

The Standing Senate Committee on Social Affairs, Science and Technology

Interim Report on
the state of health care system in Canada

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

Chair

The Honourable Michael J. L. Kirby

Deputy Chair

The Honourable Marjory LeBreton

MARCH 2001

TABLE OF CONTENTS

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

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

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

MEMBERSHIP

Standing Senate Committee on Social Affairs, Science and Technology

The Honourable Michael J. L. Kirby, Chair
The Honourable Marjory LeBreton, Deputy Chair

The Honourable Senators :

Catherine S. Callbeck
Erminie J. Cohen
Joan Cook
Jane Marie Cordy
Joyce Fairbairn
Alasdair B. Graham
Janis G. Johnson
Lucie Pépin
Douglas Roche
Brenda Robertson

* Sharon Carstairs (or Fernand Robichaud)
* John Lynch-Staunton (or Noel A. Kinsella)

Original Members agreed to by Motion of the Senate :

The Honourable Senators :

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

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

The Honourable Senators :

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

* *Ex Officio* members

FOREWORD

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

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

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

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

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

The Honourable Michael J.L. Kirby
Chair

The Honourable Marjory LeBreton
Deputy Chair

THE HEALTH OF CANADIANS

THE FEDERAL ROLE

VOLUME ONE – THE STORY SO FAR



INTRODUCTION

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

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

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

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

TABLE 1
HEALTH CARE STUDY:
INDIVIDUAL PHASES AND PROPOSED TIMEFRAMES

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

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

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

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

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

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

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

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

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

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

CHAPTER ONE:

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

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

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

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

1.1 Federal Role in Health and Health Care

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

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

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

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

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

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

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

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

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

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

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

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

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

³ Keith Banting (9:62).

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

1.2 Cost-Sharing Arrangements

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

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

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

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

⁴ Tom Kent (13:30).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

⁷ Hon. Marc Lalonde (15:7).

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

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

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

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

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

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

⁸ Tom Kent (13:33).

⁹ Hon. Marc Lalonde (15:6-7).

1.3 Functioning of the EPF Block Funding

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

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

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

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

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

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

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

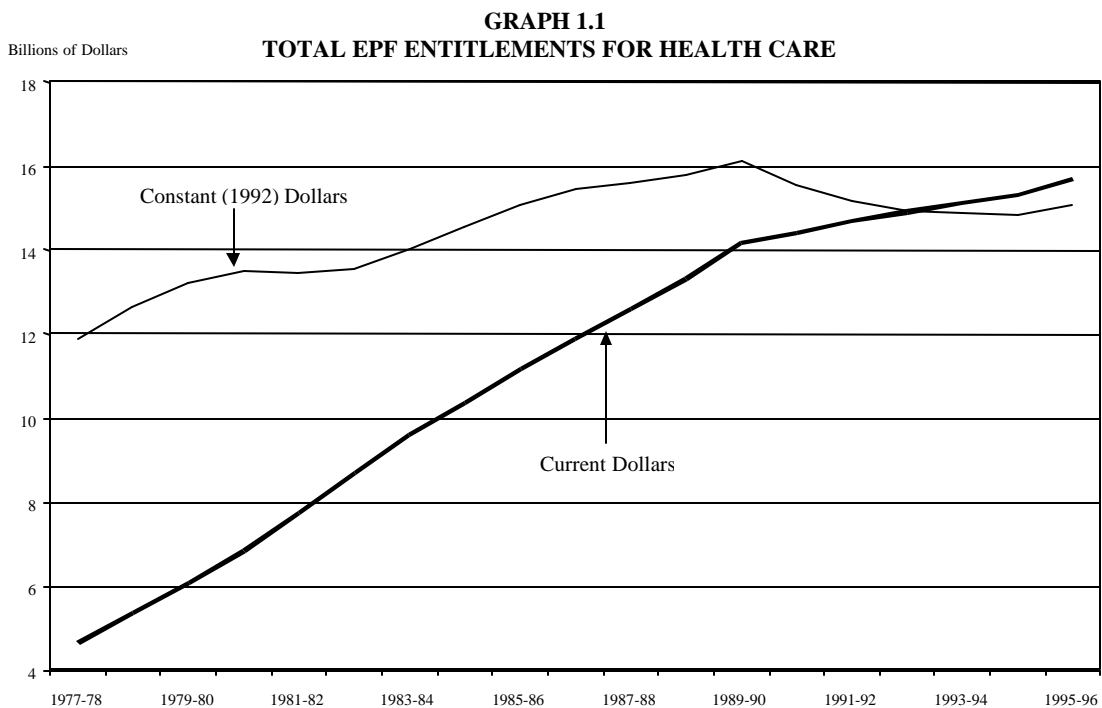
In an effort to reduce the federal deficit, the escalator was modified on several occasions. In 1983-84 and 1984-85, the escalator associated with the education portion of EPF was capped at 6% and 5% respectively (if the formula based on the growth in the GDP per capita had been used, the education component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

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

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

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

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



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

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

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

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

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

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

Source: Department of Finance and Library of Parliament.

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

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

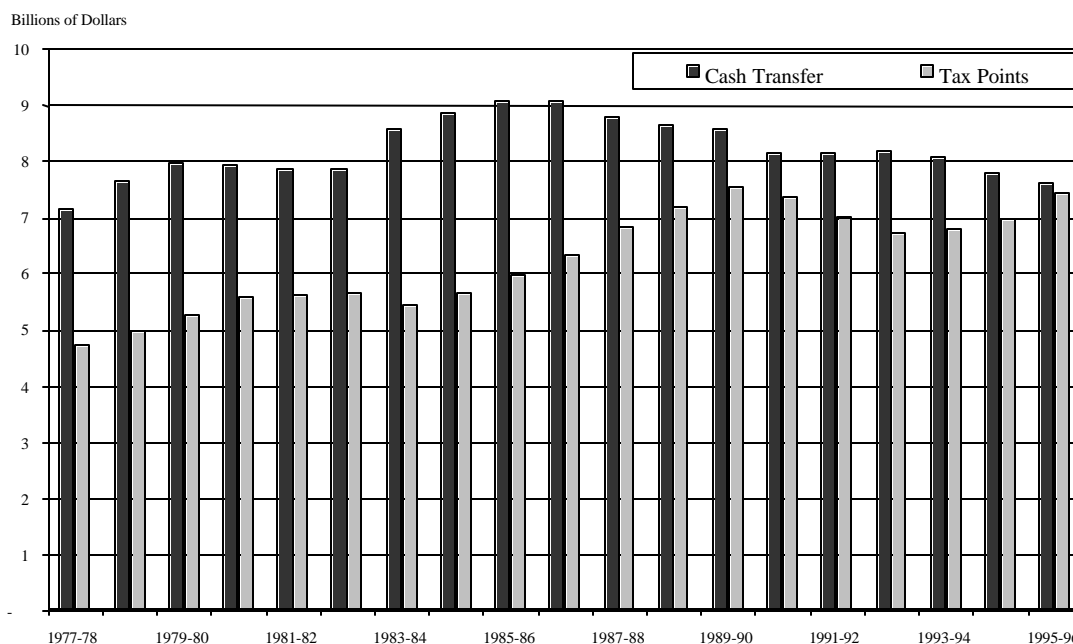
Graph 1.2 shows the diverging paths of transfers in the form of cash and tax points resulting from the limits to the overall rate of growth in EPF entitlements. While the cash transfers for health care declined continually between 1986-87 and 1995-96, the value of the tax transfers increased in real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

¹³ Hon. Marc Lalonde (15:7).

¹⁴ *Ibid.*

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

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



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

1.4 The CHST

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

TABLE 1.2
A BRIEF HISTORY OF THE CHST

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

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

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

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

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

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

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

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

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

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

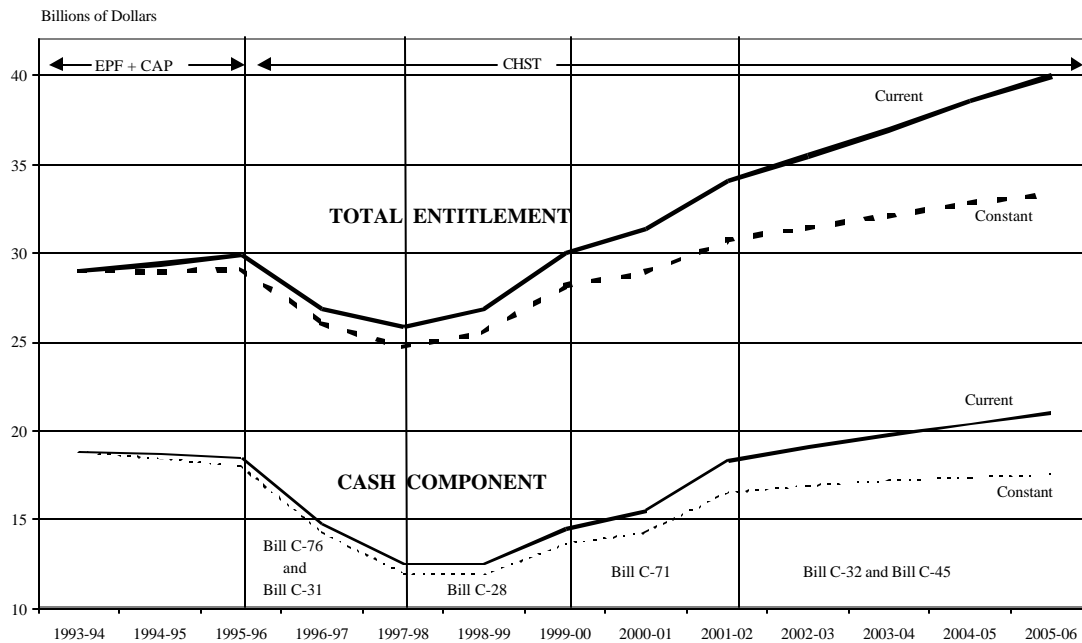
Clearly, as we all know, the CHST represented a cut in cash transfers at a time of broad cutbacks in federal spending to address the deficit situation. However, the value to the provinces of the tax point portion of the CHST continued to grow as the economy grew.

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

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

¹⁸ *Ibid.*, p. 6.

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



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

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

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

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

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

1.5 Tax Points versus Cash Transfers

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

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

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

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

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

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

Hon. Monique Bégin (16:8).

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

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

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

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

²¹ Hon. Marc Lalonde (15:13).

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

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

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

1.6 The Federal Contribution to Health Care

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

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

²² Hon. Marc Lalonde (15:10-11).

²³ Keith Banting (9:65).

