# ACCESSIBILITY TO HOSPITAL SERVICES – IS THERE A CRISIS?

Standing Senate Committee
on
Social Affairs, Science and
Technology

J
103
H7
34-2
S6
A123

CHAIR
The Honourable Lorna Marsden

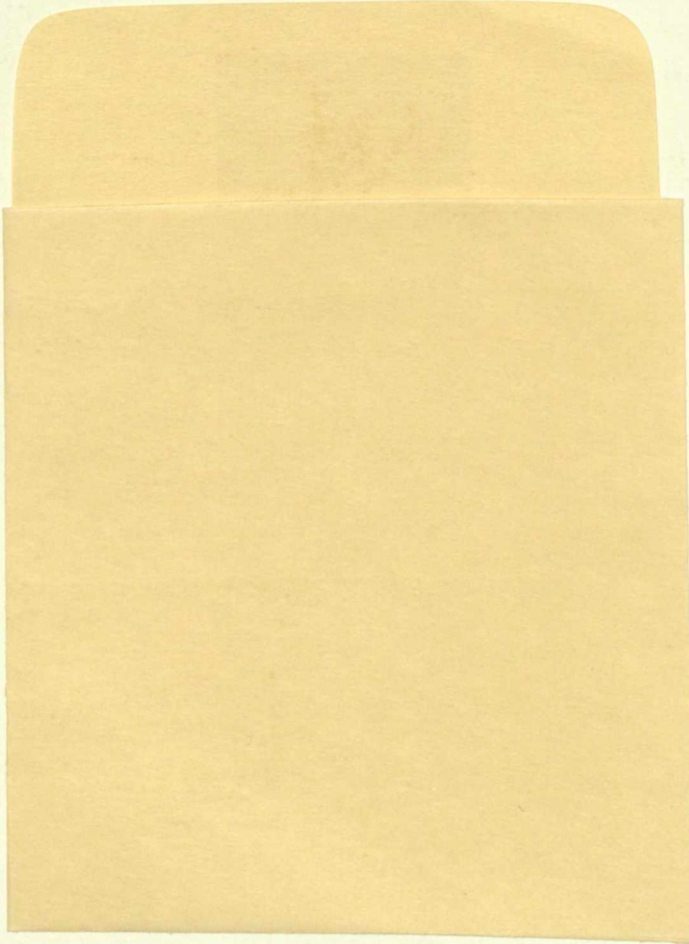
DEPUTY CHAIR
The Honourable Brenda Robertson

Second Session
Thirty-Fourth Parliament

June 1990

BIBLIOTHÈQUE DU PARLEMENT
LIBRARY OF PARLIAMENT
3 2354 00041 891 6

BIBLIOTHÈQUE DU PARLEMENT
LIBRARY OF PARLIAMENT
3 2354 00041 850 2



J
103
H7
34-2
S6
A123

# ACCESSIBILITY TO HOSPITAL SERVICES – IS THERE A CRISIS?

LIBRARY OF PARLIAMENT
CANADA
1990 07 12
BIBLIOTHÈQUE DU PARLEMENT

**Standing Senate Committee on Social Affairs, Science and Technology**

**CHAIR**
**The Honourable Lorna Marsden**

**DEPUTY CHAIR**
**The Honourable Brenda Robertson**

**Second Session**
**Thirty-Fourth Parliament**

**June 1990**

# MEMBERSHIP

The Honourable Senator Lorna Marsden, *Chair*

The Honourable Senator Brenda Robertson, *Deputy Chair*

and

The Honourable Senators:

Jack Austin, P.C.
Lorne Bonnell
Paul David
Philippe Gigantès
Jacques Hébert
Michael Kirby
*Allan MacEachen P.C.
(or Royce Frith)
Lorna Marsden
Jack Marshall
*Lowell Murray, P.C.
(or William Doody)
Brenda Robertson
Mira Spivak
Norbet Thériault
Arthur Tremblay

LIBRARY OF PARLIAMENT
CANADA
BIBLIOTHÈQUE DU PARLEMENT

**Ex Officio Members*

Note: The Honourable Senators Cochrane, Fairbairn, Haidasz and MacQuarrie also participated in the proceedings of the Committee.

# ORDERS OF REFERENCE

**Extract from the *Minutes of Proceedings of the Senate*, Wednesday, June 28, 1989:**

Pursuant to the Order of the Day, the Senate resumed the debate on the motion of the Honourable Senator David, seconded by the Honourable Senator Poitras:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to undertake a preliminary study of problems encountered in short-term care hospitals and institutions under the National Health Program in Canada; and

That the Committee present its report no later than March 31, 1990.

After debate, and —

The question being put on the motion, it was —

Resolved in the affirmative.

**Extract from the *Minutes of Proceedings of the Senate*, Wednesday, March 14, 1990:**

The Honourable Senator Marsden moved,
Seconded by the Honourable Senator Turner:

That the Order of Reference of the Standing Senate Committee on Social Affairs, Science and Technology dated June 28, 1989, respecting problems encountered in short-term care hospitals and institutions under the National Health Program in Canada, be amended by deleting the words "March 31, 1990" and substituting therefore the words "June 29, 1990".

The question being put on the motion, it was —

Resolved in the affirmative.

Gordon Barnhart
*Clerk of the Senate*

# ORDERS OF REFERENCE

*Extract from the Minutes of Proceedings of the Senate, Wednesday, June 28, 1989:*

Pursuant to the Order of the Day, the Senate resumed the debate on the motion of the Honourable Senator David, seconded by the Honourable Senator Poitras:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to undertake a preliminary study of problems encountered in short-term care hospitals and institutions under the National Health Program in Canada; and

That the Committee present its report no later than March 31, 1990.

After debate, and—

The question being put on the motion, it was—

Resolved in the affirmative.

*Extract from the Minutes of Proceedings of the Senate, Wednesday, March 14, 1990:*

The Honourable Senator Marsden moved,
Seconded by the Honourable Senator Turner:

That the Order of Reference of the Standing Senate Committee on Social Affairs, Science and Technology dated June 28, 1989 respecting problems encountered in short-term care hospitals and institutions under the National Health Program in Canada be amended by deleting the words "March 31, 1990" and substituting therefor the words "June 29, 1990".

The question being put on the motion, it was—

Resolved in the affirmative.

Gordon Barnhart
*Clerk of the Senate*

# REPORT OF THE COMMITTEE

The Standing Senate Committee on Social Affairs, Science and Technology has the honour to present its

# FIFTEENTH REPORT

Your Committee, which was authorized to study and report on the problems encountered in short-term care hospitals and institutions under the National Health Program in Canada, has, in obedience to its Order of Reference of Wednesday, June 28, 1989, proceeded to that inquiry and now presents its Report.

Respectfully submitted,

Lorna Marsden
*Chair*

# ACKNOWLEDGEMENT

The Committee wishes to express its gratitude to the many witnesses whose concern for the future of our national health-care system brought them before us. The Committee is indebted to its research adviser, Patricia MacDonald, and the staff of the Parliamentary Centre for Foreign Affairs and Foreign Trade, as well as to Mary Colbran-Smith, health-care consultant and researcher, and Bruce Squires, assistant researcher, and Jean Michel Roy, Clerk of the Committee.

Lorna Marsden
*Chair*

# TABLE OF CONTENTS


Page

CHAPTER 1: TERMS OF REFERENCE ........ 1

CHAPTER 2: IS THERE A CRISIS? ........ 5

Public Opinion Surveys ........ 5

Media Accounts ........ 5

Waiting Lists ........ 6

Regional Variations ........ 6

Provincial Reports ........ 7

Accessibility to Specialized Hospital Services ........ 7

CHAPTER 3: PROPOSED FEDERAL INITIATIVES FOR HOSPITAL SERVICE DELIVERY ........ 9

Human Resource Planning ........ 9

Accessibility to Acute-Care Beds in the Context of an Aging Population ........ 12

Utilization Management ........ 18

Medical Technology Assessment ........ 19

CHAPTER 4: PROPOSED FEDERAL POLICY INITIATIVES ........ 21

I: Funding ........ 21

a) Established Programs Financing ........ 21

b) Capital Funding ........ 25

c) Research Grants ........ 26

II: National Leadership ........ 27

a) Health Promotion ........ 27

b) National Health Objectives ........ 28

c) Initiatives for Improved Hospital Management ........ 28

d) National Health Care Advisory Council ........ 31

III: Legislation ........ 32

CHAPTER 5: CONCLUSION ........ 35

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS ........ 37

APPENDIX 1 .......... 39

APPENDIX 2 .......... 43

APPENDIX 3 .......... 45

APPENDIX 4 .......... 47

# CHAPTER 1: TERMS OF REFERENCE

The study on accessibility to acute-care hospital services had its origin in a notice of inquiry put forward by Senator Paul David on April 5, 1989:

> ...I shall draw the Senate's attention to research on the evolution of health care costs in Canada and its consequences and to the need to establish a committee or subcommittee to examine the question.[1]

In his speech to the Senate on May 2, 1989, Senator David related the results of a study on health-care costs that he completed in 1989.[2] The report concluded that although constant dollar health expenditures rose by an average of under 5 per cent per year during the 1975-85 period, major policy decisions related to financing and expenditures would be required in the near future. Pressures would come from a scarcity of public funds, provincial disparities in the range of health services offered, the growing needs of an aging population and the costs incurred by an increase of available and new medical technologies. As well, Senator David pointed to congested emergency rooms, long waiting lists, bed closures and outdated hospital equipment as evidence of constraints facing hospitals.

Senator David proposed a review of the advantages and disadvantages of the present system of health care with a view to making recommendations in accordance with the needs of Canadians and financial resources available. While several Senators supported this proposal, there was some agreement that the focus was too broad.[3]

After consultation with the Standing Senate Committee on Social Affairs, Science and Technology (the Committee) to narrow the terms of reference of the proposed study, Senator David moved on June 27th:

> That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to undertake a preliminary study of problems encountered in short term care hospitals and institutions under the National Health Program in Canada; and
>
> That the Committee present its report no later than March 31, 1990.

In the fall of 1989, the terms of reference were further narrowed to address the issue of accessibility and major problems facing acute-care hospitals, as follows:

Accessibility to the services of the acute-care hospital is coming under increased scrutiny by the public. Attention has focused on reported bed closing, long waiting lists for elective surgery and diagnostic procedures, delays in treatment, constraints on capital funding and staffing problems. Experts concur that the financial pressures on hospitals will become more acute as they deal with the increasing costs of medical technology and growing demands for hospital services from an aging population. Recent experience suggests the possibility that accessibility to the services of acute-care hospitals may be eroded and will be further threatened as competition for scarce resources becomes more intense.

Direct responsibility for the delivery of Canadian health-care services, including hospital services, rests with provincial governments. However, in the *Canada Health Act*, the federal government sets down its responsibility for determining and enforcing national program standards for health-care services. In order to qualify for funding under the *Established Programs Financing Act*, provinces must satisfy the program criteria outlined in the *Canada Health Act* applying to the following: public administration; comprehensiveness; universality; portability; and accessibility.

These program criteria must be met by all Canadian hospitals. The issue of accessibility, though, is the most serious problem now facing financially constrained hospitals.

The Committee will focus on the major difficulties confronting acute-care hospitals in Canada and how these issues and problems may affect patient accessibility to hospital services.

This study is not intended to deal with all the problems and issues facing acute-care hospitals. Rather, our intention is to have witnesses appear before the Committee to describe the major issues facing hospitals, including:

— the presence, frequency and seriousness of waiting lists for diagnostic procedures, treatment and surgery;
— the effects of the increasing costs of medical technology on hospitals and their implications for patient accessibility;
— the impact of an aging population on hospital expenditures and on the availability of acute-care services;
— hospital staffing issues and their relationship to patient accessibility to hospital services.

Representatives of national health associations, the provinces and the territories were asked to appear as witnesses before the Committee. No province or territory accepted this invitation. However, Saskatchewan provided a written submission and offered to send, if required, its medical advisor as a witness.

A health official from another province responded, as follows:

> The whole issue of the Canadian health care system, both from a service delivery perspective and from an overall funding perspective, has been the subject of ongoing bilateral discussions between provincial ministers of Health and Finance and their federal colleagues. Both issues are best pursued in this bilateral forum.

Only British Columbia, Prince Edward Island, Saskatchewan, Nova Scotia and the Yukon responded to a questionnaire prepared by the Committee. The list of witnesses who testified is provided in Appendix 1.

The Committee accepted an invitation from the Canadian Cardiovascular Society to visit the University of Ottawa Heart Institute, where members had an opportunity to observe a highly specialized hospital service and hear a presentation on the problems of cardiac care units across Canada.

The Secretary of the Demographic Review, Dr. E.M. Murphy of Health and Welfare Canada, presented the results of its Review, describing the demographic trends that are shaping the future of Canada in order to assist the Committee in its examination of the problems of the aging.

