research

<sup>143</sup> Dr. Nuala Kenny (42:59-60).

<sup>144</sup> National Council on Ethics in Human Research, *Protecting Human Research Subjects: Case-Based Learning for Canadian Research Ethics Boards and Researchers*, Ottawa, 2000, p. 7.

projects within their institutions. They have the power to approve, reject, request modifications to, or terminate any proposed or ongoing research involving human subjects. In effect, the REB attests, for each research protocol, that the proposed research, if it is carried out in the manner agreed to by the REB, meets or exceeds standards of ethics that Canadians expect.

The dominant national policy for the ethics of research involving humans, the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS), was published by CIHR, the SSHRC and NSERC in 1998. The TCPS followed earlier policies (MRC, 1978, 1987, and SSHRC, 1976). The Panel and Secretariat on Research Ethics, launched in November 2001 by the three federal research funding agencies, are responsible for coordinating the evolution and interpretation of the TCPS. The objective is to keep the TCPS up-to-date in response to the rapidly evolving advances in knowledge, research and technology.

The *Tri-Council Policy Statement* has been adopted by academic institutions (where the majority of health research involving humans is carried out) and by some governmental departments and agencies, including the Department of National Defence (DND) and the National Research Council (NRC).

Health Canada is establishing its own Research Ethics Board, which will also use the TCPS, to assess the ethical acceptability of in-house research, research that is contracted to non-Health Canada researchers which requires ethical review and research applications to CIHR or other funding agencies. Health Canada has also adopted the International Conference on Harmonization (ICH) guidelines applying to clinical trials involving the participation of human subjects.<sup>145</sup>

Since the 1970s, in accord with national policies governing ethics in research involving humans, some 300 local REBs in Canada have been established in a variety of settings including universities, government laboratories, community organizations and teaching and community hospitals. In many teaching hospitals, at least 50% of the research protocols reviewed by REBs are clinical trials that are sponsored by industry for purposes of testing new pharmaceutical interventions in human health so as to meet the regulatory licensing requirements of Health Canada and the USA Food and Drug Administration. In addition, some company-based and private for-profit REBs have developed over the last few years to allow REB review of privately sponsored research outside academic institutions, and hence without access to local REBs. In Alberta, all physicians who are not covered by an institutional REB are required to use the REB of the Alberta College of Physicians and Surgeons. Newfoundland is moving towards establishing a single REB for all health research in the province.

In 1989, the National Council on Ethics in Human Research (NCEHR) was created by the MRC with the support of Health Canada and the Royal College of Physicians and Surgeons of Canada. NCEHR works to foster high ethical standards for the conduct of research involving humans across the country by offering advice on the implementation of the TCPS, primarily through educational activities and site visits to local REBs. NCEHR is now funded by CIHR, SSHRC, NSERC, Health Canada and the Royal College of Physicians and Surgeons.

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<sup>145</sup> Despite the care taken by the three federal granting agencies and Health Canada in the international harmonization of guidelines applying to clinical trials involving human subjects, the Committee would like to be in no doubt that any Canadian participating in clinical trials from outside Canada be protected by ethical standards that are at least as stringent as those applying here.

### 5.7.2 Issues With Respect to Research Involving Human Subjects<sup>146</sup>

The *Tri-Council Policy Statement*, in effect Canada's national statement of policy for ethical conduct in health research involving humans, appears to be consistent with world standards. For the most part, REBs in Canada seem to operate to a high standard, building on more than two decades of experience and the dedication of many people across the country. However, the Committee learned that serious gaps have been identified in a number of reports released in recent years by NCEHR and CIHR, as well as by the Law Commission of Canada.<sup>147</sup> A summary of the main issues or gaps identified in these reports is presented below:

- Although the *Tri-Council Policy Statement* sets very high standards, there is currently no oversight mechanism to ensure compliance with these standards. On the one hand, there is no process of certification, accreditation or regular inspection of the research ethics review procedures performed by REBs. On the other hand, and though more REBs are starting to address this issue, few monitor the conduct of research once a research protocol has been approved. In other words, REBs often have limited knowledge of what happens after they have approved a research protocol.
- Some concerns were raised about real or perceived conflicts of interest by researchers or institutions. Though international consensus suggests that REBs would be established within research institutions, and that the work of REBs requires close collaboration with other institutional responsibilities, REBs must be able to operate free from institutional or researcher pressures.
- Similarly, a lack of public oversight of private REBs that act independently or through Contract Research Organizations hired by drug companies raises concerns about their independence and conflicts of interest.
- There is a basic need for more resources for REBs. As the work becomes increasingly complicated with globalization, technology and commercialization, REBs are struggling to find committee chairs or even members.
- There are currently no standard training requirements for Canadian REB members and researchers in research ethics. However, in the absence of similar Canadian standards, Canadian researchers must meet American

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<sup>146</sup> The following section does not deal with the ethical boundaries surrounding research into human reproductive health as federal legislation is expected to be tabled soon in the House of Commons. The Committee recognizes that this area is at the cutting edge of applied research and evolves rapidly. In our view, all research involving human reproductive material, human organisms derived from such material, other human cell lines, or part of any of them (including human genes) should be subject to full ethical review by REBs and application of the TCPS and other applicable legislation.

<sup>147</sup> More specifically, see the following four reports: 1) NCEHR (formerly National Council on Bioethics in Human Research or NCBHR), "Protecting and Promoting the Human Research Subject: A Review of the Function of Research Ethics Boards in Canadian Faculties of Medicine", *NCBHR Communiqué*, Volume 6 (1), 1995, pp 3-28; 2) Draft report of the Task Force established by the NCEHR to study models of accreditation for human research protection programs in Canada, September 28, 2001; 3) McDonald, Michael (Principal Investigator), *The Governance of Health Research Involving Human Subjects*, research sponsored by the Law Commission of Canada, Ottawa, May 2000; 4) Draft Report of the Task Force on Continuing Review, CIHR, 2001.

educational standards for American funded health research involving human subjects.

- The current ethics review processes are “producer-driven” rather than “consumer-driven”. In other words, there is a lack of representative participation in governance on the part of research subjects.
- There is an urgent need for empirical research on the effects of health research on human subjects as well as on the effectiveness of the ethics governance procedures.

To sum up, the governance, transparency and accountability of the ethics review processes in Canada need to be improved:

*(...) we were surprised to see how substantial the gaps were between the ideals expressed in policy and the ground arrangements for accountability, effectiveness and the other criteria for good governance.<sup>148</sup>*

The Committee agrees with many reports that the central concern for Canada is the public accountability of the overall processes for assuring the ethics of research involving humans. We recognize the excellent work that has been done across Canada by dedicated people in many environments who have strived to ensure that health research involving human subjects meets the highest standards of ethics, and we are confident that the standards achieved in Canada are as good as any in the world. Indeed, the report released by the Law Commission of Canada stated:

***The Committee agrees with many reports that the central question for Canada is the public accountability of the overall processes for assuring the ethics of research involving humans.***

*We are also very much impressed with the calibre of scholarly, ethics and legal expertise represented on many REBs. And, at a general level, Canadians scholars are prominent internationally in research regarding legal and ethical aspects of human subjects research.<sup>149</sup>*

However, the Committee believes that the present varied structures and approaches to health research ethics are inconsistent with the public accountability that an area of this importance requires. Accordingly, we urge the various leading stakeholders of health research

***We urge the various leading stakeholders of health research involving human subjects to work together to develop a governance system for health research involving human subjects that can meet the following objectives: the promotion of socially beneficial research; the protection of research participants; and the maintenance of trust between the research community and society as a whole.***

<sup>148</sup> Professor Michael MacDonald, Law Commission of Canada.

<sup>149</sup> *Ibid*, p. 300.

involving human subjects to work together to develop a governance system for health research involving human subjects that can meet the following objectives: the promotion of socially beneficial research; the protection of research participants; and the maintenance of trust between the research community and society as a whole.<sup>150</sup> This initiative should involve Health Canada, CIHR, other federal funding agencies, the Panel and Secretariat on Research Ethics, industrial research sponsors, research institutes, health professional licensing bodies and associations, NCEHR, the newly created Canadian Association of Research Ethics Boards, etc. Therefore, the Committee recommends:

**That 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.**

**That 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 as 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**

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<sup>150</sup> These objectives correspond to those that were identified in the McDonald report cited in the previous footnote.

**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.**

### **5.7.3 Animals in Research**

Because animals are biologically very similar to humans, animals are used in research to develop new biological knowledge that has a high chance of applicability to the human condition. However, because animals are not identical to humans, new knowledge that arises from research with animals must be tested in humans before it is applied to human health.

Ethical concerns about the use of animals by humanity, particularly their use in research, have been recognized since the 19<sup>th</sup> century, especially in England. In Canada, these concerns caused MRC and NRC to undertake studies leading in 1968 to the creation of the Canadian Council on Animal Care (CCAC). Currently, CCAC receives 87% of its \$1.2 million budget from CIHR and NSERC to cover CCAC services to the research institutions that they fund. CCAC obtains the rest of its revenues from fees for service charged to governmental and private institutions.

CCAC awards the Certificate of Good Animal Practice<sup>®</sup> to institutions that it determines are in compliance with its standards. Compliance is determined through site visits by assessment panels. CIHR and NSERC make participation in the CCAC program mandatory for all those who wish to receive their research funding and inform institutions that they will withdraw funds from institutions that CCAC states are not in compliance with its standards. The CCAC reports that institutions generally comply with its recommendations.<sup>151</sup>

In its brief to the Committee, the Coalition for Biomedical Health Research stated that CCAC standards are recognized both nationally and internationally:

*(...) research that complies with CCAC guidelines and policies constitutes ethically sound and responsible activity.*

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<sup>151</sup> Louis-Nicolas Fortin and Thérèse Leroux, "Reflections on Monitoring Ethics Review of Research with Human Subjects in Canada", *NCEHR Communiqué*, Summer 1997.



*(...) CCAC's nationally and internationally accepted standards (...) provide the needed balance between the protection of animals and the benefits that are gained by the use of animals in science.*<sup>152</sup>

The formal structure of the CCAC, along with its monitoring program, is regarded by many, in Canada and abroad, as an optimal model enabling it to work effectively at arm's length from and with government.<sup>153</sup> In addition, recent report suggested that such a model could be considered in the field of research involving human subjects. For example:

*An interesting model in Canada and one, which I think we need to look at seriously with regard to an accreditation process for human research, is the Canadian Council on Animal Care. (...) it now has remarkable credibility with international recognition. (...) It remains a very interesting and almost uniquely Canadian model. It has federal fiscal support and yet, functioning on its own, setting standards and having a very respected accreditation process for animal research.*<sup>154</sup>

The Committee acknowledges that CCAC performs a world class service to Canadians in a cost-effective manner. Though there is no doubt that some Canadians will disagree, mainly those who reject any use of animals in research, the Committee believes that the CCAC offers clear evidence that a very sensitive area that requires minute by minute attention and care can be effectively managed by an approach based on:

***The Committee acknowledges that CCAC performs a world class service to Canadians at a remarkably low cost.***

- Belief, until proven wrong, that institutions and individuals are seeking to work in a manner that reflects the values of Canadians;
- A firm foundation in increasing awareness and training of individuals on issues and standards;
- An assessment approach that is based on internationally recognized standards and that leads to certification of facilities and processes, that involves experts and lay persons, and that operates in a collegial manner until the point when there is evidence of wrongdoing and failure to take the necessary corrective measures.

While not advocating simply copying CCAC's mechanisms into the challenge of governance of research involving humans, the Committee believes that much can be learned from CCAC's experience. The Committee, however, identifies a gap in the interactions between the CCAC and the federal government. Though numerous departments and agencies place themselves under CCAC's assessment program for research involving animals that is carried out in their own facilities, and CIHR and NSERC require compliance with CCAC's standards as a

<sup>152</sup> Coalition for Biomedical and Health Research, Brief to the Committee, p. 8.

<sup>153</sup> Sub-Committee on Ethics, *The Ethics Mandate of the Canadian Institutes of Health Research: Implementing a Transformative Vision*, Working Paper prepared for the Interim Governing Council of the CIHR, 10 November 1999, pp. 18-19.

<sup>154</sup> Dr. Henry Dinsdale, Speech to the National Workshop of the NCEHR, March 2001, p. 5.

condition of receiving research funds, we believe that this is not enough. Therefore, we recommend:

**That 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.**

#### **5.7.4 Privacy of Personal Health Information**

All personal information is precious to individuals, but information about personal health is probably the most sensitive to most people. Health information goes to a person's most intimate identity, not only because it directly affects the individual him or herself, but also because it can affect family members and others, as well as other aspects of the person's life, such as his/her employment or insurability.

The right to privacy and confidentiality of personal health information is a very important value for Canadians. Now more than ever, Canadians need reassurance that their privacy and confidentiality will be respected in this era of rapidly advancing technology. However, the quality of their health and health care is also a value that Canadians cherish very dearly. Health care providers, health care managers and health researchers need access to personal health information to improve the health of Canadians, strengthen health services and sustain a high quality health care system. The present challenge for Canadians is to set acceptable limits around the right to privacy, on the one hand, and the need for access to information (by health care providers, managers and researchers) on the other, in order to achieve an appropriate balance between them.

***The right to privacy and confidentiality of personal health information is a very important value for Canadians.***

The *Personal Information Protection and Electronic Documents Act* or PIPEDA, promulgated in June 2000, has stimulated intensive debate and study of this question in the past two years. The health sector had not recognized the potential effects of this legislation on health research and health care management until the legislative review of the Bill was well advanced through the House of Commons. Representatives from various parts of the health sector therefore intervened strongly in hearings before this Senate Committee in late 1999. Their testimony clearly demonstrated that the health sector was not part of the broad consensus supporting the bill, and also that there was no consensus within the health sector itself as to an

appropriate solution to the issues about privacy of health information which are raised by the bill. As a result, the Committee concluded that there was a significant degree of uncertainty surrounding the application of PIPEDA to personal health information that required clarification. In response to the Committee's recommendation<sup>155</sup>, therefore, the federal government decided to delay the application of PIPEDA to personal health information until January 1, 2002. This delay would allow one extra year from the time of proclamation to motivate government and relevant stakeholders in the health sector to resolve these uncertainties and formulate a solution that is appropriate for the protection of personal health information.

The Committee is pleased that several groups in the health sector have seriously addressed many of the concerns raised by PIPEDA, and in particular, the need to protect personal health information, while at the same time allow restricted use of such information for essential purposes such as health research and health care management (which includes the provision, management, evaluation and quality assurance of health services).

Over the past two years, CIHR has undertaken a wide-range analysis of the privacy issues and initiated a broad consultation process with various stakeholders, culminating in recommendations for the interpretation and application of PIPEDA to health research.<sup>156</sup>

CIHR's recommendations set out precise legal wording in the form of proposed regulations under PIPEDA that, without changing the Act, would facilitate its interpretation and application in the area of health research. These recommendations were presented to the Committee as the most realistic, short-term solution, recognizing that PIPEDA would not likely be amended before January 1, 2002. CIHR emphasizes that its proposed regulations, though significantly limited by the current wording of PIPEDA, could nevertheless provide the necessary guidance to help clarify certain ambiguous terms in a manner that will achieve the objectives of the Act without impeding vitally important research. CIHR is also of the view that regulations, as legally binding instruments, are necessary to enable researchers, and Canadians in general, to understand what the law expects of them and how to govern their conduct accordingly. Furthermore, such regulations could provide the necessary basis on which provinces and territories could develop substantially similar legislation before January 1, 2004, as provided for by PIPEDA.<sup>157</sup>

Finally, CIHR recognizes the need for further work with various stakeholders and the provinces to establish an overall, more coherent, comprehensive and harmonized legal or policy framework for the health sector. Ultimately, whatever law or policy governs this area needs to be interpreted and applied in a flexible and feasible manner, and users need to develop more detailed guidelines for promoting best information practices in their daily work.

The Committee has considered the regulations proposed by CIHR and we commend CIHR for its efforts in this regard. We fully support the intent of the proposed

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<sup>155</sup> Second report of the Standing Senate Committee on Social Affairs, Science and Technology, 36<sup>th</sup> Parliament, 2<sup>nd</sup> Session, 6 December 1999.

<sup>156</sup> CIHR, *Recommendations for the Interpretation and Application of the Personal Information Protection and Electronic Documents Act in the Health Research Context*, 30 November 2001. CIHR's proposed regulations are available on the CIHR Website at [http://www.cihr.ca/about\\_cihr/ethics/recommendations\\_e.pdf](http://www.cihr.ca/about_cihr/ethics/recommendations_e.pdf).

<sup>157</sup> Indeed, the Act gives provinces and territories until January 1, 2004, to develop substantially similar legislation.

regulations. As stated in its Fourteenth Report dated December 14, 2001<sup>158</sup>, the Committee believes that these regulations should be given serious consideration and, therefore, we recommend:

**That regulations such as those proposed by the Canadian Institutes of Health Research receive their fullest and fairest consideration in discussion 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.**

A second and parallel initiative was undertaken by a Privacy Working Group composed of representatives from the Canadian Dental Association, the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, and the Consumers Association of Canada. The Privacy Working Group addressed the need to access personal health information for the purposes of health care management. In a report submitted to Health Canada, the Privacy Working Group enunciated the following principles.<sup>159</sup>

- Confidentiality of information in health care delivery is of great importance to Canadians. Fear of disclosure to others of personal health information is likely to harm the trust that is essential in the relationship between patients and providers, and hence limits the willingness to seek care, or to impart information that is important to patient care.
- While an individual's right to privacy of personal health information is of great importance, it is not absolute. This right is subject to reasonable limits, prescribed by law, to appropriately balance the individual's right to privacy and societal needs, as can be reasonably justified in a free and democratic society.
- Individuals have the right to: privacy of their personal health information; decide whether and under what conditions they want such information collected, used or disclosed; know about and have access to their health records and ensure their accuracy; and have recourse when they suspect a breach of their privacy.
- In parallel, health care providers and organizations have obligations to: treat personal health information as confidential; safeguard privacy and confidentiality using appropriate security methods; use identifiable information only with the individual's consent except when the law requires disclosure or there is compelling evidence for societal good under strict

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<sup>158</sup> Standing Senate Committee on Social Affairs, Science and Technology, *Fourteenth Report*, 37<sup>th</sup> Parliament, 1<sup>st</sup> Session, 14 December 2001.

<sup>159</sup> Privacy Working Group, *Privacy Protection and Health Information: Understanding the Implementation Issues*, report submitted to Health Canada, December 2000.

conditions; restrict the collection, use and disclosure of personal health information to de-identified information, unless the need for identifiable information is demonstrated; and, implement policies, procedures and practices to achieve privacy protection.

When the Committee met in December 2001 to examine progress made with respect to the application of PIPEDA to health care, we were informed that, while the members of the Privacy Working Group agreed on many issues, they had not yet achieved a definitive and unified position. The Privacy Working Group was of the view that progress towards achieving consensus would require the active involvement and leadership of the federal government. The federal government, however, has taken the position that the concerns of the Privacy Working Group should be resolved between the members of the group and the Privacy Commissioner.

The Committee believes that further guidance and direction is needed in respect of the provision, management, evaluation and quality assurance of health services. For this purpose, constructive and collective efforts by *all* affected parties must be made to address the relevant issues, and government must lead by example. As stated in its 14<sup>th</sup> Report, the Committee recommends:

**That 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.**

Like other Canadians, the members of the Committee place a very high priority on the protection of personal health information. Though protection of personal health information is understandably of very high importance, we must recognize what else is at risk if access is summarily rejected because of perceived threats to the privacy and confidentiality. Rather than give absolute status to the right to privacy, the Committee believes that Canadians must engage in a careful and thoughtful consideration of the reasons why personal information is needed for health research and health care management purposes, the social benefits that accrue to Canadians individually and collectively as a result, and the conditions that must be met before access is allowed. Because of its long-standing responsibility in funding health care and financing health research, the federal government should play a major role in promoting greater public awareness and facilitating greater debate in regard to these issues.

***The Committee believes that Canadians must engage in a careful and thoughtful consideration of the reasons why personal information is needed for health research and health care management purposes, the social benefits that accrue to Canadians individually and collectively as a result, and the conditions that must be met before access is allowed.***

CIHR's *Draft Case Studies Involving Secondary Use of Personal Information in Health Research* (December 2001) constitutes an excellent model for encouraging discussion and broader understanding through very concrete examples of real health research projects involving

secondary use of personal information. Parallel efforts by others to develop similar case studies illustrating why and how personal information is used for health care management purposes would also be extremely valuable. In light of the above, the Committee recommends:

**That 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.**

This being said, the Committee believes that if Canadians are to allow restricted access to personal health information for essential functions, such as health research and health care management, it is imperative that their personal health information be adequately protected. We wish to emphasize the importance of ensuring, all the while, that Canadians remain confident that the privacy of their personal health information is being respected. We see here, once again, a major federal role to promote a fulsome discussion of the relevant ethical issues and examination of the control and review mechanisms necessary for ensuring that the secondary use of personal information for health care management and health research purposes is conducted in an open, transparent and accountable manner. Therefore, the Committee recommends:

**That 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 with 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.**

#### **5.7.5 Genetic Privacy**

The discussion above has addressed issues of privacy of personal health information arising from databases from the existing health care system. The Committee recognizes that new technologies allowing analysis of genes is also introducing new considerations into the management of personal health information. The exploding abilities to link DNA sequences to disease offer the potential both to greatly increase the health care of the individual but also to intrude into the privacy of both the individual and his or her relatives. In addition, these technologies allow the prediction of diseases that have not yet become evident. However, a majority of these predictions represent increased probability of the incidence of the disease, the test being often statistical in nature (e.g., the likelihood is twice that of the general population) rather than absolute (as for Huntington's disease, for example).

The application of the new genetic technologies to human health is as yet in its infancy, but at least some of the potential benefits and harms are becoming evident. The concerns include the fear that access to genetic information on individuals might affect their employability or insurability.

The Committee is pleased that interdepartmental discussions are underway within the federal government on this wide range of issues, and encourages their pursuit to provide guidance and advice on means of addressing these complex issues in the best interests of Canadians.

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#### **5.7.6 Potential Situations of Conflict of Interest**

Advances in human health often involve participation of researchers in academia, in government and in industry. The boundaries between these are becoming increasingly blurred, and much mutual trust and collaboration is required between them. For example:

- The large majority of published health research in Canada is done by researchers in academic institutions, who obtain funding from government, philanthropic and industrial sources.
- Academic researchers are increasingly entrepreneurial, and are the source of many start-up companies which are providing fast economic growth in the biological revolution.
- Industries obtain many of their ideas for new commercial entities, including new interventions in health, from academic research, and are starting to establish research centres in academe in exchange for right of first refusal on intellectual property.

- Government regulates health interventions, as well as contributing to knowledge through its in-house research. Regulations depend on research carried out by industry, often in academic institutions, which is assessed by governmental scientists, who may call on academic scientists for advice and other assistance.

The potential for conflicts of interest are obvious, as are the concerns that, for example, industrial interests in protecting intellectual property and commercial interests might adversely affect the performance or publication of research carried out in public institutions or with public funds. Media attention has rightly focused on instances when these fears appear to have been realised.

The Committee acknowledges that industrial research is an essential component of health research and health care. In fact, our growing abilities to promote health and to prevent, diagnose or treat disease are very largely due to industry. In addition, despite a number of publicized cases with evidence of conflict of interest, the Committee is of the view that the majority of industry works to high standards of ethics, fully consistent with the expectations of Canadians. Indeed, companies cannot expect to survive in today's world if they flout society's expectations.

***The Committee is of the view that the majority of industry works to high standards of ethics, fully consistent with the expectations of Canadians. Indeed, companies cannot expect to survive in today's world if they flout society's expectations.***

However, the Committee understands that the growing role of industry in Canada's health research spectrum, particularly in clinical trials, is a cause for concern. This was highlighted in a recent editorial by the International Committee on Medical Journal Editors, which laid out the ground rules for avoiding conflict of interest in publications.<sup>160</sup> In particular, there is a need to find an appropriate balance between clinical research performed in the academic sector, the ability to compare different treatments for the same disease, the focus of research on diseases in which profits are most likely, (e.g., diseases of wealthy as opposed to poor nations), the publication of negative results (e.g., the need for a registry of all clinical trials), and related areas.

The Committee welcomes the work of CIHR in expanding the collaborative health research programs between academic and industrial research through the University-Industry Program and the CIHR/Rx&D<sup>161</sup> Program. We understand that CIHR partnerships with industry need to be encouraged. However, there is a need to consider whether explicit guidelines should be developed; these guidelines could assist in determining the impact of ethically problematic areas in CIHR's relations with industry. We have learned that CIHR has set up a working group to study this issue. Therefore, the Committee recommends:

**That the Canadian Institutes of Health Research, in partnership with industry and other stakeholders, continue**

<sup>160</sup> See *Canadian Medical Association Journal*, 18 September 2001, Vol. 165, pp. 786-788.

<sup>161</sup> Partnership between CIHR and Canada's Research-Based Pharmaceutical Companies.



**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 SIX

### PLANNING FOR HUMAN RESOURCES IN HEALTH CARE

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In its previous reports, the Committee documented the importance of coming to terms with the many complex human resource issues in the health care sector. It suggested in Volume Four that this is one area where it is legitimate to speak in terms of a crisis. All subsequent evidence, whether from witnesses representing the full range of health care professionals, from recent academic research or from new reports, has merely served to confirm this initial finding. In this chapter, we review this evidence and present the Committee's recommendations, grouped under two main headings: developing a national strategy to deal with the crisis in the area of health human resources, and the reform of the delivery of primary care and its relation to human resource issues.<sup>162</sup>

#### **6.1 Towards a national strategy for attaining self-sufficiency in health human resources**

A survey conducted by CIHI in early 2001 amongst policy-makers, managers and clinical organizations indicated that human resource issues were the dominant theme for the next two to five years.<sup>163</sup> The central manifestation of the difficulties in the area of human resources is the shortage of qualified professionals. Concern over human resource shortages has also spread to the public at large, judging by the results of a recent consultation exercise undertaken by the Government of Ontario. Increasing the number of doctors and nurses in the system was identified as the number one health care priority by thirty-five percent of the more than 400,000 respondents to its household survey, the highest percentage given to any issue.<sup>164</sup>

##### **6.1.1 Shortages of health care professionals**

Dr John Ruedy, of the Capital District Health Authority (CDHA) in Halifax, painted a general picture of shortages affecting all aspects of health care delivery. He told the Committee that,

*CDHA has recently reduced inpatient and surgical services because of a shortage of skilled nursing staff. Within CDHA we currently have 175 vacant nursing positions, with little likelihood that we will be able to fill these positions, despite efforts to recruit new graduates, upgrade licensed practical nurses, and other strategies to increase the supply of nurses. We have recently discontinued our successful liver transplantation*

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<sup>162</sup> For a more systematic treatment of the facts and figures in the area of health human resources, we refer readers to Volumes Two and Four of the Committee's ongoing study.

<sup>163</sup> Canadian Institute for Health Information (CIHI), *Canada's Health Care Providers*, 2001, p. 99.

<sup>164</sup> The Strategic Counsel, *Executive Summary: A Public Dialogue on Health Care*, January 2002, p. 19.

*program for lack of transplant surgeons. We are also experiencing serious shortages in other disciplines, notably pharmacy, laboratory and radiation therapy.*<sup>165</sup>

The Committee notes that there does not appear to be a single region of the country or a single health care discipline that is exempt from this penury of health care personnel. For example, research conducted for the Mazankowski report, released in January 2002, indicated that Alberta had an immediate need for 333 physician full-time-equivalents and that by 2004-05 an additional 1329 physicians, representing a 29% increase, would be needed.<sup>166</sup> The Association of Registered Nurses of Newfoundland and Labrador informed the Committee that in their province the “number of graduates does not meet the current demand for RNs”<sup>167</sup> and that “the current number of new graduates is 40% less than in the early 1990s when the number of funded nursing education seats were higher (180 versus an average of 273).”<sup>168</sup>

***The Committee notes that there does not appear to be a single region of the country or a single health care discipline that is exempt from this penury of health care personnel.***

The shortage of nursing personnel is not limited to registered nurses (RNs) but also extends to nursing assistants and practical nurses. Mr. Paul Moist, President of the Canadian Union of Public Employees in Manitoba, pointed out that “we are short 600 certified nursing assistants here in the city of Winnipeg, not to mention elsewhere in the province.”<sup>169</sup> Allied health professionals are also experiencing the same phenomenon. Mr. Ron Elliott, President of the Canadian Pharmacists Association, indicated that:

*Pharmacists, like physicians, nurses and other health care professionals, are facing a shortage. We estimate that we are short 1,500 full-time pharmacists in our country. The problem is particularly acute in hospital and rural settings.*<sup>170</sup>

In her testimony before the Committee, Elisabeth Ballerman, President of The Health Sciences Association of Alberta, noted that there were over 20 disciplines that were experiencing important shortages, ranging from physical and occupational therapists to radiography and medical laboratory technologists to public health inspectors.<sup>171</sup>

Dr Ruedy pointed out that this situation is not confined to Canada, telling the Committee that in Ireland, for example,

<sup>165</sup> Brief to the Committee, Nov. 6, 2001, p. 1.

<sup>166</sup> *A Framework for Reform. Context Papers: Do We Have a Shortage of Health Care Professionals*, Premier's Advisory Council on Health, Dec. 2001, p. 4.

<sup>167</sup> Brief to the Committee, Nov. 5, 2001, p. 5.

<sup>168</sup> *Ibid.*, p. 6.

<sup>169</sup> 30:87

<sup>170</sup> 38:62.

<sup>171</sup> 32:62 and brief to the Committee, Oct. 17, 2001, pp. 1-2.

*In one of the hospitals, they were dependent upon 200 Indonesian nurses to provide adequate nursing services. The entire cleaning staff were Latvian who could not speak English. So this is a universal, world-wide problem and it is going to get worse...*<sup>172</sup>

One factor that is expected to contribute to the worsening of the shortage is the aging of the health care workforce. CIHI recently reported that from 1994 to 2000, the average age of Canadians in health occupations rose almost two years from 39.1 to 40.8 years.<sup>173</sup> This trend is consistent for almost all health care providers. For example, the Committee noted in its previous report that the average age of physicians rose from 46.4 to 47.5 between 1996 and 2000, while CIHI has indicated that the average age of practicing nurses in 2000 was 43 years, up from 41 in 1994.<sup>174</sup> The aging of the workforce means that even more new graduates will be needed to replace health care professionals who will be retiring at an accelerating rate.

### **6.1.2 Towards self-sufficiency in health human resources**

The Committee strongly believes that one of the major consequences of the world-wide nature of the health human resource shortage is that it becomes necessary for countries to assess how to become self-sufficient in human resources. In no other industrialized country is this more important than here in Canada. For example, as the Committee noted in its previous reports, there is less opportunity for young Canadians to attend medical school in Canada than in any other industrialized country. According to the Association of Medical

***The Committee strongly believes that one of the major consequences of the world-wide nature of the health human resource shortage is that it becomes necessary for countries to assess how to become self-sufficient in human resources.***

Colleges of Canada (ACMC) Canada is now near last in the ratio of physicians to population among OECD countries. This situation owes much to the decrease in medical school enrolments that came about as a result of the implementation of a select number of recommendations from the Barer-Stoddart report published in 1991.

In the past, Canada has relied on International Medical Graduates (IMGs) to fill the gaps. Dr. John A. Cairns, Dean of Medicine, University of British Columbia, told the Committee that it was no longer possible for Canada to rely on past practice. He noted that the majority of IMGs

*...used to come from the U.K., but comparative practice opportunities between the U.K. and Canada are not in favour of Canada any longer. We have people going back to the U.K. We have very great difficulty recruiting people from the U.K. at the present time. We go to South Africa. The morality of that is highly questionable.*<sup>175</sup>

The ACMC has recently amplified this last point:

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<sup>172</sup> 42:83.

<sup>173</sup> CIHI, op. cit., p. 13.

<sup>174</sup> Ibid., p. 40.

<sup>175</sup> 33:76

*The morality of recruiting physicians from economically disadvantaged countries must be seriously questioned. Canada is a wealthy nation and it is inappropriate to require poorer countries to incur the heavy cost of medical education only to have their graduates aggressively recruited by a wealthy nation unwilling to make its own appropriate investments in medical education.*<sup>176</sup>

The problem of industrialized countries recruiting physicians and other health care professionals from the developing world is of great concern in countries such as South Africa. It was brought to the Committee's attention that the problem is so serious that on at least two occasions in 2001, senior officials, including the South African High Commissioner of South Africa, met with representatives of the Royal College of Physicians and Surgeons to raise their deep concern over the disturbing level of emigration of physicians, surgeons and nurses to other countries, including Canada.

The Committee agrees that it is unacceptable for Canada to poach highly trained graduates from the developing world. It is therefore convinced that, in such a context, the only remaining alternative is to work towards self-sufficiency. This requires being able to define targets for the numbers of the various types of health care provider that are required, something that is far from being an easy task.

***...it is clear to the Committee that recent efforts to increase the number of graduates from Canada's medical schools should be pursued.***

Despite these difficulties, it is clear to the Committee that recent efforts to increase the number of graduates from Canada's medical schools should be pursued. This is all the more important given the many changes taking place in the medical workforce. Many newer graduates are seeking a better balance between home and work life, and are no longer prepared to work the inordinately long hours that were once the norm. This means that more graduates will be needed. Moreover, the Committee also feels that the number of postgraduate training positions should be raised from its current ratio of one place for every graduating student. As the Committee has noted in earlier reports, funding more postgraduate positions will allow the quicker integration of IMGs seeking Canadian credentials, and afford physicians greater flexibility in planning their careers.

A decline in the number of graduates in other disciplines was also noted by various witnesses. The Saskatchewan Registered Nurses' Association pointed out that "in Canada in the early 1990's nursing programs were graduating 10,000 students, today it is closer to 4,000," with Saskatchewan having lost 300 funded seats over the same time period, resulting in waiting lists of qualified Saskatchewan

***It is thus clear to the Committee that the numbers of nursing graduates as well as of allied health professionals need to be sharply increased, and that the federal government must contribute to helping make this happen.***

<sup>176</sup> Association of Canadian Medical Colleges, *Strategic Planning for a Sustainable System of Health Care in Canada*, Oct. 2001, p. 13.

applicants.<sup>177</sup>

The Health Sciences Association of Alberta (HSAA) told the Committee that:

*Enrollment in many programs were cut back through a combination of cuts to health care and advanced education. An example is Medical Laboratory Technology in Alberta, where training schools cut enrollment from 40 students to 20 students.*<sup>178</sup>

And that:

*To take an even longer-term perspective, enrolment in colleges and universities has not only not kept up with the expanding demands of health care, but many of them have actually decreased. Human Resources Development Canada (in its Job Futures 2000 Program) indicates that many allied health worker disciplines have seen a decrease in the number of graduating students. For example, HRDC indicates that in 1997, there were 530 graduates from medical laboratory technology programs across the country - a 42% decrease from 1987. Diagnostic Imaging had a 15% decrease in graduation over the same period. This is an astounding figure, considering the ever increasing demand for technical and professional employees due to both the new technologies and a growing population.*<sup>179</sup>

The decline in the number of graduates has also been compounded by what has been called 'credential creep.' This refers to the gradual increase in the educational levels required to gain employment in a particular field, often driven by the increasing complexity of the work involved. The HSAA gave the examples of the Michener Institute in Ontario that has recently moved from a two-year program in medical radiation technology and nuclear medicine, to a five-year program, and of the proposal in Alberta to require a masters level program for entry to clinical practice in physical therapy.<sup>180</sup>

Among the consequences of 'credential creep' are that it takes longer to train new graduates, who must make a correspondingly greater commitment of time and money to acquire the necessary training, and who will therefore expect salaries that are commensurate with their levels of training and education. In addition, the proliferation of new equipment means that provision must be made for ongoing training, a process that puts further pressure on limited financial and human resources. It is of no use to invest in expensive equipment if there is not sufficient qualified personnel available to ensure that it is properly used.

It is thus clear to the Committee that the numbers of nursing graduates as well as of allied health professionals need to be sharply increased, and that the federal government must contribute to helping make this happen. The Committee therefore recommends:

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<sup>177</sup> Brief to the Committee, Oct. 16, 2001, p. 7.

<sup>178</sup> Brief to the Committee, Oct. 17, 2001, p. 4.

<sup>179</sup> *Ibid.*

<sup>180</sup> Brief to the Committee, pp. 5-6

**That 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.**
- **Review 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 student loan programs available to health care professionals and make modifications to ensure that the impact of inevitable increases in tuition fees, especially as they affect medical students, does not lead to denial of opportunity to students in lower socio-economic circumstances.**
- **Provide particular tuition support for nursing students, up to and including waiving tuition fees entirely for a limited period of time.**
- **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.**

**6.1.3 Increasing the supply of health care providers from Canada's Aboriginal peoples**

In its previous reports, the Committee noted that there was a serious shortage of health care providers from Aboriginal backgrounds. A number of witnesses addressed this problem, in particular with regard to the training of Aboriginal physicians. Dr. Henry Haddad, President of the CMA, noted that to the best of his knowledge there were only about 50 physicians from Aboriginal backgrounds in the entire country.<sup>181</sup> This represents less than one tenth of one percent of the total of more than 57,000 practising physicians in Canada in 2000.<sup>182</sup>

Dr. Joanna Bates, Associate Dean, Admission, University of British Columbia, told the Committee about initiatives taken at her University to encourage greater numbers of students from Aboriginal backgrounds to pursue careers in health-related fields. In the first place, she pointed out that it was necessary to identify barriers that come into play even before Aboriginal students graduate from high school.

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<sup>181</sup> 42:102

<sup>182</sup> CIHI, op. cit. p. 10.



*(...) we have identified a number of significant barriers to the acceptance and the involvement of Aboriginal people and students entering into faculties, not just medicine but other health careers as well. Specifically, issues around early education are major issues in having Aboriginal people achieve the level of education required to enter professional faculties. The issue of dropout rates and lack of completion at the high school level prevents many Aboriginal students from even getting to the point where they could consider a health professional career.*<sup>183</sup>

Other obstacles rooted in cultural differences make themselves felt during the admission process. She noted that admission procedures designed for non-aboriginals

*(...) do not accommodate the communication processes that occur with Aboriginal students who are raised on reserves. For example, we look for rapport development with eye contact, and that is not culturally appropriate.*<sup>184</sup>

Dr. Bates insisted that it was not a matter of applying different standards to students from different backgrounds, but rather of being aware of the full impact of culturally conditioned behaviour and sensitivities. Thus, she affirmed that:

*...we do not mean lower admission standards at all. We are often asked that question. We have similar admission standards for all applicants, but we feel that we have not been identifying appropriately excellence and performance in certain groups, including Aboriginal students.*<sup>185</sup>

The Committee expresses its support for these kinds of initiatives. It also notes with approval the financial assistance being provided to aboriginal students by organizations such as the CMA. In this regard, witnesses noted that rises in tuition fees compounded the problem of recruiting Aboriginal and other minority students to careers in health care. For example, Dr. John Ruedy of the Capital District Health District in Halifax told the Committee,

*We have had an unbelievably difficult problem in this province in attracting our Aboriginal, Mi'kmaq and Black sons and daughters into medical school. Part of that has been that high school, home and peer environments make it appear beyond expectation that these individuals could ever afford to go to medical school. It is not that they do not have the brains, it is just economically beyond them. This has been seriously augmented by the very large increases in tuition that have occurred over the last five years.*<sup>186</sup>

The Committee therefore recommends:

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<sup>183</sup> 33:58

<sup>184</sup> 33:59

<sup>185</sup> 33:59

<sup>186</sup> 42:93

**That 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.**

#### **6.1.4 Dealing with ‘The Brain Drain’**

In its previous reports the Committee noted that for both doctors and nurses, the two groups of health care professionals whose emigration from the country has provoked the most concern, it was their perceived inability to practice in a way that allowed them to make full use of their training that was often central to their decision to move abroad. This was contrary to some people’s impression that tax relief measures alone might be sufficient to lure health care professionals into returning to Canada.

A recent examination of the ‘Brain Drain’ by Ross Finnie of Queen’s University pointed out in this regard that overall reinvestment in the health care system would create a kind of virtuous circle in policy terms. By reaffirming that better health care is its own worthwhile goal it would help create the conditions that would lead to a reduction in the brain drain. This, in turn, would mean a better supply of health care professionals and reinforce further the ability of the system to provide the kind of care that these professionals have been trained to deliver.<sup>187</sup>

It is worth noting that recruiters abroad are acutely aware of the desire of Canadian health care professionals to be able to practice in a way that allowed them to make full use of their training. This point was illustrated by an article in *La Presse* that cited a recruiter from Lausanne, Switzerland, who had been importing nurses from Quebec for over 25 years. He said that, “two-thirds of Quebecers who come here say that their motivation is to be able to really put into practice the health care policy for which they have been trained.”<sup>188</sup> His efforts have been so successful over the years that 249 nurses from Quebec now work in his hospital, and Quebecers in general represent 15% of the total staff.

There are no shortcuts to making the working conditions in Canada’s hospitals sufficiently attractive to recruit and retain health care graduates. For example, the Committee highlighted in its fourth report the range of factors that would have to be addressed in order to alleviate the crisis in nursing:

- the place where the work takes place must itself be healthy, safe and secure
- the tools required to do the job must be in place
- the work being done must be interesting and attractive enough to offer its own intrinsic rewards to those who carry it out - and at the same time must be adequately rewarded, recognized and respected externally

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<sup>187</sup> Finnie, Ross, “The Brain Drain: Myth and Reality — What It Is and What Should be Done,” in *Choices* Vol. 7, No. 6, Nov. 2001, p. 18.

<sup>188</sup> Gilles Toupin “La Suisse maraude les infirmières québécoises,” *La Presse*, July 21, 2001. (Translation of: « les deux tiers des Québécois qui débarquent chez nous disent dans leurs lettres de motivation qu’ils veulent pouvoir répondre réellement à la politique en soins pour laquelle ils ont été formés ».)

- working hours and the interplay of home life and work life must be addressed, particularly in a workforce largely staffed by women

At the same time, the Committee believes that there are certain measures that should be envisaged to deal specifically with the problem of health care professionals who have moved abroad. Given that it will take years for a sufficient number of new graduates to be trained, it makes sense to work to repatriate Canadians who already have the necessary training, experience and skills.

**...the Committee believes that there are certain measures that should be envisaged to deal specifically with the problem of health care professionals who have moved abroad.**

The Committee believes that this effort should involve two main elements. On the one hand, the different levels of government and the various professional associations should work together in order to make sure that Canadians abroad are made aware of the changes being introduced into the health care system, and of the new possibilities for professional practice that are arising. The Committee notes that Nova Scotia recently undertook a 10-week campaign along these lines to woo back nurses who had left for the U.S.<sup>189</sup>

On the other hand, certain short-term incentives should be considered in order to make returning to the country as attractive as possible and to defray some of the costs associated with re-establishing oneself in professional practice. In a recent article, “Why do highly skilled Canadians stay in Canada?” the authors pointed out that,

*In the late 1960s, after a decade of the brain drain to the United States, Canada induced Canadian academics to return with a combination of attractive career opportunities and three years of federal income tax forgiveness.<sup>190</sup>*

Dr. Peter Barrett, former president of the CMA, suggests that this historical precedent could be applied to the design of some sort of short-term income tax relief targeted at doctors. The Committee believes that these same measures should also be considered for nurses and other health care professionals in short supply, where there is evidence that they have moved abroad in significant numbers. The Committee therefore recommends:

**That 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.**

<sup>189</sup> Steve Proctor, “N.S. works to rehire nurses who went south”, Halifax Herald, Nov. 29, 2001.

<sup>190</sup> Cited in Peter Barrett “Who Let the Docs Out?” in *Choices* Vol. 7, No. 6, Nov. 2001, p. 43. The original article by DeVoretz and Iturralde appeared in *Policy Options*, Vol. 22, no. 2, March 2001.

### 6.1.5 The need for a national health human resources strategy

Throughout the Committee's hearings witnesses have repeatedly stressed the need for a national health human resources strategy, a proposal which the Committee endorsed in Principle Fourteen in Chapter Two of this report. The question remains, however, as to who should be responsible for the development of such a strategy and how such a strategy should be implemented. The recommendations that have been advanced in this chapter already point to many of the reasons such a strategy is required. Thus, the Committee believes that it is difficult to see how it could be possible to attain the objective

***Thus, the Committee believes that it is difficult to see how it could be possible to attain the objective of self-sufficiency in health human resources unless there is long-term cooperation and coordination amongst all stakeholders, from government through the professional associations to educators in the health care field.***

of self-sufficiency in health human resources unless there is long-term cooperation and coordination amongst all stakeholders, from government through the professional associations to educators in the health care field.

At the same time, however, it is clear that the need for such a national strategy has long been recognized. One therefore has to wonder why it has proven to be so difficult to formulate. The British Columbia Medical Association noted in its brief to the Committee that,

*A national health human resource strategy is indeed what we need, although its development has proved virtually impossible over the course of the past three decades.<sup>191</sup>*

In the Committee's view, moving forward in this regard entails recognizing that such a strategy must not be a 'federal' one, with input only or primarily from the senior level of government, but must rather involve all stakeholders, while recognizing that the training and education of health care professionals is a provincial responsibility.

There are other factors that reinforce the need for a national strategy that are worth noting as well. Ms. June Blau, President, Saskatchewan Registered Nurses' Association, told the Committee that not only is her province not training enough nurses to meet its own needs but that other provinces have traditionally relied on nurses trained elsewhere to meet their own requirements:

*We are limited in Saskatchewan right now to 260 seats; we need at least 400. The Province of British Columbia, for example, has only ever trained 50 per cent or less because they rely on recruitment from other provinces. So we train and they use. And that has been the philosophy ever since I became a nurse.<sup>192</sup>*

<sup>191</sup> Brief to the Committee, Oct. 10, 2001, p. 5.

<sup>192</sup> 31:7

In the Committee's opinion, problems relating to inter-provincial competition for graduates in health-related fields, further highlights the centrality of developing a national strategy with regard to health human resources. Competition between different jurisdictions for scarce human resources can lead to severe disparities in the ability of various regions to provide health care services.

At the same time, of course, it is true that different provinces and regions of the country offer different attractions that will appeal to health care professionals for a variety of reasons. The Honourable Jamie Ballem, Minister of Health and Social Services in Prince Edward Island, told the Committee,

***In the Committee's opinion, problems relating to inter-provincial competition for graduates in health-related fields, further highlights the centrality of developing a national strategy with regard to health human resources.***

*We have a situation where the perception is that health care is measured by how much money you spend, how many doctors you have, how many nurses you have... However, when you try getting more doctors, they are just not available. Money is not the issue. More nurses are needed; we have 40-plus vacancies in our nursing structure right now. I budget for more than that every year, for all those vacancies, and we will pay more than that in overtime. It is not a question of creating more positions. We just cannot get the bodies.*

*Thus we are looking at how to utilize the health professionals that we have: what the mix will look like, and who does what. We are trying to have attractive recruitment and retention packages. We are trying to make the workplace something that is attractive to keep people here. We cannot compete in dollars. If it was just a case of dollars and cents, everybody would be in Alberta. We are trying to create a situation in this province whereby it is an attractive opportunity for someone to come and practise their profession.<sup>193</sup>*

There is also evidence that there is fierce financial competition for many categories of health care professionals, not only between various regions of the country, but also between public and private providers. The Health Sciences Association of Alberta gave the following examples to the Committee:

*The private sector in radiology in Alberta offers comparable wages, but usually better working hours and conditions (i.e. less shift work, weekends and call-backs). As a result, we have seen an exodus of diagnostic imaging technologists to the private sector. However, the expectations for services in the public sector has not diminished, which in turn creates an overburdened workforce of employees who remain in the public sector.*

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<sup>193</sup> 43:55

*Another example of private sector competition affecting the public sector is in pharmacy services. Because of the international shortage in Pharmacists, the private sector has been paying much higher wages than the public sector. Beyond wages, the profit sharing and other compensation schemes can result in many Pharmacists earning \$20,000-\$30,000 a year more in the private sector.<sup>194</sup>*

Finally, there is the seemingly intractable problem of the geographical maldistribution of physicians. In its previous reports the Committee repeatedly highlighted the long-standing difficulties in ensuring an adequate supply of health care professionals to the rural and remote regions of the country. Amongst the strategies that were proposed to the Committee to increase the number of physicians who were interested in practising in rural Canada was the oft-repeated idea that by exposing medical students to the reality of rural practice, many would choose to locate there. The Committee heard evidence that this kind of strategy does indeed work. Mr. John Malcolm, Chief Executive Officer, Cape Breton Regional Health Care Complex, gave the following account to the Committee:

*You must consider the needs of rural Canada. When Dr. Ruedy was Dean, his department approached us about the idea of establishing a rural family medicine program. We jumped at that – to the point that we found all of the costs to operate the program locally. The university found the cost for the residents...*

*We have no vacancies in any of the communities around the Cabot Trail and, in fact, we have one community where we appear to have one physician who wants to come more than what we need next year. If you expose people to the opportunity of rural practice, they will choose rural practice just as I choose to live in rural Canada and not return to urban Canada.<sup>195</sup>*

The Association of Canadian Medical Colleges (ACMC) has recently argued that there are three major problems that must be confronted in trying to address regional maldistribution:

- The concentration in large urban centres—physicians tend to concentrate in areas of larger population with greater ranges of educational, religious, cultural and recreational opportunities for families and working opportunities for spouses.
- The fact that rural practice has specific demands, with professional practice considerations including heavy “on-call” and “burn-out” factors in rural communities.
- The emergence of an increasing number of opportunities for physicians in urban centres as the shortage of physicians in Canada increases in urban communities.

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<sup>194</sup> Brief to the Committee, p. 5.

<sup>195</sup> 42:85-86

The ACMC also points out that the issues that need to be addressed include “recruitment of students with backgrounds that may be suited to a rural or remote practice, support of physicians in rural or remote locations (locums), improved use of telehealth, and increasing the exposure of trainees to rural and remote practices.”<sup>196</sup> The Committee agrees with these goals. It also endorses the idea that any contractual arrangements entered into by physicians promising to practice in rural areas should be voluntary. Coercive measures to force physicians into rural or remote practices are to be discouraged, as was affirmed by the Ontario Government’s January, 2001 Expert Panel on Health Professional Human Resources Report. It included as one of its core principles that “strategies to improve the distribution of health care professionals should be designed to attract and encourage them to practice in areas of need rather than penalizing them for not doing so.”<sup>197</sup>

The Committee would also like to acknowledge the enormous contribution made by the tens of thousands of Canadians who volunteer literally millions of hours of their time in the health care sector. Without them the impact of the shortages of both human and material resources that plague the health care system would be magnified many times over. CIHI notes that a recent Statistics Canada survey found that health organizations benefited from about 9% of the 1.05 billion hours that Canadians volunteered in 2000.<sup>198</sup> In this regard, Ms Maude Peach, the former Director of Volunteer Resources with the Health Care Corporation of St. John’s, told the Committee that in Newfoundland, “volunteers contribute millions of hours a year helping people who are ill, elderly, disabled, disadvantaged, and illiterate.”<sup>199</sup> The Committee wishes to encourage Canadians to continue to contribute to the health care sector by volunteering.

There have been a number of initiatives already undertaken to move in the direction of better coordinating human resource planning. A recent study released at the Premier’s conference in Victoria called for provinces and territories to consider solutions that aim to increase the number of health care workers in their own jurisdictions while not recruiting workers from other parts of the country.<sup>200</sup> Mr. William Tholl, CEO of the Canadian Medical Association (CMA), told the Committee that the CMA was working with other organizations of health care providers to develop a multi-disciplinary study that will assess human resource needs based on a disease-based or patients perspective.<sup>201</sup>

The Committee welcomes the announcement last fall by the Minister of Human Resources Development Canada (HRDC), The Honourable Jane Stewart, that her department is undertaking two important sectoral studies in order to gauge the precise human resources needs for physicians and nurses. The Committee believes that this marks an important step in the direction of developing a national approach with regard

***The Committee welcomes the announcement last fall by the Minister of Human Resources Development Canada (HRDC), The Honourable Jane Stewart, that her department is undertaking two important sectoral studies in order to gauge the precise human resources needs for physicians and nurses.***

<sup>196</sup> ACMC, *op. cit.*, p. 10.

<sup>197</sup> Cited in CAIR’s brief to the Committee, p. 14

<sup>198</sup> CIHI, *op. cit.*, p. 13.

<sup>199</sup> 41:40

<sup>200</sup> CIHI, *op. cit.*, p. 75.

<sup>201</sup> 42:109

to health human resources. Each of these studies will systematically analyse the labour market and culminate in the elaboration of a strategy designed to ensure an adequate supply of appropriately trained professionals.

The physician study will comprise three phases, lasting around three years:

- *Phase 1*, 9-12 months - A situational analysis reviewing health care delivery models, factors influencing the physician workforce and profiling the physician workforce.
- *Phase 2*, 12-18 months - A comprehensive human resource analysis of physicians to gather and analyze information on issues impacting on the supply of, and demand for, physicians.
- *Phase 3*, 12 months - Develop a human resource strategy for physicians through a consultative mechanism involving all relevant stakeholders.

For its part, the nursing study has two phases, that will take two years to complete:

- *Phase 1* (duration - 20 months) - A comprehensive analysis of the nursing labour market will be undertaken, including the development of nursing requirements under various delivery model options.
- *Phase 2* (duration - 5 months) - A systematic strategy development process will be developed, based on the information developed under Phase 1 of the project, and using input from stakeholders in the nursing sector, including provincial and territorial governments.

The Committee notes with approval the involvement of all the key stakeholders, including provincial representatives, in the process of producing these studies. Despite their importance, however, these HRDC reports should not be seen as all that needs to be done. Given the length of the anticipated time frame for the completion of these studies, the Committee feels that the measures and initiatives it has recommended in this chapter should not wait that long to be considered. The Committee wishes to stress the importance of acting quickly in this area, while at the same time making sure that the implementation of the strategies that will flow from these reports be seen as part of a longer term health human resources planning process.

***The Committee firmly believes that the federal government must play an even stronger role than it has to date in coordinating efforts to deal with health human resources shortages.***

The Committee firmly believes that the federal government must play an even stronger role than it has to date in coordinating efforts to deal with health human resources shortages. Given that it is clear that there can be no 'quick fix' and that a wide range of interests and concerns must be incorporated in the search for long-term solutions, it would seem appropriate to establish an ongoing framework for dealing with human resource issues. The Committee therefore recommends:



**That the federal Government work with other concerned parties to create a permanent national coordinating body 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-served regions, particularly the rural and remote areas of the country;**
- **examination of the possibilities for greater coordination of licensing and immigration requirements between the various levels of government.**

## **6.2 Health Human Resources and Primary Care Reform**

As the Committee pointed out in its *Issues and Options* report (Volume Four), the way the delivery of primary care is organized will have a significant impact on our ability to make the best possible use of health human resources.

Primary health care constitutes the first point of contact with the health care system. At present, primary care delivery in Canada is organized mainly around family physicians and general practitioners working in solo or small group practices. Approximately one-third of primary care physicians are solo practitioners and fewer than 10 percent of primary care physicians work in multidisciplinary practices. The vast majority of primary care practices are owned and managed by physicians. Fee-for-service (FFS) payment is the dominant form of physician remuneration. Almost 90% of family physicians surveyed by the Canadian College of

***As the Committee pointed out in its Issues and Options report (Volume Four), the way the delivery of primary care is organized will have a significant impact on our ability to make the best possible use of health human resources.***

Family Physicians in 2001, said they received some proportion of their earnings in the form of fee-for-service payments,<sup>202</sup> and FFS payments accounted for an average of 88 percent of their total income.<sup>203</sup>

There is no legislative requirement that directly establishes the dominance of FFS payment of physicians. One can, however, identify two of the central features of Canada's health care system that have contributed to the structure of primary care delivery that prevails today. On the one hand, the original bargain that was struck between government and physicians to incorporate the principle of public payment for private medical practice had the effect of placing physicians at the centre of the health care system, and enshrining FFS as the dominant mode of remuneration.<sup>204</sup> At the same time, limiting the definition of "comprehensive" medically necessary coverage under the *Canada Health Act* to hospital and physician services has reinforced this same trend.

Thus, when the Committee spoke in Volume Four of the existence of a perceived 'hierarchy' amongst the health professions, with specialist physicians at the apex, it was highlighting this structural tendency within the Canadian health care system. The fact that this structure is given shape in part by the *Canada Health Act* is one reason that it is important for the Committee to examine the issues of health human resources and primary care reform, even though the main responsibility for policy in these areas lies with Provincial and Territorial governments.

### **6.2.1 Support for Primary Care Reform**

Over the years there have been numerous initiatives aimed at encouraging different ways of delivering primary care that could take advantage of more cooperation amongst, and better coordination between, health care providers. But, as a recent study of primary care in Canada by Hutchison *et. al.*, notes:

*Despite their wide variety and substantial numbers, innovations in the organization, funding, and delivery of primary care in Canada have been at the margins of primary care rather than at its core. Except in Quebec, where 20 percent of family physicians and GPs work in CLSCs,<sup>205</sup> either full or part time, physicians participating in primary care reform projects or working in unconventional practice settings are in a tiny minority. In Ontario, with its long-established Community Health Centre and Health Service Organization programs and Canada's largest provincial primary care reform scheme, only about 5 percent of physicians participate in alternative models of primary care funding and delivery.<sup>206</sup>*

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<sup>202</sup> Canadian Institute for Health Information (CIHI), *Canada's Health Care Providers*, 2001, p. 73.

<sup>203</sup> Hutchison, Brian and Julia Abelson and John Lavis, "Primary Care in Canada: So Much Innovation, So Little Change," in *Health Affairs*, Vol. 20 No. 3, May-June 2001, p. 117.

<sup>204</sup> *Ibid.*, p. 118.

<sup>205</sup> Quebec's 'Centres locaux de services communautaires' (CLSCs) constitute a network of community clinics that offer a range of health-related services.

<sup>206</sup> Hutchison, *op. cit.*, p. 122.

During its hearings the Committee repeatedly heard that this lack of progress in reforming primary care delivery was, at present, not primarily the result of opposition from health care professionals each seeking to protect their particular bit of turf. From established physicians to residents and internes, through representatives of professional bodies and educational institutions, doctors across the country insisted that they were open to alternative forms of organizing primary care delivery and of remuneration.

In this vein, Dr. Henry Haddad, President of the Canadian Medical Association, told the Committee that “there is a prevailing myth that physicians are a barrier to change when in fact many of the progressive changes in the health care system have been more often than not physician lead.” He indicated that “Canadian physicians are willing to work in teams and the CMA has developed a “Scopes of Practice” policy that clearly supports a collaborative and cooperative approach,” adding that “contrary to popular belief, physicians are very open to alternate payment models.”<sup>207</sup>

Witnesses noted that one of the factors that had contributed to fostering this growing collaborative spirit was the narrowing of the gap in educational levels between physicians and other health care professionals. As well, the changing demographics and career patterns of newly graduated physicians has also had an impact on attitudes towards change. The Canadian Association of Internes and Residents told the Committee:

*Medical residents and new physicians often have a different set of personal and professional values, priorities, and workload expectations, flowing in part from a commitment to a more balanced approach to career, family, and well-being. These new values are increasingly playing a role in career and remuneration decisions. As a result, new physicians tend to be more open to alternative methods of compensation and health care delivery than traditional fee-for-service or solo physician practice.*<sup>208</sup>

However, some physician representatives, noting that a number of important questions remain unanswered, cautioned that primary care reform was unlikely to be a panacea for all the ills plaguing the health care system. In the words of Dr. Heidi Oetter, President of the British Columbia Medical Association:

*While the models that have been piloted to date may, arguably, provide better overall quality care, there is no evidence to date to suggest that these models have reduced costs or are generally applicable to the entire health care system. Quality must be the primary goal, but it will likely come with a higher price tag. It has been said that care delivery can conform to any two of the three characteristics of good, fast and cheap, but not all three simultaneously. Primary care is no different.*<sup>209</sup>

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<sup>207</sup> Testimony before the Committee, Halifax, Nov. 6, 2001, p. 3 of speaking notes.

<sup>208</sup> “The New Face of Medicine: Sustaining and Enhancing Medicare,” brief to the Committee, Nov. 2001, p. 4.

<sup>209</sup> Brief to the Committee, Oct. 19, 2001, p. 8.

Witnesses representing organizations of registered nurses were unanimous in their assessment that primary care reform was essential to preserving and improving the state of health of Canadians and making better use of the full range of skills possessed by diverse health care providers. Thus, the Association of Registered Nurses of Newfoundland and Labrador suggested “that the best approach for achieving the intersectoral cooperation required to formulate and implement a national population health strategy is to embrace the primary health care and wellness model as the basis for the delivery of health services in the country.”<sup>210</sup> The Saskatchewan Registered Nurses' Association affirmed their belief “that the Primary Care Teams are the fundamental building blocks to the sustainability of a publicly funded health system,”<sup>211</sup> while the Registered Nurses of Ontario urged “the Standing Committee to recommend the implementation of true primary health care reform, with 24/7 care being delivered by interdisciplinary teams of health care professionals.”<sup>212</sup>

Representatives of other categories of nurses also endorsed the idea of primary care reform. Pat Fredrickson, President of the Canadian Practical Nurses Association, told the Committee that:

*Licensed practical nurses (LPNs) are both a practical and cost effective way of alleviating the shortage of nurses and averting an even more critical nursing crisis. We would strongly support a move away from the hierarchical way of thinking to support your assumption that each profession has its particular strengths, and these all need to be properly valued and deployed.*<sup>213</sup>

She noted that across the nursing profession as a whole there has been an increase in the levels of education and training, telling the Committee that “just as the registered nurses' education and scope of practice has expanded in recent years so has that of the LPN.”<sup>214</sup> But she argued that this has not yet led to the deployment of the full competencies of LPNs, noting that “the examples in this country where the knowledge and skills of an LPN are used to their full scope of practice are few and far between.”<sup>215</sup>

And just as there have been historical tensions between nurses and doctors over scope of practice issues, so too have LPNs felt that RNs have been guilty of guarding their own prerogatives. Ms. Fredrickson told the Committee:

*The greatest underutilization is also where there is the greatest shortage of registered nurses. The biggest barrier to the utilization of the LPN is in the facilities where the unions protect the turf of the registered nurse through restrictive collective agreements.*

At the same time, representatives of the Association of Registered Nurses of Newfoundland and Labrador told the Committee that they supported “the implementation of

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<sup>210</sup> Brief to the Committee, Nov. 5, 2001, p.4.

<sup>211</sup> Brief to the Committee, Oct. 16, 2001, p. 4.

<sup>212</sup> Brief to the Committee, Oct. 30, 2001, p. 16.

<sup>213</sup> 32:56

<sup>214</sup> *Ibid.*

<sup>215</sup> 32:57

practices that enable *both RNs and LPNs to work to the full potential* of their approved scope of practice and within their level of competence.”<sup>216</sup>

Finally, representatives of some allied health care professionals also expressed support for the idea of primary care reform. The Ontario Association of Optometrists told the Committee that “as primary eye care providers, we are prepared to participate as part of the multi-disciplinary team vital to the primary care reform goals.”<sup>217</sup> Mr Ron Elliott, President of the Canadian Pharmacists Association indicated that his organization “strongly supports the need for reform of the current hierarchy of health care professionals” and that it believes “that scopes of practice need to change in order to improve effectiveness and efficiency.”<sup>218</sup>

Other witnesses also highlighted the importance of reviewing professional scope of practice rules in order to ensure that as few barriers as possible are put in the way of fruitful collaboration amongst health care providers. Mr. Gerry Fahey, Executive Director, Health Professions Council of British Columbia explained to the Committee the rationale behind the recommendations contained in a major review conducted in that province. He noted that in the old system, known as the ‘exclusive scopes-of-practice system,’ “each profession is granted a descriptive statement of its practice, which is, generally, very broad, and within that statement they have the exclusive right to perform.”<sup>219</sup> The new system that the Council proposed, based on one in place in Ontario, is called the ‘reserved-axe’ or ‘controlled-axe’ model. Mr. Fahey explained that,

*The theme of this system is to increase choice amongst health care professionals within safe parameters. In more basic terms, if people are trained and educated to perform certain tasks, they should be allowed to perform them.*<sup>220</sup>

He noted that this new system would help to promote interdisciplinary practice, and that, in particular, “the reserved-axe model will assist in promoting specialized practice for nursing and primary roles for nursing.”<sup>221</sup>

Moreover, he pointed out that there were often barriers to expanding interdisciplinary collaboration contained in legislation as well, telling the Committee that,

*(...) buried amidst all this subordinate legislation, regulatory instruments and bylaws, there are, even for one profession, many rules that create barriers for other professions. For example, there are provisions in several statutes that prevent a member of a profession from practicing with another. There are provisions preventing prescription release. There are provisions about who controls laboratory facilities. We identified these*

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<sup>216</sup> Brief to the Committee, p. 8. Emphasis in the original.

<sup>217</sup> Brief to the Committee, Oct. 29, 2001, p. 5.

<sup>218</sup> 38:61

<sup>219</sup> 33:60

<sup>220</sup> 33:61

<sup>221</sup> Ibid.

*as not only barriers to access to the public, but also barriers to solutions coming from government in terms of how they want to use health care personnel.*<sup>222</sup>

The Committee strongly believes that revisions to scope of practice rules and other regulations that promote greater flexibility and encourage collaboration amongst health care professionals are to be welcomed, and that, as noted in Principle Twelve in Chapter Two, these should be developed so as to enable all health care providers in the primary care sector to provide the full range of services for which they have been trained. It also expresses the hope that these can be made as uniform as possible across the country.

***The Committee strongly believes that revisions to scope of practice rules and other regulations that promote greater flexibility and encourage collaboration amongst health care professionals are to be welcomed.***

### **6.2.2 Inter-Disciplinary Education**

In order for primary care reform to succeed, several witnesses stressed the importance of ensuring that the education of health care professionals exposed them to the benefits and exigencies of inter-disciplinary teamwork. Dr. John H.V. Gilbert, Coordinator of Health Sciences at the University of British Columbia, affirmed that “if we are serious about changing the extant hierarchical way of thinking, then I contend we should pay serious attention to the manner in which health care professionals are educated.” He added that his sense “is that one of the reasons we are not using our health professional, again, to quote, ‘to anything like the full extent of their capabilities’, is because their educational programs are structured in such a fashion that they do not foster an understanding of the particular strengths and scopes of practice of each other.”<sup>223</sup> His conclusion was that “we need a national health education program with resources to underwrite program development and evaluation at least on a par with some of the social science institutes in the CIHR.”<sup>224</sup>

Dr. John Ruedy, Vice President Academic Affairs of the Capital District Health Authority in Halifax, expressed a similar view:

*(...) experiential learning of health professionals is dependent on students’ access to models of health care teams. Professional silos are perpetuated by educational programs that have little relationship to one another. We need to develop core professional education programs that have different exit points for different health professions.*<sup>225</sup>

The Canadian Association of Interns and Residents (CAIR) noted that medical education had already begun to shift its focus somewhat, incorporating a greater emphasis on “multi-disciplinary education, so that physicians are learning and working with other members of the health care team including nurses and nurse practitioners, physiotherapists, occupational

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<sup>222</sup> 33:61-62

<sup>223</sup> 33:111

<sup>224</sup> 33:112

<sup>225</sup> Brief to the Committee, Nov. 6, 2001, p. 3.

therapists, social workers and dentists.”<sup>226</sup> Dr. Gilbert told the Committee that the University of British Columbia had just become the first University in the world to establish a college of health disciplines,<sup>227</sup> that involves the affiliation of seven faculties that have agreed to collaborate to promote inter-disciplinary education.

Nonetheless a note of caution in this regard was sounded by CIHI in a recent study entitled *Canada’s Health Care Providers*.

*Does inter-professional education make a difference? If yes, how much? An international systematic review in May 2000 looked at its effects on professional practice and health care outcomes. Given the current state of research, the authors concluded that the jury is still out on possible outcomes.*<sup>228</sup>

### **6.2.3 What model for primary care reform?**

A concern of a number of the physicians who appeared before the Committee was that any move to reform primary care be done on a voluntary basis. The Canadian Association of Internes and Residents (CAIR) insisted that, “change will only be successful with the willing and constructive participation and input of the various providers involved in the delivery of health care; if they are alienated by the imposition of coercive measures, their needed goodwill, expertise, morale and cooperation will be seriously undermined.”<sup>229</sup>

***The Committee is convinced that the reform of primary care delivery is essential to ensuring the sustainability of Canada’s health care system.***

A second concern, expressed by the British Columbia Medical Association, had to do with the structure of the inter-disciplinary team that would be responsible for patient care in most reform scenarios. They indicated that in their view it was necessary for physicians to retain a leadership role within these group practices.

*What is important to physicians and to patients, we believe, is that each team requires a leader who will accept ultimate responsibility for the patient.*

*When patients arrive at the physician’s office, they do not know their specific condition, they simply know their symptoms. This ‘information asymmetry’ requires the professional attention of the best-trained generalist, the GP, who can treat or triage for the entire spectrum of patient needs. The full spectrum GP at the point of entry to care is a fundamental strength of Canada’s health system and highly valued by the public. The analogy that you don’t need an electrician to change a light bulb is true, once you know*

<sup>226</sup> Brief to the Committee, p. 8.

<sup>227</sup> 33:123

<sup>228</sup> CIHI, *op. cit.*, p. 60.

<sup>229</sup> Brief to the Committee, pp. 5-6.

*the light bulb is the problem. If, on the other hand, you come home and the lights won't go on, all you know is that it is dark. The problem could have multiple causes, only one of which is a faulty light bulb. If you call in a 'light bulb changer' and that doesn't solve the problem, then a fuse box technician and finally the electrician, you not only have misused resources, but may have caused harm while waiting. The point is, patients don't arrive at the physician's doorstep with a label; they arrive with a complex array of symptoms and complaints that require diagnosis.*<sup>230</sup>

Other witnesses, suggested that the reluctance that was still evident on the part of doctors to abandon their central role in the system could inhibit the reform of primary care delivery. Thus, June Blau, of the Saskatchewan Registered Nurses Association, told the Committee:

*Doctors are very powerful and do not want to abandon the fee-for-service system. They are afraid that we will short-change them. I do not think anybody realizes how many hours doctors put in per week. I have a daughter who is a family physician, so I am probably more aware than anybody. If and when we put physicians on salary, it will be a very good salary, as it ought to be.*

*We ought to be recognizing nurses in a similar way. We have to get rid of the hierarchy; doctors are not better than nurses, nurses are not better than LPNs or RPNs, and RPNs are not better than aides. This is not a hierarchy; this is a team. Each profession has some things that only it can do, each has areas of overlap, and we need to work in a team that takes advantage of all of those resources in the best way possible and achieve the efficiencies that come with that. What we have now is everybody working in silos, and with diseases in silos, instead of looking at health as a big picture.*<sup>231</sup>

On the whole, witnesses from all the health care professions believed that new forms of remuneration were essential, and that exclusive reliance on FFS was incompatible with widespread reform of primary care delivery. However, it was also generally agreed that there was no single 'cookie-cutter' formula that could be applied in all circumstances.

Witnesses argued that each form of remuneration had both advantages and disadvantages. FFS was seen to penalize physicians for spending longer periods of time with patients presenting complex cases. While it was recognized that FFS also encouraged doctors to be strong advocates for their patients within the system, there was concern that this contributed to phenomena such as the ordering of unnecessary diagnostic tests.

Capitation and rostering, on the other hand, were seen to facilitate the integration of primary care services and to emphasize quality care, including preventative medicine, over quantity, but at the cost of potentially generating an incentive for primary care

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<sup>230</sup> "Setting Sail: Health Care in Transition," brief to the Committee, Oct. 19, 2001, pp. 9-10.

<sup>231</sup> 31:21



providers to not order all the tests that might be required (because they would be responsible for covering all or part of the costs of these tests out of a fixed per-patient budget).

Several witnesses referred to the study by Hutchison *et. al.* that indicated that “strong evidence is lacking to support the superiority of any one model of organizing, funding, and delivering primary care and of many suggested model components, including group practice, multidisciplinary practice, and remuneration methods.”<sup>232</sup> It is worth citing the detailed conclusions reached by these same authors:

*As we assess the state of evidence regarding primary care physician Payment methods based on the strongest, most relevant studies we have been able to identify, we see the following:*

1. *There is suggestive evidence that patients’ assessments of overall satisfaction and access/availability are more positive in settings with FFS as opposed to salary or capitation payment.*
2. *There is minimal or conflicting evidence regarding patients’ assessments of continuity, comprehensiveness, coordination, technical quality, and interpersonal aspects of care.*
3. *There is minimal evidence regarding practice patterns (for example, frequency of home visits and length of office visits).*
4. *There is suggestive evidence that capitation payment results in higher rates of referrals to specialists.*
5. *There is minimal or conflicting evidence regarding quality, utilization, and costs of care.*
6. *There is minimal evidence regarding differences in use of non-physician providers in FFS versus capitated practices.*
7. *There is suggestive evidence of better preventive care performance by salaried and capitated physicians than by FFS physicians.*

*Effects of the range and mix of providers, working relationships and division of labor in multidisciplinary teams on health outcomes, patient and provider satisfaction, and cost-effectiveness with differing patient populations remain to be established.*<sup>233</sup>

But even though there is no current consensus on the exact form that primary care reform should take, the Committee nonetheless believes that it is possible to identify a number of key features that must be part of any reform agenda. As it indicated in Chapter Two (Principles Ten and Eleven), the Committee believes that primary care

***But even though there is no current consensus on the exact form that primary care reform should take, the Committee nonetheless believes that it is possible to identify a number of key features that must be part of any reform agenda.***

<sup>232</sup> Hutchison *et. al.*, *op. cit.*, p. 125.

<sup>233</sup> *Ibid.*, pp. 125-26.

reform should lead to primary care being provided by group practices, or clinics, which operate twenty-four hours a day seven days a week, and that the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining, capitation, fee-for-service and other incentives or rewards. Blended remuneration provides incentives for general practitioners both to work hard and to care for a large number of patients as they do now (through fee-for-service funding) and to emphasize preventive care and population health (through capitation funding).

The Committee is convinced that the reform of primary care delivery is essential to ensuring the sustainability of Canada's health care system. As it argued in Chapter Two (Principle Thirteen), the Committee also believes the reform of primary care is necessary in order to create the possibility for primary health care teams to eventually purchase health services provided by hospitals and other health care institutions on behalf of their patients.

Therefore, recognizing that:

- The delivery of primary care to the population at large is a provincial responsibility;
- There is widespread support for the significant reform of primary care;
- No single model for reorganizing primary care will be universally applicable;
- Discussion and cooperation amongst all stakeholders is essential to the successful design and implementation of primary care reform;
- Voluntary adhesion to new models of primary care delivery by both providers and consumers is to be preferred.

The Committee recommends:

**That 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;**
- **organize themselves so that they develop the capacity to purchase services from hospitals and other institutional providers on behalf of their patients;**
- **progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.**



## CHAPTER SEVEN

### TOWARDS A POPULATION HEALTH STRATEGY

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As the Committee has noted in its Phase One report, it is clear that the state of the health care system affects our health. Services such as childhood immunization, medications to reduce high blood pressure as well as heart surgery all contribute to health and well-being. In fact, estimates by the Canadian Institute for Advanced Research suggest that 25% of the health of the population is attributable to the health care system alone.<sup>234</sup> It is therefore important for governments to ensure that the health care sector continually strives to provide quality and timely services.

It has been estimated that the remaining 75% of the health of the Canadian population is attributable to a multiplicity of factors that include: biology and genetic endowment; income and social support; education; employment and working conditions; physical environment; personal health practices and skills; early childhood development; gender, and culture. The Committee heard repeatedly that, to maintain and improve health status, governments should, in addition to sustaining a good health care system, develop population health strategies. Population health strategies encompass a broad range of activities, ranging from health and wellness promotion, to illness and injury prevention through broader policies and programs that influence income distribution, access to education, housing, water quality, workplace safety, and so on.

There is increasing evidence that investing more human and financial resources in promotion, prevention and population health can improve the health outcomes for a given population. In the end, this can reduce the demand for health services and the pressures on the publicly funded health care system.

Indeed, injury and illness are very costly to the health care system. During Phase Two of its study, the Committee was informed that the total cost of illness and injury was estimated at \$156.4 billion in 1998. Direct costs (such as hospital care, physician services and health research) amounted to \$81.8 billion, while indirect costs (such as lost productivity and lower quality of life) accounted for \$74.6 billion. The diagnostic categories with the highest total costs were cardiovascular diseases, musculoskeletal diseases, cancer, injuries, respiratory diseases, diseases of the nervous system, and mental disorders.<sup>235</sup> According to witnesses, many diseases, and most injuries, can be prevented. In their view, the only way to reverse disease trends and reduce the economic burden of illness is by investing more in health and wellness promotion, disease prevention and population health.

Overall, investment in health and wellness promotion, illness prevention and population health makes good financial sense. This fact was reflected in the 2001 report of the

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<sup>234</sup> Volume One, p. 81.

<sup>235</sup> Volume Two, p. 49.

Auditor General of Canada which noted that “preventive health activities are estimated to be 6 to 45 times more effective than dealing with health problems after the fact.”<sup>236</sup>

The Committee believes that there are potentially enormous benefits to be derived from health and wellness promotion, illness prevention and population health, primarily in terms of improving health outcomes for Canadians, but also in terms of their financial impact on the publicly funded health care system. We wholeheartedly agree with the Mazankowski report which stated: “It sounds like just good common sense, but perhaps the best way to sustain Alberta’s health care system over the longer term is to take steps to enable people and communities to stay healthy.”<sup>237</sup>

***The Committee believes that there are potentially enormous benefits to be derived from health and wellness promotion, illness prevention and population health, primarily in terms of improving health outcomes for Canadians, but also in terms of their financial impact on the publicly funded health care system.***

In this chapter, the Committee outlines a series of principles based on an approach to population health that we feel should guide policy decisions. These principles flow from the evidence and documentation presented to the Committee, and are designed to lay the groundwork for a future thematic report in which the Committee will make specific recommendations on implementing these principles.

In addition to outlining the rationale behind these principles, this chapter also discusses the importance of a population health approach with regard to improving the health status of Aboriginal Canadians. The Committee wishes to stress that it intends to issue a separate report on the federal role with regard to the health of Aboriginal Canadians, and that the inclusion of a principle in this chapter that affirms the need for a population health approach in this area should not be taken as the Committee’s last word on this crucial subject.

## ***P*** ***inciple 7.1***

### **Individuals should assume responsibility for their own health.**

In 1974, the then federal Minister of Health, the Honourable Marc Lalonde, released a landmark working document entitled *A New Perspective on the Health of Canadians*. This report recognized the impact of individual behaviour on health outcomes, and stressed that individual Canadians should assume greater responsibility of their health, while also identifying broader determinants (such as the environment or socio-economic factors) that have an impact on health outcomes.

<sup>236</sup> Auditor General of Canada, *2001 Report*, Chapter 9.

<sup>237</sup> Mazankowski report, p. 14.

The Lalonde Report referred to the “behavioural threats to health” and the “self-imposed risks” that accompanied “city living, habits of indolence, the abuse of alcohol, tobacco and drugs, and eating patterns which put the pleasing of the senses above the needs of the human body.”<sup>238</sup> It also stressed that:

*While it is easy to convince a person in pain to see a physician, it is not easy to get someone not in pain to moderate insidious habits in the interest of future well-being. (...) The view that Canadians have the right “to choose their own poison” is one that is strongly held.*<sup>239</sup>

There is no doubt that individual lifestyle choices have a significant impact on one’s health. A comprehensive report prepared for the Mazankowski Commission shows that lifestyle changes can markedly reduce the incidence and severity of a number of major diseases and leading causes of death and disability, especially heart disease, stroke, hypertension, diabetes and selected cancers. Moreover, the report suggests that many people already know the kinds of thing they should be doing – making healthier eating choices, getting more active, avoiding health risks and stopping smoking. It is not clear, however, why people do not always act on what they know.<sup>240</sup>

The Mazankowski report concluded that, in the context of health care system delivery, better incentives may be needed to encourage people to stay healthy:

*A number of ideas have been suggested for encouraging people to take more responsibility for their own health. Some people have suggested tying health care premiums to actions to stay healthy, providing tax credits or other tax incentives, or using medical savings accounts or some other form of co-payment to give people more control over their own health care spending. Others have suggested there should be penalties for people who do not look after their own health.*<sup>241</sup>

The Committee agrees that individuals should assume responsibility for their own health and that incentives need to be developed to encourage them to do so. We also agree that investment must be made in policies and programs that empower Canadians to make better decisions about their own health. This is an important step if Canada is to sustain publicly funded health care in the long term.

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<sup>238</sup> Marc Lalonde, *A New Perspective on the Health of Canadians*, Working Document, Health and Welfare Canada, April 1974, pp. 5-6.

<sup>239</sup> *Ibid.*, p. 6.

<sup>240</sup> Mazankowski report, pp. 14-15.

<sup>241</sup> Mazankowski report, p. 17.

## Principle 7.2

**Government programs that enable individuals to assume greater responsibility for their own health, and particularly health promotion and illness prevention activities, must be given high priority.**

Many witnesses stressed that, though individual Canadians are responsible for their own health, government can play an important role in providing information on how to stay healthy. This point was very well captured in the testimony of Dr. Serge Boucher, from the Hôtel-Dieu Hospital in Quebec City, when he said:

*Health is up to the individual. It is the individual who decides to become obese. It is the individual who decides whether or not to smoke. It is also the individual who decides whether or not he or she should exercise. Should the State intervene? Should the State compel the individual to do something? It is very important that we pinpoint accurately what the State can or must do; namely, looking first of all after the illness. As for health, we can give information.*<sup>242</sup>

It is clear to the Committee that government programs that enable people to be responsible for their own health must be given high priority. This point was stressed as far back as 1974 in the Lalonde report. This view was reiterated again in 1986 when the then federal Minister of Health, the Honourable Jake Epp, released a report entitled *Achieving Health for All: A Framework for Health Promotion*, which focused on the broader social, economic and environmental determinants of health. Both the Lalonde report and the Epp report underlined health promotion and illness prevention as a complement to the health care system and a means to prevent the occurrence of injuries, illnesses and chronic conditions, and to enhance people's ability to manage and cope with diseases, disabilities and mental health problems.

The Committee believes that programs which enable individuals to be responsible for their own health must be given high priority. An expanded Canadian Health Network, such as the one we advocate in Chapter Four, is one important tool that could furnish Canadians with reliable, evidence-based information on health, injury and illness. Currently, the Canadian Health Network provides health promotion and disease prevention information to Canadians and is considered by many as among the best in the world. The Committee believes that we should build on this success and create a national portal for the Canadian public, which would give Canadians access to comprehensive and trusted health-related information that could support self-care decision making and be strategically linked to provincial and territorial website services to ensure consistency of health-related information across Canada.

Recognizing that Internet-based health information can only be available to those who have access to computers, the Committee believes that government must also pursue public awareness campaigns which can address a wide range of issues, such as the importance of eating healthy food, exercising regularly, not smoking and adopting safe sexual practices. These

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<sup>242</sup> Dr. Serge Boucher (39:32).



are all important messages that must be reiterated on an ongoing basis. We concur with witnesses that the role of government should not be to prescribe “good behaviour” but rather to help create an environment that allows people themselves to make the right choices.

Providing the “right information” with respect to health and illness and sustaining an ongoing public awareness campaign can significantly contribute to preventing many illnesses and most injuries, thereby improving the overall health status of the Canadian population. For example, with respect to cancer, Dr. Barbara Whyllie, Director, Cancer Control Policy, Canadian Cancer Society, pointed out that:

*(...) we know from research, or it has been estimated from research studies, that up to 70 per cent of cancer cases can be avoided by people avoiding exposure to known risk factors, which include tobacco use, diet, physical activity, exposure to the sun and occupational and environmental carcinogens.*<sup>243</sup>

With respect to injury, Dr. Robert Conn, President and Chief Executive Officer, SMARTRISK, told the Committee:

*What is most compelling about injury prevention is that over 90 per cent of all of the injuries that come to the hospital are preventable. They are predictable and preventable.*<sup>244</sup>

Witnesses stressed that health promotion and disease prevention should not be seen as a substitute for the activities of the health care system, or as existing in a world cut off from the treatment of illness and the provision of care. Rather, promotion and prevention activities should be integrated with health services delivery.

Witnesses pointed to the Canadian Heart Health Initiative as an example of a program that exhibits the requisite integration features. The Canadian Heart Health Initiative is a multilevel strategy, linking national, provincial and local health departments. The Initiative is based on a multi-factor approach – one that addresses the major risk factors that are preventable or controllable. It combines research with the implementation of community-based heart health programs, directed primarily at achieving environmental changes supportive of “heart-healthy” habits and lifestyles among the general population.

Finally, the Committee was told that health promotion and disease prevention efforts should not be undertaken only by government. Employers can benefit in investing in prevention in their workplace settings. Edward Buffett, President and Chief Executive Officer, Buffett Taylor & Associates Ltd, Employee Benefits and Workplace Wellness Consultants, gave an example of how programs initiated at the workplace have a positive impact on health and wellness:

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<sup>243</sup> Dr. Barbara Whyllie (37:135).

<sup>244</sup> Dr. Robert Conn (37:138).

*We have a lot of American data right now that makes it very clear that not only are there savings, but they are very significant. We are looking at organizations like IBM and others claiming that for every \$1 they spend on disease prevention at the worksite they get a \$6 return on their investment.*

*The best example I can give you here in Canada is Husky Injection Molding Systems Ltd. The average rate of absenteeism for their industry is 9.7 per cent. That particular organization, which is a worldwide entity based here in Canada, now has in excess of 2,000 Canadian employees, primarily at their Bolton operation, and has a rate of absenteeism of 1.2 per cent. The savings are phenomenal. Husky Injection Systems provides on-site naturopathic services. They have two physicians who visit the plant on a regular basis. They have a child care centre. Their enlightened initiatives, frankly, have made them a world-class competitive organization. That is the pay-off.<sup>245</sup>*

The Committee is convinced that investment, both by government and the private sector, in health promotion and disease prevention is essential in order to maintain and enhance the health and wellness of Canadians, and that this investment will also make a significant contribution to the sustainability of our publicly funded health care system.

***The Committee is convinced that investment, both by government and the private sector, in health promotion and disease prevention is essential in order to maintain and enhance the health and wellness of Canadians, and that this investment will also make a significant contribution to the sustainability of our publicly funded health care system.***

Similarly, with regard to injuries, Dr. Robert Conn of Smartrisk told the Committee that it costs the system \$8.7 billion to treat people who are seriously injured.<sup>246</sup> The Committee believes that more can be done with regard to injury prevention, and agrees with Dr. Conn that a national strategy, encompassing research and appropriate evidence-based programs to help prevent injury, should be seriously considered.<sup>247</sup>

<sup>245</sup> Edward Buffett (37:34-35).

<sup>246</sup> Dr. Robert Conn (37:138).

<sup>247</sup> SMARTRISK Foundation, Brief to the Committee, Oct. 29, 2001, pp. 10-11.

## Principle 7.3

**It is necessary to develop broad population health strategies that are long term, national in scope and based on multi-departmental efforts across all jurisdictions.**

As the Committee has noted in its previous reports,<sup>248</sup> the concept of population health is not a new one and has been widely endorsed by policy-makers at all levels, inside and outside of government. Central to the formulation of policy based on a population health approach is the recognition that a wide range of factors contribute to health outcomes and to the overall health status of communities and individuals. During the Committee's most recent hearings, witnesses gave many vivid examples of the importance of the broad determinants of health. For example, Gary O'Connor, Executive Director, Association of Ontario Health Centres, told the Committee that:

***As the Committee has noted in its previous reports, the concept of population health is not a new one and has been widely endorsed by policy-makers at all levels, inside and outside of government.***

*Over the past century, the most dramatic increases in health and wellness have come from sources other than the curative arts. They have come from safe drinking water, housing, income support and the use of seat belts, to name a few.*<sup>249</sup>

Similarly, Dr. Robyn Tamblyn, Associate Professor, Faculty of Medicine, McGill University, stated:

*We are just beginning to understand the determinants of health. (...) In my mind, what you are trying to tackle is the fact that there are many things that influence people's health. (...) If you really want to start much earlier in the process to determine people's health, then you will have to effectively deal with all these other sectors that will impact on health.*<sup>250</sup>

Throughout its hearings, the Committee heard repeatedly about the numerous long-term benefits that can be derived from population health strategies. However, we also learned that there are a number of difficulties associated with the design and implementation of programs and policies of a population health approach. One of them is the fact that the benefits of population health strategies can often take a long time to become apparent. This has significant consequences in a politicized system that is often not able to focus on the longer term because of the relentless short-term pressures of political life.

<sup>248</sup> See Volume One (Chapter 5), Volume Two (Chapter 4) and Volume Four (Chapter 12).

<sup>249</sup> Gary O'Connor (37:115-116).

<sup>250</sup> Dr. Robyn Tamblyn (40:82).

Another major challenge associated with devising a population health strategy is the difficulty to coordinate government activity in a context where decisions made by different ministries have an impact on health outcomes. Therefore, the responsibility for population health cannot reside exclusively with the minister of health. This difficulty is compounded several times over when the various levels of government are taken into account.

Despite the many difficulties that will have to be overcome, witnesses recognized the need for a multi-departmental and multi-jurisdictional approach to fostering the health and well-being of the Canadian population. For example, Mr. Gary O'Connor, Executive Director, Association of Ontario Health Centres, argued that:

*True health comes from an integrated approach, which would be achieved by partnerships with other ministries within the government and with other governments.*<sup>251</sup>

Multi-departmental efforts would ensure that the policies enacted by various government departments converge towards the same goals. This contrasts with the current situation in which policies may have diverging impacts on health outcomes. Dr. Tamblyn gave the following example:

*In any event, we know that exercise influences glucose metabolism. Hence, the epidemics of diabetes and obesity in younger kids are related to exercise programs. At the same time, the Ministry of Education is cutting education budgets and teachers are refusing to get involved in extracurricular activities. What are we doing? We are ignoring an opportunity to encourage and teach physical fitness. This will have downstream negative effects on health. We are choosing to ignore this and instead to make immediate cuts to education, in order to not achieve the final goal of influencing the determinants of health.*<sup>252</sup>

The Committee heard that in at least one province a serious attempt is being made to find ways to implement a multi-disciplinary, multi-departmental approach to population health. Robert C. Thompson, Deputy Minister, Department of Health and Community Services, Government of Newfoundland and Labrador, told the Committee about the Strategic Social Plan (SSP) that has been developed in his province:

*In Newfoundland and Labrador, the institutional infrastructure to mount this type of approach already exists through the Strategic Social Plan, the SSP. The SSP was started in 1998. It involves economic and social departments and agencies in a comprehensive approach to promoting health, education, self-reliance, and prosperity for people in the context of vibrant communities and sustainable regions.*

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<sup>251</sup> Mr. Gary O'Connor (37:116).

<sup>252</sup> Dr. Robyn Tamblyn (40:83).

*The SSP has resulted in multi-disciplinary committees in seven regions, identifying social priorities that can be achieved through the complimentary activities of many departments and agencies. The SSP also promotes and provides institutional support for cross-departmental planning and policy development.*<sup>253</sup>

Drawing on the experience of his own province, Dr. Roy West (St. John's), President of the Board of Directors of the National Cancer Institute of Canada, stated:

*There must be a national strategic social plan – which we have; Newfoundland is the first province to develop a provincial strategic social plan. Newfoundland is having some difficulty implementing the plan, because of lack of resources, but it is heading in the right direction, in trying to empower communities to make them healthier and to make them economically more viable.*<sup>254</sup>

The Committee believes that there are potentially enormous benefits to be derived from the development of strategies based on a population health approach. We therefore feel that it is important to attempt to overcome any difficulties that confront their elaboration and implementation. The Committee believes that, as a first step in this direction, it is important to look carefully at the experience of provinces in their attempt to implement population health strategies, and in particular at how the federal government can contribute to ensuring that sufficient resources are available.

## *Principle 7.4*

**The federal government should continue to provide leadership in the field of population health and devote more resources to population health strategies.**

Witnesses who appeared before the Committee stressed that the federal government has been recognized as a leader worldwide in elaborating the concept of population health, and many felt that it was imperative for the federal government to once again show leadership in implementing a population health strategy for all Canadians. Dr. Catherine Donovan, Medical Officer of Health, Health and Community Services, Eastern Newfoundland, indicated that, unless the federal government deploys sufficient effort and resources, many of the good ideas that have been pioneered in Canada with regard to population health strategies will lie fallow:

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<sup>253</sup> Robert C. Thompson (41:7-8).

<sup>254</sup> Dr. Roy West (41:48-49).

*[Canada] needs adequate resources to support the kind of innovative health promotion and protection programming that is going to have a long term impact on health (...). Canada has always been very good at developing theory and approaches to the promotion of population health, but we have done relatively little to follow the path that earns us international recognition.*<sup>255</sup>

The Committee believes that, because of their importance, serious consideration should be given by the federal government to devoting more attention, effort and resources to the development and implementation of population health strategies. The federal

***The federal government should lead the way in population health by breaking down the ministerial silos that compartmentalize responsibility for health and by coordinating the activities of the different departments whose policies and programs impact on health (health, environment, finance, etc.).***

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## ***P*** ***inciple 7.5***

**Government policies should be examined in terms of their impact on health status and health outcomes.**

The broad policy implication that flows from the recognition of the multiplicity of the determinants of health is that it is necessary to devise some sort of mechanism that would allow Canadians to monitor the impact of all government policy on health outcomes. One possible way to do this, which the Committee raised as an option in its previous report,<sup>256</sup> would be to charge a Health Commissioner with the responsibility of reporting to Parliament on the health impact of all federal government policy.

***The broad policy implication that flows from the recognition of the multiplicity of the determinants of health is that it is necessary to devise some sort of mechanism that would allow Canadians to monitor the impact of all government policy on health outcomes.***

A number of witnesses responded favorably to this suggestion by the Committee. For example, Jeff Wilbee, Executive Director, Alcohol and Drug Recovery Association of Ontario and Addiction Intervention Association, said that “Canada should show world leadership, through a health commissioner, in measuring and improving our population

<sup>255</sup> Dr. Catherine Donovan (41:66).

<sup>256</sup> Volume Four, p. 127.

health status.”<sup>257</sup> Similarly, Madeline Boscoe, Advocacy Coordinator, Women’s Health Clinic in Winnipeg, stated:

*We very much appreciated your comments about health promotion and population health. We think this is critical, and are delighted with the idea of a commissioner in health impact assessments. We hope these concepts will be enshrined in an act of Parliament. As a matter of fact, the joke around our place is: since we do health impact assessments for the environment, how come we do not do them for people?*<sup>258</sup>

The Committee strongly believes that the monitoring of health outcomes should be at the forefront of government policy. Principle Sixteen in Chapter Two lays out how we believe such monitoring should be performed with respect to health care delivery. Based on this principle, we advocate, in Chapter Four, the creation of a national mechanism, independent from government, responsible for monitoring and assessing the impact of health care policy on the health status of Canadians. The Committee is convinced that a similar mechanism, complementary to the first one, should be established to review and assess the impact of all government policies on health outcomes.

The Committee is convinced that the federal government could set a valuable example by financing a permanent mechanism for reporting to the Canadian public on the impact of its policies affecting health. Regardless of the exact nature of the office that would assume this responsibility, the important point is to devise a mechanism that enables all government policy to be screened through a population health lens. This would permit an ongoing analysis of health outcomes and provide some measure of overall public accountability. An annual report from such an office that focused on the broad determinants of health could also include prescriptions for how to ensure that all government policies have as positive an effect as possible on the health of Canadians.

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<sup>257</sup> Jeff Wilbee (37:131).

<sup>258</sup> Madeline Boscoe (30:59).

## Principle 7.6

### **Population health strategies must be adapted to local conditions, and their design and implementation must involve local communities.**

The evidence suggests that population health strategies in general must be carefully thought through so that they take into account the realities facing specific communities. For example, people may be less inclined to bike or jog if the streets are unsafe. This implies that rigidly designed programs applied in a uniform and highly centralized fashion are unlikely to succeed. Successful community-based programs combine an understanding of the community, with the participation of the public, and the cooperation of community organizations. Some combination of coordination and decentralized implementation is therefore required.

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Witnesses illustrated the importance of tailoring efforts to local conditions with examples from their own experience. Ms. Ingrid Larson, Member Relations Director, Community Health Services Association (Saskatoon), told the Committee:

*In terms of our experience at the west side clinic where we primarily see an urban Aboriginal clientele, the issues we deal with are social determinants of health. There, our nurses do community outreach and community development work. They are very well aware that the issues facing that community are far more than physical health issues. We then work on issues related to housing, nutrition, and all the related issues that have a substantial impact on people's well-being. It is not just about health when it comes to serving that population group. It involves some very complex issues, all of which have to be addressed.*<sup>259</sup>

The Committee acknowledges that the wide range of determinants of health can affect different communities in many different ways. We believe that in order to be able to respond to the particular configuration of health determinants that occur in each community, it is therefore essential

***The Committee acknowledges that the wide range of determinants of health can affect different communities in many different ways. We believe that in order to be able to respond to the particular configuration of health determinants that occur in each community, it is therefore essential to adapt population health strategies as best as possible to local circumstances.***

<sup>259</sup> Ms. Ingrid Larson (31:37).



to adapt population health strategies as best as possible to local circumstances.

## ***P**inciple 7.7*

**Given its fiduciary and constitutional responsibilities, the federal government should develop a population health strategy for Aboriginal Canadians.**

In Volume Four of its study, the Committee stated unequivocally that in its view, the health of our Aboriginal peoples is a national disgrace and that the federal government must take a leadership role in working to immediately redress this situation.<sup>260</sup>

In Volume Two of its study, the Committee gave an overview of some of the factors that contribute to poorer health outcomes amongst Aboriginal Canadians. We noted in this regard that there are significant socio-economic disparities between Aboriginal peoples and the general Canadian population. Aboriginal peoples are less likely to be in the labour force, and unemployment rates are higher than those of the general population. In 1995, the average employment income of the Aboriginal population was \$17,382 compared to the national average of \$26,474. The Committee also noted that Aboriginal Canadians appear to be the largest population sub-group that is the most at risk of becoming homeless in Canada, and that significant numbers of Aboriginal peoples (43%) live in inadequate housing.<sup>261</sup>

Although it did not hear extensively from Aboriginal representatives during its most recent hearings, the evidence that the Committee did gather pointed again to the many ways in which a population health approach might be suited to developing strategies to address the multi-faceted health problems confronted by Aboriginal communities. For example, the Hon. Edward Picco, Minister of Health and Social Services (Nunavut) reiterated the extent to which problems relating to socio-economic disadvantage afflicted Aboriginal communities, telling the Committee:

*The unemployment rate in Nunavut is over 20 per cent, which compares with the annual Canadian rate of 8 per cent. The average annual income among 85 per cent of our population is well below the Canadian average. Again, it goes back to (...) the socio-economic factors and health determinants.*<sup>262</sup>

He further explained how these kinds of problems have a negative impact on the health status of the Inuit in Nunavut, telling the Committee:

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<sup>260</sup> Volume Four, p. 132.

