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RESHAPING CANADA'S HEALTH CARE SYSTEM: REPORTS FROM A SENATE COMMITTEE AND A ROYAL COMMISSION

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BACKGROUND

Canadians can now explore the options outlined in two major studies of Canada's health care system, one by a Royal Commission(1) and the other by a Senate Committee.(2) The following analysis provides a succinct overview of the common concerns expressed by these two bodies and reflects on their significance and possible next steps.(3)

A. Mandates

In the spring of 2000, the Standing Senate Committee on Social Affairs, Science and Technology chaired by Senator Michael Kirby held its first public hearings on the overall state of the Canadian health care system. Then, in April 2001, the Canadian public witnessed the inauguration of a second major study when the federal government established the Royal Commission on the Future of Health Care, chaired by Roy Romanow. The Senate Committee was authorized to examine "the fundamental principles on which Canada's publicly funded health care system is based; the historical development of Canada's health care system; health care systems in foreign jurisdictions; the pressures on and constraints of Canada's health care system; and the role of the federal government in Canada's health care system." The mandate of the Royal Commission was to "inquire into and undertake dialogue with Canadians on the future

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(1) Royal Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada*, Ottawa, November 2002, http://finalreport.healthcarecommission.ca/pdf/HCC_Final_Report.pdf.

(2) Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role: Final Report*, Ottawa, October 2002, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm.

(3) This paper benefited from background work done by my colleagues Howard Chodos, Michael Dewing, Megan Furi and Odette Madore.

of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment."

B. Processes

Both bodies organized their work to provide interim documents to establish a base for ongoing debate and to elicit further input. The Senate Committee developed an issues and options paper by September 2001, as one of five background reports, while the Royal Commission released an interim report in February 2002 followed by multiple discussion papers and consultation reports. The Senate Committee produced its final report on the state of the health care system in Canada in October 2002, and the Royal Commission released its final report on the future of health care in Canada in November 2002.

C. Reports

The reports produced over the years by the Senate Committee and the Royal Commission stand as key contributions to the current debate on health care in Canada. The Senate Committee asserted, in its final report, that it had formulated "a detailed, concrete plan of action that did not focus heavily on governance issues or intergovernmental structures." This plan attached a cost to each of its recommendations, proposed a specific revenue-raising plan, and specified clearly the changes required by each of the major stakeholders – individual Canadians, health care professionals, provincial and federal governments. The Royal Commission wanted its recommendations "to serve as a roadmap for a collective journey by Canadians to reform and renew their health care system" and to outline actions to be taken in 10 critical areas, nationally and internationally.

THE HEALTH CARE SYSTEM

Not surprisingly, the two bodies shared many common concerns and made many similar recommendations to the federal government. Both argued that Canada's health care

system, in its current form, with existing demands, and given the present resources, was not sustainable. Both supported the continuance of a publicly funded system.

One key area of divergence was the role of the private sector in delivering health care. The Royal Commission was clear that delivery of direct health services (medical, surgical and diagnostic) was to be done by public or private not-for-profit entities. The Senate Committee asserted neutrality on the question of ownership, believing that private, for-profit entities were equally capable of meeting price and quality controls and, as is currently the case, should not be prohibited.

Each of the following sections of this paper includes a table providing a synopsis of key recommendations proposed by the two reports in areas of common concern. The tables focus on the main areas requiring involvement by the federal government. While highlighting the shared concerns, the tables also serve as a guide to key areas of agreement and difference.

A. Funding

While both bodies called for additional funding to come from public sources, they took somewhat divergent approaches and set out different overall funding requirements. The Royal Commission proposed that the revenues to fund provincial and territorial health care insurance plans be collected on a national tax base (from general revenues), in order to distribute the financial costs. It recommended a new, dedicated, cash-only Canada Health Transfer, distinct and separate from other social programs. The Canada Health Transfer was to amount, at a minimum, to 25% of provincial and territorial costs of insured services with an escalator set in advance for five-year periods. In terms of immediate action over the next two years, the Royal Commission proposed targeted funding for a Rural and Remote Access Fund ($1.5 billion), Diagnostic Services Fund ($1.5 billion), Primary Health Care Transfer ($2.5 billion), Home Care Transfer ($2 billion), and Catastrophic Drug Transfer ($1 billion).

The Senate Committee's approach was slightly more complicated, calling for an increase in the existing federal Canada Health and Social Transfer (CHST) to provide funding for the current system. It noted that an additional $1.5 billion could be added if the federal government designated half of the existing GST on an annual basis. It also recommended an additional $5 billion for specified programs to come from an Earmarked Fund for Health Care, with revenues raised from a National Variable Health Care Insurance Premium. The additional annual federal investment of $5 billion per year was to cover expansion of coverage in post-

hospital home care, catastrophic prescription drug costs, restructuring involving technology, capital costs, primary care reform, health promotion and prevention, human resources, and research.