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

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

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

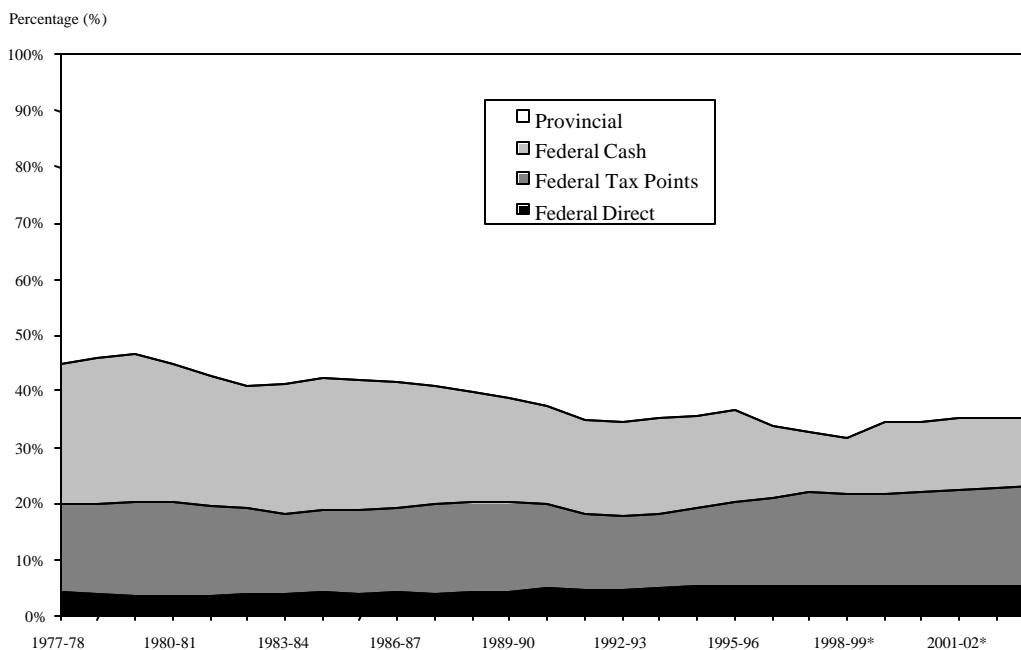
*Abby Hoffman, Senior Policy Advisor,
Health Canada (13:10).*

This information was used to construct Graph 1.4, which depicts the evolution of public health care spending by source of financing from 1977-78 to 2003-04. These data, as reported by Health Canada, show that spending on health care from provincial funds in 1999-00 is expected to amount to 65% of total health care expenditures by the public sector. Thus, the federal share for that year is approximately 35%. If tax points are not included as part of the federal contribution, then the proportion of health care spending by provincial governments totals some 82%, while the federal share is 18%.

Health Canada's data also indicate that the provincial governments' share of public health care expenditures has been increasing steadily since the late 1970s, irrespective of the method of calculation used. Concurrently, the estimated federal share has been declining since then. The value of tax transfers and federal direct funds²⁴ are increasing slightly, but the cash transfer share is largely decreasing. This downward trend could be reversed, however, with the additional federal investment in health care provided in Bill C-45 (2000).

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

GRAPH 1.4
SOURCE OF HEALTH CARE FUNDING BY THE PUBLIC SECTOR



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

1.7 The Need for Stability in Federal Funding

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

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

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

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

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

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

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

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

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

²⁵ Tom Kent (13:34-35).

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

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

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

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

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

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

²⁶ Guillaume Bissonnette (17:12).

²⁷ Hon. Monique Bégin (16:5).

²⁸ Tom Kent (13:32).

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

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

1.8 Accountability in the Use of Federal Health Care Dollars

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

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

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

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

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

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

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

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

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

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

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

³⁰ Guillaume Bissonnette (17: 11).

CHAPTER TWO:

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

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

2.1 The Origins of the *Canada Health Act*

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

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

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

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

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

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

In 1980, the Health Services Review by Justice Hall reported that health care in Canada ranked among the best in the world, but warned that direct patient charges were posing a threat to the principle of free and universal access to health care throughout the country. In response to these concerns, Parliament unanimously passed the *Canada Health Act* in 1984. Abby Hoffman told the Committee that the new Act combined and updated the conditions

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

Hon. Monique Bégin (16:3).

³¹ Michael Bliss (13:37-38).

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

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

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

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

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

³² Abby Hoffman (13:11).

³³ Hon. Marc Lalonde (15:11).

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

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

2.2 Definition/Interpretation of the National Principles and their Application

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

TABLE 2.1
THE FIVE CRITERIA OF THE CANADA HEALTH ACT

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

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

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

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

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

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

³⁴ Tom Kent (13:30).

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

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

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

TABLE 2.2
CATEGORIES OF HEALTH CARE SERVICES

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

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

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

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

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

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

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

³⁵ Abby Hoffman (13:25).

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

2.3 Enforcement Penalties under the *Canada Health Act*

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

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

Information provided by Health Canada³⁶ indicates that, on three occasions, the federal government resorted to financial penalties and reduced its contributions to some provinces that were authorizing extra-billing or imposing user charges. First, it deducted over \$246,732,000 from EPF cash transfers to all the provinces from 1984-85 to 1986-87. However, it also complied with section 20(6) of the Act, under which a province was able to

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

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

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

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

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

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

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

* Up to January 2000.

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

2.4 Is the *Canada Health Act* Still Relevant?

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

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

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

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

³⁷ Hon. Marc Lalonde (15:21).

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

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

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

2.5 Committee Commentary

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

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

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

³⁸ Hon. Monique Bégin (16:5).

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

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

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

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

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

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

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

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

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

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

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

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

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

³⁹ Tom Kent (13:40).

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

CHAPTER THREE:

PUBLIC EXPECTATIONS ABOUT HEALTH CARE

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

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

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

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

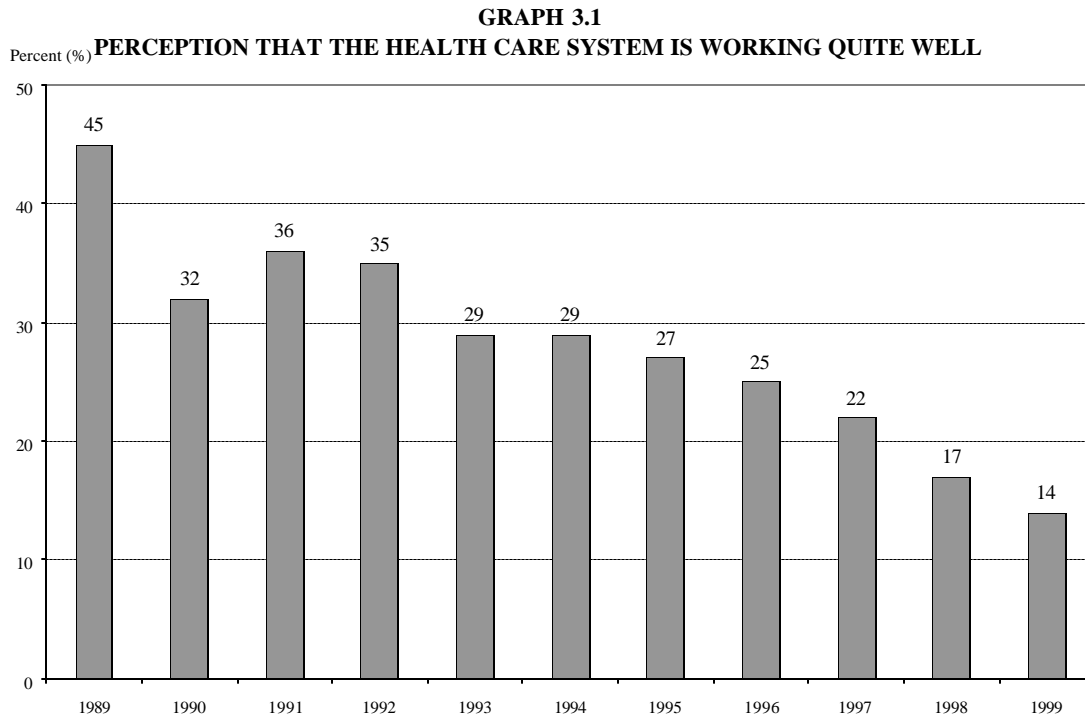
and common responsibility. However, an increasing number of Canadians are concerned that the health care system will not retain these qualities in the future. Many believe that health care in Canada is not as good now as it was in the past, because of government cuts in health care spending, longer waiting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

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

3.1 Health Care is an Important Public Policy Concern

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

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



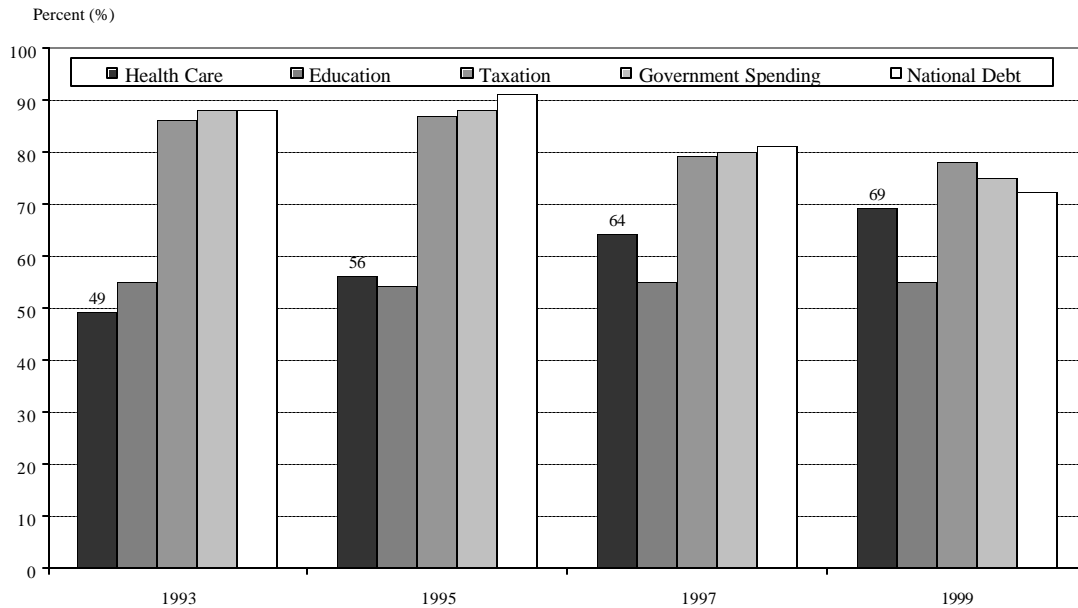
Source: Goldfarb Consultants, Presentation to the Committee, 22 March 2000, Slide 6.

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

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

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

**GRAPH 3.2
PUBLIC POLICY: SHIFTING CONCERNS**



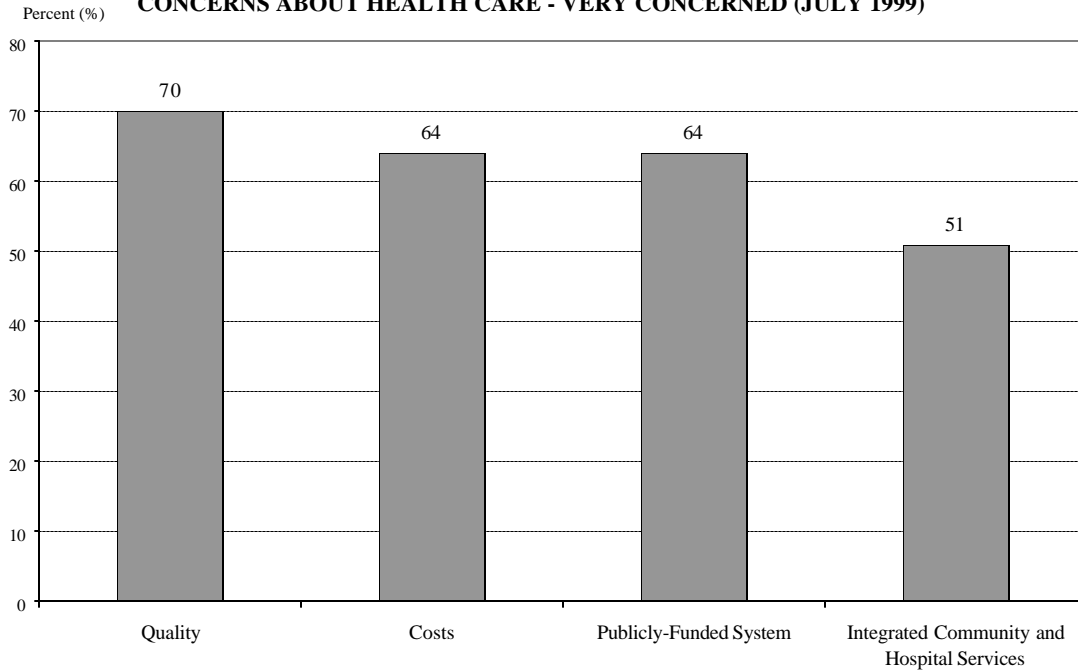
Source: Goldfarb Consultants, Presentation to the Committee, 22 March 2000, Slide 13.