<sup>261</sup> Volume Two, pp. 59-60.

<sup>262</sup> 32:23

*Mr. Chairman, I think it is also important to highlight overcrowding in Nunavut because of our housing situation. I am also the minister responsible for homelessness. In Nunavut, if you understand homelessness, you use two terms: one is "relative homelessness," and the other one is "absolute homelessness."*

*Absolute homelessness refers to the people you see on the streets in your larger cities. Relative homelessness is what we have in Nunavut, where 22 people live in a two-bedroom house, and people have to sleep in closets, on the floor, and in shifts on foam mattresses.*

*When you are in an environment like that, Mr. Chairman, when you have colds, the flu, pneumonia, and you are not getting enough to eat, of course your health status goes down. This is happening right now in Canada.*<sup>263</sup>

Evidence such as this confirms the Committee's belief that it is essential to work towards the development of "a comprehensive plan that could meet the health care needs of all Aboriginal peoples in Canada."<sup>264</sup>

***The Committee believes that it is essential to work towards the development of "a comprehensive plan that could meet the health care needs of all Aboriginal peoples in Canada."***

The Committee also previously indicated that the involvement of different jurisdictions in the delivery of health services to Aboriginal communities constituted another obstacle to the coordination of efforts aimed at improving health outcomes for Aboriginal peoples. We pointed out in Volume Two that jurisdictional barriers to the provision of health services to Aboriginal people exist on two levels.<sup>265</sup> One barrier arises from the division of powers between the federal and provincial governments and can lead to some services not being available to all communities equally. This problem was highlighted for the Committee by Minister Picco who stated with regard to Inuit Canadians:

*Mr. Chairman, I have also previously stated that Inuit expect levels of health care that are comparable with other Canadians. To achieve this, we need resources from the Government of Canada. We would strongly recommend that the Government of Canada accept and discharge its responsibility for the 85 per cent of the population of Nunavut who are Inuit.*<sup>266</sup>

Other consequences of having two jurisdictions involved in delivering health services include program fragmentation; problems with reporting mechanisms; inconsistencies,

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<sup>263</sup> 32:23

<sup>264</sup> Volume Four, p. 132.

<sup>265</sup> Volume Two, pp. 68-70.

<sup>266</sup> 32:27

gaps, or possible overlaps in programs; and impediments to developing a holistic approach to health and wellness.

Witnesses also insisted on the importance of adapting health care delivery and preventive health measures to the concrete realities of Aboriginal communities. Ms Ruth Morin, Chief Executive Officer, Nechi Institute illustrated this point:

*For instance, it became apparent to the Alberta Cancer Board that Aboriginal women had increased rates of breast cancer and were dying at a much higher rate than other Canadian women. It was discovered that Aboriginal women were not coming to get mammograms. Why? Part of the reason was due to travel, but there was also a high rate of sexual abuse associated with the whole residential school thing. Going through the whole process of getting a mammogram was seen as a huge mountain that a lot of people were not willing to climb. However, when a mobile mammogram was brought to the communities and they had lunch and they picked up the ladies and they had child care and things like that, Aboriginal women were more willing to be involved. They liked the safety of their own community, with their own people helping them. The women came, the mammograms were done, and everyone was happier.*

How to achieve an integration of all health related activities in a way that meets the needs of Aboriginal peoples, and involves them in all aspects of the design and implementation of these programs, remains unresolved. This issue was recently raised in the Interim Report of the Commission on the Future of Health Care in Canada, where it was noted that integration of health services might be fostered by allowing the provinces and territories to take charge to a greater extent:

*Traditionally, Aboriginal peoples have emphasized a more integrated and comprehensive view of health than the current health care system has provided, with its narrower focus on hospital and doctor-delivered health services. In recent decades however, provincial and territorial governments have moved toward a more integrated approach that is perhaps more consistent with traditional Aboriginal perspectives on health. As a result, there has been some movement toward the integration of Aboriginal health services within provincial and territorial health care systems and the creation of Aboriginal-specific health programs.<sup>267</sup>*

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<sup>267</sup> Interim Report of the Commission on the Future of Health Care in Canada, p. 41.

This raises the question of whether it would be possible for the provinces and territories to take advantage of the fact that they already are responsible for the delivery of health services to the general population in order to provide services in a more coordinated fashion to Aboriginal peoples as well. The Committee recognizes that there are many of possible ways to reorganize governmental responsibility for the delivery of health care to Aboriginal peoples in order to achieve a more integrated result, and that further consultation and reflection will be needed before it can issue any recommendations in this regard. Moreover, it is clear to the Committee that whatever arrangements are deemed most suitable, the federal government retains its constitutional and fiduciary responsibilities towards the Aboriginal peoples of Canada. The Committee therefore reaffirms its commitment to “the development of a National Action Plan on Aboriginal Health to improve inter-jurisdictional co-ordination of health care delivery.”<sup>268</sup> One option that should be considered in this context is for the federal government to fund health care programs that would be delivered by the provinces, on reserve as well as off reserve.

***The Committee therefore reaffirms its commitment to “the development of a National Action Plan on Aboriginal Health to improve inter-jurisdictional co-ordination of health care delivery.” One option that should be considered in this context is for the federal government to fund health care programs that would be delivered by the provinces, on reserve as well as off reserve.***

Because of the importance of the issue of the health status of Canada's Aboriginal peoples, the Committee proposes to issue a separate report that will contain its recommendations to the federal government.

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<sup>268</sup> Volume Four, p. 132.

## APPENDIX A

### **LIST OF PRINCIPLES AND RECOMMENDATIONS BY CHAPTER**

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#### **CHAPTER TWO:**

#### **PRINCIPLES TO GUIDE THE RESTRUCTURING AND FINANCING OF CANADA'S HEALTH CARE SYSTEM**

##### **Principle One**

There should be a single funder (insurer) – the government directly or through an arm's length agency – for hospital and doctor services covered under the *Canada Health Act*.

##### **Principle Two**

There should be stability of, and predictability in, government funding for public health care insurance.

##### **Principle Three**

The federal government should play a major role in sustaining a national health care insurance system.

##### **Principle Four**

The determination of what should be covered under public health care insurance should be done through an open and transparent process. Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.

##### **Principle Five**

The federal government should contribute on an ongoing basis to fund health care technology.

##### **Principle Six**

The federal government should increase its investment in those areas of health and health care for which it already has a major responsibility.

##### **Principle Seven**

The consequences arising from changes in the level or amount of government funding for hospital and medical care should be clearly understood by government and explained to the public, in as much detail as possible, at the time such changes are made and announced.

**Principle Eight**

In the first stage of health care reform, the method for remunerating hospitals should be changed from the current annual global budget to service-based funding.

**Principle Nine**

Regional health authorities should have the responsibility for purchasing hospital services provided by institutions within their region.

**Principle Ten**

Primary care renewal should lead to the provision of primary care by group practices, or clinics, which operate twenty-four hours a day seven days a week.

**Principle Eleven**

To facilitate primary care reform, the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards.

**Principle Twelve**

New scope of practice rules and other measures need to be developed in order to enable all health care providers in the primary care sector to provide the full range of services for which they have been trained.

**Principle Thirteen**

In the second stage of health care reform, an “internal market” should probably be created in which primary health care teams would purchase health services provided by hospitals and other health care institutions on behalf of their patients.

**Principle Fourteen**

A national (not exclusively federal) strategy must be developed to achieve both an adequate supply and optimal use of health care providers.

**Principle Fifteen**

Accountability and transparency in health care financing and delivery require the deployment of a system of electronic health records (EHR) that can capture and translate information on system performance and outcomes.

**Principle Sixteen**

Measuring treatment outcomes and system performance must become an essential part of the health information system. Such monitoring and evaluation of the health care delivery system should be performed independently at the national (not federal) level and be funded by government.

**Principle Seventeen**

Canada’s publicly funded health care system should be patient-oriented.

**Principle Eighteen**

Incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees for services that are deemed to be medically necessary.

**Principle Nineteen**

Programs that enable people to be responsible for their own health and to stay healthy must be given high priority. The federal government can play a leadership role in this regard.

**Principle Twenty**

For each type of major procedure or treatment, a maximum waiting time should be established, and made public. When this maximum time is reached, the insurer (government) shall pay for the patient to receive immediately the procedure or treatment in another jurisdiction including, if necessary, another country.

**CHAPTER THREE:****FINANCING AND ASSESSING HEALTH CARE TECHNOLOGY**

That the federal government initiate a long-term program to assist provinces and territories in financing both the acquisition and ongoing operation of health care technology. Such a program should incorporate clear accountability mechanisms on the part of the provinces and territories on their use of these targeted federal funds.

That the federal government increase the funding it provides to CCOHTA and other HTA agencies.

That this additional funding be used to strengthen HTA capacity in Canada as well as to improve the dissemination and promotion of HTA findings to health care providers and managers.

That the federal government provide additional funding to the Canadian Institutes for Health Research and the Canadian Health Services Research Foundation to support research into the potential impact of health care technology on health care costs.

**CHAPTER FOUR****DEPLOYING A NATIONAL HEALTH INFOSTRUCTURE**

That, once the three- to five-year period is over, the federal government provide additional financial support to Canada Infoway Inc. so that *Infoway* develop, in collaboration with the provinces and territories, a national system of electronic health records.

That the federal government, in collaboration with all stakeholders involved in the computerization of health records, define standards and rules for the collection, storage and use of such information.

That the federal government, in collaboration with the provinces and territories, undertake the establishment of a national system of evaluation on health care system performance and outcomes. Such a national system of evaluation should: 1) be built on existing expertise and institutions; 2) remain independent from governments; and 3) receive appropriate funding from the public purse. The federal government should devote substantial funding to this very important undertaking.

That the federal government maintain its support to rural health and invest in telehealth applications that will enhance access to care and improve the quality of health services in rural and remote communities.

That the federal government, in collaboration with the provinces/territories and stakeholders, develop a national health information portal, building on the success of the Canadian Health Network and the integration of provincial/regional portals.

- As a matter of priority, investments into this national portal should be made in locations where the basic systems infrastructure is inadequate, especially in rural, remote and Aboriginal communities. This would greatly enhance the capacity of all Canadians to access timely and objective electronic health information.

## **CHAPTER FIVE**

### **NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH**

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

That 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.

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

That 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.

That the federal government:

- Increase, within a reasonable timeframe, its financial contribution to extra-mural health research to achieve the level of 1% of total Canadian health care spending.



- 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.

That 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.

That 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.

That 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.

That 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.

That 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.

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

That 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.

That 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.

That 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.

That 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.

That 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 as 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 of 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.

That 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.

That regulations such as those proposed by the Canadian Institutes of Health Research receive their fullest and fairest consideration in discussion 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.

That 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.

That 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.

That 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 with 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.

That 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 SIX**

### **PLANNING FOR HUMAN RESOURCES IN HEALTH CARE**

That 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.

- Review 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 student loan programs available to health care professionals and make modifications to ensure that the impact of inevitable increases in tuition fees, especially as they affect medical students, does not lead to denial of opportunity to students in lower socio-economic circumstances.
- Provide particular tuition support for nursing students, up to and including waiving tuition fees entirely for a limited period of time.
- 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.

That 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.

That 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.

That the federal Government work with other concerned parties to create a permanent national coordinating body 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-served regions, particularly the rural and remote areas of the country;
- examination of the possibilities for greater coordination of licensing and immigration requirements between the various levels of government.

That 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;
- organize themselves so that they develop the capacity to purchase services from hospitals and other institutional providers on behalf of their patients;
- progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.

## **CHAPTER 7**

### **TOWARDS A POPULATION HEALTH STRATEGY**

#### **Principle 7.1**

Individuals should assume responsibility for their own health.

#### **Principle 7.2**

Government programs that enable individuals to assume greater responsibility for their own health, and particularly health promotion and illness prevention activities, must be given high priority.

#### **Principle 7.3**

It is necessary to develop broad population health strategies that are long term, national in scope and based on multi-departmental efforts across all jurisdictions.

#### **Principle 7.4**

The federal government should continue to provide leadership in the field of population health and devote more resources to population health strategies.

#### **Principle 7.5**

Government policies should be examined in terms of their impact on health status and health outcomes.

**Principle 7.6**

Population health strategies must be adapted to local conditions, and their design and implementation must involve local communities.

**Principle 7.7**

Given its fiduciary and constitutional responsibilities, the federal government should develop a population health strategy for Aboriginal Canadians.

## APPENDIX B

### LIST OF WITNESSES

---

#### **Monday, October 15, 2001**

*University of Manitoba:*

Linda West, Professor, Asper School of Business

*Frontier Centre for Public Policy:*

Peter Holle, President

*Western Canadian Task Force on Health Research and Economic Development:*

Dr. Henry Friesen, Team Leader

Dr. John Foerster

Dr. Audrey Tingle

Chuck Laflèche

*Regional Health Authorities of Manitoba*

Bill Bryant, Chair, Council of Chairs

Kevin Beresford, Chair, Council of CEOs

Randy Lock, Executive Director

*Manitoba Centre for Health Policy and Evaluation:*

Dr. Nora Lou Roos

*Women's Health Clinic:*

Madeline Boscoe, Advocacy Coordinator

*Hospice and Palliative Care Manitoba:*

Dr. Paul Henteleff, Chair, Advocacy Committee

John Bond, Member of Advocacy Committee

Margaret Clarke, Executive Director

*Canadian Union of Public Employees in Manitoba (CUPE):*

Paul Moist, President

Lorraine Sigurdson, Health Care Coordinator

*Société franco-manitobaine:*

Daniel Boucher, Chief Executive Officer

*As a walk-on:*

Barry Shtatleman

#### **Tuesday, October 16, 2001**

*Saskatchewan Registered Nurses' Association:*

June Blau, President

*Victorian Order of Nurses:*

Bob Layne, Vice-President, Planning and Government Relations (Western Region)

Lois Clark, Executive Director, VON North Central Saskatchewan

Brenda Smith, National Board Member (Saskatchewan)

*Community Health Services (Saskatoon) Association:*  
Kathleen Storrie, Vice-President  
Ingrid Larson, Director, Member Relations

*As an individual:*  
Dr. John Bury

*Canadian Union of Public Employees (CUPE) Saskatchewan:*  
Tom Graham, President, CUPE Saskatchewan  
Stephen Foley, President, Health Care Council  
John Welden, Health Care Coordinator, Health Care Council

*Saskatoon Chamber of Commerce:*  
Dave Ducthak, President  
Kent Smith-Windsor, Executive Director  
Jodi Blackwell, Research and Operations Director

*Arthritis Society of Saskatchewan:*  
Sherry McKinnon, Executive Director  
Joy Tappin, Board Member

*Canadian Parks and Recreation:*  
Randy Goulden, Executive Director, Tourism Yorkton

*Métis National Council:*  
Gerald Morin, President  
Don Fidler, Director, Health Care

### **Wednesday, October 17, 2001**

*Premier's Advisory Council on Health (Alberta):*  
The Right Honourable Don Mazankowski, P.C., Chair  
Peggy Garritty

*Department of Health and Social Services (Nunavut):*  
The Hon. Edward Picco, Minister

*Calgary Health Region:*  
Jack Davis, CEO

*Capital Health Authority:*  
Sheila Weatherill, President and CEO

*Canadian Practical Nurses Association:*  
Pat Fredrickson, President

*University of Alberta - Faculty of Nursing:*  
Dr. Donna Wilson

*Health Sciences Association of Alberta:*  
Elisabeth Ballermann, President

*Alberta Association of Registered Nurses:*  
Sharon Richardson, President



*United Nurses of Alberta:*  
Heather Smith, President

*Friends of Medicare:*  
Christine Burdett, Provincial Chair  
Tammy Horne, Member

*As an individual:*  
Kevin Taft, MLA

*Western Canada Waiting List Project:*  
John McGurran, Project Director

*Primary Care Initiative:*  
Dr. June Bergman

*Alberta Consumers Association:*  
Wendy Armstrong

*Fédération des communautés francophones et acadiennes du Canada :*  
George Arès, President

*National Advisory Council on Aging:*  
Pat Raymaker, Chairwoman

*Alberta Council on Aging:*  
Neil Reimer, Secretary/Treasurer

*Nechi Institute:*  
Ruth Morin, Chief Executive Officer  
Richard Jenkins, Director of Marketing and Health Promotion

*Executive of the Alberta and Northwest Conference of the United Church of Canada - Health Advisory Committee:*  
Louise Rogers  
Kent Harold  
Don Junk

*As a walk-on:*  
Noel Somerville

**Thursday, October 18, 2001**

*Commission on Medicare, Saskatchewan:*  
Ken Fyke, Former Chair

*Tommy Douglas Research Institute:*  
Dave Barrett, Chair  
Marc Eliesen, Co-Chair

*Market-Media International Corporation:*  
Joan Gadsby, President

*University of British Columbia, Family Practice Residency Program:*  
Dr. J. Galt Wilson, Program Director - Prince George Site

*University of British Columbia:*  
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Dr. Joanna Bates, Associate Dean, Admissions

*Health Professions Council:*  
Dianne Tingey, Member  
Gerry Fahey, Research Director

*Cambie Surgery Centre:*  
Dr. Brian Day, Founder

*As an individual:*  
Cynthia Ramsay, Health Economist

*Health Association of British Columbia:*  
Lorraine Grant, Chair of the Board of Directors  
Lisa Kallstrom, Executive Director

*University of British Columbia:*  
Dr. John H. V. Gilbert, Coordinator of Health Sciences

*University of British Columbia - Vancouver Hospital and Health Sciences Centre:*  
Professor Charles Wright, Director, Centre for Clinical Epidemiology and Evaluation

*University of British Columbia – Centre for Health Services and Policy Research:*  
Professor Barbara Mintzes

*Professional Association of Residents of British Columbia:*  
Dr. Kristina Sharma

### **Friday, October 19, 2001**

*Canadian Medical Association:*  
Dr. Peter Barrett, Past President  
Dr. Arun Garg, Chair, Council on Health Policy and Economics

*British Columbia Medical Association:*  
Dr. Heidi Oetter, President  
Darrell Thomson, Director, Economics and Policy Analysis

*University of British Columbia, Anxiety Disorders Unit, Department of Psychiatry:*  
Dr. Peter D. McLean, Professor and Director

*Maples Surgical Centre (Manitoba)*  
Dr. Mark Godley

### **Monday, October 29, 2001**

*Canadian Radiation Oncology Services:*  
Dr. Thomas McGowan, President and Medical Director

*Canadian Taxpayers Federation:*  
Walter Robinson, Federal Director

*Canadian Council of Churches:*  
Stephen Allen, Member of Commission for Justice and Peace and Co-Chair of the Commission's Ecumenical Health Care

*Buffett Taylor Employee Benefits and Workplace Wellness Consultants:*  
Edward Buffett, President and CEO

*As an individual:*  
Michael Rachlis

*Medical Reform Group:*  
Dr. Joel Lexchin

*At Work Health Solutions Inc.:*  
Dr. Arif Bhimji, Founder and President; Medical Director of Liberty Health  
Gery Barry, President and CEO of Liberty Health

*Consumers' Association of Canada:*  
Jean Jones, Chair of the Health  
Mel Fruitman, President

*Ontario Association of Optometrists:*  
Dr. Joseph Chan

*Medical Devices Canada (MEDEC):*  
Peter Goodhand, President

*AstraZeneca:*  
Gerry McDole, President and CEO

*Comcare Health Services:*  
Mary Jo Dunlop, President St. Michael Hospital

*Saint Michael's Hospital:*  
Jeffrey Lozon, President and CEO

*Association of Ontario Health Centres:*  
Gary O'Connor, Executive Director

*Ontario Medical Association:*  
Kenneth Sky, President

*The Arthritis Society:*  
Denis Morrice, President and CEO

*SMARTRISK:*  
Dr. Robert Conn, President and CEO

*Canadian Cancer Society:*  
Dr. Barbara Whyllie, Director, Cancer Control Policy  
Cheryl Mayer, Director, Cancer Control Programs Alcohol and Drug Recovery Association of Ontario and  
Addiction Intervention Association  
Jeff Wilbee, Executive Director

**Tuesday, October 30, 2001**

*Canadian Institute for Health Information:*  
Michael Decter, Chairman, Board of Directors

*Ontario Hospital Association:*  
David MacKinnon, President and CEO

*Registered Nurses Association of Ontario:*  
Doris Grinspun, Executive Director

*McMaster University - Department of Economics:*  
Jeremiah Hurley, Professor

*University of Toronto - Public Health Science Department:*  
Dr. Cameron Mustard, Professor

*University of Toronto:*  
Colleen Flood, Professor

*Drug Trading Company Limited:*  
Larry Latowsky, President and CEO  
Jane Farnham, Vice President Pharmacy

*Canadian Pharmacists Association:*  
Ron Elliott, President

*GlaxoSmithKline:*  
Geoffrey Mitchinson, Vice -president, Public Affairs

*Medtronic:*  
Donald A. Hurley, President

*Canadian Association for the Fifty Plus:*  
Dr. Bill Gleberzon, Associate Executive Director  
Lilian Morgenthal, President

*Canadian Association for Community:*  
Cheryl Gulliver, President  
Connie Laurin-Bowie  
Margot Easton

*Roeher Institute:*  
Cameron Crawford, President

*As individuals:*  
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Robert S.W. Campbell

**Wednesday, October 31, 2001**

*As Individuals:*  
The Honourable Claude Forget  
The Honourable Claude Castonguay  
André-Pierre Contandriopoulos, Professor, Faculty of Medicine, University of Montreal

*Hôtel Dieu Hospital:*  
Dr. Serge Boucher

*Conseil du patronat du Québec:*  
Gilles Taillon, President

*Canadian Chamber of Commerce:*

Nancy Hughes-Anthony, President and Chief Executive Officer  
Michael N. Murphy, Senior Vice-President, Policy

*As Individuals:*

Jean-Luc Migué  
Lee Soderstrom, Professor, Department of Economics, McGill University

*Montreal Economic Institute:*

Michel Kelly-Gagnon, Executive Director  
Dr. Edwin Coffey, Retired Associate Professor, Faculty of Medicine, McGill University, and Former President of the Quebec Medical Association

*Frosst Health Care Foundation:*

Dr. Monique Camerlain, President of the Board of Directors  
Janet Dunbrack, Executive Director.

**Thursday, November 1, 2001**

*Association des optométristes du Québec:*

Dr. Langis Michaud, President  
Marie-Josée Crête, Deputy Director General  
Clairmont Girard, Advisor

*Collège des médecins du Québec:*

Dr. Yves Lamontagne, President  
Dr. André Garon, Deputy Secretary General

*As an Individual:*

Robert Dorion

*Canadian Life and Health Insurance Association:*

Mark Daniels, President  
Greg Traversy, Executive Vice-President  
Yves Millette, Senior Vice-President, Quebec Affairs  
Frank Fotia, Vice-President, Group Insurance.

*As Individuals:*

Dr. Margaret Somerville, Acting Director, McGill Centre for Medicine, Ethics and Law, McGill University  
Dr. Robyn Tamblyn, Associate Professor, Department of Economics, McGill University

*Merck Frosst Canada Ltd.:*

Kevin Skilton, Director, Policy Planning  
Dr. Terrance Montague, Executive Director, Patient Health

*Association québécoise des droits des retraités (AQDR):*

Ann Gagnon, Advisor on Health  
Yollande Richer, Vice-President, Communications  
Myroslaw Smereka, Director General

**Monday, November 5, 2001**

*Department of Health and Community Services, Newfoundland:*

Robert C. Thompson, Deputy Minister

*Department of Health and Community Services, Newfoundland:*

Beverly Clarke, Assistant Deputy Minister

*Victoria Order of Nurses (VON Canada):*  
Patricia Pilgrim, President, St. John's Branch  
Bernice Blake Dibblee, Executive Director, St. John's Branch

*Association of Registered Nurses of Newfoundland and Labrador:*  
Sharon Smith, President

*Canadian Union of Public Employees, Newfoundland:*  
Wayne Lucas, President

*As an individual:*  
Maud Peach

*National Cancer Institute of Canada:*  
Dr. Roy West, President

*Health and Community Services, Newfoundland:*  
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*Weight Watchers:*  
Marlene Bayers, Regional Manager

*Newfoundland Cancer Treatment and Research Foundation:*  
Bertha H. Paulse, Chief Executive Officer

*As an individual:*  
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## **Tuesday, November 6, 2001**

*Canadian Auto Workers (CAW):*  
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*Nova Scotia Association of Health Organizations:*  
Robert Cook, President and CEO

*Insurance Bureau of Canada:*  
George Anderson, President and CEO  
Paul Kovacs, Senior Vice-President Policy and Chief Economist

*Canadian Coalition Against Insurance Fraud:*  
Mary Lou O'Reilly, Executive Director

*Atlantic Institute for Market Studies:*  
Dr. David Zitner, Fellow on Health Policy

*Dalhousie University:*  
Nuala Kenny, Professor of Pediatrics and Chair, Department of Bioethics  
Dr. Vivek Kusumakar, Head, Mood Disorders Research Group, Department of Psychiatry  
Lawrence Nestman, Professor, School of Health Services Administration

*Nova Scotia Valley Caregivers Support Group:*  
Maxine Barrett

*Elizabeth May Chair in Women's Health and the Environment, Dalhousie University:*  
Sharon Batt, Chair

*Feminists for Just and Equitable Public Policy:*  
Ms. Georgia MacNeil, Chair Person

*Cape Breton Regional Health Care Complex:*  
John Malcom, CEO  
Dr. Mahmood Naqvi, Medical Director, Cape Breton Regional Facility

*Capital District Health Authority:*  
Dr. John Ruedy, Vice-President, Academic Affairs

*Dalhousie University:*  
Thomas Rathwell, Professor and Director, School of Health Services Administration

*Canadian Medical Association:*  
Dr. Henry Haddad, MD, President  
Bill Tholl, Secretary General  
Dr. Bruce Wright, President of the Medical Society of Nova Scotia  
Dr. Dana W. Hanson, President-Elect

*Dalhousie University:*  
Dr. Desmond Leddin, Head, Division of Gastroenterology  
Dr. George Kephart, Director, Population Health Research Unit, Department of Community and Epidemiology  
Dr. Kenneth Rockwood, Faculty of Medicine, Division of Geriatric Medicine

*Cobequid Community Health Board:*  
Ryan Sommers

*Health Canada:*  
Anne-Marie Leger, Policy Analyst

### **Wednesday, November 7, 2001**

*Department of Health and Social Services, Prince Edward Island:*  
The Honourable Jamie Ballem, Minister

*PEI Seniors Advisory Council:*  
Heather Henry-MacDonald, Chair

*Canadian Union of Public Employees, PEI Division:*  
Bill A. McKinnon, National Representative  
Ms. Donalda MacDonald, President  
Raymond Léger, Research Representative

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Deborah Bradley, Manager of Public Health Policy

*College of Family Physicians of Canada:*  
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*Queen Elizabeth Hospital:*  
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*Queen's Regional Health Authority:*  
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*West Prince Regional Health Authority:*  
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*Department of Health and Social Services:*  
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*Department of Health and Social Services, Prince Edward island:*  
Rory Francis, Deputy Minister  
Bill Harper, Assistant Deputy Minister  
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*Southern Kings Health Authority:*  
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*Department of Health and Social Services:*  
Susan Maynard, Senior Health Planner  
Kathleen Flanagan-Rochon, Community Services Coordinator

*Evangeline Health Centre:*  
Elise Arsenault, Coordinator

*East Prince Regional Health Authority:*  
David Riley, Chief Executive Officer

*Dalhousie University:*  
Dr. Stan Kutcher, Department Head of the Community Health and Epidemiology/ Psychiatry

### **Thursday Nov. 8, 2001**

*Faculty of Nursing, University of New Brunswick:*  
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*New Brunswick Health Care Association:*  
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*Canadian Association of Chain Drug Stores:*  
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William Morrissey, Former Deputy Minister of Health, Province of New Brunswick

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Bryan Ferguson, Partner

*Société des Acadiens et Acadiennes du Nouveau-Brunswick:*  
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*Canadian Snowbird Association:*  
Bob Jackson, President



*New Brunswick Senior Citizens Federation Inc.:*  
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Eilleen Malone, Member

*Catholic Health Association of Canada:*  
Sandra Keon, Secretary Treasurer; and Vice-President of Clinical Programs, Pembroke Hospital

*Miramichi Police Force:*  
Michael Gallagher, Corporal, Drug Section

*Canadian Union of Public Employees, New Brunswick:*  
Raymond Léger, Research Representative

*Federal Superannuates National Association:*  
Rex G. Guy, National President  
Roger Heath, Research and Communications Officer

*Union of New Brunswick Indians:*  
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Wanda Paul Rose, Coordinator  
Norville Getty, Consultant

*Nurses Association of New Brunswick:*  
Roxanne Tarjan, Director General

**Thursday, February 21, 2002**

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Kathleen Connors, President

*Canadian Health Coalition:*  
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*Federal Superannuates National Co-ordinator:*  
Rex G. Guy, National President  
Roger Heath, Research and Communications Officer

**Thursday, March 7, 2002**

*Canadian Healthcare Association:*  
Sharon Sholzberg-Gray, President and CEO  
Kathryn Tregunna, Director, Policy Development

*Canadian Labour Congress:*  
Kenneth V. Georgetti, President  
Cindy Wiggins, Senior Researcher, Social and Economic Policy Department

❖ ❖ ❖

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Alberta Centre for Injury Control and Research  
Amgen Canada Inc.  
Ancaster-Dundas-Flamborough-Aldershot New Democratic Party Riding Association Executive Committee  
B.C. Better Care Pharmacare Coalition  
Bruce Bigham  
Brain Injury Association of Nova Scotia  
Canada West Foundation  
Canadian Association of Emergency Physicians (CAEP)  
Canadian Association of Internes and Residents  
Canadian Caregiver Coalition  
Canadian Cochrane Network and Centre  
Canadian Drug Manufacturers Association (CDMA)  
Canadian Strategy for Cancer Control  
Chemical Sensitivities Information Exchange Network Manitoba (CSIENM)  
Conestoga College (Pat Bower, Course instructor)  
Faith Partners (Ottawa)  
Federation of Medical Women in Canada  
Dr. Michael Gordon, Baycrest Centre for Geriatric Care  
Serena Grant  
Home-based Spiritual Care  
Kidney Foundation of Canada  
Kids First Parent Association of Canada  
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Jim Ludwig  
Dr. Keith Martin  
Dr. Ross McElroy  
Dr. Malcom S. McPhee  
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Moose Jaw-Thunder Creek District Health Board  
Dr. Earl B. Morris  
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John Neilson  
Ontario Psychological Association  
Roy L. Piepenburg (Liberation Consulting)  
Red Deer Network in Support of Medicare  
Dr. Robert S. Russell  
Society of Obstetricians and Gynaecologists of Canada  
Christa Streicher  
Elaine Tostevin



The Senate

Standing Senate Committee on Social Affairs,  
Science and Technology

# The Health of Canadians - The Federal Role

Final Report on the state of the health care  
system in Canada

*Chair:*

The Honourable Michael J. L. Kirby

*Deputy Chair:*

The Honourable Marjory LeBreton

October 2002

**Volume Six:  
Recommendations  
for Reform**

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The Standing Senate Committee on Social Affairs, Science and Technology

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The Honourable Michael J. L. Kirby

*Deputy Chair*  
The Honourable Marjory LeBreton

OCTOBER 2002



# TABLE OF CONTENTS

---

<b>TABLE OF CONTENTS.....</b>	<b>i</b>
<b>ORDER OF REFERENCE.....</b>	<b>vii</b>
<b>SENATORS.....</b>	<b>viii</b>
<b>LIST OF ABBREVIATIONS.....</b>	<b>ix</b>
<b>ACKNOWLEDGEMENTS.....</b>	<b>xi</b>
<b>FOREWORD.....</b>	<b>xiii</b>
<b>INTRODUCTION.....</b>	<b>1</b>
<b>PART I: ACCOUNTABILITY.....</b>	<b>3</b>
<b>CHAPTER ONE.....</b>	<b>5</b>
THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS.....	5
1.1 Summary of Some Key Points from Volumes One through Five.....	5
1.1.1 <i>The role of the federal government</i> .....	5
1.1.2 <i>Objectives of federal health care policy</i> .....	6
1.1.3 <i>The current system is not fiscally sustainable</i> .....	8
1.1.4 <i>A national health care guarantee is critical to successful reform</i> .....	10
1.2 Improving Governance – The Need for a National Health Care Commissioner .....	11
1.2.1 <i>Canadian Medical Association (CMA)</i> .....	13
1.2.2 <i>Colleen Flood and Sujit Choudry</i> .....	14
1.2.3 <i>Tom Kent</i> .....	15
1.2.4 <i>Duane Adams</i> .....	15
1.2.5 <i>Lawrence Nestman</i> .....	16
1.3 The Committee’s Proposal.....	17
<b>PART II: EFFICIENCY MEASURES.....</b>	<b>23</b>
<b>CHAPTER TWO .....</b>	<b>25</b>
HOSPITAL RESTRUCTURING AND FUNDING IN CANADA .....	25
2.1 Funding Methods for Hospitals in Canada: Advantages and Disadvantages.....	27
2.1.1 <i>Line-by-line</i> .....	28
2.1.2 <i>Ministerial discretion</i> .....	29
2.1.3 <i>Population-based</i> .....	29
2.1.4 <i>Global budget</i> .....	30
2.1.5 <i>Policy-based</i> .....	31
2.1.6 <i>Facility-based</i> .....	32

2.1.7	<i>Project-based</i> .....	32
2.1.8	<i>Service-based</i> .....	32
2.2	<b>Service-Based Funding: Review of International Experience</b> .....	33
2.2.1	<i>United States</i> .....	33
2.2.2	<i>United Kingdom</i> .....	34
2.2.3	<i>France</i> .....	34
2.2.4	<i>Denmark</i> .....	35
2.2.5	<i>Norway</i> .....	35
2.2.6	<i>Review of international experience by the Comité Bédard</i> .....	36
2.3	<b>The Rationale for Service-Based Funding in Canada</b> .....	36
2.3.1	<i>Appropriateness of service mix</i> .....	40
2.3.2	<i>Over-servicing and up-coding</i> .....	40
2.3.3	<i>Rates, information and data</i> .....	41
2.3.4	<i>Innovation</i> .....	42
2.3.5	<i>Comprehensive health care</i> .....	43
2.3.6	<i>Escalation of costs</i> .....	43
2.3.7	<i>Lack of simplicity</i> .....	43
2.3.8	<i>Committee commentary</i> .....	44
2.4	<b>Academic Health Sciences Centres and the Complexity of Teaching Hospitals</b> .....	46
2.5	<b>Small and Rural Community Hospitals</b> .....	48
2.6	<b>Financing the Capital Needs of Canadian Hospitals</b> .....	50
2.7	<b>Public Versus Private Health Care Institutions</b> .....	53
	<b>Appendix 2.1 Academic Health Sciences Centres in Canada and their Affiliated Hospitals and Regional Health Authorities</b> .....	59

## **CHAPTER THREE ..... 63**

	<b>DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES</b> .....	63
3.1	<b>RHAs Across Canada: A Portrait</b> .....	64
3.2	<b>RHAs: Goals and Achievements</b> .....	66
3.3	<b>Barriers that Prevent RHAs from Functioning to Their Fullest Potential</b> .....	67
3.4	<b>RHAs and the Potential for Internal Markets</b> .....	70
3.5	<b>Committee Commentary</b> .....	74

## **CHAPTER FOUR..... 77**

	<b>PRIMARY HEALTH CARE REFORM</b> .....	77
4.1	<b>Why is Primary Health Care Reform Needed?</b> .....	77
4.2	<b>The Provinces and Primary Care Reform</b> .....	80
4.2.1	<i>Recent reports</i> .....	80
4.2.2	<i>The Ontario Family Health Network</i> .....	81
4.2.3	<i>Quebec</i> .....	85
4.2.4	<i>New Brunswick</i> .....	85
4.3	<b>Overcoming the Barriers to Change</b> .....	86
4.4	<b>The Federal Role</b> .....	90
	<b>Appendix 4.1: GP Fundholding in Great Britain</b> .....	93



**PART III: THE HEALTH CARE GUARANTEE ..... 97**

**CHAPTER FIVE ..... 99**

TIMELY ACCESS TO HEALTH CARE.....	99
5.1 The Right to Health Care – Public Perception or Legal Right?.....	100
5.2 The Extent to which Publicly Insured Health Services are Available Outside the Publicly Funded Health Care System.....	101
5.3 Timely Health Care and Section 7 of the Canadian Charter of Rights and Freedoms.....	102
5.4 Committee Commentary.....	108

**CHAPTER SIX.....109**

THE HEALTH CARE GUARANTEE.....	109
6.1 The Public Perception of the Problem of Waiting Lists.....	109
6.2 The Reality of the Waiting List Problem.....	110
6.3 Canadian Experience .....	111
6.3.1 Cardiac Care Network of Ontario.....	111
6.3.2 The Western Canada Waiting List Project.....	111
6.4 International Experience.....	113
6.4.1 Sweden.....	113
6.4.2 Denmark.....	114
6.5 Committee Recommendations.....	116
6.6 The Potential Consequences of Not Implementing a Health Care Guarantee .....	119
6.7 Concluding Thoughts on the Health Care Guarantee.....	120

**PART IV: CLOSING THE GAPS IN THE SAFETY NET..... 123**

**CHAPTER SEVEN .....125**

EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS.....	125
7.1 Trends in Drug Spending .....	126
7.2 International Comparisons.....	128
7.3 Coverage for Prescription Drugs in Canada.....	130
7.3.1 Public prescription drug insurance plans.....	130
7.3.2 Private prescription drug insurance plans.....	131
7.3.3 Plan features and their relation to protection from severe drug expenses .....	132
7.4 An Emerging Issue: Catastrophic Prescription Drug Expenses.....	132
7.5 Protecting Canadians Against Catastrophic Prescription Drug Expenses.....	137
7.5.1 How the plan would work.....	138
7.5.2 The benefits of the plan.....	140
7.5.3 How much would the plan cost?.....	141
7.5.4 Committee's Proposal for a Catastrophic Prescription Drug Insurance Plan.....	142
7.6 The Need for a National Drug Formulary.....	143

**CHAPTER EIGHT .....145**

EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE .....	145
8.1 Brief Review of Key Points about Home Care from Volumes Two and Four.....	145
8.2 Other Options .....	147

8.3	The Extra-Mural Program in New Brunswick.....	148
8.3.1	<i>Building on the New Brunswick example: direct referrals to home care.....</i>	<i>150</i>
8.4	Organizing and Delivering Post-Acute Home Care.....	151
8.4.1	Definition of post-acute home care.....	151
8.4.1.1	When does Post-Acute Home Care (PAHC) servicing start?.....	151
8.4.1.2	When does PAHC servicing end?.....	152
8.4.2	Organizational arrangements for PAHC.....	153
8.4.3	Who provides PAHC?.....	155
8.5	The Cost of a National Post-Acute Home Care Program.....	156
8.5.1	How to calculate the cost of a national PAHC program.....	156
8.5.2	What about hidden costs?.....	157
8.5.3	How much will a national PAHC program cost?.....	158
8.6	Paying for Post-Hospital Home Care.....	158
<b>CHAPTER NINE.....</b>		<b>163</b>
EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE.....		163
9.1	The Need for a National Palliative Home Care Program.....	163
9.2	Financial Assistance to Caregivers Providing Palliative Care at Home.....	164
9.3	Caregiver Tax Credit.....	166
9.4	Job Protection.....	167
9.5	Concluding Remarks.....	167
<b>PART V: EXPANDING CAPACITY AND BUILDING INFRASTRUCTURE .....</b>		<b>169</b>
<b>CHAPTER TEN .....</b>		<b>171</b>
THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE.....		171
10.1	Health Care Technology.....	171
10.2	Electronic Health Records.....	175
10.3	Evaluation of Quality, Performance and Outcomes.....	177
10.4	Protection of Personal Health Information.....	179
<b>CHAPTER ELEVEN .....</b>		<b>185</b>
HEALTH CARE HUMAN RESOURCES.....		185
11.1	The Extent of Health Human Resource Shortages.....	185
11.2	Health Human Resources: The Need for a National Strategy.....	188
11.3	Increasing the Number of Physicians Trained in Canada.....	191
11.4	Integrating International Medical Graduates.....	193
11.5	Alleviating the Shortage of Nurses.....	194
11.6	Allied Health Professionals .....	197
11.7	Funding Post-Graduate Training.....	198
11.8	Health Human Resources: Scope of Practice Rules Review .....	198
11.9	Committee Commentary .....	199
<b>CHAPTER TWELVE.....</b>		<b>201</b>
NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH.....		201
12.1	Assuming Leadership in Canadian Health Research.....	202
12.2	Engaging the Scientific Revolution.....	205
12.3	Securing a Predictable Environment for Health Research .....	208
12.3.1	<i>Federal funding for health research.....</i>	<i>209</i>

12.3.2	<i>Federal in-house health research</i> .....	212
12.4	Enhancing Quality in Health Services and in Health Care Delivery .....	213
12.5	Improving the Health Status of Vulnerable Populations .....	215
12.6	Commercializing the Outcomes of Health Research .....	217
12.7	Applying the Highest Standards of Ethics to Health Research .....	221
12.7.1	<i>Research involving human subjects</i> .....	222
12.7.2	<i>Issues with respect to research involving human subjects</i> .....	224
12.7.3	<i>Animals in research</i> .....	227
12.7.4	<i>Privacy of personal health information</i> .....	229
12.7.5	<i>Genetic privacy</i> .....	234
12.7.6	<i>Potential situations of conflict of interest</i> .....	235

## **PART VI: HEALTH PROMOTION AND DISEASE PREVENTION..... 237**

### **CHAPTER THIRTEEN..... 239**

HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE .....	239
13.1 Trends in Diseases .....	242
13.1.1 <i>Infectious diseases</i> .....	243
13.1.2 <i>Chronic diseases</i> .....	243
13.1.3 <i>Injury</i> .....	244
13.1.4 <i>Mental health</i> .....	244
13.2 The Economic Burden of Illness .....	245
13.3 The Need for a National Chronic Disease Prevention Strategy .....	246
13.4 Strengthening Public Health and Health Promotion .....	249
13.5 Toward Healthy Public Policy: The Need for Population Health Strategies .....	250

## **PART VII: FINANCING REFORM..... 253**

### **CHAPTER FOURTEEN..... 255**

HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED .....	255
14.1 More Money Is Needed for Health Care .....	256
14.2 The Financing Role of the Federal Government .....	260
14.3 How New Federal Funding for Health Care Should Be Managed .....	262

### **CHAPTER FIFTEEN..... 265**

HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED .....	265
15.1 The Amount of Increased Federal Funding Required .....	267
15.2 Potential Sources of Increased Federal Funding .....	270
15.3 General Taxation .....	271
15.4 Earmarked Taxation .....	275
15.5 Payroll Taxes .....	278
15.6 National Health Care Premiums .....	280
15.7 User Charges .....	282
15.8 Medical Savings Accounts .....	284
15.9 Pre-Funding for Health Care .....	285
15.10 Committee Commentary .....	286
15.11 Current Federal Funding for Health Care .....	291

<b>CHAPTER SIXTEEN .....</b>	<b>295</b>
THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE .....	295
16.1 Private Health Care Insurance in Canada and Selected OECD Countries.....	297
16.2 Review of Recent Literature on the Impact of Private Health Care Insurance and Private For-Profit Delivery.....	299
16.3 Committee Commentary .....	302
<b>PART VIII: THE CANADA HEALTH ACT.....</b>	<b>305</b>
<b>CHAPTER SEVENTEEN .....</b>	<b>307</b>
THE CANADA HEALTH ACT.....	307
17.1 Universality.....	308
17.2 Comprehensiveness.....	309
17.3 Accessibility .....	313
17.4 Portability .....	315
17.5 Public Administration.....	316
17.6 Committee Commentary .....	319
<b>CONCLUSION.....</b>	<b>321</b>
<b>APPENDIX A .....</b>	<b>A-1</b>
LIST OF RECOMMENDATIONS BY CHAPTER.....	A-1
<b>APPENDIX B.....</b>	<b>A-19</b>
LIST OF PRINCIPLES FROM VOLUME FIVE (APRIL 2002).....	A-19
<b>APPENDIX C.....</b>	<b>A-23</b>
LIST OF WITNESSES.....	A-23

## ORDER OF REFERENCE

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Extract from the Journals of the Senate of Tuesday, October 8, 2002:

Resuming debate on the motion of the Honourable Senator Kirby seconded by the Honourable Senator Pélissier:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:

- a) The fundamental principles on which Canada's publicly funded health care system is based;
- b) The historical development of Canada's health care system;
- c) Health care systems in foreign jurisdictions;
- d) The pressures on and constraints of Canada's health care system; and
- e) The role of the federal government in Canada's health care system;

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament and the First Session of the Thirty-seventh Parliament be referred to the Committee;

That the Committee submit its final report no later than October 31, 2002;

That the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 60 days after the tabling of that report; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

The question being put on the motion, it was adopted.

ATTEST :

Paul C. Bélisle  
*Clerk of the Senate*

## SENATORS

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The following Senators have participated in the study on the state of the health care system undertaken by the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee  
The Honourable Marjory LeBreton, Deputy Chair of the Committee

and

The Honourable Senators:

Catherine S. Callbeck  
Joan Cook  
Jane Cordy  
Joyce Fairbairn, P.C.  
Wilbert Keon  
Yves Morin  
Lucie Pépin  
Brenda Robertson  
Douglas Roche

*Ex-officio members of the Committee:*

The Honourable Senators: Sharon Carstairs, P.C. (or Fernand Robichaud, P.C.) and John Lynch-Staunton (or Noel A. Kinsella)

*Other Senators who have participated from time to time on this study:*

The Honourable Senators Atkins, Banks, Beaudoin, Carney, Cochrane, Cohen,\* DeWare,\* Ferretti Barth, Grafstein, Graham, P.C., Hubley, Joyal, P.C., Lawson, Léger, Losier-Cool, Maheu, Mahovlich, Meighen, Milne, Murray, Rompkey, St. Germain, Sibbeston, Stratton, Tunney\*, and Wilson\*

\* retired

## LIST OF ABBREVIATIONS

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<b>ACAHO</b>	Association of Canadian Academic Healthcare Organizations	<b>CT</b>	Computed Tomogram (scan)
<b>ACMC</b>	Association of Canadian Medical Colleges	<b>DND</b>	Department of National Defence
<b>ACST</b>	Advisory Council on Science and Technology	<b>DRG</b>	Diagnostic Related Group
<b>AHSC</b>	Academic Health Sciences Centre	<b>EHR</b>	Electronic Health Record
<b>CAN</b>	Canadian Nurses Association	<b>EI</b>	Employment Insurance
<b>CAPE</b>	Clinicians Assessment and Professional Enhancement	<b>EMP</b>	Extra-Mural Program
<b>CBAC</b>	Canadian Biotechnology Advisory Committee	<b>EPF</b>	Established Programs Financing
<b>CCAC</b>	Canadian Council on Animal Care	<b>F/P/T</b>	federal/provincial/territorial
<b>CCHSA</b>	Canadian Council on Health Services Accreditation	<b>FAE</b>	Fetal Alcohol Effects
<b>CCN</b>	Cardiac Care Network of Ontario	<b>FAS</b>	Fetal Alcohol Syndrome
<b>CCOHTA</b>	Canadian Coordinating Office for Health Technology Assessment	<b>FFS</b>	Fee-for-service
<b>CDPAC</b>	Chronic Disease Prevention Alliance of Canada	<b>FHN</b>	Family Health Networks
<b>CFI</b>	Canada Foundation for Innovation	<b>FMG</b>	Family Medicine Groups
<b>CHA</b>	<i>Canada Health Act</i>	<b>GDP</b>	Gross Domestic Product
<b>CHSRF</b>	Canadian Health Services Research Foundation	<b>GP</b>	General Practitioner
<b>CHST</b>	Canada Health and Social Transfer	<b>HRDC</b>	Human Resources Development Canada
<b>CIAR</b>	Canadian Institute for Advanced Research	<b>HTA</b>	Health Care Technology Assessment
<b>CIDA</b>	Canadian International Development Agency	<b>HTF</b>	Health Transition Fund
<b>CIHI</b>	Canadian Institute for Health Information	<b>ICH</b>	International Conference on Harmonization
<b>CIHR</b>	Canadian Institutes of Health Research	<b>ICT</b>	information and communications technologies
<b>CLSC</b>	<i>Centre local de services communautaires</i> (community health centre)	<b>IDRC</b>	International Development Research Centre
<b>CMA</b>	Canadian Medical Association	<b>IMG</b>	International Medical Graduates
<b>CPP</b>	Canada Pension Plan	<b>IT</b>	Information Technology
<b>CRC</b>	Canada Research Chairs	<b>JPPC</b>	Joint Policy and Planning Committee
<b>CSTA</b>	Council of Science and Technology Advisors	<b>LPN</b>	Licensed Practical Nurse
		<b>MEF</b>	Medical Equipment Fund

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<b>MOHLTC</b>	Ontario Ministry of Health and Long-Term Care	<b>PPP</b>	Purchasing Power Parity
<b>MRC</b>	Medical Research Council of Canada	<b>PPS</b>	Prospective Payment System
<b>MRI</b>	Magnetic Resonance Imaging	<b>QPP</b>	Quebec Pension Plan
<b>MSA</b>	Medical Savings Account	<b>REB</b>	Research Ethics Board
<b>NACA</b>	National Advisory Committee on Aging	<b>RHA</b>	Regional Health Authority
<b>NBEMH</b>	New Brunswick Extra-Mural Hospital	<b>RHC</b>	Regional Hospital Corporation
<b>NCEHR</b>	National Council on Ethics in Human Research	<b>RN</b>	Registered Nurse
<b>NHEX</b>	National Health Expenditure Database	<b>Rx&amp;D</b>	Canada's Research -Based Pharmaceutical Companies
<b>NHRDP</b>	National Health Research and Development Program	<b>SSHRC</b>	Social Sciences and Humanities Research Council
<b>NHS</b>	National Health Service	<b>TCPS</b>	<i>Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans</i>
<b>NRC</b>	National Research Council	<b>UBC</b>	University of British Columbia
<b>NSERC</b>	Natural Sciences and Engineering Research Council	<b>URS</b>	Urgency Rating Score
<b>ODB</b>	Ontario Drug Benefit	<b>WCB</b>	Workers' Compensation Board
<b>OECD</b>	Organisation for Economic Co-operation and Development	<b>WCWL</b>	Western Canada Waiting List
<b>OFHN</b>	Ontario Family Health Network		
<b>OHA</b>	Ontario Hospital Association		
<b>OMA</b>	Ontario Medical Association		
<b>PAHC</b>	Post-Acute Home Care		
<b>PCG</b>	Primary Care Groups		
<b>PCN</b>	Primary Care Network		
<b>PCR</b>	Primary Care Reform		
<b>PCT</b>	Primary Care Trust		
<b>PENCE</b>	Protein Engineering Network of Centres of Excellence		
<b>PET</b>	Positron Emission Tomography (scan)		
<b>PHCTF</b>	Primary Health Care Transition Fund		
<b>PIPEDA</b>	<i>Personal Information Protection and Electronic Documents Act</i>		
<b>PMSI</b>	<i>Programme de Médicalisation du Système d'Information</i>		



## ACKNOWLEDGEMENTS

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The Committee wants to publicly acknowledge the enormous assistance it has received during the past two years from those who have worked so hard in helping the Committee to produce its six reports.

The Committee particularly wants to express its deep appreciation to:

- Odette Madore and Dr. Howard Chodos of the Research Branch of the Library of Parliament, the full-time research staff of the Committee, who have been deeply involved in all drafts of the six reports that the Committee has released during this study. Without their extraordinary help, these reports would not have been completed in such a short time, nor in such a competent manner.
- Catherine Piccinin, the Committee Clerk and her Administrative Assistant, Debbie Pizzoferrato, who were responsible for organizing all the meetings the Committee held on the health care issue, including scheduling the appearances of all the witnesses, for overseeing the translation and printing of all six reports, and for responding to thousands of requests for information about the Committee's work and for copies of the Committee's reports.
- Dr. Duncan Sinclair, the former chair of the Health Services Restructuring Commission of Ontario, who gave so generously of his time and expertise in reviewing, editing and offering suggestions for improvement in all of the drafts of the Committee's reports.
- The staff of each of the members of the Committee, who have had to endure a substantially increased work load for the past two years.

To all of these people, we express our heartfelt thanks for a job very well done.

The Committee worked long hours over many months, requiring the services of a large number of procedural, research and administrative officers, editors, reporters, interpreters, translators, messengers, publications, broadcasting, printing, technical and logistical staff who ensured the progress of the work and reports of the Committee. We wish to extend our appreciation for their efficiency and hard work.



## FOREWORD

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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 has heard the views of over 400 witnesses. 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 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 Chief Executive Officer 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 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*:

- To formulate a detailed, concrete *plan of action* that did not focus heavily on governance issues or intergovernmental structures;
- To attach a *cost* to its recommendations and propose a specific *revenue raising plan*. For its report to be truly useful, the Committee felt it could not be vague on the question of precisely how its recommendations would be funded;
- To specify clearly the *changes* that each of the major stakeholders – individual Canadians, health care professionals, provincial and federal governments, etc. – would have to make so that the Committee's reform plan could be implemented successfully.

- To make clear the *consequences of not changing*, and hence of not reforming, the health care system.

The Committee feels that there is a real window of opportunity for implementing the kind of reform that is needed to ensure the long-term sustainability of Canada's 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 sustainability for the foreseeable future. It looks forward to pursuing its work in this direction, along with all those who share this objective.



**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.**





## INTRODUCTION

For the past two years the Standing Senate Committee on Social Affairs, Science and Technology has been studying the state of the Canadian health care system and the federal role in that system. The Committee has sat for over 200 hours and held 76 meetings. Most of these meetings were public sessions during which the Committee heard from over 400 witnesses, many of whom represented organizations that have thousands of members (such as the Canadian Medical Association and the Canadian Nurses Association).

To date the Committee has published five reports. This sixth report contains the Committee's final recommendations for reform and renewal of the Canadian health care system. These recommendations flow from the principles enunciate in Volume Five. The major topics covered in the five previous reports, as well as the subjects to be treated in future reports, are summarized in the following table:

Phases	Content	Timing of Report
<b>One</b>	Historical Background and Overview, Myths and Realities	March 2001
<b>Two</b>	Future Trends, Their Causes and Impact on Health Care Costs	January 2002
<b>Three</b>	Health Care Models and Practices in Other Countries	January 2002
<b>Four</b>	Issues and Options	September 2001
<b>Five</b>	Principles for Restructuring the Hospital and Doctor System and Recommendations on Several Health Care Issues	April 2002
<b>Six</b>	Recommendations with respect to Financing and Restructuring the Hospital and Doctor System and Closing the Gaps in Drug and Home Care Coverage	October 2002
<b>Thematic Studies</b>	Aboriginal Health, Women's Health, Mental Health, Rural Health, Population Health, Home Care and Palliative Care	At future dates to be determined

As the table indicates, following the release of this report, the Committee intends to examine a number of additional health-related issues. These studies will result in a series of thematic reports on: 1) Aboriginal health; 2) women's health; 3) mental health; 4) rural health; 5) population health, including literacy issues; 6) home care; and 7) palliative care.

In addition, the Committee held public hearings in September 2002 to examine the document *French-Language Healthcare – Improving Access to French-Language Health Services*, a study coordinated by the Fédération des communautés francophones et acadiennes du Canada for the Consultative Committee for French-Speaking Minority Communities. The Committee will be

releasing a report on this issue, and readers of this volume are strongly encouraged to read that report as well.

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

- recommendations on restructuring the current hospital and doctor system to make it more efficient and more effective in providing timely and quality patient care;
- recommendations on enacting a health care guarantee that would ensure that patients receive treatment within a specified maximum amount of time for major hospital or diagnostic procedures; if the waiting time is exceeded, 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 on expanding public health care 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 lives at home;
- recommendations that strengthen the federal contribution to, and role in, developing health care infrastructure, including health information systems, health care technology, the evaluation of health care system performance and outcomes, the supply of health human resources, health research, wellness promotion and illness prevention, and the nation's 16 Academic Health Sciences Centres;
- recommendations on how additional federal revenue should be raised, and on how this new revenue should be administered in a transparent and accountable manner in order to implement the recommendations in this report;
- observations on 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.

***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.***



# **Part I:** **Accountability**

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# CHAPTER ONE

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

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To formulate realistic recommendations to improve the provision of health care services to Canadians, it is necessary first to have a clear view of the health care system now and an assessment of its strengths and weaknesses. From the outset, the Committee has sought to portray accurately the reality of Canada's health care system and to separate myth from fact.<sup>1</sup>

The Committee believes that an ongoing evaluation of the health care system is essential, conducted in as objective a fashion as possible. In this chapter the Committee presents its recommendations for the creation of a new National Health Care Council chaired by a Health Care Commissioner charged with carrying out this task by producing an annual report on the state of the health care system and the health status of Canadians.

Before turning to this, however, we begin with a brief review of some key elements from previous volumes of the Committee's study. These summarize the basic approach that the Committee has adopted in the course of its multi-volume study, as well as the objectives it has sought to achieve in developing its recommendations.

### 1.1 Summary of Some Key Points from Volumes One through Five

#### 1.1.1 The role of the federal government

The Committee identified the various roles of the federal government in health and health care; Volume Four set out these roles, together with a set of policy objectives for each.<sup>2</sup> The Committee also affirmed the legitimacy and importance of the federal government's roles from a number of perspectives:

- First, it is clear that Canadians strongly support national principles in health care and look to the federal government to play an important role in maintaining these principles;
- Second, federal funding for health care is especially critical at this time of reform and renewal. As the Committee makes clear in the present volume, making changes in the way the health care system is structured and operates will require spending more money - money that must be raised primarily by the federal government;
- Third, and some would say most important, only the federal government is in a position to make sure that all provinces and territories, regardless of the size

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<sup>1</sup> See Volume One, *The Story So Far*, Chapter Six, Myths and Realities, pp. 93ff.

<sup>2</sup> See Volume Four, *Issues and Options*, Chapters Three and Four, pp. 9-26.

of their economies, have at their disposal the financial resources to meet the health care needs of their citizens. This redistributive role of the federal government is fundamental to what many call “the Canadian way.”

- Fourth, fundamental changes to the health care system should not be confined to one or two provinces. Our national system requires inter-provincial harmonization in which the federal government has a crucial role to play, through, for example, its use of financial incentives and/or penalties to encourage provincial and territorial governments to adopt country-wide standards.
- Fifth, the Committee believes strongly that the substantial sums of money transferred by the federal government to the provinces and territories for health care should ensure that the federal government has a seat at the table when restructuring of the health care system is discussed. The principle of accountability to the taxpayers requires the federal government to have a say in how that money is spent.

***It is very clear to the Committee that Canadians want the provinces, the territories and the federal government to work collaboratively in partnership to facilitate health care renewal. Canadians are impatient with blame-laying; they want intergovernmental cooperation and positive results.***

Finally, it is very clear to the Committee that Canadians want the provinces, the territories and the federal government to work collaboratively in partnership to facilitate health care renewal. Canadians are impatient with blame-laying; they want intergovernmental cooperation and positive results.

### **1.1.2 Objectives of federal health care policy**

The Committee has pointed out that federal policy in health care flows from two overarching objectives – objectives that the Committee strongly supports as the primary goals to be pursued by the federal government in the field of health care. These two objectives are:

- *To ensure that all Canadians have timely access to medically necessary health 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 Committee believes that federal policy in health care flows from two objectives:***

- ***To ensure that all Canadians have timely access to 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.***

Implicit in these two objectives, particularly the first, is the requirement that the medically necessary services provided under Medicare be of high quality. Clearly, providing access to services of inferior quality would defeat the purpose of Canada’s health care system.

With respect to the pre-eminent piece of federal legislation in health care, the *Canada Health Act* (1984), the Committee has repeatedly expressed its unqualified support for the four patient-oriented principles in the *Canada Health Act*. The Committee has also endorsed the intent of the fifth principle of the *CHA*, although it is of a different character:

- 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, when they travel within Canada or move from one province to another.
- The principle of **public administration** does not focus on the patient but “is rather the means of achieving the end to which the other four principles are directed.”<sup>3</sup> The public administration condition of the *Canada Health Act* is the basis for the single insurer/funder model that the Committee has endorsed in Volume Five under Principle One.<sup>4</sup> This condition of the Act requires provincial and territorial health care insurance plans to be managed on a not-for-profit basis by a public agency.

The Committee has also agreed with the Honourable Monique Bégin, the federal Minister of Health at the time that the *Canada Health Act* was passed, that the principle of public administration has come to be misunderstood.<sup>5</sup> The Committee strongly supports the single-payer insurance system whereby the government is the funder of hospital and doctor services.

The public administration principle refers to the *funding* of hospital and doctor services, *not to the delivery* of those services.

***The principle of public administration has come to be misunderstood. The Committee strongly supports the single-payer insurance system whereby the government is the funder of hospital and doctor services. The public administration principle refers to the funding of hospital and doctor services, not to the delivery of those services.***

The misunderstanding of the principle of public administration has arisen out of the confusion between publicly funded and administered health insurance and the actual delivery of health care services themselves. Under the *Canada Health Act*, services do not have to be

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<sup>3</sup> Volume One, p. 41.

<sup>4</sup> Volume Five, pp. 23-25.

<sup>5</sup> See her testimony before the Committee, May 8, 2002 (54:5).

delivered by public agencies. Indeed, in Canada today the great majority of health care services are delivered by a variety of private providers and institutions.

The Committee reaffirms its commitment to the principle that every Canadian should be guaranteed access to medically necessary services by a publicly funded and administered insurance program, everywhere in Canada. This has been the essence of Canadian health care policy for over 30 years, and is clearly reflected in the *Canada Health Act*.

Pursuit of the objectives of Canadian health care policy involves a “contract” between Canadians and their governments – federal, provincial and territorial. Canadians pay taxes to their governments, which then use the money (in part) to fund a universal insurance plan that provides to all Canadians first-dollar coverage for medically necessary services delivered by hospitals and doctors. These services must be accessible, comprehensive, and portable among provinces and territories. The “contract” requires governments (federal and provincial/territorial) as insurers, to use the funds collected from Canadians to meet the two policy objectives stated above, i.e., to ensure that Canadians are publicly insured and have timely access to medically necessary hospital and doctor services of high quality.

### **1.1.3 The current system is not fiscally sustainable**

The Committee’s next step was to tackle the question of whether or not the system, in its current form and given current levels of government funding, was sustainable. In Volume Five, the Committee defined a fiscally sustainable health care system as one on which Canadians could rely both today and in the future, given governments’ predicted fiscal capacity and taxpayers’ willingness to pay.

Two constraints must be taken into account in assessing fiscal sustainability. The first is the willingness of taxpayers to pay (consent of the governed). The second is the need, for economic development purposes, for governments to keep tax rates competitive with those in other OECD countries, and particularly with the United States.

In the Committee’s view, long-term fiscal sustainability depends on the ratio of public expenditures on health care to other government spending. If this ratio becomes too large it may indicate that spending on health care is crowding out other necessary government spending.

The Committee recognizes that sustainability can also be considered in terms of the total share of the Gross Domestic Product (GDP) that is devoted to health care, whether paid through the public purse or privately. However, what that share should be is impossible to say without thorough analysis of the benefits Canadians derive from health care. Conducting such a cost-benefit analysis is precluded at present by the system’s lack of the capacity to capture, record, share, and otherwise manage health information. So the best the Committee can do is observe that Canada’s spending

***Regardless of how it is expressed, there is only one source of funding for health care– the Canadian public – and it has been shown conclusively that the most cost-effective way of funding health care services is by using a single (in our case, publicly administered or governmental) insurer/payer model.***

on health care, expressed as a share of GDP, is roughly comparable to that of other developed countries apart from the United States, where it is clearly much higher than in any other industrialized country.

The Committee is keenly aware that shifting more of the cost to individual patients and their families via private payments, the facile “solution” recommended by many, is really nothing more than an expensive way of relieving or, at the least, diminishing governments’ problem. Regardless of how it is expressed (as a share of GDP, share of government spending, etc.), there is only one source of funding for health care – the Canadian public – and it has been shown conclusively that the most cost-effective way of funding health care is by using a single (in our case, publicly administered or governmental) insurer/payer model.

The Committee believes strongly that Canada should continue to adhere to this most efficient and effective model of universal health care insurance, and it is clear to the Committee that Canadians believe this too. Therefore, in formulating its recommendations, the Committee has not concentrated on measures of funding related to GDP. Instead, it has sought to assess how much public spending is necessary to sustain Medicare and, in particular, how much is needed to accomplish the changes that are essential if this highly popular and largely publicly funded program is to meet the needs of Canadians into the twenty-first century.

During the Committee’s cross-country hearings, a wide range of witnesses, including health care managers, providers and consumers, expressed deep concern about rising health care costs and their impacts both on governments’ budgets and on patient care. Based on this testimony as well as on numerous reports, the Committee has concluded that rising costs strongly indicate that Canada’s publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels.

The lack of sustainability is already manifest in the fact that the system does not currently have sufficient resources to respond to all the demands that are placed upon it. In particular, timely access to quality health services is increasingly not the norm. The Committee is aware that no system providing services that are perceived to be “free” can ever fully meet the demands placed on it, and that at present we are unable to discriminate between the demand and the genuine need for timely access to health services of all kinds. Nonetheless, the widespread perception of deterioration in the quality of service available to Canadians highlights the fact that Canadians must decide what future course of action they want their governments to take. The Committee stressed that there are three basic options from which the Canadian public must choose:

***The Committee has concluded that rising costs strongly indicate that Canada’s publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels.***

- Growing waiting lists as a result of increased rationing of publicly funded health services;
- Increasing government revenue;
- Making some services available more quickly to those who can afford to pay privately for them by allowing the development of a parallel privately funded

tier of health services, supplementary to the publicly funded system maintained for all other Canadians.<sup>6</sup>

As will be evident in the remainder of this report, the Committee fervently hopes that Canadians will agree with the Committee that the second option is the most desirable choice. Having unanimously reached this conclusion, the Committee has departed from usual practice in parliamentary committee reports by specifying in some detail how much additional public money is required to ensure the long-term fiscal sustainability of the health care system, recommending where this new money should be spent, and recommending how the increased government revenue could be raised.

The Committee has concluded that an additional \$5 billion is needed annually to reform and renew the health care system. This is the estimated annual cost of implementing the Committee's recommendations. The Committee also stresses, however, that unless changes are made to the structure and functioning of the system, no amount of new money will make the current system sustainable over the long term. This \$5 billion in new federal money must be used to buy change, to reform and renew the system.

***Unless changes are made to the structure and functioning of the system, no amount of new money will make the current system sustainable over the long term. This \$5 billion in new federal money must be used to buy change, to reform and renew the system.***

#### **1.1.4 A national health care guarantee is critical to successful reform**

In general, the principle that the Committee has followed in working out its vision for reform of the system has been that incentives for all participants must be introduced in the publicly funded hospital and doctor system – providers, institutions, governments and patients – to deliver, manage and use health care more efficiently and effectively. In particular, although it does not stand entirely on its own, one element that is key to the successful reform of the system is what the Committee has called the health care guarantee.

This recommendation, described in detail in Chapter Six, is designed to address the problem of growing waiting times for access to health services by requiring governments to meet reasonable standards, by ensuring patients have access to services in their own jurisdiction, elsewhere in Canada or, if necessary, in another country. Meeting reasonable patient service standards is an essential part of the health care contract between Canadians and their governments. The Committee believes that by judiciously investing the new money and legislatively enshrining the principle of the health care guarantee, it will be possible to restore the Canadians' confidence that their governments will spend their tax dollars in ways that reinforce the publicly funded health care system and ensure that the system provides access to medically necessary services when and where they are needed.

In presenting its proposals, the Committee also believes that it was important to acknowledge that its preferred option for raising new money, and its plan on how to spend it,

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<sup>6</sup> Note that the "delisting" of services means requiring Canadians to pay privately for specific services that once were paid for under the publicly administered and funded health insurance program (Medicare).



including implementing the health care guarantee, are not the only options available. If, after public discussion, governments decide that they are not willing to pay more to fund hospital and doctor services, or if the insurer (government) decides not to implement the health care guarantee, then the result would be the continued (and probably increased) rationing of services and lengthening of waiting times.

Moreover, as the Committee points out in Chapter Five below, allowing waiting times to grow longer - that is, failing to implement the health care guarantee - could have significant additional consequences. Such failure is highly likely to lead to the Supreme Court issuing a judgment that since timely access to needed medical service is not being provided in the publicly funded system, then government can no longer deny Canadians the right to purchase private insurance to cover the cost of paying for the provision of service elsewhere, i.e., at private health care institutions in Canada. Thus, failing to implement the health care guarantee is likely to move the Canadian health care system in the direction of introducing a second private tier of services available only to those who can afford to pay for them out-of-pocket or through supplementary private health care insurance.

When this possibility was raised in previous reports, some commentators felt that the Committee was in fact advocating greater privatization of the health care system. As this volume should make abundantly clear, that is not the case.

The Committee has worked out a detailed, concrete and realistic plan that, if implemented integrally, will lead to strengthening the publicly funded health care system in Canada and guarantee its sustainability for the foreseeable future. However, this option costs money, and the great majority of Canadians would be required to contribute additionally in taxes in order to implement the proposed plan. In the event that governments are unwilling to raise increased revenue to invest in the publicly funded health care system, it is essential that Canadians fully understand the implications of such a decision. One such implication is likely to be not only the continued deterioration of the system, but also judgments by the courts that hasten the development of a parallel private system of health care in Canada.

## **1.2 Improving Governance – The Need for a National Health Care Commissioner**

An essential element to enable Canadians to make informed choices, now and in the future, is for the Canadian public to have access to a reliable and non-partisan assessment of the true state of the health care system. The remainder of this chapter sets out the Committee's proposal to create an institutional structure that would give Canadians such an assessment annually.

***The Committee believes that it is essential to improve the governance of Canada's health care system.***

It is essential to improve the governance of Canada's health care system. The question of governance (which is to say leadership) brings together a number of issues that the Committee has raised in previous volumes and that witnesses have addressed from a number of perspectives.

One thing is very clear. Canadians are tired of the endless finger-pointing and blame-shifting that have been recurring features of intergovernmental relations in the health care field. As the Honourable Monique Bégin has accurately pointed out, the current state of federal-provincial relations is dysfunctional.<sup>7</sup> On far too many occasions, each side seems more interested in attributing blame for the system's apparent deterioration to the other, rather than taking the lead to ensure that the health services Canadians need and deserve are there when they need them.

Fundamentally the underlying issue is one of accountability. In order to establish who is to be held accountable for the deficiencies (and also the strengths) of the health care system, the Committee has repeatedly pointed out that detailed and reliable information on the performance of the system and on health outcomes is essential. This is why the Committee has placed such importance on the development of a capacity for health information management, on putting in place a national system of electronic patient records<sup>8</sup> and on sustaining and expanding the health research infrastructure.<sup>9</sup> The Committee has drawn attention to the important contribution that the Canadian Institute for Health Information (CIHI) has already made to improving our knowledge of the state of the health care system; it is clear that this positive source of experience must be built upon.

Information must be analyzed and interpreted objectively if it is to serve as a reliable guide to evidence-based decision-making. In Volume Five, the Committee identified four fundamental elements that are necessary to create the capacity to evaluate fully and fairly the performance of the health care system and the health status of the Canadian population, as well as to hold the appropriate parties accountable:

- First, such evaluation must be conducted by a body that is independent of government. The Committee expressed its strong support for “the view of witnesses and provincial reports that the roles of the funder and provider should be separated from that of the evaluator in order to obtain independent assessment of health care system performance and outcomes.”<sup>10</sup> Only in this way can actual and perceived conflicts of interest be avoided and the credibility of evaluation reports with the Canadian public be assured.
- Second, the Committee affirmed that “such independent evaluation should be performed at the national (not federal) level.”<sup>11</sup> The reality of the Canadian health care system is that it is a joint responsibility of the provincial/territorial and federal governments. No body that reports exclusively to, or was created exclusively by, one level or the other would have the necessary credibility.
- Third, while the evaluation must be conducted by an independent, arms-length agency, it must be funded by government. Moreover, as we will argue below, leadership in providing the necessary financing for this initiative must

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<sup>7</sup> Monique Bégin, “Renewing Medicare,” *Canadian Medical Association Journal*, July 9, 2002, p. 47.

<sup>8</sup> See Chapter 10.

<sup>9</sup> See Chapter 12.

<sup>10</sup> Vol. 5, p. 51.

<sup>11</sup> Ibid.

be provided by the federal government, despite the “national” (as opposed to federal) character of the evaluation organization.

- Finally, as noted above, it is essential that this undertaking build on the successes of existing organizations, such as the Canadian Institute for Health Information (CIHI) and the Canadian Council for Health Services Accreditation (CCHSA). The Committee makes specific recommendations with regard to these organizations in Chapter Ten.

The Committee believes, however, that, on their own, existing organizations are not enough. What is needed is a permanent independent body charged with reporting annually to the Canadian public on the state of the nation’s health care system and on the health status of Canadians. The Committee also believes that this body should be responsible for advising the federal government, on an annual basis, on how new money raised for renewing and reforming the health care system should be allocated. Such a body must have sufficient resources at its disposal, and work with CIHI and CCHSA (and possibly others), to collect and assess the data and information it requires.

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Such a body must have sufficient resources at its disposal, and work with CIHI and CCHSA (and possibly others), to collect and assess the data and information it requires.

Before setting out the Committee’s own proposal, we review briefly some other ideas that have been put forward in recent months that describe ways of providing the Canadian public with annual evaluation reports on the state of the health care system. In the Committee’s view, the various proposals contain many useful elements, but none fully meets the Committee’s requirements.

### **1.2.1 Canadian Medical Association (CMA)**

The CMA has proposed a two-pronged approach.<sup>12</sup> First, it advocates the adoption of a Canadian Health Charter with three main parts: a vision statement, a section on national planning and coordination, and a section on roles, rights and responsibilities. This Charter would set the parameters for better national planning and coordination, particularly with respect to reviewing core health care services; developing national benchmarks for the timeliness and quality of health care; determining resource needs, including health human resources and information technology; and establishing national goals and targets to improve the health of Canadians.

The CMA’s proposal also provides for the creation of a Canadian Health Commission, a permanent, depoliticized forum at the national level for ongoing dialogue and debate. The commission’s mandate would include the following responsibilities:

- Monitor compliance with the Canadian Health Charter

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<sup>12</sup> See its document, *A Prescription for Sustainability*, June 2002.

- Report annually to Canadians on the performance of the health care system and the health status of the population
- Advise the Conference of Federal–Provincial–Territorial Ministers of Health on critical health-related issues.

The commission proposed by the CMA would be chaired by a Canadian Health Commissioner, who would be an officer of Parliament (similar to the Auditor General) appointed for a five-year term by consensus among the federal, provincial and territorial governments. The commission would operate at arm's length from governments, yet maintain close links with government agencies such as the Canadian Institute for Health Information and the Canadian Institutes of Health Research. Its deliberations would be made public, and its composition would not be constituency-based but would reflect a broad range of perspectives and expertise.

### **1.2.2 Colleen Flood and Sujit Choudry**

In a paper prepared for the Romanow Commission,<sup>13</sup> Professors Colleen Flood and Sujit Choudry of the University of Toronto argue that there is a real need for a non-partisan national body, protected from day-to-day politics, with a longer-term view than is possible for an elected government. They propose the creation of a Medicare Commission that would be an expert, independent body, appointed jointly by provincial and federal governments, but funded by the federal government.

The role of this Medicare Commission would include:

- determining specific performance indicators to help provinces achieve national standards set out in the *Canada Health Act*;
- publishing (in conjunction with the Canadian Institute for Health Information) annual reports on the performance of provincial health insurance systems;
- providing financial assistance to those provinces that undertake to implement the processes or programs identified by the Commission.

Funding for the commission would be separate from federal transfers for health care. It would consist of new federal money, a consolidation of all one-off payment initiatives in the health care area currently undertaken by the federal government (for example, in primary care and other areas).

One possible method Flood and Choudry describe for composing the commission is for each province to appoint 1 commissioner and the federal government to appoint 5, for a total of 15 full-time commissioners, who would then select a chief commissioner from among themselves. All decisions would require a two-thirds majority, meaning that federal commissioners would require support from a majority of provincial commissioners for any

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<sup>13</sup> Colleen M. Flood and Sujit Choudry, *Strengthening the Foundations: Modernizing the Canada Health Act*, Discussion Paper No.13, released by the Commission on the Future of Health Care, August 2002.

decision.<sup>14</sup> The commission that they propose would have an expert staff of health service researchers and would make its reports publicly available, including specific findings on the compliance of provincial health care plans with national standards.

### **1.2.3 Tom Kent**

Tom Kent was a senior federal public servant at the time Medicare was created, and is often referred to as a father of Medicare. Her has suggested that Ottawa and the provinces appoint, by consensus, an advisory council with a wide range of expertise.<sup>15</sup> The purpose is neither to replace provincial management of provincial programs nor to impair federal accountability for the principles of Medicare. Rather, the council is conceived as a collaborative mechanism that would be a bridge between the two levels of government, thereby bringing political reality into harmony with the way most Canadians already see Medicare, namely, as a joint responsibility within our federal system.

Kent's council would be funded jointly by the federal and provincial governments. It would employ an executive director and staff, who would be neither federal nor provincial officials. It would report to a joint committee of health ministers, for which it would conduct investigations and make recommendations over the whole range of medicare principles and practices.

The proposed council would provide a focus for collaboration that would facilitate innovation and efficiencies, as well as provide a forum for broader consultation on health policy. Administratively, it could be used to supervise the implementation of agreements on such matters as electronic health records, health care information, a national drug formulary, bulk purchasing, facility sharing, etc. Importantly, Kent argues that the agency could foster public accountability by preparing regular reports for the ministerial committee to issue.

### **1.2.4 Duane Adams**

In his review of proposals for improving the governance of the Canadian health care system,<sup>16</sup> the late Professor Duane Adams, founding director of the Saskatchewan Institute of Public Policy, noted that "there may be benefits to the federation and the Canadian people if an external-to-government health oversight body were added to the Canadian health system's governance mechanism." He points out that even though most governments are very sceptical and leery of these "arm's-length" agencies because they have the potential to "deplete the unilateral power of governments," "an independent oversight body should be seen as one option in a range of possibilities, to enhance public participation, transparency, public accountability, and public confidence."

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<sup>14</sup> It should be noted that is formula would appear to allow the provincial commissioners to band together to make decisions that were unanimously opposed by the federal commissioners.

<sup>15</sup> Tom Kent, *Medicare: It's Decision Time*, The Caledon Institute of Social Policy, 2002.

<sup>16</sup> Duane Adams, "Conclusions: proposals for advancing federalism, democracy and governance of the Canadian health system," in *Federalism, Democracy and Health Policy in Canada*, ed. Duane Adams, McGill-Queen's University Press, 2002.

One option presented by Adams was a Canadian Health Council that would have an element of public participation and employ a small number of permanent staff. Its functions might include:

- monitoring the Canadian health system, and regularly advising governments and Canadians about its findings;
- appraising specific Canada-wide health issues of immediate public concern and developing practical options to address them;
- serving as a neutral fact-finding body for intergovernmental disputes concerning the *Canada Health Act* and other issues referred to it by governments, and serving upon request by governments as a facilitator/mediator in the dispute resolution process;
- providing an annual report to the public about the performance of the health system and emerging issues;
- taking some defined responsibility to test innovative health service delivery and management concepts of national significance;
- perhaps serving as one possible vehicle to assemble and disseminate best practice experiences from the Regional Health Authorities across Canada.

This Council would be part of a network of bodies that would contribute to improving the governance of the health care system. It could include representatives from the Canada Health Services Research Foundation, the Canadian Institutes of Health Research, the Canadian Institute for Health Information, and the Canadian Council on Health Services Accreditation.

### **1.2.5 Lawrence Nestman**

In his testimony before the Committee,<sup>17</sup> Professor Lawrence Nestman from the School of Health Services Administration at Dalhousie University drew on the experience of the Dominion Council of Health in the 1960s. This Council was a permanent body where deputies and ministers liaised with a number of health commissions at both the federal and provincial levels. It had a permanent secretariat staffed by highly skilled people who related to full-time public servants in provincial health departments. This arrangement enabled greater continuity in policy making and more coordination of federal-provincial relationships than is possible today. Professor Nestman therefore proposed “the concept of a revised Dominion Council of Health for the federal government as well as some kind of permanent infrastructure in the provinces [that] would improve federal-provincial relations and provide continuity as well as some arm’s length input for the day-to-day operations.”<sup>18</sup>

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<sup>17</sup> May 9, 2002. (*Proceedings* Issue 55)

<sup>18</sup> *Ibid.*, 55:13.

### 1.3 The Committee's Proposal

While each of the above proposals contains interesting elements and valuable suggestions, none meets fully the Committee's view of what is required. Moreover, they all tend to assign much broader mandates to the bodies they recommend than the Committee feels is appropriate at this time. The Committee agrees with the many witnesses who stressed the importance of taking measures to "depoliticize" the management of the

health care system. However, the Committee feels that this will be a long-term process, and that it is important to begin with the evaluation function only. Therefore, the Committee believes that the mandate of the independent evaluation body should be to publish an annual report on the state of the health care system, and on the health status of Canadians, as well as whatever other reports it feels are needed to spur improvements in health outcomes and the delivery of health care in Canada. The Committee believes it would also be appropriate for this independent evaluation body to advise the federal government on how new money raised to reform and renew the health care system should be spent (see Chapter Fourteen).

***The Committee believes that the mandate of the independent evaluation body should be to publish an annual report on the state of the health care system, and on the health status of Canadians, as well as whatever other reports it feels are needed to spur improvements in health outcomes and the delivery of health care in Canada.***

To legitimate such reports with all levels of government, and yet to ensure their independent production and thereby their credibility with the Canadian public, the Committee recommends that the following structures and procedures be put in place.

First, a new federal/provincial/territorial (F/P/T) body is required. This committee must be structured so that neither the federal nor the provincial/territorial representatives are able to dominate it. It is therefore proposed that the committee be composed of one provincial/territorial representative from each of the five major regions of the country (Atlantic, Quebec, Ontario, Prairies, British Columbia), and five representatives from the federal government. The provincial/territorial representatives would be selected in a manner that remains to be determined.<sup>19</sup>

This F/P/T committee, after consulting with a broad range of health care stakeholders, would appoint a National Health Care Commissioner. It would also select the members of a National Health Care Council that the Commissioner would chair from among those nominated by the Commissioner. In making nominations to the Council, the Commissioner would have the responsibility of ensuring that the membership of the Council is balanced, and that the public at large is represented. Councillors should be appointed on the basis of their ability to take a global view of the health care system, and not as representatives of specific health care constituencies.

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<sup>19</sup> This form of provincial/territorial representation is already used in the composition of the Board of Directors of Canadian Blood Services, whose mission is to manage the blood and blood products supply for Canadians in all provinces except Quebec. Four of its Directors represent one of each of the following regions: (a) British Columbia and Yukon, (b) Prairies, Northwest Territories and Nunavut, (c) Ontario, and (d) Atlantic.

So that the selection of the Commissioner and the members of the Council not be dominated by either the federal or provincial/territorial representatives, a two-thirds majority would be required for all appointments. With 10 members on the F/P/T committee, seven votes would be required to confirm all appointments, meaning that neither the federal nor the provincial/territorial representatives could succeed on their own. This procedure further guarantees that the members of the Council would be independent of government (having being nominated by the Commissioner), yet possessing sufficient legitimacy to lend weight to their report (having been appointed by the F/P/T committee).

The Commissioner should be appointed for a five-year term, with the possibility of a single renewal. Council members should be appointed for three-year terms, with the possibility of a single renewal. Half the council would be up for renewal every three years. Eight is a reasonable number of councillors, a total of nine including the Commissioner. They should be adequately compensated for their work with the Council, but would not be full-time employees. A full-time staff would report to the Commissioner.

The Council would have ultimate responsibility for the publication of the annual report and would present it to each Ministry of Health with a request that it be tabled with all federal, provincial and territorial legislatures. The Committee recommends that all F/P/T Ministers of Health respond formally within six months to the annual report that the National Health Care Council would produce. While the Committee recognizes that it would not be possible to require legally that the F/P/T Ministers of Health respond to the annual report, it believes that the Ministers should accept responsibility for issuing a formal response within a six-month period. This would be much like the current requirement for the federal government to respond within a specified time frame to the recommendations made by House of Commons committees. It would ensure that serious consideration is given to the Council's annual report. Furthermore, since the Council's annual report would simultaneously be made public, there would be additional public pressure on all governments to consider carefully and respond to the report and its recommendations.

The Committee believes that the federal government should show leadership by providing the funding for the work of the Commissioner and the Council. This funding should come from the new money that the Committee recommends be raised in Chapter Fifteen.

Should the Commissioner and the Council see the need to broaden the scope of their work, or should the federal and provincial governments initiate such expansion, the provision of any additional funding should be the responsibility of governments on a 50/50 federal/provincial basis, and not necessarily fall exclusively on the shoulders of the federal government.

The Commissioner would be responsible for hiring the necessary professional and technical staff to carry out the Council's mandate. In this regard, however, the Commissioner should not attempt to duplicate the work of existing organizations. Rather, the Commissioner would cooperate with CIHI and CCHSA, and other concerned federal and provincial organizations, to ensure application of the most efficient methods possible to gather the data and information required to produce the annual report (see Chapter Ten).



The Committee believes that, structured in this way, the National Health Care Council chaired by an independent Health Care Commissioner meets the four conditions described earlier:

- The process has a national and not purely federal character;
- The Commissioner and the Council are independent of government, yet have the legitimacy of having been appointed by government representatives;
- The production of an annual report is funded by government;
- The work of the Commissioner and the Council builds on existing organizations.

In summary, then, the Committee recommends that:

**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;**

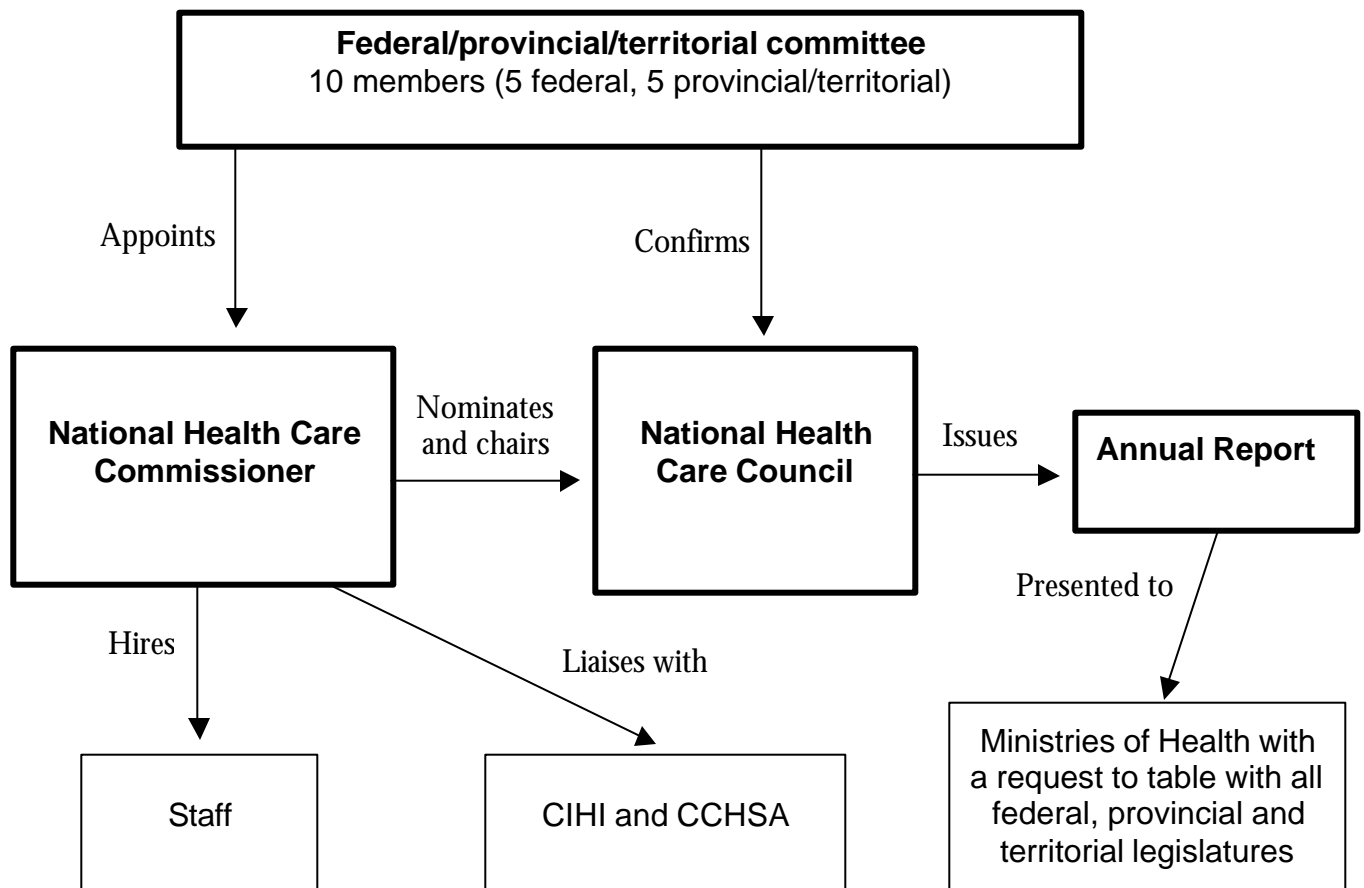
**The National Health Care Commissioner be charged with the following responsibilities:**

- **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.**

**Figure 1.1**  
**Proposal For A National Health Care Commissioner**  
**and A National Health Care Council**





## **Part II: Efficiency Measures**

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## CHAPTER TWO

### HOSPITAL RESTRUCTURING AND FUNDING IN CANADA

With few exceptions, Canadian hospitals exist as not-for-profit entities.<sup>20</sup> Ownership usually resides with community-based not-for-profit corporations, religious organizations, or (rarely) with municipal governments or universities. Apart from psychiatric hospitals, provincial/territorial governments rarely own hospitals. In all cases, however, the vast majority of hospital revenues come from a single funder – the provincial/territorial department of health.

**TABLE 2.1**  
**HOSPITAL SPENDING IN CANADA, 1986 TO 2001**  
**(AS A PERCENTAGE OF TOTAL HEALTH CARE EXPENDITURES)**

	1986	1991	1996	1998	2001
<b>British Columbia</b>	37.0	34.1	30.4	29.6	28.1
<b>Alberta</b>	39.8	39.1	30.1	29.8	29.9
<b>Saskatchewan</b>	34.3	34.0	26.7	26.3	28.2
<b>Manitoba</b>	39.3	37.8	33.2	32.1	30.0
<b>Ontario</b>	37.9	36.0	33.2	30.6	29.6
<b>Quebec</b>	46.9	44.4	38.0	38.4	36.4
<b>New Brunswick</b>	42.6	40.9	39.1	36.8	38.1
<b>Nova Scotia</b>	47.0	46.1	38.7	40.5	37.8
<b>Prince Edward Island</b>	38.6	38.9	36.1	35.6	34.7
<b>Newfoundland</b>	46.2	47.8	43.4	41.4	39.3
<b>Average Canada</b>	<b>41.0</b>	<b>39.9</b>	<b>34.9</b>	<b>34.1</b>	<b>33.2</b>

Source: Calculations done by the Economics Division, Parliamentary Research Branch, Library of Parliament. Based on data from the Canadian Institute for Health Information, "Health Expenditure by Use of Funds, By Source of Finance, Province/Territory 1975-2001," *National Health Expenditure Database (NHEX)*.

Note : Hospitals include all hospitals approved by provincial governments providing acute care, extended and chronic care, rehabilitation and convalescent care, and psychiatric care, as well as nursing stations and outpost hospitals. "Average Canada" represents the unweighted average for the provinces.

Provincial governments spent some \$32.1 billion on hospitals in 2001.<sup>21</sup> This represented almost a third of total provincial/territorial government expenditures on health care. Hospitals represent the largest category of health care spending in Canada. However, their share has been declining significantly. For example, in 1986, spending on hospitals, as a percentage of total health care spending, averaged roughly 41% among the provinces. By 2001, this share fell to an average of approximately 33% (see Table 2.1). This sharp decline is due primarily to

<sup>20</sup> Only 5% of hospitals in Canada are private for-profit institutions.

<sup>21</sup> Canadian Institute for Health Information, "Health Expenditure by Use of Funds, By Source of Finance, Province/Territory 1975-2001," *National Health Expenditure Database (NHEX)* ([http://www.cihi.ca/dispPage.jsp?cw\\_page=statistics\\_results\\_source\\_nhex\\_e](http://www.cihi.ca/dispPage.jsp?cw_page=statistics_results_source_nhex_e)).

changes in knowledge and technology that increasingly permit diagnoses and therapies to be provided safely out-of-hospital and to consequent hospital downsizing and restructuring across the country. As the proportion of health care spending devoted to hospital care has decreased, that allocated to home care and other forms of community-based care has increased.

In Volume Five, the Committee enunciated a number of principles regarding the funding of hospitals. Principle One stated that Canada should keep its current single funder/insurer model for financing hospital services, and that this single insurer should be government.<sup>22</sup> Principle Eight stated that the current methods used for remunerating Canadian hospitals should be replaced by service-based funding.<sup>23</sup>

The Committee believes that service-based funding will achieve a number of important objectives, including: measuring in an appropriate manner the cost of specific hospital services; improving overall hospital efficiency; enabling the public to compare hospitals based on their performance; enhancing hospital accountability; fostering competition among hospitals; reducing waiting lists and encouraging the further development of centres of specialization.

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The Committee also acknowledged in Volume Five that modifications to a pure service-based funding model may be necessary for teaching hospitals and possibly for very small community hospitals. We also believe that the federal government should consider contributing to the capital investment needs of Canadian hospitals, particularly academic health science centres (or teaching hospitals) and hospitals located in areas of exceptionally high population growth.

This chapter provides information on hospital funding in Canada, summarizes the testimony received on this issue and reiterates the Committee's view of the merits of service-based funding. The chapter is divided into seven sections. Section 2.1 reviews and compares current methods used for funding hospitals in Canada. Section 2.2 describes service-based funding and reviews relevant international experience. Section 2.3 details the Committee's rationale for recommending service-based funding for hospitals in Canada and highlights the various challenges posed by this mode of hospital remuneration. Sections 2.4 and 2.5 examine in detail the particular issues raised with respect to academic health science centres and small and rural community hospitals. Section 2.6 examines the issue of capital needs of Canadian hospitals. Finally, Section 2.7 provides the Committee's view on public versus private (for-profit and not-for-profit) hospitals.

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<sup>22</sup> Volume Five, pp. 23-25.

<sup>23</sup> Volume Five, pp. 36-39.



## 2.1 Funding Methods for Hospitals in Canada: Advantages and Disadvantages<sup>24</sup>

Provincial/territorial governments use a variety of approaches to finance hospitals. There is no one model that can accurately portray the financing of hospitals in Canada. Furthermore, provinces/territories do not use a single method to distribute funds to their hospitals. Most rely on a primary funding approach to allocate the majority of funds and a number of secondary methods to apportion lesser amounts.

Methods of hospital funding used in Canada, both primary and secondary, include: line-by-line, ministerial discretion, population-based, global budget, policy-based, facility-based, project-based and service-based. As Table 2.2 shows, provincial governments rely on seven of these methods to finance the operating costs of hospitals. Funds for capital purposes (to pay for hospital construction, major building renovations, and high-cost equipment purchases) are provided in all provinces using a project-based method.

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<sup>24</sup> Unless otherwise indicated, the information provided in this section is based on the following documents:

Sheila Block, *The Ontario Alternative Budget 2002 – Health Spending in Ontario: Bleeding our Hospitals*, Canadian Centre for Policy Alternatives (Ontario), May 2002 ([www.policyalternatives.ca](http://www.policyalternatives.ca)).

Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et spécialisés (Comité Bédard), *La budgétisation et la performance financière des centres hospitaliers*, Santé et services sociaux, Government of Quebec, 2002 ([www.msss.gouv.qc.ca](http://www.msss.gouv.qc.ca)).

Jeffrey C. Lozon and Robert M. Fox, “Academic Health Sciences Centres Laid Bare,” *Healthcare Papers*, Vol. 2, No. 3, 2002, pp. 10-36 (<http://www.longwoods.com/hp/2-3academic/index.html>).

Les Vertesi, *Broken Promises: Why Canadian Medicare is in Trouble and What Can be Done to Save It*, Document tabled with the Standing Senate Committee on Social Affairs, Science and Technology, 2001.

Ian McKillop, George H. Pink and Lina M. Johnson, *The Financial Management of Acute Care in Canada – A Review of Funding, Performance Monitoring and Reporting Practices*, Canadian Institute for Health Information, March 2001 ([http://www.cihi.ca/dispPage.jsp?w\\_page=GR\\_32\\_E](http://www.cihi.ca/dispPage.jsp?w_page=GR_32_E)).

Danish Ministry of Health, *Hospital Funding and Casemix*, September 1999 ([http://www.sum.dk/publika/eng/hosp\\_casemix/](http://www.sum.dk/publika/eng/hosp_casemix/)).

Nizar Ladak, *Understanding How Ontario Hospitals are Funded: An Introduction*, Joint Policy and Planning Committee, Ontario, March 1998 ([www.jppc.org](http://www.jppc.org)).

**TABLE 2.2**  
**HOSPITALS IN CANADA BY PROVINCE, 2000**

Province	Number of Hospitals	Number of Beds per 1,000	Primary Funding Approach	Secondary Funding Approach
BC	80	3.7	Line-by-Line and Pop.-Based	Policy-Based
ALTA	115	3.5	Population-Based	Policy-Based
SASK	71	3.7	Population-Based	None
MAN	79	4.1	Ministerial Discretion	None
ONT	163	2.3	Global Budget	Multiple <sup>1</sup>
QC	95	3.0	Global Budget	Multiple <sup>2</sup>
NB	30	5.3	Line-by-Line and Pop.-Based	None
NS	35	3.3	Ministerial Discretion	None
PEI	7	3.4	Ministerial Discretion	None
NFLD	33	4.6	Ministerial Discretion	None

Source: McKillop *et al.* (2001), Table 1.1 (p. 9), Table 3.2 (p. 46) and Table 3.5 (p. 53). Population data from Statistics Canada, CANSIM II, Table 051-0001.

