On February 6, 2002, Roy Romanow tabled in the House of Commons his Interim Report of the Commission on the Future of Health Care in Canada. There was a great deal of media attention, public and political commentary on the release of the Interim Report.

On January 23, 2002, there was another perhaps more significant report on the health care system in Canada, which did not receive the same level of media commentary and public/political discussion.1 The Standing Senate Committee on Social Affairs, Science and Technology released two volumes/reports. One report examines the health care systems in other countries (volume three),2 while the other report, Volume Two: Current Trends and Future Challenges, examined the factors that can affect the affordability and sustainability of the Canadian health care system, including the aging population, spending on drugs, advances in health care technology, disease trends, the health status of Aboriginal People, human resources, health research and information, home care and rural health.3 The reports from the Standing Senate Committee are also known as the Kirby reports, which are named after the Chair, Senator Michael Kirby.

It is interesting to compare the Kirby reports, particularly the volume that examines the factors that affect the affordability and sustainability of Medicare, with Romanow’s Interim Report. Both are the result of fact-finding, information gathering processes that involved hearing testimony from expert witnesses and through commissioned research. However, the Kirby report is of greater substance than the Romanow report, because it provides research results, statistics and other evidence, which the Committee analysed in order to “separate myth from reality.” As a result, the Kirby report provides a clearer picture of what factors drive costs in the health care system – and which do not.

In the Report, the Committee indicates the direction that it is leaning toward in its recommendations. For example, the Committee seems to envisage a greater role for the federal government in several areas, including health promotion and disease prevention, the health of Aboriginal Canadians,4 and leading the development of a national human resource strategy.

As the Kirby report illustrates, there are many myths and misunderstandings about the Canadian health care system. The Standing Senate Committee shows that the evidence does not support the many “myths” about the Canadian health care system. Some examples are provided below.

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1 The Kirby report was released the same day that Alberta Health and Wellness Minister Gary Mar released an action plan, Alberta: Health First, Building a Better Public Health Care System to begin implementing the reforms recommended by the Premier’s Advisory Council (also known as the Mazankowski Report), the latter of which received much media, political and public discussion. The Kirby report was likely overshadowed by Mazankowski’s final report, which was released two weeks earlier on January 8.

2 Volume Three: Health Care Systems in Other Countries, will be the subject of a future TGA Policy Note.

3 This report presents the evidence obtained during the second phase of the Standing Senate Committee’s study on health care. See Appendix, Table 1 for phases.

4 TGA wrote a previous policy note devoted to this subject, which describes Aboriginal health and Aboriginal health programs in greater detail, as examined by Volume Two of the Kirby Committee.
Demographic Aging

The Standing Senate Committee rejects the “nightmare high-cost” scenario that assumes that, while people live longer, they still get sick or become disabled at the same age as now. For instance, Canadians are living both longer and more healthily. Consider that the health of the current generation of 45 to 64 year olds is better than that of the same category twenty years ago. Also, there appears to be no clear correlation between the amount different countries spend on health care and the age profile of their population. For instance, the United States spends close to 14 percent of its GDP on health care but the proportion of seniors in its population is less than 13 percent, whereas Sweden spends less than 9 percent of its GDP on health care, even though its proportion of seniors is 17 percent of the population.

Further, the Kirby report argues that although the aging of the population will be one of the important drivers of cost increases to health care over the coming decades, it is not the only one, and probably is not even the most important one. For example, Health Canada’s projections anticipate that although population aging will account for an increasing percentage of the growth in health care expenditures in the period from 2001-2030, it will still represent less than 30 percent of the total projected growth. Other cost drivers include the use of new technology and innovation, the cost of new drugs, changing public expectations, and new and changing patterns of diseases.

Pre-funding Options

The Standing Senate Committee studied various proposals for ‘pre-funding’ the costs associated with an aging population. A pre-funding mechanism would allow future expenses to be paid for by the people who would actually make use of them. One suggestion is that part of the current Canada Health and Social Transfer (CHST) from the federal government to the provinces and territories could be converted into a “senior’s health grant.” For example, part of the CHST could be replaced with a new grant, set at $3,000 per senior, and initially offset the grant with matching decreasing elsewhere so that it is cost-neutral in the first year. Over time, the grant could escalate at the same rate per capita as other grants relative to the general population, but being geared to the seniors’ population, it would grow more quickly. In that way, some of the demographic pressure on federal transfers could be accommodated.