# CHAPTER 2: IS THERE A CRISIS?

It is difficult to accurately measure accessibility to acute-care services. To appreciate the dimensions of this issue, the Committee examined the following: public opinion surveys, media accounts, reported waiting lists, regional variations and provincial reports, and visited a cardiac care unit.

**Public Opinion Surveys**

Canadians have expressed satisfaction with the health-care system and judge access to adequate services as a right. However, recent polls indicate a change in attitude.

An Ontario poll in late 1989 shows that 48 per cent are not confident they would have prompt access to high technology procedures, if needed.[4]

A Decima poll in the spring of 1988 shows that Canadians acknowledge that governments may not be able to maintain the present standards of care at current funding levels.[5] The majority polled believe that inefficiency and wasteful spending in hospitals and medical facilities contributes to rising health expenditures.

In addition, this survey shows that just under half of Canadians indicate they would support limiting access to highly specialized treatments by making them available in only one or two hospitals in the region.[6] A majority in British Columbia, Ontario and large urban centres oppose this approach, perhaps seeing it as a potential withdrawal of services, while support is highest in Quebec, the Prairies and in rural communities.

**Media Accounts**

Media accounts describe treatment delays, long waiting lists, bed closures and nursing shortages.

"Heart patients may be sent to the U.S.," (The Ottawa Citizen, Jan. 14, 1990); "Les urgences des hopitaux sont de nouveau engorgées," (La Presse, Montreal, Nov. 9, 1989); "Heart patients face numbers crunch," (Calgary Herald, Apr. 30, 1989); "Limited funds stymie elective surgery," (Halifax Chronicle Herald, Jan. 30, 1989); "Bed shortages blamed for patient line ups," (Winnipeg Free Press, Jan. 13, 1989); "Emergency rooms still strained beyond limits, doctors complain," (Montreal Gazette, Dec. 7, 1988); "Boy's death awaiting surgery to be probed," (Globe and Mail, Jan. 31, 1990).

Opinion varies as to whether these accounts accurately reflect the reality of the present situation.

**Waiting Lists**

Witnesses commented on their concern about hospital waiting lists. Dr. Ferguson, director of the New Brunswick Extra-Mural Hospital, stated that acute-care hospitals in Saint John, Fredericton and Moncton are experiencing waiting lists of approximately 2,000 individuals, or a waiting time of two months.[7] However, Mr. Fyke, of the Greater Victoria Hospital Society, remarked that waitlists are not a useful measurement because they vary so greatly.[8]

The Canadian Medical Association (CMA) commented that accurate collection and analysis of hospital waiting lists has proved to be difficult because of many factors: organization of the system under investigation; hospital management policies; practice pattern of physicians; available human and technical resources; and population mix under investigation.[9]

However, the CMA encouraged the development of systematic reviews of waiting lists across a region to ensure that individuals are on only one list and have not received treatment or experienced a change of medical condition.

The Canadian Nurses Association (CNA) also emphasized the need to verify waiting lists and eliminate multiple patient counting as a way to minimize delays in hospital admissions.[10]

The Ministry of Health (Saskatchewan) reports a 38 per cent decrease in waiting lists since 1987, with an 18 per cent reduction in the past year. Change is attributed to aggressive management policies.[11]

**Regional Variations**

Witnesses addressed the issue of excessive waiting lists in large urban centres. Mr. Marcoux, of the Conseil de la santé et des services sociaux de la région de Montréal métropolitain, stated:

> The Montreal Regional Council collected daily data from 26 hospitals operating emergency rooms between October 1 and November 15 (1989). These figures show a 127 per cent stretcher occupancy rate in our region. The occupancy rate reached 140 per cent in the 15 busiest emergency rooms in Montreal.[12]

Mr. Gamble, of the Hospital Council of Metropolitan Toronto, stated that Toronto has developed a central resource registry with terminals in 23 acute-care hospitals providing occupancy data, which is updated five times daily.[13] The goal of the registry is to monitor waiting lists.

The Yukon noted in the Committee's questionnaire:

> Access to local services has not substantially changed. However, access to tertiary care centres in Vancouver and Edmonton has deteriorated as evidenced by growing waiting lists.[14]

Public concern is further heightened by the announcement in February 1990 that the British Columbia Ministry of Health had arranged to send up to 200 cardiac patients to hospitals in the state of Washington for urgent cardiac surgery.

**Provincial Reports**

Since 1983 there has been an increasing number of provincial health commissions and task forces (see Appendix 2). The key reasons for these investigations include: cost increases; human resource problems; concerns related to the organizational structure of health-care delivery; and issues related to quality assurance and medical technology assessment.

Although no effort is made to synthesize these reports, recommendations with respect to cost controls, funding and cost-effectiveness include: reducing the number of acute-care beds and freezing hospital capital construction initiatives; freezing hospital budgets, salaries and fees; global budgeting initiatives; increasing the number of outpatient clinics and community and home support systems; and addressing human resource issues.

Many provinces addressed the need for an overall redirection of the health-care system. From an organizational perspective, recommendations related to rational planning as opposed to institutional rivalry, more efficient and appropriate use of hospital beds and more controlled introduction of high-cost medical technology. From the management position, recommendations focused on the application of evaluative research because inadequate collection and usage of data on patient health status is affecting the quality of hospital management and planning.

**Accessibility to Specialized Hospital Services**

Public attention has focused recently on delays for cardic care treatment at many acute-care hospitals across Canada. It is an anxiety that has attracted considerable media attention. The Canadian Cardiovascular Society (the Society) remarked:

> Cardiovascular care in Canada has been seriously affected by the increasing costs of medical technology and growing demands for accessibility to this technology...It is also anticipated that improved diagnostic technologies will result in earlier recognition of heart disease for which health care intervention may prove beneficial.[15]

The Society conducted a systematic review of 46 of the largest cardiac-care facilities in Canada in preparation for our study. Of the 33 centres that responded to the review, 20 identified major problems with patient accessibility.

The occupancy rate in all cardiac centres across Canada is extremely high, varying from 84 per cent in Alberta to 96 per cent in Quebec. The total number of persons on elective waiting lists for open heart surgery was reported to be 4,000 as of January 11, 1990. Waiting lists for cardiac catheterization, angioplasty and open heart surgery were on average eight, five and 16 weeks respectively.

The Society concluded that there is a shortfall of coronary-care beds, and waiting periods are excessive.

The Committee believes that systematic reviews are valuable for evaluating accessibility to hospital services, and encourages accurate tracking of waiting lists.

**The Committee concludes there is evidence of problems in acute-care hospitals that threatens accessibility to services, particularly in large urban centres. The Committee believes it is necessary to "sound the alarm" in order to prevent a generalized crisis. These concerns are urgent and must be addressed by governments and involved groups within the health-care system.**

# CHAPTER 3:
# PROPOSED FEDERAL INITIATIVES FOR HOSPITAL SERVICE DELIVERY

*The Constitution Act, 1867*, states in section 92(7), "the Establishment, Maintenance and Management of Hospitals...," is an exclusive provincial responsibility. Under the hospital insurance scheme initiated by the federal government, all provinces provide insured hospital services for their residents. While health is a function assigned to the provinces, the federal government provides funding in accordance with the *Established Programs Financing Act, 1977* on condition that the delivery of health-care services accords with the federal stipulations described in the *Canada Health Act*.

The Committee in its study has been fully aware of the limited role of the federal government in the delivery of hospital services. However, we assert that significant federal assistance can be directed to the provinces, especially in a collaborative fashion, to enable the provinces to continue to deliver quality services. The federal government must maintain a strong presence in order to guarantee national program objectives. Thus, the Committee recommends federal initiatives for hospital service delivery in the balance of this chapter, and federal policy initiatives in Chapter 4.

**Human Resource Planning**

The successful provision of quality acute-care hospital services depends on an adequate supply of health-care providers. Witnesses noted that effective human resource planning is a key factor in providing accessible hospital services. While many recommendations have been made in this area, few have been implemented. This appears to be the result of a lack of coordination of initiatives at the provincial level, and limited federal leadership.

Approximately eight per cent of the Canadian labour force is directly or indirectly involved in the health-care system. The hospital sector is highly labour intensive, with wages comprising more than 70 per cent of operating budgets.

Nursing is the largest occupational group in our health-care system, with salaries accounting for approximately 30 per cent of total hospital costs.

Despite steady growth in the number of practising nurses, shortages persist and are predicted to increase in the future if immediate action is not taken. Shortages have affected remote geographical areas as well as the specialty areas. The situation is critical during night and week-end shifts, holiday periods and in large centres — Montreal, Toronto and Vancouver.

The Canadian Cardiovascular Society cites nursing shortages as a cause of surgical delays. Bed closures in Montreal are attributed to nursing shortages.[16] British Columbia reported 353 nursing vacancies in September 1989.[17] Toronto identifies a nursing vacancy rate of over twice that of the rest of Ontario.[18] The Health Sciences Centre in Winnipeg expresses similar concerns: "...we lose those well trained individuals to other provinces and other facilities...the working environment has to be examined seriously."[19]

The CNA noted that the demand for nurses has grown in response to factors such as the increase in severity of illness, changes in illness patterns and treatment practices, and demographic shifts.

> Canada-wide, nursing hours per patient-day increased from 3.3 hours during the early 1960s to over 5 hours during the late 1970s; nursing hours per surgical procedure increased from less than 9 to 11.5 hours; nursing hours per delivery in the obstetrical suite increased from 11 to 21 hours.[20]

Witnesses claimed work dissatisfaction is a major factor affecting the retention of nursing staff. The CNA stated:

> The most frequently cited dissatisfiers in the hospital workplace were lack of adequate staffing to ensure quality care, too many non-nursing duties, lack of involvement in organizational decision-making, lack of educational opportunities, and inflexible work schedules. Factors causing dissatisfaction also included salaries and benefits, opportunities for career mobility, respect from colleagues in nursing and other disciplines, recognition of nursing's contribution to patients' well-being, and the limited ability to practice as a professional.[21]

and

> ...the other part of that is what we call the "nurse-ella" syndrome. After a certain hour, a nurse can suddenly do all sorts of things that she cannot do before those hours. The demarcation line is when the people who normally do those things go home and refuse to work, or are not scheduled to work those shifts. Many hospitals still have nurses being pharmacists in the evening.[22]

Shortages of nurses, caused in part by discontent within the profession, has affected accessibility to hospital services. Solutions have been identified by the nursing profession, for example:

1. Implementation of recommendations of provincial reports that address nursing morale and working conditions in areas such as: developing strategies for staff retention; building flexibility into scheduling; expanding the role of nurses; developing acceptable nursing workload measurement systems; undertaking impact analysis to determine the effects on nursing requirements before new or expanded programs are started; increasing compensation; increasing job sharing or other reduced work-week options.

2. Creation of alternative nursing systems in hospital and community settings. For example, a United States study found that the use of a clinical nurse specialist in the care of very low birth weight infants resulted in earlier discharges at savings of $18,000 (US) per infant.[23]

3. Development of nursing workload measurement tools to reflect nursing practice and patient needs.

4. Formation of demonstration projects to illustrate and evaluate changes in hospital management practices. For example, a recently announced Newfoundland project in primary nursing care could be used as a protype:

> The purpose of the project is to demonstrate that a measurable improvement in health status of communities in Newfoundland can be effected through provision of primary health care services managed and provided largely by nurses.[24]

**The Committee recommends that the federal government establish a National Health Human Resource Planning Council to provide direction and leadership in the implementation of solutions to address the issue of nursing shortages. This body must work in collaboration with the provinces and professional associations.**

As well as nursing shortages, most provinces report shortages of physiotherapists, occupational therapists and speech therapists. A federal-provincial report on rehabilitation personnel (June 1988) stated there were serious shortfalls in all of these groups.[25] Projected shortages for 1991 were reported to be 8.2 per cent, 16.3 per cent and 11.6 per cent respectively.

Several recommendations were presented: expanding enrolment quotas of rehabilitation education programs; minimizing immigration barriers for qualified workers; facilitating re-entry into practice; improving the level of job satisfaction; and examining alternative means of delivery of rehabilitation services.

Another area of concern is shortages of specialized medical technicians. For example, the September 1989 cutbacks in cancer treatment at the Toronto Princess Margaret Hospital were in response to acute shortages of radiology technicians.[26]

While the Committee appreciates the primary importance of physicians in acute-care hospitals and their influence on the issue of accessibility, it is a large and complex problem which the Committee does not feel it can adequately study within the context of this report.