(1) Policy-Based, Facility-Based, Population-Based and Service-Based.

(2) Population-Based and Policy-Based.

Note: Number of beds for Nova Scotia includes acute care only.

More specifically, two provinces (British Columbia and New Brunswick) use a line-by-line method. Four provinces (Manitoba, Prince Edward Island, Nova Scotia, Newfoundland) use a ministerial discretion method. Two provinces (Alberta and Saskatchewan) have primary operating funding approaches with a population-based method, while two others (Ontario and Quebec) use global budgets. The policy-based method is the most commonly used secondary funding approach in four provinces (British Columbia, Alberta, Ontario and Quebec). Two provinces (Ontario and Quebec) also use a population-based method in combination with the primary method.<sup>25</sup> At present, only Ontario uses a service-based method for financing selected hospital services.

### **2.1.1 Line-by-line**

Line-by-line budgeting used to be the most popular method of hospital financing in Canada. This method involves negotiating amounts for specific line items (or inputs) such as in-patient nursing services or medical/surgical supplies. The total budget allocation for an individual hospital, then, is simply the sum of the line items. British Columbia and New Brunswick still rely on line-by-line budgeting (combined with a population-based method) as their primary budgeting approach.

On the positive side, line-by-line budgeting allows provincial ministries of health to link specific activities with policy objectives through direct spending. For example, a province that wishes to promote day surgery could increase the line funding available for this activity by a

<sup>25</sup> Although the classification of funding method may be the same for a number of jurisdictions, the way in which the method is implemented may differ.

factor greater than that applied to the in-patient nursing line. Line-by-line funding also gives hospitals a higher degree of financial predictability than some other methods.

However, this method has a number of disadvantages which have caused several provincial ministries to move away from the approach. On the one hand, the line-by-line method prevents reallocation among lines and thus reduces flexibility in managing funds. On the other hand, the approach is not related to performance and therefore does not encourage efficiency. In addition, line-by-line budgeting provides information only on the cost of inputs, not on the cost or quality of outputs. Moreover, the effort involved in scrutinizing line-by-line budget detail is significant. The most serious disadvantage, however, is that it tends to diminish the capacity of hospital boards and managers to link the hospital's activities directly with the needs of the community it serves.

### **2.1.2 Ministerial discretion**

With this method, funding is based on decisions made by the provincial minister of health in response to specific requests by the hospital concerned. This method is used as the primary funding approach in Manitoba, Nova Scotia, Prince Edward Island and Newfoundland.

Although the ministerial discretion method is highly subjective, it offers a number of advantages. From the government's perspective, this method is extremely flexible; ministerial decisions are not constrained by formulas or other predetermined budgeting methods.

The major drawback of this funding approach is that it risks being myopic, inconsistent and overtly "political." Significant changes in funding can and do occur with a new government or a change in policy. Furthermore – and this is critical from the Committee's point of view – this method clearly lacks transparency. Witnesses told the Committee repeatedly that there is a need to depoliticize hospital financing. For example, Mark Rochon of the Ontario Hospital Association stated that:

*We need to consider and promote mechanisms that (...) insulate, as much as we can and are able to do, decisions concerning the provision of health services from politics.<sup>26</sup>*

### **2.1.3 Population-based**

Population-based methods use demographic information such as age, gender, socio-economic status and mortality rates to forecast the demand for hospital services. Matching the predicted demand for certain health services with the estimated cost of providing these services yields a spending forecast for individual hospitals (or for regional health authorities). At present, Alberta and Saskatchewan use population-based funding as their primary methods, while British Columbia and New Brunswick use it in combination with a line-by-line budget approach. Newfoundland, Nova Scotia, Ontario and Quebec are currently considering adopting a population-based approach as their primary funding method.

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<sup>26</sup> Mark Rochon, Ontario Hospital Association (56:42).

The Committee learned that a population-based method, employing formulae strictly to distribute funds, can be objective, equitable and accommodate the needs of particular regions and hospitals. In addition, the CEO of the Calgary Health Region, Jack Davis, told the Committee that in Alberta, the population funding system had helped to depoliticize the allocation of resources.<sup>27</sup>

However, ensuring that a population-based formula accounts for all the factors that affect the health care a population requires is complex and difficult to implement. Such a method requires good information systems that are resource-intensive (equipment, databases, staff).

This budgeting method may become too complex and create a lack of transparency with users unable to understand or predict how funding amounts have been determined. According to Les Vertesi, Chief of the Department of Emergency Medicine at the Royal Columbian Hospital (Vancouver), a population-based funding model can only provide an estimate of where health care resources will be needed; it will not provide incentives for better service.<sup>28</sup>

#### **2.1.4 Global budget**

Global budget methods adjust previous spending (such as last year's base allocation) to derive a proposed funding level for the upcoming year. The focus is on the total hospital budget rather than on individual service activities or cost centres within the hospital. Adjustments can be made to the base amount using a multiplier (such as the rate of inflation) or a lump-sum amount to establish the funding level for future periods. Quebec introduced global budgets as its primary funding approach in 1994, while Ontario has used this method since 1969.<sup>29</sup>

The Committee learned that because hospital activities change little from year to year, provincial governments find it much easier to simply repeat the previous year's allotment with an adjustment for inflation or population growth. Therefore, global budgets are straightforward to calculate for the provincial government and predictable for the hospital. Dr. Vertesi explained that global budgets gained popularity mainly because they allowed governments to control costs while at the same time granting hospital management a great deal of discretion in the allocation of funds among a hospital's various operations.<sup>30</sup>

Similarly, in its brief, the Canadian Healthcare Association made the argument that global budgets encourage efficiency by permitting hospitals to distribute savings from one area of operation to another area of need. The Association further argued that global funding

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<sup>27</sup> Jack Davis, Calgary Health Region (53:40).

<sup>28</sup> Les Vertesi (2001), *op. cit.*, p. 117.

<sup>29</sup> Barer, M.L. (1995), "Hospital Financing in Canada," Chapter Two in *Hospital Funding in Seven Countries*, Office of Technology Assessment: U.S. Congress, p. 23.  
(<http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1995/9525/952504.PDF>)

<sup>30</sup> Les Vertesi (2001), *op. cit.*, p. 31.

allows the delivery of comprehensive, integrated health care, which, in the long run, can reduce overall health care costs.<sup>31</sup>

Despite these advantages, many witnesses expressed the view that global budgets have numerous drawbacks and that, according to Dr. Vertesi, this mode of hospital remuneration is “an archaic funding model.”<sup>32</sup> First, the Committee was told that funding under a global budget is unrelated to the services that are actually provided by a hospital. Second, we also heard that any inequities that exist between hospitals are perpetuated through global budgets. Third, witnesses stressed that global budgets do not encourage hospitals to improve performance; indeed, they can perpetuate and reward inefficient hospitals and penalize more efficient ones. Fourth, the Committee learned that funding under a global budget cannot accommodate changes in population and management structures. Last, but perhaps most important, witnesses raised the fact that there is a progressive and permanent loss of information under global budgets about what specific hospital services cost; hospitals have no incentive to measure such unit costs.

Overall, the majority of witnesses agreed that after years of global budgets in a number of provinces, no one knows how much anything costs any more and that, as a result, it is difficult to know even approximately what the public is getting for its spending on hospitals. The Committee believes that the lack of costing data with respect to hospital services is inconsistent with our vision of what a twenty-first 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 which services in which hospitals are provided efficiently, and which are not.

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### **2.1.5 Policy-based**

Under this method, funding is distributed to achieve specific policy objectives. Unlike the ministerial discretion approach, where the health department (or minister) responds to individual requests for funding, a funding decision under the policy-based method has an equal effect on all institutions that provide the services encouraged by a particular policy (such as a 48-hour postpartum stay in a family birthing unit).

From the government’s perspective, this method provides the department with a mechanism to ensure that policy initiatives are embraced by hospitals. Nonetheless, many hospitals consider that this method of funding interferes with their operations and provision of

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<sup>31</sup> Canadian Healthcare Association, Brief to the Committee, June 2002, p. 6.

<sup>32</sup> Les Vertesi (53:44).

services. Furthermore, it is not a very predictable source of funding, since funding patterns will change if governments or policies change.

### **2.1.6 Facility-based**

Facility-based methods use characteristics of the hospital, such as size, amount of teaching activity, occupancy and distance from nearest tertiary facility (specialized care centres, etc.), to estimate operating costs. This approach recognizes that the structure of different hospitals can influence the cost of providing identical services.

Funding under a facility-based approach attempts to accommodate differences in organizational structure (rural versus urban hospitals, teaching versus community hospitals, and so on). It is, however, insufficiently responsive to changes in demographics or in disease patterns. Furthermore, facility-based funding does not reward utilization efficiencies.

### **2.1.7 Project-based**

Project-based methods distribute funds in response to proposals for a one-time need. This method is often used by provincial/territorial governments to finance significant capital expenditures (such as building a new hospital wing). Project based budgeting is distinct from policy-based budgeting: the former method directs funding to an individual hospital for a specific identified need, while the latter apportions a pool of money among various hospital to effect policy initiated by government.

### **2.1.8 Service-based**

Service-based funding for hospital services is often referred to as a “case-mix-based approach” in Canadian and international literature; both concepts are used interchangeably in this chapter.

Case-mix-based or service-based methods use the volume and type of cases treated (such volume of dialysis, bypass surgery, knee or hip replacement, etc.) by a hospital to determine funding. More precisely, case-mix measurement requires two essential components: 1) the classification of patients into clinically meaningful groups that use similar levels of hospital resources, and 2) the attachment of a weight to each group to estimate relative resource use. These weights usually reflect the average cost of treating the patients in each group; they are used to construct individual hospital case-mix indices that measure average patient resource intensity, usually relative to a national norm. A higher case-mix index indicates greater patient resource intensity. Therefore, under service-based funding, hospitals are reimbursed for the episode of care for which the patient is admitted and based on the type of service or procedure performed on the patient.

The current literature on case-mix-based approaches seems to suggest that such methods fund hospitals more equitably than other methods. A particularly attractive characteristic of case-mix-based approaches is that they encourage efficiency and performance. International evidence indicates a clear trend toward such approaches.

Ontario used a service-based funding method in the summer of 2001 to distribute \$95 million of additional lump-sum funding to hospitals. The new funding methodology was developed by the Joint Policy and Planning Committee (JPPC). The JPPC recommended that this methodology be implemented gradually over the next three years and that its impact be monitored.<sup>33</sup>

## **2.2 Service-Based Funding: Review of International Experience**

### **2.2.1 United States**

As in Canada, hospitals represent the single largest category of health care spending in the United States. The organization of the American hospital sector is, however, one of the most complex in the world with a heterogeneous collection of hospitals, payers and funding methods.<sup>34</sup> In 1998, 28% of hospitals were classified as public (state or local government) hospitals, 58% as private, not-for-profit hospitals and 14% as private for-profit hospitals.<sup>35</sup> Financing for hospital services comes from a number of private insurers, out-of-pocket costs and from the Medicaid and Medicare programs.<sup>36</sup>

In 1983, the Health Care Financing Administration (now Centers for Medicare and Medicaid Services) introduced the Prospective Payment System (PPS), under which hospitals were paid according to a case-mix-based approach, the Diagnostic Related Groups (DRGs) classification. Eighty-one percent of hospitals are now remunerated using the DRG system.<sup>37</sup> The rates that are paid to hospitals are based on the average costs of a specific treatment and are independent of a patient's actual length of stay in hospital.<sup>38</sup> These rates may be adjusted upward if a hospital services a population with a disproportionately high number of low-income residents. While most hospitals use a common rate-setting methodology, actual rates are determined by each individual state. All rates are reviewed annually by the United States Congress. Private insurance companies and managed care plans are free to set their own hospital rates according to state guidelines, if any.

The wide variety of payers and payment rates under the DRG classification has led hospitals to develop detailed information systems that are equated with high administrative costs. Nonetheless, DRGs allow for the comparison of resource use across American hospitals and, as a result, encourage competition among institutions. Appearing before the Committee, Dr. Duncan Sinclair, former chair of the Ontario Health Services Restructuring Commission, said:

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<sup>33</sup> Ontario Joint Policy and Planning Committee, *Hospital Funding Report Using 2000/01 Data*, Reference Document No. RD 9-12, October 2001 ([www.jppc.org](http://www.jppc.org)).

<sup>34</sup> Laschober, Mary, and James Vertrees, "Hospital Financing in the United States," Chapter Eight in *Hospital Funding in Seven Countries*, Office of Technology Assessment; U.S. Congress, 1995, p. 136. (<http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1995/9525/952510.PDF>)

<sup>35</sup> Comité Bédard (2001), p. 38.

<sup>36</sup> Medicaid is a joint federal-state program that provides health care insurance for low-income Americans. Medicare is a federal health care insurance program responsible for covering individuals 65 years old and over. Together, these two programs cover roughly 30% of the American population.

<sup>37</sup> Comité Bédard (2001), p. 38.

<sup>38</sup> Two lists of rates are used, based on whether a hospital is located in an urban area (defined as more than a million inhabitants) or a non-urban area.

*it is not a bad idea to have hospitals paid basically on the basis of DRGs and the volume related to those, much along the line of what is common in the United States. That is a very good idea.*<sup>39</sup>

The literature suggests that “DRG creep” (or “up-coding”) has become a common problem among American hospitals. This problem occurs when hospitals attempt to maximize their reimbursements by choosing diagnostic codes that result in higher payments that may not be medically justified.<sup>40</sup> However, the Committee was also told that close auditing of the DRG category into which a patient is put has substantially reduced the amount of DRG creep, particularly since there have been some high-profile cases when health care firms and their executives have been convicted of fraud associated with this practice.

### **2.2.2 United Kingdom**

Britain’s major reform of the National Health Service (NHS) came in 1991 when it introduced internal competition by separating the “purchaser” from the “provider” of health services. Hospitals were set up as independent “trusts” and were expected to negotiate contracts with purchasers – Fundholding doctors and District Health Authorities. To accommodate this model, case-mix systems were introduced as the method of payment. The NHS reforms were severely criticized because they led to significant increases in administrative costs.

More reforms took place in 1997, substituting cooperation for the previous emphasis on competition. But hospital funding has remained the same. Currently, District Health Authorities are financed based on their populations. Hospitals are then funded by the District Health Authorities based on case-mix methods.

### **2.2.3 France**

The hospital sector in France is split between public hospitals, which handle roughly 75% of hospital activity, and private hospitals, responsible for the remaining 25%. The two types of hospitals are remunerated differently. All public hospitals receive global operating budgets that are based on the previous year’s amount and increased annually by a rate determined by government. Private hospitals, on the other hand, are paid through a combination of a per diem rate for the number of cases handled.

France is currently considering a move towards case-mix financing for public hospitals. For almost 20 years, the French hospital sector has been developing DRG-style case-mix information systems. In 1996, the *Programme de Médicalisation du Système d’Information* (PMSI) released for the first time reliable patient data, designed specifically for French conditions. When used to measure the performance of French hospitals, the PMSI data revealed significant disparities in performance and capabilities among institutions and regions. French analysts feel that the present system of global budgets perpetuates these disparities.

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<sup>39</sup> Dr. Duncan Sinclair (50:12).

<sup>40</sup> PricewaterhouseCoopers Healthcare (2000) “Health Care Fraud and abuse: DRG creep,” *Issues* (<http://www.pwcglobal.com/extweb/manissue.nsf/DocID/80FFF2EE2B921FC9852566D7004D5BC>).



#### **2.2.4 Denmark<sup>41</sup>**

Most hospitals in Denmark are public hospitals owned and financed by county councils. Fewer than 1% of the total number of beds are in private for-profit hospitals. In the Copenhagen area, the municipally owned and financed hospitals are organized as a public company, the Copenhagen Hospital Corporation. The corporation is controlled by a board, with members appointed by the municipalities and the national government, including representatives from the private sector.

Until recently, the predominant method for allocating resources to hospitals was through prospective global budgets fixed by county councils. Large capital investments are decided jointly by county councils and hospitals and provided through project-based funding.

While global budgeting proved effective in controlling hospital expenditures, it provided limited economic incentives to increase efficiency at the point of delivery, and limited incentives to increase activity in relation to demand, thus contributing to increasing waiting lists for some procedures. In response to these inefficiencies, funds were allocated to the counties in 1997 to allow them to experiment with service-based funding. To increase the incentives to treat patients from other counties, in 1999 the national government decided to introduce full DRG payments for the treatment of such patients. The use of deliberately high DRG rates was expected to increase competition between hospitals.

In 2000, the national government formally introduced a system combining global budget and DRG rates with negotiated activity targets for each hospital. Under the new scheme, each hospital receives an up-front budget corresponding to 90% of the DRG rates related to the case-mix in the negotiated activity target, with the remaining 10% allocated according to the actual activity performed. Hospitals that provide more treatments than their negotiated target receive extra funds. The national government plans to encourage experiments in which more than 10% of a hospital's income is activity based.

#### **2.2.5 Norway<sup>42</sup>**

Fewer than 1% of all hospital beds and 5% of outpatient services in Norway are private. Norway's counties are responsible for financing all public hospitals, with the exception of one regional hospital owned and operated by the national government.

Between 1980 and 1997, Norwegian hospitals received global budgets from their counties. While it was agreed that this system allowed governments to control costs and the distribution of resources, a Royal Commission, appointed in 1987, found that global budgets encouraged some hospitals to restrict their services in order to keep within their budgets.

As a result of the commission's recommendations, counties, on behalf of hospitals, were remunerated by the national government by a combination of cost per case, based on the DRG system, and global budgets. The reform, introduced in 1997, was intended

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<sup>41</sup> The information provided in this section is based on European Observatory on Health Care Systems, *Health Care Systems in Transition – Denmark*, 2001. <http://www.euro.who.int/observatory/TopPage>.

<sup>42</sup> The information provided in this section is based on European Observatory on Health Care Systems, *Health Care Systems in Transition – Norway*, 2000. (<http://www.euro.who.int/document/e68950.pdf>).

to increase hospital in-patient activity, raise productivity and shorten waiting lists. The new payment method was introduced gradually: in 1997, 70% of grants to counties were according to a needs-based formula while the remaining 30% were paid based on the previous year's in-patient activity, using national standard DRG rates. In 1998, this was changed to 55% formula-based and 45% activity-based and finally moved to a 50-50 split in 1999. Since 1999, day care surgery has been financed based entirely on the DRG system. Teaching hospitals receive two additional grants: one to cover teaching and research, and the other to finance the treatment of complex and costly patient cases.

### **2.2.6 Review of international experience by the Comité Bédard**

In June 2000, the Quebec Department of Health established a task force to examine the financing of hospitals in the province. This task force, the *Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et spécialisés*, was headed by Denis Bédard. The *Comité Bédard* released its report in December 2001. One section of the report reviewed hospital budgeting in the United States, United Kingdom, France, Belgium and Norway. The *Comité Bédard* made a number of interesting observations based on this international review:

- Population-based approaches are widely used and recognized as an equitable mode for funding hospitals.
- There is a move away from global budgeting and a trend towards deploying information systems based on the DRG model.
- Countries are looking for mechanisms that can link information on hospital use and hospital delivery of services.
- There is a trend toward the development of more sophisticated methods for assessing hospitals' financial performance.
- More emphasis is placed on quality of care in the delivery of hospital services.

Overall, the *Comité Bédard* recommended a budgeting method for Quebec hospitals based on DRGs and performance. It was recognized that adjustments would have to be made for teaching hospitals. The *Comité Bédard* also recommended that the Quebec Department of Health build on the work of the Canadian Institute for Health Information (CIHI) rather than attempting to develop its own database on case-mix groups (CIHI's work is discussed in more detail below).

## **2.3 The Rationale for Service-Based Funding in Canada**

It has been recognized both in Canada and internationally that detailed information on the use of hospital (and other) resources is essential to the efficient delivery of desired outcomes in health care. With current approaches to funding hospitals in Canada, decisions are not usually based on detailed costing information, since funding is either decided politically or based on historical trends and, in any case, the necessary information is just not available.

As explained in Section 2.1 above, provinces have tried recently to improve their decision-making ability by introducing funding models that depend on more and better information, such as population-based funding. However, this method for determining budgets can provide only rough estimates of what a hospital's needs might be. Moreover, depending on the efficiency of the facility, there is no guarantee that the hospital will successfully and effectively turn these resources into the desired services with the desired outcomes. Therefore, the Committee believes that current hospital funding mechanisms, where these are based on funding inputs and not on final outcomes, must be revised to focus on performance in delivering hospital services.

***The Committee believes that current hospital funding mechanisms, where these are based on funding inputs and not on final outcomes, must be revised to focus on performance in delivering hospital services.***

The majority of the witnesses that appeared before the Committee supported the idea of moving to service-based funding for hospitals. For example, Michael Decter, former Deputy Minister of Health in Manitoba and Ontario and currently Chairman, Board of Directors, Canadian Institute for Health Information (CIHI), stated:

*The right way of funding hospitals, in my view, is to fund them for what they do, for what they actually accomplish in outcome terms.<sup>43</sup>*

The following advantages of service-based funding were brought to the attention of the Committee:

- Better Information – Witnesses told the Committee that service-based funding increases the need for better information, something the Committee considers essential to measure the performance of the health care system in terms of quality and outcomes.<sup>44</sup> In fact, the lack of critical information currently hobbles health care providers and government decision-makers alike. In its brief, the Canadian Healthcare Association indicated that: “Our members fully support the need for costing services and improving performance measurement and benchmarking.”<sup>45</sup>
- Transparency and Accountability – Witnesses stressed that, because the service-based approach relates funding to the actual services provided by a hospital, accountability for the use of public funds and transparency of costs would be substantially improved. For example, the submission of the Ontario Hospital Association to the Committee stated that “the public would see the direct connection between the level of funding and the number and types of procedures that are performed, thereby opening up health care funding to public scrutiny.”<sup>46</sup>

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<sup>43</sup> Michael Decter (52:12).

<sup>44</sup> Mark Rochon, Ontario Hospital Association (56:43).

<sup>45</sup> Canadian Healthcare Association, Brief to the Committee, June 2002, p. 6.

<sup>46</sup> Ontario Hospital Association, Brief to the Committee, May 22, 2002, p. 36.

- **Equity in the Distribution of Funding** – With its “price times volume” approach, many witnesses considered service-based funding to be a more equitable means of funding hospitals than through current methods.<sup>47</sup> In addition, by attaching a price to specific hospital services, service-based funding enables the funder to influence change by changing the value attached to specific services.
- **Investment in Capital** – Dr. Les Vertesi informed the Committee that the health care system in Canada is “under-capitalized.” He blamed this on the use of global budgets, which do not attract capital. He argued that service-based funding, on the other hand, attracts outside capital to build facilities.
- **Independence** – Many witnesses believed that a move to service-based funding would result in hospitals becoming more independent from government. This would help to de-politicize decision-making with respect to hospital services. The Canadian Healthcare Association disagreed with this point, arguing that service-based funding would most likely lead to greater rather than less micromanagement by governments.<sup>48</sup> The Committee does not share this view. Along with the majority of witnesses, we believe that service-based funding will provide hospitals with the needed flexibility to allocate financial and human resources according to principles of best practice, efficiency and locally-determined needs.
- **Reduction in size of Provincial Health Departments** – Indeed, the Committee believes that service-based funding will enormously reduce the amount of top down, control and command micromanagement of hospitals which now characterizes all provincial departments of health. The reduction in the role of these departments should lead to a corresponding reduction in the number of their employees.
- **Patient-Oriented Service Delivery** – Dr. Vertesi stated that by paying hospitals for the services they actually provide, patients become a source of income rather than a burden to the facility. Service-based funding creates incentives for providers to increase efficiency, service volumes, and patient satisfaction, precisely what is needed currently.<sup>49</sup>
- **Efficiency and Performance** – Current hospital funding mechanisms do not provide the right incentives and often produce perverse results with respect to financial management. In fact, a 1998 study by the Ontario Joint Policy and Planning Committee showed that with global budgets there is no correlation between hospital deficits/surpluses and cost-efficiency in the Ontario hospital sector. More precisely, the study concluded that there are a number of inefficient Ontario hospitals that run budget surpluses and an even greater number that are considered cost-efficient but have deficits.<sup>50</sup>

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<sup>47</sup> This opinion was also expressed by Ladak (1998), *op. cit.*, p. 3.

<sup>48</sup> Canadian Healthcare Association, Brief to the Committee, p. 7.

<sup>49</sup> Les Vertesi (2001), *op. cit.*, p. 118.

<sup>50</sup> Ontario Joint Policy and Planning Committee Financial Issues Advisory Group (1998), “Understanding the Financial Pressures of Ontario Hospitals: Short and Long Term Solutions”, Document No. RD 7-10.

Service-based funding changes the financing perspective from paying hospitals a specific amount to meet their anticipated needs to paying them according to what they actually do. As elsewhere in the economy, this fosters both efficiency and performance.

- **Multiple Ownership Structures** – The combination of a single funder/insurer, service-based funding and the separation of funder and provider means that the funder is neutral on the issue of who owns a hospital. The funder/insurer would purchase the service from that institution offering the best price, provided that it met the necessary quality standards. Such an institution could be either publicly owned or owned by a private not-for-profit or for-profit organization. As indicated in Volume Five, the Committee believes that the patient and the funder/insurer will be served equally no matter what the corporate ownership of a health care institution maybe, as long as the two following conditions are met: 1) all institutions in a province are paid the same amount for performing any given medical procedure or service; 2) all institutions, no matter their ownership, are subjected to the same rigorous, independent quality control and evaluation system. The Committee emphasizes that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the *Canada Health Act*.<sup>51</sup> Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, privately owned, not-for-profit institutions.<sup>52</sup>
- **Flexibility in Changing Priorities** – Service-based funding allows government to change priorities with respect to particular procedures and services by altering the amount it will pay for them.
- **Competition to Provide the Best Services** – Service-based funding will lead to particular services being provided at hospitals which are most efficient and perform the greatest number (highest volumes) of these services. Competition in the provision of services will improve quality and force those hospitals that wish to continue providing particular services to do so even more efficiently.
- **Centres of Excellence** – The Committee heard many times that a service-based funding method would lead to the development of centres of specialization – or “centres of excellence”, as they were referred to by a

***The Committee emphasizes that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the Canada Health Act.***

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( [www.jppc.org](http://www.jppc.org))

<sup>51</sup> This point is clearly enunciated in a document prepared for the Commission on the Future of Health Care in Canada by Colleen Flood and Sujit Choudhry, *Strengthening the Foundations: Modernizing the Canada Health Act*, Discussion Paper No. 13, August 2002.

<sup>52</sup> Volume Five, pp. 38-39.

number of witnesses – for the provision of certain treatments or surgeries. Such change in the delivery of hospital services should be encouraged because of the efficiencies it brings. This would also contribute to improving the quality of services. Indeed, recent articles in the *New England Journal of Medicine* have shown that the best indicator of quality, whether it is surgery or a diagnostic procedure, is volume. The advantages of specialization for selected hospital services were acknowledged by provincial premiers and territorial leaders who agreed, at their January 2002 meeting, to share human resources and equipment by developing “Sites of Excellence” for a number of complex surgical procedures.<sup>53</sup> There are, obviously, desirable limits to the Centre of Excellence concept that are reached when accessibility to services is compromised by virtue of the fact that the hospital offering a particular service is far away. A balance thus needs to be struck between the quality and cost-effectiveness/efficiency principles and that of ready accessibility.<sup>54</sup>

While most witnesses stated that they supported a move to service-based funding for hospitals, the Committee was cautioned that there are a number of substantial challenges in the implementation of such a funding model. These challenges are summarized below.

### **2.3.1 Appropriateness of service mix**

Service-based funding is attractive to hospital managers because they are responsible for choosing which services their institution will provide and at what levels. With this discretion available to management, hospitals will adjust their service mix in order to earn the highest possible returns consistent with meeting the needs of the population they serve. Hospitals will be encouraged to specialize in those services they can do best, and those for which the rates of remuneration are most attractive; they will reduce to the point of not providing those low-volume services that are not, for them, appropriately funded. In highly populated urban areas, this would lead to facilities specializing in the provision of certain services. However, the Committee was told that in smaller, rural communities, particularly those located some distance from a major urban centre, preserving accessibility to particular services may well claim priority. In this case, hospitals may choose to continue to provide needed services despite relatively low rates of remuneration. It is, therefore, essential that rates be reviewed and revised on a regular basis. The concerns with respect to small and rural community hospitals are discussed in Section 2.5.

### **2.3.2 Over-servicing and up-coding**

With a hospital's finances dependent on the volume and mix of services it provides, incentives are created to encourage efficiency and to increase productivity. There is concern, however, that remunerating hospitals for each service performed could lead to over-servicing and, possibly, improper billing (“DRG creep”). The issue of over-servicing arises with

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<sup>53</sup> Specialized hospital services include for example paediatric cardiac surgery and gamma knife neurosurgery.

<sup>54</sup> For example, with paediatric coronary surgery, given the relatively small number of children affected and the generally reparative nature of the problems (as opposed to life-threatening), the case is compelling to concentrate those procedures in very few centres (as is now being done in Ontario). But for adult coronary artery by-pass, for example, it would make no sense to have only one Centre in Ontario doing them.

physicians who are paid on a fee-for-service basis. The Committee believes that this method of payment has led some physicians to concentrate on the number of patients seen rather than quality of their care. The Committee was told, however, that while the possibility of over-servicing always exists with hospitals, it is less likely to occur given that many “players”, such as referring and consulting physicians and, of course, patients themselves, are involved in every decision to provide a given person with a specified service in hospital.

In the opinion of Dr. Duncan Sinclair, former Commissioner of the Ontario Health Services Restructuring Commission:

*[t]he danger is very much less in hospitals, given that the hospital itself is not the gatekeeper. However, one would have to be careful to avoid collusion between those who are the gatekeepers of hospital function and the hospitals themselves.<sup>55</sup>*

Some witnesses stressed that over-servicing is especially dangerous in a system such as that in Canada where hospital-based specialists are also paid under a fee-for-service scheme. This problem can be greatly alleviated, however, by having hospital-based specialists paid under a different remuneration scheme, as in Sweden and the United Kingdom.

Under a service-based funding system, cases are given weights in relation to their severity and the corresponding use of resources: the higher the case weight, the greater the remuneration. Therefore, hospitals have an incentive to up-code, that is, to report the highest weight for each case, whether this classification is justified or not.

Michael Decter raised the concern of improper billing or up-coding with respect to service-based funding:

*I think service-based funding is the right way with a couple of caveats. You must have a system that is well enough documented and data strong enough you do not get gamed. As you will remember, a major hospital chain in the U.S. – HCA Columbia – was litigated by the government of the United States for cheating them to the tune of hundreds of millions, if not billions of dollars, by having their thumb on the scale on the coding.<sup>56</sup>*

Audits, fines and penalties will have to be put in place to prevent abuse of the payment system. A detailed and accurate set of costing rates will also reduce the incentives to up-code. Having an independent system of evaluation, as recommended in Chapters One and Ten, would alleviate this problem to a great extent.

### **2.3.3 Rates, information and data**

Before service-based funding can be implemented, reliable case costing information and methodologies must be developed. Sharon Scholzberg-Gray, President and CEO of the Canadian Healthcare Association, informed the Committee that shifting to an

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<sup>55</sup> Duncan Sinclair (50:12).

<sup>56</sup> Michael Decter (52:13).

entirely service-based funding system requires costing data that do not yet exist. In its brief, the Association also indicated that:

*The costing data that has been developed in Ontario has taken 10 years to develop. While it has been an important and necessary initiative, there are still significant operational issues to deal with including: the fact that this process only covers 50-60% of hospital services (it does a good job of inpatient services and surgeries, but not outpatient services); there is a need to add “complexity factors” (such as recognizing the unique situation of remote hospitals and teaching hospitals); and the tendency to allocate administrative costs to services that are not covered by the process, thus appearing to be very efficient. Given the ongoing challenges of establishing an Ontario system, one can imagine the magnitude and complexity of issues that need to be resolved when developing a pan-Canadian costing system.<sup>57</sup>*

Currently, the Canadian Institute for Health Information (CIHI) is responsible for the collection, establishment and revision of service case rates. The work on collecting costing data in Canada began in 1983, when the Hospital Medical Records Institute undertook to develop a Canadian database on case-mix groups, which is now maintained by CIHI. At the time of implementation, the lack of comprehensive Canadian case-mix costing data resulted in the importation of American cost data (New York State and Maryland) that were adjusted for Canadian lengths of stay. Now, CIHI uses data from selected hospitals in Alberta and Ontario to estimate the case-mix weights.

Kevin Empey, Chief Financial Officer of University Health Network in Toronto, stressed that more hospitals must submit costing data if accurate remuneration rates are to be established. He indicated, for example, that in 2000 only 2 of the 13 teaching hospitals in Ontario and 3 of the province’s 69 community hospitals, along with a small number of Alberta hospitals, provided costing data for the establishment of Canadian case rates.<sup>58</sup> In order to develop sufficiently current and detailed rates, it is essential that the majority of hospitals be required to produce and submit costing data. Kevin Empey also stressed that:

*We need a system which either creates an incentive or a penalty to motivate institutions to provide data and to participate in the inputting of it. This would end up with a better structure and better data.<sup>59</sup>*

### **2.3.4 Innovation**

In its brief, the Canadian Healthcare Association argued that service-based funding, with its focus on providing services at the lowest cost, would discourage innovation, both with respect to new procedures and new technology.<sup>60</sup> This is especially a concern for Academic Health Sciences Centres and teaching hospitals. Teaching facilities must be able to try

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<sup>57</sup> Canadian Healthcare Association, Brief to the Committee, p. 7.

<sup>58</sup> Kevin Empey (56:45).

<sup>59</sup> *Ibid.*

<sup>60</sup> Canadian Healthcare Association, Brief to the Committee, p. 6.



new and highly specialized, but very costly, procedures without being put at risk by a rate-based system. It is therefore important that case-mix funding approaches not create perverse incentives by discouraging innovation of this (or any) kind. The concerns raised with respect to teaching hospitals are discussed in Section 2.4.

### **2.3.5 Comprehensive health care**

Members of the Canadian Healthcare Association pointed out that service-based funding focuses on “procedure-driven” health care instead of the provision of comprehensive and integrated care. In other words, service-based funding would simply encourage health care providers to respond to sickness and to concentrate less on a broad continuum of services, including health promotion and disease prevention. They felt that funding under global budgets helped to provide more extensive care than service-based funding would be able to. Indeed, Mark Rochon of the Ontario Hospital Association, who supported the idea of a move towards service-based funding, also made the comment:

*I think we need also to recognize that there are some aspects of service that perhaps ought to be funded with other than a service based approach. I am thinking, for example, of services that relate to health promotion and prevention. Perhaps the argument could be made that stand-by services such as emergency rooms could also be funded on a global basis.<sup>61</sup>*

### **2.3.6 Escalation of costs**

In the opinion of the Canadian Healthcare Association, it was precisely this type of procedure-driven care – one that would be fostered by service-based funding – that has resulted in an escalation of costs:

*The cost escalations currently being experienced within our health system are almost entirely related to “cost of procedures” related to physician services and drug costs. Service based funding would encourage a continuation of these current practices.<sup>62</sup>*

The Committee does not support this opinion. As stated in Volume Five, we believe that service-based funding fundamentally changes the incentives, with the result that cost escalation will be reduced in the long run.<sup>63</sup>

### **2.3.7 Lack of simplicity**

Many witnesses told the Committee that if service-based funding were to be implemented, a number of adjustments would have to be made to the rates in order to accommodate institutions such as teaching hospitals and smaller, rural hospitals. Sharon

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<sup>61</sup> Mark Rochon, Ontario Hospital Association (56:43)

<sup>62</sup> Canadian Healthcare Association, Brief to the Committee, p. 6.

<sup>63</sup> Volume Five, pp. 36-39.

Sholzberg-Gray, President and CEO of the Canadian Healthcare Association, observed that while the vast majority of the witnesses supported service-based funding, each witness suggested modifications that, in aggregate, could lead to an extremely complex funding system:

*What we noted in reviewing some of the testimony of people who came before this Committee to speak about service based funding is that (...) they all wanted special complications formula – that is, if you are a teaching hospital, one formula; if you are in a remote area, a different approach; if you do certain things, another approach.<sup>64</sup>*

The Committee has already acknowledged in Volume Five that some adjustments would be necessary to service-based funding to accommodate the variety of hospitals.<sup>65</sup> The adjustments that would have to be considered for teaching centres and for small rural hospitals are discussed in Sections 2.4 and 2.5 of the present volume.

### **2.3.8 Committee commentary**

The Committee concurs with witnesses that, as much as possible, hospitals should be funded for the specific services they provide, that is, according to service-based funding. Service-based funding is the most appropriate method for financing the operational costs of hospitals, though we recognize that additional investment may be needed for capital purposes in many Canadian hospitals (see Section 2.6 below). The Committee believes that service-based funding has numerous advantages over the methods currently used to finance hospitals in Canada. In our view, Canadians will greatly benefit from service-based funding in terms of quality and timeliness of hospital care, as well as in terms of transparency, accountability and performance reporting.

***The Committee believes that service-based funding has numerous advantages over the methods currently used to finance hospitals in Canada.***

The Committee recognizes that hospital funding is a provincial matter; nonetheless, the federal government could be of considerable assistance in promoting of service-based funding. In our view, the federal government, as part of its role in supporting the health care infrastructure and the health info-structure (see Volume Four)<sup>66</sup>, should provide some of the funding necessary to enable the provinces to implement service-based funding. This federal funding should be part of the federal investment in health information systems that this Committee recommends in Chapter Ten. Furthermore, the Committee believes that CIHI can play a major role in the estimation of case-mix groups and their relative weights, both of which are needed to implement service-based funding.

If Canadians are to derive the most benefits from publicly funded or insured hospital services, service-based funding must be implemented. Moreover, hospitals also will gain a lot from service-based funding. This mode of remuneration will allow them to identify

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<sup>64</sup> Sharon Sholzberg-Gray (60:27).

<sup>65</sup> Volume Five, pp. 36-39.

<sup>66</sup> Volume Four, pp. 95-105.

inefficient practices and hence help improve their productivity. As a result, hospitals will be able to compete on the basis of quality of care.

The Committee acknowledges that the implementation of service-based funding will take time. Following the experience in European countries, the new payment method should be introduced gradually; at the early stages, hospitals should be remunerated by a combination of service-based funding and their traditional funding methods. The portion of funding allocated through service-based funding should grow each year and that allocated by the traditional methods should shrink correspondingly, until at the end of the implementation period hospitals are remunerated entirely by service-based funding.

For instance, similar to the Norwegian experience, the funding split might begin with hospitals being remunerated 70% by traditional methods and 30% through service-based funding. The funding mix might then progress to a 50-50 split, to 70% service-based funding, and then finally to 100% service-based funding.

Therefore, the Committee recommends that:

**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.**

## 2.4 Academic Health Sciences Centres and the Complexity of Teaching Hospitals

Teaching hospitals in Canada form part of what is known as Academic Health Sciences Centres (AHSCs). AHSCs consist of a teaching hospital, a university faculty of medicine, and other health-related research and health care institutes (see Appendix 2.1 for a list of the 16 AHSCs in Canada and their affiliated hospitals). Because these centres are responsible for not only patient care but also teaching and research, they are much more complex than community hospitals. They also offer the newest and most highly sophisticated services and treat the most difficult, complex cases.

**AHSCs consist of a teaching hospital, a university faculty of medicine, and other health-related research and health care institutes. Because these centres are responsible for not only patient care but also teaching and research, they are much more complex than community hospitals.**

Hospitals with teaching/research activity have higher costs per weighted case than community hospitals. This is due to the required teaching infrastructure, specialized programs, higher utilization of diagnostic testing, and the use of resources needed for more innovative and aggressive treatment procedures:

*Studies have shown that procedure costs at academic health science centres are higher than in community hospitals. This is not only due to the costs of the complexity of care provided or the introduction and evaluation of leading-edge practice. To fulfill its teaching and research mandate, some clinical procedures cost more than average and result in lengths of stay that may be longer than average. Additionally, a major research and education centre incurs facility and operating costs as a result of providing space and supporting the medical staff in these endeavours.<sup>67</sup>*

Because of the educational and research aspects of AHSCs, funding comes traditionally from at least two separate provincial government departments and, within those departments, from a variety of sources. While it is almost impossible to distinguish precisely the academic mission from the health care delivery mission, government funding can be placed into three broad categories.<sup>68</sup>

First, the department of education provides operating grants to universities that in turn provide budgets for health faculties, including salaries for their academic staff. Second, the department of health provides hospitals with budgets for clinical education to pay the salaries of post-graduate trainees and partial support of the incomes of clinical faculty. Third, hospitals receive operating grants from provincial health ministries to help pay for the added cost of research and training activity.

<sup>67</sup> S. Kevin Empey, Brief to the Committee, 22 May 2002, p. 12.

<sup>68</sup> Lozon and Fox (2002), *op. cit.*, p. 16.

As a result of this complexity, service-based funding poses a number of problems particular to AHSCs. Patients of AHSC often require very sophisticated treatment, the cost of which may not be accurately captured in case-mix measurement systems. For instance, Kevin Empey, Chief Financial Officer, University Health Network (Toronto), stated:

*(...) both pacemaker and defibrillator implants are included in the same [case-mix group] and thus would be assigned the same case weights and funded identically. This weighting, and any rate-based funding would not reflect the dramatic differences in the costs of the devices implanted. The cost of a typical defibrillator implant procedure is approximately 2.5 times that of a pacemaker implant.*<sup>69</sup>

Similarly, it is estimated that the cost of one multi-organ transplant costs \$213,000 per patient. However, due to the complexity and the uniqueness of the treatment, rates have not been determined in Canada for the transplants. As a result, teaching hospitals in Toronto receive funding at the same rate as for single-organ transplants, which is a fraction of the true cost of the multi-organ treatment.<sup>70</sup> For these reasons, Dr. Hugh Scott of the McGill University Health Centre stated:

*if you want to put it in a formula, there has to be multiples. Any time we try to put cardiac surgery and psychotherapy in a magic formula, there will be problems. When you then add in a teaching environment and so on, you will have even more problems. I look forward to simplicity and elegance, I think sometimes multiple factors have to be taken into account.*<sup>71</sup>

Dr. Jeffrey Lozon from St. Michael's Hospital (Toronto) discussed the complexity of financing teaching hospitals given the variety of activities they perform:

*The most appropriate funding vehicle is the one that most closely aligns the accountability of the academic health sciences centre and its outputs in a fair funding system. Our centres are accountable for their outputs. However, it must be understood that our outputs are going to be different than what they would be in a community hospital or in a rural environment. They will be more complex. We have different levels of output: we have output around the knowledge that we create; and we have output around the numbers of students that were educated.*

*We would probably be uncomfortable with a one-size-fits-all funding formula that might suggest my hospital be as low cost as a hospital in Yorkton, Saskatchewan. The hospitals do different things and so the cost varies. We need to measure the things we do*

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<sup>69</sup> S. Kevin Empey, Brief to the Committee, 22 May 2002, p. 6.

<sup>70</sup> S. Kevin Empey, *op. cit.*, p.10.

<sup>71</sup> Dr. Hugh Scott (63:17).

*and we need to be held as accountable as the hospital in Yorkton. However, it is a more complicated endeavour than strictly counting up the dollars.*<sup>72</sup>

The AHSC experts who appeared before the Committee supported the service-based funding methodology as long as case-mix groups and weights are established for AHSCs, distinct from those developed for community hospitals. Such a funding methodology for AHSCs should take into account a variety of factors, including the complexity of procedures and treatments, the introduction of new technologies and the use of costly drugs. Experts also stressed that consideration should be given to funding the cost of teaching and research infrastructure out of a different envelope with its own set of incentives for efficient delivery.

In their recent paper “Academic Health Sciences Centres Laid Bare”, Jeffrey Lozon and Robert Fox stated that AHSCs should be considered a national resource in the health care system and that the federal government should enhance its role in the funding of AHSCs. The authors argued that “no longer can the AHSC struggle to arrange funding from a variety of providers and without the support of the federal government.”<sup>73</sup>

The Committee agrees with the witnesses that Academic Health Sciences Centres are distinct from community hospitals in that they perform a wide range of complex activities ranging from delivery, to teaching and research. Accordingly, the Committee recommends that:

**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.**

Moreover, the Committee strongly believes that, since they play an essential role in teaching, performing research and delivering sophisticated care, AHSCs constitute a national resource in the Canadian health care system. They are a crucial part of the health care infrastructure in Canada. Thus, the federal government is particularly well positioned to sustain AHSCs across the country, through its well-recognized roles in financing post-secondary education, funding health research, supporting health care delivery, financing health care technology and planning human resources in health care. These issues are discussed in subsequent chapters in this report.

***The Committee believes that AHSCs constitute a national resource in the Canadian health care system. The federal government is particularly well positioned to sustain AHSCs across the country.***

## **2.5 Small and Rural Community Hospitals**

Because larger and medium-sized community hospitals do not face the same set of challenges as small or rural community hospitals, problems might arise if the same funding

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<sup>72</sup> Dr. Jeffrey Lozon (63:16-17).

<sup>73</sup> Lozon, Jeffrey and Robert Fox (2002), “Academic Health Sciences Centres Laid Bare”, lead paper in *Healthcare Papers*, Vol. 2 No. 3, p. 30.

formula were to be applied to both types of hospitals. For example, Raisa Deber, Professor at the University of Toronto, stated that:

*(...) on issues related to service-based funding, particularly for hospitals in smaller provinces or smaller communities, (...) such funding will not be enough to cover the infrastructure costs of running the organization.*<sup>74</sup>

In addition, the Canadian Healthcare Association indicated in its brief that:

*Service-based funding would be difficult to implement in rural and remote areas, particularly if there is only one provider and/or organization available to provide services.*<sup>75</sup>

The review of the testimony provided to the Committee suggests that, for the most part, small and rural community hospitals are faced with problems of:

1. Limited economies of scale – Small rural hospitals are often faced with fixed overhead costs and low or unpredictable patient volumes. This leads to higher costs per patient.
2. Isolation – A hospital in rural Canada is considered to be isolated if the next closest hospital is more than 150 km away. That hospital then becomes the primary provider of health care for an entire geographic area. A hospital that is responsible for a large region must be able to provide a greater range of services despite low and sporadic patient volumes.
3. Remoteness – Remoteness refers to the distance between a hospital and the closest tertiary hospital care centre. Hospitals can be remote but not isolated (a number of hospitals may serve a particular region but be at a considerable distance from a tertiary hospital care centre). However, much like isolated hospitals, remote hospitals often have higher fixed overhead costs and must provide a wider range of health care services compared to community hospitals located near tertiary centres. All these factors result in higher costs per patient.
4. Special needs population – Many remote hospitals must care for special needs populations such as residents of First Nations reserves. The health status of these residents is often below the provincial average, which leads to higher admission rates.<sup>76</sup>

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<sup>74</sup> Raisa Deber (59:12).

<sup>75</sup> Canadian Healthcare Association, Brief to the Committee, p. 7.

<sup>76</sup> Ladak (1998), *op. cit.*, p. 31.

Therefore, the funding formula used for larger community hospitals is often not suitable for small and rural hospitals. As a result, the funding formula must take into consideration the particular challenges faced by smaller, rural and remote hospitals.

A number of the witnesses were concerned about the effect of a service-based funding method on the mix of services offered by rural and smaller community hospitals. For example, Mark Rochon of the Ontario Hospital Association stated:

*We also need to consider that service-based funding should not create incentives for providers to stop offering necessary services in communities. The needs of specific communities must be considered as well as the adequacy of service provided in those communities.*<sup>77</sup>

Kevin Empey, of University Health Network, added that:

*Some providers, when it becomes a full rate based or service based system, will choose to specialize a little more or get out of something. Certainly in small communities you cannot afford the major providers, that is, the hospitals, to get out of something just because of the rates.*<sup>78</sup>

The Committee agrees with the witnesses that, in order to preserve access to commonly required services, service-based funding should be adjusted to reflect the particular circumstances of small and rural community hospitals. Therefore, the Committee recommends that:

**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.**

## **2.6 Financing the Capital Needs of Canadian Hospitals**

As indicated in Section 2.1.7, provinces and territories use a method for funding hospital capital expenditures that is different from the method used in relation to funding

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<sup>77</sup> Mark Rochon (56:43).

<sup>78</sup> S. Kevin Empey (56:45).



operating costs. All provinces and territories use a project based method as their capital funding approach. The project based method is well suited to large-scale, one-time projects.

The Committee was told that the capital needs of Canadian hospitals are significant. We heard that the current level of capital investment by provincial and territorial governments, along with hospitals' well established fundraising infrastructure and charitable giving, is not sufficient to ensure the sustainability of the hospital sector in Canada. Information provided to the Committee revealed that:

- Between 1982 and 1998, real public per capita spending on new hospital construction decreased from \$50 to \$2, or a reduction of 5.3% annually.<sup>79</sup>
- Since 1998, real public per capita expenditures on new hospital machinery and equipment has fallen by 1.8% annually.<sup>80</sup>

As a result, there is a substantial gap between the need for new and renovated physical plant and equipment and a hospital's ability to finance capital investment. For this reason, several witnesses proposed that the federal government provide some funding. The Association of Canadian Academic Healthcare Organizations told the Committee that there is precedent in this regard:

*It should also be noted that there is a precedent when it comes to the role of the federal government in this area. In 1948, the federal government introduced the Hospital Construction Grants Program – which was funded on a cost-sharing basis with the provinces.<sup>81</sup>*

The Canadian Medical Association stated that, in addition to government investment in hospital capital, it may be necessary for hospitals to develop innovative approaches to financing capital infrastructure. According to the Association, there is a need to explore the concept of public-private partnerships to address capital infrastructure needs as an alternative to relying solely on government funding.<sup>82</sup>

While the Committee has supported the consolidation of the hospital sector that has taken place in recent years in all provinces, we are very concerned that the number of beds in some hospitals may not be sufficient to respond to the significant increase in demand for hospital services that exists in a few areas in Canada where there is high and fast population growth. Indeed, we learned that there are a few regions of the country in which population growth has been so great that more hospital beds are needed now and many more will be needed in the coming years. This is particularly true of some metropolitan areas of Alberta (Calgary), British Columbia (Abbotsford, Vancouver), Nova Scotia (Halifax), Ontario (Oshawa, Toronto), Quebec (Montreal), and Saskatchewan (Saskatoon).<sup>83</sup>

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<sup>79</sup> Association of Canadian Academic Healthcare Organizations, Brief to the Committee, 13 June 2002, p. 17.

<sup>80</sup> *Ibid.*

<sup>81</sup> *Ibid.*

<sup>82</sup> Canadian Medical Association, *For Commissioner Romanow: A Prescription for Sustainability*, 6 June 2002, p. 26.

<sup>83</sup> Based on the 2001 Census data of Statistics Canada (<http://geodepot2.statcan.ca/Diss/Highlights/>).

Accordingly, the Committee believes that the federal government should get involved once again, as it did in 1948, in financially supporting hospitals with the greatest capital needs. Such federal participation would not involve ongoing financing but should rather be considered a “catch-up” measure. Even though it would be a one time measure, federal funding for any given project could be spread over a period of several years.

Specifically, the decision to provide federal support for hospital capital should be made on the basis of a formula that would indicate that, when population growth in a particular region exceeds the provincial average by 50%, the federal government would make one-time only funding available on a cost-shared basis with the province for capital investment in hospital expansion. Such federal investment could work as follows: the hospital should be able to take the federal commitment to pay a fixed amount per year over a 10-year period to a financial institution and borrow against that commitment so that construction could begin right away.

The Committee also believes that provincial/territorial governments should give consideration to public-private partnerships as a means to obtain additional investment in hospital capital. Therefore, the Committee recommends that:

**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.**

Capital investment is also of concern for AHSCs. The Association of Canadian Academic Healthcare Organizations informed the Committee that building replacement is underfunded and depreciation is not fully recognized by the federal and provincial governments for funding purposes. Furthermore, most capital investment decisions appear to be based on short-term responses to needs rather than a long-term planning horizon. In some cases, additions or renovations are made to poor structures, when full reconstruction might have been a better policy decision.

While there are variations in the capital requirements of teaching hospitals, it is clear that significant investment is needed. For example:

- The Montreal University Health Centre has undertaken an evaluation of existing facilities (in which some buildings are 40 to 100 years old) and determined that it will cost \$475 million to upgrade its facilities.
- The University Health Network of Toronto estimates that its capital requirements for the next 10 years will be over \$500 million (i.e., in excess of \$50 million per year).
- The St. John's Healthcare Corporation (Newfoundland) recently completed the development of a Children's and Rehabilitation Centre at a cost of \$70 million.

Based on the information made available to the Committee, the Committee concluded that the federal government should contribute some \$4 billion for the infrastructure renewal of the 16 AHSC sites. We believe that such federal funding should be provided in response to requests initiated by AHSCs themselves, subject to review by a group of independent experts. This, in our view, would ensure transparency.

More precisely, AHSCs should be required to accompany a request with a sound rationale for additional resources. Each application should be evaluated on its own merits by an independent expert group that would report to the Minister of Health. Moreover, in order to ensure accountability, successful applicants should report on their disposition of the funds received.

Therefore the Committee recommends that:

**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.**

## 2.7 Public Versus Private Health Care Institutions

In Section 2.3 above, the Committee underlined many advantages to service-based funding for hospitals, one of which relates to the ownership structure of health care institutions. We indicated that service-based funding means that the insurer (the government) would be *neutral* with respect to the ownership of a hospital. The funder/insurer would purchase the service from an institution, provided that it met the necessary quality standards. Since comparable institutions would be paid the same amount of money for a given procedure, and since all institutions would be subject to the same independent and rigorous quality control and evaluation system, the

***Service-based funding means that the insurer (the government) would be neutral with respect to the ownership of a hospital.***

ownership structure would not be a matter of public policy concern. For this reason, the Committee is neutral to the ownership question.

As indicated in Volume Five, the Committee believes that the patient and the funder/insurer will be served equally no matter what the corporate ownership of a health care institution may be, as long as the two conditions enumerated above with respect to pricing and quality control are met. The Committee wants to emphasize that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should

***The Committee wants to emphasize that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the Canada Health Act. Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, either public or private not-for-profit institutions.***

be prohibited, just as they are not now prohibited under the *Canada Health Act*. Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, either public or private not-for-profit institutions.

Furthermore, the Committee recognizes that there is no reason why the private for-profit provision of publicly funded health services would result in a so-called “two-tier” health care structure, as long as the *funding* of services remains *publicly* based and referrals to institutions continue to be determined by clinical need. This situation with respect to hospitals is no different from the provision of primary health care, most diagnostic services, and some day surgeries – services that are currently delivered in Canada by private for-profit entrepreneurs and facilities.

Currently, within Canada’s health care system, only 5% of hospital care is delivered by the private for-profit sector. For example, the Shouldice hospital in Ontario is a private for-profit facility; its status was grandfathered when Medicare was enacted in that province. Facilities like this one are regulated on a rate of return basis, to reduce the risk of overcharging patients. In Alberta, private for-profit facilities are allowed, under provincial legislation (Bill 11), to compete with public and private not-for-profit hospitals for the provision of a set of publicly insured surgical services. Canada also has a number of private for-profit health care facilities (“private clinics”) that treat only patients who pay privately for the services they receive.

***The Committee recognizes that there is no reason why the private for – profit provision of publicly funded health services would result in a so-called “two-tier” health care structure, as long as the funding of services remains publicly based and referrals to institutions continue to be determined by clinical need.***

Despite the presence of these private for-profit health care institutions and facilities in Canada, which appear to provide the same quality of care as not-for-profit and public institutions, an intense debate continues about the potential role and impact of for-profit hospitals and clinics in the health care system. This debate culminated in May 2002 with the publication of a meta-analysis study by P. J. Devereaux *et al.* in the *Canadian Medical Association Journal*. This study found, based on a review of 15 different observational studies, “that private

for-profit ownership of hospitals in comparison with private not-for-profit ownership in the United States results in a higher risk of death for patients.”<sup>84</sup> The authors concluded that the profit motive of private for-profit hospitals may result in limitation of care that adversely affect patient outcomes:

*Why is there an increase in mortality in for-profit institutions? Typically, investors expect a 10%–15% return on their investment. Administrative officers of private for-profit institutions receive rewards for achieving or exceeding the anticipated profit margin. In addition to generating profits, private for-profit institutions must pay taxes and may contend with cost pressures associated with large reimbursement packages for senior administrators that private not-for-profit institutions do not face. As a result, when dealing with populations in which reimbursement is similar (such as Medicare patients), private for-profit institutions face a daunting task. They must achieve the same outcomes as private not-for-profit institutions while devoting fewer resources to patient care.*<sup>85</sup>

When he appeared before the Committee, Dr. Arnold Relman, Former Editor-in-Chief of *The New England Journal of Medicine*, expressed similar views:

*(...) most, not all of the current problems of the U.S. health care system, and they are numerous, result from the growing encroachment of private for-profit ownership and competitive markets on a sector of our national life that properly belongs in the public domain. It is no coincidence that no health care system in the industrialized world is as heavily commercialized as ours, and none is as expensive, inefficient, inequitable, or as unpopular. Indeed, just about the only people happy with our current market-driven health care system in the U.S. are the owners and investors in the for-profit industries now living off the system.*<sup>86</sup>

On the basis of this evidence, many observers have noted that it is plausible, if not likely, that the results of the American experience can be generalized to the Canadian context should Canada decide to “open the door” to private for-profit hospitals.

The Committee learned, however, that the Devereaux *et al.* study has a number of caveats. First, Brian J. Ferguson, Professor at the Department of Economics at the University of Guelph (Ontario), informed the Committee in a recent paper that the authors of the meta-analysis specifically excluded public hospitals from their study, on the basis that Canadian hospitals are technically private not-for-profit institutions behaving more or less like American private not-for-profit hospitals.<sup>87</sup> Professor Ferguson argued, however, that private

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<sup>84</sup> P.J. Devereaux *et al.*, “A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-for-Profit Hospitals”, in *Canadian Medical Association Journal*, Vol. 166, No. 11, 28 May 2002, pp. 1399-1406.

<sup>85</sup> *Ibid.*, pp. 1404-1405.

<sup>86</sup> Dr. Arnold Relman (48:8-9).

<sup>87</sup> For more information, please consult the recent paper by Brian S. Ferguson, *A Comment on the Devereaux et al. Meta-Analysis of Mortality in Private American Hospitals*, Draft, Department of Economics, University of Guelph, Ontario, June 2002.

not-for-profit hospitals in the United States do not operate at all in the same environment as Canadian private not-for-profit hospitals: American private not-for-profit hospitals work in a very competitive context and have considerably more freedom in terms of decision-making than their Canadian counterparts.

In this regard, Professor Ferguson contended that Canadian private not-for-profit hospitals are much more like American public hospitals than they are like American private not-for-profit hospitals. In his view, including public hospitals in the Devereaux *et al.* meta-analysis could have led to very different results.<sup>88</sup> In fact, a number of studies have shown that public hospitals in the United States have higher risk-adjusted 30-day mortality than for-profit hospitals, which in turn have higher mortality than not-for-profit hospitals.<sup>89</sup>

Second, Professor Ferguson also criticized the methodology used by Devereaux *et al.* on several grounds: criteria for the inclusion of pertinent literature; selection of particular results for inclusion in the analysis; choice of the dependent variable; omission of some variables; etc.<sup>90</sup> Finally, in a different paper, Professor Ferguson indicated that it is almost impossible to derive proper conclusions on the potential role of private for-profit hospitals in Canada from the American literature.<sup>91</sup> The health care system in the United States is made up of several public and private insurers, involves a multiplicity of public and private (not-for-profit and for-profit) providers, and operates under intense competitive pressures – a situation that is unlikely to happen in Canada with our single insurer system.

Moreover, the regulatory framework for the provision of hospital care in the United States is different from that in Canada. This explains why we cannot simply transpose what is happening in the United States to Canada. For example, Dr. Arnold Relman told the Committee:

*Throughout the American health care system there is inadequate regulation of private, for-profit health care, as well as private not-for-profit health care. In the for-profit system, there is so much money in for-profit nursing, hospital care, ambulatory services, and pharmaceutical services that the regulatory agencies have been co-opted, at times you might say intimidated, by the political and financial influence of the owners.*

*(...) In the United States, there is a huge amount of money involved in providing for-profit health care. That money in part is used to ensure that regulation is weak. It applies to the Food and Drug Administration. It applies to all sorts of regulatory agencies. I served for six years on a state agency studying the quality of care in Massachusetts hospitals. It is very clear to me that financial concerns play a major role.*

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<sup>88</sup> *Ibid.*

<sup>89</sup> These studies are summarized in a paper by Stephen Duckett, “Does it Matter Who Own Health Facilities”, in *Journal of Health Services Research Policy*, Vol. 6, No. 1, January 2001, pp. 59-62.

<sup>90</sup> Brian J. Ferguson, *op. cit.*, June 2002.

<sup>91</sup> Brian S. Ferguson, *Profits and the Hospital Sector: What Does the Literature Really Say?*, Health policy working paper prepared for the Atlantic Institute for Market Studies, February 2002.

*(...) If we did have good, aggressive, unbiased regulation, many of the problems I have talked about in terms of quality would be solved. However, we do not.*<sup>92</sup>

The findings of the Devereaux *et al.* analysis also contrast with those a Canadian study published in 1999 in the *Canadian Medical Association Journal* which compared the quality of care in licensed and unlicensed homes for the aged in the Eastern Townships of Quebec.<sup>93</sup> For example, this study found the quality of care provided to elderly residents by large unlicensed (private for-profit) long-term care facilities to be comparable to that of large licensed (private not for profit) facilities.<sup>94</sup> In addition, the study found that the majority of both licensed and unlicensed long-term care facilities (no matter what their size) were delivering care of relatively good quality.

Overall, the Committee acknowledges that the literature on the comparative costs, quality, effectiveness and general behaviour of private for-profit and private not-for-profit facilities is quite extensive. We also recognize that these studies reach mixed conclusions. Some of them suggest that for-profit facilities perform better, while others conclude that not-for-profit facilities or public hospitals do so. Still, other studies have found no difference in the performance of the two.

Given the evidence in the literature, the Committee believes that leaving the *Canada Health Act* as it currently is – which means permitting private for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) – will *not*, as some critics maintain, weaken or destroy the health care system as we know it now. Other advanced countries, with perfectly well functioning universal, publicly funded and organized health care systems (such as Australia, Denmark, Germany, the Netherlands, Sweden and the United Kingdom), already permit private for-profit hospitals to exist; their presence has not caused any insurmountable problems or difficulties.

***The Committee believes that leaving the Canada Health Act as it currently is – which means permitting private for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) – will not, as some critics maintain, weaken or destroy the health care system as we know it now.***

The debate surrounding public versus private not-for-profit versus private for-profit health care institutions does not seem to arouse the same kind of passion elsewhere. As a matter of fact, the Committee reviewed the operation of the health care system of seven different countries (see Volume Three) and visited three countries (Denmark, Sweden, United Kingdom), and found that there are no articles or studies in European countries and Australia comparing the quality or outcomes of for-profit and not-for-profit or public hospitals. In this sense, this debate is uniquely North American.

<sup>92</sup> Dr. Arnold Relman (48:23).

<sup>93</sup> Gina Bravo *et al.*, «Quality of Care in Unlicensed Homes for the Aged in the Eastern Townships of Quebec, *Canadian Medical Association Journal*, Vol. 160, No. 10, 18 May 1999, pp. 1441-1445.

<sup>94</sup> The interpretation of the study findings in terms of ownership status (for profit versus not for profit) were facilitated by information provided by the statistician who participated in the realization of this study, Marie-France Dubois.

The Committee believes that it is unlikely that, as a result of the introduction of service-based funding, Canada would see the emergence of full-scale private for-profit hospitals, such as those that operate in Australia or the United Kingdom: in both countries, private health care insurance runs parallel to the public system, and physicians are permitted to have large-scale private practices, a system that seems unlikely to develop in Canada. It is more likely that private clinics would remain small and specialized. Such clinics would emerge in niches where their founders expect to be able to make a profit by operating at lower cost than the public system does, either by taking advantage of economies of scale or, as seems more likely, by taking advantage of economies of specialization. These clinics would bring additional capital into the health care system, since they would be funded privately. This is another reason it is unlikely that they would develop into full-scale general hospitals: private funding for so ambitious, and also risky, an enterprise would be much harder to come by than would funding for specialized clinics.

The Committee strongly believes that there is a need to improve hospital performance and to develop hospital report cards in Canada, regardless of ownership. This can be appropriately done through the independent evaluation process recommended in Chapters One and Ten of this report. Requiring that a single regulatory process apply to *all* health care institutions would contribute much to ensuring high quality of care no matter where it is provided.



## **Appendix 2.1**

### **Academic Health Sciences Centres in Canada and their Affiliated Hospitals and Regional Health Authorities**

#### **1. Memorial University of Newfoundland and Labrador**

Healthcare Corporation of St. John's  
The General Hospital  
St. Clare's Mercy Hospital  
Janeway Children's Health and Rehabilitation Centre  
Waterford Hospital  
Dr. L.A. Miller Centre  
Dr. Walter Templeman Health Centre

#### **2. Dalhousie University**

Capital Health  
IWK Health Centre  
Queen Elizabeth Health Sciences Centre II  
Dartmouth General Hospital  
East Coast Forensic Hospital  
Eastern Shore Memorial Hospital  
Hants Community Hospital  
The Nova Scotia Hospital  
Twin Oaks Memorial Hospital  
Musquodoboit Valley Memorial Hospital  
Atlantic Health Sciences Corporation\*  
Saint John Regional Hospital  
St. Joseph's Hospital  
Sussex Health Centre  
Charlotte County Hospital  
Grand Manan Facility

#### **3. Université Laval**

Centre Hospitalier Universitaire de Québec  
Hôpital Laval, Institut Universitaire de Cardiologie et de Pneumologie

#### **4. Université de Sherbrooke**

Centre Universitaire de santé de L'Estrie  
Sherbrooke Geriatric University Institute

#### **5. Université de Montréal**

Centre Hospitalier de l'Université de Montréal  
Hôpital Sainte-Justine  
Institut Cardiologie de Montréal  
Hôpital Maisonneuve-Rosemont  
Hôpital du Sacré-Coeur de Montréal

Institut Universitaire de Gériatrie de Montréal

**6. McGill University**

Montreal University Health Centre  
Jewish General Hospital  
St. Mary's Hospital  
Douglas Hospital

**7. University of Ottawa**

Sisters of Charity of Ottawa (SCO) Health Services  
Ottawa Hospital  
Children's Hospital of Eastern Ontario

**8. Queen's University**

Kingston General Hospital  
Hotel Dieu Hospital  
Providence Continuing Care Centre

**9. University of Toronto**

University Health Network  
St. Michael's Hospital  
The Hospital for Sick Children  
Sunnybrook Health Sciences Corporation  
Mount Sinai Hospital  
Toronto Rehabilitation Institute  
Baycrest Centre for Geriatric Care  
Centre for Addiction and Mental Health

**10. McMaster University**

Hamilton Health Sciences Centre  
St. Joseph's Hospital

**11. University of Western Ontario**

London Health Sciences Centre  
St. Joseph's Health Centre

**12. University of Manitoba**

Winnipeg Regional Health Authority  
St. Boniface General Hospital  
Health Sciences Centre

**13. University of Saskatchewan**

Saskatoon District Health Board  
Royal University Hospital  
Saskatoon City Hospital  
St. Paul's Hospital  
Regina Health District  
Regina General Hospital  
Pasqua Hospital

**14. University of Calgary**

Calgary Health Authority  
Rockyview Hospital  
Foothills Hospital  
Alberta Children's Hospital  
Peter Lougheed Hospital

**15. University of Alberta**

Capital Health Authority  
Royal Alexandra Hospital  
University of Alberta Hospital  
Grey Nuns and Misericordia Hospital

**16. University of British Columbia**

Provincial Health Services Authority  
Children's and Women's Health Centre  
BC Cancer Agency  
Vancouver Coastal Health Authority  
Vancouver Hospital and Health Science Centre  
Providence Health Care/St. Paul's Hospital

Source: Based on information provided by Glenn Brimacombe, Chief Executive Officer, Association of Canadian Academic Healthcare Organizations.

\*AHSC functions as main New Brunswick campus for Dalhousie University and Memorial University of Newfoundland and Labrador.



## CHAPTER THREE

### DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES

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In Volume Five of its study on health care, the Committee advocated major restructuring of the hospital and doctor system, leading to the devolution of operational responsibility for health care spending from provincial governments (ministries of health) to regional health authorities (RHAs). Under such reform, RHAs would become responsible for purchasing health services from hospitals and other health care institutions on behalf of the populations they serve. If a province so wished, RHAs could also become responsible for purchasing primary health care and prescription drugs.<sup>95</sup> Devolving responsibility for the *full* range of health services from provincial ministries of health to RHAs would lead to a better-integrated, more coordinated and truly patient-oriented system of health care delivery.

This type of reform, which has already been implemented in varying degrees in a number of countries, including Sweden and the United Kingdom, was also proposed in the report of the Premier's Advisory Council on Health in Alberta (the Mazankowski report).<sup>96</sup> The Committee believes that RHAs have done a commendable job of integrating and organizing health services for people in their regions during the last decade in Canada, and that they should be given more responsibility and authority for delivering and/or contracting for the full range of publicly insured health services.

***The Committee believes that RHAs have done a commendable job of integrating and organizing health services for people in their regions during the last decade in Canada, and that they should be given more responsibility and authority for delivering and/or contracting for the full range of publicly insured health services.***

The Committee also believes that such reform would foster competition among health care providers (both individual and institutional) and encourage cost-effectiveness and efficiency in service delivery. As stated in Volume Five, the Committee is aware that reforms of this type will have to be adapted to the particular circumstances that prevail in different parts of the country in order to take into account the number and type of health care providers that operate in each region, as well as factors such as the urban/rural mix. We also acknowledge that the goals intended by this reform will have to be achieved through other means in Ontario, the Yukon and Nunavut, since there are no RHAs in these jurisdictions.<sup>97</sup>

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<sup>95</sup> Volume Five, pp. 39-40.

<sup>96</sup> Premier's Advisory Council on Health, (Right Hon. Don Mazankowski, Chair), *A Framework for Reform*, December 2001 (<http://www.premiersadvisory.com/>).

<sup>97</sup> The Committee was told that one of the reasons explaining why there are no RHAs in Ontario is the fact that the Greater Toronto Area is too big for a RHA. One possibility could be to consider implementing the RHA model elsewhere in that province, while another model allowing for the integration of care could be implemented in the GTA.

This chapter is divided into five sections. Section 3.1 provides a general portrait of RHAs across Canada in terms of their current structure, size, scope of responsibility and funding. Section 3.2 reviews the objectives for which RHAs were established and summarizes RHAs' achievements in light of those objectives. Section 3.3 discusses the barriers which currently prevent RHAs from fulfilling their responsibilities to their fullest potential. Section 3.4 describes how reforms based on some "internal market" approaches have the potential to address these concerns through the devolution of further responsibility to RHAs. Finally, Section 3.5 enunciates the Committee's position on the role of RHAs in Canada.

### **3.1 RHAs Across Canada: A Portrait<sup>98</sup>**

In Canada, regional health authorities are playing an ever-increasing role in health care. In the past 14 years, all provinces (except Ontario) and the Northwest Territories have devolved responsibility for the management of substantial parts of the health care system from provincial/territorial governments (ministries of health) to RHAs. The common definition for RHAs in Canada is as follows:

*Regional health authorities are autonomous health care organizations with responsibility for health care administration within a defined geographic region within a province or territory. They have appointed or elected boards of governance and are responsible for funding and delivering community and institutional health services within their regions.<sup>99</sup>*

Despite this common definition, RHAs across Canada differ greatly in size, structure, scope of responsibility, and number per province/territory. Table 3.1 provides information on the current number and approximate date of establishment of RHAs in each jurisdiction, as well as data on the population served. Regionalization of health care is a fairly recent phenomenon in many provinces. While some provinces have recently reduced the number of RHAs (for example, British Columbia went from 52 to 6), others have increased the number (by 1 in New Brunswick and from 4 to 9 in Nova Scotia). In addition, the size of the population served by a RHA varies widely both between and within provinces.

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<sup>98</sup> Unless otherwise indicated, the information contained in this section is based on the following documents: Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 ([www.oha.com](http://www.oha.com)).

Regionalization Research Centre, *What is Regionalization?* (<http://www.regionalization.org/>).

Ian McKillop, George H. Pink and Lina M. Johnson, *The Financial Management of Acute Care in Canada, – A Review of Funding, Performance Monitoring and Reporting Practices*, Canadian Institute for Health Information, March 2001 ([http://www.cihi.ca/dispPage.jsp?cw\\_page=GR\\_32\\_E](http://www.cihi.ca/dispPage.jsp?cw_page=GR_32_E)).

Peggy Leatt, George H. Pink and Michael Guerriere, "Towards a Canadian Model of Integrated Health Care", *HealthCare Papers*, Vol. 1, No. 2, Spring 2000, pp. 13-35.

(<http://www.longwoods.com/hp/spring00/Papers2.pdf>)

British Columbia Medical Association, *Regionalization of Health Care*, BCMA Policy and Reports, 1997 (<http://www.bcma.org/IssuesPolicy/PolicyPapersReports/regionalization/default.asp>).

Jonathan Lomas, *Regionalization and Devolution: Transforming Health, Reshaping Politics?* Occasional Paper No. 2, October 1997 (<http://www.regionalization.org/OP2.pdf>).

Jonathan Lomas, "Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the issues", *Canadian Medical Association Journal*, Vol. 156, Issue 3, February 1997, pp. 371-377 (<http://www.cmaj.ca/>).

<sup>99</sup> Definition provided by the Regionalization Research Centre.

**TABLE 3.1**  
**REGIONAL HEALTH AUTHORITIES (RHAs), 2002**

	<b>DATE ESTABLISHED</b>	<b>NUMBER OF RHAs</b>	<b>POPULATION SERVED (range or average)</b>
British Columbia	1997	6	320,000 to 1.3 million
Alberta	1994	17	20,000 to 900,000
Saskatchewan	1992	12	30,000 to 50,000
Manitoba	1997-1998	12	7,000 to 650,000
Ontario	-	-	-
Quebec	1989-1992	18	411,000
Nova Scotia	1996	9	34,000 to 384,000
New Brunswick	1992	8	95,000
Prince Edward Island	1993-1994	5	143,000
Newfoundland	1994	6	143,000
Yukon	-	-	-
Northwest Territories	1988-1997	9	386 to 17,897
Nunavut	-	-	-

Source: Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 ([www.oha.com](http://www.oha.com)).

Table 3.2 provides information on the scope of services for which RHAs are responsible in each province/territory. The scope varies significantly. Hospital services are common to RHAs in all provinces. In addition, in some provinces, laboratory services, long-term care, home care and a variety of other health services are provided by RHAs through contracts with private not-for-profit and private for-profit organizations. RHAs in Quebec have been particularly successful in integrating a wide range of health, social and mental services. However, physician services, prescription drugs and cancer care have not been devolved to regions and continue to be administered and funded centrally by all provincial/territorial governments.

**TABLE 3.2**  
**SERVICES ADMINISTERED BY REGIONAL HEALTH AUTHORITIES**

	Hospitals	Long Term Care	Home Care	Public Health	Mental Health	Rehab	Social Services	Local Ambulance	Labs
BC	X	X	X	X	X	X			X
ALTA	X	X	X	X		X			X
SASK	X	X	X	X	X	X		X	
MAN	X	X	X	X		X		X	X
QC	X	X	X	X	X	X	X	X	X
NB	X		X					X	X
NS	X			X	X	X			X
PEI	X	X	X	X	X	X	X		
NFLD	X	X	X	X	X	X	X		
NWT	X	X	X	X		X	X		X

Source: Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 ([www.oha.com](http://www.oha.com)).

RHAs differ in the degree of their decision-making authority. In some provinces, RHAs operate within specific, provincially determined administrative and fiscal constraints (Nova Scotia, Manitoba, British Columbia), while others have greater autonomy (Alberta, Saskatchewan, Prince Edward Island). Only in a few provinces do RHAs have an elected board of directors (in Alberta, for example, RHAs have a partially elected board). And only a few boards include representatives from health care providers (as in British Columbia). None has any role in raising revenue, but all are responsible for local planning, setting priorities, allocating funds and managing services for better integration and greater effectiveness and efficiency, within provincially defined policy guidelines. Many also have some direct role in delivering services, or at least employing health care providers other than physicians.

RHAs receive funding from the provincial/territorial government, usually through global budgets that are based on historical spending levels for the population served. Some jurisdictions (such as Alberta, British Columbia and Saskatchewan) have moved to needs-based per-capita funding (adjusted for population, age, sex and need indicators).

### **3.2 RHAs: Goals and Achievements<sup>100</sup>**

Initially, the objectives of devolving health care decisions to the regional level were multiple. According to the Canadian literature, they included: 1) cost containment; 2) responsiveness to local needs; 3) local control of decision-making; 4) coordination and integration of services; 5) efficient use of health care resources; 6) improved access; 7) effective management; 8) greater accountability; 9) emphasis on population health and wellness; and 10) better health outcomes.

<sup>100</sup> For more information, see for example the following two documents: 1) Robert Bear, "Can Medicare Be Saved? Reflections from Alberta", in *Healthcare Papers*, Summer 2000, pp. 60-67; 2) The Mazankowski report (December 2001).



There have been few evaluations of regionalization to determine the extent to which these goals have been or are now being met. However, the testimony received by the Committee and the evidence available from the literature suggest that RHAs have been very successful in many respects:

- RHAs provide health services at reduced administrative costs. For example, the Capital Health Region located in Edmonton devotes less than 3% of its total budget to administrative costs.
- RHAs have a strong focus on illness prevention and public health and ensure interactive relationships with their communities.
- RHAs are well suited to the integration and coordination of the institutions and organizations providing health services. In doing so, they deliver greater efficiencies, higher quality of service and continuous quality improvement.
- Better integration and coordination at the regional level allow for the use of the least costly providers commensurate with accessibility and quality of care goals for each individual consumer.
- Integrated health service delivery at the level of RHAs enhances the ability to respond to service demands, such as Emergency Department pressures, through integrated responses using home care, continuing care and acute care resources.
- RHAs have greater flexibility in reallocating and consolidating clinical services between health care providers and institutions.

Overall, RHAs are pivotal to the health care system, acting as intermediaries 1) between the patient and the provider, 2) between government and the local population, and 3) between the insurer (government) and the various providers. In this regard, the Committee views RHAs as key players in the reform of Canada's health care system. They offer tremendous opportunities for renewing and sustaining health care in Canada.

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### **3.3 Barriers that Prevent RHAs from Functioning to Their Fullest Potential<sup>101</sup>**

During its study, the Committee learned that a number of barriers currently prevent RHAs from operating to their fullest potential. These are summarized below:

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<sup>101</sup> Unless otherwise indicated, the information presented in this section is based on the following documents:  
The Mazankowski report (December 2001).

Glenn G. Brimacombe and Lorraine Pigeon, *A Review of the Funding Flows of Regional Health Authorities in British Columbia*, The Conference Board of Canada, 2001.

Cam Donaldson, Gillian Currie and Craig Mitton, "Integrating Canada's Disintegrated Health Care System – Lessons from Abroad", *C.D. Howe Institute Commentary*, April 2001 ([www.cdhowe.org](http://www.cdhowe.org)).

- While RHAs are responsible for delivering health services according to the needs of their populations, their budgets are, in some provinces, almost completely determined by government and their performance targets are set by government. In these provinces, RHAs have few options if they are unable to meet their residents' health needs within their existing financial resources. A number of observers have suggested that RHA boards must spend a great deal of their energies lobbying the province for increased funding. They have suggested that this effort would be better spent on setting their own priorities and achieving their own set of objectives rather than responding to the priorities and objectives set for them by government.
- There are weaknesses in RHAs' planning and budgeting of resources, as well as gaps in reporting performance. Currently, RHAs are required to provide business and budget plans to the province. In some cases, however, these plans are very general in nature. Specific targets are not set and agreed to by both parties, and budgets are more in the nature of guidelines rather than setting formal limits on what can be spent and for what purposes. Some analysts have suggested that agreements with the provincial government should clearly spell out what happens if RHAs do not manage to live within their budgets or do not achieve their performance targets. This would greatly improve transparency and enhance accountability.
- A useful example of how setting specific targets can be done in practice was brought to the attention of the Committee. Alberta Health and Wellness, along with Capital Health of Edmonton and Calgary Health Region, annually set target volumes for a number of province-wide services (such as organ transplants, open heart surgery, major trauma and burn care and complex neurosurgery). These targets are set based on health status, incidence of health conditions and trend data. The ability of these two Albertan RHAs to achieve the targets and the associated health outcomes are monitored annually.
- While doctors direct much of what happens in health care, they are remunerated independently of RHAs. For example, if a physician orders a laboratory test or an X-ray, it is the RHA that carries the financial burden, not the physician. David Kelly, former Assistant Deputy Minister of Health in Alberta and British Columbia, told the Committee:

*Health regions have been in place now in western Canada for the better part of a decade, with a mandate and the resources to provide many publicly paid for health care services. However, to date these regions have been given virtually no responsibility for the provision of physician services. Physician payment remains a responsibility of Health Ministries, which negotiate province-wide contracts with the physicians' unions. To date, these contracts, in my opinion, have done little to assist in the integration of physician's services with regional health care services, or to promote primary care reform. A notable exception is the decision by Alberta in 1994 to move the responsibility and resources for the provision of all laboratory services, both hospital and contracted private laboratory, to*

*the health regions. This step, which moved about 10% of the physician budget to the regions, produced substantial savings and an integrated lab service at the regional level. Both the Fyke and Mazankowski reports recommend that at least part of the responsibility for the payment of physician services should move to the regions (...).<sup>102</sup>*

This problem could be significantly ameliorated if the cost of physician services was included in the budget of RHAs rather than having physicians paid separately by provincial/territorial governments. Perhaps more important, moving both drug therapy and primary health care to the budget of RHAs would ensure, from the patients' perspective, a fully integrated health care system (or a "seamless system"):

*(...) the move to regional health authorities may have reduced some of the problems of uncoordinated care among organizations but it is not clear whether it has improved integration of many patient-care processes. Essential components for integrated care have been excluded from the authority of regional bodies – drugs and medical care being the most important. A regional health authority without responsibility for physicians and pharmaceuticals cannot provide integrated health care.<sup>103</sup>*

In light of this evidence, the Committee believes that increased responsibility for decision-making related to the full range of health services, enhanced responsibility for planning and better control over the allocation of resources would lead to greater integration of health services; these are all appropriate roles for RHAs in the publicly funded health care system today and in the future.

***The Committee believes that increased responsibility for decision-making related to the full range of health services, enhanced responsibility for planning and better control over the allocation of resources would lead to greater integration of health services; these are all appropriate roles for RHAs in the publicly funded health care system today and in the future.***

This requires governments to move away from "top-down" approaches and toward devolving the management and governance of health care at the regional level. The role of government should be that of overall system governance, setting policies with respect to the health of the population, negotiating strategic plans and budgets and funding RHAs to achieve their objectives.

A policy-based on some of the principles of an "internal market" approach is one potential reform that would devolve greater responsibility to RHAs, depoliticize health care decisions at the regional level, encourage more competition and more choice in the health care sector and provide Canadians with a truly seamless health care system.

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<sup>102</sup> David Kelly, Brief to the Committee, pp. 7-8.

<sup>103</sup> Peggy Leatt *et al.* (Spring 2000), p. 18.

### 3.4 RHAs and the Potential for Internal Markets<sup>104</sup>

The concept of “internal markets” may sound quite complex, but it simply refers to the introduction of market-like mechanisms into the publicly funded health care system. These market-style incentives would take place on the *delivery* and *allocation* sides of health care systems, not on the *financing* side. Internal market reforms are introduced in pursuit of efficiencies in the delivery of care and in the allocation mechanisms that distribute revenue to the health care providers and institutions.

The markets are “internal” because they involve, on both the demand and supply sides, entities within the publicly funded health care system itself. On the demand side, there is a publicly funded purchaser that operates as the agent for the population of patients being served. On the supply side, there is another entity providing the service. In this context, the purchaser would be the RHA, while the provider could be a hospital, specialist, laboratory, primary care physician, etc.

A number of observers have suggested that the Canadian health care system already involves several characteristics inherent to internal markets. For example, in most provinces RHAs purchase or contract for hospital services on behalf of their citizens. Prior to that, a global budget or some population-based funding is negotiated separately between the government and each RHA.

What has not happened yet in Canada is 1) the clear, explicit devolution of responsibility from governments to RHAs for the purchasing of the *full* range of health services; and 2) the establishment of a consistent framework of expectations, so that a variety of providers could compete for funding on a level playing field, with clear accountability, using a business or performance contract model. In some instances, RHAs currently simply pass the budget received from their provincial/territorial governments on to hospitals, based on historical spending patterns. In addition, none of the RHAs in Canada is responsible for the budget of physicians (hospital-based specialists or primary health care doctors) or for the spending on prescription drugs. As a result, there can be no competition (and no market-like behaviour) among health care providers and institutions, and no real integration of the various publicly insured health services.

Some Canadian experts contend that an internal market approach based on RHAs acting as the purchasing agents would foster effective management of health services and improve the quality of care in their regions:

*With an internal market, regional health authorities hold the purse strings and choose between providers on the basis of quality and cost, rather than simply funding the decisions of those using the resources.*<sup>105</sup>

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<sup>104</sup> The information provided in this section is based on the following documents:

European Observatory on Health Care Systems, *Health Care Systems in Eight Countries: Trends and Challenges*, April 2002 (<http://www.euro.who.int/observatory/TopPage>).

Volume Three, Chapters Four and Five, January 2002.

Volume Five, April 2002.

Applying the principles of internal market reform at the regional level does not imply that hospitals currently owned by RHAs must be turned to the private sector. There is opportunity to apply the rationale behind internal market reforms in Canada through competitive contracts among the RHAs and the various public (RHA owned) hospitals. Competition can be further enhanced when private providers are allowed to compete with public providers for some publicly insured health services (such as day surgery and long term care). In addition to enhanced competition, these contracts between RHAs and their hospitals could set specific performance targets; this would greatly improve the accountability of hospitals and other health care providers.

The Committee holds the view that reforms based on internal market approaches have the potential to introduce competition among hospitals, other institutions and individual health care providers. Competition will also provides the incentives for providers to become more efficient and cost-conscious and to make decisions about what to provide, to whom, and what standard of service they can achieve.

Furthermore, the Committee believes that such reforms would ensure that RHAs have the necessary flexibility to reconfigure services in a way that is more in line with population needs. Perhaps most important, reforms based on internal market

***The Committee believes that an internal market reform can reconfigure services in a way that is more in line with population needs.***

principles solve the current problem in some provinces of top-down management by provincial health departments. In addition, an internal market approach will introduce a much greater degree of transparency into the system and enhance the accountability of all parts of the system.

Internal market reforms involving the devolution of clear responsibility to regional health bodies have been implemented in Sweden and the United Kingdom. In Sweden, prior to reforms, hospitals were owned and operated directly by the county councils, which were responsible for financing and delivering health services and which employed most physicians, both hospital-based physicians and those providing primary health care. The reforms brought new contractual arrangements and new payment schemes.

More precisely, public hospital management was devolved from county council control to independent boards of directors. Hospital remuneration was changed to Diagnostic Related Groups (DRGs), a form of service-based funding (like the one recommended in Chapter Two of this report). Reforms of the primary health care sector were also introduced to allow county councils to purchase physician services. A number of primary health care physicians now operate privately under contract with the county councils; they are reimbursed by the county councils on a fee-for-service basis. Some other county councils have introduced capitation payments for primary health care physicians. Overall, estimates suggest that county councils in which internal market reforms were implemented were able to reduce costs by 13% over those who retained the status quo.

In the pre-reform system of the United Kingdom, hospitals were state-owned and operated by the National Health Service (NHS) through its RHAs. The budget of each

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<sup>105</sup> Cam Donaldson *et al.* (April 2001), p. 8.

RHA was determined by the central government and was based on a weighted capitation formula. Each hospital's budget was then determined regionally through an administrative process involving negotiations between its management and the relevant RHA. Hospital specialists were salaried employees of the NHS. A major critique of the system was that RHAs were purchasing services on behalf of their local populations, but at the same time they were running the local hospitals. Thus, they had a pronounced conflict of interest aimed at protecting those hospitals.

When internal market reforms were introduced, RHAs ceased to manage their own hospitals directly and became responsible, as purchasing organizations, for contracting with NHS hospitals and private providers to deliver the services required by their resident populations. Hospitals, for their part, were transformed into NHS Trusts: that is, not-for-profit organizations within the NHS but outside the direct ownership of RHAs. A system of DRGs was developed for providing payment to hospitals.

A review of the literature suggests that there has been little rigorous evaluation of the role of RHAs as purchasers of care in the United Kingdom. The fact that all RHAs became purchasers at the beginning of the reforms meant that there was little scope for comparative analysis. According to some experts, the internal markets did not function as originally envisaged because of a lack of incentive on both sides of the market to make restructuring work.

Perhaps more important, responsibility for primary health care was never devolved to RHAs. Primary health care physicians were encouraged to establish GP Fundholding practices. GP Fundholders were given a fund to purchase, on behalf of their patients, prescription drugs, hospital-based physician services and some hospital care. As such, most primary health care physicians practising as GP Fundholders became rival purchasers to RHAs. In fact, the GP Fundholding system became so popular that the central government decided to pass purchasing responsibilities from RHAs to GP Fundholders (which later became Primary Care Trusts).

According to Donaldson, Currie and Mitton (2001), the potential for turning RHAs into purchasers exists in Canada. RHAs now exist in most provinces/territories and the fact that most of Canada's health care is consumed in and around large cities allows, in their view, for plenty of potential competition among providers. They stress, however, that there are challenges to overcome.

- First, the method of remunerating hospitals would have to change if market-like incentives were to work. That is, hospitals would have to be remunerated according to service-based funding. This is one of the reasons why the Committee has recommended service-based funding in Chapter Two.
- Second, if hospitals were to commit to contracts established with RHAs, more control would have to be exerted by hospitals over those who work in them. Ultimately, this would require that responsibility for the budget of hospital-based specialists be devolved to RHAs.
- Third, to achieve a fully integrated or ("seamless") health care system, the budget for primary health care physicians would have to be allocated to

RHAs for contracting with physicians in their region. Physicians or groups of physicians should be able to choose the option of entering into contracts with RHAs or working outside the system. This would require a revision of the current mode for remunerating doctors.

- And fourth, serious consideration should be given to devolving authority for spending on prescription drugs to RHAs.

According to the Mazankowski report, RHAs are ready to take up these challenges. More precisely, the report stated:

- RHAs should consider establishing contracts with hospitals in their region as well as alternative ownership arrangements and payment mechanisms.
- RHAs should be encouraged to contract with a variety of providers including clinics, private and not-for-profit providers, groups of health care providers (including primary health care physicians) and other regions.
- RHAs should be encouraged to foster the development of centres of specialization. RHAs with specialized expertise should be able to market those services to other regions and enter into contracts with other regions to deliver services. In this way, regions would generate a sufficient volume of services to allow them to achieve better outcomes.

The Committee acknowledges the fact that, while internal markets can improve efficiency in large urban centres and populated areas, they cannot work properly in regions with a low population density. This point was also raised by Michael Decter, currently Chair of CIHI's Board of Directors and formerly Deputy Minister of Health in Ontario, when he stated:

*(...) population density is underrated as a factor in the ability to implement an internal market. It is one of the hazards of the European experience brought to Canada. Purchaser/provider splits work well where you have enough density of population and enough density of providers to have some competition.*

*(...) We have two realities in Canada. We have a good portion of the population, perhaps 70 percent, living in a handful of big cities where I think this model can work. The competition could be virtuous in terms of driving a better price and quality over time. In the rest of it, you need strategies to have enough service there to meet the needs. It is not a matter of competition. It is more a matter of stability of funding and strategies to allow providers to actually locate.<sup>106</sup>*

The Committee also acknowledges that there are currently no RHAs in Ontario, the Yukon and Nunavut. Accordingly, reforms based on internal markets with RHAs having responsibility for the full range of health services would not be possible in these jurisdictions. Alternative approaches to integrating health service delivery and improving efficiency will therefore need to be considered.

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<sup>106</sup> Michael Decter (52:12).

### 3.5 Committee Commentary

The Committee believes that the devolution of further responsibility to regional health authorities is an important step in reforming health care in Canada. In fact, RHAs exist in most provinces and a large percentage of health care spending occurs in and around large cities, creating the potential for competition among the various providers and institutions. We strongly believe that now is the time for RHAs to be given greater control over the *full* range of health care spending in their region.

***The Committee strongly believes that now is the time for RHAs to be given greater control over the full range of health care spending in their region.***

The Committee acknowledges that establishing market-style incentives among health care institutions requires sufficient numbers of providers and a significant population base. Thus, while a number of regions across Canada would be capable of undertaking internal market reforms, some of the smaller provinces and some regions within the larger ones would be unable to do so. In our view, internal market reforms should be done in those geographic locations where gains can be achieved in terms of effectiveness and efficiency.

The Committee also believes that a reform based on the principle of internal markets is the solution to the various barriers that prevent RHAs from operating to their fullest potential. On the one hand, political interference will be minimized when RHAs are given the freedom and responsibility for achieving targets and performance standards. On the other hand, RHAs will have the needed flexibility to allocate their financial resources more cost-effectively and more in line with the needs of the population they serve. In addition, bringing the primary health care envelope under the authority of the RHAs will ensure that they have the levers to exercise more control over these costs. Moreover, devolution of financial responsibility for hospital services, hospital-based physicians and primary health care will encourage competition and allow RHAs to deliver/contract for the most efficient and timely services. Finally, assuming responsibility for the full range of health services will result in a better integrated and more patient-oriented health care system.

The Committee acknowledges that the introduction of internal market principles within the publicly funded health care system requires changing the method of remunerating hospitals. We believe that service-based funding is the most appropriate method, and our recommendation to that effect is detailed in Chapter Two.

The Committee is also aware that, in order to be successful, internal market reforms require detailed and reliable costing information. We also believe that the recommendations we make in relation to the full deployment of a national system of electronic health records, along with an independent evaluation of performance and

***Despite the fact that the management and delivery of health services is an “intensively provincial matter”, the Committee is of the view that the federal government can play an important role in improving health care delivery at the regional level through its sustained investment into the health care infrastructure, the evaluation of health care system outcomes and the supply of human resources in health care.***



outcomes (see Chapter Ten), will greatly facilitate such reform.

We understand that there have been few, if any, rigorous assessments of the internal market reforms undertaken in other countries. We believe that the influence of many factors, such as introducing different reforms simultaneously, has made it difficult to isolate the impact of the internal market reforms undertaken elsewhere. For this reason, the Committee feels it is important to monitor and evaluate the impact that reforms based on internal market principles can have in Canada on productivity, health outcomes, access to publicly insured services, waiting times, etc., and to report this information to Canadians.

Despite the fact that the management and delivery of health services is an “intensively provincial matter,” the Committee is of the view that the federal government can play an important role in improving health care delivery at the regional level through its sustained investment into health care infrastructure (particularly the development of the information systems that make it possible to move to service-based funding for hospitals), the evaluation of health care system outcomes, and the supply of human resources in health care (each of these issues is addressed in subsequent chapters of this report).

Therefore, the Committee recommends that:

**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

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#### 4.1 Why is Primary Health Care Reform Needed?

Primary health care constitutes a patient's first point of contact with the health care system. According to the Canadian Medical Association, "primary medical care includes the diagnosis, treatment and management of health problems; prevention and health promotion; and ongoing support, with family and community intervention where needed."<sup>107</sup>

At present, primary care delivery in Canada is organized mainly around family physicians and general practitioners working solo or in small group practices. Approximately one-third of primary care physicians work alone and fewer than 10 percent work in multidisciplinary practices. The vast majority of primary care practices are owned and managed by physicians. Fee-for-service (FFS) payment is the dominant form of physician remuneration.

A variety of weaknesses and problems with the way in which primary care is generally delivered in Canada have been noted. These include:

- fragmentation of care and services;
- inefficient use of health care providers;
- lack of emphasis on health promotion;
- barriers to access (care not available after hours and on weekends);
- poor information sharing, collection, and management;
- misalignment of incentives, especially fee-for-service remuneration that rewards episodic more than continuing care and health promotion/disease prevention.<sup>108</sup>

A fairly wide consensus is emerging that the creation of primary care groups (PCGs) is central to reform of primary care delivery, and just about every major provincial report issued in recent years has recommended some version of primary care reform (see section 4.2.1). As Michael Decter, former Deputy Minister of Health in Ontario, told the Committee:

***There is a fairly wide consensus emerging that the creation of primary care groups (PCGs) is central to reform of primary care delivery, and just about every major provincial report issued in recent years has recommended some version of primary care reform.***

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<sup>107</sup> Cited in Ann L. Mable and John Marriott, *Health Transition Fund Synthesis Series – Primary Health Care*, June 2002, p. 1.

<sup>108</sup> *Ibid.*, p. 2.

*The single biggest thing is to move from a model that cannot really work any more — which is solo practice — to groups. Those groups could have many configurations.*<sup>109</sup>

Primary care groups are practices composed of several physicians; they can also incorporate other health care professionals (potentially including nurses, nurse practitioners, physiotherapists, dietitians, midwives, psychologists, etc.).

In nearly all existing models of primary care groups, patients have to enrol with a specific group or physician within a defined group for a definite period of time. The PCG is then responsible for ensuring access to primary care for enrolled (rostered) patients 24 hours a day, seven days a week. Once enrolled, patients are expected to remain with their designated primary health care group for a specific period, usually six months to a year, unless they change their place of residence. The primary care physician or team acts as the gatekeeper to the rest of the health care system, referring enrolled patients to specialists. As now, the choice of specialist would be negotiated with the patient, by the primary care physician concerned. However, the rostered patient would not have direct access to a specialist (as is, in theory, the case now) or to other family physicians outside the group, except, of course, in urgent situations.

There are several potential advantages to a system based on PCGs, including:

- Guaranteed patient access on a 24/7 basis to the patient's own team of doctors and other providers;
- Better utilization of the spectrum of health care providers, and better coordination of patient services, through interdisciplinary teamwork;
- Potential cost savings in the longer term by reducing demand on expensive emergency rooms and specialists' services and by making sure that the most appropriately qualified professional handles each task;
- Provision of health promotion and illness prevention measures to patients.

In Volume Five, the Committee accepted the need for diversity in the models of primary care groups appropriate for the many and diverse regions and provinces of the country. The Committee drew on the various reports (see section 4.2.1) to establish a list of desirable attributes for all models of multi-disciplinary primary health care teams, including:

- The provision of a comprehensive range of services, 24 hours a day, seven days a week;
- Delivery of services by the most appropriately qualified health care professional;
- Adoption of alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae;
- Integration of health promotion and illness prevention strategies in the teams' day-to-day work.