SENATE COMMITTEE	ROYAL COMMISSION
Establish an Earmarked Fund for Health Care that is distinct and separate from the Consolidated Revenue Fund. Establish a National Variable Health Care Insurance Premium to raise the necessary federal revenue. Make a significant additional cash contribution to current CHST funding, possibly by designating half of all GST revenue. The share of the federal annual contribution to which a province/territory is entitled be weighted in some way by the percentage of its population aged 70 years and over.	Establish a new, dedicated, cash-only Canada Health Transfer and include an escalator that is set in advance for five-year periods. Provide targeted funding for the next two years to establish: • a new Rural and Remote Access Fund; • a new Diagnostic Services Fund; • a Primary Health Care Transfer; • a Home Care Transfer; and • a Catastrophic Drug Transfer.

B. National Oversight

Both bodies saw health care as a national endeavour requiring national oversight and collaboration. Recognizing that the *Canada Health Act* provides the framework for a national approach, both indicated support for the existing principles while asking for clarifications. There were, however, some differences in approach relating to the *Canada Health Act*. The Royal Commission, with its recommendation for funding falling under the legislation, saw a place for a sixth principle on accountability to enable Canadians to hold their governments accountable for results. The Senate Committee, on the other hand, specified that much of the additional funding should fall outside the *Canada Health Act*. On the specific issue of timely access to health care, the Senate Committee recommended a Health Care Guarantee, whereas the Royal Commission added this aspect to its proposed criteria for a Canadian Health Covenant. To facilitate national cooperation and leadership, the Royal Commission recommended a Health Council of Canada; the proposed council had commonalities with the National Health Care Council and National Coordinating Committee for Health Human Resources recommended by the Senate Committee. Furthermore, the Senate Committee envisioned the establishment of a permanent Committee on Public Health Care Insurance Coverage to review health care insurance coverage and to develop standards for coverage decisions.

SENATE COMMITTEE	ROYAL COMMISSION
Provide $10 million annually for a National Health Care Commissioner and a National Health Care Council, for activities including an annual report on the health care system and the health status of Canadians and advice to the federal government on the allocation of the new money. Require the provinces and territories to report annually to the Canadian public on their utilization of federal money from the Earmarked Fund for Health Care, and subject the fund to an annual audit by the Auditor General of Canada. Establish and make public a maximum needs-based waiting time for each type of major procedure or treatment, and require the insurer (government) to pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country, when the maximum time is reached. (This is called the Health Care Guarantee.) Establish, in collaboration with the provinces and territories, a permanent Committee on Public Health Care Insurance Coverage to review and make recommendations to the National Health Care Council on the set of services that should be covered under public health care insurance. Provide additional annual funding of $50 million to the Canadian Institute for Health Information and an annual investment of $10 million to the Canadian Council on Health Services Accreditation, to establish a national system of evaluation of health care system performance and outcomes to facilitate the work of the National Health Care Commissioner.	Establish, in conjunction with provincial and territorial governments, a Health Council of Canada to facilitate cooperation and provide national leadership. Have the Health Council initially establish common indicators and measure performance; establish benchmarks, collect information and report publicly on efforts to improve quality, access and outcomes; and coordinate existing health technology assessment activities. Have the Health Council in the longer term provide ongoing advice and coordination for primary health care transformation, the development of national strategies for the health workforce, and the resolution of disputes under a modernized *Canada Health Act.* Establish a new Canadian Health Covenant as a common declaration of Canadians' and their governments' commitment to a universally accessible, publicly funded health care system. Use the new Diagnostic Services Fund to improve access to medically necessary diagnostic services and use the proposed Health Council of Canada to ensure that they are assessed and integrated appropriately. Use the proposed Health Council of Canada to track and report progress on the efforts of provincial and territorial governments to reduce waiting lists.

C. Specific Initiatives

The difficulties of implementing reform in primary care, of removing obstacles to home care and of easing prescription drug costs received attention from both bodies with many similar and some different approaches. On primary care, the Senate Committee called for financial support for the creation of multi-disciplinary primary health care teams, allocating $50 million per year from the additional federal investment needed. The Royal Commission proposed to use the $2.5-billion Primary Care Health Transfer over two years to "fast-track"

movement on continuity of care, early detection and action, better information on needs and outcomes, and incentives to achieve change. With regard to home care, the Royal Commission proposed a $2-billion Home Care Transfer to cover such care for mental health, for post-acute, and for palliative care services. The Senate Committee allocated $550 million per year to post-acute home care and $250 million per year to palliative care, both funded through the new federal investment. On drug costs, the Royal Commission indicated that ultimately all prescription drug coverage should fall under the *Canada Health Act*. However, it proposed an initial catastrophic drug program funded through a $1-billion special transfer. The Senate Committee proposed that $500 million be invested annually by the federal government in paying for prescription drugs that exceed a certain limit. Like the home care and palliative care initiatives, this would fall outside the *Canada Health Act*.

