



Second Session  
Thirty-seventh Parliament, 2002

SENATE OF CANADA

---

*Proceedings of the Standing  
Senate Committee on*

## **Social Affairs, Science and Technology**

*Chair:*

The Honourable MICHAEL KIRBY

---

Friday, October 25, 2002

---

**Issue No. 2**

---

THE THIRD REPORT OF THE COMMITTEE  
(The state of the health care system in Canada entitled  
“The Health of Canadians — The Federal Role —  
Volume Six: Recommendations for Reform”)  
(Part I to III)

---

Deuxième session de la  
trente-septième législature, 2002

SÉNAT DU CANADA

---

*Délibérations du Comité  
sénatorial permanent des*

## **Affaires sociales, des sciences et de la technologie**

*Président:*

L'honorable MICHAEL KIRBY

---

Le vendredi 25 octobre 2002

---

**Fascicule n° 2**

---

LE TROISIÈME RAPPORT DU COMITÉ  
(L'état du système de santé au Canada intitulé  
«La santé des canadiens — Le rôle du gouvernement  
fédéral — Volume six: Recommandations  
en vue d'une réforme») (parties I à III)

---

THE STANDING SENATE COMMITTEE ON  
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chair*

The Honourable Marjory LeBreton, *Deputy Chair*  
and

The Honourable Senators:

Callbeck	Keon
* Carstairs, P.C. (or Robichaud, P.C.)	Léger
Cook	* Lynch-Staunton (or Kinsella)
Cordy	Morin
Di Nino	Robertson
Fairbairn, P.C.	Roche

*\*Ex Officio Members*  
(Quorum 4)

LE COMITÉ SÉNATORIAL PERMANENT DES  
AFFAIRES SOCIALES, DES SCIENCES ET  
DE LA TECHNOLOGIE

*Président*: L'honorable Michael Kirby

*Vice-présidente*: L'honorable Marjory LeBreton  
et

Les honorables sénateurs:

Callbeck	Keon
* Carstairs, c.p. (ou Robichaud, c.p.)	Léger
Cook	* Lynch-Staunton (ou Kinsella)
Cordy	Morin
Di Nino	Robertson
Fairbairn, c.p.	Roche

*\* Membres d'office*  
(Quorum 4)

**REPORT OF THE COMMITTEE**

Friday, October 25, 2002

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

**THIRD REPORT**

Your Committee, which was authorized by the Senate on Tuesday, October 8, 2002 to examine and report upon the state of the health care system in Canada, now tables its final report entitled *Volume Six: Recommendations for Reform*.

Respectfully submitted,

**RAPPORT DU COMITÉ**

Le vendredi 25 octobre 2002

Le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie a l'honneur de déposer son

**TROISIÈME RAPPORT**

Votre Comité, qui a été autorisé par le Sénat le mardi 8 octobre 2002 à examiner pour en faire rapport l'état du système de soins de santé au Canada, dépose maintenant son rapport final intitulé *Volume six: Recommandations en vue d'une réforme*.

Respectueusement soumis,

*Le président,*

**MICHAEL KIRBY**

*Chair*



The Senate

Standing Senate Committee on Social Affairs,  
Science and Technology

# The Health of Canadians - The Federal Role

Final Report on the state of the health care  
system in Canada

*Chair:*

The Honourable Michael J. L. Kirby

*Deputy Chair:*

The Honourable Marjory LeBreton

October 2002

**Volume Six:  
Recommendations  
for Reform**

*Ce document est disponible en français.*



Available on the Parliamentary Internet:  
[www.parl.gc.ca](http://www.parl.gc.ca)  
(Committee Business – Senate – Recent Reports)  
37<sup>th</sup> Parliament – 2<sup>nd</sup> Session

The Standing Senate Committee on Social Affairs, Science and Technology

Final Report on  
the state of the health care system in Canada

*The Health of Canadians - The Federal Role*  
*Volume Six:*  
*Recommendations for Reform*

*Chair*

The Honourable Michael J. L. Kirby

*Deputy Chair*

The Honourable Marjory LeBreton

OCTOBER 2002



# TABLE OF CONTENTS

---

<b>TABLE OF CONTENTS</b> .....	<b>i</b>
<b>ORDER OF REFERENCE</b> .....	<b>vii</b>
<b>SENATORS</b> .....	<b>viii</b>
<b>LIST OF ABBREVIATIONS</b> .....	<b>ix</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>xi</b>
<b>FOREWORD</b> .....	<b>xiii</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>PART I: ACCOUNTABILITY</b> .....	<b>3</b>
<b>CHAPTER ONE</b> .....	<b>5</b>
THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS.....	5
1.1 Summary of Some Key Points from Volumes One through Five.....	5
1.1.1 <i>The role of the federal government</i> .....	5
1.1.2 <i>Objectives of federal health care policy</i> .....	6
1.1.3 <i>The current system is not fiscally sustainable</i> .....	8
1.1.4 <i>A national health care guarantee is critical to successful reform</i> .....	10
1.2 Improving Governance – The Need for a National Health Care Commissioner.....	11
1.2.1 <i>Canadian Medical Association (CMA)</i> .....	13
1.2.2 <i>Colleen Flood and Sujit Choudry</i> .....	14
1.2.3 <i>Tom Kent</i> .....	15
1.2.4 <i>Duane Adams</i> .....	15
1.2.5 <i>Lawrence Nestman</i> .....	16
1.3 The Committee’s Proposal.....	17
<b>PART II: EFFICIENCY MEASURES</b> .....	<b>23</b>
<b>CHAPTER TWO</b> .....	<b>25</b>
HOSPITAL RESTRUCTURING AND FUNDING IN CANADA.....	25
2.1 Funding Methods for Hospitals in Canada: Advantages and Disadvantages.....	27
2.1.1 <i>Line-by-line</i> .....	28
2.1.2 <i>Ministerial discretion</i> .....	29
2.1.3 <i>Population-based</i> .....	29
2.1.4 <i>Global budget</i> .....	30
2.1.5 <i>Policy-based</i> .....	31
2.1.6 <i>Facility-based</i> .....	32



2.1.7	<i>Project-based</i> .....	32
2.1.8	<i>Service-based</i> .....	32
2.2	<b>Service-Based Funding: Review of International Experience</b> .....	33
2.2.1	<i>United States</i> .....	33
2.2.2	<i>United Kingdom</i> .....	34
2.2.3	<i>France</i> .....	34
2.2.4	<i>Denmark</i> .....	35
2.2.5	<i>Norway</i> .....	35
2.2.6	<i>Review of international experience by the Comité Bédard</i> .....	36
2.3	<b>The Rationale for Service-Based Funding in Canada</b> .....	36
2.3.1	<i>Appropriateness of service mix</i> .....	40
2.3.2	<i>Over-servicing and up-coding</i> .....	40
2.3.3	<i>Rates, information and data</i> .....	41
2.3.4	<i>Innovation</i> .....	42
2.3.5	<i>Comprehensive health care</i> .....	43
2.3.6	<i>Escalation of costs</i> .....	43
2.3.7	<i>Lack of simplicity</i> .....	43
2.3.8	<i>Committee commentary</i> .....	44
2.4	<b>Academic Health Sciences Centres and the Complexity of Teaching Hospitals</b> .....	46
2.5	<b>Small and Rural Community Hospitals</b> .....	48
2.6	<b>Financing the Capital Needs of Canadian Hospitals</b> .....	50
2.7	<b>Public Versus Private Health Care Institutions</b> .....	53
	<b>Appendix 2.1 Academic Health Sciences Centres in Canada and their Affiliated Hospitals and Regional Health Authorities</b> .....	59

## **CHAPTER THREE ..... 63**

	<b>DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES</b> .....	63
3.1	<i>RHAs Across Canada: A Portrait</i> .....	64
3.2	<i>RHAs: Goals and Achievements</i> .....	66
3.3	<i>Barriers that Prevent RHAs from Functioning to Their Fullest Potential</i> .....	67
3.4	<i>RHAs and the Potential for Internal Markets</i> .....	70
3.5	<i>Committee Commentary</i> .....	74

## **CHAPTER FOUR..... 77**

	<b>PRIMARY HEALTH CARE REFORM</b> .....	77
4.1	<i>Why is Primary Health Care Reform Needed?</i> .....	77
4.2	<i>The Provinces and Primary Care Reform</i> .....	80
4.2.1	<i>Recent reports</i> .....	80
4.2.2	<i>The Ontario Family Health Network</i> .....	81
4.2.3	<i>Quebec</i> .....	85
4.2.4	<i>New Brunswick</i> .....	85
4.3	<i>Overcoming the Barriers to Change</i> .....	86
4.4	<i>The Federal Role</i> .....	90
	<b>Appendix 4.1: GP Fundholding in Great Britain</b> .....	93

**PART III: THE HEALTH CARE GUARANTEE ..... 97**

**CHAPTER FIVE ..... 99**

TIMELY ACCESS TO HEALTH CARE..... 99

5.1 The Right to Health Care – Public Perception or Legal Right?..... 100

5.2 The Extent to which Publicly Insured Health Services are Available Outside the Publicly Funded Health Care System..... 101

5.3 Timely Health Care and Section 7 of the Canadian Charter of Rights and Freedoms..... 102

5.4 Committee Commentary ..... 108

**CHAPTER SIX.....109**

THE HEALTH CARE GUARANTEE..... 109

6.1 The Public Perception of the Problem of Waiting Lists..... 109

6.2 The Reality of the Waiting List Problem..... 110

6.3 Canadian Experience ..... 111

6.3.1 *Cardiac Care Network of Ontario*..... 111

6.3.2 *The Western Canada Waiting List Project*..... 111

6.4 International Experience..... 113

6.4.1 *Sweden*..... 113

6.4.2 *Denmark*..... 114

6.5 Committee Recommendations..... 116

6.6 The Potential Consequences of Not Implementing a Health Care Guarantee ..... 119

6.7 Concluding Thoughts on the Health Care Guarantee..... 120

**PART IV: CLOSING THE GAPS IN THE SAFETY NET..... 123**

**CHAPTER SEVEN .....125**

EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS..... 125

7.1 Trends in Drug Spending ..... 126

7.2 International Comparisons..... 128

7.3 Coverage for Prescription Drugs in Canada..... 130

7.3.1 *Public prescription drug insurance plans*..... 130

7.3.2 *Private prescription drug insurance plans*..... 131

7.3.3 *Plan features and their relation to protection from severe drug expenses* ..... 132

7.4 An Emerging Issue: Catastrophic Prescription Drug Expenses..... 132

7.5 Protecting Canadians Against Catastrophic Prescription Drug Expenses..... 137

7.5.1 *How the plan would work*..... 138

7.5.2 *The benefits of the plan*..... 140

7.5.3 *How much would the plan cost?*..... 141

7.5.4 *Committee's Proposal for a Catastrophic Prescription Drug Insurance Plan*..... 142

7.6 The Need for a National Drug Formulary..... 143

**CHAPTER EIGHT .....145**

EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE ..... 145

8.1 Brief Review of Key Points about Home Care from Volumes Two and Four..... 145

8.2 Other Options ..... 147

8.3	The Extra-Mural Program in New Brunswick.....	148
8.3.1	<i>Building on the New Brunswick example: direct referrals to home care.....</i>	<i>150</i>
8.4	Organizing and Delivering Post-Acute Home Care.....	151
8.4.1	<i>Definition of post-acute home care.....</i>	<i>151</i>
8.4.1.1	<i>When does Post-Acute Home Care (PAHC) servicing start?.....</i>	<i>151</i>
8.4.1.2	<i>When does PAHC servicing end?.....</i>	<i>152</i>
8.4.2	<i>Organizational arrangements for PAHC.....</i>	<i>153</i>
8.4.3	<i>Who provides PAHC?.....</i>	<i>155</i>
8.5	The Cost of a National Post-Acute Home Care Program.....	156
8.5.1	<i>How to calculate the cost of a national PAHC program.....</i>	<i>156</i>
8.5.2	<i>What about hidden costs?.....</i>	<i>157</i>
8.5.3	<i>How much will a national PAHC program cost?.....</i>	<i>158</i>
8.6	Paying for Post-Hospital Home Care.....	158
<b>CHAPTER NINE.....</b>		<b>163</b>
EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE.....		163
9.1	The Need for a National Palliative Home Care Program.....	163
9.2	Financial Assistance to Caregivers Providing Palliative Care at Home.....	164
9.3	Caregiver Tax Credit.....	166
9.4	Job Protection.....	167
9.5	Concluding Remarks.....	167
<b>PART V: EXPANDING CAPACITY AND BUILDING INFRASTRUCTURE .....</b>		<b>169</b>
<b>CHAPTER TEN.....</b>		<b>171</b>
THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE.....		171
10.1	Health Care Technology.....	171
10.2	Electronic Health Records.....	175
10.3	Evaluation of Quality, Performance and Outcomes.....	177
10.4	Protection of Personal Health Information.....	179
<b>CHAPTER ELEVEN.....</b>		<b>185</b>
HEALTH CARE HUMAN RESOURCES.....		185
11.1	The Extent of Health Human Resource Shortages.....	185
11.2	Health Human Resources: The Need for a National Strategy.....	188
11.3	Increasing the Number of Physicians Trained in Canada.....	191
11.4	Integrating International Medical Graduates.....	193
11.5	Alleviating the Shortage of Nurses.....	194
11.6	Allied Health Professionals .....	197
11.7	Funding Post-Graduate Training.....	198
11.8	Health Human Resources: Scope of Practice Rules Review .....	198
11.9	Committee Commentary .....	199
<b>CHAPTER TWELVE.....</b>		<b>201</b>
NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH.....		201
12.1	Assuming Leadership in Canadian Health Research.....	202
12.2	Engaging the Scientific Revolution.....	205
12.3	Securing a Predictable Environment for Health Research .....	208
12.3.1	<i>Federal funding for health research.....</i>	<i>209</i>

12.3.2	<i>Federal in-house health research</i> .....	212
12.4	Enhancing Quality in Health Services and in Health Care Delivery.....	213
12.5	Improving the Health Status of Vulnerable Populations.....	215
12.6	Commercializing the Outcomes of Health Research.....	217
12.7	Applying the Highest Standards of Ethics to Health Research.....	221
12.7.1	<i>Research involving human subjects</i> .....	222
12.7.2	<i>Issues with respect to research involving human subjects</i> .....	224
12.7.3	<i>Animals in research</i> .....	227
12.7.4	<i>Privacy of personal health information</i> .....	229
12.7.5	<i>Genetic privacy</i> .....	234
12.7.6	<i>Potential situations of conflict of interest</i> .....	235

**PART VI: HEALTH PROMOTION AND DISEASE PREVENTION..... 237**

**CHAPTER THIRTEEN..... 239**

	HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE.....	239
13.1	Trends in Diseases.....	242
13.1.1	<i>Infectious diseases</i> .....	243
13.1.2	<i>Chronic diseases</i> .....	243
13.1.3	<i>Injury</i> .....	244
13.1.4	<i>Mental health</i> .....	244
13.2	The Economic Burden of Illness.....	245
13.3	The Need for a National Chronic Disease Prevention Strategy.....	246
13.4	Strengthening Public Health and Health Promotion.....	249
13.5	Toward Healthy Public Policy: The Need for Population Health Strategies.....	250

**PART VII: FINANCING REFORM..... 253**

**CHAPTER FOURTEEN..... 255**

	HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED.....	255
14.1	More Money Is Needed for Health Care.....	256
14.2	The Financing Role of the Federal Government.....	260
14.3	How New Federal Funding for Health Care Should Be Managed.....	262

**CHAPTER FIFTEEN..... 265**

	HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED.....	265
15.1	The Amount of Increased Federal Funding Required.....	267
15.2	Potential Sources of Increased Federal Funding.....	270
15.3	General Taxation.....	271
15.4	Earmarked Taxation.....	275
15.5	Payroll Taxes.....	278
15.6	National Health Care Premiums.....	280
15.7	User Charges.....	282
15.8	Medical Savings Accounts.....	284
15.9	Pre-Funding for Health Care.....	285
15.10	Committee Commentary.....	286
15.11	Current Federal Funding for Health Care.....	291

<b>CHAPTER SIXTEEN .....</b>	<b>295</b>
THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE .....	295
16.1 Private Health Care Insurance in Canada and Selected OECD Countries.....	297
16.2 Review of Recent Literature on the Impact of Private Health Care Insurance and Private For-Profit Delivery.....	299
16.3 Committee Commentary .....	302
 <b>PART VIII: THE CANADA HEALTH ACT.....</b>	 <b>305</b>
 <b>CHAPTER SEVENTEEN .....</b>	 <b>307</b>
THE CANADA HEALTH ACT.....	307
17.1 Universality.....	308
17.2 Comprehensiveness.....	309
17.3 Accessibility .....	313
17.4 Portability .....	315
17.5 Public Administration.....	316
17.6 Committee Commentary .....	319
 <b>CONCLUSION.....</b>	 <b>321</b>
 <b>APPENDIX A .....</b>	 <b>A-1</b>
LIST OF RECOMMENDATIONS BY CHAPTER.....	A-1
 <b>APPENDIX B.....</b>	 <b>A-19</b>
LIST OF PRINCIPLES FROM VOLUME FIVE (APRIL 2002).....	A-19
 <b>APPENDIX C.....</b>	 <b>A-23</b>
LIST OF WITNESSES.....	A-23

## ORDER OF REFERENCE

---

Extract from the Journals of the Senate of Tuesday, October 8, 2002:

Resuming debate on the motion of the Honourable Senator Kirby seconded by the Honourable Senator P  pin:

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 pressures 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 and the First Session of the Thirty-seventh Parliament be referred to the Committee;

That the Committee submit its final report no later than October 31, 2002;

That the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 60 days after the tabling of that report; 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.

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

ATTEST :

Paul C. B  lisle  
*Clerk of the Senate*

## **SENATORS**

---

The following Senators have participated in the study on the state of the health care system undertaken by the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee  
The Honourable Marjory LeBreton, Deputy Chair of the Committee

and

The Honourable Senators:

Catherine S. Callbeck  
Joan Cook  
Jane Cordy  
Joyce Fairbairn, P.C.  
Wilbert Keon  
Yves Morin  
Lucie Pépin  
Brenda Robertson  
Douglas Roche

*Ex-officio members of the Committee:*

The Honourable Senators: Sharon Carstairs, P.C. (or Fernand Robichaud, P.C.) and John Lynch-Staunton (or Noel A. Kinsella)

*Other Senators who have participated from time to time on this study:*

The Honourable Senators Atkins, Banks, Beaudoin, Carney, Cochrane, Cohen,\* DeWare,\* Ferretti Barth, Grafstein, Graham, P.C., Hubley, Joyal, P.C., Lawson, Léger, Losier-Cool, Maheu, Mahovlich, Meighen, Milne, Murray, Rompkey, St. Germain, Sibbeston, Stratton, Tunney\*, and Wilson\*

\* retired

## LIST OF ABBREVIATIONS

---

<b>ACAHO</b>	Association of Canadian Academic Healthcare Organizations	<b>CT</b>	Computed Tomogram (scan)
<b>ACMC</b>	Association of Canadian Medical Colleges	<b>DND</b>	Department of National Defence
<b>ACST</b>	Advisory Council on Science and Technology	<b>DRG</b>	Diagnostic Related Group
<b>AHSC</b>	Academic Health Sciences Centre	<b>EHR</b>	Electronic Health Record
<b>CAN</b>	Canadian Nurses Association	<b>EI</b>	Employment Insurance
<b>CAPE</b>	Clinicians Assessment and Professional Enhancement	<b>EMP</b>	Extra-Mural Program
<b>CBAC</b>	Canadian Biotechnology Advisory Committee	<b>EPF</b>	Established Programs Financing
<b>CCAC</b>	Canadian Council on Animal Care	<b>F/P/T</b>	federal/provincial/territorial
<b>CCHSA</b>	Canadian Council on Health Services Accreditation	<b>FAE</b>	Fetal Alcohol Effects
<b>CCN</b>	Cardiac Care Network of Ontario	<b>FAS</b>	Fetal Alcohol Syndrome
<b>CCOHTA</b>	Canadian Coordinating Office for Health Technology Assessment	<b>FFS</b>	Fee-for-service
<b>CDPAC</b>	Chronic Disease Prevention Alliance of Canada	<b>FHN</b>	Family Health Networks
<b>CFI</b>	Canada Foundation for Innovation	<b>FMG</b>	Family Medicine Groups
<b>CHA</b>	<i>Canada Health Act</i>	<b>GDP</b>	Gross Domestic Product
<b>CHSRF</b>	Canadian Health Services Research Foundation	<b>GP</b>	General Practitioner
<b>CHST</b>	Canada Health and Social Transfer	<b>HRDC</b>	Human Resources Development Canada
<b>CIAR</b>	Canadian Institute for Advanced Research	<b>HTA</b>	Health Care Technology Assessment
<b>CIDA</b>	Canadian International Development Agency	<b>HTF</b>	Health Transition Fund
<b>CIHI</b>	Canadian Institute for Health Information	<b>ICH</b>	International Conference on Harmonization
<b>CIHR</b>	Canadian Institutes of Health Research	<b>ICT</b>	information and communications technologies
<b>CLSC</b>	<i>Centre local de services communautaires</i> (community health centre)	<b>IDRC</b>	International Development Research Centre
<b>CMA</b>	Canadian Medical Association	<b>IMG</b>	International Medical Graduates
<b>CPP</b>	Canada Pension Plan	<b>IT</b>	Information Technology
<b>CRC</b>	Canada Research Chairs	<b>JPPC</b>	Joint Policy and Planning Committee
<b>CSTA</b>	Council of Science and Technology Advisors	<b>LPN</b>	Licensed Practical Nurse
		<b>MEF</b>	Medical Equipment Fund



<b>MOHLTC</b>	Ontario Ministry of Health and Long-Term Care	<b>PPP</b>	Purchasing Power Parity
<b>MRC</b>	Medical Research Council of Canada	<b>PPS</b>	Prospective Payment System
<b>MRI</b>	Magnetic Resonance Imaging	<b>QPP</b>	Quebec Pension Plan
<b>MSA</b>	Medical Savings Account	<b>REB</b>	Research Ethics Board
<b>NACA</b>	National Advisory Committee on Aging	<b>RHA</b>	Regional Health Authority
<b>NBEMH</b>	New Brunswick Extra-Mural Hospital	<b>RHC</b>	Regional Hospital Corporation
<b>NCEHR</b>	National Council on Ethics in Human Research	<b>RN</b>	Registered Nurse
<b>NHEX</b>	National Health Expenditure Database	<b>Rx&amp;D</b>	Canada's Research -Based Pharmaceutical Companies
<b>NHRDP</b>	National Health Research and Development Program	<b>SSHRC</b>	Social Sciences and Humanities Research Council
<b>NHS</b>	National Health Service	<b>TCPS</b>	<i>Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans</i>
<b>NRC</b>	National Research Council	<b>UBC</b>	University of British Columbia
<b>NSERC</b>	Natural Sciences and Engineering Research Council	<b>URS</b>	Urgency Rating Score
<b>ODB</b>	Ontario Drug Benefit	<b>WCB</b>	Workers' Compensation Board
<b>OECD</b>	Organisation for Economic Co-operation and Development	<b>WCWL</b>	Western Canada Waiting List
<b>OFHN</b>	Ontario Family Health Network		
<b>OHA</b>	Ontario Hospital Association		
<b>OMA</b>	Ontario Medical Association		
<b>PAHC</b>	Post-Acute Home Care		
<b>PCG</b>	Primary Care Groups		
<b>PCN</b>	Primary Care Network		
<b>PCR</b>	Primary Care Reform		
<b>PCT</b>	Primary Care Trust		
<b>PENCE</b>	Protein Engineering Network of Centres of Excellence		
<b>PET</b>	Positron Emission Tomography (scan)		
<b>PHCTF</b>	Primary Health Care Transition Fund		
<b>PIPEDA</b>	<i>Personal Information Protection and Electronic Documents Act</i>		
<b>PMSI</b>	<i>Programme de Médicalisation du Système d'Information</i>		

## ACKNOWLEDGEMENTS

---

The Committee wants to publicly acknowledge the enormous assistance it has received during the past two years from those who have worked so hard in helping the Committee to produce its six reports.

The Committee particularly wants to express its deep appreciation to:

- Odette Madore and Dr. Howard Chodos of the Research Branch of the Library of Parliament, the full-time research staff of the Committee, who have been deeply involved in all drafts of the six reports that the Committee has released during this study. Without their extraordinary help, these reports would not have been completed in such a short time, nor in such a competent manner.
- Catherine Piccinin, the Committee Clerk and her Administrative Assistant, Debbie Pizzoferrato, who were responsible for organizing all the meetings the Committee held on the health care issue, including scheduling the appearances of all the witnesses, for overseeing the translation and printing of all six reports, and for responding to thousands of requests for information about the Committee's work and for copies of the Committee's reports.
- Dr. Duncan Sinclair, the former chair of the Health Services Restructuring Commission of Ontario, who gave so generously of his time and expertise in reviewing, editing and offering suggestions for improvement in all of the drafts of the Committee's reports.
- The staff of each of the members of the Committee, who have had to endure a substantially increased work load for the past two years.

To all of these people, we express our heartfelt thanks for a job very well done.

The Committee worked long hours over many months, requiring the services of a large number of procedural, research and administrative officers, editors, reporters, interpreters, translators, messengers, publications, broadcasting, printing, technical and logistical staff who ensured the progress of the work and reports of the Committee. We wish to extend our appreciation for their efficiency and hard work.



## FOREWORD

---

This report is the culmination of a two-year study by the Standing Senate Committee on Social Affairs, Science and Technology. During this period, the Committee has heard the views of over 400 witnesses. The Committee wishes to express its sincerest thanks for the effort these witnesses made to give us their advice on what needs to be done to reform Canada's health care system and make it fiscally sustainable.

As one would expect, given the complex, ideological and political nature of health care issues, the advice we received was often conflicting. Nevertheless, the Committee considered seriously the views of all the witnesses in arriving at our recommendations.

The recommendations in this report reflect the *unanimous* view of the eleven Senators on the Committee (seven Liberals, three Progressive Conservatives, and one Independent). The experience of the eleven Committee members in public policy and health-related issues is as deep as it is varied. The Committee includes:

- two doctors: Yves Morin, a former Dean of Medicine at Laval University, and Wilbert Keon, the Chief Executive Officer of the Ottawa Heart Institute;
- two former provincial ministers of health: Brenda Robertson and Catherine Callbeck, who was also a provincial premier;
- two former Members of Parliament: Douglas Roche and Lucie Pépin, who was also a nurse;
- a former federal cabinet minister and former journalist: Joyce Fairbairn;
- two community activists: Joan Cook, who served for many years on various hospital boards, and Jane Cordy, who was also a teacher;
- two former senior members of a Prime Minister's office: Marjory LeBreton and Michael Kirby, who was also a former federal Secretary to the Cabinet for Federal-Provincial Relations.

The Committee believes that its recommendations meet *the four objectives the Committee set for itself at the outset of its work*:

- To formulate a detailed, concrete *plan of action* that did not focus heavily on governance issues or intergovernmental structures;
- To attach a *cost* to its recommendations and propose a specific *revenue raising plan*. For its report to be truly useful, the Committee felt it could not be vague on the question of precisely how its recommendations would be funded;
- To specify clearly the *changes* that each of the major stakeholders – individual Canadians, health care professionals, provincial and federal governments, etc. – would have to make so that the Committee's reform plan could be implemented successfully.

- To make clear the *consequences of not changing*, and hence of not reforming, the health care system.

The Committee feels that there is a real window of opportunity for implementing the kind of reform that is needed to ensure the long-term sustainability of Canada's health care system. The Committee believes it has worked out a detailed, concrete and realistic plan which, if implemented integrally, would lead to the strengthening of the publicly funded health care system in Canada and help guarantee its sustainability for the foreseeable future. It looks forward to pursuing its work in this direction, along with all those who share this objective.



**The health of the people is really the foundation  
upon which all their happiness and  
all their powers as a state depend.**

*Benjamin Disraeli – July 24, 1877*

**It is to the Canadian people, and their improved health,  
that the Committee dedicates this report.**





## INTRODUCTION

---

For the past two years the Standing Senate Committee on Social Affairs, Science and Technology has been studying the state of the Canadian health care system and the federal role in that system. The Committee has sat for over 200 hours and held 76 meetings. Most of these meetings were public sessions during which the Committee heard from over 400 witnesses, many of whom represented organizations that have thousands of members (such as the Canadian Medical Association and the Canadian Nurses Association).

To date the Committee has published five reports. This sixth report contains the Committee's final recommendations for reform and renewal of the Canadian health care system. These recommendations flow from the principles enunciate in Volume Five. The major topics covered in the five previous reports, as well as the subjects to be treated in future reports, are summarized in the following table:

<b>Phases</b>	<b>Content</b>	<b>Timing of Report</b>
<b>One</b>	Historical Background and Overview, Myths and Realities	March 2001
<b>Two</b>	Future Trends, Their Causes and Impact on Health Care Costs	January 2002
<b>Three</b>	Health Care Models and Practices in Other Countries	January 2002
<b>Four</b>	Issues and Options	September 2001
<b>Five</b>	Principles for Restructuring the Hospital and Doctor System and Recommendations on Several Health Care Issues	April 2002
<b>Six</b>	Recommendations with respect to Financing and Restructuring the Hospital and Doctor System and Closing the Gaps in Drug and Home Care Coverage	October 2002
<b>Thematic Studies</b>	Aboriginal Health, Women's Health, Mental Health, Rural Health, Population Health, Home Care and Palliative Care	At future dates to be determined

As the table indicates, following the release of this report, the Committee intends to examine a number of additional health-related issues. These studies will result in a series of thematic reports on: 1) Aboriginal health; 2) women's health; 3) mental health; 4) rural health; 5) population health, including literacy issues; 6) home care; and 7) palliative care.

In addition, the Committee held public hearings in September 2002 to examine the document *French-Language Healthcare – Improving Access to French-Language Health Services*, a study coordinated by the Fédération des communautés francophones et acadiennes du Canada for the Consultative Committee for French-Speaking Minority Communities. The Committee will be



releasing a report on this issue, and readers of this volume are strongly encouraged to read that report as well.

The recommendations contained in Volume Six can be grouped into six categories:

- recommendations on restructuring the current hospital and doctor system to make it more efficient and more effective in providing timely and quality patient care;
- recommendations on enacting a health care guarantee that would ensure that patients receive treatment within a specified maximum amount of time for major hospital or diagnostic procedures; if the waiting time is exceeded, the health care guarantee would require the insurer/government to pay the cost of the patient receiving the necessary service in another jurisdiction or another country;
- recommendations on expanding public health care insurance to include coverage for catastrophic prescription drug costs, immediate post-hospital home care costs, and costs of providing palliative care for patients who choose to spend the last weeks of their lives at home;
- recommendations that strengthen the federal contribution to, and role in, developing health care infrastructure, including health information systems, health care technology, the evaluation of health care system performance and outcomes, the supply of health human resources, health research, wellness promotion and illness prevention, and the nation's 16 Academic Health Sciences Centres;
- recommendations on how additional federal revenue should be raised, and on how this new revenue should be administered in a transparent and accountable manner in order to implement the recommendations in this report;
- observations on the consequences that would arise if the additional federal revenues that the Committee recommends be raised are not invested in the health care system.

As some of these recommendations will require the financial participation of the provincial and territorial governments if they are to be implemented, the Committee is keenly aware of the importance of fostering a spirit of cooperation and collaboration amongst the various levels of government in the course of working to reform and renew Canada's health care system.

***As some of these recommendations will require the financial participation of the provincial and territorial governments if they are to be implemented, the Committee is keenly aware of the importance of fostering a spirit of cooperation and collaboration amongst the various levels of government in the course of working to reform and renew Canada's health care system.***

# **Part I: Accountability**

---



# CHAPTER ONE

## THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS

---

To formulate realistic recommendations to improve the provision of health care services to Canadians, it is necessary first to have a clear view of the health care system now and an assessment of its strengths and weaknesses. From the outset, the Committee has sought to portray accurately the reality of Canada's health care system and to separate myth from fact.<sup>1</sup>

The Committee believes that an ongoing evaluation of the health care system is essential, conducted in as objective a fashion as possible. In this chapter the Committee presents its recommendations for the creation of a new National Health Care Council chaired by a Health Care Commissioner charged with carrying out this task by producing an annual report on the state of the health care system and the health status of Canadians.

Before turning to this, however, we begin with a brief review of some key elements from previous volumes of the Committee's study. These summarize the basic approach that the Committee has adopted in the course of its multi-volume study, as well as the objectives it has sought to achieve in developing its recommendations.

### 1.1 Summary of Some Key Points from Volumes One through Five

#### 1.1.1 The role of the federal government

The Committee identified the various roles of the federal government in health and health care; Volume Four set out these roles, together with a set of policy objectives for each.<sup>2</sup> The Committee also affirmed the legitimacy and importance of the federal government's roles from a number of perspectives:

- First, it is clear that Canadians strongly support national principles in health care and look to the federal government to play an important role in maintaining these principles;
- Second, federal funding for health care is especially critical at this time of reform and renewal. As the Committee makes clear in the present volume, making changes in the way the health care system is structured and operates will require spending more money - money that must be raised primarily by the federal government;
- Third, and some would say most important, only the federal government is in a position to make sure that all provinces and territories, regardless of the size

---

<sup>1</sup> See Volume One, *The Story So Far*, Chapter Six, Myths and Realities, pp. 93ff.

<sup>2</sup> See Volume Four, *Issues and Options*, Chapters Three and Four, pp. 9-26.

of their economies, have at their disposal the financial resources to meet the health care needs of their citizens. This redistributive role of the federal government is fundamental to what many call “the Canadian way.”

- Fourth, fundamental changes to the health care system should not be confined to one or two provinces. Our national system requires inter-provincial harmonization in which the federal government has a crucial role to play, through, for example, its use of financial incentives and/or penalties to encourage provincial and territorial governments to adopt country-wide standards.
- Fifth, the Committee believes strongly that the substantial sums of money transferred by the federal government to the provinces and territories for health care should ensure that the federal government has a seat at the table when restructuring of the health care system is discussed. The principle of accountability to the taxpayers requires the federal government to have a say in how that money is spent.

***It is very clear to the Committee that Canadians want the provinces, the territories and the federal government to work collaboratively in partnership to facilitate health care renewal. Canadians are impatient with blame-laying; they want intergovernmental cooperation and positive results.***

Finally, it is very clear to the Committee that Canadians want the provinces, the territories and the federal government to work collaboratively in partnership to facilitate health care renewal. Canadians are impatient with blame-laying; they want intergovernmental cooperation and positive results.

### **1.1.2 Objectives of federal health care policy**

The Committee has pointed out that federal policy in health care flows from two overarching objectives – objectives that the Committee strongly supports as the primary goals to be pursued by the federal government in the field of health care. These two objectives are:

- *To ensure that all Canadians have timely access to medically necessary health services regardless of their ability to pay for these services.*
- *To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.*

***The Committee believes that federal policy in health care flows from two objectives:***

- ***To ensure that all Canadians have timely access to medically necessary services regardless of their ability to pay for these services.***
- ***To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.***

Implicit in these two objectives, particularly the first, is the requirement that the medically necessary services provided under Medicare be of high quality. Clearly, providing access to services of inferior quality would defeat the purpose of Canada’s health care system.

With respect to the pre-eminent piece of federal legislation in health care, the *Canada Health Act* (1984), the Committee has repeatedly expressed its unqualified support for the four patient-oriented principles in the *Canada Health Act*. The Committee has also endorsed the intent of the fifth principle of the *CHA*, although it is of a different character:

- The principle of **universality**, which means that public health care insurance must be provided to all Canadians;
- The principle of **comprehensiveness**, which is meant to guarantee that all medically necessary hospital and doctor services are covered by public health care insurance;
- The principle of **accessibility**, which means that financial barriers to the provision of publicly funded health services, such as user charges, are discouraged, so that needed care is available to all Canadians regardless of their income;
- The principle of **portability**, which means that all Canadians are covered under public health care insurance, when they travel within Canada or move from one province to another.
- The principle of **public administration** does not focus on the patient but “is rather the means of achieving the end to which the other four principles are directed.”<sup>3</sup> The public administration condition of the *Canada Health Act* is the basis for the single insurer/funder model that the Committee has endorsed in Volume Five under Principle One.<sup>4</sup> This condition of the Act requires provincial and territorial health care insurance plans to be managed on a not-for-profit basis by a public agency.

The Committee has also agreed with the Honourable Monique Bégin, the federal Minister of Health at the time that the *Canada Health Act* was passed, that the principle of public administration has come to be misunderstood.<sup>5</sup> The Committee strongly supports the single-payer insurance system whereby the government is the funder of hospital and doctor services. The public administration principle refers to the *funding* of hospital and doctor services, *not to the delivery* of those services.

***The principle of public administration has come to be misunderstood. The Committee strongly supports the single-payer insurance system whereby the government is the funder of hospital and doctor services. The public administration principle refers to the funding of hospital and doctor services, not to the delivery of those services.***

The misunderstanding of the principle of public administration has arisen out of the confusion between publicly funded and administered health insurance and the actual delivery of health care services themselves. Under the *Canada Health Act*, services do not have to be

---

<sup>3</sup> Volume One, p. 41.

<sup>4</sup> Volume Five, pp. 23-25.

<sup>5</sup> See her testimony before the Committee, May 8, 2002 (54:5).

delivered by public agencies. Indeed, in Canada today the great majority of health care services are delivered by a variety of private providers and institutions.

The Committee reaffirms its commitment to the principle that every Canadian should be guaranteed access to medically necessary services by a publicly funded and administered insurance program, everywhere in Canada. This has been the essence of Canadian health care policy for over 30 years, and is clearly reflected in the *Canada Health Act*.

Pursuit of the objectives of Canadian health care policy involves a “contract” between Canadians and their governments – federal, provincial and territorial. Canadians pay taxes to their governments, which then use the money (in part) to fund a universal insurance plan that provides to all Canadians first-dollar coverage for medically necessary services delivered by hospitals and doctors. These services must be accessible, comprehensive, and portable among provinces and territories. The “contract” requires governments (federal and provincial/territorial) as insurers, to use the funds collected from Canadians to meet the two policy objectives stated above, i.e., to ensure that Canadians are publicly insured and have timely access to medically necessary hospital and doctor services of high quality.

### **1.1.3 The current system is not fiscally sustainable**

The Committee’s next step was to tackle the question of whether or not the system, in its current form and given current levels of government funding, was sustainable. In Volume Five, the Committee defined a fiscally sustainable health care system as one on which Canadians could rely both today and in the future, given governments’ predicted fiscal capacity and taxpayers’ willingness to pay.

Two constraints must be taken into account in assessing fiscal sustainability. The first is the willingness of taxpayers to pay (consent of the governed). The second is the need, for economic development purposes, for governments to keep tax rates competitive with those in other OECD countries, and particularly with the United States.

In the Committee’s view, long-term fiscal sustainability depends on the ratio of public expenditures on health care to other government spending. If this ratio becomes too large it may indicate that spending on health care is crowding out other necessary government spending.

The Committee recognizes that sustainability can also be considered in terms of the total share of the Gross Domestic Product (GDP) that is devoted to health care, whether paid through the public purse or privately. However, what that share should be is impossible to say without thorough analysis of the benefits Canadians derive from health care. Conducting such a cost-benefit analysis is precluded at present by the system’s lack of the capacity to capture, record, share, and otherwise manage health information. So the best the Committee can do is observe that Canada’s spending

***Regardless of how it is expressed, there is only one source of funding for health care– the Canadian public – and it has been shown conclusively that the most cost-effective way of funding health care services is by using a single (in our case, publicly administered or governmental) insurer/payer model.***

on health care, expressed as a share of GDP, is roughly comparable to that of other developed countries apart from the United States, where it is clearly much higher than in any other industrialized country.

The Committee is keenly aware that shifting more of the cost to individual patients and their families via private payments, the facile “solution” recommended by many, is really nothing more than an expensive way of relieving or, at the least, diminishing governments’ problem. Regardless of how it is expressed (as a share of GDP, share of government spending, etc.), there is only one source of funding for health care – the Canadian public – and it has been shown conclusively that the most cost-effective way of funding health care is by using a single (in our case, publicly administered or governmental) insurer/payer model.

The Committee believes strongly that Canada should continue to adhere to this most efficient and effective model of universal health care insurance, and it is clear to the Committee that Canadians believe this too. Therefore, in formulating its recommendations, the Committee has not concentrated on measures of funding related to GDP. Instead, it has sought to assess how much public spending is necessary to sustain Medicare and, in particular, how much is needed to accomplish the changes that are essential if this highly popular and largely publicly funded program is to meet the needs of Canadians into the twenty-first century.

During the Committee’s cross-country hearings, a wide range of witnesses, including health care managers, providers and consumers, expressed deep concern about rising health care costs and their impacts both on governments’ budgets and on patient care. Based on this testimony as well as on numerous reports, the Committee has concluded that rising costs strongly indicate that Canada’s publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels.

The lack of sustainability is already manifest in the fact that the system does not currently have sufficient resources to respond to all the demands that are placed upon it. In particular, timely access to quality health services is increasingly not the norm. The Committee is aware that no system providing services that are perceived to be “free” can ever fully meet the demands placed on it, and that at present we are unable to discriminate between the demand and the genuine need for timely access to health services of all kinds. Nonetheless, the widespread perception of deterioration in the quality of service available to Canadians highlights the fact that Canadians must decide what future course of action they want their governments to take. The Committee stressed that there are three basic options from which the Canadian public must choose:

***The Committee has concluded that rising costs strongly indicate that Canada’s publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels.***

- Growing waiting lists as a result of increased rationing of publicly funded health services;
- Increasing government revenue;
- Making some services available more quickly to those who can afford to pay privately for them by allowing the development of a parallel privately funded



tier of health services, supplementary to the publicly funded system maintained for all other Canadians.<sup>6</sup>

As will be evident in the remainder of this report, the Committee fervently hopes that Canadians will agree with the Committee that the second option is the most desirable choice. Having unanimously reached this conclusion, the Committee has departed from usual practice in parliamentary committee reports by specifying in some detail how much additional public money is required to ensure the long-term fiscal sustainability of the health care system, recommending where this new money should be spent, and recommending how the increased government revenue could be raised.

The Committee has concluded that an additional \$5 billion is needed annually to reform and renew the health care system. This is the estimated annual cost of implementing the Committee's recommendations. The Committee also stresses, however, 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. This \$5 billion in new federal money must be used to buy change, to reform and renew the system.

***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. This \$5 billion in new federal money must be used to buy change, to reform and renew the system.***

#### **1.1.4 A national health care guarantee is critical to successful reform**

In general, the principle that the Committee has followed in working out its vision for reform of the system has been that incentives for all participants must be introduced in the publicly funded hospital and doctor system – providers, institutions, governments and patients – to deliver, manage and use health care more efficiently and effectively. In particular, although it does not stand entirely on its own, one element that is key to the successful reform of the system is what the Committee has called the health care guarantee.

This recommendation, described in detail in Chapter Six, is designed to address the problem of growing waiting times for access to health services by requiring governments to meet reasonable standards, by ensuring patients have access to services in their own jurisdiction, elsewhere in Canada or, if necessary, in another country. Meeting reasonable patient service standards is an essential part of the health care contract between Canadians and their governments. The Committee believes that by judiciously investing the new money and legislatively enshrining the principle of the health care guarantee, it will be possible to restore the Canadians' confidence that their governments will spend their tax dollars in ways that reinforce the publicly funded health care system and ensure that the system provides access to medically necessary services when and where they are needed.

In presenting its proposals, the Committee also believes that it was important to acknowledge that its preferred option for raising new money, and its plan on how to spend it,

---

<sup>6</sup> Note that the “delisting” of services means requiring Canadians to pay privately for specific services that once were paid for under the publicly administered and funded health insurance program (Medicare).

including implementing the health care guarantee, are not the only options available. If, after public discussion, governments decide that they are not willing to pay more to fund hospital and doctor services, or if the insurer (government) decides not to implement the health care guarantee, then the result would be the continued (and probably increased) rationing of services and lengthening of waiting times.

Moreover, as the Committee points out in Chapter Five below, allowing waiting times to grow longer - that is, failing to implement the health care guarantee - could have significant additional consequences. Such failure is highly likely to lead to the Supreme Court issuing a judgment that since timely access to needed medical service is not being provided in the publicly funded system, then government can no longer deny Canadians the right to purchase private insurance to cover the cost of paying for the provision of service elsewhere, i.e., at private health care institutions in Canada. Thus, failing to implement the health care guarantee is likely to move the Canadian health care system in the direction of introducing a second private tier of services available only to those who can afford to pay for them out-of-pocket or through supplementary private health care insurance.

When this possibility was raised in previous reports, some commentators felt that the Committee was in fact advocating greater privatization of the health care system. As this volume should make abundantly clear, that is not the case.

The Committee has worked out a detailed, concrete and realistic plan that, if implemented integrally, will lead to strengthening the publicly funded health care system in Canada and guarantee its sustainability for the foreseeable future. However, this option costs money, and the great majority of Canadians would be required to contribute additionally in taxes in order to implement the proposed plan. In the event that governments are unwilling to raise increased revenue to invest in the publicly funded health care system, it is essential that Canadians fully understand the implications of such a decision. One such implication is likely to be not only the continued deterioration of the system, but also judgments by the courts that hasten the development of a parallel private system of health care in Canada.