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<sup>109</sup> 52:9

- Full integration of electronic patient health records into the delivery of care.

One issue that surfaced during the Committee's most recent hearings was whether primary care reform would lead to noticeable cost savings. Some witnesses suggested that, because PCGs allow for all providers to practise to the full extent of their scope of practice, it should be possible to save money by having the most appropriately qualified provider deliver each service. These witnesses saw a potential source of savings in the fact that, for example, up to 60-70% of the procedures performed by physicians could be done by nurses or nurse practitioners (nurses with advanced qualifications). They felt that two things could be accomplished by transferring these tasks to other qualified personnel who are not as highly paid as physicians: money could be saved in the short term, and physicians would also be able devote a greater proportion of their time to those tasks for which only they are qualified, many of which are now referred to specialists because primary care physicians lack the time to do them.<sup>110</sup>

While all witnesses agreed that there would be efficiency gains by allowing physicians to concentrate on the full range of procedures where their particular training and skills were required, several witnesses questioned whether the anticipated cost savings would in fact be generated. For example, Dr. Peter Barrett, former president of the CMA, noted that:

*expanding the primary care team to include nurses, pharmacists, dieticians and others, while desirable, will cost the system more, not less. Therefore, we need to change our way of thinking about primary care reform. We must think of this as an investment, not in terms of cost savings but as a cost effective way to meet the emerging, unmet needs of Canadians.*<sup>111</sup>

At the same time, the Committee feels that there would be factors that would indeed operate to reduce costs. Dr. Barrett's comment is based on the assumption that there is a large amount of unmet need which, as a result of primary care reform, would be filled because more health care professionals will be supplying more services. Under a fee-for-service arrangement, this would obviously cost more money. At the same time, however, if primary care physicians provide services through the full range of their competency, there would also be a decrease in referrals to specialists.<sup>112</sup>

However all witnesses argued that even if there were no short-term cost savings, the importance of primary care reform was not diminished. Rather, the discussion brought to the fore other reasons for pushing it forward. In the words of Professor Brian Hutchison of McMaster University:

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<sup>110</sup> This point is well illustrated by the following facts from a 1999 report of the Ontario Health Services Restructuring Commission, cited in Volume Four of the Committee's study (p. 110). One third of billings by specialists in Ontario in 1997 (at a total cost of \$1.4 billion) was work that could have been done by family doctors. The five most frequently used billing codes by Ontario family doctors in 1997, which account for about 69% of the total amount billed by these doctors (at a cost of \$1.2 billion), were for: intermediate assessments (well baby care), general assessments, minor assessments, individual psychotherapy, and counselling. The clinical consultants to the Ontario Health Services Restructuring Commission were of the opinion that most, if not all of the services these bills represent could well be provided by nurse practitioners, nurses and many well-trained health professionals.

<sup>111</sup> 56:12

<sup>112</sup> Research done for the Ontario Health Services Restructuring Commission shows that the most dramatic decrease in referrals would be to dermatologists and ear-nose-and-throat specialists.

*The emphasis on cost control has led to a focus on nurse practitioners as substitutes for physicians. The other dimension that needs to be explored is their potential for broadening the scope of primary care and providing a greater emphasis on health promotion, prevention and health counselling, where they have a great deal to offer, probably more than physicians. We should think of nurse practitioners in a complementary role, not mainly with the idea of saving money. We should view them in terms of improving health.*<sup>113</sup>

The Committee strongly endorses this point of view. Indeed, the synthesis report on various primary health care projects undertaken under the auspices of Health Canada's Health Transition Fund provides further evidence in this direction. Discussing a project that evaluated the role of a nurse practitioner in the context of a multidisciplinary team working out of a Calgary clinic, the report says:

*Although the physicians were not initially clear on the role of the nurse practitioner, the project soon saw nurse practitioners facilitating communication among various providers, "significantly" increasing access to care, improving quality, and handling cases, thus allowing physicians to spend more time with patients who required their services; 95 per cent of patients were satisfied with the initiative.*<sup>114</sup>

## **4.2 The Provinces and Primary Care Reform**

In this section, we review briefly the highlights of six provincial reports that contain recommendations for primary care reform. We then look at recent implementation initiatives in three provinces, Ontario, Quebec and New Brunswick, that have progressed beyond report-writing and pilot projects.

### **4.2.1 Recent reports**

Table 4.1 (end of chapter) presents an overview of the different proposals contained in six reports released since late 1999,<sup>115</sup> organized according to a number of key

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<sup>113</sup> 58:13

<sup>114</sup> Marriott Mable, *op cit.*, p. 20

<sup>115</sup> These reports are:

1. Health Services Restructuring Commission (Duncan Sinclair, Chair), *Primary Health Care Strategy – Advice and Recommendations to the Honourable Elizabeth Witmer, Minister of Health*, Government of Ontario, December 1999.
2. Commission d'étude sur les services de santé et les services sociaux (Michel Clair, Commissioner), *Emerging Solutions – Report and Recommendations*, January 2001
3. Saskatchewan Commission on Medicare (Kenneth Fyke, commissioner), *Caring for Medicare – Sustaining a Quality System*, April 2001
4. Premier's Advisory Council on Health (Right Hon. Don Mazankowski, Chair), *A Framework for Reform*, report to the Premier of Alberta, December 2001, pp. 52-53.
5. Primary Care Advisory Committee (Kathy LeGrow, Chair), *The Family Physician's Role in a Continuum of Care Framework for Newfoundland and Labrador*, A Framework for Primary Care Renewal, Department of Health and Community Services, Newfoundland and Labrador, December 2001.
6. Report from the Premier's Health Quality Council, *Health Renewal*, Government of New Brunswick, January 2002.

elements of primary care reform. All six contain many important similarities and a number of significant differences.

All of the reports advocated the delivery of comprehensive primary care through some form of multidisciplinary team, usually 24 hours a day, seven days a week. However, the means suggested for achieving this objective varied considerably, as did the detail provided in the various reports. It is important to note that all stressed the need for the introduction of some form of Electronic Health Record (EHR – see Chapter Ten), although not all linked this need directly to their proposals for primary care reform.

The reports differed in their descriptions of the multi-disciplinary teams, and in the ways in which they envisaged the connections between primary care groups and other health care providers such as hospitals. Only a minority of the reports advocated specific alternate funding mechanisms, and only two presented explicit proposals for rostering.

Although it is too early to say whether the recommendations of these various reports will be implemented, the Ontario example is perhaps instructive. The Health Services Restructuring Commission (Sinclair) Report was both the first to be issued and contained the most detailed outline of how primary care reform should be carried out. As Ontario became the first to begin implementation of a province-wide scheme for primary care reform it is interesting to note that the actual model being put in place appears to be less uniform, as well as more flexible and voluntary than the plan contained in the report.

#### **4.2.2 The Ontario Family Health Network**

The Ontario Family Health Network (OFHN) was created in March 2001 as a semi-arm's-length agency that reports to the Ontario Ministry of Health and Long-Term Care (MOHLTC). The OFHN provides family physicians with information, administrative support and technology funding to support the voluntary creation of Family Health Networks (FHNs) in their communities.

The FHN model encourages groups of family doctors and allied health professionals, such as nurse practitioners, to work together to provide accessible, co-ordinated care to patients enrolled with them. OFHN provides funding, guidelines and support, but doctors voluntarily decide to form a local FHN and plan how they will work together to best serve their patients.

A minimum of five physicians (one of whom must act as group leader) and 4,000 enrolled patients are required to form an FHN, which can be spread over more than one site. In addition to regular office hours, one FHN office must be open from 5 p.m. to 8 p.m. Monday to Thursday, and three hours each day on the weekend. After hours, rostered patients have access to a phone line staffed by nurses, with support from a FHN doctor on call.

Pilots, known as Primary Care Networks, were created in 1998. Between 1998 and 2000, 14 pilot networks were created in seven communities, today embracing more than 178 physicians and approximately 270,000 enrolled patients. In November 2001, the Ontario Medical Association (OMA) voted to allow the OFHN to begin offering Family Health Network agreements to doctors in northern and rural Ontario. In January 2002, the OMA voted to allow

a general contract agreement to be released to family doctors throughout the province. In May 2002, a group of six doctors from the Dorval Medical Associates in Oakville formed the province's first Family Health Network.

Patients who sign on to an FHN agree to contact their Family Health Network doctor first when they need a health service, unless they are travelling or in an emergency situation. They also agree to allow the Ministry of Health and Long-Term Care to provide to the FHN doctor some information about health services received by the patients from family physicians outside their network. In addition, the MOHLTC can release to the Family Health Network doctor dates of immunizations, cervical screenings and mammograms.

Referrals to specialists, or to other family physicians for second opinions, is done by the Family Health Network physician in consultation with each patient. Patients can continue to use the services of their doctor without joining that doctor's FHN. Similarly, if they decide to cancel their enrolment in their doctor's FHN, they do not have to change family doctors. He or she can continue to see that doctor on the same basis as before they joined the network. Patients are free to change the doctor with whom they are enrolled up to twice a year. If, however, they are seeing another general practitioner on a regular basis, the doctor with whom they are enrolled can remove them from his or her Family Health Network roster of patients.

Physician satisfaction has been high and, to date, no physicians have left the pilot networks. The agreements that physicians sign in order to create an FHN address patient and physician rights and responsibilities, physician compensation, and administrative support.

Payment for rostered patients - which is weighted by age and gender (see Table 4.2) and covers a basket of 57 common primary care services - is expected to amount to about 60% of FHN revenue. There are additional payments for providing preventive health services such as vaccinations, Pap smears and mammography; bonuses for repatriating patients who previously saw other physicians for any of the core primary care services; an on-call fee; and premiums for non-core services such as deliveries and hospital in-patient care.

**TABLE 4.2**  
**RATIO FOR PAYMENT OF BASE RATE PAYMENT AND**  
**SPECIAL PAYMENT BY AGE AND SEX**

<b>Age</b>	<b>Male</b>	<b>Female</b>	<b>Average</b>
00-04	1.05	1.00	1.03
05-09	0.55	0.54	0.55
10-14	0.44	0.46	0.45
15-19	0.46	0.82	0.64
20-24	0.46	1.03	0.74
25-29	0.50	1.07	0.79
30-34	0.58	1.08	0.83
35-39	0.72	1.17	0.95



Age	Male	Female	Average
40-44	0.80	1.20	1.01
45-49	0.88	1.30	1.11
50-54	1.02	1.46	1.25
55-59	1.16	1.47	1.33
60-64	1.27	1.50	1.40
65-69	1.43	1.58	1.52
70-74	1.66	1.69	1.69
75-79	1.99	2.01	2.00
80-84	2.08	2.08	2.08
85-89	2.34	2.37	2.36
90+	2.64	2.68	2.67

Note: \$96.85 is the multiplier for the base rate payment.

Source: Matt Borsellino, "Primary Care Payment Options Become Available," *The Medical Post*, 4 December 2001, p. 8.

Physicians can also bill for continuing medical education, and each network is entitled to up to \$25,000 annually to defray additional administration costs. FHNs are also eligible for funding to set up an information technology system, including electronic patient records, drug interaction alerts, tracking of preventive care measures and electronic billing.

A physician who does an "average" amount of office work, hospital, obstetrics and ER, with a roster size of 1,480, patients might be paid \$254,846 under the blended model. For a physician who only does office work and has a roster size of 1,423 patients, the annual payment might be \$204,256. For a roster of only 598 patients, gross payment is \$105,455.

Dr. Elliot Halparin, a Georgetown, Ont., family physician and President of the OMA, said average payment under the blended model of the urban FHN template is an estimated \$244,500, assuming a roster size of 1,600 patients. This compares with \$210,700 under traditional fee-for-service. The numbers are based on the average billings of the 6,500 to 7,000 Ontario family physicians who provide comprehensive care.

While it is too early to attempt any evaluation of the actual OFHN project, an assessment of the pilot projects (Primary Care Networks or PCNs) that preceded the full rollout was done by PriceWaterhouseCoopers for the MOHLTC in October 2001. Some of the conclusions are worth noting:

- The top five benefits physicians have experienced in being part of a PCN are: the lifestyle and practice-style benefits of the capitation model; better care for patients; information technology (IT); increased income; shared call and coverage for absences.
- The top challenges physicians have faced in being part of a PCN are: administrative demands; IT; patient rostering; dealing with the Ministry.

- To date, the involvement of nurse practitioners and other health care providers in the networks has been limited, although patients report very high satisfaction with nurse practitioners.
- Role definition and team integration have been challenges in integrating nurse practitioners into PCNs; the nurse practitioner to physician ratio extremely low in many PCNs.
- It has been proposed that nurse practitioners might have an impact on cost-effectiveness, but there is no definitive evidence on the economic impact of nurse practitioners in the PCNs.
- There is high physician satisfaction with capitation, and preliminary evidence of changed behaviours due to capitation incentives.
- The teletriage service appears to have had a positive impact on emergency room utilization. Data from the teletriage service provider suggests that in the absence of the teletriage service, callers would have made 1,874 visits to hospital emergency rooms. However, the teletriage service advised only 871 callers to seek emergency care – a difference of 1,003 visits.

The report also noted three categories of barriers that impede the progress of the networks:

- *Implementation barriers.* Examples include delays in various IT components, insufficient multidisciplinary resources, inability to respond to higher than anticipated teletriage call volumes, and insufficient patient and public education about the reform.
- *Model barriers.* Examples include a physician-centric approach to the reform, issues with the bonus codes and capitation rates, insufficient feedback to physicians on outside use, and the need for specific performance measures for the PCNs.
- *Systemic barriers.* Examples include physician shortages, the health care funding structure, lack of integration with reforms in other health sectors and gaps in service.

The Committee feels it is important to note that the model adopted in Ontario differs considerably from that advocated by the Hospital Restructuring Commission. The Commission had wanted governments to stop paying for individual services performed by physicians and move to a model in which the PCG as a whole would be funded primarily using capitation. In the Committee's view this proposal would have led to the creation of genuine group practices, instead of the kind of practice that seems to be emerging in Ontario, where practitioners who remain essentially independent work together under a single roof. The Committee agrees with the approach recommended by the Hospital Restructuring Commission.

However, two other provinces recently announced initiatives in primary care reform that more closely resemble the recommendations of the reports that had been commissioned in their respective jurisdictions.

### **4.2.3 Quebec**

On June 4, 2002, the Quebec Minister of Health and the President of the Quebec Federation of General Practitioners announced that they had reached agreement on arrangements for establishing the first 20 family medicine groups (FMGs). This is part of a plan to create over 300 of these groups over the next four years, by which point, as recommended by the Clair Commission, they are expected to provide primary care service to 75% of the province's population.<sup>116</sup>

The creation of FMGs is voluntary, as is patient enrolment. Each FMG will involve 6 to 10 physicians and nurses and provide a full complement of primary care services to 10-20,000 patients.<sup>117</sup> During an initial transitional phase, physicians will continue to be remunerated for clinical activity in the same way as now (fee-for-service, salary, etc.), but will also receive payment on an hourly basis for activities associated with the operation of the FMG, such as the coordination of services for enrolled patients, or interdisciplinary collaboration with other providers, as well as a yearly premium for each patient on their roster.<sup>118</sup>

Patients enrol with the doctor of their choice within a given FMG. Enrolment lasts a year and is automatically renewed unless the patient cancels in writing. Patients agree to consult their doctor (or someone else from the FMG) first, unless it is an emergency or they are travelling. FMGs are open for extended hours and guarantee service 24/7 using telephone emergency service.<sup>119</sup>

The Quebec government has committed \$15 million to finance the creation of the first 20 FMGs, split three ways: \$5 million for additional physician compensation; \$5 million for office computerization and equipment; \$5 million to hire nurses.<sup>120</sup> Each FMG must be approved by the Minister and must have in place a contract with a local CLSC (community health centre) as well as an agreement with the regional health board.

The Quebec government also recently introduced legislation, jointly sponsored by the health and justice ministries, that redefines the role of physicians, allowing them to delegate more duties to nurses. Nurses will specialize in areas such as surgery, cardiology and neo-natal intensive care, as well as performing extra tasks in a variety of settings, including in emergency rooms.<sup>121</sup>

### **4.2.4 New Brunswick**

The Government of New Brunswick recently announced two related measures that follow up on the recommendations on primary care reform contained in the Premier's Health Quality Council Report. On May 8, 2002 the government brought down legislation intended to introduce nurse practitioners to the province's health system and allow registered

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<sup>116</sup> Ministère de la Santé et des Services sociaux (MSSS) press release, June 4, 2002.

<sup>117</sup> *Health Edition*, Vol. 6 No. 23, June 7, 2002, p. 4

<sup>118</sup> MSSS fiche technique, « Résumé de l'entente particulière entre la FMOQ et le MSSS relative aux groupes de médecine de famille. »

<sup>119</sup> MSSS fiche technique, "Le groupe de médecine de famille."

<sup>120</sup> *Health Edition*, op. cit.

<sup>121</sup> *Medical Post*, May 14, 2002.

nurses to make greater use of their skills and training. The legislation will provide for the creation and registration of nurse practitioners, and will also enable front-line nurses working in primary care to deal with certain non-urgent conditions on their own, without the direct intervention of a physician.<sup>122</sup> They will be able to order laboratory tests and a variety of diagnostic procedures and also to issue prescriptions for some drugs.

The Minister of Health also announced that the government will spend \$2.1 million to establish at least two community health centres in the province during the current fiscal year.<sup>123</sup> These centres will use multidisciplinary teams of health professionals, including nurse practitioners.

Both physician and nurses' organizations have been supportive. In fact, in April 2002 the New Brunswick Medical Society had proposed that some nursing services be billed directly to Medicare so that both physicians and nurses could see patients. It reasoned that this would allow family physician practices to take on more patients, shorten waiting lists for specialists and even attract some nurses back to the profession.

#### **4.3 Overcoming the Barriers to Change**

The Committee welcomes these provincial initiatives. We note that, for the first time, they move primary health care reform off the drawing board and into the realm of concrete application. These developments therefore offer grounds for guarded optimism that significant reform of primary care delivery is possible in Canada. However, there remain a number of barriers to change that must be overcome.

For example, with respect to Ontario, a number of witnesses expressed concern over the "physician-centric" nature of the OFHN. One of these, Professor Hutchison, told the Committee that the Ontario model was:

*...a very limited model that reflects the process by which it was negotiated — bilateral negotiations between the government and the Ontario Medical Association. There were no non-physician stakeholders involved in the discussion. It was a private, "behind closed doors" set of negotiations.*

*Although it has interesting elements, it is a pretty traditional approach. It changes funding (physician payment) methodology, but it does not change a lot of other things. It certainly does not provide many opportunities for providers to develop and evaluate varying arrangements that involve non-physician providers such as nurse practitioners, social workers, midwives, and so on. It is a physician-centred model.<sup>124</sup>*

Reinforcing that, Dr. Peter Barrett insisted that "to ensure comprehensive and integrated family care, family physicians should remain as the central provider and coordinator

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<sup>122</sup> News Release 453, May 8, 2002.

<sup>123</sup> *Medical Post*, Vol. 38 No. 21, May 21, 2002.

<sup>124</sup> 58:23

of timely access to publicly-funded medical services.”<sup>125</sup> Dr. Ruth Wilson, the Chair of the OFHN, acknowledged in her testimony that the current Ontario model was a starting point, and that she was “expecting and hoping the relationships with other professionals will grow as we put family health networks in place,”<sup>126</sup> adding that “we have a large process of change to introduce if we are to convince the thousands of family physicians in Ontario to accept this model.”<sup>127</sup>

In this regard, the President of the OMA, Dr. Elliott Halparin, noted that it will take time before physicians sign on in large numbers:

*I think it will be a bit like popping popcorn: A few kernels will pop to begin with, but then there will be a lot of popping going on when people understand that this acknowledges the complexities involved in providing comprehensive care, that it is good for patients and, by extension, good for physicians.*<sup>128</sup>

More generally, witnesses pointed to the continued presence of a variety of barriers to the implementation of primary care reform. These include:

- The vested interests of various professional groups
- Shortages of qualified personnel
- Fee-for-service as the dominant method of physician remuneration
- High start-up costs
- The absence of electronic information infrastructure

The issue that seemed to spark the most controversy among the Committee’s witnesses was the first. Some felt that strong action, by government if necessary, was needed to break the log-jam with regard to professional groups protecting their respective turfs. Claude Forget, former Minister of Health in Quebec, argued that the “sector is not unlike a medieval guild system in the sense that it is rigid and does not allow the use of someone from another related profession if you find that you are in a deficit situation, and move him or her over.”<sup>129</sup>

Graham Scott, former Deputy Minister of Health in Ontario, expressed a similar view, pointing out that “we have a very well-funded, well-organized, and powerful monster in the form of each one of these health professional organizations,”<sup>130</sup> and that “the eventual threatened hammer of forced legislation”<sup>131</sup> was required to bring the parties to the table in order to revise the existing regulation of scopes of practice.

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<sup>125</sup> 56:10

<sup>126</sup> 57:7

<sup>127</sup> 57:17

<sup>128</sup> 56:22

<sup>129</sup> 53:54

<sup>130</sup> 53:47

<sup>131</sup> 53:49

Other witnesses, however, stressed that primary care reform could not be imposed upon health care providers, but will work only if adopted voluntarily. Dr. Les Vertesi, Medical Director at the Royal Columbian Hospital in Vancouver, argued that “there are some things such as primary health care reform that have to be done by the providers because the detail is incredibly important.”<sup>132</sup> And Professor Hutchison noted that, “the chances of imposing reforms on unwilling providers are very small, partly because I do not think the public sees primary care reform as offering huge advantages to them.”<sup>133</sup>

With regard to scopes of practice, Ms. Kelly Kay, of the Canadian Practical Nurses Association, noted that:

*[the fact that] Licensed Practical Nurses continue to experience artificial limits to practice, that nurse practitioners must struggle for recognition and remuneration and that other professionals such as physiotherapists still face restrictions to direct access are examples that speak to continuing barriers imposed upon professional groups.*<sup>134</sup>

At the same time, physician representatives noted the progress that had been made among professional organizations in agreeing to common principles for determining scopes of practice. Dr. Barrett pointed out that:

*The Canadian Medical Association had developed a “scopes of practice” policy that clearly supports a collaborative and cooperative approach, which has been supported in principle by the Canadian Nurses Association and the Canadian Pharmacists Association. We indeed have a signed document to that effect.*<sup>135</sup>

In Volume Five, the Committee expressed its support for the revision of scope of practice rules in order to allow all health care providers to deliver the full range of services for which they have been trained.<sup>136</sup> In the Committee’s view, these should be as standardized as possible across the country. The synthesis report of the Health Transition Fund’s primary care projects reached a similar conclusion, notably with regard to nurse practitioners:

**...the Committee expressed its support for the revision of scope of practice rules in order to allow all health care providers to deliver the full range of services for which they have been trained. In the Committee’s view, these should be as standardized as possible across the country.**

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<sup>132</sup> 53:90

<sup>133</sup> 58:12

<sup>134</sup> 61:4

<sup>135</sup> 56:12

<sup>136</sup> See also Chapter Eleven for additional comments on the need to reform scope of practice rules.

*A federal/provincial/territorial initiative should develop national standards for terminology and scope of practice. It should include legislative requirements that support an expanded role for nurses and nurse practitioners.*<sup>137</sup>

The Committee endorses this conclusion and believes that the federal government should take the initiative in this regard.

Some witnesses suggested that the key ingredient lacking in order to make more rapid progress in implementing primary care reform is political will. In this vein, Michael Decter told the Committee:

*It is not about the right model; it is about moving the yardsticks. We have spent a long time looking for the perfect model for primary care reform. It has worked in some places largely because someone just had the will to do it.*<sup>138</sup>

Witnesses reiterated the point made by the Committee in Volume Five that no single model could be applied in the same fashion in all parts of the country. Kelly Kay stated, “primary health care service delivery will look different in each community” since “communities must customize primary health care services in response to their own identified needs.”<sup>139</sup> For her part, Dr. Susan Hutchison, Chair of the GP Forum of the Canadian Medical Association, told the Committee:

*The mix of health care providers varies based on the needs of the population. There is no ideal mix. What works best is an adequate human resource to meet the needs of the population. The mix of providers is dictated by the services required to address these patient needs. The ideal range of services for a given team would depend on the needs of the population and the available mix of providers. There may be considerable variability between the needs of a given population, as is the case in Aboriginal populations, for example.*<sup>140</sup>

The Synthesis Report on Health Transition Fund projects in primary care (June 2002), reached a similar conclusion, noting that “the health system has already demonstrated its capacity and ability to support organizational variations and could continue to do this within an overarching theme of primary health care integration.”<sup>141</sup> It also drew a number of lessons that coincide with the recommendations made by the Committee in Volume Five, both with respect to the basic features a reformed primary care system should have, and to developing a national health human resources strategy and implementing a national electronic health record. In particular, it concluded:

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<sup>137</sup> Marriott Mable, *op. cit.*, p. 29.

<sup>138</sup> 52:16

<sup>139</sup> 61:5

<sup>140</sup> 56:15

<sup>141</sup> Marriott Mable, *op. cit.*, p. 24

*The first-hand experience gained through the HTF projects offers new insights and reinforces long-standing knowledge about aspects of primary health care: the benefits of group practices and multidisciplinary teams; the untapped potential of nurses; and the linkages between determinants, health promotion and disease, and injury prevention.*<sup>142</sup>

The report also insisted that certain conditions were necessary to the success of primary care reform, arguing that “the development of a common electronic health record and access to computers and other technology for services, information, and research is essential to successful primary health care.”<sup>143</sup>

#### **4.4 The Federal Role**

In Volume Five the Committee recommended that:

**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.**

Ongoing financial support for reform initiatives that lead to the creation of multidisciplinary primary health care teams would represent a continuation of the commitment to primary care reform that the federal government displayed in funding the \$150 million Health Transition Fund, of which over \$60 million was spent on projects related to primary care

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<sup>142</sup> *Ibid.*

<sup>143</sup> *Ibid.*, p.25



reform. The federal government also committed \$560 million out of the \$800-million Primary Health Care Transition Fund (PHCTF) that was created as a result of the First Ministers Conference in 2000 to assist the provinces and territories in broadening and accelerating primary health care initiatives. This money is to be allocated on a per capita basis. To access these funds, each provincial and territorial government must develop one proposal showing how their PHCTF funding will support the transitional costs associated with primary health care reform.

However, the PHCTF is not an ongoing program. The Committee recognizes that the start-up costs for primary care groups can be substantial. Based on the actual costs of implementing primary care reform in Quebec, this cost could be as much as \$750,000 per group, while earlier estimates from Quebec had placed this cost as high as \$1 million per group.

The Committee therefore recommends that:

**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.**

This money would be in addition to any funds made available through the PHCTF and should enable the creation of between 50 and 65 primary care groups per year.

In order for primary care groups to function effectively, the Committee is convinced that they must act as gatekeepers to the rest of the health care system. For example, patients who are enrolled in a particular PCG must have incentives, both positive and negative, to ensure that they consult their PCG physician rather than seek care from specialists on their own. Referrals to specialists should therefore be made by a primary care provider in consultation with the patient.

Nevertheless, the Committee does not believe it appropriate to prohibit patients from consulting other doctors, especially specialists, should they so desire. But it does believe that patients who choose to seek care elsewhere, care that could be provided adequately within the PCG with which they are enrolled, should bear the financial consequences of their decisions. In other words, patients should be obliged to pay a fee in order to consult other physicians, including specialists, when they do so on their own initiative.

***In order for primary care groups to function effectively, the Committee is convinced that they must act as gatekeepers to the rest of the health care system.***

In Volume Five, the Committee also recommended the establishment of an ongoing framework to deal with human resource issues, in particular by creating a permanent national coordinating body for health human resources composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include coordinating initiatives to ensure that adequate numbers of graduates are being trained to meet the goal of Canadian self-sufficiency in health human resources.<sup>144</sup>

<sup>144</sup> See also Chapter Eleven of this volume.

With respect to the development of electronic health records, the Committee recommended in Volume Five that the Canada Health Infoway initiative be extended beyond its current 3-5 year mandate in order to develop, in collaboration with the provinces and territories, a national system of electronic health records. Several witnesses suggested not only that the development of electronic health records is crucial to the reform of primary health care, but that it is an area in which the federal government can exercise leadership.

In the words of Jack Davis, CEO of the Calgary Health Region, “the one area I would see that has a real potential for federal investment is the electronic health record.”<sup>145</sup> Dr. Kenneth Sky, past president of the Ontario Medical Association, suggested that “for physicians, the IT component of primary care reform is a big incentive,”<sup>146</sup> and Michael Decter felt that electronic health records were so important that “bribery is in order in this particular sphere. I would bribe the doctors to convert.”<sup>147</sup>

The Committee agrees that the federal government should take the lead role in expediting the development of a national electronic health record, and presents specific recommendations to this effect in Chapter Ten.

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<sup>145</sup> 53:88

<sup>146</sup> 56:22

<sup>147</sup> 52:14

## **Appendix 4.1: GP Fundholding in Great Britain**

In discussions of primary care reform, reference is often made to the British experience in the 1990s with the introduction of “internal markets”. Before 1990, it was accurate to describe the British National Health Service (NHS) as being run by a monolithic bureaucracy that controlled all aspects of the system. At that time, NHS hospitals and community health care units were state-owned and operated by the NHS’s regional health authorities. Each hospital’s budget was determined through an administrative process involving negotiations between its management and the NHS administration. GPs provided care through a “rostering” system that required patients to register with one GP, who then acted as “gatekeeper” to the rest of the system. GPs worked under contract with the NHS and were remunerated through a mixed system that combined a salary with capitation based on the number of patients on a doctor’s list.

With primary care reform, introducing internal markets allowed some general practices to volunteer as “Fundholders”. Family practices that served a sufficient number of patients became purchasers who were then able to contract with hospitals and other community-based providers (such as district nurses) for defined services. Fundholder budgets were restricted for the purchase of hospital and community services; they could not be used to supplement GPs incomes. GPs have always been paid by the NHS as independent, self-employed professionals. The various reforms enacted throughout the 1990s, such as fundholding and more recently the creation of Primary Care Groups and Trusts, have not fundamentally affected the ways in which British GPs derive their incomes.

In the early 1990s the GP fundholding system was expected to be only a small part of the overall reform process, but it quickly became more popular than anyone had anticipated, due to a variety of factors. There was evidence early on that fundholders could secure improved services for their patients. This created a bandwagon effect; few physicians wanted to be left behind. The Conservative government reinforced this trend by offering further benefits (e.g. computers) exclusively to fundholding practices. Moreover, fundholding gave GPs a central and more authoritative role in the overall system than they had had previously. Consultants (specialists) were forced to become more responsive and accountable to GPs who had the option to take their business (referrals) elsewhere.

The Labour government under Tony Blair, first elected in 1997, was critical of a number of aspects of internal market reform. In particular, it felt that GP fundholding had allowed a form of “two-tierism” to develop in Britain because patients of GP Fundholders were often able to obtain treatment more quickly than patients of non-Fundholders. This was considered inimical to the founding principles of the NHS, and as a result Labour sought to curb the forms of competition they saw as being at the root of emerging inequalities.

In April 1999, government required all GPs to join a Primary Care Group (PCG - groupings of GP practices in geographical areas far larger than the previous fundholding model, covering between 50,000 to 250,000 people.) PCGs brought local primary care providers together under a board dominated by GPs, but also representing nurses and other local community providers. PCGs were expected to develop through stages to become “Trusts” (PCTs) able to assume full responsibility for commissioning (contracting for) care and for the

provision of community health services for their population. By April 2002, nearly all the PCGs had made the transition to Trust status.

In principle, this evolution gave all GPs the benefits of fundholding, a single regional budget encompassing general medical services, and prescription drugs, as well as hospital and specialist care. However, a recent assessment by the King's Fund suggests that there is still some way to go before PCTs "will be able to realise their undoubted potential." The authors of this study concluded that PCTs are developing at different speeds and that while "they have made progress in developing and integrating primary and community care...their commissioning and health improvement functions are, as yet, limited."<sup>148</sup>

It is worth noting that until the market reforms of the 1990s, GPs retained a monopoly on primary care delivery through their role as gatekeepers to all other dimensions of the system. A number of reforms introduced by the Labour government have allowed nurse-led providers to assume a growing role in this regard. These have included the creation of a nurse-staffed 24-hour telephone advice line (NHS Direct) and the creation of a number of walk-in centres where initial assessments are performed by nurses, who can then refer patients to local GPs if necessary.

A number of factors make it very difficult to draw definitive conclusions from the British experience that can be easily applied to the Canadian context. There have not always been sufficient data available, and the rapidity of change has not facilitated careful study. Moreover, given the very different structure of the two systems, it is difficult to apply the lessons to the Canadian health care system. However, a number of points bear mention:

- In the first place, despite the Labour Government's opposition to the form taken by the "internal market" under the previous Conservative government, the Labour government has nonetheless retained key elements of the purchaser-provider split the Conservatives introduced.
- Second, the transition that the Blair government has engineered from GP fundholding to the creation of PCGs and PCTs would seem to highlight the successes of the fundholding scheme more than its deficiencies. It is because the fundholding GPs were successful in negotiating with hospital trusts on behalf of their patients that fears of "two-tierism" emerged.
- Third, the shift to grant a greater role in the delivery of primary health care services to nurses and other providers parallels similar recommendations that have been voiced consistently in the Canadian debate over primary care reform.

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<sup>148</sup> John Appleby and Anna Coote, *Five Year Health Check*, King's Fund, April 2002, p. 47.

**TABLE 41**  
**REVIEW OF RECENT PROVINCIAL REPORTS CONTAINING RECOMMENDATIONS**  
**ON PRIMARY HEALTH CARE REFORM**

Report	Scope of service	Team Composition	Remuneration	Size of practice	EHR*	Rostering	External Relations
Sinclair (Ont.) Dec. 1999	Comprehensive primary care would be provided 24 hours a day, seven days a week; this would be achieved through after-hours clinics (or extended office hours) and around-the-clock telephone triage.	Physicians and nurse practitioners as "core providers", in an interdisciplinary team including: registered nurses, midwives, psychologists and social workers, pharmacists, physiotherapists, dieticians, Individual health care providers would work to the full extent of their scope of practice.	Group rather than individual funding, primarily on the basis of capitation supplemented by other methods; group determines how its member providers are reimbursed. Not merely office sharing.	Three distinct models: <u>urban</u> – 6 MDs, 2 NPs for about 1,680 patients; <u>rural</u> – 2 MDs and 2 NPs for 1,293 patients; <u>remote</u> – 1 MD and 3 NPs for 1,142 patients.	Yes	Yes	Each practice would be responsible for developing agreements with other health care organizations and providers (hospitals, specialists, public health, rehabilitation centres, long-term care facilities, home care, community care).
Clair (Que.) Jan. 2001	Group practices would ensure round-the-clock, seven-days-a-week coverage. Services to include health promotion and disease prevention, diagnosis and treatment, referral to hospitals and specialists, coordination of continuum of care, and referral to social care.	Practices comprise only physicians and nurse practitioners, but they work in partnership with the existing network of CLSCs (social workers, dieticians, psychologists, physiotherapists, etc.).	A blended system of remuneration that includes elements of capitation, a lump sum for participation in some programs, and FFS for prevention or to promote productivity.	6 to 10 physicians working in a polyclinic or within a CLSC with the collaboration of 2 to 3 nurse practitioners, and responsible for between 1,000 and 1,800 persons.	Yes	Yes	Contract with the regional health authority, and between the primary care group practice and the CLSC. Regional health authorities would be responsible for coordinating the network of primary care group practices with other service providers.
Fyke (Sask.) Apr. 2001	Group practices would make services available around the clock. Outside of office hours, telephone calls would be forwarded to a nearby group member; 24-hour back-up through a provincial call centre. No explicit list of services.	Primary care group practices would involve a variety of providers including physicians, nurse practitioners, midwives, physiotherapists, dieticians, home care workers, and professionals in the areas of mental health, rehabilitation, addiction and public health.			Yes		Regional health authorities would organize and manage primary care group practices, contracting with or otherwise employing all providers including physicians.

Report	Scope of service	Team Composition	Remuneration	Size of practice	EHR*	Rostering	External Relations
Mazan-kowski (Alta.) Dec. 2001	Gives very general approval to the idea of primary health care reform. Comprehensive care would be delivered by multidisciplinary teams.	Teams might include a family doctor, nurse or nurse practitioner, mental health worker, social worker and others.	Identifies FFS as a barrier to change. Suggests that a blended funding model is the best likely alternative, and sees the Ontario Family Health Network as an excellent example.		Yes		Physicians should be given the option of contracting with Regional Health Authorities for a portion of their income.
Nfld. Dec. 2001	A network of primary health care teams providing a 'Continuum of Care' (including preventative, promotive, curative, supportive and rehabilitative care).	Primary care physicians would work collaboratively with other health care providers and other physicians. Within each team, each health care provider would practice at the highest level of his or her respective skill set.	Did not endorse any specific funding method (no universal model) but seemed to support some form of flexible, blended funding. No mention of capitation.		Yes		Regional boards would outline for physicians what medical services are required for their region. Physician groups would enter into formal arrangements with boards to ensure delivery of the full basket of services listed in the agreement.
N.B. Jan. 2002	Access to a comprehensive range of ambulatory services 24-hours a day, seven-days a week, coordinated from one location, where possible a Community Health Centre. Where these would not be open 24 hours a day, phone calls would be re-directed to an around the clock service site.	A collaborative model and a team approach to providing primary care. Family physicians would not see every patient and other members from the team of health providers could provide consultation and/or perform treatment services. The goal would be to make full use of all providers based on their respective knowledge, skills and abilities.		All primary care services, where feasible, should be provided or coordinated through a network of Community Health Centres. These would be viewed as the physical 'nucleus' of primary care in the community.	Yes		Other providers could be accessed via telehealth and/or on site at the Community Health Centre.

\*Electronic Health Record

Source: Library of Parliament

# **Part III: The Health Care Guarantee**







## CHAPTER FIVE

### TIMELY ACCESS TO HEALTH CARE

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Most of Volume Six covers specific issues relating to the delivery of health care. Hospital restructuring, financing health care, primary health care reform and expanding public coverage for prescription drugs, some home care and palliative care are all critical components of a fiscally sustainable health care system. This chapter, however, focuses on a less frequently discussed, but very important, issue – the right to health care and the implications of the *Canadian Charter of Rights and Freedoms* (the Charter) for the provision of *timely* access to medically necessary care.

*Timely* access to needed care does not necessarily mean immediate access. Nor is the issue of timely access limited to life-threatening situations. Timely access means that service is being provided consistent with clinical practice guidelines to ensure that a patient's health is not negatively affected while waiting for care.

***The Committee feels it is important to stress that timely access to needed care does not necessarily mean immediate access. Nor is the issue of timely access limited to life-threatening situations. Timely access means that service is being provided consistent with clinical practice guidelines to ensure that a patient's health is not negatively affected while waiting for care.***

The issue of timely access to health care is of particular importance at this time for the following reasons. First, repeated public opinion polls increasingly have shown that the greatest concern Canadians have about the existing publicly funded health care system is the perceived length of waiting times for diagnostic services, hospital care and access to specialists. This concern is evidence that timely access to health care – as that is defined by patients – is often not available.

Second, the lack of timely access to needed care can seriously contribute to the deterioration of a person's health and well-being. Given this fact, it is likely that increasing pressures will be exerted on governments, hospitals and physicians to ensure that medically necessary care is provided, within the publicly funded health care system, in a timely manner. It is also very likely that, failing substantial improvement, Canadians will exert pressure on government to make it legally possible for individuals to obtain timely care in a parallel private hospital and doctor system.

Third, if the pressure on government is not effective, for the reasons described below, the Committee believes that the courts are likely to rule unconstitutional current laws that effectively prevent Canadians from paying privately, in Canada, for health care services that are publicly insured.

Therefore, 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.

Do Canadians have a right to health care? Can Canadians be prevented from obtaining timely care when the publicly funded health care system fails to ensure timely access? This chapter addresses these questions.

## 5.1 The Right to Health Care – Public Perception or Legal Right?

To begin, it is important to distinguish between a legal right to health care and the public perception of the existence of that right. In Volume Four, the Committee noted the existence of public opinion polls that reveal that Canadians, encouraged by politicians and the media, believe they have a constitutional right to receive health care even though no such right is explicitly contained in the Charter.<sup>149</sup> Nor does any other Canadian law specifically confer that right, although government programs exist to provide publicly funded health services.<sup>150</sup>

***The Committee has previously noted the existence of public opinion polls that reveal that Canadians believe they have a constitutional right to receive health care even though no such right is explicitly contained in the Charter.***

The preamble to the *Canada Health Act*<sup>151</sup> (the Act) states that:

*continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.*

As well, section 3 of the Act provides that the primary objective of Canadian health care policy is:

*to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.*

These statements from the *Canada Health Act*, supportive as they are, do not grant a right to health care.

Similarly, international instruments such as the *Universal Declaration of Human Rights, 1948*, to which Canada is a signatory, speak of the right to a standard of living adequate for health and well-being, including medical care and the right to security in the event of sickness and disability; but they too do not provide a basis for a constitutional, or even legal, right to health care.<sup>152</sup>

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<sup>149</sup> Volume Four, p. 38.

<sup>150</sup> Colleen Flood and Tracy Epps, *Can a Patients' Bill of Rights Address Concerns About Waiting Lists?* Draft Working Paper, Health Law Group, Faculty of Law, University of Toronto, October 9, 2001, p. 7.

<sup>151</sup> R.S. 1985, c. C-6.

<sup>152</sup> The Canadian Bar Association Task Force on Health Care, *What's Law Got To Do With It? Health Care Reform in Canada*, (Ottawa: The Canadian Bar Association, August 1994) p. 24.

Clearly, there is a significant discrepancy between what the public believes and the absence of a legal right to health care.

Despite the absence of a legislated right to health care, there is a growing body of literature and court decisions on the effect of the *Canadian Charter of Rights and Freedoms* in the context of health care. Of particular interest are the implications of section 7 of the Charter for the provision of timely health care in Canada.

## **5.2 The Extent to which Publicly Insured Health Services are Available Outside the Publicly Funded Health Care System**

In Volume Four, the Committee discussed the impact of the *Canada Health Act* on the provision of privately funded health care. We stressed that the Act does not prohibit the provision of privately paid-for health services. Rather, the Act sets out the conditions under which the provinces and territories will receive or be denied full federal funding for providing medically necessary physician and hospital services to their residents.<sup>153</sup>

In order to receive full federal funding, provincial and territorial public health care insurance plans must meet the five key conditions: public administration, comprehensiveness, portability, universality and accessibility. The *Canada Health Act* also creates an important incentive for the provinces and territories to discourage doctors and hospitals from extra-billing patients or imposing user charges for medically necessary health services. If extra-billing occurs or user charges are required, the federal cash contribution provided under the CHST can be reduced by an equivalent amount.

The *Canada Health Act* does not contain prohibit health care providers who do not bill their provincial health care insurance plans from delivering, and being compensated privately for, provincially insured health services. Moreover, the Act does not limit, in any way, the delivery of publicly insured services by privately owned (not-for-profit or for-profit) service delivery institutions. Indeed, private health care institutions currently deliver publicly insured health services in every province. What the *Canada Health Act* does is provide for significant financial penalties when provinces allow private payments for publicly insured services, particularly where extra-billing and user charges are involved.

Provincial and territorial legislation work in tandem with the *Canada Health Act* to discourage and/or prevent medically necessary services from being provided outside the publicly funded health care system. Physicians can opt out of providing services in the public health care system and bill patients directly, but a variety of provincial regulations effectively discourage physicians from doing so. Many provinces prohibit opted-out doctors from charging patients more than the public system rate. Some provinces deny reimbursement to patients who receive insured health services from opted-out doctors. Moreover, the majority of provinces do not permit private health care insurance to be purchased for services insured under provincial health

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<sup>153</sup> Volume Four, pp. 38-39.

care plans, even though all of them allow residents to purchase private insurance for hospital and physician services that are not classified as “medically necessary.”<sup>154</sup>

In Volume Four, the Committee said:

*The Canada Health Act along with provincial/territorial legislation has prevented the emergence of a private health care system that would compete directly with the publicly funded one. It is simply not economically feasible for patients, physicians or health care institutions to be part of a parallel system.*<sup>155</sup>

The end result is that Canadians have few, if any, real options in this country when the publicly funded health care system fails to provide timely care. Those who can afford to do so may seek care in the United States, but most simply wait hoping, sometimes in vain, that the public system can accommodate them.

***The Committee is concerned that Canadians have few, if any, real options in this country when the publicly funded health care system fails to provide timely care. Those who can afford to do so may seek care in the United States, but most simply wait hoping, sometimes in vain, that the public system can accommodate them.***

### **5.3 Timely Health Care and Section 7 of the Canadian Charter of Rights and Freedoms**

The presence of long waiting lists for certain medically necessary treatments and hence the absence of timely care raise a number of issues, not the least of which relate to the rights and entitlements of patients who are waiting for care. In this regard, in its Volume Four, the Committee posed the following questions:

*If a right to health care is recognized under section 7 of the Charter, and if access to publicly funded health services is not timely, can governments continue to discourage the provision of private health care through the prohibition of private insurance?*

*Is it just and reasonable in a free and democratic society that government ration the supply of publicly funded health services (through budgetary allocations to health care) and simultaneously, effectively prevent individuals from obtaining the service in Canada, even at their own expense?*<sup>156</sup>

These questions have provoked considerable debate that, in the Committee’s view, has significant implications for the Canadian health care system, as we know it. Indeed,

<sup>154</sup> Colleen M. Flood, Tom Archibald, “The illegality of private health care in Canada”, *Canadian Medical Association Journal*, March 20, 2001, 164 (6), p. 825-830.

<sup>155</sup> Volume Four, p. 40.

<sup>156</sup> *Ibid.*

the Committee raised these questions both to stimulate discussion and to caution governments that policies and laws that restrict, or discourage, access to privately funded health care will be increasingly difficult, if not impossible, to maintain if timely access to medically necessary care is not provided in the publicly funded system.

Thus, in the Committee's opinion, the failure to deliver timely health services in the publicly funded system, 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.

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The *Canadian Charter of Rights and Freedoms* guarantees certain fundamental rights and freedoms. Section 7 of the Charter states:

*Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*

Although the Charter makes no explicit references to health care, it has been argued that section 7 has significant implications in the health care question. The section 7 argument is not based on a constitutional guarantee to government-funded health care, but rather on the section 7 rights to liberty and security of the person which, it could be argued, may be impaired if adequate and timely health care cannot be provided in the publicly funded health care system.

These rights, then, could be interpreted to imply that if individuals are unable to get timely care within the publicly funded health care system, governments should not be able to prevent an individual from paying for the service in order to obtain the service elsewhere in Canada. That is, while health care itself may not be a right, individuals do have the right not to be prevented by government from seeking timely health care elsewhere in Canada, if the service cannot be provided in a timely manner within the publicly funded system.

In 1994, the Canadian Bar Association Task Force on Health Care expressed the opinion that there is no right to health care under the Charter. This conclusion was based on the view that the Charter is often interpreted as a negative rather than a positive instrument – one that generally does not compel governments to act in a particular manner, but rather protects Canadians against coercive government action.<sup>157</sup>

In the context of health care, then, the Charter might not require governments to ensure that a certain level of health care is available in the publicly funded system, but the

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<sup>157</sup> *What's Law Got To Do With It? Health Care Reform in Canada*, (1994) p. 26.

Charter could be employed to stop governments from taking restrictive measures that deny individuals from having the freedom to seek health care on their own in Canada when the publicly funded system fails to provide such care in a timely manner.

Indeed, the Task Force pointed out that individuals could advance the legal argument that section 7 includes a right to purchase health services when government cannot ensure, or is not willing to ensure, the provision of adequate services (which could clearly include a government not providing the service in a timely manner).<sup>158</sup>

Legal experts told the Committee that section 7 has application to health care and it is just a matter of time before its parameters are explored more thoroughly in the courts. Recent judicial decisions give evidence of a probable expansion of the Charter in relation to health care. Cases based on section 15 of the Charter, the equality section, have had some success.<sup>159</sup> But the implications of section 7 for timely access to health services have yet to be fully tested in the courts.

In a recent C.D. Howe Institute Commentary, entitled *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*,<sup>160</sup> authors Stanley Hartt and Patrick Monahan examine whether governments can prohibit or impede Canadians from accessing medically necessary health services by paying for them privately, if timely access to such services is not available in the publicly funded health care system.

Basing their analysis on section 7<sup>161</sup> of the Charter, Hartt and Monahan conclude that, when the publicly funded health care system fails to provide timely access to medically necessary care, restrictions on private payment or the purchase of private health care insurance violate an individual's right to liberty and security of the person guaranteed by section 7 and are inconsistent with the principles of fundamental justice. Because this Commentary is probably the most detailed examination of the application of section 7 in the health care context to date, the Committee believes it is worth outlining Hartt and Monahan's arguments in some detail.

Hartt and Monahan maintain that an individual's decisions with respect to his or her medical care are fundamental personal decisions affecting health, life and death and are therefore protected under the section 7 liberty guarantee. Consequently, when governments effectively prevent individuals from obtaining health care outside the publicly funded system, they have a concomitant obligation to ensure that timely care is provided within that system.

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<sup>158</sup> *Ibid.*, p. 94.

<sup>159</sup> In *Eldridge v. British Columbia (Attorney General)* [1997] 3 SCR 624, the Supreme Court of Canada held that the provincial government's failure to fund sign-language interpreters in hospitals under its public health insurance system discriminated against deaf patients on the basis of physical disability and violated their equality rights under section 15 of the Charter.

<sup>160</sup> Stanley H. Hartt Q.C., Patrick J. Monahan, *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*, C.D. Howe Institute, Commentary, No. 164, May 2002.

<sup>161</sup> According to Hartt and Monahan (p. 9), a claim under section 7 of the Charter has three aspects:

1) An action of a legislature or government that deprives a person of one or more of "life, liberty and security of the person"; 2) The deprivation must be contrary to the principles of fundamental justice; 3) The violation cannot be justified under section 1 of the Charter, which requires that a violation of a protected right must be a "reasonable limit" that can be demonstrably justified in a free and democratic society.

Hence, when the public system cannot or will not deliver timely care, Hartt and Monahan argue that individuals should be free to acquire the necessary care elsewhere. And hence, under these circumstances, restrictions on the ability to access care outside the public system, including restrictions on the right to buy private health care insurance, constitute a violation of the right to make personal decisions affecting life and health as provided under section 7's liberty guarantee.<sup>162</sup>

The right to security of the person under section 7 has both a physical and a psychological aspect which, on the basis of the 1988 Supreme Court of Canada decision in the *Morgentaler* case, Hartt and Monahan interpret as encompassing the adverse physical and psychological impacts associated with excessive waiting for medical care. They assert:

*Where governments institute measures that delay or impede access to medically necessary services and where that delay materially increases medical risks or otherwise results in adverse health consequences, the violation of security of the person is clear.*<sup>163</sup>

Even if there is a limitation on the right to liberty or security of the person, however, section 7 will not be violated unless it can be shown that the limitation is inconsistent with the "principles of fundamental justice." While the courts have concluded that fundamental justice has both procedural and substantive aspects, the term has not been specifically defined. Hartt and Monahan argue that it is manifestly unfair, and therefore contrary to the principles of fundamental justice, to establish a system where medically necessary services are for all intents and purposes accessible only through the public health care regime but are unavailable on a timely basis.<sup>164</sup>

Consequently, Hartt and Monahan maintain that, if health services are not available on a timely basis, then provincial governments cannot legally prohibit Canadians from obtaining those services in Canada, nor can the federal government use the financial penalties in the *Canada Health Act* to compel the provinces to enforce constitutionally invalid restrictions.<sup>165</sup> In other words, governments cannot fail to ensure the provision of timely access to medically necessary health services and at the same time prevent Canadians from obtaining such services outside the publicly funded system. This includes governments being unable to prevent Canadians from acquiring private health care insurance to cover the cost of purchasing such services outside the publicly funded system.

***Hartt and Monahan maintain that, if health services are not available on a timely basis, then provincial governments cannot legally prohibit Canadians from obtaining those services in Canada, nor can the federal government use the financial penalties in the Canada Health Act to compel the provinces to enforce constitutionally invalid restrictions.***

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<sup>162</sup> *Ibid.*, p. 17.

<sup>163</sup> *Ibid.*, p. 15.

<sup>164</sup> *Ibid.*, p. 20-21.

<sup>165</sup> *Ibid.*, p. 5.

It would follow, if Hartt and Monahan are correct, that the Charter would prevent the prohibition by government of an individual's right to obtain health services privately when the government fails to provide such services in a timely manner:

*Existing restrictions on the private purchase of medically necessary services are entirely justifiable in circumstances where such medical services are available on a timely basis through the public system,*<sup>166</sup>

*(...) where the publicly funded health care system fails to deliver timely access to medically necessary care, governments act unlawfully in prohibiting Canadians from using their own resources to purchase those services privately in their own country. In these circumstances, the restrictions on private payment and private health insurance that are found in the laws of various provinces force Canadians into a system that, at a minimum compromises their health and potentially may endanger their lives.*<sup>167</sup>

However, Hartt and Monahan's analysis does not conclude that the only remedy is for government to relax the restrictions on an individual's ability to purchase private health care insurance. Indeed, Hartt and Monahan believe governments can do one of two things – governments can either finance and structure the publicly funded health care system in such a way that it provides timely access to medically necessary care, or they can allow Canadians to buy that care if such access is not available in the publicly funded health care system in a timely manner.<sup>168</sup>

The Committee finds the Hartt and Monahan analysis compelling. However, at the same time, it should be noted that the Quebec Superior Court reached a different conclusion in a case [*Chaoulli c. Québec (Procureure général)*]<sup>169</sup> where section 7 of the Charter was used to dispute the Quebec government's prohibition on the purchase of private health care insurance to pay for the private provision of health services which are also covered under the provincial health care insurance plan. *Chaoulli* dealt with the plaintiff's wish to buy private insurance for future care and treatment to which timely access *might* be denied. In other words, the *Chaoulli* case dealt with potential future events that *might* possibly take place, and not with events that had already occurred. Thus, the *Chaoulli* case is not directly on the issue discussed in the Hart and Monahan paper because it is dealing with a speculative future event.

**Governments can do one of two things – governments can either finance and structure the publicly funded health care system to provide timely access to medically necessary care, or they can allow Canadians to buy that care if such access is not available in the publicly funded health care system in a timely manner.**

<sup>166</sup> *Ibid.*, p. 3.

<sup>167</sup> *Ibid.*, p. 4.

<sup>168</sup> *Ibid.*

<sup>169</sup> [2000] J. Q. No. 470 (QL) (C.S.Q. Piche J.)



The Quebec Superior Court refused the Chaoulli claim, concluding that, although prohibitions on private insurance could violate rights of liberty and security of the person under section 7 of the Charter, it was nevertheless consistent with the principles of fundamental justice under section 7 to deny the ability to purchase private insurance for medical services covered under the Quebec public health care insurance plan.<sup>170</sup>

In determining whether the Quebec restrictions were consistent with the “principles of fundamental justice” and therefore not a violation of section 7, the Court sought to balance the right to purchase private health care insurance against the collective goal of ensuring equal access to medically necessary health services for all Quebec residents. To allow private health care insurance, in the court’s view, would compromise the integrity, proper functioning and viability of the publicly funded health care system.<sup>171</sup> In reflecting on this court decision, it is important to keep in mind that this was a decision by a court of first instance and has yet to be commented on by an appellate court or by the Supreme Court of Canada.

It is also worth noting that this conclusion was reached in spite of the fact that in European countries and Australia, which have universal and publicly funded health care systems, the purchase of private health care insurance is permitted and does not appear to have caused irreparable damage to the functioning and viability of their publicly funded health care systems.

It must also be pointed out that experience in these countries severely weakens the argument which some have made that even if the prohibition on purchasing health care insurance violates an individual’s right to timely health care, this violation can be justified under section 1 of the Charter. In order for this argument to be valid, the violation must be a “reasonable limit” that can be “demonstrably justified in a free and democratic society.” Since other free and democratic societies have universal health care systems and also allow individuals to purchase health care insurance which can be used to cover the cost of obtaining such services outside the publicly funded system, and since the health care systems in these countries appear to function effectively, the courts may be unwilling to accept the argument that the violation of an individual’s right to timely health care (by prohibiting a parallel private system) is a “reasonable limit that can be demonstrably justified.”

Although not argued on Charter grounds, another Quebec case (*Stein v. Quebec (Régie de l’Assurance-maladie)*) took a different approach by holding the provincial government responsible for reimbursing a patient’s medical expenses incurred in the United States for treatment for a life-threatening condition when timely access to the required care was not available in Quebec.<sup>172</sup> In the Stein case, the patient was advised to seek surgery for life-threatening cancer no later than four to eight weeks after the diagnosis. After waiting longer than the suggested period for the required treatment, Stein sought medical care in New York. Subsequently, Stein contested the Quebec health care insurance board’s refusal to reimburse his medical expenses. The court sided with Stein, noting that in his circumstances, where the danger to his life was increasing daily, it was unreasonable for him to have to wait for surgery in Montreal. In this case, it is worth noting the emphasis the court placed on timely access to care.

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<sup>170</sup> *Ibid.*, para. 243.

<sup>171</sup> *Ibid.*, para. 261-263.

<sup>172</sup> *Stein v. Québec (Régie de l’Assurance-maladie)*, [1999] QJ No. 2724.

## 5.4 Committee Commentary

Even though Canadian courts have not yet established a right to health care under the Charter, it is clear to the Committee that, 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 increasingly difficult, if not impossible, to justify. The rights to liberty and to security of the person under section 7 of the Charter are likely to be violated when timely access to publicly funded health care is denied and, simultaneously, Canadians are effectively prevented from obtaining the required care elsewhere in Canada.

***The failure to address effectively the issue of the lack of access to timely care is also highly likely to lead to the establishment of a parallel private hospital and doctor system.***

The failure to address effectively the issue of the lack of access to timely care is also highly likely to lead to the establishment of a parallel private hospital and doctor system. Therefore, solving the waiting time issue, or lack of timely care problem, is critical if Canada is to preserve the single payer model of health care that Canadians, and the Committee, so strongly support.

It is the Committee's strong belief that governments should not be passive and wait for the courts to determine how Canadians will gain timely access to medically necessary care. The time has come when governments *must* address the waiting time problem.

Governments cannot continue to turn a blind eye to the increasing problem of the lack of timely access to health care. They, and the providers of care themselves – particularly hospitals and physicians *must* find a solution to the problem of providing timely access to appropriate levels of health care.

The Committee's preferred approach to solve the problem of long waiting times, and thus avoid the development of a parallel private system, is twofold: first, more money must be invested in health care for the purposes described in the other chapters of this report; and second, governments must establish a national health care guarantee – a set of nationwide standards for timely access to key health services – the parameters of which we explore in the next chapter.

***It is the Committee's strong belief that governments should not be passive and wait for the courts to determine how Canadians will gain timely access to medically necessary care. The time has come when governments must address the waiting time problem.***

#### 6.1 The Public Perception of the Problem of Waiting Lists

The accessibility principle of the *Canada Health Act* stipulates that Canadians should have “reasonable access” to insured health services. However, the Act does not define what constitutes reasonable access. Lately, concerns about access to health care have been associated with the problem of waiting lists and times – that is, lack of timely access is increasingly perceived to be a major problem plaguing the health care system. Of course, “timely” is a subjective word; what is timely to one person may be an eternity for another, particularly where illness is involved. Nevertheless, the Committee believes that “timely access” describes more accurately what the public expects from the publicly funded health care system than “reasonable access.”

Results of a study conducted by Statistics Canada released in July 2002<sup>173</sup> provide, for the first time, a reliable indication of the extent to which Canadians perceive lengthening waiting times to be a major failing of the publicly funded health care system. The survey revealed that “almost one in five Canadians who accessed health care for themselves or a family member in 2001 encountered some form of difficulty, ranging from problems getting an appointment to lengthy waiting times.”<sup>174</sup> And, of the estimated 5 million people who visited a specialist, roughly 18%, or 900,000 people, reported that waiting for care affected their lives. The majority of these people (59%) reported worry, anxiety or stress. About 37% said they experienced pain. The report concluded that:

***The Committee learned that almost one in five Canadians who accessed health care for themselves or a family member in 2001 encountered some form of difficulty, ranging from problems getting an appointment to lengthy waiting times.***

*Perhaps the most significant information regarding access to care was about waiting times. According to the results of the survey, Canadians reported that waiting for services care was clearly a barrier to care... Long waits were clearly not acceptable to Canadians, particularly when they experienced adverse affects such as worry and anxiety or pain while waiting for care.*<sup>175</sup>

These new Statistics Canada data suggest strongly that the anecdotal evidence concerning the growing problem of waiting lists cited by the Committee previously corresponds to a real and growing problem confronting the publicly funded health care system in Canada.

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<sup>173</sup> *Access to Health Care Services in Canada, 2001*, Claudia Sanmartin, Christian Houle, Jean-Marie Berthelot, and Kathleen White, Statistics Canada, June 2002.

<sup>174</sup> Statistics Canada, *The Daily*, July 15, 2002.

<sup>175</sup> *Access to Health Care*, p. 21.

The Committee is firmly convinced that this problem must be addressed. The status quo is simply unacceptable. Before presenting the Committee's recommendations, this chapter examines Canadian and international experience in dealing with the problem of waiting times.

## 6.2 The Reality of the Waiting List Problem

One of the aspects of the waiting list issue that the Committee has found most troubling is the lack of accurate data on the numbers of Canadians who must wait to consult specialists, obtain diagnostic procedures or receive treatment in a hospital, and the absence of accurate

***One of the aspects of the waiting list issue that the Committee has found most troubling is the lack of accurate data on the numbers of Canadians who must wait to consult specialists, obtain diagnostic procedures or receive treatment in a hospital, and the absence of accurate data on the length of time they are having to wait and for what services relating to what diseases, conditions and indications.***

data on the length of time they are having to wait and for what services relating to what diseases, conditions and indications. This lack of data poses a serious dilemma for public policy makers. There is strong public perception of a serious waiting list problem, but few or no data by which to measure the extent of that problem, and few standards and protocols to assign needs-based priority to those waiting for treatment.

On the one hand, whether a social problem is real or only perceived, governments naturally want to be seen to be responding to it. On the other hand, with regard to the waiting list problem, if, from the perspective of genuine clinical need (as opposed to patient demand), the health of patients is not being compromised while waiting for diagnosis or treatment, there is little justification for spending a lot of money increasing the supply of the health care resources in question. Determining the true extent of waiting list problems, and their impact on the health and well-being of the people affected, is fundamental to formulating an appropriate public policy response.

What is known is that there are two excellent examples of objectively prioritized waiting lists in Canada – the Cardiac Care Network of Ontario and the Western Canada Waiting List Project. These show that, with the creation of disciplined waiting lists in which patients receive treatment according to their priority of need and within a timeframe set by clinical guidelines, the problem of waiting and the perception that the times are too long can be alleviated and in many cases resolved.

These examples also show that the use of needs-based clinical guidelines for waiting list management makes clear the real need for new resources; i.e., when patients with prioritized need cannot be provided with timely access by waiting list management alone and hence when new resources are needed. Moreover, if new resources are required, whether the resources be money, equipment, health care providers or hospital beds, a needs-based approach to managing waiting lists shows clearly what type, and how much, of the various new resources are required.

From a policy standpoint, therefore, it is essential that Canada begin to develop, as quickly as possible, an accurate database on waiting lists together with needs-based service

criteria for people waiting for care, like the criteria described in the next section. Indeed, one of the reasons for the Committee's emphasis on the need for a dramatic and accelerated improvement in health information systems (see Chapter Ten) is precisely to enable the development of prioritized waiting lists and data on their application.

However, the Committee believes that Canadians should not have to wait until completion of this essential step to address a problem that should have been tackled years ago. Patients and their families must see clear evidence, first, of governments' determination to act and second, of progress on the waiting list problem. Therefore, in section 6.5 below, the Committee recommends that a "health care guarantee," that is, a set of needs-based maximum waiting times, be put in place *immediately*.

### **6.3 Canadian Experience**

As stated above, two Canadian examples provide strong evidence that it is possible to tackle the problem of waiting lists.

#### **6.3.1 Cardiac Care Network of Ontario**

The Cardiac Care Network of Ontario (CCN) has long been recognized as a model for managing waiting times, primarily by creating a needs-based priority order of waiting. Established in 1990 to coordinate, facilitate and monitor access to advanced cardiac care as well as to advise the ministry on adult cardiac care issues, CCN has since developed processes to facilitate and monitor patient access, a broad range of guidelines for cardiac services and a comprehensive provincial cardiac information system to support the provision of care, research and continuous improvement in services. Initially focused on cardiac surgery, CCN's priorities have been broadened to include catheterization, angioplasty and stents, as well as pacemakers, implantable cardiac defibrillators and cardiac rehabilitation.

CCN uses information about patients and their medical condition to calculate an urgency rating score (URS). The URS is a guideline to aid in prioritizing patients' need for care, i.e., a disciplined waiting list based on relative need for the services concerned. It is also used in monitoring the timely availability of care throughout the province. Regardless of the service needed, the more serious a patient's condition (as determined by the patient's URS), the sooner he or she receives care. As a result of CCN's efforts, waiting times for bypass surgery have dropped substantially since the mid-1990s. Median waiting times for patients whose need is considered to be urgent have consistently remained at about three days, regardless of variation in the total number of patients on the list.<sup>176</sup>

#### **6.3.2 The Western Canada Waiting List Project**

The results of the Western Canada Waiting List (WCWL) project, published in March 2001,<sup>177</sup> indicate that it may be possible to generalize the kind of system employed by the

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<sup>176</sup> See the submission of the Cardiac Care Network to the Commission on the Future of Health Care in Canada, October 29, 2001.

<sup>177</sup> *From Chaos to Order: Making Sense of Waiting Lists in Canada*, Final Report, the Western Canada Waiting List Project, March 2001.

CCN and apply it to other major illnesses and procedures. The WCWL project is a collaborative undertaking by a variety of organizations, including regional health authorities, provincial medical associations, provincial ministries of health, and health research centres. It was established to address the perception of significant and long-standing problems of access to health care in Western Canada and to influence the way in which waiting lists are structured, managed, and perceived.

In Canada, patient prioritization is not standardized for any medical service (with the exception of CCN in Ontario). This means that there is currently no provincially or nationally accepted method of measuring or defining waiting times for medical services, nor are there standards and criteria for “acceptable” waits for the vast majority of health services. It is impossible, therefore, to determine whether, from a clinical point of view, patients have waited a reasonable or unreasonable length of time to access care. The absence of standardized criteria and methods to prioritize patients waiting for care means that patients are placed and prioritized on waiting lists based on a range of clinical and non-clinical criteria that vary by individual referring physician across institutions, regional health authorities, and provinces.

Production of physician-scored point-count tools for assigning priority to patients on waiting lists was the overarching goal of the WCWL project. This task was carried out in five significantly different clinical areas: cataract surgery; general surgery procedures; hip and knee replacement; MRI scanning; and children’s mental health. A set of priority criteria and a scoring system were developed through extensive clinical input from panel members. These went through several stages of empirical work assessing their validity and reliability. Clinicians who tested the priority setting tools generally concluded that they had the potential to be useful in clinical settings.

The results from the WCWL project indicate that clinicians, administrators, and the public believe that better management of waiting lists is necessary, possible and appropriate. What is necessary now is to develop appropriate standards and criteria to work out acceptable waiting times for patients at different levels of priority of need. The WCWL was not able to undertake this work, given that it was not part of the mandate associated with its funding.

Nonetheless, the authors of the WCWL final report contended that there is a strong possibility of achieving some semblance of order in establishing treatment priorities and access to elective care. Experience from other jurisdictions has shown that systematic approaches and priority setting techniques can be used to improve the management of waiting times. Research conducted for the WCWL project<sup>178</sup> suggested a number of approaches to make this happen, including the following:

- the process to establish standard definitions for waiting times should be national in scope
- standard definitions should focus on four key waiting periods – waiting for primary care consultation; for initial specialist consultation; for diagnostic tests; and for surgery.

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<sup>178</sup> Sanmartin, Claudia, “Toward Standard Definitions of Waiting Times for Health Care Services,” p.361.

As CCN and the WCWL clearly show, substantial improvement in both the reality and perception of the waiting list problem is possible through adopting an approach based on the clinical needs of patients on waiting lists. Since few or no data are yet available to establish how much the problem can be improved with new waiting list management techniques, there are those who suggest that it would be jumping the gun to act before the real, as opposed to the perceived, extent of the waiting list problem is fully understood. They believe that implementing measures such as the Committee's proposed health care guarantee (described in section 6.5, below) would be premature. The Committee rejects this point of view. In the Committee's view, Canadians deserve a health care guarantee *now*. At the least, such a guarantee would serve as a spur to the creation of the necessary standards, criteria and information systems. Certainly, a health care guarantee would alleviate much of the current anxiety of patients and their families.

***In the Committee's view,  
Canadians deserve a health  
care guarantee now.***

## **6.4 International Experience**

While there are no definitive conclusions to be drawn from international experience, there is evidence that establishing formal maximum waiting times for specific procedures can have a positive influence on reducing actual waiting times. Several factors limit the lessons that can be drawn from international examples. In the first place, health care systems are extremely complex and are rooted in the particular history and culture of the country in which they operate. With respect to the specification of maximum waiting times – or what the committee has called the health care guarantee – experience is limited to a small number of countries, is very recent, and recommended maximum waiting times have been subject to revision. Despite these caveats, the Committee believes it is possible to draw on international experience to improve the situation relating to waiting times in Canada.

### **6.4.1 Sweden**

In its previous reports,<sup>179</sup> the Committee referred to the Swedish experience in the early 1990s with a form of health care guarantee. This guarantee established a maximum waiting time for diagnostic tests (90 days), certain types of elective surgery (90 days), and consultations with primary care doctors (8 days) and specialists (90 days). Sweden also put in place a system where waiting times for major procedures are posted daily on a website. People can check the website and may choose to travel to the hospital and next available physician or surgeon with the shortest waiting time.

In 1997, a revised health care guarantee came into force – the so-called “0/7/90” guarantee. It stipulates that patients must receive care from a nurse practitioner in a primary health care centre the same day and that an appointment with a physician must be offered within seven days. Finally, should a patient need referral to a specialist, an appointment must be offered with three months. When appointments cannot be offered within these time limits, the patient is entitled to see a health care provider in another county at no additional cost. When

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<sup>179</sup> See, for example, Vol. 5, p. 56 and Vol. 3, p. 33.

treatment is required, the health care guarantee states that it must be provided without delay but no maximum waiting times are specified.

Overall, the care guarantee in Sweden appears to do more to improve patients' freedom of choice than constitute a mechanism to regulate waiting times. Under the Stockholm County Council, for example, patients can choose among many providers and institutions but in practice relatively few patients exercise this freedom of choice, and not all even know of its availability. For the most part, Swedes place high value on proximity to care; it seems that the vast majority of patients prefer to receive care in their own county rather than travel elsewhere, even if it means waiting longer.

#### **6.4.2 Denmark<sup>180</sup>**

In Denmark, the Ministry of Health and the Association of County Councils, who are jointly responsible for funding and delivering health care services, agreed in 1993 on a target, to be reached by the end of 1995, of a three-month maximum waiting time for all non-acute surgical treatment. The guarantee was accompanied by financial incentives for the counties to meet this target. But, in spite of increased activity and generally decreasing waiting times, it proved impossible for the counties to fulfill the guarantee and it was subsequently revoked in 1997.

Until very recently, a "political" approach was used to encourage reduction in waiting times by providing associated increases in health care funding. Differentiated targets were developed based on assessments of the impact of waiting times on different patient groups. As of March 2000, targets had been set for life-threatening heart conditions (two, three or five weeks depending on the specific diagnosis and treatment available), breast cancer, lung cancer, uterine cancer and intestinal cancer (two weeks from referral to preliminary investigation, two weeks from patient acceptance of surgery to surgical intervention, and two weeks from surgery to the start of post-surgical treatment).

A central government report published in 2000 indicated that the overall percentage of patients waiting more than three months fell from 32% in 1995 to 28% in 1997 and 21% in 1998. In 1998, 71% of all patients were treated immediately, 14% were treated within a month and 8% had to wait more than three months. The average waiting time for surgical procedures declined from 93 days in 1995 to 87 days in 1997.

Since 1997, the Ministry of Health has posted on the Internet expected waiting times at different hospitals for 24 types of diagnoses. This initiative was intended to broaden patients' ability to choose among hospitals throughout the country. In June 2001, the Social Democratic government announced an investment of 500 million kroner (about \$100 million CAD) to reduce further waiting times for cancer treatment, and followed that with legislation to expand guaranteed minimum waiting times to patients with all forms of cancer.

Nonetheless, in the Danish elections in November 2001, concern over growing waiting times at public hospitals was one of the factors that contributed to the defeat of the

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<sup>180</sup> For a detailed description of the Danish health care system, see *Health Care Systems in Transition: Denmark*, Signild Vallgarda Allan Krasnik and Karsten Vrangbaek, the European Observatory on Health Care Systems, 2001.



Social Democrats at the hands of the right-wing Liberal Party. The new government has since allocated a further 1.5 billion kroner (about \$290 million CAD) to be distributed throughout the publicly funded hospital system solely for the purpose of reducing waiting lists.

The government has also declared that, as of July 1, 2002, patients forced by the public system to wait longer than two months for treatment of any kind have the right to choose a private hospital or a hospital in another country without paying additional fees. As in Sweden, the Danes see this as an extension of patient choice, rather than a true health care guarantee. Mr. John Erik Petersen, Head of Department, Ministry of Health and the Interior, Government of Denmark, who testified before the Committee via videoconference, explained it as follows:

*We introduced a free choice of hospitals among the public hospitals 10 years ago. However, we have not yet had free choice for the few Danish private hospitals, nor hospitals abroad.*

*As of July 1, we are introducing an extended free choice of hospital to include private hospitals and hospitals in other countries in cases where the patient cannot be treated in the public hospitals in his own country or neighbouring counties within two months. That is where the care guarantee comes in. It is not really a guarantee, but it is an extended free choice after two months of waiting time.*

*We also have a care guarantee, but that is only in a few areas of life-threatening cancer and heart diseases. That has been in effect for a year now. That is a guarantee in the sense that the councils, the hospitals, are obliged to find care opportunities for the patient within the time limits, which are shorter than two months. They are obliged to find care for the patient, which is not the case with the extended free choice. You get a free choice to private hospitals or abroad if you wait more than two months, but there is no guarantee that there is a private hospital that will take care of you.<sup>181</sup>*

Interestingly, as in Sweden, the Danes do not expect many people to take advantage of the new guarantees. Mr. Petersen further explained:

*With regard to the two-month time limit, we do not foresee that all waiting times over two months will disappear in Denmark. We know already from the existing free choice among public hospitals that patients often choose to wait longer to be treated at their local hospitals rather than travelling to Europe and other parts of the country, even though Denmark is a rather small country. Therefore, we do not foresee that that many people will take advantage of this offer.<sup>182</sup>*

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<sup>181</sup> Committee Proceedings, June 17, 2002. 64:4.

<sup>182</sup> *Ibid.*, 64:

The Danish witnesses suggested to the Committee that the determination of two months as the period after which Danes could exercise free choice of hospital had more to do with political dynamics than with evidence-based clinical decision-making. This contrasts with the maximum waiting times for cancer and heart diseases that were established on the basis of clinical criteria. Nonetheless, the two-month guarantee represented, in the words of Dr. Steen Friberg Nielsen, CEO, Top Management Academy, Government of Denmark, “a political decision regarding the level of service”<sup>183</sup> that the government was committed to offer its citizens.

## **6.5 Committee Recommendations**

The Committee believes that there are two sets of factors that contribute to the perceived growing problem of waiting times in Canada.

One is the apparent shortage of personnel and diagnostic equipment. In the Committee’s view, these shortages have been severely exacerbated by decisions taken by governments at all levels over the past decade – decisions made as governments sought to reduce health care costs (and other public expenditures) dramatically. This has led to a situation in which some components of the health care system are increasingly unable to respond to the demands that are placed upon them. In a system that strives to treat everyone equally, this imbalance between the supply of services and the demand for them has resulted in growing waiting times, and, as the Statistics Canada data show, growing public concern over their length.

But the lack of disciplined, prioritized waiting lists based on standards, criteria and clinical, need-based data on the condition of patients substantially exacerbates this problem. The absence of data certainly makes it harder to determine what to do about it. In fact, in Canada’s health care system it is impossible to distinguish effectively between genuine, clinically based patient needs on the one hand, and, on the other, patient- and physician-generated demand for immediate service (when waiting would have no impact on the person’s health).

Not all waiting lists are the result of shortages. As already noted, evidence suggests it is possible to reduce these waiting times by tackling them head-on, as CCN has done in Ontario. We strongly suggest that a major factor contributing to growing waiting times has been the slowness of the “players” in the system – hospitals and their specialist physicians and surgeons in particular – to apply systematic management to waiting lists for all major procedures, diagnostic tests and consultations. In the same spirit in which it supports all efforts to improve the efficiency of the health care system, the Committee welcomes attempts to find better ways to manage waiting lists, such as the WCWL project, so that patients in the greatest need are tended to first and that, wherever possible, waiting times for everybody are kept to a minimum. The Committee believes, however, that it is highly unlikely that better management of waiting lists will, on its own, suffice to resolve the waiting list problem. Undoubtedly some of it is attributable to shortages.

The question then arises why the situation has been allowed to deteriorate to the point where almost one in five Canadians reports difficulty in accessing needed health services in a timely manner. In the Committee’s view, one reason is that cost-cutting – or, more precisely,

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<sup>183</sup> *Ibid.*, 64:

the failure to continue to increase funding at the same rate as growth in health care costs – has been an option attractive to government. This option has proven possible to implement relatively easily, the reason being that, to date, governments have not had to bear the burden of the consequences that result from their cost-cutting decisions. Instead, these costs have been borne largely by patients who face longer waiting times for health services.

In keeping with its philosophy that the best way to reform a complex system such as health care delivery is to introduce appropriate incentives for all the players involved, the Committee is firmly convinced that governments must be made to bear the responsibility for their decisions. Thus, the Committee believes that the blame for the waiting list problem should be placed where it belongs – on the shoulders of governments for not funding the system adequately, and jointly on governments and providers of health services, the providers for not developing clinical, needs-based waiting list management systems and governments for not demanding and funding such systems to ensure the rationality of waiting lists, including those that are attributable to underfunding. The Committee believes that governments must pay for the remedy, namely patient treatment in another jurisdiction, while waiting list management systems are being developed and put in place.

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Therefore, the Committee recommends that:

**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 Committee realizes that governments may well take the position that if a patient does not receive timely access for a medically necessary service, and hence becomes entitled to service elsewhere under the health care guarantee, the responsibility (or blame) may rest with the hospital or its physicians for not being sufficiently efficient in the use of existing resources and not managing waiting lists well enough. Under these circumstances, the government may well seek to recover the costs incurred through the care guarantee from the hospital and/or the physician(s) concerned. That is, governments may well place the responsibility for meeting the maximum waiting times on the shoulders of those responsible for actually managing the system. This is reasonable if it can be shown that underfunding is not the sole or even the primary cause of a patient waiting too long for a service.

But this is an issue to be resolved between governments and the institutions and the physicians that they fund. Patients should not be affected. Their sole concern should be to get needed treatments in a timely fashion and to have them paid for publicly. Therefore, in the first instance, governments as the patient's insurer should have the responsibility of meeting the health care guarantee.

***The point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient's health or quality of life is at risk of deteriorating significantly as a result of further waiting. Waiting times would be established by scientific bodies using clinical, evidence-based criteria.***

The point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient's health or quality of life is at risk of deteriorating significantly as a result of further waiting. Waiting times would be established by scientific bodies using clinical, evidence-based criteria. In order to accomplish this, the Committee recommends that:

**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.**

The Committee recognizes that it is necessary to deal simultaneously with both sets of factors noted above. First, the techniques for effectively managing waiting lists based on sound clinical methods must be brought to bear on the management of waiting times in an efficient and equitable manner. Second, for sufficient resources to be made available so that this

can happen, the political will must be there, and government must therefore have an incentive to act appropriately.

Since government has the responsibility for funding an adequate supply of essential services provided by hospitals and doctors, it has an obligation to help them meet reasonable standards of patient service. This is the essence of a patient-oriented system and of the health care “contract” between Canadians and their governments.

A maximum waiting time guarantee gives concrete form to this obligation. Were it to be implemented, such a health care guarantee would mean that government would have to shoulder the responsibility of needed care not being delivered in a timely fashion, provided, of course, the funded hospitals and physicians discharge their parts of the bargain by developing and using clinical criteria to prioritize needs-based waiting lists and by employing their resources in an optimally cost-effective manner. Allowing waiting times to increase would no longer represent a cost-free option for governments, nor for hospitals and doctors, when underfunding is not the primary reason for prolonged waiting, since they would be required to pay to have patients obtain treatment in other jurisdictions.

Other Canadian reports have made similar recommendations for dealing with waiting times. Based on a review of the Swedish experience, the report of the Premier’s Advisory Council on Health in Alberta (the Mazankowski report) recommended the establishment of a care guarantee of 90 days for selected services. According to the Advisory Council, this guarantee would provide an incentive for health care providers and regional health authorities to take appropriate action to manage and shorten waiting lists. Their report stressed that patients may need to give up their preference for a specific physician or hospital if they want to be treated within the 90-day period. In addition, if regional health authorities are unable to provide service within this period, they would have to consider other options, such as getting the service from another region. Services could be provided by either a public or a private provider.

More recently, the Canadian Medical Association endorsed the Committee’s health care guarantee proposal and included it in its document *A Prescription for Sustainability* issued on June 6, 2002. The CMA proposed that “guidelines and standards around quality and waiting times”<sup>184</sup> be established for a clearly defined basket of core services, and argued that “if the publicly funded health care system fails to meet the specified agreed-upon standards for timely access to core services, then patients must have other options to allow them to obtain this required care through other means.”<sup>185</sup> The Committee is pleased that the CMA has adopted its proposal.

## **6.6 The Potential Consequences of Not Implementing a Health Care Guarantee**

There are two pieces of the puzzle that must be in place in order to make significant progress in reducing waiting times, in renewing the health care contract between Canadians and their governments, and in restoring the confidence of the Canadian public in their health care system. First, governments at all levels must back their words with deeds by

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<sup>184</sup> The Canadian Medical Association, *A Prescription for Sustainability*, p. 16

<sup>185</sup> *Ibid.*, pp. 16-17.

committing to a health care guarantee that establishes the right of Canadians to receive the care that they need in a timely manner; and second, this commitment must be applied using the best possible system for managing waiting times.

As the delivery of health care in Canada is a provincial responsibility, the health care guarantee must be adopted by the provinces/territories if it is to be implemented. The Committee believes that the principal way in which the federal government can contribute to the implementation of the health care guarantee is to ensure that there is agreement between the federal and provincial governments on the ways to make the financing of publicly insured health services stable and predictable. The Committee believes strongly that federal funding must be maintained at an adequate and predictable level and discusses in detail issues related to financing in Chapters Fourteen and Fifteen of this report.

Nonetheless, it is important to consider the consequences that would follow from a refusal on the part of the provinces to adopt the health care guarantee. In the preceding chapter, the Committee made the case that governments can no longer have it both ways – they cannot fail to provide timely access to medically necessary care in the publicly funded health care system and, at the same time, prevent Canadians from acquiring those services through private means. Thus, one consequence of not implementing the health care guarantee would be to render it highly likely that the current legal prohibition on the creation of a parallel private health care insurance and delivery system would be challenged successfully in the courts.

A second consequence would be that it would fall to the federal government to consider enacting its own legislation to enforce the health care guarantee. The federal government could, for example, consider setting national maximum waiting times on its own for various procedures, at the expiration of which the health care guarantee would come into effect. When a patient exceeded the maximum waiting time, the federal government could then pay the cost of treating the patient in another jurisdiction, including in the United States, and deduct the cost from the cash it transferred under the CHST to the province in which the patient resides.

Thus the penalty for violating the health care guarantee would be similar to the penalty that provinces now incur for violating the *Canada Health Act*. Currently, in cases where the federal government finds that a province has applied user charges or engaged in extra billing that are prohibited under the Act, it can withhold from the funds it would otherwise have transferred to the province an amount equivalent to what the provinces have received.

Obviously, the adoption of such legislation by the federal government would be highly contentious. However, it would ensure that a national health care guarantee of maximum waiting times came into effect – an outcome that the Committee insists must happen and that the Committee believes would also be strongly supported by the Canadian public.

## **6.7 Concluding Thoughts on the Health Care Guarantee**

The Committee believes that it should be possible for the federal and provincial/territorial governments to reach agreement on a national set of maximum waiting times for various procedures. It passionately hopes that it will not be necessary for unilateral action to be taken by the federal government or for a parallel system of private delivery, financed by private insurance, to emerge as a result of judicial decisions. The Committee has pointed to

these potential consequences of not implementing the health care guarantee only because it categorically rejects the status quo: Canadians in need of medically necessary services *must* be given *timely* access to them.

It is also important to note that the Committee's recommendation that the health care guarantee be implemented overlaps with a number of other important recommendations contained in this report. For example, health information systems and the means of evaluating performance and outcomes such as the Committee has recommended in Chapter Ten must be put in place in order to monitor waiting times across the country, so that patients receive timely treatment and the standards imposed by the health care guarantee can be monitored. In addition, the reform of primary health care delivery along the lines the Committee has proposed in Chapter Four is essential to the efficient and timely provision of health care in the twenty first century.





## **Part IV: Closing the Gaps in the Safety Net**

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## CHAPTER SEVEN

### EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS

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In previous volumes, the Committee highlighted a number of critical issues with respect to prescription drug insurance coverage in Canada and the cost of prescription drugs:

- In recent years, the cost of prescription drugs has escalated faster than all other elements in health care. Spending on prescription drugs accounts for a very significant and increasing share of public sector health care expenditures. The expectation is that the upward pressures on prescription drug costs will continue as new, effective, but very costly, drugs (particularly those genetically tailored to the individual) enter the Canadian market in the next decade.
- The *Canada Health Act* does not apply to prescription drugs used outside the hospital setting, and publicly funded drug coverage varies considerably from province to province. This contrasts sharply with the policy in many OECD countries, in which publicly funded coverage is provided for prescription drugs as well as hospital and doctor services.
- Private insurance coverage for prescription drugs provided through employer-sponsored plans or individual insurance policies varies significantly in terms of design, eligibility and out-of-pocket costs to plan members.
- Despite the availability of both public and private drug insurance plans, many Canadians have no coverage at all for prescription drugs. Moreover, among those with some form of coverage (either public or private), there is substantial variation in its nature and quality.
- Financial hardship due to high prescription drug expenses is increasingly a real risk – indeed, it is a reality – for many individual and families in Canada.

This chapter reviews trends in drug costs and examines the current level of insurance coverage for prescription drugs in Canada. Particular attention is devoted to the absence and insufficiency of coverage for very high prescription drug expenses. The chapter presents the Committee's observations on Canadians' need for enhanced protection against severe or "catastrophic" prescription drug expenses, and its recommendations on how the federal government should contribute to achieving this goal.

***The Committee strongly supports the view that 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.***

As stated in previous volumes, as well as in the present volume, the Committee strongly supports the view that no Canadian should suffer undue financial hardship as a result of

having to pay health care bills. This basic principle at the root of Canadian health care policy should be applied to prescription drug expenses.

## **7.1 Trends in Drug Spending<sup>186</sup>**

The Canadian Institute for Health Information reports that since 1997 spending on drugs (both prescription and non-prescription) has been the second-largest category of health care spending in Canada, behind hospitals but now ahead of spending on physician services. It is expected that final figures will show that in 2001, spending on drugs was equivalent to almost 50% of the amount spent on hospitals.

Spending on drugs has grown from \$3.8 billion in 1985 to \$15.5 billion in 2001. During this 16-year period, data from CIHI show that spending on drugs has grown faster than inflation and beyond the rate attributable to population growth. More precisely, from 1985 to 1992, drug expenditures increased on average by 12% annually. Between 1992 and 1996, they grew by an average of 5% annually. The growth rate then rose to around 10% in 1997 and 1998, and dropped to around 8% in 1999. Although the data have not yet been finalized, the average growth rate of drug spending is expected to have been about 7% in 2000 and 9% in 2001.

Prescription drugs make up the largest component of the total spending on drugs (79% in 2001, up from 67% in 1985). Non-prescription drugs accounted for the remaining 21% of drug spending in 2001 (compared to 33% in 1985). For the most part, non-prescription drugs are purchased directly by consumers and paid for out-of-pocket. By contrast, many payers are involved in the financing of prescription drugs. They include both the public sector (provincial/territorial Pharmacare programs, federal government plans for specific groups and Workers' Compensation Boards) and the private sector (private insurance plans and individuals).

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<sup>186</sup> Most of the information provided in this section is based on data from the Canadian Institute for Health Information, *Drug Expenditure in Canada, 1985-2001*, Ottawa, April 2002. The media release for this report is available on CIHI's Website at [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=media\\_24apr2002\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_24apr2002_e)

**TABLE 7.1**  
**SPENDING ON PRESCRIPTION DRUGS BY SOURCE OF FINANCE**  
**(PERCENTAGE)**

	1985	1988	1999	2001
P/T Governments	40.6	42.6	38.2	42.0
Federal Government	2.3	1.9	2.4	2.4
Workers' Compensation Boards <sup>1</sup>	0.5	0.6	3.1	4.8
<b>Sub-Total Public Sector</b>	<b>43.4</b>	<b>45.1</b>	<b>43.7</b>	<b>49.2</b>
Private Insurers	N/A	30.5	33.5	29.9
Out-of-Pocket	N/A	24.4	22.8	20.9
<b>Sub-Total Private Sector</b>	<b>56.6</b>	<b>54.9</b>	<b>56.3</b>	<b>50.8</b>
<b>Total All Sources</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

1) Data from 1997 and beyond include spending by WCBs as well as the Quebec Drug Insurance Fund.  
N/A: not available.

Source: CIHI (April 2002), *Drug Expenditure in Canada, 1985-2001*, and Economics Division, Parliamentary Research Branch, Library of Parliament.

In 1985, 57% of prescription drug spending came from the private sector (see Table 7.1). By 2001, it had decreased to 51%. Correspondingly, the share of prescription drugs financed from public sources increased steadily from 43% to 49%. Table 7.1 also shows that the total proportion of prescription drugs paid out-of-pocket by individual Canadians has decreased from 24.4% in 1988 to 20.9% in 2001. That is, an increasing share of total prescription drug spending in Canada is being picked up by public sector drug coverage plans.

CIHI data on drug spending do not include drugs dispensed in hospitals, which it classifies as hospital expenditure. Estimates provided by CIHI in its April 2002 report suggest that drug expenditures in hospitals amounted to \$1.1 billion in 2001. In addition, the share of total hospital expenditures spent on drugs has consistently increased between 1985 and 2001, from 2.8% to 3.4%. CIHI notes, however, that the rate of growth in drug expenditures in hospitals has been slower than that of out-of-hospital drug spending. Although there may have been some shift in drug spending from hospitals to the community, CIHI stresses that more research is required to examine the relationship between drug utilization in and out-of-hospital.

Many observers expect out-of-hospital costs of prescription drugs to grow substantially in the coming years, for a number of reasons:

- The cost of developing and marketing new drug therapies has risen rapidly as pharmaceutical companies tackle more challenging diseases and face more stringent drug approval processes around the world.
- Rapid scientific progress has introduced the possibility of developing new genetically tailored drugs, applicable to a small number of patients suffering with chronic degenerative conditions, that are potentially extremely effective and also enormously costly.

- Many of the newer drug therapies are targeted at chronic conditions treated at home, as opposed to acute conditions treated in hospital.
- Changes in medical practice and new technology have replaced some hospital-based treatment with home care, which is now being provided for a number of conditions with high drug therapy costs.

The net effect is that many Canadians now incur high levels of prescription drug costs that were inconceivable only a few years ago.

## 7.2 International Comparisons

In comparison to selected OECD countries, Canada allocates a large proportion of its total health care spending to drugs, ranking second in 1998 to the United Kingdom. In the same year, Canada ranked fourth for the level of drug spending per capita, after the United States, Germany and Sweden. Spending on drugs varies greatly across countries and is influenced by numerous factors, including specific public policy traditions and institutional characteristics (reimbursement systems for users and providers, prescribing habits, etc.).<sup>187</sup>

***Many Canadians now incur high levels of prescription drug costs that were inconceivable only a few years ago.***

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<sup>187</sup> Stephane Jacobzone, *Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals*, Occasional Paper No. 40, Labour Market and Social Policy, OECD, April 2000 ([www.oecd.org](http://www.oecd.org)).

**TABLE 7.2**  
**PUBLIC INSURANCE COVERAGE FOR PRESCRIPTION DRUGS**

	Formulary	Cost Sharing
<b>Australia</b>	<ul style="list-style-type: none"> <li>▪ National formulary listing only drugs that receive a positive assessment with respect to safety, quality, clinical efficacy and cost-effectiveness.</li> <li>▪ Therapeutic reference-based pricing.<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary.</li> <li>▪ Exemptions for some segments of the population.</li> <li>▪ Higher cost sharing for brand-name drugs when generic copies are available.</li> <li>▪ Individuals must pay for drugs not listed on the formulary.</li> </ul>
<b>Germany</b>	<ul style="list-style-type: none"> <li>▪ The federal government maintains a “negative list” of drugs that are not entitled to public reimbursement.</li> <li>▪ Therapeutic reference-based pricing.<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed co-payment per prescription. Co-payment varies by type of beneficiary and size of prescription.</li> </ul>
<b>Netherlands</b>	<ul style="list-style-type: none"> <li>▪ National formulary.</li> <li>▪ Therapeutic reference-based-pricing.<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary.</li> <li>▪ Exemptions for some segments of the population.</li> </ul>
<b>Sweden</b>	<ul style="list-style-type: none"> <li>▪ There is no national formulary, but each county council has developed its own list.</li> <li>▪ All drugs prescribed by doctors and hospitals are purchased by a single national agency, Apotekbolaget, a state-owned company that owns all pharmacies in Sweden..</li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary.</li> <li>▪ Exemptions for some segments of the population.</li> </ul>
<b>United Kingdom</b>	<ul style="list-style-type: none"> <li>▪ National formulary under the NHS.</li> <li>▪ There is also a negative list, that excludes some drugs from NHS prescription on the grounds of poor therapeutic value or excessive cost.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed amount per prescription.</li> <li>▪ Exemptions for some segments of the population.</li> </ul>

<sup>1)</sup> Therapeutic reference-based pricing ensures that the government pays only up to the price of a lower-priced drug that is therapeutically interchangeable with, or equivalent to, the prescribed drug.

Source: Stephane Jacobzone, *Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals*, Occasional Paper No. 40, Labour Market and Social Policy, OECD, April 2000; Donald Willison et al., *International Experience with Pharmaceutical Policy: Common Challenges and Lessons for Canada*, Project funded under Health Canada’s Health Transition Fund, 30 April 2001; Senate Committee on Social Affairs (Volume Three); and Economics Division Parliamentary Research Branch, Library of Parliament.

In contrast, Canada and the United States exhibit a much lower public share of spending on drugs, which is largely explained by the fact that the entire population of other countries is covered for prescription drugs by public insurance. Also, the countries with which Canada and the United States are compared have formularies restricting the number of drugs

covered under public insurance, and they impose cost sharing (co-payments, co-insurance and deductibles) with waivers for certain groups of beneficiaries (see Table 7.2).

### **7.3 Coverage for Prescription Drugs in Canada<sup>188</sup>**

Currently, coverage for prescription drugs in Canada is offered through a mixture of public and private insurance plans described briefly below.

#### **7.3.1 Public prescription drug insurance plans**

With respect to public plans it is worth noting that:

1. All provinces have public prescription drug programs that cover virtually all the drug costs of low-income seniors (those receiving GIS, the Guaranteed Income Supplement), a group that constitutes about 5% of Canada's adult population. This group is thus fully protected from catastrophic prescription drug expenses. All provinces except Newfoundland also offer coverage to higher-income seniors as well.
2. All provinces also have programs that provide prescription drug coverage for recipients of social assistance, a group that comprised 6.8% of the population in 2000, protecting them also from catastrophic prescription drug expenses.
3. The federal government assumes the full cost of providing prescription drugs (as well as other health services) for some Aboriginal populations and certain armed forces veterans. These groups, which account for approximately 2% of the Canadian population, are thereby fully protected against catastrophic prescription drug expenses.
4. Provincial governments in British Columbia, Saskatchewan, Manitoba, and Ontario have prescription drug plans targeted to the general population that provide a protective cap (in some cases based on family income) on the personal cost of drug expenses borne by individuals.
5. Quebec mandates prescription drug coverage with an out-of-pocket cap no greater than \$750 for all residents, whether under employer-sponsored programs or the provincial program.

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<sup>188</sup> This section is based on information provided by Fraser Group/Tristat Resources, *Drug Expenses Coverage in the Canadian Population: Protection From Severe Drug Expenses*, August 2002. This study was sponsored by the Canadian Life and Health Insurance Association at the request of the Committee.



6. Alberta offers to all residents a public, voluntary, premium-based prescription drug insurance plan that provides significant drug expense coverage after a three month waiting period.

In summary, a significant number of public drug plans provide a significant degree of protection against personal financial hardship to Canadians who face very high expenses for prescription drugs. However, the federal government does not directly contribute to any of the provincial plans.

### **7.3.2 Private prescription drug insurance plans**

Private sector drug insurance plans contribute significantly to Canadians' prescription drug coverage:

1. They are an entirely voluntary initiative, sponsored mostly by employers but also by unions, joint union/employer entities and educational institutions. In addition, about 1% of Canadians are covered by health insurance policies purchased individually.
2. An estimated 2.4 million Canadians belong to private-sector plans that cover 100% of prescription drug expenses, thus completely protecting their members from financial hardship attributable to very high drug costs. An additional 300,000 have plans that, in combination with public prescription drug coverage, provide 100% coverage.
3. An estimated 9.7 million Canadians (the 2.4 million mentioned above plus an additional 7.3 million Canadians, totalling 55% of those in private-sector plans) have private-sector plans that include an overall protective cap on the out-of-pocket costs of individual plan members.
4. The remaining 8.1 million Canadians in private-sector plans (45% of those in private-sector plans) have coverage that, for the most part, provides substantial – but not complete – protection from catastrophic prescription drug expenses.

In Volume Four, the Committee recounted the real-life experience of one Atlantic Canadian whose experience illustrated this last point. A professional librarian and member of a good-quality employer-sponsored plan, the individual in question faced personal out-of-pocket costs of \$17,000 annually attributable to his wife's requirement for prescription drugs that cost \$50,000 a year.