3.2 Canadians Are Concerned About Quality, Access and Universality

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

⁴⁰ Chris Baker (9:31-32).

GRAPH 3.3
CONCERNS ABOUT HEALTH CARE - VERY CONCERNED (JULY 1999)



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

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

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

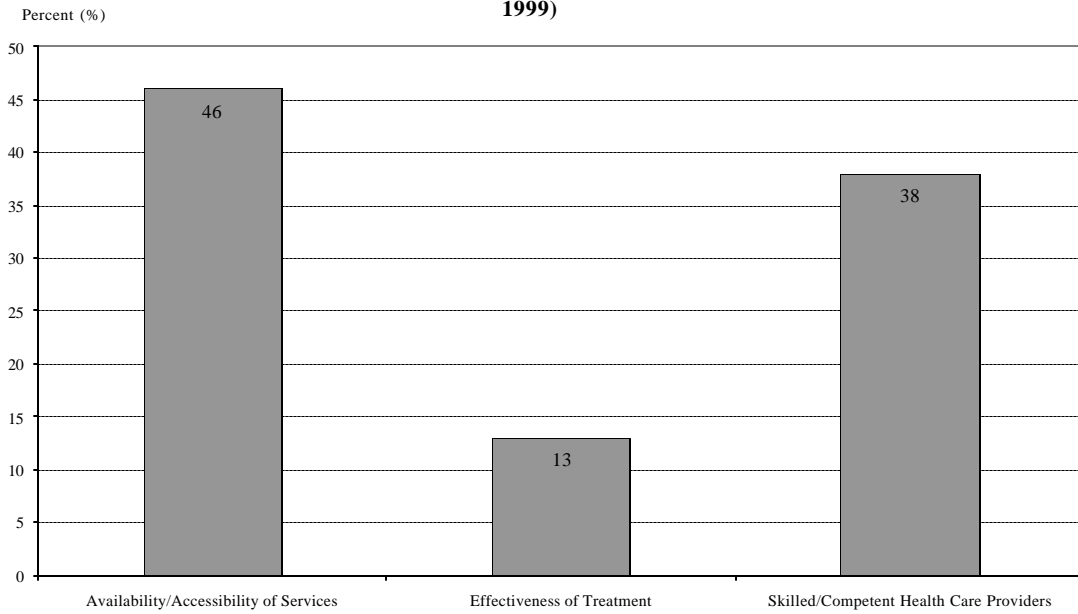
Chris Baker, V-P, Environics Research Group (9:33).

3.3 Health Care is a Priority

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

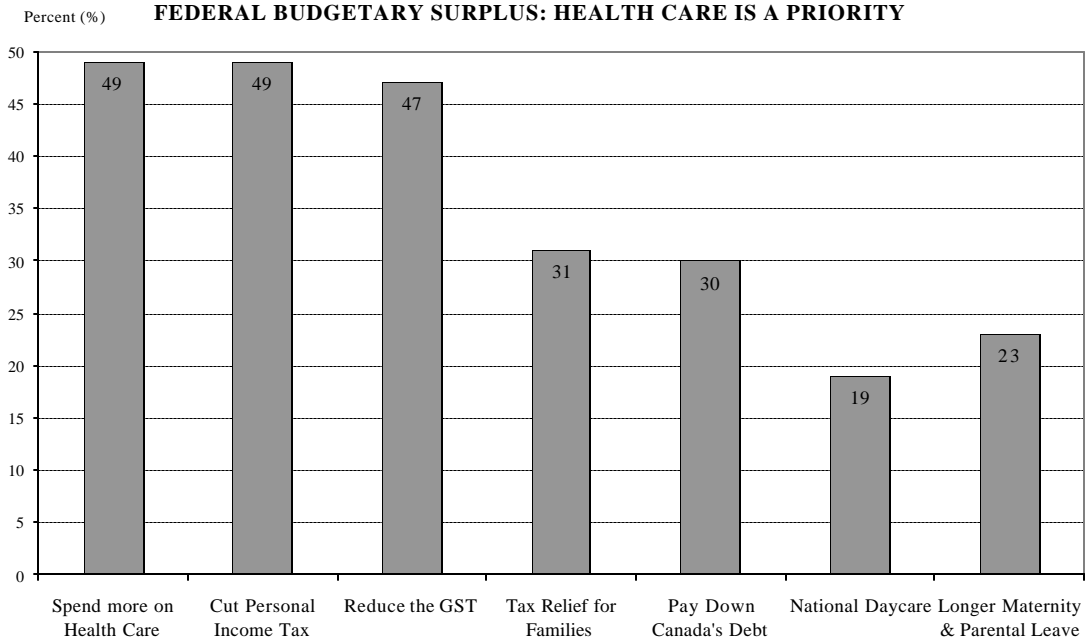
⁴¹ Chris Baker (9:32).

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



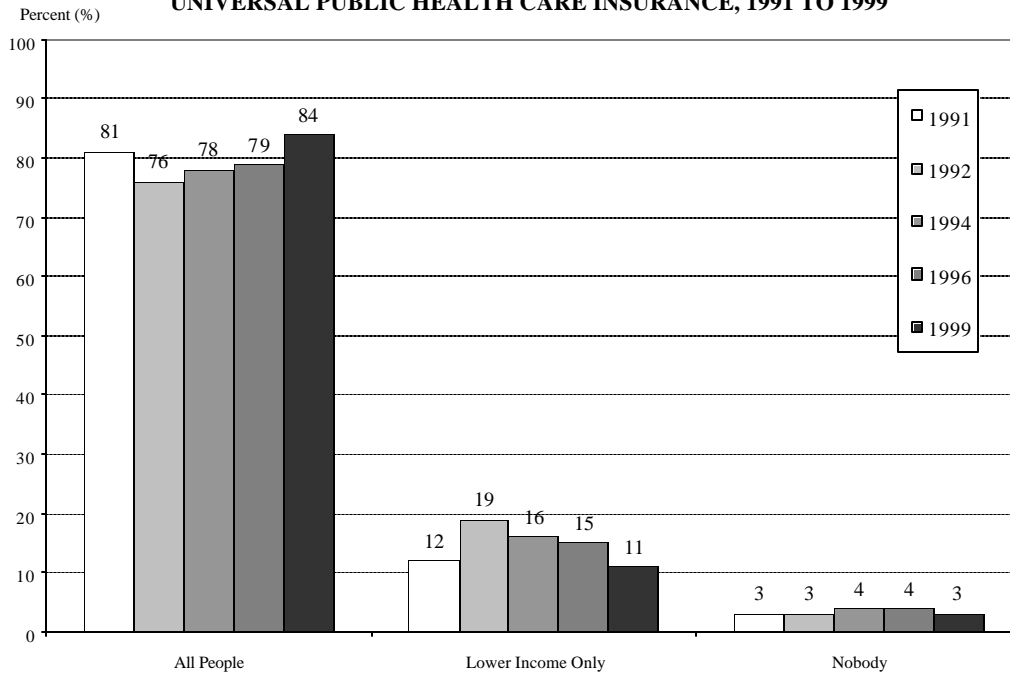
Source: Environics Research Group, Presentation to the Committee, 22 March 2000, Slide 26.

GRAPH 3.5
FEDERAL BUDGETARY SURPLUS: HEALTH CARE IS A PRIORITY



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

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



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

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

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

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

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

Abby Hoffman from Health Canada expressed similar views:

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

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

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

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

3.4 Health Care is a Federal/Provincial Partnership

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

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

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

⁴² Chris Baker (9:32).

⁴³ Abby Hoffman (13:27).

⁴⁴ Graham Scott (20:13)

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

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

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

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

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

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

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

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

⁴⁵ Dr. Scott Evans (9:38).

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

3.6 Decreasing Support for User Charges and Private Initiatives

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

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

3.7 Committee Commentary

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

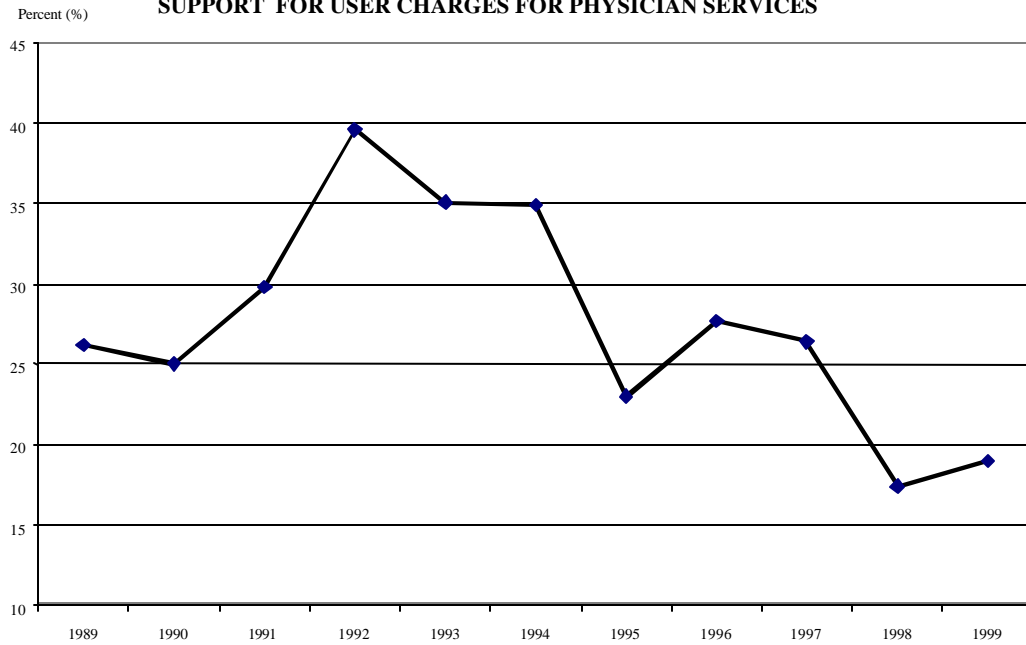
Certainly much of the financial restructuring in the health care system, and the response of the media and the various advocacy groups to that, have all contributed to this general sense of declining faith.⁴⁹

⁴⁷ *Ibid.*, pp. 31-32.

⁴⁸ *Ibid.*, p. 2.

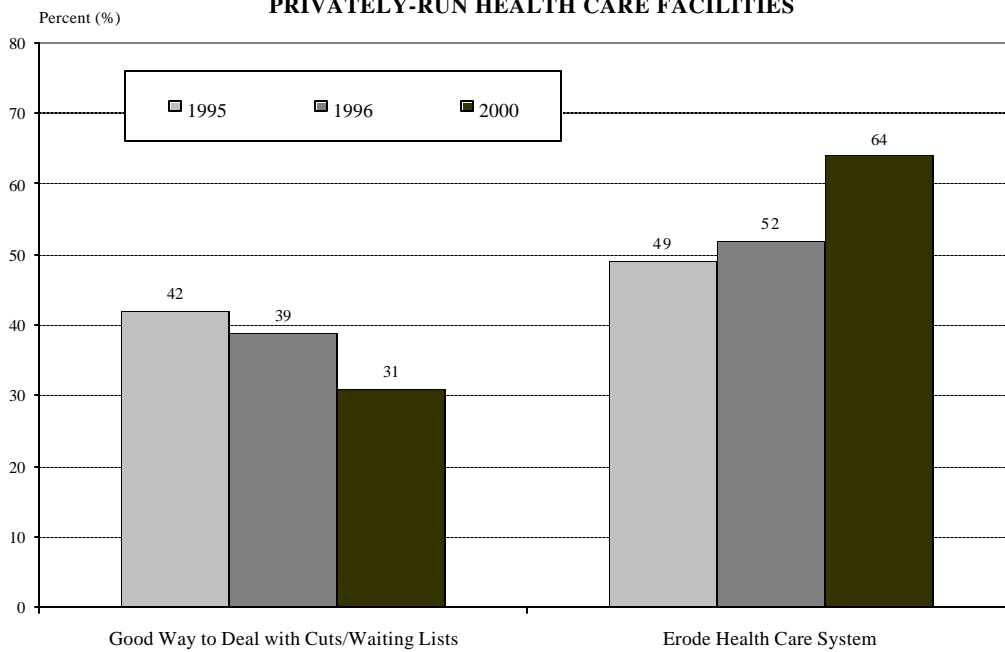
⁴⁹ Dr. Scott Evans (9:34-35).

