October 29, 2002

On October 25, 2002 the Standing Senate Committee on Social Affairs, Science and Technology, led by Senator Michael Kirby, released its Final Report on the state of the health care system in Canada. Its recommendations touch on a broad array of health reform issues, from funding obstacles to system restructuring to primary care reform. The report argues that Canada’s publicly funded health care system is not fiscally sustainable in its current form and that continuing the status quo would lead to an eventual collapse of the public system. The following are some of the report’s key recommendations:

Funding

The Committee estimates that an additional $5 billion is needed annually to reform and renew the health care system. This amount should be used to ‘buy reform’ rather than to fund a fundamentally unsustainable system. The Committee emphasizes that unless changes are made to the structure and functioning of the system, no amount of new money will make the current system sustainable over the long term. New federal funding for health care should be managed according to four parameters:

- Increased federal revenue for health care must go into an Earmarked Fund that is separate and distinct from the Consolidated Revenue Fund
- Increased federal revenue for health care must be targeted
- Federal health care funding should not be transferred via the Canadian Health and Social Transfer
- The federal government should be advised annually by the new National Health Care Council on how the money in the Earmarked Fund should be spent
- All governments must be made accountable for how additional federal funding for health care is spent

It is the view of the Senate Committee that additional funding for health care can come only from the people of Canada, either through the public purse or, by default, privately. Public funding could be drawn from a variety of sources: general taxation, dedicated payroll taxes paid by employers and employees (and based on labour earnings), public health care insurance premiums, or an earmarked health care tax. Public funding could also be generated from taxable health care benefits, which means making publicly funded health care benefits received by an individual subject to income tax.

Private financing sources considered by the Committee include various forms of user charges for publicly insured health services, contributions under Medical Savings Accounts (MSAs) or other similar plans, and private health care insurance. However, the Committee favours the single insurer model, warning of the potential implications for the publicly funded health care system of allowing private health care insurance in Canada.

Several options are presented on how governments might meet their financial obligations: general taxation, earmarked taxation, payroll taxes, national health care premiums, user charges, medical savings accounts, and pre-funding for health care. Following an evaluation of each of the aforementioned revenue-raising methods, the Committee concludes that the two most effective methods are the National Health Care Sales Tax (increasing the national sales tax to 8.5 percent) or the Variable National Health Care Insurance Premium, which would vary with the individual’s taxable income (for example, individuals with an income between $31,678 and $63,354 would pay $1 per day or $370 per year).
Accountability

The Senate Committee recognizes that Canadians demand and deserve increased accountability for health care decisions. The Committee believes that Canadians would be willing to contribute more to public health care spending only if they are convinced that the money will actually be spent on health care and that it will be spent wisely. Thus, the Committee recommends that the federal government subject the Earmarked Fund for Health Care to an annual audit (to be made public) by the Auditor General of Canada. The report also encourages the federal government to require the provinces and territories to report annually to the Canadian public on their utilization of federal money from the Earmarked Fund for Health Care.

In order to establish responsibility for the strengths and deficiencies of the health care system, the Committee calls for an independent, non-partisan Health Council (headed by a Health Commissioner) to provide detailed and reliable information about the performance of the system and on health outcomes. This autonomous Council would report annually to Canadians on the performance of the health care system.

Electronic Health Records

The Committee recommends the creation of a national system of electronic patient records to ameliorate the management of health information across the country. Not only could an Electronic Health Records (EHR) system greatly improve health care system management, efficiency and accountability; it could also enhance the quality and timeliness in health care delivery. Moreover, the data collected from an EHR system could provide very useful information for the purpose of health research, should appropriate privacy policies be set in place. To achieve these goals, the Senate Committee recommends additional federal funding to Canada Health Infoway (a private not-for-profit corporation in charge of furthering the cause of electronic health records) of $2 billion over a five-year period, or an annual allocation of $400 million.

Primary Health Care Reform

At present, primary care delivery in Canada is founded upon family physicians and general practitioners working alone or in small group practices. The dominant means of payment for these physicians is the fee-for-service (FFS) system. The Senate Report recommends the creation of primary care groups (PCGs) as a means of increasing access, saving long-term costs and stressing illness prevention measures. Primary care groups are practices composed of several physicians, but may also incorporate other health care professionals such as nurses, nurse practitioners, physiotherapists, dieticians, midwives, psychologists etc..

The system envisioned by the Senate Committee differs from the recent initiatives in Ontario in its desire to eliminate the direct government funding of individual services. The Committee instead agrees with the recommendation of the Ontario Hospital Restructuring Commission whereby the PCG as a whole would be primarily funded using capitation. The Senate Committee feels the latter funding model would create genuine group practices rather than encouraging essentially independent practitioners merely to practice together under a single roof.

To assist the provinces set up primary health care groups, the Senate Committee recommends the federal government provide $50 million per year in addition to the $800 million earmarked for primary care reform under the September 2000 health care funding agreement.
Home Care

The Senate Committee recommends that post-acute home care costs should be publicly funded under Medicare because they are incurred as a direct extension of hospital care. Post-acute home care, as defined in the Report, are home care services that begin within 30 days of the in-patient or same-day hospital discharge date. Initiation of home care beyond 30 days of discharge is unlikely to be directly related to previous hospitalization.

