HOUSE OF COMMONS
CANADA

THE HEALTH CARE SYSTEM IN CANADA AND ITS FUNDING: NO EASY SOLUTIONS

FIRST REPORT OF THE STANDING COMMITTEE ON HEALTH AND WELFARE, SOCIAL AFFAIRS, SENIORS AND THE STATUS OF WOMEN
(reconstituted Committee)

Bob Porter, M.P.
Chairman

JUNE 1991

The Health care system in Canada and its funding.

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Président: Bob Porter

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Health and Welfare, Social Affairs, Seniors and the Status of Women

Procès-verbaux et témoignages du Comité permanent de la

Santé et du Bien-être social, des Affaires sociales, du Troisième âge et de la Condition féminine

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RESPECTING:

Pursuant to the Special Order adopted by the House on Friday, May 17, 1991, consideration of the Draft Report on the health care system in Canada and its funding

INCLUDING:

The First Report to the House

CONCERNANT:

En vertu de l'ordre spécial adopté par la Chambre le vendredi 17 mai 1991, étude du projet de rapport sur le régime de soins de santé au Canada et son financement

Y COMPRIS:

Le premier rapport à la Chambre

Third Session of the Thirty-fourth Parliament, 1991

Troisième session de la trente-quatrième législature, 1991

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ACKNOWLEDGEMENTS

In November 1989, the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women initiated hearings on the health care system in Canada and its funding.

The Committee invited submissions and heard from over fifty individuals and organizations. The contributions of those who participated in the hearings by sharing their expertise and insight in the complex and varied areas of the Canadian health care system were invaluable to the study.

The Committee wishes to express its sincere appreciation to the Clerk of the Committee, Clairette Bourque, who organized meetings, assisted in translation and co-ordinated the hearings of witnesses.

This report could not have been completed without the competent and skilled Research Officers of the Library of Parliament. Joan Vance and Odette Madore provided valuable research assistance and experience to the Committee in the preparation and completion of the report. Maureen Baker was most helpful to the Committee for the first half of the study. Raisa Deber, from the University of Toronto, was also helpful to the Committee, as a consultant.

The Members of the Committee are also indebted to the support staff of the Committees Directorate and the Translation Bureau of Secretary of State for their work during this study.

In conclusion, the Chairman would like to sincerely thank the Members of the Committee for their cooperation during the hearings and for their dedication to the completion of this report.

REPORT TO THE HOUSE

THE STANDING COMMITTEE ON HEALTH AND WELFARE, SOCIAL AFFAIRS, SENIORS AND THE STATUS OF WOMEN

(reconstituted Committee)

has the honour to present its

FIRST REPORT

Pursuant to Standing Order 108(2), your Committee has considered the health care system in Canada and its funding. It has adopted this report which reads as follows:

ORDERS OF REFERENCE

Extract from the* Votes and Proceedings *of the House of Commons of Friday, May 17, 1991:

By unanimous consent, it was ordered,—That the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women as it existed on the last day of the Second Session of the present Parliament be reinstated for the sole purpose of completing its report on the Health Care System in Canada and its funding, such reconstituted committee being a separate and distinct entity from the Standing Committee of the same name as listed in Standing Order 104;

That for the purpose of this order, the Standing Orders relating to committees in effect at the end of the Second Session of the present Parliament, continue to apply;

That the evidence adduced by the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women in the Second Session of the present Parliament be deemed to have been referred to the Committee;

That all motions and orders adopted by the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women in the Second Session of the present Parliament necessary for the completion of its report be deemed to have been adopted by the Committee in the present Session; and

That this Committee hereby appointed table its report to the House no later than June 1, 1991 and that upon tabling of the report, the Committee shall cease to exist.

ATTEST

ROBERT MARLEAU

Clerk of the House of Commons

Extract from the* Votes and Proceedings *of the House of Commons of Wednesday, May 29, 1991:

By unanimous consent, it was ordered,—That further to the Order of the House made Friday, May 17, 1991 respecting the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, the Committee be authorized to table its Report not later than Friday, June 21, 1991.

ATTEST

ROBERT MARLEAU

Clerk of the House of Commons

TERMS OF REFERENCE (ADOPTED BY THE COMMITTEE ON OCTOBER 19, 1989)

THE HEALTH CARE SYSTEM AND ITS FUNDING: FOCUS OF THE STUDY

1. THE AGING POPULATION AND ITS IMPACT ON THE HEALTH CARE SYSTEM

Only 11% of the Canadian population is now 65 years of age and older, but this percentage is expected to rise to about 27% by 2031. Some studies have indicated that elderly people, especially older seniors, tend to use a larger proportion of health care resources than younger adults. Researchers disagree, however, about the extent of morbidity in the future. The future elderly compared to the present elderly may be healthier due to more accessible health care, advances in medical technology and healthier lifestyles throughout their lives. On the other hand, they may experience a longer period of disability and illness with increased life expectancy.

- Do current methods of financing encourage less costly alternatives to institutionalized care for frail elderly and chronically ill persons?
- How can we plan future health care services for elderly persons based on projections of present trends?

2. THE ACCESSIBILITY OF VARIOUS TYPES OF HEALTH CARE SERVICES TO ALL REGIONS AND CATEGORIES OF PEOPLE

- How can we assure that an adequate level of health services is available to those in rural and remote areas?
- How can we make physical and mental health services more accessible to the poor, aboriginal peoples, immigrants and cultural minorities?

- How can we assure that health services are accessible to children and youth, and appropriate for their special needs?
- To what extent are the poor, immigrants and aboriginal groups affected by the practice of de-insuring selected procedures and services in some provinces?
- What is the role of health promotion and disease prevention in improving the health status of disadvantaged groups?
- Given the absence of a clear division between health promotion and social interventions (such as better housing, specialized housing and transportation for the elderly and disabled, nutritional counselling and social work), can community health centres and community service centres serve to link curative health, health promotion and social programs?

3. HEALTH CARE HUMAN RESOURCES: SUPPLY, UTILIZATION AND GEOGRAPHIC DISTRIBUTION OF PROFESSIONAL AND OTHER HEALTH CARE WORKERS

- What is the relationship between the availability and distribution of human resources in the health sector (physicians, nurses and other health care professionals) and the quality and cost-effectiveness of health care delivery?
- What is the role of other non-medical professionals, such as midwives, chiropractors, psychologists, nurse practitioners, physiotherapists, occupational therapists and massage therapists in the health care system? Should Canadians have direct fully-insured access to these professionals? Should these professionals be allowed to make decisions concerning the need for non-medical services such as home care?

THE HEALTH CARE SYSTEM IN CANADA AND ITS FUNDING: NO EASY SOLUTIONS

INTRODUCTION

The general purpose of this study is to determine the ability of current fiscal arrangements to provide an adequate, stable yet flexible funding base for a health care system that responds to the needs of Canadians. In this report, the Committee is seeking solutions to this funding dilemma while, at the same time, addressing some specific concerns, namely, the impact of the aging population on the health care system, access to care, health care human resources and health research.

This study was initiated in the previous Parliament by the National Health and Welfare Committee under the chairmanship of Dr. Bruce Halliday. That Committee heard witnesses and presented an Interim Report to the House of Commons on 13 September 1988, which provides background information for the present study.

In November 1989, the House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women resumed the study of the Canadian health care system and its funding. Between November 1989 and January 1991, the Committee received numerous briefs and heard from a wide range of witnesses concerning the strengths and weaknesses of the system. Witnesses included the Minister of National Health and Welfare, government officials, health policy analysts, university researchers, associations of health care providers and consumers, and advisory councils and advocacy groups. On 18 June 1990, the Committee presented its Interim Report to the House of Commons summarizing recurring themes in the briefs and testimony of witnesses received to mid-April.

The Canadian health care system poses a significant challenge to Canadians and their governments as they attempt to create and maintain a cost-effective health care system which provides high quality health care to all Canadians. Over the past twenty or thirty years, Canada's health care spending has increased substantially. Much of this growth was due, initially, to the introduction of public medical and hospital insurance.

More recently, the expansion of the health care delivery system, increasing sophistication of modern medicine, and a corresponding rise in health consumer expectations, and demographic changes have contributed to an increase in health spending. The Committee also recognizes the limitations imposed on the study by the changing economic and constitutional environment and acknowledges that there is no easy solution to this dilemma.

CHAPTER 1

HEALTH EXPENDITURE IN CANADA

Information on health expenditure in Canada, on both a national and provincial basis, is discussed in this chapter. In addition, information on how Canada's expenditures compare to those in other Organization for Economic Cooperation and Development (OECD) countries is presented. Finally, some of the factors that OECD studies have found to be associated with upward trends in health spending are considered, on the premise that they may inform our efforts to deal with this problem in Canada.

A. NATIONAL HEALTH EXPENDITURES[1]

Table 1 shows total national health expenditure for selected years between 1960 and 1990. Data are provided for five year intervals between 1960 and 1975 and for every year between 1975 and 1990. It should be noted that figures after 1987 are estimates.[2]

In 1960, health care spending totalled $2.1 billion, or about $120 per capita, and represented 5.5% of GNP. By 1987, total health expenditure was $48 billion or $1,870 per capita and represented 9% of GNP. In 1990, national health care expenditures are estimated to be approximately $60 billion or $2,266 per capita, accounting for about 9.2% of GNP.

The growth in national health expenditures in the 1960s and early 1970s was largely due to the introduction of national hospital and medical care insurance, which all provinces had in place by 1961 and 1975 respectively. Also, the increase in health spending between 1960 and 1987 is due, in part, to inflation. In constant dollars (1981), health expenditures rose from $7.2 billion to $32 billion over this period.

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1 Health expenditure, both national and provincial, includes all health expenditure, private as well as government or public.

2 Unless otherwise indicated, the source of figures on health expenditure in this chapter is Health and Welfare Canada, *Health Expenditures in Canada, 1975-1987*, Ottawa, September 1990.

TABLE 1

Health Expenditure For Selected Years

Year	(millions of $)	(% of GNP)
1960	2,142	5.5
1965	3,415	6.0
1970	6,253	7.1
1975	12,267	7.2
1976	14,119	7.2
1977	15,500	7.2
1978	17,248	7.3
1979	19,412	7.2
1980	22,703	7.5
1981	26,650	7.7
1982	31,150	8.6
1983	34,511	8.7
1984	37,310	8.6
1985	40,407	8.7
1986	44,285	9.0
1987	47,935	9.0
1988	51,800	8.9
1989	56,100	8.9
1990	60,228	9.2

Total national health expenditures grew from $12.2 billion in 1975 to $47.9 billion in 1987, an increase of 291%, or 12% per year. During the same period GNP increased by 216%, or just over 10% per year. Since 1975, the rate of growth in national health expenditures has been similar to that of GNP, except for the 1979–1983 period, generally acknowledged as a period of economic downturn, when growth in health expenditure was considerably higher than growth in GNP.

The OECD estimates that member countries devoted, on average, 6.5% of Gross Domestic Product (GDP) to health in 1975 and 7.3% in 1987 (Table 2).[3]

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3 OECD, *Health Care Systems in Transition: The Search for Efficiency,* Social Policy Studies No. 7, Paris, 1990, p. 10.

It is important to acknowledge that there are a number of basic difficulties in making international comparisons of health care systems and their funding. This is because of the limited compatibility of data and methodological problems arising from comparing different economic, demographic, cultural and institutional structures. OECD studies take these complicating factors into account and there is some consensus that, in spite of these difficulties, there are lessons to be learned from looking at other health care systems.[4]

Canada was somewhat above the OECD average with national health expenditures of 7.3% of GDP in 1975 and 8.6% of GDP in 1987 (Table 2). Compared to rates of GDP devoted to health by particular OECD countries, Canada's rate of expenditure on health at 8.6% of GDP in 1987, was much higher than rates of 3.5% for Turkey, 5.3% for Greece or 6% for Spain, roughly comparable to that of France, Netherlands, Austria, Germany and Sweden, but significantly lower than that of the United States.

In the period between 1960 and 1975, public sector spending on health in Canada rose from 43% in 1960 to 76% in 1975 following the introduction of national health insurance. Since 1975, public sector spending as a percentage of national health expenditure has remained relatively steady (74% in 1987). This proportion of public spending on health care is similar to that in other OECD countries, where, on average, almost 80% of all health expenditures are financed by the public sector. In the United States, however, public expenditure on health in 1987 was only 41% of national expenditures.

4 Please refer to the glossary for an explanation of the difference between GNP, used in Table 1, and GDP as used by OECD countries and in discussions of provincial health expenditures in Canada.

TABLE 2

Total And Public Health Expenditure As A Percent Of Gross Domestic Product: Organization For Economic Cooperation And Development Countries, 1975–1987[5]

	Total expenditure				Public expenditure			
Country	1975	1980	1985	1987	1975	1980	1985	1987
	Percent							
Australia	5.7	6.5	7.0	7.1	3.6	4.0	5.0	5.1
Austria	7.3	7.9	8.1	8.4	5.1	5 .5	5.4	5.7
Belgium	5.8	6.6	7.2	7.2	4.6	5.4	5.5	5.5
Canada	7.3	7.4	8.4	8.6	5.6	5.6	6.4	6.5
Denmark	6.5	6.8	6.2	6.0	6.0	5.8	5.3	5.2
Finland	6.3	6.5	7.2	7.4	5.0	5.1	5.7	5.8
France	6.8	7.6	8.6	8.6	5.2	6.2	6.9	6.7
Germany	7.8	7.9	8.2	8.2	6.2	6.2	6.4	6.3
Greece	4.1	4.3	4.9	5.3	2.5	3.5	4.0	4.0
Iceland	5.9	6.4	7.3	7. 8	5.3	5.7	6.4	6.9
Ireland	7.7	8.5	8.0	7.4	6.4	7.8	7.1	6.4
Italy	5.8	6.8	6.7	6.9	5.0	5.6	5.4	5.4
Japan	5.5	6.4	6.6	6.8	4.0	4.5	4.8	5.0
Luxembourg	5.7	6.8	6.7	7.5	5.2	6.3	6.0	6.9
Netherlands	7.7	8.2	8.3	8.5	5.9	6.5	6.6	6.6
New Zealand	6.4	7.2	6.6	6.9	5.4	6.0	5.6	5.7
Norway	6.7	6.6	6.4	7.5	6.4	6.5	6.1	7.4
Portugal	6.4	5. 9	7.0	6.4	3.8	4.2	4.0	3.9
Spain	5.1	5.9	6.0	6.0	3.6	4.4	4.3	4.3
Sweden	8.0	9.5	9.4	9.0	7.2	8.7	8.6	8.2
Switzerland	7.0	7.3	7. 7	7.7	4.8	5.0	5.2	5.2
Turkey	--	--	--	3.5	--	--	--	1.4
United Kingdom	5.5	5.8	6.0	6.1	5.0	5.2	5.2	5.3
United States	8.4	9.2	10.6	11.2	3.6	3.9	4.5	4.6
Mean	6.5	7.0	7.4	7.3	5.0	5.5	5.7	5.6

5 OECD, *op. cit.* p. 10.

Trends in public sector health expenditure as a percent of GDP in Canada are similar to those of other OECD countries where public expenditure has tended to increase as a proportion of total health expenditure over the past 20 or 30 years. AsTable 2 indicates, public health expenditure in Canada was 5.6% of GDP in 1975 and 6.5% in 1987. The comparable average rates for OECD countries were 5% in 1975 and 5.6% in 1987. It can be noted that the Canadian rate of public expenditure as a percentage of GDP in 1987 was about the same as that of many other countries, including France, Germany, Iceland, the Netherlands and Luxembourg. Finally, Canada's public health expenditure in 1987 as a percent of GDP was significantly lower than that of Sweden and Norway but significantly higher than that of the United States, Turkey, Spain, Portugal and Greece.

The OECD estimates, on the other hand, that Canada had a rate of per capita spending on health ($1,483) second only to that of the United States ($2,051) in 1987.[6]

It appears that Canada's per capita spending on health, relatively high compared to that of other OECD countries, could be related to higher age dependency ratios in the population. A study of the impact of health policy in OECD countries over the 50 years between 1980 and 2030 predicts that, just on the basis of population aging alone, the implications could be greatest, among OECD countries, for Canada, Finland and Japan. Moreover, the study points to additional factors that may affect Canada's ability to finance the increased expenditures resulting from population aging.

The OECD study suggests that the burden of health expenditure falls mainly on the working population and, as such, the ability of countries to finance the increased expenditures resulting from population aging will depend on changes in the relative size of the productive population as reflected in dependency ratios, as well as labour force participation rates, unemployment rates and productivity. The OECD study predicts that Canada will be among those countries to face the largest increases in age dependency ratios. Also, large increases in demand for long-term care are expected as a result of the higher incidence of chronic disease, the larger cohorts moving into older age groups and the increases in the duration of services across OECD countries. Use rates, for medically-oriented residential facilities, according to the OECD study, tend to be higher in Canada and the United States, while the highest rates for use of publicly funded home care services were in the United Kingdom and Sweden and the lowest in Switzerland, Canada and Germany.[7]

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6 *Ibid.*, pp. 11-12.

7 Meyer, Jack, *The Implications of Ageing Populations for Health Care Policy and Expenditures, 1984* (internal working paper), and *The Social Policy Implications of Ageing Populations*, OECD, Paris, forthcoming.

Table 3 shows Canada's national health expenditure by sector for 1975, 1987 and 1990. Federal government expenditure declined from 30.8% of national health expenditure in 1975 to 29.5% in 1987 and 27.7% in 1990. Health expenditures by provincial and local governments have remained fairly constant as a percentage of national expenditure and private expenditure has increased from 23.6% in 1975 to 25.8% in 1987 and 27.5% in 1990.

Total health expenditure by category of expenditure for 1975 and 1987 is indicated in Table 4. Hospital and other institutional services have always accounted for the biggest share of health care budgets. According to Table 4, the percentage of health expenditure on hospitals decreased from 44.4% to 39.2% between 1975 and 1987 and expenditure on home care increased from 0.3% to 0.8%. This indicates the beginning of a trend away from institutional care and toward more community and home care, a trend the federal government may wish to encourage in light of the OECD findings. The proportion of total health expenditures associated with physicians and drugs increased somewhat during the period, while the proportion associated with capital expenditures showed a moderate decline. All other categories of expenditure include other health professionals, ambulances, appliances, public health, administration and miscellaneous costs. Among these categories, dentists' services in particular showed a modest increase.

TABLE 3

Total Health Expenditure By Sector For 1975, 1987 and 1990

(percentage distribution)

Sector	1975	1987	1990
Federal Government	30.8	29.5	27.7
Provincial Governments	43.4	42.6	43.4
Local Governments	1.1	1.1	0.6
Workers Compensation	0.9	0.8	0.8
Private	23.6	25.8	27.5
Total	100.0	100.0	100.0

TABLE 4

Total Health Expenditure By Category For Selected Years
(percentage distribution)

Category	1975	1987
Hospitals	44.4	39.2
Other Institutions	9.7	10.3
Home Care	0.3	0.8
Physicians	15.7	16.0
Drugs	8.9	11.6
Capital Expenditure	5.0	4.4
Health Research	0.8	0.9
All Other Categories	15.2	16.7
	100.0	100.0

B. PROVINCIAL HEALTH EXPENDITURES

Provincially, health care costs account for roughly one third of provincial government budgets and, in recent decades, health care spending has represented a growing share of provincial GDP. Among the provinces, health spending varies from a low of 7.7% of provincial GDP in Alberta, in 1987, to a high of 12% in Prince Edward Island (Table 5). Among the ten provinces, health spending as a percentage of provincial GDP tends to be lower in Central Canada and the West than in Atlantic Canada. Over the period 1975 to 1987, health spending as a percentage of provincial GDP rose in every province. In New Brunswick, Manitoba, Alberta and British Columbia, the increase was about 2% and in Saskatchewan it was more than 4%.

Per capita health spending also varies widely by province from a low of $1,473 in Newfoundland, in 1987, to a high of $1,985 in Ontario for a $512 difference between the two provinces.

Federal government health expenditure as a percentage of public expenditure declined from 40.3% in 1975 to 38.2% in 1990. Federal transfers to the provinces declined from 27.6% of total national health expenditure in 1975 to 25% in 1990. This decline is due to the impact of the changes to EPF funding arrangements. Further changes to EPF in 1990 and 1991 will accelerate this trend to decreased federal contributions to the provinces for health care.

TABLE 5

Provincial Health Expenditures As Percentage Of Provincial Gross Domestic Products For 1975 And 1987

Province	1975	1987
Newfoundland	10.7	11.7
Prince Edward Island	12.0	12.2
Nova Scotia	10.1	11.6
New Brunswick	8.8	10.8
Quebec	8.0	8.9
Ontario	6.7	8.2
Manitoba	7.9	10.0
Saskatchewan	6.7	11.0
Alberta	5.5	7.7
British Columbia	7.1	8.9

C. CONTROLLING HEALTH CARE COSTS

Studies seem to indicate that the increase in health costs is a major problem associated with social policy in all OECD countries. The OECD associates the following factors with the persistent upward trend in health spending, most of which the Committee heard about in some form from witnesses with regard to the Canadian system:

1. Until the early 1980's, real growth in health expenditures was in excess of real GDP growth, posing potential future problems for governments if slower economic growth persists;
2. Concentration of health expenditures on a relatively small proportion of the population with high medical care needs, e.g. the frail elderly;
3. Increased utilization and intensity of services;
4. Increases in the number of hospital beds and physicians so that most countries face significant surpluses of both;
5. Significant differences across and within countries in availability and use of resources, both in terms of hospital stays and surgical rates, which do not appear to be related to health outcomes;

6. Substantial increases in hospital expenditures, generally in excess of the overall inflation rate, with hospitals representing an increasingly large share of total health expenditures;

7. Evidence of inappropriate use of services (e.g. use of hospital emergency services for primary care) resulting in misallocations of resources and adverse iatrogenic effects (e.g. inappropriate or overmedication of the elderly sometimes resulting in hospitalization);

8. Large capital and operating costs associated with the implementation of certain new technologies;

9. The demonstrated cost-saving potential of some payment systems, competitive bidding arrangements, capitated reimbursement arrangements and new types of delivery arrangements;

10. Programmes concentrating on health promotion, health education, and lifestyles as effective means of reducing health spending;

11. Increased awareness of the amount of resources devoted to certain population groups, including terminally ill patients, and to decisions by individuals concerning the right to die;

12. Increased concern about financing and delivery of long-term health services, the interaction between health and social services systems, and the importance of appropriate case management.[8]

Canada seems to be experiencing problems similar to those of most other OECD countries when it comes to controlling rising costs, while providing the efficient delivery of quality health care. At a time when economic growth is slow and government deficits are mounting, there are serious concerns about the problems associated with maintaining the level of health care and improving it in the future.

Other OECD countries have tried various formulas in an effort to reduce health care costs. Some countries have opted for user fees and market-oriented approaches, including competitive bidding. Others have adopted comprehensive budget policies and new delivery arrangements, such as Health Maintenance Organizations (HMO). Still others have moved to limit the number of medical students or have turned their attention to educating consumers about the appropriate use of health services. Some countries have taken a tight regulatory approach, such as limits on the use of hospital beds and

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8 OECD, *Financing and Delivering Health Care -- A Comparative Analysis of OECD Countries,* Social Policy Studies No. 4, Paris, 1987, p. 13.

equipment. The 1987 OECD study observes that individuals and societies have begun to recognize the concept of limits and the difficult economic, social and ethical choices that such limits impose.

Some witnesses and experts note that countries that already have high quality health services are facing a situation where their additional investments provide fewer tangible benefits. The witnesses explain that spending additional funds on health care does not necessarily translate into improvements in the health status of a population. In short, the problem appears to be determining the optimal level of resources that a society wishes to dedicate to health care.

CHAPTER 2

THE FEDERAL GOVERNMENT'S ROLE IN THE FUNDING OF HEALTH CARE

This chapter contains a description of the constitutional framework for federal government intervention in health and a historical review of federal health legislation. It also provides an examination of changes in federal government contributions to provincial health insurance plans. Finally, there is a discussion of the federal government's role in health care funding.

A. THE CONSTITUTIONAL FRAMEWORK

Generally speaking, the provinces and territories are primarily responsible under the Constitution for providing health care services. The federal government's intervention in this sector stems essentially from its constitutional spending power.

In 1867, the Fathers of Confederation could not foresee how organized health care would grow over the years. Health was therefore not a major concern in the discussions preceding the drafting of the *British North America Act*. As a result, the Constitution contains few specific references to health in the division of legislative powers between the central government and those of the provinces and territories.

Subsections 91(11) and 92(7) are the only constitutional provisions expressly concerning health. Under subsection 91(11), the Parliament of Canada is granted legislative authority over quarantine and the establishment and maintenance of marine hospitals, while subsection 92(7) provides that the provincial legislatures may legislate on "the Establishment, Maintenance and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals". In the context of the times, this last provision was probably intended to encompass most health services. The delivery of health care has therefore traditionally been recognized as a matter of essentially provincial jurisdiction.

In areas under its jurisdiction, the federal government developed and maintains health services for aboriginal people, the population of the Yukon, immigrants, the Canadian Armed Forces, veterans and the inmates of federal penitentiaries.

The federal government also invoked its power under subsection 91(27) of the Constitution concerning criminal law to pass the *Food and Drugs Act*, the *Narcotic Control Act* and the *Proprietary or Patent Medicine Act* (in effect until 1977).