Another method of pre-funding identified was the proposal from the Clair Commission in Quebec for a special “loss-of-autonomy fund” that would be financed through employer and employee contributions. Similar to a dedicated pension fund, it could be managed by an arms-length body that would ensure its financial viability and that its resources would be used to help finance a broader range of services for the aging population.

Spending on Drugs

Drugs continue to consume an increasing share of Canada’s health care dollar, accounting for the second largest category of health expenditures next to hospital services. There have been many suggestions that drug costs are increasing because of price increases. However, the Committee found evidence suggesting that the growth in drug costs has been driven largely by increased utilization of drugs and a shift from older, less-expensive medications to newer, costlier forms of drug therapy, but less so by price increases.

Canadian prices for patented medicines were eight percent below median international prices in 2000. One study found that the Canadian prices for non-patented single source drugs were, on average, 30 percent higher than the median international prices of the seven countries used by the Patented Medical Prices Review Board (PMPRB) for comparative purposes. Data from the Federal/ provincial/ Territorial
Task Force on Pharmaceutical Prices indicate a clear trend toward higher generic drug prices in relation to their brand name equivalents.

Drug prices also vary from province to province. For example, in 1997, the highest price province, Nova Scotia, had prices that were 5% higher than the lowest price province, Manitoba.

Further, the Committee also heard that there is increasing evidence of inappropriate prescribing and use of medicines. Inappropriate prescribing appears to be a problem, particularly in relation to seniors. Eleven percent to 46 percent of seniors receive at least one inappropriate prescription per year. Moreover, prescribing errors account for approximately 19 percent to 36 percent of drug-related hospital admissions.

Patient non-compliance with prescription drug regimens and early discontinuance of medications for chronic conditions in estimated to be as high as 50 percent. Inappropriate prescription drug use costs the health care system substantial amounts of money. One study showed that the economic costs of inappropriate prescription drug use in Canada was between $7 to $9 billion annually.

The Kirby report also notes that there is evidence that Canadians do not have uniform coverage for prescription drugs. While some Canadians have no coverage at all, others are under-insured. Lack of coverage for prescription drugs and under-coverage are of particular concern for residents of the Atlantic provinces. The lack of drug coverage often means that people are not able to pay for drugs and thereby forgo the health benefits that would be achieved by drug therapy – which may strain other areas of the health care system.

**Primary Care Reform**

The Kirby report argues that the current fee-for-service system has serious drawbacks, particularly with regard to providing even current levels of care to the elderly. Geriatric practice requires time and health care professional resources that are less readily provided when physicians’ sole source of income is fee-for-service payment. For example, a middle-aged patient usually has a simple problem and can be run through a doctor’s office in about 15 or 20 minutes. However, the average consultation for a senior would take an hour to an hour and a half because a senior may have a backdrop of five problems and is taking six drugs. In most provinces, you are paid exactly the same amount for each patient. These kinds of prospects have a major impact on the recruitment of geriatric specialists.

The Committee stated that it agrees with witnesses that pharmacists can play a crucial role in primary care reform and that better integration of the work of physicians with that of pharmacists can greatly reduce the economic burden of inappropriate drug prescribing and use.

**Health Care Technology**

Although Canada is the 5th highest among OECD countries in terms of total spending on health care (as a percentage of GDP), it is generally among the bottom third of OECD countries in the availability of health care technology. Canada also lags behind other countries in terms of the more advanced health care technology.

For example, many of Canada’s standard x-ray machines and other machines in hospitals are functionally inadequate because they are simply too old to do the job for which they were designed. Between 30 percent and 63 percent of imaging technology currently used in Canada is outdated.

The shortage of new technology and the use of outdated equipment impede exact diagnosis and inhibit high quality treatment. The low availability of health care technology in Canada has translated into
limited access to care and lengthened waiting times. Overall, waiting times have grown by more than 40 percent since 1994. However, providing the health care sector with all the technology it needs would not solve all the problems because there is not an appropriate level of professionals to operate that equipment.

There is also a lack of Health Technology Assessment (HTA) done in Canada. HTA is the process of evaluating medical technologies and their use. Although there are various health care technology assessment agencies, federally and provincially, experts told the Committee that not enough attention is devoted to HTA in Canada. Therefore, health care technologies are often introduced into Canada’s health care system with insufficient knowledge of their safety, effectiveness, and cost. The Committee agrees that technology assessment is a critical activity and that more HTA needs to be undertaken when considering the introduction of a new technology or the replacement of existing medical equipment. The Committee argues that the federal government should devote more funding to health technology assessment.