The Committee recently heard of another Atlantic Canadian resident whose medication for pulmonary hypertension (a life-threatening condition) costs more than \$100,000 a year. The individual in question's current expenses are over \$4,600 monthly (or \$55,000 annually) in order to cover the insurance premium, the drug, the peripherals needed to administer the drug, additional necessary medications and oxygen tanks. An anticipated increase

in dosage within the next year will increase the monthly bill to approximately \$5,150, or \$61,800 annually. People become eligible for government assistance in this province only once they have exhausted all their savings, including RRSPs.

### **7.3.3 Plan features and their relation to protection from severe drug expenses**

While prescription drug insurance plans have many different features and attributes, only four relate to the extent of protection such plans offer against catastrophic drug expenses. These are: deductibles, co-payments/co-insurance, annual or lifetime maximums, and out-of-pocket caps.

A *deductible* is the amount of drug expense that must be paid initially by an individual before the drug insurance plan reimburses any expense. The deductible is normally applied to a calendar or plan year. Deductibles are commonly expressed as fixed dollar amounts, but some legislated public drug insurance programs use amounts related to family income. Deductibles, unless they are extraordinarily high, usually have minimal impact on the degree of protection a plan provides against catastrophic drug expenses.

*Co-payments and co-insurance* correspond to the portion of the cost of each prescription that must be paid by the individual. Co-payments take the form of a flat amount per prescription (e.g., \$5), while co-insurance requires a fixed percentage per prescription (e.g. 5%). Co-payments can also include the pharmacist's professional dispensing fee (as opposed to the cost of the drug itself). They do not protect individuals, as in the professional librarian example cited above, from very high personal expenses resulting from the prolonged use of very expensive drugs.

An *annual or lifetime maximum* restricts to a specific amount the total amount of prescription drug expenses that a plan will pay on behalf of a plan member. Expenses in excess of this amount are to be paid out-of-pocket. For instance, a plan with a \$5,000 annual maximum would pay no more than that in a given year. The higher the maximum, the greater the protection. It is highly unusual for public prescription drug insurance plans to impose maxima. Some private-sector plans do, but most have unlimited coverage or specify very high annual or lifetime maxima such as a million dollars.

Finally, *out-of-pocket caps* are provisions of plans that restrict the total amount of deductibles, co-payments and co-insurance to be imposed on an individual during a given year. These may be expressed either as a fixed upper limit (e.g., \$1,500) or as an amount related to family income (e.g., 3%). Many prescription drug insurance plans, particularly private-sector plans, do not have explicit caps on out-of-pocket drug expenses. This feature in a drug plan guarantees the insured individual protection against catastrophic prescription drug expenses. The lower this limit, the higher the degree of protection.

## **7.4 An Emerging Issue: Catastrophic Prescription Drug Expenses**

Generally, the direct financial impact of the rise in drug spending described above is relatively modest because the proportion of average household expenditures spent on

prescription drugs remains small in absolute terms. CIHI data show that in 1999 the annual per capita expenditure on prescription drugs was \$331.38, of which \$75.49 was paid for out-of-pocket.

Nonetheless, some individuals and families can and *do* incur much more substantial expenses. While it is important to recognize that this affects relatively few people for the moment, the Committee believes that the problem warrants careful attention because:

1. Most important, some individuals do experience substantial personal financial hardship in paying for drug expenses, thereby frustrating the fundamental objective of Canadian health policy referred to above.
2. Those facing a significant personal financial burden may discontinue (or not begin) treatment requiring expensive medications.
3. Physicians may admit patients to more costly hospital based treatment so they are spared the high costs for drugs dispensed for use out of hospital.
4. Doctors may prescribe and patients may demand cheaper but less effective drugs.
5. Individuals may stay on social assistance rather than seek employment in order to maintain drug coverage.
6. The drug plan to which the affected individual belongs may experience sufficient financial expenditures that it prompts the plan sponsor to limit or discontinue it, thereby reducing or eliminating drug expense protection for all members of the plan. Other drug plan sponsors may take pre-emptive action to reduce the financial risk of catastrophic drug costs to their own plans

Estimates by Fraser Group/Tristat Resources show that currently 98% of the Canadian population is covered by one or more public and/or private prescription drug coverage plans (see Table 7.3). Two percent of Canadians (some 600,000 individuals) have no prescription drug coverage whatsoever and must assume full personal financial exposure in the event they require expensive prescription drugs.

***Two percent of Canadians (some 600,000 individuals) have no prescription drug coverage whatsoever and must assume full personal financial exposure in the event they require expensive prescription drugs.***

**TABLE 7.3**  
**PRESCRIPTION DRUG EXPENSE COVERAGE IN THE CANADIAN POPULATION**

<b>Covered by</b>	<b>Percent of Population</b>
Public Plans	53%
Private Plans	58%
Both Public and Private	13%
No Coverage	2%

Source: Fraser Group/Tristat Resources, Drug Expense Coverage in the Canadian Population: Protection From Severe Drug Expenses, August 2002, p. 11.

Fraser Group/Tristat Resources also analyzed the variations in the current levels of protection from severe drug expenses by province. Tables 7.4 and 7.5 show the percentage of the population of each province that would face various levels of out-of-pocket expenses when confronted with total prescription drug expenses of either \$5,000 (Table 7.4) or \$20,000 (Table 7.5). Each table divides the population of the province into four groups according to how much they would each pay out-of-pocket: (a) those who would pay up to \$750; (b) those who would pay between \$751 and \$2,000; (c) those who would pay over \$2,000; (d) those with no coverage at all.

Thus, for example, Table 7.4 indicates that 70% of B.C. residents with drug expenses of \$5,000 pay no more than \$750 out of pocket, while the remaining 30% of B.C. residents pay between \$751 and \$2,000. In Newfoundland, only 48% of the population who spend \$5,000 on prescription drugs pay up to \$750, while 24% of population of that province pay between \$751 and \$2,000. However, there are also 28% of Newfoundlanders who have no coverage at all and therefore have to pay the full \$5,000.

For those with \$20,000 in prescription drug expenses (Table 7.5), the percentages of B.C. residents with each level of out of pocket expenses remain the same. In Newfoundland, 48% of the population still pay only up to \$750, and the same 28% of the population have no coverage and must pay the full \$20,000. The 24% of the population that paid between \$751 and \$2,000 when faced with drug expenses of \$5,000, now has to pay over \$2000.

While the lack of coverage for a substantial proportion of Atlantic Canada residents remains a striking feature of the national pattern, the tables also point to significant variations in out-of-pocket levels among provinces that have programs covering their entire population. Quebec stands out as having the least variation in protection levels, followed by British Columbia, Manitoba and Saskatchewan.

**TABLE 7.4**  
**OUT-OF-POCKET COSTS FOR PRESCRIPTION DRUG EXPENSES OF \$5,000**  
**(PERCENTAGE OF POPULATION)**

	<b>Up to \$750</b>	<b>\$751 - \$2,000</b>	<b>Over \$2,000</b>	<b>No coverage</b>	<b>Total</b>
BC	70%	30%	0%	0%	100%
ALTA	43%	57%	0%	0%	100%
SASK	68%	24%	8%	0%	100%
MAN	84%	13%	3%	0%	100%
ONT	70%	25%	5%	0%	100%
QC	100%	0%	0%	0%	100%
NB	45%	28%	0%	27%	100%
NS	47%	29%	0%	24%	100%
PEI	48%	25%	0%	27%	100%
NFLD	48%	24%	0%	28%	100%
<b>Canada</b>	<b>73%</b>	<b>23%</b>	<b>2%</b>	<b>2%</b>	<b>100%</b>

**TABLE 7.5**  
**OUT-OF-POCKET COSTS FOR PRESCRIPTION DRUG EXPENSES OF \$20,000**  
**(PERCENTAGE OF POPULATION)**

	<b>Up to \$750</b>	<b>\$751 - \$2,000</b>	<b>Over \$2,000</b>	<b>No coverage</b>	<b>Total</b>
BC	70%	30%	0%	0%	100%
ALTA	43%	0%	57%	0%	100%
SASK	67%	25%	8%	0%	100%
MAN	84%	13%	3%	0%	100%
ONT	70%	12%	18%	0%	100%
QC	100%	0%	0%	0%	100%
NB	45%	0%	28%	27%	100%
NS	47%	0%	29%	24%	100%
PEI	48%	0%	25%	27%	100%
NFLD	48%	0%	24%	28%	100%
<b>Canada</b>	<b>73%</b>	<b>20%</b>	<b>5%</b>	<b>2%</b>	<b>100%</b>

Source: Fraser Group/Tristat Resources, Drug Expense Coverage in the Canadian Population: Protection From Severe Drug Expenses, August 2002, pp. 48-49.

Data from the same group also indicate that coverage for the great majority of Canadians (89%) provides a protective cap on out-of-pocket costs regardless of the amount of high prescription drug expenses. However, 9% of the Canadian population have drug coverage plans without such protective caps, that require co-payments or have reimbursement limits. For these individuals, out-of-pocket costs increase as their prescription drug expenses increase.

In total, 11% of Canadians are at substantial risk of significant financial hardship from high prescription drug expenses paid out of their own pockets. Table 7.6 illustrates the out-of-pocket costs for an individual requiring prescription medications costing \$20,000 per year.<sup>189</sup>

**TABLE 7.6**

Plan Type	Plan Parameters		Out-of-Pocket Cost (\$)
	Deductible	Co-payment	
A common employee benefit plan	0	0	0
Social assistance in many provinces	0	0	0
Indian Affairs NIHB	0	0	0
Another common employee benefit plan	\$25	0	25
Alberta Seniors Plan	0	30% not to exceed \$25 per prescription	About 900 (assuming 3 prescriptions per month)
Quebec RAMQ for individuals under age 65	\$100	25% out-of-pocket (capped at \$750)	750
British Columbia Pharmacare	\$800	0	800
Ontario Trillium Plan (for family income of \$60,000)	4% of adjusted family income		2,400
Most common employee benefit plan	0	20%	4,000
Federal Civil Service	\$60	20%	4,048
Alberta Non-Group Program	0	30%	6,000
No Coverage	N/A	N/A	20,000

In a separate analysis of claims data from a large number of employer sponsored drug plans (approximately half of all plans in Canada), research presented to the Committee showed that for the year 2000:

<sup>189</sup> While this is not a common occurrence, approximately 4,000 individuals in private plans exceeded this level of expense in 2000. A comparable figure for public plans is not available.

- A few individuals had drug expenses exceeding \$200,000.
- About one person per thousand insured had personal medical expenses (supplemental to medicare) exceeding \$10,000. The great majority of these expenses were for prescription drugs.

From these data, it is estimated that some three persons per thousand or about 53,000 persons covered by private-sector plans experienced drug expenses exceeding \$5,000 in the year 2000.

***It is possible to say, therefore, with some confidence that more than 100,000 Canadians experience annual drug expenses exceeding \$5,000; that number is virtually certain to increase in the years ahead.***

Published data from the Ontario Drug Benefit program suggest that the frequency of drug expenses exceeding \$5,000 may be several times higher (between 10 and 20 per thousand) within public plans covering seniors and those unable to work. This is not particularly surprising since public plans cover all seniors, who represent the age segment of the population most likely to make high use of prescription drugs.

It is possible to say, therefore, with some confidence that more than 100,000 Canadians experience annual drug expenses exceeding \$5,000; that number is virtually certain to increase in the years ahead. How these heavy expenses are paid – that is, how much is paid by a private insurance plan, how much by a public insurance plan and how much by the individual out-of-pocket – will, of course, vary from individual to individual.

## **7.5 Protecting Canadians Against Catastrophic Prescription Drug Expenses**

In developing its proposal to expand the federal government's role in health care to include protection against the impact of severe or "catastrophic" prescription drug expenses, the Committee has sought to accomplish two objectives.

First, and foremost, the Committee wants to make sure that no Canadian individual or family is exposed to undue financial hardship as a result of having to pay all, or even a significant fraction, of the costs of extremely expensive and/or prolonged prescription drug treatments. This is entirely consistent with the basic public policy objectives underpinning the system of public health care insurance in Canada.

Second, the Committee wants to create the conditions for long-term sustainability of current prescription drug coverage programs, both provincial public and private supplementary drug insurance plans, in the face of escalating prescription drug costs and the anticipated introduction of increasingly expensive and effective drug therapies.

***Specifically, the Committee's proposal calls for the federal government to take over responsibility for 90% of prescription drug expenses that exceed a certain limit that qualifies them as "catastrophic."***

The Committee's proposed plan therefore builds on, rather than replaces, Canada's extensive current systems of provincial prescription drug coverage and private

supplementary drug insurance plans. The Committee's intent, therefore, is to present a feasible and realistic program that will inject new federal money into expanding available coverage in ways that will protect Canadians against undue financial hardship resulting from severe or catastrophic prescription drug expenses.

Specifically, the Committee's proposal calls for the federal government to take over responsibility for 90% of prescription drug expenses that exceed a certain limit that qualifies them as "catastrophic." The federal government should establish criteria and conditions that private and provincial/territorial public plans would have to meet to be eligible to receive this federal assistance. In exchange, the federal government would assume 90% of the expense of protecting Canadian individuals and families against catastrophic drug expenses. In order to ensure uniformity of coverage throughout the country, and in order to be able to control which drugs are eligible to be covered under this program, it will also be necessary to establish a national drug formulary (see section 7.6, below).

***In order to ensure uniformity of coverage throughout the country, and in order to be able to control which drugs are eligible to be covered under this program, it will also be necessary to establish a national drug formulary.***

The Committee is aware that the final parameters of the catastrophic prescription drug insurance plan would have to be established through negotiations between all the concerned parties – the federal and provincial/territorial governments as well as supplementary drug plan sponsors and carriers. However, the Committee feels that the basic contours of the plan it has worked out constitute a realistic and acceptable framework for implementation.

### **7.5.1 How the plan would work**

To qualify for federal assistance, provinces/territories would have to put in place a program that would ensure that residents of the province/territory would never be obliged to pay out-of-pocket more than 3% of their family income for prescription drugs. That is, personal prescription drug expenses for any family of the province/territory would be capped at 3% of the individual's total family income. The federal government would agree to pay 90% of prescription drug expenditures in excess of \$5,000 for individuals for whom the combined total of their out-of-pocket expenses and the provincial contribution for which they were eligible was greater than \$5,000 in a single year. Thus, the participating provincial/territorial governments would have to pay only 10% of the cost that exceeded \$5,000 of supplying prescription drugs to families who incurred catastrophic drug expenses (i.e., those whose total drug expenses exceeded \$5,000 for the year).

***To qualify for federal assistance, provinces/territories would have to put in place a program that would ensure that residents of the province/territory would never be obliged to pay out-of-pocket more than 3% of their family income for prescription drugs.***



To qualify for federal assistance, sponsors of private supplementary prescription 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. That is, for private-sector plans, out-of-pocket costs for plan members would be capped at \$1,500 in any given year. For plans that meet this criterion, the federal government would then agree to pay 90% of prescription drug costs in excess of \$5,000 for individual plan members whose total prescription drug costs exceed \$5,000 per year, with the plan paying the remaining 10%. Thus, each individual plan member's out-of-pocket costs would be capped at either 3% of family income or \$1,500, whichever is less.

***To qualify for federal assistance, sponsors of 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 \$1500 per year. Private supplementary drug plans would retain responsibility for drug expenses up to \$5000.***

Private supplementary drug plans would retain responsibility for drug expenses up to \$5,000, and would be strongly encouraged to put in place a pooling mechanism to assist all plans in dealing with costs in the \$1,500 – \$5,000 range. Private plan sponsors would, of course, be able to offer additional benefits and enhancements beyond the minimum requirements to be eligible for federal assistance.

The net result of this new program to protect Canadian individuals and families against the consequences of severe prescription drug expenses would be that no one would ever be obliged to pay more than 3% of their family income for prescription drugs. Those who are members of a private plan that participates in the federal program would never pay more than \$1,500 or 3% of their family income for prescription drugs, whichever is lower. Depending on whether or not an individual is a member of a private plan, the first \$5,000 in total prescription drug expenses would be paid by some combination of individual out-of-pocket spending, public and private insurance. The federal government would then pay 90% of the prescription drug costs over \$5,000 incurred by any individual in the course of a single year, with the remaining 10% of the costs over \$5,000 being paid by either a provincial or a private supplementary plan.

To illustrate how this program would work in practice, consider the following example. Three individuals each incur \$10,000 in prescription drug expenses in the course of a given year. One of them, Jane, earns \$60,000 annually. Another, Bob, earns \$30,000. Both Jane and Bob are enrolled in supplementary private insurance plans that meet the federal eligibility criteria for catastrophic prescription drug coverage. The third, Anne, is self-employed and also earns \$60,000 a year, but does not have private supplementary drug insurance. All three live in a province that participates in the federal plan.

In Anne's case, she would seek assistance from the provincial prescription drug insurance plan. Since 3% of Anne's income is \$1,800, she would be entitled to receive \$8,200 from the provincial plan to meet her total cost of \$10,000.

In Bob's case, his out-of-pocket expenses would be capped at \$1,500 under his private supplementary drug insurance plan. However, 3% of his income is only \$900. Bob

would therefore be entitled to a \$600 rebate from his insurance plan, so his total out-of-pocket expenditure does not exceed 3% of his income.<sup>190</sup>

In Jane's case, her out-of-pocket expenses would, like Bob, be capped at \$1,500 by her private supplementary plan, but since 3% of her income (\$1,800) is greater than her out-of-pocket costs (\$1,500), she would not be entitled to additional assistance.

Let's now suppose that Jane and Bob get married. They still each incur \$10,000 in prescription drug expenses annually, for a total of \$20,000. Their family income is now \$90,000 (\$60,000+\$30,000). Their private supplementary insurance plan caps their out-of-pocket expenses at \$1,500 each, for a total of \$3,000. However, 3% of their family income is only \$2,700. Jane and Bob, therefore, are entitled to receive a \$300 rebate from the provincial government.

The federal government's contribution would be paid either to the provinces or to the supplementary private insurance plans, but not directly to individuals. These payments would be made at regular pre-determined intervals (quarterly, semi-annually or annually) and claims submitted to the federal program would, of course, be subject to periodic audit to ensure that they corresponded to expenses that were actually incurred.

### **7.5.2 The benefits of the plan**

Taken together, these measures would provide effective protection against catastrophic prescription drug expenses for all Canadians and offer additional benefits to those with lower incomes by capping out-of-pocket expenses at 3% of family income. The plan also contains incentives for both the provincial/territorial governments and private supplementary plan sponsors to participate.

For the provinces and territories, the Committee's plan is structured so that the federal government provides financial assistance for some coverage that all provinces/territories already offer, such as paying the costs of catastrophic prescription drug expenses of seniors and people on social assistance. The federal contribution would therefore free up provincial money and enable provinces to pay for whatever improvements to provincial prescription drug plans are required to put in place the guarantee that no resident incur out-of-pocket costs in excess of 3% of his/her income. Furthermore, it shifts the onus from the provinces to the federal government to deal with the increasing incidence of very high (catastrophic) drug costs attributable to escalation in the cost of drugs themselves and the introduction of new, more sophisticated, and particularly expensive drug therapies.

Thus, even those provinces/territories that do not currently provide any coverage against catastrophic expenses for the working population under the age of 65 (and that

***The net result would be, of course, a real step forward for those Canadians (roughly 600,000 people) who currently have no protection whatsoever against catastrophic prescription drug expenses.***

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<sup>190</sup> Note that it should be possible to work out a payment plan that enables people who are not in a position to wait for a rebate from the government at the end of the year to benefit from a credit at the point of purchase, or some similar scheme to reduce their actual out of pocket expenses to a manageable limit.

might also have difficulty participating in a traditional federal cost-sharing program because of a lack of available provincial money to match the federal dollars) are likely to derive sufficient financial benefit under this program to allow them to meet the federal eligibility criterion. The net result would be, of course, a real step forward for those Canadians (roughly 600,000 people) who currently have no protection whatsoever against catastrophic prescription drug expenses.

The Committee's proposal would also help ensure the long-term sustainability of private supplementary drug insurance plans for those that agree to cap their members' out-of-pocket expenses at \$1,500 per year. It would remove the spectre of extreme volatility in plan costs due to catastrophic drug expenses. Moreover, potential plan sponsors who have hesitated to adopt supplementary prescription drug benefit plans in the past out of fear of potentially facing catastrophic drug costs may now be more inclined to introduce them. This is particularly important for small and new businesses, enabling them to offer more competitive benefits packages to prospective employees than would otherwise be possible.

### **7.5.3 How much would the plan cost?**

It is estimated that implementing this federal initiative to protect all Canadians against catastrophic prescription drug costs would cost approximately \$500 million per year. At the request of the Committee, this cost estimate was prepared using a large-scale micro-simulation model of national drug coverage constructed by the Fraser Group and Tristat Resources, researchers who have authored several major studies of prescription drug coverage in Canada. Their most recent study, *Drug Expense Coverage in the Canadian Population: Protection from Severe Drug Expenses*, was presented to the Senate Committee on June 12, 2002.

The model by the Fraser Group and Tristat Resources is built on four key data files:

- The Statistics Canada Survey of Labour Income Dynamics (SLID) sample of approximately 60,000 Canadian households provides the basic demographic characteristics.
- The Statistics Canada Survey of Work Arrangements is used to establish supplementary drug coverage status.
- The Plan Parameter File, which establishes the terms of the public and private plans, was developed from an analysis of public plan provisions and records of 80,000 employer-sponsored plans.
- The Drug Need File, containing the estimated average annual drug expense for each age and gender group as well as the probability distribution by size of expense, is based on an analysis of supplementary drug plan claims data as well as published data from some public programs.

The entire model is balanced to aggregate benchmarks derived from macro statistics provided by the Canadian Institute for Health Information for the year 2000, adjusted for the characteristics of the sample frame used by the Statistics Canada surveys.

The Committee has added an additional cushion to the raw output from the model with a view to providing a prudent and robust estimate that is believed to overestimate somewhat the likely costs.

#### **7.5.4 Committee's Proposal for a Catastrophic Prescription Drug Insurance Plan**

In summary, then, the Committee recommends that:

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

**For all eligible plans, the federal 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.**

## 7.6 The Need for a National Drug Formulary

It is clear to the Committee that, in order to implement its plan to protect Canadian individuals and families from catastrophic prescription drug costs in a uniform and equitable manner across the country, it will be necessary to establish a national drug formulary. The concept of a national drug formulary was brought to the Committee's attention by a number of witnesses during its study.

A drug formulary refers to a list of prescription drugs that are supplied under public drug insurance plans. A "national" drug formulary does not mean that the federal government alone would be responsible for determining which prescription drugs would be on it. Rather, a national formulary is best conceived in terms of harmonization among the federal, provincial and territorial participants together with the participation of other interested stakeholders.

As the Committee noted in Volume Four of its study, the benefits of a national drug formulary include the following:

- Elimination of the potential for log-rolling, or pressuring one province to add a drug to its formulary because another has already done so;
- Enhanced ability to undertake and make available nationally the research needed to understand whether the benefits of a new (and costlier) drug genuinely represent a significant improvement on existing (and cheaper) drugs.<sup>191</sup>

The establishment of a national drug formulary could lead the way to the creation of a single national buying agency – one that covers all provincial/territorial/federal jurisdictions. The substantial buying power of such an agency would strengthen the ability of public prescription drug insurance plans to negotiate the lowest possible purchase prices from drug companies.

Given the plan to protect Canadians against catastrophic prescription drug costs, a national drug formulary would mean that all Canadians would receive comparable coverage and access to drugs regardless of where they lived. It would also enable the funders of the program to exercise control over which drugs were eligible for coverage. The Committee believes that, since the federal government will be funding 90% of the cost, it is essential that the federal government be at the table when these decisions are made. Moreover, given the potential for exponential growth in the costs of new drug therapies, the funders of the program will have to agree jointly which drugs are covered under the plan. The Committee therefore recommends that:

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

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<sup>191</sup> Volume Four, p. 71.



## CHAPTER EIGHT

### EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE

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#### 8.1 Brief Review of Key Points about Home Care from Volumes Two and Four

Spending on home care in Canada (both public and private) has increased continually over the past two decades (see Figures 8.1 and 8.2). In previous Volumes, the Committee noted that there is no consensus about what services should be included in the definition of home care. Home health care services can cover some acute care (intravenous therapy and dialysis, for example), long-term care (for individuals with degenerative diseases such as Alzheimer's or chronic physical or mental disabilities), and end-of-life care for those with terminal conditions. In addition to health care, home care can include social support services such as monitoring, homemaking, nutritional counselling and meal preparation. It extends along a wide continuum of care.

There are two basic kinds of home care providers: formal caregivers such as nurses, therapists, and personal support workers; and informal caregivers, usually family members or friends. The 1998/99 Population Health Survey found that the majority of those who reported needing care in the home due to aging, chronic illness or disability received no formal, publicly funded care whatsoever. Between 80% and 90% of all home care provided to people with these needs is unpaid. The survey did not report the extent to which needs not paid for from public funds are being paid for privately, met by informal caregivers, or simply not met.

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. The Committee heard that home care can fulfill a number of functions, notably:

***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.***

- it substitutes for services provided by hospitals and long-term care facilities;
- it maintains clients' capacity to remain in their current environment, usually their homes, as an alternative to moving to another and often more costly venue such as a long-term care facility; and
- it reduces dependency, primarily by providing monitoring at additional short-run but lower long-run costs.

Many witnesses contended that when home care is substituted for acute care – usually hospital-based care – it should be considered the same as acute care delivered in other settings and, accordingly, should be encompassed under the *Canada Health Act*.

Currently, each province and territory offers some form of home care program, but not as a “medically necessary” service under the *Canada Health Act*. Therefore, publicly funded home care programs vary greatly across the country in terms of eligibility, scope of coverage and applicable user charges. Although its provision has increased in most provinces in recent years, public spending on home care still represents a small proportion of overall provincial health care budgets.

Recent studies suggest that although home care is generally cost-effective, it is clear that in many cases institutionalized care remains more efficient, particularly for the frail elderly. Of course, institutionalized care is always more convenient for service providers.

But cost and the ease of service delivery are not the only factors to be taken into account. Many people want to receive care if it is available to them in their homes, rather than in institutions.

In Volume Four (section 8.10), the Committee outlined four options for federal contributions to the financing of home care:

1. *A National Home Care Program*

Under this option, the federal government would increase its transfers to assist the provinces and territories to develop home care programs in their respective jurisdictions. The federal government would work closely with the provinces and territories to develop national home care standards, a critical issue if home care is to become a fully integrated component of Canada’s health care delivery system.

2. *Tax Credit and Tax Deduction to Home Care Consumers*

The federal government could offer enhanced financial assistance to home care consumers through tax changes that build upon existing income tax provisions. Alternatively new tax incentives could be created to encourage people to put money aside for their long-term care needs.

3. *Creating a Dedicated Insurance Fund to Cover the Need for Home Care*

Using a dedicated, capitalized insurance fund approach such as that suggested by the Clair Commission in Quebec, home care could be offered as benefits in kind or as monetary benefits.



#### 4. *Specific Measures Aimed at Informal Caregivers*

The reduction in in-patient hospital services has increased the burden of care on families and friends of home care patients. Currently, more than 3 million Canadians – mostly women – provide unpaid care to ill family members in the home. This option would provide further financing support for Canada's informal caregivers, using the Canada Pension Plan (CPP) and/or Employment Insurance programs to assist those who leave the workforce temporarily to provide informal care.

### 8.2 Other Options

These options were focused on federal involvement in all three aspects of home care (substitution, maintenance and prevention). The only specific aspect that was raised in Volume Five was in relation to the development of a national health info-structure and concerned the need to invest in tele-homecare. In Volume Five, the Committee also announced its intention to produce a thematic study on the issue of home care in the near future.

In subsequent testimony, the Committee heard that it is important to consider devising a national home care strategy in stages, beginning with the function of home care as a substitute for acute care.

Health Canada showed in 1999<sup>192</sup> that on a national basis, one-third of home care's clientele has acute needs and two-thirds employ its long-term services (Table 8.1). The latter are recipients of continuing care, while the former are post-acute care recipients, usually those requiring services for a short period following hospitalization. Recent hospital transformations through closures, mergers, reductions in lengths of stay, and changes to the size and function of hospitals have shifted the traditional home care caseload, putting greater emphasis on post-acute home care recipients.

Home care is no longer the preserve of the elderly. Forty-five percent of home care recipients in Ontario are under 65 years of age and 15 percent are children.<sup>193</sup> Moreover, the services profiles are distinct for the two main groups of home care clients. The post-acute care group receives care for a short period, generally less than 90 days; the other, made up primarily of elderly and disabled people, receives care on a continuing basis. For short-term recipients, nursing services make up the lion's share (63.0%) of home care received; the remaining services are divided between personal support (20.6%) and various other therapies (16.4%). In contrast, for continuing care recipients,

***Recent hospital transformations through closures, mergers, reductions in lengths of stay, and changes to the size and function of hospitals have shifted the traditional home care caseload, putting a heavier emphasis on post-acute home care recipients.***

<sup>192</sup> "Provincial and Territorial Home Care Programs: A Synthesis for Canada," Health Canada, June 1999.

<sup>193</sup> Laporte A, Croxford R, Coyte PC: Access to home care services The role of socio-economic status. Presentation at the Canadian Health Economics Research Association Conference, Halifax, May 2002.

personal support is the most prevalent service (59.2%), followed by nursing care (35.5%); therapeutic services are rarely necessary.<sup>194</sup>

**TABLE 8.1**  
**PERCENTAGE OF ACUTE, LONG-TERM, AND OTHER CLIENTS, 1996-97**  
**(JURISDICTIONS WHERE DATA ARE AVAILABLE)**

<b>Province/ Territory</b>	<b>Acute Care Clients</b>	<b>Long-Term Care Clients</b>	<b>Others</b>	<b>Total</b>
B.C.	56.4	34.5	N/A	90.9
Alta.	41.0	52.0	7.0	100.0
Sask.	22.9	70.5	6.6	100.0
Que.	21.1	63.7	15.2	100.0
N.B.	53.3	46.6	N/A	99.9
P.E.I.	20.0	75.0	5.0	100.0
Y.T.	16.6	73.7	9.6	99.9
<b>Canada</b>	<b>33.0</b>	<b>58.0</b>	<b>8.7</b>	<b>99.7</b>

The Committee believes the model of home care delivery pioneered in New Brunswick should be highlighted.

### **8.3 The Extra-Mural Program in New Brunswick**

Founded in 1981, under then Health Minister, now Senator, Brenda Robertson (a member of this Committee), the New Brunswick Extra-Mural Hospital (NBEMH) was Canada's first government-funded home-hospital program. It is often cited as a possible model for other jurisdictions. Designated as a Hospital Corporation under the New Brunswick Hospital Act, its services were eligible to be insured by the province. "The mission of the NBEMH was to provide a comprehensive range of coordinated healthcare services for individuals of all ages for the purpose of promoting, maintaining and/or restoring health within the context of their daily lives."<sup>195</sup>

In 1996, a major restructuring of the NBEMH took place. A change in legislation changed the status of the NBEMH from that of a Hospital Corporation to its current status as an Extra-Mural Program (EMP). Management of the existing service delivery units devolved to the eight Region Hospital Corporations (RHCs). The RHCs manage hospital facilities, community health care centres (four sites in the province), and the Extra-Mural Service Delivery Units located in their territory. While management of service delivery has been decentralized, overall direction, including development, standard setting, funding, and monitoring of the EMP

<sup>194</sup> Ibid.

<sup>195</sup> Brief to the Committee, p. 3.

is the responsibility of the Hospital Services Division of the New Brunswick Department of Health and Community Services.

Thirty service delivery sites provide for the delivery of EMP services to clients across the entire province. Staff includes clinical coordinators, liaison nurses, support staff, and field staff representing the disciplines of clinical nutrition, nursing, occupational therapy, physiotherapy, speech language pathology, social work, and respiratory therapy. All professional staff members are employees of the EMP who work in interdisciplinary teams. Support services such as homemaking and meals-on-wheels are contracted. Direct care staff provides the case-management function as well. Nursing services are available 24 hours a day, seven days a week, while all other disciplines deliver services Monday to Friday.

Clients of the program fall into one of four categories or groupings:

- **Acute Care:** The objective is to facilitate early discharge or prevent admissions to more costly facilities, including hospitals; to improve or restore function through the provision of assessment and intervention in clients' natural environments. Services include, but are not limited to, selective chemotherapy, oxygen therapy, diabetes management, IV therapy, wound care, intravenous hydration and medication administration, and post-operative rehabilitation.
- **Continuing Care:** the objective is to maintain and prevent further deterioration in health/function so that individuals can remain in their current environments for as long as possible. Services include, but are not limited to, oxygen therapy; medication assessment, management, and monitoring; seating and positioning; adaptive equipment aids/prescription; support for individuals on mechanical ventilation; and group therapy.
- **Promotive/Preventive Care:** The purpose is to provide information, advice, or any planned combination of educational and organizational supports to maintain or enhance health; to prevent the occurrence of injuries, illnesses, chronic conditions and their resulting disabilities.
- **Palliative Care:** the objective is to provide interventions that help alleviate pain and manage the symptoms of a terminal illness; to provide support and respite to individuals and their informal support networks so individuals may die at home or delay admission to a medical care facility for as long they so choose.

Assessment, treatment, education, and consultation are a component of each type of care. The services provided are intended to promote client independence for as long as possible. At its inception the budget for the EMP was \$250,000. As shown in Table 8.2, in a province with a total population of just over 750,000 it has grown into a program with a budget around \$40 million. It offers an example of how it is possible to phase in a comprehensive home care program over time.

### 8.3.1 Building on the New Brunswick example: direct referrals to home care

The Committee took particular note of the fact that the New Brunswick EMP enabled doctors to refer patients directly to the program. Cheryl Hansen, Provincial Director of the EMP, told the Committee that “between 50 to 60 per cent of the EMP total caseload is for acute care services or is the acute care replacement and substitution function of hospitals.” In her brief to the Committee she further indicated that “approximately 55% of acute care clients are admitted directly from the community,”<sup>196</sup> without

**[...] “approximately 55% of acute care clients are admitted directly from the community,” without having been admitted to a hospital. The Committee highlights this aspect of the EMP in the hope that other jurisdictions will consider developing similar programs that offer the possibility of extending the range of services available to Canadians under the Canada Health Act in an effective and cost-efficient fashion.**

having been admitted to a hospital. The Committee highlights this aspect of the EMP in the hope that other jurisdictions will consider developing similar programs that offer the possibility of extending the range of services available to Canadians under the *Canada Health Act* in an effective and cost-efficient fashion.

**TABLE 8.2  
EXTRA-MURAL PROGRAM – ASSORTED DATA**

	1996-97	1997-98	1998-99†	1999-00†	2000-01*‡
Staff (FTE)	527	590	592	608	668
Separations <sup>3</sup>	10,866	11,972	12,680	13,924	19,941
Nursing Visits <sup>1, 3</sup>	270,145	275,586	295,817	326,630	282,813
Rehab. Visits <sup>2, 3</sup>	34,107	64,080	93,459	87,946	78,609
Other Visits <sup>3</sup>	40,457	42,587	43,522	45,040	39,148
Total Visits	344,709	382,253	432,720	459,616	400,570
Gross Expenditures (\$M)	\$28.6	\$31.7	\$35.0	\$37.2	\$39.7
Average Cost / Visit <sup>3</sup>	\$83	\$83	\$81	\$81	\$99
Average Cost / Separation <sup>3</sup>	\$2,632	\$2,662	\$2,758	\$2,674	\$1,990

Source: New Brunswick Department of Health and Wellness, Annual Report 2000-2001.

Notes:

1. Includes occupational therapy, physiotherapy and speech language pathology visits.
2. Includes social work, clinical nutrition, and respiratory therapy visits.
3. For 1999-2000 fiscal year only, due to the implementation of a new EMP information system, statistics are estimated based on activity data collected from April to September 1999.

† Staffing and volume increases attributed to the Rehabilitation Services Plan

\* Preliminary data

‡ Statistics may vary from previous years as EMP went live with a new information system in 2000-01 (EMP Information System). Collection of statistics is according to New Brunswick MIS guidelines in 2000-01.

<sup>196</sup> Brief to the Committee, p. 3.

## 8.4 Organizing and Delivering Post-Acute Home Care

In this section and the two that follow, the Committee outlines its specific proposal for a national program to provide publicly funded insurance coverage for post-acute home care, that is, for people requiring treatment at home following an episode of hospitalization.<sup>197</sup> We describe mechanisms for the financing, delivery and organization of home care following hospitalization.

Although other types of home care services are also important contributors to good health, the Committee believes it is important to focus at this time on the financing, organizing, and delivery of post-acute home care. The Committee's objective is to stimulate the development of a new national program that provides public insurance coverage for services that are now delivered to Canadians in their own residences and are not therefore covered under the provisions of the *Canada Health Act*. Although we do not now propose a comprehensive home care program, the Committee is convinced that it is important to begin with what we believe to be a fiscally feasible expansion of the health care safety net in Canada.

***...the Committee believes it is important to focus at this time on the financing, organizing, and delivery of post-acute home care.***

### 8.4.1 Definition of post-acute home care

Post-acute home care refers to the provision of home care services to patients who have experienced an episode of hospital care. The first challenge to face in developing a national program for post-acute home care is in the identification and classification of home care following hospital care and linking relevant home care services to an initial episode of hospital care, whether in-patient care or same-day surgery.

***...the Committee is convinced that it is important to begin now a fiscally feasible expansion of the health care safety net in Canada. We believe our proposed program meets the test of fiscal feasibility.***

#### 8.4.1.1 When does Post-Acute Home Care (PAHC) servicing start?

Fortunately, studies have explored the definition of post-acute home care (PAHC) in the context of health service restructuring.<sup>198</sup> Most experts have defined post-acute home care recipients as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date. Initiation of home care beyond 30 days of

<sup>197</sup> The Committee wishes to acknowledge the invaluable assistance of Dr. Peter Coyte in the preparation of its proposal for the development of a national publicly funded program for post-acute home care. Professor Coyte is Professor of Health Economics and CHSRF/CIHR Health Services Chair at the University of Toronto. He is also the Co-Director of the Home and Community Care Evaluation and Research Centre, and the President of Canadian Health Economics Research Association. Many of the specific recommendations were developed by Professor Coyte in a background paper prepared at the request of the Committee.

<sup>198</sup> Coyte PC, Young W: Regional variations in the use of home care services in Ontario, 1993/1995. *Canadian Medical Association Journal*, 161:4, 376-380, 1999; Coyte PC, Young W: *Reinvestment in and use of home care services*, Technical Report No. 97-05-TR, Institute for Clinical Evaluative Studies: Toronto, Ontario, November, 1997; Coyte PC, Young W, DeBoer D: *Home care report for the Health Services Restructuring Commission*. Report to the Health Services Restructuring Commission, Health Services Restructuring Commission: Toronto, 1997.

discharge is unlikely to be directly related to previous hospitalization.<sup>199</sup> An interval shorter than 30 days might exclude episodes of home care that were related to the prior hospitalization but were postponed because of scheduling or other difficulties.

***The Committee therefore proposes that post-acute home care recipients should be defined as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date.***

The Committee therefore proposes that post-acute home care recipients should be defined as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date.

#### **8.4.1.2 When does PAHC servicing end?**

While there appears to be consensus in the literature on the definition of who should initially qualify as a PAHC recipient, the identification of those home care services that are relevant or attributable to the original hospitalization represents a greater challenge. The current ad hoc solution has usually been to impose an arbitrary date beyond which further in-home servicing may be presumed to be unrelated to the original reason(s) for hospitalization. In some instances this cut-off date has been one year after discharge;<sup>200</sup> in other cases it has been 60 days. One rationale for use of the 60 day limit is that it is consistent with the short stay (or short term) classification of home care episodes; episodes of home care that extend beyond 60 days are then classified as long stay (or continuing care).

It is important to note, that over 50% of PAHC recipients are discharged from home care before 30 days of home care have elapsed, and almost 70% before 60 days; only 12.7% receive PAHC past six months. The Committee has decided to adopt a cut-off date of three months, that is a period inbetween 60 days and six months. Hence, somewhere in the range of 75-80% of PAHC recipients will have been discharged from home care before the three months have elapsed.

The Committee therefore recommends that:

**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.**

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<sup>199</sup> Hollander M: *The costs, and cost-effectiveness of continuing care services in Canada*. Queen's-University of Ottawa Economic Projects Ottawa, 1-113, 1994; Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997); Kenney GM: How access to long-term care affects home health transfers. *Journal of Health Politics Policy and Law*, 83: 412-414, 1993.

<sup>200</sup> Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997).

#### **8.4.2 Organizational arrangements for PAHC**

The national estimates of the total cost of the Committee's PAHC program will be derived below. The manner in which such funds are allocated and the mechanisms used to assign responsibility for the organization and delivery of such care are tremendously important. This section outlines mechanisms for the finance, organization and delivery of PAHC.

Control and responsibility for the organization and delivery of PAHC varies across Canada but is usually the responsibility of organizations that are distinct from hospitals. This has created parallel sets of entrenched interests, pitting organizations responsible for hospital care against those responsible for home care, and creating conflict that has foreclosed on or restricted opportunities for service integration, stifled innovation and put unnecessary limits on service cost-effectiveness.

Therefore the Committee believes that it would be a mistake to continue to fund those organizations charged with the distinct responsibility to negotiate, select, approve, and evaluate (internal or external) contractual arrangements with home care providers. The development (or perpetuation) of a separate program for PAHC that entails another set of vested interests would do little to ensure that funding follows the care recipient. The financing of PAHC should be first directed to hospitals, and the Committee recommends that:

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

There is an abundance of evidence to indicate that hospitals respond in predictable ways to financial incentives. The introduction of service-based reimbursement, whereby hospitals are reimbursed at a fixed rate for each type of service delivered (in keeping with the Committee's recommendations on hospital funding in

Chapter Two), would provide incentives to shorten lengths of stay and to shift the hospital caseload toward day surgery and away from in-patient care.<sup>201</sup> Furthermore, given the relationship between PAHC and hospital care, the introduction of service-based reimbursement for hospitals would increase their demand for PAHC.<sup>202</sup>

***Directing the funding for the provision of PAHC 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 PAHC.***

<sup>201</sup> A variety of studies have explored the classification of linked episodes of hospital care and PAHC. Based on the work performed for the Health Services Restructuring Commission in Ontario, for example, each inpatient and same day surgery hospitalization could be assigned to one of twenty-five mutually exclusive and exhaustive Major Clinical Categories (MCCs) in the case of inpatient care, and one of six Day Procedure Groups (DPGs) in the case of same day surgery. [Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997); Kenney (1993); Canadian Institute for Health Information: *Length of stay database by CMG*. Ottawa. Canadian Institute for Health Information, 1994. Canadian Institute for Health Information: *DPG booklet*. Ottawa. Canadian Institute for Health Information, 1996.]

<sup>202</sup> Kenney (1993); Kenney GM: Understanding the effects of PPS on Medicare home health use. *Inquiry*, 28: 129-139, 1991.

Directing funding for the provision of PAHC 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 PAHC.<sup>203</sup> In contrast, if a separate organization were financed for the provision of in-home care, the potential cost-savings achieved through either shorter hospital stays or the use of day surgery would be much less likely to be captured, and hence, would not have a direct impact on decisions regarding service provision.

Consequently, the Committee believes that efficiency gains in the provision of both hospital care and PAHC are better advanced through the vertical integration and joint financing of these services, and recommends that:

**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.**

Furthermore, in the Committee's view, PAHC programs should not be restricted only to nursing and therapy services. This could lead to distorted patterns of practice because PAHC recipients, like many patients using other forms of home care, utilise a full array of home care services. Limiting the scope of services covered under the program might encourage hospitals to substitute nursing services for other kinds of personal support services that would be more cost effective, raising, rather than lowering, the aggregate cost of care.

This point was reinforced by the experience of the New Brunswick Extra-Mural Program. In her brief to the Committee, Cheryl Hansen indicated that one of the lessons they learned was that:

*The acute care substitute function of homecare requires a comprehensive team working collaboratively to meet the needs of the client and family. An essential component of acute care services is the provision of appropriate short term home support services e.g., homemaking.[...]The funding and provision of adequate short term support needs to be addressed in order for the replacement/ substitution function of homecare to occur in a fashion that ensures quality service for the client and family.*<sup>204</sup>

For these reasons the Committee believes that the reimbursement arrangements for the provision of home care following hospital care should be flexible in order to encourage innovation and efficiency and recommends that:

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<sup>203</sup> Kenney (1993).

<sup>204</sup> Brief to the Committee, June 17, 2002, p. 7.



**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.**

#### **8.4.3 Who provides PAHC?**

The Committee recognizes that the methods by which PAHC is organized and delivered is a separate question from how these services are funded, and that many different forms of service delivery are feasible. In some circumstances, hospitals may provide the services themselves; in others, hospitals may contract with not-for-profit or for-profit home care service providers; in yet other circumstances, hospitals may contract with third-party agencies that sub-contract with home care service providers.

***In some circumstances, hospitals may provide the services themselves; in other situations hospitals may contract with not-for-profit or for-profit home care service providers, or in other circumstances hospitals may contract with third party agencies that sub-contract with home care service providers.***

The organizational options for PAHC are many and offer a variety of potential benefits. First, the establishment of separate third party home care agencies may present some hospitals with an opportunity to pool resources and gain economies of scale in service provision, despite the potential to incur additional contracting and other administrative costs.

Second, hospitals may develop dedicated in-home service teams to deal with the particular community circumstances faced by care recipients.

Finally, hospitals may contract-out (or out-source) the provision of PAHC to home care service providers. This arrangement has a number of advantages. It can permit service specialization by providers familiar with circumstances in the community; it offers the prospect of service integration between hospital and PAHC; and it yields opportunities to take advantage of cost savings associated with improvements in patterns of care.

The Committee therefore recommends that:

**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.**

Regardless of the organizational arrangement selected, the providers of PAHC should receive service-based reimbursement. As described in detail in Chapter 2, the amount of money a provider is paid under service-based funding depends on the acuity of the case being

***Regardless of the organizational arrangement selected, the providers of PAHC should receive service-based reimbursement.***

treated. Thus, service-based funding levels would be determined by clinical guidelines. This method ensures that the PAHC service providers receive a flat rate for their services to a specific patient, thereby encouraging service innovation and integration, and enhancing the efficient and effective allocation of health care services.

Reimbursing home care service providers with a fixed, predetermined payment offers a number of incentives. First, providers may retain residual income and therefore have the incentive to select the most efficient ways of delivering services. Second, to take advantage of economies of scale and scope, both vertical and horizontal service integration may occur. Such integrated organizations may be in a better position than other organizations to delegate tasks cost-effectively and improve the continuity of care. Third, to the extent to which payment exceeds the costs incurred in service provision, incentives exist for such organizations to compete for additional care recipients.<sup>205</sup>

However, there is a negative incentive given that this reimbursement method also tends to encourage the avoidance of care recipients with high service needs, i.e., “cherry-picking.” Also, in the absence of a vigilant program of evaluation, organizations may be tempted to skimp on service provision, potentially leading to diminished quality of care. Consequently, the determination of an appropriate risk-adjusted service-based payment that closely reflects the service needs of PAHC recipients and the introduction of a systematic program of outcome performance, are policies that must be developed in concert with modified funding schemes to ensure cost-effective and uniformly accessible PAHC of high quality.

The Committee therefore recommends that:

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

## **8.5 The Cost of a National Post-Acute Home Care Program**

### **8.5.1 How to calculate the cost of a national PAHC program**

As shown in Figure 8.3 (at the end of this chapter), there are wide interprovincial variations in per capita public home care expenditures in Canada, variations that persist even after adjusting for the age-sex composition of the underlying population. While the average per capita public funding for home care in fiscal year 2000 was \$87.51, there was a four-fold variation in such expenditures, ranging from the highest in New Brunswick (\$193.76) to the lowest in Prince Edward Island (\$47.85) and Quebec (\$51.89).<sup>206</sup> These variations are due, in

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<sup>205</sup> Valdeck BC, Miller NA: The Medicare home health initiative. *Health Care Financing Review*, 16:1, 7 – 16, 1994; Phillips BR, Brown RS, Bishop CE, et al: Do preset per visit payments affect home health agency behaviour? *Health Care Financing Review*, 16:1, 91- 107, 1994.

<sup>206</sup> Health Canada: *Health expenditures in Canada by age and sex 1980-81 to 2000-01*. Health Policy and Communications Branch, Health Canada: Ottawa, August, 2001.

part, to the extent to which the provincial publicly funded home care program is extensive (as it is in New Brunswick) or quite restricted (as it is in Prince Edward Island and Quebec).

Nationally, public home care expenditures were \$2,690.9 million in fiscal year 2000.<sup>207</sup> In order to identify the proportion associated with PAHC, the Committee used methods based on previous work in Ontario for the Health Services Restructuring Commission.<sup>208</sup> All home care recipients were identified for fiscal year 1997 and assigned to one of four mutually exclusive categories, as shown in Figure 8.4 (at the end of this chapter), based on their use of home care in relation to an episode of hospital care.

Home care recipients were first classified according to whether they had had an episode of hospital care, whether inpatient or same-day surgery, during fiscal year 1997.<sup>209</sup> If they had had an episode of hospital care, the pattern of home care provision within 30 days of discharge was analyzed. If the first home care visit following hospital discharge took place within thirty days, the pattern of use of home care services in the 30 days prior to hospitalization was analyzed. Accordingly, the four home care recipient categories were: no hospitalization; no PAHC; PAHC without prior home care; and PAHC with prior home care.

The use of home care services and the average cost of such services were analyzed for one year following either the first home care service date (for recipients who did not receive PAHC) or the first home care service date following hospital discharge (for recipients who received PAHC).

Two estimates are offered for the proportion of total home care costs attributable to PAHC. The first (high) estimate is based on the proportion of home care *recipients* that received PAHC, while the second (low) estimate is based on the proportion of *expenditures* attributable to such care. While 42.8% of home care recipients received PAHC services, only 26.5% of total home care expenditures were attributable to such care. The use of both estimates on which to base the cost of a national PAHC program recognizes the uncertainty associated with developing cost estimates for a program of this kind, given the absence of a health information system relating to the use of home care services.

### **8.5.2 What about hidden costs?**

In addition to home care service costs, other costs associated with the provision of PAHC are hidden in other provincial spending categories. Drug costs are a major item that is hidden. For fiscal year 2001, the Ontario Drug Benefit (ODB) program expenditure attributable to home care recipients was estimated at \$86.8 million.<sup>210</sup> While this amount probably underestimates provincial drug program costs associated with the provision of home care, it may be used to approximate the hidden costs associated with the provision of PAHC.<sup>211</sup>

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<sup>207</sup> *Ibid*.

<sup>208</sup> Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997).

<sup>209</sup> See Figure 8.4.

<sup>210</sup> Peter Coyte, Personal Communication, Mr. Carl Marshall, Associate Director, Administration, Finance and Eligibility, Drug Programs Branch, Ontario Ministry of Health and Long -Term Care, 2002.

<sup>211</sup> Suppose the identified ODB program expenditures attributable to home care only represents the hidden costs incurred by those under sixty-five years of age during their home care episode. Under this assumption, estimates of

### **8.5.3 How much will a national PAHC program cost?**

A calculation done for the Committee combined estimates of the hidden costs with those for the direct service costs and, converting to 2002 dollars, used the growth in home care funding in Ontario between fiscal years 2000 and 2002 of 11.9% and estimated the cost of providing post-acute home care for a one-year period following hospitalization. This yielded a total cost estimate for a national PAHC program of between \$1,021.1 million and \$1,511.8 million for fiscal year 2002.<sup>212</sup> Given that the Committee has recommended a period of three months' coverage, it is legitimate to fix the estimated cost of the program at approximately \$1,100 million per year. The Committee recognizes that this estimate is probably somewhat high.

## **8.6 Paying for Post-Hospital Home Care**

The Committee believes the cost of a national PAHC program should be shared equally between the provincial and federal governments. It therefore recommends that:

**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.**

This brings the total cost (in fiscal year 2002 dollars) of a National PAHC Program to be borne by the federal government to approximately \$550 million per year.

It is also necessary to ask, however, whether the person receiving the home care – the patient – should also contribute to the cost of this expansion of publicly insured health care services. There are two ways of looking at this question.

The first is that the need for this expanded service arises as a result of the individual's having been in hospital and that the service is therefore simply an extension of hospital care which, under Medicare, should be "free" to the patient and paid entirely out of public funds. Moreover, one advantage of implementing this option of providing first-dollar coverage is that, since the full cost of home care coverage will be paid by the PAHC program, there is no reason for patients to object to shorter hospital stays. That is, no disincentive is introduced to the transfer of patients from high-cost hospital care to less expensive non-hospital care. This increases the likelihood of realizing efficiency gains for the health care system as a whole.

The second approach is that since patients are, for the most part, paying currently for at least some aspects of this home care service, it is reasonable that patients

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the hidden costs associated with an episode of home care are \$627.97 (in 2001 dollars). Since these costs are assumed to be uniform across all categories of home care recipients, they may be used to compute a "hidden cost" inflation factor for PAHC. This inflation factor may be defined as one plus the ratio of the hidden costs (\$627.97) to the cost per PAHC recipient. The latter depends on the home care costs attributable to PAHC recipients divided by the number of such recipients (137,915 from Figure 4). Using figures from Ontario, in conjunction with the high estimate for PAHC costs, the hidden cost inflation factor is (1.1731), while this factor is (1.2796) when using the low estimate for PAHC costs.

<sup>212</sup> The low estimate was calculated as \$2,690.9 million \* 1.119 \* 0.265 \* 1.2796, while the high estimate was derived as \$2,690.9 million \* 1.119 \* 0.428 \* 1.1731.

continue to pay a small part of the cost, provided that the actual dollar amount paid by the patient is adjusted in proportion to his or her income. The amount paid by the individual patient should be small enough to meet the test of the Committee's second objective for publicly funded health care, namely, that no Canadian should suffer undue financial hardship as a result of having to pay health care bills.

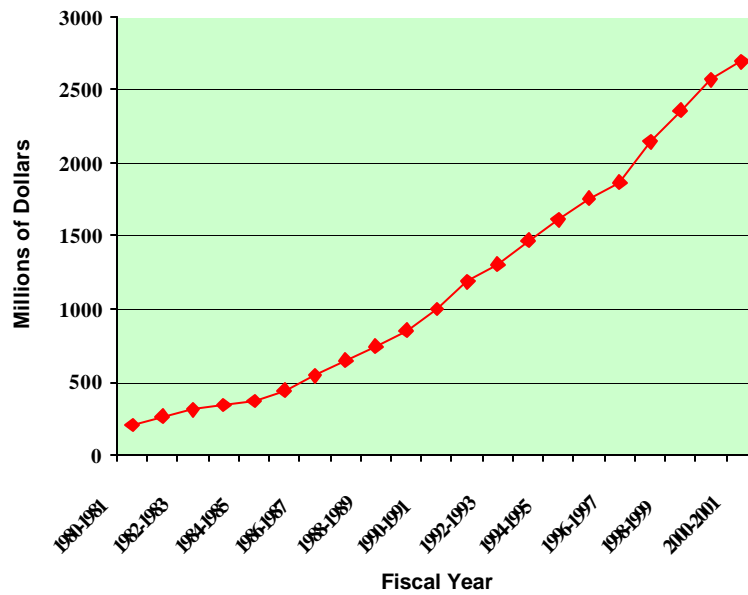
One method that has been suggested for implementing this second approach involves treating insured services as taxable benefits. Using this model, at the end of each year, people who had received services under the PAHC program would be sent a statement from the provincial government indicating the total cost of the home care services obtained. This cost would then become a taxable benefit. Patients could be protected against undue financial hardship as a result of having to pay this increased tax by capping the maximum amount of additional income tax any individual would have to pay at 3% of the individual's income.

This second view holds also that any new public money spent for expanded health care services should benefit those Canadians who can least afford to pay for these services; those who can afford to make a financial contribution to the cost should do so. Only by adopting this approach to the expansion of the public health care system, this argument continues, can Canada afford to close the widening gaps in the health care safety net. Indeed, this is one of the reasons the Committee's proposal for an insurance program to protect Canadians against catastrophic drug costs includes an element of "patient pay."

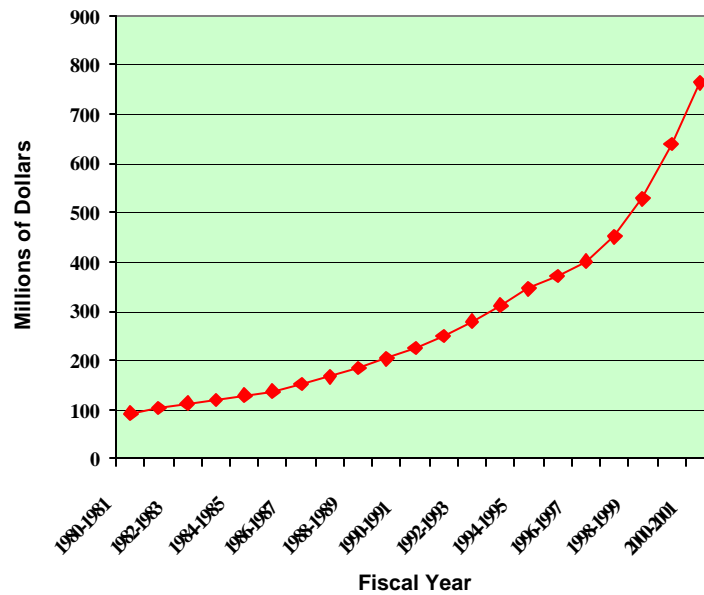
Nevertheless, with respect to its proposed new PAHC program, the Committee, after considerable reflection, agrees with the first view. Although it is concerned about the precedent of first-dollar coverage for expanded publicly funded services, the Committee believes that the advantages in terms of encouraging efficiency – encouraging the transfer of patients from higher-cost hospital beds to lower-cost home care beds – and equity, outweigh the disadvantages. With respect to the expansion of public health insurance to include post-acute home care, the Committee therefore recommends that:

**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).**

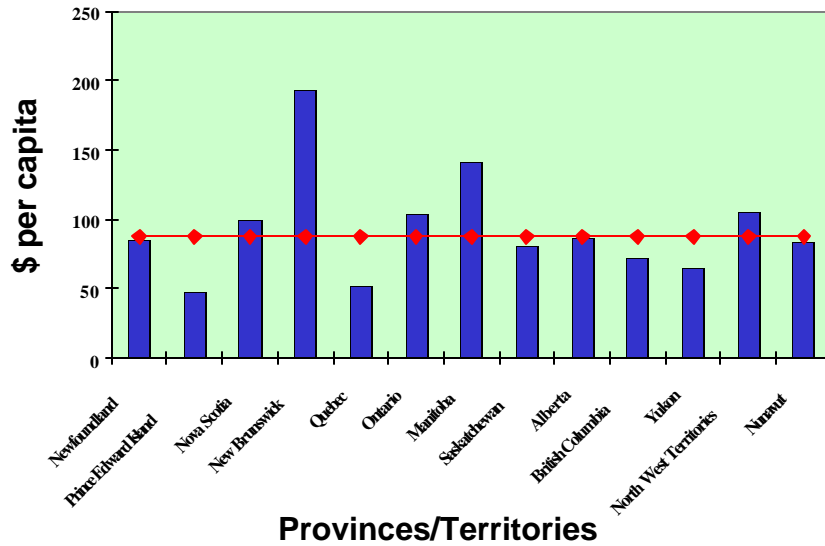
**Figure 8.1: Public Home Care Expenditures in Canada  
1980-81 to 2000-01**



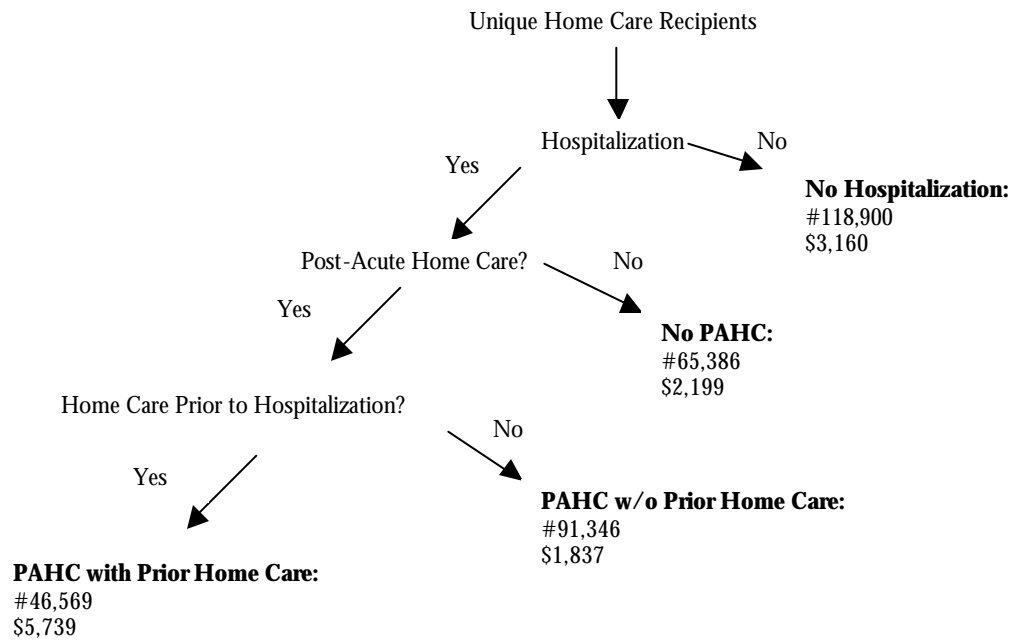
**Figure 8.2: Private Home Care Expenditures in Canada  
1980-81 to 2000-01**



**Figure 8.3: Per Capita Public Home Care Expenditures for Canadian Provinces and Territories, 2000-01**



**Figure 8.4: Home Care Recipients and Mean Expenditures (in 2002 Dollars)**







## CHAPTER NINE

### **EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE**

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Throughout the different phases of the hearings, the importance of palliative and end-of-life care was brought to the Committee's attention. Palliative care is a special kind of health care for individuals and families who are living with a life-threatening illness that has reached such an advanced stage that death is on the horizon.

The goal of palliative care is to provide the best possible quality of life for the terminally ill by ensuring their comfort and dignity and relieving pain and other symptoms. 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.

#### **9.1 The Need for a National Palliative Home Care Program**

Palliative care can be offered in a variety of places — at home, in hospitals, in long-term care facilities, and occasionally in hospices. As was reported by the Senate Subcommittee to Update *Of Life and Death* in June 2000, palliative care services in Canada are often fragmented and frequently nonexistent. Patients may not have access to palliative care services until very close to death and in many cases not at all. The report also indicated that palliative care in hospitals is usually paid for by a provincial health plan, which typically covers professional care and drugs, medical supplies, and equipment while the person remains in the hospital. In long-term care facilities, however, residents may be required to pay varying amounts for their care and supplies.

***The Committee believes that 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.***

The Committee believes that 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.

Different components of the health care system are involved in the many facets of palliative, end-of-life care. From a policy perspective, it is important that the federal and provincial/territorial governments work together to ensure that Canadians are well cared for and have choice in care at the end of their lives.

The Committee recognizes the importance of providing access to palliative care services for Canadians of all ages and across all relevant sectors of the health care system, hospitals, hospices, community services, as well as non-governmental organizations. It also recognizes that enabling universal access to palliative care services at all of these sites would require major changes that would be very hard to implement.

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. But the services necessary in the home are often not available. Where they do exist it is usually as result of initiatives taken at the community level or by local institutions and regional health authorities, rather than as a consequence of government policy intended to reach the whole Canadian population.

The Committee is convinced that it is essential for the federal government to make a substantial contribution to making palliative care services available to Canadians in their homes. However, it has proven impossible to obtain the data that would permit accurate estimates of the cost of a national palliative home care program. None of the experts or potential sources of accurate statistical information on palliative care with whom the Committee consulted had detailed costs on palliative home care. Nonetheless, the Committee believes the federal government should set aside the funds now to cover the initial costs of a program that should be developed in conjunction with the provinces and territories and paid for on a 50:50 cost-sharing basis. The Committee therefore recommends that:

***While the Committee is aware that there are important limits to what the federal government can achieve directly in this area, it is nonetheless convinced that it is essential for the federal government to make a substantial contribution to making palliative care services available to Canadians in their homes.***

**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.**

## **9.2 Financial Assistance to Caregivers Providing Palliative Care at Home**

In addition to helping establish a national program to pay the costs of end-of-life care for Canadians who choose to die in their own homes, there are also other measures that the federal government should consider in order to alleviate the burden that now falls on the shoulders of thousands of informal caregivers.

These are discussed in this section and the ones that follow.

***In addition to helping to establish a national program to pay the costs of end-of-life care for Canadians who choose to die in their own homes, there are also other measures that the federal government should consider in order to alleviate the burden that now falls on the shoulders of thousands of informal caregivers.***

Most of the costs of care in the home are currently assumed by the dying person's family. During Phase Two of its study, the Committee was told that, in general, the majority of informal caregivers are women who must often simultaneously manage responsibility

both for aging parents and their own children while also holding down full-time paid work. This combination of responsibilities can not only lead to stress-related illness and loss of work time for the caregiver, but may also increase the risk of neglect and mistreatment of those receiving care.

In its 1999 report, *Caring about Caregiving: The Eldercare Responsibilities of Canadian Workers and the Impact on Employers*, the Conference Board of Canada found that 48% of those providing personal care in the home said it was very difficult to balance their personal and job responsibilities; 42% of them experienced a great deal of stress in trying to juggle their various roles; 57% felt that they did not have enough time for themselves; 53% cut back on sleep; and 44% had experienced minor health problems in the past six months.

These statistics, which apply to all caregivers at home and not just those delivering palliative care, illustrate how reliance on informal caregivers imposes costs on Canadians, while at the same time saving the health care system money. If care were not provided informally, in all likelihood greater costs would be incurred by hospitals and other providers.

In Volume Four, the Committee insisted on the importance of providing support to informal caregivers. It recognized that current tax provisions are inadequate to compensate informal caregivers for the time and resources they provide. The Committee highlighted the fact that the National Advisory Committee on Aging (NACA) had recommended that the Canada Pension Plan (CPP) and the Employment Insurance (EI) program be adjusted to accommodate individuals who leave the workforce temporarily to provide informal care.

With increased support in the form of a policy to provide caregivers with financial and information resources, dying Canadians would have access to quality care and would be able to choose where they wished to spend their final days. Increased assistance to caregivers would ensure that they have the knowledge, skills, income security, job protection and other supports they require to provide care to the dying while maintaining their own health and well-being throughout the dying and grieving process.

***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.***

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.

In Volume Four, the Committee referred to statistics from NACA that estimated that providing benefits through the EI system to persons leaving the workforce to care for an ailing relative would increase the overall cost of EI by about \$670 million per year. This estimate was based on the total number of caregivers and a 10-week period of benefit payment. Using

figures from Statistics Canada on the actual number of palliative care patients, and reducing slightly the period of eligibility for benefits, the Committee has determined that the overall cost to the EI system for providing benefits to informal caregivers who were caring for palliative care patients would be significantly less than NACA had calculated.

In 1999, 219,530 Canadians died. Not all, however, required palliative care. By eliminating accidental deaths and certain types of illness, the Committee has determined that approximately 160,000 Canadians can be expected to require palliative care in any given year. Using the average EI rate of \$257 per week and a period of 6 weeks (instead of the 10-week period used by the National Council on Aging), providing EI benefits to individuals providing palliative care in the home would cost approximately \$240 million per year. The Committee believes that up to six weeks of leave should be granted to employees who provide palliative care to a dying relative at home, and that the federal government should consider allowing employees who take advantage of this leave to be eligible to receive EI benefits. The Committee therefore recommends that:

**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.**

### **9.3 Caregiver Tax Credit**

The Employment Insurance system is not the only avenue that exists for providing support to caregivers. Tax credits are another option. The 1998 budget recognized that families caring for an ill loved one required government assistance, and implemented a tax credit that applies to individuals residing with, and providing in-home care for, an elderly parent or grandparent or an infirm, dependent relative. This credit reduces combined federal-provincial tax by up to \$600.

The federal government also provides a medical expense tax credit. This credit allows Canadians to deduct the cost of certain medical devices, aids or equipment. A number of other tax credits also exist, including the disability tax credit and the attendant care expense deduction.

The Committee recommends that:

**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.**

## 9.4 Job Protection

Under the Constitution, the provinces have the primary responsibility for labour legislation, including job protection. However, there are areas that fall under federal jurisdiction, including the federal public service, military personnel, and individuals working in federal penitentiaries. People employed in these areas are governed by the Canada Labour Code and the Treasury Board assumes responsibility for employees of the federal government.

With regard to job protection, it would be possible for the federal government to take a leadership role in ensuring that people under its jurisdiction who take time off from work in order to care for a dying relative not endanger their employment status. The Committee therefore recommends that:

**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.**

Furthermore, the federal government could take additional steps with regard to its own employees. The Committee recommends that:

**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.**

## 9.5 Concluding Remarks

The federal government can provide strong leadership and support for dying Canadians and their families, in particular by ensuring that Canadians who choose to die at home have access to the services that they need to do so with dignity. A new cost-shared palliative home care program would represent a major step toward making this possible.

As well, the additional measures recommended in this chapter would significantly improve the situation confronting family members who care for the dying at home. The Employment Insurance option would provide immediate financial assistance. Moreover, it would likely trigger job protection legislation in the provinces, as did extended maternity benefit legislation.

The disadvantage of this option is that it is only available to insured workers. Tax credits, on the other hand, have the advantage of providing broader

***The federal government is in a position to provide strong leadership and support for dying Canadians and their families, in particular by ensuring that Canadians who choose to die at home have access to the services that they need to do so with dignity.***

coverage. However, such credits do not offer earnings replacement during the time of need, nor would they likely help to initiate job protection legislation.

Taken together, all the measures recommended in this chapter constitute a package that, if implemented, would mark real progress towards making quality end-of-life care for Canadians a reality.

# **Part V:**

# **Expanding Capacity and**

# **Building Infrastructure**





## CHAPTER TEN

### THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE

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In Volume Five, the Committee presented its findings and general recommendations with respect to the role of the federal government in health care infrastructure.<sup>213</sup> These recommendations were based on the third of the roles the Committee spelled out in Volume Four for the federal government in health and health care, a role intended to “support health care infrastructure and health infostructure.”<sup>214</sup>

In this chapter, the Committee provides more specific details on its recommendations relating to health care technology (Section 10.1), electronic health records (Section 10.2) and evaluation of quality, performance and outcomes (Section 10.3) – three areas of Canadian health care infrastructure which the Committee strongly feels must be given priority by the federal government.

***The Committee strongly believes that health care technology, electronic health records and the evaluation of quality, performance and outcomes are three areas of Canadian health care infrastructure that must be given priority by the federal government.***

The collection of patient information under a system of EHR and the related use of such information for the purpose of 1) clinical practice, 2) system management, 3) performance and outcome evaluation, and 4) health research, raise a number of important and complex issues with respect to the protection of personal health information; these are reviewed in Section 10.4

#### 10.1 Health Care Technology

In Volume Five, the Committee noted that, despite the importance of health care technology in delivering timely and high-quality health services, the availability of many new technologies continues to be disproportionately low in Canada in comparison with other OECD countries. More specifically, Canada ranks 21<sup>st</sup> of 28 OECD countries in the availability of CT scanners, 19<sup>th</sup> of 22 in availability of lithotriptors, and 19<sup>th</sup> of 27 in availability of MRIs. Its only acceptable ranking is in the availability of radiation equipment, where it ranks 6<sup>th</sup> out of 17.

Data also show that this technology gap is widening. For example, the availability of MRIs in Canada worsened between 1986 and 1995 relative to other OECD countries, including Australia, France, the Netherlands and the United States.<sup>215</sup>

In addition, we noted in Volume Five that the aging of health care technology is also of concern. For example, information provided to the Committee indicated that between 30% and 63% of imaging technology currently used in Canada is outdated. Not only can the

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<sup>213</sup> Volume Five, pp. 69-89.

<sup>214</sup> Volume Four, p. 9.

<sup>215</sup> Volume Five, pp. 69-70.

outdated nature of health care technology negatively affect the health of a patient, but it also raises concerns about the legal liability of health care providers.<sup>216</sup>

The Committee is concerned that the shortage of health care technology and the use of outdated equipment impede exact diagnosis and inhibit high-quality treatment. Moreover, we are concerned that the deficit in health care technology has been translated into limited access to needed care and lengthened waiting times. In our view, health care technologies are key to providing Canadians with timely and high-quality health care.

***The Committee is concerned that the shortage of health care technology and the use of outdated equipment impede exact diagnosis and inhibit high-quality treatment. Moreover, we are concerned that the deficit in health care technology has translated into limited access to needed care and lengthened waiting times.***

In September 2000, the federal government responded to the deficit in health care technology by establishing the Medical Equipment Fund (MEF). The MEF allocated \$1 billion (transferred on a per capita basis over a two-year period) to the provinces and territories for the purchase of health care technology. The Committee has welcomed this injection of new federal funds. However, we raised a number of concerns in Volume Five about the MEF:

- First, some provinces have not applied for their share of this fund, possibly because the federal government requires matching grants that some of the poorer provinces have difficulty financing.
- Second, additional resources are required to operate the new equipment. Even if provinces can afford their share of the capital investment, they may have difficulty funding the additional ongoing operating costs.
- Third, the investment did not address the problem of old equipment that needs to be upgraded.
- Fourth, even with this new funding, Canada still does not rank at a level comparable to other OECD countries.
- And finally, there are apparently no mechanisms to ensure accountability on the part of the provinces/territories as to exactly where money targeted to purchasing new equipment is actually spent.

In July 2002, the Canadian Medical Association gave the Committee a report on the Medical Equipment Fund that addressed many of these concerns.<sup>217</sup> This background paper made the following observations:

- Because of the lack of a transparent accountability mechanism, it is very difficult to determine whether the MEF reached its intended destination.

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<sup>216</sup> Volume Five, p. 70.

<sup>217</sup> Canadian Medical Association, *Whither the Medical Equipment Fund?*, Background paper and technical notes, July 2002.

- Of the \$1 billion allocated through the MEF, approximately 60% was used for new (incremental) spending on health care technology, while 40% was used to pay for already planned expenditures.
- The MEF resulted in a modest to significant improvement in the availability of health care technology in Canada compared to other OECD countries. For example, the gap in health care technology has been reduced significantly in terms of radiation equipment and MRIs since the introduction of the MEF, while a substantial gap remains with respect to CT scans, PET scans and lithotriptors.
- An estimated investment of \$1.15 billion is still needed to bring Canada up to the 1997 level of the 7-OECD country average. Of this amount, \$650 million is required for the purchase of new medical equipment and \$500 million is required for additional operating costs. The latter amount is critical to ensure that the purchasing funds can in fact be used by all provinces/territories; otherwise, the investments may not be made due to the lack of fiscal capacity of some provinces/territories.

The overall estimate by the Canadian Medical Association is very conservative; the calculation rests on only selective technologies (CT scans, MRIs, lithotriptors, PET scans and linear accelerators). Moreover, the \$1.15 billion investment in health care technology would bring Canada only to the level in 1997 of the other OECD countries for these five specific technologies.<sup>218</sup>

***The Committee believes that additional funding is required for the purchase of health care technology. We also believe that the federal government should support the provinces and territories to purchase new medical equipment.***

Other calculations by the Association of Canadian Academic Healthcare Organizations suggest that between \$1.7 and \$2.5 billion (or some \$420 million per year over five years) is required by Academic Health Sciences Centres (AHSCs) for the purchase and operation of advanced medical equipment.

The findings in the papers by both the Canadian Medical Association and the Association of Canadian Academic Healthcare Organizations reinforce the observations and conclusions made by the Committee in Volume Five. Accordingly, we believe that additional funding is required for the purchase of health care technology. We also believe that the federal government should support the provinces and territories to purchase new medical equipment.

It is the view of the Committee that the federal government should ensure that any new funding for health care technology be spent on *incremental* purchases of medical equipment and not to offset already planned expenditures. Moreover, we strongly feel that a better accountability mechanism is needed for

***The Committee strongly feels that a better accountability mechanism is needed for targeted federal funds such as the Medical Equipment Fund.***

<sup>218</sup> Association of Canadian Academic Healthcare Organizations, *Background Information in Support of a National Teaching Centre Health Infrastructure Fund*, Draft Submission to the Committee, 6 August 2002.

targeted federal funds such as the MEF.

The Committee also noted in Volume Five that there is a need to perform more health care technology assessment (HTA) when considering the introduction of a new technology or the replacement of existing medical equipment.<sup>219</sup> HTA provides information on safety, clinical effectiveness and economic efficiency and also considers the social, legal and ethical implications of the use of health care technology. The Committee stressed that all levels of government invest less than \$8 million in total in Canada on HTA, whereas the United Kingdom provides some \$100 million to its national HTA body, the National Institute for Clinical Evidence. Accordingly, we recommended in Volume Five that the federal government provide additional funding to HTA agencies for the purpose of assessing new and existing health care technology.

Finally, the Committee believes that a significant portion of the funding for the purchase of health care technology should be provided to AHSCs that currently house a large proportion of advanced medical equipment. AHSCs are also well suited, given their physical and clinical infrastructure, to undertake state-of-the-art HTA activities. It is the view of the Committee that federal funding for health care technology should not be provided to privately owned and operated clinics since they do not perform teaching, assessment and research activities.

The Committee acknowledges the important role of AHSCs in introducing and assessing new health care technology. We also recognize that community hospitals require additional investment in new medical equipment as well. It is our view that the federal government must play a leading role in sustaining long-term investment in needed health care technology.

The Committee does not believe, however, that a program such as the MEF is the means by which such a goal should be achieved. We agree with witnesses that federal funding should be provided within a multi-year fiscal framework, responding to requests initiated by health care institutions themselves with review by a group of independent experts. This would, in our view, provide a more *effective* and *accountable* model of governance.

***The Committee agrees with witnesses that federal funding should be provided within a multi-year fiscal framework, responding to requests initiated by health care institutions themselves with review by a group of independent experts.***

More precisely, under this model, teaching hospitals, community hospitals and regional health authorities would be required to accompany a request with a sound rationale for additional resources. Each application would be evaluated on its own merits by an independent expert group that would report to the Minister of Health. Moreover, in order to ensure accountability, successful applicants would have to report on their disposition of the funds received. Therefore, the Committee recommends that:

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<sup>219</sup> Volume Five, pp. 72-75.

**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.**

## **10.2 Electronic Health Records**

The electronic health record (EHR) is based on an automated provider-based system within an electronic network that provides complete patients' health records including visits to physicians, hospital stays, prescription drugs, laboratory tests, and so on. In Volume Five, the

***The electronic health record (EHR) is based on an automated provider-based system within an electronic network that provides complete patients' health records including visits to physicians, hospital stays, prescription drugs, laboratory tests, and so on.***

Committee stressed that an EHR system is the first step in gathering health-related information that will allow for evidence-based decision making throughout the whole health care system. An EHR system also offers tremendous opportunities to integrate the various components of Canada's health care system that currently work in silos.<sup>220</sup>

An important characteristic of an EHR system is that it can make patient data available to health care providers and institutions anywhere on a need-to-know basis by connecting interoperable databases that have adopted the required data and technical standards. Not only can an EHR system greatly improve quality and timeliness in health care delivery; it can also enhance health care system management, efficiency and accountability. Moreover, the data collected from an EHR system can provide very useful information for the purpose of health research.

The benefits of an EHR system are numerous:

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<sup>220</sup> Volume Five, pp. 78-80.

*National, interoperable EHR solutions that bring comprehensive and portable information to health providers and their patients will empower Canadians and help to significantly improve the quality, safety, accessibility, timeliness and efficiency of services.*

*Furthermore, EHR solutions will enable the creation, analysis and dissemination of the best possible evidence from across Canada and around the world as a basis for more informed decisions by patients, citizens and caregivers; by health professionals and providers; and by health managers and policymakers. They will also help maximize the return on ICT investments through alignment, and drive the development of common standards and interoperability.<sup>221</sup>*

All levels of government in Canada have recognized the importance of developing and deploying EHR systems. On September 11, 2000, the First Ministers agreed to work together to develop an interlinked EHR system over the next three years and to work collaboratively to develop common data standards to ensure compatibility and interoperability of provincial health information networks together with stringent protection of personal health information.

In support of the agreement reached by the First Ministers, the federal government committed \$500 million in 2000-01 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 members of *Infoway* are the Deputy Ministers of Health of the provincial, territorial and federal governments. *Infoway* is governed by a Board of Directors who are representatives of regions of Canada.<sup>222</sup> The Board also involves some independent directors.

In July 2002, *Infoway* forwarded a copy of its business plan to the Committee. As part of its business plan, *Infoway* intends to invest in projects that enhance patient care, build on the existing base of information management, ensure leverage of financial investments and align federal, provincial and territorial priorities in a sustained fashion in order to achieve a pan-Canadian EHR system.

The Committee recognizes that the cost of building a pan-Canadian, interoperable EHR system will greatly exceed the initial \$500-million investment contributed by the federal government. Indeed, data from *Infoway* suggest that implementing a coordinated system of EHR throughout Canada will require \$2.2 billion. Without coordination, that is if jurisdictions implement EHR in isolation from each other, the one-time costs of EHR

***The Committee believes that both Canadians and their publicly funded health care system will benefit greatly if the system of electronic health records is national in scope. Indeed, a national EHR system is critical. To achieve this, the federal government must provide leadership and the necessary resources.***

<sup>221</sup> Linda Lizotte-MacPherson, President and CEO of *Infoway*, Letter to the Committee, 24 July 2002, p. 7.

<sup>222</sup> To date, Quebec has elected not to participate as a member and as such has not availed itself of its right to appoint a representative to *Infoway's* Board of Directors.

deployment would reach \$3.8 billion. Accordingly, achieving the full deployment of an EHR system will require a significant alignment of effort on the part of all jurisdictions, a pooling of resources, partnerships with the private sector and new sources of funding.

Overall, the Committee is very enthusiastic about the work undertaken by *Infoway* in deploying a national system of EHR. We believe that both Canadians and their publicly funded health care system will benefit greatly if the system of electronic health records is national in scope. Indeed, a *national* EHR system is critical. It is our view that, to achieve this, the federal government must provide leadership and the necessary resources. Therefore, the Committee reiterates its recommendation from Volume Five that:

**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.**

Furthermore, the Committee recommends that:

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

The issue of privacy, confidentiality and protection of personal health information in the context of an EHR system is perhaps the most sensitive one raised during the Committee's hearings on this question. We address this question in detail in Section 10.4 below. However, it is worth noting here that an EHR system has the potential to actually improve the present situation with respect to the privacy of patients' health information. Currently, the privacy of individual health records is not secure. Moreover, patients do not have effective access to their own records and, in fact, don't even know where those records are. The Committee is of the view that, in the absence of a common EHR, both privacy and health care are substantially at risk from the wide dispersal of fragments of a patient's record here and there in doctor's offices, hospitals, public health units, home care providers' files, nursing homes, etc.

***The Committee is of the view that, in the absence of a common EHR, both privacy and health care are substantially at risk from the wide dispersal of fragments of a patient's record here and there in doctors' offices, hospitals, public health units, home care providers, nursing homes, etc.***

### **10.3 Evaluation of Quality, Performance and Outcomes**

In Volume Five,<sup>223</sup> the Committee stated that long-term investment in information and communication technology, including an HER system, will allow the collection

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<sup>223</sup> Volume Five, pp. 80-83.

of more timely and better information on access to care, quality delivery, system performance and patients' outcomes. We also indicated that while governments must finance the HER system, they should not be responsible for assessing health data and evaluating quality and outcomes. We agreed with witnesses that, currently, collection and evaluation of health-related information is done by the same people who are responsible for paying for, and for providing, health services – that is, governments.

Accordingly, we noted the fact that there is no independent assessment of outcomes and no external audit of the impact of various procedures on patients. This concern was also raised by various provincial commissions on health care. Based on the testimony and provincial reports, the Committee concluded that the role of the evaluator of the health care system must be separated from that of the insurer and provider in order to obtain an independent assessment of health care system performance and outcomes.

***The Committee is convinced that the role of the evaluator of the health care system must be separated from that of the insurer and provider in order to obtain an independent assessment of health care system performance and outcomes.***

As explained in great detail in Chapter One, the Committee believes that such independent evaluation should be performed at the national (not federal) level. This would allow for the pooling of expertise, thereby making the most effective use of the limited human resources currently available in Canada, and result in major economies of scale. This is why we have recommended in Chapter One the appointment of a National Health Care Commissioner charged with providing comments and recommendations on health care system performance, health status and health outcomes.

***The Committee believes that such independent evaluation should be performed at the national (not federal) level by the National Health Care Commissioner recommended in Chapter One.***

Moreover, the Committee believes that the work of the National Health Care Commissioner in evaluating health care system performance and outcomes should build on those national organizations that are currently devoted to the task of performing independent health care system evaluation.

One organization that the Committee believes strongly should collaborate in a national system of independent evaluation is the Canadian Institute for Health Information (CIHI). In our view, CIHI has a credible history in collecting standardized data and developing indicators for the health care system. Its work has been developed through a cooperative process involving various jurisdictions and multiple stakeholders.

In addition, CIHI already has extensive data holdings that serve to support monitoring of the health care system (in a variety of fields such as human resources, adverse events, waiting times, Case Mix Groups (CMGs), system performance, health status indicators, financial

***It is the view of the Committee that CIHI has a credible history in developing indicators for the health care system.***



management, and so on). Furthermore, CIHI has already established credible mechanisms for reporting to the public.

Since its inception, CIHI has been providing the Canadian public, health care managers and policy makers with excellent information. However, its budget, which is currently set at \$95 million over four years (2001-2005), falls short of the investment necessary to provide the information required to plan, manage and report on the impact on the health care system changes recommended by the Committee. Thus, we believe strongly that CIHI's budget must be augmented considerably.

Another national organization, the Canadian Council on Health Services Accreditation (CCHSA), has built a solid foundation on the basis of a voluntary accreditation process for health care institutions. The Committee learned that its strength derives from its primary focus on continuous quality improvement, a strength that should be preserved.

The Committee believes that, as part of a national system of evaluation, the mandate of CCHSA should be expanded to require regular accreditation, at regular intervals, for all sectors of health care (RHAs, public and private hospitals, primary health care settings, etc.). Accreditation should be based on well recognized national standards. If standards are not met and remediation is inadequate, then accreditation should not be given. The accreditation process would be supportive of a transparent accountability process.

Therefore, the Committee recommends that:

**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.**

#### **10.4 Protection of Personal Health Information**

Electronic health records will likely affect the application of fair information principles in a number of ways. As compatible EHR systems are developed and implemented across the country, the traditional, bilateral relationship between patient and provider will be transformed into a more complex web of interactions between the patient and the health care system.

By their very nature, paper records are limited to discrete pieces of personal information that could feasibly be gathered in paper form, contained in a specific physical location, often collected by a single provider and accessible to that same provider in the context of one individual encounter at a time. This contrasts with EHRs, which can assemble a more complete, comprehensive and longitudinal record of a person's health information originating

from multiple sources, captured in electronic form that is readily available and potentially accessible to multiple authorized users, in real-time, irrespective of location.

This transformation will inevitably affect how patients can meaningfully and practically exercise their right to protection of personal health information. Likewise, this transformation will affect how responsibility and accountability are coordinated and shared among the multiple users of that information.

For these reasons, advancements in health information technology, including the development and implementation of EHRs, are often perceived as threats to individual privacy. This is in part due to the potential for increased access by multiple users and the seeming lack of patient control over personal health information. This being said, however, health information technology also provides a real opportunity for increased protection of privacy, as compared to paper records, through more effective security safeguards to restrict access and enhanced tracking features to audit all transactions. It also offers the opportunity for increased, rather than diminished, personal access to and control of health information by patients. These potential advantages balance the potential threats of EHRs.

***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.***

A system of EHRs is planned as the first critical phase in the development of an eventual pan-Canadian health info-structure. The immediate and obvious benefits of EHRs in the context of primary health care include improved efficiency of the system through more effective management of patients' health records and integrated health services delivery. EHRs also promise improved health care by giving providers access to a more comprehensive understanding of their patients' health status as an essential aid for proper diagnosis, effective treatment and safe prescriptions, particularly in situations of emergency or out-of-province care.

***EHRs also promise improved health care by giving providers access to a more comprehensive understanding of their patients' health status as an essential aid for proper diagnosis, effective treatment and safe prescriptions, particularly in situations of emergency or out-of-province care.***

Moreover, the pan-Canadian health info-structure promises to empower patients with better health information as well. This will allow patients to make more informed choices about their own health, the health of others and the health care system. A health infostructure will allow health care managers to evaluate service providers better and will enhance accountability of the system. It will also provide researchers with the evidentiary bases needed to continue to improve health care and better understand the determinants of health.<sup>224</sup>

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<sup>224</sup> Canada Health Infoway, *Paths to Better Health*, Final Report of the Advisory Council on Health Infostructure. December 1999

Currently, there are three main privacy issues that must be addressed for EHRs to become a reality in Canada in the next five to seven years. These are:

1. The need for a more harmonized approach to privacy across all jurisdictions to allow for more consistent conditions for sharing personal health information among users and more consistent protection of personal health information for patients.
2. The need to develop robust and effective privacy safeguards, policies and procedures that can be implemented in a pragmatic, practical and cost-effective manner.
3. The need to build public confidence that personal health information will be protected in an electronic world.<sup>225</sup>

Currently, there is significant variation in privacy laws and data access policies across the country that poses a challenge for EHR systems that are dependent on inter-sectoral and inter-jurisdictional flows of personal health information. Differences in rules on how the scope of purpose is defined, the form of consent required, the conditions for substitute decision-making, the criteria for non-consensual access to personal health information, periods for retention of data and requirements for destruction, to name but a few, must be seriously addressed in order to enable the development of EHR systems.

In addition, existing oversight bodies in different sectors and jurisdictions have varying delegated legislative authority over some parts of an EHR system, but not others. Without some overarching coordination, this piecemeal approach will render very difficult, in practice, any system of review and oversight, process for approval, procedure for investigation and application of sanctions.

The Committee encourages ongoing federal/provincial/territorial efforts to develop a harmonized approach to protecting personal health information. In particular, the Committee recommends that:

**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;**

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<sup>225</sup> See Advisory Council on Health Infostructure, *Canada Health Infoway, Paths to Better Health*, Final Report, December 1999; Federal/Provincial/Territorial Advisory Committee on Health Infostructure, *Tactical Plan for a Pan-Canadian Health Infostructure*, 2001 Update; discussions of Regional Fora held by Canada Health Infoway Inc. summarized at <http://www.canadahealthinfoway.ca/sub.php?lang=en&secLoc=frm>).

- **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.**

Another major challenge facing EHR development is the need to find ways of implementing compatible EHR systems in a manner that both protects people's right to privacy of personal health information and is feasible and workable in practice. While there may be ways of introducing the most stringent physical, technological and organizational safeguards possible, these may simply not work in practice or be cost-effective. Moreover, safeguards change significantly over time as technology and customary practice evolves, requiring constant updating and upgrading. Organizations must distinguish passing trends from well-tested and proven state-of-the-art measures and make realistic investment choices accordingly.

In an EHR environment, many players will be involved in the collection of personal health information for inclusion in the common record. There will be many authorized users that can potentially gain rightful access to the EHR, adding information and collectively participating in the development of the record. As control will be shared among various players and users, so too shall accountability be shared. A real challenge lies in coordinating and apportioning responsibilities so that patients' rights do not fall between the cracks. Despite the seemingly amorphous environment of an EHR system, patients must be able to direct their questions and concerns to an identifiable, responsible entity and exercise, in a meaningful way, their rights to access, correction and redress in the event of non-compliance.

Therefore, the Committee recommends that:

**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.**

In order to enable the development and implementation of EHRs, public trust and confidence are indispensable. There is currently little research on understanding the determinants of Canadians' attitudes about the use of their personal health information for different purposes. Such research is vital if EHRs are to be developed and implemented in a manner that takes into account these determinants and respects people's underlying concerns in specific contexts.

While the advantages of EHRs may be obvious to those who are in the business of developing them, these advantages must also be made obvious to individual Canadians. The promise of an eventual pan-Canadian health info-structure belongs to everyone. An informed and meaningful dialogue should occur, engaging all key stakeholders, including patient groups and consumer representatives. Providers will be better equipped to improve the quality of the care they deliver and integrate their services; policy-makers and managers will be better informed and able to ensure access to health care and accountability for actions throughout the system; researchers will be able to evaluate the effectiveness of health care products and services and better understand the determinants of Canadians' health; members of the public will be better empowered to make informed choices about their own health, their health care and about health-related policy. An open, transparent, and iterative public communication strategy would go a long way to bring home the many benefits of EHRs and the truly inclusive vision of an eventual pan-Canadian health info-structure. Therefore, the Committee recommends that:

**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

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#### 11.1 The Extent of Health Human Resource Shortages

Over the course of its hearings the Committee has heard overwhelming evidence of a persistent human resource shortage in all sectors of the health care system, affecting specialist physicians as well as family practitioners, registered nurses as well as licensed practical nurses, laboratory technologists as well as pharmacists. Addressing the supply 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.

***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.***

Hardly a month goes by without the release of a new study or report that further documents the breadth and the gravity of the situation. A number of these that have appeared since the release of the Committee's last report tell a familiar story.

According to a new report issued by the Canadian Institute for Health Information (CIHI) in June 2002, physician supply in Canada peaked in 1993 and has suffered a 5% decline since then, bringing the ratio of physicians to population down to the level it was 15 years ago.<sup>226</sup> This report provided one more graphic illustration of the extent of the human resource shortage and its consequences, including fewer family doctors, fewer younger physicians and heavier workloads for doctors.

Two recent provincial documents on physician supply also lend further support to the view expressed by the Committee in its previous reports that the human resource question is one area where it is increasingly legitimate to speak in terms of a crisis confronting the system. The Quebec College of Physicians examined the numbers of doctors actually in practice, rather than relying on raw registration numbers, and found that the province would need more than 1,400 additional physicians to provide necessary services to the population.<sup>227</sup>

For its part, the Ontario Medical Association estimated that there was a further net loss of 110 physicians from that province between 1999-2000, bringing the total shortfall to an estimated 1,585 physicians. The report indicates that there are now over 100 underserved communities in the province.<sup>228</sup>

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<sup>226</sup> Dr. Benjamin TB Chan, *From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s?*, Canadian Institute for Health Information, June 2002.

<sup>227</sup> *Medical Post*, June 4, 2002.

<sup>228</sup> Ontario Medical Association "Position paper on physician workforce policy and planning", April 2002.

At the same time, the Committee is concerned that all of the studies referred to above focus on the number of practising physicians, and do not address the problem of productivity. Clearly, improving physician productivity would reduce the numbers of additional physicians required in Canada.

For example, most surgeons say that they could increase their productivity if they were given more operating time, and greater access to short term beds for their patients, who could then complete their recovery at home.<sup>229</sup> This fact raises the following policy question: is it better to remove the existing roadblocks to improved surgeon productivity, or to produce more surgeons who will, like their predecessors, not be as productive as they could be or want to be because institutional constraints prevent them from increasing their productivity? Policy questions like these cannot be properly answered without a much better understanding of the current level of productivity of physicians and the barriers to increasing that productivity.

***...the Committee is concerned that all of the studies referred to above focus on the number of practising physicians, and do not address the problem of productivity.***

The Committee believes that it is essential that independent research organizations, not affiliated with the medical profession, undertake detailed studies of physician productivity and of the barriers that impede increases in productivity. Government, as the funder of the system, and those who actually provide health services must understand the factors that influence productivity in health care and how the productivity of the key personnel in the system can be improved.

***The Committee believes that it is essential that independent research organizations not affiliated to the medical profession (such as CIHI or the CIHR), undertake detailed studies of physician productivity.***

In other fields, the availability of, for example, information technology has increased the productivity of other professionals over the past 20 years. Surely better diagnostic equipment, more effective drugs, improved out-of-hospital treatments, combined with the improved health status of Canadians over the past 20 years should have made physicians more productive. But whether this has actually happened is not known. This is why the proposed research is needed.

The Committee believes that similar observations to those about physician productivity could also be made about other health care professionals. The Committee therefore recommends that:

**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.**

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<sup>229</sup> See Chapter 8 of this volume for the Committee's proposal for a post-hospital home care program



Three recently issued reports provide additional data on the extent of the shortage of nurses. CIHI reported in June 2002 that although there was a slight increase (1.2%) in the number of nurses employed in Canada between 1997 and 2001, it was not sufficient to keep pace with population growth. There are thus fewer nurses per capita in the country today than five years ago. The report also indicated that the nursing workforce is aging rapidly, with the average age of RNs employed in nursing going from 42.4 years in 1997 to 43.7 years in 2001.<sup>230</sup>

A study conducted for the Canadian Nurses Association that examined trends since 1966 noted “throughout the entire 35 years covered by the data series, the nursing workforce has seen the age composition shift to older age groups.”<sup>231</sup> The CNA report also made projections with regard to nursing supply and demand for the next 10 to 15 years, concluding that “there will be a shortage of 78,000 RNs in 2011 and 113,000 RNs by 2016.”<sup>232</sup>

The Final Report of the Canadian Nursing Advisory Committee, chaired by Mr. Michael Decter, was released in August 2002. It identified three barriers to a quality workplace for Canadian nurses,<sup>233</sup> namely:

- the need for an increased number of nurses;
- the need to improve the education and maximize the scope of practice of nurses;
- the need to improve working conditions of nurses.

Amongst its 51 recommendations designed to help eliminate these barriers, the Advisory Committee advocated that the number of new, first-year seats in schools of nursing for Registered Nurses be increased by 25% (roughly 1,100 new seats) in September 2004 and that this number be adjusted upward by a further 20% in each of the subsequent four years.

Still, not enough is known about the productivity of nurses and what could be done to improve it. For example, in its report, the Canadian Nursing Advisory Committee endorses the need for “provincial and federal resources [...] to be directed toward the development of accurate and manageable strategies to measure and report on workload.”<sup>234</sup> The Committee believes that the same type of productivity research that is proposed with respect to physicians is also needed in order to understand better how nurses spend their time at work, and what institutional barriers stand in the way of improved productivity. This is why the recommendation made above includes all health care professionals.

Although allied health professionals receive less public attention, the Committee has repeatedly drawn attention to the fact that the human resource shortage is not limited to doctors and nurses. For example, the Committee noted in previous Volumes that over 20

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<sup>230</sup> Canadian Institute for Health Information, *Supply and Distribution of Registered Nurses in Canada, 2001 Report*, June 2002.

<sup>231</sup> Canadian Nurses Association, *Planning for the Future: Nursing Human Resource Projections*, June 2002, p. 20.

<sup>232</sup> *Ibid.*, p. 1.