Beyond the legislative authority granted to the Parliament of Canada in certain fields, the Constitution, as interpreted by the courts, confers upon the federal government the power to use the Consolidated Revenue Fund to purchase any item it wishes, provided the order authorizing the expenditure in question does not fall within an area of provincial jurisdiction. This constitutional spending power then enables the federal government to make payments to the provinces and to individuals in areas where it has little or no direct power, e.g. health and post-secondary education.

Consequently, funding arrangements have developed in which the federal government finances health care jointly with the provinces. The federal government also carries out a wide range of activities intended to protect Canadians from hazards to health: e.g. food safety and nutritional quality, safety and effectiveness of drugs and medical devices, reduction and monitoring of environmental health hazards and sensitivities, prevention and control of the spread of AIDS and infectious diseases as well as the impact on individuals of their socio-economic environment. In the area of health promotion, the federal government develops and delivers, in cooperation with the provinces, territories and non-government organizations, health education and information in areas such as nutrition, alcohol, tobacco and drug use, family and personal health care. It also supports scientific research and related activities and provides for the training and maintenance of research personnel.

B. FEDERAL HEALTH LEGISLATION

The beginnings of the present national health insurance system can be traced back to 1948. In that year the federal government introduced national health grants. The grants financed projects such as public health surveys (in relation to tuberculosis, venereal disease, cancer, infant and maternal hygiene and the promotion of mental health), surveys of laboratory, radiological, rehabilitation and other health services, the training of health professionals and hospital construction. A number of provinces received federal government grants under this grants program which can be considered a stimulus in the early development of our national health care system.

Parliament passed the *Hospital Insurance and Diagnostic Services Act* in 1957, authorizing the federal government to pay half the cost of provincial hospital insurance plans that met minimum eligibility and protection criteria. The fundamental principles of the Act included the national character of the insurance scheme and standardized universal hospital coverage for all citizens. In 1958, the insurance programs of five provinces (Newfoundland, Manitoba, Saskatchewan, Alberta and British Columbia) became eligible under the terms and conditions of the program's cost-sharing arrangement. After 1961, the hospital plans of all provinces met the federal standards and received federal contributions for that purpose.

In 1964, the Royal Commission on Health Services (the Hall Commission) conducted the most complete inquiry and the most detailed analysis ever produced on the subject of health care in Canada. In the Commission's view, the *Hospital Insurance and Diagnostic Services Act* favoured the development of hospital services to the detriment of other services. The Commission strongly recommended in its report that the federal government enter into an agreement with the provinces to provide grants according to a fiscal need formula to assist the provinces and territories to introduce and operate comprehensive, universal programs of personal health services. They recommended that the programs should consist of the following services, with the provinces and territories exercising the right to determine the order of priority of each service and the timing of its introduction: medical services, dental care for children, expectant mothers and public assistance recipients, prescription drugs, optical services for children and public assistance recipients, prosthetic services and home care services. [9]

Federal government participation in insured health services began to grow in the mid-1960s, following the recommendations of the Hall Commission. The *Medical Care Act* was passed in 1966. Under the Act, the federal government agreed to a cost-sharing arrangement with those provinces whose systems complied with the principles set out in that statute. Accordingly, the federal government would pay a per capita amount equal to 50% of the cost of services insured by the participating provinces. The principles of the Act required that the provincial systems cover all services provided by doctors, insure all residents, be administered by public authorities and offer benefits that would be portable from province to province. Since 1972, all provinces have had their own health insurance systems that meet the national standards.

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9 The Royal Commission on Health Services, *Report*, 1964, p. 10.

In 1966, Parliament also acted on another Hall Commission recommendation and passed the *Health Resources Fund Act*. The purpose of this Act was to provide financial assistance for the organization, acquisition, construction, renovation and equipping of educational and research facilities in the health field. This assistance program, which ended in 1978, led to the creation of a number of new medical schools.

As noted above, the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act* provided that the federal financial contribution would represent approximately one-half the costs incurred by the provincial systems. Consequently, any increase in provincial expenditures would result in an increase in federal financial support. For both the provinces and the federal government these financing arrangements had some disadvantages. The federal government's room to manoeuvre in controlling expenditures was restricted and provincial governments felt their flexibility in the development of their health services was limited. For these reasons, cost-sharing arrangements were replaced in 1977 by unconditional, lump sum grants (block funding). The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977*, which provided for block funding, did not change the basic principles of the *Hospital Insurance Act* or the *Medical Care Act*. However, the federal government's contribution became conditional on the compliance of the provincial health plans with the principles set out in the two Acts and it changed the method of calculating federal contributions. As Malcolm Taylor observed in his in-depth analysis, *Health Insurance and Canadian Public Policy*, federal funds would continue to be made available but the amounts would be adjusted to increases in Gross National Product (GNP) rather than the actual costs of health services programs. [10] Under the new Act, the federal government's total contribution to health and post-secondary education was calculated on the basis of the average federal contributions in 1975-1976 indexed to a moving average of per capita GNP growth. Details of the method of calculating transfers under Established Programs Financing (EPF) are provided in Appendix E.

Total EPF transfers consist of two components: cash and tax points. The fiscal transfer represents 13.5 personal income tax points and one corporate income tax point. Quebec receives a special abatement of an additional 8.5 personal income tax points. Approximately 67.9% of total tax transfers go to health. The cash transfer corresponds to the difference between a province's total entitlement and the value of the tax transfer.

Transfers under EPF initially included compensation to the provinces for the termination of a revenue guarantee program put in place to make up for changes resulting from fiscal reform in 1972. Throughout the consultations that led to EPF, the

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10 Second Edition, McGill-Queens University Press, Kingston and Montreal, 1987, p. 487.

provinces requested this compensation. The federal government agreed to give one personal income tax point and the cash equivalent of another point and these were added to the cash and tax contributions under EPF, ending in 1979-1980. The experts do not agree on whether the revenue guarantee can be considered as part of EPF transfers.

In 1984, the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act* were consolidated in the *Canada Health Act*. The purpose of the *Canada Health Act* was "to establish criteria and conditions that must be met before full payment may be made under the Act of 1977 (EPF) in respect of insured health services and extended health care services provided under provincial law". According to the Act, each provincial health insurance plan must meet certain criteria in order to receive federal financial support for insured health services and extended health care services. These conditions, which were set out in the previous statutes, are public administration (s. 8), comprehensiveness (s. 9), universality (s. 10), portability (s. 11) and accessibility (s. 12).

Public administration means that the provincial system must be administered on a non-profit basis by a public authority appointed or designated by the government of the province and subject to audits of its accounts and financial transactions.

Comprehensiveness implies that the system must deliver all insured health services provided by hospitals, medical practitioners or dentists and, where authorized, services provided by other health professionals.

Universality requires that 100% of the insured persons of a province be entitled to the insured health services provided by the plan on uniform terms and conditions.

The principle of portability ensures that when people take up residence in another province, the province of origin must pay the cost of insured health services during a minimum period of residence or waiting period imposed by the new province of residence, a period not in excess of three months. Portability also means that insured persons who are temporarily absent from their province and who receive health services will have those costs paid in accordance with certain terms and conditions.

According to the accessibility criterion, insured health services must be provided on uniform terms and conditions, and Canadians must be guaranteed satisfactory access to insured health services without any direct or indirect barrier such as extra billing and/or user fees. Accessibility also means that reasonable compensation must be provided for all insured health services rendered by doctors or dentists and that adequate payment must be made to hospitals in respect of the cost of insured health services.

The insured health services defined by the Act include all medically necessary hospital services and all medically required physician services, as well as surgical-dental services requiring a hospital for their proper performance. As for extended health care services, they include nursing home, intermediate care, adult residential care, home care and ambulatory health care.

The *Canada Health Act* differs from the two Acts that preceded it in that it prescribes financial penalties for provinces that permit extra billing or charge user fees. Corresponding changes were made to EPF legislation.

In 1986, in the wake of budget cuts associated with concern about the federal deficit, Parliament passed the *Act to Amend the Federal-Provincial Fiscal Arrangements, 1977* (C-96), restricting growth in federal EPF transfer payments. Transfers continued to be linked to economic and demographic growth, although their annual per capita growth rate was 2% lower than the rate under the previous formula.

In 1991, the *Government Expenditures Restraint Act* (C-69) froze per capita EPF transfers at their 1989-1990 level for two years. This meant that EPF transfers in 1990-1991 and 1991-1992 would increase at the rate of population growth in each province. In addition, for subsequent fiscal years, the Act imposes an additional 1% reduction in the indexing factor for the total contribution. In other words, starting in 1992-1993, the growth rate of contributions paid under EPF will decline by 3%.

In the federal 1991 budget speech, Mr. Wilson announced that the freeze on per capita EPF entitlements would be extended to 1994-1995. This means that total EPF entitlements will continue to grow in line with the increase in population of each province. In addition, growth in EPF entitlements will be limited to a rate of growth of GNP per capita less three percentage points starting in 1995-1996. The following section provides a brief analysis of the changes made in federal contributions under EPF.

C. CHANGES IN FEDERAL CONTRIBUTIONS UNDER EPF

The table provided in Appendix E shows cash and tax transfers to the provinces under EPF since 1977. The totals were used to prepare Figure 1, which shows changes in federal contributions to the provinces including lump-sum transfers, cash transfers and tax transfers. It will be seen that the changes differ greatly depending whether the transfers were made in cash or tax points. Since 1984-1985, growth in cash transfers has remained below that of tax transfers. Growth in cash transfers has been negative since 1989-1990.

Changes in EPF transfers can be examined in the broader context of federal government finances (Figure 2) and economic growth.

FIGURE 1

EPF Transfers for Health

year over year percentage change

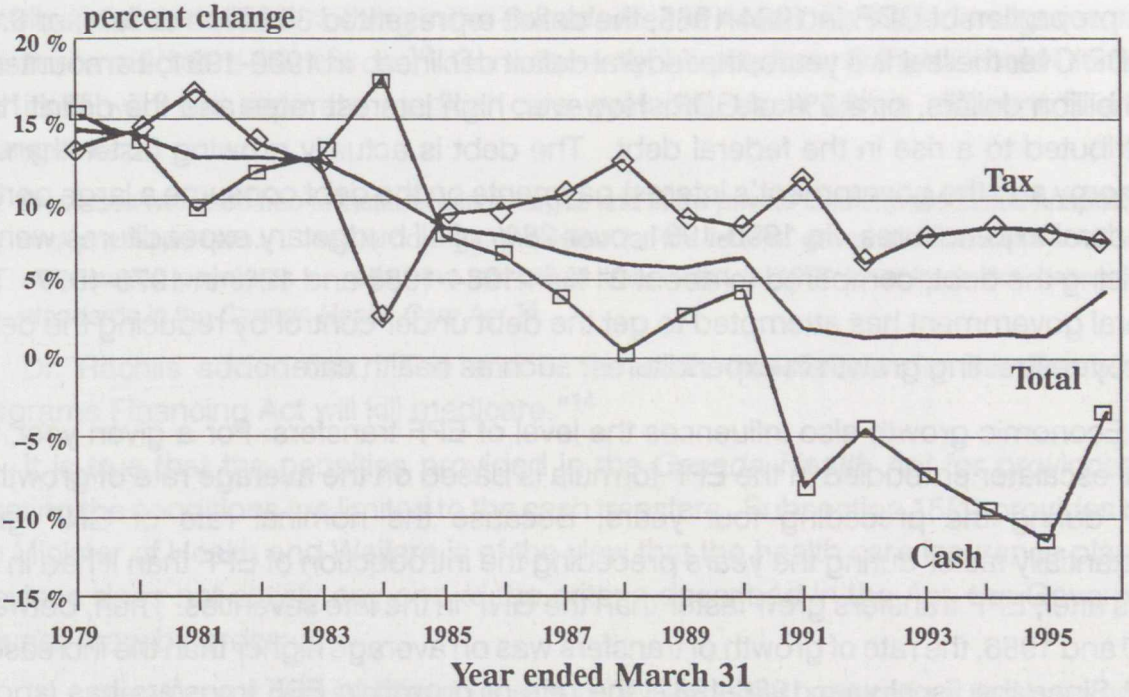
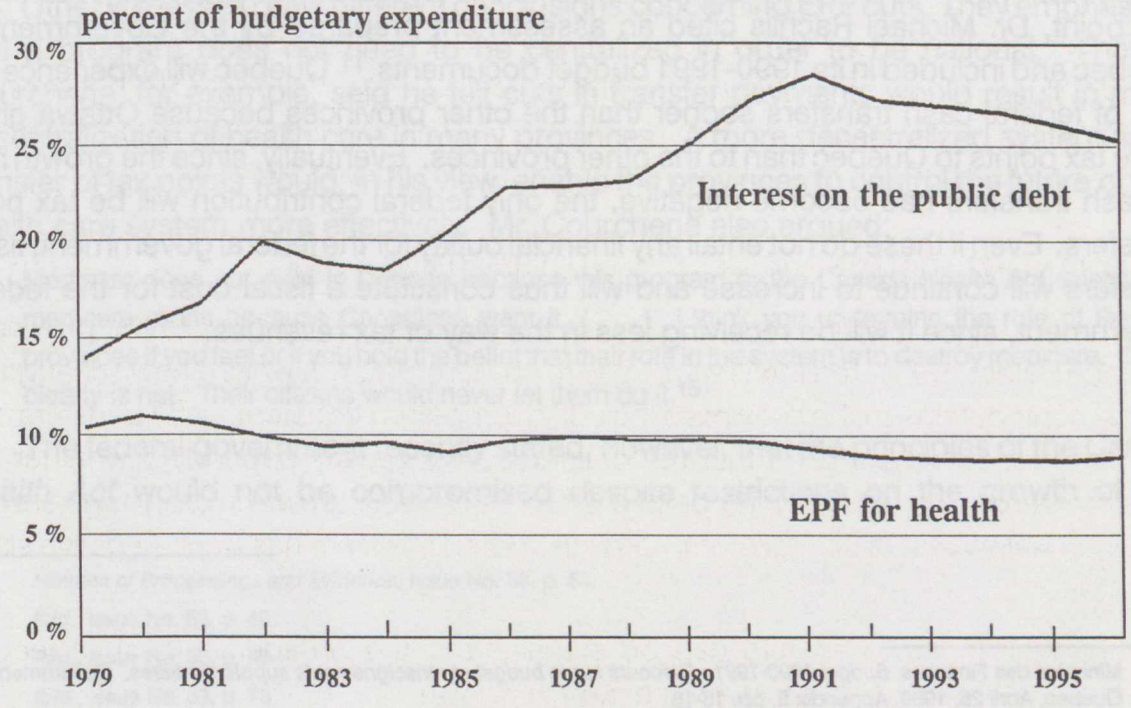


FIGURE 2

EPF (Health) and Interest on the Debt

Percent of Federal Budgetary Expenditure



Projections based on Department of Finance estimates

During the early eighties, the federal deficit was very important in absolute terms and as a proportion of GDP. In 1984-1985, the deficit represented 38 billion dollars, or 8.6% of GDP. Over the last five years, the federal deficit declined. In 1990-1991, it amounted to 30.5 billion dollars, or 4.5% of GDP. However, high interest rates and the deficit have contributed to a rise in the federal debt. The debt is actually growing faster than the economy and the government's interest payments on the debt consume a large portion of federal expenditures. In 1990-1991, over 28% of all budgetary expenditures went to servicing the debt, compared to about 21% in 1984-1985 and 12% in 1976-1977. The federal government has attempted to get the debt under control by reducing the deficit and by restraining growth in expenditures, such as health care.

Economic growth also influences the level of EPF transfers. For a given year, the fiscal escalator embodied in the EPF formula is based on the average rate of growth of GNP during the preceding four years. Because the nominal rate of GNP grew substantially faster during the years preceding the introduction of EPF than it had in the years after, EPF transfers grew faster than the GNP in the late seventies. Then, between 1980 and 1986, the rate of growth of transfers was on average higher than the increase in GNP. Since the fiscal year 1986-1987, the rate of growth in EPF transfers has lagged behind the rate of growth in GNP. Based on projections in the 1991 federal budget, this trend could continue over the next few years.

Some witnesses said that the federal government will stop making cash payments before the end of the decade as a result of restrictions on the growth of EPF transfers. On this point, Dr. Michael Rachlis cited an assessment prepared by the Government of Quebec and included in its 1990-1991 budget documents.[11] Quebec will experience the end of federal cash transfers sooner than the other provinces because Ottawa gives more tax points to Quebec than to the other provinces. Eventually, since the growth rate of cash transfers has become negative, the only federal contribution will be tax point transfers. Even if these do not entail any financial outlay for the federal government, fiscal transfers will continue to increase and will thus constitute a fiscal cost for the federal government, since it will be receiving less in the way of tax revenues.

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11 Ministère des Finances, *Budget 1990-1991 : Discours sur le budget et renseignements supplémentaires*, Government of Quebec, April 26, 1990, Appendix E, pp. 16-18.

Dr. Rachlis pointed out in his testimony that, when there are no further cash contributions under EPF, nothing in the *Canada Health Act* allows the federal government to enforce medicare standards.[12] Consequently, he predicts, Canada could ultimately find itself with ten separate medical care systems, each with a different financing arrangement:

> Provinces would be free to institute user charges and allow private insurance for basic hospital and physician care. There is no legal provision for the federal government to cut back its equalization payments or recall the tax points transferred in 1977 to enforce the national standards in the *Canada Health Care Act*.[13]

Dr. Rachlis added that, "The end of the cash transfers under the Established Programs Financing Act will kill medicare."[14]

It is true that the penalties provided in the *Canada Health Act* for provinces not meeting the conditions are limited to the cash transfers. Subsection 15(1) provides that if the Minister of Health and Welfare is of the view that the health care insurance plan of a province does not satisfy any one of the criteria described in the Act, the Governor in Council may, by order:

> (a) direct that any cash contribution or amount payable to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or
>
> (b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution or amount payable to that province for a fiscal year be withheld.

Other witnesses drew different conclusions concerning EPF cuts. They emphasized that a program does not need to be centralized in order to be national. Thomas Courchene, for example, said he felt cuts in transfer payments would result in major decentralization of health care in many provinces. A more decentralized system and a transfer of tax points would, in his view, enable the provinces to control the future of their health care system more effectively. Mr. Courchene also argued:

> Medicare does not exist in Canada because this program or the *Canada Health Act* exists; medicare exists because Canadians want it. (. . .) I think you undermine the role of the provinces if you feel or if you hold the belief that their role in the system is to destroy medicare. It clearly is not. Their citizens would never let them do it.[15]

The federal government recently stated, however, that the principles of the *Canada Health Act* would not be compromised despite restrictions on the growth of EPF

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12 *Minutes of Proceedings and Evidence*, Issue No. 53, p. 54.

13 *Ibid.*, Issue No. 53, p. 46.

14 *Ibid.*, Issue No. 53, p. 45.

15 *Ibid.*, Issue No. 53, p. 70.

transfers. In the 1991 budget speech, the Minister of Finance said: "Legislation will be introduced to ensure that the federal government continues to have the means to enforce these national medicare principles."[16]

D. WHAT CAN OR SHOULD THE FEDERAL GOVERNMENT DO IN RELATION TO HEALTH CARE?

Since the inception of "block funding" in 1977, federal contributions as a percentage of the total cost of the Canadian health care system have gradually decreased. There are those who argue that this trend will undermine the federal government's ability to maintain national standards under the *Canada Health Act*. Others see it as having more positive impacts on the health care system.

Professor Contandriopoulos, who is generally critical of this trend said:

> The (federal) government's strength and ability to uphold the principles of unity despite provincial differences, which principles set Canada apart from other countries . . . .are linked to the key role the government plays in the area of funding. Those principles are the very basis of that funding. If the federal government withdraws funding the provincial systems will crumble. [17]

In a similar vein, the Canadian Hospital Association (CHA) advised that:

> Reductions in EPF transfers challenge provincial governments to reduce health care and post-secondary education budgets or increase taxes. A national framework of stable and adequate EPF funding is a prerequisite to achieving health goals. In the case of health manpower, cuts to EPF threaten both the health system in which health professionals work as well as the education system in which they are trained.[18]

Professor Thomas Courchene, on the other hand, sees the following scenario as an outcome of the struggle by provincial governments to control health care costs:

> . . . We are now witnessing at the provincial level a flowering of experimentation . . . in funding approaches, in payment systems, in information and smart card systems, in alternative approaches to institutionalization, in approaches to local delivery, in integrating health and social services, in coverage, and on and on. From Ottawa's perspective the system might well appear to be fragmenting, but in reality what is occurring is that the system is dramatically attempting . . . to save medicare. If any of these experiments turn out to excel in terms of delivery or cost efficiency, they will immediately spread across the (national) system.[19]

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16 Minister of Finance, *Budget,* Tabled in the House of Commons on February 26, 1991, p. 21.

17 *Minutes of Proceedings and Evidence*, Issue No. 23, p. 8.

18 Brief, p. 12.

19 *Minutes of Proceedings and Evidence*, Issue No. 53, p. 69.

In Mr. Courchene's view "Something like the *Canada Health Act*" makes it more difficult for provinces to control costs and he pointed out that in his view, provincial politicians are under even greater pressures than federal ones to maintain the principles of medicare.

Some provinces do see federal national standards as interfering with their ability to control program costs. The recent Quebec government reform package requested that the *Canada Health Act* be amended to allow for a services tax on supplementary drug insurance programs, dental care, eye care and orthotic and prosthetic services.[20] They later decided not to introduce this aspect of their reform package at this time. The Quebec government more recently decided not to introduce this aspect of their reform package at this time.

Similarly, the former British Columbia Minister of Finance and Corporate Affairs, the Honourable Mel Couvelier, in proposing "disentanglement"[21] as one approach to greater fiscal stability, offered as one reason for this proposal the point that:

> The federal government has, through the imposition of program standards, continued to interfere with provincial efforts to control program costs. It has done so even while attempting to downgrade its funding commitments to the provinces.[22]

It is clear that there are divergent and strongly held views on this issue.

The Committee considered four apparent options for the federal government in the health care field. These options tend to represent two extremes on a continuum of possibilities as well as two more modest approaches. Within each of these options, a broad range of alternatives could be implemented. Only a few of these alternatives are briefly considered in the following discussion.

OPTION 1 The federal government could assume total responsibility for the administration, delivery and funding of health care in Canada.

This option requires the greatest changes in the status quo and, therefore, we can only speculate on the outcome of such an approach. It seems apparent that this option would require constitutional change, as the delivery of health care services has been

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20 Government of Quebec, Ministry of Health and Social Services, *A Reform Centred on the Citizen*, 7 December 1990, pp. 81-82.

21 Report of the Western Finance Ministers, July 1990. This report said that disentanglement requires a fundamental re-examination of federal and provincial spending responsibilities and revenue capacity. This would be aimed at reducing federal spending in areas of provincial responsibility with an accompanying transfer of adequate fully-equalized tax room.

22 Honourable Mel Couvelier, *Resolving Canada's Dangerous Fiscal Situation Through Renewed Federalism and Fiscal Discipline*, 10 September 1990, pp. 3-4.

interpreted as a provincial responsibility. It would also require renegotiation and agreement between the federal, provincial and territorial governments on arrangements providing the financial basis of health care.

Option 1 would co-ordinate and standardize the administration, delivery and funding of health care across Canada and could facilitate the enforcement of national standards by the federal government, as well as increasing financial accountability. This approach would not necessarily contradict the findings of those provincial studies which recommend that the health care system be more decentralized, since regional structures can allow responsibility, funding and planning at a central level, with administration and delivery done locally.

OPTION 2 The federal government could maintain a strong role in national health care, including a strong funding role which enables the enforcement of the criteria and conditions that each provincial health insurance plan must meet in order to receive full federal cash contributions.

The federal government could maintain the funding basis of its traditional role, as some witnesses suggested, by re-establishing the original EPF block funding formula in which the calculation of cash contributions to the provinces takes into account population size and growth in GNP.

In the absence of increased cash contributions, the federal government can, as stated by Finance Minister Michael Wilson in his February 1991 budget speech, introduce federal legislation to ensure that the federal government has the means to enforce the principles set out in the *Canada Health Act*. [23] It is unclear at this time what the content of this implied legislation might be.

The federal government could amend the *Canada Health Act* to permit a broader range of options to the provinces in financing and delivering health care. User fees have been discussed in this context. The Health Services Review (1979-1980) and the House of Commons Task Force (1981), the recommendations of which paved the way for the *Canada Health Act*, both concluded that "user pay" endangered the principle of reasonable access. [24] This Committee reaffirms these principles of the *Canada Health Act* relating to user-fees and extra-billing.

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23 *House of Commons Debates,* February 26, 1991, p. 17689.

24 E.M. Hall, *Canada's National Provincial Health Program for the 1980's*, Health and Welfare Canada, Ottawa, 1980. Canada, Parliamentary Task Force on Federal-Provincial Relations, *Fiscal Federalism in Canada*, Supply and Services Canada, Ottawa, 1981.

OPTION 3 The federal government can negotiate its role in relation to health care with the provinces.

Option 3 would require the development of a national policy on health care. Development of this policy would include the division of responsibility for health between the federal, provincial and territorial governments, the basics of funding under EPF, and the principles of the *Canada Health Act*.

OPTION 4 The provincial and territorial governments could assume total responsibility for the administration, delivery and funding of their own health care. Options 3 and 4 are not mutually exclusive and therefore, Option 4 can also be seen as one of the alternatives under Option 3.