## **1.2 Improving Governance – The Need for a National Health Care Commissioner**

An essential element to enable Canadians to make informed choices, now and in the future, is for the Canadian public to have access to a reliable and non-partisan assessment of the true state of the health care system. The remainder of this chapter sets out the Committee's proposal to create an institutional structure that would give Canadians such an assessment annually.

***The Committee believes that it is essential to improve the governance of Canada's health care system.***

It is essential to improve the governance of Canada's health care system. The question of governance (which is to say leadership) brings together a number of issues that the Committee has raised in previous volumes and that witnesses have addressed from a number of perspectives.

One thing is very clear. Canadians are tired of the endless finger-pointing and blame-shifting that have been recurring features of intergovernmental relations in the health care field. As the Honourable Monique Bégin has accurately pointed out, the current state of federal-provincial relations is dysfunctional.<sup>7</sup> On far too many occasions, each side seems more interested in attributing blame for the system's apparent deterioration to the other, rather than taking the lead to ensure that the health services Canadians need and deserve are there when they need them.

Fundamentally the underlying issue is one of accountability. In order to establish who is to be held accountable for the deficiencies (and also the strengths) of the health care system, the Committee has repeatedly pointed out that detailed and reliable information on the performance of the system and on health outcomes is essential. This is why the Committee has placed such importance on the development of a capacity for health information management, on putting in place a national system of electronic patient records<sup>8</sup> and on sustaining and expanding the health research infrastructure.<sup>9</sup> The Committee has drawn attention to the important contribution that the Canadian Institute for Health Information (CIHI) has already made to improving our knowledge of the state of the health care system; it is clear that this positive source of experience must be built upon.

Information must be analyzed and interpreted objectively if it is to serve as a reliable guide to evidence-based decision-making. In Volume Five, the Committee identified four fundamental elements that are necessary to create the capacity to evaluate fully and fairly the performance of the health care system and the health status of the Canadian population, as well as to hold the appropriate parties accountable:

- First, such evaluation must be conducted by a body that is independent of government. The Committee expressed its strong support for “the view of witnesses and provincial reports that the roles of the funder and provider should be separated from that of the evaluator in order to obtain independent assessment of health care system performance and outcomes.”<sup>10</sup> Only in this way can actual and perceived conflicts of interest be avoided and the credibility of evaluation reports with the Canadian public be assured.
- Second, the Committee affirmed that “such independent evaluation should be performed at the national (not federal) level.”<sup>11</sup> The reality of the Canadian health care system is that it is a joint responsibility of the provincial/territorial and federal governments. No body that reports exclusively to, or was created exclusively by, one level or the other would have the necessary credibility.
- Third, while the evaluation must be conducted by an independent, arms-length agency, it must be funded by government. Moreover, as we will argue below, leadership in providing the necessary financing for this initiative must

---

<sup>7</sup> Monique Bégin, “Renewing Medicare,” *Canadian Medical Association Journal*, July 9, 2002, p. 47.

<sup>8</sup> See Chapter 10.

<sup>9</sup> See Chapter 12.

<sup>10</sup> Vol. 5, p. 51.

<sup>11</sup> *Ibid.*

be provided by the federal government, despite the “national” (as opposed to federal) character of the evaluation organization.

- Finally, as noted above, it is essential that this undertaking build on the successes of existing organizations, such as the Canadian Institute for Health Information (CIHI) and the Canadian Council for Health Services Accreditation (CCHSA). The Committee makes specific recommendations with regard to these organizations in Chapter Ten.

The Committee believes, however, that, on their own, existing organizations are not enough. What is needed is a permanent independent body charged with reporting annually to the Canadian public on the state of the nation’s health care system and on the health status of Canadians. The Committee also believes that this body should be responsible for advising the federal government, on an annual basis, on how new money raised for renewing and reforming the health care system should be allocated. Such a body must have sufficient resources at its disposal, and work with CIHI and CCHSA (and possibly others), to collect and assess the data and information it requires.

***What is needed is a permanent independent body charged with reporting annually to the Canadian public on the state of the nation’s health care system and on the health status of Canadians. The Committee also believes that this body should be responsible for advising the federal government, on an annual basis, on how new money raised for renewing and reforming the health care system should be allocated.***

Such a body must have sufficient resources at its disposal, and work with CIHI and CCHSA (and possibly others), to collect and assess the data and information it requires.

Before setting out the Committee’s own proposal, we review briefly some other ideas that have been put forward in recent months that describe ways of providing the Canadian public with annual evaluation reports on the state of the health care system. In the Committee’s view, the various proposals contain many useful elements, but none fully meets the Committee’s requirements.

### **1.2.1 Canadian Medical Association (CMA)**

The CMA has proposed a two-pronged approach.<sup>12</sup> First, it advocates the adoption of a Canadian Health Charter with three main parts: a vision statement, a section on national planning and coordination, and a section on roles, rights and responsibilities. This Charter would set the parameters for better national planning and coordination, particularly with respect to reviewing core health care services; developing national benchmarks for the timeliness and quality of health care; determining resource needs, including health human resources and information technology; and establishing national goals and targets to improve the health of Canadians.

The CMA’s proposal also provides for the creation of a Canadian Health Commission, a permanent, depoliticized forum at the national level for ongoing dialogue and debate. The commission’s mandate would include the following responsibilities:

- Monitor compliance with the Canadian Health Charter

---

<sup>12</sup> See its document, *A Prescription for Sustainability*, June 2002.

- Report annually to Canadians on the performance of the health care system and the health status of the population
- Advise the Conference of Federal–Provincial–Territorial Ministers of Health on critical health-related issues.

The commission proposed by the CMA would be chaired by a Canadian Health Commissioner, who would be an officer of Parliament (similar to the Auditor General) appointed for a five-year term by consensus among the federal, provincial and territorial governments. The commission would operate at arm's length from governments, yet maintain close links with government agencies such as the Canadian Institute for Health Information and the Canadian Institutes of Health Research. Its deliberations would be made public, and its composition would not be constituency-based but would reflect a broad range of perspectives and expertise.

### **1.2.2 Colleen Flood and Sujit Choudry**

In a paper prepared for the Romanow Commission,<sup>13</sup> Professors Colleen Flood and Sujit Choudry of the University of Toronto argue that there is a real need for a non-partisan national body, protected from day-to-day politics, with a longer-term view than is possible for an elected government. They propose the creation of a Medicare Commission that would be an expert, independent body, appointed jointly by provincial and federal governments, but funded by the federal government.

The role of this Medicare Commission would include:

- determining specific performance indicators to help provinces achieve national standards set out in the *Canada Health Act*;
- publishing (in conjunction with the Canadian Institute for Health Information) annual reports on the performance of provincial health insurance systems;
- providing financial assistance to those provinces that undertake to implement the processes or programs identified by the Commission.

Funding for the commission would be separate from federal transfers for health care. It would consist of new federal money, a consolidation of all one-off payment initiatives in the health care area currently undertaken by the federal government (for example, in primary care and other areas).

One possible method Flood and Choudry describe for composing the commission is for each province to appoint 1 commissioner and the federal government to appoint 5, for a total of 15 full-time commissioners, who would then select a chief commissioner from among themselves. All decisions would require a two-thirds majority, meaning that federal commissioners would require support from a majority of provincial commissioners for any

---

<sup>13</sup> Colleen M. Flood and Sujit Choudry, *Strengthening the Foundations: Modernizing the Canada Health Act*, Discussion Paper No.13, released by the Commission on the Future of Health Care, August 2002.

decision.<sup>14</sup> The commission that they propose would have an expert staff of health service researchers and would make its reports publicly available, including specific findings on the compliance of provincial health care plans with national standards.

### **1.2.3 Tom Kent**

Tom Kent was a senior federal public servant at the time Medicare was created, and is often referred to as a father of Medicare. Her has suggested that Ottawa and the provinces appoint, by consensus, an advisory council with a wide range of expertise.<sup>15</sup> The purpose is neither to replace provincial management of provincial programs nor to impair federal accountability for the principles of Medicare. Rather, the council is conceived as a collaborative mechanism that would be a bridge between the two levels of government, thereby bringing political reality into harmony with the way most Canadians already see Medicare, namely, as a joint responsibility within our federal system.

Kent's council would be funded jointly by the federal and provincial governments. It would employ an executive director and staff, who would be neither federal nor provincial officials. It would report to a joint committee of health ministers, for which it would conduct investigations and make recommendations over the whole range of medicare principles and practices.

The proposed council would provide a focus for collaboration that would facilitate innovation and efficiencies, as well as provide a forum for broader consultation on health policy. Administratively, it could be used to supervise the implementation of agreements on such matters as electronic health records, health care information, a national drug formulary, bulk purchasing, facility sharing, etc. Importantly, Kent argues that the agency could foster public accountability by preparing regular reports for the ministerial committee to issue.

### **1.2.4 Duane Adams**

In his review of proposals for improving the governance of the Canadian health care system,<sup>16</sup> the late Professor Duane Adams, founding director of the Saskatchewan Institute of Public Policy, noted that “there may be benefits to the federation and the Canadian people if an external-to-government health oversight body were added to the Canadian health system’s governance mechanism.” He points out that even though most governments are very sceptical and leery of these “arm’s-length” agencies because they have the potential to “deplete the unilateral power of governments,” “an independent oversight body should be seen as one option in a range of possibilities, to enhance public participation, transparency, public accountability, and public confidence.”

---

<sup>14</sup> It should be noted that is formula would appear to allow the provincial commissioners to band together to make decisions that were unanimously opposed by the federal commissioners.

<sup>15</sup> Tom Kent, *Medicare: It's Decision Time*, The Caledon Institute of Social Policy, 2002.

<sup>16</sup> Duane Adams, “Conclusions: proposals for advancing federalism, democracy and governance of the Canadian health system,” in *Federalism, Democracy and Health Policy in Canada*, ed. Duane Adams, McGill-Queen’s University Press, 2002.

One option presented by Adams was a Canadian Health Council that would have an element of public participation and employ a small number of permanent staff. Its functions might include:

- monitoring the Canadian health system, and regularly advising governments and Canadians about its findings;
- appraising specific Canada-wide health issues of immediate public concern and developing practical options to address them;
- serving as a neutral fact-finding body for intergovernmental disputes concerning the *Canada Health Act* and other issues referred to it by governments, and serving upon request by governments as a facilitator/mediator in the dispute resolution process;
- providing an annual report to the public about the performance of the health system and emerging issues;
- taking some defined responsibility to test innovative health service delivery and management concepts of national significance;
- perhaps serving as one possible vehicle to assemble and disseminate best practice experiences from the Regional Health Authorities across Canada.

This Council would be part of a network of bodies that would contribute to improving the governance of the health care system. It could include representatives from the Canada Health Services Research Foundation, the Canadian Institutes of Health Research, the Canadian Institute for Health Information, and the Canadian Council on Health Services Accreditation.

### **1.2.5 Lawrence Nestman**

In his testimony before the Committee,<sup>17</sup> Professor Lawrence Nestman from the School of Health Services Administration at Dalhousie University drew on the experience of the Dominion Council of Health in the 1960s. This Council was a permanent body where deputies and ministers liaised with a number of health commissions at both the federal and provincial levels. It had a permanent secretariat staffed by highly skilled people who related to full-time public servants in provincial health departments. This arrangement enabled greater continuity in policy making and more coordination of federal-provincial relationships than is possible today. Professor Nestman therefore proposed “the concept of a revised Dominion Council of Health for the federal government as well as some kind of permanent infrastructure in the provinces [that] would improve federal-provincial relations and provide continuity as well as some arm’s length input for the day-to-day operations.”<sup>18</sup>

---

<sup>17</sup> May 9, 2002. (*Proceedings*, Issue 55)

<sup>18</sup> *Ibid.*, 55:13.

### 1.3 The Committee's Proposal

While each of the above proposals contains interesting elements and valuable suggestions, none meets fully the Committee's view of what is required. Moreover, they all tend to assign much broader mandates to the bodies they recommend than the Committee feels is appropriate at this time. The Committee agrees with the many witnesses who stressed the importance of taking measures to "depoliticize" the management of the

health care system. However, the Committee feels that this will be a long-term process, and that it is important to begin with the evaluation function only. Therefore, the Committee believes that the mandate of the independent evaluation body should be to publish an annual report on the state of the health care system, and on the health status of Canadians, as well as whatever other reports it feels are needed to spur improvements in health outcomes and the delivery of health care in Canada. The Committee believes it would also be appropriate for this independent evaluation body to advise the federal government on how new money raised to reform and renew the health care system should be spent (see Chapter Fourteen).

***The Committee believes that the mandate of the independent evaluation body should be to publish an annual report on the state of the health care system, and on the health status of Canadians, as well as whatever other reports it feels are needed to spur improvements in health outcomes and the delivery of health care in Canada.***

To legitimate such reports with all levels of government, and yet to ensure their independent production and thereby their credibility with the Canadian public, the Committee recommends that the following structures and procedures be put in place.

First, a new federal/provincial/territorial (F/P/T) body is required. This committee must be structured so that neither the federal nor the provincial/territorial representatives are able to dominate it. It is therefore proposed that the committee be composed of one provincial/territorial representative from each of the five major regions of the country (Atlantic, Quebec, Ontario, Prairies, British Columbia), and five representatives from the federal government. The provincial/territorial representatives would be selected in a manner that remains to be determined.<sup>19</sup>

This F/P/T committee, after consulting with a broad range of health care stakeholders, would appoint a National Health Care Commissioner. It would also select the members of a National Health Care Council that the Commissioner would chair from among those nominated by the Commissioner. In making nominations to the Council, the Commissioner would have the responsibility of ensuring that the membership of the Council is balanced, and that the public at large is represented. Councillors should be appointed on the basis of their ability to take a global view of the health care system, and not as representatives of specific health care constituencies.

---

<sup>19</sup> This form of provincial/territorial representation is already used in the composition of the Board of Directors of Canadian Blood Services, whose mission is to manage the blood and blood products supply for Canadians in all provinces except Quebec. Four of its Directors represent one of each of the following regions: (a) British Columbia and Yukon, (b) Prairies, Northwest Territories and Nunavut, (c) Ontario, and (d) Atlantic.



So that the selection of the Commissioner and the members of the Council not be dominated by either the federal or provincial/territorial representatives, a two-thirds majority would be required for all appointments. With 10 members on the F/P/T committee, seven votes would be required to confirm all appointments, meaning that neither the federal nor the provincial/territorial representatives could succeed on their own. This procedure further guarantees that the members of the Council would be independent of government (having being nominated by the Commissioner), yet possessing sufficient legitimacy to lend weight to their report (having been appointed by the F/P/T committee).

The Commissioner should be appointed for a five-year term, with the possibility of a single renewal. Council members should be appointed for three-year terms, with the possibility of a single renewal. Half the council would be up for renewal every three years. Eight is a reasonable number of councillors, a total of nine including the Commissioner. They should be adequately compensated for their work with the Council, but would not be full-time employees. A full-time staff would report to the Commissioner.

The Council would have ultimate responsibility for the publication of the annual report and would present it to each Ministry of Health with a request that it be tabled with all federal, provincial and territorial legislatures. The Committee recommends that all F/P/T Ministers of Health respond formally within six months to the annual report that the National Health Care Council would produce. While the Committee recognizes that it would not be possible to require legally that the F/P/T Ministers of Health respond to the annual report, it believes that the Ministers should accept responsibility for issuing a formal response within a six-month period. This would be much like the current requirement for the federal government to respond within a specified time frame to the recommendations made by House of Commons committees. It would ensure that serious consideration is given to the Council's annual report. Furthermore, since the Council's annual report would simultaneously be made public, there would be additional public pressure on all governments to consider carefully and respond to the report and its recommendations.

The Committee believes that the federal government should show leadership by providing the funding for the work of the Commissioner and the Council. This funding should come from the new money that the Committee recommends be raised in Chapter Fifteen.

Should the Commissioner and the Council see the need to broaden the scope of their work, or should the federal and provincial governments initiate such expansion, the provision of any additional funding should be the responsibility of governments on a 50/50 federal/provincial basis, and not necessarily fall exclusively on the shoulders of the federal government.

The Commissioner would be responsible for hiring the necessary professional and technical staff to carry out the Council's mandate. In this regard, however, the Commissioner should not attempt to duplicate the work of existing organizations. Rather, the Commissioner would cooperate with CIHI and CCHSA, and other concerned federal and provincial organizations, to ensure application of the most efficient methods possible to gather the data and information required to produce the annual report (see Chapter Ten).

The Committee believes that, structured in this way, the National Health Care Council chaired by an independent Health Care Commissioner meets the four conditions described earlier:

- The process has a national and not purely federal character;
- The Commissioner and the Council are independent of government, yet have the legitimacy of having been appointed by government representatives;
- The production of an annual report is funded by government;
- The work of the Commissioner and the Council builds on existing organizations.

In summary, then, the Committee recommends that:

**New federal/provincial/territorial committee made up of five provincial/territorial and five federal representatives be struck. Its mandate would be to appoint a National Health Care Commissioner and the other eight members of a National Health Care Council from among the Commissioner's nominees;**

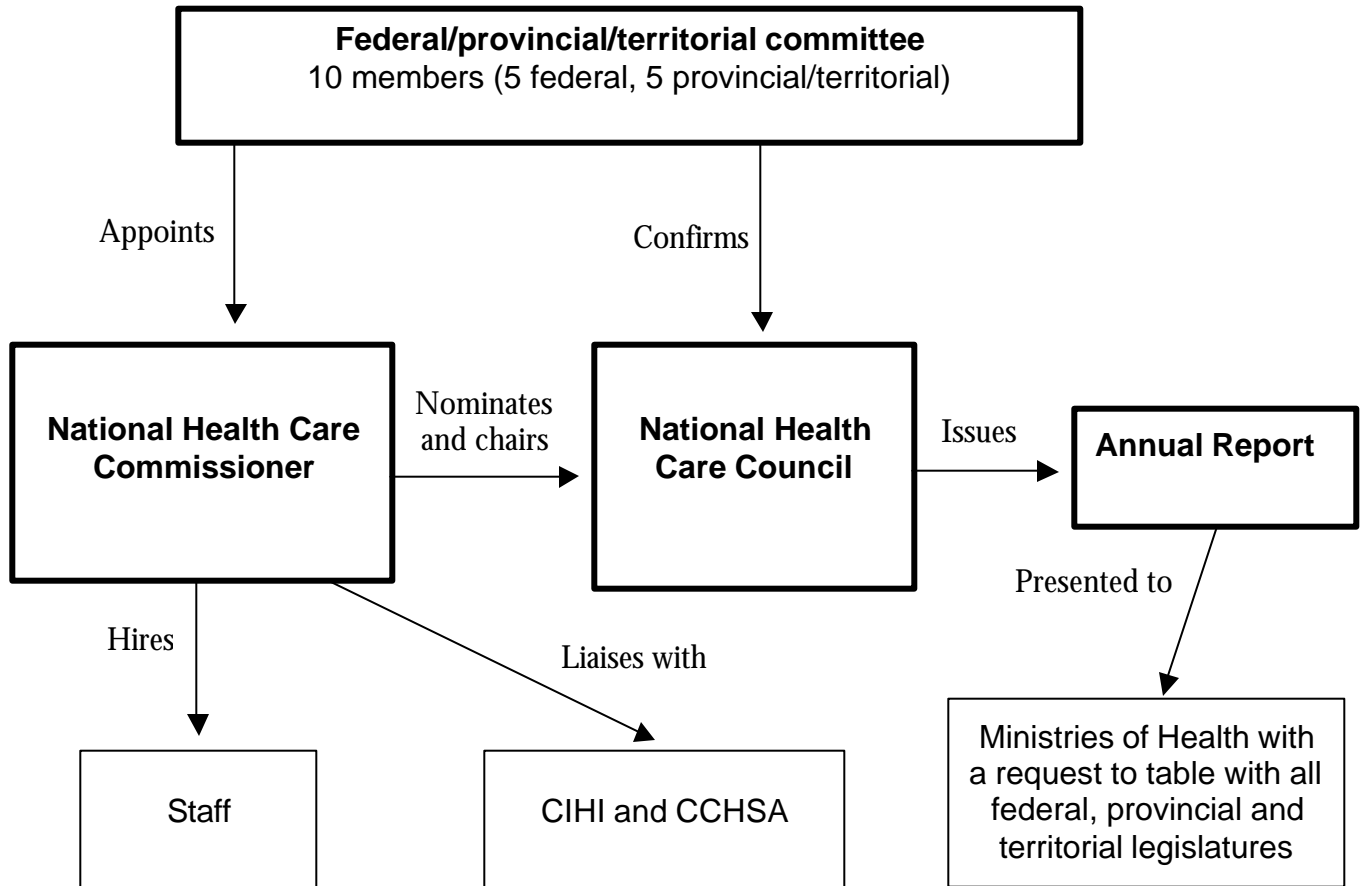
**The National Health Care Commissioner be charged with the following responsibilities:**

- **To put nominations for members to a National Health Care Council before the F/P/T committee and to chair the Council once the nominees have been ratified;**
- **To oversee the production of an annual report on the state of the health care system and the health status of Canadians. The report would include findings and recommendations on improving health care delivery and health outcomes in Canada, as well as on how the federal government should allocate new money raised to reform and renew the health care system;**
- **To work with the National Health Care Council to advise the federal government on how it should allocate new money raised to reform and renew the health care system in the ways recommended in this report;**
- **To hire such staff as is necessary to accomplish this objective and to work closely with existing**

**independent bodies to minimize duplication of functions.**

**The federal government provide \$10 million annually for the work of the National Health Care Commissioner and the National Health Care Council that relates to producing an annual report on the state of the health care system and the health status of Canadians, and to advising the federal government on the allocation of new money raised to reform and renew the health care system.**

**Figure 1.1**  
**Proposal For A National Health Care Commissioner**  
**and A National Health Care Council**





# **Part II: Efficiency Measures**

---



## CHAPTER TWO

### HOSPITAL RESTRUCTURING AND FUNDING IN CANADA

With few exceptions, Canadian hospitals exist as not-for-profit entities.<sup>20</sup> Ownership usually resides with community-based not-for-profit corporations, religious organizations, or (rarely) with municipal governments or universities. Apart from psychiatric hospitals, provincial/territorial governments rarely own hospitals. In all cases, however, the vast majority of hospital revenues come from a single funder – the provincial/territorial department of health.

**TABLE 2.1**  
**HOSPITAL SPENDING IN CANADA, 1986 TO 2001**  
**(AS A PERCENTAGE OF TOTAL HEALTH CARE EXPENDITURES)**

	1986	1991	1996	1998	2001
<b>British Columbia</b>	37.0	34.1	30.4	29.6	28.1
<b>Alberta</b>	39.8	39.1	30.1	29.8	29.9
<b>Saskatchewan</b>	34.3	34.0	26.7	26.3	28.2
<b>Manitoba</b>	39.3	37.8	33.2	32.1	30.0
<b>Ontario</b>	37.9	36.0	33.2	30.6	29.6
<b>Quebec</b>	46.9	44.4	38.0	38.4	36.4
<b>New Brunswick</b>	42.6	40.9	39.1	36.8	38.1
<b>Nova Scotia</b>	47.0	46.1	38.7	40.5	37.8
<b>Prince Edward Island</b>	38.6	38.9	36.1	35.6	34.7
<b>Newfoundland</b>	46.2	47.8	43.4	41.4	39.3
<b>Average Canada</b>	<b>41.0</b>	<b>39.9</b>	<b>34.9</b>	<b>34.1</b>	<b>33.2</b>

Source: Calculations done by the Economics Division, Parliamentary Research Branch, Library of Parliament. Based on data from the Canadian Institute for Health Information, "Health Expenditure by Use of Funds, By Source of Finance, Province/Territory 1975-2001," *National Health Expenditure Database (NHEX)*.

Note : Hospitals include all hospitals approved by provincial governments providing acute care, extended and chronic care, rehabilitation and convalescent care, and psychiatric care, as well as nursing stations and outpost hospitals. "Average Canada" represents the unweighted average for the provinces.

Provincial governments spent some \$32.1 billion on hospitals in 2001.<sup>21</sup> This represented almost a third of total provincial/territorial government expenditures on health care. Hospitals represent the largest category of health care spending in Canada. However, their share has been declining significantly. For example, in 1986, spending on hospitals, as a percentage of total health care spending, averaged roughly 41% among the provinces. By 2001, this share fell to an average of approximately 33% (see Table 2.1). This sharp decline is due primarily to

<sup>20</sup> Only 5% of hospitals in Canada are private for-profit institutions.

<sup>21</sup> Canadian Institute for Health Information, "Health Expenditure by Use of Funds, By Source of Finance, Province/Territory 1975-2001," *National Health Expenditure Database (NHEX)* ([http://www.cihi.ca/dispPage.jsp?cw\\_page=statistics\\_results\\_source\\_nhex\\_e](http://www.cihi.ca/dispPage.jsp?cw_page=statistics_results_source_nhex_e)).



changes in knowledge and technology that increasingly permit diagnoses and therapies to be provided safely out-of-hospital and to consequent hospital downsizing and restructuring across the country. As the proportion of health care spending devoted to hospital care has decreased, that allocated to home care and other forms of community-based care has increased.

In Volume Five, the Committee enunciated a number of principles regarding the funding of hospitals. Principle One stated that Canada should keep its current single funder/insurer model for financing hospital services, and that this single insurer should be government.<sup>22</sup> Principle Eight stated that the current methods used for remunerating Canadian hospitals should be replaced by service-based funding.<sup>23</sup>

The Committee believes that service-based funding will achieve a number of important objectives, including: measuring in an appropriate manner the cost of specific hospital services; improving overall hospital efficiency; enabling the public to compare hospitals based on their performance; enhancing hospital accountability; fostering competition among hospitals; reducing waiting lists and encouraging the further development of centres of specialization.

***The Committee believes that service-based funding will achieve a number of important objectives, including: measuring in an appropriate manner the cost of specific hospital services; improving overall hospital efficiency; enabling the public to compare hospitals based on their performance; enhancing hospital accountability; fostering competition among hospitals; reducing waiting lists and encouraging the further development of centres of specialization.***

The Committee also acknowledged in Volume Five that modifications to a pure service-based funding model may be necessary for teaching hospitals and possibly for very small community hospitals. We also believe that the federal government should consider contributing to the capital investment needs of Canadian hospitals, particularly academic health science centres (or teaching hospitals) and hospitals located in areas of exceptionally high population growth.

This chapter provides information on hospital funding in Canada, summarizes the testimony received on this issue and reiterates the Committee's view of the merits of service-based funding. The chapter is divided into seven sections. Section 2.1 reviews and compares current methods used for funding hospitals in Canada. Section 2.2 describes service-based funding and reviews relevant international experience. Section 2.3 details the Committee's rationale for recommending service-based funding for hospitals in Canada and highlights the various challenges posed by this mode of hospital remuneration. Sections 2.4 and 2.5 examine in detail the particular issues raised with respect to academic health science centres and small and rural community hospitals. Section 2.6 examines the issue of capital needs of Canadian hospitals. Finally, Section 2.7 provides the Committee's view on public versus private (for-profit and not-for-profit) hospitals.

---

<sup>22</sup> Volume Five, pp. 23-25.

<sup>23</sup> Volume Five, pp. 36-39.

## 2.1 Funding Methods for Hospitals in Canada: Advantages and Disadvantages<sup>24</sup>

Provincial/territorial governments use a variety of approaches to finance hospitals. There is no one model that can accurately portray the financing of hospitals in Canada. Furthermore, provinces/territories do not use a single method to distribute funds to their hospitals. Most rely on a primary funding approach to allocate the majority of funds and a number of secondary methods to apportion lesser amounts.

Methods of hospital funding used in Canada, both primary and secondary, include: line-by-line, ministerial discretion, population-based, global budget, policy-based, facility-based, project-based and service-based. As Table 2.2 shows, provincial governments rely on seven of these methods to finance the operating costs of hospitals. Funds for capital purposes (to pay for hospital construction, major building renovations, and high-cost equipment purchases) are provided in all provinces using a project-based method.

---

<sup>24</sup> Unless otherwise indicated, the information provided in this section is based on the following documents:

Sheila Block, *The Ontario Alternative Budget 2002 – Health Spending in Ontario: Bleeding our Hospitals*, Canadian Centre for Policy Alternatives (Ontario), May 2002 ([www.policyalternatives.ca](http://www.policyalternatives.ca)).

Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et spécialisés (Comité Bédard), *La budgétisation et la performance financière des centres hospitaliers*, Santé et services sociaux, Government of Quebec, 2002 ([www.msss.gouv.qc.ca](http://www.msss.gouv.qc.ca)).

Jeffrey C. Lozon and Robert M. Fox, "Academic Health Sciences Centres Laid Bare," *Healthcare Papers*, Vol. 2, No. 3, 2002, pp. 10-36 (<http://www.longwoods.com/hp/2-3academic/index.html>).

Les Vertesi, *Broken Promises: Why Canadian Medicare is in Trouble and What Can be Done to Save It*, Document tabled with the Standing Senate Committee on Social Affairs, Science and Technology, 2001.

Ian McKillop, George H. Pink and Lina M. Johnson, *The Financial Management of Acute Care in Canada - A Review of Funding, Performance Monitoring and Reporting Practices*, Canadian Institute for Health Information, March 2001 ([http://www.cihi.ca/dispPage.jsp?ow\\_page=GR\\_32\\_E](http://www.cihi.ca/dispPage.jsp?ow_page=GR_32_E)).

Danish Ministry of Health, *Hospital Funding and Casemix*, September 1999 ([http://www.sum.dk/publika/eng/hosp\\_casemix/](http://www.sum.dk/publika/eng/hosp_casemix/)).

Nizar Ladak, *Understanding How Ontario Hospitals are Funded: An Introduction*, Joint Policy and Planning Committee, Ontario, March 1998 ([www.jppc.org](http://www.jppc.org)).

**TABLE 2.2**  
**HOSPITALS IN CANADA BY PROVINCE, 2000**

Province	Number of Hospitals	Number of Beds per 1,000	Primary Funding Approach	Secondary Funding Approach
BC	80	3.7	Line-by-Line and Pop.-Based	Policy-Based
ALTA	115	3.5	Population-Based	Policy-Based
SASK	71	3.7	Population-Based	None
MAN	79	4.1	Ministerial Discretion	None
ONT	163	2.3	Global Budget	Multiple <sup>1</sup>
QC	95	3.0	Global Budget	Multiple <sup>2</sup>
NB	30	5.3	Line-by-Line and Pop.-Based	None
NS	35	3.3	Ministerial Discretion	None
PEI	7	3.4	Ministerial Discretion	None
NFLD	33	4.6	Ministerial Discretion	None

Source: McKillop *et al.* (2001), Table 1.1 (p. 9), Table 3.2 (p. 46) and Table 3.5 (p. 53). Population data from Statistics Canada, CANSIM II, Table 051-0001.

- (1) Policy-Based, Facility-Based, Population-Based and Service-Based.  
(2) Population-Based and Policy-Based.

Note: Number of beds for Nova Scotia includes acute care only.

More specifically, two provinces (British Columbia and New Brunswick) use a line-by-line method. Four provinces (Manitoba, Prince Edward Island, Nova Scotia, Newfoundland) use a ministerial discretion method. Two provinces (Alberta and Saskatchewan) have primary operating funding approaches with a population-based method, while two others (Ontario and Quebec) use global budgets. The policy-based method is the most commonly used secondary funding approach in four provinces (British Columbia, Alberta, Ontario and Quebec). Two provinces (Ontario and Quebec) also use a population-based method in combination with the primary method.<sup>25</sup> At present, only Ontario uses a service-based method for financing selected hospital services.

### **2.1.1 Line-by-line**

Line-by-line budgeting used to be the most popular method of hospital financing in Canada. This method involves negotiating amounts for specific line items (or inputs) such as in-patient nursing services or medical/surgical supplies. The total budget allocation for an individual hospital, then, is simply the sum of the line items. British Columbia and New Brunswick still rely on line-by-line budgeting (combined with a population-based method) as their primary budgeting approach.

On the positive side, line-by-line budgeting allows provincial ministries of health to link specific activities with policy objectives through direct spending. For example, a province that wishes to promote day surgery could increase the line funding available for this activity by a

<sup>25</sup> Although the classification of funding method may be the same for a number of jurisdictions, the way in which the method is implemented may differ.

factor greater than that applied to the in-patient nursing line. Line-by-line funding also gives hospitals a higher degree of financial predictability than some other methods.

However, this method has a number of disadvantages which have caused several provincial ministries to move away from the approach. On the one hand, the line-by-line method prevents reallocation among lines and thus reduces flexibility in managing funds. On the other hand, the approach is not related to performance and therefore does not encourage efficiency. In addition, line-by-line budgeting provides information only on the cost of inputs, not on the cost or quality of outputs. Moreover, the effort involved in scrutinizing line-by-line budget detail is significant. The most serious disadvantage, however, is that it tends to diminish the capacity of hospital boards and managers to link the hospital's activities directly with the needs of the community it serves.

### **2.1.2 Ministerial discretion**

With this method, funding is based on decisions made by the provincial minister of health in response to specific requests by the hospital concerned. This method is used as the primary funding approach in Manitoba, Nova Scotia, Prince Edward Island and Newfoundland.

Although the ministerial discretion method is highly subjective, it offers a number of advantages. From the government's perspective, this method is extremely flexible; ministerial decisions are not constrained by formulas or other predetermined budgeting methods.

The major drawback of this funding approach is that it risks being myopic, inconsistent and overtly "political." Significant changes in funding can and do occur with a new government or a change in policy. Furthermore – and this is critical from the Committee's point of view – this method clearly lacks transparency. Witnesses told the Committee repeatedly that there is a need to depoliticize hospital financing. For example, Mark Rochon of the Ontario Hospital Association stated that:

*We need to consider and promote mechanisms that (...) insulate, as much as we can and are able to do, decisions concerning the provision of health services from politics.<sup>26</sup>*

### **2.1.3 Population-based**

Population-based methods use demographic information such as age, gender, socio-economic status and mortality rates to forecast the demand for hospital services. Matching the predicted demand for certain health services with the estimated cost of providing these services yields a spending forecast for individual hospitals (or for regional health authorities). At present, Alberta and Saskatchewan use population-based funding as their primary methods, while British Columbia and New Brunswick use it in combination with a line-by-line budget approach. Newfoundland, Nova Scotia, Ontario and Quebec are currently considering adopting a population-based approach as their primary funding method.

---

<sup>26</sup> Mark Rochon, Ontario Hospital Association (56:42).

The Committee learned that a population-based method, employing formulae strictly to distribute funds, can be objective, equitable and accommodate the needs of particular regions and hospitals. In addition, the CEO of the Calgary Health Region, Jack Davis, told the Committee that in Alberta, the population funding system had helped to depoliticize the allocation of resources.<sup>27</sup>

However, ensuring that a population-based formula accounts for all the factors that affect the health care a population requires is complex and difficult to implement. Such a method requires good information systems that are resource-intensive (equipment, databases, staff).

This budgeting method may become too complex and create a lack of transparency with users unable to understand or predict how funding amounts have been determined. According to Les Vertesi, Chief of the Department of Emergency Medicine at the Royal Columbian Hospital (Vancouver), a population-based funding model can only provide an estimate of where health care resources will be needed; it will not provide incentives for better service.<sup>28</sup>

#### **2.1.4 Global budget**

Global budget methods adjust previous spending (such as last year's base allocation) to derive a proposed funding level for the upcoming year. The focus is on the total hospital budget rather than on individual service activities or cost centres within the hospital. Adjustments can be made to the base amount using a multiplier (such as the rate of inflation) or a lump-sum amount to establish the funding level for future periods. Quebec introduced global budgets as its primary funding approach in 1994, while Ontario has used this method since 1969.<sup>29</sup>

The Committee learned that because hospital activities change little from year to year, provincial governments find it much easier to simply repeat the previous year's allotment with an adjustment for inflation or population growth. Therefore, global budgets are straightforward to calculate for the provincial government and predictable for the hospital. Dr. Vertesi explained that global budgets gained popularity mainly because they allowed governments to control costs while at the same time granting hospital management a great deal of discretion in the allocation of funds among a hospital's various operations.<sup>30</sup>

Similarly, in its brief, the Canadian Healthcare Association made the argument that global budgets encourage efficiency by permitting hospitals to distribute savings from one area of operation to another area of need. The Association further argued that global funding

---

<sup>27</sup> Jack Davis, Calgary Health Region (53:40).

<sup>28</sup> Les Vertesi (2001), *op. cit.*, p. 117.

<sup>29</sup> Barer, M.L. (1995), "Hospital Financing in Canada," Chapter Two in *Hospital Funding in Seven Countries*, Office of Technology Assessment: U.S. Congress, p. 23.  
(<http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1995/9525/952504.PDF>)

<sup>30</sup> Les Vertesi (2001), *op. cit.*, p. 31.

allows the delivery of comprehensive, integrated health care, which, in the long run, can reduce overall health care costs.<sup>31</sup>

Despite these advantages, many witnesses expressed the view that global budgets have numerous drawbacks and that, according to Dr. Vertesi, this mode of hospital remuneration is “an archaic funding model.”<sup>32</sup> First, the Committee was told that funding under a global budget is unrelated to the services that are actually provided by a hospital. Second, we also heard that any inequities that exist between hospitals are perpetuated through global budgets. Third, witnesses stressed that global budgets do not encourage hospitals to improve performance; indeed, they can perpetuate and reward inefficient hospitals and penalize more efficient ones. Fourth, the Committee learned that funding under a global budget cannot accommodate changes in population and management structures. Last, but perhaps most important, witnesses raised the fact that there is a progressive and permanent loss of information under global budgets about what specific hospital services cost; hospitals have no incentive to measure such unit costs.

Overall, the majority of witnesses agreed that after years of global budgets in a number of provinces, no one knows how much anything costs any more and that, as a result, it is difficult to know even approximately what the public is getting for its spending on hospitals. The Committee believes that the lack of costing data with respect to hospital services is inconsistent with our vision of what a twenty-first century service sector ought to be: that is, a sector capable of providing timely and high-quality care on the basis of strong evidence-based decision making, and held accountable as a result of governments (and the public) knowing which services in which hospitals are provided efficiently, and which are not.

***The Committee believes that the lack of costing data with respect to hospital services is inconsistent with our vision of what a 21<sup>st</sup> century service sector ought to be: that is, a sector capable of providing timely and high-quality care on the basis of strong evidence-based decision making and held accountable as a result of governments (and the public) knowing what services in what hospitals are provided efficiently and those that are not.***

### **2.1.5 Policy-based**

Under this method, funding is distributed to achieve specific policy objectives. Unlike the ministerial discretion approach, where the health department (or minister) responds to individual requests for funding, a funding decision under the policy-based method has an equal effect on all institutions that provide the services encouraged by a particular policy (such as a 48-hour postpartum stay in a family birthing unit).

From the government’s perspective, this method provides the department with a mechanism to ensure that policy initiatives are embraced by hospitals. Nonetheless, many hospitals consider that this method of funding interferes with their operations and provision of

---

<sup>31</sup> Canadian Healthcare Association, Brief to the Committee, June 2002, p. 6.

<sup>32</sup> Les Vertesi (53:44).

services. Furthermore, it is not a very predictable source of funding, since funding patterns will change if governments or policies change.

### **2.1.6 Facility-based**

Facility-based methods use characteristics of the hospital, such as size, amount of teaching activity, occupancy and distance from nearest tertiary facility (specialized care centres, etc.), to estimate operating costs. This approach recognizes that the structure of different hospitals can influence the cost of providing identical services.

Funding under a facility-based approach attempts to accommodate differences in organizational structure (rural versus urban hospitals, teaching versus community hospitals, and so on). It is, however, insufficiently responsive to changes in demographics or in disease patterns. Furthermore, facility-based funding does not reward utilization efficiencies.

### **2.1.7 Project-based**

Project-based methods distribute funds in response to proposals for a one-time need. This method is often used by provincial/territorial governments to finance significant capital expenditures (such as building a new hospital wing). Project based budgeting is distinct from policy-based budgeting: the former method directs funding to an individual hospital for a specific identified need, while the latter apportions a pool of money among various hospital to effect policy initiated by government.

### **2.1.8 Service-based**

Service-based funding for hospital services is often referred to as a “case-mix-based approach” in Canadian and international literature; both concepts are used interchangeably in this chapter.

Case-mix-based or service-based methods use the volume and type of cases treated (such volume of dialysis, bypass surgery, knee or hip replacement, etc.) by a hospital to determine funding. More precisely, case-mix measurement requires two essential components: 1) the classification of patients into clinically meaningful groups that use similar levels of hospital resources, and 2) the attachment of a weight to each group to estimate relative resource use. These weights usually reflect the average cost of treating the patients in each group; they are used to construct individual hospital case-mix indices that measure average patient resource intensity, usually relative to a national norm. A higher case-mix index indicates greater patient resource intensity. Therefore, under service-based funding, hospitals are reimbursed for the episode of care for which the patient is admitted and based on the type of service or procedure performed on the patient.

The current literature on case-mix-based approaches seems to suggest that such methods fund hospitals more equitably than other methods. A particularly attractive characteristic of case-mix-based approaches is that they encourage efficiency and performance. International evidence indicates a clear trend toward such approaches.

Ontario used a service-based funding method in the summer of 2001 to distribute \$95 million of additional lump-sum funding to hospitals. The new funding methodology was developed by the Joint Policy and Planning Committee (JPPC). The JPPC recommended that this methodology be implemented gradually over the next three years and that its impact be monitored.<sup>33</sup>

## **2.2 Service-Based Funding: Review of International Experience**

### **2.2.1 United States**

As in Canada, hospitals represent the single largest category of health care spending in the United States. The organization of the American hospital sector is, however, one of the most complex in the world with a heterogeneous collection of hospitals, payers and funding methods.<sup>34</sup> In 1998, 28% of hospitals were classified as public (state or local government) hospitals, 58% as private, not-for-profit hospitals and 14% as private for-profit hospitals.<sup>35</sup> Financing for hospital services comes from a number of private insurers, out-of-pocket costs and from the Medicaid and Medicare programs.<sup>36</sup>

In 1983, the Health Care Financing Administration (now Centers for Medicare and Medicaid Services) introduced the Prospective Payment System (PPS), under which hospitals were paid according to a case-mix-based approach, the Diagnostic Related Groups (DRGs) classification. Eighty-one percent of hospitals are now remunerated using the DRG system.<sup>37</sup> The rates that are paid to hospitals are based on the average costs of a specific treatment and are independent of a patient's actual length of stay in hospital.<sup>38</sup> These rates may be adjusted upward if a hospital services a population with a disproportionately high number of low-income residents. While most hospitals use a common rate-setting methodology, actual rates are determined by each individual state. All rates are reviewed annually by the United States Congress. Private insurance companies and managed care plans are free to set their own hospital rates according to state guidelines, if any.

The wide variety of payers and payment rates under the DRG classification has led hospitals to develop detailed information systems that are equated with high administrative costs. Nonetheless, DRGs allow for the comparison of resource use across American hospitals and, as a result, encourage competition among institutions. Appearing before the Committee, Dr. Duncan Sinclair, former chair of the Ontario Health Services Restructuring Commission, said:

---

<sup>33</sup> Ontario Joint Policy and Planning Committee, *Hospital Funding Report Using 2000/01 Data*, Reference Document No. RD 9-12, October 2001 ([www.jppc.org](http://www.jppc.org)).

<sup>34</sup> Laschober, Mary, and James Vertrees, "Hospital Financing in the United States," Chapter Eight in *Hospital Funding in Seven Countries*, Office of Technology Assessment; U.S. Congress, 1995, p. 136. (<http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1995/9525/952510.PDF>)

<sup>35</sup> *Comité Bédard* (2001), p. 38.

<sup>36</sup> Medicaid is a joint federal-state program that provides health care insurance for low-income Americans. Medicare is a federal health care insurance program responsible for covering individuals 65 years old and over. Together, these two programs cover roughly 30% of the American population.

<sup>37</sup> *Comité Bédard* (2001), p. 38.

<sup>38</sup> Two lists of rates are used, based on whether a hospital is located in an urban area (defined as more than a million inhabitants) or a non-urban area.



*it is not a bad idea to have hospitals paid basically on the basis of DRGs and the volume related to those, much along the line of what is common in the United States. That is a very good idea.*<sup>39</sup>

The literature suggests that “DRG creep” (or “up-coding”) has become a common problem among American hospitals. This problem occurs when hospitals attempt to maximize their reimbursements by choosing diagnostic codes that result in higher payments that may not be medically justified.<sup>40</sup> However, the Committee was also told that close auditing of the DRG category into which a patient is put has substantially reduced the amount of DRG creep, particularly since there have been some high-profile cases when health care firms and their executives have been convicted of fraud associated with this practice.

### **2.2.2 United Kingdom**

Britain’s major reform of the National Health Service (NHS) came in 1991 when it introduced internal competition by separating the “purchaser” from the “provider” of health services. Hospitals were set up as independent “trusts” and were expected to negotiate contracts with purchasers – Fundholding doctors and District Health Authorities. To accommodate this model, case-mix systems were introduced as the method of payment. The NHS reforms were severely criticized because they led to significant increases in administrative costs.

More reforms took place in 1997, substituting cooperation for the previous emphasis on competition. But hospital funding has remained the same. Currently, District Health Authorities are financed based on their populations. Hospitals are then funded by the District Health Authorities based on case-mix methods.