Witnesses addressed the need for human resource planning to address the problem of accessibility. Mr. Gamble stated:

> We need improved manpower planning. The successful development of new models of health care service provision, including the future provision of appropriate institutional acute care, will depend on an adequate supply of appropriately trained health care providers.[27]

Professor Angus, Department of Community Health and Epidemiology, Queen's University, remarked:

> Government has to deal with the whole issue of coordinated labour planning. At present, decisions regarding the supply and training of health care professionals are largely the responsibility of educational institutions and provincial ministries of education.[28]

**The Committee concludes that shortages of available nurses and other groups has affected accessibility to acute-care hospitals. The Committee reiterates its recommendation to establish a National Health Human Resource Planning Council to provide direction and leadership in the implementation of solutions to address the issue of manpower planning in the hospital environment. This body must work in collaboration with the provinces and professional associations.**

**Accessibility to Acute-Care Beds in the Context of an Aging Population**

The aging of the Canadian population and its effect on the health-care system has been the focus of much research and analysis. Those over 65 years of age are the heaviest users of the health-care system, which raises concern about the appropriateness of the system's structure and our ability to finance the future delivery of health and hospital services for this group.

Today, approximately 11 per cent of Canadians are 65 years or older. As can be seen in Figure 1, this is expected to increase to approximately 13 per cent by the year 2001 and to over 20 per cent by the year 2026. At current fertility and immigration rates, the percentage of the population over age 65 would level off after 2026, as indicated by Dr. Murphy.[29]

A 1984 Woods Gordon study predicted that, if current delivery patterns of care continue, population growth and aging would result in an average extra annual spending growth of 1.4 per cent through to the year 2021. The study also identified the need for an additional 118,000 hospital beds and 276,000 long-term care beds by 2021.[30]

A witness referred the Committee to a federal government publication:

> ...unless alternate measures are taken, the single factor of the aging of the population would, itself, result in every existing hospital bed being filled by someone over the age of 65 by 2031. Statistics Canada has recently reiterated this, forecasting that by the year 2036, Canadians will require 100 million bed days per annum compared with 41.5 million in 1984 and that 90 per cent of that increase will be due to the elderly.[31]

Compounding the problems of some hospitals is the high proportion of elderly in large urban centres. Mr. Marcoux stated:

> The number of elderly Montrealers increased from 10.8 per cent of the population in 1981 to 12 per cent in 1986...it is estimated that Montreal's elderly will account for 17.2 per cent of the city's population by 1996.[32]

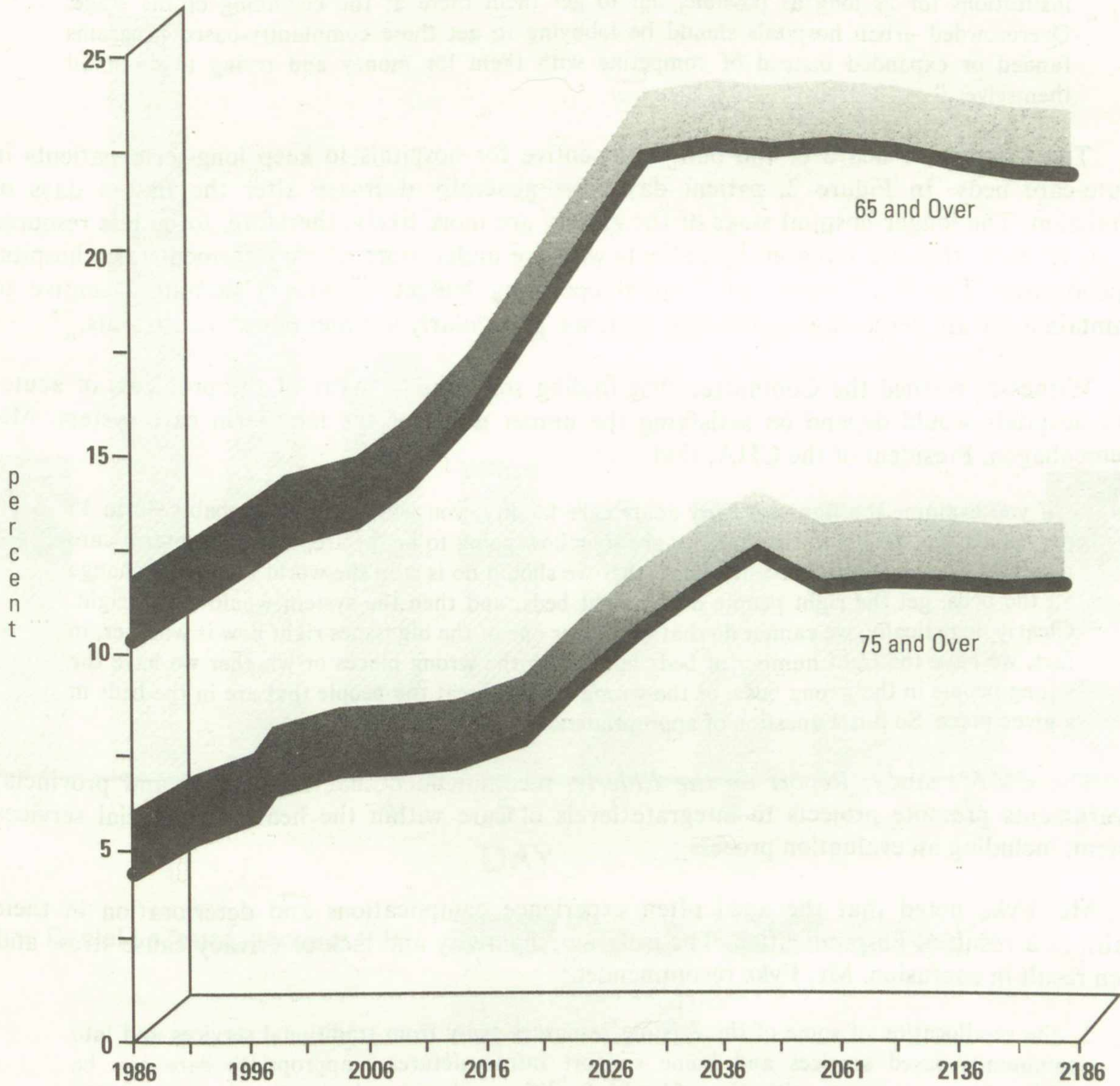
Evidence is clear that persons 65 years and older use a large number of acute-care services. Representing only 11 per cent of the present population, the elderly consume more patient days in general hospitals and have lengths of stay twice that of other groups. The Canadian Hospital Association (CHA) remarked:

> Projections suggest that by 2001, 51.8 per cent of hospital patient days will be used by persons over 65 years of age. Currently over 25 per cent of admissions to acute care facilities are for people over 65 years of age...as the older segment of the population increases, cost pressures will increase because more older people will need care and because older people require more care for longer periods of time.[33]

Within the group over 65 years of age, there are wide variations in health and social services requirements. After the age of 75, and particularly after 85, chronic disease and disability grows and costs to the health-care delivery system increase rapidly. A dramatic increase in the utilization of acute-care hospital services occurs in the short period before death. For example, it has been estimated that approximately 75 per cent of all health-care expenses occur in the last 6 months of life.[34]

# Figure 1

## The Older Old




Percent of Population 65 and older and 75 and older

Source: Health and Welfare Canada,
Charting Canada's Future: A Report of the Demographic Review.
December 1989

Hospitals complain that too many acute-care beds are being occupied inappropriately by patients awaiting transfer to chronic and extended-care facilities or they are unable to go home because of inadequate home and community support systems. The pejorative term "bed blockers" is often used to describe these beds, estimated at from 10 per cent to 20 per cent.

Professor Angus stated:

> Expanded home services are needed to empty what we pejoratively call "bed blockers"...Remember that the name of the game should be to keep people out of acute-care institutions for as long as possible, not to get them there at the beginning of the stage. Overcrowded urban hospitals should be lobbying to get those community-based programs funded or expanded instead of competing with them for money and trying to do it all themselves.[35]

The Committee heard of the built-in incentive for hospitals to keep long-term patients in acute-care beds. In Figure 2, patient day costs generally decrease after the first 4 days of admission. The longer hospital stays of the elderly are more likely, therefore, to be less resource intensive. Beds that are replaced by patients who are under more active treatment raise hospital expenditures. The fixed nature of hospital operating budgets creates a definite incentive to maintain a certain percentage of low-cost patients, particularly in times of cost constraints.

Witnesses warned the Committee that finding solutions to many of the problems of acute-care hospitals would depend on satisfying the unmet needs of the long-term care system. Ms. Clemenhagen, President of the CHA, said:

> ...if you examine the figures at any acute care facility, you will find that probably 30 to 35 per cent of the people in that facility are somehow going to be, or are, really long-term care patients...Somebody said recently that what we should do is stop the world for a day, change all the beds, get the right people in the right beds, and then the system would be all right. Clearly, logistically, we cannot do that. However one of the big issues right now is whether, in fact, we have the right number of beds but just in the wrong places or whether we have the wrong people in the wrong beds, or the wrong staff to treat the people that are in the beds in a given place. So it is a question of appropriateness of care.[36]

The CMA's study, *Report on the Elderly*, recommended that the federal and provincial governments promote projects to integrate levels of care within the health and social services system, including an evaluation process.

Mr. Fyke noted that the aged often experience complications and deterioration in their health as a result of hospitalization. The isolation, inactivity and lack of privacy cause stress and often result in confusion. Mr. Fyke recommended:

> ...the re-allocation of some of the existing resources away from traditional services and into community-based services and home support infrastructures ...appropriate care can be achieved by appropriate utilization of health facilities, rather than by increased acute care.[37]

Steps need to be taken to develop the following: day care facilities; day hospitals; temporary nursing-care beds; rehabilitative programs; and home psychogeriatric programs.[38]

The Ministry of Health (Saskatchewan) noted the significant effect of community alternatives on the needs of the acute-care system.

## Figure 2

# COMPONENTS OF PATIENT DAY COST

TOTAL RESOURCE USE

1 2 3 4 5 6 7 8 9 10

DAY

**Source: Daniel LeTouzé, January 1990**

ADMISSION/ DISCHARGE

THERAPEUTIC/ DIAGNOSTIC

CUSTODIAL/ HOTEL CARE

> Emphasizing community-based alternatives to inpatient care can reduce pressures on the acute and long-term care systems to expand institutional care capacity.[39]

Saskatchewan remarked that the establishment of their Home Care Program, for example, in 1986 has been effective in removing the necessity for institutionalization, or in significantly delaying it, for approximately 20,000 of the province's elderly and disabled.

The Honourable Perrin Beatty, Minister of National Health and Welfare, stated:

> Clearly, the federal government does have a role to play...in terms of ensuring that there are support structures in the community to make it possible for people to manage.[40]

The New Brunswick Extra-Mural Hospital (the Hospital) is an example of an innovative program emphasizing community-based alternatives to in-patient care for the elderly, the disabled and the terminally ill. The Hospital was established in 1981 under the New Brunswick *Public Hospitals Act* in response to factors, such as: population growth; escalating construction costs; increasing costs in the high-technology hospitals; and changing patterns of disease away from short-term acute illness towards long-term degenerative conditions.

The goals of the Hospital include: providing an alternative to hospital admission and delaying admission to nursing homes; facilitating earlier discharge from an institution; providing long-term, continuous care; and encouraging provision and coordination of support services.

The Hospital comprises 14 local service delivery units. The central administration is in Fredericton, while each local unit is managed by a unit coordinator who is a health-care professional, such as a nurse or a therapist.

As of January 1990, the Hospital was caring for 1,800 patients with a *per diem* cost of thirty-four dollars per patient. The total operating budget for the past fiscal year was $14 million. Dr. Ferguson stated:

> ...we try to cost less than half of a nursing home day or half of a hospital day, if it is a hospital replacement. If it costs us $150 per day to keep a patient out of a $400 per day hospital bed, then that is a very good bargain.[41]

The Hospital has a special relationship with physicians.

> This is rather incongruous because they are asking for privileges to look after their own patients in the patient's home, but it also means they are able to use our resources in looking after these patients. They also have the advantage of having our professional staff report to them on a regular basis...Medicare in New Brunswick has been very understanding. Fees have been introduced which apply to Extra-Mural hospital patients and not to other patients.[42]

How does the Hospital impact on acute-care hospital costs? While this program is costly in the short term, it eases the burden on acute-care hospitals.