Under either Option 3 or Option 4, the funding and delivery of health care services could be the responsibility of the provinces, with an accompanying transfer of tax room from the federal government to the provinces, and the federal government could retain its present responsibilities in health prevention and promotion, fitness and amateur sport, and services to Indian people, immigrants, and federal public servants. This could include a continuing role for the federal government in education, research, the development of a national health information system and national policy objectives.

Options 1, 2 and 3 could be compatible with the development of a national policy incorporating specified national objectives in the health care field. In a decentralized system in which funding and delivery of health care in their jurisdictions would be the responsibility of the provinces and territories (Option 4), maintaining standards would presumably also be the responsibility of the provinces and territories.

RECOMMENDATION

Having considered these four options the Committee recommends:

1. **That the federal government, in co-operation with the provincial and territorial governments, develop a clearly stated national policy on health care that is consistent with the existing *Canada Health Act*. Development of this policy would include the division of responsibilities for health between the federal, provincial and territorial governments, the basics of funding under EPF and the standards of the *Canada Health Act*.**

CHAPTER 3

PLANNING AND DELIVERING HEALTH CARE

Many expert witnesses are of the view that, compared to other OECD countries, Canada has managed to contain health care costs quite successfully, and that, generally, Canadians are in as good or better health as people in other countries. Dr. David Naylor pointed out that, as a percentage of GNP, Canada comes out about the middle of the OECD rankings, because our GNP remained "reasonably robust" but, in terms of what Canada spends on a per capita basis, we have the second most expensive system in the world. [25]

Dr. Naylor also said that, waiting lists notwithstanding, the most recent survey of users (1990) shows that the majority of Canadians are content with their health care system. Dr. Naylor suggests that the popularity of the Canadian system probably stems from the combination of first dollar coverage, free choice of provider and personalized attention inherent in the maintenance of a private practice framework for medical care. [26]

At the same time, the health care system is currently facing fiscal, socio-economic, technological and demographic challenges and there is the sense that changes must be made. The provinces are experiencing a wide range of problems and this has led them to the creation of task forces or royal commissions in the attempt to find solutions.

In the current economic situation, and in view of increasing government deficits, the problem of financing the health care system is becoming particularly acute. Witness André-Pierre Contandriopoulos said that our health care system is plagued on the one hand by expansionist forces and on the other by cutbacks in resources. Accordingly, he suggested that we must agree to rethink what we know about health determinants; what we know today is quite different from what we knew when we were setting up our health care system 25 or 30 years ago.[27]

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25 *Minutes of Proceedings and Evidence*, Issue No. 43, p. 5.

26 Naylor, C.D., *The Canadian Health Care System: An Overview and Some Comparisons with America*, article submitted to the Committee, pp. 16-17.

27 *Minutes of Proceedings and Evidence*, Issue No. 23, pp. 7-8.

A. HEALTH PROMOTION AND PREVENTION OF ILLNESS

A variety of witnesses, particularly those involved in studies of population health and epidemiology, recommended that the federal government involve itself in a major way in the development of a long-term health policy giving top priority to health factors related to the environment and quality of life, including the living conditions and development of young children. Such a policy, in their view, would perhaps have greater positive impact on health in the long term than increased spending on the medical-hospital sector.

Because improved health is associated with improved standards of living, some witnesses consider it essential that any health promotion and disease prevention program directed to a disadvantaged group be preceded by social programs guaranteeing an income permitting that group to be adequately housed and fed. This is part of a call for a broader definition of health that goes beyond that of the present health care delivery system (Canadian Dietetic Association, Consumers' Association of Canada, Canadian Health Coalition, Canadian Institute of Child Health, National Advisory Council on Aging, Victorian Order of Nurses). Accordingly, such organizations recommend that governments redirect health care dollars to programs of prevention and promotion, including initiatives to alleviate the social causes of illness. Some witness groups expressed, for example, the need for more health promotion programs that would produce behaviourial changes and help reduce risks to health associated with lifestyle, such as the use of tobacco, alcohol, and drugs, and poor dietary habits (Canadian Institute of Child Health, Canadian Dietetic Association, Consumers' Association of Canada).

The federal government has a long history of involvement in the prevention of illness and disease, including measures to protect the supply of food, water and drugs for medical purposes, promoting good nutrition and the prevention and spread of infectious diseases.

Since the 1970s, the Canadian government has embraced a health promotion approach to health. Health promotion, based on a World Health Organization model, is referred to as a "holistic" approach because it focuses on the physical and social environment as it relates to the health of the population (environmental pollution, family violence, highway accidents, stress, substance abuse, etc.). Health promotion within the health care field itself implies the sharing of responsibility and resources by governments and health professionals, with individuals planning their personal health strategies with community and other support groups not previously regarded as part of the health care team.

In speaking to the Committee of what the federal government has tried to do to "get a handle on costs", the Minister of National Health and Welfare said:

> I am convinced that the focus of our system has to shift away from a curative approach to a preventive approach. It does not mean we will not continue to do anything we can to respond to disease after it occurs or respond to accidents after they occur. We have to do that, but it is infinitely cheaper for us to stop a child from ever starting to smoke than it is to treat somebody who contracts cancer. It is infinitely cheaper for us to educate people on how to avoid contracting AIDS than it is for us to provide services to them once they become infected with the disease. It is infinitely cheaper for us to prevent drug abuse and alcoholism in Canada than it is to treat the problem once it has occurred.[28]

Federal government expenditure on health promotion and prevention is a much smaller proportion of the federal government expenditure on health than is the expenditure on curative care. For example, the federal government estimates that 1.2% ($84.9 million) of the Health Program budget of Health and Welfare Canada will be spent on health services and promotion in 1991-92, while 83.8% ($5.8 billion) is expected to go to claims on health insurance.[29]

Some witnesses suggested that health depends on factors outside what we have traditionally defined as the health care system, such as environmental, social and economic factors. They said these factors should be a matter of concern in the allocation of resources. Dr. Jonathan Lomas said, for example,

> . . . more money into the health care system will do very little . . . more money to produce health is better spent elsewhere, outside the health care system. [30]

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28 *Ibid.*, Issue No. 28, p. 32.

29 Health and Welfare Canada, *1991-1992 Estimates*, Part III, pp. 2-12.

30 *Minutes of Proceedings and Evidence*, Issue No. 52, p. 120.

Dr. Jane Fulton similarly told the Committee:

> In my view we do not need to spend any more money on health care. We need to spend money on housing, on transportation and on the environment. Here are areas in which I think you (the federal government) have some policy power under the Constitution, . . . [31]

RECOMMENDATIONS

2. **That the federal government develop policies to make the nation healthy in those areas where it has jurisdiction under the Constitution, including the environment and areas that affect quality of life such as housing, income, employment and post-secondary education.**

3. **That the federal government emphasize illness prevention and health promotion and devote greater resources to education and information for consumers with the objective of making them full partners and knowledgeable decision-makers in their own health care.**

4. **That a Canada Health Council, representing health care providers, consumers, researchers and others, be established and financed to advise the federal government on matters related to national health care.**

B. THE HEALTH CARE DELIVERY SYSTEM

Canada provides universal health insurance coverage for its population through health insurance programs jointly financed by federal, provincial and territorial authorities. Provincial and territorial authorities design their own health insurance programs following national standards codified in the *Canada Health Act*. Provincial plans must meet those standards in order to qualify for full federal cash contributions to their programs.

Provincial and territorial health insurance plans must cover medically necessary hospital services, physicians' services and certain surgical dental procedures. Provinces are not required to insure residents for the costs of eyeglasses, outpatient prescriptive drugs, general dental care and semi-private or private hospital accommodation. However, most provinces include an outpatient prescription drug benefit for the elderly and individuals who qualify for social assistance.

The *Canada Health Act* does not specify what benefits are required in a "comprehensive" program and provinces and territories can and do include additional benefits that are not required under the national standards.

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31 *Ibid.*, Issue No. 15, p. 6.

Coverage of long-term care is not required under the *Canada Health Act* but the federal government makes an equal per capita contribution to the provinces and territories in support of nursing home care, home care and ambulatory health care.

While they cannot impose user fees or extra-billing without losing federal financial support, provinces have considerable latitude in determining how their share of health care costs are financed. They may institute insurance premiums and sales taxes and use general revenues or a combination of approaches. Health insurance is the single largest program funded by provincial governments, but there is considerable variation in the amount of resources that each jurisdiction devotes to health care and the rate by which health care costs are increasing.

1. The Advantages And Disadvantages Of The Canadian Health Care System

For the objective observer, there are many advantages to the Canadian system of financing and delivering health care. Recently, American health care analysts have been studying the Canadian system of health care in their attempts to improve their own system. A paper by the United States Congressional Research Service points to some of the advantages and disadvantages which are seen in the Canadian system.[32]

Advantages include universal coverage for the population, comprehensive services with considerable latitude for the provinces in terms of determining how their share of health costs will be financed, minimum standards of care in all provinces and territories, portability to all parts of Canada, no dollar limits on the amount of necessary medical care that individuals may receive, freedom for physicians to make individual medical decisions for patients without constraints faced by American physicians such as utilization review and managed care, relatively low administrative costs due to the requirement in the *Canada Health Act* for non-profit administration (administration costs are approximately 1.5% to 2.5% of Canadian health expenditures in 1987, compared to 6% to 8% in the United States) and broad public support.

According to the authors of the same paper, disadvantages of the Canadian health care system, as compared to the system in the United States, include waiting lists and rationing by queue for some services, limits on hospital budgets and number of physicians in some specialties and high technologies, less innovation in delivery and financing of care, a lack of cost-sharing requirements which appears to encourage over-use, longer average hospital stays and heavier reliance on institutionalization to care for the elderly.

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32 Fuchs, Beth C. and Joan Sokolovsky, *The Canadian Health Care System*, February 20, 1990.

2. Some Proposed Solutions To The Problems Of Financing Health Care In Canada

During the Committee's public hearings, witnesses presented a number of options as at least partial solutions to financing problems. These options included reallocation of public funds, privatization of certain aspects of the health care system, changing the system of remuneration for physicians and increasing applied research efforts to develop new, innovative and more efficient ways to deliver high quality care.

a. Reallocation Of Public Funds

Many witnesses argued that the problems currently facing the health care system are not so much the result of underfunding as of maldistribution of funds over the various categories of services. They emphasized the fact that funding arrangements tend to favour curative services that comply with the medical model. Generally, they argued that resource reallocation would make it possible to prevent needless hospitalizations and provide access to appropriate community and home care services in particular. Hospitalization is the most costly single component in the system and deserves special attention. It seems apparent that an emphasis on community and home care, health promotion and health consumer education will be cost-effective in the long-term but it is still unclear, according to some witnesses, what the impact will be on costs in the shorter term.

Although it is popular wisdom that community-based care could be more cost-effective than institutional care, Dr. Raisa Deber cautioned the Committee that, unless such services are provided within a fixed budget and managed so as to limit services to those who would otherwise be in institutions, costs would probably increase.

On the reallocation of funds, Kenneth Fyke said:

> I am not directly advocating either cost curtailment or financial aid for our present system. What I am advocating is the reallocation of some of the existing resources away from traditional services and into community-based services and home support infrastructures. It is well documented throughout the literature that a substantial proportion of inpatient hospital care is non-acute; that is, it does not have to be provided in an acute-care inpatient hospital setting. In many of these instances, care can be provided in less expensive settings such as outpatient clinics or in the patient's home. [33]

Similarly, other witnesses said this recommended reallocation of resources would make possible more efficient use of available funds, help meet current and future health care needs more effectively and help slow the growth in health care costs in Canada.

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33 Brief, p. 5.

RECOMMENDATION

5. That the federal government consult with the provinces and territories in developing a framework for the gradual shift of sufficient institutional resources (human, financial and technological) to more appropriate levels of community, home care and social support services.

b. Privatization Of Certain Aspects Of The Health Care System

The public sector currently accounts for nearly three-quarters of health expenditures in Canada. Some observers argue that increased privatization in the financing of health care would, by definition, limit public expenditures in the health sector. For example, research and the testimony of some witnesses suggest that user charges for hospital or physician services, by increasing their nominal cost, would eventually lead to less use of those services. User charges might encourage users to try to choose the most appropriate care provider (e.g. the community clinic rather than the hospital emergency service) and to avoid needless visits. Others argue, on the contrary, that research and experience seem to indicate an absence of any significant links between direct charges to patients and the use of services. Furthermore, critics of user charges say that such fees would discourage those at lower income levels from seeking the care they need.

Kenneth Fyke said that user charges have unfortunate consequences and often prove ineffective. He cited a study by the Rand Corporation in the United States which indicated that user fees reduced demand for hospital services in all cases, that is, both where hospital care was appropriate and where it was not. It is apparently uncertain, then, whether user charges would help limit inappropriate rather than appropriate use of hospital facilities. In addition, Mr. Fyke said:

> Studies show that "user" or "deterrent" fees deter the low income groups. This is the very group that we have attempted, through public financing, to ensure obtain equal access to health care because we believe access to hospital and medical services should not be dependent upon income. In fact it is this belief, and the resulting equity in our system, that is one of our greatest achievements. It sets our system above most others, particularly the American system where 35 million people, predominantly the working poor, have no health insurance coverage.[34]

A mixed private and public health services structure was also discussed during the hearings. According to Dr. Theodore Marmor, such a structure causes distortions between the two sectors and leads to numerous secondary effects, such as waiting lines in public hospitals. Discussing the experience of Israel and Great Britain, he explained:

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24 *Ibid.*, p. 7.

> The incentive is for the physician to be able to establish a queue in the public sector and then say "If you want to get your hip replacement in less than three months, come and see me in the afternoon in my private office". That is consistently an observation in all systems where physicians are allowed to practise both publicly and privately.[35]

Another form of privatization, proposed by Mr. Claude Castonguay, could lead to the creation of a more competitive market based on consumer choices. Mr. Castonguay felt that certain types of resources, such as housing resources for the elderly, should not always be financed out of public funds. In his view, certain types of health care services could be privatized and patients should first pay for the services and then be refunded later by the public system. Since beneficiaries would be free to decide where they would obtain the service, they would, according to Mr. Castonguay, choose the most efficient service. In this view, privatization of some services would create more competition between various types of institutions, which would improve the performance of the system.

On the other hand, in terms of the overall use of national resources, some observers fear that this type of privatization might actually contribute to higher health care costs. Comparative international evidence seems clear that systems of mixed public and private finance cost a good deal more, both for care and particularly for administration, than universal public systems. [36]

Dr. Marmor cited the American experience to suggest that private financing may undermine control of health costs, pointing out that the United States is the only OECD country to have failed to get its costs under control.

c. *Changing The System Of Remuneration For Physicians*

At present, most physicians in Canada are paid on a fee-for-service basis. Some witnesses were of the view that this method of payment contributes significantly to the rising costs of health care. The main criticism of the fee-for-service method is that it leads to over-use of health services. Witnesses in favour of changing present arrangements for paying physicians say that such a change would permit greater control of health care costs. They also indicated that such a change would help eliminate certain medically unjustified procedures.

Dr. Lomas told the Committee that replacing fee-for-service with other methods of payment would make it possible not only to reduce health care costs, but also to prevent some non-essential types of care from being provided, In this connection, he noted:

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35 *Minutes of Proceedings and Evidence*, Issue No. 52, p. 93.

36 Evans, Dr. Robert, "Reading the Menu with Better Glasses: Aging and Health Policy Research", *Aging and Health: Linking Research and Public Policy*, Steven J. Lewis, Lewis Publishers, Michigan, 1989, p. 145.

> . . . interestingly, we seem to have some effect on the quality of care by moving, for instance, to an HMO style of care, capitation payment. In that capitation payment you find that indeed the discretionary procedures as a proportion for procedures performed in a fee-for-service comparison was about 50%. In the HMO it was about 30%.[37]

Comparing fee-for-service with salary arrangements, he came to similar conclusions:

> Here the appropriateness of a particular procedure, in this case carotid endartectomy [sic], was at a level of about 65% appropriateness for those who were on salary and 45% appropriateness for those who are on fee-for-service. So even a salaried position population was doing 35% of their carotid endartectomies [sic] for inappropriate indications.[38]

Consequently, while payment mechanisms other than fee-for-service may make it possible to prevent some inappropriate procedures, they probably will not eliminate them altogether.

It also appears that it would be difficult to change the fee-for-service system. Dr. David Naylor observed that this system predominates in Canada and that it would be difficult to contemplate other methods within our health insurance system. He said:

> . . . if you have an open-ended, first dollar, universal system where doctors can float in and out of the marketplace, open their offices, establish fee-for-service private practice and know that they are going to have full coverage for their services, it is very difficult to establish any kind of competing paradigm in payment when that is the dominant and major mode.[39]

A study by Contandriopoulos, Lemay and Tessier[40] suggests that there is no ideal method for paying physicians. All compensation arrangements have their advantages and disadvantages. Nevertheless, a number of witnesses suggested adjusting payment methods according to the type of service provided. For example, since the fee-for-service method does not take into account the amount of time doctors spend with a patient, it was suggested that they be paid a salary for practising in rest homes, chronic hospitals and community care programs and for making house calls. For example, Dr. Philip Berger, a member of a group of primary care physicians who care for AIDS patients in downtown Toronto, told the Committee that much of his work, particularly in the later stages of the disease, consists of extensive counselling by telephone or house call, services to which categories of payment in the fee-for-service system do not accurately correspond.

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37 *Minutes of Proceedings and Evidence*, Issue No. 52, p. 85.

38 *Ibid.*

39 *Ibid.*, Issue No. 43, p. 8.

40 *Les coûts et le financement du système socio-sanitaire*, Commission d'enquête sur les services de santé et les services sociaux, Quebec City, 1988.

RECOMMENDATIONS

6. **That within two years, the federal government produce a complete report, based on a compilation of existing research and pilot studies of physician remuneration systems, with a particular emphasis on the appropriateness of certain remuneration systems for specific practice situations.**

7. **That the federal government encourage the provinces and territories to continue to develop innovative alternatives to existing remuneration systems for physicians.**

d. Increasing Applied Research Efforts

It became apparent in the course of the hearings that three areas in applied research deserved further attention: quality assurance, systems of delivering and managing services, and technology assessment.

Witnesses suggested that the relationship between cost-effectiveness and quality of care is not self-evident. Some witnesses advised that Canada needs to pursue more applied research on innovative and appropriate ways of delivering care. They felt that such research would inform policy makers and service providers. It was recommended that efforts be made to synthesize, coordinate and distribute the results of such research and translate it into directives at the national level.

Although witnesses called for alternative solutions to current health care arrangements, few offered cost-related data on such measures. It is therefore necessary that evaluation procedures be built into any pilot projects in this area.

Many witnesses suggested the need to evaluate the contribution of new technologies to the quality and cost-effectiveness of care. The Committee sees the recently established Canadian Coordinating Office for Health Technology Assessment as an important step in this area.

A discussion of the issues in the research area and recommendations appear in Chapter 7.

CHAPTER 4

THE IMPACT OF THE AGING POPULATION

A. DEMOGRAPHIC TRENDS

The impact of the aging Canadian population on the health care system is currently a matter of great concern. The proportion of the population 65 years and older is expected to double within the next 50 years, while the proportion of those 85 years and over will probably grow twice as fast. The report of the Demographic Review by Health and Welfare Canada shows that, by 1986, Canada's age structure was changing from one in which there were large numbers of young people and comparatively few older people, to one where, by 2031, it is predicted that middle-aged and older people will predominate. The latter older age structure is typical for modern low-fertility societies and is already in place in many European countries. Sweden, for example, now has an age graph resembling that projected for Canada in 2031.[41]

International comparisons suggest that older populations are not in themselves a problem. Sweden and West Germany, both dynamic and resourceful societies, are among the countries with the oldest populations. Most developing countries have higher fertility rates, higher population growth rate and therefore much younger populations than Canada. It is predicted that all countries, over the next century, will move toward similar age structures that are somewhat older than those of today's oldest societies.[42]

Experience elsewhere suggests that planning and thoughtful utilization of resources, including health resources, will be required to ensure Canada's continued prosperity while it accommodates an older population.

B. THE AGING POPULATION AND THE COST OF HEALTH CARE

The increased proportion of seniors in the population, combined with their tendency to use more health care than younger people, raises the fear that utilization rates and costs will sky-rocket. There are divergent views on the impact of the aging population on

41 Health and Welfare Canada, *Charting Canada's Future: A Report of the Demographic Review*, 1989, p. 19.

42 *Ibid.*, p. 21.

health-care costs. There are those who believe that increased costs associated with the aging population will bring about either collapse or major change in present arrangements of funding medical and hospital care in Canada. Others predict that, while the rise in the proportion of the elderly population will produce substantially higher health-care costs, both per capita and as a percentage of the gross national product, the largest part of the increase is some decades off, and when it comes, it will not be of 'crisis' magnitude. Some studies even suggest that health-care costs may be reduced by advances in technology and organization, given proper planning and appropriate changes in health policy.[43]

In a paper entitled "Can We Afford An Aging Society", the Chief Statistician of Canada, Ivan P. Fellegi, states that affordability will depend on the performance of the economy and on unforeseeable changes.[44] This paper, focusing on the three most costly social programs, health, education and pensions, says:

> . . . trends would seem to indicate that the growth rate of government expenditures which is attributable to an aging society will be comparable to the economic growth rates observed during the last 30 years. Therefore, should long term economic growth continue as it has in the past and unit costs evolve as assumed, then public expenditures in health, education and pensions would represent 50 years from now about the same claim on the economy as at present – in spite of the aging of the population.[45]

Mr. Fellegi points out, however, that coping effectively and humanely with the aging of Canadian society will require "a series of social adjustments whose cumulative impact might be quite fundamental".[46]

Some observers of health care take the view that the health care system is underfunded and to support their claim point to increases in the length of waiting lists for high-tech procedures such as cardiac surgery, lithotripsy, and renal dialysis, and patients in ambulances re-routed from one hospital to another due to overburdened emergency services and unavailability of hospital beds. The elderly, sometimes referred to as "bed blockers" are frequently viewed as major contributors to these and other problems in the provision of health care services and subsequent increases in health care costs.

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43 Denton, Frank T. and Byron Spencer, "Population Aging and Future Health Costs in Canada", *Canadian Public Policy*, Vol. 9, No. 2, June 1983, pp. 155-163.

44 *Canadian Economic Observer*, Vol. 1, October 1988, pp. 4.1 - 4.34.

45 *Ibid.*, pp. 4.1 - 4.2.

46 *Ibid.*, p. 4.2.

C. THE AGING POPULATION AND THE USE OF HEALTH CARE SERVICES

Although seniors are major consumers of health care, a study by the Canadian Medical Association (CMA) confirms that most of them are not sick and can continue to live independently in the community with such help from support services as is needed from time to time.[47]

Many witnesses told the Committee that, unfortunately, these services are often fragmented, uncoordinated or simply unavailable. An emphasis on the medical model of care and a distribution of resources in which there are few incentives to take non-institutional approaches to care are seen to be at the root of these problems. Dr. Dorothy Ley, Chairperson of the CMA Committee that produced the above study on health care for the elderly, advised the Committee that we should be spending more money on the 65 to 75 year olds to enhance their independence and quality of life, thereby reducing the need for the long periods of intensive care which are at present required by many people at the end of life.[48]

Witnesses reported that 80% of community care to the elderly is informal care (Dr. Ley, Dr. Peter Glynn, CMA). The need for respite care and support for informal caregivers was expressed. Traditionally , informal care has been provided primarily by women but that pool of caregivers is gradually decreasing as women enter the work force. Witnesses suggested that, in planning community care services for the future, the fact that women in the work force have expectations of community services different from those of women who work in the home must also be taken into account.

RECOMMENDATION

8. That the federal government place on the agenda for the next Federal-Provincial Health Ministers' Conference the development of services to provide support and respite for volunteer caregivers of elderly and disabled Canadians.

According to a Statistics Canada study, the rate of severity of disability increases dramatically with age. The percentage of seniors with severe disabilities increases from 20% at age 65-74 to 49% at age 85 or older. [49]

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47 *Health Care for the Elderly: Today's Challenges, Tomorrow's Options*, Report of the CMA Committee on the Health Care of the Elderly, 1987, pp. 4-5.

48 *Minutes of Proceedings and Evidence*, Issue No. 16.

49 Dunn, Dr. Peter A., *Barriers Confronting Seniors With Disabilities In Canada*, Special Topic Series from the Health and Activity Limitation Survey, 1990, p. 10.

The Statistics Canada study shows that approximately 84% of seniors with disabilities live in households and the remaining 16% live in institutions. The 1987 CMA study showed that, in 1981, seniors were 10% of the population of Canada and it was estimated that they accounted for 40% of total health expenditure. [50] At present, seniors make up roughly 11% of the Canadian population yet, according to the best estimates available at this time, account for about 40% of total health expenditure. The three main reasons identified in the Statistics Canada study why many of these elderly disabled Canadians cannot enjoy normal daily activities are: lack of support services, poverty and the fact that communities are designed for the able-bodied. Cost was found to be the main reason why disabled seniors living at home do not have mobility aids and housing adaptations such as handrails and ramps.[51]

RECOMMENDATION

9. That the federal government, as part of the development of a national health policy, establish objectives for improving the access of seniors and the disabled to a broad range of services which affect their health.