### **2.2.3 France**

The hospital sector in France is split between public hospitals, which handle roughly 75% of hospital activity, and private hospitals, responsible for the remaining 25%. The two types of hospitals are remunerated differently. All public hospitals receive global operating budgets that are based on the previous year’s amount and increased annually by a rate determined by government. Private hospitals, on the other hand, are paid through a combination of a per diem rate for the number of cases handled.

France is currently considering a move towards case-mix financing for public hospitals. For almost 20 years, the French hospital sector has been developing DRG-style case-mix information systems. In 1996, the *Programme de Médicalisation du Système d’Information* (PMSI) released for the first time reliable patient data, designed specifically for French conditions. When used to measure the performance of French hospitals, the PMSI data revealed significant disparities in performance and capabilities among institutions and regions. French analysts feel that the present system of global budgets perpetuates these disparities.

---

<sup>39</sup> Dr. Duncan Sinclair (50:12).

<sup>40</sup> PricewaterhouseCoopers Healthcare (2000) “Health Care Fraud and abuse: DRG creep,” *Issues* (<http://www.pwcglobal.com/extweb/manissue.nsf/DocID/80FFF2EE2B921FC9852566D7004D5BC>).

### **2.2.4 Denmark<sup>41</sup>**

Most hospitals in Denmark are public hospitals owned and financed by county councils. Fewer than 1% of the total number of beds are in private for-profit hospitals. In the Copenhagen area, the municipally owned and financed hospitals are organized as a public company, the Copenhagen Hospital Corporation. The corporation is controlled by a board, with members appointed by the municipalities and the national government, including representatives from the private sector.

Until recently, the predominant method for allocating resources to hospitals was through prospective global budgets fixed by county councils. Large capital investments are decided jointly by county councils and hospitals and provided through project-based funding.

While global budgeting proved effective in controlling hospital expenditures, it provided limited economic incentives to increase efficiency at the point of delivery, and limited incentives to increase activity in relation to demand, thus contributing to increasing waiting lists for some procedures. In response to these inefficiencies, funds were allocated to the counties in 1997 to allow them to experiment with service-based funding. To increase the incentives to treat patients from other counties, in 1999 the national government decided to introduce full DRG payments for the treatment of such patients. The use of deliberately high DRG rates was expected to increase competition between hospitals.

In 2000, the national government formally introduced a system combining global budget and DRG rates with negotiated activity targets for each hospital. Under the new scheme, each hospital receives an up-front budget corresponding to 90% of the DRG rates related to the case-mix in the negotiated activity target, with the remaining 10% allocated according to the actual activity performed. Hospitals that provide more treatments than their negotiated target receive extra funds. The national government plans to encourage experiments in which more than 10% of a hospital's income is activity based.

### **2.2.5 Norway<sup>42</sup>**

Fewer than 1% of all hospital beds and 5% of outpatient services in Norway are private. Norway's counties are responsible for financing all public hospitals, with the exception of one regional hospital owned and operated by the national government.

Between 1980 and 1997, Norwegian hospitals received global budgets from their counties. While it was agreed that this system allowed governments to control costs and the distribution of resources, a Royal Commission, appointed in 1987, found that global budgets encouraged some hospitals to restrict their services in order to keep within their budgets.

As a result of the commission's recommendations, counties, on behalf of hospitals, were remunerated by the national government by a combination of cost per case, based on the DRG system, and global budgets. The reform, introduced in 1997, was intended

---

<sup>41</sup> The information provided in this section is based on European Observatory on Health Care Systems, *Health Care Systems in Transition – Denmark*, 2001. <http://www.euro.who.int/observatory/TopPage>.

<sup>42</sup> The information provided in this section is based on European Observatory on Health Care Systems, *Health Care Systems in Transition – Norway*, 2000. (<http://www.euro.who.int/document/e68950.pdf>).

to increase hospital in-patient activity, raise productivity and shorten waiting lists. The new payment method was introduced gradually: in 1997, 70% of grants to counties were according to a needs-based formula while the remaining 30% were paid based on the previous year's in-patient activity, using national standard DRG rates. In 1998, this was changed to 55% formula-based and 45% activity-based and finally moved to a 50-50 split in 1999. Since 1999, day care surgery has been financed based entirely on the DRG system. Teaching hospitals receive two additional grants: one to cover teaching and research, and the other to finance the treatment of complex and costly patient cases.

### **2.2.6 Review of international experience by the Comité Bédard**

In June 2000, the Quebec Department of Health established a task force to examine the financing of hospitals in the province. This task force, the *Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et spécialisés*, was headed by Denis Bédard. The *Comité Bédard* released its report in December 2001. One section of the report reviewed hospital budgeting in the United States, United Kingdom, France, Belgium and Norway. The *Comité Bédard* made a number of interesting observations based on this international review:

- Population-based approaches are widely used and recognized as an equitable mode for funding hospitals.
- There is a move away from global budgeting and a trend towards deploying information systems based on the DRG model.
- Countries are looking for mechanisms that can link information on hospital use and hospital delivery of services.
- There is a trend toward the development of more sophisticated methods for assessing hospitals' financial performance.
- More emphasis is placed on quality of care in the delivery of hospital services.

Overall, the *Comité Bédard* recommended a budgeting method for Quebec hospitals based on DRGs and performance. It was recognized that adjustments would have to be made for teaching hospitals. The *Comité Bédard* also recommended that the Quebec Department of Health build on the work of the Canadian Institute for Health Information (CIHI) rather than attempting to develop its own database on case-mix groups (CIHI's work is discussed in more detail below).

## **2.3 The Rationale for Service-Based Funding in Canada**

It has been recognized both in Canada and internationally that detailed information on the use of hospital (and other) resources is essential to the efficient delivery of desired outcomes in health care. With current approaches to funding hospitals in Canada, decisions are not usually based on detailed costing information, since funding is either decided politically or based on historical trends and, in any case, the necessary information is just not available.

As explained in Section 2.1 above, provinces have tried recently to improve their decision-making ability by introducing funding models that depend on more and better information, such as population-based funding. However, this method for determining budgets can provide only rough estimates of what a hospital's needs might be. Moreover, depending on the efficiency of the facility, there is no guarantee that the hospital will successfully and effectively turn these resources into the desired services with the desired outcomes. Therefore, the Committee believes that current hospital funding mechanisms, where these are based on funding inputs and not on final outcomes, must be revised to focus on performance in delivering hospital services.

***The Committee believes that current hospital funding mechanisms, where these are based on funding inputs and not on final outcomes, must be revised to focus on performance in delivering hospital services.***

The majority of the witnesses that appeared before the Committee supported the idea of moving to service-based funding for hospitals. For example, Michael Decter, former Deputy Minister of Health in Manitoba and Ontario and currently Chairman, Board of Directors, Canadian Institute for Health Information (CIHI), stated:

*The right way of funding hospitals, in my view, is to fund them for what they do, for what they actually accomplish in outcome terms.<sup>43</sup>*

The following advantages of service-based funding were brought to the attention of the Committee:

- Better Information – Witnesses told the Committee that service-based funding increases the need for better information, something the Committee considers essential to measure the performance of the health care system in terms of quality and outcomes.<sup>44</sup> In fact, the lack of critical information currently hobbles health care providers and government decision-makers alike. In its brief, the Canadian Healthcare Association indicated that: “Our members fully support the need for costing services and improving performance measurement and benchmarking.”<sup>45</sup>
- Transparency and Accountability – Witnesses stressed that, because the service-based approach relates funding to the actual services provided by a hospital, accountability for the use of public funds and transparency of costs would be substantially improved. For example, the submission of the Ontario Hospital Association to the Committee stated that “the public would see the direct connection between the level of funding and the number and types of procedures that are performed, thereby opening up health care funding to public scrutiny.”<sup>46</sup>

---

<sup>43</sup> Michael Decter (52:12).

<sup>44</sup> Mark Rochon, Ontario Hospital Association (56:43).

<sup>45</sup> Canadian Healthcare Association, Brief to the Committee, June 2002, p. 6.

<sup>46</sup> Ontario Hospital Association, Brief to the Committee, May 22, 2002, p. 36.

- Equity in the Distribution of Funding – With its “price times volume” approach, many witnesses considered service-based funding to be a more equitable means of funding hospitals than through current methods.<sup>47</sup> In addition, by attaching a price to specific hospital services, service-based funding enables the funder to influence change by changing the value attached to specific services.
- Investment in Capital – Dr. Les Vertesi informed the Committee that the health care system in Canada is “under-capitalized.” He blamed this on the use of global budgets, which do not attract capital. He argued that service-based funding, on the other hand, attracts outside capital to build facilities.
- Independence – Many witnesses believed that a move to service-based funding would result in hospitals becoming more independent from government. This would help to de-politicize decision-making with respect to hospital services. The Canadian Healthcare Association disagreed with this point, arguing that service-based funding would most likely lead to greater rather than less micromanagement by governments.<sup>48</sup> The Committee does not share this view. Along with the majority of witnesses, we believe that service-based funding will provide hospitals with the needed flexibility to allocate financial and human resources according to principles of best practice, efficiency and locally-determined needs.
- Reduction in size of Provincial Health Departments – Indeed, the Committee believes that service-based funding will enormously reduce the amount of top down, control and command micromanagement of hospitals which now characterizes all provincial departments of health. The reduction in the role of these departments should lead to a corresponding reduction in the number of their employees.
- Patient-Oriented Service Delivery – Dr. Vertesi stated that by paying hospitals for the services they actually provide, patients become a source of income rather than a burden to the facility. Service-based funding creates incentives for providers to increase efficiency, service volumes, and patient satisfaction, precisely what is needed currently.<sup>49</sup>
- Efficiency and Performance – Current hospital funding mechanisms do not provide the right incentives and often produce perverse results with respect to financial management. In fact, a 1998 study by the Ontario Joint Policy and Planning Committee showed that with global budgets there is no correlation between hospital deficits/surpluses and cost-efficiency in the Ontario hospital sector. More precisely, the study concluded that there are a number of inefficient Ontario hospitals that run budget surpluses and an even greater number that are considered cost-efficient but have deficits.<sup>50</sup>

---

<sup>47</sup> This opinion was also expressed by Ladak (1998), *op. cit.*, p. 3.

<sup>48</sup> Canadian Healthcare Association, Brief to the Committee, p. 7.

<sup>49</sup> Les Vertesi (2001), *op. cit.*, p. 118.

<sup>50</sup> Ontario Joint Policy and Planning Committee Financial Issues Advisory Group (1998), “Understanding the Financial Pressures of Ontario Hospitals: Short and Long Term Solutions”, Document No. RD 7-10.

Service-based funding changes the financing perspective from paying hospitals a specific amount to meet their anticipated needs to paying them according to what they actually do. As elsewhere in the economy, this fosters both efficiency and performance.

- Multiple Ownership Structures – The combination of a single funder/insurer, service-based funding and the separation of funder and provider means that the funder is neutral on the issue of who owns a hospital. The funder/insurer would purchase the service from that institution offering the best price, provided that it met the necessary quality standards. Such an institution could be either publicly owned or owned by a private not-for-profit or for-profit organization. As indicated in Volume Five, the Committee believes that the patient and the funder/insurer will be served equally no matter what the corporate ownership of a health care institution maybe, as long as the two following conditions are met: 1) all institutions in a province are paid the same amount for performing any given medical procedure or service; 2) all institutions, no matter their ownership, are subjected to the same rigorous, independent quality control and evaluation system. The Committee emphasizes that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the *Canada Health Act*.<sup>51</sup> Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, privately owned, not-for-profit institutions.<sup>52</sup>
- Flexibility in Changing Priorities – Service-based funding allows government to change priorities with respect to particular procedures and services by altering the amount it will pay for them.
- Competition to Provide the Best Services – Service-based funding will lead to particular services being provided at hospitals which are most efficient and perform the greatest number (highest volumes) of these services. Competition in the provision of services will improve quality and force those hospitals that wish to continue providing particular services to do so even more efficiently.
- Centres of Excellence – The Committee heard many times that a service-based funding method would lead to the development of centres of specialization – or “centres of excellence”, as they were referred to by a

***The Committee emphasizes that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the Canada Health Act.***

---

( [www.jppc.org](http://www.jppc.org) )

<sup>51</sup> This point is clearly enunciated in a document prepared for the Commission on the Future of Health Care in Canada by Colleen Flood and Sujit Choudhry, *Strengthening the Foundations: Modernizing the Canada Health Act*, Discussion Paper No. 13, August 2002.

<sup>52</sup> Volume Five, pp. 38-39.

number of witnesses – for the provision of certain treatments or surgeries. Such change in the delivery of hospital services should be encouraged because of the efficiencies it brings. This would also contribute to improving the quality of services. Indeed, recent articles in the *New England Journal of Medicine* have shown that the best indicator of quality, whether it is surgery or a diagnostic procedure, is volume. The advantages of specialization for selected hospital services were acknowledged by provincial premiers and territorial leaders who agreed, at their January 2002 meeting, to share human resources and equipment by developing “Sites of Excellence” for a number of complex surgical procedures.<sup>53</sup> There are, obviously, desirable limits to the Centre of Excellence concept that are reached when accessibility to services is compromised by virtue of the fact that the hospital offering a particular service is far away. A balance thus needs to be struck between the quality and cost-effectiveness/efficiency principles and that of ready accessibility.<sup>54</sup>

While most witnesses stated that they supported a move to service-based funding for hospitals, the Committee was cautioned that there are a number of substantial challenges in the implementation of such a funding model. These challenges are summarized below.

### **2.3.1 Appropriateness of service mix**

Service-based funding is attractive to hospital managers because they are responsible for choosing which services their institution will provide and at what levels. With this discretion available to management, hospitals will adjust their service mix in order to earn the highest possible returns consistent with meeting the needs of the population they serve. Hospitals will be encouraged to specialize in those services they can do best, and those for which the rates of remuneration are most attractive; they will reduce to the point of not providing those low-volume services that are not, for them, appropriately funded. In highly populated urban areas, this would lead to facilities specializing in the provision of certain services. However, the Committee was told that in smaller, rural communities, particularly those located some distance from a major urban centre, preserving accessibility to particular services may well claim priority. In this case, hospitals may choose to continue to provide needed services despite relatively low rates of remuneration. It is, therefore, essential that rates be reviewed and revised on a regular basis. The concerns with respect to small and rural community hospitals are discussed in Section 2.5.

### **2.3.2 Over-servicing and up-coding**

With a hospital’s finances dependent on the volume and mix of services it provides, incentives are created to encourage efficiency and to increase productivity. There is concern, however, that remunerating hospitals for each service performed could lead to over-servicing and, possibly, improper billing (“DRG creep”). The issue of over-servicing arises with

---

<sup>53</sup> Specialized hospital services include for example paediatric cardiac surgery and gamma knife neurosurgery.

<sup>54</sup> For example, with paediatric coronary surgery, given the relatively small number of children affected and the generally reparative nature of the problems (as opposed to life-threatening), the case is compelling to concentrate those procedures in very few centres (as is now being done in Ontario). But for adult coronary artery by-pass, for example, it would make no sense to have only one Centre in Ontario doing them.

physicians who are paid on a fee-for-service basis. The Committee believes that this method of payment has led some physicians to concentrate on the number of patients seen rather than quality of their care. The Committee was told, however, that while the possibility of over-servicing always exists with hospitals, it is less likely to occur given that many “players”, such as referring and consulting physicians and, of course, patients themselves, are involved in every decision to provide a given person with a specified service in hospital.

In the opinion of Dr. Duncan Sinclair, former Commissioner of the Ontario Health Services Restructuring Commission:

*[t]he danger is very much less in hospitals, given that the hospital itself is not the gatekeeper. However, one would have to be careful to avoid collusion between those who are the gatekeepers of hospital function and the hospitals themselves.<sup>55</sup>*

Some witnesses stressed that over-servicing is especially dangerous in a system such as that in Canada where hospital-based specialists are also paid under a fee-for-service scheme. This problem can be greatly alleviated, however, by having hospital-based specialists paid under a different remuneration scheme, as in Sweden and the United Kingdom.

Under a service-based funding system, cases are given weights in relation to their severity and the corresponding use of resources: the higher the case weight, the greater the remuneration. Therefore, hospitals have an incentive to up-code, that is, to report the highest weight for each case, whether this classification is justified or not.

Michael Decter raised the concern of improper billing or up-coding with respect to service-based funding:

*I think service-based funding is the right way with a couple of caveats. You must have a system that is well enough documented and data strong enough you do not get gamed. As you will remember, a major hospital chain in the U.S. – HCA Columbia – was litigated by the government of the United States for cheating them to the tune of hundreds of millions, if not billions of dollars, by having their thumb on the scale on the coding.<sup>56</sup>*

Audits, fines and penalties will have to be put in place to prevent abuse of the payment system. A detailed and accurate set of costing rates will also reduce the incentives to up-code. Having an independent system of evaluation, as recommended in Chapters One and Ten, would alleviate this problem to a great extent.

### **2.3.3 Rates, information and data**

Before service-based funding can be implemented, reliable case costing information and methodologies must be developed. Sharon Scholzberg-Gray, President and CEO of the Canadian Healthcare Association, informed the Committee that shifting to an

---

<sup>55</sup> Duncan Sinclair (50:12).

<sup>56</sup> Michael Decter (52:13).



entirely service-based funding system requires costing data that do not yet exist. In its brief, the Association also indicated that:

*The costing data that has been developed in Ontario has taken 10 years to develop. While it has been an important and necessary initiative, there are still significant operational issues to deal with including: the fact that this process only covers 50-60% of hospital services (it does a good job of inpatient services and surgeries, but not outpatient services); there is a need to add “complexity factors” (such as recognizing the unique situation of remote hospitals and teaching hospitals); and the tendency to allocate administrative costs to services that are not covered by the process, thus appearing to be very efficient. Given the ongoing challenges of establishing an Ontario system, one can imagine the magnitude and complexity of issues that need to be resolved when developing a pan-Canadian costing system.<sup>57</sup>*

Currently, the Canadian Institute for Health Information (CIHI) is responsible for the collection, establishment and revision of service case rates. The work on collecting costing data in Canada began in 1983, when the Hospital Medical Records Institute undertook to develop a Canadian database on case-mix groups, which is now maintained by CIHI. At the time of implementation, the lack of comprehensive Canadian case-mix costing data resulted in the importation of American cost data (New York State and Maryland) that were adjusted for Canadian lengths of stay. Now, CIHI uses data from selected hospitals in Alberta and Ontario to estimate the case-mix weights.

Kevin Empey, Chief Financial Officer of University Health Network in Toronto, stressed that more hospitals must submit costing data if accurate remuneration rates are to be established. He indicated, for example, that in 2000 only 2 of the 13 teaching hospitals in Ontario and 3 of the province’s 69 community hospitals, along with a small number of Alberta hospitals, provided costing data for the establishment of Canadian case rates.<sup>58</sup> In order to develop sufficiently current and detailed rates, it is essential that the majority of hospitals be required to produce and submit costing data. Kevin Empey also stressed that:

*We need a system which either creates an incentive or a penalty to motivate institutions to provide data and to participate in the inputting of it. This would end up with a better structure and better data.<sup>59</sup>*

### **2.3.4 Innovation**

In its brief, the Canadian Healthcare Association argued that service-based funding, with its focus on providing services at the lowest cost, would discourage innovation, both with respect to new procedures and new technology.<sup>60</sup> This is especially a concern for Academic Health Sciences Centres and teaching hospitals. Teaching facilities must be able to try

---

<sup>57</sup> Canadian Healthcare Association, Brief to the Committee, p. 7.

<sup>58</sup> Kevin Empey (56:45).

<sup>59</sup> *Ibid.*

<sup>60</sup> Canadian Healthcare Association, Brief to the Committee, p. 6.

new and highly specialized, but very costly, procedures without being put at risk by a rate-based system. It is therefore important that case-mix funding approaches not create perverse incentives by discouraging innovation of this (or any) kind. The concerns raised with respect to teaching hospitals are discussed in Section 2.4.

### **2.3.5 Comprehensive health care**

Members of the Canadian Healthcare Association pointed out that service-based funding focuses on “procedure-driven” health care instead of the provision of comprehensive and integrated care. In other words, service-based funding would simply encourage health care providers to respond to sickness and to concentrate less on a broad continuum of services, including health promotion and disease prevention. They felt that funding under global budgets helped to provide more extensive care than service-based funding would be able to. Indeed, Mark Rochon of the Ontario Hospital Association, who supported the idea of a move towards service-based funding, also made the comment:

*I think we need also to recognize that there are some aspects of service that perhaps ought to be funded with other than a service based approach. I am thinking, for example, of services that relate to health promotion and prevention. Perhaps the argument could be made that stand-by services such as emergency rooms could also be funded on a global basis.<sup>61</sup>*

### **2.3.6 Escalation of costs**

In the opinion of the Canadian Healthcare Association, it was precisely this type of procedure-driven care – one that would be fostered by service-based funding – that has resulted in an escalation of costs:

*The cost escalations currently being experienced within our health system are almost entirely related to “cost of procedures” related to physician services and drug costs. Service based funding would encourage a continuation of these current practices.<sup>62</sup>*

The Committee does not support this opinion. As stated in Volume Five, we believe that service-based funding fundamentally changes the incentives, with the result that cost escalation will be reduced in the long run.<sup>63</sup>

### **2.3.7 Lack of simplicity**

Many witnesses told the Committee that if service-based funding were to be implemented, a number of adjustments would have to be made to the rates in order to accommodate institutions such as teaching hospitals and smaller, rural hospitals. Sharon

---

<sup>61</sup> Mark Rochon, Ontario Hospital Association (56:43)

<sup>62</sup> Canadian Healthcare Association, Brief to the Committee, p. 6.

<sup>63</sup> Volume Five, pp. 36-39.

Sholzberg-Gray, President and CEO of the Canadian Healthcare Association, observed that while the vast majority of the witnesses supported service-based funding, each witness suggested modifications that, in aggregate, could lead to an extremely complex funding system:

*What we noted in reviewing some of the testimony of people who came before this Committee to speak about service based funding is that (...) they all wanted special complications formula – that is, if you are a teaching hospital, one formula; if you are in a remote area, a different approach; if you do certain things, another approach.<sup>64</sup>*

The Committee has already acknowledged in Volume Five that some adjustments would be necessary to service-based funding to accommodate the variety of hospitals.<sup>65</sup> The adjustments that would have to be considered for teaching centres and for small rural hospitals are discussed in Sections 2.4 and 2.5 of the present volume.

### **2.3.8 Committee commentary**

The Committee concurs with witnesses that, as much as possible, hospitals should be funded for the specific services they provide, that is, according to service-based funding. Service-based funding is the most appropriate method for financing the operational costs of hospitals, though we recognize that additional investment may be needed for capital purposes in many Canadian hospitals (see Section 2.6 below). The Committee believes that service-based funding has numerous advantages over the methods currently used to finance hospitals in Canada. In our view, Canadians will greatly benefit from service-based funding in terms of quality and timeliness of hospital care, as well as in terms of transparency, accountability and performance reporting.

***The Committee believes that service-based funding has numerous advantages over the methods currently used to finance hospitals in Canada.***

The Committee recognizes that hospital funding is a provincial matter; nonetheless, the federal government could be of considerable assistance in promoting of service-based funding. In our view, the federal government, as part of its role in supporting the health care infrastructure and the health info-structure (see Volume Four)<sup>66</sup>, should provide some of the funding necessary to enable the provinces to implement service-based funding. This federal funding should be part of the federal investment in health information systems that this Committee recommends in Chapter Ten. Furthermore, the Committee believes that CIHI can play a major role in the estimation of case-mix groups and their relative weights, both of which are needed to implement service-based funding.

If Canadians are to derive the most benefits from publicly funded or insured hospital services, service-based funding must be implemented. Moreover, hospitals also will gain a lot from service-based funding. This mode of remuneration will allow them to identify

---

<sup>64</sup> Sharon Sholzberg-Gray (60:27).

<sup>65</sup> Volume Five, pp. 36-39.

<sup>66</sup> Volume Four, pp. 95-105.

inefficient practices and hence help improve their productivity. As a result, hospitals will be able to compete on the basis of quality of care.

The Committee acknowledges that the implementation of service-based funding will take time. Following the experience in European countries, the new payment method should be introduced gradually; at the early stages, hospitals should be remunerated by a combination of service-based funding and their traditional funding methods. The portion of funding allocated through service-based funding should grow each year and that allocated by the traditional methods should shrink correspondingly, until at the end of the implementation period hospitals are remunerated entirely by service-based funding.

For instance, similar to the Norwegian experience, the funding split might begin with hospitals being remunerated 70% by traditional methods and 30% through service-based funding. The funding mix might then progress to a 50-50 split, to 70% service-based funding, and then finally to 100% service-based funding.

Therefore, the Committee recommends that:

**Hospitals should be funded under a service-based remuneration scheme. This method of funding is particularly well suited for community hospitals located in large urban centres. In order to achieve this, a number of steps must be undertaken:**

- **A sufficient number of hospitals should be required to submit information on case rates and costing data to the Canadian Institute for Health Information;**
- **The Canadian Institute for Health Information, in collaboration with the provinces and territories, should establish a detailed set of case rates to reduce incentives to up-code.**
- **The federal government should devote ongoing funding to the Canadian Institute for Health Information for the purpose of collecting and estimating the data needed to establish service-based funding.**
- **The shift to service-based funding should occur as quickly as possible. The Committee considers a five-year period to be a reasonable timeframe for the full implementation of the new hospital funding.**

## 2.4 Academic Health Sciences Centres and the Complexity of Teaching Hospitals

Teaching hospitals in Canada form part of what is known as Academic Health Sciences Centres (AHSCs). AHSCs consist of a teaching hospital, a university faculty of medicine, and other health-related research and health care institutes (see Appendix 2.1 for a list of the 16 AHSCs in Canada and their affiliated hospitals). Because these centres are responsible for not only patient care but also teaching and research, they are much more complex than community hospitals. They also offer the newest and most highly sophisticated services and treat the most difficult, complex cases.

**AHSCs consist of a teaching hospital, a university faculty of medicine, and other health-related research and health care institutes. Because these centres are responsible for not only patient care but also teaching and research, they are much more complex than community hospitals.**

Hospitals with teaching/research activity have higher costs per weighted case than community hospitals. This is due to the required teaching infrastructure, specialized programs, higher utilization of diagnostic testing, and the use of resources needed for more innovative and aggressive treatment procedures:

*Studies have shown that procedure costs at academic health science centres are higher than in community hospitals. This is not only due to the costs of the complexity of care provided or the introduction and evaluation of leading-edge practice. To fulfill its teaching and research mandate, some clinical procedures cost more than average and result in lengths of stay that may be longer than average. Additionally, a major research and education centre incurs facility and operating costs as a result of providing space and supporting the medical staff in these endeavours.<sup>67</sup>*

Because of the educational and research aspects of AHSCs, funding comes traditionally from at least two separate provincial government departments and, within those departments, from a variety of sources. While it is almost impossible to distinguish precisely the academic mission from the health care delivery mission, government funding can be placed into three broad categories.<sup>68</sup>

First, the department of education provides operating grants to universities that in turn provide budgets for health faculties, including salaries for their academic staff. Second, the department of health provides hospitals with budgets for clinical education to pay the salaries of post-graduate trainees and partial support of the incomes of clinical faculty. Third, hospitals receive operating grants from provincial health ministries to help pay for the added cost of research and training activity.

---

<sup>67</sup> S. Kevin Empey, Brief to the Committee, 22 May 2002, p. 12.

<sup>68</sup> Lozon and Fox (2002), *op. cit.*, p. 16.

As a result of this complexity, service-based funding poses a number of problems particular to AHSCs. Patients of AHSC often require very sophisticated treatment, the cost of which may not be accurately captured in case-mix measurement systems. For instance, Kevin Empey, Chief Financial Officer, University Health Network (Toronto), stated:

*(...) both pacemaker and defibrillator implants are included in the same [case-mix group] and thus would be assigned the same case weights and funded identically. This weighting, and any rate-based funding would not reflect the dramatic differences in the costs of the devices implanted. The cost of a typical defibrillator implant procedure is approximately 2.5 times that of a pacemaker implant.*<sup>69</sup>

Similarly, it is estimated that the cost of one multi-organ transplant costs \$213,000 per patient. However, due to the complexity and the uniqueness of the treatment, rates have not been determined in Canada for the transplants. As a result, teaching hospitals in Toronto receive funding at the same rate as for single-organ transplants, which is a fraction of the true cost of the multi-organ treatment.<sup>70</sup> For these reasons, Dr. Hugh Scott of the McGill University Health Centre stated:

*if you want to put it in a formula, there has to be multiples. Any time we try to put cardiac surgery and psychotherapy in a magic formula, there will be problems. When you then add in a teaching environment and so on, you will have even more problems. I look forward to simplicity and elegance, I think sometimes multiple factors have to be taken into account.*<sup>71</sup>

Dr. Jeffrey Lozon from St. Michael's Hospital (Toronto) discussed the complexity of financing teaching hospitals given the variety of activities they perform:

*The most appropriate funding vehicle is the one that most closely aligns the accountability of the academic health sciences centre and its outputs in a fair funding system. Our centres are accountable for their outputs. However, it must be understood that our outputs are going to be different than what they would be in a community hospital or in a rural environment. They will be more complex. We have different levels of output: we have output around the knowledge that we create; and we have output around the numbers of students that were educated.*

*We would probably be uncomfortable with a one-size-fits-all funding formula that might suggest my hospital be as low cost as a hospital in Yorkton, Saskatchewan. The hospitals do different things and so the cost varies. We need to measure the things we do*

---

<sup>69</sup> S. Kevin Empey, Brief to the Committee, 22 May 2002, p. 6.

<sup>70</sup> S. Kevin Empey, *op. cit.*, p.10.

<sup>71</sup> Dr. Hugh Scott (63:17).

*and we need to be held as accountable as the hospital in Yorkton. However, it is a more complicated endeavour than strictly counting up the dollars.*<sup>72</sup>

The AHSC experts who appeared before the Committee supported the service-based funding methodology as long as case-mix groups and weights are established for AHSCs, distinct from those developed for community hospitals. Such a funding methodology for AHSCs should take into account a variety of factors, including the complexity of procedures and treatments, the introduction of new technologies and the use of costly drugs. Experts also stressed that consideration should be given to funding the cost of teaching and research infrastructure out of a different envelope with its own set of incentives for efficient delivery.

In their recent paper “Academic Health Sciences Centres Laid Bare”, Jeffrey Lozon and Robert Fox stated that AHSCs should be considered a national resource in the health care system and that the federal government should enhance its role in the funding of AHSCs. The authors argued that “no longer can the AHSC struggle to arrange funding from a variety of providers and without the support of the federal government.”<sup>73</sup>

The Committee agrees with the witnesses that Academic Health Sciences Centres are distinct from community hospitals in that they perform a wide range of complex activities ranging from delivery, to teaching and research. Accordingly, the Committee recommends that:

**Service-based funding should be augmented by an additional funding method that would take into account the unique services provided by Academic Health Sciences Centres, including teaching and research.**

Moreover, the Committee strongly believes that, since they play an essential role in teaching, performing research and delivering sophisticated care, AHSCs constitute a national resource in the Canadian health care system. They are a crucial part of the health care infrastructure in Canada. Thus, the federal government is particularly well positioned to sustain AHSCs across the country, through its well-recognized roles in financing post-secondary education, funding health research, supporting health care delivery, financing health care technology and planning human resources in health care. These issues are discussed in subsequent chapters in this report.

***The Committee believes that AHSCs constitute a national resource in the Canadian health care system. The federal government is particularly well positioned to sustain AHSCs across the country.***

## **2.5 Small and Rural Community Hospitals**

Because larger and medium-sized community hospitals do not face the same set of challenges as small or rural community hospitals, problems might arise if the same funding

---

<sup>72</sup> Dr. Jeffrey Lozon (63:16-17).

<sup>73</sup> Lozon, Jeffrey and Robert Fox (2002), “Academic Health Sciences Centres Laid Bare”, lead paper in *Healthcare Papers*, Vol. 2 No. 3, p. 30.

formula were to be applied to both types of hospitals. For example, Raisa Deber, Professor at the University of Toronto, stated that:

*(...) on issues related to service-based funding, particularly for hospitals in smaller provinces or smaller communities, (...) such funding will not be enough to cover the infrastructure costs of running the organization.*<sup>74</sup>

In addition, the Canadian Healthcare Association indicated in its brief that:

*Service-based funding would be difficult to implement in rural and remote areas, particularly if there is only one provider and/or organization available to provide services.*<sup>75</sup>

The review of the testimony provided to the Committee suggests that, for the most part, small and rural community hospitals are faced with problems of:

1. Limited economies of scale – Small rural hospitals are often faced with fixed overhead costs and low or unpredictable patient volumes. This leads to higher costs per patient.
2. Isolation – A hospital in rural Canada is considered to be isolated if the next closest hospital is more than 150 km away. That hospital then becomes the primary provider of health care for an entire geographic area. A hospital that is responsible for a large region must be able to provide a greater range of services despite low and sporadic patient volumes.
3. Remoteness – Remoteness refers to the distance between a hospital and the closest tertiary hospital care centre. Hospitals can be remote but not isolated (a number of hospitals may serve a particular region but be at a considerable distance from a tertiary hospital care centre). However, much like isolated hospitals, remote hospitals often have higher fixed overhead costs and must provide a wider range of health care services compared to community hospitals located near tertiary centres. All these factors result in higher costs per patient.
4. Special needs population – Many remote hospitals must care for special needs populations such as residents of First Nations reserves. The health status of these residents is often below the provincial average, which leads to higher admission rates.<sup>76</sup>

---

<sup>74</sup> Raisa Deber (59:12).

<sup>75</sup> Canadian Healthcare Association, Brief to the Committee, p. 7.

<sup>76</sup> Ladak (1998), *op. cit.*, p. 31.



Therefore, the funding formula used for larger community hospitals is often not suitable for small and rural hospitals. As a result, the funding formula must take into consideration the particular challenges faced by smaller, rural and remote hospitals.

A number of the witnesses were concerned about the effect of a service-based funding method on the mix of services offered by rural and smaller community hospitals. For example, Mark Rochon of the Ontario Hospital Association stated:

*We also need to consider that service-based funding should not create incentives for providers to stop offering necessary services in communities. The needs of specific communities must be considered as well as the adequacy of service provided in those communities.*<sup>77</sup>

Kevin Empey, of University Health Network, added that:

*Some providers, when it becomes a full rate based or service based system, will choose to specialize a little more or get out of something. Certainly in small communities you cannot afford the major providers, that is, the hospitals, to get out of something just because of the rates.*<sup>78</sup>

The Committee agrees with the witnesses that, in order to preserve access to commonly required services, service-based funding should be adjusted to reflect the particular circumstances of small and rural community hospitals. Therefore, the Committee recommends that:

**In developing a service-based remuneration scheme for financing of community hospitals, consideration be given to the following factors:**

- **Isolation: hospitals located in rural and remote areas are expected to incur higher costs than those in large urban centres. An adjustment should reflect this fact.**
- **Size: small hospitals are expected to incur higher costs per weighted case than larger hospitals. An adjustment should recognize this fact.**

## **2.6 Financing the Capital Needs of Canadian Hospitals**

As indicated in Section 2.1.7, provinces and territories use a method for funding hospital capital expenditures that is different from the method used in relation to funding

---

<sup>77</sup> Mark Rochon (56:43).

<sup>78</sup> S. Kevin Empey (56:45).

operating costs. All provinces and territories use a project based method as their capital funding approach. The project based method is well suited to large-scale, one-time projects.

The Committee was told that the capital needs of Canadian hospitals are significant. We heard that the current level of capital investment by provincial and territorial governments, along with hospitals' well established fundraising infrastructure and charitable giving, is not sufficient to ensure the sustainability of the hospital sector in Canada. Information provided to the Committee revealed that:

- Between 1982 and 1998, real public per capita spending on new hospital construction decreased from \$50 to \$2, or a reduction of 5.3% annually.<sup>79</sup>
- Since 1998, real public per capita expenditures on new hospital machinery and equipment has fallen by 1.8% annually.<sup>80</sup>

As a result, there is a substantial gap between the need for new and renovated physical plant and equipment and a hospital's ability to finance capital investment. For this reason, several witnesses proposed that the federal government provide some funding. The Association of Canadian Academic Healthcare Organizations told the Committee that there is precedent in this regard:

*It should also be noted that there is a precedent when it comes to the role of the federal government in this area. In 1948, the federal government introduced the Hospital Construction Grants Program – which was funded on a cost-sharing basis with the provinces.<sup>81</sup>*

The Canadian Medical Association stated that, in addition to government investment in hospital capital, it may be necessary for hospitals to develop innovative approaches to financing capital infrastructure. According to the Association, there is a need to explore the concept of public-private partnerships to address capital infrastructure needs as an alternative to relying solely on government funding.<sup>82</sup>

While the Committee has supported the consolidation of the hospital sector that has taken place in recent years in all provinces, we are very concerned that the number of beds in some hospitals may not be sufficient to respond to the significant increase in demand for hospital services that exists in a few areas in Canada where there is high and fast population growth. Indeed, we learned that there are a few regions of the country in which population growth has been so great that more hospital beds are needed now and many more will be needed in the coming years. This is particularly true of some metropolitan areas of Alberta (Calgary), British Columbia (Abbotsford, Vancouver), Nova Scotia (Halifax), Ontario (Oshawa, Toronto), Quebec (Montreal), and Saskatchewan (Saskatoon).<sup>83</sup>

---

<sup>79</sup> Association of Canadian Academic Healthcare Organizations, Brief to the Committee, 13 June 2002, p. 17.

<sup>80</sup> *Ibid.*

<sup>81</sup> *Ibid.*

<sup>82</sup> Canadian Medical Association, *For Commissioner Romanow: A Prescription for Sustainability*, 6 June 2002, p. 26.

<sup>83</sup> Based on the 2001 Census data of Statistics Canada (<http://geodepot2.statcan.ca/Diss/Highlights/>).

Accordingly, the Committee believes that the federal government should get involved once again, as it did in 1948, in financially supporting hospitals with the greatest capital needs. Such federal participation would not involve ongoing financing but should rather be considered a “catch-up” measure. Even though it would be a one time measure, federal funding for any given project could be spread over a period of several years.

Specifically, the decision to provide federal support for hospital capital should be made on the basis of a formula that would indicate that, when population growth in a particular region exceeds the provincial average by 50%, the federal government would make one-time only funding available on a cost-shared basis with the province for capital investment in hospital expansion. Such federal investment could work as follows: the hospital should be able to take the federal commitment to pay a fixed amount per year over a 10-year period to a financial institution and borrow against that commitment so that construction could begin right away.

The Committee also believes that provincial/territorial governments should give consideration to public-private partnerships as a means to obtain additional investment in hospital capital. Therefore, the Committee recommends that:

**The federal government provide capital financial support for the expansion of hospitals located in areas of exceptionally high population growth; that is, areas in which the population growth exceeds the average rate of growth in the province by 50% or more. Such federal financial support should account for 50% of the total capital investment needed. In total, the federal government should devote \$1.5 billion to this initiative over a 10-year period, or \$150 million annually.**

**The federal government should encourage the provinces and territories to explore public-private partnerships as a means of obtaining additional investment in hospital capacity.**

Capital investment is also of concern for AHSCs. The Association of Canadian Academic Healthcare Organizations informed the Committee that building replacement is underfunded and depreciation is not fully recognized by the federal and provincial governments for funding purposes. Furthermore, most capital investment decisions appear to be based on short-term responses to needs rather than a long-term planning horizon. In some cases, additions or renovations are made to poor structures, when full reconstruction might have been a better policy decision.

While there are variations in the capital requirements of teaching hospitals, it is clear that significant investment is needed. For example:

- The Montreal University Health Centre has undertaken an evaluation of existing facilities (in which some buildings are 40 to 100 years old) and determined that it will cost \$475 million to upgrade its facilities.
- The University Health Network of Toronto estimates that its capital requirements for the next 10 years will be over \$500 million (i.e., in excess of \$50 million per year).
- The St. John's Healthcare Corporation (Newfoundland) recently completed the development of a Children's and Rehabilitation Centre at a cost of \$70 million.

Based on the information made available to the Committee, the Committee concluded that the federal government should contribute some \$4 billion for the infrastructure renewal of the 16 AHSC sites. We believe that such federal funding should be provided in response to requests initiated by AHCSs themselves, subject to review by a group of independent experts. This, in our view, would ensure transparency.

More precisely, AHSCs should be required to accompany a request with a sound rationale for additional resources. Each application should be evaluated on its own merits by an independent expert group that would report to the Minister of Health. Moreover, in order to ensure accountability, successful applicants should report on their disposition of the funds received.

Therefore the Committee recommends that:

**The federal government contribute \$4 billion over the next 10 years (or \$400 million annually) to Academic Health Sciences Centres for the purpose of capital investment.**

**Academic Health Sciences Centres be required to report on their use of this federal funding.**

## **2.7 Public Versus Private Health Care Institutions**

In Section 2.3 above, the Committee underlined many advantages to service-based funding for hospitals, one of which relates to the ownership structure of health care institutions. We indicated that service-based funding means that the insurer (the government) would be *neutral* with respect to the ownership of a hospital. The funder/insurer would purchase the service from an institution, provided that it met the necessary quality standards. Since comparable institutions would be paid the same amount of money for a given procedure, and since all institutions would be subject to the same independent and rigorous quality control and evaluation system, the

***Service-based funding means that the insurer (the government) would be neutral with respect to the ownership of a hospital.***

ownership structure would not be a matter of public policy concern. For this reason, the Committee is neutral to the ownership question.

As indicated in Volume Five, the Committee believes that the patient and the funder/insurer will be served equally no matter what the corporate ownership of a health care institution may be, as long as the two conditions enumerated above with respect to pricing and quality control are met. The Committee wants to emphasize that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should

***The Committee wants to emphasize that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the Canada Health Act. Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, either public or private not-for-profit institutions.***

be prohibited, just as they are not now prohibited under the *Canada Health Act*. Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, either public or private not-for-profit institutions.

Furthermore, the Committee recognizes that there is no reason why the private for-profit provision of publicly funded health services would result in a so-called “two-tier” health care structure, as long as the *funding* of services remains *publicly* based and referrals to institutions continue to be determined by clinical need. This situation with respect to hospitals is no different from the provision of primary health care, most diagnostic services, and some day surgeries – services that are currently delivered in Canada by private for-profit entrepreneurs and facilities.

Currently, within Canada’s health care system, only 5% of hospital care is delivered by the private for-profit sector. For example, the Shouldice hospital in Ontario is a private for-profit facility; its status was grandfathered when Medicare was enacted in that province. Facilities like this one are regulated on a rate of return basis, to reduce the risk of overcharging patients. In Alberta, private for-profit facilities are allowed, under provincial legislation (Bill 11), to compete with public and private not-for-profit hospitals for the provision of a set of publicly insured surgical services. Canada also has a number of private for-profit health care facilities (“private clinics”) that treat only patients who pay privately for the services they receive.

***The Committee recognizes that there is no reason why the private for – profit provision of publicly funded health services would result in a so-called “two-tier” health care structure, as long as the funding of services remains publicly based and referrals to institutions continue to be determined by clinical need.***

Despite the presence of these private for-profit health care institutions and facilities in Canada, which appear to provide the same quality of care as not-for-profit and public institutions, an intense debate continues about the potential role and impact of for-profit hospitals and clinics in the health care system. This debate culminated in May 2002 with the publication of a meta-analysis study by P. J. Devereaux *et al.* in the *Canadian Medical Association Journal*. This study found, based on a review of 15 different observational studies, “that private

for-profit ownership of hospitals in comparison with private not-for-profit ownership in the United States results in a higher risk of death for patients.<sup>84</sup> The authors concluded that the profit motive of private for-profit hospitals may result in limitation of care that adversely affect patient outcomes:

*Why is there an increase in mortality in for-profit institutions? Typically, investors expect a 10%–15% return on their investment. Administrative officers of private for-profit institutions receive rewards for achieving or exceeding the anticipated profit margin. In addition to generating profits, private for-profit institutions must pay taxes and may contend with cost pressures associated with large reimbursement packages for senior administrators that private not-for-profit institutions do not face. As a result, when dealing with populations in which reimbursement is similar (such as Medicare patients), private for-profit institutions face a daunting task. They must achieve the same outcomes as private not-for-profit institutions while devoting fewer resources to patient care.<sup>85</sup>*

When he appeared before the Committee, Dr. Arnold Relman, Former Editor-in-Chief of *The New England Journal of Medicine*, expressed similar views:

*(...) most, not all of the current problems of the U.S. health care system, and they are numerous, result from the growing encroachment of private for-profit ownership and competitive markets on a sector of our national life that properly belongs in the public domain. It is no coincidence that no health care system in the industrialized world is as heavily commercialized as ours, and none is as expensive, inefficient, inequitable, or as unpopular. Indeed, just about the only people happy with our current market-driven health care system in the U.S. are the owners and investors in the for-profit industries now living off the system.<sup>86</sup>*

On the basis of this evidence, many observers have noted that it is plausible, if not likely, that the results of the American experience can be generalized to the Canadian context should Canada decide to “open the door” to private for-profit hospitals.

The Committee learned, however, that the Devereaux *et al.* study has a number of caveats. First, Brian J. Ferguson, Professor at the Department of Economics at the University of Guelph (Ontario), informed the Committee in a recent paper that the authors of the meta-analysis specifically excluded public hospitals from their study, on the basis that Canadian hospitals are technically private not-for-profit institutions behaving more or less like American private not-for-profit hospitals.<sup>87</sup> Professor Ferguson argued, however, that private

---

<sup>84</sup> P.J. Devereaux *et al.*, “A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-for-Profit Hospitals”, in *Canadian Medical Association Journal*, Vol. 166, No. 11, 28 May 2002, pp. 1399-1406.