<sup>233</sup> *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses*, Advisory Committee on Health Human Resources, 2002, p. 3.

<sup>234</sup> p. 36

disciplines reported experiencing important shortages, ranging from physical and occupational therapists to radiography and medical laboratory technologists to public health inspectors.

Moreover, witnesses indicated that despite these shortages, enrolments in training programs are being cut. One example was medical laboratory technology in Alberta, where places in training schools had been cut from 40 to 20 students. Witnesses also referred to other disturbing figures, considering the ever-increasing demand for technical and professional employees attributable both to new technologies and to a growing population. For example, there has been a 42% decrease in the number of graduates from medical laboratory technology programs across the country since 1987, while diagnostic imaging produced 15% fewer graduates over the same period. The Canadian Society for Medical Laboratory Science has predicted a nation-wide shortage of general medical laboratory technologists within the next 5 to 15 years.

A further illustration was provided by the Canadian Pharmacists Association. It noted that a shortage of pharmacists is a problem in many countries including Canada, the United Kingdom and the United States. The under-supply of pharmacists translates into increased vacancies, longer delays in filling vacancies, increases in overtime hours, and market-based wage increases that exceed the cost of living. Another recent study suggests that well over 2,000 additional pharmacists could readily find work in Canada.

The decline in the number of graduates has also been compounded by what has been called “credential creep.” This refers to the gradual increase in the educational levels required to gain employment in a particular field, said to be driven by increasing complexity of the work involved. Among the consequences of “credential creep” are that it takes longer to train new graduates, thereby exacerbating the existing shortages of all health care professionals.

Credential creep also has other consequences. On the one hand, it can lead to the transfer of some programs from community colleges to universities; on the other, it can lead to graduates seeking higher levels of compensation they believe are justified by the additional training they have undergone.

The Committee is concerned that these developments occur without sufficient independent study to verify that the changes in the level of qualification and remuneration are warranted. The Committee believes that a review of the length of time required to train various health care professionals is needed, as well as an examination of what is the most appropriate educational institution to provide the needed training.

## **11.2 Health Human Resources: The Need for a National Strategy**

The Committee believes strongly that one of the major consequences of the growing world-wide shortage of health human resources is that Canada must develop a strategy to enable the country to become self-sufficient in health human resources.

***The Committee believes strongly that one of the major consequences of the growing world-wide shortage of health human resources is that Canada must develop a strategy to enable the country to become self-sufficient in health human resources.***

In the Committee's view, moving forward in this regard entails recognizing that such a strategy cannot be a "federal" one but must rather involve all stakeholders, bearing in mind that the training and education of health care professionals is a provincial responsibility. For Canada to attain the objective of self-sufficiency in health human resources, long-term cooperation and coordination among all stakeholders in the health care field are essential.

In the Committee's opinion, problems relating to interprovincial competition for graduates in health-related fields further highlight the necessity to develop a national health human resources strategy. Competition among different jurisdictions for scarce human resources, whether interprovincial or international, can lead to severe regional disparities in the ability to provide health care services.

The Committee believes that the federal government must play a much stronger role than it has to date in coordinating efforts to develop and implement a national health human resource strategy and to deal with shortages. Given that it is clear that there can be no "quick fix" to the crisis in health human resources, and that a wide range of interests and concerns must be considered in the search for long-term solutions, it seems to the Committee appropriate to recommend the establishment of an ongoing framework to deal with human resource issues. The Committee therefore recommended in Volume Five that:

***The Committee believes that the federal government must play a much stronger role than it has to date in coordinating efforts to deal with health human resources shortages.***

**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.**

As noted earlier, the Committee also believes that the National Coordinating Committee on Health Human Resources should assume responsibility for studying how the productivity of health care professionals can be improved. It is also clear to the Committee that no single group of professionals, nor any single level of government, should predominate in the deliberations of the proposed National Coordinating Committee.

The Committee also recommends that the federal government undertake a number of specific initiatives designed to increase the supply of health care professionals, namely that:

**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.**

In previous volumes, the Committee had noted that there was a serious shortage of health care providers from Aboriginal backgrounds. In order to help to address this problem the Committee also recommended in Volume Five that:

**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.**

Moreover, since all the measures described in the above recommendations take time to implement, various shorter-term measures are required to deal with the health human resources crisis. One such avenue involves the tax system. Short-term tax incentives were used in the late 1960s and early 1970s to attract university professors to Canada at a time when the country faced a severe shortage of qualified university faculty members. The Committee believes a similar approach should be considered at this time with respect to health care professionals. It therefore further recommends that:

**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 following sections of this chapter contain additional observations related to the health human resources shortage in Canada, as well as a number of further recommendations to help alleviate it.

### **11.3 Increasing the Number of Physicians Trained in Canada**

The recent CIHI report referred to above has made a new contribution to the discussion of physician supply in Canada by assigning weights to the various factors that have contributed to the decline in the ratio of physicians to population:

- about 25% of the decline can be attributed to longer postgraduate training for doctors, both because family doctors now require two years of postgraduate training instead of one before entering independent practice, and because a higher proportion of doctors are choosing to become specialists, which requires much longer training periods;
- 22% of the drop was attributable to fewer foreign doctors entering Canada;
- 17% was caused by increased physician retirement;
- to date, only 11% of the decline can be attributed to decreased enrolment in medical schools, but the full effect of the cuts of the 1990s will only be felt in coming years.

The author of the report, Dr. Ben Chan, notes that several key mistakes were made in policy design during the 1990s. In the first place, unintended consequences were not taken into account. For example, it was not fully appreciated that increasing the length of training (e.g., two rather than one year of postgraduate training for family physicians) permanently reduces the supply of physicians. Second, policies were not reviewed frequently

enough, so the effects of a number of policies combined in unexpected ways to generate a larger shortage than was anticipated. Finally, measures that gave the system flexibility were eliminated; for example, students were forced to lock into career choices at very early stages in their undergraduate education without the benefit of practical experience or the possibility of changing their minds at a later date.<sup>235</sup>

The Committee remains convinced that the only long-term solution to the human resources crisis remains the development of a national strategy that focuses on training enough physicians and other health professionals in Canada to meet the country's needs, as well as on increasing physician productivity. A recent estimate provided to the Committee by Dr. Abraham Fuks, President of the Association of Canadian Medical Colleges (ACMC), indicated that simply to maintain the current physician to population ratio, 2,500 students would have to enter medical school by 2005, an increase of 640 students from the 2001 first-year enrolment of 1,860.<sup>236</sup>

***The Committee remains convinced that the only long-term solution to the human resources crisis remains the development of a national strategy that focuses on training enough physicians and other health professionals in Canada to meet the country's needs, as well as on increasing physician productivity.***

In Volume Five, the Committee recommended that the federal government provide ongoing financial assistance to the provinces to increase enrolments in Canadian medical schools. According to the ACMC, the cost per place in a Canadian medical school is currently estimated at \$260,000 over a four-year period. An additional 640 students would therefore cost approximately \$160 million per year once the new levels of enrolment were attained.<sup>237</sup> The Committee believes that this would be money well spent, and therefore recommends that:

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

Moreover, it is important to bear in mind Dr. Chan's conclusion that it is necessary to review regularly the levels of enrolment to ensure that they remain in accord with evolving circumstances. Dr. Fuks estimated that in order to offset current physician shortages (rather than merely maintaining the current physician to population ratio) it would be necessary to increase enrolments further to 3,000 first-year students by 2009. It is important to note, however, that such forecasts do not take into account the impact of potential improvements in productivity. The Committee believes it necessary to keep a careful watch on the situation, and recommends that:

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<sup>235</sup> Dr. Ben Chan, "How Canada can better manage its MD supply," *Medical Post*, June 25, 2002.

<sup>236</sup> Dr. Abraham Fuks, Brief to the Committee, July 23, 2002.

<sup>237</sup> The cost per student, per year is one quarter of the total of \$260,000, that is \$65,000. However, once there are the desired number of new students enrolled in each year of the four-year medical degree program, this \$65,000 per student per year must be multiplied by four, so that the total cost of the new *places* is \$260,000 per year.

**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.**

Clearly, however, it will take time to raise the levels of enrolment, and it will be even longer before these increases translate into greater numbers of doctors in the field. In the short term, then, measures should also be taken to relieve some of the pressure. The Committee has already reiterated its recommendation from Volume Five that the federal government explore the possibility of adopting short-term tax incentives in order to repatriate health care professionals working abroad.

There are also a number of highly skilled and well-trained Canadians who are completing their basic medical education outside Canada, notably in Australia, Ireland and the UK. Dr. Fuks told the Committee that many of these students, who are receiving their training in high-quality medical faculties, are eager to return to Canada. The Committee believes that there should, therefore, be a robust policy of recruitment for such expatriate Canadians to return to Canada for post-graduate training and practice in this country.

In order to accommodate these returning students, as well as the international medical graduates discussed below, it will also be necessary to increase the number of post-graduate residency positions. Based on figures provided by the Association of Canadian Medical Colleges,<sup>238</sup> the Committee therefore recommends that:

**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.**

As the Committee noted in Volume Five, this will also allow Canadian physicians who are already in practice greater opportunity to re-enter postgraduate training and pursue additional qualifications.

#### **11.4 Integrating International Medical Graduates**

Another measure specific to dealing with the shortage of physicians is the development of a national plan to make better use of international medical graduates (IMGs) already here. In the past, Canada has been able to rely on recruitment from abroad to fill some of the gaps. For example, over 50% of doctors practising in Saskatchewan are international medical graduates who have been trained elsewhere and recruited to Saskatchewan later in their careers. However, other countries now face many of the same shortages that confront our system. There does not seem to make much sense for all developed countries to poach endlessly each other's highly trained health care professionals.

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<sup>238</sup> Dr. Fuks, *op. cit.*

Most experts estimate that there are currently at least 2,000 international medical graduates in Canada who are not licensed to work as physicians.<sup>239</sup> There is no common program for issuing credentials to IMGs, and each province has a limited program for admitting IMGs to residency programs. For example, Ontario reserves 40 spots for IMG training, but despite 1,000 applications last year only 25 were admitted.

There are some signs of progress, however. In April 2001, Manitoba launched the first permanent program in Canada to assist IMGs to obtain medical licences. It relies on a three-stage Clinicians Assessment and Professional Enhancement (CAPE) process, an evaluation tool developed by the University of Manitoba's faculty of medicine, to assess the medical knowledge and clinical skill of foreign-trained doctors. The CAPE program has proved so successful that the College of Physicians and Surgeons of Nova Scotia refers IMG applicants who do not have licensed North American training or clinical practice experience to the Manitoba program for assessment.<sup>240</sup>

Members of the Association of Canadian Medical Colleges recently concluded that there is a pressing need for a national strategy, incorporating national standards, to assist in integrating IMGs into the Canadian medical workforce. They proposed that there be a common evaluation program that would allow IMGs to be classified in one of four categories: their education and training is equivalent and they should be licensed to practise in Canada; they need some extra training; their medical education is equivalent but they need to do postgraduate training here; or neither their education nor training is adequate and they have to begin again at a medical school in Canada.

The Committee therefore recommends that:

**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.**

## **11.5 Alleviating the Shortage of Nurses**

As noted earlier in this chapter, a study conducted for the Canadian Nurses Association indicated that the country would be short 78,000 RNs in 2011 and that this shortfall could reach 113,000 by 2016. The study reached these conclusions despite using what it calls relatively optimistic assumptions with regard to the number of nursing graduates that can be anticipated in the coming five years. The report estimates that "the output from Canada's nursing schools is expected to grow from 4,599 graduates in the year 2000 to more than 9,000 per annum by the year 2007."<sup>241</sup> (See Table 11.1, below).

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<sup>239</sup> *Medical Post*, June 11, 2002.

<sup>240</sup> Pamela Clarke, "The Foreign Question," *Medical Post*, May 28, 2002.

<sup>241</sup> CNA, *op. cit.*, p. 1.



**TABLE 11.1**  
**NUMBER OF NURSING GRADUATES, 1999-2008\***

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Canada	5,221	4,599	5,499	6,782	7,578	7,678	7,834	8,829	9,182	9,382

Source: Projections by Eva Ryten for the Canadian Nurses Association, June, 2002.

\* 1999-2001, actual data; 2002-208, projections

But even with almost doubling the number of graduates, and an expected influx of 1,200 nurses trained abroad every year from 2002 onwards, the study categorically affirmed that it will not be possible to meet the anticipated demand for nursing services. Nor is there a sufficiently large pool of trained nurses who are not currently employed in nursing who could be enticed back into the profession in order to help deal with the shortfall. In fact, the report points out that:

*It is particularly relevant to note that in both 2000 and 2001, there were fewer than 3,000 RNs who were not working as nurses but looking for jobs in nursing. This is a tiny number compared with the total stock of RNs in the country.<sup>242</sup>*

Nonetheless, the Committee believes that everything possible should be done to entice those qualified nurses who have left the profession to return to active nursing. This is all the more important since, even if it were deemed advisable to substitute licensed practical nurses (LPNs) for RNs, the report notes that there are not enough qualified LPNs to make up the shortfall either.

*For licensed practical nurses to meet a significant portion of nursing service requirements that cannot be met by RNs due to the nursing shortage, the LPN complement would have to be growing at an extremely rapid rate. But, in fact, the number of LPNs has been stagnant or decreasing for nearly 20 years. In 1983, there were 83,539 LPNs in Canada. By 1999, this number was down to 66,100.<sup>243</sup>*

At the same time, Ms. Kelly Kay of the Canadian Practical Nurses Association told the Committee that:

*In most jurisdictions, licensed practical nurses are in short supply. However, there are still situations such as in the province of Ontario where 1,400 registered practical nurses reported on their last registration data form that they were seeking employment in nursing.<sup>244</sup>*

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<sup>242</sup> *Ibid.*, p. 13.

<sup>243</sup> *Ibid.*, p. 74.

<sup>244</sup> 61:25

Although in 1997 it appeared that the trend was towards a decline in the number of applications to nursing schools, this no longer seems to be true. Ms. Ginette Lemire-Rodger, outgoing president of the CAN, explained to the Committee that:

*In Canada, this year alone, thousands of well-qualified students have been turned away. The universities reject them because there are only 70 places for every 800 applications across the country. There is no lack of young people and not-so-young people wanting to take up nursing, but the governments are not funding the seats in the universities.*<sup>245</sup>

Clearly, then, everything points to the need to increase the number of nursing graduates in fairly dramatic fashion. The committee noted in Volume Five that Human Resources Development Canada (HRDC) has undertaken a major sector study in order to make recommendations with regard to the supply of nurses. However, as Michael Dexter remarked to the Committee:

***Clearly, then, everything points to the need to increase the number of nursing graduates in fairly dramatic fashion.***

*I know the Government of Canada through HRDC is funding two large studies. To paraphrase David Sackett, you do not need a double blind, random clinical trial to apply common sense. Common sense would say we need more nurses in this country and we need them urgently.*<sup>246</sup>

In calculating how many new places should be allotted, the CNA report cautions that in the long run it is important to avoid

*periods of either very sharp increases or decreases in output over short spaces of time. Doing this repeatedly over long periods of time leads to a roller coaster of surpluses and shortages in supply. Ideally, levels of output would increase gradually each year in line with increased needs.*<sup>247</sup>

Had there not been a serious underfunding of nursing positions during the nineties, the CNA estimates that the number of graduates needed would still have been of the order of 10,000 per annum. The CNA report explained that this is because “even if the crisis of the 90s had never occurred, Canada would be facing nursing shortages in both 2011 and 2016, albeit of a smaller magnitude, because of the impending retirement of the larger graduating cohorts who are being replaced by smaller ones.”<sup>248</sup> Taking the consequences of the erroneous decisions of the nineties into account, the CNA felt it prudent to recommend that nursing programs be expanded in order to attain an annual output of 12,000 graduates.

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<sup>245</sup> 61:16

<sup>246</sup> 52:8

<sup>247</sup> CNA, *op. cit.*, p. 76.

<sup>248</sup> *Ibid.*, p. 73.

The Committee endorses this estimate. Table 11.1 gives the projections contained in the report for current and projected provincial output of graduates until 2008. The Committee recommends that:

**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.**

Using the figures given in Table 11.1 that indicate the anticipated levels of nursing graduates, this means that by 2008 it will be necessary to graduate an additional 2,618 nurses. The numbers could be increased as follows to build towards this figure:

**TABLE 11.2**

	2004	2005	2006	2007	2008
Current anticipated number of graduates	7,678	7,834	8,829	9,182	9,382
Projected number of graduates given additional federal funding	8,000	9,000	10,000	11,000	12,000

The Committee was told by the CNA that each additional nursing position in Ontario cost \$7,700 per year. Based on a four-year program, this translates into approximately \$30,000 to train each new nurse. Extending this estimate to all nursing places across the country, it would cost approximately \$80 million per year to bring the number of nursing graduates to the 12,000 level recommended by the CNA.<sup>249</sup> To be sure that sufficient funds are available, and in light of the seriousness of the nursing shortage, the Committee believes that it would be prudent to set aside a further \$10 million in the hope that more nurses could graduate even sooner. The Committee therefore recommends that:

**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.**

## **11.6 Allied Health Professionals**

The Committee was not able to obtain sufficient data to work out a detailed proposal with regard to the precise numbers of new graduates that would be needed to respond

<sup>249</sup> This calculation was done on the same basis as for the medical students (i.e. 2,618. x \$30,000)

to the shortages of allied health professionals discussed earlier in this chapter. Nonetheless, the Committee believes that it is essential for the federal government to commit funds to addressing these pressing needs. The Committee therefore recommends that:

**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.**

### **11.7 Funding Post-Graduate Training**

The cost of training new health care professionals does not end the moment they graduate from university or college. There are additional costs that are borne in large part by academic health sciences centres, not only for physicians but for the full range of health care professionals. The Association of Canadian Academic Healthcare Organizations (ACAHO) has estimated the additional costs associated with increases in health care training positions for all the health care professions to be in the range of \$300 – \$550 million over the course of their training cycle (or between \$60 and \$110 million per year). These costs include funding for instructors, space, overhead and supplies. The Committee therefore recommends that:

**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.**

### **11.8 Health Human Resources: Scope of Practice Rules Review**

The final area of the Committee's human resource recommendations involves the need for a thorough independent review of the scope of practice rules for the various health care professions. This review needs to focus on removing the barriers to fruitful collaboration that now exist among health care professionals and that prevent some health care professionals (e.g., nurse practitioners) from using the full set of skills for which they have been trained.

***The final area of the Committee's human resource recommendations involves the need for a thorough independent review of the scope of practice rules for the various health care professions.***

The importance of dealing with this problem on an urgent basis was clearly stated by Dr. Duncan Sinclair, the Chair of the Ontario Health Service Restructuring Commission, in his testimony to the Committee:

*Having a doctor do work that a nurse practitioner or nurse could do is like calling an electrician to change a light bulb or a licensed mechanic out of the garage to fill your tank and check the oil and tire pressure – would they do a good job? They would do an excellent job! But would it be a good use of their time, training and expertise? It would not! It would constitute an expensive and inefficient use of scarce resources, both of money and the expertise of very talented people.<sup>250</sup>*

The Committee believes that such expensive and inefficient use of scarce human resources needs to cease *now*. As noted in Chapter Four on Primary Health Care Reform, the synthesis report of the Health Transition Fund's primary care projects concluded with regard to nurse practitioners that:

*A federal/provincial/territorial initiative should develop national standards for terminology and scope of practice. It should include legislative requirements that support an expanded role for nurses and nurse practitioners.<sup>251</sup>*

The Committee therefore recommends that:

**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.**

## **11.9 Committee Commentary**

The Committee acknowledges that there needs to be an increase in the number of people employed in each of the health care professions, and our recommendations are designed to address this problem.

But the Committee is also very concerned about the overall costs that this increase in human resource supply will entail for the system as a whole. The Committee is keenly aware, for example, that physicians are the major cost-drivers in the system.<sup>252</sup> Since increasing

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<sup>250</sup> See Volume Four of the Committee's study, *Issues and Options*, p. 110-11.

<sup>251</sup> Ann L. Mable and John Marriott, *Health Transition Fund Synthesis Series – Primary Health Care*, June 2002, p. 29.

<sup>252</sup> There is also evidence to suggest that Canadian physicians are well remunerated compared to physicians in other countries. OECD data indicates that the ratio of average physician income to average employee compensation in Canada was 3.2. Only ratios in the United States (5.5) and Germany (3.4) were higher than Canada's, while the ratio

the supply of physicians does not decrease the average cost that each physician imposes on the system, as the number of practising physicians increases the only way in which the system could remain fiscally sustainable is for significant productivity improvements also to occur.

The Committee therefore feels that it is necessary for the increase in the numbers of educational positions to be accompanied by detailed studies of how to improve the productivity of each of the health care professions. If these studies are not done, and if productivity is not substantially improved, the Committee is concerned that this could lead to an unsustainable escalation of overall health care costs.

***The Committee therefore feels that it is necessary for the increase in the numbers of educational positions to be accompanied by detailed studies of how to improve the productivity of each of the health care professions.***

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was much lower in a number of other countries such as Australia (2.1), France (1.9) and the UK (1.4). See, Reinhardt, Uwe E., Peter S. Hussey and Gerard F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999" in *Health Affairs*, May-June, 2002, p. 175.

## CHAPTER TWELVE

### NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH<sup>253</sup>

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Health research is about creating and applying new knowledge with respect to health and health care. Health research encompasses a full spectrum of activities that range from biomedical research, to clinical research, to health services research, and to population health research:

- **Biomedical research** pertains to biological organisms, organs, and organ systems. For example, this type of research would use animal or human tissues or cell culture to understand how the body controls the production of blood cells in the bone marrow, how those controls break down in leukemia, and how normal controls might be reinstated by treatment with drugs.
- **Clinical research** relates to studies involving human participants, healthy or ill. An example would include clinical trials on humans to test the toxicity and effectiveness of a possible new treatment for leukemia that has shown promising results in basic biomedical research, and then to compare the new drug with other drugs in terms of their net benefit to patients.
- **Health services research** embraces health care delivery, administration, organization and financing. An example might be research into the mechanisms for handling patients with leukemia, from the means for diagnosis, through their treatment in hospital, on an out-patient basis, or at home, to their long-term follow-up through hospital or community care.
- **Population health research** focuses on the broad factors that influence health status (socio-economic conditions, gender, culture, literacy, etc.). An example might be a study using large databases of personal health information gained from a number of sources to learn whether the incidence of leukemia is associated with environmental or other factors.

Health research is the source of new knowledge about human health, how to maintain optimal health, how to prevent, diagnose and treat disease, and how to manage our health care system. Health research leads to the development of new or improved drug therapy, treatment, medical equipment and devices, and new ways of organizing and delivering health care. Health research also contributes to a better understanding of the complex interplay of the social, economic, environmental, biological and genetic determinants that affect our health and our susceptibility to disease.

The Committee was told that health research fosters the creation of knowledge-based employment, which in turn contributes to reversing the brain drain observed in the country. Overall, witnesses stressed that health research improves the personal and economic health of Canadians and enhances our international competitiveness:

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<sup>253</sup> This chapter is an updated version of Chapter Five included in Volume Five, pp. 91-125.

*Health research provides enormous economic, social and health care rewards to society. The jobs that are created by these investments are high-quality, well-paying, knowledge-based positions that generate worldwide recognition for Canadians. These investments also support the rejuvenation of academic institutions across the country. They help train new health professionals in the latest technologies and techniques and they provide important support for the health care delivery system in Canada. Most importantly, the results of these activities lead directly to better ways to treat patients, which ensures a healthier and more productive population.*<sup>254</sup>

The Committee also heard that health research could serve as a catalyst to regional economic development and that the health services innovations generated through health research activities could greatly contribute to enhancing the quality and sustainability of Canada's health care system. As health research activity spreads out from the academic health sciences centres and government and into more community-based settings, we can anticipate that standards of care will improve, as health care providers engaged in health research will be better connected with the most recent information. Overall, health research provides tremendous opportunities for both economic and health care progress.

The Committee believes that Canada must actively engage in health research to capture its share of benefits. The Committee also strongly believes that the federal government has a critical role to play as a facilitator, catalyst, performer, consensus builder and coordinator in the overall effort to nurture excellence in health research. This chapter addresses a series of issues, including funding, partnerships and ethics, which we believe deserve close attention if Canada is to achieve the highest standard of excellence in health research.<sup>255</sup>

***The Committee believes that Canada must actively engage in health research to capture its share of benefits.***

## **12.1 Assuming Leadership in Canadian Health Research**

As Table 12.1 shows, health research in Canada is characterized by a complex network that involves a wide range of disciplines and a multiplicity of performers carrying out their research activities in a variety of locations. In Canada, health research is performed by universities, teaching hospitals, business enterprises, government, and non-profit organizations. This research is financed from a variety of public, private, Canadian and foreign sources.

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<sup>254</sup> Dr. Barry D. McLennan, Chair of the Coalition for Biomedical and Health Research (CBHR), *The Improving Climate for Health Research in Canada*, Brief to the Committee, 9 May 2001, p. 2.

<sup>255</sup> The Committee wishes to say that sections 12.1 and 12.2 of this chapter were inspired by a speech given by Dr. Kevin Keough, Chief Scientist at Health Canada, at the third annual Amyot Lecture organized by Health Canada. We found his lecture very useful in highlighting some of the challenges and opportunities facing health research.



**TABLE 12.1**  
**THE CANADIAN HEALTH RESEARCH NETWORK**

DISCIPLINES	LOCATIONS	SOURCES OF FUNDING
<ul style="list-style-type: none"> <li>▪ Clinical Disciplines</li> <li>▪ Social Sciences and Humanities</li> <li>▪ Epidemiology</li> <li>▪ Life Sciences</li> <li>▪ Cellular and Molecular Biology</li> <li>▪ Chemistry</li> <li>▪ Engineering</li> <li>▪ Computing and Mathematical Sciences</li> <li>▪ Health Services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Academia (Universities, Teaching Hospitals, Research Institutes)</li> <li>▪ Industry</li> <li>▪ Government</li> <li>▪ Physicians' Practices</li> <li>▪ Community Organizations</li> <li>▪ Community Hospitals</li> <li>▪ Others</li> </ul>	<ul style="list-style-type: none"> <li>▪ Governments (Federal, Provincial, Departments, Funding Agencies)</li> <li>▪ Non-Government Organizations and National Voluntary Organizations</li> <li>▪ International Sources</li> <li>▪ Industry</li> <li>▪ Universities</li> <li>▪ Others</li> </ul>

The different stakeholders in health research collaborate with each other in various ways: government-university, university-industry, government-industry. In fact, the Committee was told that science is a continuum and the multiple components of health research cannot exist independently of the others. Each component has an important, albeit changing, research role to play in ensuring maximum health benefits for Canadians.

The federal government has always played an important role in health research as a funder, performer and user of research. The federal government financially supports health research carried out in universities, teaching hospitals and research institutes (extramural research); it performs health research in its own laboratories (intramural or in-house research); and it utilizes the outcomes of health research carried out elsewhere. Moreover, the federal government has an important role to play in setting national priorities for health research.

The Committee believes that, in a country as vast as Canada, the federal government has a catalytic leadership role in working with the provincial and territorial governments to ensure that our health care system is driven by research and innovation. To be successful, the federal government needs to have a close collaboration with the provinces and territories to sustain a culture that supports the creation and use of knowledge generated by health research.

In addition, the Committee agrees with a 1999 report of the Council of Science and Technology Advisors that health research performed, funded and used by the federal government must be of the highest quality. It must be demonstrated to meet or

***The Committee agrees that health research performed, funded and used by the federal government must be of the highest quality. It must be demonstrated to meet or exceed international standards of excellence in science, technology and ethics.***

exceed international standards of excellence in science, technology and ethics.<sup>256</sup>

The Committee was informed that, as the cost, complexity and pace of advancement in health research accelerate, individual organizations no longer have the resources or expertise to work in a vacuum:

*Traditionally, investigators have worked in isolation, pursuing their own research agendas and living grant-to-grant. This scattered, ad hoc approach simply won't work in today's world when the complexity of science requires the pooling of resources.*<sup>257</sup>

At the third annual Amyot Lecture organized by Health Canada, Dr. Kevin Keough, Chief Scientist at Health Canada, stated that it is necessary to adopt an inclusive (or horizontal) approach to health research and to find new ways to partner – that is, to bring together multidisciplinary teams of scientists from across the whole health research system to combine their intellectual, financial and physical resources in conducting the research required to better understand the complex and highly interconnected world in which we live.<sup>258</sup>

The Committee agrees with Dr. Keough that it is critical to sustain effective partnerships and to distribute the effort of individual partners in a manner that will maximize the output of Canadian health research. In our view, complementary and collaborative approaches to health research are not only feasible and cost-effective, but also contribute to better research outcomes for all stakeholders. This overarching goal can only be met if the role of the federal government continues to adapt to the changing health research environment. In addition to being a performer, funder and user of health research, the federal government must become more active as a catalyst and a facilitator.

***The Committee agrees that it is critical to sustain effective partnerships and to distribute the effort of individual partners in a manner that will maximize the output of Canadian health research.***

The Committee strongly believes that the federal government should assume leadership in Canadian health research and, therefore, we recommend that:

**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**

<sup>256</sup> Council of Science and Technology Advisors, *Building Excellence in Science and Technology (BEST): The Federal Roles in Performing Science and Technology*, December 1999, p. 5.

<sup>257</sup> The Western Canadian Task Force on Health Research and Economic Development, *Seizing the Future – Health as an Engine of Economic Growth for Western Canada*, Summary of the Report, August 2001, p. 2.

<sup>258</sup> Dr. Kevin Keough, Amyot Lecture, October 2001.

**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.**

Dr. Keough stressed that, as a starting point, the federal government should encourage the interchange of health research scientists between government, academia and the private sector. A freer flow of scientists would enhance the quality of Canadian health research, improve science and research advice to government, maximize the contribution of Canadian scientists to the whole health research community, and contribute to the renewal of the science base in all sectors. The Committee shares similar views and, therefore, recommends that:

**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.**

The Committee wishes to acknowledge the important role played by national voluntary organizations in health research. These organizations act as a key bridge at the national level between health research and its application through knowledge transfer of information to researchers, health care providers and the general public. It is the view of the Committee that, given the knowledge and experience these national voluntary organizations bring, as well as the significant proportion of the health research enterprise which they support, they must be included in the multistakeholders collaboration in health research.

## **12.2 Engaging the Scientific Revolution**

Witnesses told the Committee that health research in Canada and throughout the world is currently undergoing a scientific revolution. They explained that this revolution in health research is fuelled by the ongoing advances in genomics, engineering and cell biology. Research in these scientific disciplines will have a profound effect on the detection, diagnosis and treatment of various genetically linked diseases. Elucidation of the physiological processes associated with various conditions will require years of efforts to identify the relevant genes and to determine how they interact.

*We are in the midst of a profound global revolution being driven by our rapidly emerging understanding of the molecular basis of life, of human biology and of disease. Like prior revolutions in science, this revolution is being driven by the collision of diverse disciplines and approaches: genetics, molecular biology, the broader bio-sciences, [information technology] and computational methodologies, small molecules and surface chemistry, bioethics, epidemiology, health economics, and the social sciences and humanities. The pace of this health research revolution is still accelerating, driven by significant global investments by governments, industry and philanthropy.*<sup>259</sup>

As the human genome project approaches completion, the next challenge is to understand the function of the 30,000-40,000 genes that humans appear to possess. These genes encode the entire protein set or proteome estimated at 2 million. Thus, the next frontier in biology appears to be proteomics, the cataloging and functional description of all proteins in living organisms, which is far more complex and promising than genomics.

Similarly, advances in biomedical engineering and miniaturization on the molecular scale will push development of more sophisticated devices for diagnosis and therapy – targeted delivery of drugs, biological testing, molecular imaging, and tissue and organ repair. Canada has a real opportunity to become a world leader in this field of “nanotechnology” or “nanomedicine.”

The study and use of stem cells is another good example of the potential impact that health research can have on health and health care. Stem cells have the unique property, whatever their origin, of becoming specialized cells. Currently, both the research community and related stakeholders are very enthusiastic about the potential of stem cells, both from embryonic and adult sources. It is anticipated that research on these cells will lead to treatments for serious diseases such as Parkinson’s, Alzheimer’s, diabetes and spinal cord injuries. It is also widely believed that these cells can ultimately be manipulated to grow into virtually any tissue or organ thus providing much needed organs for transplant.

Recent research has been successful in programming human embryonic stem cells into producing insulin. Normally, this function is performed by specialized pancreatic islet cells. Should this treatment prove to be able to provide a cure for diabetes, which is presently being treated by regular injection of insulin, it will not only improve the quality of life for the individual, but will also ease the economic burden of disease. In a different study, stem cells isolated from the skin of animals were coaxed into becoming neural, muscular and fat cells.

Other areas where the scientific revolution has a definite impact are chemistry and computer science where advances in molecular modelling combined with synthetic chemistry change the way novel drugs are discovered. Bioinformatics and robotics are also areas that will benefit health research.

The scientific revolution in health research is not limited to basic and biomedical research; it is also creating tremendous opportunities for research into health services and population health. More than ever before, research is undertaken in Canada and abroad to find

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<sup>259</sup> Dr. Alan Bernstein, president of the CIHR, *Health Research Revolution – Innovation Will Shape This Century*.

new ways of delivering quality care and to understand the implications of the interaction of the determinants that affect the health of a population.

At the third Amyot Lecture, Dr. Keough stressed that advances in health research, and the need for governments and individuals to accommodate them, will continue to accelerate. This means that governments must be able to both perform and rely on good science, which is based on sound research harnessed for the public good. The government's effectiveness in integrating progresses from emerging areas such as biotechnology and nanotechnology depends on this principle.

The Committee agrees with Dr. Keough that it is imperative for Canada to take up the challenges wrought by the scientific revolution. We are convinced that countries with a strong health research network are more capable of translating advances and innovations into cost-effective health services, modern and internationally competitive policy and regulatory frameworks, new or adaptive products, and new health promotion activities. An energetic health research environment contributes to improved health, higher quality of life, and an efficient health care system. This in turn engenders public confidence, a vibrant business environment and a strong economy.

Along with Dr. Keough, the Committee believes that good science is good economics and that the government has a crucial role in maximizing the gains for Canada and its citizens. Clearly, the costs of doing good science are high; but the costs of not doing it are even higher. These scientific developments are rapidly expanding and there is fierce competition in the field. Along with numerous witnesses, the Committee is convinced that Canada cannot afford to fall behind. The potential pay-off is a fast and economically beneficial transfer of knowledge and its conversion into tangible benefits for the Canadian population.

***The Committee believes that good science is good economics and that the government has a crucial role in maximizing the gains for Canada and its citizens.***

It is the opinion of the Committee that such a formidable challenge can be met only through a concerted effort by government, industry, academia, non-governmental organizations and international organizations. Each of these partners has its own specific role. However, coordination and support should be provided by the federal government, through its agencies and departments, especially CIHR and Health Canada. Therefore, the Committee recommends that:

**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 Committee strongly believes that Canada can be a world leader in health research, building on our strengths in human genetics, stem cell biology, population health, bioethics, proteomics, and health economics. We have a tremendous opportunity to apply the

knowledge generated from genomics and proteomics research to the study of human populations and human research. For example, the CIHR through its institutes of Genetics and Health Services and Policy Research are partnering with the Federal/Provincial/Territorial Coordinating Committee on Genetics and Health to identify and prioritize emerging issues that can be addressed through research.

The field of genomics and proteomics in Canada could benefit from a more integrated investment approach. For example, with a long-standing record of excellence in protein science research and training, Canada is well positioned to make a significant contribution in proteomics. The Canadian Proteomics Initiative – a partnership between CIHR's Institute of Genetics and the Protein Engineering Network of Centres of Excellence (PENCE) – is working to build on the federal government's investments to date in infrastructure to build a large-scale national program that will ensure that Canada's remains internationally competitive. Therefore, the Committee recommends that:

**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.**

### **12.3 Securing a Predictable Environment for Health Research**

As indicated in Volume Two, the federal government has had a long tradition in financing health research.<sup>260</sup> The most recent estimates by Statistics Canada indicate that the majority (some 79%) of federally funded health research is “extramural” as it takes place in universities and hospitals (68%), private non-profit organizations (6%), and business enterprises (4%).<sup>261</sup>

The principal federal funding body for health research is the Canadian Institutes of Health Research (CIHR). In fact, CIHR is the only federal entity whose budget is entirely devoted to health research. Its creation in 2000 involved a major evolution of the mandate of the Medical Research Council of Canada (MRC) and incorporation of the National Health Research and Development Program (NHRDP), formerly Health Canada's main financing instrument for extramural health research. Despite the creation of CIHR, Health Canada is still involved in the financing of some extramural health research in a wide range of fields (children's health, women's health, Aboriginal health, etc.).

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<sup>260</sup> Volume Two, pp. 93-104.

<sup>261</sup> Statistics Canada, *Estimates of Total Expenditures on Research and Development in the Health Field in Canada, 1988 to 2000*, Catalogue No. 88F0006XIE01006, April 2001.

There are also a number of federal research-oriented bodies whose funding focuses entirely on health-related research. These include namely the Canadian Health Services Research Foundation (CHSRF) and the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). Many feel that for a country of the size of Canada, there are too many federal funding organizations.

In addition, there are several secondary sources of extramural federal health research funding. More precisely, the federal government is responsible for a number of research councils, agencies and programs that devote (to various extents) a portion of their budget for health-related research. These include the Natural Sciences and Engineering Research Council (NSERC), the Social Sciences and Humanities Research Council (SSHRC), the Canada Foundation for Innovation (CFI), the Canada Research Chairs (CRCs), and the Networks of Centres of Excellence.<sup>262</sup> The federal government has also funded Genome Canada, a not-for-profit corporation dedicated to developing and implementing a national strategy in genomic research.

The remainder of the federally funded health research (some 21%) is “intramural” or “in-house” research, that is research conducted in federal government facilities. Federal facilities in which health-related research is performed include Health Canada, Statistics Canada, the National Research Council, Human Resources Development Canada, Agriculture Canada, Environment Canada (in partnership with Health Canada) and the Canadian Food Inspection Agency.

### **12.3.1 Federal funding for health research**

The federal government has, on many occasions, demonstrated its commitment to health research. The Committee applauds the high priority for research given in the 2001 Speech from the Throne and particularly its announcement to increase funding for health research:

*Our government's overriding goal is nothing less than branding Canada as the most innovative country in the world – as the place to be for knowledge creation; where our best and brightest can make their discoveries; where the global research stars of today and tomorrow are born; becoming the magnet for new investments and new ventures.*

*(...) The Government of Canada will (...) provide a further major increase in funding to the Canadian Institutes of Health Research, to enhance their research into disease*

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<sup>262</sup> The NCEs are supported and overseen by the three Canadian granting agencies (CIHR, NSERC and SSHRC). It is worth noting that eight networks, of the currently funded 22 NCEs, conduct health research in the fields of: arthritis, bacterial diseases, vaccines and immunotherapeutics for cancer and viral diseases, stroke, health evidence application, genetic diseases, stem cells and protein engineering. Some of the other NCEs may have impact on health and health care (e.g. Institute for Robotics and Intelligent Systems or Canadian Water Network).

*prevention and treatment, the determinants of health, and the effectiveness of the health care system.*<sup>263</sup>

The Committee also recognizes the creation of CIHR as a major achievement in health research. We laud the increased funding for CIHR announced in the December 2001 Budget Speech, despite the severe financial pressures the federal government faces. In addition, the creation of, and funding for, the Canada Foundation for Innovation in 1997, followed by the Millennium Scholarships, the Canada Research Chairs, and Genome Canada, are clear indications that health research and innovation are integral to public health-related policy in Canada.

Throughout its study, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other industrialized countries in this regard. In fact, the role of national government in financing health research, expressed in purchasing power parity (PPP) per capita, is much higher in the United States, the United Kingdom, France and Australia than in Canada. For example, as stated in Volume Two, the American government provided in 1998 four times more funding per capita to health research than did the Canadian government.<sup>264</sup>

***Throughout its study, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other industrialized countries in this regard.***

Witnesses unanimously recommended that the federal government's share of total spending on extramural health research be increased to 1% of total health care spending in Canada, from its current level of approximately 0.5%. This could involve increasing CIHR's current budget to \$1 billion from the current level of \$560 million. Additional resources should also be devoted to federally performed health research (discussed in the following section). Overall, increased investment in extramural and in-house health research would bring the level of the federal contribution to health research more in line with that of national governments in other OECD countries. More importantly, this would help maintain a vibrant, innovative and leading edge health research industry.

Another concern brought to the attention of the Committee related to the long-term nature of research in contrast to existing budgetary program planning. High quality research is very competitive internationally and requires long-term commitments. Young researchers, on whom Canada's future in research depends, commit their careers on the basis of their perceptions of the long-term environment for research. Canada will not attract or keep excellent people without providing an excellent environment for research. Research pays little attention to national borders. The world

***The Committee strongly supports the view that health research money is money to support the best and brightest minds. Ultimately, Canada's challenge in health research is a challenge to attract and retain outstanding people.***

<sup>263</sup> Government of Canada, *Speech from the Throne*, First Session of the 37<sup>th</sup> Parliament, 30 January 2001.

<sup>264</sup> Volume Two, p. 97.



recognizes excellence, and competes vigorously for it.

The Committee strongly supports the view that health research money is money to support the best and the brightest minds. At least two-thirds of funds for health research go to salaries and training stipends for highly qualified and motivated researchers, research assistants, technicians, research trainees, etc. Ultimately, Canada's challenge in health research is a challenge to attract and retain outstanding people.

The role of the federal government is central to this competition for excellent researchers. In particular, CIHR is the long-term source of research funds for the health research activities stimulated by the Research Chairs, the Canadian Foundation for Innovation, and Genome Canada, all of which are adding greatly to Canada's capacity for excellence in research. CIHR is also an essential partner for research stimulated by the many health research charities.

Overall, the Committee believes that the federal government must establish and maintain long-term stability in the Canadian health research environment. Providing an adequate and predictable level of funding is a necessary prerequisite. We agree with witnesses that the federal government must increase its investment in health research so that federal extramural funding accounts for 1% of total health care spending.

In our view, such additional federal funding should be directed to research projects that can have a significant impact on health status or that contribute substantially to improvements in health care quality and delivery. Research in such fields as population health, public health, health services delivery, clinical practice guidelines, early child development, and women's and Aboriginal health should be given the highest priority.

The Committee also believes that the establishment of CIHR has resulted in the creation of a broad platform upon which to launch bold new initiatives in health research. Moreover, we believe that CIHR and its 13 Institutes must insist on the translation of knowledge generated by research; this will ensure that the results of health research are translated into action including changes in clinical practice, health care policy, and individual behaviours.

Health research is a long-term investment; many research projects span a researcher's whole career, and grants are usually awarded for three- to five-year terms, which are simply not consistent with the one-year-at-a-time budget allocation to CIHR. Overall, the Committee recommends that

#### **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.**

### **12.3.2 Federal in-house health research**

A report by the Council of Science and Technology Advisors identified a clear need for the federal government to perform in-house research. This report stressed that the federal government must have an adequate research capacity to deliver the following key roles:

- Support for decision making, policy development and regulations.
- Development and management of standards.
- Support for public health, safety, environment and/or defence needs.
- Enabling economic and social development.<sup>265</sup>

In other words, the ability of the federal government to set policy and enforce regulations requires it to have an appropriate in-house research capacity. In addition, the government needs to have access to the highest possible quality scientific and technological information in a time frame that meets its needs. Failure to use the best available data and analysis could expose the government to liabilities for damages caused by those decisions.

The major key player in federal intramural health research is Health Canada, for which this function is critical to the fulfillment of its mandate. The department is mandated to help the people of Canada maintain and improve their health and to ensure their safety. Thus, in addition to access to top-quality scientific and technological information, Health Canada must obtain advice to set policy and enforce regulations. The required in-house research capacity includes expertise in:

- the state and spread of disease;
- ensuring the safety of food, water and health products, including pharmaceuticals;
- air quality issues; and,
- fulfilling health promotion obligations.

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<sup>265</sup> Council of Science and Technology Advisors (CSTA), *Building Excellence in Science and Technology (BEST): The Federal Role in Performing Science and Technology*, 16 December 1999, p. 12. The CSTA consists of a group of external experts providing the federal government with on science and technology issues.

To undertake these responsibilities, Health Canada's researchers must possess independent knowledge and skills over a wide range of scientific disciplines, ranging from the behavioural sciences to cellular and molecular biology. In addition, Health Canada must have an adequate in-house capacity to assimilate, interpret and extrapolate the knowledge obtained from other health research partners. Finally, the department must be able to draw widely on expertise and facilities that are not available in-house.

Overall, the Committee learned that Health Canada has a unique role. In order to meet its mandate, the department must be able to provide the best possible independent science advice related to its legislated responsibilities, to undertake a wide range of scientific activities related to its role as regulator and policy advisor, and to provide evidence-based health services and programs. This unique obligation requires Health Canada to have the necessary science and research capacity to fulfill these three functions.

The Committee feels it is important to acknowledge that Health Canada has taken an important step in ensuring, through the appointment in 2001 of a Chief Scientist, that it possess the ability to meet its mandate. The Chief Scientist and his office play a pivotal role in bringing leadership and coherence to Health Canada's scientific responsibilities and activities by championing the principles of alignment, linkages and excellence espoused by the Council of Science and Technology Advisors.

The Committee strongly believes that there is a clear need for the federal government to perform health research and that it must have the capacity to deliver its mandate. The Committee also acknowledges the importance for Health Canada of partnering with stakeholders outside of government when necessary. Therefore, the Committee recommends that:

***The Committee strongly believes that there is a clear need for the federal government to perform health research and that it must have the capacity to deliver its mandate.***

#### **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.**

### **12.4 Enhancing Quality in Health Services and in Health Care Delivery**

As indicated on numerous occasions in this report, the Canadian health care delivery system is facing a very serious situation, marked by rising costs, a high degree of dissatisfaction and high expectations. While many recommendations for change to the publicly funded health care system have been made over the years, most of them have not been based on

scientific evidence, but rather have been grounded on anecdotal evidence or political posturing. For these reasons, research on all aspects of Canada's publicly funded health care system is, at the present time, very critical for health care policy makers and managers.

Areas in need of more research are varied and include:

- health promotion policies
- disease and injury prevention strategies (at both the individual and population levels)
- determinants of health
- approaches to primary care management
- new modes of remuneration for health care providers and institutions
- decision-making by health care providers and users
- organizational care delivery models
- health care policy management
- health care resources allocation
- impact of selected areas of privatized health care
- pharmaco-economics
- assessment and utilization of health care technology and equipment.

Clinical research and the involvement of health care providers themselves in health research are key elements in ensuring that fundamental research is translated into better health and health care. Clinical trials and large-cohort population health research studies are under-supported in Canada, in part due to the large, long-term financial commitment that is required before such studies can be launched. Urgent investment in training and subsequent career support is needed for clinician investigators in Canada. Harassed by ever increasing demands for clinical service, they find it increasingly difficult to remain competitive in competitions for grants and awards.

In Canada, a wide range of organizations are involved in health services research. It is the view of the Committee that, at this critical time for our health care delivery system, it is essential that this type of research be well funded and that these research centres and their investigators take part in the present debate about the future structure of the Canadian hospital and doctor system and about how the growing gaps in health care coverage can be closed.

Moreover, many studies have shown that there is a major gap between new knowledge and its application in every day medicine. For example, only 46% of elderly

***The Committee believes that the federal government, given its unique role in health research, should commit a significant investment in promoting in partnership with the provinces and territories, the adoption of research findings in clinical practice.***

patients were given pneumococcal vaccine, though it is the group most at risk for suffering from such infections. Aspirin, although recommended for all adult diabetic patients, was prescribed in only 20% of cases, and counselling on HIV transmission was given to less than 3% of adolescents during physician's office visits.<sup>266</sup> In addition, wide variations in practice patterns and outcomes persist across regions as well as across provinces. The Committee believes that the federal government, given its unique role in health research, should commit a significant investment to promoting, in partnership with the provinces and territories, the adoption of research findings in clinical practice. This must be done while continuing to support new research on priority health issues and the development of new tools, so that in the future this knowledge and the new tools can be translated into and implemented to produce improved health and enhanced health care.

Overall, the Committee acknowledges that more health research should be undertaken in order to enhance quality in health services and in health care delivery. Therefore, we recommend that:

**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.**

## **12.5 Improving the Health Status of Vulnerable Populations**

There are many groups in Canadian society that have, for numerous reasons, less immediate access to health services appropriate to their specific needs. Examples include individuals with mental health problems, individuals with addiction problems, people with physical disabilities, some ethnic minorities, women in difficult circumstances, people living in rural and remote communities, the homeless and the poor. The Committee acknowledges that there is an urgent need in Canada to support cross-disciplinary health research that will provide new evidence on the diverse factors that influence health status, and on approaches to improving access to needed health care for vulnerable groups. CIHR has recently set up a strategic plan through three of its Institutes to study this crucial problem, but more resources are needed. Therefore, the Committee recommends that:

**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.**

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<sup>266</sup> JAMA, vol. 286, p. 1834 (2001).

In Volume Four of its health care study, the Committee stated that the health of Aboriginal Canadians is a national disgrace. There is a disproportionately, and completely unacceptable, large gap in health indicators between Aboriginal and non-Aboriginal Canadians. Aboriginal peoples experience much higher incidence of many health problems, including: significantly higher rates of cancer, diabetes and arthritis; heart disease among men; suicide among young men; HIV/AIDS; and morbidity and mortality related to injuries. Infant mortality rates are twice to three times the national average, with high rates of fetal alcohol syndrome and fetal alcohol effects (FAS/FAE), and poor nutrition. Approximately 12% of Aboriginal children have asthma, in comparison with 5% of all Canadian children. This last trend is attributable, at least in part, to environmental health issues, such as the presence of moulds in houses.<sup>267</sup>

The Committee believes that research is perhaps the most important element that will help improve the health status of Aboriginal Canadians. In our view, the creation of CIHR's Institute of Aboriginal Peoples' Health is an important step in this direction. Health Canada, which delivers numerous programs and services to First Nations and Inuit communities, needs to strengthen its research capacity as well as its capacity to translate health research into effective public policy. In particular, Health Canada requires a strong research capacity to:

***The Committee believes that research is perhaps the most important element that will help improve the health status of Aboriginal Canadians.***

- compile and analyze available population-based information to identify trends, emerging issues, and differences across geographic regions or communities;
- review programs and services to identify the most effective practices in First Nations and Inuit communities and to assess timely progress in addressing key health issues; and
- maintain and augment the capacity to analyze research both nationally and internationally, and integrate best practice into policy and program development, implementation and evaluation.

Therefore, the Committee recommends as a matter of urgency that:

**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.**

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<sup>267</sup> Volume Four, pp. 129-135.

Research into the field of health in developing countries is also of concern. The Committee learned that very little research activity is directed towards health problems that affect developing countries. In fact, data suggest that less than 10% of health research is devoted to diseases or conditions that account for 90% of the global disease burden.

The primary causes of morbidity and mortality in developing countries can be grouped under four general areas: malnutrition, poor sexual and reproductive health, communicable diseases, and non-communicable diseases including injuries. A recent report by the World Health Organization shows that long-term economic growth is impossible where large numbers of people are malnourished, sick or dying.

It is the view of the Committee that, given its expertise and excellence in health research, Canada should assume a leadership role in this area. The federal government has taken a step in the right direction. In a first-ever collaborative effort, four Canadian government organizations have joined their forces to formalize a shared commitment to address the problems of global health through research. The Canadian International Development Agency (CIDA), CIHR, the International Development Research Centre (IDRC) and Health Canada have formed the Global Health Research Initiative. Not only will this joint undertaking allow the four partners to operate their programs and research more effectively, it will also contribute to a great humanitarian cause – the health protection of citizens of all countries, including Canadians. This is the beginning; much more needs to be done. Therefore, the Committee recommends that:

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

## **12.6 Commercializing the Outcomes of Health Research**

One outcome of health research is the creation of new knowledge. New knowledge is in itself of great value to society but the overall impact of health research is maximized when new knowledge is translated into social and economic benefits. Commercialization of health research outcomes represents one way to achieve this knowledge translation.

***New knowledge is in itself of great value to society but the overall impact of health research is maximized when new knowledge is translated into social and economic benefits. Commercialization of health research outcomes represents one way to achieve this knowledge translation.***

Commercialization of health research can happen at many different stages of research and each stage faces different challenges. For example, one of the main challenges facing commercialization of academic health research (occurring in universities and hospitals) is that their early stage of development makes the investment of capital by private sector very risky, thus speculative. By contrast, once a product is marketable, such as the late stage clinical trials (mainly performed by large research-based pharmaceutical firms), the main challenges relate to

intellectual property and the patent regime, as well as to approval and monitoring of drugs. Commercialization of health research outcomes brings numerous benefits including:

- improved health, resulting in a more productive workforce;
- enhanced health services quality;
- increased efficiency in health care system delivery;
- expanded research funding leveraged from commercialization and research partnerships;
- enhanced job creation with newly formed companies;
- and greater economic activity from the manufacturing, marketing and sales of new health care products and services.

In its brief to the Committee, the Council for Health Research in Canada indicated that spin-off biotechnology companies formed by CIHR-funded scientists are an important by-product of public investment in health research:

*For instance, 23 companies have been formed at the University of British Columbia employing 732 people. At McGill, 18 companies have been formed employing 392 people. At the University of Ottawa, 10 companies have been formed employing 459 people. Such companies cannot flourish without public investments to fund a steady discovery pipeline.*<sup>268</sup>

Visudyne is one example of Canadian health research that has produced some powerful advances in health care. The drug, which is approved for use in over 30 countries, is the only approved treatment for age-related macular degeneration, the leading cause of age-related blindness. This treatment was developed at the University of British Columbia (UBC) and was funded, in part, by the federal government. UBC assisted in the start-up of QLT Inc. to commercialize this product that has head offices in Vancouver, employs over 350 people and has a market capitalization of \$1.5US billion.

Another example is 3TC, the only inhibitor of HIV reverse transcriptase with few or no side effects and a common component of treatment for HIV/AIDS, which also arose out of federally funded research performed in Montreal. BioChem Pharma Inc., prior to its acquisition by Shire Pharmaceuticals plc. (based in the United Kingdom), had head offices in Montreal, employed 278 people, and had a market capitalization of \$3.7US billion.

These examples illustrate the potential of health research to treat disease, create employment and generate economic benefits for Canada. While many academic technologies are licensed to foreign companies, it is reasonable to expect that value should be created and retained in Canada wherever possible and appropriate when the federal government has made investments in health research.

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<sup>268</sup> Council for Health Research in Canada, *Health Research: The Engine of Innovation*, Brief to the Committee, 30 December 2001, p. 2.



As stated in Section 12.2, “good science is good economics.” However, during his testimony, Dr. Henry Friesen, Team Leader of the Western Canadian Task Force on Health Research and Economic Development, told the Committee that the conditions are not presently in place to enable publicly funded health research to maximize the returns to Canadian taxpayers.<sup>269</sup> In the opinion of this Task Force, the capacity for research commercialization is sub-optimal and clearly unacceptable.<sup>270</sup>

Similar findings were presented in a 1999 report published by the Advisory Council on Science and Technology (ACST) and prepared by its Expert Panel on the Commercialization of University Research.<sup>271</sup> The Expert Panel made the case that research results from federal funding of university research, where there is commercialization potential, should be managed as an asset that can return benefits to the Canadian economy and Canadian taxpayers. The Expert Panel also showed that the United States has a much better track record in commercialization of university-based research than Canada, despite a growing private sector involvement in funding research at Canadian universities.

Most major research institutions (universities and research hospitals) in Canada have in-house technology commercialization offices that are funded by university sources and, in cases of successful offices, by revenue derived from operation. Currently, the expenses associated with commercialization activities are not covered by direct federal research funding. The Committee learned that the vast majority of these technology commercialization offices have costs that exceed their revenue. They are operated as a cost centre and not as a profit centre for the institution. However, while their function is not critical to the research enterprise (creation of new knowledge), an argument could be made to include costs of operating these offices in the calculation of indirect research costs since technology commercialization is a research-related activity.

The question of funding indirect costs in Canadian research by the federal granting agencies has been one of contention in recent years. It has been recognized as one element to explain the lower level of competitiveness of Canadian researchers. Indirect costs are those expenses associated with administration, maintenance, commercialization and the salary of the principal investigator that is attributable to the research project. The ACST in its 1999 report<sup>272</sup> and subsequent publications has made the recommendation that the federal government increase its investment by supporting the indirect costs of sponsored research. Similarly, the brief of the Council for Health Research in Canada stressed:

*[The] indirect costs of research must be funded in order to provide a cutting-edge research environment that will fully realize the benefits of the government's Innovation Agenda.*

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<sup>269</sup> See Committee Proceedings, Issue No. 30.

<sup>270</sup> Western Canadian Task Force on Health Research and Development, *Shaping the Future of Health Research and Economic Development in Western Canada*, August 2001, pp. 19-20.

<sup>271</sup> Expert Panel on the Commercialization of University Research, *Public Investments in University Research: Reaping the Benefits*, Advisory Council on Science and Technology, 4 May 1999.

<sup>272</sup> *Ibid.*

(...) *The Council believes it should be a priority for the government to develop a specific, long-term plan to address this issue as soon as possible.*<sup>273</sup>

The Committee acknowledges that, in its December 2001 Budget, the federal government provided a one-time investment of \$200 million through the granting councils to help alleviate the financial pressures that are associated with the rising indirect costs of research activities, including commercialization. We both hope that universities and research hospitals will use some of these funds to improve their commercialization abilities, and that the federal government will make this investment permanently recurrent.

The Committee agrees with witnesses and recent reports that there is a need to find ways to maximize the returns to Canadians from the commercialization of federally funded health research. We believe that the federal government should establish the necessary conditions to enable researchers and those technology commercialization offices providing support and services to researchers to perform to their full potential in commercializing the results of federally funded health research.

***The Committee agrees with witnesses and recent reports that there is a need to find ways to maximize the returns to Canadians from the commercialization of federally funded health research. We believe that the federal government should establish the necessary conditions to enable researchers and those technology commercialization offices providing support and services to researchers to perform to their full potential in commercializing the results of federally funded health research.***

Further, the Committee believes that CIHR, Canada's premier vehicle for funding health research with a legislated mandate to translate knowledge into improved health, is uniquely positioned to assess the recommendations made by the Western Canadian Task Force, the ACST's Expert Panel and other studies on technology commercialization as they apply to health research. We believe that CIHR should use these reports as the basis for developing and delivering on an innovation strategy that considers programs, policies and people. In our view, such a strategy would see CIHR support and strengthen the capacity of academic technology commercialization offices to maximize the transfer of technologies to market, thereby creating of Canadian companies and jobs and enhancing Canada's innovation capacity. In addition, we believe that this innovation strategy must be developed within a framework that includes governing principles of public good and benefit to Canada so that any strategy to maximize the social and economic impact does not threaten academic freedom or influence the direction of research or the delivery of health care. Therefore, the Committee recommends that:

**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.**

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<sup>273</sup> Council for Health Research in Canada, Brief to the Committee, p. 5.

**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.**

One aspect of the commercialization of health research outcomes that generated controversy recently is the issuance of patents for higher life forms. This subject goes deeply into ethical, intellectual property, and economical issues. Although these questions are highly relevant to Canadian health research and the work of this Committee, they are debated elsewhere. Indeed, the Canadian Biotechnology Advisory Committee (CBAC) has been mandated by the federal government to provide advice on this crucial issue. The CBAC published an interim report on the subject at the end of 2001 where it recommended that human beings at all stages of development, are not patentable.<sup>274</sup> Further, the report recommended that a systematic research program be undertaken to assess the impact of biotechnology patents on various aspects of health services. It is clearly an issue that deserves serious consideration, but is beyond the scope of this report.

## **12.7 Applying the Highest Standards of Ethics to Health Research**

The preceding sections have demonstrated Canada's growing excellence in, and high priority for, health research. However, history has shown that the pursuit of new knowledge in health research can lead, for example, to abuse of the people who are involved as the subjects of research, to invasions of privacy, and to abuse of animals. In various ways, numerous reports have emphasized that new knowledge must not be gained at the expense of abuse of humans and other life forms, and that excellence in health research requires excellence in ethics.

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<sup>274</sup> Canadian Biotechnology Advisory Committee, *Biotechnology and intellectual property: patenting of higher life forms and related issues*, Interim report to the Government of Canada Biotechnology Ministerial Coordinating Committee, Ottawa, November 2001.

But what is ethics? Laura Shanner, Professor at the University of Alberta, told the Committee that “ethics” is a “systematic, reasoned attempt to understand and make the best possible decisions about matters of fundamental human importance.”<sup>275</sup> When we refer to ethical issues informed by biological knowledge in medicine, we refer to “bioethics.” Dr. Nuala Kenny, Professor of Pediatrics at Dalhousie University (Nova Scotia), defined bioethics as follows:

*Bioethics is a particular understanding of ethics that brings the discipline of philosophy to assist in making value-laden decisions. It is about the right and the good. It is a practical discipline. Bioethics is ethics in the realm of the biosphere, human biology. It is actually broader than human health, but most people use it in that context.*

*It asks how, in a pluralistic society, do you lay out the values, the issues and the interests at stake when making a decision about the right and the good, generally about an individual patient situation. Then, how do you assist the relevant parties in establishing some kind of priority, so that if there are competing goods or competing harms, you make your choices in a responsible way.*<sup>276</sup>

In many fields, difficult decisions often involve consideration of numerous factors, each implicating different – and often conflicting – values, principles, viewpoints, beliefs, expectations, fears, hopes, etc. When facing such difficult decisions, people may reach different conclusions not only because they consider different factors, but also because they weigh them against each other in different ways. The practical effect of the discipline of ethics is to help those who face complex decisions to identify the inherent values and principles, to weigh them against each other, and to come to the best possible decision. Though based on strong theoretical foundations, ethics in health care and health research deals with real life situations.

Because research seeks constantly to expand the forefront of knowledge, it poses the most challenging questions of ethics. The purpose of this section is to survey some of the major areas of research ethics in terms of the policies and mechanisms now present and/or needed in Canada, to ensure that health research is carried out in a manner that meets the ethical standards of Canadians.

### **12.7.1 Research involving human subjects**

Health research must involve humans as research subjects. While research with other life forms can provide much essential knowledge, in the end only research directly on human beings can tell us, for example, whether a potential new approach to prevention, diagnosis or treatment of disease is safe enough to use in humans, whether it actually helps patients, what its side effects are, and whether it is better than a treatment that is already available.

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<sup>275</sup> Laura Shanner, *Ethical Theories in Bioethics and Health Law*, University of Alberta, Brief to the Committee, 2000, p. 1.

<sup>276</sup> Dr. Nuala Kenny (42:59-60).

Research subjects, often patients with diseases whose treatment is under study, bear the risks of the research so that others may gain from the knowledge that research is intended to provide. Research involving humans poses many risks: abuse of people, misuse, exploitation, breaches of privacy, confidentiality, etc. Because health research raises such a wide range of issues, an international consensus has developed over the last 50 years or so. This international consensus, which started with the Nuremberg Code (1947) and the Declaration of Helsinki (1964, revised in 2000), requires that the ethical aspects of any research project involving humans be reviewed and approved, with modifications if needed, by an appropriately constituted ethics committee (in Canada called “Research Ethics Board” or REB) before the research project is started.

***Research subjects, often patients with diseases whose treatment is under study, bear the risks of the research so that others may gain from the knowledge that research is intended to provide.***

The Research Ethics Board “is a societal mechanism to ensure the protection of research participants.”<sup>277</sup> REBs are multidisciplinary local institution-based boards, independent of the investigator and research sponsor, established to review the ethical standards of research projects within their institutions. They have the power to approve, reject, request modifications to, or terminate any proposed or ongoing research involving human subjects. In effect, the REB attests, for each research protocol, that the proposed research, if it is carried out in the manner agreed to by the REB, meets or exceeds standards of ethics that Canadians expect.

The dominant national policy for the ethics of research involving humans, the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS), was published by CIHR, the SSHRC and NSERC in 1998. The TCPS followed earlier policies (MRC, 1978, 1987, and SSHRC, 1976). The Panel and Secretariat on Research Ethics, launched in November 2001 by the three federal research funding agencies, are responsible for coordinating the evolution and interpretation of the TCPS. The objective is to keep the TCPS up-to-date in response to the rapidly evolving advances in knowledge, research and technology.

The *Tri-Council Policy Statement* has been adopted by academic institutions (where the majority of health research involving humans is carried out) and by some governmental departments and agencies, including the Department of National Defence (DND) and the National Research Council (NRC).

Health Canada is establishing its own Research Ethics Board, which will also use the TCPS, to assess the ethical acceptability of in-house research, research that is contracted to non-Health Canada researchers which requires ethical review and research applications to CIHR or other funding agencies. Health Canada has also adopted the International Conference on Harmonization (ICH) guidelines applying to clinical trials involving the participation of human subjects.<sup>278</sup>

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<sup>277</sup> National Council on Ethics in Human Research, *Protecting Human Research Subjects: Case-Based Learning for Canadian Research Ethics Boards and Researchers*, Ottawa, 2000, p. 7.

<sup>278</sup> Despite the care taken by the three federal granting agencies and Health Canada in the international harmonization of guidelines applying to clinical trials involving human subjects, the Committee would like to be in no doubt that any Canadian participating in clinical trials from outside Canada be protected by ethical standards that are at least as stringent as those applying here.

Since the 1970s, in accord with national policies governing ethics in research involving humans, some 300 local REBs in Canada have been established in a variety of settings including universities, government laboratories, community organizations and teaching and community hospitals. In many teaching hospitals, at least 50% of the research protocols reviewed by REBs are clinical trials that are sponsored by industry for purposes of testing new pharmaceutical interventions in human health so as to meet the regulatory licensing requirements of Health Canada and the USA Food and Drug Administration. In addition, some company-based and private for-profit REBs have developed over the last few years to allow REB review of privately sponsored research outside academic institutions, and hence without access to local REBs. In Alberta, all physicians who are not covered by an institutional REB are required to use the REB of the Alberta College of Physicians and Surgeons. Newfoundland is moving towards establishing a single REB for all health research in the province.

In 1989, the National Council on Ethics in Human Research (NCEHR) was created by the MRC with the support of Health Canada and the Royal College of Physicians and Surgeons of Canada. NCEHR works to foster high ethical standards for the conduct of research involving humans across the country by offering advice on the implementation of the TCPS, primarily through educational activities and site visits to local REBs. NCEHR is now funded by CIHR, SSHRC, NSERC, Health Canada and the Royal College of Physicians and Surgeons.

### **12.7.2 Issues with respect to research involving human subjects<sup>279</sup>**

The *Tri-Council Policy Statement*, in effect Canada's national statement of policy for ethical conduct in health research involving humans, appears to be consistent with world standards. For the most part, REBs in Canada seem to operate to a high standard, building on more than two decades of experience and the dedication of many people across the country. However, the Committee learned that serious gaps have been identified in a number of reports released in recent years by NCEHR and CIHR, as well as by the Law Commission of Canada.<sup>280</sup> A summary of the main issues or gaps identified in these reports is presented below:

- Although the *Tri-Council Policy Statement* sets very high standards, there is currently no oversight mechanism to ensure compliance with these standards. On the one hand, there is no process of certification, accreditation or regular inspection of the research ethics review procedures performed by REBs. On the other hand, and though more REBs are starting to address this issue, few monitor the conduct of research once a research protocol has been approved.

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<sup>279</sup> The following section does not deal with the ethical boundaries surrounding research into human reproductive health as federal legislation is expected to be tabled soon in the House of Commons. The Committee recognizes that this area is at the cutting edge of applied research and evolves rapidly. In our view, all research involving human reproductive material, human organisms derived from such material, other human cell lines, or part of any of them (including human genes) should be subject to full ethical review by REBs and application of the TCPS and other applicable legislation.

<sup>280</sup> More specifically, see the following four reports: 1) NCEHR (formerly National Council on Bioethics in Human Research or NCBHR), "Protecting and Promoting the Human Research Subject: A Review of the Function of Research Ethics Boards in Canadian Faculties of Medicine", *NCBHR Communiqué*, Volume 6 (1), 1995, pp 3-28; 2) Draft report of the Task Force established by the NCEHR to study models of accreditation for human research protection programs in Canada, September 28, 2001; 3) McDonald, Michael (Principal Investigator), *The Governance of Health Research Involving Human Subjects*, research sponsored by the Law Commission of Canada, Ottawa, May 2000; 4) Draft Report of the Task Force on Continuing Review, CIHR, 2001.

In other words, REBs often have limited knowledge of what happens after they have approved a research protocol.

- Some concerns were raised about real or perceived conflicts of interest by researchers or institutions. Though international consensus suggests that REBs would be established within research institutions, and that the work of REBs requires close collaboration with other institutional responsibilities, REBs must be able to operate free from institutional or researcher pressures.
- Similarly, a lack of public oversight of private REBs that act independently or through Contract Research Organizations hired by drug companies raises concerns about their independence and conflicts of interest.
- There is a basic need for more resources for REBs. As the work becomes increasingly complicated with globalization, technology and commercialization, REBs are struggling to find committee chairs or even members.
- There are currently no standard training requirements for Canadian REB members and researchers in research ethics. However, in the absence of similar Canadian standards, Canadian researchers must meet American educational standards for American funded health research involving human subjects.
- The current ethics review processes are “producer-driven” rather than “consumer-driven.” In other words, there is a lack of representative participation in governance on the part of research subjects.
- There is an urgent need for empirical research on the effects of health research on human subjects as well as on the effectiveness of the ethics governance procedures.

To sum up, the governance, transparency and accountability of the ethics review processes in Canada need to be improved:

*(...) we were surprised to see how substantial the gaps were between the ideals expressed in policy and the ground arrangements for accountability, effectiveness and the other criteria for good governance.<sup>281</sup>*

The Committee agrees with many reports that the central concern for Canada is the public accountability of the overall processes for assuring the ethics of research involving humans. We recognize the excellent work that has been done across Canada by dedicated people in many environments who have strived to ensure that health research involving human subjects meets the highest standards of ethics, and we are confident that the standards

***The Committee agrees with many reports that the central question for Canada is the public accountability of the overall processes for assuring the ethics of research involving humans.***

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<sup>281</sup> Professor Michael MacDonald, Law Commission of Canada.

achieved in Canada are as good as any in the world. Indeed, the report released by the Law Commission of Canada stated:

*We are also very much impressed with the calibre of scholarly, ethics and legal expertise represented on many REBs. And, at a general level, Canadian scholars are prominent internationally in research regarding legal and ethical aspects of human subjects research.*<sup>282</sup>

However, the Committee believes that the present varied structures and approaches to health research ethics are inconsistent with the public accountability that an area of this importance requires. Accordingly, we urge the various leading stakeholders of health research involving human subjects to work together to develop a governance system for health research involving human subjects that can meet the following objectives: the promotion of socially beneficial research; the protection of research participants; and the maintenance of trust between the research community and society as a whole.<sup>283</sup> This initiative should involve Health Canada, CIHR, other federal funding agencies, the Panel and Secretariat on Research Ethics, industrial research sponsors, research institutes, health professional licensing bodies and associations, NCEHR, the newly created Canadian Association of Research Ethics Boards, etc. Therefore, the Committee recommends:

***We urge the various leading stakeholders of health research involving human subjects to work together to develop a governance system for health research involving human subjects that can meet the following objectives: the promotion of socially beneficial research; the protection of research participants; and the maintenance of trust between the research community and society as a whole.***

**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;**

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<sup>282</sup> *Ibid.*, p. 300.

<sup>283</sup> These objectives correspond to those that were identified in the McDonald report cited in the previous footnote.



- **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.**

### **12.7.3 Animals in research**

Because animals are biologically very similar to humans, animals are used in research to develop new biological knowledge that has a high chance of applicability to the human condition. However, because animals are not identical to humans, new knowledge that arises from research with animals must be tested in humans before it is applied to human health.

Ethical concerns about the use of animals by humanity, particularly their use in research, have been recognized since the 19<sup>th</sup> century, especially in England. In Canada, these concerns caused MRC and NRC to undertake studies leading in 1968 to the creation of the Canadian Council on Animal Care (CCAC). Currently, CCAC receives 87% of its \$1.2 million budget from CIHR and NSERC to cover CCAC services to the research institutions that they

fund. CCAC obtains the rest of its revenues from fees for service charged to governmental and private institutions.

CCAC awards the Certificate of Good Animal Practice<sup>®</sup> to institutions that it determines are in compliance with its standards. Compliance is determined through site visits by assessment panels. CIHR and NSERC make participation in the CCAC program mandatory for all those who wish to receive their research funding and inform institutions that they will withdraw funds from institutions that CCAC states are not in compliance with its standards. The CCAC reports that institutions generally comply with its recommendations.<sup>284</sup>

In its brief to the Committee, the Coalition for Biomedical Health Research stated that CCAC standards are recognized both nationally and internationally:

*(...) research that complies with CCAC guidelines and policies constitutes ethically sound and responsible activity.*

*(...) CCAC's nationally and internationally accepted standards (...) provide the needed balance between the protection of animals and the benefits that are gained by the use of animals in science.*<sup>285</sup>

The formal structure of the CCAC, along with its monitoring program, is regarded by many, in Canada and abroad, as an optimal model enabling it to work effectively at arm's length from and with government.<sup>286</sup> In addition, recent report suggested that such a model could be considered in the field of research involving human subjects. For example:

*An interesting model in Canada and one, which I think we need to look at seriously with regard to an accreditation process for human research, is the Canadian Council on Animal Care. (...) it now has remarkable credibility with international recognition. (...) It remains a very interesting and almost uniquely Canadian model. It has federal fiscal support and yet, functioning on its own, setting standards and having a very respected accreditation process for animal research.*<sup>287</sup>

The Committee acknowledges that CCAC performs a world class service to Canadians in a cost-effective manner. Though there is no doubt that some Canadians will disagree, mainly those who reject any use of animals in research, the Committee believes that the CCAC offers clear evidence that a very sensitive

***The Committee acknowledges that CCAC performs a world class service to Canadians at a remarkably low cost.***

<sup>284</sup> Louis-Nicolas Fortin and Thérèse Leroux, "Reflections on Monitoring Ethics Review of Research with Human Subjects in Canada", *NCEHR Communiqué*, Summer 1997.

<sup>285</sup> Coalition for Biomedical and Health Research, Brief to the Committee, p. 8.

<sup>286</sup> Sub-Committee on Ethics, *The Ethics Mandate of the Canadian Institutes of Health Research: Implementing a Transformative Vision*, Working Paper prepared for the Interim Governing Council of the CIHR, 10 November 1999, pp. 18-19.

<sup>287</sup> Dr. Henry Dinsdale, Speech to the National Workshop of the NCEHR, March 2001, p. 5.

area that requires minute by minute attention and care can be effectively managed by an approach based on:

- Belief, until proven wrong, that institutions and individuals are seeking to work in a manner that reflects the values of Canadians;
- A firm foundation in increasing awareness and training of individuals on issues and standards;
- An assessment approach that is based on internationally recognized standards and that leads to certification of facilities and processes, that involves experts and lay persons, and that operates in a collegial manner until the point when there is evidence of wrongdoing and failure to take the necessary corrective measures.

While not advocating simply copying CCAC's mechanisms into the challenge of governance of research involving humans, the Committee believes that much can be learned from CCAC's experience. The Committee, however, identifies a gap in the interactions between the CCAC and the federal government. Though numerous departments and agencies place themselves under CCAC's assessment program for research involving animals that is carried out in their own facilities, and CIHR and NSERC require compliance with CCAC's standards as a condition of receiving research funds, we believe that this is not enough. Therefore, we recommend that:

**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.**

#### **12.7.4 Privacy of personal health information**

All personal information is precious to individuals, but information about personal health is probably the most sensitive to most people. Health information goes to a person's most intimate identity, not only because it directly affects the individual him or herself, but also because it can affect family members and others, as well as other aspects of the person's life, such as his/her employment or insurability.

The right to privacy and confidentiality of personal health information is a very important value for Canadians. Now more than ever, Canadians need reassurance that their privacy and confidentiality will be respected in this era of rapidly advancing technology. However, the quality of their health and health care is also a value that Canadians cherish very dearly. Health care providers, health care managers and health researchers need access to personal health information to improve the health of Canadians, strengthen health services and sustain a high quality health care system. The present challenge for Canadians is to set acceptable limits around the right to privacy, on the one hand, and the need for access to information (by health care providers, managers and researchers) on the other, in order to achieve an appropriate balance between them.

***The right to privacy and confidentiality of personal health information is a very important value for Canadians.***

The *Personal Information Protection and Electronic Documents Act* or PIPEDA, promulgated in June 2000, has stimulated intensive debate and study of this question in the past two years. The health sector had not recognized the potential effects of this legislation on health research and health care management until the legislative review of the Bill was well advanced through the House of Commons. Representatives from various parts of the health sector therefore intervened strongly in hearings before this Senate Committee in late 1999. Their testimony clearly demonstrated that the health sector was not part of the broad consensus supporting the bill, and also that there was no consensus within the health sector itself as to an appropriate solution to the issues about privacy of health information which are raised by the bill. As a result, the Committee concluded that there was a significant degree of uncertainty surrounding the application of PIPEDA to personal health information that required clarification. In response to the Committee's recommendation<sup>288</sup>, therefore, the federal government decided to delay the application of PIPEDA to personal health information until January 1, 2002. This delay would allow one extra year from the time of proclamation to motivate government and relevant stakeholders in the health sector to resolve these uncertainties and formulate a solution that is appropriate for the protection of personal health information.

The Committee is pleased that several groups in the health sector have seriously addressed many of the concerns raised by PIPEDA, and in particular, the need to protect personal health information, while at the same time allow restricted use of such information for essential purposes such as health research and health care management (which includes the provision, management, evaluation and quality assurance of health services).

Over the past two years, CIHR has undertaken a wide-range analysis of the privacy issues and initiated a broad consultation process with various stakeholders, culminating in recommendations for the interpretation and application of PIPEDA to health research.<sup>289</sup>

CIHR's recommendations set out precise legal wording in the form of proposed regulations under PIPEDA that, without changing the Act, would facilitate its interpretation and application in the area of health research. These recommendations were presented to the

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<sup>288</sup> Second report of the Standing Senate Committee on Social Affairs, Science and Technology, 36<sup>th</sup> Parliament, 2<sup>nd</sup> Session, 6 December 1999.

<sup>289</sup> CIHR, *Recommendations for the Interpretation and Application of the Personal Information Protection and Electronic Documents Act in the Health Research Context*, 30 November 2001. CIHR's proposed regulations are available on the CIHR Website at [http://www.cihr.ca/about\\_cihr/ethics/recommendations\\_e.pdf](http://www.cihr.ca/about_cihr/ethics/recommendations_e.pdf).

Committee as the most realistic, short-term solution, recognizing that PIPEDA would not likely be amended before January 1, 2002. CIHR emphasizes that its proposed regulations, though significantly limited by the current wording of PIPEDA, could nevertheless provide the necessary guidance to help clarify certain ambiguous terms in a manner that will achieve the objectives of the Act without impeding vitally important research. CIHR is also of the view that regulations, as legally binding instruments, are necessary to enable researchers, and Canadians in general, to understand what the law expects of them and how to govern their conduct accordingly. Furthermore, such regulations could provide the necessary basis on which provinces and territories could develop substantially similar legislation before January 1, 2004, as provided for by PIPEDA.<sup>290</sup>

Finally, CIHR recognizes the need for further work with various stakeholders and the provinces to establish an overall, more coherent, comprehensive and harmonized legal or policy framework for the health sector. Ultimately, whatever law or policy governs this area needs to be interpreted and applied in a flexible and feasible manner, and users need to develop more detailed guidelines for promoting best information practices in their daily work.

The Committee has considered the regulations proposed by CIHR and we commend CIHR for its efforts in this regard. We fully support the intent of the proposed regulations. As stated in its Fourteenth Report dated December 14, 2001<sup>291</sup>, the Committee believes that these regulations should be given serious consideration and, therefore, we recommend that:

**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.**

A second and parallel initiative was undertaken by a Privacy Working Group composed of representatives from the Canadian Dental Association, the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, and the Consumers Association of Canada. The Privacy Working Group addressed the need to access personal health information for the purposes of health care management. In a report submitted to Health Canada, the Privacy Working Group enunciated the following principles.<sup>292</sup>

- Confidentiality of information in health care delivery is of great importance to Canadians. Fear of disclosure to others of personal health information is

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<sup>290</sup> Indeed, the Act gives provinces and territories until January 1, 2004, to develop substantially similar legislation.

<sup>291</sup> Standing Senate Committee on Social Affairs, Science and Technology, *Fourteenth Report*, 37<sup>th</sup> Parliament, 1<sup>st</sup> Session, 14 December 2001.

<sup>292</sup> Privacy Working Group, *Privacy Protection and Health Information: Understanding the Implementation Issues*, report submitted to Health Canada, December 2000.

likely to harm the trust that is essential in the relationship between patients and providers, and hence limits the willingness to seek care, or to impart information that is important to patient care.

- While an individual's right to privacy of personal health information is of great importance, it is not absolute. This right is subject to reasonable limits, prescribed by law, to appropriately balance the individual's right to privacy and societal needs, as can be reasonably justified in a free and democratic society.
- Individuals have the right to: privacy of their personal health information; decide whether and under what conditions they want such information collected, used or disclosed; know about and have access to their health records and ensure their accuracy; and have recourse when they suspect a breach of their privacy.
- In parallel, health care providers and organizations have obligations to: treat personal health information as confidential; safeguard privacy and confidentiality using appropriate security methods; use identifiable information only with the individual's consent except when the law requires disclosure or there is compelling evidence for societal good under strict conditions; restrict the collection, use and disclosure of personal health information to de-identified information, unless the need for identifiable information is demonstrated; and, implement policies, procedures and practices to achieve privacy protection.

When the Committee met in December 2001 to examine progress made with respect to the application of PIPEDA to health care, we were informed that, while the members of the Privacy Working Group agreed on many issues, they had not yet achieved a definitive and unified position. The Privacy Working Group was of the view that progress towards achieving consensus would require the active involvement and leadership of the federal government. The federal government, however, has taken the position that the concerns of the Privacy Working Group should be resolved between the members of the group and the Privacy Commissioner.

The Committee believes that further guidance and direction is needed in respect of the provision, management, evaluation and quality assurance of health services. For this purpose, constructive and collective efforts by *all* affected parties must be made to address the relevant issues, and government must lead by example. As stated in its 14<sup>th</sup> Report, the Committee recommends that:

**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.**

Like other Canadians, the members of the Committee place a very high priority on the protection of personal health information. Though protection of personal health information is understandably of very high importance, we must recognize what else is at risk if access is summarily rejected because of perceived threats to the privacy and confidentiality. Rather than give absolute status to the right to privacy, the

Committee believes that Canadians must engage in a careful and thoughtful consideration of the reasons why personal information is needed for health research and health care management purposes, the social benefits that accrue to Canadians individually and collectively as a result, and the conditions that must be met before access is allowed. Because of its long-standing responsibility in funding health care and financing health research, the federal government should play a major role in promoting greater public awareness and facilitating greater debate in regard to these issues.

***The Committee believes that Canadians must engage in a careful and thoughtful consideration of the reasons why personal information is needed for health research and health care management purposes, the social benefits that accrue to Canadians individually and collectively as a result, and the conditions that must be met before access is allowed.***

CIHR's *Draft Case Studies Involving Secondary Use of Personal Information in Health Research* (December 2001) constitutes an excellent model for encouraging discussion and broader understanding through very concrete examples of real health research projects involving secondary use of personal information. Parallel efforts by others to develop similar case studies illustrating why and how personal information is used for health care management purposes would also be extremely valuable. In light of the above, the Committee recommends that:

**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.**

This being said, the Committee believes that if Canadians are to allow restricted access to personal health information for essential functions, such as health research and health care management, it is imperative that their personal health information be adequately protected. We wish to emphasize the importance of ensuring, all the while, that Canadians remain confident that the privacy of their personal health information is being respected. We see here, once again, a major federal role to promote a fulsome discussion of the relevant ethical issues

and examination of the control and review mechanisms necessary for ensuring that the secondary use of personal information for health care management and health research purposes is conducted in an open, transparent and accountable manner. Therefore, the Committee recommends that:

**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.**

#### **12.7.5 Genetic privacy**

The discussion above has addressed issues of privacy of personal health information arising from databases from the existing health care system. The Committee recognizes that new technologies allowing analysis of genes is also introducing new considerations into the management of personal health information. The exploding abilities to link DNA sequences to disease offer the potential both to greatly increase the health care of the individual but also to intrude into the privacy of both the individual and his or her relatives. In addition, these technologies allow the prediction of diseases that have not yet become evident. However, a majority of these predictions represent increased probability of the incidence of the disease, the test being often statistical in nature (e.g., the likelihood is twice that of the general population) rather than absolute (as for Huntington's disease, for example).

The application of the new genetic technologies to human health is as yet in its infancy, but at least some of the potential benefits and harms are becoming evident. The concerns include the fear that access to genetic information on individuals might affect their employability or insurability.

***The Committee is pleased that interdepartmental discussions are underway within the federal government on this wide range of issues, and encourages their pursuit to provide guidance and advice on means of addressing these complex issues in the best interests of Canadians.***



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#### **12.7.6 Potential situations of conflict of interest**

Advances in human health often involve participation of researchers in academia, in government and in industry. The boundaries between these are becoming increasingly blurred, and much mutual trust and collaboration is required between them. For example:

- The large majority of published health research in Canada is done by researchers in academic institutions, who obtain funding from government, philanthropic and industrial sources.
- Academic researchers are increasingly entrepreneurial, and are the source of many start-up companies that are providing fast economic growth in the biological revolution.
- Industries obtain many of their ideas for new commercial entities, including new interventions in health, from academic research, and are starting to establish research centres in academia in exchange for right of first refusal on intellectual property.
- Government regulates health interventions, as well as contributing to knowledge through its in-house research. Regulations depend on research carried out by industry, often in academic institutions, which is assessed by governmental scientists, who may call on academic scientists for advice and other assistance.

The potential for conflicts of interest are obvious, as are the concerns that, for example, industrial interests in protecting intellectual property and commercial interests might adversely affect the performance or publication of research carried out in public institutions or with public funds. Media attention has rightly focused on instances when these fears appear to have been realised.

The Committee acknowledges that industrial research is an essential component of health research and health care. In fact, our growing abilities to promote health and to prevent, diagnose or treat disease are very largely due to industry. In addition, despite a number of publicized cases with evidence of conflict of interest, the Committee is of the view that the majority of industry works to high standards of ethics, fully consistent with the expectations of Canadians. Indeed, companies cannot expect to survive in today's world if they flout society's expectations.

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However, the Committee understands that the growing role of industry in Canada's health research spectrum, particularly in clinical trials, is a cause for concern. This was highlighted in a recent editorial by the International Committee on Medical Journal Editors, which laid out the ground rules for avoiding conflict of interest in publications.<sup>293</sup> In particular, there is a need to find an appropriate balance between clinical research performed in the academic sector, the ability to compare different treatments for the same disease, the focus of research on diseases in which profits are most likely, (e.g., diseases of wealthy as opposed to poor nations), the publication of negative results (e.g., the need for a registry of all clinical trials), and related areas.

The Committee welcomes the work of CIHR in expanding the collaborative health research programs between academic and industrial research through the University-Industry Program and the CIHR/Rx&D<sup>294</sup> Program. We understand that CIHR partnerships with industry need to be encouraged. However, there is a need to consider whether explicit guidelines should be developed; these guidelines could assist in determining the impact of ethically problematic areas in CIHR's relations with industry. We have learned that CIHR has set up a working group to study this issue. Therefore, the Committee recommends that:

**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.**

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<sup>293</sup> See *Canadian Medical Association Journal*, 18 September 2001, Vol. 165, pp. 786-788.

<sup>294</sup> Partnership between CIHR and Canada's Research-Based Pharmaceutical Companies.

# **Part VI: Health Promotion and Disease Prevention**

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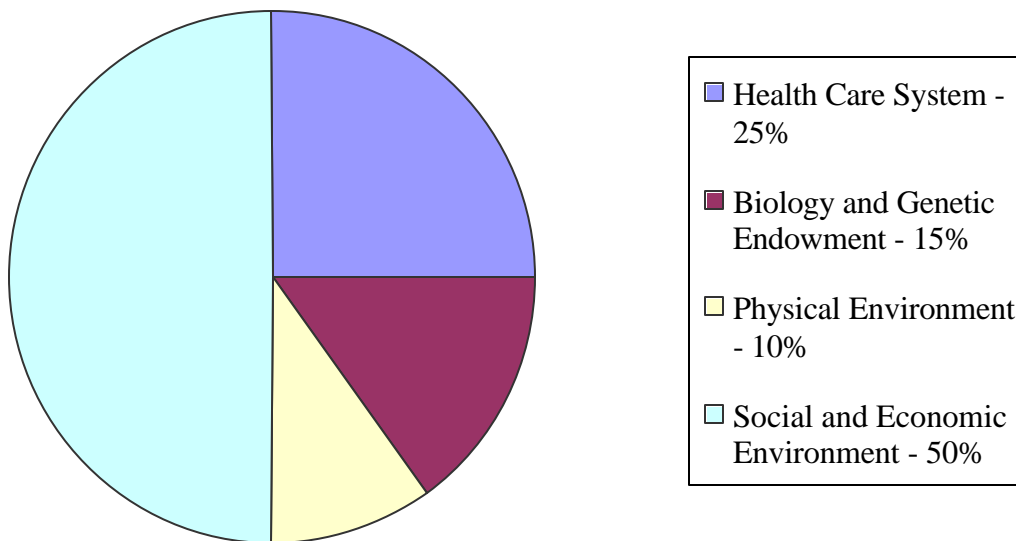
## CHAPTER THIRTEEN

### HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE

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As the Committee has noted in Volume One, it is clear that the health care system is an important contributor to good health. Services as widely varied as childhood immunization, medications to reduce high blood pressure or prevent asthma, and heart surgery all contribute to health and well-being. In fact, the Canadian Institute for Advanced Research estimates that 25% of the health of the population is attributable to the health care system alone (see Chart 13.1).<sup>295</sup> Obviously, it is important that the health care sector is fiscally sustainable and continually strives to provide timely services of high quality. Many of the recommendations made by the Committee in this report are designed specifically to achieve sustainability, timeliness, quality and efficiency in health care delivery, all with the objective of improving the health and well-being of Canadians.

**CHART 13.1**  
**ESTIMATED IMPACT OF DETERMINANTS OF HEALTH ON THE**  
**HEALTH STATUS OF THE POPULATION**



Source: Estimation by the Canadian Institute for Advanced Research, Graph available on Health Canada's Website.

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<sup>295</sup> Volume One, p. 81.

The remaining 75% of the health of the Canadian population is determined by a multiplicity of factors outside the health care system. These factors, which are often referred to as the “non-medical determinants of health,” include: biology and genetic endowment; income and social support; education and literacy; employment and working conditions; physical environment; personal health practices and skills; early childhood development; gender; and culture.

Throughout its study, the Committee was told repeatedly that, to maintain and improve health status, governments should, in addition to sustaining a good health care system, develop public policies and programs that address these non-medical determinants of health. Such policies and programs encompass a wide spectrum of interrelated activities, ranging from health and wellness promotion, through illness and injury prevention and public health and health protection, to broader population health strategies. These are all components of a healthy public policy:

- **Health and Wellness Promotion:** these activities are designed to encourage Canadians to take a more active role in improving their health through, for example, exercise and healthy food and lifestyle choices.
- **Illness and Injury Prevention:** consists of activities directed toward decreasing the probability of individuals, families and communities contracting specific diseases and injuries. Prevention activities seek to reduce unwanted health outcomes by reducing or eliminating associated risk factors. Immunization, early detection of disease through screening programs and reduction of exposure to potentially injurious activities (use of seat belts in the car, fences around pools, safer roads, etc.) are examples of illness and injury prevention.
- **Public Health and Health Protection:** are intended to protect the health of Canadians against current and emerging health threats. This includes the surveillance and control of disease outbreaks and trends (in both infectious and chronic illnesses) and the monitoring of safety and effectiveness of a variety of products (such as food, drugs and medical devices), as well as environmental health assessments.
- **Population Health Strategies:** include a wide range of government policies and programs that can influence income redistribution, access to education, housing, water quality, workplace safety, and so on – all major determinants of the health of a population.
- **Healthy Public Policy:** is a concept that encompasses health and wellness promotion, disease and injury prevention, public health and health protection, as well as population health. Under a healthy public policy strategy, every major action, program and policy of government is evaluated in terms of its implications for the health of Canadians. Healthy public policy requires an intersectoral approach – one that engages the several sectors that are responsible for, or affect, each of the determinants of health.

There is increasing evidence that investing more human and financial resources in promotion, prevention, protection and population health can significantly improve the health

outcomes for a given population. In the end, this can reduce the demand for health services and the pressures on the publicly funded health care system.

The Committee was told and is aware, however, that promotion, prevention, protection and population health activities do not claim anything like the close focus and high status that health care has in the eyes of the Canadian public and, obviously, public policy decision makers. Although it is clear that, collectively, the non-medical determinants of health have far greater impact on the health of the population than health care, the fact is that the very positive outcomes from promotion, prevention, protection and population health activities are generally visible only over the longer term, and thus they are less newsworthy. Because they are less likely to capture the attention of the general public, they are less attractive politically.

The Committee believes that 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.

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The focus on wellness was recently addressed by the Government of Newfoundland and Labrador in its five-year strategic health plan. The first goal of this plan incorporates a wellness strategy built on health promotion, illness and injury prevention, health protection and early child development.<sup>296</sup> The Committee applauds such initiative.

The Committee strongly supports the opinion of many witnesses that additional funding in these fields is essential for Canada to develop healthy public policies that focus on improving the health and well-being of the population, rather than concentrating only on curing people when they get sick. Moreover, the Committee believes that the federal government can and must play a leadership role in this area.

In this chapter, the Committee sets out its findings and recommendations with respect to the role of the federal government in promoting healthy public policies. Section 13.1 provides information on trends in disease and injury in Canada. Section 13.2 presents data on the economic burden of disease and injury. Section 13.3 discusses the need for a national chronic disease prevention strategy. Section 13.4 examines the concerns raised with respect to public health, health protection and health and wellness promotion. Section 13.5 discusses the broader context of the determinants of health, and highlights the possibilities of moving toward healthy public policy in Canada.

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<sup>296</sup> Minister of Health and Community Services, *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador*, September 2002 ([www.gov.nf.ca/health/strategichealthplan](http://www.gov.nf.ca/health/strategichealthplan)).

### 13.1 Trends in Diseases<sup>297</sup>

During the twentieth century, the application of new knowledge and technology in two key areas – public health (through the provision of clean water and sanitation) and health care – has significantly altered the pattern of disease. The causes of mortality have shifted away from acute, infectious diseases to non-communicable (chronic) diseases (see Table 13.1).

Chronic diseases, such as cancer and cardiovascular disease, are now the leading causes of death and disability in Canada, with accidental injuries the third most common. However, some infectious diseases once thought conquered – such as tuberculosis – are re-emerging as the infectious agents that cause them have developed resistance to antibiotics. Rapid international transport of foods and people also increases the opportunities for the spread of infectious diseases.

**TABLE 13.1**  
**LEADING CAUSES OF DEATH (AGE-STANDARDIZED)**  
**RATE PER 100,000**

<b>1921-25</b>	
Cardiovascular and renal disease	221.9
Influenza, bronchitis and pneumonia	141.1
Diseases of early infancy	111.0
Tuberculosis	85.1
Cancer	75.9
Gastritis, duodenitis, enteritis and colitis	72.2
Accidents	51.5
Communicable diseases	47.1
<b>All causes</b>	<b>1,030.0</b>
<b>1996-97</b>	
Cardiovascular diseases (heart disease and stroke)	240.2
Cancer	184.8
Chronic obstructive pulmonary diseases	28.4
Unintentional injuries	27.7
Pneumonia and influenza	22.1
Diabetes mellitus	16.7
Hereditary/degenerative diseases of the central nervous system	14.7
Diseases of the arteries, arterioles and capillaries	14.3
<b>All causes</b>	<b>654.4</b>

Source: Susan Crompton, "100 Years of Health", *Canadian Social Trends*, Statistics Canada, Catalogue 11-008, No. 59, Winter 2000, p. 13.

<sup>297</sup> Most of the information contained in this section can be found in Volume Two, Chapter Four, "Disease Trends", pp. 45-55.



### 13.1.1 Infectious diseases

In the early 1920s, heart and kidney diseases were the leading causes of death, followed by influenza, bronchitis and pneumonia, and diseases of early infancy. Tuberculosis took more lives than cancer. Intestinal illnesses such as gastritis, enteritis and colitis, and communicable diseases such as diphtheria, measles, whooping cough and scarlet fever, were also common causes of death.

Public health programs, combined with the large-scale introduction of vaccines and antibiotics, have led to a major shift in the pattern of diseases, with a move away from infectious diseases to chronic diseases. Many infectious diseases persist, however. Indeed, Dr. Paul Gully, Director General at the Centre for Infectious Disease Prevention and Control (Health Canada), told the Committee that the death rate from infectious diseases in Canada has increased since 1980.<sup>298</sup> He pointed to seven infectious disease trends that, in his view, threaten Canadians:

- Many infectious diseases, such as AIDS and hepatitis C, persist;
- There are new and emerging infectious disease threats, including mad cow disease and *E. coli*, as well as the West Nile Virus;
- Global travel and migration can quickly introduce new diseases into the population;
- Environmental changes, such as global warming, deforestation, and tainted water, may increase the spread of infections;
- Behavioural changes, particularly high-risk sexual practices and drug use, can foster the spread of HIV and other infectious diseases;
- Public resistance to immunization could cause a resurgence in, for example, polio and measles;
- Anti-microbial resistance in infectious organisms may reduce the effectiveness of traditional curative measures, such as antibiotics.<sup>299</sup>

### 13.1.2 Chronic diseases

According to the National Population Health Survey, in 1998-1999, more than half of all Canadians, or 16 million people, reported suffering from a chronic condition. The most common were allergies, asthma, arthritis, back problems, and high blood pressure.<sup>300</sup>

Cardiovascular disease is the leading cause of death in Canada, accounting for 37% of all deaths. Mortality from cardiovascular disease has been declining in Canada since 1970 among both men and women, although more slowly in women. Cancer in its major forms

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<sup>298</sup> Dr. Paul Gully, Brief to the Committee, 4 April 2001, p. 2.

<sup>299</sup> Dr. Paul Gully, *op. cit.*, p. 5.