GRAPH 3.7
SUPPORT FOR USER CHARGES FOR PHYSICIAN SERVICES



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

GRAPH 3.8
PRIVATELY-RUN HEALTH CARE FACILITIES



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

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

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

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

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

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

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

⁵⁰ Dr. John S. Millar (14:35).

⁵¹ Dr. John S. Millar (14:35).

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

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

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

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

⁵² Sholom Glouberman (9:18-19).

⁵³ Dr. Scott Evans (9:37).

CHAPTER FOUR:

TRENDS IN HEALTH CARE EXPENDITURES

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

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

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

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

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

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

4.1 Global Trends – From 1975 to 2000

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

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

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

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

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

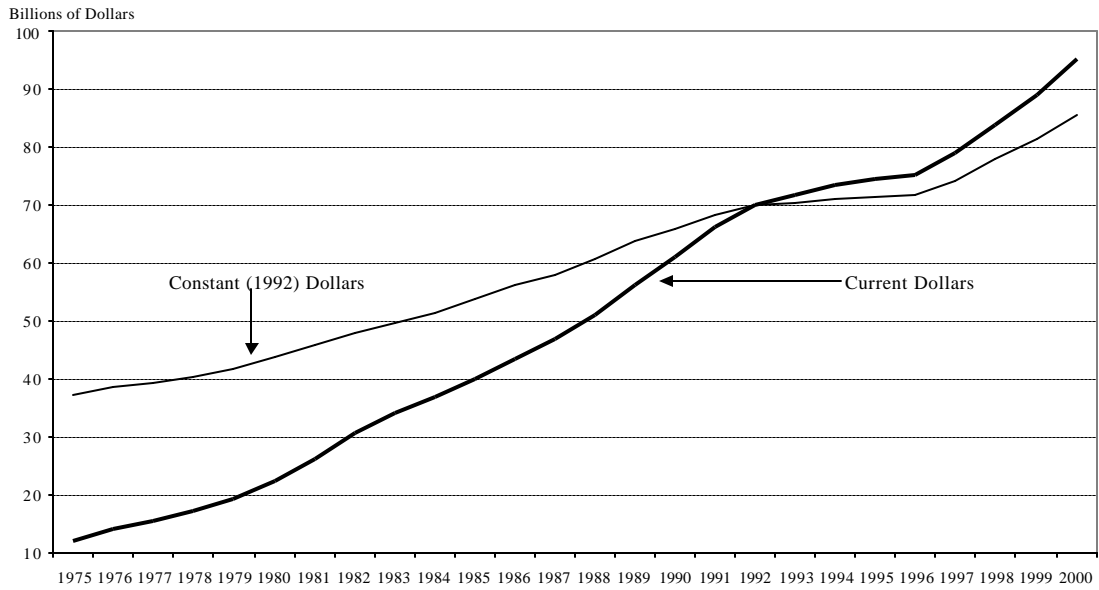
⁵⁵ More precisely, total health care spending grew at an average annual rate of 11.1% over the period 1975 to 1991. Then, growth fell substantially to an average annual rate of 2.6% between 1991 and 1996. The average annual rate of growth is expected to have risen to some 6.0% between 1996 to 2000.

⁵⁶ Abby Hoffman (13:8).

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

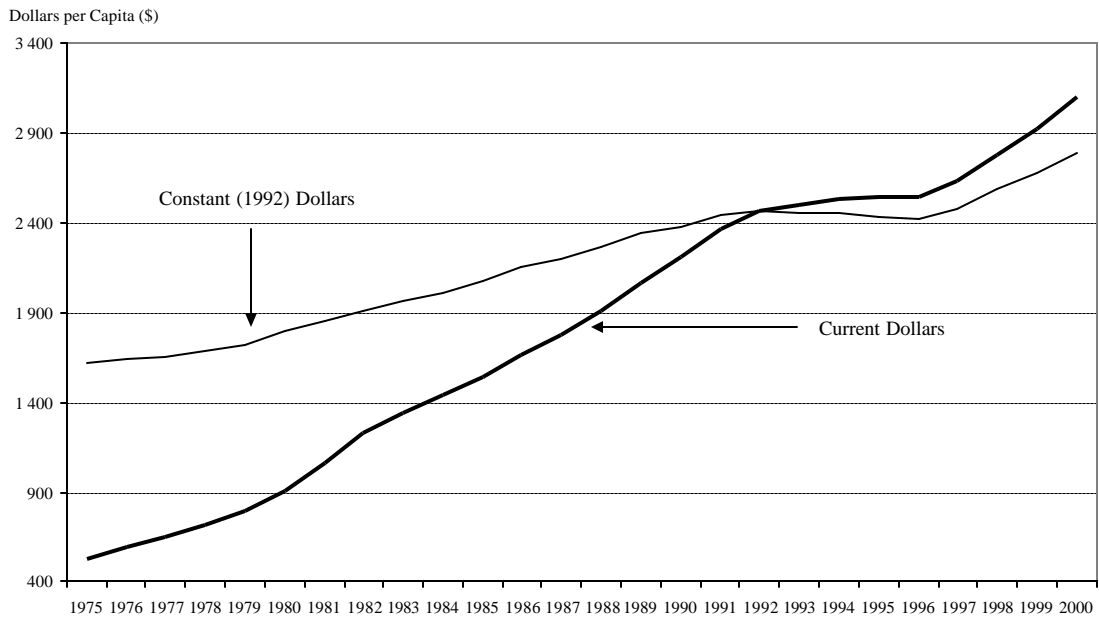
⁵⁸ Real rates of growth averaged 3.8% between 1975 and 1991, 1.0% between 1991 and 1996 and 4.6% between 1996 and 2000.

GRAPH 4.1
TOTAL HEALTH CARE EXPENDITURES IN CANADA



Source: CIHI(2000) and Library of Parliament.

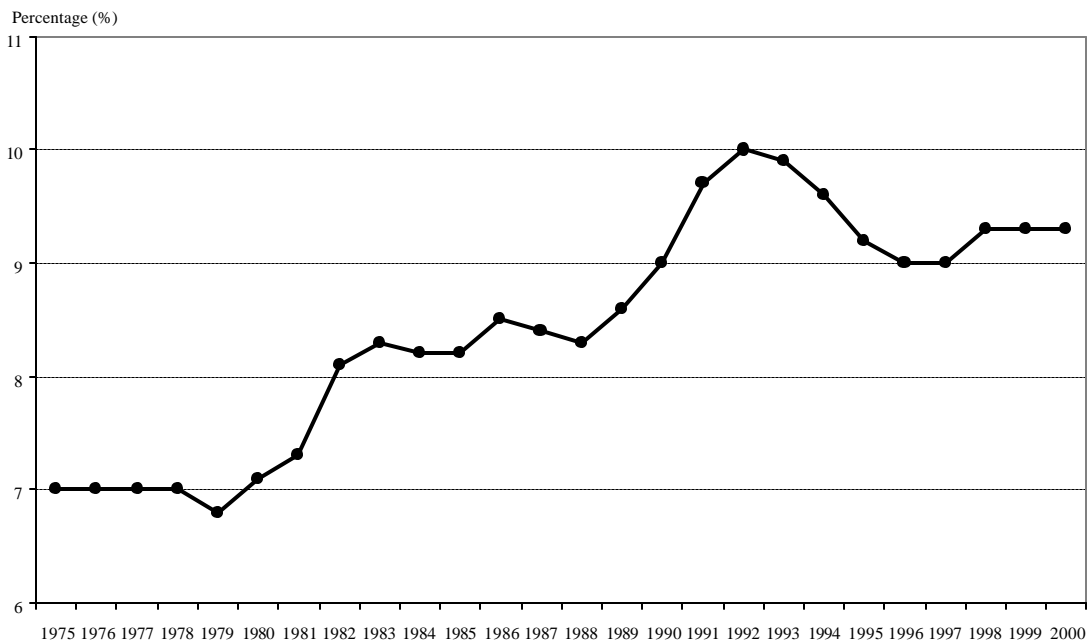
GRAPH 4.2
TOTAL HEALTH CARE EXPENDITURES IN CANADA



Source: CIHI(2000) and Library of Parliament.

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

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



Source: CIHI(2000) and Library of Parliament.

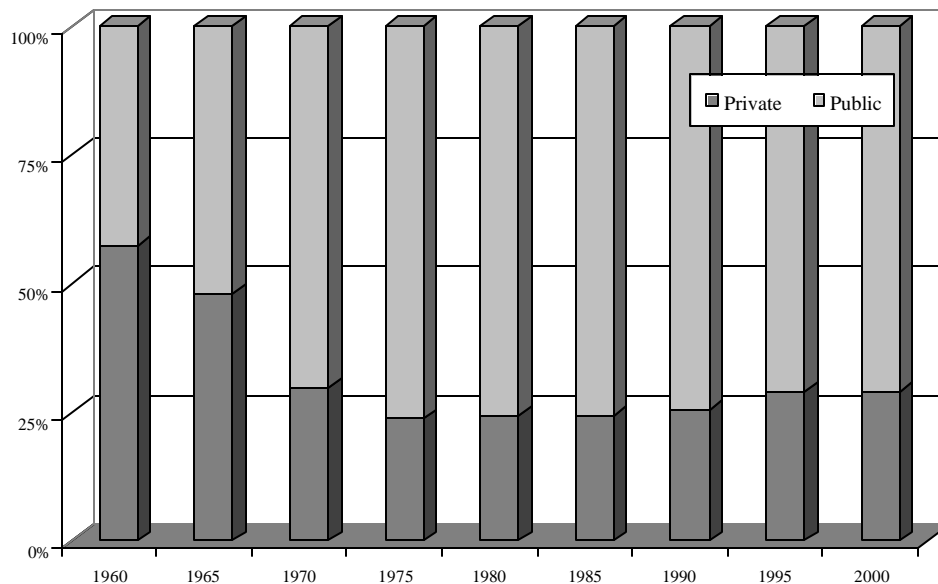
Another way to measure how much Canada spends on health care is to calculate health care expenditures as a percentage of gross domestic product (GDP).⁵⁹ This indicator, which is referred to as the “health care to GDP ratio”, reflects the extent to which Canada devotes productive resources to health care.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