> We speed the "through-put" of patients through a hospital. That increases hospital costs...Any other method of increasing the through-put of patients through the hospital system would involve the construction, equipping and maintenance of new beds.[43]

As Dr. Ferguson indicated:

> The government made it clear...we would not be used to close beds...the Extra-Mural Hospital would be used as a means of making the existing complement of beds go further...be sufficient for a longer period of time...and thus reduce the number of new beds which would have to be built.[44]

Relations with New Brunswick's acute-care hospitals are excellent. The New Brunswick Hospital Association passed a resolution urging the government to complete the establishment of the Hospital model across the province as a priority.[45]

The Committee supports initiatives, such as the New Brunswick example, because such initiatives encourage a more appropriate distribution of resources between the institutional and community-based sectors. **The Committee recommends that the federal government make it a priority to fund projects that incorporate alternative approaches to the delivery of health care. The Committee encourages Health and Welfare Canada to provide a Health Innovation Fund of at least $1 million a year over a period of five years, to stimulate and evaluate pilot projects related to alternative delivery approaches.**

Finally, witnesses noted the potential effect of the proposed Goods and Services Tax (GST) on the provision of home and community support services for the elderly. Several national health associations addressed the impact of the GST on health delivery systems in presentations to the House of Commons Standing Committee on Finance in the fall of 1989. It was noted at that time that this specific federal taxation instrument may potentially erode the financial position of hospitals, nursing homes and home and community support systems.

The Department of Finance has announced that there will be no additional tax burden on the hospital sector as a result of the GST because hospitals will receive a rebate on the tax paid for services. However, because hospitals provide some taxable and some tax-exempt supplies (health-care services), many feel it is inevitable that they will be faced with an added administrative financial burden.

Nursing homes and other organizations providing health-care services will be subject to the GST and will not be eligible for the rebates available to public hospitals. Although private nursing services offered to such institutions and in the home will be tax exempt, the GST may create a disincentive in some cases to deinstitutionalize. For example, individuals requiring special services other than nursing care, which are necessary to remain in the community (with the exception of Meals-on-Wheels, which is tax exempt), will be subject to payment of the GST.

In responding to a question on the effect of the GST, the CNA commented:

> ...unless the definition of "taxable base" extends to new, innovative kinds of programming not attached to the current definition of a hospital, we are going to see the hospital being the umbrella for everything that exists because that is the only way to get the greatest tax base...you will have a tax system which will be far less advantageous to community health centres and institutions which are not bona fide hospitals.[46]

Thus, members of the Committee express reservations as to the benefit of this form of taxation as it might affect alternative health-care services.

**Utilization Management**

Utilization management refers to a proactive joint medical staff-management process in which a hospital continually works towards maintaining and improving the quality of care through effective use of resources.[47] Cost constraints and funding shortages have put increasing pressure on hospital administrators and funding bodies to examine the cause-effect relationship between hospital service delivery and subsequent results.

In November 1989, the Ministry of Health (Ontario) hosted a conference in Toronto on "Quality Assurance and Effectiveness in Health Care." In addressing the conference, Chair Jonathan Lomas stated that the primary objective of health and hospital care should be to improve or maintain the population's health. The second objective should be to strive to achieve technical competence, accessible services, efficient institutions and patient satisfaction.

Studies have indicated that from 10 per cent to 20 per cent of procedures performed in the health-care system are unnecessary and inappropriate. The key to effective utilization management is to identify the 10-20 per cent and eliminate it. For example, the July, 1989, *New Brunswick Report of the Commission on Selected Health Care Programs*, stated that:

> Too much attention has been given to providing the resources for health services, such as personnel, buildings and equipment, with not enough going to outcomes and results.[48]

The Honourable Perrin Beatty stated:

> There is a growing consensus among experts and among politicians that the problem is not the amount of funding in the system, but the appropriateness of the care we fund...there is increasing evidence that all care may not be equally appropriate.[49]

Mr. Fyke noted that inappropriate utilization was found to be the result of ineffective physician practices, inefficient hospital operations and the lack of alternative services.[50]

Mr. Gamble stated: "...(there is) a need to ensure that the most appropriate service is being provided at the most appropriate site for the health needs of the local population."[51]

The following strategies for appropriate technology utilization have been proposed by R.N. Battista and cited by both the CMA and the CNA:

> Include equipment costs in the hospitals budget; encourage acute care hospitals to share expensive equipment; allocate expensive new technologies to specified facilities; reorganize acute care delivery to encourage the adoption of cost saving technologies, and involve physicians more directly in the institutional budgeting process.[52]

Issues related to utilization must be addressed, for example: the down-sizing of hospital systems; accelerated shift to out-patient care; continued increase in public expectations; and focus on measuring outcomes of care. In responding to these problems, initiatives have been undertaken to develop outcome-oriented indicators of quality. The CHA stated that, in conjunction with the CMA, CNA, the Long-Term Care Association, and the Standards Association, it recommended that the Canadian Council on Health Facilities Accreditation develop and validate outcome-oriented indicators of quality for high-volume, high-risk, problem-prone areas of care.

The Ministry of Health (Saskatchewan) has recommended that funding be available at the federal level to increase efforts to address quality assurance through utilization management of health-care services.[53]

**The Committee surmises that sharing of information is critical to the implementation of comprehensive and systematic evaluations of hospital service outcomes. The Committee recommends that the federal government co-sponsor, in collaboration with provincial governments, conferences on utilization management.**

**Medical Technology Assessment**

The recent increase in the use of medical technology has created a set of ethical, legal and financial problems. Although some technologies have lowered health-care costs through preventive, rapid and effective treatment, others have raised costs significantly.

Acute-care centres are increasingly concerned about the growing capital and operating costs of new technology. In the Coopers and Lybrand national study almost 40 per cent of the 320 administrators surveyed said that medical technology is not worth the cost because it does not improve the outcome for patients. The report forecasts the need for more cost-benefit analyses in the future.[54]

The cost of medical technologies has not been adequately studied in Canada. A team of researchers at McMaster University underlined the need for a systematic process of medical technology assessment and evaluation in view of the following findings: technologies are often accepted for general use without evaluation; technologies that have been evaluated and accepted for use on this basis are often utilized for conditions beyond those covered by the evaluation; and situations exist in which utilization of some technologies is not cost effective in that an equally effective and lower-cost technology exists but is not utilized.[55]

Complicating this are competing influences from new technologies, for example: consumers expect that modern medical technology will be available and accessible and will be used by their physicians; physicians are concerned about providing good care while minimizing the possibility of litigation due to errors in diagnosis and treatment; and hospitals and governments are concerned about the capital and operating costs of new technologies.[56]

There are few incentives in the system for either appropriate diffusion or utilization of medical technology.

> Without implying any maliciousness, it does seem fair to say that the vested interests of manufacturers, hospital administrators, physicians and consumers (both individually and collectively) all reinforce tendencies toward technology expansion.[57]

Dr. Deber of the Department of Health Administration, University of Toronto, suggests that any medical technology intervention promising increased benefits for no increased costs should be adopted; any sacrifice of benefits without a cost advantage should not be adopted.[58] When the costs and benefits of two alternatives are identical, the choice is a toss up without major consequence, except to the suppliers of the alternatives. The tough choices therefore are: how

much cost should be paid for how much increased benefit, and how much benefit should be sacrificed for how much of a cost savings? Dr. Deber stated that there is a special need for incentives in making these tough choices.

The CHA indicated:

> Each technology has cost implications — both direct purchase costs and utilization costs. Evaluating the appropriateness of technology diffusion and utilization is methodologically difficult but must be addressed. The significant cost impact of health technology, 'high tech' and 'low tech', particularly technology with uncertain benefits, requires a conservative approach to diffusion based on the results of individual scrutiny and evaluation. The current movement towards Technology Assessment Councils, both provincially and nationally, is very positive.[59]

Saskatchewan reported the creation of a Medical Technology Fund to assist hospitals with the acquisition of high-cost medical technology and the development of a national coordinating office for technology assessment.[60] Quebec, Ontario, Saskatchewan and British Columbia have recently established provincial medical technology assessment bodies.

A national effort in this area has led to the creation of the Canadian Coordinating Office for Health Technology Assessment, which is an independent corporation headed by a board of representatives from the federal and provincial health ministries. The annual budget will be shared between the provinces and the federal government. The office will be located in Ottawa. The terms of reference are attached (see Appendix 3).

The CMA remarked:

> ...the newly created Canadian Coordinating Office for Health Technology Assessment will provide information and a framework that can be used by policy makers and other decision-makers in the dissemination and use of new and old diagnostic and therapeutic technology.[61]

**The Committee concludes that the establishment of a Canadian Coordinating Office for Health Technology Assessment is an important innovation, which it welcomes. The Committee supports the outlined functions and objectives of the Office, but expresses reservations about the adequacy of its annual budget ($500,000).**

# CHAPTER 4: PROPOSED FEDERAL POLICY INITIATIVES

Federal policy initiatives are limited by the jurisdictional nature of the delivery of health-care services. However, there is an array of strategies available to the federal government to foster accessibility to hospital services. Recommendations for implementing these strategies will be reviewed below under the headings; funding, leadership, and legislation.

**I: Funding**

a) *Established Programs Financing*

The "spending power" of the federal Parliament is nowhere explicit in the *Constitution Act, 1867*, but is inferred from the powers to levy taxes (s.91(3)), to legislate in relation to "public property" (in section 91(1A)), and to appropriate federal funds (s.106). *The Established Programs Financing Act, 1977* (the Act) establishes the authority for the federal transfer of funds to the provinces in support of three cost-shared programs: hospital insurance, medical care and post-secondary education.

In 1982 with the passage of Bill C-97, the name of the Act was changed to the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act* (EPF Act).

The EPF Act, as amended in 1982, provides for a predetermined level of financial support from the federal government to the provinces. The amount is based on the rate of change in the gross national product (GNP). Currently, all provinces receive equal per capita transfers, comprised of a mix of cash payments and tax points.

Federal programs aimed at reducing the deficit have limited the growth of federal transfers. In 1986, Bill C-96, *An Act to amend the Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act,* decreased the rate of growth from approximately seven per cent to five per cent for the period ending 1991. This change was estimated to result in a reduction of over $4 billion for the period 1986-91.

In the April 1989 budget, the government announced a further one per cent reduction in the rate of growth of EPF transfers. Federal expenditures were expected to be lowered by $200 million in the first year, with increased savings in future years.

On February 20, 1990, Finance Minister Michael Wilson, announced a two-year freeze on EPF transfers to the provinces at the current level of $755 per capita. In addition, Ontario, Alberta and British Columbia will have increases in their social programs, under the Canada Assistance Plan, limited to five per cent a year for two years. The federal government reported that the freeze will save $870 million in the first year and $1.7 billion in the second. After 1992-93, the government intends to limit EPF growth to the rate of growth of GNP minus three per cent.[62]

Witnesses expressed concerns regarding these events. In particular, there is apprehension that the April 1989 announcement of a further one per cent reduction in transfers will create added hardships for the provinces and ultimately acute-care hospitals (Figure 3).

The Ministry of Health (Saskatchewan) wrote:

> The health component of EPF transfers has not kept pace with increases in provincial health expenditures, placing ever-increasing demand on provincial allocations.[63]

The Ministry of Health (British Columbia) reported they would have received an additional $268 million if federal transfers had kept pace with provincial expenditures.[64]

The CHA noted:

> The cumulative loss which the provinces have already experienced from 1986/87 to 1989/90 due to the 2 per cent reduction in EPF growth is $2.6 billion. The projected cumulative loss to the provinces from 1990/91 to 1995/96 due to the combined 3 per cent reduction in growth is $19.4 billion. The overall cumulative loss to the provinces from 1986/87 to 1995/96 totals $22 billion...The current situation with respect to EPF is one of no growth...The logical conclusion drawn from the progressive shifting of responsibility from the federal government to the provinces is that the federal government is withdrawing from its role in health care.[65]

Witnesses emphasized the importance of a strong federal presence in the funding of health care and the maintenance of national objectives. Dr. Horne of Corporate Planning and Development, Health Sciences Centre, Winnipeg, stated:

> The federal government is the co-financier of the system and its historic role has produced what Malcolm Taylor called the "steering effect" on the health care system...The federal cash is, in a sense, the glue that binds the system together and I think it is something that should be maintained. There is likely to be ever increasing criticism of the federal attempt to manage the deficit through reduction in the escalator of transfers to the provinces for health and education.[66]

Professor Contandriopoulos of the Department of Health Administration, University of Montreal, stated:

> ...if the funding decreases and the legislative constraints become too onerous, there is, in my opinion, a serious risk of greater provincial autonomy with respect to the four major principles.[67]

Mr. Fyke noted:

> I believe the federal government must continue to transfer payments to provincial governments at a level which maintains equity and fairness across Canada and allows the provinces to maintain total health spending at the current level of GNP.[68]

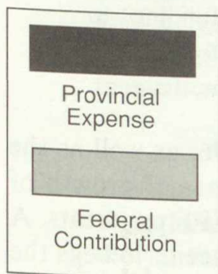
Testimony underlines the importance of a strong federal presence, maintained through its funding mechanism. Without this presence, national goals such as accessibility will be in serious jeopardy.

This concern was heightened by recommendations from the Quebec Hospital Association (QHA) favouring the introduction of user fees.

