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

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ORDER OF REFERENCE

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

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

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 infostructure, 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 21st 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 21st 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 19th century cottage industry rather than a 21st century service industry, consisting as it does largely of individual physician practices which are not clustered together into group practices, making 7/24 service is 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 21st 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 21st century service industry, instead of remaining an industry mired in a 19th 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 21st 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:

OPTIONS FOR THE FINANCING ROLE OF THE FEDERAL GOVERNMENT	
Changes in Health Care Delivery (8.2)	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)
Form of Federal Funding for Health Care (8.3)	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)
Raising Government Revenue for Health Care (8.4)	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)
Private Health Care Insurance (8.4.6)	For Health Services Delivered both Publicly and Privately
Public Health Care Coverage (8.7)	De-listing Services (8.7.1)
	Expanding Coverage (8.7.2)
Reducing the Cost of Prescription Drugs (8.8)	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)
Expanding Coverage for Prescription Drugs (8.9)	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)
Home Care (8.10)	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 listsbecome 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 20th 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

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.*[1]

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

[1] Debates of the Senate (Hansard), 2nd Session, 36th 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

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 21st 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 revolutionalize 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

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
FINANCING ROLE*: the transfer of funds for the provision of health services administered by other jurisdictions*
RESEARCH AND EVALUATION ROLE*: funding innovative health research and evaluation of innovative pilot projects*
INFRASTRUCTURE ROLE*: support for the health care infrastructure and the health infostructure, including human resources*
POPULATION HEALTH ROLE*: health protection, health and wellness promotion, illness prevention, and population health*
SERVICE DELIVERY ROLE*: the direct provision of health services to specific population groups*

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

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.[2] 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.

[2] 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 20th 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:

THE DIRECT PROVISION OF HEALTH SERVICES TO ABORIGINAL CANADIANS

The Committee proposes that the following objectives ought to apply to the service delivery role of the federal government:

- *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 and ensure the full participation of the Aboriginal population in the design and implementation of these services;*
- *To implement and sustain population health strategies specifically designed for Aboriginal peoples.*

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 21ST CENTURY CONTEXT FOR HEALTH CARE POLICY

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 20th century.

Indeed, it is possible to trace the outlines of what a 21st 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 19th century cottage industry rather than a 21st 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 21st 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 been 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 21st century service industry, rather than remaining mired in a 19th 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 21st 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,[3] 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.

[3] 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 21st 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

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

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."[4] 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

[4] 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,[5] 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 <u>not</u> 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?

[5] 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".[6]

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 publicattach 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.

[6] 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;
- confidentially 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

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."[7] 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.[8]

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

[7] *Caring for Medicare*, the Commission on Medicare, Saskatchewan, April 2001, p. 79.
[8] 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 infostructure, 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.[9] 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 prove 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

[9] 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."[10]

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.

[10] 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.

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.[11] 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.

[11] 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.[12] 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,

[12] 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.

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.[13] 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.[14] 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.

[13] 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."

[14] 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[15] and in 2000 by Tom Kent.[16]

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

[15] Ministère de la santé et des services sociaux, *Un financement équitable à la mesure de nos moyens*, Government of Quebec, 1991, pp. 78-82.
[16] 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.[17]

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

[17] 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."[18]

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?

[18] 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).

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%.[19]

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

	% Covered
Canada	**97**
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.

[19] 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.[20] It is clear that the residents of Atlantic provinces require substantial improvement in their drug insurance coverage.

[20] 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.[21]

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.[22]

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

[21] Palmer d'Angelo Consulting Inc., *National Pharmacare Cost Impact Study*, September 1997.
[22] 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% or 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 care-giving. 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.

OPTIONS FOR THE FINANCING ROLE OF THE FEDERAL GOVERNMENT	
Changes in Health Care Delivery (8.2)	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)
Form of Federal Funding for Health Care (8.3)	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)
Raising Government Revenue for Health Care (8.4)	*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)
Private Health Care Insurance (8.4.6)	For Health Services Delivered both Publicly and Privately
Public Health Care Coverage (8.7)	De-listing Services (8.7.1)
	Expanding Coverage (8.7.2)

Reducing the Cost of Prescription Drugs (8.8)	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)
Expanding Coverage for Prescription Drugs (8.9)	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)
Home Care (8.10)	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

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 extent 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

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 5th 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."[23] 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

23 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."[24]

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.[25] 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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24 First Ministers Meeting, *Communiqué on Health*, News Release, 11 September 2000.

25 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 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.

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 1st, 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 1st, 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 31st, 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."[26] 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

[26] 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

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,[27] 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[28] are not prepared to work the long hours that were once considered normal, meaning that more physicians could be needed in the future.

[27] CIHI, Health Care in Canada, 2001.

[28] 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 cooperage 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.[29] 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[30] (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

[29] As reported in the *Globe and Mail*, Saturday, July 28, 2001, p. A1.

[30] 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 specialities 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 21st 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

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 20th 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.[31]

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.

[31] 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

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

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:

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