SENATE COMMITTEE	ROYAL COMMISSION
PRIMARY CARE	
Continue work with the provinces and territories to reform primary care delivery and provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care teams. Commit $50 million per year of the new revenue to assist the provinces in setting up primary care groups.	Use the proposed Primary Health Care Transfer to "fast-track" primary health care implementation. Have the proposed Health Council of Canada sponsor a National Summit on Primary Health Care within two years and play a leadership role in following up and reporting to Canadians.
HOME CARE	
Establish a new National Post-Acute Home Care Program, to be jointly financed with the provinces and territories on a 50:50 basis. Co-fund on a 50:50 basis a National Palliative Home Care Program designed by the provinces and territories. Examine the feasibility of providing Employment Insurance benefits for six weeks to cover family leave for palliative care services and of expanding available tax measures for palliative care. Amend the *Canada Labour Code* to allow employee leave for family crises, encourage similar provincial labour code changes, and enact job protection for federal employees caring for dying family members.	Use the proposed new Home Care Transfer to support expansion of the *Canada Health Act* to include medically necessary home care services in the following areas: • Home mental health case management and intervention services; • Home care services for post-acute patients, including coverage for medication management and rehabilitation services; and • Palliative home care services to support people in their last six months of life. Direct Health Canada and Human Resources Development Canada to develop proposals for direct support to informal caregivers.

SENATE COMMITTEE	ROYAL COMMISSION
DRUG COVERAGE	
Introduce a program to protect Canadians against catastrophic prescription drug expenses and agree to pay, for all eligible plans, 90% of all prescription drug expenses over $5,000 for those individuals for whom the combined total of their out-of-pocket expenses and the contribution that a province/territory incurs on their behalf exceeds $5,000 in a single year. Require provinces and territories to ensure that no family of the province/territory would be obliged to pay more than 3% of family income for prescription drugs; sponsors of existing private supplementary drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out-of-pocket expenses that exceed $1,500 per year; this would cap each individual plan member's out-of-pocket costs at either 3% of family income or $1,500, whichever is less. Work closely with the provinces and territories to establish a single national drug formulary.	Use the proposed new Catastrophic Drug Transfer to reduce disparities in drug coverage across the country. Reimburse provincial governments for 50% of the cost of prescription drugs provided under their existing programs after a pre-set threshold of $1,500 per patient; make it conditional on the provincial governments using the funds transferred, in the first instance, for expanding their existing drug programs. Establish a new National Drug Agency to work collaboratively with provinces and territories to evaluate and approve new prescription drugs, provide ongoing evaluation of existing drugs, negotiate and contain drug prices, and provide comprehensive, objective and accurate information to health care providers and to the public; develop standards for the collection and dissemination of prescription drug data on drug utilization and outcomes; and create a national prescription drug formulary based on a transparent and accountable evaluation and priority-setting process.

D. Human Resources

In this area, the reports used similar data and expressed common concerns about the distribution of physicians, about barriers to practice, about training for team approaches and generally about the need for a comprehensive national plan on health care professionals. The Senate Committee, however, made many more detailed recommendations, specifying particular targets to counter physician and nurse shortages and designating precise dollars to purchase educational openings. The Royal Commission noted its priorities for rural and remote access and for advanced diagnostics, and took the different route of channelling spending on education and training through new short-term funds and the proposed long-term transfer.

SENATE COMMITTEE	ROYAL COMMISSION
Create a permanent National Coordinating Committee for Health Human Resources to monitor levels of enrolment in Canadian medical schools and make recommendations to the federal government. Contribute $160 million per year to enable Canadian medical colleges to enrol 2,500 first-year students by 2005, and contribute financially to increasing the number of post-graduate residency positions in medicine to a ratio of 120 per 100 graduates of Canadian medical schools. Commit $90 million per year to enable Canadian nursing schools to graduate 12,000 nurses by 2008. Commit $40 million per year from the recommended new revenues to assist the provinces in raising the number of allied health professionals who graduate each year. Devote $75 million per year of the recommended new money to assist Academic Health Sciences Centres with costs associated with expanding the number of training slots for the full range of health care professionals. Work with the provinces and medical and nursing faculties to finance places for students from Aboriginal backgrounds and to facilitate the return of expatriate Canadian health care professionals.	Use a portion of the proposed Rural and Remote Access Fund, the Diagnostic Services Fund, the Primary Health Care Transfer, and the Home Care Transfer to improve the supply and distribution of health care providers, encourage changes to their scopes and patterns of practice, and ensure that the best use is made of the mix of skills of different health care providers. Have the Health Council of Canada: • collect, analyze and regularly report on information about the Canadian health workforce, including critical issues related to the recruitment, distribution, and remuneration of health care providers; • review existing education and training programs and provide recommendations to the provinces and territories on more integrated education programs for preparing health care providers, particularly for primary health care settings; and • develop a comprehensive plan for addressing issues related to the supply, distribution, education and training, remuneration, skills and patterns of practice for Canada's health workforce.