## Figure 3
## Federal and Provincial Health Expense
## as a Percent of Total Health Spending

***Source:*** *Canadian Hospital Association, Position paper, Impact of the 1989 Federal budget changes to EPF, July 1989*

**Note:** *Internal document unpublished*



The Canadian health system is therefore in a bind. On one hand, demand for services, as a result of the aging population and technological developments is growing all the time. On the other, in the present context, governments cannot increase their own contributions and adequately meet the public's need for hospital services.

The Association (QHA) therefore believes that it is imperative to diversify the sources of funding for the health and social services system and that to this end, private contributions increase relative to public funding. Diversifying the sources of funding in no way calls into question the principle of universality. This principle is fundamental and any new source of funding will necessarily take account of the user's ability to pay.[69]

As well, the QHA suggested several hospital service items that could be privately charged if the *Canada Health Act* was altered to allow them to do so without financial penalties.

**The Committee recommends that the federal government reconsider its policy of containment of EPF transfer payments with respect to hospital and medical services, and, in consultation with the provinces, seek an acceptable compromise in order to maintain a strong presence in the delivery of health-care services.**

While witnesses supported the objectives of the *Canada Health Act* and stressed the importance of the federal government's role in the funding of the health-care system, they expressed anxieties over the containment of EPF transfer payments and the EPF system of block grants from the federal to the provincial governments. Dr. Horne stated:

...With the shift to block funding in EPF, I think there is increasing recognition that the federal lever is much shorter and less effective...and is at serious risk of becoming completely ineffective...[70]

Block funding provides the provinces with the legal right to make a judgement that would have EPF cash transfers used for some other purpose. Thus, any savings that can be generated by reducing a service would accrue to the province and that saving could then be redirected to other provincial projects. Because provinces are experiencing great pressure related to the use of their limited fiscal resources, there is a growing concern that they will use their discretion in ways that could undermine the national character of the system.

The CNA stated:

If the federal government were to put some funds behind its enunciated policy of Health for All — A Framework for Health Promotion — ...if it were to put some transfer funding...to implement these programs, the provincial governments could use that funding to build sea ports or dry docks...[71]

The amendments to the EPF Act described in 1986 with the passage of C-96, as well as the April, 1989, budget announcement of a further one per cent reduction in the rate of growth of EPF transfers, has the effect of reducing or containing the health component of EPF payments. A shrinking cash transfer suggests evidence of a shrinking federal presence. Such a scenario begs the following question: how will a diminished federal appearance impact on the use of EPF to maintain our national program of health care or, will all Canadians have access to a high quality health-care system, regardless of their financial means?

Despite responsibility for health care being assigned to the provinces, the system has been shaped by a national commitment to excellence, and by national objectives. The objectives regarding the financing of hospital and medical care are and have always been clearly identified as being: accessibility, universality, portability, comprehensiveness and public administration.

Accessibility has been the focus of our study. This objective can not always be fully realized because of factual circumstances, such as great geographical distances to facilities. Disturbing evidence has been presented to demonstrate a potential threat related to policy decisions rather than circumstantial realities. For example, the QHA recommends favouring the introduction of user fees because it believes it is necessary to diversify the sources of funding for the health and social services system.

The CNA asserted:

> In addition we are concerned about the nature of the strength of the federation:..If we do not have a strong national presence and strong national standards, will there truly be even more "haves" than "have-nots" and will we be further into a two-tiered system?[72]

The Committee believes that attention must be focused on two potential perils to our national policy of health care: unconditional block funding, and legislative impediments to the articulation and application of the national objectives. **The Committee recommends that the relevant program areas relating to hospital insurance and medical care be clearly identified for federal government EPF transfer payments, while at the same time recognizing the constraints of the *Constitution Act, 1867*. The Committee further recommends that national objectives, such as accessibility, should not be jeopardized by constitutional amendments.**

b) *Capital Funding*

Capital funding of hospitals refers to the money that is available for the purchase of physical plants and equipment. It is often referred to as building or equipment capital.

Witnesses addressed the need for increased levels of capital funding for many acute-care hospitals in Canada. The situation in large urban areas appears urgent.

Mr. Marcoux noted:

> A recent study (in Quebec) puts the annual cost of maintaining all types of equipment at $175 million. At present, only $25 million is allocated for this purpose, barely 14 per cent of the amount required...The system manages to survive today with the help of hospital foundations.

and

> Users have lost some confidence in this equipment and feel that anywhere from 25 to 40 per cent of the units should be replaced as soon as possible... The current rate of replacement corresponds to a lifespan of 40 years...average equipment lifespan is 10 years at most.[73]

The CHA referred to a study conducted six years ago:

> There was a need for $24 billion over the next 10 years merely to maintain the capital stock. This would mean an expenditure of $2.42 billion per year. The 1981 actual expenditure was $1.66 billion and in 1982 it was $1.7 billion. CHA estimates that there is a shortfall of at least $770 million each year in the maintenance of health care facility capital stock, without even considering modernization and expansion requirements.[74]

The Chair of the CMA's committee on hospitals noted that his hospital had been assigned $1 million for medical equipment next year, while the amount required to replace the needed equipment was estimated to be $18 million.

Mr. Gamble noted a shortfall of approximately $250 million for capital needs.

> This enormous difference between the identified capital needs of the industry and the availability of capital funds from the provincial government has led to intense competition between the hospitals in Toronto and has resulted in massive capital fundraising campaigns. We have approximately $600 million worth of fundraising going on at any given time in metropolitan Toronto for hospital capital projects.[75]

**The Committee concludes that the reported inadequacy of capital funding of hospitals in many areas of Canada must be addressed by the proposed National Health Care Advisory Council, to ensure that buildings and equipment are maintained in order to provide quality care.**

c) *Research Grants*

Research grants at the federal level for health-care delivery issues are allocated primarily through the National Health Research and Development Program (NHRDP) at Health and Welfare Canada, the Natural Sciences and Engineering Research Council (NSERC), the Social Sciences and Humanities Research Council (SSHRC) and the Medical Research Council (MRC).

The Honourable Perrin Beatty suggested that it is appropriate for the federal government to provide funds for research in the area of hospital service delivery. He stated NHRDP is putting large amounts of money into health delivery issues.[76]

However, an examination of NHRDP research awards for the period 1988-89 revealed that only 5.3 per cent of total awards of $26.5 million are directed to hospital delivery issues. There were no awards granted in 1988-89 by NSERC in the area of hospital management, despite a total annual research budget of $240 million. Finally, MRC has no history of funding research in this area. Similarly, it was concluded that grants awarded under SSHRC were almost non-existent in a budget of $84 million.

Witnesses spoke of the potential benefits of increased research grants directed to hospital service delivery areas. Professor Contandriopoulos stated:

> I add...the importance of the federal government's continued role...in all areas of research. It should continue its role, particularly in research on the relationships between welfare, economic development, health and the health care system.[77]

The CNA noted:

> There exists a fundamental need to recognize the value of nursing research, both basic and applied, for the improvement of quality care and the appropriate utilization of resources...For 10 years we have lobbied, together with the Canadian Association of University Schools of Nursing, for increased funding for research and research training within the existing federal structure.[78]

As described above, research is lacking in the areas of utilization management and medical technology. There is a growing need at the national level to determine and measure the value of the health oriented outcomes. Federally funded research directed to such an evaluation would be a significant contribution to the challenge of effective delivery.

**The Committee recommends that federal granting bodies (for example, the Medical Research Council and National Health Research and Development Program) give priority to the funding of research related to hospital service delivery issues.**

**II: National Leadership**

a) *Health Promotion*

Virtually all of the witnesses commented on a wide recognition of the close relationship between social, economic and cultural factors as determinants of health status. However, there is a lack of consensus about the role hospitals should play in health promotion initiatives. The House of Commons Standing Committee on Health and Welfare Canada noted in their Interim Report on the Canadian Health-Care System:

> ...hospitals should be considered to be among the health promoters in Canada, and that incentives should be provided to assist institutions in providing health promotion.[79]

Mr. Fyke noted:

> Hospitals and the acute care they offer, are but one part of our internationally admired health care program. Canada has focused on the treatment of illness rather than outcomes of health. Attention to health promotion and prevention, lifestyle counselling, health public policy, and community and home support offers greater potential to impact the health of Canadians than does a limited focus on the treatment of illness.[80]

Similarly, the CNA asserted:

> While it is important to attend to the problems of the illness system through innovations, it is equally important to refocus the system to a better balance of illness care, rehabilitation, prevention and promotion.[81]

The Honourable Perrin Beatty stated:

> The federal government has a very real constitutional role to play in the area of health promotion...[82]

**The Committee believes that more national involvement is needed to educate the public on health matters. The Committee recommends that the federal government provide funds targeted for innovative pilot projects in the area of health promotion.**

b) *National Health Objectives*

A rational approach to resource allocation must take place within the context of a national health policy and a set of national health objectives. The CHA stated:

> Health objectives target specific improvements in the health status of the population and can also include specific objectives for sectors such as the institutional sector. The Canadian Hospital Association believes that specific, measurable national health objectives can be set and policy implemented around these objectives. The association deplores the lack of established mechanisms at the national level to set health objectives and measure achievement. The Association has repeatedly called upon Health and Welfare Canada to lead, in collaboration with other levels of government and health care associations to define specific, measurable health objectives for Canadians...[83]

Dr. Horne noted:

> The health goal-setting exercise...will identify the limits of intervention, or at least the limits to improvement in population health and child health...Also, it will put into perspective what can reasonably be expected from the use of more hospital beds, more technology, more nurses and more doctors.[84]

Some provinces have included the setting of health objectives in their strategic planning processes in an effort to improve the efficiency and effectiveness of health-care delivery in their province. For example, the *Ontario Health Review* of 1987 proposed the following goals: to achieve equity in health opportunities; to enable the people of Ontario to achieve their health potential; to increase their health expectancy; and to provide services and create public policies that support health; and recommended: a management process that directs resources toward the achievement of health goals; coordination and collaboration among agencies concerned with health; and the appropriate use of technology.[85]

**Given the importance various groups have put on the need to develop national health objectives, the Committee recommends that the federal government give priority to the setting of national objectives, which should be clearly defined and incorporated into health policies.**

c) *Initiatives for Improved Hospital Management*

Management of acute-care hospitals falls within the jurisdiction of local authorities, hospital administrators and provincial governments. The role of the federal government is limited to national co-operative initiatives that assist the provinces in addressing the challenge of hospital management.

Two national cooperative initiatives in this area are the National Hospital Productivity Improvement Program (NHPI) and the Management Information Systems Project (MIS), which merged April 1, 1990. They are information systems that provide management tools for the measurement of hospital productivity and outcome.

The NHPI is a joint, cost-shared federal-provincial and professional program, directed by the Federal-Provincial Sub-Committee on Productivity Improvement. Conducted in collaboration with the provinces, health institutions, health professionals and national associations, the program

includes over 20 workload measurement systems that provide a uniform approach to the quantification of human resource outputs in the hospital setting.

Similarly, the MIS Project is a national co-operative effort of government and provincial hospital and health associations, under the authority of the Federal-Provincial Advisory Committee on Institutional and Medical Services. The Project has produced the MIS Guidelines, which consist of nineteen manuals providing detailed recording standards for management information. The Guidelines help hospitals develop management information systems that forecast more effectively, control costs and utilize resources to their maximum potential. The challenge for hospitals will be to actually use this information in making management decisions.

Witnesses indicated that change is needed at many levels of the system, and incentives must be in place to ensure effective hospital management.

Professor Angus stated:

> The incentive pattern in most existing and organizational reimbursement structures in the health care system actually and perversely encourages the use of more and more costly resources. On the one hand, you have a volume driven or a fee-for-service, and on the other, you have globalized hospital budgets. So you have something that is designed to grow and something that is designed either to be held flat or to decrease, and the twain shall never meet.[86]

The CHA noted:

> Incentives, in a context which permits experimentation, can result in improved utilization of limited resources. To be useful, incentives must be consistent. The current reality which promotes efficiency in policy documents and then almost penalizes efficient health care facilities for their surpluses must be replaced by a policy that consistently rewards high performance organizations and identifies where marginal performers must improve. Management's challenge is to seek efficiencies. These slow the escalation of costs thereby ensuring the availability of resources for future service delivery. In Canada's publicly funded system, governments are in the position to provide consistent incentives to stimulate management to seek efficiencies.[87]

It is predicted that Canadians will increasingly examine management alternatives, such as merging of institutions, in the search for cost-effective, efficient delivery of services.

Mr. Fyke described an alternative approach to delivering hospital care, whereby two acute-care hospitals merged to form the Greater Victoria Hospital Society (GVHS) in order to provide more cost-effective and efficient hospital management. The results of this experiment provide important management information.