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

4.2 Public versus Private Spending

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

GRAPH 4.4
PUBLIC AND PRIVATE SHARES OF TOTAL HEALTH CARE EXPENDITURES

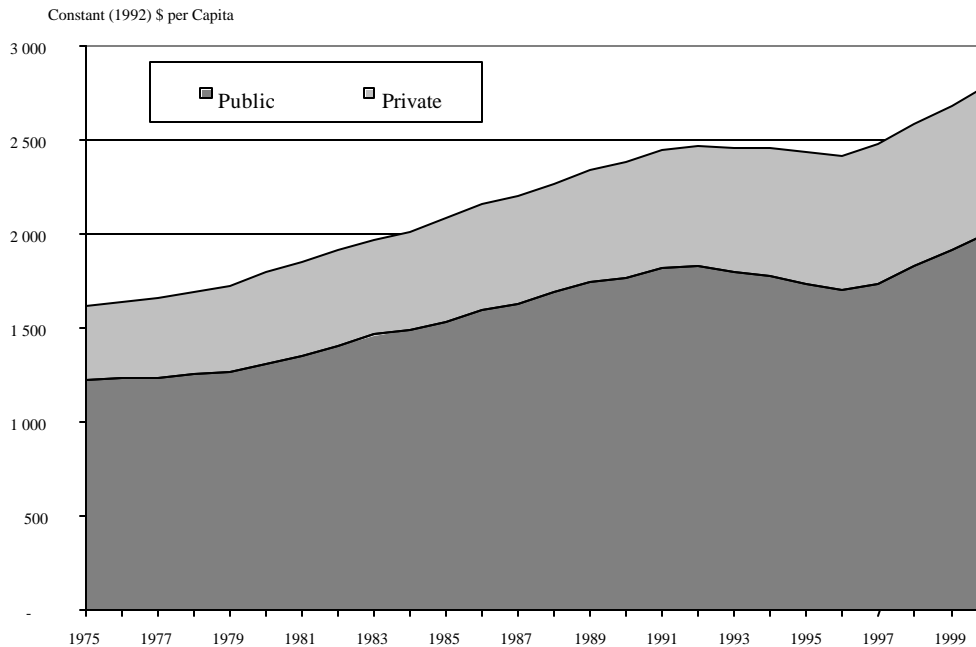


Source: Vern Hicks (1999), CIHI (2000) and Library of Parliament.

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

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

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



Source: CIHI (2000) and Library of Parliament.

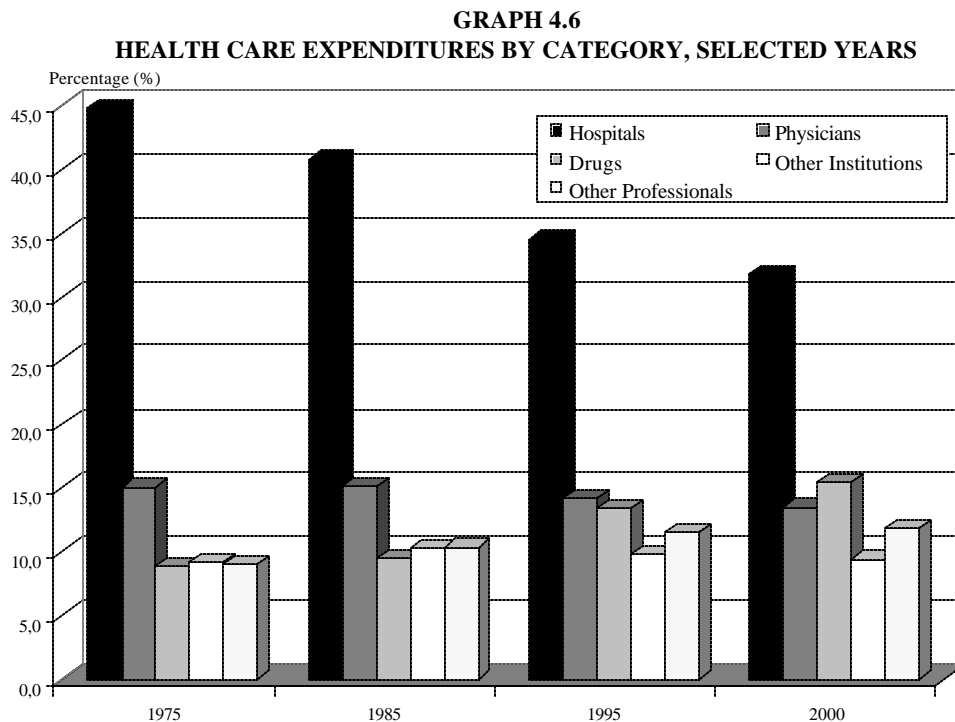
Once again, it is useful to consider trends when expenditures are adjusted for both inflation and population size. Graph 4.5 shows that public sector expenditures per capita in constant dollars increased continuously from 1975 to 1992. Between 1992 and 1996, public sector expenditures on health care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

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

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

4.3 Categories of Expenditures

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



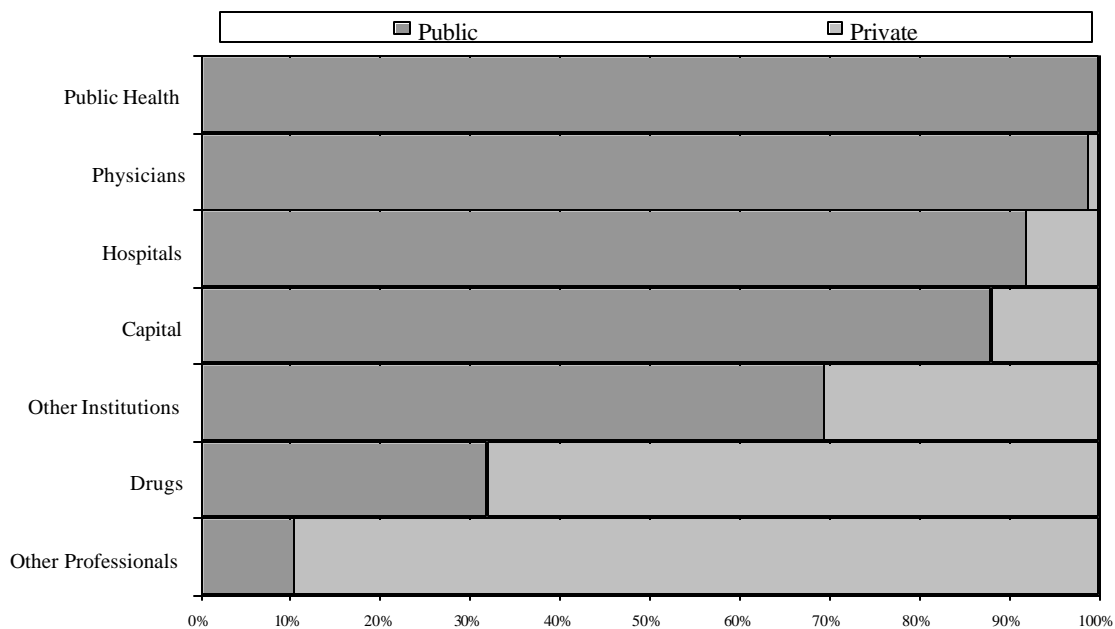
Source: CIHI(2000) and Library of Parliament.

⁶¹ Abby Hoffman (13:8).

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

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

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



Source: CIHI (2000) and Library of Parliament.

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

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

4.4 International Comparisons

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

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

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

TABLE 4.1

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

*1997 data.

Source: OECD Health Data 2000.

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

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

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

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

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

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

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

TABLE 4.2

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

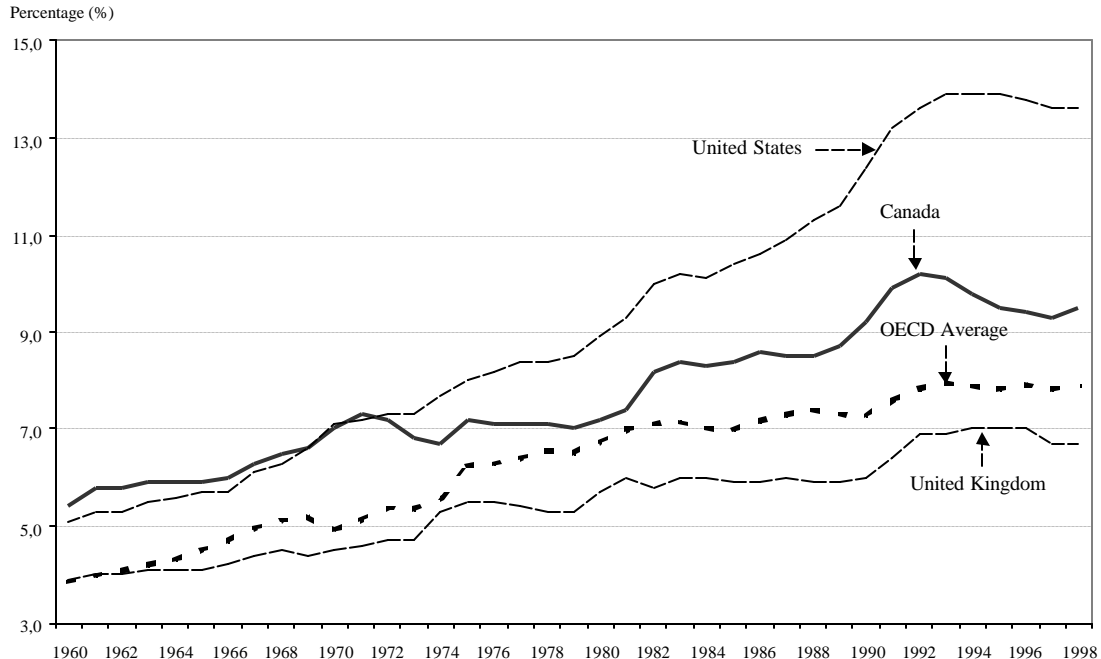
*1997 data.

Source: OECD Health Data 2000.

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

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

GRAPH 4.8
HEALTH CARE SPENDING AS A PERCENTAGE OF GDP



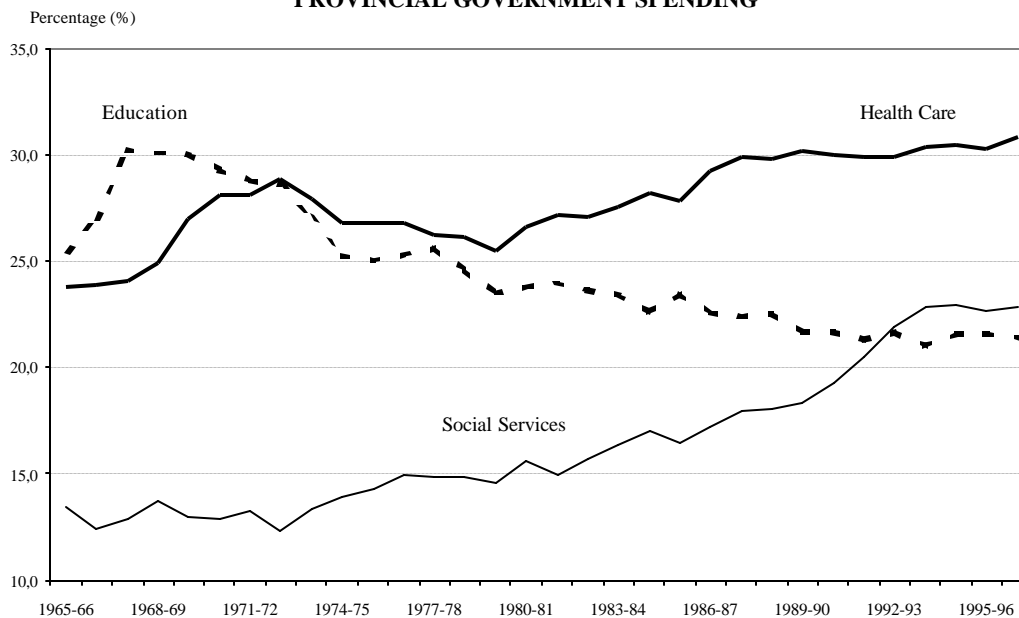
Source: OECD Health Data (2000) and Library of Parliament.