<sup>85</sup> *Ibid.*, pp. 1404-1405.

<sup>86</sup> Dr. Arnold Relman (48:8-9).

<sup>87</sup> For more information, please consult the recent paper by Brian S. Ferguson, *A Comment on the Devereaux et al. Meta-Analysis of Mortality in Private American Hospitals*, Draft, Department of Economics, University of Guelph, Ontario, June 2002.

not-for-profit hospitals in the United States do not operate at all in the same environment as Canadian private not-for-profit hospitals: American private not-for-profit hospitals work in a very competitive context and have considerably more freedom in terms of decision-making than their Canadian counterparts.

In this regard, Professor Ferguson contended that Canadian private not-for-profit hospitals are much more like American public hospitals than they are like American private not-for-profit hospitals. In his view, including public hospitals in the Devereaux *et al.* meta-analysis could have led to very different results.<sup>88</sup> In fact, a number of studies have shown that public hospitals in the United States have higher risk-adjusted 30-day mortality than for-profit hospitals, which in turn have higher mortality than not-for-profit hospitals.<sup>89</sup>

Second, Professor Ferguson also criticized the methodology used by Devereaux *et al.* on several grounds: criteria for the inclusion of pertinent literature; selection of particular results for inclusion in the analysis; choice of the dependent variable; omission of some variables; etc.<sup>90</sup> Finally, in a different paper, Professor Ferguson indicated that it is almost impossible to derive proper conclusions on the potential role of private for-profit hospitals in Canada from the American literature.<sup>91</sup> The health care system in the United States is made up of several public and private insurers, involves a multiplicity of public and private (not-for-profit and for-profit) providers, and operates under intense competitive pressures – a situation that is unlikely to happen in Canada with our single insurer system.

Moreover, the regulatory framework for the provision of hospital care in the United States is different from that in Canada. This explains why we cannot simply transpose what is happening in the United States to Canada. For example, Dr. Arnold Relman told the Committee:

*Throughout the American health care system there is inadequate regulation of private, for-profit health care, as well as private not-for-profit health care. In the for-profit system, there is so much money in for-profit nursing, hospital care, ambulatory services, and pharmaceutical services that the regulatory agencies have been co-opted, at times you might say intimidated, by the political and financial influence of the owners.*

*(...) In the United States, there is a huge amount of money involved in providing for-profit health care. That money in part is used to ensure that regulation is weak. It applies to the Food and Drug Administration. It applies to all sorts of regulatory agencies. I served for six years on a state agency studying the quality of care in Massachusetts hospitals. It is very clear to me that financial concerns play a major role.*

---

<sup>88</sup> *Ibid.*

<sup>89</sup> These studies are summarized in a paper by Stephen Duckett, “Does it Matter Who Own Health Facilities”, in *Journal of Health Services Research Policy*, Vol. 6, No. 1, January 2001, pp. 59-62.

<sup>90</sup> Brian J. Ferguson, *op. cit.*, June 2002.

<sup>91</sup> Brian S. Ferguson, *Profits and the Hospital Sector: What Does the Literature Really Say?*, Health policy working paper prepared for the Atlantic Institute for Market Studies, February 2002.

*(...) If we did have good, aggressive, unbiased regulation, many of the problems I have talked about in terms of quality would be solved. However, we do not.*<sup>92</sup>

The findings of the Devereaux *et al.* analysis also contrast with those a Canadian study published in 1999 in the *Canadian Medical Association Journal* which compared the quality of care in licensed and unlicensed homes for the aged in the Eastern Townships of Quebec.<sup>93</sup> For example, this study found the quality of care provided to elderly residents by large unlicensed (private for-profit) long-term care facilities to be comparable to that of large licensed (private not for profit) facilities.<sup>94</sup> In addition, the study found that the majority of both licensed and unlicensed long-term care facilities (no matter what their size) were delivering care of relatively good quality.

Overall, the Committee acknowledges that the literature on the comparative costs, quality, effectiveness and general behaviour of private for-profit and private not-for-profit facilities is quite extensive. We also recognize that these studies reach mixed conclusions. Some of them suggest that for-profit facilities perform better, while others conclude that not-for-profit facilities or public hospitals do so. Still, other studies have found no difference in the performance of the two.

Given the evidence in the literature, the Committee believes that leaving the *Canada Health Act* as it currently is – which means permitting private for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) – will *not*, as some critics maintain, weaken or destroy the health care system as we know it now.

***The Committee believes that leaving the Canada Health Act as it currently is – which means permitting private for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) – will not, as some critics maintain, weaken or destroy the health care system as we know it now.***

Other advanced countries, with perfectly well functioning universal, publicly funded and organized health care systems (such as Australia, Denmark, Germany, the Netherlands, Sweden and the United Kingdom), already permit private for-profit hospitals to exist; their presence has not caused any insurmountable problems or difficulties.

The debate surrounding public versus private not-for-profit versus private for-profit health care institutions does not seem to arouse the same kind of passion elsewhere. As a matter of fact, the Committee reviewed the operation of the health care system of seven different countries (see Volume Three) and visited three countries (Denmark, Sweden, United Kingdom), and found that there are no articles or studies in European countries and Australia comparing the quality or outcomes of for-profit and not-for-profit or public hospitals. In this sense, this debate is uniquely North American.

---

<sup>92</sup> Dr. Arnold Relman (48:23).

<sup>93</sup> Gina Bravo *et al.*, «Quality of Care in Unlicensed Homes for the Aged in the Eastern Townships of Quebec, *Canadian Medical Association Journal*, Vol. 160, No. 10, 18 May 1999, pp. 1441-1445.

<sup>94</sup> The interpretation of the study findings in terms of ownership status (for profit versus not for profit) were facilitated by information provided by the statistician who participated in the realization of this study, Marie-France Dubois.



The Committee believes that it is unlikely that, as a result of the introduction of service-based funding, Canada would see the emergence of full-scale private for-profit hospitals, such as those that operate in Australia or the United Kingdom: in both countries, private health care insurance runs parallel to the public system, and physicians are permitted to have large-scale private practices, a system that seems unlikely to develop in Canada. It is more likely that private clinics would remain small and specialized. Such clinics would emerge in niches where their founders expect to be able to make a profit by operating at lower cost than the public system does, either by taking advantage of economies of scale or, as seems more likely, by taking advantage of economics of specialization. These clinics would bring additional capital into the health care system, since they would be funded privately. This is another reason it is unlikely that they would develop into full-scale general hospitals: private funding for so ambitious, and also risky, an enterprise would be much harder to come by than would funding for specialized clinics.

The Committee strongly believes that there is a need to improve hospital performance and to develop hospital report cards in Canada, regardless of ownership. This can be appropriately done through the independent evaluation process recommended in Chapters One and Ten of this report. Requiring that a single regulatory process apply to *all* health care institutions would contribute much to ensuring high quality of care no matter where it is provided.

## **Appendix 2.1**

### **Academic Health Sciences Centres in Canada and their Affiliated Hospitals and Regional Health Authorities**

#### **1. Memorial University of Newfoundland and Labrador**

Healthcare Corporation of St. John's  
The General Hospital  
St. Clare's Mercy Hospital  
Janeway Children's Health and Rehabilitation Centre  
Waterford Hospital  
Dr. L.A. Miller Centre  
Dr. Walter Templeman Health Centre

#### **2. Dalhousie University**

Capital Health  
IWK Health Centre  
Queen Elizabeth Health Sciences Centre II  
Dartmouth General Hospital  
East Coast Forensic Hospital  
Eastern Shore Memorial Hospital  
Hants Community Hospital  
The Nova Scotia Hospital  
Twin Oaks Memorial Hospital  
Musquodoboit Valley Memorial Hospital  
Atlantic Health Sciences Corporation\*  
Saint John Regional Hospital  
St. Joseph's Hospital  
Sussex Health Centre  
Charlotte County Hospital  
Grand Manan Facility

#### **3. Université Laval**

Centre Hospitalier Universitaire de Québec  
Hôpital Laval, Institut Universitaire de Cardiologie et de Pneumologie

#### **4. Université de Sherbrooke**

Centre Universitaire de santé de L'Estrie  
Sherbrooke Geriatric University Institute

#### **5. Université de Montréal**

Centre Hospitalier de l'Université de Montréal  
Hôpital Sainte-Justine  
Institut Cardiologie de Montréal  
Hôpital Maisonneuve-Rosemont  
Hôpital du Sacré-Coeur de Montréal

Institut Universitaire de Gériatrie de Montréal

**6. McGill University**

Montreal University Health Centre  
Jewish General Hospital  
St. Mary's Hospital  
Douglas Hospital

**7. University of Ottawa**

Sisters of Charity of Ottawa (SCO) Health Services  
Ottawa Hospital  
Children's Hospital of Eastern Ontario

**8. Queen's University**

Kingston General Hospital  
Hotel Dieu Hospital  
Providence Continuing Care Centre

**9. University of Toronto**

University Health Network  
St. Michael's Hospital  
The Hospital for Sick Children  
Sunnybrook Health Sciences Corporation  
Mount Sinai Hospital  
Toronto Rehabilitation Institute  
Baycrest Centre for Geriatric Care  
Centre for Addiction and Mental Health

**10. McMaster University**

Hamilton Health Sciences Centre  
St. Joseph's Hospital

**11. University of Western Ontario**

London Health Sciences Centre  
St. Joseph's Health Centre

**12. University of Manitoba**

Winnipeg Regional Health Authority  
St. Boniface General Hospital  
Health Sciences Centre

**13. University of Saskatchewan**

Saskatoon District Health Board  
Royal University Hospital  
Saskatoon City Hospital  
St. Paul's Hospital  
Regina Health District  
Regina General Hospital  
Pasqua Hospital

**14. University of Calgary**

Calgary Health Authority  
Rockyview Hospital  
Foothills Hospital  
Alberta Children's Hospital  
Peter Lougheed Hospital

**15. University of Alberta**

Capital Health Authority  
Royal Alexandra Hospital  
University of Alberta Hospital  
Grey Nuns and Misericordia Hospital

**16. University of British Columbia**

Provincial Health Services Authority  
Children's and Women's Health Centre  
BC Cancer Agency  
Vancouver Coastal Health Authority  
Vancouver Hospital and Health Science Centre  
Providence Health Care/St. Paul's Hospital

Source: Based on information provided by Glenn Brimacombe, Chief Executive Officer, Association of Canadian Academic Healthcare Organizations.

\*AHSC functions as main New Brunswick campus for Dalhousie University and Memorial University of Newfoundland and Labrador.



## CHAPTER THREE

### DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES

---

In Volume Five of its study on health care, the Committee advocated major restructuring of the hospital and doctor system, leading to the devolution of operational responsibility for health care spending from provincial governments (ministries of health) 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. If a province so wished, RHAs could also become responsible for purchasing primary health care and prescription drugs.<sup>95</sup> Devolving responsibility for the *full* range of health services from provincial ministries of health to RHAs would lead to a better-integrated, more coordinated and truly patient-oriented system of health care delivery.

This type of reform, which has already been implemented in varying degrees in a number of countries, including Sweden and the United Kingdom, was also proposed in the report of the Premier's Advisory Council on Health in Alberta (the Mazankowski report).<sup>96</sup> The Committee believes that RHAs have done a commendable job of integrating and organizing health services for people in their regions during the last decade in Canada, and that they should be given more responsibility and authority for delivering and/or contracting for the full range of publicly insured health services.

***The Committee believes that RHAs have done a commendable job of integrating and organizing health services for people in their regions during the last decade in Canada, and that they should be given more responsibility and authority for delivering and/or contracting for the full range of publicly insured health services.***

The Committee also believes that such reform would foster competition among health care providers (both individual and institutional) and encourage cost-effectiveness and efficiency in service delivery. As stated in Volume Five, the Committee is aware that reforms of this type will have to be adapted to the particular circumstances that prevail in different parts of the country in order to take into account the number and type of health care providers that operate in each region, as well as factors such as the urban/rural mix. We also acknowledge that the goals intended by this reform will have to be achieved through other means in Ontario, the Yukon and Nunavut, since there are no RHAs in these jurisdictions.<sup>97</sup>

---

<sup>95</sup> Volume Five, pp. 39-40.

<sup>96</sup> Premier's Advisory Council on Health, (Right Hon. Don Mazankowski, Chair), *A Framework for Reform*, December 2001 (<http://www.premiersadvisory.com/>).

<sup>97</sup> The Committee was told that one of the reasons explaining why there are no RHAs in Ontario is the fact that the Greater Toronto Area is too big for a RHA. One possibility could be to consider implementing the RHA model elsewhere in that province, while another model allowing for the integration of care could be implemented in the GTA.

This chapter is divided into five sections. Section 3.1 provides a general portrait of RHAs across Canada in terms of their current structure, size, scope of responsibility and funding. Section 3.2 reviews the objectives for which RHAs were established and summarizes RHAs' achievements in light of those objectives. Section 3.3 discusses the barriers which currently prevent RHAs from fulfilling their responsibilities to their fullest potential. Section 3.4 describes how reforms based on some "internal market" approaches have the potential to address these concerns through the devolution of further responsibility to RHAs. Finally, Section 3.5 enunciates the Committee's position on the role of RHAs in Canada.

### **3.1 RHAs Across Canada: A Portrait<sup>98</sup>**

In Canada, regional health authorities are playing an ever-increasing role in health care. In the past 14 years, all provinces (except Ontario) and the Northwest Territories have devolved responsibility for the management of substantial parts of the health care system from provincial/territorial governments (ministries of health) to RHAs. The common definition for RHAs in Canada is as follows:

*Regional health authorities are autonomous health care organizations with responsibility for health care administration within a defined geographic region within a province or territory. They have appointed or elected boards of governance and are responsible for funding and delivering community and institutional health services within their regions.<sup>99</sup>*

Despite this common definition, RHAs across Canada differ greatly in size, structure, scope of responsibility, and number per province/territory. Table 3.1 provides information on the current number and approximate date of establishment of RHAs in each jurisdiction, as well as data on the population served. Regionalization of health care is a fairly recent phenomenon in many provinces. While some provinces have recently reduced the number of RHAs (for example, British Columbia went from 52 to 6), others have increased the number (by 1 in New Brunswick and from 4 to 9 in Nova Scotia). In addition, the size of the population served by a RHA varies widely both between and within provinces.

---

<sup>98</sup> Unless otherwise indicated, the information contained in this section is based on the following documents: Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 ([www.oha.com](http://www.oha.com)).

Regionalization Research Centre, *What is Regionalization?* (<http://www.regionalization.org/>).

Ian McKillop, George H. Pink and Lina M. Johnson, *The Financial Management of Acute Care in Canada, – A Review of Funding, Performance Monitoring and Reporting Practices*, Canadian Institute for Health Information, March 2001 ([http://www.cihi.ca/dispPage.jsp?cw\\_page=GR\\_32\\_E](http://www.cihi.ca/dispPage.jsp?cw_page=GR_32_E)).

Peggy Leatt, George H. Pink and Michael Guerriere, "Towards a Canadian Model of Integrated Health Care", *HealthCare Papers*, Vol. 1, No. 2, Spring 2000, pp. 13-35.

(<http://www.longwoods.com/hp/spring00/Papers2.pdf>)

British Columbia Medical Association, *Regionalization of Health Care*, BCMA Policy and Reports, 1997 (<http://www.bcma.org/IssuesPolicy/PolicyPapersReports/regionalization/default.asp>).

Jonathan Lomas, *Regionalization and Devolution: Transforming Health, Reshaping Politics?* Occasional Paper No. 2, October 1997 (<http://www.regionalization.org/OP2.pdf>).

Jonathan Lomas, "Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the issues", *Canadian Medical Association Journal*, Vol. 156, Issue 3, February 1997, pp. 371-377 (<http://www.cmaj.ca/>).

<sup>99</sup> Definition provided by the Regionalization Research Centre.

**TABLE 3.1  
REGIONAL HEALTH AUTHORITIES (RHAs), 2002**

	<b>DATE ESTABLISHED</b>	<b>NUMBER OF RHAs</b>	<b>POPULATION SERVED (range or average)</b>
British Columbia	1997	6	320,000 to 1.3 million
Alberta	1994	17	20,000 to 900,000
Saskatchewan	1992	12	30,000 to 50,000
Manitoba	1997-1998	12	7,000 to 650,000
Ontario	-	-	-
Quebec	1989-1992	18	411,000
Nova Scotia	1996	9	34,000 to 384,000
New Brunswick	1992	8	95,000
Prince Edward Island	1993-1994	5	143,000
Newfoundland	1994	6	143,000
Yukon	-	-	-
Northwest Territories	1988-1997	9	386 to 17,897
Nunavut	-	-	-

Source: Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 ([www.oha.com](http://www.oha.com)).

Table 3.2 provides information on the scope of services for which RHAs are responsible in each province/territory. The scope varies significantly. Hospital services are common to RHAs in all provinces. In addition, in some provinces, laboratory services, long-term care, home care and a variety of other health services are provided by RHAs through contracts with private not-for-profit and private for-profit organizations. RHAs in Quebec have been particularly successful in integrating a wide range of health, social and mental services. However, physician services, prescription drugs and cancer care have not been devolved to regions and continue to be administered and funded centrally by all provincial/territorial governments.



**TABLE 3.2**  
**SERVICES ADMINISTERED BY REGIONAL HEALTH AUTHORITIES**

	Hospitals	Long Term Care	Home Care	Public Health	Mental Health	Rehab	Social Services	Local Ambulance	Labs
BC	X	X	X	X	X	X			X
ALTA	X	X	X	X		X			X
SASK	X	X	X	X	X	X		X	
MAN	X	X	X	X		X		X	X
QC	X	X	X	X	X	X	X	X	X
NB	X		X					X	X
NS	X			X	X	X			X
PEI	X	X	X	X	X	X	X		
NFLD	X	X	X	X	X	X	X		
NWT	X	X	X	X		X	X		X

Source: Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 ([www.oha.com](http://www.oha.com)).

RHAs differ in the degree of their decision-making authority. In some provinces, RHAs operate within specific, provincially determined administrative and fiscal constraints (Nova Scotia, Manitoba, British Columbia), while others have greater autonomy (Alberta, Saskatchewan, Prince Edward Island). Only in a few provinces do RHAs have an elected board of directors (in Alberta, for example, RHAs have a partially elected board). And only a few boards include representatives from health care providers (as in British Columbia). None has any role in raising revenue, but all are responsible for local planning, setting priorities, allocating funds and managing services for better integration and greater effectiveness and efficiency, within provincially defined policy guidelines. Many also have some direct role in delivering services, or at least employing health care providers other than physicians.

RHAs receive funding from the provincial/territorial government, usually through global budgets that are based on historical spending levels for the population served. Some jurisdictions (such as Alberta, British Columbia and Saskatchewan) have moved to needs-based per-capita funding (adjusted for population, age, sex and need indicators).

### **3.2 RHAs: Goals and Achievements<sup>100</sup>**

Initially, the objectives of devolving health care decisions to the regional level were multiple. According to the Canadian literature, they included: 1) cost containment; 2) responsiveness to local needs; 3) local control of decision-making; 4) coordination and integration of services; 5) efficient use of health care resources; 6) improved access; 7) effective management; 8) greater accountability; 9) emphasis on population health and wellness; and 10) better health outcomes.

<sup>100</sup> For more information, see for example the following two documents: 1) Robert Bear, “Can Medicare Be Saved? Reflections from Alberta”, in *Healthcare Papers*, Summer 2000, pp. 60-67; 2) The Mazankowski report (December 2001).

There have been few evaluations of regionalization to determine the extent to which these goals have been or are now being met. However, the testimony received by the Committee and the evidence available from the literature suggest that RHAs have been very successful in many respects:

- RHAs provide health services at reduced administrative costs. For example, the Capital Health Region located in Edmonton devotes less than 3% of its total budget to administrative costs.
- RHAs have a strong focus on illness prevention and public health and ensure interactive relationships with their communities.
- RHAs are well suited to the integration and coordination of the institutions and organizations providing health services. In doing so, they deliver greater efficiencies, higher quality of service and continuous quality improvement.
- Better integration and coordination at the regional level allow for the use of the least costly providers commensurate with accessibility and quality of care goals for each individual consumer.
- Integrated health service delivery at the level of RHAs enhances the ability to respond to service demands, such as Emergency Department pressures, through integrated responses using home care, continuing care and acute care resources.
- RHAs have greater flexibility in reallocating and consolidating clinical services between health care providers and institutions.

Overall, RHAs are pivotal to the health care system, acting as intermediaries 1) between the patient and the provider, 2) between government and the local population, and 3) between the insurer (government) and the various providers. In this regard, the Committee views RHAs as key players in the reform of Canada's health care system. They offer tremendous opportunities for renewing and sustaining health care in Canada.

***The Committee views RHAs as key players in the reform of Canada's health care system. They offer tremendous opportunities for renewing and sustaining health care in Canada.***

### **3.3 Barriers that Prevent RHAs from Functioning to Their Fullest Potential<sup>101</sup>**

During its study, the Committee learned that a number of barriers currently prevent RHAs from operating to their fullest potential. These are summarized below:

---

<sup>101</sup> Unless otherwise indicated, the information presented in this section is based on the following documents: The Mazankowski report (December 2001).

Glenn G. Brimacombe and Lorraine Pigeon, *A Review of the Funding Flows of Regional Health Authorities in British Columbia*, The Conference Board of Canada, 2001.

Cam Donaldson, Gillian Currie and Craig Mitton, "Integrating Canada's Disintegrated Health Care System – Lessons from Abroad", *C.D. Howe Institute Commentary*, April 2001 ([www.cdhowe.org](http://www.cdhowe.org)).

- While RHAs are responsible for delivering health services according to the needs of their populations, their budgets are, in some provinces, almost completely determined by government and their performance targets are set by government. In these provinces, RHAs have few options if they are unable to meet their residents' health needs within their existing financial resources. A number of observers have suggested that RHA boards must spend a great deal of their energies lobbying the province for increased funding. They have suggested that this effort would be better spent on setting their own priorities and achieving their own set of objectives rather than responding to the priorities and objectives set for them by government.
- There are weaknesses in RHAs' planning and budgeting of resources, as well as gaps in reporting performance. Currently, RHAs are required to provide business and budget plans to the province. In some cases, however, these plans are very general in nature. Specific targets are not set and agreed to by both parties, and budgets are more in the nature of guidelines rather than setting formal limits on what can be spent and for what purposes. Some analysts have suggested that agreements with the provincial government should clearly spell out what happens if RHAs do not manage to live within their budgets or do not achieve their performance targets. This would greatly improve transparency and enhance accountability.
- A useful example of how setting specific targets can be done in practice was brought to the attention of the Committee. Alberta Health and Wellness, along with Capital Health of Edmonton and Calgary Health Region, annually set target volumes for a number of province-wide services (such as organ transplants, open heart surgery, major trauma and burn care and complex neurosurgery). These targets are set based on health status, incidence of health conditions and trend data. The ability of these two Albertan RHAs to achieve the targets and the associated health outcomes are monitored annually.
- While doctors direct much of what happens in health care, they are remunerated independently of RHAs. For example, if a physician orders a laboratory test or an X-ray, it is the RHA that carries the financial burden, not the physician. David Kelly, former Assistant Deputy Minister of Health in Alberta and British Columbia, told the Committee:

*Health regions have been in place now in western Canada for the better part of a decade, with a mandate and the resources to provide many publicly paid for health care services. However, to date these regions have been given virtually no responsibility for the provision of physician services. Physician payment remains a responsibility of Health Ministries, which negotiate province-wide contracts with the physicians' unions. To date, these contracts, in my opinion, have done little to assist in the integration of physician's services with regional health care services, or to promote primary care reform. A notable exception is the decision by Alberta in 1994 to move the responsibility and resources for the provision of all laboratory services, both hospital and contracted private laboratory, to*

*the health regions. This step, which moved about 10% of the physician budget to the regions, produced substantial savings and an integrated lab service at the regional level. Both the Fyke and Mazankowski reports recommend that at least part of the responsibility for the payment of physician services should move to the regions (...).<sup>102</sup>*

This problem could be significantly ameliorated if the cost of physician services was included in the budget of RHAs rather than having physicians paid separately by provincial/territorial governments. Perhaps more important, moving both drug therapy and primary health care to the budget of RHAs would ensure, from the patients' perspective, a fully integrated health care system (or a "seamless system"):

*(...) the move to regional health authorities may have reduced some of the problems of uncoordinated care among organizations but it is not clear whether it has improved integration of many patient-care processes. Essential components for integrated care have been excluded from the authority of regional bodies – drugs and medical care being the most important. A regional health authority without responsibility for physicians and pharmaceuticals cannot provide integrated health care.<sup>103</sup>*

In light of this evidence, the Committee believes that increased responsibility for decision-making related to the full range of health services, enhanced responsibility for planning and better control over the allocation of resources would lead to greater integration of health services; these are all appropriate roles for RHAs in the publicly funded health care system today and in the future.

***The Committee believes that increased responsibility for decision-making related to the full range of health services, enhanced responsibility for planning and better control over the allocation of resources would lead to greater integration of health services; these are all appropriate roles for RHAs in the publicly funded health care system today and in the future.***

This requires governments to move away from "top-down" approaches and toward devolving the management and governance of health care at the regional level. The role of government should be that of overall system governance, setting policies with respect to the health of the population, negotiating strategic plans and budgets and funding RHAs to achieve their objectives.

A policy-based on some of the principles of an "internal market" approach is one potential reform that would devolve greater responsibility to RHAs, depoliticize health care decisions at the regional level, encourage more competition and more choice in the health care sector and provide Canadians with a truly seamless health care system.

---

<sup>102</sup> David Kelly, Brief to the Committee, pp. 7-8.

<sup>103</sup> Peggy Leatt *et al.* (Spring 2000), p. 18.

### 3.4 RHAs and the Potential for Internal Markets<sup>104</sup>

The concept of “internal markets” may sound quite complex, but it simply refers to the introduction of market-like mechanisms into the publicly funded health care system. These market-style incentives would take place on the *delivery* and *allocation* sides of health care systems, not on the *financing* side. Internal market reforms are introduced in pursuit of efficiencies in the delivery of care and in the allocation mechanisms that distribute revenue to the health care providers and institutions.

The markets are “internal” because they involve, on both the demand and supply sides, entities within the publicly funded health care system itself. On the demand side, there is a publicly funded purchaser that operates as the agent for the population of patients being served. On the supply side, there is another entity providing the service. In this context, the purchaser would be the RHA, while the provider could be a hospital, specialist, laboratory, primary care physician, etc.

A number of observers have suggested that the Canadian health care system already involves several characteristics inherent to internal markets. For example, in most provinces RHAs purchase or contract for hospital services on behalf of their citizens. Prior to that, a global budget or some population-based funding is negotiated separately between the government and each RHA.

What has not happened yet in Canada is 1) the clear, explicit devolution of responsibility from governments to RHAs for the purchasing of the *full* range of health services; and 2) the establishment of a consistent framework of expectations, so that a variety of providers could compete for funding on a level playing field, with clear accountability, using a business or performance contract model. In some instances, RHAs currently simply pass the budget received from their provincial/territorial governments on to hospitals, based on historical spending patterns. In addition, none of the RHAs in Canada is responsible for the budget of physicians (hospital-based specialists or primary health care doctors) or for the spending on prescription drugs. As a result, there can be no competition (and no market-like behaviour) among health care providers and institutions, and no real integration of the various publicly insured health services.

Some Canadian experts contend that an internal market approach based on RHAs acting as the purchasing agents would foster effective management of health services and improve the quality of care in their regions:

*With an internal market, regional health authorities hold the purse strings and choose between providers on the basis of quality and cost, rather than simply funding the decisions of those using the resources.*<sup>105</sup>

---

<sup>104</sup> The information provided in this section is based on the following documents: European Observatory on Health Care Systems, *Health Care Systems in Eight Countries: Trends and Challenges*, April 2002 (<http://www.euro.who.int/observatory/TopPage>). Volume Three, Chapters Four and Five, January 2002. Volume Five, April 2002.

Applying the principles of internal market reform at the regional level does not imply that hospitals currently owned by RHAs must be turned to the private sector. There is opportunity to apply the rationale behind internal market reforms in Canada through competitive contracts among the RHAs and the various public (RHA owned) hospitals. Competition can be further enhanced when private providers are allowed to compete with public providers for some publicly insured health services (such as day surgery and long term care). In addition to enhanced competition, these contracts between RHAs and their hospitals could set specific performance targets; this would greatly improve the accountability of hospitals and other health care providers.

The Committee holds the view that reforms based on internal market approaches have the potential to introduce competition among hospitals, other institutions and individual health care providers. Competition will also provides the incentives for providers to become more efficient and cost-conscious and to make decisions about what to provide, to whom, and what standard of service they can achieve.

Furthermore, the Committee believes that such reforms would ensure that RHAs have the necessary flexibility to reconfigure services in a way that is more in line with population needs. Perhaps most important, reforms based on internal market principles solve the current problem in some provinces of top-down management by provincial health departments. In addition, an internal market approach will introduce a much greater degree of transparency into the system and enhance the accountability of all parts of the system.

***The Committee believes that an internal market reform can reconfigure services in a way that is more in line with population needs.***

Internal market reforms involving the devolution of clear responsibility to regional health bodies have been implemented in Sweden and the United Kingdom. In Sweden, prior to reforms, hospitals were owned and operated directly by the county councils, which were responsible for financing and delivering health services and which employed most physicians, both hospital-based physicians and those providing primary health care. The reforms brought new contractual arrangements and new payment schemes.

More precisely, public hospital management was devolved from county council control to independent boards of directors. Hospital remuneration was changed to Diagnostic Related Groups (DRGs), a form of service-based funding (like the one recommended in Chapter Two of this report). Reforms of the primary health care sector were also introduced to allow county councils to purchase physician services. A number of primary health care physicians now operate privately under contract with the county councils; they are reimbursed by the county councils on a fee-for-service basis. Some other county councils have introduced capitation payments for primary health care physicians. Overall, estimates suggest that county councils in which internal market reforms were implemented were able to reduce costs by 13% over those who retained the status quo.

In the pre-reform system of the United Kingdom, hospitals were state-owned and operated by the National Health Service (NHS) through its RHAs. The budget of each

---

<sup>105</sup> Cam Donaldson *et al.* (April 2001), p. 8.

RHA was determined by the central government and was based on a weighted capitation formula. Each hospital's budget was then determined regionally through an administrative process involving negotiations between its management and the relevant RHA. Hospital specialists were salaried employees of the NHS. A major critique of the system was that RHAs were purchasing services on behalf of their local populations, but at the same time they were running the local hospitals. Thus, they had a pronounced conflict of interest aimed at protecting those hospitals.

When internal market reforms were introduced, RHAs ceased to manage their own hospitals directly and became responsible, as purchasing organizations, for contracting with NHS hospitals and private providers to deliver the services required by their resident populations. Hospitals, for their part, were transformed into NHS Trusts: that is, not-for-profit organizations within the NHS but outside the direct ownership of RHAs. A system of DRGs was developed for providing payment to hospitals.

A review of the literature suggests that there has been little rigorous evaluation of the role of RHAs as purchasers of care in the United Kingdom. The fact that all RHAs became purchasers at the beginning of the reforms meant that there was little scope for comparative analysis. According to some experts, the internal markets did not function as originally envisaged because of a lack of incentive on both sides of the market to make restructuring work.

Perhaps more important, responsibility for primary health care was never devolved to RHAs. Primary health care physicians were encouraged to establish GP Fundholding practices. GP Fundholders were given a fund to purchase, on behalf of their patients, prescription drugs, hospital-based physician services and some hospital care. As such, most primary health care physicians practising as GP Fundholders became rival purchasers to RHAs. In fact, the GP Fundholding system became so popular that the central government decided to pass purchasing responsibilities from RHAs to GP Fundholders (which later became Primary Care Trusts).

According to Donaldson, Currie and Mitton (2001), the potential for turning RHAs into purchasers exists in Canada. RHAs now exist in most provinces/territories and the fact that most of Canada's health care is consumed in and around large cities allows, in their view, for plenty of potential competition among providers. They stress, however, that there are challenges to overcome.

- First, the method of remunerating hospitals would have to change if market-like incentives were to work. That is, hospitals would have to be remunerated according to service-based funding. This is one of the reasons why the Committee has recommended service-based funding in Chapter Two.
- Second, if hospitals were to commit to contracts established with RHAs, more control would have to be exerted by hospitals over those who work in them. Ultimately, this would require that responsibility for the budget of hospital-based specialists be devolved to RHAs.
- Third, to achieve a fully integrated or ("seamless") health care system, the budget for primary health care physicians would have to be allocated to

RHAs for contracting with physicians in their region. Physicians or groups of physicians should be able to choose the option of entering into contracts with RHAs or working outside the system. This would require a revision of the current mode for remunerating doctors.

- And fourth, serious consideration should be given to devolving authority for spending on prescription drugs to RHAs.

According to the Mazankowski report, RHAs are ready to take up these challenges. More precisely, the report stated:

- RHAs should consider establishing contracts with hospitals in their region as well as alternative ownership arrangements and payment mechanisms.
- RHAs should be encouraged to contract with a variety of providers including clinics, private and not-for-profit providers, groups of health care providers (including primary health care physicians) and other regions.
- RHAs should be encouraged to foster the development of centres of specialization. RHAs with specialized expertise should be able to market those services to other regions and enter into contracts with other regions to deliver services. In this way, regions would generate a sufficient volume of services to allow them to achieve better outcomes.

The Committee acknowledges the fact that, while internal markets can improve efficiency in large urban centres and populated areas, they cannot work properly in regions with a low population density. This point was also raised by Michael Decter, currently Chair of CIHI's Board of Directors and formerly Deputy Minister of Health in Ontario, when he stated:

*(...) population density is underrated as a factor in the ability to implement an internal market. It is one of the hazards of the European experience brought to Canada. Purchaser/provider splits work well where you have enough density of population and enough density of providers to have some competition.*

*(...) We have two realities in Canada. We have a good portion of the population, perhaps 70 percent, living in a handful of big cities where I think this model can work. The competition could be virtuous in terms of driving a better price and quality over time. In the rest of it, you need strategies to have enough service there to meet the needs. It is not a matter of competition. It is more a matter of stability of funding and strategies to allow providers to actually locate.<sup>106</sup>*

The Committee also acknowledges that there are currently no RHAs in Ontario, the Yukon and Nunavut. Accordingly, reforms based on internal markets with RHAs having responsibility for the full range of health services would not be possible in these jurisdictions. Alternative approaches to integrating health service delivery and improving efficiency will therefore need to be considered.

---

<sup>106</sup> Michael Decter (52:12).



### 3.5 Committee Commentary

The Committee believes that the devolution of further responsibility to regional health authorities is an important step in reforming health care in Canada. In fact, RHAs exist in most provinces and a large percentage of health care spending occurs in and around large cities, creating the potential for competition among the various providers and institutions. We strongly believe that now is the time for RHAs to be given greater control over the *full* range of health care spending in their region.

***The Committee strongly believes that now is the time for RHAs to be given greater control over the full range of health care spending in their region.***

The Committee acknowledges that establishing market-style incentives among health care institutions requires sufficient numbers of providers and a significant population base. Thus, while a number of regions across Canada would be capable of undertaking internal market reforms, some of the smaller provinces and some regions within the larger ones would be unable to do so. In our view, internal market reforms should be done in those geographic locations where gains can be achieved in terms of effectiveness and efficiency.

The Committee also believes that a reform based on the principle of internal markets is the solution to the various barriers that prevent RHAs from operating to their fullest potential. On the one hand, political interference will be minimized when RHAs are given the freedom and responsibility for achieving targets and performance standards. On the other hand, RHAs will have the needed flexibility to allocate their financial resources more cost-effectively and more in line with the needs of the population they serve. In addition, bringing the primary health care envelope under the authority of the RHAs will ensure that they have the levers to exercise more control over these costs. Moreover, devolution of financial responsibility for hospital services, hospital-based physicians and primary health care will encourage competition and allow RHAs to deliver/contract for the most efficient and timely services. Finally, assuming responsibility for the full range of health services will result in a better integrated and more patient-oriented health care system.

The Committee acknowledges that the introduction of internal market principles within the publicly funded health care system requires changing the method of remunerating hospitals. We believe that service-based funding is the most appropriate method, and our recommendation to that effect is detailed in Chapter Two.

The Committee is also aware that, in order to be successful, internal market reforms require detailed and reliable costing information. We also believe that the recommendations we make in relation to the full deployment of a national system of electronic health records, along with an independent evaluation of performance and

***Despite the fact that the management and delivery of health services is an “intensively provincial matter”, the Committee is of the view that the federal government can play an important role in improving health care delivery at the regional level through its sustained investment into the health care infrastructure, the evaluation of health care system outcomes and the supply of human resources in health care.***

outcomes (see Chapter Ten), will greatly facilitate such reform.

We understand that there have been few, if any, rigorous assessments of the internal market reforms undertaken in other countries. We believe that the influence of many factors, such as introducing different reforms simultaneously, has made it difficult to isolate the impact of the internal market reforms undertaken elsewhere. For this reason, the Committee feels it is important to monitor and evaluate the impact that reforms based on internal market principles can have in Canada on productivity, health outcomes, access to publicly insured services, waiting times, etc., and to report this information to Canadians.

Despite the fact that the management and delivery of health services is an “intensively provincial matter,” the Committee is of the view that the federal government can play an important role in improving health care delivery at the regional level through its sustained investment into health care infrastructure (particularly the development of the information systems that make it possible to move to service-based funding for hospitals), the evaluation of health care system outcomes, and the supply of human resources in health care (each of these issues is addressed in subsequent chapters of this report).

Therefore, the Committee recommends that:

**Regional health authorities in major urban centres be given control over the cost of physician services in addition to their responsibility for hospital services in their regions. Authority for prescription drug spending should also be devolved to RHAs.**

**Regional health authorities should be able to choose between providers (individual or institutional) on the basis of quality and costs, and to reward the best providers with increased volume. As such, RHAs should establish clear contracts specifying volume of services and performance targets.**

**The federal government should encourage the devolution of responsibility from provincial/territorial governments to regional health authorities, and participate in evaluating the impact of internal market reforms undertaken at the regional level.**



## CHAPTER FOUR

### PRIMARY HEALTH CARE REFORM

---

#### 4.1 Why is Primary Health Care Reform Needed?

Primary health care constitutes a patient's first point of contact with the health care system. According to the Canadian Medical Association, "primary medical care includes the diagnosis, treatment and management of health problems; prevention and health promotion; and ongoing support, with family and community intervention where needed."<sup>107</sup>

At present, primary care delivery in Canada is organized mainly around family physicians and general practitioners working solo or in small group practices. Approximately one-third of primary care physicians work alone and fewer than 10 percent work in multidisciplinary practices. The vast majority of primary care practices are owned and managed by physicians. Fee-for-service (FFS) payment is the dominant form of physician remuneration.

A variety of weaknesses and problems with the way in which primary care is generally delivered in Canada have been noted. These include:

- fragmentation of care and services;
- inefficient use of health care providers;
- lack of emphasis on health promotion;
- barriers to access (care not available after hours and on weekends);
- poor information sharing, collection, and management;
- misalignment of incentives, especially fee-for-service remuneration that rewards episodic more than continuing care and health promotion/disease prevention.<sup>108</sup>

A fairly wide consensus is emerging that the creation of primary care groups (PCGs) is central to reform of primary care delivery, and just about every major provincial report issued in recent years has recommended some version of primary care reform (see section 4.2.1). As Michael Decker, former Deputy Minister of Health in Ontario, told the Committee:

***There is a fairly wide consensus emerging that the creation of primary care groups (PCGs) is central to reform of primary care delivery, and just about every major provincial report issued in recent years has recommended some version of primary care reform.***

---

<sup>107</sup> Cited in Ann L. Mable and John Marriott, *Health Transition Fund Synthesis Series – Primary Health Care*, June 2002, p. 1.

<sup>108</sup> *Ibid.*, p. 2.

*The single biggest thing is to move from a model that cannot really work any more — which is solo practice — to groups. Those groups could have many configurations.<sup>109</sup>*

Primary care groups are practices composed of several physicians; they can also incorporate other health care professionals (potentially including nurses, nurse practitioners, physiotherapists, dieticians, midwives, psychologists, etc.).

In nearly all existing models of primary care groups, patients have to enrol with a specific group or physician within a defined group for a definite period of time. The PCG is then responsible for ensuring access to primary care for enrolled (rostered) patients 24 hours a day, seven days a week. Once enrolled, patients are expected to remain with their designated primary health care group for a specific period, usually six months to a year, unless they change their place of residence. The primary care physician or team acts as the gatekeeper to the rest of the health care system, referring enrolled patients to specialists. As now, the choice of specialist would be negotiated with the patient, by the primary care physician concerned. However, the rostered patient would not have direct access to a specialist (as is, in theory, the case now) or to other family physicians outside the group, except, of course, in urgent situations.

There are several potential advantages to a system based on PCGs, including:

- Guaranteed patient access on a 24/7 basis to the patient's own *team* of doctors and other providers;
- Better utilization of the spectrum of health care providers, and better coordination of patient services, through interdisciplinary teamwork;
- Potential cost savings in the longer term by reducing demand on expensive emergency rooms and specialists' services and by making sure that the most appropriately qualified professional handles each task;
- Provision of health promotion and illness prevention measures to patients.

In Volume Five, the Committee accepted the need for diversity in the models of primary care groups appropriate for the many and diverse regions and provinces of the country. The Committee drew on the various reports (see section 4.2.1) to establish a list of desirable attributes for all models of multi-disciplinary primary health care teams, including:

- The provision of a comprehensive range of services, 24 hours a day, seven days a week;
- Delivery of services by the most appropriately qualified health care professional;
- Adoption of alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae;
- Integration of health promotion and illness prevention strategies in the teams' day-to-day work.

---

<sup>109</sup> 52:9

- Full integration of electronic patient health records into the delivery of care.

One issue that surfaced during the Committee's most recent hearings was whether primary care reform would lead to noticeable cost savings. Some witnesses suggested that, because PCGs allow for all providers to practise to the full extent of their scope of practice, it should be possible to save money by having the most appropriately qualified provider deliver each service. These witnesses saw a potential source of savings in the fact that, for example, up to 60-70% of the procedures performed by physicians could be done by nurses or nurse practitioners (nurses with advanced qualifications). They felt that two things could be accomplished by transferring these tasks to other qualified personnel who are not as highly paid as physicians: money could be saved in the short term, and physicians would also be able devote a greater proportion of their time to those tasks for which only they are qualified, many of which are now referred to specialists because primary care physicians lack the time to do them.<sup>110</sup>

While all witnesses agreed that there would be efficiency gains by allowing physicians to concentrate on the full range of procedures where their particular training and skills were required, several witnesses questioned whether the anticipated cost savings would in fact be generated. For example, Dr. Peter Barrett, former president of the CMA, noted that:

*expanding the primary care team to include nurses, pharmacists, dieticians and others, while desirable, will cost the system more, not less. Therefore, we need to change our way of thinking about primary care reform. We must think of this as an investment, not in terms of cost savings but as a cost effective way to meet the emerging, unmet needs of Canadians.<sup>111</sup>*

At the same time, the Committee feels that there would be factors that would indeed operate to reduce costs. Dr. Barrett's comment is based on the assumption that there is a large amount of unmet need which, as a result of primary care reform, would be filled because more health care professionals will be supplying more services. Under a fee-for-service arrangement, this would obviously cost more money. At the same time, however, if primary care physicians provide services through the full range of their competency, there would also be a decrease in referrals to specialists.<sup>112</sup>

However all witnesses argued that even if there were no short-term cost savings, the importance of primary care reform was not diminished. Rather, the discussion brought to the fore other reasons for pushing it forward. In the words of Professor Brian Hutchison of McMaster University:

---

<sup>110</sup> This point is well illustrated by the following facts from a 1999 report of the Ontario Health Services Restructuring Commission, cited in Volume Four of the Committee's study (p. 110). One third of billings by specialists in Ontario in 1997 (at a total cost of \$1.4 billion) was work that could have been done by family doctors. The five most frequently used billing codes by Ontario family doctors in 1997, which account for about 69% of the total amount billed by these doctors (at a cost of \$1.2 billion), were for: intermediate assessments (well baby care), general assessments, minor assessments, individual psychotherapy, and counselling. The clinical consultants to the Ontario Health Services Restructuring Commission were of the opinion that most, if not all of the services these bills represent could well be provided by nurse practitioners, nurses and many well-trained health professionals.

<sup>111</sup> 56:12

<sup>112</sup> Research done for the Ontario Health Services Restructuring Commission shows that the most dramatic decrease in referrals would be to dermatologists and ear-nose-and-throat specialists.