The Final Report argues that funding for post-acute home care should be administered by hospitals, and that hospitals should have the option of providing the services directly or contracting with not-for-profit or for-profit home care service providers or third party agencies. Funding should be jointly financed, with 50 percent paid by the federal government and 50 percent by the provinces and territories. The cost of this program is estimated at $550 million per year, but is expected to provide greater long-term savings by alleviating demand for hospital beds.

Palliative Care

The Final Report recognizes the importance of providing access to palliative care services for Canadians of all ages across all sectors of the health care system, including hospitals, hospices, community services, as well as non-governmental organizations. However, the Committee also acknowledges that providing such services would require extensive reforms, and that an accurate cost estimate of providing universal palliative care services is currently unavailable.

Increased assistance to caregivers in the form of financial and information resources is needed to ensure that informal caregivers have the knowledge, skills, income security, job protection and other supports they require to provide care to the dying while maintaining their own health and well-being throughout the process. The Committee therefore recommends that the federal government examine the feasibility of allowing Employment Insurance benefits to be provided for a period of six weeks to employed Canadians who choose to take leave to provide palliative care services to a dying relative at home.

The Committee further recommends that this initiative be accompanied by an expansion of the tax measures already available to people providing care to dying family members or to those who purchase such services on their behalf so they may deduct the cost of certain medical devices, aids or equipment. The Report also calls on the federal and provincial governments to amend their labour codes to allow employee leave for family crisis situations, such as care of a dying family member.

Hospital Funding

The Final Report recommends a shift from the current global funding method for hospitals to a service-based funding method. The Committee argues that such a change would create competition between institutions for improved service delivery, increase patient-oriented service delivery, enhance transparency and accountability of institutional performance and improve operating efficiencies.

Public Health and Health Promotion

The Final Report acknowledges the degenerating state of Canada’s public health programs and infrastructure. Low, inconsistent funding is recognized to have put public health programs and infrastructure under considerable stress. Thus, the Senate Committee recommends additional funding of $200 million to sustain, better coordinate and integrate the public health infrastructure in Canada.
**Prescription Drugs**

The Committee recommends expanding the provisions of Canada’s public health system to protect against catastrophic prescription drug costs, building on the diverse plans already available in many Canadian jurisdictions. The proposal laid out in the Final Report would guarantee that no Canadian would ever be required to pay out of pocket more than three percent of total family income for prescription drugs.

The Senate Committee proposes that the first $5,000 (per person, annually) be paid by a combination of provincial/territorial drug plans, private insurance and individual contribution (which would be capped at three percent of family income). Beyond $5,000, the Federal government would pay 90 percent of drug costs, with the other 10 percent paid by either provincial/territorial plans or by a private insurer. The cost of the plan is estimated at $500 million per year.

**Regional Health Authorities**

Of particular importance to Ontario’s health care system is the Senate Committee’s recommendation for a major restructuring of the hospital and doctor system, by devolving operational responsibility for health care spending from provincial governments to regional health authorities (RHAs). Under such reform, RHAs would become responsible for purchasing health services from hospitals and other health care institutions on behalf of the populations they serve. Devolving responsibility for the full range of health services from provincial ministries of health to RHAs, which has been implemented to varying degrees across the country, is said to create a more integrated, better-coordinated patient-oriented system of health care delivery. Interestingly, Ontario is the only province in Canada that does not have a system of RHAs, opting instead for a local planning role for the 16 District Health Councils (DHCs).

**Comments**

The health care guarantee suggested in the Final Report is an interesting ‘remedy’ for the sometimes lengthy wait lists for crucial treatments. The guarantee would, in effect, cap patients’ wait lists for major treatments and procedures. Should services not become available within the predetermined time span, the government would pay for the procedure to be immediately performed in another jurisdiction (either in Canada or the United States). Oddly, it appears that even after years of research of ways to improve Canada’s health care system, experts are still allowing for contingency plans. Ideally, the recommendations contained in the report would eliminate the need for such ‘health care guarantees’ by identifying the reform mechanisms necessary to remedy our deteriorating health services.

On a broader note, Senator Kirby’s Final Report is surprisingly similar to the anticipated recommendations of the Final Report by the Health Care Commission led by Roy Romanow (due to be released in November). The Kirby report contains proposals to expand the scope of publicly funded health services, particularly in the areas of post-acute home care, palliative care and prescription drugs. Such policy decisions were thought to be more in line with Romanow’s political views; Kirby was believed to favour greater private sector involvement in health care provision. Though Kirby does not bar the possibility of an expanded role for the private sector, the report clearly outlines the committee’s preference for a publicly funded, universally accessible health system.


For a more detailed analysis of the Senate Committee’s Report, please contact Trent Gow at the number listed below.
Thompson Gow & Associates will continue to monitor new developments in Canada’s health care reform debate, including an analysis of the upcoming Romanow Report this November.