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

4.5 Health Care is a Priority in the Provinces

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

GRAPH 4.9
HEALTH CARE, EDUCATION AND SOCIAL SERVICES AS A PERCENTAGE OF
PROVINCIAL GOVERNMENT SPENDING



Source: Statistics Canada, CANSIM and Library of Parliament.

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

4.6 Committee Commentary

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

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

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

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

CHAPTER FIVE:

HEALTH STATUS AND THE CONCEPT OF POPULATION HEALTH

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

5.1 Health Status of Canadians

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

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

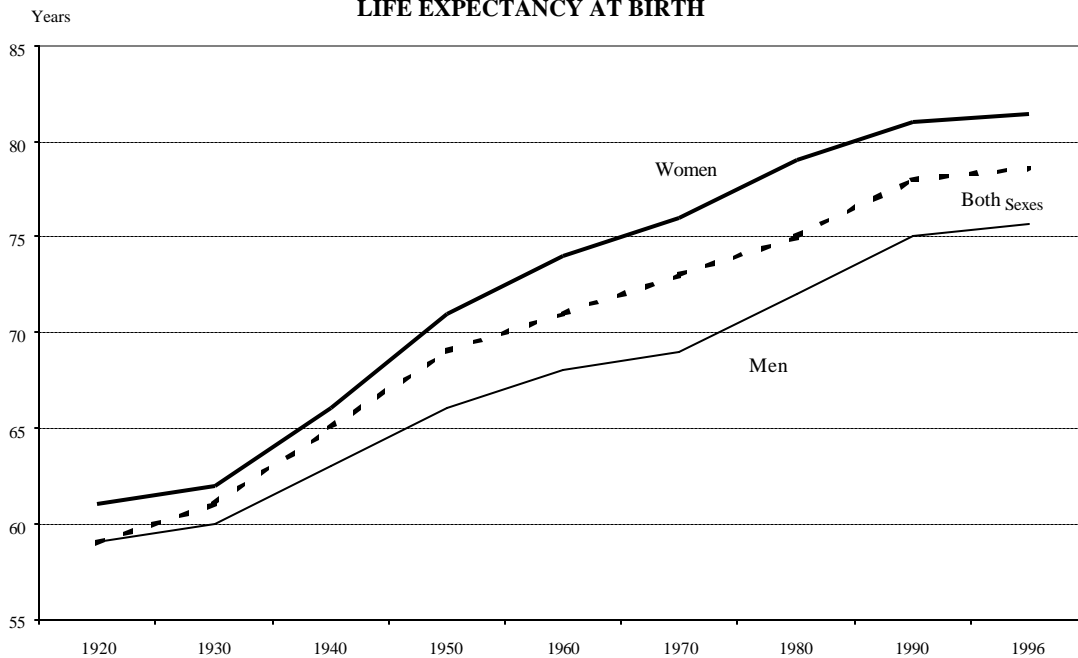
Dr. John S. Millar, V-P, Research and Analysis, CIHI (14:33).

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

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

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

GRAPH 5.1
LIFE EXPECTANCY AT BIRTH

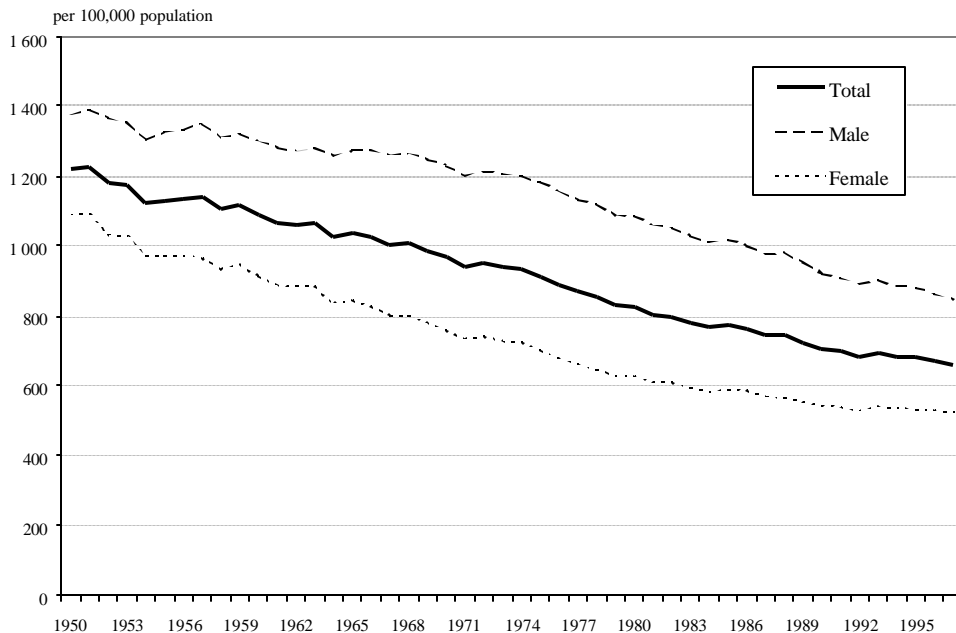


Source: Statistics Canada, Canadian Statistics (<http://www.statcan.ca>), Second Report on the Health of Canadians, and Library of Parliament.

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

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

GRAPH 5.2
AGE-STANDARDIZED MORTALITY RATES, ALL CAUSES

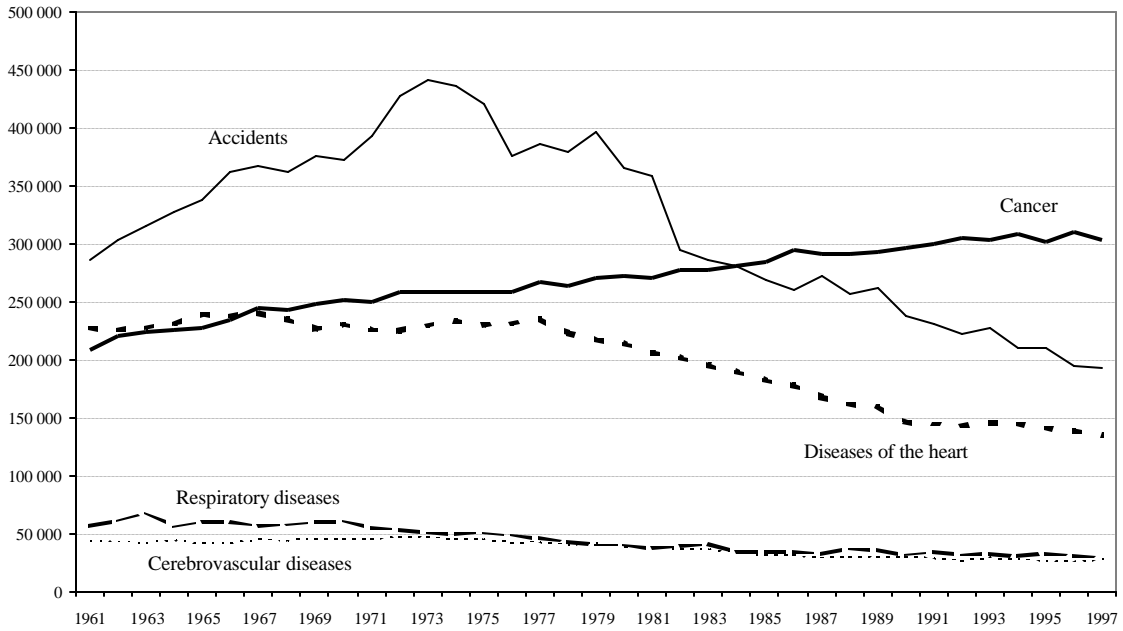


Source: Statistics Canada, *Health Statistics at a Glance*, Publication No. 82F0075XCB, 1999, and Library of Parliament.

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

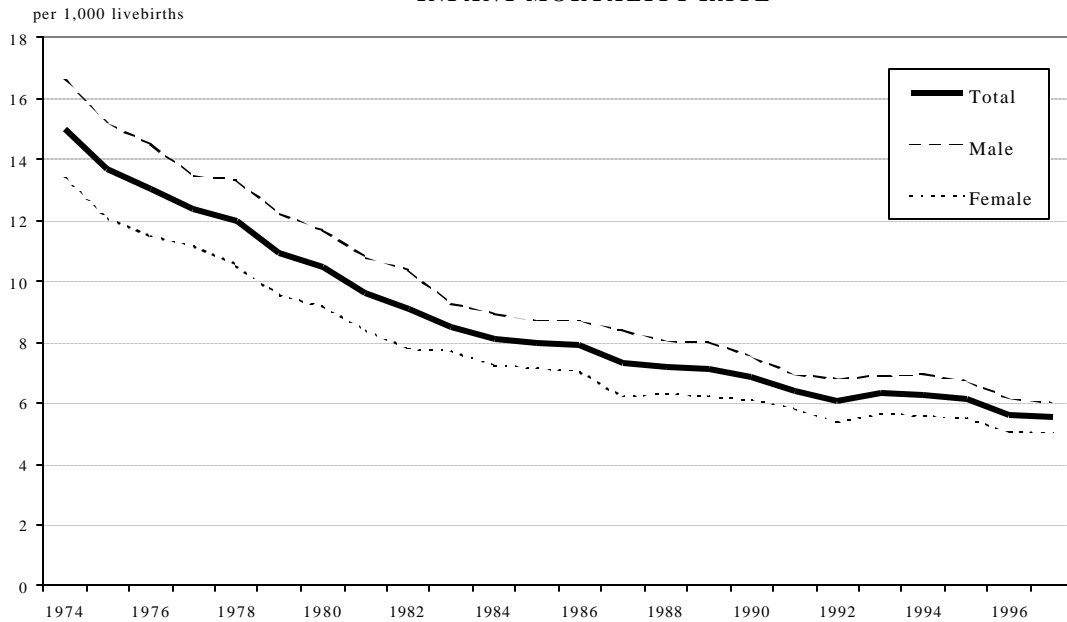
Long term trends in PYLL by major causes of death are presented in Graph 5.3. In 1997, there were over one million PYLL due to all causes, the most important being cancer, accidents and heart disease. As the graph indicates, cancer has been the leading cause of PYLL since 1984, and is the only major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

GRAPH 5.3
POTENTIAL YEARS OF LIFE LOST BY MAJOR CAUSE



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

GRAPH 5.4
INFANT MORTALITY RATE



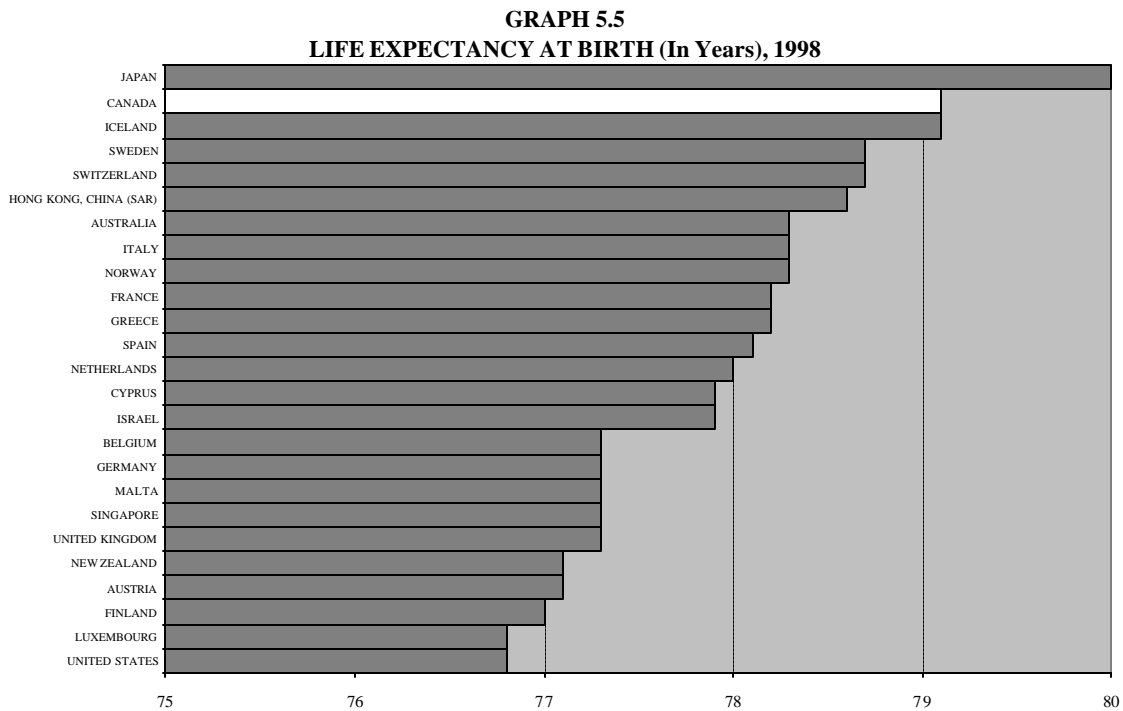
Source: Statistics Canada, *Health Statistics at a Glance*, Publication No. 82F0075XCB, 1999, and Library of Parliament.