<sup>300</sup> Dr. Christina Mills, Brief to the Committee, 4 April 2001, p. 4.

is the second-leading cause of death and is the leading cause of potential years of life lost<sup>301</sup> before age 70 (accounting for over one-third of all potential years of life lost). Cancer is primarily a disease of older Canadians; 70% of new cancer cases and 83% of deaths due to cancer occur among those who are 60 or older. Death rates from cancer have declined slowly for men since 1990, but have remained relatively stable among women over the same period. However, lung cancer rates for women are now four times higher than they were in 1971.

### **13.1.3 Injury**

In 1995-1996, injuries accounted for 217,000 hospital admissions in Canada. By far the highest rates of hospital admissions due to injuries were among Canadians over the age of 65. Falls remain an important cause of injury among seniors and children under 12. Among children, poisoning was the next most important cause of injury-related admission to hospital in 1996. For adolescents and adults under the age of 65, motor vehicle accidents constituted the second most important cause. The vast majority of injuries are accidental (about 66%).<sup>302</sup>

### **13.1.4 Mental health**

The National Population Health Survey of 1994-1995 found that approximately 29% of Canadians experienced a high level of stress; 6% of Canadians felt depressed; 16% of Canadians reported that their lives were adversely affected by stress; and 9% had some cognitive impairment such as difficulties thinking and remembering. Work prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health estimated that about 3% of Canadians suffer from severe and chronic mental disorders that can cause serious functional limitations and social and economic impairment, such as bipolar personality and schizophrenia. This translates into approximately one in every 35 Canadians over 15 years of age.<sup>303</sup>

Mental stress and disorders leading to mental illness can strike at different periods in life. Autism, behavioural problems and attention deficit disorder most commonly affect children. Adolescence is the typical onset of eating disorders and schizophrenia. Adulthood is a time when depression may manifest itself more obviously. Senior years are marred by Alzheimer's and other forms of dementia, although depression is also often identified in the elderly.

Because of the importance of mental health among Canadians, the Committee will hold specific hearings and table a separate report to present its findings and recommendations to the federal government.

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<sup>301</sup> The internationally recognized indicator of "potential years of life lost" refers to the number of years of life lost when a person dies before a specified age, say age 75. A person dying at age 25, for example, has lost 50 years of life.

<sup>302</sup> Federal/Provincial/Territorial Advisory Committee on Population Health, *Toward a Healthy Future – Second Report on the Health of Canadians*, Ottawa, 1999, p. 19.

<sup>303</sup> Kimberly McEwan and Elliot Goldner, *Accountability and Performance Indicators for Mental Health Services and Supports: A Resource Kit*, prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Ottawa, 2000, p. 30.

### 13.2 The Economic Burden of Illness

The only available estimates on the economic burden of illness and injury in Canada were published in 1997 by Health Canada; they apply to 1993. That year, the total cost of illness and injury was estimated to be \$156.9 billion, or 22% of GDP. Direct costs (such as hospital care, physician services and health research) amounted to \$71.7 billion, while indirect costs (such as lost productivity) accounted for \$85.1 billion.

As Table 13.2 shows, the diagnostic categories with the highest total costs were cardiovascular diseases (\$19.7 billion or 15.3% of total costs), musculoskeletal diseases (\$17.8 billion or 13.8%), injuries (\$14.3 billion or 11.1%), cancer (\$13.1 billion or 10.1%), respiratory diseases (\$12.2 billion or 9.4%), diseases of the nervous system (\$9.6 billion or 7.4%), and mental illness (\$7.8 billion or 6%). Infectious diseases accounted for 2.0% of the total economic burden of illness (\$2.6 billion).

**TABLE 13.2**  
**ECONOMIC BURDEN OF ILLNESS BY DIAGNOSTIC CATEGORY, 1993**  
**(IN MILLIONS OF DOLLARS)**

	DIRECT COSTS <sup>1</sup>		INDIRECT COSTS		TOTAL COST	
	Percent	Cost	Percent	Cost	Percent	Cost
Infectious/Parasitic	1.8	786	2.2	1,857	2.0	2,643
Cancer	7.3	3,222	11.6	9,845	10.1	13,067
Endocrine/Related	3.0	1,334	2.5	2,086	2.6	3,419
Blood Diseases	0.6	274	0.2	173	0.3	447
Mental Disorders	11.4	5,051	3.3	2,787	6.1	7,839
Nervous System/Sense	5.1	2,252	8.6	7,321	7.4	9,573
Cardiovascular	16.7	7,354	14.5	12,368	15.3	19,722
Respiratory	8.6	3,787	9.9	8,393	9.4	12,181
Digestive	7.5	3,326	3.4	2,920	4.8	6,247
Genitourinary	5.1	2,248	0.9	786	2.3	3,034
Pregnancy	4.6	2,025	0.8	690	2.1	2,715
Skin/Related	2.0	892	0.1	122	0.8	1,014
Musculoskeletal	5.6	2,460	18.0	15,328	13.8	17,788
Birth Defects	0.7	305	0.4	334	0.5	639
Perinatal Conditions	1.2	551	0.4	332	0.7	883
Ill-defined Conditions	4.2	1,851	3.0	2,517	3.4	4,368
Injuries	7.1	3,122	13.2	11,222	11.1	14,343
Well-Patient Care	6.2	2,741	0.0	0	2.1	2,741
Other	1.2	549	7.1	6,040	5.1	6,589
<b>TOTAL</b>	<b>100.0</b>	<b>44,130</b>	<b>100.0</b>	<b>85,123</b>	<b>100.0</b>	<b>129,253</b>

A total of \$27.6 billion in direct costs were not classifiable by diagnostic category.

Source: Laboratory Centre for Disease Control (Health Canada), *Economic Burden of Illness in Canada, 1993*. 1997, pp. 10-11.

### 13.3 The Need for a National Chronic Disease Prevention Strategy

These statistics suggest that chronic diseases are not only the leading cause of death and disability in Canada but account for the largest proportion of the economic burden of illness. Moreover, information given to the Committee indicates that 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.<sup>304</sup> More specifically:

- Cardiovascular diseases, including coronary artery disease and stroke, are responsible for 38% of all deaths among Canadians each year, and are one of the leading reasons for hospitalization.
- Cancer is the second most important cause of death in Canada, responsible for 29% of all deaths each year, and accounting for almost one third of potential years of life lost.
- Chronic obstructive lung disease is the fifth most common cause of death in Canada and is the only cause of death that is increasing in prevalence. Asthma is the most common chronic respiratory disease of children; it is the leading cause of hospital admission and school absenteeism among children in Canada.
- Over one million Canadians live with diabetes. It is a major cause of coronary heart disease and a leading cause of blindness and limb amputations. Among Aboriginal Canadians, the prevalence of diabetes is three times as high as among other Canadians. In total, diabetes accounts annually for about 25,000 potential years of life lost.

During its study, the Committee was told repeatedly that most chronic diseases are entirely preventable. Moreover, a report prepared by Terrence Sullivan, Vice President and Head, Division of Preventive Oncology, Cancer Care Ontario, indicates that many chronic diseases – particularly cardiovascular disease, cancer, chronic obstructive lung disease and diabetes – share common causes. More specifically, poor diet, lack of exercise, smoking, stress and excessive alcohol intake – all lifestyle issues – are recognized as the leading social/behavioural risk factors for these diseases. These risk factors are also often associated with other physical and physiological states that elevate the risk of chronic disease – including overweight/obesity, high blood pressure/hypertension, high blood cholesterol/hypercholesterolemia, and glucose intolerance/diabetes.<sup>305</sup> If reduced or eliminated, these common lifestyle risk factors would greatly lessen the prevalence and economic burden of these chronic diseases.

The fact that the vast majority of Canadians are exposed to one or more of these common risk factors<sup>306</sup> suggests that the overall health status of the population could be

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<sup>304</sup> Advisory Committee on Population Health, *Advancing Integrated Prevention Strategies in Canada: An Approach to Reducing the Burden of Chronic Diseases*, Discussion Paper, 10 June 2002.

<sup>305</sup> Terrence Sullivan, *Preventing Chronic Disease and Promoting Public Health: An Agenda for Health System Reform*, August 2002.

<sup>306</sup> An analysis from the 2000 Canadian Community Health Survey indicated that 65% of Canadians showed more than one risk factor for chronic disease.

substantially improved by a stronger focus on chronic disease prevention, in parallel with controlling infectious diseases. In recognition of this fact and the potential for joint action, major national health organizations (Canadian Cancer Society, Canadian Diabetes Association, Heart and Stroke Foundation of Canada, Canadian Council for Tobacco Control, Coalition for Active Living, and Dieticians of Canada) have recently come together with Health Canada to form the Chronic Disease Prevention Alliance of Canada (CDPAC).

In addition to this new strategic alliance, there are also several important nation-wide chronic disease initiatives, such as: the Canadian Diabetes Strategy, Canadian Heart Health Initiative, Canadian Cardiovascular Disease Action Plan, Canadian Strategy for Cancer Control, and many other federal/provincial/territorial joint initiatives.

However, the Committee was told that there is a need to integrate, coordinate and strengthen all these diverse initiatives into a national chronic disease prevention strategy. According to Sullivan, Canada should build from the knowledge, success and failure of the existing initiatives to push the agenda forward with renewed vigour.<sup>307</sup>

In addition to better integration of the various current initiatives, there is a need for:

- Increased federal leadership, including political leadership and sustained financial and human resources.
- Development of a common vision across all the major chronic disease organizations, leading to a set of specific goals and objectives.
- Partnerships with the provinces/territories and stakeholders in private sector and non-government organizations.
- Surveillance systems for chronic disease and associated risk factors that will also track progress toward the attainment of strategic goals.
- Greater investment in prevention initiatives that are tailored to regional differences.

The national chronic disease prevention strategy should incorporate a combination of public education efforts, mass media programs and policy interventions. These interventions should be implemented through multiple settings (primary health care, education system, workplace, community) and address the need of various priority populations (e.g., Aboriginal Canadians, rural communities, women, etc.).

The direct benefits of a national chronic disease prevention strategy would be substantial, encompassing the avoidance of unnecessary premature disease, enhanced population health status, improved productivity and reduced health care costs. Estimates are that over a ten year period the decreased health care costs resulting from reduced utilization of hospital and doctor services could be as much as 10%.<sup>308</sup>

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<sup>307</sup> Terrence Sullivan, *op. cit.*, p. 7.

<sup>308</sup> Terrence Sullivan, *op. cit.*, p. 10.

The Committee agrees with many witnesses that now is the time for the federal government to lead a national initiative to reduce the prevalence and economic burden of chronic disease in Canada. In our view, the federal government is particularly well suited to assume such leadership, given its long-standing role in health promotion and disease prevention and its legislative authority with respect to health surveillance and health protection.

A national chronic disease prevention strategy will improve the health of Canadians and contribute to the sustainability of the publicly funded health care system. The Committee believes that the Chronic Disease Prevention Alliance of Canada can assist with the design and implementation of this strategy.

While we feel that the federal government must act as a leader, it is important to collaborate with provincial/territorial governments, the private sector, and voluntary health sector partners – if we are to effect the needed changes. Therefore, the Committee recommends that:

***The Committee agrees with many witnesses that now is the time for the federal government to lead a national initiative to reduce the prevalence and economic burden of chronic disease in Canada. In our view, the federal government is particularly well-suited to assume such leadership, given its longstanding role in health promotion and disease prevention and its legislative authority with respect to health surveillance and health protection.***

**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.**

### 13.4 Strengthening Public Health and Health Promotion

A report produced for the Committee by Dr. Joseph Losos, Director of the Institute of Population Health (University of Ottawa), states that public health/health protection often functions silently as the sentinel for health – through monitoring, testing, analyzing, intervening, informing, promoting and preventing – until something happens unexpectedly. In such instances (such as: Walkerton, food-borne outbreaks, infectious disease outbreaks, increasing chronic disease clusters), the crisis and profile of public health incidents quickly reach major proportions. Perhaps most important, often this occurs at a great cost in human suffering, possibly death and financial expense for often preventable occurrences.<sup>309</sup>

According to the *Canadian Medical Association Journal*, a major problem with public health interventions is that funding is low, often unstable or inconsistent. The result is that the public health care infrastructure in Canada is under considerable stress.<sup>310</sup>

Another major barrier to effective public health is fragmentation: all provinces and territories have separate public health legislation. The federal government also has direct statutory responsibilities for regulatory aspects of public health (e.g., disease surveillance, food and drugs, devices, biologics, some environmental health, consumer products). This welter of regulatory authority results in complex negotiations among the various “players” and less than optimal coordinated activity. Such fragmentation limits the effectiveness of public health efforts and results in a lack of clear accountability and leadership. In the view of many experts, there is an immediate need for strong federal leadership to rectify this unhappy and less-than-productive situation.<sup>311</sup>

Similarly, government funding for health promotion is very low relative to spending on health care. In addition, health promotion is practised both by governments and non-government organizations. While most of these efforts have proven effective, their fragmentation has resulted in a poorly coordinated or integrated health promotion infrastructure. More important, no health goals have been set nationally for health promotion as there have been in the United States.<sup>312</sup>

The Committee believes strongly that programs and policies with respect to public health, health protection and health and wellness promotion are critical to enhancing the health of Canadians. We believe that a coordinated and integrated approach is needed and that, once again, the federal government can and should play a leadership role. We believe also that more funding is needed in this area. Given its statutory authority with respect to health protection and its long-standing role in health promotion, the federal government should devote more funding to health protection and promotion. Therefore, the Committee recommends that:

**The federal government ensure strong leadership and provide additional funding to sustain, better coordinate and**

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<sup>309</sup> Dr. Joseph Losos, *Promotion and Protection of the Health and Wellbeing of the Population – Vision of Federal/National Roles*, 4 September 2002, p.1.

<sup>310</sup> “Public Health on the Ropes”, Editorial, and Richard Schabas, “Public Health: What is to be done?”, *Canadian Medical Association Journal*, Vol. 166, No. 10, 14 May 2002.

<sup>311</sup> Dr. Losos, *op. cit.*

<sup>312</sup> Dr. Losos, *op. cit.*, p. 1.

**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.**

### **13.5 Toward Healthy Public Policy: The Need for Population Health Strategies**

As described above, the term “population health” is used to describe the multiplicity and range of factors that all contribute to health. These many factors encompass both the medical and the non-medical determinants of health. The concept of population health is not new. Indeed, for almost 30 years, Canada has played a leading role worldwide in elaborating the concept of population health:

- In 1974, the then federal Minister of Health, Marc Lalonde, released a working document entitled *A New Perspective on the Health of Canadians*. This report stressed that a high quality health care system was only one component of a healthy public policy, which should take into account human biology (research), lifestyle and the physical, social and economic environments. The Lalonde report was extremely influential in shaping broader approaches to health both in Canada and internationally. At the federal level, it led, among other things, to a variety of social marketing campaigns such as ParticipAction, Dialogue on Drinking, and the Canada Food Guide.
- In 1986, the report *Achieving Health for All*, released by the then federal Minister of Health, Jake Epp, led to the initiatives related to Canada’s Drug Strategy, the Heart Health Initiative, Healthy Communities, the National AIDS Strategy, etc.
- In 1989, the Canadian Institute for Advanced Research (CIAR), then headed by Dr. Fraser Mustard, proposed that the determinants of health do not work in isolation but that it is the complex interaction among determinants that can have the most significant effect on health. This work, along with more recent findings by Dr. Mustard, has, among other things, led to the development of the joint federal and provincial/territorial initiative on early childhood development.
- In 1994, the population health approach was officially endorsed by the federal, provincial and territorial Ministers of Health in a report entitled *Strategies for Population Health: Investing in the Health of Canadians*.
- In September 2000, all Ministers of Health agreed to give priority to action on the broader, underlying conditions that make Canadians healthy or unhealthy.



There is increasing evidence on the impact of the determinants of health on the health status of Canadians, particularly with respect to the socio-economic determinants. For example, the *Second Report on the Health of Canadians*<sup>313</sup> pointed out that:

- Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes;
- Large disparities in income distribution lead to increases in social problems and poorer health among the population as a whole;
- Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy;
- Canadians with high levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier food;
- Studies in neurobiology have confirmed that experiences from conception to age 6 have the greatest influence of any time in the life cycle on the connecting and conditioning of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health right throughout the lifespan;
- Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning are particularly important in maintaining health and cognitive capacity in old age;
- Despite reductions in infant mortality rates, improvements in education levels, and reductions in substance abuse in many Aboriginal communities, First Nations and Inuit people remain at higher risk than the Canadian population as a whole for illness and early death;
- Men are more likely to die prematurely than women, largely as a result of heart disease, fatal accidental injuries, cancer and suicide. Women are more likely to suffer from depression, stress, chronic conditions, and injuries and deaths resulting from family violence;
- Older Canadians are far more likely than younger Canadians to have physical illnesses, but young people report the lowest levels of psychological well-being.

Despite the available evidence, no jurisdiction in Canada and no country in the world has designed and implemented programs and policies firmly based on a population health approach. The fact is that there remain significant practical obstacles to the design of concrete programs that can be sustained over the long haul.

In the first place, the multiplicity of factors that influence health status means that it is extremely difficult to associate cause and effect, especially since the effects of a given

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<sup>313</sup> Federal/Provincial/Territorial Advisory Committee on Population Health, *Toward a Healthy Future - Second Report on the Health of Canadians*, Ottawa, 1999.

intervention are often obvious only after many years. Because political horizons are often of a shorter-term nature, the long timeframe for judging the impact of policy in this area can be a serious disincentive to the elaboration and implementation of population health strategies.

Furthermore, it is very difficult to coordinate government activity across the diverse factors that influence health status. The structure of most governments does not easily lend itself to inter-ministerial responsibility for tackling complex problems. This difficulty is compounded several times over when various levels of governments, together with many non-governmental players, are taken into account, as they must be if population health strategies are to be truly effective.

Although many difficulties are associated with developing an effective population health approach, the Committee believes it is important for Canada to continue to strive to set an example by exploring innovative ways to turn good theory into sound practice that will contribute to improving the population's health status.

Moreover, the Committee believes, along with many witnesses, that, given its clear responsibility for so many policies and programs that affect health (health, environment, agriculture, finance, etc.), the federal government should lead the way in population health by coordinating the activities of the different departments concerned. Along with Dr. Losos, we believe the best coordinator would be the federal Minister of Health. As a first step, all policies and programs established by the federal government should be assessed in terms of their impact on the health status of Canadians. Health impact assessment should become a routine component of all new public policies and programs at the federal level.<sup>314</sup>

***The Committee believes, along with many witnesses, that given its clear responsibility for so many policies and programs that impact on health (health, environment, agriculture, finance, etc.), the federal government should lead the way in population health by coordinating the activities of the different concerned departments.***

Ideally, the Ministers of Health in all Canadian jurisdictions would take on the role of “champions for population health” and advocate health as the major consideration in all initiatives, irrespective of sector. This would lead to the development throughout Canada of a truly “healthy public policy.”

In a subsequent report, the Committee will set out its findings and recommendations on the potential for, and the implications of, healthy public policy in Canada.

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<sup>314</sup> Dr. Losos, *op. cit.*, p. 5.

# **Part VII: Financing Reform**

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## CHAPTER FOURTEEN

### HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED

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In Volume Five, the Committee stressed its conclusion that, as currently structured, Canada's publicly funded health care system is not fiscally sustainable.<sup>315</sup> Accordingly, there is a need to undertake major reform in the way physician and hospital services are funded in order to preserve and enhance the publicly funded health care system, a system to which Canadians are committed and that has served them so well over the last few decades.

In Volume Five, the Committee stated its view that 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 interrelated 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 diminish Canada's ability to generate investment, create jobs and keep Canada competitive with other OECD countries, and particularly with the United States.<sup>316</sup>

***It is the view of the Committee that 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 interrelated 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.***

To address the question about the fiscal sustainability of the publicly funded health care system, the Committee examined, in its Volume Five, current and projected trends in health care spending.<sup>317</sup> We documented the continuing upward pressures on health care costs due to the rapidly rising costs of drugs and new technology, Canada's aging population, the high and increasing cost of health care human resources and growing public expectations. Based on this information and numerous studies and reports on the increasing costs of health care in Canada, the Committee concluded that Canada's publicly funded health care system, as it is currently operated, is *not* fiscally sustainable given current funding levels.

This chapter examines the implications of this conclusion. Section 14.1 summarizes the multidimensional pressures that, in the view of the Committee, will put considerable additional strain on governments' budgets for health care both in the short and in

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<sup>315</sup> Volume Five, p. 7.

<sup>316</sup> *Ibid.*

<sup>317</sup> Volume Five, pp. 7-9.

the long term, and that led us to conclude that more money is needed to sustain the publicly funded health care system and particularly to effect changes to improve its effectiveness and efficiency. Section 14.2 provides the Committee's view on the financing role of the federal government in sustaining a national health care insurance system. Section 14.3 describes a new management system that the Committee believes strongly should be applied to new federal funding for health care.

## 14.1 More Money Is Needed for Health Care

In Volume Five<sup>318</sup>, the Committee examined current and projected trends in health care spending. They are summarized, once again, below.

Data from the Canadian Institute for Health Information (CIHI) show that health care spending in Canada topped \$95 billion in 2000, an increase of 6.9% over the previous year. After adjusting for inflation and population growth, there was a real increase in spending of 4.1% between 1999 and 2000.

Data show also that the pace of growth in health care spending is increasing. In fact, real spending per capita is rising faster today than at any time since the 1980s. There are real, continuing upward pressures on Canada's health care costs:

- **Drug Costs:** The cost of drugs currently accounts for over 15% of total (public and private) health care spending. It is forecast to have climbed to \$14.7 billion in 2000, up 9% from the year before. The Committee noted in Volume Two that, between 1990 and 2000, drug spending per capita increased by almost 93%, more than twice the average increase for health care spending in total (40%).<sup>319</sup> New, effective, but very costly, drugs are expected to enter the Canadian market in the next decade (vaccine against AIDS, new immunological cure for juvenile diabetes, etc.), further exacerbating upward pressures on overall drug costs.
- **New Technology:** Canada needs to invest more in health care technology and health information systems. The Committee's Volume Two indicated that every \$1-billion capital investment in new medical equipment requires an additional \$700 million to cover related operating and maintenance costs.<sup>320</sup> In fact, an estimated \$2.5 billion in capital is required to bring Canada's investment in health care technology to a level equivalent to that of other OECD countries (see Chapter Ten). Similarly, estimates suggest that between \$6 and \$10 billion (over a six- to eight-year period) is required to achieve full implementation of a Canadian health info-structure, or between \$1 to \$1.25 billion annually (see Chapter Ten).
- **Aging Population:** In 1998, 12% of Canadians were 65 or older. That year, more than 43% of provincial and territorial government spending on health care went to services for seniors. According to Statistics Canada, by 2010

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<sup>318</sup> Volume Five, pp. 6-12.

<sup>319</sup> Volume Two, p. 20.

<sup>320</sup> Volume Two, p. 41 and p. 114.

seniors will represent 14.6% of the population, a percentage that rises to 23.6% as the peak of the baby boom generation enters retirement by 2031. Expensive procedures, rarely if ever previously performed on elderly patients, are increasingly available to them.<sup>321</sup> Estimates suggest that the impact of population aging will account for an additional 1% of total health care costs each year. Although this percentage appears to be quite small in the larger scheme of things, in dollar terms it amounts to approximately \$1 billion annually in increased health care costs, continuing for decades.

- **Cost of Health Care Human Resources:** Labour costs account for about 75% of spending on health care. According to the report of Premier's Advisory Council on Health in Alberta (the Mazankowski report), in 2001-02 over half the budget increase for health care went to salary increases in that province. This trend is likely to be maintained throughout Canada.
- **Health Research:** Unprecedented support for health research will lead to the development of many new technologies and drugs. This year, some US\$40 billion will be spent on health research in the G7 countries, leading to effective, but costly, technologies in the fields of genomics, proteomics, nanotechnology, etc.
- **Growing Public Expectations:** Many observers have noted that increasing public demand for physician and hospital services will have a major impact on future costs. In his interim report, Roy Romanow puts this point very well: "One of the most significant cost drivers is how our own expectations have grown over the past few decades. We expect the best in terms of technology, treatments, facilities, research and drugs, and as a consequence, we may be placing demands on our governments that are not sustainable over time."<sup>322</sup> Canadians are more like North Americans than Europeans when it comes to public expectations. More precisely, 64% of Canadians are very interested in new medical discoveries, compared to 66% of Americans and 44% of Europeans.
- **Health Care Restructuring:** Restructuring, renewing and reforming health care will cost a considerable amount of money. For example, it has been estimated that establishing primary health care teams in Quebec would cost, on average, \$750,000 per team (see Chapter Four).
- **Gaps in the Health Care Safety Net:** As pointed out in Chapters Seven, Eight and Nine of this report, currently there are serious gaps in our health care safety net, particularly with respect to prescription drugs, home care and palliative care. Expanding public coverage to reduce or close these gaps in insurance coverage will require additional government funding.

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<sup>321</sup> For example, cardiac procedures (e.g. PTCA) performed on the elderly are increasing by 12% annually; joint surgery (e.g. knee replacement) is increasing at an annual rate of 8%; renal dialysis is increasing by 14% a year (at a cost of \$50,000 annually per patient).

<sup>322</sup> Commission on the Future of Health Care in Canada (Roy J. Romanow Commissioner), *Shape the Future of Health Care, Interim Report*, February 2002, p. 25.

The Committee was told that even conservative projections of future health care costs estimate that those costs will increase by at least one percentage point over the increase in GDP for the indefinite future. Given the publicly funded nature of Canada's health care system, these cost pressures will put considerable strain on governments' budgets, both in the short and in the long term. This has been well documented by provincial and territorial ministers of health in their 2000 report of cost drivers as well as by many reports tabled with the Committee.

For example, a report prepared for the Ontario Hospital Association estimated that close to 38% of total provincial program spending went to health care in 2000-2001, up from 33% in 1992-1993.<sup>323</sup> For its part, the Canadian Taxpayers Federation projected that this proportion will hit 50% as early as 2007 in British Columbia and New Brunswick.<sup>324</sup> Similarly, the Conference Board of Canada estimated that over the period 2000-2020, public per capita spending on health care (adjusted for inflation) will increase by 58%, compared to an increase of only 17% in public per capita spending on all other government services and programs.<sup>325</sup>

This increase in the percentage of government spending devoted to health care provides the clearest indication of the financial pressures felt by governments charged with funding health care. A wide range of witnesses, including health care managers, providers and consumers, expressed deep concerns about rising health care costs and their impact on governments' budgets, both in terms of crowding out other government programs such as education and social services, and imperilling the governments' overall fiscal stability. This testimony and many related reports have persuaded the Committee that, in addition to other necessary reforms, it is essential to invest additional money into Canada's health care system in order to renew and sustain it.

In contrast, a recent report by University of Waterloo Professor Gerard Boychuk contended that there is no fiscal crisis in health care.<sup>326</sup> In his view, there is no fiscal crisis in the sense that Canada's spending on health care has remained relatively constant when taken as a percentage of GDP or as a percentage of overall government revenues. This analysis, however, is presented with a number of caveats. First, it does not consider the projections in health care costs that clearly indicate that health care spending will increase at a rate higher than the growth in either GDP or government revenue. Second, Professor Boychuk recognized the fact that health care is crowding out the provision of other public goods, but considered this as a serious problem only from the provincial perspective, not from the national perspective. This argument avoids the fact that although there are two levels of government involved in funding health care, there is only one set of taxpayers who, no matter where they live, must bear the burden of increasing health care costs. Third, Professor Boychuk argued that the federal government took advantage of the switch from the Established Programs Financing (EPF) to the CHST to reduce its share of health care spending. In his view, publicly funded health care is no longer affordable from a provincial perspective as a result of reduced federal transfers. The logical conclusion to

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<sup>323</sup> TEAQ Associates, *Getting the Right Balance: A Review of Federal-Provincial Fiscal Relations and the Funding of Public Services*, prepared for the Ontario Hospital Association, December 2001, p. 21.

<sup>324</sup> Walter Robinson, *The Patient, The Condition, The Treatment – A CTF Research and Position Paper on Health Care*, Canadian Taxpayers Federation, September 2001, p. 59.

<sup>325</sup> Glenn G. Brimacombe, Pedro Antunes and Jane McIntyre, *The Future Cost of Health Care in Canada, 2000 to 2020 – Balancing Affordability and Sustainability*, The Conference Board of Canada, 2001, p. 21.

<sup>326</sup> Gerard Boychuk, *The Changing Political and Economic Environment of Health Care in Canada*, Discussion Paper, Commission on the Future of Health Care in Canada, July 2002.



this argument would seem, therefore, to be that the federal government should provide more money for health care.

The Committee does not support Professor Boychuk's view that the source of the sustainability crisis is political rather than fiscal. We received overwhelming evidence to support our conclusion that the publicly funded health care system is not fiscally sustainable given current funding levels and that, consequently, more money is needed to restructure and renew Medicare and to close the gaps in the existing health care safety net.

Some individuals and organizations disagree with this conclusion. They claim that operating the health care system more efficiently would save enough money so that no new sources of funding would be required. The Committee has always acknowledged the critical importance of improving effectiveness and efficiency in the management and delivery of health services. In fact, the restructuring recommendations outlined in Chapters Two, Three, Four, Six, Ten and Eleven are designed to achieve this objective.

The Committee does not believe that there is sufficient evidence to support the hypothesis that efficiency gains alone will be enough to obviate the need for additional funding. Jack Davis, CEO of Calgary Regional Health Authority and former secretary to the Cabinet in the Government of Alberta echoed this view when he stated:

*The belief that some magical efficiency will come along that will generate productivity levels in our health care system that are beyond anything that exists anywhere on this planet is naive and unrealistic.<sup>327</sup>*

Canada's publicly funded health care system must be restructured and made much more effective and efficient. But the Committee believes, as it has stated previously, that responsible planning of public policy must include additional funding for health care, including funding the cost of restructuring the system.

Given the federal government's role in the financing of health care, the Committee believes strongly that the government has a critical role to play in sustaining and renewing health care in Canada. We acknowledge, however, that, given all the competing demands for federal government expenditures (e.g., agriculture, the armed forces, the environment, urban infrastructure and so on), any additional funding from federal sources will have to come from *new* money, not from revenue transferred into the health care envelope from existing sources.

***The Committee wishes to stress that, given all the competing demands for federal government expenditures (e.g. agriculture, the armed forces, the environment, urban infrastructure and so on), any additional funding from federal sources will have to come from new money, not from revenue transferred into the health care envelope from existing sources.***

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<sup>327</sup> Jack Davis (53:59).

We turn, therefore, to confront the most difficult health care issue facing policy makers and indeed all Canadians: how should additional funds for health care be raised? Should these new revenues come from increases in existing taxes, or from new forms of taxation or other levies? Should they come from individuals and/or businesses and flow to government by way of taxes or health care insurance premiums or should they come directly from individuals and/or businesses directly into health care? Jack Mintz, President and CEO of the CD Howe Institute, raised this question eloquently:

*Governments will need more revenues because of the rising public share of health care costs over time. Therefore, we must think carefully about how we want to fund the public provision of health care. What is the appropriate way of financing that? This is an important question that Canadians should be asking themselves, because that will be an increasing burden for Canadians as a whole.*<sup>328</sup>

Furthermore, in considering how such additional funding ought to be raised, we must keep in mind that Canada's personal taxes are the highest of the G7 countries and among the highest in the OECD. The Committee believes therefore that Canadians must balance their desire for publicly funded health services against both their willingness to pay taxes to fund them publicly and the need for Canadian tax levels to be set so as to maintain our ability to invest and create new jobs, keeping us competitive with other OECD countries, particularly the United States. The Committee's recommendations on how to raise additional federal funding for health care are presented in Chapter Fifteen.

## **14.2 The Financing Role of the Federal Government**

Many witnesses emphasized the fact that historically the federal government has played a major role in financing publicly insured health services. Moreover, public opinion surveys show repeatedly that Canadians want and expect the federal government to continue to be a major player in Canada's publicly funded health care system.

The Committee believes that, to preserve the spirit of the Medicare program that it pioneered several decades ago, the federal government must play a major role in meeting the serious challenges now facing our publicly funded health care system. We reiterate Principle Three from Volume Five: "The federal government should play a major role in sustaining a national health care insurance system."<sup>329</sup>

***The Committee believes that the federal government, through its financing role, can facilitate, encourage and accommodate the provinces and territories in their efforts to restructure, reconfigure and renew their health care systems.***

The Committee believes that the federal government, through its financing role, can facilitate, encourage and accommodate the provinces and territories in their efforts to restructure, reconfigure and renew their health care systems. The Committee is convinced that

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<sup>328</sup> Jack Mintz (62:5).

<sup>329</sup> Volume Five, p. 29.

the vast majority of Canadians are looking to the federal government to collaborate with, support and form partnerships with the provinces/territories and health care providers to effect needed changes in the health care system. In fact, as discussed in Volume Five, there are many reasons why the federal government's role is important<sup>330</sup>.

First, Canadians strongly support national principles in health care, and they look to the federal government to play a strong role in setting and maintaining them and to ensure their application throughout the country. As it now stands, the federal government's ability to participate in the development and application of nationwide standards and to recommend appropriate policies to provincial and territorial governments depends in large part on the size of its financial contribution.

Second, and some would say most important, only the federal government is in a position to make sure that all provinces and territories, regardless of the size of their economies, have at their disposal the financial resources to meet the health care needs of their citizens. This redistributive role of the federal government is fundamental to what many call "the Canadian way." From this perspective, Sharon Sholzberg-Gray, President and CEO, Canadian Healthcare Association, stated:

*(...) we would like to add leadership as an additional role for the federal government. After all, the federal government is the only level of government that can ensure access for Canadians to comparable services, wherever they live in this country. No one provincial or territorial government can ensure that. Only the federal government can do that, and it should take leadership in this area.*<sup>331</sup>

Third, federal funding for health care is particularly critical to reform and renewal of health care; making changes in the way the health care system is structured and operates will surely result in the requirement of more rather than less money, at least in the short term.

Fourth, interprovincial harmonization with respect to what services are insured and scope of practice rules is an important element of a truly national system. The federal government has an key role in facilitating such harmonization (such as, for example, using financial means to help provincial or territorial governments to meet national standards).

***The Committee believes strongly that the money that the federal government transfers to the provinces/territories for the purpose of health care should provide it a seat at the table when the restructuring of the health care system is discussed. In our view, the federal government should not give money without having a say on how that money is spent.***

Fifth, the Committee believes strongly that the money that the federal government transfers to the provinces/territories for the purpose of health care should provide it a seat at the table when the restructuring of the health care system is discussed. In our view, the federal government should not give money without having a say on how that money is

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<sup>330</sup> Volume Five, pp. 12-14.

<sup>331</sup> Sharon Sholzberg-Gray (49:11).

spent. Canadians rightly expect that, when decisions are made about how their tax dollars are to be spent, the government to which they pay those taxes should be represented.

Finally, the Committee is also convinced that there must be stability of, and predictability in, federal funding for public health care insurance. No industry can be expected to operate effectively if, from year to year, its revenue is subject to significant fluctuations over which it has no control. In fact, effective planning, an essential element of an efficiently operated industry, is impossible unless stability and predictability of funding are assured. In other words, multi-year funding is essential if the publicly funded health care system is to be run effectively and efficiently.

### **14.3 How New Federal Funding for Health Care Should Be Managed**

Before turning to the Committee's recommendations with respect to how new additional federal funds for health care should be raised (see Chapter Fifteen), we first address the issue of how such new federal revenue should be managed. The Committee believes that Canadians will be willing to contribute more to public health care spending only *if* they are convinced that the money will actually be spent on health care, and that it will be spent wisely. This requires that the allocation of any new money that Canadians pay to the federal government for health care be subject to a process that is transparent and by which the government can be held accountable by taxpayers.

The Committee believes strongly that new federal funding for health care should be managed according to four distinct but inter-related parameters:

First, increased federal revenue for health care must go into an *earmarked fund* that is separate and distinct from the Consolidated Revenue Fund. We believe Canadians will not agree to pay increased health care contributions to the federal government unless they are assured that the money will be spent on health care, and that the money is truly incremental to the federal government's existing commitment to health care spending. This has been confirmed by a recent survey by Pollara,<sup>332</sup> which indicated that 75% of Canadians would be willing to pay more taxes if such revenue were directed to health care, and not flow into general revenue. Thus, it appears that, for Canadians, health care is unique, different from other publicly funded goods and services: earmarking funds for health care would ensure that public funding remains less susceptible to the vagaries of political decisions with respect to the allocation of government's financial resources.

***The Committee believes that increased federal revenue for health care must go into an earmarked fund that is separate and distinct from the Consolidated Revenue Fund.***

Second, increased federal revenue for health care must be *targeted*. The Committee is convinced that new federal funding must be used for the purposes outlined in this report, particularly those that would

***The Committee strongly believes that new federal money given to the provinces and territories must buy change or reform; additional money should not be used to fund the publicly funded health care system as it is presently structured.***

<sup>332</sup> Pollara, *Health Care in Canada Survey 2002*, June 2002.

expand public health care coverage (as described in Chapters Seven, Eight and Nine) and those that will improve the effectiveness and efficiency of the health care delivery system (such as service-based funding for hospitals, primary health care reform, health care technology, electronic health records, health research and evaluation, and so on). In other words, new federal money given to the provinces and territories must buy change or reform; new money should not be used to fund the operation of the publicly funded health care system as it is presently structured.

Third, and as a corollary to the second point, the Committee is strongly opposed to increased federal funding for health care being given to the provinces and territories under the mechanism of the Canada Health and Social Transfer (CHST). CHST transfers cannot be targeted for specific purposes, nor can the provinces and territories be held accountable for how the money is spent. Similarly, the Committee is equally strongly opposed to the transfer of additional tax points to the provinces and territories. In the first place, the transfer of tax points has a very unequal impact on different provinces. Second, once the tax points have been transferred, the federal government has no authority over how the resulting revenue is spent.

***The Committee is strongly opposed to increased federal funding for health care being given to the provinces and territories under the mechanism of the Canada Health and Social Transfer (CHST).***

Fourth, the Committee is convinced that the federal government should be advised annually on how the money in the earmarked fund should be spent. This advice should be given in the annual report produced by the National Health Care Council, as recommended in Chapter One. The advice given to the government should be made public to ensure transparency and accountability.

***The Committee is convinced that the federal government should be advised annually by the National Health Care Council on the priorities that should be attached to expenditures out of the earmarked fund.***

And fifth, it is imperative that all governments be made accountable for how additional federal funding for health care is spent. It is the view of the Committee that Canadians must be able to see that the money is being spent for its targeted purposes. Accordingly, both levels of government – federal and provincial/territorial governments – must therefore *share accountability*.

***It is the view of the Committee that, from a federal perspective, 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.***

***Similarly, provincial and territorial governments should be required to report annually to Parliament and the Canadian public on their utilization of earmarked health care funds provided by the federal government.***

From a federal perspective, an annual audit by the Auditor General of Canada of the earmarked fund should specify how the money in the fund has been spent; the results of the audit should be made public. From a provincial/territorial perspective, their use of earmarked federal funds must be

coupled with a requirement for transparent accountability to show the public that the funds have indeed been spent for the specific health care purposes to which they were targeted. In order to do so, provincial and territorial governments should be required to report annually to the Canadian public on their utilization of earmarked health care funds provided by the federal government.

Therefore, the Committee recommends that:

**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.**

If Canadians are indeed willing (as we believe they are) to strengthen the investment by their federal government in health care, and if federal and provincial/territorial governments are willing to collaborate in restructuring and expanding Medicare, then the Committee believes Canada's publicly funded health care system can be made not only fiscally sustainable, but also capable of entering a new era based on its increased efficiency, quality, timeliness, transparency and accountability.

## CHAPTER FIFTEEN

### HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED<sup>333</sup>

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As stated in Chapter One of Volume Five as well as earlier in this report, the Committee has received sufficient evidence, based on both the testimony of witnesses and various reports, to conclude that Canada's publicly funded health care system is not fiscally sustainable. It is, therefore, imperative to invest additional money into our health care system in order to renew and sustain it.

Additional funding for health care can come only from the people of Canada, either through the public purse or privately. As shown in Table 15.1, *public funding* can be drawn from general taxation (the primary form of health care financing in Canada, Australia and the United Kingdom) or from dedicated payroll taxes paid by employers and employees and based on labour earnings (as in Germany and the Netherlands). Public funding may also involve public health care insurance premiums (as in Alberta and British Columbia) or an earmarked health care tax (as in Australia). Finally, public funding for health care could be generated from taxable health care benefits, that is, making publicly funded health care benefits received by an individual subject to income tax.<sup>334</sup>

***In the view of the Committee, it is imperative to invest additional money into our health care system in order to renew and sustain it.***

***Additional funding for health care can only come from the people of Canada, through either the public purse or privately.***

*Private financing* sources discussed at the Committee's hearings include various forms of user charges for publicly insured health services, contributions under Medical Savings Accounts (MSAs) or other similar plans, and private health care insurance. In contrast to Canada, user charges for publicly insured health services are required in Australia, Germany, the Netherlands, Sweden and the United Kingdom (amongst other countries). Systems of MSAs are currently in place in Singapore, South Africa and the United States.

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<sup>333</sup> This chapter is based on the testimony received by the Committee as well as on a thorough review of the literature on this topic. In addition, a paper by Robert D. Brown and Michanne Haynes (July 2002) prepared at the request of the Committee, entitled *Financing Options for Funding and Incremental Increase in Federal Spending on the Health Sector*, provided useful guidance in the writing of this chapter.

<sup>334</sup> We are not aware of any country requiring that health care benefits for publicly insured services be taxable, although a number of proposals of this type have been put forward in Canada.

**TABLE 15.1**  
**SOURCES OF FUNDING FOR HEALTH CARE**

SECTOR	SOURCE
<b>PUBLIC</b>	<ul style="list-style-type: none"> <li>• General Taxation – which incorporates both direct taxation (personal and corporate income tax) and indirect taxes;</li> <li>• Earmarked Tax– a tax earmarked for a specific purpose, such as taxable health care benefits (whereby the health care costs incurred during a year are added to taxable income);</li> <li>• Payroll Taxes – contributions related to labour earnings and paid by employees and/or employers;</li> <li>• Public Health Care Insurance Premiums – an amount (flat or income-related) paid by everyone for the right to be covered under public health care insurance.</li> </ul>
<b>PRIVATE</b>	<ul style="list-style-type: none"> <li>• User Charges – which correspond to a form of payment made by a patient at the time a publicly funded health service is rendered;</li> <li>• Medical Savings Accounts – health care accounts set up to pay for the health care expenses of an individual or his/her family<sup>(a)(b)</sup>;</li> <li>• Private Health Care Insurance – purchased by individuals or through employers' sponsored plans..</li> </ul>

(a) Some proposals suggest that MSAs be funded publicly or, as proposed by some in Canada, as a mixture of public and private sources.

(b) There exists also some other plans involving individual responsibility for some costs but not incurred at the point of service.

Source: Economics Division, Parliamentary Research Branch, Library of Parliament; Brown and Haynes (2002).

Private health care insurance could be used to supplement, complement or replace publicly funded health care. In the event that additional money is not invested into health care as the Committee recommends in this report, or that government fails to ensure timely access to needed care, it is likely that there would be great pressure and, as suggested in Chapter Five, probably a legal obligation on government, to let those Canadians who can afford to do so purchase private health care insurance to obtain privately delivered health services.

Private insurance would, however, move away from the single insurer model that the Committee strongly favours, and would lead to a parallel private delivery system. The potential implications for the publicly funded health care system of allowing private health care insurance in Canada are not discussed in this chapter but are reviewed thoroughly in Chapter Sixteen.

***Private insurance would move away from the single insurer model that the Committee strongly favours and would lead to a parallel private delivery system.***



## **15.1 The Amount of Increased Federal Funding Required**

The Committee believes that the federal government must provide additional funding for the reform and renewal of the publicly funded health care system. Based on our calculations, implementation of the recommendations given in Chapters Two through Thirteen, when combined with a significant contingency amount that reflects the considerable uncertainty involved in forecasting future costs in the health care field, will require an additional federal investment of approximately \$5 billion annually (see Table 15.2).

The amount of \$5 billion shown in Table 15.2 is the Committee's estimate of the annual increase in health care costs that would result from expanding public health care insurance to close the gaps in the existing plans (as described in Chapters Seven, Eight and Nine) and from investing in measures to make the current hospital and doctor system more effective and efficient (as described in Chapters Two, Three, Four, Ten, Eleven, Twelve and Thirteen). This amount is *in addition to* the current federal contribution to health care (through the CHST and other programs). It is also in addition to any increase in federal funding that may be required to support the *existing* hospital and doctor system, as a transition measure until the changes recommended in this report can come into full effect.

**TABLE 15.2**  
**ADDITIONAL ANNUAL FEDERAL INVESTMENT NEEDED TO IMPLEMENT**  
**THE RECOMMENDATIONS IN THIS REPORT**

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

(a) 90% federal funding.

(b) 50/50 federal and provincial/territorial cost-sharing program.

(c) 100% federal funding.

Source: See the previous chapters.

The Committee believes that the total amount of \$5 billion per year in new funding is a realistic sum and an acceptable amount that the federal government, and indeed Canadians through their taxes, ought to be willing to invest in health care on an ongoing basis.

The amounts shown against each purpose in Table 15.2 are estimates. The amount spent for the various purposes listed will vary somewhat from year to year depending on the priority attached to each purpose in any given year. These priorities, and the allocation of funds to each purpose, should be set on an annual basis by the federal government on the advice of the National Health Care Council, as described in Chapters One and Fourteen.

The new federal investment in health care recommended by the Committee *must* be used to support change. It is worthwhile noting that 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. Some 10% of the proposed expenditures will be invested in health research, outcome evaluation and performance reporting. We have incorporated a 20% annual contingency to provide the necessary flexibility in federal investment.

It is also worth pointing that, out of the \$5 billion in new federal investment, a large proportion is for transitional costs that will decrease as efficiency and effectiveness changes are put in place. Once the 5-year or 10-year period is over, the money used during the transition period will be available for other health care priorities.

The Committee acknowledges that some of its recommendations – particularly with respect to post-hospital home care, palliative care and investment in community hospitals – require cost-sharing with the provinces/territories. In our view, these additional costs will not constitute a significant additional financial burden for provincial/territorial governments under these programs, since the federal 50% investment recommended by the Committee would *replace* money which some of the provinces/territories are now spending in these areas. It is not possible, however, given the limited resources the Committee has at its disposal, to evaluate precisely the extent of these savings to the provinces/territories. Similarly, it is not possible for the Committee to calculate the increased cost to each jurisdiction for the proposed cost-shared programs.

***The Committee acknowledges that some of its recommendations – particularly with respect to post-hospital home care, palliative care and investment in community hospitals – require cost-sharing with the provinces/territories. In our view, these additional costs will not constitute a significant additional financial burden for provincial/territorial governments under these programs, since the federal 50% investment recommended by the Committee would replace money which some of the provinces/territories are now spending in these areas. (...) It is thus fair to say that the Committee's recommendations would generate savings of at least \$1.5 billion for the provinces and territories.***

More important, in some of the Committee's recommendations, the federal money directly replaces funds that the provinces/territories would otherwise have to spend. For example, the proposed new federal funding in the areas of health care technology, hospital capital, primary health care reform and human resources – which amounts to some \$1.5 billion – would entirely substitute for investment that provincial and territorial governments would have to make in order to reform and renew their health care system. It is thus fair to say that the Committee's recommendations would generate savings of *at least* \$1.5 billion for the provinces and territories. This would be in addition to any savings resulting from effectiveness and efficiency gains from our proposed reform, and the Committee expects these savings to be substantial once the changes we recommend are all in place and fully operational.

## 15.2 Potential Sources of Increased Federal Funding

From which source should the new federal investment in health care come? Should the federal government simply increase the rate of one or more of the existing direct and indirect taxes (general taxation)? Or should the government employ new taxation measures linked specifically to the funding of health care, such as an earmarked tax for health care, or make health care benefits taxable as income, or use earmarked payroll taxes or a national health care insurance premium? Should the federal government also consider an increase in private financing for health care through user charges, MSAs or other plans involving individual responsibility for some health care costs?

This chapter examines these questions in detail. It reviews the advantages and disadvantages of the full range of public and private methods of funding an incremental federal contribution to health care, including general taxation, earmarked taxation, taxable health care benefits, payroll taxes, and public health care insurance premiums. It also provides a discussion of user charges, MSAs and the concept of pre-funding health care.

In considering each of the potential federal revenue sources, the Committee evaluates each of them according to the same set of criteria. These criteria are equity, efficiency, intergenerational fairness, stability and visibility:

- *Equity* deals mainly with income redistribution and social justice. It may be defined as the extent to which contributions to the financing of health care insurance are based on ability to pay (income distribution) as well as the extent to which access to such insurance is based on need (social justice).
- *Efficiency* is concerned with the optimal allocation of resources. A system is efficient if it creates minimum distortions and disincentives in the rest of the economy (in terms, for example, of reduced business investment, lower consumption and living standards, damage to the labour market and job creation, deterioration in international competitiveness, and so on). Efficiency can also encompass cost-effectiveness, that is, the extent to which revenue for health care is generated at the lowest possible administrative and compliance cost.
- *Intergenerational fairness* compares the distribution of the cost burden between younger and older people or between workers and retirees.
- *Stability* refers to the degree of predictability of future funding levels.
- *Visibility* denotes the ability of citizens to link their contributions to government spending on health care (at each level of government) to the benefits that they receive.

These criteria have helped the Committee to decide which source(s) of funding appear(s) to be the most appropriate to raise additional federal revenue for health care.

At the outset, the Committee wishes to emphasize that new financing sources must ensure that the health care system will continue to meet the needs of Canadians in a way that will neither overwhelm other requirements for government finance nor give rise to an unacceptable tax burden on citizens or businesses. The additional revenue requirements must

also be structured so as to do the least damage to the economy in terms of job creation and income growth. Moreover, the new revenue sources must make Canadians better aware of the link between the public health care benefits they receive and the taxes that they incur to pay for them.

### **15.3 General Taxation**

Currently, federal funding for health care is derived from general taxation. General taxation is very broad and encompasses both direct and indirect taxes. Direct taxes, which can be levied on individuals, households or corporations, include personal income tax and corporate taxation. Indirect taxes, which are levied on transactions and commodities, include, for example, sales tax, value-added tax and excise taxes.

Currently, none of the direct or indirect taxes that make up federal general taxation offer much visibility or link between the taxes paid and the services received. Indeed, this is the primary reason that many Canadians describe Canada's health care system as being free. The various federal revenues generated through direct and indirect taxation are currently collected into one single fund – the Consolidated Revenue Fund. As a result, there is no direct link between taxation and public health care spending, despite the fact that a substantial part of government revenues are used to pay for health care costs. This contrasts greatly with earmarked taxation (see Section 15.4, below) in which the tax revenue corresponding to the “earmarked” service goes into a designated fund to be used only for that specific purpose.

All forms of direct and indirect taxation have varying implications for equity and efficiency. Direct taxes levied on individuals are frequently progressive: the amount paid rises with income so that high-income people pay proportionately more than low-income people. This leads to a redistribution of income from individuals with higher income to those with less.

Indirect taxes such as sales taxes are usually considered regressive, as the payments are related to consumption of the taxed good or service: high-income people pay proportionately less indirect tax as a percentage of their income (although they pay more in absolute terms). That is, because poorer individuals spend a larger proportion of their income on consumption than richer persons, the burden of a consumption tax falls more heavily on them. However, over a lifetime, consumption is roughly proportional to income over a broad range of earnings; hence, the regressiveness of a consumption tax is not as large as might be initially thought. Further, various offsetting measures, such as the GST Tax Credit, can reduce the regressiveness of a consumption tax.

In his brief to the Committee, Robert Evans, Professor of Health Economics at the University of British Columbia, explained:

*Taxes are described as progressive if an individual's tax liability rises more than proportionately as income rises, such that higher income individuals not only pay more,*

*but pay a larger share of their incomes. Conversely, regressive taxation results in lower income people paying a larger share of their incomes in tax.*<sup>335</sup>

The implication of general taxation on equity therefore depends on both the structure of a country's direct and indirect tax systems and the relative amounts of revenue raised by each form of tax.<sup>336</sup> Studies using OECD data suggest that, in countries in which general taxation funds most health care, the mix of direct and indirect taxes used renders the overall taxation mildly progressive.<sup>337</sup>

In 2000, Canada relied on direct taxes for 57% and indirect taxes for 43% of its total taxation revenue. Data also suggest that the Canadian tax system has become more progressive over the last decade: in 1993, Canada collected 49% of its tax revenues from indirect taxes.<sup>338</sup>

When compared with other OECD countries that use tax financing for health care, Canada is above average in its reliance on the personal income tax.<sup>339</sup> In fact, only Denmark, Australia and New Zealand rely to a greater extent on the personal income tax as a percentage of total tax revenues.<sup>340</sup> In terms of its reliance on the corporate income tax, Canada is again slightly above the average of countries with a health care system funded out of general taxation.<sup>341</sup> Finally, Canada is below the average in its use of consumption or indirect taxes, relative to all taxes.<sup>342</sup> Therefore, it could be said that Canada has one of the more progressive tax systems among OECD countries.

From another perspective, however, the fact that Canada has significantly higher personal income tax rates than the United States means that Canada is less attractive for skilled, high-income workers. The higher personal income tax rates also raise the cost of investment capital in Canada derived from personal savings, and therefore discourage investment, productivity and future growth. Indeed, the Committee was told:

*While a number of factors (higher government debt and social spending) are likely to mean that Canada will continue to have for some time higher personal tax rates than the U.S., it is nevertheless good policy to avoid increasing the spread between US and Canadian rates, and in the long term to reduce these differences. Accordingly, there are major policy reasons for not imposing a significant increase in personal tax rates and widening the personal tax gap with the U.S.*<sup>343</sup>

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<sup>335</sup> Robert Evans, Brief to the Committee, 3 June 2002, p. 2.

<sup>336</sup> Derek Wanless, *Securing our Future Health: Taking a Long-Term View*, Interim Report, November 2001, p. 51. ([http://www.hm-treasury.gov.uk/Consultations\\_and\\_Legislation/wanless/consult\\_wanless\\_interimrep.cfm](http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_interimrep.cfm)).

<sup>337</sup> Elias Mossialos and Anna Dixon, "Funding Health Care in Europe: Weighing up the Options," Chapter Twelve in *Funding Health Care: Options for Europe*, 2002, pp. 272-300.

<sup>338</sup> According to Statistics Canada's data taken from CANSIM II, Table 380-0022.

<sup>339</sup> Caroline Chapain and François Vaillancourt, "Le financement des services de santé au Québec," in *Le système de santé québécois: Un modèle en transformation*, edited by C. Bégin, 1999, pp. 101-121.

<sup>340</sup> OECD (2000), *Revenue Statistics 1965-1999*, Table 11.

<sup>341</sup> OECD (2000), Table 13.

<sup>342</sup> OECD (2000), Table 27.

<sup>343</sup> Brown and Haynes (2002), p. 13.

Similarly, the Committee heard that it would be difficult and inadvisable to increase corporate income tax to support the incremental costs of increased federal spending on health care. The base for corporate taxation is smaller than the base for personal income tax or a payroll tax, and is also much more variable. Furthermore, increasing corporate tax rates would have a very negative impact on rates of return on capital investments in Canada, and therefore would discourage both investment and job creation. Even existing businesses could be influenced to relocate outside of Canada in response to what would be a very significant increase in tax burdens. Overall, many witnesses argued that the corporate tax is unsuitable for raising additional revenues to finance health care.

The Committee was told that with an increase in the federal personal income tax there would be significant costs to efficiency, measured in terms of labour supply, savings and investment. We were told that a tax on income imposes a “double tax” on savings, since the income out of which savings are made is subject to income tax, and then the returns on the savings are themselves subject to additional tax.

Nevertheless, because financing the health care system by general taxation draws revenue from a wide base, it helps to minimize the distortions taxation creates in the economy. Furthermore, financing health care through general taxation involves low administrative costs.<sup>344</sup>

Under general tax-financed systems, as opposed to those financed by earmarked taxes, decisions about how much should be spent on health care necessarily require trade-offs to be made among other government spending priorities, such as social programs or tax or debt reduction. As a result, funding health care through general taxation means that the allocation to health care is subject to spending negotiations within government. While this provides some element of accountability, it also greatly politicizes the decision-making process.

Another disadvantage of funding health care through general taxation is that it can leave the health care system vulnerable in times of economic slowdown or fiscal constraint. Economic slowdowns result in lower tax revenues and increased pressures to reduce public spending. This, therefore, negatively affects the stability of health care funding. It should be noted, however, that all tax revenues fluctuate with the economy and that general revenues tend to fluctuate less than many specific forms of taxes.

Finally, and perhaps most important, witnesses stressed that direct and indirect taxation do not have the same impact in terms of intergenerational fairness. Personal income tax extracts a greater proportion of government revenues from the younger working population than from retirees. Thus, Canada’s changing demographics, which reflect a rise in the proportion of retirees relative to the working population, would be associated with a decreasing tax base and smaller revenues for any given income tax rate. As a result, the use of direct taxation, particularly personal income tax, to finance the publicly funded health care system could involve significant subsidization of the health care needs of the elderly by the younger working population. In this perspective, Jack Mintz, President and CEO of the C.D. Howe Institute, told the Committee that:

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<sup>344</sup> Derek Wanless (2001), p. 50.

*In fact, the OECD has estimated that, as the population ages, the tax/GDP ratio in Canada will fall by 1.5 points. This is because elderly people, once they retire, tend to have lower incomes and, therefore, pay less tax than workers. There may be some taxes that would be better if you were going to fund health care expenditures, because the majority of health care expenditures are weighted heavily toward the elderly in the last years of their lives. Therefore, as the population ages and the benefits paid out to the elderly increase, if you have taxes that are particularly falling on working Canadians they will have to bear a bigger responsibility for those benefits.*<sup>345</sup>

In contrast, the Committee was informed that demographic changes have less impact on government revenue generated through indirect taxation, such as a consumption tax. Moreover, consumption taxes may be preferable, on the grounds of economic efficiency, to corporate income tax. David Stewart-Patterson, Senior Vice-President, Policy, Canadian Council of Chief Executives, stressed that point when he stated:

*In considering tax policy, however, we must remember that not all taxes are equal in terms of their economic impact. As the Department of Finance has estimated, an extra dollar of revenue raised through corporate taxes may do nine times as much damage to economic growth as a dollar raised through sales tax. The more Canada chooses to spend on health care through the public system, therefore, the more it will have to shift its tax mix toward a consumption base in order to remain competitive.*<sup>346</sup>

Jack Mintz from the C.D. Howe Institute held similar views:

*(...) consumption taxes have been found to have lower distortionary costs to the economy and they tend to be more efficiently imposed. They are smoother than, for example, income taxes over the life cycle of individuals because working income tends to peak during working lives before falling off in retirement years. At the same time, consumption tends to be lower than income during the years in which people are accumulating savings, and consumption tends to be high in retirement years relative to income as that is when people are drawing down assets to consume during their retirement years. Consumption taxes also tend to be proportional to the consumption of individuals over a life cycle. One could make it progressive by having a tax credit, such as the GST tax credits which provides relief, particularly for lower income Canadians.*<sup>347</sup>

David Kelly, former Deputy Minister of Health in British Columbia, also suggested that consumption taxes generate less distortion in the economy:

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<sup>345</sup> Jack Mintz (62:6).

<sup>346</sup> David Stewart-Patterson, Brief to the Committee, 17 June 2002, p. 4.

<sup>347</sup> Jack Mintz (62:7).



*If the decision has been taken to increase funding for health care and the question is what should be the revenue source, I would do exactly what the B.C. government did a few months ago when it discovered that it did not have sufficient revenue to cover rising health care costs – it increased the consumption tax.*

*(...) I say that for three reasons. First, it raises revenue quickly. Second, we have to keep our income tax, corporate tax, payroll tax and so on within shooting distance of the Americans, which significantly constraints our policy flexibility. Third, it is a visible tax. It would make consumers fully aware of the implications of health care cost increases. It might bring additional consumer pressure to bear on the cost side of the equation which, from my point of view, would be healthy.<sup>348</sup>*

To sum up, the decision to consider direct versus indirect taxation as a means of increasing federal revenue for the purpose of health care will necessarily require that some trade-off be made between equity, intergenerational fairness and efficiency. The testimony received by the Committee suggests that the objective should be first of all to ensure that any new tax is as efficient as possible so that it causes as little damage to the economy (including job creation and economic growth) as possible, and then subsequently to achieve whatever progressivity is desired in the system through supplementary measures such as low-income tax credits or high-income surtaxes.

## **15.4 Earmarked Taxation**

Earmarked taxes are taxes from which the revenue is dedicated to a specific use. Earmarked taxes can be either direct or indirect. An earmarked tax for health care has several advantages over general taxation. For example, it may reduce public resistance to paying the tax because it is clearly associated with a use that provides benefits to the public. Establishing genuine linkage between taxation and spending makes the funding of health care more transparent and responsive. Another advantage of earmarking taxation is that it makes people feel more connected to the tax system which, in turn, may increase the pressures on health care providers and institutions to improve quality and access to services. Earmarked revenues may also be more stable since they are less susceptible to the vagaries of political decisions with respect to the allocation of the government's financial resources.

Many witnesses presented strong arguments in favour of earmarked taxes. In the view of these witnesses, earmarking taxes for health care is what Canadians want. For example, Dr. Les Vertesi, Chief of the Department of Emergency Medicine at the Royal Columbian Hospital (Vancouver), told the Committee:

*I believe that the public is prepared to put more money into their public health care system, but not into taxes that go into general revenue. It is a trust issue. The record on governments taxing people and then ensuring that money goes into designated services is not good, or at least certainly the perception is that it is not good. The trust has been*

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<sup>348</sup> David Kelly (59:40-41).

*broken. People do not want to give money to governments and have it just disappear. They are prepared to do so if they are assured that the money will go into health care, and especially into health care in their local area (...).*<sup>349</sup>

There are, however, a number of disadvantages associated with earmarked taxes. Not all taxes that bear the name or appearance of an earmarked tax are strictly earmarked to an identified use in practice. This is particularly true if the revenue from the earmarked tax is merged together with other tax revenues. This weakens the connection between revenue and expenditure and consequently undermines the population's trust that the tax will be devoted to the named purpose. For a tax to be effectively earmarked, the revenue it generates must go into a specific, dedicated fund, and not into the Consolidated Revenue Fund.

Earmarking taxes also introduces rigidity into the government budgetary process, because expenditure on the program for which the tax is earmarked is determined by the revenue generated and not by policy decisions. Another disadvantage is that the revenue derived from a single earmarked tax can be cyclical and susceptible to variability in periods of economic expansion or slowdown.

Also, separating health care from other areas of public spending might lead to pressure to have other budget items funded separately by earmarked taxes. If this happened in a number of areas it would make it difficult for the government to generate a large enough Consolidated Revenue Fund to be able to pay the cost of necessary but less popular government programs, such as foreign aid. Thus, having a large number of earmarked taxes is simply not workable.

In Volume Four, the Committee presented an option under which the cost of publicly funded health care that an individual receives during a year be treated as a taxable benefit for that year. Thus, the individual would pay income tax on the cost of the health services provided, subject to an annual maximum. This method of taxation would raise additional revenue for health care and promote individual accountability for the use of health care.<sup>350</sup> Under this option, which corresponds to one form of earmarked tax, individuals would be required to add the cost of the health services that they received during the year to their taxable income. Such an option has been advocated in recent years, particularly by Jack Mintz *et al.* (1998),<sup>351</sup> Tom Kent (2000)<sup>352</sup> and most recently by Mintz, Aba, and Goodman (2002).<sup>353</sup>

Under the plan proposed by Mintz, Aba and Goodman, individuals would be charged a tax of 40% of the health care costs they incurred during the year, up to a maximum of 3% of the individual's annual income. Families with an income of less than \$10,000 would be exempt from paying tax on any service they received through the publicly funded health care system. Under this scheme, the more an individual used the services of the health care system,

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<sup>349</sup> Dr. Les Vertesi (53:62).

<sup>350</sup> Volume Four, pp. 63-64.

<sup>351</sup> Jack Mintz, Michael Gordon and Duanjie Chen, "Funding Canada's Health Care System: A Tax-Based Alternative to Privatization," in *Canadian Medical Association Journal*, 8 September 1998, pp.493-496.

<sup>352</sup> Tom Kent, *What Should Be Done About Medicare*, The Caledon Institute of Social Policy, August 2000.

<sup>353</sup> Jack Mintz, S. Aba and W.D. Goodman (2002), "Funding Public Provision of Private Health: The Case for a Copayment Contribution through the Tax System," *C.D. Howe Institute Commentary – The Health Papers*, No. 163.

the higher the individual's contribution to the system would be in that year, up to the maximum 3% of income.

Mintz, Aba and Goodman argued that, by relating the individual's contribution to the actual health services that are used, and by encouraging users to consider the costs, efficiency would be gained in the use of health care resources. The authors also contended that limiting individual health care taxes to a maximum of 3% of annual income would ensure that the costs would remain affordable to the taxpayer and thus no one would be deprived of needed health services. This would also prevent the costs of health care from imposing a catastrophic burden on any taxpayer.

Using survey data on health care utilization rates, Mintz, Aba and Goodman estimated that 62% of Canadians would pay the maximum contribution of 3% of their annual income in any one year. Overall, this would generate \$6.6 billion annually in tax revenue (or about 16% of total public spending on physicians, hospitals and other health care institutions). They estimated that it would also lead to a decrease of 13.5% in the use of health services, the value of which they estimated to be \$6.3 billion. The authors believe that additional administrative costs would be minimal since the contribution would be collected through the provincial/territorial personal income tax system.

A number of witnesses discussed proposals such as the one by Mintz *et al.*. For example, Paul Darby, Director, Economic Forecasting, Conference Board of Canada, stated:

*It has a high degree of attractiveness in that it does remove some of the mystery surrounding the cost of health care to various users of the system. It does have the advantage of tying those costs, to some extent at least, to payment. I am not sure it completely gets around the issue of redistribution or the burden perhaps falling on the less advantaged members of society.*<sup>354</sup>

The option of a taxable health care benefit would help ensure visibility. It would also improve somewhat the stability of public health care funding. Such an option would have an impact that in some ways would be similar to direct taxation in terms of efficiency and distortion in the economy. However, it would increase Canada's reliance on the personal income tax, which is already well above that of other OECD countries.

But perhaps most important, the main argument presented to the Committee against a taxable health care benefit is that some people will have the perception that they would be paying for health care twice – once through general taxation and once through the additional income tax they would pay for the specific health services that they would receive during the year. The argument of “double payment” led the Alberta Premier's Advisory Council on Health to decide not to support making health care a taxable benefit.<sup>355</sup>

The Committee was told that a relatively efficient way of generating new federal revenue to pay for health care would be to use some portion of a general consumption tax, such

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<sup>354</sup> Paul Darby (59:17).

<sup>355</sup> Mazankowski report, p. 55.

as the GST, and have it earmarked for health care. The GST is the major federal consumption tax in Canada and, according to many witnesses, it is a relatively efficient tax. Because of its broad and generally non-distorting coverage, many witnesses contended that it would be the most suitable consumption tax to increase to pay for additional federal spending on health care.

The GST option, however, would be somewhat more regressive than personal income taxation. Nonetheless, the proposal to earmark an increase in the GST for the purpose of health care received very broad support during the Committee's hearings. For example, Paul Darby explained that:

*(...) the Conference Board's position on how to address the financing issues over the next 30 years tends towards consumption taxes, such as the GST. We would tend to try to avoid taxes on working, which would include income and payroll taxes. We sense that, at this point, taxes on consumption would probably have the least disincentive effects among the various tax options one could consider. (...) We would want to see a specific link between the taxation and the spending on health care, in the hopes that those taxes would, as a result, be much more politically palatable to the general public.<sup>356</sup>*

Mr. Darby suggested that rebates for low-income Canadians through income tests, such as the current GST Tax Credit, could be provided for an earmarked and increased GST in order to improve equity and progressivity. In addition, if the rebates for the increase in the GST were similar in structure to the current GST rebates, they would add little to the scheme's administrative cost.

## **15.5 Payroll Taxes**

In many OECD countries (such as Germany and the Netherlands), public funding for health care is generated from an earmarked payroll tax. Contributions under this payroll tax are usually compulsory and shared between the employee and the employer. These contributions are levied on labour earnings and are held by a body operating at arm's length from government ("Sickness Funds"). The predominant attraction for earmarked payroll taxes (or "social insurance") in many OECD countries is the independence of the insurer or agency from government and the perceived greater responsiveness of the insurer to the patient or consumer.

In Canada, both the federal and provincial/territorial governments currently use earmarked payroll taxes in one form or another. At the federal level they include: premiums for Employment Insurance and Canada Pension Plan contributions (the CPP/QPP is both a federal and provincial responsibility). Provincial payroll taxes include: workers' compensation premiums (collected in all provinces) and health care/post-secondary education taxes (levied in Quebec, Manitoba, Ontario, Newfoundland and the Northwest Territories), with the latter not generally being firmly dedicated to any specific use.

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<sup>356</sup> *Ibid.*, (59:5).

An earmarked payroll tax as a means of collecting revenue for the purpose of health care has the advantages previously mentioned for earmarked taxes. For example, it can be paid into a separate fund. It is highly visible and transparent and, therefore, usually more acceptable to the public. In other words, higher levels of transparency under a system of payroll taxes weaken resistance to contribution increases compared with general taxation increases. In addition, payroll tax revenue is, at least in theory, better protected from annual political interference, since budgetary and spending decisions can be devolved to independent bodies. Equally important, levying the tax only on labour income avoids distortions to savings and investment. Finally, revenue generated from payroll taxes also appears to be more stable. In this perspective, a recent report states:

*In Belgium, where health care is financed about equally from taxation and social insurance contributions, the deviation of average annual growth was greater for revenue from government sources than non-government sources. (...) In other words, annual government spending on health care fluctuated more than insurance-based revenue. (...) Consequently, relying more on funding from general taxation than on payroll contributions is likely to make revenue less stable.*<sup>357</sup>

Earmarking a payroll tax, however, has a number of disadvantages. Because employers are usually required to contribute to part of the cost of health care insurance, this results in higher labour costs, inhibits job creation and reduces the international competitiveness of a country's economy. Moreover, a payroll tax relies on a more narrow revenue base (labour earnings). Accordingly, it would require a higher rate of a payroll tax to raise a given amount of revenue than would a general income tax on all income. This may explain why general tax revenue is also used as an important revenue source in countries with health care payroll tax systems. In these countries, general tax funds are usually transferred to health care insurance funds to cover the contributions of the non-employed population. General tax revenues may also cover the deficits of public health care insurance funded by payroll taxes.

In contrast to general taxation, a payroll tax may also impede job mobility; employees may be unwilling to move to a non-covered job (such as self-employment) in some systems for fear of higher contribution payments or fewer benefits (as in the United States).

The potential negative impact of payroll taxes on industry was one of the justifications for diversifying funding sources from an employee/employer contribution system to an income-tax-based system under the Juppé Plan in France. More precisely, France significantly reduced the employee contribution rate (from 5.5% in 1997 to 0.75% in 2000) and dedicated its General Social Contribution Tax specifically to health care (the tax rate was increased from 3.4% to 7.5% of personal income). Italy and Spain went a step further by shifting completely from payroll tax to a general tax-revenue-financed health care system.

Another criticism of payroll taxes with respect to efficiency is that the various European Sickness Funds, which are responsible for collecting and managing the contributions made by employers and employees, have little incentive to control costs because they have the

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<sup>357</sup> Mossialos and Dixon (2002), chapter twelve, p. 285.

ability to raise contribution rates. Also, the existence in some countries of multiple funds and the lack of integration in purchasing health services often results in high administration costs.

It could also be argued that health care financing via a payroll tax system is vulnerable to periods of economic downturn, since reduced revenues from lower employment and freezes in income levels would result in smaller contributions to Sickness Funds. Furthermore, with the financing burden concentrated on employers and employees, the negative impacts on certain labour-intensive sectors of the economy could be significant.

Finally, with respect to equity, available evidence from Germany and the Netherlands suggests that funding health care through payroll tax tends to be regressive. This is probably because the design of these two systems allows higher-income earners, who already possess private insurance, to opt out of the public health care insurance plan.

An important element of payroll tax, however, is the smaller impact it has on the overall Canadian economy when compared to other forms of taxation. Preliminary calculations by the Department of Finance showed that an extra dollar of tax revenue raised through payroll taxes cost the economy 27 cents in real loss of output. This is compared to \$1.55 in loss of output for every extra dollar of corporate income tax and 56 cents for personal income tax. Sales taxes were shown to be the least distorting source of tax revenue, creating only 17 cents of output loss.<sup>358</sup> In the context of international competitiveness, there is still some room for payroll taxes in Canada: OECD data show that Canada depends less on this form of taxation relative to other industrialized countries.<sup>359</sup>

However, a crucial factor with respect to payroll taxes is that, in terms of intergenerational fairness, payroll tax has an impact similar to but worse than income taxation: the burden is borne entirely by the younger and working population.

## 15.6 National Health Care Premiums

A public health care insurance premium is a fixed lump-sum amount paid by either an individual or a family for the purpose of financing publicly insured health services. In some systems, health care insurance premiums are fixed amounts paid *regardless* of income and *independent* of usage of the health care system. This form of premium is currently used in both British Columbia and Alberta, although there are some exemptions for low-income individuals and families in the two provinces.

This method of funding is considered to be quite efficient for two reasons. First, the financing burden is spread over a wide base (the entire population) rather than just the employed, as is the case with most payroll taxes. This means that all sectors of the economy are treated equally, and due to the flat nature of premium payments, individuals have little incentive to alter their behaviour (whether to consume more or less, whether to work more or less, etc). Second, health care insurance premiums do not differentiate between the younger and older segments of the population, thereby ensuring inter-generational fairness.

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<sup>358</sup> Department of Finance. Data presented by the OECD, *OECD Economic Surveys – Canada 1997*, November 1997, p. 85.

<sup>359</sup> OECD, *Revenue Statistics 1965-2000*, 2001.

*Whether a person works or not they would still have to pay the amount. This would be the least distortionary of the types of taxes that could be levied, and the one most conducive to the demographic issues we will face down the road.*<sup>360</sup>

A flat health care insurance premium does not affect marginal income tax rates, as an increase in personal income taxation would, and therefore has a less distorting impact on the economy in terms of savings and investment.

In terms of equity, flat premiums for public health care insurance would tend to hit low-income Canadians the hardest, although some low-income relief could be used to soften that impact. Also, middle-income Canadians would have to pay the same health care premium as rich ones. Therefore flat premiums are clearly regressive, as they benefit most those with high incomes. They do, however, benefit those with high health care needs, since they pay the same amount of premium as those who use the health care system only slightly.

Overall, the equitable characteristics of a system financed by flat premiums appear to be quite limited. The Committee was informed that, for greater equity, premiums should be linked to income in some manner and some groups of the population should be exempted from paying them. The suggestion to use variable premiums adjusted to income levels was recently made in the Mazankowski report, *A Framework for Reform*, prepared for the Premier of Alberta in 2001.

In his brief to the Committee, David Kelly provided a lengthy statement on the benefits of a national health care insurance premium:

*There may well be need for additional federal revenues to support the Canadian health care system, and a federal health care premium would be one means of raising funds in a fashion which provides visibility for the federal financial contribution.*

*(...) The provincial premiums programs which operate in Alberta and British Columbia raise significant revenue for those provinces. Premiums are fixed amounts applied universally (payment is mandatory), income-related (reduced or eliminated for lower income earners), but unrelated to program eligibility (late or non payment does not result in termination of benefits to an individual or family). Premiums are collected where possible through payroll deduction, with the balance directly billed to provincial residents. The administrative costs of collecting premiums by a process separate from the income tax system are nontrivial.*

*(...) Were a federal health care premium to be introduced, it would certainly make sense to collect it through the income tax system, rather than through a separate administrative procedure. That is, one could provide for deduction at source, quarterly payments, and annual reconciliation through the existing tax collection structure, rather than invoicing*

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<sup>360</sup> Jack Mintz (62:7).

*all Canadian families on a monthly or quarterly basis. There are many potential designs for the structure of a federal premium – it could be a flat rate applied equally to all residents, or a flat rate with relief for lower income earners as in the two provinces which levy their own premiums, or a surtax applied proportionally or in some other fashion on top of the income tax. All these options have their own equity implications. It should be kept in mind that there is a very substantial element of income redistribution associated with the financing of Canada's universal health care program. Any move to finance the system in part through a premium which is less progressive than existing funding sources would affect the nature of that income distribution, and so add to the list of value issues which the Committee must sort through.*<sup>361</sup>

In conclusion, premiums could constitute a visible and equitable means of raising the money for the purpose of health care, provided that they are structured in a way to ensure progressivity (that is, premiums should vary in proportion to income).

## **15.7 User Charges**

User charges are usually defined as a form of payment (covering a portion of the cost of services) made by a patient at the time a health service is rendered. That is, they represent an up-front charge to the patient. In Volume Four of its health care study, the Committee described the different forms of user charges:

- Co-insurance, the simplest form of user charge, requires the patient to pay a fixed percentage (say, 5%) of the cost of services received. Thus, the higher the cost of the service, the larger the fee. Many private-sector drug insurance plans require this method of payment.
- Co-payment is an alternative to co-insurance. Instead of having to pay a share of costs, the patient is required to pay a nominal fee per service (for example \$5) which does not necessarily bear any relation to the cost of the service. The same amount is charged, no matter what the cost of the health care provided. This form of user charge exists in many countries, such as Sweden.
- Under a system of deductibles, the patient is required to pay the total costs of services received over a certain period up to a certain ceiling, the deductible. Above the ceiling, costs of services to the patient are covered by the insurance plan. All users must pay the deductible, which is independent of the quantity of services received. Again, this form of insurance-based user charge is required in some countries.<sup>362</sup>

Some commentators have suggested that user charges of relatively modest size can be a useful means of discouraging overuse of the health care system, and of creating some personal sense of responsibility for the use of the system. However, much of the literature with respect to user charges concludes that these charges deter some individuals from seeking

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<sup>361</sup> David Kelly, Brief to the Committee, pp. 2-3.

<sup>362</sup> Volume Four, p. 62.



necessary as well as unnecessary care, and do so in a way that falls disproportionately on the poor. Professor Robert Evans told the Committee that user charges raise serious issues of access and equity:

*It is well-known and extensively documented that a relatively small proportion of the population use a very high proportion of health care services, both in any one time period and over longer times. A recent study in B.C., now being written up for publication, shows that the five percent of the adult population with the highest use of physicians' services (measured in dollars of billings) not only accounted for 33.7% of total billings, but made up 43.5% of hospital admissions and used 69.3% of inpatient days. These people were generally quite ill, typically with major and multiple problems. There were on average older – almost half were over 60 – came from poorer neighbourhoods, and had a death rate nearly eight times that of the general population. For most of them, there seems to be no realistic prospect of their paying over half of the costs that they generate, even if such an extraordinarily skewed distribution of financial burden were acceptable to the general population.<sup>363</sup>*

It is worth noting that Canada is the only industrialized country that prohibits user charges for publicly insured health services. Despite their use elsewhere, the Committee reviewed the evidence on user charges in Canada and concluded in Volume Five that access to publicly funded hospitals and doctors should not depend on the income or wealth of individual Canadians.<sup>364</sup> We explained that most of the spending and waste in the health care system are beyond patient control; the major expenses, and the decisions that give rise to these expenses, are incurred or influenced by health care providers on behalf of their patients. These decisions are not made by the patients themselves. Moreover, the Committee was told that implementing modest user charges could incur administrative costs that would nearly equal the revenue generated from such charges.

**The Committee reviewed the evidence on user charges in Canada and concluded that access to publicly funded hospitals and doctors should not depend on the income or wealth of individual Canadians.**

For all these reasons, the Committee enunciated in Volume Five Principle Eighteen, which states that while incentives need to be developed to encourage patients to use the hospital and doctor system as efficiently as possible, such incentives should *not* include up-front user charges.

Some form of patient payment, however, could be used in implementing the primary health care reform that the Committee is proposing in Chapter Four. It should not be labelled as a user charge, but rather as an “orientation fee.” When primary health care physicians make referrals to specialists, patients do not incur any costs. Should the patient decide to take an appointment to a medical specialist without any referral, he or she should be liable for part or all of the cost incurred by this visit. This form of patient payment is required in Denmark.

<sup>363</sup> Robert Evans, Brief to the Committee, 3 June 2002, p. 6.

<sup>364</sup> Volume Five, pp. 53-54.

## 15.8 Medical Savings Accounts

As described in Volume Three of the Committee's study on health care, Medical Savings Accounts (MSAs) are health care accounts, similar to bank accounts, set up to pay for the health care expenses of an individual (or family).<sup>365</sup> They are often established in conjunction with high-deductible (or catastrophic) health care insurance. Money contributed to an MSA belongs to, and is controlled by, the account holder, accumulates on a tax-free basis and is not taxed if used for health care purposes. Unused MSA funds can be utilized for other purposes to the benefit of the account holder.

MSAs usually involves three levels of payment. First, money in the account is used for normal medical expenses. Next, if the account is exhausted and the deductible has not been reached, the user pays the expenses personally. Third, public health care insurance covers expenses beyond the deductible.

MSA systems are operating in a few jurisdictions, including Singapore, South Africa and parts of the United States. The general theory behind MSAs is that consumers would make more judicious and cost-effective decisions if they were spending their own money, rather than relying on the "free" publicly funded services. As a result, MSAs would limit (if not eliminate) unnecessary utilization of health services, reduce the pressures on public health care funding and encourage efficiency.

A number of proposals for MSAs have been put forward in recent years in Canada.<sup>366</sup> Given the interest of a number of Canadians in MSAs, the Committee reviewed the literature on the topic and held discussions with various individuals and experts. Based on the evidence received, we believe that, although MSAs have some interesting elements, they would not be appropriate in our publicly funded hospital and doctor system.

First, there is no consensus among experts on the impact of MSAs on a country's health status and overall health care costs. On the one hand, some maintain that MSAs increase consumer choice, encourage patients to make more prudent use of health services and reduce health care spending. On the other hand, others contend that MSAs can realize only small health care savings at best, segment the risk in the insurance market, drive up costs and have an adverse impact on health as people, particularly the poor and unhealthy, cut back on necessary health care. Moreover, the most recent literature suggests that current knowledge of MSAs is too limited to recommend their incorporation into the Canadian health care system.<sup>367</sup>

However, the impact on equity is certainly the aspect that is of most concern to the Committee. Like user charges, MSAs transfer part of the responsibility for health care spending from government directly to patients. Furthermore, they do so in a manner that falls disproportionately on the poor and on those who are sick, whether rich or poor. In fact, MSAs

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<sup>365</sup> Volume Three, Chapter Seven, pp. 53-63.

<sup>366</sup> See the following documents: 1) William McArthur, Cynthia Ramsay and Michael Walker ed., *Healthy Incentives: Canadian Health Reform in a Canadian Context*, The Fraser Institute, 1996; 2) Cynthia Ramsay, "Medical Savings Accounts", *Critical Issues Bulletin*, The Fraser Institute, 1998; 3) David Gratzer, *Code Blue – Reviving Canada's Health Care System*, ECW Press, 1999; 4) Dennis Owens and Peter Holle, *Universal Medical Savings Accounts*, Frontier Centre for Public Policy, Policy Series No. 5, July 2000.

<sup>367</sup> Samuel E.D. Shortt, "Medical Savings Accounts in Publicly Funded Health Care Systems: Enthusiasm versus Evidence", in *Canadian Medical Association Journal*, Vol. 167, No. 2, 23 July 2002, pp. 159-162.

reduce the subsidy that the well now pay to the poor. A recent study reports that, if MSAs were implemented in Manitoba for hospitals and physician services, then the sickest 20% of residents in that province would become personally responsible for over \$60 million of health care costs.<sup>368</sup>

In Volume Four, the Committee indicated that a system of MSAs might be contemplated for application in a limited sphere, such as paying for long-term care facilities, where there are already significant private out-of-pocket charges. However, MSAs should *not* be applied in the broader health care field involving presently insured services.

Therefore, the Committee strongly believes that funding for medically required hospital care and physician services must remain the responsibility of a publicly funded and administered health care insurance program. This is consistent with Principle Four in our Volume Five, which stated: “Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.”<sup>369</sup>

***The Committee strongly believes that funding for medically required hospital care and physician services must remain the responsibility of a publicly funded and administered health care insurance program.***

## **15.9 Pre-Funding for Health Care**

In the context of an aging population, the option of pre-funding health care is gaining some popularity. Pre-funding involves setting aside funds today to meet all or part of projected future cost increases in health care, so as to enable Canada to maintain a relatively stable (or at least more stable) annual ratio of health care spending to GDP. Excess revenues gathered now for such pre-funding would be placed in a special account, to be made available later for stabilization purposes.

Unfortunately, the costs of full pre-funding are high, even when the stabilization is attempted over a period of 30-40 years during which Canada's population will be getting significantly older. Accordingly, there may not be the popular will to implement a long term pre-funding plan now when the need to meet immediate cost pressures in the system is seen to be urgent. And the question could be raised, as with earmarked taxation, as to why health care costs only should be pre-funded – what about other costs that will also vary with aging of the population?

It has been suggested that it may be more practical to consider the pre-funding of only some elements of overall health care costs, specifically those relating to health services for the elderly, such as home and institutional care, that are not now publicly funded. Such pre-funding might be accomplished through a government plan financed by current taxation or through private health care insurance coverage. Such a scheme (comparable to MSAs) would assist individuals to save for future health care costs on a tax-efficient basis, especially if the

<sup>368</sup> Evelyn L. Forget, Raisa Deber and Leslie L. Roos, “Medical Savings Accounts: Will They Reduce Costs?”, in *Canadian Medical Association Journal*, Vol. 167, No. 2, 23 July 2002, pp. 143-147.

<sup>369</sup> Volume Five, p. 30.

premiums are deductible and earnings on accumulated funds are exempt from tax. Ultimately, pre-funding would relieve the publicly funded health care system of some costs that it now incurs in subsidizing some of those who need such services.

A variant of this approach was proposed by the Clair Commission in Quebec, which recommended that a separately managed fund be established to pre-fund the costs of both home and institutional care for individuals no longer able to care for themselves. The Commission recommended that the fund be financed by a mandatory premium (tax) on personal income from all sources, and be for the benefit of those (particularly the elderly) whose inability to care for themselves was long-term (over six months). Such a plan would provide an improvement in and integration of existing services for long-term disability and yet avoid a rapid rise in health care costs for an aging population.

This approach has a number of advantages: its financing structure is highly visible and the funds generated are wholly dedicated. The degree of equity of this funding method, as well as its impact on efficiency and intergenerational fairness, would depend on the source of revenue used to raise the money – personal income tax, public premiums or private health care insurance.

Given that the need to raise additional revenue to fund health care is urgent, the Committee does not endorse pre-funding. In our view, it would be very difficult to justify setting aside funds for future needs while substantial sums of money are required now throughout the publicly funded health care system to undertake its restructuring, renewal and expansion.

### **15.10 Committee Commentary<sup>370</sup>**

Sections 15.3 to 15.9 above have described a wide variety of possible options for raising \$5 billion annually in new federal government revenue; they have also presented in some detail the advantages and disadvantages associated with each option in terms of five specific criteria – equity, efficiency, intergenerational fairness, stability and visibility. On the basis of this information, the Committee reached conclusions about the approaches it favours.

We wish to say, up front, that there is no such thing as a “good” tax. There are, however, specific objectives that a new tax or revenue-generating initiative designed to pay for a specific public benefit should meet:

- The tax should be apportioned fairly and reasonably over the groups that will be called upon to pay it;
- The tax should have the least possible adverse effect on economic activity and growth in relation to the revenues raised;
- The tax should involve modest administrative costs of compliance for taxpayers and collection costs to government;

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<sup>370</sup> The Committee is indebted to Robert D. Brown, former chairman of Price Waterhouse, and his research assistant Michanne Haynes, for many of the calculations and revenue estimates presented in this chapter. The assistance of the Department of Finance in supplying statistical data is gratefully acknowledged.

- The justification for the tax should be clearly apparent to the public, preferably by associating the revenue directly with the benefits of the spending;
- The tax should produce 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;
- To justify its collection, the tax should be perceived to result in some tangible improvements to the system and to health care coverage.

On balance, the evidence available on how different revenue sources affect equity shows that equity is best served when health care is funded through personal income taxation or consumption taxes, rather than through payroll taxes or fixed premiums. In addition, from an efficiency viewpoint, international experience indicates that payroll taxation may affect the labour market more negatively than general taxation, because contributions are levied only on wages and employers are liable for part of the contribution. Finally, research shows that, whatever the method of raising revenue, the level of economic activity at any given time significantly influences the ability of a country to raise money for health care (or for any other purpose). Moreover, spending on health care has an opportunity cost, and other sectors may take priority in times of economic contraction or military conflict.

However, a major advantage of both payroll taxation and premiums over existing income and other general taxation is that they are more visible, transparent and predictable sources of financing. Earmarked taxation would certainly help in bringing more visibility, and possibly even greater stability, to a tax-funded health care system.

The Committee is of the view that increased federal revenue for hospital and doctor services should not come disproportionately from those who are ill. These services are now perceived to be “free.” The method of raising revenue should not be perceived as a “tax on the sick.” For this reason, the Committee rejects all forms of financing that call for individuals to pay directly on the basis of their utilization of the hospital and doctor system.

***The Committee is of the view that increased federal revenue for hospital and doctor services should not come disproportionately from those who are ill. The method of raising revenue should not be perceived as a “tax on the sick.”***

Furthermore, the Committee believes that the increased federal revenue should be raised based on ability to pay; that is, to ensure equity, individuals with higher incomes should pay more than individuals with lower incomes. For this reason, the Committee rejects the option of a flat national health care insurance premium. But, as we discuss below, we are not opposed to the option of a progressive health care insurance premium structure.

With respect to direct taxation, calculations done on behalf of the Committee by Brown and Haynes indicate that it would be necessary to increase the rate applicable to each taxable income bracket of personal income tax by 1.1 percentage points in order to raise \$5 billion in additional federal revenue. Another way to finance an incremental annual federal spending on health care through the personal income tax would be to impose a 5.7% surtax on

all federal tax. The Committee was told that these two options would, however, reverse approximately one-third of the 2000 federal personal tax cuts provided under the five-year tax plan and raise marginal tax rates significantly.

Calculations by Brown and Haynes also indicate that it would be necessary to increase the general rate of corporate tax by 7 percentage points in order to raise an additional \$5 billion in federal revenue. This would, however, reverse all present and scheduled future cuts in corporate tax, leaving Canada's rates uncompetitive internationally. This would, therefore, severely affect the Canadian business sector, employment and the overall economy.

The Committee is convinced that the changes to the Canadian tax structure that lead to increased revenue should be done in a way that keeps Canada's tax rates, including personal income tax rates, relatively competitive with other OECD countries, particularly the United States. In addition, for the sake of intergenerational fairness, we believe that the working population should not bear a disproportionate burden of taxation relative to the retired population. For these reasons, and based on the estimates given above, the Committee rejects the option of raising funds by increasing personal income taxes or corporate income taxes.

Although there appears to be some room for a payroll tax from an international competitiveness perspective, the Committee rejects this option on the grounds of intergenerational fairness. It would be unfair to require one segment of the population – working Canadians – to bear the costs of increased investment in the publicly funded health care system. This is particularly true in the context of an aging population with a reducing proportion of that population in the workforce.

***It is the view of the Committee that it would be unfair to require one segment of the population – working Canadians – to bear the costs of increased investment in the publicly funded health care system. This is particularly true in the context of an aging population.***

Therefore, the Committee concludes that there are two possible ways in which \$5 billion could be raised annually from Canadians and which comply with the set of criteria and objectives listed above. The first option is a *National Health Care Sales Tax*. The testimony received by the Committee suggests that, although this option might be considered mildly regressive, the benefits gained from an efficiency point of view far outweigh the impact on equity. In addition, expanded tax credit rebates would greatly reduce the impact of sales tax on lower-income people. The tax would be collected using the same base as the Goods and Services Tax (GST) so that its collection would be straightforward. Calculations done for the Committee suggest that the rate of tax required to raise \$5 billion annually would be around 1.5% (precisely, 13%). Thus, under the National Health Care Sales Tax 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 individual's taxable income as shown in Table 15.3. For each taxable income bracket currently used for the purpose of calculating an

individual's federal personal income tax, a flat premium would be charged. The premium would then increase (indeed double) for individuals in the following income bracket.

**TABLE 15.3**  
**ANNUAL FEDERAL REVENUE GENERATED FROM A VARIABLE**  
**NATIONAL HEALTH CARE INSURANCE PREMIUM**

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

1. Taxfilers in the taxable income bracket from \$0 to \$31,677 with no net federal tax liability (net of non-refundable tax credits) will not be liable for any health care premium.
2. In addition, taxfilers in this first bracket who do have net federal tax will pay the lesser of \$185 or 10% of taxable income not offset by the income equivalent to the amount of the non-refundable tax credits. This provision is designed to prevent the premium payable by taxpayers in this bracket with only modest net federal tax from being disproportionate to their income tax. For example, suppose that a taxfiler has a taxable income of \$9,934. The federal tax on this taxable income is 16%, which amounts to \$1,590. But this taxfiler also has \$9,000 on which he/she can claim the 16% of non-refundable tax credits or \$1,440. Thus, the net federal tax for this taxfiler is \$150 (\$1,590 minus \$1,440). For taxfilers in this income bracket, the premium corresponds to 10% of the value obtained from the difference between the taxable income (e.g. \$9,934) and the amounts on which the non-refundable tax credits are claimed (e.g. \$9,000). The taxfiler in the above example has a \$150 net federal tax from taxable income of \$934 in excess of the amounts on which the refundable tax credits are calculated; this taxfiler would thus pay a premium of \$93.40 (that is, 10% of \$934) instead of \$185, the normal premium for this bracket.
3. There is a total of 15.4 million taxfilers with income less than \$31,677 of whom only 7.9 million pay net federal tax. The average premium for all taxfilers in this bracket is \$71. For the 7.9 million with net federal tax, the average premium is \$170.
4. Individual taxfilers in the 22%, 26% and 29% brackets are subject to "notch relief", so that their premium will not be more than the premium for the income bracket below theirs, plus 10% of their income exceeding the bracket threshold. This provision is designed to prevent a taxpayer who receives income that puts him/her just over the bottom of the next income bracket from facing an abrupt and steep increase in premium. For example, an individual with income of \$33,177 (\$1,500 in excess of the 22% bracket threshold of \$31,677) would pay \$185 (the premium of the previous bracket) plus \$150 (\$1,500 times 10%) for a total premium of \$335, instead of the normal premium of \$370 for this bracket.
5. Calculation based on 2001-2002 data.

Source: Robert D. Brown and Michanne Haynes. Based on data provided by the Department of Finance.

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. Thus, the Variable National Health Care Insurance Premium is progressive across the entire income spectrum, but it is virtually flat within each income bracket.<sup>371</sup>

Although the Variable National Health Care Insurance Premium would be calculated through the income tax, it is *not* equivalent to an increase in personal income tax. The premium has some aspects of an income tax (because it is subject to some variation in incomes), but in fact it basically varies by taxable income bracket, not income. Moreover, the premium would have only a very moderate impact on marginal income tax rates, which would rise only at the “notch points” where the higher premium in the next bracket is phased in. Therefore, marginal rates would be relatively unchanged and, accordingly, would have much less impact on personal incentives to earn, save and invest than that which would result from an increase in personal income taxation.

The Committee understands that it is up to the federal government to decide which of the two options, either a National Health Care Sales Tax *or* a Variable National Health Care Insurance Premium, is most appropriate to raise the needed \$5 billion annually. Both options for raising \$5 billion annually in new federal health care revenue have advantages and disadvantages.

***Both options for raising \$5 billion annually in new federal health care revenue have advantages and disadvantages.***

On the one hand, the National Health Care Sales Tax would be simple to administer, as it would be based on the identical tax base to the GST. In addition, this option has a built-in growth factor, as sales tax revenue grows with the economy. Since health care spending is forecast to grow at a rate faster than the growth in GDP, having a built-in growth factor is important. Moreover, the National Health Care Sales Tax would not be significantly regressive, particularly since the GST tax credit rebate program would be extended to the new tax. Nonetheless, a major barrier to any sales tax increase is strong public opposition to such taxes in general, and the GST in particular.

On the other hand, the Variable National Health Care Insurance Premium has the advantage of being progressive as the amount of premium increases, in stages, with income. Such a

***The most important issue is for Canadians to agree to contribute \$5 billion annually in new federal revenue for health care.***

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<sup>371</sup> As indicated in Section 15.4, the Committee rejects the option of a flat annual health care premium because it is clearly regressive. For example, calculations indicate that it would require an annual flat premium of \$425 for every taxfiler with income over \$20,000 to generate \$5 billion in revenue. But there are over 136,000 taxfilers who have income in excess of \$20,000 and who pay no tax because of the application of credits such as the Charitable Donation Credit. For this group, the payment of a flat premium would be a significant additional burden. If the flat rate premium were modified so that it could not exceed 5% of taxable income in excess of the \$20,000 threshold, then the required annual premium would increase to \$500, and there would still be some taxfilers with no net tax who would be required to pay some of the premium.



national premium would also be consistent with the way in which individuals usually buy insurance, namely by paying for it through an annual premium. However, the premium option has the significant disadvantage that the more steps there are in the premium structure, the closer the premium is to an income tax increase and, for reasons stated earlier in this chapter, the Committee is opposed to an income tax increase. Moreover, the fewer steps there are in the premium structure (hence the less it looks like an income tax), the more regressive this option becomes.

From the Committee's perspective, 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 described above is eventually chosen as the revenue raising mechanism is less important than agreement to raise the \$5 billion. Nevertheless, in choosing between the two options, the Committee recommends the National Variable Health Care Insurance Premium. Therefore, the Committee recommends that:

***In choosing between the two options, the Committee recommends the National Variable Health Care Insurance Premium.***

**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.**

### **15.11 Current Federal Funding for Health Care**

The Committee recognizes that the \$5 billion in increased spending is not the entire increase in federal health care spending that will be required in the years ahead. The cost of the hospital and doctor system to which the federal government now contributes will continue to grow. The increased revenues required to cover these increasing costs will have to be funded out of the efficiency savings that result from the restructuring recommendations proposed in this report, and from the general growth in federal revenues from existing tax sources.

This raises the question of whether, in order to substantially improve transparency and accountability in federal health care spending, the 62% of federal CHST cash transfers that are currently notionally attributed to health care (according to Finance Canada's estimation) ought to be paid for through an *earmarked* tax source (as described in Section 15.4 above). This would help the public considerably in understanding how much federal money is spent on health care. Canadians would thus see a more direct link between the taxes they pay and the health services

***In order to substantially improve transparency and accountability in federal health care spending, the 62% of federal CHST cash transfers which are currently notionally attributed to health care ought to be paid for through an earmarked tax source.***

they receive. It would also greatly help to dispel the widely held perception that health care is “free.”