*The emphasis on cost control has led to a focus on nurse practitioners as substitutes for physicians. The other dimension that needs to be explored is their potential for broadening the scope of primary care and providing a greater emphasis on health promotion, prevention and health counselling, where they have a great deal to offer, probably more than physicians. We should think of nurse practitioners in a complementary role, not mainly with the idea of saving money. We should view them in terms of improving health.*<sup>113</sup>

The Committee strongly endorses this point of view. Indeed, the synthesis report on various primary health care projects undertaken under the auspices of Health Canada's Health Transition Fund provides further evidence in this direction. Discussing a project that evaluated the role of a nurse practitioner in the context of a multidisciplinary team working out of a Calgary clinic, the report says:

*Although the physicians were not initially clear on the role of the nurse practitioner, the project soon saw nurse practitioners facilitating communication among various providers, "significantly" increasing access to care, improving quality, and handling cases, thus allowing physicians to spend more time with patients who required their services; 95 per cent of patients were satisfied with the initiative.*<sup>114</sup>

## **4.2 The Provinces and Primary Care Reform**

In this section, we review briefly the highlights of six provincial reports that contain recommendations for primary care reform. We then look at recent implementation initiatives in three provinces, Ontario, Quebec and New Brunswick, that have progressed beyond report-writing and pilot projects.

### **4.2.1 Recent reports**

Table 4.1 (end of chapter) presents an overview of the different proposals contained in six reports released since late 1999,<sup>115</sup> organized according to a number of key

---

<sup>113</sup> 58:13

<sup>114</sup> Marriott Mable, *op cit.*, p. 20

<sup>115</sup> These reports are:

1. Health Services Restructuring Commission (Duncan Sinclair, Chair), *Primary Health Care Strategy – Advice and Recommendations to the Honourable Elizabeth Witmer, Minister of Health*, Government of Ontario, December 1999.
2. Commission d'étude sur les services de santé et les services sociaux (Michel Clair, Commissioner), *Emerging Solutions – Report and Recommendations*, January 2001
3. Saskatchewan Commission on Medicare (Kenneth Fyke, commissioner), *Caring for Medicare – Sustaining a Quality System*, April 2001
4. Premier's Advisory Council on Health (Right Hon. Don Mazankowski, Chair), *A Framework for Reform*, report to the Premier of Alberta, December 2001, pp. 52-53.
5. Primary Care Advisory Committee (Kathy LeGrow, Chair), *The Family Physician's Role in a Continuum of Care Framework for Newfoundland and Labrador*, A Framework for Primary Care Renewal, Department of Health and Community Services, Newfoundland and Labrador, December 2001.
6. Report from the Premier's Health Quality Council, *Health Renewal*, Government of New Brunswick, January 2002.

elements of primary care reform. All six contain many important similarities and a number of significant differences.

All of the reports advocated the delivery of comprehensive primary care through some form of multidisciplinary team, usually 24 hours a day, seven days a week. However, the means suggested for achieving this objective varied considerably, as did the detail provided in the various reports. It is important to note that all stressed the need for the introduction of some form of Electronic Health Record (EHR – see Chapter Ten), although not all linked this need directly to their proposals for primary care reform.

The reports differed in their descriptions of the multi-disciplinary teams, and in the ways in which they envisaged the connections between primary care groups and other health care providers such as hospitals. Only a minority of the reports advocated specific alternate funding mechanisms, and only two presented explicit proposals for rostering.

Although it is too early to say whether the recommendations of these various reports will be implemented, the Ontario example is perhaps instructive. The Health Services Restructuring Commission (Sinclair) Report was both the first to be issued and contained the most detailed outline of how primary care reform should be carried out. As Ontario became the first to begin implementation of a province-wide scheme for primary care reform it is interesting to note that the actual model being put in place appears to be less uniform, as well as more flexible and voluntary than the plan contained in the report.

#### **4.2.2 The Ontario Family Health Network**

The Ontario Family Health Network (OFHN) was created in March 2001 as a semi-arm's-length agency that reports to the Ontario Ministry of Health and Long-Term Care (MOHLTC). The OFHN provides family physicians with information, administrative support and technology funding to support the voluntary creation of Family Health Networks (FHNs) in their communities.

The FHN model encourages groups of family doctors and allied health professionals, such as nurse practitioners, to work together to provide accessible, co-ordinated care to patients enrolled with them. OFHN provides funding, guidelines and support, but doctors voluntarily decide to form a local FHN and plan how they will work together to best serve their patients.

A minimum of five physicians (one of whom must act as group leader) and 4,000 enrolled patients are required to form an FHN, which can be spread over more than one site. In addition to regular office hours, one FHN office must be open from 5 p.m. to 8 p.m. Monday to Thursday, and three hours each day on the weekend. After hours, rostered patients have access to a phone line staffed by nurses, with support from a FHN doctor on call.

Pilots, known as Primary Care Networks, were created in 1998. Between 1998 and 2000, 14 pilot networks were created in seven communities, today embracing more than 178 physicians and approximately 270,000 enrolled patients. In November 2001, the Ontario Medical Association (OMA) voted to allow the OFHN to begin offering Family Health Network agreements to doctors in northern and rural Ontario. In January 2002, the OMA voted to allow



a general contract agreement to be released to family doctors throughout the province. In May 2002, a group of six doctors from the Dorval Medical Associates in Oakville formed the province's first Family Health Network.

Patients who sign on to an FHN agree to contact their Family Health Network doctor first when they need a health service, unless they are travelling or in an emergency situation. They also agree to allow the Ministry of Health and Long-Term Care to provide to the FHN doctor some information about health services received by the patients from family physicians outside their network. In addition, the MOHLTC can release to the Family Health Network doctor dates of immunizations, cervical screenings and mammograms.

Referrals to specialists, or to other family physicians for second opinions, is done by the Family Health Network physician in consultation with each patient. Patients can continue to use the services of their doctor without joining that doctor's FHN. Similarly, if they decide to cancel their enrolment in their doctor's FHN, they do not have to change family doctors. He or she can continue to see that doctor on the same basis as before they joined the network. Patients are free to change the doctor with whom they are enrolled up to twice a year. If, however, they are seeing another general practitioner on a regular basis, the doctor with whom they are enrolled can remove them from his or her Family Health Network roster of patients.

Physician satisfaction has been high and, to date, no physicians have left the pilot networks. The agreements that physicians sign in order to create an FHN address patient and physician rights and responsibilities, physician compensation, and administrative support.

Payment for rostered patients - which is weighted by age and gender (see Table 4.2) and covers a basket of 57 common primary care services - is expected to amount to about 60% of FHN revenue. There are additional payments for providing preventive health services such as vaccinations, Pap smears and mammography; bonuses for repatriating patients who previously saw other physicians for any of the core primary care services; an on-call fee; and premiums for non-core services such as deliveries and hospital in-patient care.

**TABLE 4.2  
RATIO FOR PAYMENT OF BASE RATE PAYMENT AND  
SPECIAL PAYMENT BY AGE AND SEX**

<b>Age</b>	<b>Male</b>	<b>Female</b>	<b>Average</b>
00-04	1.05	1.00	1.03
05-09	0.55	0.54	0.55
10-14	0.44	0.46	0.45
15-19	0.46	0.82	0.64
20-24	0.46	1.03	0.74
25-29	0.50	1.07	0.79
30-34	0.58	1.08	0.83
35-39	0.72	1.17	0.95

Age	Male	Female	Average
40-44	0.80	1.20	1.01
45-49	0.88	1.30	1.11
50-54	1.02	1.46	1.25
55-59	1.16	1.47	1.33
60-64	1.27	1.50	1.40
65-69	1.43	1.58	1.52
70-74	1.66	1.69	1.69
75-79	1.99	2.01	2.00
80-84	2.08	2.08	2.08
85-89	2.34	2.37	2.36
90+	2.64	2.68	2.67

Note: \$96.85 is the multiplier for the base rate payment.

Source: Matt Borsellino, "Primary Care Payment Options Become Available," *The Medical Post*, 4 December 2001, p. 8.

Physicians can also bill for continuing medical education, and each network is entitled to up to \$25,000 annually to defray additional administration costs. FHNs are also eligible for funding to set up an information technology system, including electronic patient records, drug interaction alerts, tracking of preventive care measures and electronic billing.

A physician who does an "average" amount of office work, hospital, obstetrics and ER, with a roster size of 1,480, patients might be paid \$254,846 under the blended model. For a physician who only does office work and has a roster size of 1,423 patients, the annual payment might be \$204,256. For a roster of only 598 patients, gross payment is \$105,455.

Dr. Elliot Halparin, a Georgetown, Ont., family physician and President of the OMA, said average payment under the blended model of the urban FHN template is an estimated \$244,500, assuming a roster size of 1,600 patients. This compares with \$210,700 under traditional fee-for-service. The numbers are based on the average billings of the 6,500 to 7,000 Ontario family physicians who provide comprehensive care.

While it is too early to attempt any evaluation of the actual OFHN project, an assessment of the pilot projects (Primary Care Networks or PCNs) that preceded the full rollout was done by PriceWaterhouseCoopers for the MOHLTC in October 2001. Some of the conclusions are worth noting:

- The top five benefits physicians have experienced in being part of a PCN are: the lifestyle and practice-style benefits of the capitation model; better care for patients; information technology (IT); increased income; shared call and coverage for absences.
- The top challenges physicians have faced in being part of a PCN are: administrative demands; IT; patient rostering; dealing with the Ministry.

- To date, the involvement of nurse practitioners and other health care providers in the networks has been limited, although patients report very high satisfaction with nurse practitioners.
- Role definition and team integration have been challenges in integrating nurse practitioners into PCNs; the nurse practitioner to physician ratio extremely low in many PCNs.
- It has been proposed that nurse practitioners might have an impact on cost-effectiveness, but there is no definitive evidence on the economic impact of nurse practitioners in the PCNs.
- There is high physician satisfaction with capitation, and preliminary evidence of changed behaviours due to capitation incentives.
- The teletriage service appears to have had a positive impact on emergency room utilization. Data from the teletriage service provider suggests that in the absence of the teletriage service, callers would have made 1,874 visits to hospital emergency rooms. However, the teletriage service advised only 871 callers to seek emergency care – a difference of 1,003 visits.

The report also noted three categories of barriers that impede the progress of the networks:

- *Implementation barriers.* Examples include delays in various IT components, insufficient multidisciplinary resources, inability to respond to higher than anticipated teletriage call volumes, and insufficient patient and public education about the reform.
- *Model barriers.* Examples include a physician-centric approach to the reform, issues with the bonus codes and capitation rates, insufficient feedback to physicians on outside use, and the need for specific performance measures for the PCNs.
- *Systemic barriers.* Examples include physician shortages, the health care funding structure, lack of integration with reforms in other health sectors and gaps in service.

The Committee feels it is important to note that the model adopted in Ontario differs considerably from that advocated by the Hospital Restructuring Commission. The Commission had wanted governments to stop paying for individual services performed by physicians and move to a model in which the PCG as a whole would be funded primarily using capitation. In the Committee's view this proposal would have led to the creation of genuine group practices, instead of the kind of practice that seems to be emerging in Ontario, where practitioners who remain essentially independent work together under a single roof. The Committee agrees with the approach recommended by the Hospital Restructuring Commission.

However, two other provinces recently announced initiatives in primary care reform that more closely resemble the recommendations of the reports that had been commissioned in their respective jurisdictions.

### 4.2.3 Quebec

On June 4, 2002, the Quebec Minister of Health and the President of the Quebec Federation of General Practitioners announced that they had reached agreement on arrangements for establishing the first 20 family medicine groups (FMGs). This is part of a plan to create over 300 of these groups over the next four years, by which point, as recommended by the Clair Commission, they are expected to provide primary care service to 75% of the province's population.<sup>116</sup>

The creation of FMGs is voluntary, as is patient enrolment. Each FMG will involve 6 to 10 physicians and nurses and provide a full complement of primary care services to 10-20,000 patients.<sup>117</sup> During an initial transitional phase, physicians will continue to be remunerated for clinical activity in the same way as now (fee-for-service, salary, etc.), but will also receive payment on an hourly basis for activities associated with the operation of the FMG, such as the coordination of services for enrolled patients, or interdisciplinary collaboration with other providers, as well as a yearly premium for each patient on their roster.<sup>118</sup>

Patients enrol with the doctor of their choice within a given FMG. Enrolment lasts a year and is automatically renewed unless the patient cancels in writing. Patients agree to consult their doctor (or someone else from the FMG) first, unless it is an emergency or they are travelling. FMGs are open for extended hours and guarantee service 24/7 using telephone emergency service.<sup>119</sup>

The Quebec government has committed \$15 million to finance the creation of the first 20 FMGs, split three ways: \$5 million for additional physician compensation; \$5 million for office computerization and equipment; \$5 million to hire nurses.<sup>120</sup> Each FMG must be approved by the Minister and must have in place a contract with a local CLSC (community health centre) as well as an agreement with the regional health board.

The Quebec government also recently introduced legislation, jointly sponsored by the health and justice ministries, that redefines the role of physicians, allowing them to delegate more duties to nurses. Nurses will specialize in areas such as surgery, cardiology and neo-natal intensive care, as well as performing extra tasks in a variety of settings, including in emergency rooms.<sup>121</sup>

### 4.2.4 New Brunswick

The Government of New Brunswick recently announced two related measures that follow up on the recommendations on primary care reform contained in the Premier's Health Quality Council Report. On May 8, 2002 the government brought down legislation intended to introduce nurse practitioners to the province's health system and allow registered

---

<sup>116</sup> Ministère de la Santé et des Services sociaux (MSSS) press release, June 4, 2002.

<sup>117</sup> *Health Edition*, Vol. 6 No. 23, June 7, 2002, p. 4

<sup>118</sup> MSSS fiche technique, « Résumé de l'entente particulière entre la FMOQ et le MSSS relative aux groupes de médecine de famille. »

<sup>119</sup> MSSS fiche technique, "Le groupe de médecine de famille."

<sup>120</sup> *Health Edition*, op. cit.

<sup>121</sup> *Medical Post*, May 14, 2002.

nurses to make greater use of their skills and training. The legislation will provide for the creation and registration of nurse practitioners, and will also enable front-line nurses working in primary care to deal with certain non-urgent conditions on their own, without the direct intervention of a physician.<sup>122</sup> They will be able to order laboratory tests and a variety of diagnostic procedures and also to issue prescriptions for some drugs.

The Minister of Health also announced that the government will spend \$2.1 million to establish at least two community health centres in the province during the current fiscal year.<sup>123</sup> These centres will use multidisciplinary teams of health professionals, including nurse practitioners.

Both physician and nurses' organizations have been supportive. In fact, in April 2002 the New Brunswick Medical Society had proposed that some nursing services be billed directly to Medicare so that both physicians and nurses could see patients. It reasoned that this would allow family physician practices to take on more patients, shorten waiting lists for specialists and even attract some nurses back to the profession.

### **4.3 Overcoming the Barriers to Change**

The Committee welcomes these provincial initiatives. We note that, for the first time, they move primary health care reform off the drawing board and into the realm of concrete application. These developments therefore offer grounds for guarded optimism that significant reform of primary care delivery is possible in Canada. However, there remain a number of barriers to change that must be overcome.

For example, with respect to Ontario, a number of witnesses expressed concern over the "physician-centric" nature of the OFHN. One of these, Professor Hutchison, told the Committee that the Ontario model was:

*...a very limited model that reflects the process by which it was negotiated — bilateral negotiations between the government and the Ontario Medical Association. There were no non-physician stakeholders involved in the discussion. It was a private, "behind closed doors" set of negotiations.*

*Although it has interesting elements, it is a pretty traditional approach. It changes funding (physician payment) methodology, but it does not change a lot of other things. It certainly does not provide many opportunities for providers to develop and evaluate varying arrangements that involve non-physician providers such as nurse practitioners, social workers, midwives, and so on. It is a physician-centred model.<sup>124</sup>*

Reinforcing that, Dr. Peter Barrett insisted that "to ensure comprehensive and integrated family care, family physicians should remain as the central provider and coordinator

---

<sup>122</sup> News Release 453, May 8, 2002.

<sup>123</sup> *Medical Post*, Vol. 38 No. 21, May 21, 2002.

<sup>124</sup> 58:23

of timely access to publicly-funded medical services.”<sup>125</sup> Dr. Ruth Wilson, the Chair of the OFHN, acknowledged in her testimony that the current Ontario model was a starting point, and that she was “expecting and hoping the relationships with other professionals will grow as we put family health networks in place,”<sup>126</sup> adding that “we have a large process of change to introduce if we are to convince the thousands of family physicians in Ontario to accept this model.”<sup>127</sup>

In this regard, the President of the OMA, Dr. Elliott Halparin, noted that it will take time before physicians sign on in large numbers:

*I think it will be a bit like popping popcorn: A few kernels will pop to begin with, but then there will be a lot of popping going on when people understand that this acknowledges the complexities involved in providing comprehensive care, that it is good for patients and, by extension, good for physicians.*<sup>128</sup>

More generally, witnesses pointed to the continued presence of a variety of barriers to the implementation of primary care reform. These include:

- The vested interests of various professional groups
- Shortages of qualified personnel
- Fee-for-service as the dominant method of physician remuneration
- High start-up costs
- The absence of electronic information infrastructure

The issue that seemed to spark the most controversy among the Committee’s witnesses was the first. Some felt that strong action, by government if necessary, was needed to break the log-jam with regard to professional groups protecting their respective turfs. Claude Forget, former Minister of Health in Quebec, argued that the “sector is not unlike a medieval guild system in the sense that it is rigid and does not allow the use of someone from another related profession if you find that you are in a deficit situation, and move him or her over.”<sup>129</sup>

Graham Scott, former Deputy Minister of Health in Ontario, expressed a similar view, pointing out that “we have a very well-funded, well-organized, and powerful monster in the form of each one of these health professional organizations,”<sup>130</sup> and that “the eventual threatened hammer of forced legislation”<sup>131</sup> was required to bring the parties to the table in order to revise the existing regulation of scopes of practice.

---

<sup>125</sup> 56:10

<sup>126</sup> 57:7

<sup>127</sup> 57:17

<sup>128</sup> 56:22

<sup>129</sup> 53:54

<sup>130</sup> 53:47

<sup>131</sup> 53:49

Other witnesses, however, stressed that primary care reform could not be imposed upon health care providers, but will work only if adopted voluntarily. Dr. Les Vertesi, Medical Director at the Royal Columbian Hospital in Vancouver, argued that “there are some things such as primary health care reform that have to be done by the providers because the detail is incredibly important.”<sup>132</sup> And Professor Hutchison noted that, “the chances of imposing reforms on unwilling providers are very small, partly because I do not think the public sees primary care reform as offering huge advantages to them.”<sup>133</sup>

With regard to scopes of practice, Ms. Kelly Kay, of the Canadian Practical Nurses Association, noted that:

*[the fact that] Licensed Practical Nurses continue to experience artificial limits to practice, that nurse practitioners must struggle for recognition and remuneration and that other professionals such as physiotherapists still face restrictions to direct access are examples that speak to continuing barriers imposed upon professional groups.*<sup>134</sup>

At the same time, physician representatives noted the progress that had been made among professional organizations in agreeing to common principles for determining scopes of practice. Dr. Barrett pointed out that:

*The Canadian Medical Association had developed a “scopes of practice” policy that clearly supports a collaborative and cooperative approach, which has been supported in principle by the Canadian Nurses Association and the Canadian Pharmacists Association. We indeed have a signed document to that effect.*<sup>135</sup>

In Volume Five, the Committee expressed its support for the revision of scope of practice rules in order to allow all health care providers to deliver the full range of services for which they have been trained.<sup>136</sup> In the Committee’s view, these should be as standardized as possible across the country. The synthesis report of the Health Transition Fund’s primary care projects reached a similar conclusion, notably with regard to nurse practitioners:

**...the Committee expressed its support for the revision of scope of practice rules in order to allow all health care providers to deliver the full range of services for which they have been trained. In the Committee’s view, these should be as standardized as possible across the country.**

---

<sup>132</sup> 53:90

<sup>133</sup> 58:12

<sup>134</sup> 61:4

<sup>135</sup> 56:12

<sup>136</sup> See also Chapter Eleven for additional comments on the need to reform scope of practice rules.

*A federal/provincial/territorial initiative should develop national standards for terminology and scope of practice. It should include legislative requirements that support an expanded role for nurses and nurse practitioners.<sup>137</sup>*

The Committee endorses this conclusion and believes that the federal government should take the initiative in this regard.

Some witnesses suggested that the key ingredient lacking in order to make more rapid progress in implementing primary care reform is political will. In this vein, Michael Decter told the Committee:

*It is not about the right model; it is about moving the yardsticks. We have spent a long time looking for the perfect model for primary care reform. It has worked in some places largely because someone just had the will to do it.<sup>138</sup>*

Witnesses reiterated the point made by the Committee in Volume Five that no single model could be applied in the same fashion in all parts of the country. Kelly Kay stated, “primary health care service delivery will look different in each community” since “communities must customize primary health care services in response to their own identified needs.”<sup>139</sup> For her part, Dr. Susan Hutchison, Chair of the GP Forum of the Canadian Medical Association, told the Committee:

*The mix of health care providers varies based on the needs of the population. There is no ideal mix. What works best is an adequate human resource to meet the needs of the population. The mix of providers is dictated by the services required to address these patient needs. The ideal range of services for a given team would depend on the needs of the population and the available mix of providers. There may be considerable variability between the needs of a given population, as is the case in Aboriginal populations, for example.<sup>140</sup>*

The Synthesis Report on Health Transition Fund projects in primary care (June 2002), reached a similar conclusion, noting that “the health system has already demonstrated its capacity and ability to support organizational variations and could continue to do this within an overarching theme of primary health care integration.”<sup>141</sup> It also drew a number of lessons that coincide with the recommendations made by the Committee in Volume Five, both with respect to the basic features a reformed primary care system should have, and to developing a national health human resources strategy and implementing a national electronic health record. In particular, it concluded:

---

<sup>137</sup> Marriott Mable, *op. cit.*, p. 29.

<sup>138</sup> 52:16

<sup>139</sup> 61:5

<sup>140</sup> 56:15

<sup>141</sup> Marriott Mable, *op. cit.*, p. 24



*The first-hand experience gained through the HTF projects offers new insights and reinforces long-standing knowledge about aspects of primary health care: the benefits of group practices and multidisciplinary teams; the untapped potential of nurses; and the linkages between determinants, health promotion and disease, and injury prevention.*<sup>142</sup>

The report also insisted that certain conditions were necessary to the success of primary care reform, arguing that “the development of a common electronic health record and access to computers and other technology for services, information, and research is essential to successful primary health care.”<sup>143</sup>

#### **4.4 The Federal Role**

In Volume Five the Committee recommended that:

**The federal government continue to work with the provinces and territories to reform primary care delivery, and that it provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care teams that:**

- **are working to provide a broad range of services, 24 hours a day, 7 days a week;**
- **strive to ensure that services are delivered by the most appropriately qualified health care professional;**
- **utilise to the fullest the skills and competencies of a diversity of health care professionals;**
- **adopt alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae;**
- **seek to integrate health promotion and illness prevention strategies in their day-to-day work;**
- **progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.**

Ongoing financial support for reform initiatives that lead to the creation of multidisciplinary primary health care teams would represent a continuation of the commitment to primary care reform that the federal government displayed in funding the \$150 million Health Transition Fund, of which over \$60 million was spent on projects related to primary care

---

<sup>142</sup> *Ibid.*

<sup>143</sup> *Ibid.*, p.25

reform. The federal government also committed \$560 million out of the \$800-million Primary Health Care Transition Fund (PHCTF) that was created as a result of the First Ministers Conference in 2000 to assist the provinces and territories in broadening and accelerating primary health care initiatives. This money is to be allocated on a per capita basis. To access these funds, each provincial and territorial government must develop one proposal showing how their PHCTF funding will support the transitional costs associated with primary health care reform.

However, the PHCTF is not an ongoing program. The Committee recognizes that the start-up costs for primary care groups can be substantial. Based on the actual costs of implementing primary care reform in Quebec, this cost could be as much as \$750,000 per group, while earlier estimates from Quebec had placed this cost as high as \$1 million per group.

The Committee therefore recommends that:

**The federal government commit \$50 million per year of the new revenue the Committee has recommended it raise to assist the provinces in setting up primary care groups.**

This money would be in addition to any funds made available through the PHCTF and should enable the creation of between 50 and 65 primary care groups per year.

In order for primary care groups to function effectively, the Committee is convinced that they must act as gatekeepers to the rest of the health care system. For example, patients who are enrolled in a particular PCG must have incentives, both positive and negative, to ensure that they consult their PCG physician rather than seek care from specialists on their own. Referrals to specialists should therefore be made by a primary care provider in consultation with the patient.

Nevertheless, the Committee does not believe it appropriate to prohibit patients from consulting other doctors, especially specialists, should they so desire. But it does believe that patients who choose to seek care elsewhere, care that could be provided adequately within the PCG with which they are enrolled, should bear the financial consequences of their decisions. In other words, patients should be obliged to pay a fee in order to consult other physicians, including specialists, when they do so on their own initiative.

***In order for primary care groups to function effectively, the Committee is convinced that they must act as gatekeepers to the rest of the health care system.***

In Volume Five, the Committee also recommended the establishment of an ongoing framework to deal with human resource issues, in particular by creating a permanent national coordinating body for health human resources composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include coordinating initiatives to ensure that adequate numbers of graduates are being trained to meet the goal of Canadian self-sufficiency in health human resources.<sup>144</sup>

---

<sup>144</sup> See also Chapter Eleven of this volume.

With respect to the development of electronic health records, the Committee recommended in Volume Five that the Canada Health Infoway initiative be extended beyond its current 3-5 year mandate in order to develop, in collaboration with the provinces and territories, a national system of electronic health records. Several witnesses suggested not only that the development of electronic health records is crucial to the reform of primary health care, but that it is an area in which the federal government can exercise leadership.

In the words of Jack Davis, CEO of the Calgary Health Region, “the one area I would see that has a real potential for federal investment is the electronic health record.”<sup>145</sup> Dr. Kenneth Sky, past president of the Ontario Medical Association, suggested that “for physicians, the IT component of primary care reform is a big incentive,”<sup>146</sup> and Michael Decter felt that electronic health records were so important that “bribery is in order in this particular sphere. I would bribe the doctors to convert.”<sup>147</sup>

The Committee agrees that the federal government should take the lead role in expediting the development of a national electronic health record, and presents specific recommendations to this effect in Chapter Ten.

---

<sup>145</sup> 53:88

<sup>146</sup> 56:22

<sup>147</sup> 52:14

## **Appendix 4.1: GP Fundholding in Great Britain**

In discussions of primary care reform, reference is often made to the British experience in the 1990s with the introduction of “internal markets”. Before 1990, it was accurate to describe the British National Health Service (NHS) as being run by a monolithic bureaucracy that controlled all aspects of the system. At that time, NHS hospitals and community health care units were state-owned and operated by the NHS’s regional health authorities. Each hospital’s budget was determined through an administrative process involving negotiations between its management and the NHS administration. GPs provided care through a “rostering” system that required patients to register with one GP, who then acted as “gatekeeper” to the rest of the system. GPs worked under contract with the NHS and were remunerated through a mixed system that combined a salary with capitation based on the number of patients on a doctor’s list.

With primary care reform, introducing internal markets allowed some general practices to volunteer as “Fundholders”. Family practices that served a sufficient number of patients became purchasers who were then able to contract with hospitals and other community-based providers (such as district nurses) for defined services. Fundholder budgets were restricted for the purchase of hospital and community services; they could not be used to supplement GPs incomes. GPs have always been paid by the NHS as independent, self-employed professionals. The various reforms enacted throughout the 1990s, such as fundholding and more recently the creation of Primary Care Groups and Trusts, have not fundamentally affected the ways in which British GPs derive their incomes.

In the early 1990s the GP fundholding system was expected to be only a small part of the overall reform process, but it quickly became more popular than anyone had anticipated, due to a variety of factors. There was evidence early on that fundholders could secure improved services for their patients. This created a bandwagon effect; few physicians wanted to be left behind. The Conservative government reinforced this trend by offering further benefits (e.g. computers) exclusively to fundholding practices. Moreover, fundholding gave GPs a central and more authoritative role in the overall system than they had had previously. Consultants (specialists) were forced to become more responsive and accountable to GPs who had the option to take their business (referrals) elsewhere.

The Labour government under Tony Blair, first elected in 1997, was critical of a number of aspects of internal market reform. In particular, it felt that GP fundholding had allowed a form of “two-tierism” to develop in Britain because patients of GP Fundholders were often able to obtain treatment more quickly than patients of non-Fundholders. This was considered inimical to the founding principles of the NHS, and as a result Labour sought to curb the forms of competition they saw as being at the root of emerging inequalities.

In April 1999, government required all GPs to join a Primary Care Group (PCG - groupings of GP practices in geographical areas far larger than the previous fundholding model, covering between 50,000 to 250,000 people.) PCGs brought local primary care providers together under a board dominated by GPs, but also representing nurses and other local community providers. PCGs were expected to develop through stages to become “Trusts” (PCTs) able to assume full responsibility for commissioning (contracting for) care and for the

provision of community health services for their population. By April 2002, nearly all the PCGs had made the transition to Trust status.

In principle, this evolution gave all GPs the benefits of fundholding, a single regional budget encompassing general medical services, and prescription drugs, as well as hospital and specialist care. However, a recent assessment by the King's Fund suggests that there is still some way to go before PCTs "will be able to realise their undoubted potential." The authors of this study concluded that PCTs are developing at different speeds and that while "they have made progress in developing and integrating primary and community care...their commissioning and health improvement functions are, as yet, limited."<sup>148</sup>

It is worth noting that until the market reforms of the 1990s, GPs retained a monopoly on primary care delivery through their role as gatekeepers to all other dimensions of the system. A number of reforms introduced by the Labour government have allowed nurse-led providers to assume a growing role in this regard. These have included the creation of a nurse-staffed 24-hour telephone advice line (NHS Direct) and the creation of a number of walk-in centres where initial assessments are performed by nurses, who can then refer patients to local GPs if necessary.

A number of factors make it very difficult to draw definitive conclusions from the British experience that can be easily applied to the Canadian context. There have not always been sufficient data available, and the rapidity of change has not facilitated careful study. Moreover, given the very different structure of the two systems, it is difficult to apply the lessons to the Canadian health care system. However, a number of points bear mention:

- In the first place, despite the Labour Government's opposition to the form taken by the "internal market" under the previous Conservative government, the Labour government has nonetheless retained key elements of the purchaser-provider split the Conservatives introduced.
- Second, the transition that the Blair government has engineered from GP fundholding to the creation of PCGs and PCTs would seem to highlight the successes of the fundholding scheme more than its deficiencies. It is because the fundholding GPs were successful in negotiating with hospital trusts on behalf of their patients that fears of "two-tierism" emerged.
- Third, the shift to grant a greater role in the delivery of primary health care services to nurses and other providers parallels similar recommendations that have been voiced consistently in the Canadian debate over primary care reform.

---

<sup>148</sup> John Appleby and Anna Coote, *Five Year Health Check*, King's Fund, April 2002, p. 47.

**TABLE 41**  
**REVIEW OF RECENT PROVINCIAL REPORTS CONTAINING RECOMMENDATIONS**  
**ON PRIMARY HEALTH CARE REFORM**

<b>Report</b>	<b>Scope of service</b>	<b>Team Composition</b>	<b>Remuneration</b>	<b>Size of practice</b>	<b>EHR*</b>	<b>Rostering</b>	<b>External Relations</b>
Sinclair (Ont.) Dec. 1999	Comprehensive primary care would be provided 24 hours a day, seven days a week; this would be achieved through after-hours clinics (or extended office hours) and around-the-clock telephone triage.	Physicians and nurse practitioners as "core providers", in an interdisciplinary team including: registered nurses, midwives, psychologists and social workers, pharmacists, physiotherapists, dieticians, Individual health care providers would work to the full extent of their scope of practice.	Group rather than individual funding, primarily on the basis of capitation supplemented by other methods; group determines how its member providers are reimbursed. Not merely office sharing.	Three distinct models: <u>urban</u> – 6 MDs, 2 NPs for about 1,680 patients; <u>rural</u> – 2 MDs and 2 NPs for 1,293 patients; <u>remote</u> – 1 MD and 3 NPs for 1,142 patients.	Yes	Yes	Each practice would be responsible for developing agreements with other health care organizations and providers (hospitals, specialists, public health, rehabilitation centres, long-term care facilities, home care, community care).
Clair (Que.) Jan. 2001	Group practices would ensure round-the-clock, seven-days-a-week coverage. Services to include health promotion and disease prevention, diagnosis and treatment, referral to hospitals and specialists, coordination of continuum of care, and referral to social care.	Practices comprise only physicians and nurse practitioners, but they work in partnership with the existing network of CLSCs (social workers, dieticians, psychologists, physiotherapists, etc.).	A blended system of remuneration that includes elements of capitation, a lump sum for participation in some programs, and FFS for prevention or to promote productivity.	6 to 10 physicians working in a polyclinic or within a CLSC with the collaboration of 2 to 3 nurse practitioners, and responsible for between 1,000 and 1,800 persons.	Yes	Yes	Contract with the regional health authority, and between the primary care group practice and the CLSC. Regional health authorities would be responsible for coordinating the network of primary care group practices with other service providers.
Fyke (Sask.) Apr. 2001	Group practices would make services available around the clock. Outside of office hours, telephone calls would be forwarded to a nearby group member; 24-hour back-up through a provincial call centre. No explicit list of services.	Primary care group practices would involve a variety of providers including physicians, nurse practitioners, midwives, physiotherapists, dieticians, home care workers, and professionals in the areas of mental health, rehabilitation, addiction and public health.			Yes		Regional health authorities would organize and manage primary care group practices, contracting with or otherwise employing all providers including physicians.

<b>Report</b>	<b>Scope of service</b>	<b>Team Composition</b>	<b>Remuneration</b>	<b>Size of practice</b>	<b>EHR*</b>	<b>Rostering</b>	<b>External Relations</b>
Mazan-kowski (Alta.) Dec. 2001	Gives very general approval to the idea of primary health care reform. Comprehensive care would be delivered by multidisciplinary teams.	Teams might include a family doctor, nurse or nurse practitioner, mental health worker, social worker and others.	Identifies FFS as a barrier to change. Suggests that a blended funding model is the best likely alternative, and sees the Ontario Family Health Network as an excellent example.		Yes		Physicians should be given the option of contracting with Regional Health Authorities for a portion of their income.
Nfld. Dec. 2001	A network of primary health care teams providing a 'Continuum of Care' (including preventative, promotive, curative, supportive and rehabilitative care).	Primary care physicians would work collaboratively with other health care providers and other physicians. Within each team, each health care provider would practice at the highest level of his or her respective skill set.	Did not endorse any specific funding method (no universal model) but seemed to support some form of flexible, blended funding. No mention of capitation.		Yes		Regional boards would outline for physicians what medical services are required for their region. Physician groups would enter into formal arrangements with boards to ensure delivery of the full basket of services listed in the agreement.
N.B. Jan. 2002	Access to a comprehensive range of ambulatory services 24-hours a day, seven-days a week, coordinated from one location, where possible a Community Health Centre. Where these would not be open 24 hours a day, phone calls would be re-directed to an around the clock service site.	A collaborative model and a team approach to providing primary care. Family physicians would not see every patient and other members from the team of health providers could provide consultation and/or perform treatment services. The goal would be to make full use of all providers based on their respective knowledge, skills and abilities.		All primary care services, where feasible, should be provided or coordinated through a network of Community Health Centres. These would be viewed as the physical 'nucleus' of primary care in the community.	Yes		Other providers could be accessed via telehealth and/or on site at the Community Health Centre.

\*Electronic Health Record

Source: Library of Parliament

# **Part III: The Health Care Guarantee**





## CHAPTER FIVE

### TIMELY ACCESS TO HEALTH CARE

---

Most of Volume Six covers specific issues relating to the delivery of health care. Hospital restructuring, financing health care, primary health care reform and expanding public coverage for prescription drugs, some home care and palliative care are all critical components of a fiscally sustainable health care system. This chapter, however, focuses on a less frequently discussed, but very important, issue – the right to health care and the implications of the *Canadian Charter of Rights and Freedoms* (the Charter) for the provision of *timely* access to medically necessary care.

*Timely* access to needed care does not necessarily mean immediate access. Nor is the issue of timely access limited to life-threatening situations. Timely access means that service is being provided consistent with clinical practice guidelines to ensure that a patient's health is not negatively affected while waiting for care.

***The Committee feels it is important to stress that timely access to needed care does not necessarily mean immediate access. Nor is the issue of timely access limited to life-threatening situations. Timely access means that service is being provided consistent with clinical practice guidelines to ensure that a patient's health is not negatively affected while waiting for care.***

The issue of timely access to health care is of particular importance at this time for the following reasons. First, repeated public opinion polls increasingly have shown that the greatest concern Canadians have about the existing publicly funded health care system is the perceived length of waiting times for diagnostic services, hospital care and access to specialists. This concern is evidence that timely access to health care – as that is defined by patients – is often not available.

Second, the lack of timely access to needed care can seriously contribute to the deterioration of a person's health and well-being. Given this fact, it is likely that increasing pressures will be exerted on governments, hospitals and physicians to ensure that medically necessary care is provided, within the publicly funded health care system, in a timely manner. It is also very likely that, failing substantial improvement, Canadians will exert pressure on government to make it legally possible for individuals to obtain timely care in a parallel private hospital and doctor system.

Third, if the pressure on government is not effective, for the reasons described below, the Committee believes that the courts are likely to rule unconstitutional current laws that effectively prevent Canadians from paying privately, in Canada, for health care services that are publicly insured.

Therefore, solving the timely access problem is critical if Canada is to preserve the single insurer model of the publicly funded hospital and doctor system that Canadians, and the Committee, so strongly support.

Do Canadians have a right to health care? Can Canadians be prevented from obtaining timely care when the publicly funded health care system fails to ensure timely access? This chapter addresses these questions.

## 5.1 The Right to Health Care – Public Perception or Legal Right?

To begin, it is important to distinguish between a legal right to health care and the public perception of the existence of that right. In Volume Four, the Committee noted the existence of public opinion polls that reveal that Canadians, encouraged by politicians and the media, believe they have a constitutional right to receive health care even though no such right is explicitly contained in the Charter.<sup>149</sup> Nor does any other Canadian law specifically confer that right, although government programs exist to provide publicly funded health services.<sup>150</sup>

***The Committee has previously noted the existence of public opinion polls that reveal that Canadians believe they have a constitutional right to receive health care even though no such right is explicitly contained in the Charter.***

The preamble to the *Canada Health Act*<sup>151</sup> (the Act) states that:

*continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.*

As well, section 3 of the Act provides 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.*

These statements from the *Canada Health Act*, supportive as they are, do not grant a right to health care.

Similarly, international instruments such as the *Universal Declaration of Human Rights, 1948*, to which Canada is a signatory, speak of the right to a standard of living adequate for health and well-being, including medical care and the right to security in the event of sickness and disability; but they too do not provide a basis for a constitutional, or even legal, right to health care.<sup>152</sup>

---

<sup>149</sup> Volume Four, p. 38.

<sup>150</sup> Colleen Flood and Tracy Epps, *Can a Patients' Bill of Rights Address Concerns About Waiting Lists?* Draft Working Paper, Health Law Group, Faculty of Law, University of Toronto, October 9, 2001, p. 7.

<sup>151</sup> R.S. 1985, c. C-6.

<sup>152</sup> The Canadian Bar Association Task Force on Health Care, *What's Law Got To Do With It? Health Care Reform in Canada*, (Ottawa: The Canadian Bar Association, August 1994) p. 24.

Clearly, there is a significant discrepancy between what the public believes and the absence of a legal right to health care.

Despite the absence of a legislated right to health care, there is a growing body of literature and court decisions on the effect of the *Canadian Charter of Rights and Freedoms* in the context of health care. Of particular interest are the implications of section 7 of the Charter for the provision of timely health care in Canada.

## **5.2 The Extent to which Publicly Insured Health Services are Available Outside the Publicly Funded Health Care System**

In Volume Four, the Committee discussed the impact of the *Canada Health Act* on the provision of privately funded health care. We stressed that the Act does not prohibit the provision of privately paid-for health services. Rather, the Act sets out the conditions under which the provinces and territories will receive or be denied full federal funding for providing medically necessary physician and hospital services to their residents.<sup>153</sup>

In order to receive full federal funding, provincial and territorial public health care insurance plans must meet the five key conditions: public administration, comprehensiveness, portability, universality and accessibility. The *Canada Health Act* also creates an important incentive for the provinces and territories to discourage doctors and hospitals from extra-billing patients or imposing user charges for medically necessary health services. If extra-billing occurs or user charges are required, the federal cash contribution provided under the CHST can be reduced by an equivalent amount.

The *Canada Health Act* does not contain prohibit health care providers who do not bill their provincial health care insurance plans from delivering, and being compensated privately for, provincially insured health services. Moreover, the Act does not limit, in any way, the delivery of publicly insured services by privately owned (not-for-profit or for-profit) service delivery institutions. Indeed, private health care institutions currently deliver publicly insured health services in every province. What the *Canada Health Act* does is provide for significant financial penalties when provinces allow private payments for publicly insured services, particularly where extra-billing and user charges are involved.

Provincial and territorial legislation work in tandem with the *Canada Health Act* to discourage and/or prevent medically necessary services from being provided outside the publicly funded health care system. Physicians can opt out of providing services in the public health care system and bill patients directly, but a variety of provincial regulations effectively discourage physicians from doing so. Many provinces prohibit opted-out doctors from charging patients more than the public system rate. Some provinces deny reimbursement to patients who receive insured health services from opted-out doctors. Moreover, the majority of provinces do not permit private health care insurance to be purchased for services insured under provincial health

---

<sup>153</sup> Volume Four, pp. 38-39.

care plans, even though all of them allow residents to purchase private insurance for hospital and physician services that are not classified as “medically necessary.”<sup>154</sup>

In Volume Four, the Committee said:

*The Canada Health Act along with provincial/territorial legislation has prevented the emergence of a private health care system that would compete directly with the publicly funded one. It is simply not economically feasible for patients, physicians or health care institutions to be part of a parallel system.*<sup>155</sup>

The end result is that Canadians have few, if any, real options in this country when the publicly funded health care system fails to provide timely care. Those who can afford to do so may seek care in the United States, but most simply wait hoping, sometimes in vain, that the public system can accommodate them.

***The Committee is concerned that Canadians have few, if any, real options in this country when the publicly funded health care system fails to provide timely care. Those who can afford to do so may seek care in the United States, but most simply wait hoping, sometimes in vain, that the public system can accommodate them.***

### **5.3 Timely Health Care and Section 7 of the Canadian Charter of Rights and Freedoms**

The presence of long waiting lists for certain medically necessary treatments and hence the absence of timely care raise a number of issues, not the least of which relate to the rights and entitlements of patients who are waiting for care. In this regard, in its Volume Four, the Committee posed the following questions:

*If a right to health care is recognized under section 7 of the Charter, and if access to publicly funded health services is not timely, can governments continue to discourage the provision of private health care through the prohibition of private insurance?*

*Is it just and reasonable in a free and democratic society that government ration the supply of publicly funded health services (through budgetary allocations to health care) and simultaneously, effectively prevent individuals from obtaining the service in Canada, even at their own expense?*<sup>156</sup>

These questions have provoked considerable debate that, in the Committee’s view, has significant implications for the Canadian health care system, as we know it. Indeed,

---

<sup>154</sup> Colleen M. Flood, Tom Archibald, “The illegality of private health care in Canada”, *Canadian Medical Association Journal*, March 20, 2001, 164 (6), p. 825-830.

<sup>155</sup> Volume Four, p. 40.

<sup>156</sup> *Ibid.*

the Committee raised these questions both to stimulate discussion and to caution governments that policies and laws that restrict, or discourage, access to privately funded health care will be increasingly difficult, if not impossible, to maintain if timely access to medically necessary care is not provided in the publicly funded system.

Thus, in the Committee's opinion, the failure to deliver timely health services in the publicly funded system, as evidenced by long waiting lists for services, is likely to lay the foundation for a successful Charter challenge to laws that prevent or impede Canadians from personally paying for medically necessary services in Canada, even if these services are included in the set of publicly insured health services.

***In the Committee's opinion, the failure to deliver health services in the publicly funded system, as evidenced by long waiting lists for services, is likely to lay the foundation for a successful Charter challenge to laws that prevent or impede Canadians from personally paying for medically necessary services in Canada, even if these services are included in the set of publicly insured health services.***

The *Canadian Charter of Rights and Freedoms* guarantees certain fundamental rights and freedoms. Section 7 of the Charter states:

*Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*

Although the Charter makes no explicit references to health care, it has been argued that section 7 has significant implications in the health care question. The section 7 argument is not based on a constitutional guarantee to government-funded health care, but rather on the section 7 rights to liberty and security of the person which, it could be argued, may be impaired if adequate and timely health care cannot be provided in the publicly funded health care system.

These rights, then, could be interpreted to imply that if individuals are unable to get timely care within the publicly funded health care system, governments should not be able to prevent an individual from paying for the service in order to obtain the service elsewhere in Canada. That is, while health care itself may not be a right, individuals do have the right not to be prevented by government from seeking timely health care elsewhere in Canada, if the service cannot be provided in a timely manner within the publicly funded system.

In 1994, the Canadian Bar Association Task Force on Health Care expressed the opinion that there is no right to health care under the Charter. This conclusion was based on the view that the Charter is often interpreted as a negative rather than a positive instrument – one that generally does not compel governments to act in a particular manner, but rather protects Canadians against coercive government action.<sup>157</sup>

In the context of health care, then, the Charter might not require governments to ensure that a certain level of health care is available in the publicly funded system, but the

---

<sup>157</sup> *What's Law Got To Do With It? Health Care Reform in Canada*, (1994) p. 26.