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

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

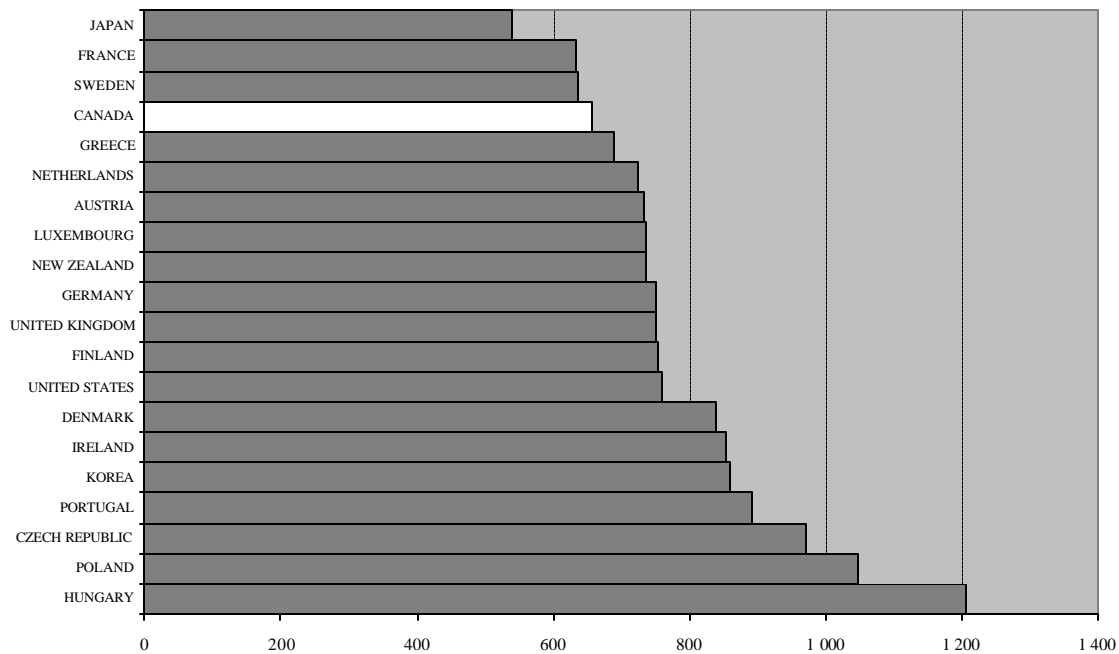
5.2 How Does Canada Compare to Other Countries?

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



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

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

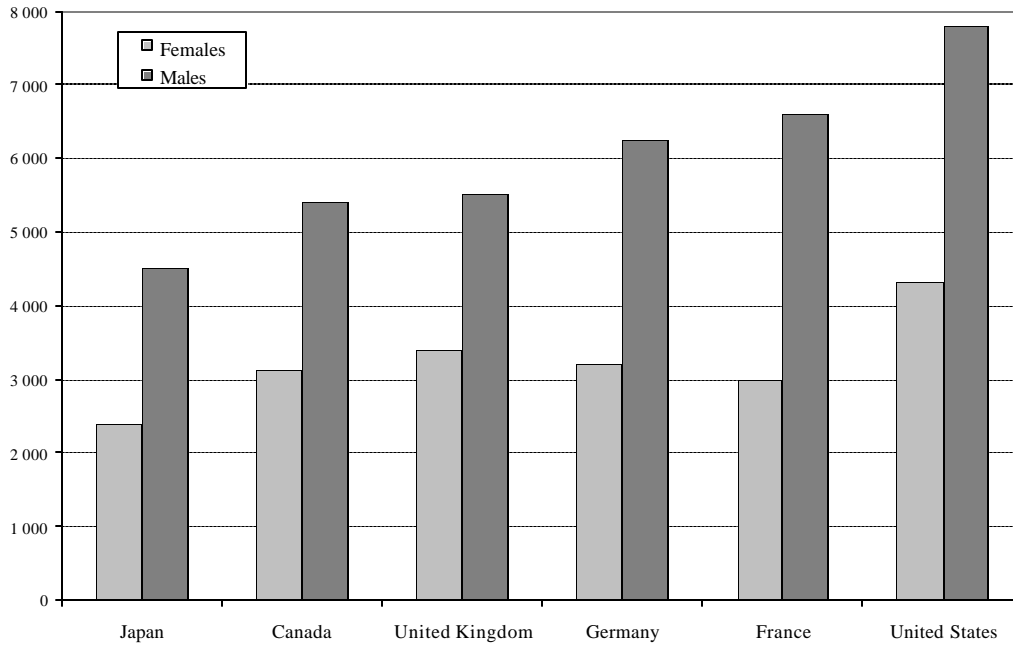


Source: OECD Health Data (2000) and Library of Parliament.

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

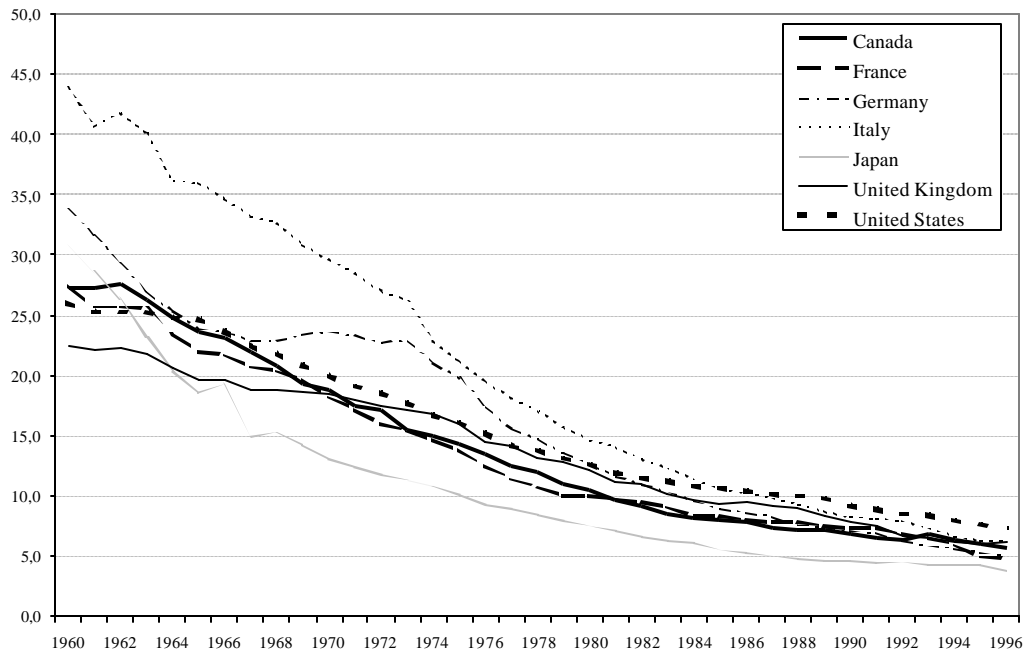
Like Canada, other industrialized countries have seen a decline in their infant mortality rates over the past few decades (see Graph 5.8). In 1960, the rates ranged from a low of 22 per 1,000 in the United Kingdom to a high of 44 per 1,000 in Italy. By 1996, the rates had fallen to a low of 4 in Japan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

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



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

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

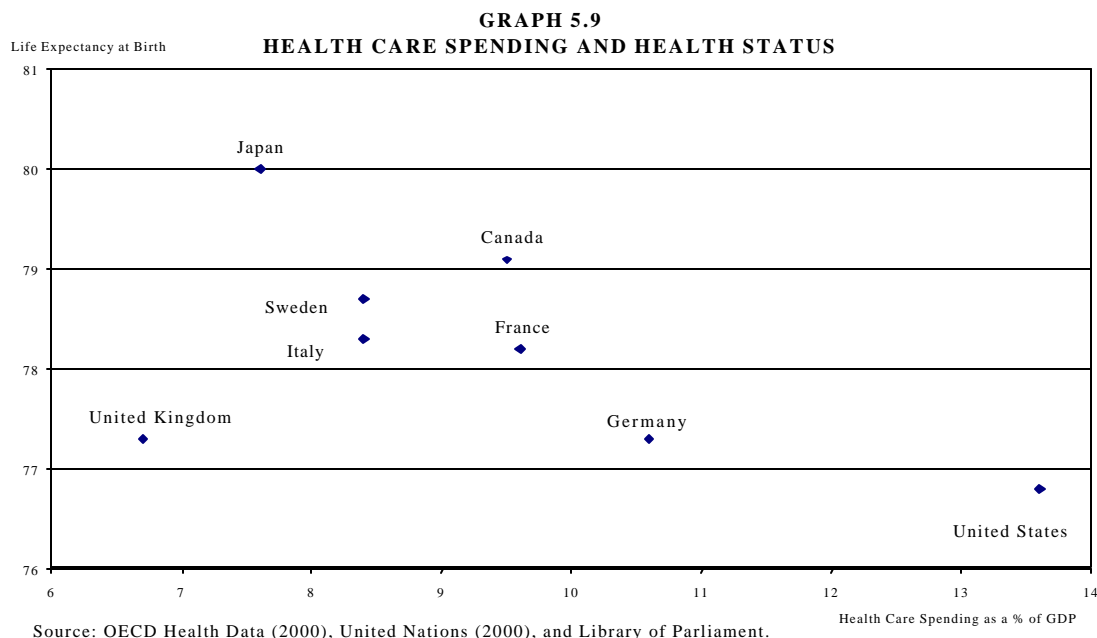


Source: OECD Health Data (2000) and Library of Parliament

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

5.3 Health Care Expenditures and Health Status

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

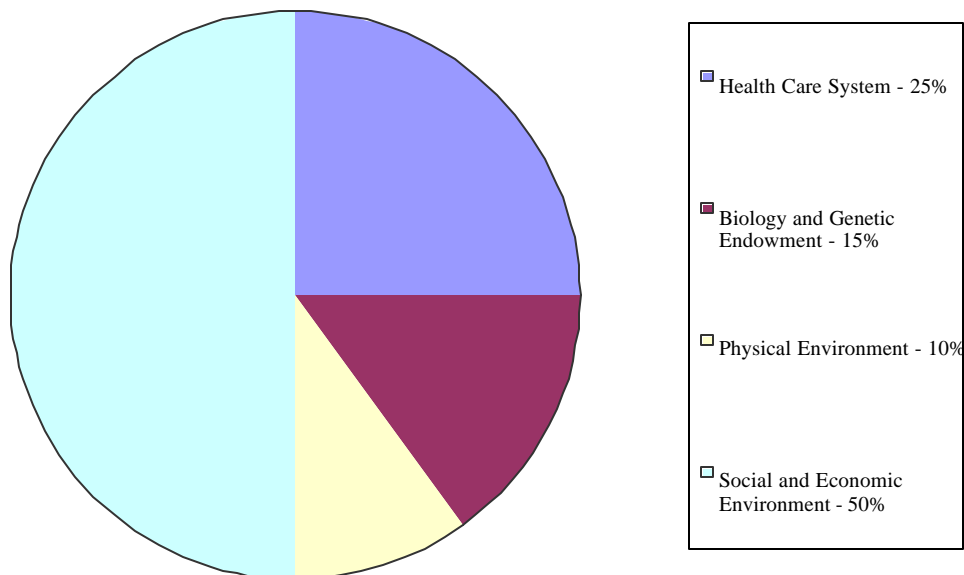


It is obvious that there is no clear relationship between a country's health care spending and the health status of its population. In other words, the health status of a population depends on many factors of which health care is only one.