**Home Care**

Home care encompasses an array of health, social or educational services that enable an individual requiring support to live and participate in society outside an acute or long-term care setting. Home care can be provided by formal providers who are predominately nurses, therapists, homemakers, and personal support workers. Many studies show that effective home care contributes to lower long-term costs for the health care system.

There are four key variables that will reinforce the demand for further growth in home care:

- **Hospital bed reductions**: shorter hospital stays, early discharge and the use of outpatient procedures all place more reliance upon community services;
- **Rapid population growth over 65 years of age**: While many seniors live at home, their home care use increases with age and disability. The highest use of home care occurs in the senior population aged 85 years and up;
- **Pressures on informal caregivers**: The majority of informal caregivers are women who support their family members and who must often manage simultaneously responsibility for aging parents, for their own children and full-time paid work. More women are being conscripted into unpaid health care work and do so without training and with few supports;
- **Advances in technology**: conditions that previously required hospitalization, such as pain control, can now be managed at home.

Many individuals who need home care services may do without them because they cannot afford the costs.

There is strong support for changes to the way that home care is currently organized, delivered and financed. In particular, there are actions needed to develop national standards. Home care services, and access to those services, vary across the country, depending on which province a person resides. Further, there are no national training standards for home care workers with some being very well trained and others hardly at all. National standards could be one way of ensuring both an effective Canadian health care system and equitable treatment of Canadians in all parts of the country.

The Committee supports increased public policy being given to home care and alternative care provisions. Although there has been extensive discussion around the issue of home care as a substitute for acute care, insufficient attention has been given to home care as a substitution for services provided in long-term and
residential facilities. Moreover, there is a lack of data and research about home care in relation to palliative care and home care with respect to prevention of incapacity through social and other supports.

**Rural Health**

Rural realities and health care needs of rural Canadians are different that those of Canadians living in urban areas. Rural Canada may have special needs based on factors such as age, gender, ethnicity, and occupation. For instance, various studies have shown that:

- Seniors in Canada are over-represented in rural regions, as are children and youth under the age of 20. There are particular issues for seniors needing assisted home care or long-term care and for children and youth with special medical needs or who are in abusive situations.

- Farmers, fishers, foresters, and miners can face serious health hazards in their jobs. In addition to accidents related to the increasingly complex machinery used in these occupations, there are hazardous exposures to chemicals, noise, long working hours, temperature extremes, infectious diseases, and stress.

- While Aboriginal peoples face an array of health problems related to their socio-economic status, they also experience some of the cultural insensitivity experienced by new immigrants such as lack of services in their own language, health care personnel who are unaware of cultural practices, and problems associated with services designed for a mainstream population.

Compared to urban areas, life expectancy in rural regions is shorter while death rates and infant mortality rates are higher.

Ontario and British Columbia have the lowest percentage of rural residents while the territories and Atlantic provinces have the highest. In fact, almost half of the population of Atlantic Canada live in rural areas.

Canadians living in rural and remote areas are limited to a smaller range of health care providers when seeking care than are their urban counterparts. Rural residents must travel long distances and incur additional costs for transportation and other needs such as hotels. Studies show that travel can also negatively affect their health.

The recruitment and retention of health care personnel, including physicians, specialists, nurses, technicians, social workers, physiologists and nutritionists, in remote and rural areas of Canada have been ongoing concerns. Access to physician services is a particular problem.

The Committee is to submit its final report no later than June 30, 2002.
Appendix: Background

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

ORDER OF REFERENCE

Extract from the Journals of the Senate of March 1, 2001:

Resuming debate on the motion of the Honourable Senator LeBreton, seconded by the Honourable Senator Kinsella:

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

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

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament be referred to the Committee;

That the Committee submit its final report no later than June 30, 2002; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

After debate,

The question being put on the motion, it was adopted.

ATTEST:

Paul C. Bélisle

Clerk of the Senate

In response to this broad and complex mandate, in March 2001, the Committee re-launched its multi-year and multi-faceted study comprising five major phases. Table 1 provides information on each individual phase and their respective timeframes.
**TABLE 1**
HEALTH CARE STUDY:
INDIVIDUAL PHASES AND PROPOSED TIMEFRAMES

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