While those between 65 and 84 years use hospitals about three times as much as those between 25 and 64 years, those over 85 (frequently referred to as the "frail elderly") use hospitals about five times as much. A small group of seniors (less than 5%) actually use most of the hospital days.[52]

Increasing use of institutional and medical health services by the elderly should clearly be a serious concern in the development of health care policy. Research indicates that, in the past, changes in how patients are treated have been much more significant than changes in the number of patients, and their ages, who were available for treatment. Some witnesses suggested that we consider the broader question of how much the increased use of hospital and physician services by the elderly is really a reflection of the unavailability or lack of accessibility to more appropriate levels of care (e.g. community and homecare alternatives to institutional care, direct access to non-medical health practitioners) rather than increasing illness or need.

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50 CMA, 1987, pp. 4-5. The study found that, in 1981-1982, seniors used 48% of the patient-days in general and allied special hospitals and 72% of those in long-term facilities. Seniors were also estimated to account for one third of the days in psychiatric hospitals and 20% of physician's services for a combined estimated figure of 40% ($10 billion) of total health care expenditure.

51 Dunn, Dr. Peter A., *op. cit.*, pp. 1-2.

52 Mustard, J. Fraser, "Aging and Health: Research, Policy, and Resource Allocation", *Aging and Health: Linking Research and Public Policy*, Steven J. Lewis, Lewis Publishers, Michigan, 1989, p. 189.

A study on the use of medical services by the elderly in British Columbia found that:

> The importance of the underlying explanations to health care policy cannot be overemphasized. Increased age-specific per-capita use reflecting underlying increases in rates of illness warrants quite different policy initiatives from those most appropriate for addressing system-driven increases.[53]

Witnesses warned against viewing aging as a disease and emphasized the difficulties associated with the current tendency to confuse geriatric problems (diseases of the aged) with gerontological problems (normal aging). Evidence suggests that, as we age, there is a progressive decline in body functions, the rate of which can be influenced by disease but which is not due to disease. We can anticipate that care and support will be required as individuals gradually experience a decline in function due to aging and suffer from a variety of chronic illnesses. Some research and witnesses to the Committee emphasized the urgency of defining health policy issues related to aging more broadly than the health care system as we know it. Dr. Fraser Mustard says, for example:

> Individuals who have adequate income and control over their own housing and transportation, as long as they are of sound mind and body, have a better quality of life and live longer than individuals who have fewer economic resources and control over their lives. A society's policies on pensions, housing and other forms of economic support are all significant for the quality of life, health status and function of older individuals.[54]

The National Advisory Council on Aging (NACA) also expressed this broader view of health care for seniors saying:

> To provide adequate health care, it is necessary to assure access to a broad spectrum of services that go far beyond the medical model of health and far beyond the walls of health care institutions to meet the physical, mental and social health needs of older Canadians. [55]

Some witnesses to the Committee expressed the view that current methods of financing health care do not recognize the multi-dimensional nature of health and put too much emphasis on acute, institutional and curative services. The Victorian Order of Nurses, for example, believes that "current methods of government financing discourage less costly alternatives to institutionalized care for frail, elderly and chronically ill persons".[56] Witnesses also informed the Committee of the need for seniors to have easier and more efficient access to a wide range of services, including health care, through a single point of access, e.g. the Seniors' Wellness Centres which are part of the Victoria Health Project.

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53 Morris L. Barer, Indra R. Pulcins, Robert G. Evans, Clyde Hertzman, Jonathan Lomas and Geoffrey M. Anderson, "Trends in use of medical services by the elderly in British Columbia" , *Canadian Medical Association Journal*, Vol. 141, 1989, p. 45.

54 Mustard, J. Fraser, *op. cit.*, p. 189.

55 Brief, p. 11.

56 Brief, p. 1.

There is no one system of care for the elderly in Canada. Each province has a range of services contingent upon availability of financial and human resources, on the development and direction of health care and social services and on the philosophy of care in a particular province. Services are delivered by physicians, allied health care personnel, various social agencies, volunteers, friends and family members. Funds for services to the elderly are provided by federal, provincial and local governments and voluntary organizations. The report of the CMA's Committee on the Health Care of the Elderly, witnesses and recent studies by the Canadian Nurses Association (CNA) and National Advisory Council on Aging identified the following deficiencies in health care for the elderly:

- Too much emphasis on the medical model of care, making it difficult for the elderly to access other professional and vital services such as home care.
- Fragmentation of care due to the arbitrary division of responsibility for care between ministries, agencies and departments at all levels of government as a major hindrance to continuity of care.
- Insufficient teaching of gerontology and geriatric medicine at all levels of education in the health and social care fields, resulting in too few qualified and interested personnel.
- Need for an expansion of community services for the elderly available before and after sickness has occurred to prevent premature and inappropriate institutionalization.
- Inappropriate and inflexible financing of professional, institutional and community care which often does not keep up with changing needs.
- An inappropriate attitude of "benevolent paternalism" toward seniors on the part of the public and professionals which encourages premature institutionalization and discourages them from exercising their option to remain in the community, particularly when it involves personal risk.
- Confusion and lack of compatibility in the terminology used in different jurisdictions for types and levels of institutional and home care making it difficult to compare delivery, cost and quality of care from one province to another.[57]

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57 CNA, *Health Care Reform For Seniors*, Ottawa, November 1989, and NACA, *Aging and NACA: The NACA Position On Community Services In Health Care For Seniors*, January 1990.

RECOMMENDATIONS

10. **That resources be directed toward informing and empowering seniors as consumers of health care services in order that they can share, with their families, health care professionals, and informal caregivers, the responsibility to make healthy choices about their own health.**

11. **That the federal government, in cooperation with the provinces and territories, establish a common terminology across all health jurisdictions in Canada to facilitate comparisons in the quality and cost of institutional, community and home care.**

12. **That the federal government fund research, education and development of special expertise in geriatrics and gerontology for health and social care professionals.**

13. **That the federal government, as part of a national health policy, plan for the future health care of seniors, taking into account current and future lifestyles, the role of the family, the availability of social services, the financial resources of seniors, and the needs of physically and mentally challenged seniors.**

A problem of excessive utilization of medication by the elderly has been identified. As stated in a recent report of the proceedings of an invitational workshop on this issue, the problem is best defined as the inappropriate provision or use of medications, or the use of medication where some other approach would work better.[58]

The National Advisory Council on Aging reported that approximately 40% of emergency room visits and 10 to 20% of all hospital admissions of seniors are directly or indirectly related to the improper use of medication.[59] Seniors have three times the incidence of adverse reaction to drugs that young people have. The recent Report of the Pharmaceutical Inquiry of Ontario says that 80% of adverse drug reactions are avoidable.[60]

There are a number of major causes of adverse drug reactions in the elderly. The 1987 study by the CMA found that the presence of multiple conditions requiring multiple drugs increases the possibility of adverse reactions among the elderly. Confusion about dosage, timing and sequence of medications and, as is the case with members of our

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58 Province of British Columbia Ministry of Health, *Medication Use And Elderly People*, Vancouver, 1989, p. 7.

59 Brief, p. 18.

60 *Prescriptions for Health*, Frederick H. Lowy, Chairman, Toronto, 1990, pp. x-xi.

society in general, self-medication with over-the-counter drugs are common in adverse drug reactions. [61] The 1990 Ontario study also found that some physicians' lack of training in geriatric prescribing, dual prescribing systems in hospitals and in post-discharge care, increased drug sensitivity among seniors and improper storage also contribute to adverse reactions.[62]

The British Columbia workshop identified the need to help seniors understand and use medications correctly and appropriately. They spoke of the urgency of encouraging and assisting physicians, pharmacists and nurses to provide and monitor medications wisely.[63] The Ontario study and a number of witnesses recommended the development of a "smart card" to facilitate drug utilization, monitoring and review.

The evidence suggests that control of this problem would also represent reductions in health care costs through reduced costs for provincial drug programs and avoiding procedures, hospitalization and even institutionalization related to the misuse of medication. The National Advisory Council on Aging says that most of the increased cost of provincial drug programs for seniors (approximately 90% in some provinces over the past 5 to 10 years) has been due to the rising cost of drugs (an increase nearly 54% over 5 years).[64]

The Pharmaceutical Manufacturers Association of Canada informed the Committee that the November 1989 report of the Patented Medicine Prices Review Board says that manufacturers' prices of patented medicines rose on average by less than the Board's Guidelines, which are based on the Consumer Price Index.[65] They pointed out that medicines are the smallest and most cost-effective component of health care costs. Nevertheless, The Pharmaceutical Inquiry in Ontario found that the Ontario Drug Benefit has been the fastest growing health care program in that province, experiencing an average annual increase of 20.4% between 1978 and 1988. While Ontario residents aged 65 and over receive free drugs from the provincial plan, the Inquiry says that some groups, mainly the working poor and people with extraordinary drug costs due to severe chronic disease or disability, do not have adequate access to needed drugs.[66]

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61 *Health Care for the Elderly: Today's Challenges, Tomorrow's Options*, Report of the CMA Committee on the Health Care of the Elderly, 1987, p. 32.

62 *Prescriptions for Health, op. cit.*, p. x.

63 Province of British Columbia Ministry of Health, *op. cit.*, p. 7.

64 Brief, p. 18.

65 *Minutes of Proceedings and Evidence*, Issue No. 53, p. 108.

66 *Prescriptions for Health, op. cit.*, p. ii.

The possibility that new interventions that extend life may actually increase the "frailty" of the average person in their period of advanced age has been explored in some research but the evidence at this time is inconclusive. A study on the delivery of health care to the aging by the Institute for Health Facilities of the Future recommends that we refine policy objectives as consisting not only of lowering mortality, but of improving the ability to function. Such policy, according to this study, would increase public awareness of the price that must sometimes be paid in disability to reduce the mortality rate and vice versa; more specifically:

> . . . . it would reinforce efforts to see that certain technological innovations, in both diagnosis and therapy, do not give rise to more harmful consequences than real advantages, particularly when the expected advantage itself is not obtained. [67]

According to Dr. D.W. Molloy of the Geriatric Research Group at McMaster University, the elderly often receive "inappropriately aggressive interventions" by the health care system mainly because there is no established mechanism whereby patients and families can express their wishes as to how an acute illness should be handled prior to occurrence of the illness. Dr. Molloy, who runs a memory clinic, said that he is particularly concerned about what is going to happen to his patients when they become too demented to make decisions on their own. He reported that recent studies suggest that up to 47% of those over 85 are demented. Dr. Molloy is currently involved in a project to develop a new Health Care Directive designed to allow the elderly, chronically ill, and disabled, and their relatives, to specify the level of care they wish to receive in the event of an acute illness. Based on his experience to date, Dr. Molloy believes that Health Care Directives could improve people's quality of life and improve their autonomy and that they would also dramatically reduce health care utilization among the elderly (he estimates by at least 5% of the total health care budget).[68]

RECOMMENDATION

14. That the federal government undertake initiatives to determine the feasibility of legislation allowing elderly individuals to specify the level of care they wish to receive in the event of an illness which renders them incapable of making decisions at that time.

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67 *Aging: Future Health Care Delivery*, Ottawa, 1988, p. III-3.

68 *Minutes of Proceedings and Evidence*, Issue No. 53.

D. SENIORS, HEALTH CARE COSTS AND FUTURE NEEDS

This is the first generation in Canada in which people can expect to live to old age and in which average life expectancy equals or exceeds the age of mandatory retirement. By 2021, it is expected that 18% of the population will be elderly. Many have predicted that future cohorts of seniors will be different from the seniors of today, in ways which may significantly affect their health care needs. Some observers argue that future cohorts will expect retirement and will be better prepared for it, mentally and financially. Others are of the view that recent trends in public pensions mean that people will be less financially secure in their retirement. More seniors will live alone rather than with a spouse, because of the higher number of divorced and single people now in the younger age groups and this may have the effect of increasing the number of seniors requiring support services. Third, the informal care now provided mostly by women will decrease as more women work outside the home. Also, the expectations of community support services are likely to increase among women who have been in the workplace. [69] It will be important in planning services to anticipate these and other differences that may distinguish tomorrow's seniors from today's.

On the one hand, there is the view that part of the gains in overall life expectancy have been obtained at the expense of increased disability and increased health care costs.[70]

Others say that maximum lifespan (as distinct from life expectancy) is relatively fixed (natural death) and that, the onset of chronic illness characterized by disability and dependence can be compressed in a relatively short period near the end of life (compressed morbidity) suggesting tomorrow's seniors will be less likely to need health services than today's.[71]

Such theories are still speculative and further research is required to provide a stable body of knowledge on which to base future health policy. It seems clear that the implementation of illness prevention and health promotion measures which postpone the period of disability at the end of life and thereby prolong independence can be productive in the long-term. In the short-term, we must address the immediate problem of how to provide appropriate levels of care for the rapidly increasing number of seniors.

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69 CMA, 1987, p. 7.

70 Wilkins, R. and O. Adams, *Healthfulness of Life*, Institute for Research on Public Policy, Montreal, 1983.

71 Fries, J.F., "Aging, Natural Death and The Compression of Morbidity", *New England Journal of Medicine*, Vol. 303, 1980.

CHAPTER 5

ACCESSIBILITY TO HEALTH CARE

The accessibility principle, as defined in the *Canada Health Act*, requires reasonable access by Canadians to insured health services unimpeded by charges or other factors. Pursuit of the objective of equal access to medically necessary hospital and physician services has been a dominant feature of Canadian health policy since the Second World War. Under the *Hospital Insurance and Diagnostic Services Act* of 1957 and the *Medical Care Act* of 1966, federal funds were made available for provincial health insurance programs if certain criteria were met, i.e., comprehensive coverage, universality, portability, non-profit administration. These principles were reaffirmed in the *Canada Health Act* of 1984. This means that all citizens of Canada should have access to health care services on the basis of need rather than ability to pay. Nevertheless, in the opinion of some witnesses to the Committee, problems of accessibility continue to exist.

The Committee heard reports of cases where patients had difficulties accessing acute care facilities, particularly for certain high technology procedures such as cardiac surgery. Witnesses representing the elderly and the physically and mentally disabled reported problems in accessing the community, homecare, social and support services which they require. The Committee was also informed of the unmet health needs of women, children and the poor. Despite the fact that Canadians have access to most hospital and medical services without direct financial burden, there are still differences in the relative use of health services by rich and poor Canadians, as well as differences in health status and life expectancy. Similar differences exist between aboriginal people, immigrants and cultural minorites and the general population. In these cases, witnesses urged that considerations of access should go beyond the question of who pays at the time of the service to include cultural barriers to care. Finally, those less-populated geographical areas farthest removed from urban centres have their own particular problems of accessibility.

A. ACUTE CARE FACILITIES

Universal health care, as currently provided for under the *Canada Health Act*, has succeeded in bringing about a high degree of equality in access to and utilization of hospital and medical services. Recent media reports, however, suggest there are

treatment delays, waiting lists, bed closures and shortages of nurses and technicians that imply there are still some problems with access to care, particularly acute care and high technology procedures. Accompanying reports suggest that such problems result in some people going to the United States for treatment.[72]

Opinion varies on the extent to which these reports accurately reflect the current situation.

An accurate assessment of the total number of Canadian health insurance dollars paid out for Canadians receiving treatment in the United States and the type of treatment (e.g. emergency or elective, type of procedure or diagnosis) is not possible at this time. This seems largely due to the difficulties and costs associated with manipulating the data necessary for such calculations. Available information suggests that these expenditures are considerable in some areas close to the U.S.-Canada border (e.g. Southern Ontario, British Columbia) and apparently quite insignificant for others (e.g. the Territories). Some health care providers believe that problems of accessibility to acute care are the result of underfunding in the face of consumer-driven demand. That demand tends to increase as the public's expectations of what the health care system can or should provide rises. Others, including health policy analysts and some consumer groups, are of the view that problems of accessibility are related more to health funding arrangements and the management of health care resources. They see a maldistribution of health care resources in which ineffective, inefficient and often unevaluated use of resources is the norm. The Canadian Hospital Association (CHA) sees a combination of the above factors at the root of the problem. In explaining why the expected rate of increase in health expenditure has not come about, the CHA says:

> The first challenge is the federal government's progressive cuts to the Established Programmes Financing (EPF) transfers since 1986. Cutbacks in the EPF transfers restrict flexibility in service delivery at the provincial level.[73]

The CHA goes on to say:

> The second challenge is the health system's generalized inability to measure and critically assess both costs and quality of care.[74]

With respect to the second challenge relative to the management of the health care system, Dr. David Naylor suggested to the Committee that:

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72 "Waiting Lists 'Price of Universal Health Care'", *Calgary Herald*, March 7, 1990; "Emergency Rooms Still Strained Beyond Limits, Doctors Complain", *Montreal Gazette*, December 7, 1988; "Ontario Cancer Care Waiting List More Than Double in Year", *Globe and Mail*, October 1, 1990; "Limited Funds Stymie Elective Surgery", *Halifax Chronicle Herald*, January 30, 1989; "Heart Patients May Be Sent to U.S.", *Ottawa Citizen*, January 14, 1990; "Addicts Seek U.S. Treatment to Avoid Ontario Delays", *Globe and Mail*, May 7, 1990.

73 Brief, p. 4.

74 *Ibid.*

> On the innovative side—and I am not talking here about medical innovation, but management innovation and delivery innovation—we fail abysmally. We have had open-ended private practice, fee-for-service framework, hospitals on global budgets with no clear accountability and central co-ordination, and the whole system of state-dependent contractors without central management for 20 years, and we have done virtually nothing about it.[75]

He also said:

> In the last five years we have seen the emergence of painfully visible and obvious non-price rationing, with waiting lists, (. . .) comparisons showing the lack of availability of certain advanced technologies relative to our American neighbour, (. . .).[76]

Dr. Naylor suggested that there is this type of non-price rationing in every system but that it was previously (prior to 1984) less visible in Canada. He sees, as an alternative, better management and control of the supply of health care: e.g. managed waiting lists, better informed consent for medical and surgical procedures and quality assurance mechanisms to make sure that the costs and benefits of a procedure outweigh the risks.

Witnesses also identified over-use, lack of a complementary range of services, hospital staffing problems and policy decisions (i.e. to expand or reduce the number of insured services covered under a health insurance plan) as some other factors associated with problems of access.

The claim is made that there is an over-use of acute care facilities because more appropriate community-based alternatives are not available. Kenneth Fyke, of the Greater Victoria Hospital Society, told the Committee, for example, that:

> Many people, of all ages but particularly the elderly, experience complications and deterioration in their health when they are admitted to hospital. The isolation, inactivity and lack of privacy cause stress and often result in confusion. The unfortunate consequences of hospitalization could be reduced if the location of care was appropriate.[77]

Research indicates that the elderly have higher utilization rates of both hospital and medical services than the general population. For example, studies in British Columbia, Manitoba, Saskatchewan and Alberta report similar trends in this utilization.[78]

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75 *Minutes of Proceedings and Evidence*, Issue No. 43, p. 23.

76 *Ibid.*, p. 15.

77 Brief, pp. 5-6.

78 Evans, Robert E., "Reading the Menu with Better Glasses: Aging and Health Policy Research", Lewis, 1989, p. 189; Barer, Morris L. et al, "Trends in Use of Medical Services by the Elderly in British Columbia", *Canadian Medical Association Journal*, Vol. 141: 39-45; Roch, D.J., et al, *Manitoba and Medicare, 1971 to the Present*, Manitoba Department of Health, Winnipeg, 1985, pp. 56-70; *Review Committee to the Minister of Health, Study into the Growth of Health Services*, Saskatchewan Department of Health, Regina, 1989; Research by Professor Richard Plain, University of Alberta, 1990.

In British Columbia, there has been a decline in hospital utilization rates, since 1969, among children over 28 days and for adults up to the age of 50 years. In comparison, hospital utilization rates for children under 28 days [79] and for people over 75 years have increased. Studying the impact of shifts in use patterns, this research finds that the unadjusted rate of hospital days per capita rose by just over 5% but, within this total, acute care use dropped by about one third and the rate of long-stay patients (those whose hospital stays were 60 days or longer) nearly tripled.[80]

Similarly, this research indicates that rates of use of medical services among the elderly also increased between 1975 and 1986 in British Columbia. Dr. Evans points out in this regard that the growth of physician supply in Canada outstrips population growth by 1.5% to 2% per year. [81] The area with the fastest growth in use by the elderly is specialist care, particularly diagnostic services. The average number of specialists seen by people aged 75 years or more doubled over the study period.

An analysis of the Manitoba experience yields findings similar to those in British Columbia with respect to increased use of physicians among the oldest age groups. The Manitoba study concludes that there has been an overall expansion in servicing for all age groups in the period since 1971. The physician to population ratio in Manitoba has risen rapidly over the same period, while average physician workloads and incomes, according to this study, have remained stable. Health policy analysts say that the reasons for this pattern of use of medical services is still unclear.

RECOMMENDATION

15. That the federal government address the issues around the use of acute care services by funding research into the development of a system of coordinated and integrated health services which would provide a continuity of care between acute care hospitals, and extended, community and home care, thereby facilitating access to appropriate levels of care.

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79 The increase in utilization rates for children under 28 days reflects the decline in infant mortality rates over the same period, particularly among low birthweight babies.

80 Evans, *R., op. cit.*, 1989.

81 *Ibid.*, p. 152.

B. COMMUNITY CARE, HOME CARE, SOCIAL SUPPORT AND PREVENTIVE SERVICES

Witnesses often spoke of access in terms broader than those required by the *Canada Health Act*. A variety of witnesses favoured a more comprehensive definition of health and a wider range of insured services in the health care system. The National Advisory Council on Aging's view of health care for seniors is one example:

> To provide adequate health care, it is necessary to assure access to a broad spectrum of services that go far beyond the medical model of health and far beyond the walls of health care institutions to meet the physical, mental and social health needs of older Canadians.[82]

A Health and Welfare Canada study of mental disorders among the elderly similarly concludes that:

> It is recognized increasingly that the social and public health problems of aging and old age cannot be resolved through a traditional single-track, sectorial approach. An integrated approach combining social, behavioural and medical knowledge and skills has a better chance of ensuring that the needs of the aged population are met. [83]

Ray Jackson of the Science Council of Canada observes that the "health establishment" is adapting to a number of changes that have taken place over the past few decades, including the demographic shift to an older population and the shift from infectious diseases to chronic and degenerative diseases. He says, in this regard:

> It is generally realized that after-the-fact treatment of chronic and degenerative diseases does not have a high success rate. Since the origin of diseases lie mainly in social, environmental, nutritional, genetic and lifestyle factors, prevention will be the only really effective approach to the improvement of health and the reduction of health care costs. [84]

Current funding arrangements provide health insurance to cover the cost of care within a "medical model", where health is defined as the absence of illness. Many witnesses (including Dr. Mustard and Professor Contandriopoulos) suggested that funding arrangements based solely on this model of care do not provide the breadth of services required. They pointed out, for example, that little help is available to those who are seeking to take preventive steps or to use available technology and expertise in order to maximize independent living. The National Advisory Council on Aging also expressed this view with respect to seniors. The Science Council paper points out that as the health establishment adapt to its changing environment:

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82 Brief, p. 11.

83 Guidelines for *Comprehensive Services to Elderly Persons with Psychiatric Disorders*, Mental Health Division, Health Services and Promotion Branch, 1988, p. 32.

84 *Issues in Preventive Health Care*, Report of the Science Council of Canada, 1985, p. 3.

> There are inevitable struggles over who belongs (what practitioners are legitimate from the point of view of public safety and eligible for reimbursement from insurance schemes) and who controls. [85]

The provinces have some latitude in determining which non-medical services should be provided to the insured population as part of the provincial health care system and, in fact, the range of such services covered under provincial plans varies considerably. In the view of some witnesses, the *Canada Health Act* does not go far enough in requiring the provinces to provide certain non-medical health personnel and services. These witnesses would like to see a broader range of services, including those of physiotherapists, chiropractors, psychologists, occupational therapists and nutritionists, integrated into health care insurance system. In addition, there are those who recommend that these non-medical health professionals be established, in addition to physicians, as points of access to the insured health care system. Groups representing hospitals and physicians, however, suggest a review and evaluation of the quality of care, liability and cost implications before opening the system to non-medical health personnel.

RECOMMENDATION

16. That the federal government, in cooperation with the provincial and territorial governments, evaluate the use of a wider range of health care professionals within the insured health care system.

C. GEOGRAPHICAL DISTRIBUTION OF HEALTH CARE SERVICES

Uneven development and distribution of health care services create some problems of access in high density urban areas, as well as in some rural and less densely populated areas. Rural and remote areas and areas of low economic growth have more difficulty attracting and retaining health care professionals, particularly those in highly specialized disciplines. The Canadian Hospital Association acknowledges, however, that the major nursing shortages in Ontario are in urban centres, particularly downtown Toronto.

A need for well-coordinated primary, chronic care and geriatric services seems prevalent everywhere. Witnesses reported a lack of services in regions with low population densities and a shortage of adequate support services in local communities in every region (Consumers' Association of Canada, Canadian Dietetic Association, Victorian Order of Nurses, Canadian Pharmaceutical Association, National Advisory Council on Aging). In some regions, services are available only in hospitals. The

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85 *Ibid.*

Consumers' Association of Canada suggests that support should be given to rural hospitals so that they can provide diversified services such as mobile services and day centres that meet the needs of the community. Some witnesses, including the Canadian Pharmaceutical Association, feel that a study of the health care needs of rural populations is required.