The GVHS was incorporated in 1984 and is one of the largest multi-hospital systems in Canada. Acute, intermediate, extended and rehabilitation care services are provided through approximately 1,050 beds spread over 6 geographical sites. Before amalgamation, the two hospitals operated in a competitive and hostile environment, which contributed to unnecessary duplication of services and lack of co-operation.

> Frequent surgical cancellations combined with patients in beds in hallways, sunrooms, treatment rooms and linen closets plus patients who waited in the Emergency Department for

24 to 48 hours prior to being placed in a ward bed, symbolized the problems in the quality of health care these hospitals were providing...There was a mood of crisis in Victoria's health care. As a result, a bold step was taken by government. That step was to amalgamate the two hospitals under one authority.

Amalgamation was a critical step but that in itself is not necessarily the solution to accessibility problems. Amalgamation did create a climate conducive to recruiting highly competent staff and to trying new innovative approaches. Concurrent with amalgamation we at GVHS have attempted to establish a climate of working with our government, our community and our physicians to solve problems rather than blame various parties.[88]

One of the first steps the GVHS took was to identify reasons for inappropriate utilization in their facility and to develop and implement a quality-utilization management program that focused on the severity of the patient's illness.

A criteria based utilization review model developed in the United States by Interqual was incorporated to allow GVHS to perform concurrent comparisons of the clinical characteristics of their patients against an explicit defined set of criteria. The second component is a retrospective evaluation in which the outcomes are compared to peer established norms and standards of care. The retrospective review monitors clinical and utilization outcomes, allowing medical staff quality assurance reviewers and individual physicians to compare the outcomes of cases to norms and standards of care for similar severity ratings by Diagnostic Related Groupings, by medical procedure, by medical department or by individual.[89]

An important goal of the program has been the identification of problems such as the lack of alternatives to acute care. Extensive co-operation was required between the hospital, community health-care providers and the Ministry of Health.

It became evident that a flexible approach to budget allocation was required to transfer resources from the institutional sector to the under developed community and home support care system.[90]

Various initiatives undertaken since 1988 to assist people to stay in their own homes include: the quick response team (nurses and physiotherapists who travel to patients' homes to assess and provide care); expansion of home support services; a community physiotherapy program; initiatives for early hospital discharge and rigorous screening of placements for long-term care.

In 1988, the GVHS, in co-operation with the Ministry of Health and the Capital Regional District, created the Victoria Health Project, to address the question of high institutional rates of elderly persons.

Although the number of frail elderly persons over the age of 70 in the Capital Regional District has steadily increased by approximately 1200 per year, the number of persons requiring institutionalization is actually dropping. There has been a marked decline in the number of elderly persons inappropriately occupying acute care hospital beds, and the waitlists for nursing home placement have reached the lowest point in years. Over the past 18 months, the number of individuals in need of facility care has decreased by 30 per cent, from 1051 to 739....

If we had maintained the utilization patterns of 1983 we would require by this date approximately 90 additional acute beds and approximately 360 additional long-term care

> beds in the Victoria area...we believe that there will be no need to build new hospital or facility beds in Victoria prior to the year 2000 ...a goal has been set to reduce the per cent of persons over age 65 who are in facilities from 6.5 per cent to 5.8 per cent...by the year 2000.[91]

The Committee believes that the GVHS example is an important source of management information that should be shared by the provinces. **The Committee recommends that the federal government, in co-operation with provincial governments and involved associations and facilities, plan a series of conferences to address hospital management issues such as inter-hospital coordination, and to facilitate an exchange of information among interested groups.**

d) *National Health Care Advisory Council*

Numerous organizations have addressed the need for an independent national health advisory body to act as a research and coordinating centre. Given the major problems facing hospitals outlined in the foregoing, such a body has the potential to be effective in preventing the development of a generalized crisis in the health system. It has been suggested that this body should cross jurisdictional boundaries in its endeavour and should advise both federal and provincial governments of its findings, as well as offer direction for the development of national health-care policies.

The CNA recommended the creation of an independent Health Council to advise government on matters relating to health care on a national basis.[92] Similarly, the CHA, in its submission to the House of Commons Standing Committee on Health and Welfare Canada in May 1988 noted that it had advocated the formation of such a body since 1979.

The Health Council of Canada, as proposed by the CHA, would not be another level of bureaucracy; it would be modelled on an organization similar to the Economic Council of Canada, the Hudson Institute and the Institute for Research on Public Policy. This council would be funded through private and public sources.[93]

In 1986, the National Ad Hoc Committee on a Canadian Health Council made the following proposal:

> For many years, a number of organizations have been concerned that there has been little or no coherent effort in Canada to develop a broad set of health priorities and goals and to develop overall strategies and objectives for the achievement of the goals. This has brought about the proposition for the establishment of a health council to carry out policy research, generate and publish findings, evaluate programs, initiate research and establish a broad data base.[94]

The 1984 Task Force on the Allocation of Health-Care Resources also advocated a national health council:

> ...(to) provide direct access for providers and consumers to the political process. The council's mandate would be to identify the key problems related to health, to visualize new horizons, to resolve jurisdictional disputes between providers, to serve as a watchdog to the Federal-Provincial Council of Health Ministers, and to be an overall guardian of the integrity of the health care system.[95]

The Committee believes that such a council would play a valuable research-oriented role in studying many important issues: innovative hospital management; capital funding; utilization management; and incentives related to the appropriate distribution of resources between the institutional and community sectors.

**The Committee recommends that the federal government, in consultation with provincial governments, initiate discussions on the creation of a National Health Care Advisory Council. Such a body would promote research and coordinate assistance to the provinces concerning the many issues related to the efficient delivery of hospital services.**

### III: Legislation

As stated above, the delivery of health-care services is the responsibility of the provinces while the obligation for establishing and enforcing objectives rests with the federal government, as described in the *Canada Health Act* (Act), section 3:

> It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

Financing of the system is provided for under the *Established Programs Financing Act* (EPF). Eligibility for EPF transfer payments is governed by the *Canada Health Act*, section 7:

> ...the health care insurance plan of the province must throughout the fiscal year, satisfy (the) criteria...respecting the following matters:
> (a) public administration;
> (b) comprehensiveness;
> (c) universality;
> (d) portability; and
> (e) accessibility.

Accessibility is defined in section 12(1) of the Act:

> In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province:
> (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;
> (b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
> (c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and
> (d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Accessibility as set forth in section 12(1) is defined solely within the context of removing financial barriers. Section 3 focuses on "reasonable access" in the context of the suspension of financial barriers "or other barriers," without describing "other barriers." While the Committee

appreciates the importance of eliminating financial barriers, this addresses only one aspect of accessibility and so, necessarily, limits federal monitoring to a single dimension.

Dr. Horne noted:

> It is generally understood that the reasonable access principle refers to primarily financial terms and conditions and not geographic or other dimensions of access to care.[96]

Professor Angus stated:

> I do not think anyone has defined reasonable access. Without some idea of what it means, it is very difficult to monitor and apply any regulations or follow-up actions on areas which are not honouring this reasonable access clause...I think this is one of the reasons why it is difficult to do any effective monitoring of the Canada Health Act.[97]

The Health Insurance Directorate of Health and Welfare Canada monitors the program criteria of the Act and reports to Parliament in accordance with section 23:

> The Minister shall, as soon as possible after the termination of the fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and the operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

This summary of provincial reports is called the Canada Health Act — Annual Report.

The Insurance Directorate is responsible for the following: monitoring extra-billing and user-fee practices; reviewing provincial legislation to ensure that the provincial regulations meet the program criteria; receiving the annual reports of the provincial health insurance plans and hospital commissions; and monitoring the media and all public correspondence in order to ascertain whether program criteria are being met. No public record of this monitoring process is made available in the Annual Report.

At present, there are no specific guidelines or systematic processes developed for federal monitoring of the program criteria of the Act beyond those stated above. Examination of the Annual Reports for the past few years shows a wide variance among provinces on the reporting of accessibility. Examples of the lack of uniformity used to judge accessibility are the provincial reports of "reasonable access" in the 1988-89 Annual Report (see Appendix 4).

Although all provinces report the elimination of financial barriers such as extra-billing and user fees, reporting on other measures (for example, waiting lists, geographical disparities in the provision of services and adequate numbers of hospital beds and health-care professionals) differs among provinces.

Examination of the responses to the Committee's questionnaire reveals that the five responding provinces and territories do have monitoring systems for waiting times, and lists in place. Why is the federal government not reporting this information to Parliament? With the exception of the Yukon, there is no attempt to judge or measure accessibility to hospital services in the Annual Report.

**The Committee concludes that the expression "reasonable access," as described in the *Canada Health Act*, has been restricted to an interpretation based solely on financial barriers, and that any future amendments define this expression in more inclusive terms. The Committee recommends that Health and Welfare Canada develop guidelines that require detailed provincial reporting on national health-care objectives, to identify and minimize excessive waiting time for diagnostic procedures and acute-care treatment.**

# CHAPTER 5: CONCLUSION

In its hearings the Standing Senate Committee on Social Affairs, Science and Technology listened to some of the most important health-care provider groups and leading experts on the subject of health provision in acute-care hospitals in Canada. The evidence and arguments have been presented in the body of this report. The Committee has concluded that if we are to avoid a major national crisis in accessibility to health services, especially in crowded urban cores, action must be taken without delay. We have focused our attention on the contribution that the federal government can make to avoid this crisis.

The problems confronting Canada's acute-care hospitals and service providers are complex and the solutions are not clear-cut. The provinces have already given these issues high priority. The resource limitations and the rising share of provincial budgets being consumed by health-care expenditures have led virtually every province to undertake major studies, which are referred to in this report.

The question facing Canadians is, how can we provide adequate health care to all Canadians? As some have put it, "Can we afford the ideal system we have put in place?"

Our Committee concludes that, while health-care expenditures will continue to increase with the escalation of medical technology, the changing demographic structure, and the rising demand for good health care, there are the means to curtail the increase in costs and still provide excellent health care.

Witnesses gave testimony of inefficiencies in acute-care hospitals arising from a variety of sources. This testimony and examples provided in the report show that many acute-care centres in our country have instituted innovative administrative responses to these problems. In answering our terms of reference, we believe that it is possible to stimulate and facilitate innovations and at the same time consider where increased funding will have the greatest pay back to the system.

There are many concerned groups in the health-care system, including government at all levels, national and provincial health organizations and health-care professionals, all of whom share responsibility for attaining efficiencies and adaptations. The recommendations of this report are designed to facilitate collaboration among them and to define the leading role that should be carried out by the federal government.

All of the witnesses said that a strong federal government presence in the health-care system must be maintained to ensure that national objectives and, particularly, accessibility are protected. Recent reductions in the growth of federal contributions for health care have substantially weakened the federal presence and have jeopardized the future of our national health-care system. We are now beginning to see pressure from groups, such as the Quebec Hospital Association, to raise needed funds from private sources and this may be the beginning of a trend that may compromise the original aims of the *Canada Health Act*.