Charter could be employed to stop governments from taking restrictive measures that deny individuals from having the freedom to seek health care on their own in Canada when the publicly funded system fails to provide such care in a timely manner.

Indeed, the Task Force pointed out that individuals could advance the legal argument that section 7 includes a right to purchase health services when government cannot ensure, or is not willing to ensure, the provision of adequate services (which could clearly include a government not providing the service in a timely manner).<sup>158</sup>

Legal experts told the Committee that section 7 has application to health care and it is just a matter of time before its parameters are explored more thoroughly in the courts. Recent judicial decisions give evidence of a probable expansion of the Charter in relation to health care. Cases based on section 15 of the Charter, the equality section, have had some success.<sup>159</sup> But the implications of section 7 for timely access to health services have yet to be fully tested in the courts.

In a recent C.D. Howe Institute Commentary, entitled *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*,<sup>160</sup> authors Stanley Hartt and Patrick Monahan examine whether governments can prohibit or impede Canadians from accessing medically necessary health services by paying for them privately, if timely access to such services is not available in the publicly funded health care system.

Basing their analysis on section 7<sup>161</sup> of the Charter, Hartt and Monahan conclude that, when the publicly funded health care system fails to provide timely access to medically necessary care, restrictions on private payment or the purchase of private health care insurance violate an individual's right to liberty and security of the person guaranteed by section 7 and are inconsistent with the principles of fundamental justice. Because this Commentary is probably the most detailed examination of the application of section 7 in the health care context to date, the Committee believes it is worth outlining Hartt and Monahan's arguments in some detail.

Hartt and Monahan maintain that an individual's decisions with respect to his or her medical care are fundamental personal decisions affecting health, life and death and are therefore protected under the section 7 liberty guarantee. Consequently, when governments effectively prevent individuals from obtaining health care outside the publicly funded system, they have a concomitant obligation to ensure that timely care is provided within that system.

---

<sup>158</sup> *Ibid.*, p. 94.

<sup>159</sup> In *Eldridge v. British Columbia (Attorney General)* [1997] 3 SCR 624, the Supreme Court of Canada held that the provincial government's failure to fund sign-language interpreters in hospitals under its public health insurance system discriminated against deaf patients on the basis of physical disability and violated their equality rights under section 15 of the Charter.

<sup>160</sup> Stanley H. Hartt Q.C., Patrick J. Monahan, *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*, C.D. Howe Institute, Commentary, No. 164, May 2002.

<sup>161</sup> According to Hartt and Monahan (p. 9), a claim under section 7 of the Charter has three aspects:

1) An action of a legislature or government that deprives a person of one or more of "life, liberty and security of the person"; 2) The deprivation must be contrary to the principles of fundamental justice; 3) The violation cannot be justified under section 1 of the Charter, which requires that a violation of a protected right must be a "reasonable limit" that can be demonstrably justified in a free and democratic society.

Hence, when the public system cannot or will not deliver timely care, Hartt and Monahan argue that individuals should be free to acquire the necessary care elsewhere. And hence, under these circumstances, restrictions on the ability to access care outside the public system, including restrictions on the right to buy private health care insurance, constitute a violation of the right to make personal decisions affecting life and health as provided under section 7's liberty guarantee.<sup>162</sup>

The right to security of the person under section 7 has both a physical and a psychological aspect which, on the basis of the 1988 Supreme Court of Canada decision in the *Morgentaler* case, Hartt and Monahan interpret as encompassing the adverse physical and psychological impacts associated with excessive waiting for medical care. They assert:

*Where governments institute measures that delay or impede access to medically necessary services and where that delay materially increases medical risks or otherwise results in adverse health consequences, the violation of security of the person is clear.*<sup>163</sup>

Even if there is a limitation on the right to liberty or security of the person, however, section 7 will not be violated unless it can be shown that the limitation is inconsistent with the "principles of fundamental justice." While the courts have concluded that fundamental justice has both procedural and substantive aspects, the term has not been specifically defined. Hartt and Monahan argue that it is manifestly unfair, and therefore contrary to the principles of fundamental justice, to establish a system where medically necessary services are for all intents and purposes accessible only through the public health care regime but are unavailable on a timely basis.<sup>164</sup>

Consequently, Hartt and Monahan maintain that, if health services are not available on a timely basis, then provincial governments cannot legally prohibit Canadians from obtaining those services in Canada, nor can the federal government use the financial penalties in the *Canada Health Act* to compel the provinces to enforce constitutionally invalid restrictions.<sup>165</sup> In other words, governments cannot fail to ensure the provision of timely access to medically necessary health services and at the same time prevent Canadians from obtaining such services outside the publicly funded system. This includes governments being unable to prevent Canadians from acquiring private health care insurance to cover the cost of purchasing such services outside the publicly funded system.

***Hartt and Monahan maintain that, if health services are not available on a timely basis, then provincial governments cannot legally prohibit Canadians from obtaining those services in Canada, nor can the federal government use the financial penalties in the Canada Health Act to compel the provinces to enforce constitutionally invalid restrictions.***

---

<sup>162</sup> *Ibid.*, p. 17.

<sup>163</sup> *Ibid.*, p. 15.

<sup>164</sup> *Ibid.*, p. 20-21.

<sup>165</sup> *Ibid.*, p. 5.



It would follow, if Hartt and Monahan are correct, that the Charter would prevent the prohibition by government of an individual's right to obtain health services privately when the government fails to provide such services in a timely manner:

*Existing restrictions on the private purchase of medically necessary services are entirely justifiable in circumstances where such medical services are available on a timely basis through the public system,<sup>166</sup>*

*(...) where the publicly funded health care system fails to deliver timely access to medically necessary care, governments act unlawfully in prohibiting Canadians from using their own resources to purchase those services privately in their own country. In these circumstances, the restrictions on private payment and private health insurance that are found in the laws of various provinces force Canadians into a system that, at a minimum compromises their health and potentially may endanger their lives.<sup>167</sup>*

However, Hartt and Monahan's analysis does not conclude that the only remedy is for government to relax the restrictions on an individual's ability to purchase private health care insurance. Indeed, Hartt and Monahan believe governments can do one of two things – governments can either finance and structure the publicly funded health care system in such a way that it provides timely access to medically necessary care, or they can allow Canadians to buy that care if such access is not available in the publicly funded health care system in a timely manner.<sup>168</sup>

The Committee finds the Hartt and Monahan analysis compelling. However, at the same time, it should be noted that the Quebec Superior Court reached a different conclusion in a case [*Chaoulli c. Québec (Procureure général)*]<sup>169</sup> where section 7 of the Charter was used to dispute the Quebec government's prohibition on the purchase of private health care insurance to pay for the private provision of health services which are also covered under the provincial health care insurance plan. *Chaoulli* dealt with the plaintiff's wish to buy private insurance for future care and treatment to which timely access *might* be denied. In other words, the *Chaoulli* case dealt with potential future events that *might* possibly take place, and not with events that had already occurred. Thus, the *Chaoulli* case is not directly on the issue discussed in the Hart and Monahan paper because it is dealing with a speculative future event.

**Governments can do one of two things - governments can either finance and structure the publicly funded health care system to provide timely access to medically necessary care, or they can allow Canadians to buy that care if such access is not available in the publicly funded health care system in a timely manner.**

<sup>166</sup> *Ibid.*, p. 3.

<sup>167</sup> *Ibid.*, p. 4.

<sup>168</sup> *Ibid.*

<sup>169</sup> [2000] J. Q. No. 470 (QL) (C.S.Q. Piche J.)

The Quebec Superior Court refused the Chaoulli claim, concluding that, although prohibitions on private insurance could violate rights of liberty and security of the person under section 7 of the Charter, it was nevertheless consistent with the principles of fundamental justice under section 7 to deny the ability to purchase private insurance for medical services covered under the Quebec public health care insurance plan.<sup>170</sup>

In determining whether the Quebec restrictions were consistent with the “principles of fundamental justice” and therefore not a violation of section 7, the Court sought to balance the right to purchase private health care insurance against the collective goal of ensuring equal access to medically necessary health services for all Quebec residents. To allow private health care insurance, in the court’s view, would compromise the integrity, proper functioning and viability of the publicly funded health care system.<sup>171</sup> In reflecting on this court decision, it is important to keep in mind that this was a decision by a court of first instance and has yet to be commented on by an appellate court or by the Supreme Court of Canada.

It is also worth noting that this conclusion was reached in spite of the fact that in European countries and Australia, which have universal and publicly funded health care systems, the purchase of private health care insurance is permitted and does not appear to have caused irreparable damage to the functioning and viability of their publicly funded health care systems.

It must also be pointed out that experience in these countries severely weakens the argument which some have made that even if the prohibition on purchasing health care insurance violates an individual’s right to timely health care, this violation can be justified under section 1 of the Charter. In order for this argument to be valid, the violation must be a “reasonable limit” that can be “demonstrably justified in a free and democratic society.” Since other free and democratic societies have universal health care systems and also allow individuals to purchase health care insurance which can be used to cover the cost of obtaining such services outside the publicly funded system, and since the health care systems in these countries appear to function effectively, the courts may be unwilling to accept the argument that the violation of an individual’s right to timely health care (by prohibiting a parallel private system) is a “reasonable limit that can be demonstrably justified.”

Although not argued on Charter grounds, another Quebec case (*Stein v. Quebec (Régie de l’Assurance-maladie)*) took a different approach by holding the provincial government responsible for reimbursing a patient’s medical expenses incurred in the United States for treatment for a life-threatening condition when timely access to the required care was not available in Quebec.<sup>172</sup> In the Stein case, the patient was advised to seek surgery for life-threatening cancer no later than four to eight weeks after the diagnosis. After waiting longer than the suggested period for the required treatment, Stein sought medical care in New York. Subsequently, Stein contested the Quebec health care insurance board’s refusal to reimburse his medical expenses. The court sided with Stein, noting that in his circumstances, where the danger to his life was increasing daily, it was unreasonable for him to have to wait for surgery in Montreal. In this case, it is worth noting the emphasis the court placed on timely access to care.

---

<sup>170</sup> *Ibid.*, para. 243.

<sup>171</sup> *Ibid.*, para. 261-263.

<sup>172</sup> *Stein v. Québec (Régie de l’Assurance-maladie)*, [1999] QJ No. 2724.

## 5.4 Committee Commentary

Even though Canadian courts have not yet established a right to health care under the Charter, it is clear to the Committee that, when timely access to appropriate care is not available in the publicly funded health care system, the prohibition of private payment for health services becomes increasingly difficult, if not impossible, to justify. The rights to liberty and to security of the person under section 7 of the Charter are likely to be violated when timely access to publicly funded health care is denied and, simultaneously, Canadians are effectively prevented from obtaining the required care elsewhere in Canada.

***The failure to address effectively the issue of the lack of access to timely care is also highly likely to lead to the establishment of a parallel private hospital and doctor system.***

The failure to address effectively the issue of the lack of access to timely care is also highly likely to lead to the establishment of a parallel private hospital and doctor system. Therefore, solving the waiting time issue, or lack of timely care problem, is critical if Canada is to preserve the single payer model of health care that Canadians, and the Committee, so strongly support.

It is the Committee's strong belief that governments should not be passive and wait for the courts to determine how Canadians will gain timely access to medically necessary care. The time has come when governments *must* address the waiting time problem.

Governments cannot continue to turn a blind eye to the increasing problem of the lack of timely access to health care. They, and the providers of care themselves – particularly hospitals and physicians *must* find a solution to the problem of providing timely access to appropriate levels of health care.

The Committee's preferred approach to solve the problem of long waiting times, and thus avoid the development of a parallel private system, is twofold: first, more money must be invested in health care for the purposes described in the other chapters of this report; and second, governments must establish a national health care guarantee – a set of nationwide standards for timely access to key health services – the parameters of which we explore in the next chapter.

***It is the Committee's strong belief that governments should not be passive and wait for the courts to determine how Canadians will gain timely access to medically necessary care. The time has come when governments must address the waiting time problem.***

#### 6.1 The Public Perception of the Problem of Waiting Lists

The accessibility principle of the *Canada Health Act* stipulates that Canadians should have “reasonable access” to insured health services. However, the Act does not define what constitutes reasonable access. Lately, concerns about access to health care have been associated with the problem of waiting lists and times – that is, lack of timely access is increasingly perceived to be a major problem plaguing the health care system. Of course, “timely” is a subjective word; what is timely to one person may be an eternity for another, particularly where illness is involved. Nevertheless, the Committee believes that “timely access” describes more accurately what the public expects from the publicly funded health care system than “reasonable access.”

Results of a study conducted by Statistics Canada released in July 2002<sup>173</sup> provide, for the first time, a reliable indication of the extent to which Canadians perceive lengthening waiting times to be a major failing of the publicly funded health care system. The survey revealed that “almost one in five Canadians who accessed health care for themselves or a family member in 2001 encountered some form of difficulty, ranging from problems getting an appointment to lengthy waiting times.”<sup>174</sup> And, of the estimated 5 million people who visited a specialist, roughly 18%, or 900,000 people, reported that waiting for care affected their lives. The majority of these people (59%) reported worry, anxiety or stress. About 37% said they experienced pain. The report concluded that:

***The Committee learned that almost one in five Canadians who accessed health care for themselves or a family member in 2001 encountered some form of difficulty, ranging from problems getting an appointment to lengthy waiting times.***

*Perhaps the most significant information regarding access to care was about waiting times. According to the results of the survey, Canadians reported that waiting for services care was clearly a barrier to care... Long waits were clearly not acceptable to Canadians, particularly when they experienced adverse affects such as worry and anxiety or pain while waiting for care.<sup>175</sup>*

These new Statistics Canada data suggest strongly that the anecdotal evidence concerning the growing problem of waiting lists cited by the Committee previously corresponds to a real and growing problem confronting the publicly funded health care system in Canada.

---

<sup>173</sup> *Access to Health Care Services in Canada, 2001*, Claudia Sanmartin, Christian Houle, Jean-Marie Berthelot, and Kathleen White, Statistics Canada, June 2002.

<sup>174</sup> Statistics Canada, *The Daily*, July 15, 2002.

<sup>175</sup> *Access to Health Care*, p. 21.

The Committee is firmly convinced that this problem must be addressed. The status quo is simply unacceptable. Before presenting the Committee's recommendations, this chapter examines Canadian and international experience in dealing with the problem of waiting times.

## 6.2 The Reality of the Waiting List Problem

One of the aspects of the waiting list issue that the Committee has found most troubling is the lack of accurate data on the numbers of Canadians who must wait to consult specialists, obtain diagnostic procedures or receive treatment in a hospital, and the absence of accurate data on the length of time they are having to wait and for what services relating to what diseases, conditions and indications. This lack of data poses a serious dilemma for public policy makers. There is strong public perception of a serious waiting list problem, but few or no data by which to measure the extent of that problem, and few standards and protocols to assign needs-based priority to those waiting for treatment.

***One of the aspects of the waiting list issue that the Committee has found most troubling is the lack of accurate data on the numbers of Canadians who must wait to consult specialists, obtain diagnostic procedures or receive treatment in a hospital, and the absence of accurate data on the length of time they are having to wait and for what services relating to what diseases, conditions and indications.***

On the one hand, whether a social problem is real or only perceived, governments naturally want to be seen to be responding to it. On the other hand, with regard to the waiting list problem, if, from the perspective of genuine clinical need (as opposed to patient demand), the health of patients is not being compromised while waiting for diagnosis or treatment, there is little justification for spending a lot of money increasing the supply of the health care resources in question. Determining the true extent of waiting list problems, and their impact on the health and well-being of the people affected, is fundamental to formulating an appropriate public policy response.

What is known is that there are two excellent examples of objectively prioritized waiting lists in Canada – the Cardiac Care Network of Ontario and the Western Canada Waiting List Project. These show that, with the creation of disciplined waiting lists in which patients receive treatment according to their priority of need and within a timeframe set by clinical guidelines, the problem of waiting and the perception that the times are too long can be alleviated and in many cases resolved.

These examples also show that the use of needs-based clinical guidelines for waiting list management makes clear the real need for new resources; i.e., when patients with prioritized need cannot be provided with timely access by waiting list management alone and hence when new resources are needed. Moreover, if new resources are required, whether the resources be money, equipment, health care providers or hospital beds, a needs-based approach to managing waiting lists shows clearly what type, and how much, of the various new resources are required.

From a policy standpoint, therefore, it is essential that Canada begin to develop, as quickly as possible, an accurate database on waiting lists together with needs-based service

criteria for people waiting for care, like the criteria described in the next section. Indeed, one of the reasons for the Committee's emphasis on the need for a dramatic and accelerated improvement in health information systems (see Chapter Ten) is precisely to enable the development of prioritized waiting lists and data on their application.

However, the Committee believes that Canadians should not have to wait until completion of this essential step to address a problem that should have been tackled years ago. Patients and their families must see clear evidence, first, of governments' determination to act and second, of progress on the waiting list problem. Therefore, in section 6.5 below, the Committee recommends that a "health care guarantee," that is, a set of needs-based maximum waiting times, be put in place *immediately*.

### **6.3 Canadian Experience**

As stated above, two Canadian examples provide strong evidence that it is possible to tackle the problem of waiting lists.

#### **6.3.1 Cardiac Care Network of Ontario**

The Cardiac Care Network of Ontario (CCN) has long been recognized as a model for managing waiting times, primarily by creating a needs-based priority order of waiting. Established in 1990 to coordinate, facilitate and monitor access to advanced cardiac care as well as to advise the ministry on adult cardiac care issues, CCN has since developed processes to facilitate and monitor patient access, a broad range of guidelines for cardiac services and a comprehensive provincial cardiac information system to support the provision of care, research and continuous improvement in services. Initially focused on cardiac surgery, CCN's priorities have been broadened to include catheterization, angioplasty and stents, as well as pacemakers, implantable cardiac defibrillators and cardiac rehabilitation.

CCN uses information about patients and their medical condition to calculate an urgency rating score (URS). The URS is a guideline to aid in prioritizing patients' need for care, i.e., a disciplined waiting list based on relative need for the services concerned. It is also used in monitoring the timely availability of care throughout the province. Regardless of the service needed, the more serious a patient's condition (as determined by the patient's URS), the sooner he or she receives care. As a result of CCN's efforts, waiting times for bypass surgery have dropped substantially since the mid-1990s. Median waiting times for patients whose need is considered to be urgent have consistently remained at about three days, regardless of variation in the total number of patients on the list.<sup>176</sup>

#### **6.3.2 The Western Canada Waiting List Project**

The results of the Western Canada Waiting List (WCWL) project, published in March 2001,<sup>177</sup> indicate that it may be possible to generalize the kind of system employed by the

---

<sup>176</sup> See the submission of the Cardiac Care Network to the Commission on the Future of Health Care in Canada, October 29, 2001.

<sup>177</sup> *From Chaos to Order: Making Sense of Waiting Lists in Canada*, Final Report, the Western Canada Waiting List Project, March 2001.

CCN and apply it to other major illnesses and procedures. The WCWL project is a collaborative undertaking by a variety of organizations, including regional health authorities, provincial medical associations, provincial ministries of health, and health research centres. It was established to address the perception of significant and long-standing problems of access to health care in Western Canada and to influence the way in which waiting lists are structured, managed, and perceived.

In Canada, patient prioritization is not standardized for any medical service (with the exception of CCN in Ontario). This means that there is currently no provincially or nationally accepted method of measuring or defining waiting times for medical services, nor are there standards and criteria for “acceptable” waits for the vast majority of health services. It is impossible, therefore, to determine whether, from a clinical point of view, patients have waited a reasonable or unreasonable length of time to access care. The absence of standardized criteria and methods to prioritize patients waiting for care means that patients are placed and prioritized on waiting lists based on a range of clinical and non-clinical criteria that vary by individual referring physician across institutions, regional health authorities, and provinces.

Production of physician-scored point-count tools for assigning priority to patients on waiting lists was the overarching goal of the WCWL project. This task was carried out in five significantly different clinical areas: cataract surgery; general surgery procedures; hip and knee replacement; MRI scanning; and children’s mental health. A set of priority criteria and a scoring system were developed through extensive clinical input from panel members. These went through several stages of empirical work assessing their validity and reliability. Clinicians who tested the priority setting tools generally concluded that they had the potential to be useful in clinical settings.

The results from the WCWL project indicate that clinicians, administrators, and the public believe that better management of waiting lists is necessary, possible and appropriate. What is necessary now is to develop appropriate standards and criteria to work out acceptable waiting times for patients at different levels of priority of need. The WCWL was not able to undertake this work, given that it was not part of the mandate associated with its funding.

Nonetheless, the authors of the WCWL final report contended that there is a strong possibility of achieving some semblance of order in establishing treatment priorities and access to elective care. Experience from other jurisdictions has shown that systematic approaches and priority setting techniques can be used to improve the management of waiting times. Research conducted for the WCWL project<sup>178</sup> suggested a number of approaches to make this happen, including the following:

- the process to establish standard definitions for waiting times should be national in scope
- standard definitions should focus on four key waiting periods – waiting for primary care consultation; for initial specialist consultation; for diagnostic tests; and for surgery.

---

<sup>178</sup> Sanmartin, Claudia, “Toward Standard Definitions of Waiting Times for Health Care Services,” p.361.

As CCN and the WCWL clearly show, substantial improvement in both the reality and perception of the waiting list problem is possible through adopting an approach based on the clinical needs of patients on waiting lists. Since few or no data are yet available to establish how much the problem can be improved with new waiting list management techniques, there are those who suggest that it would be jumping the gun to act before the real, as opposed to the perceived, extent of the waiting list problem is fully understood. They believe that implementing measures such as the Committee's proposed health care guarantee (described in section 6.5, below) would be premature. The Committee rejects this point of view. In the Committee's view, Canadians deserve a health care guarantee *now*. At the least, such a guarantee would serve as a spur to the creation of the necessary standards, criteria and information systems. Certainly, a health care guarantee would alleviate much of the current anxiety of patients and their families.

***In the Committee's view,  
Canadians deserve a health  
care guarantee now.***

## **6.4 International Experience**

While there are no definitive conclusions to be drawn from international experience, there is evidence that establishing formal maximum waiting times for specific procedures can have a positive influence on reducing actual waiting times. Several factors limit the lessons that can be drawn from international examples. In the first place, health care systems are extremely complex and are rooted in the particular history and culture of the country in which they operate. With respect to the specification of maximum waiting times – or what the committee has called the health care guarantee – experience is limited to a small number of countries, is very recent, and recommended maximum waiting times have been subject to revision. Despite these caveats, the Committee believes it is possible to draw on international experience to improve the situation relating to waiting times in Canada.

### **6.4.1 Sweden**

In its previous reports,<sup>179</sup> the Committee referred to the Swedish experience in the early 1990s with a form of health care guarantee. This guarantee established a maximum waiting time for diagnostic tests (90 days), certain types of elective surgery (90 days), and consultations with primary care doctors (8 days) and specialists (90 days). Sweden also put in place a system where waiting times for major procedures are posted daily on a website. People can check the website and may choose to travel to the hospital and next available physician or surgeon with the shortest waiting time.

In 1997, a revised health care guarantee came into force – the so-called “0/7/90” guarantee. It stipulates that patients must receive care from a nurse practitioner in a primary health care centre the same day and that an appointment with a physician must be offered within seven days. Finally, should a patient need referral to a specialist, an appointment must be offered with three months. When appointments cannot be offered within these time limits, the patient is entitled to see a health care provider in another county at no additional cost. When

---

<sup>179</sup> See, for example, Vol. 5, p. 56 and Vol. 3, p. 33.



treatment is required, the health care guarantee states that it must be provided without delay but no maximum waiting times are specified.

Overall, the care guarantee in Sweden appears to do more to improve patients' freedom of choice than constitute a mechanism to regulate waiting times. Under the Stockholm County Council, for example, patients can choose among many providers and institutions but in practice relatively few patients exercise this freedom of choice, and not all even know of its availability. For the most part, Swedes place high value on proximity to care; it seems that the vast majority of patients prefer to receive care in their own county rather than travel elsewhere, even if it means waiting longer.

#### **6.4.2 Denmark<sup>180</sup>**

In Denmark, the Ministry of Health and the Association of County Councils, who are jointly responsible for funding and delivering health care services, agreed in 1993 on a target, to be reached by the end of 1995, of a three-month maximum waiting time for all non-acute surgical treatment. The guarantee was accompanied by financial incentives for the counties to meet this target. But, in spite of increased activity and generally decreasing waiting times, it proved impossible for the counties to fulfill the guarantee and it was subsequently revoked in 1997.

Until very recently, a "political" approach was used to encourage reduction in waiting times by providing associated increases in health care funding. Differentiated targets were developed based on assessments of the impact of waiting times on different patient groups. As of March 2000, targets had been set for life-threatening heart conditions (two, three or five weeks depending on the specific diagnosis and treatment available), breast cancer, lung cancer, uterine cancer and intestinal cancer (two weeks from referral to preliminary investigation, two weeks from patient acceptance of surgery to surgical intervention, and two weeks from surgery to the start of post-surgical treatment).

A central government report published in 2000 indicated that the overall percentage of patients waiting more than three months fell from 32% in 1995 to 28% in 1997 and 21% in 1998. In 1998, 71% of all patients were treated immediately, 14% were treated within a month and 8% had to wait more than three months. The average waiting time for surgical procedures declined from 93 days in 1995 to 87 days in 1997.

Since 1997, the Ministry of Health has posted on the Internet expected waiting times at different hospitals for 24 types of diagnoses. This initiative was intended to broaden patients' ability to choose among hospitals throughout the country. In June 2001, the Social Democratic government announced an investment of 500 million kroner (about \$100 million CAD) to reduce further waiting times for cancer treatment, and followed that with legislation to expand guaranteed minimum waiting times to patients with all forms of cancer.

Nonetheless, in the Danish elections in November 2001, concern over growing waiting times at public hospitals was one of the factors that contributed to the defeat of the

---

<sup>180</sup> For a detailed description of the Danish health care system, see *Health Care Systems in Transition: Denmark*, Signild Vallgarda Allan Krasnik and Karsten Vrangbaek, the European Observatory on Health Care Systems, 2001.

Social Democrats at the hands of the right-wing Liberal Party. The new government has since allocated a further 1.5 billion kroner (about \$290 million CAD) to be distributed throughout the publicly funded hospital system solely for the purpose of reducing waiting lists.

The government has also declared that, as of July 1, 2002, patients forced by the public system to wait longer than two months for treatment of any kind have the right to choose a private hospital or a hospital in another country without paying additional fees. As in Sweden, the Danes see this as an extension of patient choice, rather than a true health care guarantee. Mr. John Erik Petersen, Head of Department, Ministry of Health and the Interior, Government of Denmark, who testified before the Committee via videoconference, explained it as follows:

*We introduced a free choice of hospitals among the public hospitals 10 years ago. However, we have not yet had free choice for the few Danish private hospitals, nor hospitals abroad.*

*As of July 1, we are introducing an extended free choice of hospital to include private hospitals and hospitals in other countries in cases where the patient cannot be treated in the public hospitals in his own country or neighbouring counties within two months. That is where the care guarantee comes in. It is not really a guarantee, but it is an extended free choice after two months of waiting time.*

*We also have a care guarantee, but that is only in a few areas of life-threatening cancer and heart diseases. That has been in effect for a year now. That is a guarantee in the sense that the councils, the hospitals, are obliged to find care opportunities for the patient within the time limits, which are shorter than two months. They are obliged to find care for the patient, which is not the case with the extended free choice. You get a free choice to private hospitals or abroad if you wait more than two months, but there is no guarantee that there is a private hospital that will take care of you.<sup>181</sup>*

Interestingly, as in Sweden, the Danes do not expect many people to take advantage of the new guarantees. Mr. Petersen further explained:

*With regard to the two-month time limit, we do not foresee that all waiting times over two months will disappear in Denmark. We know already from the existing free choice among public hospitals that patients often choose to wait longer to be treated at their local hospitals rather than travelling to Europe and other parts of the country, even though Denmark is a rather small country. Therefore, we do not foresee that that many people will take advantage of this offer.<sup>182</sup>*

---

<sup>181</sup> Committee Proceedings, June 17, 2002. 64:4.

<sup>182</sup> *Ibid.*, 64:

The Danish witnesses suggested to the Committee that the determination of two months as the period after which Danes could exercise free choice of hospital had more to do with political dynamics than with evidence-based clinical decision-making. This contrasts with the maximum waiting times for cancer and heart diseases that were established on the basis of clinical criteria. Nonetheless, the two-month guarantee represented, in the words of Dr. Steen Friberg Nielsen, CEO, Top Management Academy, Government of Denmark, “a political decision regarding the level of service”<sup>183</sup> that the government was committed to offer its citizens.

## **6.5 Committee Recommendations**

The Committee believes that there are two sets of factors that contribute to the perceived growing problem of waiting times in Canada.

One is the apparent shortage of personnel and diagnostic equipment. In the Committee’s view, these shortages have been severely exacerbated by decisions taken by governments at all levels over the past decade – decisions made as governments sought to reduce health care costs (and other public expenditures) dramatically. This has led to a situation in which some components of the health care system are increasingly unable to respond to the demands that are placed upon them. In a system that strives to treat everyone equally, this imbalance between the supply of services and the demand for them has resulted in growing waiting times, and, as the Statistics Canada data show, growing public concern over their length.

But the lack of disciplined, prioritized waiting lists based on standards, criteria and clinical, need-based data on the condition of patients substantially exacerbates this problem. The absence of data certainly makes it harder to determine what to do about it. In fact, in Canada’s health care system it is impossible to distinguish effectively between genuine, clinically based patient needs on the one hand, and, on the other, patient- and physician-generated demand for immediate service (when waiting would have no impact on the person’s health).

Not all waiting lists are the result of shortages. As already noted, evidence suggests it is possible to reduce these waiting times by tackling them head-on, as CCN has done in Ontario. We strongly suggest that a major factor contributing to growing waiting times has been the slowness of the “players” in the system – hospitals and their specialist physicians and surgeons in particular – to apply systematic management to waiting lists for all major procedures, diagnostic tests and consultations. In the same spirit in which it supports all efforts to improve the efficiency of the health care system, the Committee welcomes attempts to find better ways to manage waiting lists, such as the WCWL project, so that patients in the greatest need are tended to first and that, wherever possible, waiting times for everybody are kept to a minimum. The Committee believes, however, that it is highly unlikely that better management of waiting lists will, on its own, suffice to resolve the waiting list problem. Undoubtedly some of it is attributable to shortages.

The question then arises why the situation has been allowed to deteriorate to the point where almost one in five Canadians reports difficulty in accessing needed health services in a timely manner. In the Committee’s view, one reason is that cost-cutting – or, more precisely,

---

<sup>183</sup> *Ibid.*, 64:

the failure to continue to increase funding at the same rate as growth in health care costs – has been an option attractive to government. This option has proven possible to implement relatively easily, the reason being that, to date, governments have not had to bear the burden of the consequences that result from their cost-cutting decisions. Instead, these costs have been borne largely by patients who face longer waiting times for health services.

In keeping with its philosophy that the best way to reform a complex system such as health care delivery is to introduce appropriate incentives for all the players involved, the Committee is firmly convinced that governments must be made to bear the responsibility for their decisions. Thus, the Committee believes that the blame for the waiting list problem should be placed where it belongs – on the shoulders of governments for not funding the system adequately, and jointly on governments and providers of health services, the providers for not developing clinical, needs-based waiting list management systems and governments for not demanding and funding such systems to ensure the rationality of waiting lists, including those that are attributable to underfunding. The Committee believes that governments must pay for the remedy, namely patient treatment in another jurisdiction, while waiting list management systems are being developed and put in place.

***In keeping with its philosophy that the best way to reform a complex system such as health care delivery is to introduce appropriate incentives for all the players involved, the Committee is firmly convinced that governments must be made to bear the responsibility for their decisions. Thus, the Committee believes that the blame for the waiting list problem should be placed where it belongs – on the shoulders of governments for not funding the system adequately, and jointly on governments and providers of health services, the providers for not developing clinical, needs-based waiting list management systems and governments for not demanding and funding such systems to ensure the rationality of waiting lists, including those that are attributable to underfunding. The Committee believes that governments must pay for the remedy, namely patient treatment in another jurisdiction, while waiting list management systems are being developed and put in place.***

Therefore, the Committee recommends that:

**For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public.**

**When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country (e.g., the United States). This is called the Health Care Guarantee.**

The Committee realizes that governments may well take the position that if a patient does not receive timely access for a medically necessary service, and hence becomes entitled to service elsewhere under the health care guarantee, the responsibility (or blame) may rest with the hospital or its physicians for not being sufficiently efficient in the use of existing resources and not managing waiting lists well enough. Under these circumstances, the government may well seek to recover the costs incurred through the care guarantee from the hospital and/or the physician(s) concerned. That is, governments may well place the responsibility for meeting the maximum waiting times on the shoulders of those responsible for actually managing the system. This is reasonable if it can be shown that underfunding is not the sole or even the primary cause of a patient waiting too long for a service.

But this is an issue to be resolved between governments and the institutions and the physicians that they fund. Patients should not be affected. Their sole concern should be to get needed treatments in a timely fashion and to have them paid for publicly. Therefore, in the first instance, governments as the patient's insurer should have the responsibility of meeting the health care guarantee.

***The point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient's health or quality of life is at risk of deteriorating significantly as a result of further waiting. Waiting times would be established by scientific bodies using clinical, evidence-based criteria.***

The point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient's health or quality of life is at risk of deteriorating significantly as a result of further waiting. Waiting times would be established by scientific bodies using clinical, evidence-based criteria. In order to accomplish this, the Committee recommends that:

**The process to establish standard definitions for waiting times be national in scope.**

**An independent body be created to consider the relevant scientific and clinical evidence.**

**Standard definitions focus on four key waiting periods – waiting time for primary health care consultation; waiting time for initial specialist consultation; waiting time for diagnostic tests; waiting time for surgery.**

The Committee recognizes that it is necessary to deal simultaneously with both sets of factors noted above. First, the techniques for effectively managing waiting lists based on sound clinical methods must be brought to bear on the management of waiting times in an efficient and equitable manner. Second, for sufficient resources to be made available so that this

can happen, the political will must be there, and government must therefore have an incentive to act appropriately.

Since government has the responsibility for funding an adequate supply of essential services provided by hospitals and doctors, it has an obligation to help them meet reasonable standards of patient service. This is the essence of a patient-oriented system and of the health care “contract” between Canadians and their governments.

A maximum waiting time guarantee gives concrete form to this obligation. Were it to be implemented, such a health care guarantee would mean that government would have to shoulder the responsibility of needed care not being delivered in a timely fashion, provided, of course, the funded hospitals and physicians discharge their parts of the bargain by developing and using clinical criteria to prioritize needs-based waiting lists and by employing their resources in an optimally cost-effective manner. Allowing waiting times to increase would no longer represent a cost-free option for governments, nor for hospitals and doctors, when underfunding is not the primary reason for prolonged waiting, since they would be required to pay to have patients obtain treatment in other jurisdictions.

Other Canadian reports have made similar recommendations for dealing with waiting times. Based on a review of the Swedish experience, the report of the Premier’s Advisory Council on Health in Alberta (the Mazankowski report) recommended the establishment of a care guarantee of 90 days for selected services. According to the Advisory Council, this guarantee would provide an incentive for health care providers and regional health authorities to take appropriate action to manage and shorten waiting lists. Their report stressed that patients may need to give up their preference for a specific physician or hospital if they want to be treated within the 90-day period. In addition, if regional health authorities are unable to provide service within this period, they would have to consider other options, such as getting the service from another region. Services could be provided by either a public or a private provider.

More recently, the Canadian Medical Association endorsed the Committee’s health care guarantee proposal and included it in its document *A Prescription for Sustainability* issued on June 6, 2002. The CMA proposed that “guidelines and standards around quality and waiting times”<sup>184</sup> be established for a clearly defined basket of core services, and argued that “if the publicly funded health care system fails to meet the specified agreed-upon standards for timely access to core services, then patients must have other options to allow them to obtain this required care through other means.”<sup>185</sup> The Committee is pleased that the CMA has adopted its proposal.

## **6.6 The Potential Consequences of Not Implementing a Health Care Guarantee**

There are two pieces of the puzzle that must be in place in order to make significant progress in reducing waiting times, in renewing the health care contract between Canadians and their governments, and in restoring the confidence of the Canadian public in their health care system. First, governments at all levels must back their words with deeds by

---

<sup>184</sup> The Canadian Medical Association, *A Prescription for Sustainability*, p. 16

<sup>185</sup> *Ibid.*, pp. 16-17.

committing to a health care guarantee that establishes the right of Canadians to receive the care that they need in a timely manner; and second, this commitment must be applied using the best possible system for managing waiting times.

As the delivery of health care in Canada is a provincial responsibility, the health care guarantee must be adopted by the provinces/territories if it is to be implemented. The Committee believes that the principal way in which the federal government can contribute to the implementation of the health care guarantee is to ensure that there is agreement between the federal and provincial governments on the ways to make the financing of publicly insured health services stable and predictable. The Committee believes strongly that federal funding must be maintained at an adequate and predictable level and discusses in detail issues related to financing in Chapters Fourteen and Fifteen of this report.

Nonetheless, it is important to consider the consequences that would follow from a refusal on the part of the provinces to adopt the health care guarantee. In the preceding chapter, the Committee made the case that governments can no longer have it both ways – they cannot fail to provide timely access to medically necessary care in the publicly funded health care system and, at the same time, prevent Canadians from acquiring those services through private means. Thus, one consequence of not implementing the health care guarantee would be to render it highly likely that the current legal prohibition on the creation of a parallel private health care insurance and delivery system would be challenged successfully in the courts.

A second consequence would be that it would fall to the federal government to consider enacting its own legislation to enforce the health care guarantee. The federal government could, for example, consider setting national maximum waiting times on its own for various procedures, at the expiration of which the health care guarantee would come into effect. When a patient exceeded the maximum waiting time, the federal government could then pay the cost of treating the patient in another jurisdiction, including in the United States, and deduct the cost from the cash it transferred under the CHST to the province in which the patient resides.

Thus the penalty for violating the health care guarantee would be similar to the penalty that provinces now incur for violating the *Canada Health Act*. Currently, in cases where the federal government finds that a province has applied user charges or engaged in extra billing that are prohibited under the Act, it can withhold from the funds it would otherwise have transferred to the province an amount equivalent to what the provinces have received.

Obviously, the adoption of such legislation by the federal government would be highly contentious. However, it would ensure that a national health care guarantee of maximum waiting times came into effect – an outcome that the Committee insists must happen and that the Committee believes would also be strongly supported by the Canadian public.

## **6.7 Concluding Thoughts on the Health Care Guarantee**

The Committee believes that it should be possible for the federal and provincial/territorial governments to reach agreement on a national set of maximum waiting times for various procedures. It passionately hopes that it will not be necessary for unilateral action to be taken by the federal government or for a parallel system of private delivery, financed by private insurance, to emerge as a result of judicial decisions. The Committee has pointed to

these potential consequences of not implementing the health care guarantee only because it categorically rejects the status quo: Canadians in need of medically necessary services *must* be given *timely* access to them.

It is also important to note that the Committee's recommendation that the health care guarantee be implemented overlaps with a number of other important recommendations contained in this report. For example, health information systems and the means of evaluating performance and outcomes such as the Committee has recommended in Chapter Ten must be put in place in order to monitor waiting times across the country, so that patients receive timely treatment and the standards imposed by the health care guarantee can be monitored. In addition, the reform of primary health care delivery along the lines the Committee has proposed in Chapter Four is essential to the efficient and timely provision of health care in the twenty first century.