The Canadian Hospital Association pointed out, with respect to Northern Canada, that we do not really have a definition of what access means within the system:

> . . . whether it means I have it on the spot, within 10 minutes of my house, or there is provision for me to receive the service regardless of whether that means travelling or not . . . the question is what is reasonable to have on the spot within the northern communities as opposed to what is reasonable to have within reasonable air ambulance time and the cost of trade-offs in doing that. [86]

RECOMMENDATIONS

17. That the federal government facilitate through research the development and refinement of health care services to better meet the needs of rural and northern Canadians.

18. That the federal government, through federal-provincial funding arrangements, support innovative recruitment and retention programs in areas of the country where shortages of health personnel have been identified.

D. GROUPS WITH SPECIAL NEEDS

The Committee was advised by a variety of witnesses that the poor, women, children and youth, the elderly and disabled, aboriginal people, immigrants and cultural minorities all have special needs that may affect access to appropriate health care services. Witnesses and research tend to suggest that problems of access to health care services are reflected in the fact that these groups have a lower health status than the Canadian population as a whole.

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86 *Minutes of Proceedings and Evidence*, Issue No. 38, p. 17.

1. The Poor

Research indicates a link between poverty and ill health. The national health insurance program greatly reduced the disparities in health status between rich and poor in Canada but such disparities continue to exist, despite continuing efforts to remove barriers to access. Research shows that low income groups continue to have higher rates of mortality, morbidity and disability than the general population.[87]

Life expectancy of a poor person at birth in Canada in 1986 was 3.7 years less than that of a wealthy person and such evidence is said to demonstrate the link between poor health and poor socio-economic conditions. This link is particularly strong among children. According to the Canadian Institute of Child Health, the mortality rate, in 1986, for children under 20 years of age, in the lowest income quintile was 56% higher than for those in the highest income quintile. The infant mortality rate (deaths in the first year of life) in the poorest group was twice as high as in the highest income group.[88]

The impact of poverty on health is particularly evident among aboriginal people. Federal government research indicates that aboriginal people are much more likely than other Canadians to rely on social assistance and live in crowded housing conditions without central heating, conditions frequently associated with poor health.[89]

2. Children And Youth

Infant mortality rates in Canada declined by about 78% between 1953 and 1986. Reasons for this decline, according to some research, include, better health care before and after birth and improved nutrition.[90] Nevertheless, recent studies show disparities in child health related to income, geography and cultural factors.[91]

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87 Health and Welfare Canada, *The Active Health Report*, 1987, pp.35-38; Health and Welfare Canada, *The Health of Canadians: Report of the Canadian Health Survey, 1978-79*, Ottawa, 1981; Wilkins, R. and Orville B. Adams, *Healthfulness of Life: A Unified View of Mortality, Institutionalization and Non-Institutionalized Disability in Canada, 1978*, Institute for Research on Public Policy, Montreal, 1983; Wilkins, R., Owen Adams and Anna Brancker, *Changes in Mortality by Income in Urban Canada from 1971 to 1986: Diminishing Absolute Differences, Persistence of Relative Inequality*, Health Policy Division, Health and Welfare Canada and the Health Division, Statistics Canada, Ottawa, June 1989.

88 Brief, p. 2.

89 Hagey, N. Janet, Gilles Larocque and Catherine McBride, *Highlights of Aboriginal Conditions, 1981-2001*, Part II, Social Conditions, Quantitative Analysis & Socio-demographic Research Working Paper Series 89-2, Finance and Professional Services, Indian Affairs Canada, December 1989, pp. 13-14.

90 Statistics Canada, *Canada Year Book 1990*, Ottawa, 1989, p. 3-2.

91 The Canadian Institute on Child Health, *The Health of Canada's Children: A CICH Profile*, Ottawa, 1989; *Ontario Child Health Study: Summary of Initial Findings*, Queen's Printer of Ontario, 1989.

While the rate of infant mortality was cut nearly in half within each income group (quintile), between 1971 and 1986, the rate among the lowest income group in 1986 was still almost double the rate for the highest income group. [92] Research similarly finds that the risk of death from infectious diseases, accidents and low birthweight, as well as of developmental disabilities, is higher among low-income children than among Canadian children in general.

Low birthweight is said to be the single most important cause of infant mortality. Studies find that mothers in the lowest income quintile have the highest incidence of low birthweight babies. The Ontario Medical Association reports that a number of factors associated with risk to health, including smoking, age and nutritional status, are also associated with the social class of mothers.[93]

The survival of low birthweight premature babies has been dramatically improved in recent years and, while this is a success story on the one hand, it creates stresses on the health care system on the other. Dr. Robin Walker, Chief of Neonatology at Queen's University and Vice-President of the Canadian Council on Children and Youth, told the House of Commons Standing Committee on National Health and Welfare in May 1988, during the early stages of the present study, that these babies are usually born 16 or 17 weeks early. They have to stay in intensive care through that time and often weeks or months longer than this, because of problems with lungs and other body systems. Dr. Walker said the cost of caring for each of these surviving babies is about $100,00 and so, he said, we are talking about a "very large amount of money" for nursing care alone.[94] In addition, experts predict that as many as 20% of premature low birthweight babies suffer varying degrees of long-term illness and disability, the human and economic costs of which are difficult to measure.[95]

Low birthweight not only has a high probability of lowering of an individual's quality of life but is also very costly to the health care system. On the optimistic side, it seems apparent that this is an area where investments in health promotion and prevention could be very productive, both for the individuals, in terms of better health and higher quality of life, and for Canadian society, of which they could be productive members.

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92 Wilkins, Adams and Brancker, *op. cit.*, 1989.

93 Ontario Medical Association, Submission to the Ontario Social Assistance Review Committee, 9 January 1987.

94 *Minutes of Proceedings and Evidence*, House of Commons Standing Committee on National Health and Welfare, 2nd Session, 33rd Parliament, Issue No. 45, p. 5.

95 Chance, Dr. Graham, *The John T. Law Lecture*, Fourth National Conference on Regionalized Perinatal Care and Prevention of Handicap, Ottawa, 11 November, 1988.

Witness groups (e.g. the Canadian Institute of Child Health, the Canadian Consumers' Association and the Canadian Dietetic Association) spoke of the importance of health promotion, particularly among young people, to produce behavioural changes, such as giving up tobacco products, alcohol and poor dietary habits, that will reduce risks to health.

The need to broaden the concept of health care to include social support services was also expressed in the context of children's health. For example, such services are regarded by many witnesses as essential in the fight against low birthweight in babies of low-income mothers.

The Committee was also reminded that the health status of Canada's aboriginal children is lower than that of Canadian children in general. In 1986, for example, infant mortality for status Indians was still twice that of the Canadian population (17 per 1,000 for Indians compared to 8 per 1,000 for Canada).[96] Similarly, the Native Council of Canada informed the Committee that rates of postnatal mortality, fetal alcohol syndrome, suicide (particularly among young people 15-24 years of age), and violent deaths are much higher among aboriginal people than in the Canadian population as a whole.[97]

It seems self evident that the health of children should be a priority in health care policy and planning. Children represent the future of Canada and research and practice suggest that if people begin their lives in good health the risk of illness and disability in later life is greatly reduced. Healthier people would presumably have a positive impact on the cost of health care and make for a generally more productive society.

RECOMMENDATIONS

19. **That the federal government take an interdepartmental approach to develop a strategy to reduce the threat posed by poverty to the health of children and youth.**

20. **That a federal-provincial interdepartmental advisory committee be established to develop strategies to change behaviour, (e.g. avoiding use of tobacco products, alcohol, and poor eating habits) thereby reducing risk factors associated with poor health in children and youth (e.g. low birthweight and fetal alcohol syndrome).**

21. **That the promotion and advertising of tobacco products be phased out as soon as reasonably possible.**

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96 Hagey et al., *op. cit.*, p. 5.

97 Brief, pp. 1-2.

22. **That advertising for alcoholic beverages reflect responsible use and positive societal values.**

23. **That health warnings, directed toward pregnant women, be placed on alcoholic beverages.**

3. Women

The Canadian Advisory Council on the Status of Women advised the Committee that, because health services often do not take into account the fact that the health needs of men and women are different, there are instances where existing services do not meet the needs of women. This is particularly the case with those needs which derive from women's reproductive capacity and their experiences as women in society. The Council's concerns with regard to women's health care requirements include:

> . . . access to reproductive health services, including abortion for all women in Canada; access to other health care services, including a broadened definition of such services and of professional categories covered by health insurance plans such as midwifery, especially taking into consideration the particular needs of women living in rural and remote areas; and the role of stress, which because of inadequate programs and services remains too often an unacknowledged, undiagnosed and untreated health hazard to Canadian women. [98]

The Council believes that access to family planning services, in conjunction with sex education in the schools, is the most significant factor in reducing the need for abortion services. They identify regional disparities in access to family planning information and urge the federal government to take a leadership role, ensuring that such information is available to all women throughout Canada. Aboriginal women have particularly severe problems of access, often compounded by poverty and lack of sensitivity to their cultural concerns.

The Council suggests that improving access to appropriate health services for rural women would include either establishing services closer to home or studying the feasibility of transporting people to services in urban centres. Expenses incurred for transportation, lodging and child care must also be taken into account.

RECOMMENDATIONS

24. **That the federal government take a leadership role and, consulting with the provinces and territories promote: (1) access to family planning information and (2) access to family life education in all regions of Canada.**

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98 *Minutes of Proceedings and Evidence*, Issue No. 22, p. 5.

25. That the federal government use its powers under the *Canada Health Act* to insist that all provinces and territories make access to therapeutic abortion available to all women.

4. Aboriginal People

While the health status of aboriginal people has improved considerably over the past 20 years, the status of health of both those living on and off reserves is still significantly below the Canadian average. Life expectancy at birth increased and infant mortality decreased for all Canadians, including aboriginal people, during this period but the gains in health status achieved by aboriginal people were still well behind those achieved by other Canadians. The life expectancy at birth of status Indians, for example, was 10 years less than that of the national population in 1981 and the projected figure for 2001 is below the 1981 figures for Canadians as a whole. [99] To some extent, these differences in health status are related to problems of accessibility to the health care system faced by aboriginal people.

Dr. Gillian Lynch of Health and Welfare Canada pointed out that the services required by aboriginal people are not, because of their history, culture and other unique characteristics, the same as those for Canadians as a whole. [100]

Both Dr. Lynch and the Native Council advised the Committee of the role of traditional medicine and ancestral customs in health care for aboriginal people. In isolated communities, escorts and interpreters are provided so that patients can communicate with doctors and other health personnel. Many are of the view, however, that more participation by aboriginal people in the delivery of health services would greatly improve their access to quality care. In part, this would involve the creation of more career opportunities for aboriginal people in the health sector and the transfer of responsibility for health services in their communities to aboriginal people themselves. These areas have received attention over the past two decades and in some cases such control either already exists or planning towards it is ongoing.

The Indian and Inuit Health Careers Program of the Medical Services Branch of Health and Welfare Canada promotes participation of aboriginal people in health careers. While this program has had some success, it applies only to those living on reserves. Speaking generally of the supply of native health professionals, the Native Council of Canada said:

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99 Hagey et al., *op. cit.*, p. 6.

100 Acting Assistant Deputy Minister, Medical Services Branch, Health and Welfare Canada, *Minutes of Proceedings and Evidence*, Issue No. 12.

> There is a tremendous need for native doctors, nurses, dentists and other health care professionals . . . . This must be changed by encouraging our youth and providing opportunities for them in the health professions. [101]

The Native Council went on to say that many of their young people attend universities and colleges and qualify in the health professions but that they must be given opportunity, incentives and support to return to their own communities and work there in the health care field.

The need for comprehensive statistics on the numbers and distribution of aboriginal health care professionals as a basis for planning is evident. Knowledge about the current supply of aboriginal health care professionals is at best fragmented.

There is a high level of consensus that a move toward aboriginal control of their own health services would empower aboriginal people to deal with their own health problems and thereby contribute to their better health.

There is also an initiative at Medical Services Branch to transfer health programs to Indian communities that want this responsibility. Prior to entering formally into a transfer agreement with the Branch, bands and tribal councils may apply for funding to do the preparation necessary (setting up and training a health board, conducting a health needs assessment and preparing a community health plan) for their successful takeover of health responsibilities.[102] Eight transfer arrangements have been signed, nine others are being negotiated and 69 pre-transfer planning projects have been approved.[103] This trend in transferring responsibility for health services from the federal government to aboriginal people is consistent with the more general trend to self-government for aboriginal people. Some see these as a very important development towards further improving the health of aboriginal Canadians.[104] For Indian communities choosing to maintain some or all existing services from the federal government, they are assured that there will be no loss in service level and quality, compared with communities choosing to operate their own health program.

Dr. Lynch further indicated that at present, despite the resources allocated to health services on reserves, such services are often fragmented and not uniformly available. Resources on reserves to meet health and other needs are further stretched by the

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101 *Minutes of Proceedings and Evidence*, Issue No. 19, pp. 5-6.

102 *Minutes of Proceedings and Evidence*, Issue No. 12, p. 7.

103 Health and Welfare Canada, *Estimates 1991-1992*, Part III, p. 2-72.

104 Pekeles, Dr. Gary, (with the 1986/87 Indian and Inuit Health Committee of the Canadian Paediatric Society) "The Health of Indian and Inuit Children in Canada in the 1980's and 1990's", *Canadian Family Physician*, Vol. 34, July 1988, pp. 1567-1568.

requirements of Bill C-21 to end sexual discrimination in the *Indian Act*.[105] Lack of resources could create problems for ongoing efforts to transfer control of health programs to aboriginal people.

It is also recognized that the health problems faced by aboriginal people go beyond the parameters of traditional health care. According to Dr. Lynch, this is a multidisciplinary issue requiring input from various sectors, including social services, housing and environmental services.[106]

The Native Council told the Committee that aboriginal people who live outside reserves also experience problems with access to health care services. The Council says,"We do not believe it is good enough for the provinces to say that native people have access to the same services as the rest of the provincial population".[107] Cultural and linguistic differences may be barriers to care for aboriginal people in the service system provided to the general public in the provinces and territories. Recent provincial studies of health care services in Quebec and Saskatchewan have recommended changes to ensure that their provincial health care services better meet the needs of aboriginal people in their jurisdiction. The Native Council is of the view that federal programs affecting the health of Natives should be expanded to include aboriginal people who live outside reserves. [108]

5. Immigrants And Cultural Minorities

Some witnesses informed the Committee that linguistic and cultural differences may also create problems of access to appropriate health care services for immigrants and cultural minorities. Even if health care facilities are physically available, they cannot be effective for those members of the community who do not have appropriate oral and written language skills or who live in areas where the service is not sensitive to their particular cultural customs and heritage. The Victorian Order of Nurses, for example, pointed to the need to help immigrants avail themselves of services and for particular attention to be paid to culturally sensitive areas such as behavioural or dietary restrictions

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105 *Fifth Report* of the Standing Committee on Aboriginal Affairs and Northern Development in consideration of the implementation of the *Act to amend the Indian Act* as passed by the House of Commons on June 12, 1985, August, 1988. pp. 71-75.

106 *Minutes of Proceedings and Evidence,* Issue No. 12, p. 9.

107 Brief, p. 7.

108 *Ibid.*

based on religious beliefs or simply long-standing food preferences.[109] Similarly, Dr. Morton Beiser, Chairman of the Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, said in his brief that:

> Even though, in theory, immigrants and ethnocultural minorities have the same access to health care as all Canadians, this does not guarantee that they use it or that they receive equally good treatment. [110]

The Task Force also observed that when practitioners are fluent in the language and culture of immigrants and cultural minorities, patients from these groups tend to use services more readily, disclose information more fully, and follow through with treatment more faithfully than when an interpreter is required. The report goes on to say, however, that there is a very short supply of minority group practitioners because of barriers that prevent them from using their skills in Canada. Professionals trained in other countries are often barred from practice by licensing restrictions and by the admissions requirements of post-graduate institutions.[111]

The Committee noted that the recent report of the Standing Committee on Industry, Science and Technology, Regional and Northern Development recommended that governments seek to eliminate barriers that prevent the use of the skills of landed immigrants. [112]

RECOMMENDATION

26. That governments seek to eliminate unnecessary barriers and promote equal opportunities, for health care professionals with foreign-obtained credentials to qualify and practise in Canada.

The National Council on Aging suggested four methods to make physical and mental health services more accessible to elderly immigrants and members of cultural minorities; the methods would apply equally well to other members of these groups.

1. Encourage and assist cultural minorities to acquire oral and written language skills in one of the official languages.
2. Encourage and assist cultural communities to identify physical and mental health service problems encountered by their members and take part in efforts to find solutions.

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109 Brief, p. 15.

110 Brief, p. 12.

111 Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, *After the door has been opened,* Canada, 1988, p. 59.

112 *Canada Must Compete*, Ottawa, December, 1990, p. 8.

3. Take into account the cultural heritage and customs of cultural minorities when planning health services in institutions and communities.

4. Ensure that an adequate system of contacts and information is established, preferably by members of the cultural communities themselves, so that the members of cultural minorities may be made aware of the services available to them.

It must be acknowledged that immigrant women and women who are members of cultural minorities are doubly disadvantaged, in terms of the problems they face, in accessing appropriate health care services.

RECOMMENDATION

27. That the federal government take a leadership role and assist the provincial and territorial governments to modify and develop health care services that are sensitive to the needs of women, aboriginal people, immigrants and cultural minorities.

E. MENTAL ILLNESS

Problems of access to psychiatric services are reported for all regions of Canada. The Canadian Mental Health Association (CMHA) points out that "Mental health expenditures are small relative to overall health spending"[113] and there is an apparent need for a comprehensive analysis of mental health spending in Canada. The CMHA indicated to the Committee that while the present resources are allocated to institutions, the chronically mentally ill population now lives largely in the community. It reported, however, that, in Ontario for example, only 4.5% of mental health spending in 1985-1986 went to community services.

Dr. Barry Jones, Director of the Schizophrenia Program of the Royal Ottawa Hospital, estimated that 7% of all hospital beds are occupied by people with schizophrenia alone. He warned, however, that:

> . . . before we move people out of institutions we must be ready to provide appropriate care in the community, not in jails, crowded boarding homes or in the street.[114]

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113 Brief, p. 1.

114 *Minutes of Proceedings and Evidence*, Issue No. 46, p. 9.

Dr. Jones estimated that 50% of the homeless and 10% of the population in jails have severe mental illness. He further indicates that perhaps 25% of the patients in his program fluctuate between living in the community and living in hospitals during episodes of acute illness. He further claims that many patient relapses can be attributed to the very poor environment into which patients are placed in the community.

The Canadian Psychiatric Association (CPA) is similarly concerned with problems of access to psychiatric health care services and the need to link health and social services, especially housing. The CPA commented that:

> . . . psychiatric clinicians report encountering a degree of inflexibility and lack of creativity within the health care system that effectively prevents less expensive alternatives to institutional care from being offered . . . [115]

Dr. Molloy [116] and the CPA expressed concern about the relatively large percentage of the elderly population in the over eighty group suffering from chronic psychiatric illness. It is members of this group, according to the CPA, that often have the poorest social supports and requires institutionalization for safety and adequacy of care; there seems to be no reason to believe that they will necessarily be healthier in the future. Therefore, the CPA takes the view that:

> . . . planning for the future of health care services, for both the elderly and the chronically psychiatrically ill, based on an optimistic projection of increased healthiness would be dangerous because it may grossly underfund a system which is at present already considered to be underfunded (. . .) planning for the future with the same kind of morbidity levels that we see today would be much more appropriate.[117]

Several witnesses, including the CPA, also emphasized the important role of health promotion and disease prevention in the area of mental health. Abuse of alcohol and other substances was identified as a major factor in the development and aggravation of psychiatric disorders and the recommendation was made that greater efforts be made to educate the population about the risks of such abuse, particularly with respect to cognitive deterioration, family violence, sexual abuse and foetal alcohol syndrome.

Many witnesses feel that all health care consumers must actively participate in making decisions about their own health, as well as in planning health care services. It follows that consumers must receive appropriate and timely information in order to make decisions related to health. The CMHA says that the person with mental illness is not willing to be "a passive recipient of medical services" but wishes to "take a central role in

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115 Brief, p. 1.

116 *Minutes of Proceedings and Evidence*, Issue No. 53.

117 Brief, p. 5.

planning alternatives to conventional services." [118] While medical services will continue to be important, the CMHA predicts that "The emphasis increasingly will be on other aspects of individuals' lives, including housing, work and interpersonal relationships."[119]

Both the CMHA and the CPA seem to indicate that there is a need for information on a national basis about mental health resources, both financial and human. It was also recommended that, because we do not know whether alternative care for the frail elderly, chronically ill and/or demented will cost more, about the same, or less than what is spent now, the real costs of alternative care must be researched; the needs of these patients must be met, whether in institutional or non-institutional settings. Research into mental illness in general seems to be underfunded. Mental disorders, for example, accounted for 8.3% of direct health costs in Canada in 1986, second only to cardiovascular diseases, but accounted for only 4.9% of research costs. In the same year, in the province of Quebec, mental disorders were actually the most expensive disease category, accounting for 17.9% of provincial health care costs.

RECOMMENDATIONS

28. That the federal government adequately fund research into the comparative costs of institutional and non-institutional mental health care services.

29. That the federal government establish a national clearing house for information about mental health resources, both fiscal and human.

30. That the federal government adequately fund research on mental illness.

A shortage and maldistribution of psychiatric human resources was also cited in relation to problems of access to psychiatric services. The CPA stresses that the shortage of psychiatrists, together with the geography and demographics of Canada make the provision of adequate psychiatric services very difficult, particularly in rural and less populated areas. It is necessary to recruit psychiatrists and encourage them to remain in these areas through locums, easily access to continuing medical education, and financial and other incentives.

The CPA also drew attention to the need for a multi-disciplinary approach to psychiatric care which would include non-medical professionals such as psychologists, social workers, registered psychiatric nurses, registered nurses and occupational

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118 Brief, Executive Summary.

119 *Ibid.*

therapists as an integral part of the mental health care delivery team. A major concern, for the CPA, is what it views as the "present inadequacy in levels of education of all types of mental health care workers, including psychiatrists", particularly in the area of geriatric mental health.[120]

F. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

There is a great deal of concern with respect to access to health care services for AIDS and HIV-infected patients. The treatment of AIDS and HIV infection has, according to a number of witnesses who appeared before the Parliamentary Ad Hoc Committee on AIDS, placed "an enormous burden on the health-care community".[121]

Witnesses to the Ad Hoc Committee and to this Committee, identified problems of access by AIDS and HIV-infected patients to HIV testing and diagnostic procedures, drugs, and physician and other health care services.

The Committee was told that the first step in effective treatment is timely and reliable diagnosis. Dr. Philip Berger advised the Committee that state-of-the-art diagnostic tools are not always available and that part of the diagnosis depends on the availability of anonymous testing for HIV. Dr. Berger said that such availability is inconsistent across Canada and even within provinces. He says that those at highest risk to HIV infection are reluctant to be tested in a system where they could be identified.[122]

Similarly, former Health Minister Perrin Beatty, in announcing the federal government's strategy on AIDS, identified the guarantee of confidentiality in HIV testing as a central issue.[123]

The Parliamentary Ad Hoc Committee on AIDS acknowledged in its report that anonymous testing, which would allow testing to be done without people having to furnish any identifying information, so that only the person tested would be aware of a positive test, is a complex matter. For some proponents of anonymous testing, it is the only sufficient guarantee of confidentiality. It is generally agreed that testing should at least be voluntary, except in cases involving donation of blood, blood products, organs and tissue.

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120 *Minutes of Proceedings and Evidence*, Issue No. 39, p. 8.

121 *Confronting a Crisis*: The Report of the Parliamentary Ad Hoc Committee on AIDS, June 1990, p. 29.

122 *Minutes of Proceedings and Evidence*, Issue No. 52, p. 7.

123 Speaking Notes, 81st Annual Conference of the Canadian Public Health Association, Toronto, June 28, 1990, p. 7.

RECOMMENDATION

31. This Committee recommends that all HIV-antibody testing be accompanied by appropriate guarantees of confidentiality.[124]

In the area of research, the Committee recognizes the importance of information on levels of HIV infection in the population, particularly among certain sub-populations such as sex-trade workers, injection drug users, street people and prison populations. Such information is necessary in order to develop appropriate education and prevention programs to limit the spread of the virus.

RECOMMENDATION

32. The Committee supports the use of anonymous non-linked epidemiological surveys in AIDS research.[125]

The Canadian Aids Society (CAS) told the Ad Hoc Committee on AIDS that it believes that the sheer volume of information on treatments for AIDS and HIV infection, and the rapid changes in the information, combined with the lack of a suitable vehicle to provide physicians with access to information, are making it difficult for persons with AIDS to receive the best available medical care.[126] A national Treatment Registry on AIDS and HIV, to make available up-to-the-minute information about new drugs and emerging therapies and to ensure that treatment information is accessible to physicians, was recommended by the Ad Hoc Committee. In June 1990, the National Health and Welfare Minister announced an information system of the type recommended with initial funding of $990,000.[127] Recent reports in the media of possible delays in this project are of grave concern to Committee members.