One way to do this would be to earmark some of the seven percentage points of the GST to health care. Calculations done for the Committee indicate that it would be necessary to earmark 3.1 of the 7 percentage points of the GST (or around 45% of the revenue generated through the GST) to obtain the 62% of current federal CHST cash transfers which are related to health care.

However, given the need for an increase in the current CHST funding (at least until the full impact of the Committee’s restructuring recommendations come into effect), it is probably appropriate that, if an earmarked source is to be used for the current federal cash contribution to health care, and if the earmarked source is to be the GST, then 3.5 (rather than the calculated current 3.1) of the 7 percentage points of GST revenue (or 50% of GST revenue) should be earmarked for health care. This would increase federal base funding for health care by \$1.5 billion. In addition, transparency would be enormously enhanced by earmarking half of GST revenue to be the federal cash contribution to health care, supplemented by the additional funding required for implementation of the reforms recommended in this report.

A significant advantage of using the GST revenue as the earmarked source is that it has a built-in escalator: as the economy goes, so does the GST revenue. Thus, using 3.5 of the 7 percentage points of the GST (rather than the calculated current 3.1 percentage points) to fund the federal cash contribution to the existing publicly funded hospital and doctor system would create the stable and predictable source of federal funding that the Committee called for in Principle Two in Volume Five<sup>372</sup> as well as lead to augmentation of this federal contribution. Therefore, the Committee recommends that:

***Using 3.5 of the 7 percentage points of the GST (rather than the calculated current 3.1 percentage points) to fund the cash federal contribution to the existing publicly funded hospital and doctor system would both create the stable and predictable source of federal funding the Committee called for in Principle Two in Volume Five as well as lead to augmentation of this federal contribution.***

**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 annual cash contribution to the national hospital and doctor insurance program, 3.1 of the 7 percentage points of the GST would be required to meet the current funding levels. In this case, the Committee further recommends that:

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<sup>372</sup> Volume Five, pp. 25-28.

**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.)**

If the above two recommendations are accepted, then the federal government would be indirectly contributing *at least* an additional \$3.0 billion a year to the *existing* public hospital and doctor insurance program. \$1.5 billion would come from increasing to 3.5 percentage points the amount of GST revenue earmarked for health care, while another \$1.5 billion would, as discussed in Section 15.1, come from money that the provinces are now spending and that they would no longer have to spend once the recommendations in this report are implemented. This amount would then be reinvested in the existing health care system.

If the federal government also decided to invest the \$1-billion contingency (as discussed in Section 15.1) 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.

***The Committee believes it is important to acknowledge the fact that the health care costs of the elderly are considerably higher than the health care costs of younger people, and that some provinces have a higher percentage of their population aged 70 and over than other provinces.***

Finally, CHST transfers are currently distributed to the provinces/territories on a per capita basis. If the health care portion of the CHST is paid from an earmarked revenue source as recommended above, the Committee believes that a variation should be made to the way a province's share of the fund is determined. More precisely, we believe it is important to acknowledge the fact that the health care costs of the elderly are considerably higher than the health care costs of younger people, and that some provinces have a much higher percentage of their population aged 70 and over than other provinces. Accordingly, the Committee recommends that:

**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.**

A variety of weighting formulae are possible, and should be explored in order to improve the fairness of current federal health care contributions to the provinces and territories. However, a simple formula would be to give triple the weight to each provincial resident aged 70 years and over. This would be of significant assistance to smaller provinces while not significantly hurting wealthier ones.

## CHAPTER SIXTEEN

### THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE

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The previous chapter detailed the Committee's position with respect to how additional federal revenue should be raised and administered in order to implement our recommendations. We believe strongly that their implementation is essential if health care reform and renewal is to be undertaken, and if this is to be done in a manner that is effective, transparent and accountable. The Committee is convinced that an additional \$5 billion annually must be invested by the federal government to finance the changes necessary to secure a high-quality and fiscally sustainable health care system.

The Committee also realizes, however, that in a free and democratic society, Canadians may not be willing to pay more taxes to the federal government (through the National Health Care Insurance Premium as we recommend in this report) to support their national health care insurance system – Medicare. Conversely, the federal government may be unwilling to impose a tax increase on a reluctant population, even though the increased revenue would be spent on health care. In this case, the question then arises as to what the consequences would be. They would include the following:

***The Committee also realizes, however, that in a free and democratic society, Canadians may not be willing to pay more taxes to the federal government (through the National Health Care Insurance Premium as we recommend in this report) to support their national health care insurance system – Medicare. Conversely, the federal government may be unwilling to impose a tax increase on a reluctant population, even though the increased revenue would be spent on health care.***

In this case, the question then arises as to what the consequences would be. They would include the following:

- No proposed expansion of public health care insurance coverage to include catastrophic prescription drug costs, some post hospital home care treatment and out-of-hospital palliative care would occur;
- No reform and renewal of the hospital and doctor system would take place and major health care cost pressures would continue to erode the system;
- Nor would the essential investments in infrastructure occur, particularly those in health information management, health care technology and expanded enrolment in medical and nursing schools;
- This, in turn, would make implementation of the National Health Care Guarantee impossible. Given Canada's relative deficiency in medical equipment and health care providers to deal with waiting queues, understandably provincial governments would be unwilling to legislate a care guarantee if its implementation meant they would have to pay the cost of sending an ever increasing number of patients to the United States or elsewhere for treatment;

- A Canadian health infostructure, along with the full deployment of a system of electronic health records and a system of service-based funding for hospitals, would not be developed, thus limiting Canada's ability to evaluate the cost, effectiveness, quality, performance and outcomes of its health care system or to develop strategies to increase its productivity.

In short, in the absence of the additional investment the Committee recommends, the Canadian health care system will continue to deteriorate. The "health care contract"<sup>373</sup> between Canadians and their governments will break if Canadians are unwilling to pay an additional \$5 billion in taxes (the citizens' part of the contract) so that government can finance adequately the changes necessary for the sustainability of our publicly funded, universal, comprehensive, accessible and portable hospital and doctor insurance plan (the government part of the contract), expanded to cover, in part, out-of-hospital prescription drugs, home care and palliative care as recommended.

Under these circumstances, it seems highly probable that, for the reasons discussed in Chapter Five, 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 that would enable them to receive and pay for health services in Canada that are also included in the publicly insured set of services. Thus, a parallel private health care system is likely to emerge.

***The Committee has stated on numerous occasions, and we repeat it here again, that we are in favour of a single public funder/insurer for hospital and doctor services covered under the Canada Health Act.***

This is *not* the outcome preferred by the Committee. We have stated on numerous occasions, and we repeat it here again, that we are in favour of a single public funder/insurer for hospital and doctor services covered under the *Canada Health Act*. The single, public insurer model was, in fact, the first principle enunciated in Volume Five.<sup>374</sup> As a corollary, private insurance for publicly insured health services should continue to be disallowed, *provided* that such publicly insured services are delivered in a *timely* fashion.

Nonetheless, the Committee believes it is important to consider the implications of allowing private health care insurance to develop, together with its associated parallel privately funded hospital and doctor system. This is the purpose of this chapter. Section 16.1 describes briefly the role of private health care insurance in Canada and in selected OECD countries. Section 16.2 provides a summary of the findings of recent literature on the impact of private health care insurance on costs, access and quality in the publicly funded health care system. Finally, Section 16.3 sets out the Committee's view on the possible development of a parallel private delivery system in Canada.

***It is the view of the Committee that private insurance for publicly insured health services should continue to be disallowed, provided that such services are delivered in a timely fashion.***

<sup>373</sup> Volume Five, p. 61.

<sup>374</sup> Volume Five, pp. 23-25.

## 16.1 Private Health Care Insurance in Canada and Selected OECD Countries

Currently, the *Canada Health Act* requires public health care insurance plans to be accountable to the provincial government and to be not-for-profit. Moreover, the majority of provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island and Quebec) prohibit private companies from insuring services that are covered under public health care insurance plans.<sup>375</sup> In these provinces, private insurers are limited to providing supplementary health care benefits, such as semi-private or private accommodation during hospital stay, prescription drugs, dental care and eyeglasses – all services that are not insured under provincial health care insurance plans.

Four provinces do permit private health care insurance for services that are also publicly insured (New Brunswick, Newfoundland, Nova Scotia and Saskatchewan). Thus, patients of opted-out physicians<sup>376</sup> in these provinces can substitute private for public health care coverage. However, provincial legislation that prohibits opted-out physicians from practising both in the publicly funded system and privately has meant that few opt out. Therefore, few people purchase private health care insurance.

For example, in Nova Scotia, opted-out physicians cannot bill privately in excess of the fee specified on the public insurance fee schedule. This creates a disincentive, as physicians cannot be paid more for equivalent cases working under private insurance than if they worked within the public plan. As a result, there are very few opted-out physicians and, consequently, there is little need for private health care insurance to cover publicly insured health services.

In Newfoundland, patients of opted-out physicians are entitled to public coverage up to the amount set out in the fee schedule (in other words, patients are entitled to public funds to subsidize the cost of buying their health services in the private for-profit sector). Out-of-pocket spending by patients is thus limited to the difference between the fee charged by the opted-out physician and the publicly scheduled fee; but few physicians have opted out in Newfoundland and, therefore, there is little demand for private health care insurance.

In New Brunswick and Saskatchewan, patients of opted-out physicians cannot be subsidized by the public plan as they would be in Newfoundland. Nonetheless, there has been no significant development of private-sector in health care insurance in these two provinces.

Overall, the *Canada Health Act*, together with provincial/territorial legislation, has prevented the emergence of private health care insurance in Canada that competes directly with public insurance. It is simply not economically feasible for patients, physicians or health care institutions to participate in a private parallel system.

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<sup>375</sup> Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada", in *Canadian Medical Association Journal*, Vol. 164, No. 6, 20 March 2001, pp. 825-830.

<sup>376</sup> A physician opts out when he/she chooses to give up his/her rights to bill the public health care insurance plan and takes up practice in the private sector. Every provincial health care insurance legislation permits physicians to opt out.

This contrasts sharply with the situation in other OECD countries, in which private health care insurance can and does compete with public health care insurance, and physicians can work in and receive payments from both the public and the private sectors.<sup>377</sup> There are two different models of private insurance for health services in these countries. The first, prevalent in Germany and the Netherlands, involves a system of private insurance and service delivery that is totally separate from the public system. The second, in place in countries like Australia, Sweden and the United Kingdom, involves competition between public and private insurers and interaction between public and private providers.

In Germany and the Netherlands, private health care insurance is voluntary for those people with relatively high annual incomes (while public coverage is mandatory for those with middle and lower incomes). The private insurers must accept all those who apply for coverage and must provide benefits equivalent to those offered under the public plan. Thus, private insurers cannot “cherry-pick,” i.e., restrict coverage to patients who are healthy and wealthy, thereby leaving the public sector to pay for patients who are less healthy and wealthy. The premiums paid for private insurance are risk-related (but subject to strict regulation) and do not vary significantly for equivalent coverage.

In the United Kingdom, residents can purchase private insurance to cover the same health services provided in private hospitals as are offered in public hospitals. Although privately-insured patients in the United Kingdom usually obtain their health services outside the NHS; they can also be treated in NHS facilities in which “pay beds” are available. Physicians are permitted to earn up to 10% of their gross annual income from private practice.

In Australia, private health care insurance, as in the United Kingdom, competes with the public plan. Moreover, the Australian government actively encourages residents to acquire private health care insurance by subsidizing 30% of its cost. Premiums required under private health care insurance are strictly regulated and community-rated (i.e., a single premium applies to everyone, regardless of his/her health status). Privately insured patients may receive care in either a public or private hospital; in both cases, the public health care insurance plan subsidizes 75% of the hospital costs, while the remainder is covered by private insurance. Specialists working in public hospitals can treat patients privately and receive payment both from private and public health care insurance plans.

Private health care insurance is permitted even in Sweden, which is generally recognized as being amongst the most socialized of European countries. In Sweden, as in Australia, government legislation requires that premiums charged by private health care insurers must be community-rated. Private hospitals do not usually obtain payment from the publicly funded plan, unless care is provided through contracts with the county councils.<sup>378</sup> Physicians in Sweden are allowed to work in both the public and the private sectors.

The evidence summarized in the Committee’s Volume Three, as well as the findings of a Canadian study,<sup>379</sup> show that the vast majority of care delivered in private for-profit health care institutions in countries like Australia, New Zealand, the Netherlands, Sweden and

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<sup>377</sup> For more information on health care systems elsewhere, consult the Committee’s Volume Three.

<sup>378</sup> This, in fact, is becoming more prevalent in Scandinavian countries under their new health care guarantee.

<sup>379</sup> Cam Donaldson and Gillian Currie, *The Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity*, Institute of Health Economics (Alberta), Working Paper 00-9, 2000.



the United Kingdom is funded through private health care insurance. Also, physicians practising in those countries are usually employed in the public sector and top up their incomes by working in the private sector on a fee-for-service basis. It should be noted, however, that in all these countries the private for-profit sector is quite small.

The restriction on the role of private health care insurance in Canada as well as on physician opted-out practice is unique among OECD countries. Pressures to loosen the restrictions and create a parallel system of private insurance and delivery will increase, however, if timely access to needed services cannot be assured in the publicly funded health care system. This observation was already noted in 1996 by Glouberman and Vining when they stated that:

*It is obvious that any significant initiatives (whether implicit or explicit) to further ration publicly-financed health care will encourage increased demand for privately-financed health care.<sup>380</sup>*

Jeffrey Lozon, President of St. Michael's Hospital in Toronto and former Deputy Minister of Health in Ontario, put this question to the Committee:

*When you take the notions of a private insurance system (...) out of the discussion, you are left inevitably with the question of tax increases, whether dedicated or not. I would like to raise this: Why not allow individuals to purchase health insurance that would provide them with another level of care (...)? Why not allow individuals who have the wherewithal to say, "I do not want to have to wait six months for my hip replacement", to buy that service?<sup>381</sup>*

## **16.2 Review of Recent Literature on the Impact of Private Health Care Insurance and Private For-Profit Delivery**

Advocates for a parallel private system argue that it will ensure the sustainability of the publicly funded system (by reducing public cost pressures), improve access to the public system (by reducing waiting times), and improve quality in the public system (through competition). They also argue that private health care insurance would give patients access to greater choice and higher-quality services without compromising the public system.

By contrast, opponents of a parallel private system contend that it will create "two-tier" health care, compromise equity, increase costs, and reduce quality and access to the publicly financed system, as those who have the financial means to purchase private insurance exit to private delivery institutions. They also argue that, with higher pay-per-unit activity in the privately funded system, personnel is likely to be drawn from the public system, making waiting times longer in the public system in the absence of an adequate supply of doctors and nurses. Moreover, they contend that the private for-profit sector "cherry picks" the relatively routine, uncomplicated (and therefore less expensive) care – elective surgery and the like – and leaves to

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<sup>380</sup>Steven Glouberman and Aidan Vining, *Cure or Disease? Private Health Insurance in Canada*, University of Toronto, 1996, p. 61.

<sup>381</sup> Jeffrey Lozon (53:64).

the public system the complex, emergency and more expensive services, thereby increasing substantially the unit costs of the public system.

The Committee believes that the truth lies between those two extreme views. What does the international evidence suggest? A review of recent literature on the subject of private health care insurance and delivery indicates the following.<sup>382</sup>

- In the United Kingdom (as in New Zealand), private health care insurance has encouraged the development of private health care delivery. In both countries, physicians can work in the public as well as the private sector; physicians are usually employed in the public sector and top up their incomes by working in the private sector on a fee-for-service basis.
- In the United Kingdom (as in Germany and the Netherlands), private health care insurers pay much more than does public insurance for the same health service. For example, physicians can earn three to four times more in the private sector than in the National Health Service (NHS) for providing the same service.
- Private hospitals are well established in the United Kingdom and are regularly used by the NHS to pick up excess demand when public sector waiting times get too long (just as some provincial governments use the American private health care sector to relieve queues in Canada).
- Patients holding private health care insurance in Australia can select the physician of their choice for hospital care. Evidence suggests that these private patients get quicker access to treatments for which publicly insured patients face a queue. Queue-jumping by wealthy, privately insured patients is also prevalent in Sweden and in the United Kingdom.
- In Australia, there has been no change in public-sector waiting times following the subsidy policy to encourage private health care insurance. Similarly, evidence from New Zealand and the United Kingdom suggests that, although long public waiting times tend to fuel demand for private health care insurance, having it does not reduce the length of public waiting times.

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<sup>382</sup> See the following documents:

Brian Lee Crowley, *Private Financing, Private Delivery. Two Tier Health Care?*, Presentation to the National Health Care Leadership Conference Panel, Halifax, 27 May 2002.

Stefan Greß et al., *Private Health Insurance in Social Health Insurance Countries – Market Outcomes and Policy Implications*, Discussion Paper, February 2002.

Jeremiah Hurley et al., *Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada*, Centre for Health Economics and Policy Research Analysis, McMaster University, Working Paper 01-12, December 2001.

Colleen M. Flood, Mark Stabile and Carolyn Hughes Tuohy, *Lessons From Away: What Canada Can Learn From Other Health Care Systems*, Document prepared for the Committee, 30 April 2001.

Colleen M. Flood and Tom Archibald (March 2001), *op. cit.*

Raisa Deber et al., "Why not Private Health Insurance? 1. Insurance Made Easy", *Canadian Medical Association Journal*, Vol. 161, No. 5, 7 September 1999, pp. 539-542.

Carolyn H. Tuohy, Colleen M. Flood and Mark Stabile, *How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence From OECD Countries*, Paper submitted to the Journal of Health Politics, Policy and Law, University of Toronto.

- Evidence from Australia and the United Kingdom suggests that private parallel delivery systems tend to offer a limited range of services for niche markets; they focus on relatively simple, less complex, elective procedures, shifting the burden of the most expensive cases and patients requiring more comprehensive care to the public system.
- In the Netherlands, the government regulates the maximum fees physicians may charge for the treatment of privately insured patients. This has reduced the incentives for preferential treatment of privately insured patients compared to those publicly insured.
- In the Netherlands, two factors help prevent the health care system from becoming a “two-tier” system. First, those who purchase private health care insurance cannot fall back on the public system for some of their health care needs. Private insurers cannot just skim off the easier kinds of care like elective surgery (as happens in the United Kingdom); they must cover all needs. Second, having private insurance does not enable Dutch citizens to jump queues in the public system. It is seen as contrary to a physician’s ethical code to select patients with private insurance over other patients; patients of both kinds are treated side-by-side in the same hospitals.
- In Germany, privately insured people tend to receive more comprehensive and faster treatment than do people with public health care insurance.
- In both Germany and the Netherlands, governments quite extensively regulate private health care insurance in order to ensure affordable premiums and limit risk selection by private insurers.
- In Australia, Sweden and the United Kingdom, people who purchase private health care insurance do so out of after-tax income and must continue to pay the same rate of income tax. That is, they pay doubly for health care insurance through general taxation and private premiums. This contrasts with the situation in both Germany and the Netherlands, where residents holding private health care insurance do not contribute to any Sickness Funds.
- Data from 22 OECD countries indicate that increases in private spending on health care are associated over time with decreases in public health care funding. There appears, then, to be some justification for the concern that increasing the proportion of private financing will substitute for and dilute rather than supplement public funding.

On the basis of the evidence from other countries presented above, the Committee has concluded that no country in which a parallel private health care insurance and delivery system coexists with a public health care insurance scheme can serve as a model

***On the basis of the evidence available from other countries, the Committee has concluded that no country in which a parallel private health care insurance and delivery system coexists with a public health care insurance scheme can serve as a model that should be adopted, without change, by Canada.***

that should be adopted, without change, by Canada.

Countries in which parallel private systems compete with publicly funded health care coverage exhibit a number of problems, including: risk selection and cream skimming; no reduction in waiting lists in the public sector; queue jumping; and preferential treatment. These concerns must be appropriately addressed if governments fail, for whatever reason, to provide funding sufficient to assure timely access to care in our publicly funded Canadian health care system.

### **16.3 Committee Commentary**

It is the view of the Committee that, in the absence of governments providing adequate funding, and providers delivering effective and timely health services, to paraphrase section 1 of the Charter, it would no longer be just and reasonable in a free and democratic society to deny Canadians the right to purchase private health care insurance. They should not be denied the right to purchase private supplementary insurance to pay for services they are unable to access in a timely fashion in the publicly funded health care system.

While the Committee would regard such a development as very regrettable, and while many Canadians would strongly oppose it, it is important to recognize two facts:

- first, as indicated in Section 16.2, Canada is the *only* major industrialized country which does not have some element of a parallel private hospital and doctor system;
- second, the *current* Canadian system is not nearly as “one tier” as popular mythology would have Canadians believe.

As a matter of fact, people who can afford it can, and do, go out of Canada (usually to the United States) to access the health services they want if their only alternative is a long queue for those services in Canada.

There is also strong anecdotal evidence to suggest that the situation in Canada is similar to that in Australia, where, in the words of one of the Australian witnesses who testified before the Committee; “access to public (health) services is usually more easily obtained by wealthier and more powerful individuals who understand how the system works and have appropriate contacts in hospital service delivery and administration.”

In addition, provincial Workers’ Compensation Boards in most provinces receive preferred access to treatment for their clients based on the argument it is necessary to ensure the client gets back to work quickly (which, of course, saves the Workers’ Compensation Board money). Moreover, in some provinces, Workers’ Compensation Boards have contracts with hospitals for a specified number of beds and diagnostic procedures, thus ensuring quick access to services for WCB patients. They also make direct payments to physicians for services performed, and such payments do not count toward any provincial cap on a physician’s income.

All these facts are important for Canadians to reflect on as they consider whether they want the federal government to support or reject the Committee’s recommendation for an additional \$5-billion investment in health care.

The Committee realizes that some people will be offended by the Committee's raising the potential development of a parallel private system of health care. They are likely to claim that it is possible for Canadians to maintain the current publicly funded system without their having to put more money into the system (e.g., the \$5 billion proposed by the Committee). Such critics will probably say that:

- The current system is inefficient and that restructuring will save sufficient money to cover the increasing costs of the system. The Committee has repeatedly acknowledged the critical importance of improving the effectiveness and efficiency of the management and delivery of health care (see Chapter 2 of Volume Five and Chapters 2, 3 and 4 of this report). But the Committee has also repeatedly stated that there is *not* enough evidence to support the hypothesis that efficiency gains alone will be sufficient to avoid having to put large amounts of new funds into the system, particularly if the growing gaps in the system are to be closed. Furthermore, there is widespread to near-universal agreement that substantial amounts of additional money are required to achieve the massive and fundamental changes necessary to create a genuine health care system, capable of achieving acceptable standards of efficiency and effectiveness together with the quality of outcomes we in Canada can, and should, demand.
- In addition, those who hold the view that efficiency measures only are required to refinance the health care system gloss over the key fact that restructuring in any industry costs money - money that has to be spent before the resulting efficiency savings are realized.
- The argument will also be made that the additional \$5 billion can come from the federal surplus anticipated over time. This argument, however, completely ignores the fact that there are several other compelling demands on any federal surplus, such as agriculture, the Canadian Armed Forces, infrastructure for Canada's major cities, and so on. The Committee believes that the majority of any federal surplus should *not* be devoted only to health care or even primarily to health care. More important, since surpluses rise and fall (as now) 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.

Therefore, 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. We believe that Canadians, through their federal government, must confront head-on the choice between putting considerably more money into the health care system or having the courts rule in favour of the emergence of a parallel private system.

***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 having the courts rule in favour of the emergence of a parallel private system.***



## **Part VIII:** **The *Canada Health Act***

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## CHAPTER SEVENTEEN

### THE CANADA HEALTH ACT

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In Volume One, the Committee traced the evolution of the nation-wide principles of the Canadian health care system. We stressed the fact that although the delivery of health care is primarily within provincial/territorial jurisdiction, it does not mean that national interests are absent. For its part, the federal government established national principles and contributed to meeting the cost of health care, first through cost-sharing (from 1966 to 1977) and subsequently by block-funding.<sup>383</sup>

These national principles are currently set out in the *Canada Health Act* (the Act), which was *unanimously* enacted by Parliament in April 1984. The five national principles of the Act are:

- The principle of **universality**, which means that public health care insurance must be provided to all Canadians;
- The principle of **comprehensiveness**, which means that medically necessary hospital and doctor services are covered by public health care insurance;
- The principle of **accessibility**, which means that financial or other barriers to the provision of publicly funded health services are discouraged, so that health services are available to all Canadians when they need them;
- The principle of **portability**, which means that all Canadians are covered under public health care insurance, even when they travel within Canada and internationally or move from one province to another;
- The principle of **public administration**, which requires provincial and territorial health care insurance plans to be managed by a public agency on a not-for-profit basis. (This principle says nothing about the ownership structure of a health service *delivery* institution.)

As explained in Volume One, the Committee considers the first four principles of the *Canada Health Act* to be patient-oriented. The fifth principle – that of **public administration** – is of a completely different character. It is not patient-focussed but “is rather the means of achieving the end to which the other four principles are directed.”<sup>384</sup> The public administration condition of the *Canada Health Act* is the basis for the single insurer/funder model that the Committee endorsed in Volume Five under Principle One.<sup>385</sup>

Altogether, the five principles of the *Canada Health Act* flow from two overarching objectives for federal health care policy – objectives that the Committee strongly supports as the primary federal health care objectives. As indicated in Volume Four, these two objectives are:

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<sup>383</sup> See Volume One, Chapter Two, pp. 31-44.

<sup>384</sup> Volume One, p. 41.

<sup>385</sup> Volume Five, pp. 23-25.

- To ensure that every Canadian has *timely* access to all medically necessary health services *regardless* of his or her ability to pay for those services.
- To ensure that *no* Canadian suffers *undue* financial hardship as a result of having to pay health care bills.<sup>386</sup>

Each recommendation made in this report with respect to 1) restructuring of the hospital and doctor system, 2) establishment of a national health care guarantee, 3) improvement of the health care infrastructure, and 4) enhancement of federal funding for health care, is designed to make progress toward achieving these two overarching public policy objectives in ways that are consistent with the principles of the *Canada Health Act*. Adopted together, these recommendations will ensure the long-term sustainability of Canadian Medicare.

***All recommendations put forward by the Committee in this report are designed to make progress toward achieving the two overarching public objectives of federal health care policy in ways that are consistent with the principles of the Canada Health Act.***

The Committee's recommendations relating to the expansion of public health care coverage are also intended to preserve the primary objectives of federal health care policy, although we recognize that some of the program characteristics proposed for such expansion do not comply with the *Canada Health Act*. This is particularly true with respect to the out-of-pocket payment provisions up to an annual cap/maximum of 3% of family income proposed for catastrophic prescription drug coverage.

This chapter provides a description and interpretation of the principles of the Act in light of the Committee's recommendations. It is against the principles set out in the *Canada Health Act* and the potential for achieving the two federal health care policy objectives that the Committee's recommendations should be judged.

***It is against the principles set out in the Canada Health Act and the potential for achieving the two federal health care policy objectives that the recommendations of the Committee should be judged.***

## 17.1 Universality

The principle of universality of the *Canada Health Act* requires that *all* residents of a province or territory be entitled, on uniform terms and conditions, to the publicly funded health services covered by provincial/territorial plans. Universality is often considered by Canadians as a fundamental value that ensures national health care insurance for everyone wherever they live in the country.

Universality does not dictate a particular source of funding for the health care insurance plan. As a matter of fact, the provinces/territories can and do fund their universal plans as they wish, through premiums, dedicated or general taxation. By contrast, universal health care coverage in both Germany and the Netherlands is provided through a system of dedicated payroll taxes.

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<sup>386</sup> Volume Four, p. 16.

Moreover, universality is not necessarily achieved only through public funding. For example, universal coverage for health services is guaranteed by both Sickness Funds (public plans) and private insurers in Germany and the Netherlands. Similarly, the Quebec Pharmacare program provides universal coverage through a combination of public and private insurance.

Perhaps more important, the principle of universal coverage does *not* necessarily mean first-dollar coverage. In fact, countries that provide universal health care coverage, like Australia, Germany, the Netherlands and Sweden, permit user charges and extra-billing for publicly insured services. In Canada, first-dollar coverage for publicly funded hospital and doctor services is required under the provisions of the *Canada Health Act* that explicitly prohibit user charges and extra-billing (see Section 17.3, below).

***The Committee feels it is important to stress that the principle of universal coverage does not necessarily mean first dollar coverage.***

The principle of universality is one the Committee holds dear. It ensures that access to publicly funded health services is available to everyone, everywhere, and that no one is discriminated against on the basis of such factors as income, age, and health status. We believe that universal insurance coverage and the access it provides to the publicly funded hospital and doctor system has served Canadians extremely well. Accordingly, it should be preserved.

Similarly, the Committee believes strongly that the broadening of public coverage recommended in this report should rest on the principle of universality. In our view, coverage for catastrophic prescription drug costs, post-hospital home care and out-of-hospital palliative care must be provided to *all* Canadians, when they need them.

***The Committee is of the view that coverage for catastrophic prescription drug costs, post-hospital home care and out-of-hospital palliative care must be provided to all Canadians, when they need them.***

## **17.2 Comprehensiveness**

Health services that must be covered under the *Canada Health Act* are determined on the basis of the “medical necessity” concept under the principle of comprehensiveness. All medically necessary health services provided by hospitals and doctors must be covered under provincial/territorial health care insurance plans.

The determination of what services ought to be considered “medically necessary” is a difficult task. Most Canadians would agree that life-saving cardiac procedures are medically necessary. Most Canadians would also agree that most cosmetic surgery procedures do not meet that criterion. The difficulty comes with those services that lie between these two extremes.

Deciding what health services are to be insured and excluded has always been part of the way Canadian Medicare has functioned. These decisions are made in each province/territory by the government after negotiation with the medical profession. That is why there are differences in what is covered publicly in different provinces/territories. For example, as reviewed in Volume One, the removal of warts is no longer covered in Nova Scotia, New Brunswick, Ontario, Manitoba, Alberta, Saskatchewan and British Columbia, but remains

publicly insured in Newfoundland, Quebec and Prince Edward Island. Similarly, stomach stapling is covered in most provinces, but it is not insured in New Brunswick, Nova Scotia or the Yukon, where patients (or their private supplementary health care insurance) must pay for this procedure.<sup>387</sup>

The Committee was told repeatedly that the current process for determining what is and what is not covered under provincial/territorial health care insurance plans is conducted in secret by governments, acting with the provincial/territorial medical associations, with no public input. It is not an open and transparent process. For example, the Canadian Healthcare Association pointed that:

*Unilateral pronouncements from governments of the delisting of services are certainly not in the best interest of Canadians.*

*(...) Any discussions or decisions regarding the “basket of services” must be evidence based and involve an open and transparent process that meaningfully involves all stakeholders.*<sup>388</sup>

The Committee shares the view of the Canadian Healthcare Association and many other witnesses that transparency requires that the process of deciding what is, and what is not, to be publicly insured should be much more open than it has been historically and is now.

***The Committee shares the view of many witnesses that transparency requires that the process of deciding what is, and what is not, to be publicly insured should be much more open than it has been historically and is now.***

For this reason, the Committee enunciated Principle Four in Volume Five, which states that the determination of what should be covered under public health care insurance should be done through an open and transparent process.<sup>389</sup> This principle also reflects the views expressed in the report of the Clair Commission in Quebec and the Mazankoski report in Alberta, both of which recommended that consideration should be given to reviewing the principle of comprehensiveness of the *Canada Health Act*. Both recommended the establishment of a permanent committee, made up of citizens, ethicists, health care providers and scientists, to review and make decisions on the range of services that should be covered publicly. Such a review would set the boundaries between publicly insured and privately funded health services; it would also lead to evidence-based (as opposed to the current negotiated process) decision making with respect to what services should be covered under public health care insurance.

The Committee believes strongly that the permanent committee charged with revising the set of publicly funded health services should be broad-based in membership and not be composed entirely of experts. We believe that input from those who would be directly

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<sup>387</sup> Volume One, pp. 98-99.

<sup>388</sup> Canadian Healthcare Association, Brief to the Committee, May 2002, pp. 3-4.

<sup>389</sup> Volume Five, pp. 30-32.

affected by the committee's decisions – namely, citizens – is essential if the process is to be truly open and is to have public credibility and acceptability.

The Committee also believes that there should be rational standards to define those services covered publicly in each province/territory. This would bring more uniformity to public health care coverage across the country. Therefore, the Committee recommends that:

**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.**

It must be recognized that revising the comprehensive basket of publicly insured health services is not intended to reduce costs. It is intended to improve both transparency and evidence-based decisions with respect to comprehensiveness of publicly funded health services. The purpose of such a review is to use clinical, evidence-based, research to ensure that publicly insured health services are those that are most clinically effective in preventing disease, restoring and maintaining health, and alleviating pain and suffering.

Another important critique raised with respect to the principle of comprehensiveness of the *Canada Health Act* relates to its limited scope of coverage. In Volume One, the Committee stated that the *Canada Health Act* is very limited: it is centred on medically necessary health services provided by hospitals and doctors. Moreover, the Act applies to a shrinking range because fewer services are provided now in hospitals. Thanks to new knowledge and technologies, many more health services can be provided safely and effectively on an ambulatory basis or at home. Hospital stays are shorter; drug therapy often enables people to avoid hospital-based care altogether.

As shown in Volume Three, there is a sharp contrast between Canada and other OECD countries in terms of the scope of its public health care coverage. Many countries with a similar share of public spending in total health care expenditures provide coverage that is much broader than Canada's, encompassing such items as prescription drugs (Australia, Germany, Sweden, the United Kingdom), home care (Germany, Sweden), and long-term care (Germany, the Netherlands).

As described elsewhere in this report, when services and prescription drugs are provided outside hospitals, they fall outside the ambit of the *Canada Health Act*. As a result, these services are not usually provided cost-free to the patients, nor are they necessarily provided in accordance with the principles of accessibility, comprehensiveness and universality.<sup>390</sup> Moreover, testimony received by the Committee suggests that, more and more often, individual Canadians bear heavy financial burdens as a result of incurring very high out-of-pocket expenditures to obtain these services.

Based on the evidence it gathered throughout its hearings, and as set out in Chapters Seven, Eight and Nine of this report, the Committee has come to the conclusion that there is a need to expand public health care insurance coverage to encompass three new applications: catastrophic prescription drug costs, post-hospital home care costs, and palliative home care costs.

It is the view of the Committee that broadening public health care coverage to encompass catastrophic prescription drug costs, post-hospital home care costs and palliative home care costs is consistent with the primary objectives of federal health care policy. This is particularly true with respect to catastrophic prescription drug costs if we are to meet the second objective of federal health care policy – that no Canadian suffers undue financial hardships as a result of having to pay health care bills.

***It is the view of the Committee that broadening public health care coverage to encompass catastrophic drug costs, post-hospital home care costs and palliative home care costs is consistent with the primary objectives of federal health care policy.***

The Committee acknowledges that national parameters will have to be developed for both post-hospital home care and palliative care delivered out-of-hospital. This would be consistent with the original intent of the national health care insurance program. The Committee on Public Health Care Insurance Coverage could play a major role in this area. Therefore, the Committee recommends that:

**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.**

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<sup>390</sup> Volume One, pp. 35-36.

### 17.3 Accessibility

The principle of accessibility in the *Canada Health Act* stipulates that Canadians should have “reasonable access” to insured hospital and doctor services. However, the Act does not provide a clear definition as to what constitutes reasonable access. Although originally the primary concern was to eliminate financial barriers, lately the concern over access to health care has been associated primarily with the problem of waiting times. There is no doubt that a major problem of the current health care system is one of *timely* access. As stated earlier, it is the view of the Committee that “timely access” describes more accurately what Canadians expect from the publicly funded health care system than “reasonable access.”

The Committee believes that, since governments have the responsibility of providing funding sufficient to ensure an adequate supply of the essential services of hospitals and doctors, this responsibility carries with it the obligation to ensure reasonable standards of access. This is the essence of a patient-oriented system and of the health care “contract” between Canadians and their governments.

It is the view of the Committee that a maximum waiting time guarantee for publicly insured health services would meet this obligation. For this reason, we have, in Chapter Six, recommended establishment of a National Health Care Guarantee.

***In the view of the Committee, the National Health Care Guarantee is the essence of a patient-oriented system and of the health care “contract” between Canadians and their governments.***

How (and where) does a National Health Care Guarantee fit in the context of the *Canada Health Act*? There are a number of possibilities:

1. The health care guarantee could be added as a sixth principle to the Act. As such, provincial and territorial governments that failed to comply with the National Health Care Guarantee would be subject to the financial penalties currently present in the *Canada Health Act*.
2. The health care guarantee could be appended to the *Canada Health Act* or expressed in the preamble of the Act. This excludes the possibility of enforcement or penalty by the federal government.
3. The National Health Care Guarantee could be introduced in new legislation, similar to the *Canada Health Act*, but subject to different principles, different enforcement mechanisms and different penalties.

***The Committee has concluded that the National Health Care Guarantee would be most effective if implemented through legislation distinct from the Canada Health Act.***

The Committee has concluded that the National Health Care Guarantee would be most effective if implemented through legislation *distinct* from the *Canada Health Act*. A new Act giving effect to the National Health Care Guarantee would ensure that the definition of *timely* access to needed hospital and doctor services is set uniformly across the country and that the

federal government plays a major role in this guarantee. Therefore, the Committee recommends that:

**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.**

Another important provision of the *Canada Health Act* relating to the accessibility criterion is that insured people have uniform access to hospital and doctor services without any financial barrier. It is for this reason that user charges and extra-billing are not permitted for services covered under the *Canada Health Act*.

However, the question of whether patients should make a financial contribution with respect to the new publicly insured health services we recommend is one that should be addressed. The Committee believes that Canada’s public purse cannot afford first dollar coverage for the broader range of health services the Committee is recommending. We have suggested, therefore, in our proposal for catastrophic prescription drug cost coverage that individuals make a financial contribution to the cost of the prescription drugs they take.

***The question of whether patients should make a financial contribution with respect to new publicly insured health services is one that should be addressed. The Committee believes that Canada’s public purse cannot afford first-dollar coverage for the broader range of health services the Committee is recommending.***

Requiring some financial contribution from patients for the expanded set of publicly insured services is not consistent with the *Canada Health Act*. Therefore, it is not possible simply to add “catastrophic prescription drugs” to the current list of medically required services set out in the *Canada Health Act*.

The Committee’s proposal to expand public health care coverage to post-hospital home care for a three-month period and to insure at home palliative care costs appears to be consistent with both the spirit and the letter of the *Canada Health Act*. However, the Committee is recommending that this expansion in coverage be funded through a new cost-sharing mechanism totally different from the CHST. This additional federal funding will be subject to a number of conditions (including accountability and transparency) that are not currently found under the CHST or the *Canada Health Act*. Federal funding for coverage of catastrophic prescription drugs will also be provided through the new funding mechanism, not the CHST.

***The Committee believes that the expansion of public coverage to include catastrophic prescription drugs, post-hospital home care and palliative care in the home must be authorized through new federal legislation, and not under the Canada Health Act.***

For all these reasons, the Committee believes that the expansion of public coverage to include catastrophic prescription drugs, post-hospital home care and palliative care



in the home must be authorized through new federal legislation, and not under the *Canada Health Act* (see Section 17.6 below).

## 17.4 Portability

The portability criterion of the *Canada Health Act* requires that the provinces and territories extend medically necessary hospital and physician coverage to their residents during temporary absences (business or vacation) from the province or territory. This allows individuals to travel away from their home province or territory and yet retain their public health care insurance coverage. This portability requirement applies to emergency health services: residents must seek prior approval from their home province health care insurance plan for non-emergency (elective) health services provided out-of-province.

The principle of portability also applies when residents move from one province or territory to another: they must retain their coverage for insured health services by the “home” province during a minimum waiting period in the “host” province that does not exceed three months. After the waiting period, the new province or territory of residence assumes the responsibility for public health care coverage.

Canadians are also entitled to portable public health care insurance coverage when they are temporarily out of the country. Most provinces, however, limit the reimbursement of the cost of emergency health services obtained outside Canada under their public health care insurance. For this reason, Canadians are strongly encouraged to purchase supplementary private health care insurance when they travel in another country.

Within Canada, the portability provision of the *Canada Health Act* is generally implemented through bilateral reciprocal billing agreements among the provinces and territories for hospital and physician services. These agreements are interprovincial, not federal, and signing them is not a requirement of the *Canada Health Act*.<sup>391</sup> The rates prescribed within these agreements are those of the host province (apart from Quebec, which pays home-province rates), and the agreements are meant to ensure that Canadian residents travelling in another province/territory, for the most part, will not face any user charges at the point of service for medically required hospital and physician services.

Reciprocal billing is a convenient administrative arrangement. However, it is but one method of satisfying the portability criterion of the Act. A requirement for patients to pay “up front” and seek reimbursement from their home province or territory also satisfies the portability criterion of the Act as long as access to a medically necessary insured service is not denied based on the patient’s inability to pay.<sup>392</sup>

Overall, the principle of portability under the *Canada Health Act* provides Canadians with peace of mind when they travel within Canada or when they move from one province/territory to another. Perhaps more important, the principle of portability is closely

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<sup>391</sup> The Government of Quebec has not always been signatory to these agreements.

<sup>392</sup> At present, portability does not always apply to Quebec residents as many providers in other provinces will not treat Quebec residents if they do not pay the medical fees upfront. In many cases, this is not possible and Quebec residents have been transferred in ambulance for long distances in difficult circumstances back to Quebec.

linked to that of universality and it certainly encourages uniformity in public health care coverage.

The Committee believes that portability is an important national principle that should be maintained when expanding public coverage to catastrophic prescription drug costs, post-hospital home care and palliative care costs.

***The Committee believes that portability is an important national principle that should be maintained when expanding public coverage to catastrophic prescription drug costs, post-hospital home care and palliative care costs.***

## **17.5 Public Administration**

The public administration criterion of the *Canada Health Act* relates to the *administration* of provincial/territorial health care insurance plans for medically necessary health services. It stipulates that provincial/territorial health care insurance plans must be administered by a public agency on a not-for-profit basis. The principle of public administration was underlined in Volume Five under Principle One, which states that there should be a single funder/insurer – the government – for hospital and doctor services covered under the *Canada Health Act*.<sup>393</sup>

In the view of the Committee, a single funder system yields considerable efficiencies over any form of multi-funder arrangement, including administrative, economic and informational economies of scale. Furthermore, since a publicly funded hospital and doctor system has become a fundamental element of Canadian society, the Committee believes that the single funder should be government.

***In the view of the Committee, a single funder system yields considerable efficiencies over any form of multi-funder arrangement, including administrative, economic and informational economies of scale. Furthermore, since a publicly funded hospital and doctor system has become a fundamental element of Canadian society, the Committee believes that the single funder should be government.***

In Volume Five, we explained that a compelling argument for the retention of a single public funder or insurer for the hospital and doctor system is that Canadians support it strongly. The Committee agrees that this central element of our system must be maintained, *provided* that the system meets appropriate standards for high-quality services delivered in a timely manner.

Many witnesses told the Committee that giving primary financial responsibility to a single funder provides the Canadian health care system with a more efficient administration of health care insurance than is possible under a multi-funder system. They also testified that Canada's publicly financed single insurer system for medically necessary health services eliminates costs associated with the marketing of competitive health care insurance policies, billing for and collecting premiums, and evaluating insurance risks.

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<sup>393</sup> Volume Five, pp. 23-25.

Another strong argument in favour of public health care insurance is the fact that very few Canadians can afford not to be covered. It therefore makes sense to have everyone covered by a single plan. A single insurer system providing universal coverage also means that no one will deny themselves needed health care because they have what they feel to be a more pressing use for their money (perhaps for food, shelter, clothing, etc.). Nor will anyone be denied necessary care due to their inability to pay.

Yet another important advantage relates to the principle of risk sharing. The more who share the risk (all Canadians), the lower the cost of insuring against all risks.

The Committee also heard that a single insurer makes a lot of economic sense for Canadian industry and is an important element of Canadian competitiveness. This point was put eloquently by Paul Darby, Director of Economic Forecasting and Analysis, Conference Board of Canada, when he stated:

*(...) our largely single payer system has significant efficiency advantages, in general, and that these in turn help improve our industrial competitiveness. We should not lose these advantages.*<sup>394</sup>

A single funder model implies that there will not be, within Canada, a parallel, private insurance sector that competes with public insurance for the funding of hospital and doctor services under the *Canada Health Act*, at least in those hospitals and with those doctors that care for publicly insured patients.

Up to now, the single insurer model has discouraged the growth of a second tier of health care that many claim would pose a significant threat to Canada's publicly funded health care system. We point out, however, that parallel public and private health care systems exist in most other industrialized countries.

In Chapters Five, Six and Sixteen, the Committee has raised the concern that laws that, in effect, prevent the development of a parallel private system, and hence help preserve the principle of public administration of the *Canada Health Act*, may be struck down by the courts if the publicly funded and insured health care system fails to provide *timely* and quality care. Should this happen, the principle of public administration would have to be revisited. The Committee believes that, Through implementation of its recommendations, our publicly funded health care system can provide timely access to services of very high quality and that Canada's single insurer model for hospitals and doctors will be preserved.

***It is the hope of the Committee that Canada's single insurer model for hospitals and doctors will be preserved.***

As noted in Volume One, it is equally important to understand clearly what the public administration principle of the *Canada Health Act* does not mean. This principle refers to the *administration* of health care insurance coverage; it does not deal with the *delivery* of publicly insured health services. The Act does not prevent provinces and territories from allowing

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<sup>394</sup> Paul Darby, Brief to the Committee, 3 June 2002, p. 2.

private (for-profit and not-for-profit) health care providers, whether individual or institutional, to deliver, and be reimbursed for, provincially insured health services, so long as extra-billing or user charges are not involved. This is, in fact, what Canadian Medicare has been from the start – a national health care insurance program based primarily on the *private* (both for-profit and not-for-profit) *delivery of publicly insured* hospital and doctor services.

The Committee is concerned that the principle of public administration is poorly understood, particularly because of the confusion between administering public health care insurance and delivering publicly insured health services. We believe that the federal government, namely through Health Canada, should clearly articulate the meaning of “public administration” and make it clear that the *Canada Health Act* does not prohibit in any way the private delivery, either for-profit or not-for-profit, of publicly funded health services. This would greatly improve the current debate about health care in this country. Therefore, the Committee recommends that:

***In Volume One, the Committee noted that it is important to understand clearly what the public administration principle of the Canada Health Act does not mean. This principle refers to the administration of health care insurance coverage; it does not deal with the delivery of publicly insured health services.***

**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.**

While the Committee is convinced that the principle of public administration must be maintained for the hospital and doctor system, it would be very difficult in our view to extend it to the broader range of health services recommended in this report. This is particularly true with respect to the expansion of public coverage against catastrophic prescription drug costs.

***The Committee believes that the expansion of coverage to include catastrophic prescription drug costs should be based on a partnership between the public and the private sectors. This is why the recommendations made in Chapter Seven are based on the collaboration of public and private insurers to ensure universal coverage for catastrophic prescription drug costs.***

Prescription drug coverage is currently provided by many insurers, ranging from governments to private insurance companies. In fact, the private drug insurance industry is already well established in Canada and it appears to be functioning well. The Committee believes, and has recommended in Chapter Seven, that the expansion of coverage to include catastrophic prescription drug costs should be based on a partnership between the public and the private sectors to ensure universal coverage for catastrophic drug costs.

## **17.6 Committee Commentary**

The Committee has no hesitation in saying that in-depth reform of the publicly funded hospital and doctor system can take place within the five national principles of the *Canada Health Act*. We believe that the Act has served Canadians relatively well in terms of providing universal and uniform coverage for hospital and doctor services. We feel that the four patient-oriented principles of the Act should be maintained for hospital and doctor services, while the principle of public administration should be clarified.

However, the Committee believes that Canadian Medicare and the *Canada Health Act* must be supplemented by two new pieces of legislation. First, as explained in Section 17.3, new federal legislation must be enacted to implement the National Health Care Guarantee. This legislated health care guarantee will improve access to the set of hospital and doctor services that are currently insured under the *Canada Health Act*. Second, the Committee's proposal to expand public coverage also requires the enactment of new legislation:

- Coverage for catastrophic prescription drug costs requires the financial participation of both public plans and private insurers (collaboration that is not consistent with the principle of public administration of the *Canada Health Act*).
- Coverage for catastrophic prescription drug costs requires that individuals make a financial contribution to cover part of the cost of the insured service (this is not consistent with the first-dollar coverage contained under the principle of accessibility of the Act).
- Coverage for catastrophic prescription drugs, post-hospital home care for a period of three months and palliative home care costs will be funded through a federal funding mechanism that is distinct from the current CHST (the principles of the *Canada Health Act* relate to the CHST only).
- The Committee believes strongly that additional federal funding provided for the expansion of public coverage must be based on specific conditions related to transparency and accountability (these principles are totally absent from the *Canada Health Act*).

While principles other than those of the *Canada Health Act* are needed for the new programs proposed in the report, the underlying value related to those services, namely, providing high-quality services on the basis of need, should remain. Similarly, access to reasonably comparable

***The Committee believes that, while principles other than those of the Canada Health Act are needed, the underlying value of receiving services on the basis of need should remain.***

services for all Canadians everywhere in the country must be assured under the legislation covering the new programs. This comparability requires the development of national standards. These should apply to all publicly funded services, whether delivered by private for-profit, private not-for-profit or public health care providers and institutions. Therefore, the Committee recommends that:

**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.**

## CONCLUSION

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Two years ago, at the outset of the Committee's work, the Committee endorsed two major public policy objectives for Canada's health care system:

- To ensure that every Canadian has timely access to medically necessary health services regardless of his or her ability to pay for those services, and
- To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.

Implicit in these two objectives, particularly the first, is the requirement that the medically necessary services provided under Medicare be of high quality. Clearly, providing access to services of inferior quality would defeat the purpose of Canada's health care system.

In addition, the Committee recognized that the value of fairness is also an important component of Canadians' views of the health care system. This value of fairness underlies the patient-oriented principles of a universal, comprehensive, portable and accessible system that the Committee – and Canadians – strongly support.

But, to Canadians, fairness also means equity of access to the system – wealthy Canadians should not be able to buy their way to the front of waiting lists in Canada. Repeated public opinion polling data have shown that having to wait months for diagnostic or hospital treatment is the greatest concern and complaint that Canadians have about the health care system. The solution to this problem is not, as some have suggested, to allow wealthy Canadians to pay for services in a private health care institution. Such a solution would violate the principle of equity of access. The solution is the care guarantee as recommended in this report.

Based on evidence presented at Committee hearings over the past two years as well as on public opinion polling data, the Committee is also aware that Canadians believe that the current system is inefficient. Moreover, Canadians are not prepared to invest additional money into the system until these inefficiencies are eliminated. The Committee realizes that changing this public perception of an inefficient system will not be easy. It will require the introduction of *incentives* to encourage all the components of the system to function more efficiently. It will also require that the system function in a much more transparent and accountable fashion, including in the ways in which public money is spent.

In formulating its recommendations, the Committee also took account of two additional factors. First, the Committee believes that if the second public policy objective given above – the no undue financial hardship objective – is to be met, steps must be taken *now* to begin to close the major gaps in the health care safety net. While the Committee believes that Canadians who are genuinely in need of help, and cannot afford to pay for it, should receive the assistance they need from public funds, this does not mean that what is needed are new first-dollar coverage programs in areas such as pharmacare or home care. In the Committee's view prudence requires that any expansion of the current system to begin to close the gaps in it must be done in small, manageable steps.

The second factor that is reflected in the Committee's recommendations is the belief that anyone proposing a plan to reform and renew the health care system has an obligation to say how their plan of reform will be paid for. Moreover, the payment method must be described in terms that are meaningful to individual Canadians.

The only way Canadians can develop an informed opinion on the merits of a proposed plan of reform is if they can clearly understand the benefits that will result from the plan, and what it will cost them to have the plan implemented.

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It is for this reason that the Committee has taken the extremely unusual (some have even described it as unique) step of both costing our recommendations *and* putting forward a recommended option for raising the new federal revenue required to implement fully our recommendations. To fail to do this would, in our view, perpetuate the myth that health care is a “free” good. This would play directly into the hands of those who oppose reform. Not to give a revenue-raising plan would also mean that the Committee had failed to meet the test of transparency and accountability, which it has insisted throughout its recommendations must apply to the health care system as a whole.

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The Committee understands that the implementation of its set of recommendations will require considerable *behavioral change on the part of all participants* in the health care system. For example:

- The change to service-based funding will alter the way in which hospitals are managed. It will make hospital management, and the health care professionals working in a hospital, much more conscious of which procedures they do efficiently and which they do inefficiently. It will also mean that hospitals in large urban areas will face competition from other hospitals and specialist clinics.
- The changes involved in primary health care reform will require family physicians to accept changes to the way they are remunerated (by replacing straight fee-for-service by a remuneration model that is primarily capitation with an added component of fee-for-service). It 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 use of patient electronic health records. (As explained in Chapter 10, the Committee believes that a system of electronic health records can be built, and the resulting information system operated, in a manner that is entirely consistent with the spirit as well as the letter of privacy laws.)
- Provincial/territorial 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/territorial 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 by allowing the system of incentives, with its associated behavioral change, to generate the desired results.
- The federal government will have to agree to the creation of an arms-length 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. This is an essential step in restoring public confidence in the system.
- 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. Included in this infrastructure are the nation's 16 Academic Health Sciences Centres, the national supply of human resources in the health care sector, technology, information systems and research.
- 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 chronic disease prevention.

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. This increased information is needed for the following reasons:

- first, to make more transparent the processes by which resource allocation decisions are made – principally with regard to money, but also including human resources;
- second, to enhance the accountability of the people, institutions and governments that decide what types of services will be covered by public health care insurance and how much of any particular service will be provided;
- third, and perhaps most important, to change the public debate from a debate about dollars to a debate about services and service levels.

Canadians have a right to debate the question of whether they are willing to pay more for improved levels of service, and they have a right to understand the linkages between funding levels and service levels. Changing the nature of the public debate about health care will mark a significant step towards gaining public support for restructuring and renewing the publicly funded hospital and doctor system.

The Committee fully recognizes that its set of recommendations will be subject to close critical scrutiny. This is entirely understandable in such a value-laden public policy issue as health care. In fact, it is likely that each reader of this report will support his or her own unique subset of recommendations.

We ask readers, however, 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.

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Similarly, 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.

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## **APPENDIX A**

### **LIST OF RECOMMENDATIONS BY CHAPTER**

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#### **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 federal 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-served 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.



## APPENDIX B

### **LIST OF PRINCIPLES FROM VOLUME FIVE (APRIL 2002)**

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The following principles, enunciated in Volume Five, have guided the Committee in developing the detailed plan of action outlined in this report.

#### **THE INSURER:**

1. There should be a single funder (insurer) – the government either directly or through an arm's length agency – for hospital and doctor services covered under the *Canada Health Act*.
2. There should be stability of, and predictability in, government funding for public health care insurance.
3. The federal government should play a major role in sustaining a national health care insurance system.
4. The determination of what should be covered under public health care insurance should be done through an open and transparent process. Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.
5. The federal government should contribute on an ongoing basis to fund health care technology.
6. The federal government should increase its investment in those areas of health and health care for which it already has a major responsibility.
7. The consequences arising from changes in the level or amount of government funding for hospital and medical care should be clearly understood by government and explained to the public, in as much detail as possible, at the time such changes are made and announced.

## **THE PROVIDER:**

8. In the first stage of health care reform, the method for remunerating hospitals should be changed from the current annual global budget to service-based funding.
9. Regional health authorities should have the responsibility for purchasing hospital services provided by institutions within their region.
10. Primary care renewal should lead to the provision of primary care by group practices, or clinics, which operate twenty-four hours a day, seven days a week.
11. To facilitate primary care reform, the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards.
12. New scope of practice rules and other measures need to be developed in order to enable all health care providers in the primary care sector to provide the full range of services for which they have been trained.
13. In the second stage of health care reform, an “internal market” should probably be created in which primary health care teams would purchase health services provided by hospitals and other health care institutions on behalf of their patients.
14. A national (not exclusively federal) strategy must be developed to achieve both an adequate supply and optimal use of health care providers.

## **THE EVALUATOR:**

15. Accountability and transparency in health care financing and delivery require the deployment of a system of electronic health records (EHR) that can capture and translate information on system performance and outcomes.
16. Measuring treatment outcomes and system performance must become an essential part of the health information system. Such monitoring and evaluation of the health care delivery system should be performed independently at the national (not federal) level and be funded by government.



**THE PATIENT:**

17. Canada's publicly funded health care system should be patient-oriented.
18. Incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees for services that are deemed to be medically necessary.
19. Programs that enable people to be responsible for their own health and to stay healthy must be given high priority. The federal government can play a leadership role in this regard.
20. For each type of major procedure or treatment a maximum waiting time should be established, and made public. When this maximum time is reached, the insurer (government) shall pay for the patient to receive immediately the procedure or treatment in another jurisdiction including, if necessary, another country



## APPENDIX C

### LIST OF WITNESSES

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#### 1<sup>ST</sup> SESSION OF THE 37<sup>TH</sup> PARLIAMENT

##### **Wednesday, April 24, 2002**

*Ontario Health Services Restructuring Commission:*  
Dr. Duncan Sinclair, Former Commissioner

##### **Thursday, April 25, 2002**

*Health Canada:*  
Marcel Nouvet, Assistant Deputy Minister, Information Analysis and Connectivity Branch  
Michel Léger, Executive Director, Strategic Alliances and Priorities Division, Information Analysis and Connectivity Branch

##### **Wednesday, May 1, 2002**

*Canadian Institute for Health Information:*  
Michael Decter, Chairman, Board of Directors

##### **Monday, May 6, 2002**

*Calgary Health Region:*  
Jack Davis, President and CEO

*As an individual:*  
Claude Forget, Former Minister of Health, Province of Quebec  
*Dalhousie University:*  
Dr. Nuala Kenny, Professor of Pediatrics and Chair, Department of Bioethics

*St. Michael's Hospital:*  
Jeffrey Lozon, President and CEO

*As an individual:*  
Graham Scott, Former Deputy Minister of Health, Province of Ontario

*Royal Columbian Hospital:*  
Dr. Les Vertesi, Medical Director

##### **Wednesday, May 8, 2002**

*As an individual:*  
The Honourable Monique Bégin, P.C.

##### **Thursday, May 9, 2002**

*Dalhousie University:*  
Professor Lawrence Nestman, School of Health Services Administration

**Wednesday, May 22, 2002***Canadian Medical Association:*

Dr. Peter Barrett, Past President

Dr. Susan Hutchison, Chair, GP Forum

*Ontario Medical Association:*

Dr. Elliot Halparin, President

Dr. Kenneth Sky, Past President

*Ontario Hospital Association:*

Mark Rochon, Member, Advocacy Committee

*Association of Canadian Academic Health Care Organizations:*

Glenn G. Brimacombe, CEO

*University Health Network:*

Kevin Empey, Chief Financial Officer

**Wednesday, May 29, 2002***Capital Health Authority:*

Dr. Ken Gardener, Vice-President, Medical Affairs

*Ontario Family Health Network:*

Dr. Ruth Wilson, Chair

Donna Segal, CEO

**Thursday, May 30, 2002***McMaster University – Centre for Health Economics and Policy Analysis (CHEPA):*

Dr. Brian Hutchison

*University of Guelph:*

Professor Brian Ferguson, Department of Economics

**Monday, June 3, 2002***University of Toronto, Department of Health Policy, Management and Evaluation:*

Professor Raisa Deber

*University of British Columbia:*

Professor Roberts G. Evans

*Canadian Taxpayers Federation:*

Walter Robinson, Federal Director

*The Conference Board of Canada:*

Paul Darby, Director, Economic Forecasting

*As an individual:*

David Kelly

**Wednesday, June 5, 2002**

*Canadian Healthcare Association:*

Sharon Sholzberg-Gray, President and CEO  
Larry Odegard, CEO, Forum

*Canadian Association of Chain Drug Stores:*

Lori Turik, Vice-President, Public Affairs  
Deb Saltmarche, Director of Pharmacy

**Thursday, June 6, 2002**

*Canadian Nurses Association:*

Ginette Lemire Rodger, President  
Robert Calnan, President-Elect

*Canadian Practical Nurses Association:*

Kelly Kay, Representative

**Wednesday, June 12, 2002**

*C.D. Howe Institute:*

Jack Mintz, President and CEO

**Thursday, June 13, 2002**

*Association of Canadian Academic Health Care Organizations:*

Glenn Brimacombe, CEO

*St. Michael's Hospital:*

Jeffrey Lozon, President and CEO

*McGill University Health Centre:*

Dr. Hugh Scott, Executive Director

*Applied Management:*

Bryan Ferguson, Partner

*Fraser Group:*

Ken Fraser

*Tristat Resources:*

Richard Shillington, Principal

**Monday, June 17, 2002 (9:00 a.m.)**

(By videoconference)

*Government of Denmark:*

John Erik Petersen, Head of Department, Ministry of Health and the Interior  
Dr. Steen Friberg Nielsen, CEO, Top Management Academy  
Morten Hjulsgaard, Head of Department, National Informatics, National Board of Health  
Dr. Arne Kverneland, Head of Division of Medical Informatics, National Board of Health

**Monday, June 17, 2002 (12:30 p.m.)**

*Government of New Brunswick, Department of Health and Wellness:*  
Cheryl Hansen, Director, Extra-Mural Program

*University of Toronto, Home Care Evaluation Research Centre:*  
Peter Coyte, Co-Director

*Hollander Analytical Services:*  
Marcus Hollander

*Canadian Council of Chief Executives:*  
David Stewart-Patterson, Senior Vice President, Policy

**VOLUME FIVE (October 15, 2001 – March 7, 2002)**

**Monday, October 15, 2001**

*University of Manitoba:*  
Linda West, Professor, Asper School of Business

*Frontier Centre for Public Policy:*  
Peter Holle, President

*Western Canadian Task Force on Health Research and Economic Development:*  
Dr. Henry Friesen, Team Leader  
Dr. John Foerster  
Dr. Audrey Tingle  
Chuck Laflèche

*Regional Health Authorities of Manitoba*  
Bill Bryant, Chair, Council of Chairs  
Kevin Beresford, Chair, Council of CEOs  
Randy Lock, Executive Director

*Manitoba Centre for Health Policy and Evaluation:*  
Dr. Nora Lou Roos

*Women's Health Clinic:*  
Madeline Boscoe, Advocacy Coordinator

*Hospice and Palliative Care Manitoba:*  
Dr. Paul Henteleff, Chair, Advocacy Committee  
John Bond, Member of Advocacy Committee  
Margaret Clarke, Executive Director

*Canadian Union of Public Employees in Manitoba (CUPE):*  
Paul Moist, President  
Lorraine Sigurdson, Health Care Coordinator

*Société franco-manitobaine:*  
Daniel Boucher, Chief Executive Officer

*As a walk-on:*  
Barry Shtatleman

**Tuesday, October 16, 2001***Saskatchewan Registered Nurses' Association:*

June Blau, President

*Victorian Order of Nurses:*

Bob Layne, Vice-President, Planning and Government Relations (Western Region)

Lois Clark, Executive Director, VON North Central Saskatchewan

Brenda Smith, National Board Member (Saskatchewan)

*Community Health Services (Saskatoon) Association:*

Kathleen Storrie, Vice-President

Ingrid Larson, Director, Member Relations

*As an individual:*

Dr. John Bury

*Canadian Union of Public Employees (CUPE) Saskatchewan:*

Tom Graham, President, CUPE Saskatchewan

Stephen Foley, President, Health Care Council

John Welden, Health Care Coordinator, Health Care Council

*Saskatoon Chamber of Commerce:*

Dave Ductchak, President

Kent Smith-Windsor, Executive Director

Jodi Blackwell, Research and Operations Director

*Arthritis Society of Saskatchewan:*

Sherry McKinnon, Executive Director

Joy Tappin, Board Member

*Canadian Parks and Recreation:*

Randy Goulden, Executive Director, Tourism Yorkton

*Métis National Council:*

Gerald Morin, President

Don Fidler, Director, Health Care

**Wednesday, October 17, 2001***Premier's Advisory Council on Health (Alberta):*

The Right Honourable Don Mazankowski, P.C., Chair

Peggy Garritty

*Department of Health and Social Services (Nunavut):*

The Hon. Edward Picco, Minister

*Calgary Health Region:*

Jack Davis, CEO

*Capital Health Authority:*

Sheila Weatherill, President and CEO

*Canadian Practical Nurses Association:*

Pat Fredrickson, President

*University of Alberta - Faculty of Nursing:*  
Dr. Donna Wilson

*Health Sciences Association of Alberta:*  
Elisabeth Ballermann, President

*Alberta Association of Registered Nurses:*  
Sharon Richardson, President

*United Nurses of Alberta:*  
Heather Smith, President

*Friends of Medicare:*  
Christine Burdett, Provincial Chair  
Tammy Horne, Member

*As an individual:*  
Kevin Taft, MLA

*Western Canada Waiting List Project:*  
John McGurran, Project Director

*Primary Care Initiative:*  
Dr. June Bergman

*Alberta Consumers Association:*  
Wendy Armstrong

*Fédération des communautés francophones et acadiennes du Canada :*  
George Arès, President

*National Advisory Council on Aging:*  
Pat Raymaker, Chairwoman

*Alberta Council on Aging:*  
Neil Reimer, Secretary/Treasurer

*Nechi Institute:*  
Ruth Morin, Chief Executive Officer  
Richard Jenkins, Director of Marketing and Health Promotion

*Executive of the Alberta and Northwest Conference of the United Church of Canada - Health Advisory Committee:*  
Louise Rogers  
Kent Harold  
Don Junk

*As a walk-on:*  
Noel Somerville

**Thursday, October 18, 2001**

*Commission on Medicare, Saskatchewan:*  
Ken Fyke, Former Chair

*Tommy Douglas Research Institute:*  
Dave Barrett, Chair  
Marc Eliesen, Co-Chair



*Market-Media International Corporation:*  
Joan Gadsby, President

*University of British Columbia, Family Practice Residency Program:*  
Dr. J. Galt Wilson, Program Director - Prince George Site

*University of British Columbia:*  
Dr. John A. Cairns, Dean of Medicine  
Dr. Joanna Bates, Associate Dean, Admissions

*Health Professions Council:*  
Dianne Tingey, Member  
Gerry Fahey, Research Director

*Cambie Surgery Centre:*  
Dr. Brian Day, Founder

*As an individual:*  
Cynthia Ramsay, Health Economist

*Health Association of British Columbia:*  
Lorraine Grant, Chair of the Board of Directors  
Lisa Kallstrom, Executive Director

*University of British Columbia:*  
Dr. John H. V. Gilbert, Coordinator of Health Sciences

*University of British Columbia - Vancouver Hospital and Health Sciences Centre:*  
Professor Charles Wright, Director, Centre for Clinical Epidemiology and Evaluation

*University of British Columbia – Centre for Health Services and Policy Research:*  
Professor Barbara Mintzes

*Professional Association of Residents of British Columbia:*  
Dr. Kristina Sharma

**Friday, October 19, 2001**

*Canadian Medical Association:*  
Dr. Peter Barrett, Past President  
Dr. Arun Garg, Chair, Council on Health Policy and Economics

*British Columbia Medical Association:*  
Dr. Heidi Oetter, President  
Darrell Thomson, Director, Economics and Policy Analysis

*University of British Columbia, Anxiety Disorders Unit, Department of Psychiatry:*  
Dr. Peter D. McLean, Professor and Director

*Maples Surgical Centre (Manitoba)*  
Dr. Mark Godley

**Monday, October 29, 2001**

*Canadian Radiation Oncology Services:*

Dr. Thomas McGowan, President and Medical Director

*Canadian Taxpayers Federation:*

Walter Robinson, Federal Director

*Canadian Council of Churches:*

Stephen Allen, Member of Commission for Justice and Peace and Co-Chair of the Commission's Ecumenical Health Care

*Buffett Taylor Employee Benefits and Workplace Wellness Consultants:*

Edward Buffett, President and CEO

*As an individual:*

Michael Rachlis

*Medical Reform Group:*

Dr. Joel Lexchin

*At Work Health Solutions Inc.:*

Dr. Arif Bhimji, Founder and President; Medical Director of Liberty Health  
Gery Barry, President and CEO of Liberty Health

*Consumers' Association of Canada:*

Jean Jones, Chair of the Health Committee  
Mel Fruitman, President

*Ontario Association of Optometrists:*

Dr. Joseph Chan

*Medical Devices Canada (MEDEC):*

Peter Goodhand, President

*AstraZeneca:*

Gerry McDole, President and CEO

*Comcare Health Services:*

Mary Jo Dunlop

*Saint Michael's Hospital:*

Jeffrey Lozon, President and CEO

*Association of Ontario Health Centres:*

Gary O'Connor, Executive Director

*Ontario Medical Association:*

Kenneth Sky, President

*The Arthritis Society:*

Denis Morrice, President and CEO

*SMARTRISK:*

Dr. Robert Conn, President and CEO

*Canadian Cancer Society:*

Dr. Barbara Whyllie, Director, Cancer Control Policy

Cheryl Mayer, Director, Cancer Control Programs, Alcohol and Drug Recovery Association of Ontario, and  
Addiction Intervention Association

Jeff Wilbee, Executive Director

**Tuesday, October 30, 2001**

*Canadian Institute for Health Information:*

Michael Decter, Chairman, Board of Directors

*Ontario Hospital Association:*

David MacKinnon, President and CEO

*Registered Nurses Association of Ontario:*

Doris Grinspun, Executive Director

*McMaster University Department of Economics:*

Jeremiah Hurley, Professor

*University of Toronto Public Health Science Department:*

Dr. Cameron Mustard, Professor

*University of Toronto:*

Colleen Flood, Professor

*Drug Trading Company Limited:*

Larry Latowsky, President and CEO

Jane Farnharm, Vice President, Pharmacy

*Canadian Pharmacists Association:*

Ron Elliott, President

*GlaxoSmithKline:*

Geoffrey Mitchinson, Vice-president, Public Affairs

*Medtronic:*

Donald A. Hurley, President

*Canadian Association for the Fifty Plus:*

Dr. Bill Gleberzon, Associate Executive Director

Lilian Morgenthal, President

*Canadian Association for Community:*

Cheryl Gulliver, President

Connie Laurin-Bowie

Margot Easton

*Roeher Institute:*

Cameron Crawford, President

*As individuals:*

Clement Edwin Babb

Robert S.W. Campbell

**Wednesday, October 31, 2001***As individuals:*

The Honourable Claude Forget

The Honourable Claude Castonguay

André-Pierre Contandriopoulos, Professor, Faculty of Medicine, University of Montreal

*Hôtel Dieu Hospital:*

Dr. Serge Boucher

*Conseil du patronat du Québec:*

Gilles Taillon, President

*Canadian Chamber of Commerce:*

Nancy Hughes-Anthony, President and Chief Executive Officer

Michael N. Murphy, Senior Vice-President, Policy

*As individuals:*

Jean-Luc Migué

Lee Soderstrom, Professor, Department of Economics, McGill University

*Montreal Economic Institute:*

Michel Kelly-Gagnon, Executive Director

Dr. Edwin Coffey, Retired Associate Professor, Faculty of Medicine, McGill University, and Former President of the Quebec Medical Association

*Frosst Health Care Foundation:*

Dr. Monique Camerlain, President of the Board of Directors

Janet Dunbrack, Executive Director.

**Thursday, November 1, 2001***Association des optométristes du Québec:*

Dr. Langis Michaud, President

Marie-Josée Crête, Deputy Director General

Clairmont Girard, Advisor

*Collège des médecins du Québec:*

Dr. Yves Lamontagne, President

Dr. André Garon, Deputy Secretary General

*As an individual:*

Robert Dorion

*Canadian Life and Health Insurance Association:*

Mark Daniels, President

Greg Traversy, Executive Vice-President

Yves Millette, Senior Vice-President, Quebec Affairs

Frank Fotia, Vice-President, Group Insurance.

*As individuals:*

Dr. Margaret Somerville, Acting Director, McGill Centre for Medicine, Ethics and Law, McGill University

Dr. Robyn Tamblyn, Associate Professor, Department of Economics, McGill University

*Merck Frosst Canada Ltd.:*

Kevin Skilton, Director, Policy Planning

Dr. Terrance Montague, Executive Director, Patient Health

*Association québécoise des droits des retraités (AQDR):*  
Ann Gagnon, Advisor on Health  
Yollande Richer, Vice-President, Communications  
Myroslaw Smereka, Director General

**Monday, November 5, 2001**

*Department of Health and Community Services, Newfoundland:*  
Robert C. Thompson, Deputy Minister  
Beverly Clarke, Assistant Deputy Minister

*Victorian Order of Nurses (VON Canada):*  
Patricia Pilgrim, President, St. John's Branch  
Bernice Blake Dibblee, Executive Director, St. John's Branch

*Association of Registered Nurses of Newfoundland and Labrador:*  
Sharon Smith, President

*Canadian Union of Public Employees, Newfoundland:*  
Wayne Lucas, President

*As an individual:*  
Maud Peach

*National Cancer Institute of Canada:*  
Dr. Roy West, President

*Health and Community Services, Newfoundland:*  
Dr. Catherine Donovan

*Weight Watchers:*  
Marlene Bayers, Regional Manager

*Newfoundland Cancer Treatment and Research Foundation:*  
Bertha H. Paulse, Chief Executive Officer

*As an individual:*  
Karen McGrath, Executive Director of Health and Community Services St. John's Region

**Tuesday, November 6, 2001**

*Canadian Auto Workers (CAW):*  
Cecil Snow, President, Nova Scotia Health Care Council

*Nova Scotia Association of Health Organizations:*  
Robert Cook, President and CEO

*Insurance Bureau of Canada:*  
George Anderson, President and CEO  
Paul Kovacs, Senior Vice-President, Policy, and Chief Economist

*Canadian Coalition Against Insurance Fraud:*  
Mary Lou O'Reilly, Executive Director

*Atlantic Institute for Market Studies:*  
Dr. David Zitner, Fellow on Health Policy

*Dalhousie University:*

Nuala Kenny, Professor of Pediatrics and Chair, Department of Bioethics  
Dr. Vivek Kusumakar, Head, Mood Disorders Research Group, Department of Psychiatry  
Lawrence Nestman, Professor, School of Health Services Administration

*Nova Scotia Valley Caregivers Support Group:*

Maxine Barrett

*Elizabeth May Chair in Women's Health and the Environment, Dalhousie University:*

Sharon Batt, Chair

*Feminists for Just and Equitable Public Policy:*

Ms. Georgia MacNeil, Chair Person

*Cape Breton Regional Health Care Complex:*

John Malcom, CEO

Dr. Mahmood Naqvi, Medical Director, Cape Breton Regional Facility

*Capital District Health Authority:*

Dr. John Ruedy, Vice-President, Academic Affairs

*Dalhousie University:*

Thomas Rathwell, Professor and Director, School of Health Services Administration

*Canadian Medical Association:*

Dr. Henry Haddad, MD, President

Bill Tholl, Secretary General

Dr. Bruce Wright, President of the Medical Society of Nova Scotia

Dr. Dana W. Hanson, President-Elect

*Dalhousie University:*

Dr. Desmond Leddin, Head, Division of Gastroenterology

Dr. George Kephart, Director, Population Health Research Unit, Department of Community and Epidemiology

Dr. Kenneth Rockwood, Faculty of Medicine, Division of Geriatric Medicine

*Cobequid Community Health Board:*

Ryan Sommers

*Health Canada:*

Anne-Marie Leger, Policy Analyst

**Wednesday, November 7, 2001**

*Department of Health and Social Services, Prince Edward Island:*

The Honourable Jamie Ballem, Minister

*PEI Seniors Advisory Council:*

Heather Henry-MacDonald, Chair

*Canadian Union of Public Employees, PEI Division:*

Bill A. McKinnon, National Representative

Ms. Donalda MacDonald, President

Raymond Léger, Research Representative

*Department of Health and Social Services:*

Mary Hughes-Power, Director of Acute and Continuing Care

Deborah Bradley, Manager of Public Health Policy

*College of Family Physicians of Canada:*

Dr. Peter MacKean, Chairman of the Board

*Queen Elizabeth Hospital:*

Iain Smith, Drug Utilization Coordinator

*PEI Pharmacy Board:*

Neila Auld, Executive Director, PEI

*Queen's Regional Health Authority:*

Sylvia Poirier, Chair

*West Prince Regional Health Authority:*

Ken Ezeard, Chief Executive Officer

*Department of Health and Social Services:*

Dr. Don Ling, Director of Medical Services

*Department of Health and Social Services, Prince Edward island:*

Rory Francis, Deputy Minister

Bill Harper, Assistant Deputy Minister

Jean Doherty, Communications Coordinator

*Southern Kings Health Authority:*

Betty Fraser, Chief Executive Officer

*Department of Health and Social Services:*

Susan Maynard, Senior Health Planner

Kathleen Flanagan-Rochon, Community Services Coordinator

*Evangeline Health Centre:*

Elise Arsenault, Coordinator

*East Prince Regional Health Authority:*

David Riley, Chief Executive Officer

*Dalhousie University:*

Dr. Stan Kutcher, Department Head of the Community Health and Epidemiology/ Psychiatry

**Thursday, November 8, 2001**

*Faculty of Nursing, University of New Brunswick:*

Dr. Margaret Dykeman

*New Brunswick Health Care Association:*

Robert Simpson, Chief Executive Officer

*Canadian Association of Chain Drug Stores:*

Sherry Porter, Atlantic Canada Representative

Sandra Aylward, Vice President, Pharmacy Services

*As individuals:*

Dr. Russell King, Former Minister of Health, Province of New Brunswick  
William Morrissey, Former Deputy Minister of Health, Province of New Brunswick

*Applied Management:*

Bryan Ferguson, Partner

*Société des Acadiens et Acadiennes du Nouveau-Brunswick:*

Daniel Thériault, Director General

*Canadian Snowbird Association:*

Bob Jackson, President

*New Brunswick Senior Citizens Federation Inc.:*

Helen Ladouceur, Member

Eilleen Malone, Member

*Catholic Health Association of Canada:*

Sandra Keon, Secretary Treasurer; and Vice-President of Clinical Programs, Pembroke Hospital

*Miramichi Police Force:*

Michael Gallagher, Corporal, Drug Section

*Canadian Union of Public Employees, New Brunswick:*

Raymond Léger, Research Representative

*Federal Superannuates National Association:*

Rex G. Guy, National President

Roger Heath, Research and Communications Officer

*Union of New Brunswick Indians:*

Nelson Solomon, Director of Health

Wanda Paul Rose, Coordinator

Norville Getty, Consultant

*Nurses Association of New Brunswick:*

Roxanne Tarjan, Director General

**Thursday, February 21, 2002**

*Canadian Federation of Nurses Unions:*

Kathleen Connors, President

*Canadian Health Coalition:*

Dr. Arnold Relman, Former editor of *New England Journal of Medicine*

Michael McBane, National Coordinator

*Federal Superannuates National Co-ordinator:*

Rex G. Guy, National President

Roger Heath, Research and Communications Officer



**Thursday, March 7, 2002**

*Canadian Healthcare Association:*

Sharon Sholzberg-Gray, President and CEO

Kathryn Tregunna, Director, Policy Development

*Canadian Labour Congress:*

Kenneth V. Georgetti, President

Cindy Wiggins, Senior Researcher, Social and Economic Policy Department

**VOLUME THREE (May 28, 2001 – June 14, 2001)**

**Monday, May 28, 2001**

*(By videoconference)*

*From the Ministry of Health, Welfare and Sports of the Netherlands:*

Dr. Hugo Hurts, Deputy Director, Health Insurance Division, Ministry of Health, Welfare and Sports of the Netherlands

*From the International Institute of Social Studies of the Netherlands:*

Professor James Bjorkman

**Thursday, June 7, 2001 (9:00 a.m.)**

*(by videoconference)*

*Swedish Parliament (Riksdag):*

Lars Elinderson, Deputy member, Committee on Health and Welfare

**Monday, June 11, 2001**

*(By videoconference)*

*German Health Ministry:*

Georg Baum, Director General, Head of Directorate Health Care

Dr. Margot Faelker, Deputy-Director, Section Financial Issues of Statutory Health Insurance

Dr. Rudolf Vollmer, Director-General, Head of Directorate Long-Term Nursing Care Insurance

*Department of Health – Economic and Operational Research Division of the United Kingdom:*

Clive Smee, Chief Economic Adviser

*University of Birmingham:*

Professor Chris Ham, Director, Health Services Management Centre

*London School of Economics:*

Professor Julien LeGrand, Richard Titmuss Professor of Social Policy, LSE Health & Social Care

**Tuesday, June 12, 2001**

*(By videoconference)*

*Australian Institute of Health and Welfare:*

Dr. Richard Madden, Director

*Australian Health Insurance Association:*

Russel Schneider, CEO

*National Centre for Epidemiology and Population Health – Australian National University*  
Dr. Tony Adams, Professor of Public Health

*Health Insurance Commission:*  
Dr. Brian Richards

*Australian Medical Association:*  
Dr. Carmel Martin, Director  
Dr. Roger Kilham

**Wednesday, June 13, 2001**

*Health Canada:*  
Ake Blomqvist, Visiting Academic, Applied Research and Analysis Directorate, Information, Analysis and Connectivity Branch and Professor, University of Western Ontario

*University of Calgary:*  
Professor Cam Donaldson, Department of Economics

*University of Toronto (by videoconference):*  
Professor Colleen Flood, Faculty of Law

*As an individual:*  
Claude Forget

*University of Toronto:*  
Professor Mark Stabile, Department of Economics  
Professor Carolyn Tuohy, Department of Political Science

**Thursday, June 14, 2001**

*(by videoconference)*

*U.S. Department of Health and Human Services:*  
Christine Schmidt, Deputy to the Deputy Assistant Secretary for Health Policy, Office of the Assistant Secretary for Planning and Evaluation  
Ariel Winter, Analyst  
Tanya Alteras, Analyst

**VOLUME TWO (March 21 2001 - June 7 2001)**

**Wednesday, March 21, 2001**

*Statistics Canada:*  
Réjean Lachapelle, Director, Demography Division  
Jean-Marie Berthelot, Manager, Health Analysis and Modeling Group, Social and Economic Studies Division  
Brian Murphy, Senior Research Analyst, Socio-Economic Modeling Group

*Canadian Institute of Actuaries:*  
David Oakden, President  
Rob Brown, Manager of Task Force on Health Care Financing  
Daryl Leech, Chair, Committee on Health Care

*National Advisory Council on Aging:*  
Dr. Michael Gordon, Member

*Conference Board of Canada:*  
James G. Frank, Ph.D., Chief Economist and Vice-President  
Glenn Brimacombe, Director of Health Program

**Thursday, March 22, 2001**

*C.D. Howe Institute:*  
William B.P. Robson, Vice-President and Director of Research

*McMaster University:*  
Byron G. Spencer, Professor

*University of Ottawa:*  
Dr. William Dalziel

**Wednesday, March 28, 2001**

*IMS Health Canada:*  
Dr. Roger A. Korman, President

*Canadian Association of Pharmacists:*  
Dr. Jeff Poston, Executive Director

*Health Promotion Research:*  
Dr. Robert Coombs, President and CEO

*Health Canada:*  
Barbara Ouellet, Director of Home Care and Pharmaceuticals, Health Care Directorate, Policy and Consultation Branch

**Thursday, March 29, 2001**

*Canadian Association of Radiologists:*  
Dr. John Radomsky

**Thursday, March 29, 2001 (cont'd)**

*Canadian Coordinating Office for Health Technology Assessment (CCHOTA):*  
Dr. Jill Sanders, President and CEO

*The Fraser Institute:*  
Martin Zelder, Director of Health Policy Research

*As an individual:*  
Professor David Feeny

**Wednesday, April 4, 2001**

*Health Canada:*  
Dr. Christina Mills, Director General, Centre for Chronic Disease Prevention and Control – Population Public Health Branch  
Dr. Paul Gully, Acting Director General, Centre for Infectious Disease Prevention and Control  
Dr. Clarence Clotney, Acting Director, Diabetes Division, Bureau of Cardio-Respiratory Diseases and Diabetes, Centre for Chronic Disease prevention and Control  
Nancy Garrard, Director, Division of Aging and Seniors

*Dalhousie University:*

Dr. David MacLean, Departmental Head, Community Health and Epidemiology

**Thursday, April 5, 2001**

*Health Canada:*

Abby Hoffman, Director General, Health Care Directorate – Health Policy and Communications Branch

Cliff Halliwell, Director General, Applied Research & Analysis Directorate, Information, Analysis and Connectivity Branch

Nancy Garrard, Director, Division of Aging and Seniors

**Thursday, April 26, 2001**

*Canadian Institute of Health Research:*

Dr. Alan Bernstein, President

*Health Canada:*

Kimberly Elmslie, Acting Executive Director, Health Research Secretariat

*Statistics Canada:*

T. Scott Murray, Director General, Institutions and Social Statistics Branch

**Wednesday, May 9, 2001**

*Canada's Research-Based Pharmaceutical Companies:*

Murray Elston, President

*Coalition for Biomedical and Health Research:*

Dr. Barry McLennan, Chairman

Charles Pitts, Executive Director

*Centre for Excellence for Women's Health:*

Dr. Pat Armstrong

*Canadian Genetic Diseases Network:*

Dr. Ronald Worton, CEO & Scientific Director

**Thursday, May 10, 2001**

*Health Canada:*

William J. Pascal, Director General, Office of Health and Information Highway, Information, Analysis and Connectivity Branch

*Canadian Institute for Health Information:*

Dr. John S. Millar, Vice-President, Research and Analysis

*Canadian Society of Telehealth:*

Dr. Robert Filler, President

*Department of Health and Wellness of New Brunswick*

David Cowperthwaite, Director of Information System

**Wednesday, May 16, 2001**

*Canadian Medical Association:*  
Dr. Peter Barrett, President

*Canadian Medical Forum Task Force 1:*  
Dr. Hugh Scully, President

*Federal Provincial Territorial Advisory Committee on Health Human Resources:*  
Dr. Thomas Ward, Chair

*Canadian Nurses Association:*  
Sandra MacDonald-Remecz, Director of Policy, Regulation and Research

*Canadian Federation of Nurses Unions:*  
Kathleen Connors, President

*Ordre des infirmières et infirmiers auxiliaires du Québec:*  
Régis Paradis, President

*Nurse Practitioners Association of Ontario:*  
Linda Jones

*Canadian Radiation and Imaging Societies in Medicine (CRISM):*  
Dr. Paul C. Johns, Past Chair

*The Canadian Chiropractic Association:*  
Dr. Tim St. Dennis, President

*Canadian Society for Medical Laboratory Science:*  
Kurt Davis, Executive Director

**Thursday, May 17, 2001**

*Canadian Home Care Association (CHCA):*  
Nadine Henningsen, Executive Director

*Canadian Association for Community Care (CACC):*  
Dr. Taylor Alexander, President

*Victorian Order of Nurses for Canada (VON Canada):*  
Diane McLeod, Vice-President, Policy, Planning and Government Relations, Central Region

**Wednesday, May 30, 2001**

*Health Canada:*  
Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch  
Jerome Berthelette, Special Advisor, Office of the Special Advisor Aboriginal Health, First Nations Inuit Health Branch  
Dr. Peter Cooney, Acting Director General, Non-Insured Health Benefits, First Nations and Inuit Health

*Indian and Northern Affairs Canada:*  
Chantal Bernier, Assistant Deputy Minister, Socio-economic Development Policy and Programs  
Terry Harrison, Director, Social Services and Justice

*Assembly of First Nations:*  
Elaine Johnston, Director of Health

*Métis National Council:*  
Gerald Morin, President

*Native Women's Association of Canada:*  
Michelle Audette, Interim Speaker and President of the Native Women Association of Quebec

*Congress of Aboriginal Peoples:*  
Scott Clark, President, United Native Nations

*Inuit Tapirisat of Canada:*  
Larry Gordon, Member ITC, Health Committee

*Pauktuutit Inuit Women's Association:*  
Veronica N. Dewar, President

*National Aboriginal Health Organization:*  
Dr. Judith Bartlett, Chair  
Richard Jock, Executive Director

*Canadian Institutes of Health Research:*  
Dr. Jeff Reading, Scientific Director, Institute of Aboriginal People's Health

*Wikwemikong Health Centre:*  
Ron Wakegijig, Healer

*National Indian and Inuit Community Health Representatives Organization:*  
Margaret Horn, Executive Director

#### **Thursday, May 31, 2001**

*Health Canada:*  
Dr. John Wooton, Special Advisor on Rural Health, Population and Public Health Branch

*Canadian Medical Association:*  
William Tholl, Secretary General and Chief Executive Officer

*Society of Rural Physicians of Canada:*  
Dr. Peter-Hutten-Czapski, President

*Consortium for Rural Health Research:*  
Dr. Judith Kulig

#### **Wednesday, June 6, 2001**

*University of Ottawa:*  
Professor Martha Jackman, Faculty of Law

*University of Calgary: (by videoconference)*  
Professor Sheila Martin, Faculty of Law

**Thursday, June 7, 2001 (11:00 a.m.)**

*Health Canada:*

Nancy Garrard, Acting Director General, Centre for Healthy Human Development, Population and Public Health Branch

Tom Lips, Senior Policy Advisor for Mental Health, Population and Public Health Branch

Carl Lakaski, Senior Analyst, Mental Health, Health Human Resources Strategies Division, Health Policy and Communications Branch

*Canadian Psychological Association:*

Dr. John Service, Executive Director

*Canadian Alliance on Mental Illness and Mental Health:*

Phil Upshall, Coordinator

*Canadian Mental Health Association:*

Bonnie Pape

*Department of Health and Wellness of New Brunswick:*

Ken Ross, Assistant Deputy Minister, Mental Health Services

**VOLUME ONE (March 2 200 – September 21, 2001)  
(2<sup>nd</sup> Session, 36<sup>th</sup> Parliament)**

**Thursday, March 2, 2000**

University of Toronto, Department of Health Administration:

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Health Canada:

Dr. Robert McMurtry, *G.D.W. Cameron Visiting Chair*

*Health Action Lobby (HEAL):*

Sharon Sholzberg-Gray, Co-Chair

Dr. Mary Ellen Jeans, *Co-Chair*

Canadian Policy Research Network:

Sholom Glouberman, Director, Health Network

**Wednesday, March 22, 2000**

Founder's Network :

Dr. Fraser Mustard

Goldfarb Consultants:

Dr. Scott Evans, Senior Statistical Consultant

Environics Research Group :

Chris Baker, Vice-President

*Health Canada:*

Wendy Watson-Wright, Director General, Policy and Major Projects Directorate, Health Promotion and Programs Branch

**Thursday, March 23, 2000**

Health Canada:

Sylvain Paradis, Acting Policy Group Manager, Policy and Major Projects Directorate, Quantitative Analysis and Research Section, Health Promotion and Programs Branch

Liz Kusey, Policy Analyst, Policy and Major Projects Directorate, Health Promotion and Programs Branch

Monique Charon, Acting Director, Program Policy and Planning, Program Policy, Transfer Secretariat and Planning Directorate, Medical Services Branch

Mary Johnston, Education Consultant, Strategic Policy and Systems Coordination Section, Childhood and Youth Division – Health Promotion and Programs Branch

Julie MacKenzie, Senior Research Analyst, Strategic Policy and Systems Coordination Section, Childhood and Youth Division – Health Promotion and Programs Branch

Queens University – School of Policy Studies:

Keith Banting, Director

**Thursday, April 6, 2000**

*University of British Columbia:*

Robert G. Evans, Director, Population Health Program

Canadian Centre for Policy Alternatives:

Colleen Fuller

The Fraser Institute:

Martin Zelder, Director of Health Policy Research

**Wednesday, May 3, 2000**

*Health Canada:*

Cliff Halliwell, Director General, Applied Research & Analysis Directorate, Information, Analysis and Connectivity Branch

Abby Hoffman, Senior Policy Advisor

Frank Fedyk, Acting Director, Canada Health Act Directorate, Policy and Consultation Branch

**Thursday, May 4, 2000**

*As an individual:*

Tom Kent

*University of Toronto:*

Michael Bliss, Professor

**Wednesday, May 10, 2000**

*University of Western Ontario:*

Ake Blomqvist, Professor

*University of Toronto:*

Colleen Flood, Professor

Mark Stabile, Professor



**Thursday, May 11, 2000**

*Canadian Institute for Health Information:*

John S. Millar, Vice-President, Research and Analysis

*McGill University:*

Margaret Somerville, Professor

*Alberta University:*

Laura Shanner, Professor

**Wednesday, May 17, 2000**

*As an individual:*

The Honourable Marc Lalonde, P.C.

**Wednesday, May 31, 2000**

*As an individual:*

The Honourable Monique Bégin, P.C.

**Wednesday, June 7, 2000**

*Department of Finance:*

Guillaume Bissonnette, General Director, Federal-Provincial Relations and Social Policy Branch

Barbara Anderson, Director, Federal-Provincial Relations Division - Federal-Provincial Relations and Social Policy Branch

**Thursday, September 21, 2000**

*As an individual:*

Graham Scott, Former Deputy Minister of Health, Province of Ontario



**OTHER WRITTEN SUBMISSIONS RECEIVED:**

Abell Medical Clinic

Alberta Centre for Injury Control and Research

Amgen Canada Inc.

Ancaster-Dundas-Flamborough-Aldershot New Democratic Party Riding Association Executive Committee

Association of Canadian Medical Colleges (ACMC)

Patricia Baird

B.C. Better Care Pharmacare Coalition

Bruce Bigham

Brain Injury Association of Nova Scotia

Robert D. Brown and Michanne Haynes

Canada Health Infoway

Canada's Research-Based Pharmaceutical Companies

Canada West Foundation

Canadian Association of Emergency Physicians (CAEP)

Canadian Association of Internes and Residents

Canadian Blood Services

Canadian Caregiver Coalition

Canadian Cochrane Network and Centre

Canadian Council on Integrated Healthcare  
Canadian Dental Hygienists Association  
Canadian Drug Manufacturers Association (CDMA)  
Canadian Strategy for Cancer Control  
Cancer Care Ontario, Division of Preventive Oncology  
Chemical Sensitivities Information Exchange Network Manitoba (CSIENM)  
Conestoga College (Pat Bower, Course instructor)  
Laurent Desjardins  
Faith Partners (Ottawa)  
Federation of Medical Women in Canada  
Sandra Finley  
Dr. Michael Gordon, Baycrest Centre for Geriatric Care  
Serena Grant  
Health Care Corporation of St. John's  
Heart and Stroke Foundation of New Brunswick  
Home-based Spiritual Care  
Kidney Foundation of Canada  
Kids First Parent Association of Canada  
Dr. Lee Kurisko  
Caterine Lindman  
Jim Ludwig  
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Dr. Ross McElroy  
Dr. Malcom S. McPhee  
Meals on Wheels of Calgary  
Medbuy Corporation  
Verna Milligan  
Moose Jaw-Thunder Creek District Health Board  
Dr. Earl B. Morris  
Fran Morrison  
Multiple Sclerosis Society of Canada  
John Neilson  
Ontario Chamber of Commerce  
Ontario Psychological Association  
Roy L. Piepenburg (Liberation Consulting)  
Red Deer Network in Support of Medicare  
Dr. Robert S. Russell  
Society of Obstetricians and Gynaecologists of Canada  
Christa Streicher  
Thames Valley District Health Council  
Elaine Tostevin  
University of Ottawa Heart Institute  
University of Ottawa Institute of Population Health (Dr. Joseph Losos, Director)



The Senate

Standing Senate Committee on Social Affairs,  
Science and Technology

# The Health of Canadians - The Federal Role

Final Report on state of the  
health care system in Canada

*Chair:*

The Honourable Michael J.L. Kirby

*Deputy Chair:*

The Honourable Marjory LeBreton

October 2002

## Highlights

## Volume Six: Recommendations for Reform

*Ce document est disponible en français.*



Available on the Parliamentary Internet:  
[www.parl.gc.ca](http://www.parl.gc.ca)  
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37<sup>th</sup> Parliament – 2<sup>nd</sup> Session

## TABLE OF CONTENTS

---

<b>TABLE OF CONTENTS .....</b>	<b>i</b>
<b>INTRODUCTION.....</b>	<b>1</b>
<b>CHAPTER ONE.....</b>	<b>4</b>
The Need for an Annual Report on the State of the Health Care System and the Health Status of Canadians .....	4
<b>CHAPTER TWO .....</b>	<b>6</b>
Hospital Restructuring and Funding in Canada .....	6
<b>CHAPTER THREE .....</b>	<b>8</b>
Devolving Further Responsibility to Regional Health Authorities.....	8
<b>CHAPTER FOUR .....</b>	<b>9</b>
Primary Health Care Reform.....	9
<b>CHAPTER FIVE.....</b>	<b>10</b>
Timely Access to Health Care .....	10
<b>CHAPTER SIX .....</b>	<b>11</b>
The Health Care Guarantee .....	11
<b>CHAPTER SEVEN .....</b>	<b>12</b>
Expanding Coverage to Include Protection Against Catastrophic Prescription Drug Costs.....	12
<b>CHAPTER EIGHT .....</b>	<b>14</b>
Expanding Coverage to Include Post-Acute Home Care.....	14
<b>CHAPTER NINE.....</b>	<b>15</b>
Expanding Coverage to Include Palliative Home Care .....	15
<b>CHAPTER TEN.....</b>	<b>16</b>
The Federal Role in Health Care Infrastructure.....	16
<b>CHAPTER ELEVEN.....</b>	<b>18</b>
Health Care Human Resources.....	18
<b>CHAPTER TWELVE.....</b>	<b>20</b>
Nurturing Excellence in Canadian Health Research .....	20

<b>CHAPTER THIRTEEN .....</b>	<b>21</b>
Healthy Public Policy: Health Beyond Health Care .....	21
<b>CHAPTER FOURTEEN .....</b>	<b>23</b>
How the New Federal Funding for Health Care Should Be Managed .....	23
<b>CHAPTER FIFTEEN .....</b>	<b>25</b>
How Additional Federal Funds for Health Care Should Be Raised.....	25
<b>CHAPTER SIXTEEN.....</b>	<b>30</b>
The Consequences of Not Making the Health Care System Fiscally Sustainable.....	30
<b>CHAPTER SEVENTEEN .....</b>	<b>31</b>
The <i>Canada Health Act</i> .....	31
<b>CONCLUSION.....</b>	<b>32</b>
<b>APPENDIX.....</b>	<b>A-1</b>
List of Recommendations by Chapter.....	A-1

# INTRODUCTION

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**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.**



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 than 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 21<sup>st</sup> 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

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***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

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***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

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***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 a pproximately \$550 million per year.

## CHAPTER NINE

### EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE

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***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

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***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

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***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

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***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

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*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

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

(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**

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

- 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

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***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

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***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

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***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**

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**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-served 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.