E. Technology

Both the Royal Commission and the Senate Committee conceded that access to health care technology for diagnosis and treatment, as well as the development of electronic health records to assist decision-making and accountability, were essential. Both called for specific funding for the purchase and implementation of additional technological equipment: the Royal Commission through a $1.5-billion, two-year fund, and the Senate Committee through $500 million annually for five years from the proposed additional annual federal investment. While both saw a role for Canada Health Infoway Inc. and both called for assessments of its ongoing work, the Senate Committee called for additional funding from proposed federal money for the development of a national system of electronic health records.

SENATE COMMITTEE	ROYAL COMMISSION
Provide a total of $2.5 billion over five years (or $500 million annually) to hospitals for purchasing and assessing health care technology. Of this funding, allocate $400 million annually to Academic Health Sciences Centres and $100 million annually to community hospitals. The community hospital funding should be cost-shared on a 50:50 basis with the provinces, while the Academic Health Sciences Centres funding should be 100% federal. Provide additional funding to Canada Health Infoway Inc. in the amount of $2 billion over five years, or an annual allocation of $400 million, to develop, in collaboration with the provinces and territories, a national system of electronic health records.	Use the new Diagnostic Services Fund to improve access to medically necessary diagnostic services. Have the Health Council of Canada take action to streamline technology assessment in Canada. Have Canada Health Infoway Inc. continue to take the lead and be responsible for developing a pan-Canadian electronic health records framework built upon provincial systems. Amend the *Criminal Code of Canada* to protect Canadians' privacy and to explicitly prevent the abuse or misuse of personal health information.

F. Other Elements

In several instances, matters of particular concern to one body received only minimal attention from the other. For example, whereas the Royal Commission devoted significant space to rural and remote communities, Aboriginal health and globalization, the Senate Committee had separate chapters on hospital restructuring and health research. With regard to health promotion and disease prevention, the Senate Committee highlighted the need for a National Chronic Disease Prevention Strategy with funding of $125 million annually and the ongoing requirement for coordinated population health strategies. On this same issue, the Royal Commission acknowledged the high cost of preventable health problems but encompassed the issue under the primary care discussion, giving it minimal review and no specific funding.

SIGNIFICANCE OF THE REPORTS

Although Canada's health care system has been the subject of intensive study for over half a century, the two reports released in 2002 provided valuable blueprints for shaping its future. They were created at a time when Canadians are seeking answers to major policy quandaries relating to the health care system. Both reports – one the result of action by the

Senate of Canada, and the other emanating from actions by the Prime Minister – respond to pressures and concerns expressed by a wide range of interested parties, including various levels of government, health care providers and ordinary citizens. Both signal the heightened concern about health care and the perceived need for federal leadership to generate a national plan.

The two inquiries reflected and articulated Canadians' values and goals, and created a framework for considering multiple concerns. They gathered information, educated the public, aired conflicting views, and generally tested the public will for change. They highlighted competing ideas, such as those dealing with the role of the public versus the private sector, the merits of organizing physicians from individual practices into group multi-professional practices, and the importance for individual Canadians of being passive or active in shaping their own system. Both emphasized the sometimes opposing interests of various provinces and other players, and indicated the trade-offs that would be necessary to move in certain directions.

NEXT STEPS

These reports do not stand alone. Over the last decade, various federal and provincial inquiries have attempted to focus public attention and governmental funding on areas of the health care system that need reform. Like the others preceding them, these reports stand only as ideas with recommendations for action. The proposals for change will be implemented and enforced only when the multiple interests and institutions in the health care area work together. However, the two reports share very similar findings, and many common recommendations may reinforce the movement to concerted and coordinated action.

In Canada's federal structure, these reports provide the blueprint for negotiation at the executive level. With a First Ministers' meeting planned for early 2003, the Prime Minister and various provincial premiers have already begun the public side of the debate. To sustain any plan that emerges from such a meeting will require ongoing engagement and cooperation from multiple players, including governments, health care providers and citizens.