The information system is expected to remedy the problem of treatment information, at least for those doctors who see large numbers of AIDS and HIV-infected patients. Unfortunately, a relatively small number of physicians are treating the largest percentage of the AIDS patients. Dr. Berger estimates, for example, that 17 doctors probably treat over 40% of all HIV-infected patients in Ontario. It is estimated that 17 physicians in the downtown Toronto HIV Primary Care Physicians Group, of which Dr. Berger is a member, care for about 3,000 people. Media reports suggest that the

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124 Ad Hoc Committee on AIDS, p. 42.

125 *Ibid.*, pp. 18-19.

126 *Ibid.*, p. 25.

127 Speaking Notes for The Honourable Perrin Beatty, Minister of National Health and Welfare, 81st Annual Conference of the Canadian Public Health Association, Toronto, June 28, p. 8.

stress and pressures on Canada's AIDS doctors are physically and emotionally exhausting and the monetary compensation is meagre. Dr. Berger cited the following factors as contributing to this problem:

1. . . . patients legitimately are attracted to physicians who have known expertise . . .
2. . . . doctors without experience are overwhelmed by the complexity of the disease . . .
3. . . . severe financial penalty and no incentive for physicians to take care of HIV-infected patients . . .[128]

Provincial medical plans do not recognize the enormous amount of time they spend in counselling visits and phone calls.

RECOMMENDATION

33. That the federal government encourage the provinces and territories to develop more flexible forms of remuneration for physicians that will more accurately reflect the needs of patients in their practice.

Once a person develops AIDS, he or she is in need of extensive and continuous care. Witnesses to the Ad Hoc Committee indicated that most of this care is provided by volunteers in a wide variety of community organizations, including support groups, hospices, palliative care facilities and home care arrangements. The federal government, through the AIDS Community Action Program, provides funding to community-based organizations for the care of patients with AIDS. This is done in part through training and education of volunteers working with community organizations. The Ad Hoc Committee recommended increased federal funding of community-based support groups as well as continuing education programs on AIDS treatment, care and support for physicians, nurses and other health professionals who entered practice before the AIDS epidemic started.

RECOMMENDATION

34. That the federal government adequately fund community-based support groups for AIDS patients and for continuing education programs on AIDS treatment and support for physicians, nurses and other health professionals.

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128 *Minutes of Proceedings and Evidence*, Issue No. 52, p. 8.

CHAPTER 6

HEALTH CARE HUMAN RESOURCES

The health sector constitutes an important part of the Canadian economy. Health care personnel made up approximately 5% of the Canadian labour force in March 1991.[129] It is clear from research and the testimony of witnesses that some problems exist in relation to the composition and distribution of health care personnel. This chapter briefly examines these difficulties and suggests how we might address them through human resources planning.

A. PHYSICIAN RESOURCES

During the last decade,[130] the increase in the number of physicians (general practitioners and specialists) practising in Canada has outpaced the rate of growth of the population. The physician-to-patient ratio has, therefore, increased considerably. In the case of active civilian physicians, excluding interns and residents, the physician-to-patient ratio went from one physician for every 656 Canadians in 1979 to one physician for every 515 Canadians in 1989. There are those who are concerned about a surplus of physicians.

Provincially, the active physician-to-patient ratio varies greatly. In 1989, it ranged from one physician for every 486 residents in British Columbia to one physician for every 748 residents in New Brunswick. Between 1979 and 1989, the proportion of specialists remained relatively stable, representing on average 50% of the physician population. The number of specialists varies from one province to the next. For example, in 1988, the ratio of resident physicians to active civilian specialists in Quebec was 964 to one, as

129 Statistics Canada, *The Labour Force*, Catalogue 71-001, p. B-29.

130 The following figures were provided by the Health Information Division, Information Systems Directorate, Policy, Planning and Information Branch, Department of National Health and Welfare, April 1990.

compared to a ratio of 1,883 to one in Newfoundland.[131] The distribution of physicians among urban, rural and remote areas is a troublesome issue with which most provincial governments have tried to deal with varying degrees of success in recent years.[132]

Comparatively speaking,[133] Canada ranks above average among OECD countries in terms of physician resources, and is close to the United States and Australia. Germany, Greece, Belgium and Sweden have proportionately more physicians than Canada; however, the number of physicians per capita is higher in Canada that it is in Japan, the United Kingdom and Switzerland. The percentage of specialists in Canada is similar to that in certain OECD countries, excluding the United States and Germany, where in 1987, specialists accounted for 84% and 54% respectively of the overall physician population. Lastly, the growing number of physicians in Canada over the last decade reflects a similar trend in other industrialized countries.

The number of women among the physician population has increased in recent years, rising from 14.2% in 1982 to 16.8% in 1987. This trend to having more women in the profession is expected to continue in the coming years, since now nearly half (46.7%) of all first-year medical students are women. Studies suggest that such a trend could affect the practice patterns of physicians because there are significant differences between men and women in hours worked per week, weeks worked per year, interruptions to working life and the average amount of time spent with patients.[134]

Finally, the supply of physicians in Canada has traditionally been increased by foreign graduates. During the period 1961-1969, the number of physicians entering Canada averaged 880 per year. The average figure for the period 1970-1979 was 740. However, in the following period 1980-1989, the number of immigrant physicians fell dramatically, averaging 385 per year. In 1989, 20% of all post-M.D. trainees of Canadian faculties of medicine had had their M.D. degree awarded outside Canada.[135]

B. NURSING RESOURCES

Over the past few decades, the rate of growth of nursing resources has annually outpaced the rate of growth of the population. In 1978, the ratio was one registered nurse for every 117 Canadians and one registered nursing assistant for every 313 Canadians.

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131 Health and Welfare Canada, *Health Personnel in Canada*, 1988, March 1990, p. 192.

132 *Canadian Physician Resources*, Report of the Canadian Medical Association Committee on Physician Resources, August 1989, pp. 29-31.

133 Comparative data were provided by the Federal-Provincial-Territorial Advisory Committee on Health Human Resources, *Report on Physician Workforce in Canada*, May 1990, Appendix A.1.

134 *Canadian Physician Resources*, p. 26.

135 Canadian Post-M.D. Education Registry, *Annual Census of Post-M.D. Trainees*, 1989-90, p. 67.

In 1988, the ratio was one registered nurse for every 104 Canadians and one registered nursing assistant for every 315 Canadians.[136] These changes stem from an increase in the demand for nursing resources, which can be traced to demographic and epidemiologic factors such as the growing complexity and gravity of illnesses, the evolving nature of illnesses and treatment methods, and the aging of the population.[137]

While the supply of nursing resources has increased, several witnesses pointed to a shortage of nurses in the rural and remote regions or in certain specialized fields in urban areas. It was pointed out that in certain regions of the country, it has always been difficult to recruit and retain nurses. Some provinces have resorted to incentives to attract nurses to remote and rural areas and to large urban centres such as Toronto. The Canadian Nurses Association (CNA) maintains that the regional shortages can be attributed to factors specific to the region; for example, the high cost of living, the nursing model used, the salary and benefits package and opportunities for ongoing training.[138] The shortage of specialized nurses has also been a long-standing concern. Some urban centres are already experiencing a shortage of nurses with specialized training, such as intensive care nurses.

The CNA further noted that, strictly speaking, there is no shortage of nursing resources. The fact that nurses are unwilling to work under the present conditions, they say, has given the impression that a shortage exists. In describing these unsatisfactory conditions, the CNA includes lack of adequate staffing in hospitals, lack of involvement in decision-making, lack of educational opportunities, too many non-nursing duties, inflexible work schedules and concerns such as salaries and benefits.

C. MENTAL HEALTH CARE HUMAN RESOURCES

According to the Canadian Mental Health Association, mental health care expenditures account for only a small percentage of total national health care expenditures. Moreover, the number of mental health specialists is relatively low. For example, there were 2,972 psychiatrists in Canada in 1988, or one psychiatrist for every 8,780 Canadians. That same year, there was one active accredited or registered psychologist for every 3,127 Canadians.[139]

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136 Health and Welfare Canada, *op. cit.*, pp. 123 and 139.

137 Canadian Nurses Association, Brief, pp. 14-15.

138 *Ibid.*, pp. 13-14.

139 Health and Welfare Canada, *op. cit.*, pp. 196 and 235.

Several witnesses reported a shortage of mental health care workers and noted that geographically, they were poorly distributed across Canada. The Advisory Committee on Mental Health also expressed concern about the shortage of psychiatric care professionals. The Committee noted in its report[140] that all the provinces are facing problems in terms of the number, distribution and mix of psychiatric specialists. Some regions and provinces, according to this report, have been unable to recruit and retain psychiatrists and current remuneration structures are not compatible with psychiatric treatment modes.

Some witnesses also testified that the level of education of mental health care workers needs to be upgraded. The Canadian Psychiatric Association similarly expressed concern about what it regards as the current inadequate levels of education of all mental health care workers, be they psychologists, social workers, psychiatric nurses, registered nurses, occupational therapists or psychiatrists. The need is particularly acute for the skills required in dealing with the psychiatric problems of the elderly. The Association notes that 5% of persons over 65 years of age suffer from dementia and that for the over-80 category, the rate rises to more than 20%. It argues that specialized studies are essential in order to maintain and develop the professional skills needed to satisfy the vast range of medical and psychosocial needs of the elderly population.[141]

D. OTHER HEALTH PROFESSIONALS

During its public hearings, the Committee heard from a wide range of professional associations, as well as from the medical and nursing professions. An overall shortage and maldistribution of health care personnel was reported. This included a maldistribution of health personnel across the regions, as well as among institutions (e.g. acute and chronic care hospitals, community care centers).

At the present time there is, for example, a shortage of rehabilitation therapists, particularly for physiotherapy, occupational, speech and hearing therapy.[142] The need for trained personnel is increasing without a corresponding increase in the number of graduates. It is anticipated that the shortage of these rehabilitation specialists will be even greater in the future, particularly given the close correlation between aging and disability.

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140 Advisory Committee on Mental Health, *Report to the Conference of Deputy Ministers of Health*, June 1990.

141 Brief, p. 6.

142 Federal-Provincial Advisory Committee on Health and Human Resources, *Federal-Provincial Report on Rehabilitation Personnel*, June 1988.

Dieticians' services are in short supply in certain communities, medical clinics, in-home health care programs, private practice and school boards. There are also long waiting lists for the services of dieticians in hospitals,[143] and a shortage of pharmacists both in hospitals and in the community. Access to pharmaceutical services in rural areas is also a problem.[144]

The range of non-medical health professional services covered by provincial health insurance plans varies from province to province. For example, the Canadian Chiropractic Association said in testimony:

> In . . . Newfoundland, Nova Scotia and New Brunswick there is no coverage from the government there at all. The fee that is paid for our services is paid directly by the patients, and 85% is covered by private insurance companies, so [in] effect most of the fee is paid by a private insurance company through their company plans or whatever. In the province of Quebec there is no coverage, and again it is private insurance companies that pay the percentage. I believe it is around 85% that is covered by a private insurance company. In the province of Ontario they cover for $210 a year and in the province of Manitoba they are covered for 15 visits. In the province of Saskatchewan they have unlimited coverage. In the province of Alberta they are covered for around 20 visits per year. In the province of British Columbia they again are covered for 11 visits per year . . .[145]

Some professional associations are asking that their services be insured under the publicly-funded plans. According to some witnesses, this would not influence the demand for non-medical professionals' services, while others fear that costs would rise.

E. HUMAN RESOURCE PLANNING

The Canadian Hospital Association noted that shortages and maldistribution of health human resources in general affect all the provinces and territories of Canada.[146] One result has been a lack of access to medically necessary services, especially in rural and remote regions, which have more difficulty attracting and holding their health care professionals, particularly in highly specialized disciplines. Waiting lists are common for specialized services, and patients often have to be transferred to other provinces or to centres far from their families and social support network. Another result is the substitution of one discipline for another, and the closing of beds and specialty units.

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143 Canadian Dietetic Association, Brief.

144 Canadian Pharmaceutical Association, Brief.

145 *Minutes of Proceedings and Evidence*, Issue No. 40, p. 26.

146 Brief, p. 5.

To solve the problem of the shortage of physicians in outlying areas, many witnesses stressed the importance of offering financial incentives to encourage medical personnel to settle in these regions. The Canadian Medical Association believes that financial incentives alone are not enough to persuade physicians to practise their profession in under-serviced areas, because other factors, such as the quality of professional and social life, the proximity of teaching institutions and the possibilities of employment for their spouses also influence the decision to move outside the major urban centres. The CMA considers that the best way of attacking the problem of under-serviced regions must be through the educational system. It argues in its brief that medical resource planning requires a shared approach, which should be national in scope, take into account provincial and territorial resources, and be based on assessment and planning of regional needs.

RECOMMENDATION

35. That the federal government develop a national policy on planning for health care human resources (physicians, nurses and other health professionals).

Under this national policy, the Committee would like to see addressed such issues as the geographic distribution of physicians and the shortage in specialities, the increasing participation of women in the medical sector, the situation in the nursing profession, the shortage and distribution of health professionals, and the appropriate role of all health care personnel.

The shortages and maldistribution of health human resources are evident in all provinces and territories. As solutions to these problems, the professional associations that appeared before the Committee recommended, among other things, planning the intake of students admitted to courses in the health professions in universities, the designing of new graduate and post-graduate programs and the expansion of training programs in hospitals and community settings. Many witnesses suggested that the federal and provincial governments should help to fund current research on improving the training, use and supervision of professionals, as well as the recruiting and retaining of personnel.

RECOMMENDATION

36. That, as part of the national policy on planning for health care human resources, the Federal-Provincial Advisory Committee on Health Human Resources establish specific national resources targets and

promote acceptance of these targets by universities, ministries of education, professional, hospital and health associations and other interested parties.

In addition, many witnesses criticized the physicians' role as the "gatekeepers" to health services. They consider that making use of other health professionals would expand the concept of health and make it possible to offer better-quality, more appropriate care at lower costs. According to the Canadian Chiropractic Association, insufficient recourse to non-medical professionals constitutes one of the major shortcomings of the Canadian health care system. The Association said that the system should encourage the widest possible recourse to qualified health professionals. It asserted that the difficulty lies in establishing a balance between the individual's right to choose the form of health care he or she prefers and the State's obligation to pay for care.

> (. . .), the data suggests that alternatives are used exclusively unless complications that require a referral (a patient uses either a mid-wife or a medical physician) so funding alternatives does not necessarily increase the costs and may substantially decrease them (virtually all the alternatives are cheaper both in direct costs—fees to the practitioner—and indirect costs—the facilities needed to deliver the care).[147]

Other witnesses, on the other hand, argued that direct access to services provided by alternative professionals carries the risk of generating a strong increase in demand and consequently a jump in costs.

147 Brief, p. 25.

CHAPTER 7

RESEARCH

There is at present considerable debate on the amount of expenditure on health and health-related research, as well as on the appropriate distribution of resources between basic and applied research. It was pointed out, in a session on Science and Research at a recent Canadian Medical Association Conference, that the definition of applied and clinical research is currently being broadened to include population health, epidemiology and health care delivery. Research on health care delivery includes studies of utilization, outcomes, cost-effectiveness, efficiency and the appropriateness or inappropriateness of interventions.[148]

Testimony by witnesses to this Committee spoke of a similar range of concerns with respect to research. The Canadian Federation of Biological Societies brought the Committee's attention to what it views as low levels of expenditure on research and development (R&D) generally in Canada, including health research.[149]

Health and Welfare Canada reports that expenditure on health research accounted for 0.8% of total health expenditure in 1975 and 0.9% in 1987 (the last year for which hard figures are available).[150] It is estimated that the 1987 figure is probably largely unchanged in 1990.

148 Watanabe, Dr. Mamoru, Dean of Medicine, University of Calgary, *3rd Annual Leadership Conference*, March 2, 1991.

149 *Minutes of Proceedings and Evidence*, Issue No. 53, p. 53.

150 *National Health Expenditures in Canada, 1975-1987*, 1990, p. 35.

A recent study of the economic burden of illness in Canada, from the Health Protection Branch of Health and Welfare Canada, found that the money spent on research efforts in all disease categories, accounted for 1% of the direct costs of all diseases and 0.5% of the total economic burden of disease.[151]

Differing views are expressed with regard to what the priorities should be in health research. The majority of the Medical Research Council (MRC) budget goes to basic research, while virtually all of the National Health Research and Development Program (NHRDP) budget of Health and Welfare Canada goes to applied research. Nearly nine times as many dollars ($241.5 million in 1990-91) go to MRC, however, as go to NHRDP ($28.1 million in 1990-91). Witnesses generally urged that more funding go to health research but some witnesses expressed concern about recent reductions in the NHRDP budget (applied research). The Canadian Federation of Biological Societies, for example, offered the view that these reductions could affect research in health care delivery and also the training of highly qualified personnel in this area.[152]

The current NHRDP budget of $28.1 million is a reduction of $1 million from the 1989-90 main estimates level. It is made up of several parts, including the AIDS, Child Sexual Abuse, Family Violence components, which have not been reduced. It is anticipated that NHRDP expenditures related to Seniors and the Drug Strategy will exceed those of 1989-1990, although there has been a "slight reduction" in the overall budgets. The balance of the cutback will be applied to the untargeted part of the NHRDP budget. This is the part of the NHRDP budget that funds projects previously identified as important to improving the quality and cost-effectiveness of health care services. Projects under the following headings have been funded in this area:

- Health Care Management,
- Health Care Delivery and Organization
- Health Care Quality and Standards/Quality Assurance and Control.[153]

Projects funded in the special areas identified above yield information on new and improved ways to deliver care.

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151 Wigle, Donald T., et al, *Economic Burden of Illness in Canada, 1986*, Bureau of Chronic Disease Epidemiology, Laboratory Centre for Disease Control, May 1990, pp. 6-7. This study includes both direct and indirect costs in the total economic cost of illness and analyses these costs by disease category. Direct costs consist of expenditure on drugs, medical care and other professional services provided by physicians, hospital care, research, pensions and benefits, non-institutional care and related services, appliances and various administrative health costs. Indirect costs include loss of future income due to premature death and the value of productivity lost in 1986 due to chronic and short-term disability. The study was able to determine direct and indirect costs by disease category for approximately 81% of the $97.2 billion estimated as the total cost of disease.

152 Brief, p. 2.

153 Health and Welfare Canada, *Information For The Parliamentary Relations Office*, November 22, 1990.

In relation to applied research, a number of witnesses (including Dr. Naylor, Dr. Mustard, Dr. Psutka and the Canadian Nurses Association) emphasized the need for "innovation" in both the management and delivery of health care services. A recent report by the National Council of Welfare stresses the need for "innovation in the delivery of health care services, as opposed to innovation in medicine".[154]

This report suggests that Medicare "locked in" established patterns of delivering health care and that since it was introduced, there have been relatively few attempts to find better or more cost-effective means of delivering services.

Provincial and territorial Ministers of Health recognized the need for innovation in 1987.[155]

More and more provinces are investing increasing amounts of money in research directed at improving the delivery of health care services. Canadianized versions of Health Maintenance Organizations are being introduced on an experimental basis in Ontario and Quebec. The Victoria Health Project was established in British Columbia to develop better ways to manage health care resources and better serve the aging population. The National Council of Welfare, concerned about provinces duplicating each others' research, recommends in its report that:

> (. . .) federal and provincial governments establish an innovations fund to support research into better and more cost-effective ways of delivering health care services across Canada.[156]

In the Council's view, such an approach would help ensure good evaluation and experiments that are designed to be relevant to more than one province. At the same time, provinces could continue to develop projects with more local than national potential.[157] Moreover, by eliminating duplication of research and sharing of research findings among all the provinces, research efforts could be more cost-effective.

Dr. Jack O'Hashi of the Canadian Medical Association (CMA), on the other hand, is of the view that we should be researching the determinants of disease. Dr. O'Hashi offered the following example:

> If, for example, you have ten people in the community who have gall-bladder disease and need to have their gall-bladders out, you are going to have to do that regardless of the number of physicians that are there, the number of hospital beds, whatever.

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154 National Council of Welfare, *Health, Health Care and Medicare*, Ottawa, Autumn 1990, pp. 38-40.

155 *Future Directions for Health Care Services*, Toronto, p. 9 (a report to the First Ministers' Economic Conference).

156 National Council of Welfare, *op. cit.*, p. 40.

157 *Ibid.*, p. 39.

(. . .) The question may be what we know about the natural history of that gall-bladder disease and if there is some way of affecting it so those people do not have problems.[158]

Dr. Robert Spasoff, speaking at the recent CMA Conference said that, in his view, the amount of research money allocated to each particular disease category should bear some resemblance to the burden the category poses on society in terms of its frequency and impact. As Dr. Spasoff points out, however, the Health and Welfare study of the economic burden of disease found major discrepancies between the burden imposed and the amount of research dollars spent on them. Injury, for example, was the category imposing the highest economic burden but it received the fewest research dollars.

Dr. Spasoff, as well as a variety of witnesses to the Committee, suggested that, to be responsive to public need, more emphasis must be given in research to environmental and socio-behavioural factors affecting health, to rehabilitation, disease prevention, health promotion and health services research. It is suggested that availability of information on the health status of the population, individual risk factors and patterns of health services use is essential to this research.

RECOMMENDATIONS

37. That the federal government adequately fund the National Health Research and Development Program to develop procedures to measure outcomes in health care rather than assuming that if the structures and processes are in place (e.g. hospitals, technology, medical personnel) the outcomes will also be satisfactory.

38. That the federal government establish a regular program of population health surveys making it possible to relate individual risk factors and patterns of use of health care services to longer term health and costs.

39. That the federal government adequately fund to the National Health Research and Development Program to support research into innovative and cost-effective ways of delivering high quality health care services across Canada.

40. That pilot projects in innovative approaches to health care funded by the federal government include evaluation procedures.

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158 *Minutes of Proceedings and Evidence*, Issue No. 36, p. 19.

CONCLUSION

This study was initiated to address concerns about the adequacy of health care funding arrangements to provide quality health care to Canadians that meets the standards of the *Canada Health Act*. Having heard numerous witnesses with diversified expertise, experience and interests in health care, the Committee has discovered that our health care system does in fact face a variety of challenges, many of which may not be solved by simply increasing our spending on the system as it currently exists. We still believe that Canada has one of the best health care systems in the world and we are committed not only to maintaining that system but also to improving upon it. The Committee heard repeatedly that rather than more financial resources for health care, we need more cost-effective and appropriate distribution of resources in a system which recognizes that health goes well beyond hospital and medical care. The national planning approach which the Committee recommends acknowledges the need to revisit the assumptions underlying our system of health care.