Le Sénat

Comité sénatorial permanent des Affaires sociales,  
des sciences et de la technologie

# La santé des Canadiens - Le rôle du gouvernement fédéral

Rapport final sur l'état du système  
de soins de santé au Canada

*Président :*  
L'honorable Michael J. L. Kirby

*Vice-présidente :*  
L'honorable Marjory LeBreton

Octobre 2002

**Volume six :  
Recommandations  
en vue d'une  
réforme**

*This document is available in English.*



Disponible sur l'Internet Parlementaire :  
[www.parl.gc.ca](http://www.parl.gc.ca)  
(Travaux des comités – Sénat – Rapports récents)  
37<sup>e</sup> législature – 2<sup>e</sup> session

Comité sénatorial permanent des affaires sociales,  
des sciences et de la technologie

Rapport final sur  
l'état du système de soins de santé au Canada

*La santé des Canadiens – Le rôle du gouvernement fédéral*  
*Volume Six :*  
*Recommandations en vue d'une réforme*

*Président*  
L'honorable Michael J. L. Kirby

*Vice-présidente*  
L'honorable Marjory LeBreton

OCTOBRE 2002



# TABLE DES MATIÈRES

---

<b>TABLE DES MATIÈRES</b> .....	<b>i</b>
<b>ORDRE DE RENVOI</b> .....	<b>vii</b>
<b>SÉNATEURS</b> .....	<b>viii</b>
<b>LISTE DES ABRÉVIATIONS</b> .....	<b>ix</b>
<b>REMERCIEMENTS</b> .....	<b>xi</b>
<b>AVANT-PROPOS</b> .....	<b>xiii</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>PARTIE I : RESPONSABILISATION</b> .....	<b>5</b>
<b>CHAPITRE UN</b> .....	<b>7</b>
LA NÉCESSITÉ D'UN RAPPORT ANNUEL SUR L'ÉTAT DU SYSTÈME DE SOINS DE SANTÉ ET SUR L'ÉTAT DE SANTÉ DES CANADIENS .....	7
1.1 Résumé de quelques points saillants des volumes un à cinq .....	7
1.1.1 <i>Le rôle du gouvernement fédéral</i> .....	7
1.1.2 <i>Objectifs de la politique fédérale en matière de soins de santé</i> .....	8
1.1.3 <i>L'actuel système n'est pas financièrement viable</i> .....	10
1.1.4 <i>Une garantie nationale de soins de santé est essentielle au succès de la réforme</i> .....	12
1.2 Améliorer la gouvernance — La nécessité d'un commissaire national aux soins de santé.....	14
1.2.1 <i>Association médicale canadienne (AMC)</i> .....	16
1.2.2 <i>Colleen Flood et Sujit Choudry</i> .....	16
1.2.3 <i>Tom Kent</i> .....	17
1.2.4 <i>Duane Adams</i> .....	18
1.2.5 <i>Lawrence Nestman</i> .....	19
1.3 La proposition du Comité .....	19
<b>PARTIE II : MESURES VISANT L'EFFICIENCE</b> .....	<b>25</b>
<b>CHAPITRE DEUX</b> .....	<b>27</b>
RESTRUCTURATION ET FINANCEMENT DES HÔPITAUX AU CANADA .....	27
2.1 Méthodes de financement des hôpitaux au Canada : Avantages et inconvénients .....	29
2.1.1 <i>Financement élément par élément</i> .....	30
2.1.2 <i>Discretion ministérielle</i> .....	31
2.1.3 <i>Financement fondé sur la population</i> .....	31
2.1.4 <i>Financement par budget global</i> .....	32
2.1.5 <i>Financement fondé sur les politiques</i> .....	34
2.1.6 <i>Financement fondé sur les établissements</i> .....	34
2.1.7 <i>Financement par projet</i> .....	34
2.1.8 <i>Financement fondé sur les services dispensés</i> .....	34
2.2 Financement fondé sur les services dispensés : Examen de l'expérience internationale.....	35

2.2.1	<i>États-Unis</i> .....	35
2.2.2	<i>Royaume-Uni</i> .....	36
2.2.3	<i>France</i> .....	37
2.2.4	<i>Danemark</i> .....	37
2.2.5	<i>Norvège</i> .....	38
2.2.6	<i>Examen de l'expérience internationale par le comité Bédard</i> .....	38
2.3	<b>Justification du financement fondé sur les services dispensés au Canada</b> .....	39
2.3.1	<i>Pertinence du choix de services</i> .....	43
2.3.2	<i>Services excessifs et surévaluation</i> .....	44
2.3.3	<i>Taux, information et données</i> .....	45
2.3.4	<i>Innovation</i> .....	46
2.3.5	<i>Soins de santé complets</i> .....	46
2.3.6	<i>Escalade des coûts</i> .....	46
2.3.7	<i>Manque de simplicité</i> .....	47
2.3.8	<i>Commentaires du Comité</i> .....	47
2.4	<b>Les centres universitaires des sciences de la santé et la complexité des hôpitaux d'enseignement</b> .....	49
2.5	<b>Petits hôpitaux et hôpitaux communautaires ruraux</b> .....	52
2.6	<b>Financement des besoins en immobilisations des hôpitaux canadiens</b> .....	54
2.7	<b>Établissements de soins de santé publics ou privés?</b> .....	57
	<b>Annexe 2.1 : Centres universitaires des sciences de la santé et hôpitaux et régies régionales de la santé affiliés</b> .....	63

## **CHAPITRE TROIS..... 67**

	<b>DÉLÉGUER PLUS DE RESPONSABILITÉS AUX RÉGIES RÉGIONALES DE LA SANTÉ</b> .....	67
3.1	<b>Un tableau des RRS au Canada</b> .....	68
3.2	<b>RRS : Objectifs et réalisations</b> .....	70
3.3	<b>Obstacles qui empêchent les RRS de mettre pleinement à profit leur potentiel</b> .....	72
3.4	<b>Les RRS et le potentiel des marchés internes</b> .....	74
3.5	<b>Commentaires du Comité</b> .....	78

## **CHAPITRE QUATRE..... 81**

	<b>RÉFORME DES SOINS DE SANTÉ PRIMAIRES</b> .....	81
4.1	<b>Pourquoi une réforme des soins de santé primaires est-elle nécessaire?</b> .....	81
4.2	<b>Les provinces et la réforme des soins primaires</b> .....	85
4.2.1	<i>Rapports récents</i> .....	85
4.2.2	<i>Le Réseau santé-famille de l'Ontario</i> .....	86
4.2.3	<i>Québec</i> .....	90
4.2.4	<i>Nouveau-Brunswick</i> .....	91
4.3	<b>Surmonter les obstacles au changement</b> .....	92
4.4	<b>Le rôle du gouvernement fédéral</b> .....	96
	<b>Annexe 4.1 : Régime d'enveloppes budgétaires pour les omnipraticiens en Grande-Bretagne</b> .....	99

**PARTIE III : LA GARANTIE DE SOINS DE SANTÉ..... 107**

**CHAPITRE CINQ.....109**

DES SOINS DE SANTE EN TEMPS OPPORTUN..... 109

5.1 Le droit aux soins de santé – Perception du public ou droit reconnu par la loi?..... 110

5.2 Disponibilité des services couverts par le régime public à l'extérieur du système public de soins de santé..... 111

5.3 Prestation de soins de santé en temps opportun et article 7 de la *Charte canadienne des droits et libertés*..... 112

5.4 Commentaires du Comité..... 119

**CHAPITRE SIX ..... 121**

LA GARANTIE DE SOINS DE SANTÉ ..... 121

6.1 Le problème des listes d'attente : la perception du public..... 121

6.2 Le problème des listes d'attente : la situation réelle..... 122

6.3 L'expérience canadienne ..... 123

6.3.1 Réseau de soins cardiaques de l'Ontario (RSCO)..... 123

6.3.2 Projet de rationalisation des listes d'attente dans l'Ouest canadien ..... 124

6.4 Expérience internationale ..... 125

6.4.1 Suède..... 126

6.4.2 Danemark..... 126

6.5 Recommandations du Comité..... 128

6.6 Les conséquences possibles d'une non-application de la garantie de soins de santé ..... 132

6.7 Quelques réflexions sur la garantie de soins de santé ..... 133

**PARTIE IV : RESSERRER LES MAILLES DU FILET DE SÉCURITÉ..... 135**

**CHAPITRE SEPT .....137**

ÉTENDRE LA COUVERTURE POUR INCLURE LA PROTECTION CONTRE LES COÛTS EXORBITANTS DES MÉDICAMENTS DE PRESCRIPTION ..... 137

7.1 Tendances des dépenses au titre des médicaments..... 138

7.2 Comparaisons avec d'autres pays..... 140

7.3 L'assurance pour les médicaments de prescription au Canada..... 142

7.3.1 Régimes publics d'assurance-médicaments..... 142

7.3.2 Régimes privés d'assurance-médicaments..... 143

7.3.3 Les caractéristiques des régimes d'assurance et leur incidence sur la protection contre les frais élevés de médicaments..... 144

7.4 Un phénomène nouveau : Les dépenses exorbitantes en médicaments de prescription..... 145

7.5 Protéger les Canadiens contre les frais exorbitants de médicaments de prescription..... 149

7.5.1 Comment fonctionnerait le régime..... 150

7.5.2 Avantages du régime proposé..... 152

7.5.3 Combien coûterait le régime?..... 153

7.5.4 Proposition du Comité relative à un régime d'assurance contre les frais exorbitants de médicaments de prescription..... 154

7.6 Nécessité d'une liste nationale des médicaments admissibles..... 155



<b>CHAPITRE HUIT.....</b>	<b>157</b>
ÉLARGIR LA COUVERTURE POUR INCLURE LES SOINS ACTIFS À DOMICILE.....	157
8.1 Bref aperçu des principaux points relevés dans les volumes deux et quatre à propos des soins à domicile.....	157
8.2 Autres options.....	159
8.3 Le programme extra-mural au Nouveau-Brunswick.....	160
8.3.1 <i>S'inspirer de l'exemple du Nouveau-Brunswick : renvois directs aux soins à domicile</i> .....	162
8.4 Organiser et fournir des soins actifs à domicile.....	163
8.4.1 <i>Définition des soins actifs à domicile</i> .....	164
8.4.1.1 <i>Quand les services de soins actifs à domicile (SAD) commencent-ils?</i> .....	164
8.4.1.2 <i>Quand les SAD se terminent-ils?</i> .....	165
8.4.2 <i>Dispositions organisationnelles pour les SAD</i> .....	165
8.4.3 <i>Qui fournit des SAD?</i> .....	167
8.5 Le coût d'un programme national de soins actifs à domicile.....	169
8.5.1 <i>Comment calculer le coût d'un programme national de SAD</i> .....	169
8.5.2 <i>Et les coûts cachés?</i> .....	170
8.5.3 <i>Combien coûtera un programme national de SAD?</i> .....	171
8.6 Payer les soins post-hospitaliers à domicile .....	171
<b>CHAPITRE NEUF.....</b>	<b>175</b>
ÉTENDRE LA COUVERTURE POUR INCLURE LES SOINS PALLIATIFS À DOMICILE.....	175
9.1 Nécessité d'un programme national de soins palliatifs.....	175
9.2 Aide financière aux fournisseurs de soins palliatifs à domicile.....	176
9.3 Crédit d'impôt pour fournisseurs de soins.....	178
9.4 Protection des emplois.....	179
9.5 Conclusion.....	179
<b>PARTIE V : ACCROÎTRE LA CAPACITÉ ET CONSTRUIRE L'INFRASTRUCTURE</b>	<b>181</b>
<b>CHAPITRE DIX.....</b>	<b>183</b>
LE RÔLE DU GOUVERNEMENT FÉDÉRAL DANS L'INFRASTRUCTURE DE SOINS DE SANTÉ .....	183
10.1 Technologies de la santé .....	183
10.2 Dossiers de santé électroniques .....	187
10.3 Évaluation de la qualité, de l'efficacité et des résultats .....	190
10.4 Protection des renseignements personnels sur la santé.....	192
<b>CHAPITRE ONZE.....</b>	<b>199</b>
LES RESSOURCES HUMAINES DE LA SANTÉ.....	199
11.1 La gravité de la pénurie de ressources humaines en santé.....	199
11.2 Les ressources humaines de la santé : Nécessité d'une stratégie nationale .....	203
11.3 Accroître le nombre de médecins formés au Canada.....	206
11.4 Intégration des diplômés en médecine étrangers.....	208
11.5 Réduire la pénurie d'infirmières .....	209
11.6 Professions paramédicales.....	213
11.7 Financement des études supérieures.....	213
11.8 Ressources humaines de la santé : Examen des règles relatives au champ de pratique.....	213
11.9 Commentaires du Comité.....	214

<b>CHAPITRE DOUZE.....</b>	<b>217</b>
FAVORISER L'EXCELLENCE DANS LA RECHERCHE CANADIENNE EN SANTÉ.....	217
12.1 Assumer le leadership dans la recherche en santé.....	219
12.2 S'engager dans la révolution scientifique.....	222
12.3 Garantir un environnement de recherche prévisible.....	225
12.3.1 <i>Le financement fédéral de la recherche en santé.....</i>	<i>226</i>
12.3.2 <i>La recherche fédérale interne en santé.....</i>	<i>229</i>
12.4 Rehausser la qualité des services de santé et de la prestation des soins.....	230
12.5 Améliorer l'état de santé des populations vulnérables.....	232
12.6 Commercialiser les résultats de la recherche en santé.....	234
12.7 Respecter les normes d'éthique les plus élevées dans la recherche en santé.....	239
12.7.1 <i>La recherche sur des sujets humains.....</i>	<i>240</i>
12.7.2 <i>Questions suscitées par la recherche sur des sujets humains.....</i>	<i>242</i>
12.7.3 <i>L'utilisation d'animaux dans la recherche.....</i>	<i>245</i>
12.7.4 <i>La confidentialité des renseignements médicaux personnels.....</i>	<i>247</i>
12.7.5 <i>La confidentialité de l'information génétique.....</i>	<i>252</i>
12.7.6 <i>Les situations possibles de conflit d'intérêts.....</i>	<i>253</i>
 <b>PARTIE VI : PROMOTION DE LA SANTÉ ET PRÉVENTION DE LA MALADIE ..</b>	 <b>257</b>
<b>CHAPITRE TREIZE.....</b>	<b>259</b>
UNE POLITIQUE PUBLIQUE « PRO-SANTÉ » – LA SANTÉ AU-DELÀ DES SOINS DE SANTÉ.....	259
13.1 Tendances de la maladie.....	262
13.1.1 <i>Maladies infectieuses.....</i>	<i>263</i>
13.1.2 <i>Maladies chroniques.....</i>	<i>264</i>
13.1.3 <i>Blessures.....</i>	<i>265</i>
13.1.4 <i>Problèmes de santé mentale.....</i>	<i>265</i>
13.2 Fardeau économique de la maladie.....	265
13.3 Nécessité d'une stratégie nationale de prévention des maladies chroniques.....	267
13.4 Renforcer la santé publique et la promotion de la santé.....	270
13.5 Vers une politique publique pro-santé – Nécessité d'élaborer des stratégies d'amélioration de la santé de la population.....	271
 <b>PARTIE VII : FINANCER LA REFORME.....</b>	 <b>275</b>
<b>CHAPITRE QUATORZE.....</b>	<b>277</b>
COMMENT ADMINISTRER LES FONDS SUPPLÉMENTAIRES QUE LE GOUVERNEMENT FÉDÉRAL CONSACRERA À LA SANTÉ.....	277
14.1 Il faut investir davantage dans le système de soins de santé.....	278
14.2 Le rôle du gouvernement fédéral en matière de financement.....	283
14.3 Comment gérer les nouveaux fonds que le gouvernement fédéral destinaera aux soins de santé.....	285

<b>CHAPITRE QUINZE.....</b>	<b>289</b>
COMMENT GÉNÉRER DES FONDS ADDITIONNELS POUR LES SOINS DE SANTÉ .....	289
15.1 Ampleur du financement fédéral additionnel requis.....	291
15.2 Sources possibles de financement fédéral accru.....	294
15.3 Impôts généraux.....	295
15.4 Impôts spécifiques .....	300
15.5 Charges sociales.....	303
15.6 Prime nationale d'assurance-santé.....	305
15.7 Frais d'utilisation.....	307
15.8 Comptes d'épargne-santé.....	309
15.9 Financement anticipé des soins de santé .....	310
15.10 Commentaires du Comité.....	312
15.11 Financement fédéral actuel des soins de santé.....	317
 <b>CHAPITRE SEIZE .....</b>	 <b>321</b>
VIABILITÉ FINANCIÈRE DU SYSTÈME DE SOINS DE SANTÉ : LES CONSÉQUENCES DE L'INACTION.....	321
16.1 L'assurance-santé privée au Canada et dans certains pays de l'OCDE.....	323
16.2 Examen de la documentation récente sur les effets d'un système privé d'assurance-santé et de prestation de soins à but lucratif .....	326
16.3 Commentaires du Comité.....	328
 <b>PARTIE VIII : LA LOI CANADIENNE SUR LA SANTÉ.....</b>	 <b>331</b>
 <b>CHAPITRE DIX-SEPT.....</b>	 <b>333</b>
LA LOI CANADIENNE SUR LA SANTÉ.....	333
17.1 Universalité.....	334
17.2 Intégralité .....	335
17.3 Accessibilité .....	339
17.4 Transférabilité .....	341
17.5 Gestion publique.....	342
17.6 Commentaires du Comité.....	345
 <b>CONCLUSION.....</b>	 <b>347</b>
 <b>ANNEXE A.....</b>	 <b>A-1</b>
LISTE DES RECOMMANDATIONS PAR CHAPITRE .....	A-1
 <b>ANNEXE B.....</b>	 <b>A-21</b>
LIST DES PRINCIPES DU VOLUME CINQ (AVRIL 2002).....	A-21
 <b>ANNEXE C.....</b>	 <b>A-23</b>
LISTE DES TÉMOINS.....	A-23

## ORDRE DE RENVOI

---

Extrait des Journaux du Sénat du 8 octobre 2002 :

Reprise du débat sur la motion de l'honorable sénateur Kirby, appuyée par l'honorable sénateur Pépin,

Que le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie soit autorisé à examiner pour en faire rapport l'état du système de soins de santé au Canada. Plus particulièrement, que le Comité soit autorisé à examiner :

- a) Les principes fondamentaux sur lesquels est fondé le système public de soins de santé au Canada;
- b) L'historique du système de soins de santé au Canada;
- c) Les systèmes de soins de santé dans d'autres pays;
- d) Le système de soins de santé au Canada — pressions et contraintes;
- e) Le rôle du gouvernement fédéral dans le système de soins de santé au Canada;

Que les mémoires reçus et les témoignages entendus sur la question par le Comité dans la deuxième session de la trente-sixième législature et la première session de la trente-septième législature soient déferés au Comité;

Que le Comité présente son rapport final au plus tard le 31 octobre 2002;

Que le Comité conserve les pouvoirs nécessaires à la diffusion de ses constatations pendant soixante jours après le dépôt de son rapport; et

Que le Comité soit autorisé, par dérogation aux règles usuelles, à déposer tout rapport auprès du greffier du Sénat si le Sénat ne siège pas à ce moment-là; et que le rapport soit réputé avoir été déposé à la Chambre du Sénat.

La motion, mise aux voix, est adoptée.

ATTESTÉ :

*Le greffier du Sénat,*

Paul C. Bélisle

## SÉNATEURS

---

Les sénateurs suivants ont participé à l'étude du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie sur l'état du système de soins de santé :

L'honorable Michael J. L. Kirby, président du Comité  
L'honorable Marjory LeBreton, vice-présidente du Comité

et

Les honorables sénateurs :

Catherine S. Callbeck  
Joan Cook  
Jane Cordy  
Joyce Fairbairn, P.C.  
Wilbert Keon  
Yves Morin  
Lucie Pépin  
Brenda Robertson  
Douglas Roche

*Membres d'office du Comité :*

Les honorables sénateurs : Sharon Carstairs C.P. (ou Fernand Robichaud, C.P.) et John Lynch-Staunton (ou Noel A. Kinsella)

*Autres sénateurs ayant participé de temps à autre à cette étude :*

Les honorables sénateurs Atkins, Banks, Beaudoin, Carney, Cochrane, Cohen,\* DeWare,\* Ferretti Barth, Grafstein, Graham, P.C., Hubley, Joyal, P.C., Lawson, Léger, Losier-Cool, Maheu, Mahovlich, Meighen, Milne, Murray, Rompkey, St. Germain, Sibbeston, Stratton, Tunney\*, et Wilson\*

\* retraité

## LISTE DES ABRÉVIATIONS

---

<b>ACDI</b>	Agence canadienne de développement international	<b>CNERH</b>	Conseil national d'éthique en recherche chez l'humain
<b>ACISU</b>	Association canadienne des institutions de santé universitaires	<b>CNRC</b>	Conseil national de recherche du Canada
<b>AFMC</b>	Association des facultés de médecine du Canada	<b>CRBS</b>	Coalition pour la recherche biomédicale et en santé
<b>AIIC</b>	Association des infirmières et infirmiers du Canada	<b>CRDI</b>	Centre de recherche pour le développement international
<b>AMC</b>	Association médicale canadienne	<b>CRM</b>	Conseil de recherches médicales du Canada
<b>APMCC</b>	Alliance pour la prévention des maladies chroniques au Canada	<b>CRSNG</b>	Conseil de recherche en sciences naturelle et en génie
<b>CAPE</b>	Clinicians Assessment and Professional Enhancement (évaluation clinique et de perfectionnement professionnel)	<b>CUSS</b>	centre universitaires des sciences de la santé
<b>CCASS</b>	Conseil canadien d'agrément des services de santé	<b>DRG</b>	diagnostic related groups (groupes homogènes de patients)
<b>CCCB</b>	Conseil consultatif canadien de la biotechnologie	<b>DRHC</b>	Développement des ressources humaines Canada
<b>CCNTA</b>	Conseil consultatif national sur le troisième âge	<b>DSE</b>	dossier de santé électronique
<b>CCPA</b>	Conseil canadien de protection des animaux	<b>EDTR</b>	Enquête sur la dynamique du travail et du revenu
<b>CER</b>	Comité d'éthique de la recherche	<b>EPTC</b>	Énoncé de politique des Trois Conseils
<b>CES</b>	compte d'épargne-santé	<b>ETS</b>	évaluation des technologies de la santé
<b>CEST</b>	Conseil d'experts en sciences et en technologie	<b>FAMM</b>	Fonds pour l'acquisition de matériel médical
<b>CHR</b>	corporation hospitalière régionale	<b>FASS</b>	Fonds pour l'adaptation des services de santé
<b>CNBRH</b>	Conseil national de la bioéthique en recherche chez les sujets humains	<b>FASSP</b>	fonds pour l'adaptation des services de santé primaires

<b>FCI</b>	Fondation canadienne pour l'innovation	<b>OCDE</b>	Organisation de coopération et de développement économiques
<b>FCRSS</b>	Fondation canadienne de la recherche sur les services de santé	<b>OMA</b>	<i>Ontario Medical Association</i>
<b>FPE</b>	financement des programmes établis	<b>PCRC</b>	Programme des chaires de recherche du Canada
<b>FPT</b>	fédéral-provincial-territorial	<b>PEM</b>	programme extra-mural
<b>GMF</b>	groupe de médecine de famille	<b>PIB</b>	produit intérieur brut
<b>GP</b>	general practitioner (omnipraticien)	<b>PME</b>	petite et moyenne entreprise
<b>GSP</b>	groupe de soins primaires	<b>PMSI</b>	Programme de Médicalisation du Système d'Information
<b>ICIS</b>	Institut canadien d'information sur la santé	<b>REER</b>	Régime enregistré d'épargne-retraite
<b>ICRA</b>	Institut canadien de recherches avancées	<b>RRS</b>	régie régionale de la santé
<b>IRM</b>	imagerie par résonance magnétique	<b>RSCO</b>	Réseau de soins cardiaques de l'Ontario
<b>IRSC</b>	Institut de recherche en santé du Canada	<b>RSF</b>	réseau santé famille
<b>IRSM</b>	Initiative de recherche en santé mondiale	<b>RSFO</b>	Réseau santé-famille de l'Ontario
<b>JPPC</b>	Joint Policy and Planning Committee	<b>SAD</b>	soins actifs à domicile
<b>LPRPDE</b>	Loi sur la protection des renseignements personnels et les documents électroniques	<b>SRG</b>	supplément de revenu garanti
<b>MSSLD</b>	ministère de la Santé et des Soins de longue durée (de l'Ontario)	<b>TCSPS</b>	Transfert canadien en matière de santé et de programmes sociaux
<b>NHS</b>	National Health Service (système national de soins de santé;)	<b>URS</b>	Urgency Rating Score (indice d'urgence)
<b>NICE</b>	<i>National Institute for Clinical Evidence</i>	<b>WCWL</b>	<i>Western Canada Waiting List</i> (projet de rationalisation des listes d'attente dans l'Ouest canadien)
<b>OCCETS</b>	Office canadien de coordination de l'évaluation des technologies de la santé		

## REMERCIEMENTS

---

Le Comité tient à remercier publiquement tous ceux dont l'appui indéfectible ces deux dernières années lui ont permis de publier les six volumes de son rapport.

Il tient en particulier à exprimer sa profonde reconnaissance aux personnes suivantes :

- Mme Odette Madore et M. Howard Chodos de la Direction de la recherche parlementaire de la Bibliothèque du Parlement qui, en leur qualité d'attachés de recherche affectés au Comité à temps plein, ont rédigé le gros des six volumes du rapport du Comité. Sans leur extraordinaire contribution, ces documents n'auraient pas pu être produits avec autant de brio et dans des délais aussi courts.
- Mme Catherine Piccinin, la greffière du Comité, et son adjointe, Mme Debbie Pizzoferrato, qui ont organisé toutes les réunions du Comité portant sur le secteur de la santé, et se sont notamment occupées de préparer l'audition des témoins, de superviser la traduction et l'impression des six volumes du rapport, de répondre à des milliers de demandes de renseignements sur les travaux du Comité et de distribuer des exemplaires des volumes du rapport.
- Le D<sup>r</sup> Duncan Sinclair, ancien président de la Commission de restructuration des services de santé de l'Ontario, qui nous a généreusement fait profiter de son expérience, ne ménageant ni son temps ni ses conseils, et dont les nombreuses suggestions ont permis d'améliorer tous les volumes du rapport.
- Le personnel des membres du Comité, dont la charge de travail s'est trouvée substantiellement accrue ces deux dernières années.

À tous et toutes, nous tenons à exprimer nos sincères remerciements pour leur excellent travail.

Le Comité a abattu un travail considérable ces deux dernières années et a pour cela dû compter sur une petite armée de préposés à la procédure, à la recherche et à l'administration, de sténographes, de correcteurs, d'interprètes, de traducteurs, de messagers, d'employés des services de publication, de radiodiffusion et d'imprimerie et de personnel technique et logistique. Nous tenons à remercier toutes ces personnes pour leur efficacité et leur labeur.





## AVANT-PROPOS

---

Le présent rapport est l'aboutissement d'une étude entreprise il y a deux ans par le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie. Au cours de cette période, nous avons recueilli le point de vue d'au-delà de 400 témoins. Le Comité tient à leur exprimer ses plus sincères remerciements pour lui avoir fait part de leur avis sur ce qui doit être fait pour réformer le système de soins de santé au Canada et le rendre financièrement viable.

Comme il fallait s'y attendre, étant donné la complexité des questions touchant les soins de santé et leur portée idéologique et politique, les avis recueillis étaient souvent contradictoires. Le Comité a néanmoins procédé à un examen attentif de tous les points de vue exprimés pour arriver à ses recommandations.

Les recommandations du présent rapport correspondent au point de vue *unanime* des onze sénateurs membres du Comité (sept libéraux, trois conservateurs et un indépendant). L'expérience des onze membres du Comité en matière de politique gouvernementale et de questions liées à la santé est aussi approfondie que variée. Le Comité compte en effet :

- deux médecins : Yves Morin, ex-doyen de la Faculté de médecine de l'Université Laval, et Wilbert Keon, président-directeur général de l'Institut de cardiologie d'Ottawa;
- deux ex-ministres de la Santé provinciaux : Brenda Robertson et Catherine Callbeck, qui a été première ministre provinciale;
- deux ex-députés fédéraux : Douglas Roche et Lucie Pépin, qui était également infirmière;
- une ex-ministre du Cabinet fédéral et ex-journaliste: Joyce Fairbairn;
- deux ex-militantes d'action communautaire : Joan Cook, qui a fait partie pendant de nombreuses années de conseils d'administration d'hôpitaux, et Jane Cordy, qui était enseignante;
- deux ex-hauts fonctionnaires du Cabinet du premier ministre : Marjory LeBreton et Michael Kirby, qui à l'époque a aussi occupé le poste de secrétaire du Cabinet fédéral pour les relations fédérales-provinciales.

Le Comité estime que ses recommandations respectent *les quatre objectifs qu'il s'était fixés au début de ses travaux, à savoir :*

- formuler un *plan d'action* détaillé et concret qui ne mette pas trop l'accent sur les questions de gouvernance ni sur les structures intergouvernementales;
- établir le *coût* de ses recommandations et proposer un *plan précis pour générer des recettes*. Pour être vraiment utile, le Comité a estimé qu'il ne pouvait se permettre de rester vague sur la question de savoir de quelle façon au juste la mise en œuvre de ses recommandations allait être financée;

- préciser clairement les *changements* que chacun des principaux intervenants — les Canadiens, les professionnels de la santé, les gouvernements provinciaux et fédéral, etc. — vont devoir effectuer pour que la mise en œuvre du plan de réforme du Comité puisse être menée à bien.
- exposer clairement les *conséquences* auxquelles nous nous exposons si nous renonçons à modifier et donc à réformer le système de soins de santé.

Le Comité est d'avis que l'occasion est idéale pour mettre en œuvre le genre de réforme nécessaire pour assurer la viabilité à long terme du système de soins de santé au Canada. Il croit avoir réussi à mettre au point un plan détaillé, concret et réaliste qui, s'il est appliqué intégralement, contribuera au renforcement du système public de soins de santé au Canada et permettra d'en assurer la viabilité dans un avenir prévisible. Il espère poursuivre ses efforts en ce sens, de concert avec tous ceux qui partagent cet objectif.



**C'est sur sa bonne santé qu'une population  
assoit son bonheur et dont dépendent  
ses pouvoirs en tant qu'État.**

**Benjamin Disraeli – 24 juillet 1877**

**C'est à la population canadienne et à l'amélioration de  
sa santé que le Comité dédie le présent rapport.**





## INTRODUCTION

Au cours des deux dernières années, le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie s'est penché sur l'état du système de soins de santé au Canada et sur l'évolution du rôle du gouvernement fédéral dans le secteur de la santé. Le Comité a siégé pendant plus de 200 heures et tenu 76 séances. La plupart de ces séances étaient publiques et lui ont permis de recueillir le point de vue d'au-delà de 400 témoins, dont bon nombre de représentants d'organismes regroupant des milliers de membres (comme l'Association médicale canadienne ou l'Association des infirmières et infirmiers du Canada).

Jusqu'ici, le Comité a publié cinq rapports. Le sixième rapport renferme les recommandations finales du Comité en vue d'une réforme et d'un renouvellement du système canadien de soins de santé. Ces recommandations découlent des principes énoncés dans le volume cinq. Les principaux sujets abordés dans les cinq rapports précédents, de même que les sujets qui seront abordés dans des rapports subséquents, sont résumés dans le tableau suivant :

<b>Phases</b>	<b>Contenu</b>	<b>Échéance du rapport</b>
<b>Un</b>	Contexte historique et aperçu	Mars 2001
<b>Deux</b>	Tendances futures, leurs causes et répercussions sur les coûts des soins des santé	Janvier 2002
<b>Trois</b>	Modèles et pratiques d'autres pays	Janvier 2002
<b>Quatre</b>	Enjeux et options	Septembre 2001
<b>Cinq</b>	Principes de restructuration des services hospitaliers et des services médicaux et recommandations visant plusieurs enjeux de la santé	Avril 2002
<b>Six</b>	Recommandations quant au financement et à la restructuration des services hospitaliers et des services médicaux et aux lacunes de la couverture relativement aux médicaments et aux soins à domicile	Octobre 2002
<b>Études thématiques</b>	La santé des Autochtones, la santé des femmes, la santé mentale, les services de santé en région rurale, la santé de la population, les soins à domicile et les soins palliatifs	Dates ultérieures à déterminer

Comme ce tableau l'indique, après la publication du présent rapport, le Comité entend examiner un certain nombre d'autres questions qui feront l'objet d'une série de rapports thématiques portant sur les sujets suivants : 1) la santé des Autochtones, 2) la santé des femmes, 3) la santé mentale, 4) les services de santé en région rurale, 5) la santé de la population, notamment les questions relatives à l'alphabétisation, 6) les soins à domicile et 7) les soins palliatifs.

Le Comité a en outre tenu des audiences publiques en septembre 2002 pour examiner le document intitulé *Santé en français — Pour un meilleur accès à des services de santé en français*, dont la publication fait suite à une étude coordonnée par la Fédération des communautés francophones et acadienne du Canada pour le Comité consultatif des communautés francophones en situation minoritaire. Le Comité publiera un rapport à ce sujet et les lecteurs du présent volume sont fortement invités à en prendre connaissance aussi.

Les recommandations contenues dans le volume six se subdivisent en six catégories :

- des recommandations en vue de la restructuration des services hospitaliers et des services médicaux pour en accroître l'efficacité et ainsi permettre la prestation en temps opportun de soins de qualité;
- des recommandations relatives à la « promulgation d'une garantie de soins » qui ferait en sorte que les patients soient traités à l'intérieur d'un délai maximal précis lorsqu'ils doivent subir une intervention importante ou obtenir un diagnostic. Une fois le délai expiré, la « garantie de soins » obligerait l'assureur/gouvernement à assumer les coûts encourus pour que le patient obtienne le service nécessaire dans un autre territoire ou dans un autre pays;
- des recommandations pour élargir la portée du régime public d'assurance-santé afin d'absorber les coûts astronomiques des médicaments de prescription, les coûts des soins post-hospitaliers offerts à domicile et les coûts liés à la prestation de soins palliatifs aux patients qui choisissent de passer les dernières semaines qui leur restent à vivre à la maison;
- des recommandations pour renforcer la contribution fédérale à l'élaboration de l'infrastructure des soins de santé et son rôle à cet égard, notamment en ce qui a trait aux systèmes d'information sur la santé, aux technologies de la santé, à l'évaluation de la performance et de l'efficacité du système de soins de santé, aux ressources humaines disponibles dans le secteur des soins de santé, à la recherche en santé, à la promotion du mieux-être et à la prévention de la maladie ainsi qu'aux seize centres universitaires des sciences de la santé;
- des recommandations quant à la façon de générer ces nouvelles recettes fédérales et de les administrer de façon transparente et responsable pour assurer la mise en œuvre des recommandations énoncées dans le présent rapport;
- des observations quant à ce qui risque d'arriver si les recettes fédérales supplémentaires que le Comité recommande d'investir dans le système de soins de santé ne le sont pas.

Comme certaines de ces recommandations, si elles sont mises en œuvre, exigeront la participation financière des gouvernements provinciaux et territoriaux, le Comité est pleinement conscient de l'importance de favoriser un esprit de coopération et de collaboration entre les divers ordres de gouvernement pour mener à bien la refonte et le renouvellement du système canadien de soins de santé.

***Comme certaines de ces recommandations exigeront la participation financière des gouvernements provinciaux et territoriaux, si elles sont mises en œuvre, le Comité est pleinement conscient de l'importance de favoriser un esprit de coopération et de collaboration entre les divers ordres de gouvernement pour mener à bien la refonte et le renouvellement du système canadien de soins de santé.***





# **Partie I : Responsabilisation**

---



# CHAPITRE UN

## LA NÉCESSITÉ D'UN RAPPORT ANNUEL SUR L'ÉTAT DU SYSTÈME DE SOINS DE SANTÉ ET SUR L'ÉTAT DE SANTÉ DES CANADIENS

---

Pour pouvoir formuler des recommandations réalistes en vue d'améliorer la prestation de soins de santé auprès des Canadiens, il faut tout d'abord avoir une vision claire du système dans son état actuel et une évaluation de ses forces et de ses faiblesses. Dès le départ, le Comité a cherché à tracer un portrait fidèle du système canadien de soins de santé et à distinguer entre mythe et réalité<sup>1</sup>.

D'après le Comité, il est essentiel de réaliser, le plus objectivement possible, une évaluation continue du système de soins de santé. Le Comité expose dans le présent chapitre ses recommandations visant la création d'un nouveau conseil national des soins de santé, présidé par un commissaire aux soins de santé chargé de produire un rapport annuel sur l'état du système de soins de santé et sur l'état de santé des Canadiens. (Dans le présent document, le genre masculin est utilisé par souci de brièveté. Le masculin doit être interprété comme comprenant le féminin).

Mais avant d'approfondir cette question, le Comité veut donner un bref aperçu de quelques éléments clés des volumes précédents de son étude. Il souhaite ainsi résumer l'approche globale qu'il a adoptée pour la réalisation de son étude en multiples volumes, ainsi que les objectifs de ses recommandations.

### 1.1 Résumé de quelques points saillants des volumes un à cinq

#### 1.1.1 Le rôle du gouvernement fédéral

Le Comité a cerné les divers rôles du gouvernement fédéral en matière de santé et de soins de santé, décrivant au volume quatre chaque rôle en indiquant pour chacun l'ensemble des objectifs que doivent viser les politiques<sup>2</sup>. Le Comité a aussi confirmé la légitimité et l'importance des divers rôles du gouvernement fédéral, et ce sous divers rapports :

- en premier lieu, il est clair que les Canadiens appuient vivement les principes nationaux des soins de santé et veulent que le gouvernement fédéral joue un grand rôle dans le respect de ces principes;
- en deuxième lieu, le financement fédéral des soins de santé est particulièrement important en cette époque de réforme et de renouvellement. En effet, le Comité explique dans le présent volume que pour changer la structure et le fonctionnement du système de soins de santé, il faudra plus d'argent, et ces fonds devront être levés principalement par le gouvernement fédéral;

---

<sup>1</sup> Voir le volume un, *Le chemin parcouru*, chapitre six, Mythes et réalités, p. 101 et suivantes.

<sup>2</sup> Voir le volume quatre, *Questions et options*, chapitres trois et quatre, p. 11-28.

- en troisième lieu, et surtout, selon certains, seul le gouvernement fédéral est à même de faire en sorte que toutes les provinces et tous les territoires, quelle que soit la taille de leur économie, aient à leur disposition les ressources financières nécessaires pour répondre aux besoins en soins de santé de leurs citoyens. Ce rôle de redistribution que joue le gouvernement fédéral fait partie intégrante de ce que bon nombre appellent « la manière canadienne »;
- en quatrième lieu, il faudra que les changements fondamentaux apportés au système de soins de santé ne s'appliquent pas seulement à une ou deux provinces. Notre système national doit reposer sur une harmonisation interprovinciale, et le gouvernement fédéral a un rôle vital à jouer à cet égard, par exemple, en ayant recours à des mesures incitatives ou à des sanctions financières afin d'encourager les provinces et les territoires à adopter des normes pancanadiennes;
- en cinquième lieu, le Comité est résolument d'avis que les importantes sommes d'argent que le gouvernement fédéral transfère aux provinces et aux territoires pour les soins de santé doivent assurer à ce dernier une place lors des discussions sur la restructuration du système de soins de santé. Puisqu'il doit rendre compte aux contribuables, le gouvernement fédéral a son mot à dire dans la façon dont l'argent est dépensé.

***Il est très clair pour le Comité que les Canadiens veulent que les provinces et les territoires ainsi que le gouvernement fédéral travaillent en collaboration comme partenaires afin de faciliter le renouvellement des soins de santé. Les Canadiens estiment que le temps n'est plus aux reproches; ils veulent une coopération intergouvernementale et des résultats concrets.***

Il est très clair pour le Comité que les Canadiens veulent que les provinces et les territoires ainsi que le gouvernement fédéral travaillent en collaboration comme partenaires afin de faciliter le renouvellement des soins de santé. Les Canadiens estiment que le temps n'est plus aux reproches; ils veulent une coopération intergouvernementale et des résultats concrets.

### **1.1.2 Objectifs de la politique fédérale en matière de soins de santé**

Le Comité a souligné que la politique fédérale en matière de soins de santé découle de deux objectifs primordiaux que le Comité appuie sans réserve comme étant les buts principaux que doit viser le gouvernement fédéral dans le domaine des soins de santé. *Ces deux objectifs sont les suivants :*

***Le Comité estime que la politique fédérale en matière de soins de santé vise deux objectifs :***

- ***Assurer à tous les Canadiens un accès en temps opportun aux services de santé médicalement nécessaires, sans égard à leur capacité de payer;***
  - ***Veiller à ce qu'aucun Canadien ne souffre de difficultés financières excessives du fait du coût des soins de santé.***
- *Assurer à tous les Canadiens un accès en temps opportun aux services de santé médicalement nécessaires, sans égard à leur capacité de payer;*

- *Veiller à ce qu'aucun Canadien ne souffre de difficultés financières excessives du fait du coût des soins de santé.*

Ces deux objectifs, et particulièrement le premier, sous-entendent que les services médicalement nécessaires fournis dans le cadre de l'assurance-santé sont de qualité élevée. En effet, à quoi servirait, aux fins du système de soins de santé du Canada, de fournir l'accès à des services de qualité inférieure?

En ce qui concerne la loi fédérale prééminente en matière de soins de santé, soit la *Loi canadienne sur la santé* (1984), le Comité a signifié à maintes reprises qu'il appuie sans réserve les quatre principes de la Loi axés sur le patient. Il souscrit aussi à l'esprit du cinquième principe de la Loi, bien qu'il soit d'une autre nature :

- le principe **d'universalité**, qui signifie que tous les Canadiens ont droit à un régime public d'assurance-santé;
- le principe **d'intégralité**, qui est censé garantir que tous les services médicalement nécessaires fournis par des hôpitaux ou des médecins sont couverts par l'assurance-santé publique;
- le principe **d'accessibilité**, qui décourage le recours à des mesures financières pouvant faire obstacle à la prestation de services de santé publics, comme les frais d'utilisation, afin que tous les Canadiens aient accès aux soins nécessaires quel que soit leur revenu;
- le principe de **transférabilité**, qui signifie que tous les Canadiens sont couverts par l'assurance-santé publique quand ils se déplacent au Canada ou déménagent dans une autre province;
- le principe de **gestion publique** n'est pas axé sur le patient, mais met l'accent « plutôt sur les moyens de réaliser les objectifs visés par les quatre autres principes »<sup>3</sup>. Or, c'est sur ce principe que repose le modèle à source unique de financement ou d'assurance que prône le Comité au volume cinq, dans le cadre du principe un<sup>4</sup>. En vertu de la condition de gestion publique que prévoit la Loi, les régimes d'assurance-santé provinciaux et territoriaux doivent être gérés par un organisme public, sans but lucratif.

Le Comité pense aussi, comme l'honorable Monique Bégin, ministre fédérale de la Santé au moment de l'adoption de la *Loi canadienne sur la santé*, que le principe de la gestion publique a depuis été mal interprété<sup>5</sup>. Il appuie vivement le système d'assurance à payeur unique en

***Le principe de la gestion publique a depuis été mal interprété. Le Comité appuie vivement le système d'assurance à payeur unique en vertu duquel seul le gouvernement finance les services fournis par les hôpitaux et les médecins. Or, le principe de la gestion publique touche le financement des services fournis par les hôpitaux et les médecins, et non leur prestation.***

<sup>3</sup> Volume un, p. 43.

<sup>4</sup> Volume cinq, p. 25-27.

<sup>5</sup> Voir son témoignage devant le Comité le 8 mai 2002 (54:5).

vertu duquel seul le gouvernement finance les services fournis par les hôpitaux et les médecins. Or, le principe de la gestion publique touche le *financement* des services fournis par les hôpitaux et les médecins, et *non leur prestation*.

Il y a un malentendu concernant le principe de la gestion publique parce que l'on n'a pas su faire une distinction entre, d'une part, le financement et la gestion de l'assurance-santé par l'État et, d'autre part, la prestation comme telle des services de soins de santé. En vertu de la *Loi canadienne sur la santé*, la prestation de ces services ne relève pas nécessairement d'organismes publics. En fait, de nos jours au Canada, la grande majorité des services de soins de santé sont dispensés par tout un éventail d'établissements et de fournisseurs privés.

Le Comité a réaffirmé sa volonté de faire respecter le principe voulant que chaque Canadien ait un accès garanti aux services médicalement nécessaires, fournis par un programme d'assurance-santé financé et géré par l'État, partout au Canada. Ce principe forme l'essence même de la politique canadienne en matière de soins de santé depuis plus de trente ans et figure clairement dans la *Loi canadienne sur la santé*.

La réalisation des objectifs de la politique canadienne en matière de soins de santé dépend du « contrat » conclu entre les Canadiens et leurs gouvernements fédéral et provinciaux ou territoriaux. Les Canadiens versent des impôts à leurs gouvernements, lesquels utilisent une partie de cet argent pour financer un régime d'assurance universelle qui fournit à tous les Canadiens une couverture au premier dollar des services médicalement nécessaires dispensés par les hôpitaux et les médecins. Ces services doivent être accessibles et complets, ainsi que transférables d'une province et d'un territoire à l'autre. En vertu du « contrat », les gouvernements — fédéral et provinciaux-territoriaux — doivent, en leur qualité d'assureur, utiliser les fonds versés par les Canadiens afin de satisfaire les deux objectifs énoncés ci-dessus, c'est-à-dire veiller à ce que les Canadiens bénéficient d'une assurance publique et qu'ils aient accès en temps opportun à des services médicalement nécessaires de haute qualité fournis par des hôpitaux et des médecins.

### **1.1.3 L'actuel système n'est pas financièrement viable**

À l'étape suivante, le Comité a cherché à savoir si le système est viable sous sa forme courante, avec les niveaux actuels de financement par le gouvernement. Dans le volume cinq, le Comité a établi la définition d'un système de soins de santé viable sur le plan financier, soit un système sur lequel les Canadiens peuvent compter maintenant et pourront compter dans l'avenir, compte tenu des moyens de l'État et de la volonté de payer des contribuables.

Deux facteurs doivent être pris en considération dans l'évaluation de la viabilité financière. Le premier facteur est la volonté de payer des contribuables (consentement des personnes gouvernées). Le deuxième est la nécessité pour les gouvernements de conserver des taux d'imposition concurrentiels par rapport aux autres pays de l'OCDE, particulièrement les États-Unis, à des fins de développement économique.

De l'avis du Comité, la viabilité financière à long terme dépend du rapport entre les dépenses publiques au titre des soins de santé et les autres dépenses. Si ce rapport devient trop élevé, ce peut être signe que les dépenses au titre de la santé empêchent d'effectuer d'autres dépenses nécessaires.

Le Comité reconnaît également que la viabilité peut être étudiée sous l'angle de la proportion du produit intérieur brut (PIB) consacrée aux soins de santé, que les fonds proviennent du trésor public ou du privé. Toutefois, il est impossible de dire quelle devrait être cette proportion sans une analyse détaillée des avantages que tirent les Canadiens des soins de santé. Or, comme le système manque de moyens pour saisir, enregistrer, partager et gérer l'information sur la santé, il n'est pas possible pour l'instant d'effectuer une telle analyse coût-avantage. Le Comité doit donc se contenter de constater que le Canada consacre aux soins de santé une part des dépenses, exprimée en termes de proportion du PIB, comparable en gros à celle d'autres pays développés, à l'exception des États-Unis qui consacrent à ce chapitre beaucoup plus que n'importe quel autre pays industrialisé.

Le Comité ne sait que trop bien que le transfert d'une plus grande part des coûts aux patients et à leurs familles en leur imposant des paiements directs, soit la « solution » facile que d'aucuns recommandent, n'est en fait qu'un moyen coûteux de régler, ou du moins d'alléger, le problème du gouvernement. Quelle que soit la façon dont elle est exprimée (en pourcentage du PIB, des dépenses gouvernementales, etc.), il n'existe qu'une source de financement des soins de santé, soit la population canadienne, et on a montré de façon concluante que la façon la plus rentable de financer les soins de santé est d'utiliser un modèle à assureur/payeur unique (en l'occurrence, un régime public ou gouvernemental).

***Quelle que soit la façon dont elle est exprimée, il n'existe qu'une source de financement, soit la population canadienne, et on a montré de façon concluante que la façon la plus rentable de financer les soins de santé est d'utiliser un modèle à assureur/payeur unique (en l'occurrence, un régime public ou gouvernemental).***

Le Comité est convaincu que le Canada doit continuer d'adhérer au modèle le plus efficace d'assurance-santé universelle, et il est clair que la population canadienne est du même avis. Par conséquent, quand il a formulé ses recommandations, le Comité n'a pas retenu les mesures de financement liées au PIB. Il a plutôt cherché à évaluer à combien doivent s'élever les dépenses publiques nécessaires pour soutenir l'assurance-santé et, en particulier, combien il faut pour réaliser les changements qui s'imposent pour que ce programme très prisé, financé en majeure partie par l'État, puisse répondre aux besoins des Canadiens au XXI<sup>e</sup> siècle.

Au cours des audiences que le Comité a tenues d'un bout à l'autre du pays, un large éventail de témoins, dont des gestionnaires, des fournisseurs et des consommateurs de soins de santé, ont exprimé de vives préoccupations face à l'escalade des coûts des soins de santé et à son incidence sur les budgets gouvernementaux et sur la qualité des soins dispensés aux patients. Fort de ces témoignages et de nombreux rapports, le Comité a conclu que la montée des coûts indique clairement que le système public de soins de santé du Canada, tel qu'il est structuré et qu'il fonctionne en ce moment, n'est pas financièrement viable compte tenu des niveaux actuels de financement.

***Le Comité a conclu que la montée des coûts indique clairement que le système public de soins de santé du Canada, tel qu'il est structuré et qu'il fonctionne en ce moment, n'est pas financièrement viable compte tenu des niveaux actuels de financement.***



Le manque de viabilité est déjà évident puisque le système n'a pas en ce moment les ressources voulues pour répondre à toutes les demandes, et on note en particulier que l'accès en temps opportun à des services de santé de qualité est de moins en moins la norme. Le Comité est bien conscient qu'aucun système fournissant des services perçus comme étant « gratuits » ne saura répondre à toutes les demandes qu'il reçoit, et qu'à l'heure actuelle nous ne sommes pas à même de faire la différence entre la demande et le véritable besoin d'accès en temps opportun à des services de santé de toutes sortes. Néanmoins, l'impression répandue d'une détérioration de la qualité des services montre bien que la population doit décider quelle orientation elle souhaite voir prendre à ses gouvernements. Selon le Comité, il existe essentiellement trois options à cet égard :

- rallonger les listes d'attente par un rationnement croissant des services de santé assurés par l'État;
- accroître les recettes du gouvernement;
- offrir certains services plus rapidement à ceux qui peuvent se les payer en autorisant l'établissement d'un système parallèle de services de santé privés qui s'ajouterait au système public offert à tous les autres Canadiens<sup>6</sup>.