**Because of the urgency of the problems that face the health-care system and because of the time needed to develop the level of knowledge and collaboration required to avoid a crisis in**

**accessibility, the Committee recommends that at future meetings of federal and provincial Ministers of Health an innovative strategy be developed for the funding of health care and preservation of national health-care objectives.**

# SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

**The Committee concludes there is evidence of problems in acute-care hospitals that threatens accessibility to services, particularly in large urban centres. The Committee believes it is necessary to "sound the alarm" in order to prevent a generalized crisis. These concerns are urgent and must be addressed by governments and involved groups within the health-care system.** (Chapter 2)

**The Committee recommends that the federal government establish a National Health Human Resource Planning Council to provide direction and leadership in the implementation of solutions to address the issue of nursing shortages. This body must work in collaboration with the provinces and professional associations.** (Chapter 3)

**The Committee concludes that shortages of available nurses and other groups has affected accessibility to acute-care hospitals. The Committee reiterates its recommendation to establish a National Health Human Resource Planning Council to provide direction and leadership in the implementation of solutions to address the issue of manpower planning in the hospital environment. This body must work in collaboration with the provinces and professional associations.** (Chapter 3)

**The Committee recommends that the federal government make it a priority to fund projects that incorporate alternative approaches to the delivery of health care. The Committee encourages Health and Welfare Canada to provide a Health Innovation Fund of at least $1 million a year over a period of five years, to stimulate and evaluate pilot projects related to alternative delivery approaches.** (Chapter 3)

**The Committee surmises that sharing of information is critical to the implementation of comprehensive and systematic evaluations of hospital service outcomes. The Committee recommends that the federal government co-sponsor, in collaboration with provincial governments, conferences on utilization management.** (Chapter 3)

**The Committee concludes that the establishment of a Canadian Coordinating Office for Health Technology Assessment is an important innovation, which it welcomes. The Committee supports the outlined functions and objectives of the Office, but expresses reservations about the adequacy of its annual budget ($500,000).** (Chapter 3)

**The Committee recommends that the federal government reconsider its policy of containment of EPF transfer payments with respect to hospital and medical services, and, in consultation with the provinces, seek an acceptable compromise in order to maintain a strong presence in the delivery of health-care services.** (Chapter 4)

**The Committee recommends that the relevant program areas relating to hospital insurance and medical care be clearly identified for federal government EPF transfer payments, while at the same time recognizing the constraints of the *Constitution Act, 1867*. The Committee further**

**recommends that national objectives, such as accessibility, should not be jeopardized by constitutional amendments.** (Chapter 4)

**The Committee concludes that the reported inadequacy of capital funding of hospitals in many areas of Canada must be addressed by the proposed National Health Care Advisory Council, to ensure that buildings and equipment are maintained in order to provide quality care.** (Chapter 4)

**The Committee recommends that federal granting bodies (for example the Medical Research Council and the National Health Research and Development Program) give priority to the funding of research related to hospital service delivery issues.** (Chapter 4)

**The Committee believes that more national involvement is needed to educate the public on health matters. The Committee recommends that the federal government provide funds targeted for innovative pilot projects in the area of health promotion.** (Chapter 4)

**Given the importance various groups have put on the need to develop national health objectives, the Committee recommends that the federal government give priority to the setting of national objectives, which should be clearly defined and incorporated into health policies.** (Chapter 4)

**The Committee recommends that the federal government, in co-operation with provincial governments and involved associations and facilities, plan a series of conferences to address hospital management issues such as inter-hospital coordination, and to facilitate an exchange of information among interested groups.** (Chapter 4)

**The Committee recommends that the federal government, in consultation with provincial governments, initiate discussions on the creation of a National Health Care Advisory Council. Such a body would promote research and coordinate assistance to the provinces concerning the many issues related to the efficient delivery of hospital services.** (Chapter 4)

**The Committee concludes that the expression "reasonable access," as described in the *Canada Health Act*, has been restricted to an interpretation based solely on financial barriers, and that any future amendments define this expression in more inclusive terms. The Committee recommends that Health and Welfare Canada develop guidelines that require detailed provincial reporting on national health-care objectives, to identify and minimize excessive waiting time for diagnostic procedures and acute-care treatment.** (Chapter 4)

**Because of the urgency of the problems that face the health-care system and because of the time needed to develop the level of knowledge and collaboration required to avoid a crisis in accessibility, the Committee recommends that at future meetings of federal and provincial Ministers of Health an innovative strategy be developed for the funding of health care and preservation of national health-care objectives.** (Chapter 5)

# APPENDIX 1

## WITNESSES WHO APPEARED BEFORE THE COMMITTEE

| Issue Number | Date | Witness |
|---|---|---|
| 8 | November 28, 1989 | The Honourable Perrin Beatty, Minister of National Health and Welfare. |
| | | *From the Department of National Health and Welfare:* |
| | | Dr. Peter Glynn, Assistant Deputy Minister, Health Services and Promotion Branch; Ms. Marie Fortier, Director General, Health Services Directorate. |
| | | *From the University of Ottawa:* |
| | | Professor Pran Manga, Faculty of Administration. |
| 9 | December 5, 1989 | *From Queen's University:* |
| | | Professor Douglas Angus, Department of Community Health and Epidemiology. |
| | | *From the "Conseil d'évaluation des technologies de la santé":* |
| | | Dr. Maurice McGregor, President. |
| 10 | December 19, 1989 | *From the Hospital Council of Metropolitan Toronto:* |
| | | Mr. Paul Gamble, Executive Director. |
| | | *From the University of Montreal:* |
| | | Mr. André-Pierre Contandriopoulos, Director, "Groupe de recherche interdisciplinaire en santé", Department of Health Administration. |
| 12 | January 16, 1990 | *From the "Conseil de la santé et des services sociaux de la région de Montréal métropolitain":* |

| Issue Number | Date | Witness |
|---|---|---|
| | | Mr. Gérard Marcoux, Director General. |
| | | *From the Health Sciences Centre, Winnipeg:* |
| | | Dr. John Horne, Senior Vice-President, Corporate Planning and Development. |
| | | *From the Canadian Hospital Association:* |
| | | Ms. Elma Heideman, Chairman Elect, Board of Directors;<br>Ms. Carol Clemenhagen, President. |
| | | *From the University of Toronto:* |
| | | Professor Raisa Deber, Department of Health Administration. |
| | | *From the "Association des Hôpitaux du Québec":* |
| | | Mr. Henri Fabre, President;<br>Dr. Jacques Brunet, First Vice-President;<br>Mr. Jacques Nadeau, Executive Vice-President;<br>Mr. Léandre Nadeau, Vice-President, Management Systems;<br>Mr. Jean-Marie Lance, Economist. |
| 13 | January 23, 1990 | *From the New Brunswick Extra-Mural Hospital:* |
| | | Dr. Gordon Ferguson, Executive Director. |
| | | From the Canadian Medical Association: |
| | | Dr. Hugh Scully, Chairman of the Council on Economics;<br>Dr. Colin McMillan, Chairman of the Political Action Committee;<br>Dr. Lionel Reese, Chairman of the Committee on Hospitals;<br>Dr. Léo-Paul Landry, Secretary-General;<br>Mr. Douglas Geekie, Director of Communications and Government Relations;<br>Mr. Orvill Adams, Director of Department of Medical Economics. |
| | | *From the Greater Victoria Hospital Society:* |
| | | Mr. Kenneth Fyke, President and Chief Executive Officer. |

| Issue Number | Date | Witness |
|---|---|---|
| 14 | January 30, 1990 | *From the Canadian Nurses Association:*<br><br>Dr. Judith Ritchie, President;<br>Ms. Judith Oulton, Executive Director;<br>Mr. Michel Simard, Public and Government Relations Manager.<br><br>*From Health and Welfare Canada:*<br><br>Dr. Michael Murphy, Assistant Deputy Minister, Secretary, Review of Demography and its Implications for Economic and Social Policy;<br>Ms. Krystyna Rudko, Director of External Relations, Review of Demography and its Implications for Economic and Social Policy.<br><br>*From the International Development Research Centre:*<br><br>Dr. Daniel Le Touzé, Senior Scientist, Health Sciences Division. |

On January 23, 1990, the Committee met with the following representatives of the Canadian Cardiovascular Society at the University of Ottawa, Heart Institute:

Dr. Wilbert Keon, President;
Dr. Eldon Smith, Vice-President;
Dr. Lyall-Higginson, Secretary;
Dr. John Cairns, Council Member.

# APPENDIX 2

## PROVINCIAL HEALTH CARE COMMISSIONS AND TASK FORCES IN CANADA SINCE 1983-84

**Newfoundland**

Royal Commission on Hospital and Nursing Home Costs, April 1983-February 1984.

A Green Paper on Our Health Care System Expenditures and Funding, January 1988, term unspecified.

Advisory Committee on Nursing Workforce, June 1987, term unspecified.

**New Brunswick**

Commission on Selected Health Care Programs, January-June 1989.

Nursing Resources Advisory Committee, term unspecified.

**Nova Scotia**

The Nova Scotia Royal Commission on Health Care, term unspecified.

**Quebec**

Commission d'Enquête sur les Services de Santé et les Services Sociaux, January 1986-December 1987.

Pour améliorer la santé et le bien-être au Québec, April 1989.

**Ontario**

Minister's Advisory Group on Health Promotion, October 1984-October 1987.

Ontario Health Review Panel, November 1986-June 1987.

Panel on Health Goals for Ontario, November 1986-August 1987.

Premier's Council on Health Strategy, term unspecified.

Joint Review Committee, June-July, 1988.

Task Force on the Use and Provision of Medical Services, term unspecified.

Health Professions Legislation Review, November 1982, term unspecified.

Task Force on the Implementation of Midwifery in Ontario, January 1986, term unspecified.

**Manitoba**

Health Advisory Network Steering Committee, ongoing from December 1988.

**Saskatchewan**

Saskatchewan Commission on Directions in Health Care, June 1988-March 1990.

**Alberta**

Advisory Committee on the Utilization of Medical Services, September 1987-September 1989.

Premier's Commission on Future Health Care for Albertans, December 1988-December 1989.

# APPENDIX 3

# TERMS OF REFERENCE FOR THE COORDINATING OFFICE FOR HEALTH TECHNOLOGY ASSESSMENT

**Purpose**

To facilitate information exchange, resource pooling and coordination of the assessment of health care technologies in accordance with priorities of the Conference of Federal-Provincial Deputy Ministers of Health. The technologies of concern include all procedures, devices, equipment and drugs used in the maintenance, restoration and promotion of health.

**Specific Functions**

1. *Coordination*

To facilitate decision making concerning the introduction of new and existing technologies and to foster the pooling of governmental efforts by:

— establishing and maintaining a clearinghouse containing both technical and policy-relevant material;
— providing information on a regular basis and on request to the provincial officials, especially those concerned with technology assessment;
— facilitating joint and coordinated action and the exchange of information by federal and provincial governments in the assessment of health technologies.

2. *Anticipating the Future*

To maintain an early warning system for new and emerging technologies by:

— establishing links with Canadian and international agencies involved in research, development and assessment;
— monitoring developments in other countries;
— scanning world literature;
— synthesizing information into simple, easy to read language;
— providing regular reports to the deputies and other federal and provincial officials.

3. *Knowledge Development*

To facilitate assessment research of health technologies by:

- — working closely with federal, provincial and other relevant agencies;
- — establishing research priorities for health technology assessment in collaboration with research funding agencies; -promoting and coordinating the funding of priorized assessment studies on new and existing health technologies;
- — promoting the development and use of techniques for assessment.

**Organization and Functioning**

The office will be accountable to a board consisting of one government representative from each province or territory and one representative from the Federal Government. The representatives should be senior government representatives who are knowledgeable about, and involved in, the management of health technology. The chair would be selected from the provincial representatives for a two-year term.

Experts or representatives of organizations concerned with technology would be invited to participate as required.

**Reporting**

The Office will submit an annual report to the Conference of Deputy Ministers. The liaison deputy would be the deputy from the same province as the chair. A progress report will be submitted in December 1989 and will include a work plan and priorities proposed by the office.

**Operational Arrangements**

- — The Office is to be funded jointly by the Federal (30%) and Provincial Governments (70%).
- — There initially will be a maximum of 5 employees, including the head.
- — The initial budget would be comprised of $250,000 for salaries and $250,000 for operating expenses.

**Evaluation**

The effectiveness of the Office will be evaluated in three years by an independent body reporting to the deputies. The criteria for evaluation will include the extent to which the Office has materially assisted governments in the appropriate adoption and use of health technologies.

# APPENDIX 4

## CANADA HEALTH ACT: ANNUAL REPORTS

**Newfoundland:**

*Reasonable Access*

There are no co-insurance charges for hospital services and no extra-billing by physicians in the province. Standard ward beds staffed and in operation totalled 2,462 and there were 632,519 patient days in the fiscal year. Preferred (private and semi-private) beds staffed and in operation totalled 973 with 106,582 patient days.

An incentive scheme is in place to attract physicians to remote areas and specialty practices. During fiscal year 1988-89, $415,738 was paid out under the Guaranteed Incentive Program by the Medical Care Plan, which included a contractual agreement with physicians in the Blanc Sablon/Labrador geographic border area.

**Prince Edward Island:**

*Reasonable Access*

Both Plans provide for insured services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons. There are no co-insurance charges for hospital services or extra-billing by physicians in the province.

In 1988-89, there were seven acute-care hospitals in the province with a total of 694 beds. Patients admitted during the fiscal year totalled 25,828 and total patient days were 201,757.

**Nova Scotia:**

*Reasonable Access*

There are no user charges or extra charges applicable under either Plan.

Over 90 per cent of the population lives within 30 minutes' travel time of the 50 provincial hospitals. A system of regional hospitals throughout the province provides specialty services to residents, in addition to the major tertiary care services in Halifax.

The province has placed no restrictions or limitations on the number of physicians who may bill the Plan. Subsidies are available to encourage physicians to locate in remote areas of the province.

**New Brunswick:**

*Reasonable Access*

Possession of a New Brunswick Hospital-Medicare card entitles eligible persons to insured services.

Hospital statistics for 1988-89 are as follows: number of patient days - 1,832,423 (excludes newborns); number of admissions - 125,607; number of separations - 126,323; number of emergency visits - 1,125,346.

Medical care statistics for 1988-89: 4,646,262 services were provided on a fee-for-service basis by in-province general practitioners and specialists. Out-of-province physicians provided 83,078 services, for a total of 4,729,340 services.

**Quebec:**

*Reasonable Access*

Everyone has the right to receive adequate health-care services without any kind of impediment.