LIST OF RECOMMENDATIONS

1. That the federal government, in co-operation with the provincial and territorial governments, develop a clearly stated national policy on health care that is consistent with the existing *Canada Health Act*. Development of this policy would include the division of responsibilities for health between the federal, provincial and territorial governments, the basics of funding under EPF and the standards of the *Canada Health Act*. (Chp. 2)

2. That the federal government develop policies to make the nation healthy in those areas where it has jurisdiction under the Constitution, including the environment and areas that affect quality of life such as housing, income, employment and post-secondary education. (Chp. 3)

3. That the federal government emphasize illness prevention and health promotion and devote greater resources to education and information for consumers with the objective of making them full partners and knowledgeable decision-makers in their own health care. (Chp. 3)

4. That a Canada Health Council, representing health care providers, consumers, researchers and others, be established and financed to advise the federal government on matters related to national health care. (Chp. 3)

5. That the federal government consult with the provinces and territories in developing a framework for the gradual shift of sufficient institutional resources (human, financial and technological) to more appropriate levels of community, home care and social support services. (Chp. 3)

6. That within two years, the federal government produce a complete report, based on a compilation of existing research and pilot studies of physician remuneration systems, with a particular emphasis on the appropriateness of certain remuneration systems for specific practice situations. (Chp. 3)

7. That the federal government encourage the provinces and territories to continue to develop innovative alternatives to existing remuneration systems for physicians. (Chp. 3)

8. That the federal government place on the agenda for the next Federal-Provincial Health Ministers' Conference the development of services to provide support and respite for volunteer caregivers of elderly and disabled Canadians. (Chp. 4)

9. That the federal government, as part of the development of a national health policy, establish objectives for improving the access of seniors and the disabled to a broad range of services which affect their health. (Chp. 4)

10. That resources be directed toward informing and empowering seniors as consumers of health care services in order that they can share, with their families, health care professionals, and informal care givers, the responsibility to make healthy choices about their own health. (Chp. 4)

11. That the federal government, in cooperation with the provinces and territories, seek to establish a common terminology across all health jurisdictions in Canada to facilitate comparisons in the quality and cost of institutional, community and home care. (Chp. 4)

12. That the federal government fund research, education and development of special expertise in geriatrics and gerontology for health and social care professionals. (Chp. 4)

13. That the federal government, as part of a national health policy, plan for the future health care of seniors, taking into account current and future lifestyles, the role of the family, the availability of social services, the financial resources of seniors and the needs of physically and mentally challenged seniors. (Chp. 4)

14. That the federal government undertake initiatives to determine the feasibility of legislation allowing elderly individuals to specify the level of care they wish to receive in the event of an illness which renders them incapable of making decisions at that time. (Chp. 4)

15. That the federal government address the issues around the use of acute care services by funding research into the development of a system of coordinated and integrated health care services which would provide a continuity of care between acute care hospitals and extended, community and home care, thereby facilitating access to appropriate levels of care. (Chp. 5)

16. That the federal government, in cooperation with the provincial and territorial governments, evaluate the use of a wider range of health care professionals within the insured health care system. (Chp. 5)

17. That the federal government facilitate through research the development and refinement of health care services to better meet the needs of rural and northern Canadians. (Chp. 5)

18. That the federal government, through federal–provincial funding arrangements, support innovative recruitment and retention programs in areas of the country where shortages of health personnel have been identified. (Chp. 5)

19. That the federal government take an interdepartmental approach to develop a strategy to reduce the threat posed by poverty to the health of children and youth. (Chp. 5)

20. That a federal–provincial interdepartmental advisory committee be established to develop strategies to change health threatening behaviour (e.g. avoiding use of tobacco products, alcohol, and poor eating habits), thereby reducing risk factors associated with poor health in children and youth (e.g. low birthweight, fetal alcohol syndrome). (Chp. 5)

21. That the promotion and advertising of tobacco products be phased out as soon as reasonably possible. (Chp. 5)

22. That the advertising for alcoholic beverages reflect responsible use and positive social values. (Chp. 5)

23. That health warnings, directed toward pregnant women, be placed on alcoholic beverages. (Chp. 5)

24. That the federal government take a leadership role and, consulting with the provinces and the territories, promote: (1) access to family planning information and, (2) access to family life education in all regions of Canada. (Chp. 5)

25. That the federal government use its powers under the *Canada Health Act* to insist that all provinces and territories make access to therapeutic abortion available to all women. (Chp. 5)

26. That governments seek to eliminate unnecessary barriers and promote equal opportunities, for health care professionals with foreign–obtained credentials, to qualify and practise in Canada. (Chp.5)

27. That the federal government take a leadership role and assist the provincial and territorial governments to modify and develop health care services that are sensitive to the needs of women, aboriginal people, immigrants and cultural minorities. (Chp. 5)

28. That the federal government adequately fund research into the comparative costs of institutional and non–institutional mental health care services. (Chp. 5)

29. That the federal government establish a national clearing house for information about mental health resources, both fiscal and human. (Chp. 5)

30. That the federal government adequately fund research on mental illness. (Chp. 5)

31. This Committee recommends that all HIV-antibody testing be accompanied by appropriate guarantees of confidentiality. (Chp. 5)

32. The Committee supports the use of anonymous, non- linked epidemiological surveys in AIDS research. (Chp. 5)

33. That the federal government encourage the provinces and territories to develop more flexible forms of remuneration for physicians that will more accurately reflect the needs of patients in their practice. (Chp. 5)

34. That the federal government adequately fund community-based support groups for AIDS patients and for continuing education programs on AIDS treatment and support for physicians, nurses and other health professionals. (Chp. 5)

35. That the federal government develop a national policy on planning for health care human resources (physicians, nurses and other health care professionals). (Chp. 6)

36. That, as part of the national policy on planning for health care human resources, the Federal-Provincial Advisory Committee on Health Human Resources establish specific national resources targets and promote acceptance of these targets by universities, ministries of Education, professional, hospital and health associations and other interested parties. (Chp. 6)

37. That the federal government adequately fund the National Health Research and Development Program to develop procedures to measure outcomes in health care, rather than assuming that if the structures and processes are in place (e.g. hospitals, technology, medical personnel) the outcomes will also be satisfactory. (Chp. 7)

38. That the federal government establish a regular program of population health surveys making it possible to relate individual risk factors and patterns of use of health care services to longer term health and costs. (Chp. 7)

39. That the federal government adequately fund to the National Health Research and Development Program to support research into innovative and cost-effective ways of delivering high quality health care services across Canada. (Chp. 7)

40. That pilot projects in innovative approaches to health care funded by the federal government include evaluation procedures. (Chp. 7)

GLOSSARY

acute care: care or treatment for illness or injury, usually of short duration or sudden onset, requiring concentrated attention by health care providers.

capitation funding: a method of paying physicians and other health care professionals a negotiated sum, on a regular basis (usually annually), for a comprehensive set of services delivered to a specified population, based on the number of patients and their age–sex distribution.

chronic care: care provided for long–lasting or long–term illness or disability (either physical or mental).

chronic disease: illness of long duration or frequent recurrence.

curative: (thing) tending to treat, especially disease.

demographics: the statistical data describing a human population in terms of age, sex, marital status and other characteristics.

disability: any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

elective treatment: treatment which is optional or not urgently necessary.

eleemossynary: dependent on charitable donations.

endarterectomy: a surgical procedure in which the passegeway and inner lining of an artery is reamed out; usually performed to remove a clot or to scrape out the lining of an arteriosclerotic vessel.

epidemiology: the study of the determinants of health and disease in human populations, including incidence, distribution and control of disease.

fee–for–service payment: a form of reimbursement through which a health professional is paid a certain amount per procedure or service performed according to a schedule of fees: the predominant form of physician reimbursement under health insurance programs in Canada.

frail elderly: members of the population who are 85 years of age and over are frequently referred to as the "frail elderly" because as a group they tend to require more health care than those between the ages of 65 and 84 years.

geriatrics: the study of conditions affecting old people.

gerontology: the study of the aged.

global budgeting: an arrangement whereby an annual all-inclusive sum is allocated to an organization (e.g. a hospital) by a funding agency for all the services to be provided by the organization.

gross domestic product (GDP): measures the annual value of production arising within geographical boundaries of Canada irrespective of whether the factors of production are resident or non-resident.

gross national product (GNP): measures the annual market value of all goods and services produced by Canadian factors of production (i.e. resident in Canada).

health expenditures: includes expenditures made by both the private and the public sectors. Health expenditures therefore include expenditures by federal, provincial, territorial and local governments, by workers' compensation boards and by private organizations and consumers.

health maintenance organization (HMO): a health care organization that acts as both insurer and provider of comprehensive but specified medical services. A defined set of physicians provides services to a voluntarily enrolled population for a prospective per capita amount (i.e. by capitation).

holistic: a description of methods of disease prevention and treatment that involve not only the physical, but the mental, psychological and emotional needs and lifestyle of a patient.

iatrogenic: caused by the process of diagnosis or treatment.

morbidity rate: the number of cases of disease per 1000 population in a given time period.

mortality rate: the number of deaths per 1000 population in a given time period.

Organization for Economic Cooperation and Development (OECD): an organization which promotes economic co-operation and development in 24 countries. The member countries of the OECD are Austria, Belgium, Canada, Denmark, France, the Federal Republic of Germany, Greece, Iceland, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom, the United States, Japan, Finland, Australia and New Zealand.

personal health care: category of care and services provided to individuals and including institutional care and related services, professional services, drugs and appliances.

public health expenditures: health expenditures by governments (federal, provincial, territorial and local).

seniors: members of the population who are 65 years of age and over.

APPENDIX A

LIST OF WITNESSES

	DATE	ISSUE No.
Association des coordonnateurs(trices) des hôpitaux de jour du Québec Marielle Delaney, Vice-President.	February 13, 1990	16
Association of Canadian Teaching Hospitals Dr. Finlay McKerracher, Secretary-Treasurer.	April 26, 1990	16
Association of Concerned Citizens for Preventive Medicine Ronald Dugas, President; Ken Basham, Vice-President.	October 25, 1990	42
Baycrest Centre for Geriatric Care Sandra Leggat, Director of Planning; Sam Ruth, Consultant.	October 25, 1990	42
***Berger, Dr. Philip B.** (University of Toronto)	January 21, 1991	52
Canadian Advisory Council on the Status of Women (CACSW) Glenda P. Simms, President; Eliane Silverman, Director of Research.	March 27, 1990	22
Canadian Association of Occupational Therapists Thelma Gill, President; Jacqueline McGarry, President Elect; Margaret Brockett, Executive Director.	April 26, 1990	26
Canadian Association of Optometrists Dr. Thomas L. Adamack, President; Dr. Margaret Hansen-des Groseilliers, Secretary-Treasurer; Dr. M.E. Woodruff, Consultant; Gerard Lambert, Executive Director.	April 10, 1990	24

	DATE	ISSUE No.
Canadian Association of Social Workers Gail McDougall, President; Kim Clare, Chairperson of the Social Policy Committee; Sandy Campbell, President of the Mid-Western Branch of the Ontario Association of Professional Social Workers.	May 10, 1990	30
Canadian Centre for Occupational Health and Safety Maureen Shaw, Chairman of the Council of Governors.	May 1st, 1990	27
Canadian Chiropractic Association Dr. John Cochrane, President; Dr. Greg Dunn, Second Vice-President.	October 18, 1990	40
Canadian Co-Operative Association Lynden Hillier, Executive Director; Thomas E. Marwick, Executive Director, Regina Community Clinic.	March 20, 1990	20
Canadian Council on Animal Care Harry Rowsell, Executive Director.	January 22, 1991	53
Canadian Dietetic Association Shirley Power, President; Bretta Maloff, Director, Nutrition Division, Calgary Health Services; Marsha Sharp, Executive Director.	May 2, 1990	27
Canadian Federation of Biological Societies Kevin M.W. Keough, President; Dr. Diane Finegood, Chair, Animal Experimentation Committee.	January 22, 1991	53
Canadian Health Coalition Kathleen Connors, Vice-Chairperson, President of the National Federation of Nurses Unions; Pamela FitzGerald, Executive Coordinator.	March 27, 1990	22
Canadian Hospital Association Carol Clemenhagen, President and Executive Director; Elma Heidemann, Chairperson, Board of Directors.	October 9, 1990	38

	DATE	ISSUE No.
Canadian Institute of Child Health Daniel H. Drown, President; Dr. Denise Avard, Vice-President, Research.	February 20, 1990	17
Canadian Medical Association Dr. Marcien Fournier, President; Dr. William J. Vail, Chairman of the CMA Committee on Physician Resources; Dr. Jack O'Hashi, Member of the CMA Committee on Health Disciplines; Dr. Peter K. Fraser, Member of the CMA Special Committee on Professional Liability in Medicine; Dr. Léo-Paul Landry, Secretary General.	June 12, 1990	36
Canadian Mental Health Association Mary D. Oordt, National President; Craig Hurst, Member of the Board of Directors; Edward J. Pennington, General Director; Bonnie Pape, Director of Program.	November 6, 1990	44
Canadian Nurses Association Dr. Judith Ritchie, President; Judith A. Oulton, Executive Director.	May 10, 1990	30
Canadian Pharmaceutical Association Leroy Fevang, Executive Director; Dr. Jeff Poston, Research Director.	June 12, 1990	36
Canadian Physiotherapy Association Nancy Plews, President; Brenda Myers, Executive Director.	November 6, 1990	44
Canadian Psychiatric Association Dr. Pierre Beausjour, Secretary; Dr. Marie-France Rivard, Consultant on Geriatric Psychiatric Issues, Royal Ottawa Hospital.	October 11, 1990	39
***Capretta, Rosalie** (McMaster University)	January 22, 1991	53
***Castonguay, Claude** (Quebec former Minister of Health, Family and Welfare (1970-71) and former Minister of Social Affairs (1971-73))	June 5, 1990	35

	DATE	ISSUE No.
Consumers' Association of Canada Jean Jones, Chairperson of the Health Council; Rachel Dalzell, Member of the Board of Directors and of the Health Council.	23 April 3, 1990	23
***Contandriopoulos, André-Pierre** (University of Montreal)	April 3, 1990	23
***Courchene, Thomas** (Queen's University)	January 22, 1991	53
***Fulton, Jane** (University of Ottawa)	February 6, 1990	15
***Fyke, Kenneth J.** (Greater Victoria Hospital Society)	January 23, 1990	13
***Gilmore, Dr. Norbert** (McGill University)	January 21, 1991	52
***Jones Dr. Barry** (Royal Ottawa Hospital)	November 22, 1990	46
***Lavoie, Joe N.** (Care Med International)	January 21, 1991	52
***Ley, Dr. Dorothy** (Canadian Medical Association Committee on Health Care for the Elderly)	February 13, 1990	16
***Lomas, Jonathan** (McMaster University)	January 21, 1991	52
***Marmor, Theodore R.** (Yale University)	January 21, 1991	52
***McMurtry, Dr. Robert Y.** (University of Calgary)	March 22, 1990	21
***Mepham, Virginia**	January 22, 1991	52
***Molloy, Dr. D.W.** (McMaster University)	January 22, 1991	53
***Mustard, Dr. Fraser** (Canadian Institute for Advanced Research)	December 10, 1990	48
National Advisory Council on Aging Susan Fletcher, Director; Joel Aldred, Member of the Ontario Advisory Council on Aging; Judith Stryckman, Chief of Research and Policy Development.	February 6, 1990	15

	DATE	ISSUE No.
National Health and Welfare Department		
The Honourable Perrin Beatty, Minister of National Health and Welfare;	December 12, 1989	11
Dr. Peter Glynn, Assistant Deputy Minister, Health Services and Promotion Branch and Acting Assistant Deputy Minister, Social Services Program Branch;	November 28, 1989	10
Dr. Gillian Lynch, Acting Assistant Deputy Minister, Medical Services Branch;	December 19, 1989	12
E. Michael Murphy, Secretary, Review of Demography and its Implications for Economic and Social Policy;	December 12, 1989 January 30, 1990	11 14
Marie Fortier, Director General, Health Services Directorate;	November 28, 1989	10
Jim Moore, Director General, Program Transfer, Policy and Planning, Medical Services Branch;	December 19, 1989	12
Ed Tupper, Director General, Public Service Health Division, Medical Services Branch.	December 19, 1989	12
Native Council of Canada		
Christopher McCormick, National Spokesperson;	March 13, 1990	9
Dorothy McCue, Health Co-ordinator.		
***Naylor, Dr. David** (University of Toronto)	November 1st, 1990	43
Nurse Practitioners Association of Ontario		
Wendy Goodine, President;	October 23, 1990	41
Carolyn Davies, President Elect.		
Partners in Research		
Dr. Bessie Borwein, Associate Dean (Research), University of Western Ontario;	December 11, 1990	49
Dr. Mark Bisby, Researcher, Department of Physiology, Queen's University.		
Ronald G. Calhoun, Executive Director.		
Pharmaceutical Manufacturers Association of Canada		
The Honourable Judith A. Erola, P.C., President;	January 22, 1991	53
Gordon Postlewaite, Director of University and Scientific Affairs and Executive Director of the PMAC Health Research Foundation.		

	DATE	ISSUE No.
***Psutka, Dr. Dennis** (McMaster University)	November 8, 1990	45
***Rachlis, Dr. Michael**	January 22, 1991	15
***Ujimoto, Dr. K. Victor** (University of Guelph)	March 8, 1990	18
Victorian Order of Nurses of Canada (VON) Dr. Helen Mussallem, President; Donna Roe, National Executive Director; Cathy Bonnah, National Coordinator for Promoting Elders Participation; Mary Buzzell, Director of Educational Development, V.O.N. Hamilton-Wentworth.	March 8, 1990	18

***Appeared as individual**

APPENDIX B

LIST OF INDIVIDUALS AND ORGANIZATIONS HAVING SUBMITTED BRIEFS

Association des coordonnateurs(trices) des hôpitaux de jour du Québec

Association of Canadian Teaching Hospitals

Association of Concerned Citizens for Preventive Medicine

Baycrest Centre for Geriatric Care

Beiser, Dr. Morton (University of British Columbia)

Canadian Advisory Council on the Status of Women

Canadian Association of Occupational Therapists

Canadian Association of Optometrists

Canadian Association of Practical Nurses and Nursing Assistants

Canadian Association of Social Workers

Canadian Centre for Occupational Health and Safety

Canadian Chiropractic Association

Canadian Co-Operative Association

Canadian Dietetic Association

Canadian Federation of Biological Societies

Canadian Health Coalition

Canadian Hospital Association

Canadian Institute of Child Health

Canadian Medical Association

Canadian Mental Health Association

Canadian Nurses Association

Canadian Pharmaceutical Association (2 briefs)

Canadian Physiotherapy Association

Canadian Psychiatric Association

Canadian Society of Hospital Pharmacists

Chappell, Neena (University of Manitoba)

Chinese Medicine and Acupuncture Association

Community Health Co-Operative Federation of Saskatchewan

Consumers' Association of Canada

Corporation professionnelle des acupuncteurs du Québec Inc.

Fulton, Jane (University of Ottawa)

Fyke, Kenneth J. (Greater Victoria Hospital Society)

Institute for Health Care Facilities of the Future

Ley, Dr. Dorothy (Beaverton, Ontario)

Metropolitan Toronto, The Community Services Department of the Municipality

National Advisory Council on Aging

Native Council of Canada

Norton, James A. (Foster Higgins)

Nurse Practitioners Association of Ontario

Ujimoto, K. Victor (University of Guelph)

Victorian Order of Nurses for Canada

Workers' Compensation Commission of Newfoundland and Labrador

APPENDIX C

LIST OF INDIVIDUALS AND ORGANIZATIONS HAVING SUBMITTED A DOCUMENT OTHER THAN A BRIEF

Canadian Alliance for Research on Schizophrenia

Canadian Association of Occupational Therapists

Canadian Chiropractic Association

Canadian Co-Operative Association

Canadian Council on Animal Care

Canadian Federation of Biological Societies

Canadian Holistic Medical Association

Canadian Medical Association

Capital Regional District Care Programs (Victoria, B.C.)

Chinese Medicine and Acupuncture Association of Canada

Community Health Co-Operative Federation of Saskatchewan

Contandriopoulos, André-Pierre (University of Montreal)

Federation of Canadian Demographers

Friends of Schizophrenics, Ottawa-Carleton Chapter

Fulton, Jane (University of Ottawa)

Manga, Pran (University of Ottawa)

McMurtry, Dr. Robert Y. (University of Calgary)

Molloy, Dr. D.W. and Virginia Mepham

National Advisory Council on Aging

National Anti-Poverty Organization

Naylor, Dr. David (University of Toronto)

Nonprescription Drug Manufacturers Association of Canada

Nurse Practitioners Association of Ontario

Reich, Dr. Carl J. (Calgary, Alberta)

Ujimoto, K. Victor (University of Guelph)

Victorian Order of Nurses for Canada

APPENDIX D

SUMMARY OF PROVINCIAL STUDIES

Constitutionally, the provincial and territorial governments have primary responsibility for the delivery of health care services. Although each provincial health care scheme must meet the criteria and conditions set out in the *Canada Health Act*, over the years, the provinces have been able to develop health care networks geared to their specific needs. The current provincial health care systems vary in style and nature.

Despite their differences, provincial health care schemes are confronted with similar challenges. Provincial health departments are deeply concerned about health expenditures. In every province of Canada, substantial sums are spent on health care; health currently accounts for about one third of provincial and territorial budgets. Health expenditures are expected to continue to rise as a result of factors such as the aging of the population, AIDS, growth in new technologies and increases in costs in human resources and institutions. Provinces are paying more attention to the limits of the traditional medical model which, it is said, places the emphasis on illness rather than health. They are also questioning current methods of funding as well as the role of a variety of the different health care professionals.

To find solutions to meet the challenges of the health care sector in the 21st century, the provinces have established commissions of inquiry or task forces. The following sections describe the mandates of these commissions and task forces and present a brief list of their main recommendations.

A. THE MANDATE OF PROVINCIAL COMMISSIONS OF INQUIRY AND TASK FORCES

The number of commissions of inquiry and task forces created by the provinces in recent years to look into health care is proof of their desire to examine all aspects of their health care systems with a view to making them more effective and efficient and to preparing for the future. Commissions of inquiry in Quebec, Alberta, Saskatchewan,

Nova Scotia, New Brunswick and Newfoundland, as well as Manitoba's advisory network, have given serious consideration to the future direction of health care programs and have already released reports. Moreover, a Royal Commission of Inquiry chaired by Dr. Robert Evans has been established in British Columbia. In Ontario, a number of task forces have been set up to look into the various features of the health care system. Furthermore, provinces conducting reviews of their health care system have met and shared their visions of health care. The Alberta Commission held a three day conference in April 1989 which was attended by representatives of many provincial committees and commissions. The conference gave participants an opportunity to exchange ideas and share their experiences about many aspects of the health care system.

While commissions and task forces were assigned different mandates all were asked to evaluate innovative approaches to meeting changing health care needs. In New Brunswick, for example, the commission examined ways of keeping costs under control in the three most expensive areas, namely: hospitals, medical care and prescription drugs. Newfoundland's Royal Commission focused its attention on hospital costs. The Commissions in Quebec, Alberta, Saskatchewan, Nova Scotia and British Columbia, along with the Manitoba advisory network, adopted a more global approach to analysing the current state of the health care system in their respective provinces.

B. SUMMARY OF THE PROVINCIAL REPORTS

The reports of the provincial commissions of inquiry and task forces acknowledge a number of facts. First of all, the residents of the provinces enjoy a relatively high level of health care and generally appear to be satisfied with their health care schemes. However, considerable inequities were noted among different population groups within the provinces. In all provinces, various regions do not benefit from the same level of health care services. The reports also raise some concerns about health care human resources, in particular shortages and geographic maldistribution. Mention was made of evolving health care needs and the many challenges which this situation presents. The relationship between the limited nature of the available resources and the virtually unlimited nature of the needs or wants places financial constraints on health care systems. Recourse to costly new technologies, duplication of services by institutions, the fee for service reimbursement scheme and the priority given to the institutional sector further add to the financial burden. All of the reports stress the need to maintain the quality and accessibility to services. However, the view is that changes are warranted if the needs of the population are to be met at the dawn of the 21st century. Of all the solutions advanced in the different reports, mention should be made of the following common recommendations:

1. That more attention be paid to the limits imposed by the traditional medical model which focuses on illness. To do so, the system must be given a new direction. Further emphasis must be placed on health and disease prevention. (New Brunswick, Nova Scotia, Quebec, Alberta, Saskatchewan)

2. That decentralization and regionalization are needed in order to improve the quality of the system and the delivery of service, and thus achieve more effective management. It is recommended that responsibilities and powers be assigned to regional health care agencies and that the services network be adapted to regional needs. Regional health care authorities could be put in charge of planning and managing all health care programs and services within their territory. (New Brunswick, Nova Scotia, Quebec, Alberta, Saskatchewan)

3. That an evaluation and planning process be devised. Some provinces have proposed the creation of a health board responsible for advising the government on provincial health policy and for controlling and evaluating the performance of the health care system. (New Brunswick, Nova Scotia)

4. That the implementation of health care technologies be rationalized. Before being adopted, new technologies should be evaluated in terms of their cost and the benefits they provide. (Nova Scotia, Quebec, Alberta)

5. With a view to improving the geographic distribution of health care workers and to enhancing development planning, that the present and future role of health care professionals be examined thoroughly, that health care human resources levels and geographic distribution be evaluated and that objectives be set with respect to university and college admissions. (Nova Scotia, Quebec, Saskatchewan)

6. That policies be drawn up respecting the number of doctors, their professional and geographic distribution and the type of work they perform. (New Brunswick, Nova Scotia, Quebec) That remuneration schemes be reconsidered and the advisability of establishing a joint remuneration system based on the place of work should be considered. (Nova Scotia, Quebec, Saskatchewan)

7. That steps be taken to encourage the redistribution of institutional care and medical services to community and home care programs. (New Brunswick, Nova Scotia) As such, profitable co-operation and better coordination should be established between the institutional network and community programs. (Nova Scotia, Quebec, Alberta, Saskatchewan)

8. That special strategies be devised for special needs groups such as cultural minorities, immigrants and Aboriginals. One proposal, for example, calls for more preventive initiatives and community and home care. (Quebec, Saskatchewan)

9. That the provinces step up their research efforts in terms of policy and health services management, as well as in terms of developing alternative solutions. (New Brunswick, Nova Scotia, Quebec, Alberta)

10. That citizens be better informed so that they know how to access the health care system. They should also be informed about the costs of health services. Some provincial reports recommend that consumers play a more active role in health services planning. (New Brunswick, Quebec, Alberta)

11. In light of the trend to higher health care costs, that funding methods and sources, the budget allocation process and remuneration schemes be reviewed. Some reports recommend that the federal and provincial governments undertake a joint study of the *Established Programs Financing Act* and that the *Canada Health Act* be reviewed. (New Brunswick, Nova Scotia, Quebec)

Quebec has already taken the first steps toward introducing some of these changes in its health care system. Recently, the Quebec government released a White Paper on their health and social services system. The primary focus of the proposed reform is on the citizen. The White Paper contends that citizens should participate in the decision-making process, bear some of the cost of services and receive services geared to their needs and place of residence.[1] Moreover, the report recommends that the *Canada Health Act* be amended so that the Quebec government could charge a services tax on certain supplementary health services.[2] Furthermore, the Quebec Liberal party is examining other propositions relating to the health care system. The Allaire Commission

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1 Department of Health and Social Services, *Une Réforme Axée sur le Citoyen*, Government of Quebec, 1990, p. 12.

2 *Ibid.* p. 88.

recently released a policy paper in which it recommended that Quebec be granted exclusive jurisdiction over health care.[3] The Quebec government plans to make public its proposals respecting areas of shared jurisdiction in the coming months.

3 Constitutional Committee of the Liberal Party of Quebec, *A Quebec Free to Choose*, January 28, 1991, pp. 43–45.

APPENDIX E

COMPUTATION OF ESTABLISHED PROGRAMS FINANCING CONTRIBUTIONS TO THE PROVINCES FOR HEALTH SERVICES

Pursuant to the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, 1977* (EPF), each province receives transfers for hospital insurance, medical services and post-secondary education. Under EPF, the basic transfer payment is computed by taking the average federal contribution in 1975-1976 and adjusting it to an escalator that takes into account a moving average of the rate of growth of GNP per capita.