5.4 The Concept of Population Health

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

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



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

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

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

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

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

The concept of population health is not new. In 1974⁶⁵, the then federal Minister of Health, Marc Lalonde, released a working document entitled *A New Perspective on the Health of Canadians*. This report put forward the idea that good health is not the result of medical care alone. For example, it proposed that changes in lifestyles or to social and physical environments would likely improve in the health status of Canadians more than would spending more money on health care delivery. The Lalonde report identified four major health determinants: human biology, environment, lifestyle and health care organization.⁶⁶

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

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

TABLE 5.1
KEY DETERMINANTS OF HEALTH

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

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

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

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

health by focusing on the broader social, economic and environmental factors affecting health.⁶⁷

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.5 What Makes Canadians Healthy or Unhealthy?

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

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

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

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

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

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

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

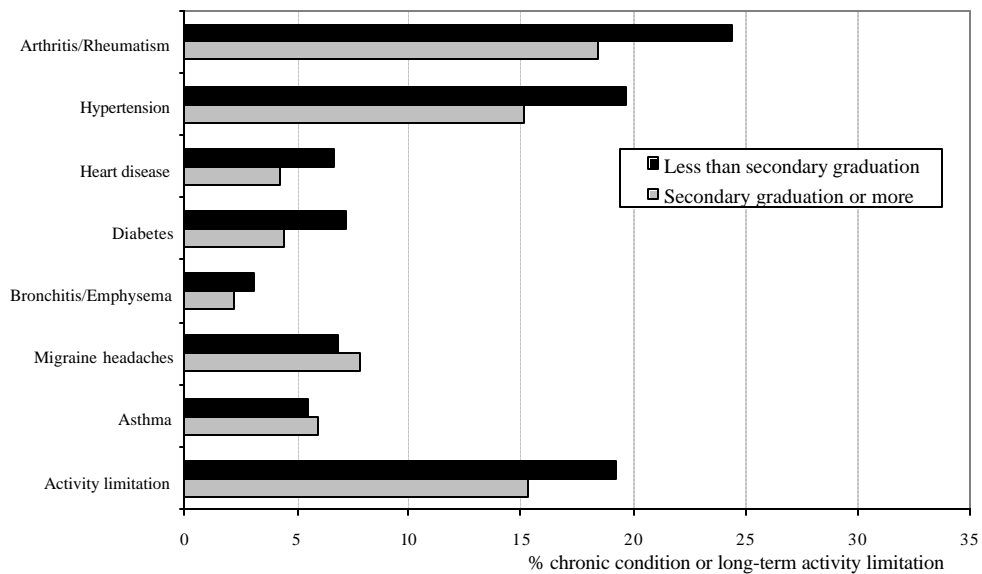
- Studies in neurobiology have confirmed that experiences from conception to age 6 have the largest influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health right into adulthood;
- Ageing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

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

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

Canada had been as low as that of the richest neighbourhoods, there would have been about 500 fewer infant deaths in 1996.⁷¹

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



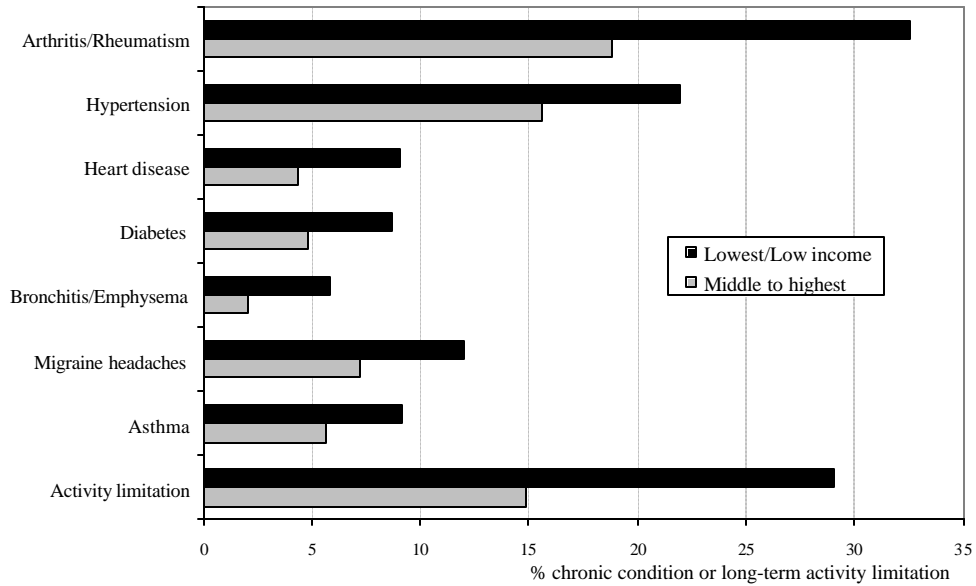
Source: "Health in mid-life," In Statistics Canada, *Health Reports*, Publication No. 82-003, Winter 1999, Vol. 11, No. 3.

5.6 Committee Commentary

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

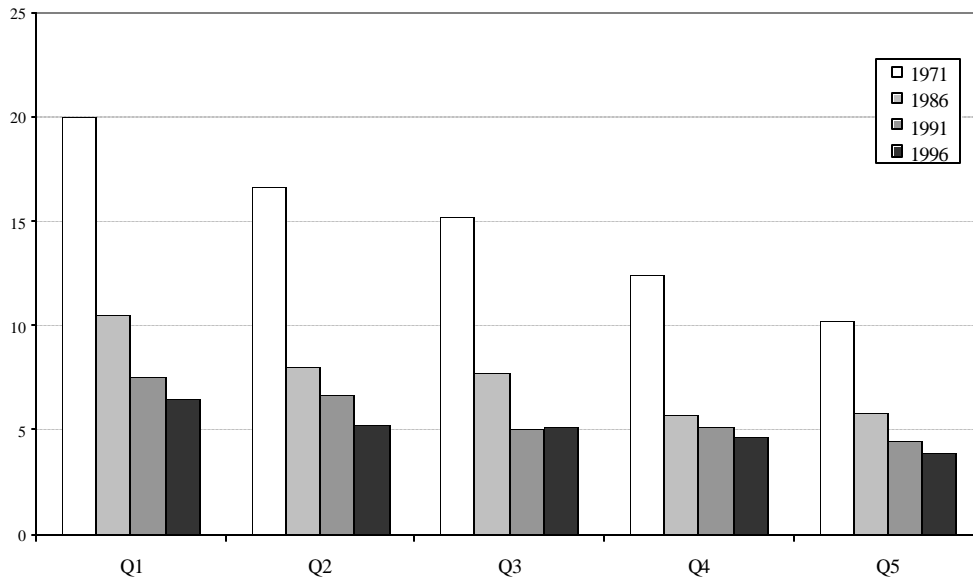
⁷¹ Statistics Canada, "Health Status of Children", *Health Reports*, Catalogue 82-003, Winter 1999, Vol. 11, No. 3.

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



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

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



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

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

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

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

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

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

⁷² Advisory Council on Health Infrastructure, *Paths to Better Health: Final Report*, Ottawa, February 1999, p. 4-1.

⁷³ Sholom Glouberman (9:9).

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

⁷⁴ Hon. Marc Lalonde (15:15).

CHAPTER SIX:

MYTHS AND REALITIES

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

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

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

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

6.1 Myths About Rising Health Care Costs

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

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

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

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

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

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

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

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

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

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

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

⁷⁵ Dr. Robert McMurtry (8:17).

attributable to ageing is estimated at less than 5%. Furthermore, Canadians are living both longer and more healthily. Therefore, the anticipated demographic impact of ageing on the health care system may need to be revised. While the costs associated with ageing must be analyzed and managed, a more significant issue concerns the health care costs that are generally incurred during the last six months of life, regardless of age. The cost of medical care individuals receive skyrockets as they near the end of their life. As a result, it is not the ageing per se of the population which has an impact on health care costs, but rather the overall increase in the population.

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

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

6.2 Myths About Public Financing

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

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

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

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

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

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

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

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

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

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

⁷⁷ Dr. John S. Millar (14:49).

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

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

6.3 Myths About the *Canada Health Act*

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

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

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

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

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

⁷⁹ Guillaume Bissonnette (17:6).

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

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

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

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

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

⁸⁰ Frank Fedyk (13:14).

⁸¹ Frank Fedyk (13:21).

TABLE 6.1
DEINSURED HEALTH CARE SERVICES BY PROVINCE

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

(1) Some exceptions may apply.

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

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

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

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

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

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

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

⁸² Health Canada, *Canada's Health Care System*, 1999, p. 2.

⁸³ *Ibid.*

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

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

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

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

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

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

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

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

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

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

6.4 Myths About Privatization

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

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

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

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

⁸⁴ Hon. Monique Bégin (16:8).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

⁸⁶ Mark Stabile (14:12).

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

6.5 Myths About Health Care Utilization

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

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

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

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

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

⁸⁷ Martin Zelder (12:39).

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

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

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

6.6 Myths About the Health Status of the Population

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

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

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

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

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

⁸⁸ Martin Zelder (12:40).

⁸⁹ Robert Evans (12:41-42).

More attention needs to be given to the non-medical determinants that promote good health (e.g. adequate income, early childhood development, employment and so on.), to the development of strategies that control health risks and prevent disease and disability, and to the need for an increased focus on evaluating and measuring health outcomes. To highlight the importance that other factors play in the health of Canadians, Dr. McMurtry provided the following examples⁹⁰:

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

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

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

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

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

⁹⁰ Robert McMurtry (8:25).

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

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

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

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

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

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

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

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

⁹³ Abby Hoffman (13:10).

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

6.7 Myths About the Need for Change

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

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

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

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

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

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

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

⁹⁵ Colleen Flood (14:19).

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

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

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

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

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

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

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

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

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

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

6.8 Myths About Health Care Providers

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

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

⁹⁶ Dr. Robert McMurtry (8:21).

⁹⁷ First Ministers' Meeting, *Communiqué on Health*, 11 September 2000 (available at www.scics.gc.ca).

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

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

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

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

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

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

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

⁹⁸ Graham W. S. Scott, Brief to the Committee, June 2000, p. 7.

⁹⁹ Dr. Mary Ellen Jeans (8:21).

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

¹⁰⁰ Dr. John S. Millar (14:5).

¹⁰¹ Dr. Mary Ellen Jeans (8:21).

CONCLUSION

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

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

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

The Next Steps

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX A - LIST OF WITNESSES

(2nd Session, 36th Parliament)

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

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