There is no extra-billing by physicians in the province. While the majority of physicians practise within the provincial Plan, Quebec allows for two other options: physicians who have withdrawn from the Plan practise outside the Plan but must agree to remuneration in accordance with the provincial fee schedule; and non-participating physicians who practise outside the Plan entirely, so that neither they, nor their patients, receive reimbursement from the Plan, except for emergency services.

In 1988-89, there were 126 acute-care hospitals in the province with a total of 33,461 beds. Patients admitted to short-term care facilities totalled an estimated 750,000. Total patient-days are estimated at 10,650,000 for fiscal year 1988-89.

**Ontario:**

*Reasonable Access*

All insured persons are entitled to all insured hospital and medical services to which federal contributions relate. No resident will be refused insured services because of financial difficulties.

Public hospitals in Ontario are required to accept persons admitted to hospitals by physicians. A user charge in respect of chronic hospital care applies, and it is permissible by virtue of subsection 19(2) of the *Canada Health Act*. Income exemption provisions ensure access to those in financial need.

In 1988-89, there were 195 acute-care hospitals in the province with a total of 44,536 beds, which included chronic, general and special rehabilitation units. Patients admitted during the fiscal year totalled 1,299,220 and total patient days were 13,383,342.

**Manitoba:**

*Reasonable Access*

All insured persons are entitled to all insured hospital and medical services to which federal contributions relate.

Manitoba states that it compares favourably with the national average in respect of hospital beds available to residents, including beds in teaching hospitals. In 1988-89, there were 99 acute-care hospitals in the province with a total of 5,539 beds. Figures on patients admitted during the fiscal year and total patient days are not available until December 1989. Separated cases totalled 182,648 and separated days totalled 1,829,724.

As well, Manitoba states that it compares favourably with the national average with respect to physician-to-population ratio. Incentive programs currently exist in order to attract physicians to some rural areas and to some specialities that are experiencing a shortage of physicians; the Standing Committee on Medical Manpower continues to address the issue.

**Saskatchewan:**

*Reasonable Access*

Saskatchewan states that reasonable access to hospital and medical services is available for Saskatchewan residents.

In 1988-89, there were 134 acute-care hospitals in the province with a total of 7,377 beds. Patients admitted during the fiscal year totalled 225,943 and total patient days were 1,699,732. No user charges exist for hospital services. There are over 1,166 active physicians throughout the province. Effective August 1985, extra-billing by physicians, dentists, chiropractors and optometrists was banned.

**Alberta:**

*Reasonable Access*

To ensure reasonable access to hospital services, Alberta, in 1987-88, had 125 acute-care hospitals and 46 auxiliary hospitals operating throughout the province. These hospitals have an approved bed complement of 12,246 acute-care beds and 5,166 auxiliary beds. The total number of acute-care and auxiliary beds (17,412) provides a ratio of 7.3 beds per 1000 population. A $14.00 per diem charge applies ($10.00 prior to January 1,1987) in auxiliary hospitals for accommodation in a standard ward after 60 days. This charge is compatible with the exclusions provided for under subsection 19(2) of the *Canada Health Act*.

Residents have access to health care facilities throughout the province. Health care professionals are highly educated and standards are rigorously maintained. To ensure reasonable access to physician services, a physician incentive program is in place to encourage physicians to locate in underserviced areas. The number of medical practitioners practising in Alberta increased by 1.98

per cent between March 1988 and March 1989, from 3,829 to 3,905. The total number of medical services in-province increased by 1.50 per cent from 26,874,732 in 1988 to 27,276,842 in 1989.

**British Columbia:**

*Reasonable Access*

British Columbia declares that there is reasonable access to hospital and medical care services. In 1988-89, the hospitals and associated beds were: 93 acute-rehabilitation care hospitals (11,396 beds); five rehabilitation hospitals (428 beds); and two federal hospitals (19 beds) used by residents and for which the provincial Plan pays a per diem rate when the beds are used. The number of beds available totalled 11,843. As well, there were 15 Diagnostic and Treatment Centres and six Red Cross Outposts.

Patients admitted to acute/rehabilitation care during the fiscal year totalled 436,751 with total patient-day services of 3,443,459.

The province also offers access to medical care services for extended care patients. In 1988-89, these care units and the associated beds were offered in: 76 acute/rehabilitation hospitals (5,721 beds) and 16 hospitals specialized in extended care (1,936 beds). The number of beds available totalled 7,657.

Patients/residents admitted to these care units during the fiscal year totalled 6,432 with total patient-day services of 2,687,937.

**Yukon:**

*Reasonable Access*

There are no user fees or co-insurance charges under the Hospital Plan. Hospital beds are readily available. No waiting list for admission exists. Yukon operates with hospital bed over-capacity, particularly in outlying areas where district hospitals may have occupancies as low as 20 per cent.

Access to specialists and tertiary hospital care is insured through a publicly funded visiting medical specialist program and a universal, first-dollar indemnity travel plan for medical treatment.

There is no extra-billing in Yukon for any services provided under the Health Care Insurance Plan.

Yukon states that it has an over-supply of physicians, dentists and dental surgeons. The physician-to-population ratio is approaching 1:500.

**North West Territories:**

*Reasonable Access*

All residents of the Northwest Territories have free access to all facilities operated by the Government of the Northwest Territories. In 1988-89, there were six acute-care hospitals in the Northwest Territories with a total of 302 beds.

# NOTES

[1] Debates of the Senate, Vol. 133, No. 3, April 5, 1989. p. 27.

[2] Ibid., Vol. 133, No. 8, May 2, 1989.

[3] Senators Pierre De Bane, Stanley Haidasz, E.W. Barootes and Lorne Bonnell all made positive comments in the Senate on the proposed study. See Debates of the Senate, Volume 133, No. 8, 12 and 21.

[4] Environics Research Group Ltd., Commissioned by the Ontario Hospital Association, Fall, 1989.

[5] Decima Quarterly Report, Spring, 1988, p. 33.

[6] Ibid., p. 39.

[7] Proceedings, Issue No. 13, p. 13:23.

[8] Mr. Ken Fyke, Written Brief, p. 10.

[9] The Canadian Medical Association, Written Brief, p. 8.

[10] The Canadian Nurses Association, Written Brief, p. 6.

[11] Saskatchewan Health, Written Brief, p. 7.

[12] Proceedings, Issue No. 12, p. 12:8.

[13] Proceedings, Issue No. 10, p. 10:32.

[14] The Yukon, Questionnaire, Question No. 1.

[15] Canadian Cardiovascular Society, Written Brief, p. 1.

[16] Mr. Gerard Marcoux, Written Brief, p. 4.

[17] British Columbia, The Questionnaire, Question No. 8(A).

[18] Mr. Paul Gamble, Hospital Council of Metropolitan Toronto, Written Brief, p. 4.

[19] Proceedings, Issue No. 12, p. 12:33.

[20] The Canadian Nurses Association, Written Brief p. 21.

[21] Ibid., p. 16.

[22] Proceedings, Issue No. 14, p. 14:12.

[23] The Canadian Nurses Association, Written Brief, p. 7.

[24] Proceedings, Issue No. 14, p. 14:8.

[25] The Federal-Provincial Report on Rehabilitation Personnel, by the Federal-Provincial Advisory Committee on Health Human Resources, June 1988, p. ii.

[26] "Cancer patients face wait for treatment", (Globe and Mail, Sept. 13, 1989).

[27] Proceedings, Issue No. 10, p. 10:31.

[28] Proceedings, Issue No. 9, p. 9:10.

[29] *Charting Canada's Future*: A Report of the Demographic Review, December, 1989.

[30] Woods Gordon, Investigation of the Impact of Demographic Change on the Health Care System in Canada, for the Task Force on the Allocation of Health Care Resources, August, 1984.

[31] Dr. Gordon Ferguson, Written Brief, p. 1.

[32] Mr. Gerard Marcoux, Written Brief, p. 7.

[33] The Canadian Hospital Association, Written Brief, p. 8.

[34] The Economic Council of Canada, *Aging with Limited Resources: Proceedings of a Colloquium on Health Care*, May 1986, Supply and Services Canada, Ottawa, p. 76-77.

[35] Proceedings, Issue No. 9, p. 9:11.

[36] Proceedings, Issue No. 12, p. 12:64.

[37] Mr. Ken Fyke, Written Brief, p. 5.

[38] Mr. Gerard Marcoux, Written Brief, p. 10.

[39] Saskatchewan Health, Written Brief, p. 3.

[40] Proceedings, Issue No. 8, p. 8:17.

[41] Proceedings, Issue No. 13, p. 13:15.

[42] Proceedings, Issue No. 13, p. 13:12.

[43] Dr. Gordon Ferguson, Written Brief, p. 8.

[44] Ibid., p. 5.

[45] Ibid., p. 6.

[46] Proceedings, Issue No. 14, p. 14:9.

[47] Catherine Cornell, "Utilization Management — Your Hospital's Key to Survival," Scarborough General Hospital, May 16, 1990.

[48] New Brunswick, *Report of the Commission on Selected Health Care Programs*, July, 1989, p. 44.

[49] Proceedings, Issue No. 8, p. 8:13.

[50] Proceedings, Issue No. 13, p. 13:44.

[51] Proceedings, Issue No. 10, p. 10:31.

[52] R.N. Battista, "La Dynamique de l'Innovation et de la Diffusion des Technologies dans le Domaine de la Sante," *Le Developpement de la Technologie*. Quebec: Gouvernement du Quebec, 1987, p. 31.

[53] Saskatchewan Health, Written Brief, p. 5.

[54] Coopers and Lybrand Consulting Group, Looking to the Future: Health Trends in Canada, 1989, p. 8.

[55] D. Feeney, et. al., eds.: *Health Care Technology: Effectiveness, Efficiency and Public Policy:* Institute for Research on Public Policy, Montreal, Quebec, 1986, p. 225.

[56] The Canadian Medical Association, *Brief to the House of Commons Standing Committee on Health, Welfare and Social Affairs*, Ottawa, June 21, 1988, p. 8.

[57] *Health Care Technology: Effectiveness, Efficiency and Public Policy*, op. cit., p. 17.

[58] Dr. Raisa Deber, Written Brief, p. 3.

[59] The Canadian Hospital Association, Written Brief, p. 7.

[60] Saskatchewan Health, Written Brief, p. 4.

[61] The Canadian Medical Association, Written Brief, p. 7.

[62] The Financial Post, February 21, 1990, p. 26.

[63] Saskatchewan, Questionnaire, Question No. 2.

[64] British Columbia Questionnaire, Question No. 2.

[65] The Canadian Hospital Association, Written Brief, p. 65.

[66] Proceedings, Issue No. 12, p. 12:29.

[67] Proceedings, Issue No. 10, p. 10:49.

[68] Mr. Ken Fyke, Written Brief, p. 2.

[69] The Quebec Hospital Association, Written Brief, p. 25.

[70] Proceedings, Issue No. 12, p. 12:29.

[71] *p Proceedings, Issue No. 14, p. 14:17.

[72] Ibid.

[73] Proceedings, Issue No. 12, p. 12:13.

[74] The Canadian Hospital Association, Written Brief, p. 6.

[75] Proceedings, Issue No. 10, p. 10:25.

[76] Proceedings, Issue No. 8, p. 8:16.

[77] Proceedings, Issue No. 10, p. 10:49.

[78] The Canadian Nurses Association, Written Brief, p. 18.

[79] Proceedings of the House of Commons Standing Committee on National Health and Welfare, Issue No. 54, September, 1988., p. 54:47.

[80] Mr. Ken Fyke, Written Brief, p.4.

[81] The Canadian Nurses Association, Written Brief, p. 8.

[82] Proceedings, Issue No. 8, p. 8:12.

[83] The Canadian Hospital Association, Written Brief, January 16, 1990, p. 11.

[84] Proceedings, Issue No. 12, p. 12:33.

[85] The Ontario Health Review Panel, November 1986-June 1987.

[86] Proceedings, Issue No. 9, p. 9:8.

[87] The Canadian Hospital Association, Written Brief, p. 10.

[88] Mr. Ken Fyke, Written Brief, p. 12.

[89] Ibid., p. 15.

[90] Ibid., p. 15.

[91] Ibid., p. 19, 20.

[92] The Canadian Nurses Association, Written Brief, p. 20.

[93] The Canadian Hospital Association, "Submission to the Minister of National Health and Welfare on Bill C-3, The Canada Health Act," January, 1984.

[94] Draft — A Proposal for a Canadian Health Council [1986], source — The Canadian Hospital Association, May 1990.

[95] *Health: A Need for Redirection*, A Task Force on the Allocation of Health Care Resources, 1984, p. 88.

[96] Proceedings, Issue No. 12, p. 12:29.

[97] Proceedings, Issue No. 9, p. 9:16.