This appendix provides details on the method used to compute provincial entitlements for health EPF and explains how cash transfers and tax point transfers are obtained.

A. COMPUTATION OF ESTABLISHED PROGRAMS FINANCING TRANSFER PAYMENTS

The total transfer for health services to which each province is entitled is computed as follows:

$$\text{Total EPF contribution payable (health)} = \left[\text{Per capita entitlement for insured health services} + \text{Per capita entitlement for complementary services}\right] * \left[\text{Escalator}\right] * \left[\text{Population of the province}\right]$$

The per capita entitlement for insured health services corresponds to the average per capita cost incurred by the federal government for hospital insurance and medical care for the base tax year of 1975-1976; the cost was, at that time, equal to $144.34 per

capita. The per capita entitlement for complementary services, which has been available since 1977-1978, totalled $20. Residents of all provinces therefore receive an equal amount for health services.

Federal EPF contributions per capita are adjusted each year using an escalator. This escalator corresponds to a three-year compound moving average of the growth of GNP per capita. The use of a moving average based on the three calendar years preceding the fiscal year during which transfers are paid eases the effects of possible sharp fluctuations in the rate of growth of GNP, thus, the escalator takes into account only the average rate of growth of GNP.

The escalator has been adjusted each time changes have been made to EPF transfers since the mid eighties. For the 1985-1986 fiscal year, the escalator used to compute EPF entitlements corresponded to:

$$\text{the cube root of } \frac{\text{(per capita GNP for 1984)}}{\text{(per capita GNP for 1981)}}$$

With the passage, in 1986, of Bill C-96, (*An Act to amend the Federal-Provincial Fiscal Arrangements and Federal Post- Secondary Education and Health Contributions Act, 1977)*, the escalator was reduced by 2%. For example, for the 1986-1987 fiscal year, the escalator was equal to:

$$\text{the cube root of } \frac{\text{(per capita GNP for 1985)}}{\text{(per capita GNP for 1982)}} - 0.02$$

In fact, the escalator was reduced by 2% from 1986-1987 to 1989-1990. Then, total per capita transfers were frozen at their 1989-1990 level. Thus, the total entitlement of a province increases solely on the basis of an increase in the province's population.

In light of the 1991 federal budget, the freeze on transfers could be extended until 1994-1995. It is also possible that the escalator will subsequently be reduced by 3%. Consequently, for 1995-1996, it could equal:

$$\text{the cube root of } \frac{\text{(per capita GNP for 1994)}}{\text{(per capita GNP for 1991)}} - 0.03$$

The legislative authority for EPF is the *Canada Health Act*. The provinces must meet the criteria and conditions set out in the legislation in order to receive their full EPF entitlement in respect of health services.

B. CASH TRANSFERS AND TAX POINT TRANSFERS

EPF transfers come in two forms: transfers in the form of personal and corporate income tax rebates and transfers in the form of cash contributions.

i) Federal income tax rebates:

Under EPF, the federal government makes tax room available to each province through a tax transfer equal to one corporate and 13.5 personal income tax points. Quebec receives a special abatement of 8.5 personal income tax points. Provinces with a fiscal capacity below the representative standard receive equalization payments so that the after-equalization transfer meets this standard (Quebec, Ontario, Manitoba, Saskatchewan and British Columbia are the provinces that set the national standard). With respect to health and post-secondary education, tax transfers are allocated as follows: 67.9% for health and 32.1% for post- secondary education.

ii) Cash contributions:

Cash transfers make up the difference between the total EPF entitlement for each province, as calculated on the basis of the escalator, and the value of the tax transfer.

The performance of the Canadian economy affects the amount of the federal contributions to the provinces in two ways: firstly, economic growth is a factor in the calculation of the escalator; and secondly, economic growth has a direct impact on federal revenues, notably revenues from personal and corporate income taxes. An economic slowdown means a lower escalator for computing the total amount of transfers. Moreover, poor economic growth means lower government tax revenues, and hence, smaller tax point transfers.

Federal contributions to provinces according to EPF are presented in the following table.

TABLE

FEDERAL CONTRIBUTIONS FOR HEALTH UNDER ESTABLISHED PROGRAMS FINANCING

(In Thousands of Dollars)

	NFLD	PEI	NS	NB	PQ	ONT	MAN	SASK	ALTA	BC	NWT	YN	TOTAL
1977-1978													
Tax	41,615	8,869	61,609	50,697	703,968	685,141	75,931	69,136	181,073	216,171	3,328	2,262	2,099,800
Cash	65,143	13,058	102,340	79,914	602,270	993,949	131,009	112,889	204,709	260,071	5,445	2,233	2,573,030
Total	106,758	21,927	163,949	130,611	1,306,238	1,679,090	206,940	182,025	385,782	476,242	8,773	4,495	4,672,830
1978-1979													
Tax	47,209	10,133	69, 835	57,668	793,131	766,864	85,778	78,714	213,905	248,320	3,822	2,620	2,377,999
Cash	78,444	16,377	119,329	96,136	655,933	1,153,613	149,276	133,421	242,420	313,176	6,132	2,660	2,966,917
Total	125,653	26,510	189,164	153,804	1,449,064	1,920,477	235,054	212,135	456,325	561,496	9,954	5,280	5,344,916
1979-1980													
Tax	52,824	11,438	79,021	64,985	896,300	867,546	96,605	89,371	262,055	292,005	4,452	2,995	2,719,597
Cash	90,889	19,679	135,961	111,811	723,887	1,303,270	166,215	153,769	289,434	369,001	7,009	3,133	3,374,058
Total	143,713	31,117	214,982	176,796	1,620,187	2,170,816	262,820	243,140	551,489	661,006	11,461	6,128	6,093,655
1980-1981													
Tax	61,204	13,287	91,449	75,249	1,037,681	996,307	110,904	103,817	327,103	350,423	5,263	3,466	3,176,153
Cash	98,726	21,435	147,514	121,384	768,067	1,426,879	178,899	167,465	332,464	412,985	7,377	3,454	3,686,649
Total	159,930	34,722	238,963	196,633	1,805,748	2,423,186	289,803	271,282	659,567	763,408	12,640	6,960	6,862,802
1981-1982													
Tax	69,082	14,908	103,127	84,746	1,170,428	1,131,385	124,886	109,143	394,693	392,346	5,819	3,862	3,604,425
Cash	109,211	23,568	163,032	133,975	851,702	1,577,527	197,430	194,979	385,025	472,216	8,546	3,984	4,121,195
Total	178,293	38,476	266,159	218,721	2,022,130	2,708,912	322,316	304,122	779,718	864,562	14,365	7,846	7,725,620
1982-1983													
Tax	76,762	16,569	115,002	94,369	1,274,055	1,302,238	139,685	121,783	455,899	430,739	7,562	3,721	4,038,384
Cash	123,627	26,681	185,212	151,984	1,009,994	1,770,078	224,963	223,338	361,343	553,089	9,075	4,633	4,644,017
Total	200,389	43,250	300,214	246,353	2,284,049	3,072,316	364,648	345,121	817,242	983,828	16,637	8,354	8,682,401
1983-1984													
Tax	79,507	17,158	118,915	97,684	1,306,136	1,374,877	144,671	119,836	433,090	423,322	8,189	3,650	4,127,035
Cash	142,483	30,747	213,108	175,063	1,202,858	2,026,357	259,267	263,097	471,252	663,738	10,503	4,983	5,463,456
Total	221,990	47,905	332,023	272,747	2,508,994	3,401,234	403,938	382,933	904,342	1,087,060	18,692	8,633	9,590,491
1984-1985													
Tax	86,243	18,848	130,239	106,660	1,422,608	1,540,045	158,972	124,604	455,513	440,291	9,556	3,940	4,497,519
Cash	151,605	33,134	228,943	187,493	1,274,999	2,158,859	279,452	291,132	516,199	743,008	11,262	5,658	5,881,744
Total	237,848	51,982	359,182	294,153	2,697,607	3,698,904	438,424	415,736	971,712	1,183,299	20,818	9,598	10,379,263
1985-1986													
Tax	94,144	20,756	143,481	116,943	1,554,778	1,735,171	175,275	128,769	466,982	468,067	9,724	4,204	4,918,294
Cash	159,552	35,177	243,167	198,191	1,336,959	2,262,886	297,048	318,873	575,548	806,007	13,315	6,228	6,252,951
Total	253,696	55,933	386,648	315,134	2,891,737	3,998,057	472,323	447,642	1,042,530	1,274,074	23,039	10,432	11,171,245
1986-1987													
Tax	102,713	22,887	157,805	128,388	1,707,981	1,948,184	193,595	182,564	454,490	508,818	9,509	4,732	5,421,666
Cash	164,163	36,582	252,217	205,201	1,363,093	2,331,188	309,416	291,788	660,854	847,848	15,020	6,305	6,483,675
Total	266,876	59,469	410,022	333,589	3,071,074	4,279,372	503,011	474,352	1,115,344	1,356,666	24,529	11,037	11,905,341

TABLE (continued)

FEDERAL CONTRIBUTIONS FOR HEALTH UNDER ESTABLISHED PROGRAMS FINANCING

(In Thousands of Dollars)

	NFLD	PEI	NS	NB	PQ	ONT	MAN	SASK	ALTA	BC	NWT	YN	TOTAL
1987-1988													
Tax	114, 275	25,607	176,613	143,282	1,911,189	2,230,565	217,045	204,332	479,894	572,154	10,663	5,046	6,090,665
Cash	164,936	36,959	254,908	206,801	1,328,957	2,323,017	313,265	294,916	688,703	865,431	14,894	6,995	6,499,782
Total	279,211	62,566	431,521	350,083	3,240,146	4,553,582	530,310	499,248	1,168,597	1,437,585	25,557	12,041	12,590,447
1988-1989													
Tax	122,714	27,827	190,726	154,322	2,049,885	2,470,867	234,193	218,811	511,736	627,341	12,085	5,469	6,625,976
Cash	168,689	38,252	262,179	212,138	1,355,779	2,365,029	321,935	300,788	717,079	903,446	14,747	7,511	6,667,572
Total	291,403	66,079	452,905	366,460	3,405,664	4,835,896	556,128	519,599	1,228,815	1,530,787	26,832	12,980	13,293,548
1989-1990													
Tax	131,846	30,117	205,125	166,196	2,222,804	2,662,375	250,786	232,929	563,607	680,157	13,131	5,988	7,165,061
Cash	174,892	39,948	272,094	220,455	1,376,629	2,487,320	332,662	308,974	743,634	964,172	15,605	7,681	6,944,066
Total	306,738	70,065	477,219	386,651	3,599,433	5,149,695	583,448	541,903	1,307,241	1,644,329	28,736	13,669	14,109,127
1990-1991													
Tax	145,198	33,043	225,933	183,436	2,460,663	2,974,994	276,181	253,476	607,047	791,394	13,912	6,258	7,971,535
Cash	163,932	37,307	255,079	207,103	1,187,495	2,274,919	311,812	286,179	725,392	898,136	15,220	7,769	6,370,343
Total	309,130	70,350	481,012	390,539	3,648,158	5,249,913	587,993	539,655	1,332,439	1,689,530	29,132	14,027	14,341,878
1991-1992													
Tax	153,000	35,000	238,000	193,000	2,593,000	3,163,000	292,000	267,000	638,000	841,000	15,000	7,000	8,435,000
Cash	157,000	36,000	246,000	199,000	1,072,000	2,173,000	301,000	275,000	720,000	876,000	14,000	7,000	6,076,000
Total	310,000	71,000	484,000	392,000	3,665,000	5,336,000	593,000	542,000	1,358,000	1,717,000	29,000	14,000	14,511,000
1992-1993													
Tax	163,000	37,000	256,000	207,000	2,779,000	3,412,000	314,000	285,000	688,000	906,000	16,000	7,000	9,070,000
Cash	148,000	34,000	232,000	187,000	911,000	2,011,000	284,000	259,000	694,000	841,000	13,000	7,000	5,621,000
Total	311,000	71,000	488,000	394,000	3,690,000	5,423,000	598,000	544,000	1,382,000	1,747,000	29,000	14,000	14,691,000
1993-1994													
Tax	175,000	40,000	275,000	222,000	2,992,000	3,699,000	338,000	307,000	746,000	980,000	17,000	8,000	9,799,000
Cash	137,000	32,000	216,000	174,000	727,000	1,811,000	265,000	241,000	662,000	801,000	12,000	6,000	5,084,000
Total	312,000	72,000	491,000	396,000	3,719,000	5,510,000	603,000	548,000	1,408,000	1,781,000	29,000	14,000	14,883,000
1994-1995													
Tax	187,000	43,000	296,000	239,000	3,222,000	4,000,000	364,000	330,000	807,000	1,059,000	19,000	9,000	10,575,000
Cash	125,000	29,000	198,000	160,000	526,000	1,594,000	244,000	222,000	627,000	754,000	11,000	5,000	4,495,000
Total	312,000	72,000	494,000	399,000	3,748,000	5,594,000	608,000	552,000	1,434,000	1,813,000	30,000	14,000	15,070,000
1995-1996													
Tax	199,000	46,000	316,000	254,000	3,448,000	4,296,000	390,000	353,000	867,000	1,137,000	20,000	10,000	11,336,000
Cash	123,000	29,000	195,000	157,000	433,000	1,532,000	241,000	218,000	635,000	759,000	10,000	5,000	4,337,000
Total	322,000	75,000	511,000	411,000	3,881,000	5,828,000	631,000	571,000	1,502,000	1,896,000	30,000	15,000	15,673,000

Source: Federal-Provincial Relations Division, Department of Finance, Established Programs Financing
1977-78 to 1987-88: Final Calculation
1988-89: First Interim Adjustment, March 8, 1990
1989-90 to 1990-91: Second Adjustment to Advance, December 11, 1990
1991-92 to 1995-96: Projections prepared by the Department of Finance, April 1991

APPENDIX F

MINORITY REPORT

The Report on health care deals with a large number of complex issues relating to health care in Canada. While I would concur with many recommendations in the Report, I do dissent with the Report in the following areas:

I. The Majority Report does not adequately deal with the cutback of Established Program Financing funding by the federal government nor with the implications of these cutbacks. It does not document the erosion of EPF by the Liberal Government in the early l980s with their withdrawal of the revenue guarantee and the introduction of the 6 and 5 program. It does not document that between 1986 and the year 2000, the present federal government will have reduced anticipated transfer payments for health to the provinces and territories by $62.4 billion. The reduction by the year 2000 will amount to $10.9 billion a year. These cuts have been well documented by the National Council of Welfare, the Library of Parliament, and the Association of Universities and Colleges in Canada. The implications of this withdrawal of funding for national Medicare are twofold:

a) The ability of the provinces to provide medical services has been severely crippled. This is particularly true of the smaller and financially weaker provinces. As a direct result of the most recent cutbacks, Newfoundland has been forced to close hospital beds, lay off medical staff, and curtail other medical services. Universal, accessible medical care has been put in jeopardy in several provinces.

b) Cash transfers under EPF will cease as early as 1996–97 for Quebec and for all other provinces within a few years. Once the federal government makes no cash payments to a province, it *will not be in a position to enforce national standards*. Indeed, the Minister of Health has already conceded that by 1996, Quebec, in regard to Medicare, "will be able to manage as it pleases." (Hansard, June 11, 1991, p. 1436)

Although the Majority Report indicates that it is feasible for the federal government to withhold other cash transfers to the provinces to enforce national medicare standards, it is inconceivable that within federal–provincial

relationships of today this would be sustained either politically or legally. Three provinces, British Columbia, Alberta and Ontario, receive no equalization payments and the limiting of their cash payments under the Canada Assistance Plan to a 5% annual growth rate has already resulted in a major court challenge.

Without national standards as outlined in the *Canada Health Act*, and without the ability to enforce these standards, there will no longer be a national Medicare system that guarantees all Canadians basic medical care. There could be 12 entirely different programs with different standards, as to universality, accessibility, comprehensiveness, portability and non-profit administration and with various types of user fees and extra billing. One of the fundamental ways Canadians define Canada, particularly as distinct from the U.S., is by our health care system. In Canada, there are no financial barriers to people seeking medical treatment, the system is relatively efficient and widely supported. Canadians move within Canada, on business, holidays and to seek employment, with the knowledge that similar health care standards are met in all provinces and territories. *This promotes a national identity and national unity*. Any changes that would result in the erosion of our national program cannot be supported by myself and will not be supported by Canadians.

The critical recommendation, number one, endorsed by all other Committee members would result in the total renegotiation of Medicare in Canada including renegotiation of "basics of funding under EPF" and renegotiation of "the standards of the *Canada Health Act*", as well as the renegotiation of "the division of responsibilities between provincial and territorial governments". Renegotiation opens the door to the provinces for notions such as "disentanglement", the introduction of user fees or extra billing, and two-tiered health care with U.S.-style private coverage all of which will undoubtedly lead to a dismantling of the national Medicare system Canadians now enjoy.

Although the Committee Report was "to determine the ability of current fiscal arrangements to provide an adequate, stable, yet flexible funding base for a health care system that responds to the needs of Canadians" (see Introduction of Majority Report), the Committee did not really address the question directly. Part of the reason is that the current fiscal arrangements have been changing constantly, due to the federal government's arbitrary and unilateral reduction in transfer payments to the provinces and territories.

It is my contention that Medicare did have a stable yet flexible funding base which has now been destroyed by the cumulative actions of successive federal governments.

RECOMMENDATIONS:

1. **That the federal government reaffirm its commitment to a comprehensive national health care program jointly financed by the provinces and territories and the federal government, by restoring the funds it has cut from the Established Programs Financing.**

2. **That the federal government reaffirm its commitment to the guarantees in the *Canada Health Act* to Canadians for a health care system that is universal, accessible, comprehensive, portable and delivered by public, non-profit means and free of user fees or extra billing by defining these guarantees in regulations that cannot be undermined or ignored by federal, provincial or territorial governments. In addition, that a social charter including health care be made part of the Constitution as the ultimate guarantee to all Canadians.**

II. The other major weakness of the Report is that it does not put enough emphasis on the responsibility of the federal government for health promotion, protection, disease prevention and medical research, both basic and applied. The federal government is better able to provide leadership and to avoid duplication and inefficiencies than are the provinces and territories.

Historically, the federal government has been the major player in these areas and funded most of the activities. The federal roles and responsibilities have been set out in both the Lalonde and Epp Reports. The Majority Report does not adequately document the cuts in federal funding in these areas in recent years. Federal government funding and leadership must be restored and strengthened in health promotion, protection and research if the broader problems now facing our health care system as outlined in the Majority Report are to be solved.

RECOMMENDATION:

3. **That the federal government reaffirm its major responsibility for health protection and promotion, disease prevention and medical research, by not only restoring budget cuts but significantly increasing program expenditures in these areas.**

Jim Karpoff,
N.D.P.—Surrey North

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the Government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings and Evidence* of the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women (*Issues Nos. 38, 39, 40, 41, 42, 43, 44, 45, 46, 48, 49, 52, 53, 54 of the Second Session and Issue No. 1 of the Third Session which includes this Report*) is tabled.

Respectfully submitted,

BOB PORTER

Chairman

MINUTES OF PROCEEDINGS

TUESDAY, MAY 21, 1991 (1)

[*Text*]

The Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women met *in camera* at 4:55 o'clock p.m. this day, in Room 307, West Block, the Chairman, Bob Porter, presiding.

Members of the Committee present: Mary Clancy, Barbara Greene, Bruce Halliday, Bob Porter.

Acting Members present: Jim Karpoff for Chris Axworthy; Rey Pagtakhan for David Dingwall.

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Joan Vance, Research Officers.

Pursuant to the Special Order adopted by the House on Friday, May 17, 1991, the Committee resumed consideration of its Draft Report on the health care system in Canada and its funding.

At 5:33 o'clock p.m., the Committee adjourned to the call of the Chair.

WEDNESDAY, MAY 22, 1991 (2)

The Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women met *in camera* at 8:03 o'clock p.m. this day, in Room 307, West Block, the Chairman, Bob Porter, presiding.

Members of the Committee present: John Cole, Mary Clancy, Barbara Greene, Bruce Halliday, Bob Porter.

Acting Members present: Jim Karpoff for Chris Axworthy; Rey Pagtakhan for David Dingwall.

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Joan Vance, Research Officers.

Pursuant to the Special Order adopted by the House on Friday, May 17, 1991, the Committee resumed consideration of its Draft Report on the health care system in Canada and its funding.

At 10:06 o'clock p.m., the Committee adjourned to the call of the Chair.

THURSDAY, MAY 23, 1991 (3)

The Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women met *in camera* at 9:21 o'clock a.m. this day, in Room 307, West Block, the Chairman, Bob Porter, presiding.

Members of the Committee present: Mary Clancy, Barbara Greene, Bruce Halliday, Bob Porter.

Acting Members present: Jim Karpoff for Chris Axworthy; Rey Pagtakhan for David Dingwall.

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Joan Vance, Research Officers.

Pursuant to the Special Order adopted by the House on Friday, May 17, 1991, the Committee resumed consideration of its Draft Report on the health care system in Canada and its funding.

At 11:41 o'clock a.m., the Committee adjourned to the call of the Chair.

TUESDAY, MAY 28, 1991 (4)

The Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women met *in camera* at 9:21 o'clock a.m. this day, in Room 307, West Block, the Chairman, Bob Porter, presiding.

Members of the Committee present: Chris Axworthy, Mary Clancy, Barbara Greene, Albina Guarnieri, Bruce Halliday, Bob Porter, Stanley Wilbee.

Acting Member present: Edna Anderson for Nicole Roy-Arcelin.

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Joan Vance, Research Officers.

Pursuant to the Special Order adopted by the House on Friday, May 17, 1991, the Committee resumed consideration of its Draft Report on the health care system in Canada and its funding.

It was agreed, – That Dr. Raisa Deber from the University of Toronto be hired to review the Draft Report on the health care system and its funding and advise the Committee, at a daily rate not exceeding $599.00, plus the miscellaneous expenses incurred.

At 10:39 o'clock a.m., the Committee adjourned to the call of the Chair.

TUESDAY, JUNE 4, 1991 (5)

The Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women met *in camera* at 3:36 o'clock p.m. this day, in Room 208, West Block, the Chairman, Bob Porter, presiding.

Members of the Committee present: Mary Clancy, Barbara Greene, Bruce Halliday, Bob Porter, Stanley Wilbee.

Acting Members present: Jim Karpoff for Chris Axworthy; Rey Pagtakhan for David Dingwall.

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Joan Vance, Research Officers. *From the University of Toronto:* Dr. Raisa Deber.

Pursuant to the Special Order adopted by the House on Friday, May 17, 1991, the Committee resumed consideration of its Draft Report on the health care system in Canada and its funding.

At 5:46 o'clock p.m., the Committee adjourned to the call of the Chair.

WEDNESDAY, JUNE 5, 1991 (6)

The Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women met *in camera* at 7:17 o'clock p.m. this day, in Room 208, West Block, the Chairman, Bob Porter, presiding.

Members of the Committee present: John Cole, Mary Clancy, Barbara Greene, Bruce Halliday, Bob Porter, Stanley Wilbee.

Acting Members present: Jim Karpoff for Chris Axworthy; Rey Pagtakhan for David Dingwall.

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Joan Vance, Research Officers.

Pursuant to the Special Order adopted by the House on Friday, May 17, 1991, the Committee resumed consideration of its Draft Report on the health care system in Canada and its funding.

At 10:22 o'clock p.m., the Committee adjourned to the call of the Chair.

WEDNESDAY, JUNE 12, 1991(7)

The Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women met *in camera* at 7:07 o'clock p.m. this day, in Room 208, West Block, the Chairman, Bob Porter, presiding.

Members of the Committee present: John Cole, Mary Clancy, Barbara Greene, Bruce Halliday, Bob Porter, Stanley Wilbee.

Acting Members present: Jim Karpoff for Chris Axworthy; Rey Pagtakhan for David Dingwall.

Other Member present: Jean-Luc Joncas.

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Joan Vance, Research Officers.

Pursuant to the Special Order adopted by the House on Friday, May 17, 1991, the Committee resumed consideration of its Draft Report on the health care system in Canada and its funding.

It was agreed, —That the Draft Report, as amended, be concurred in.

It was agreed, —That the said Report be entitled: The Health Care System in Canada and its Funding: No Easy Solutions.

Ordered, —That the Chairman present the said Report to the House.

It was agreed, —That, pursuant to Standing Order 109, the Committee request that the Government table a comprehensive response to this Report.

It was agreed, —That the Committee print 3000 copies of this Report, in tumble bilingual format, with a distinctive cover page.

It was agreed, —That the Committee authorize the printing of the dissenting opinion(s) from the Liberal Party and/or the New Democratic Party as an appendix (or appendices) to this Report.

It was agreed, —That the total amount paid by the Committee to Dr. Raisa Deber do not exceed $2894.00 including travel (Ottawa-Toronto), as stipulated in the contract.

It was agreed, —That the Committee thank the Clerk and the Research Officers for their work and dedication throughout the study.

At 9:24 o'clock p.m., the Committee adjourned.

Clairette Bourque

Clerk of the Committee