Ainsi qu'en témoignera le reste du rapport, le Comité souhaite ardemment que les Canadiens considèrent la deuxième option comme étant la meilleure. Parvenu à cette conclusion à l'unanimité, le Comité, s'écartant de la façon de faire habituelle dans les rapports des comités parlementaires, a choisi de préciser les sommes supplémentaires nécessaires pour assurer la viabilité financière à long terme du système de soins de santé, de dire comment cet argent devra être dépensé et de suggérer des options pour accroître les recettes du gouvernement.

Le Comité a conclu qu'il faut cinq milliards de dollars de plus par année pour réformer et renouveler le système de soins de santé, puisque c'est ce qu'il évalue être le coût annuel de mise en œuvre de ses recommandations. Le Comité tient toutefois à souligner aussi qu'à moins que des changements ne soient apportés à la structure et au fonctionnement du système, il n'y aura jamais assez d'argent pour en assurer la viabilité à long terme. Cette nouvelle injection de cinq milliards de dollars en fonds fédéraux doit donc servir à acheter des changements et ainsi qu'à réformer et à renouveler le système.

***À moins que des changements ne soient apportés à la structure et au fonctionnement du système, il n'y aura jamais assez d'argent pour en assurer la viabilité à long terme. Cette nouvelle injection de cinq milliards de dollars en fonds fédéraux doit donc servir à acheter des changements et ainsi qu'à réformer et à renouveler le système.***

#### **1.1.4 Une garantie nationale de soins de santé est essentielle au succès de la réforme**

En général, dans sa vision de la réforme du système, le Comité a posé comme principe l'adoption de mesures incitatives pour encourager tous les participants au système

---

<sup>6</sup> Veuillez remarquer que la désassurance de services signifie que les Canadiens devront payer de leur poche certains services offerts auparavant dans le cadre du programme public d'assurance-santé.

public de services hospitaliers et médicaux — soit les fournisseurs, les établissements, les gouvernements et les patients — à dispenser, à gérer et à utiliser les soins de santé de façon plus efficace. Un élément en particulier, essentiel au succès de la réforme du système mais qui ne saurait exister isolément, réside dans ce que le Comité a appelé la « garantie de soins de santé ».

La recommandation à cet égard, décrite en détail au chapitre six, vise à régler le problème des temps d'attente croissants pour obtenir des services de santé; il s'agit d'exiger que les gouvernements respectent des normes raisonnables, c'est-à-dire que les patients aient accès aux services dans leur propre province ou territoire, ailleurs au Canada ou, au besoin, à l'étranger. Le respect de normes raisonnables pour les services aux patients est un élément essentiel du contrat de soins de santé conclu entre les Canadiens et leurs gouvernements. Selon le Comité, en investissant judicieusement l'argent frais et en inscrivant dans la loi le principe de la « garantie de soins de santé », il sera possible de redonner confiance aux Canadiens que leurs gouvernements dépenseront l'argent perçu de façon à renforcer le système public de soins de santé et pour qu'il donne accès aux services médicalement nécessaires à l'endroit et au moment où les gens en ont besoin.

Tout en formulant des propositions, le Comité estime important de reconnaître que l'option qu'il préfère — soit la perception de recettes additionnelles - assortie d'un plan de dépenses et de la mise en œuvre de la garantie de soins de santé, ne constitue pas la seule possibilité. Si, après un débat public, les gouvernements refusent de verser davantage pour les services hospitaliers et médicaux ou si l'assureur (le gouvernement) décide de ne pas mettre en œuvre la garantie de soins de santé, le résultat sera le rationnement continu (et sans doute accru) des services et la prolongation des temps d'attente.

Or, comme le souligne le Comité plus loin au chapitre cinq, la prolongation des temps d'attente, si la garantie de soins de santé n'est pas mise en œuvre, risque d'avoir d'autres conséquences importantes. En outre, s'il y a inaction sur ce plan, la Cour suprême risque fort de juger qu'étant donné la non-prestation de services médicaux en temps opportun dans le cadre du système public, le gouvernement ne peut refuser aux Canadiens le droit de souscrire une assurance privée pour couvrir le coût d'achat de services ailleurs, c'est-à-dire auprès d'établissements privés de soins de santé au Canada. Ainsi, en omettant de mettre en œuvre la garantie de soins de santé, nous risquons fort de pousser le système canadien de soins de santé à devenir un système à deux vitesses, dont ne profiteront que ceux qui peuvent payer de leurs poches ou au moyen d'une assurance-santé privée.

Quand cette possibilité a été soulevée dans les rapports précédents, certains observateurs ont cru que le Comité préconisait une plus grande privatisation du système de soins de santé. Or, le présent volume devrait montrer clairement qu'il n'en est rien.

Le Comité a élaboré un plan détaillé, concret et réaliste qui, s'il est mis en œuvre intégralement, renforcera le système public de soins de santé au Canada et garantira sa viabilité dans un avenir prévisible. Cependant, cette option comporte un coût, et la grande majorité des contribuables canadiens seront mis à contribution en vue de la réalisation du plan proposé. Il est essentiel que les Canadiens comprennent toutes les répercussions auxquelles ils pourront s'attendre s'il arrivait que les gouvernements se montrent réticents à percevoir plus d'argent afin de l'injecter dans le système public de soins de santé. Or, une des conséquences possibles est

non seulement la détérioration continue du système, mais aussi des jugements qui précipiteront l'émergence d'un système parallèle de soins de santé privés au Canada.

## **1.2 Améliorer la gouvernance — La nécessité d'un commissaire national aux soins de santé**

Pour pouvoir faire des choix éclairés, maintenant et à l'avenir, la population canadienne doit absolument avoir accès à une évaluation fiable et objective de l'état réel du système de soins de santé. Le reste du présent chapitre décrit donc la proposition du Comité afin de créer une structure institutionnelle qui fournira une telle évaluation aux Canadiens chaque année.

***Selon le Comité, il est essentiel d'améliorer la gouvernance du système de soins de santé du Canada.***

Il est essentiel d'améliorer la gestion du système de soins de santé du Canada. La question de la gouvernance (c.-à-d., du leadership) comporte plusieurs éléments que le Comité a soulevés dans les volumes précédents et que les témoins ont abordé sous divers rapports.

Une chose est très claire. Les Canadiens en ont assez de voir les responsables des relations intergouvernementales dans le domaine des soins de santé s'adresser d'incessants reproches et se renvoyer la balle. L'honorable Monique Bégin a d'ailleurs souligné le caractère dysfonctionnel des relations fédérales-provinciales<sup>7</sup>. Beaucoup trop souvent, les deux parties semblent davantage intéressées à se reprocher l'une l'autre l'apparente détérioration du système qu'à prendre les devants pour s'assurer que les Canadiens aient accès aux services de santé dont ils ont besoin et qu'ils méritent.

Au fond, tout est une question d'imputabilité. Le Comité a souligné à maintes reprises qu'il faut des renseignements détaillés et fiables sur le rendement du système et les résultats afin de déterminer qui doit être tenu responsable des lacunes (ainsi que des forces) du système de soins de santé. Voilà pourquoi le Comité a accordé une telle importance à l'élaboration d'une capacité de gestion des renseignements sur la santé, à la création d'un système national de dossiers de santé électroniques<sup>8</sup> et à la nécessité de soutenir et d'élargir l'infrastructure de la recherche en matière de santé<sup>9</sup>. Le Comité a attiré l'attention sur l'importante contribution qu'a déjà faite l'Institut canadien d'information sur la santé (ICIS) pour ce qui est d'améliorer notre connaissance de l'état du système de soins de santé; il est clair qu'il faut tabler sur cette source d'expérience positive.

Il faut analyser et interpréter l'information objectivement pour qu'elle puisse servir de guide fiable à la prise de décisions fondées sur les faits. Dans le volume cinq, le Comité a énuméré quatre éléments fondamentaux nécessaires pour créer la capacité voulue afin d'évaluer de façon juste et complète le rendement du système de soins de santé et l'état de santé de la population canadienne, ainsi que pour obliger les parties compétentes à rendre des comptes :

- En premier lieu, une telle évaluation doit être menée par une entité indépendante du gouvernement. Le Comité appuie fortement «le point de

<sup>7</sup> Monique Bégin, « Renewing Medicare », tiré du Journal de l'Association médicale canadienne, 9 juillet 2002, p. 47.

<sup>8</sup> Voir le chapitre 10.

<sup>9</sup> Voir le chapitre 12.

vue exprimé par des témoins et des rapports provinciaux selon lequel les rôles de l'assureur et du fournisseur doivent être séparés de celui de l'évaluateur pour qu'il soit possible d'obtenir une évaluation indépendante du rendement et des résultats du système de soins de santé »<sup>10</sup>. C'est la seule façon d'éviter les conflits d'intérêts réels ou perçus et d'assurer la crédibilité des rapports d'évaluation auprès de la population canadienne.

- En deuxième lieu, le Comité est d'avis « qu'une telle évaluation indépendante doit être effectuée au niveau national (et non fédéral) »<sup>11</sup>. Le fait est que la responsabilité du système canadien de soins de santé incombe à la fois aux provinces et territoires et au gouvernement fédéral. Aucun organisme relevant exclusivement de l'un ou l'autre de ces niveaux ou créé exclusivement par un niveau ou l'autre n'aura la crédibilité nécessaire.
- En troisième lieu, même si l'évaluation doit être menée par un organisme indépendant, elle doit être financée par le gouvernement. En outre, comme nous l'expliquerons plus loin, c'est le gouvernement fédéral qui devra prendre les devants pour assurer le financement nécessaire à ce projet, malgré le caractère « national » (par opposition à fédéral) de l'organisme d'évaluation.
- En dernier lieu, ainsi que souligné ci-dessus, il est essentiel que cette entreprise prenne appui sur le succès des organismes existants, comme l'Institut canadien d'information sur la santé (ICIS) et le Conseil canadien d'agrément des services de santé (CCASS). Le Comité présente au chapitre dix des recommandations particulières à l'égard de ces organismes.

Le Comité estime toutefois que ces organismes, à eux seuls, ne suffisent pas. Il faut donc un organisme indépendant permanent chargé de faire rapport annuellement à la population canadienne de l'état du système de soins de santé du pays et de l'état de santé des Canadiens. Le Comité pense aussi que cet organisme doit avoir la responsabilité de conseiller chaque année le gouvernement fédéral sur l'affectation du surcroît

***Il faut donc un organisme indépendant permanent chargé de faire rapport annuellement à la population canadienne de l'état du système de soins de santé du pays et de l'état de santé des Canadiens. Le Comité pense aussi que cet organisme doit avoir la responsabilité de conseiller chaque année le gouvernement fédéral sur l'affectation du surcroît de recettes perçu afin de renouveler et de réformer le système de soins de santé.***

de recettes perçu afin de renouveler et de réformer le système de soins de santé. Cet organisme doit aussi être doté de ressources suffisantes et travailler en collaboration avec l'ICIS et le CCASS (et peut-être d'autres organismes) afin de recueillir et d'évaluer les données et l'information dont il a besoin.

Avant d'exposer sa propre proposition, le Comité examine brièvement quelques autres idées présentées au cours des derniers mois, sur des façons de fournir chaque année au public canadien des rapports sur l'état du système de soins de santé. Le Comité considère que les

---

<sup>10</sup> Volume 5, p. 54.

<sup>11</sup> *Ibid.*

diverses propositions contiennent de nombreux éléments utiles, mais qu'aucune ne répond à toutes ses exigences.

### **1.2.1 Association médicale canadienne (AMC)**

L'AMC propose une approche à deux volets<sup>12</sup>. En premier lieu, elle prône l'adoption d'une charte canadienne de la santé en trois parties : un énoncé de vision, une section sur la planification et la coordination nationales, et une section sur les rôles, les droits et les responsabilités. Cette charte établirait les paramètres d'une meilleure planification et coordination nationales, particulièrement en ce qui concerne : l'examen de services de santé de base; l'élaboration de repères nationaux pour déterminer la rapidité et la qualité des soins de santé; l'établissement des besoins en ressources, dont les ressources humaines et en technologie de l'information; et l'établissement d'objectifs nationaux pour ce qui est de l'amélioration de la santé des Canadiens.

La proposition de l'AMC prévoit aussi la création d'une commission canadienne de la santé, soit une tribune permanente dépolitisée au niveau national, permettant un dialogue et un débat continu. La commission aurait notamment pour mandat de :

- surveiller l'application de la charte canadienne de la santé;
- faire rapport chaque année aux Canadiens sur le rendement du système de soins de santé et sur l'état de santé de la population;
- conseiller la Conférence des ministres fédéral et provinciaux-territoriaux de la Santé sur les questions importantes liées à la santé.

La commission proposée par l'AMC serait présidée par un commissaire à la santé qui serait un mandataire du Parlement (tout comme le vérificateur général) nommé pour un mandat de cinq ans par consensus des gouvernements fédéral, provinciaux et territoriaux. La commission serait indépendante des gouvernements mais aurait des liens étroits avec des organismes gouvernementaux comme l'Institut canadien d'information sur la santé et les Instituts de recherche en santé du Canada. Ses délibérations seraient rendues publiques, et elle serait composée non pas de façon à représenter les circonscriptions mais de manière à refléter un large éventail de perspectives et de compétences.

### **1.2.2 Colleen Flood et Sujit Choudry**

Dans un document préparé pour la Commission Romanow<sup>13</sup>, les professeurs Colleen Flood et Sujit Choudry de l'Université de Toronto se disent d'avis qu'il existe un besoin réel d'avoir un organisme national non partisan, non soumis aux aléas politiques de l'heure, et plus capable d'adopter une vision à long terme que ne l'est un gouvernement élu. Ils proposent donc la création d'une commission de l'assurance-santé qui serait un organisme spécialisé et indépendant, dont les membres seraient nommés par le gouvernement fédéral et les provinces, mais dont le financement serait assuré par le gouvernement fédéral.

Le rôle confié à la commission de l'assurance-santé serait le suivant :

---

<sup>12</sup> Voir son document intitulé *A Prescription for Sustainability*, juin 2002.

<sup>13</sup> Collen M. Flood et Sujit Choudry, *Consolider les fondements : La modernisation de la Loi canadienne sur la santé*, publié par la Commission sur l'avenir des soins de santé au Canada, août 2002.

- établir des indicateurs de performance spécifiques pour aider les provinces à atteindre les normes nationales énoncées dans la *Loi canadienne sur la santé*,
- publier (en collaboration avec l'Institut canadien d'information sur la santé) des rapports annuels sur la performance des régimes d'assurance-santé des provinces;
- fournir de l'aide financière aux provinces qui entreprennent la mise en œuvre de processus ou de programmes identifiés par la commission.

Le financement de la commission serait distinct des transferts fédéraux au titre des soins de santé. Il proviendrait plutôt de nouvelles ressources fédérales qui intégreraient toutes les initiatives de paiement actuelles du gouvernement fédéral dans le domaine des soins de santé (p. ex., les soins primaires et d'autres domaines).

Les professeurs Flood et Choudry proposent une méthode pour établir la composition de la commission, soit que chaque province nomme un commissaire et que le gouvernement fédéral en nomme cinq, pour un total de 15 membres. Les commissaires serviraient à plein temps et choisiraient, dans leurs rangs, un commissaire en chef. Toutes les décisions seraient prises à la majorité des deux tiers, ce qui signifie que les commissaires fédéraux auraient besoin de l'appui d'une majorité de commissaires provinciaux pour toute décision<sup>14</sup>. La commission proposée aurait un effectif de spécialistes constitué de chercheurs du secteur de la santé et elle rendrait ses rapports publics, y compris ses observations sur la conformité des régimes de soins de santé provinciaux aux normes nationales.

### **1.2.3 Tom Kent**

Tom Kent, haut fonctionnaire fédéral au moment de la création du régime d'assurance-santé et souvent appelé le père de ce régime, a suggéré qu'Ottawa et les provinces nomment par consensus un conseil consultatif composé d'un large éventail de spécialistes<sup>15</sup>. Le but n'est ni de remplacer la gestion provinciale des programmes, ni de porter atteinte à la responsabilité fédérale à l'égard des principes de l'assurance-santé. Le conseil est plutôt vu comme un mécanisme de collaboration permettant de jeter un pont entre les deux niveaux de gouvernement de façon à ramener la réalité politique en harmonie avec la vision qu'ont la plupart des Canadiens du régime d'assurance-santé, c'est-à-dire une responsabilité conjointe au sein du système fédéral.

Le conseil que propose M. Kent serait financé à la fois par le gouvernement fédéral et les provinces. Il compterait un directeur exécutif et un effectif qui ne seraient des agents ni fédéraux ni provinciaux. L'organisme relèverait d'un comité mixte de ministres de la santé qui le chargerait d'effectuer des enquêtes et de formuler des recommandations sur toute une gamme de principes et de pratiques liés à l'assurance-santé.

L'organisme proposé servirait de plaque tournante à la collaboration et faciliterait l'innovation et les économies, en plus de servir de tribune pour une plus vaste consultation sur les politiques en matière de santé. Sur le plan administratif, il pourrait servir à superviser la mise

---

<sup>14</sup> Il convient toutefois de souligner que cette formule semble permettre aux commissaires provinciaux de se liguier ensemble pour faire adopter des décisions rejetées à l'unanimité par les commissaires fédéraux.

<sup>15</sup> Tom Kent, *Medicare: It's Decision Time*, The Caledon Institute of Social Policy, 2002.

en œuvre d'ententes sur des questions comme les dossiers de santé informatisés, l'information sur les soins de santé, une liste nationale des médicaments admissibles, l'achat en vrac, le partage d'installations, etc. Surtout, selon Kent, l'organisme favoriserait la reddition de comptes au public en préparant régulièrement des rapports pour fins de publication par le comité ministériel.

#### **1.2.4 Duane Adams**

Ayant examiné les propositions en vue d'améliorer la gouvernance du système de soins de santé canadien<sup>16</sup>, le feu professeur Duane Adams, directeur fondateur de la Saskatchewan Institute of Public Policy, a souligné que l'ajout, au mécanisme de gouvernance du système canadien de la santé, d'un organisme de surveillance de la santé extérieur au gouvernement aurait des avantages pour la fédération et pour la population canadienne. Il a signalé que même si la majorité des gouvernements sont très sceptiques et méfiants face à ces organismes « indépendants », sous prétexte qu'ils pourraient amoindrir le pouvoir unilatéral des gouvernements, un organisme de surveillance autonome doit être vu comme une solution parmi d'autres pour accroître la participation du public, la transparence, la responsabilité à l'égard du public et la confiance de la population.

Une option proposée par M. Adams est un conseil canadien de la santé doté d'un petit effectif d'employés permanents et faisant appel à la participation du public. Son rôle pourrait notamment consister à :

- suivre le système de soins de santé canadien et informer régulièrement les gouvernements et la population canadienne de ses constatations;
- évaluer certaines questions de santé pancanadiennes qui intéressent immédiatement le public et élaborer des options pratiques pour les régler;
- servir d'organisme neutre d'enquête sur les faits lors de différends intergouvernementaux touchant la *Loi canadienne sur la santé* et d'autres questions qui lui sont confiées par les gouvernements et agir, à la demande des gouvernements, comme facilitateur/médiateur dans les processus de résolution de conflits;
- présenter au public un rapport annuel sur le rendement du système de santé et sur les questions émergentes connexes;
- assumer une certaine responsabilité dans la vérification de concepts innovateurs pour la prestation et la gestion de services de santé d'importance nationale;
- peut-être servir de vecteur pour réunir et diffuser les pratiques exemplaires des régies régionales de la santé d'un bout à l'autre du Canada.

Le conseil ferait partie d'un réseau d'organismes servant à améliorer la gestion du système de soins de santé. Il pourrait comprendre des représentants de la Fondation canadienne de la recherche sur les services de santé, des Instituts de recherche en santé du Canada, de

---

<sup>16</sup> Duane Adams, « Conclusions: proposals for advancing federalism, democracy and governance of the Canadian health system », dans *Federalism, Democracy and Health Policy in Canada*, publié par Duane Adams, McGill-Queen's University Press, 2002.

l'Institut canadien d'information sur la santé et du Conseil canadien d'agrément des services de santé.

### 1.2.5 Lawrence Nestman

Lors de son témoignage devant le Comité<sup>17</sup>, le professeur Lawrence Nestman, de l'École d'administration des services de soins de santé de l'Université Dalhousie, s'est inspiré de l'expérience du Conseil fédéral d'hygiène qui existait dans les années 60. C'était un organisme permanent qui permettait aux ministres et aux sous-ministres de faire la liaison avec un certain nombre de commissions de la santé actives aux niveaux fédéral ou provincial. Il était doté d'un secrétariat permanent où travaillaient des gens hautement qualifiés qui traitaient avec les fonctionnaires dans les ministères de la Santé des provinces. Cette situation permettait une certaine continuité dans l'élaboration des politiques et une meilleure coordination des relations fédérales-provinciales que la situation actuelle. Le professeur Nestman a donc proposé : « [L]e concept d'un conseil fédéral d'hygiène version révisée pour le gouvernement fédéral, auquel s'ajouterait une quelconque infrastructure permanente dans les provinces, [qui] améliorerait les relations fédérales-provinciales et assurerait une certaine continuité, tout en injectant une certaine dose d'autonomie pour l'administration au jour le jour<sup>18</sup>».

### 1.3 La proposition du Comité

Toutes les propositions qui précèdent contiennent des éléments intéressants et des suggestions précieuses, mais aucune ne répond à toutes les exigences que le Comité juge nécessaires. En outre, toutes ces propositions attribuent aux organismes proposés des mandats beaucoup plus vastes que ce qu'envisage le Comité à l'heure actuelle. Ce dernier pense toutefois, comme de nombreux témoins, qu'il faut prendre des mesures pour « dépolitiser » la gestion du système de soins de santé. Comme il estime que ce processus en est un à très long

***Par conséquent, d'après le Comité, l'organisme indépendant d'évaluation doit avoir pour mandat de publier un rapport annuel sur l'état du système de soins de santé et sur l'état de santé des Canadiens, ainsi que de produire tous les autres rapports qu'il jugera nécessaires pour susciter des améliorations dans les résultats et la prestation des soins de santé au Canada.***

terme, il considère important se concentrer pour commencer sur la fonction d'évaluation. Par conséquent, d'après le Comité, l'organisme indépendant d'évaluation doit avoir pour mandat de publier un rapport annuel sur l'état du système de soins de santé et sur l'état de santé des Canadiens, ainsi que de produire tous les autres rapports qu'il jugera nécessaires pour susciter des améliorations dans les résultats et la prestation des soins de santé au Canada. Le Comité estime en outre qu'il conviendrait que cet organisme conseille le gouvernement fédéral sur la façon de dépenser les recettes additionnelles perçues afin de réformer et de renouveler le système de soins de santé (voir le chapitre quatorze).

Pour légitimer de tels rapports auprès de tous les niveaux de gouvernement tout en assurant leur production indépendante et, par conséquent, leur crédibilité aux yeux de la

<sup>17</sup> 9 mai 2002 (*Témoignages*, fascicule n° 55).

<sup>18</sup> *Ibid.*



population canadienne, le Comité recommande l'adoption des structures et des procédures suivantes.

En premier lieu, il faut un nouvel organisme, soit un comité fédéral-provincial-territorial (FPT). Ce comité doit être structuré de façon à ce que ni les représentants fédéraux, ni les représentants provinciaux ou territoriaux ne puissent dominer. Il est donc proposé qu'il soit composé d'un représentant provincial-territorial pour chacune des cinq grandes régions du pays (Atlantique, Québec, Ontario, Prairies, Colombie-Britannique) pour un total de cinq, ainsi que de cinq représentants du gouvernement fédéral. Le mode de sélection des représentants provinciaux-territoriaux reste à déterminer<sup>19</sup>.

Après consultation auprès d'un vaste éventail d'intervenants en santé, le comité FPT nommera alors un commissaire national aux soins de santé. Il choisira également les membres d'un conseil national des soins de santé présidé par le commissaire, en faisant une sélection parmi les candidats proposés par ce dernier. Lors des nominations au conseil, le commissaire sera chargé d'y assurer l'équilibre et de voir à ce que l'ensemble de la population soit représenté. Les conseillers seront nommés en fonction de leur capacité d'avoir une vue globale du système de soins de santé, et non en tant que représentants de groupes d'intérêts particuliers en matière de soins de santé.

Pour que la sélection du commissaire et des membres du conseil ne soit dominée ni par les représentants fédéraux, ni par les représentants provinciaux-territoriaux, toutes les nominations se feront à la majorité des deux tiers. Si le comité FPT compte 10 membres, il faudra sept voix pour confirmer une nomination, ce qui signifie que ni les représentants fédéraux ni les représentants provinciaux-territoriaux ne réussiront à eux seuls à faire élire un des leurs. Cette procédure garantira que les membres du conseil sont indépendants du gouvernement (puisque'ils auront été nommés par le commissaire), mais ils jouiront d'une légitimité suffisante pour donner du poids à leur rapport (puisque'ils auront été nommés par le comité FPT).

Le commissaire sera nommé pour un mandat de cinq ans, qui pourra être reconduit une seule fois. Les membres du conseil seront nommés pour des mandats de trois ans, lesquels pourront aussi être renouvelés une fois. La moitié du conseil sera donc renouvelée tous les trois ans. On considère que huit est un nombre raisonnable de conseillers, soit neuf au total en comptant le commissaire. Leur travail au conseil sera rémunéré adéquatement, mais ne constituera pas un emploi à plein temps. Le commissaire pourra compter sur un effectif d'employés à temps plein.

Le conseil sera responsable en dernière analyse de la publication du rapport annuel et le présentera à chaque ministère de la Santé en demandant qu'il soit déposé devant toutes les législatures, soit fédérale, provinciales et territoriales. Le Comité recommande que tous les ministres de la Santé réagissent officiellement, dans les six mois, au rapport annuel que le conseil national des soins de santé produira chaque année. Le Comité reconnaît qu'il n'est pas possible d'obliger légalement les ministres de la Santé à réagir au rapport annuel mais espère

---

<sup>19</sup> Cette forme de représentation provinciale-territoriale a été utilisée pour le conseil d'administration de la Société canadienne du sang dont la mission est de gérer le système d'approvisionnement en sang et en produits sanguins de toutes les provinces sauf le Québec. Chacune des quatre régions suivantes est représentée par un directeur différent : a) Colombie-Britannique et Yukon; b) Prairies, Territoires du Nord-Ouest et Nunavut; c) Ontario; d) Atlantique.

qu'ils accepteront de le faire, tout comme le gouvernement fédéral est tenu de réagir aux recommandations formulées par les comités de la Chambre des communes dans un délai établi. Une telle procédure fera en sorte que le rapport annuel du conseil soit pris au sérieux. En outre, comme le rapport annuel du conseil sera présenté simultanément au public, celui-ci exercera des pressions supplémentaires sur tous les gouvernements pour qu'ils étudient soigneusement le rapports et ses recommandations et y répondent.

D'après le Comité, le gouvernement fédéral doit faire preuve de leadership et financer le travail du commissaire et du conseil. Ces fonds proviendront du surcroît de recettes dont le Comité recommande la perception au chapitre quinze.

Si le commissaire et le conseil jugent nécessaire d'étendre la portée de leurs travaux, ou si les gouvernements fédéral et provinciaux demandent l'élargissement de leurs fonctions, le financement supplémentaire nécessaire devra être fourni également par les provinces et le gouvernement fédéral et ne pas incomber exclusivement à ce dernier.

Le commissaire sera chargé d'embaucher le personnel professionnel et technique nécessaire pour réaliser le mandat du conseil. Toutefois, le commissaire ne devra pas faire double emploi avec les travaux d'organismes existants. Il devra plutôt collaborer avec l'ICIS, la FCRSS et d'autres organismes fédéraux et provinciaux intéressés, afin de veiller à l'application des méthodes les plus efficaces possible pour recueillir les données et l'information nécessaires afin de produire le rapport annuel (voir le chapitre dix).

D'après le Comité, un conseil national des soins de santé ainsi structuré et présidé par un commissaire aux soins de santé indépendant répond aux quatre conditions décrites précédemment, c'est-à-dire :

- le processus revêt un caractère national et non purement fédéral;
- le commissaire et le conseil sont indépendants du gouvernement, mais leur légitimité est assurée du fait qu'ils sont nommés par des représentants du gouvernement;
- la production d'un rapport annuel est financée par le gouvernement;
- les travaux du commissaire et du conseil prennent appui sur ceux des organismes existants.

En résumé donc, le Comité recommande :

**Qu'un nouveau comité fédéral-provincial-territorial composé de cinq représentants provinciaux-territoriaux et cinq représentants fédéraux soit mis sur pied. Il aura pour mandat de nommer un commissaire national aux soins de santé et les huit autres membres d'un conseil national des soins de santé, choisis parmi les candidats proposés par le commissaire.**

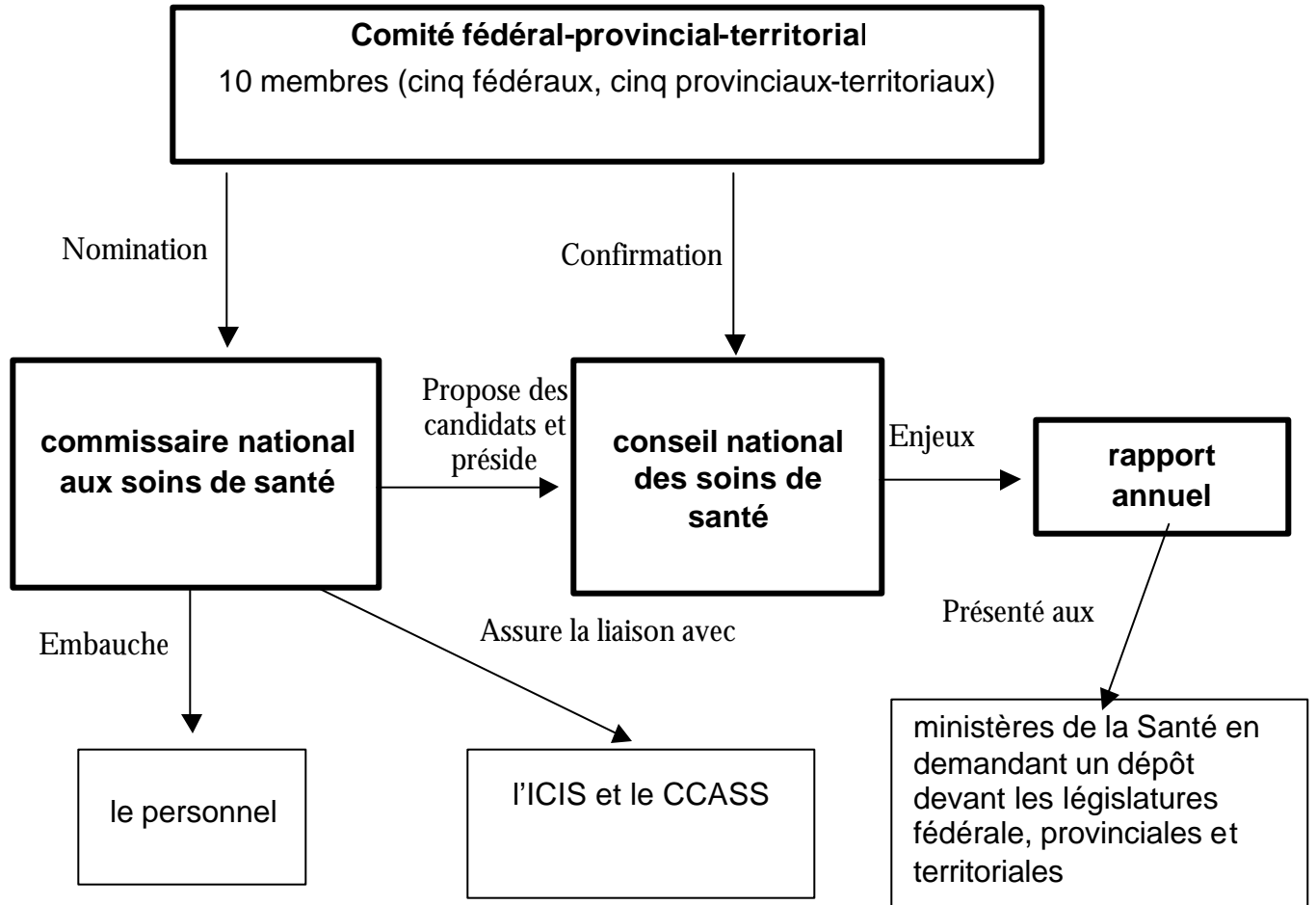
**Que le commissaire national aux soins de santé soit chargé des responsabilités suivantes :**

- **présenter au comité fédéral-provincial-territorial des candidatures pour le conseil national des soins de santé et présider le conseil une fois les nominations ratifiées;**
- **surveiller la production d'un rapport annuel sur l'état du système de soins de santé et sur l'état de santé des Canadiens qui comprendra des constatations et des recommandations pour améliorer la prestation et les résultats des soins de santé au Canada;**
- **travailler en collaboration avec le conseil national des soins de santé afin de conseiller le gouvernement fédéral sur l'affectation des recettes additionnelles perçues afin de réformer et de renouveler le système de soins de santé conformément aux recommandations formulées dans le présent rapport;**
- **embaucher le personnel nécessaire pour réaliser cet objectif et travailler en étroite collaboration avec les organismes indépendants existants afin de réduire au minimum le chevauchement des fonctions.**

**Que le gouvernement fédéral verse 10 millions de dollars par année afin de financer le travail de ce commissaire et de ce conseil en vue de produire un rapport annuel sur l'état du système de soins de santé et sur l'état de santé des Canadiens, ainsi que de conseiller le gouvernement fédéral sur l'affectation du surcroît de recettes perçu afin de réformer et de renouveler le système de soins de santé.**

**Figure 1.1**

**Création proposée d'une charge de commissaire national aux soins de santé  
et d'un conseil national des soins de santé**





# **Partie II :** **Mesures visant l'efficience**

---



## CHAPITRE DEUX

### RESTRUCTURATION ET FINANCEMENT DES HÔPITAUX AU CANADA

À quelques exceptions près, les hôpitaux canadiens existent à titre d'entités sans but lucratif<sup>20</sup>. Ils appartiennent le plus souvent à des sociétés sans but lucratif ou à des organisations religieuses, mais parfois à des administrations municipales ou à des universités. Abstraction faite des hôpitaux psychiatriques, les administrations provinciales et territoriales sont rarement propriétaires d'hôpitaux. Dans tous les cas toutefois, la vaste majorité des revenus des hôpitaux proviennent d'une source unique : le ministère de la Santé provincial ou territorial.

**TABLEAU 2.1**  
**DÉPENSES HOSPITALIÈRES AU CANADA, DE 1986 À 2001**  
**(EN POURCENTAGE DU TOTAL DES DÉPENSES EN SOINS DE SANTÉ)**

	1986	1991	1996	1998	2001
<b>Colombie-Britannique</b>	37,0	34,1	30,4	29,6	28,1
<b>Alberta</b>	39,8	39,1	30,1	29,8	29,9
<b>Saskatchewan</b>	34,3	34,0	26,7	26,3	28,2
<b>Manitoba</b>	39,3	37,8	33,2	32,1	30,0
<b>Ontario</b>	37,9	36,0	33,2	30,6	29,6
<b>Québec</b>	46,9	44,4	38,0	38,4	36,4
<b>Nouveau-Brunswick</b>	42,6	40,9	39,1	36,8	38,1
<b>Nouvelle-Écosse</b>	47,0	46,1	38,7	40,5	37,8
<b>Île-du-Prince-Édouard</b>	38,6	38,9	36,1	35,6	34,7
<b>Terre-Neuve</b>	46,2	47,8	43,4	41,4	39,3
<b>Moyenne au Canada</b>	<b>41,0</b>	<b>39,9</b>	<b>34,9</b>	<b>34,1</b>	<b>33,2</b>

Source : Calculs effectués par la Division de l'économie de la Direction de la recherche parlementaire de la Bibliothèque du Parlement sur la base de données de l'Institut canadien d'information sur la santé, « Dépenses de santé des gouvernements provinciaux et territoriaux par affectation des fonds et par source de financement, 1975-2001 », *Base de données sur les dépenses nationales de santé (BDDNS)*.

Nota : Les hôpitaux comprennent tous les hôpitaux approuvés par les administrations provinciales qui offrent des soins de courte durée, des soins prolongés et des soins de longue durée, des services de réadaptation et de convalescence, des soins psychiatriques, ainsi que les postes de soins infirmiers et les hôpitaux isolés. La « moyenne au Canada » représente la moyenne provinciale non pondérée.

Les administrations provinciales ont versé quelque 32,1 milliards de dollars aux hôpitaux en 2001<sup>21</sup>. Cela représentait presque le tiers des dépenses des administrations provinciales et territoriales en soins de santé. Les hôpitaux constituent la plus grande catégorie de dépenses en soins de santé au Canada. Toutefois, leur part diminue de façon significative. Par

<sup>20</sup> Seulement 5 % des hôpitaux du Canada sont des établissements privés à but lucratif.

<sup>21</sup> Institut canadien d'information sur la santé, « Dépenses de santé des gouvernements provinciaux et territoriaux par affectation des fonds et par source de financement, 1975-2001 », *Base de données sur les dépenses nationales en santé (BDDNS)* ([http://www.cihi.ca/dispPage.jsp?cw\\_page=statistics\\_results\\_source\\_nhex\\_e](http://www.cihi.ca/dispPage.jsp?cw_page=statistics_results_source_nhex_e))



exemple, en 1986, les hôpitaux étaient à l'origine d'environ 41 % en moyenne du total des dépenses provinciales en soins de santé. En 2001, la moyenne est tombée à environ 33 % (voir le tableau 2.1). Cette baisse marquée est imputable principalement aux changements survenus dans les connaissances et les technologies qui permettent de plus en plus d'établir le diagnostic et de dispenser des thérapies en toute sécurité à l'extérieur des hôpitaux et, par conséquent, à la diminution des effectifs et à la restructuration des hôpitaux à l'échelle du pays. Parallèlement à la baisse de la proportion des dépenses de santé consacrées aux soins hospitaliers, on observe une progression du pourcentage qui est affecté aux soins à domicile et à d'autres formes de soins communautaires.

Dans le volume cinq, le Comité a énoncé plusieurs principes relativement au financement des hôpitaux. D'après le principe un, le Canada doit conserver le modèle de la source unique de financement et d'assurance, à savoir le gouvernement<sup>22</sup>. Ensuite, au principe huit, il est proposé que les méthodes actuelles de rémunération des hôpitaux soient remplacées par un financement fondé sur les services dispensés<sup>23</sup>.

Le Comité croit que le financement fondé sur les services dispensés permettra d'atteindre plusieurs objectifs importants, notamment : établir correctement le coût individuel des services hospitaliers; améliorer l'efficacité globale des hôpitaux; permettre au public de comparer le rendement des hôpitaux; améliorer la reddition de comptes des hôpitaux; favoriser la concurrence entre les hôpitaux; réduire les listes d'attente et encourager la mise en place d'autres centres de spécialisation.

***Le Comité croit que le financement fondé sur les services dispensés permettra d'atteindre plusieurs objectifs importants, notamment : établir correctement le coût individuel des services hospitaliers; améliorer l'efficacité globale des hôpitaux; permettre au public de comparer le rendement des hôpitaux; améliorer la reddition de comptes des hôpitaux; favoriser la concurrence entre les hôpitaux; réduire les listes d'attente et encourager la mise en place d'autres centres de spécialisation.***

Le Comité a également reconnu dans le volume cinq que des modifications au modèle de financement fondé seulement sur les services dispensés pourraient être nécessaires pour les hôpitaux d'enseignement, et peut-être pour les très petits hôpitaux communautaires. Nous croyons également que l'administration fédérale devrait envisager de participer aux dépenses d'équipement des hôpitaux, particulièrement dans les centres universitaires des sciences de la santé (ou les hôpitaux d'enseignement) et les hôpitaux situés dans les régions du pays qui connaissent une croissance démographique exceptionnellement élevée.

Ce chapitre présente de l'information sur le financement des hôpitaux au Canada, résume les témoignages reçus sur cette question et réitère le point de vue du Comité sur la valeur du financement fondé sur les services dispensés. Il compte sept sections. À la section 2.1, les méthodes actuelles de financement des hôpitaux au Canada sont présentées et comparées. À la section 2.2, le fonctionnement du financement fondé sur les services dispensés est décrit et l'expérience internationale pertinente est passée en revue. La section 2.3 précise les raisons pour

---

<sup>22</sup> Volume cinq, p. 25-27.

<sup>23</sup> Volume cinq, p. 38-41.

lesquelles le Comité recommande le financement fondé sur les services dispensés et met en relief les diverses difficultés que présente ce mode de rémunération des hôpitaux. Les sections 2.4 et 2.5 traitent des particularités des centres universitaires des sciences de la santé et des hôpitaux communautaires en milieu rural. La section 2.6 porte sur la question des besoins en dépenses d'immobilisations des hôpitaux canadiens. Enfin, la section 2.7 présente le point de vue du Comité sur les avantages comparés des hôpitaux publics et des hôpitaux privés (à but lucratif et sans but lucratif).

## **2.1 Méthodes de financement des hôpitaux au Canada : Avantages et inconvénients<sup>24</sup>**

Les administrations provinciales et territoriales utilisent diverses méthodes pour financer les hôpitaux. Il n'existe pas un modèle unique qui puisse décrire de façon exacte le financement des hôpitaux au Canada. En outre, les provinces et territoires n'utilisent pas une méthode unique de distribution de fonds aux hôpitaux qui sont situés sur leur territoire. La plupart des provinces comptent sur une méthode de financement principale pour affecter la plupart des fonds et sur des méthodes secondaires pour répartir des sommes moins importantes.

Les méthodes de financement des hôpitaux utilisées au Canada, autant les méthodes principales que secondaires, comprennent le financement élément par élément, la discrétion ministérielle, le financement fondé sur la population, le budget global, le financement fondé sur les politiques, le financement fondé sur les établissements, le financement par projet et le financement fondé sur les services. Comme l'indique le tableau 2.2, les administrations provinciales utilisent sept de ces méthodes pour financer les coûts *de fonctionnement* des hôpitaux. Les fonds destinés au financement des *dépenses d'immobilisations* (construction d'hôpitaux, rénovations majeures et achat d'équipement coûteux) sont fournis dans toutes les provinces en suivant une méthode fondée sur les projets.

---

<sup>24</sup> À moins d'indication contraire, les renseignements qui ont servi à la rédaction de cette section sont fondés sur les documents suivants :

Sheila Block, *The Ontario Alternative Budget 2002 – Health Spending in Ontario: Bleeding our Hospitals*, Canadian Centre for Policy Alternatives (Ontario), mai 2002. ([www.policyalternatives.ca](http://www.policyalternatives.ca))

Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et spécialisés (Comité Bédard), *La budgétisation et la performance financière des centres hospitaliers*, Santé et Services sociaux, gouvernement du Québec, 2002. ([www.msss.gouv.qc.ca](http://www.msss.gouv.qc.ca))

Jeffrey C. Lozon et Robert M. Fox, « Academic Health Sciences Centres Laid Bare », *Healthcare Papers*, vol. 2, n° 3, 2002, p. 10-36. (<http://www.longwoods.com/hp/2-3academic/index.html>)

Les Vertesi, *Broken Promises: Why Canadian Medicare is in Trouble and What Can be Done to Save It*, document déposé au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, 2001.

Ian McKillop, George H. Pink et Lina M. Johnson, *The Financial Management of Acute Care in Canada, - A Review of Funding, Performance Monitoring and Reporting Practices*, Institut canadien d'information sur la santé, mars 2001. ([http://www.cihi.ca/dispPage.jsp?cw\\_page=GR\\_32\\_E](http://www.cihi.ca/dispPage.jsp?cw_page=GR_32_E))

Ministère de la Santé du Danemark, *Hospital Funding and Casemix*, septembre 1999. ([http://www.sum.dk/publika/eng/hosp\\_casemix/](http://www.sum.dk/publika/eng/hosp_casemix/))

Nizar Ladak, *Understanding How Ontario Hospitals are Funded: An Introduction*, Joint Policy and Planning Committee, Ontario, mars 1998. ([www.jppc.org](http://www.jppc.org))

**TABLEAU 2.2**  
**HÔPITAUX AU CANADA PAR PROVINCE, 2000**

Province	Nombre d'hôpitaux	Nombre de lits pour 1 000 habitants	Principale méthode de financement	Méthode de financement secondaire
C.-B.	80	3,7	Élément par élément et pop.	Politique
ALB.	115	3,5	Population	Politique
SASK.	71	3,7	Population	Aucun
MAN.	79	4,1	Discrétion ministérielle	Aucun
ONT.	163	2,3	Budget global	Multiple <sup>1</sup>
QC	95	3,0	Budget global	Multiple <sup>2</sup>
N.-B.	30	5,3	Élément par élément et pop.	Aucun
N.-É.	35	3,3	Discrétion ministérielle	Aucun
Î.-P.-E.	7	3,4	Discrétion ministérielle	Aucun
T.-N.	33	4,6	Discrétion ministérielle	Aucun

Source :McKillop et coll. (2001), tableau 1.1 (p. 9), tableau 3.2 (p. 46) et tableau 3.5 (p. 53). Données démographiques de Statistique Canada, CANSIM II, tableau 051-0001.

(1) Fondé sur la politique, fondé sur l'établissement, fondé sur la population et fondé sur les services.

(2) Fondé sur la population et fondé sur la politique.

Nota : Le nombre de lits pour la Nouvelle-Écosse ne concerne que les soins de courte durée.

Deux provinces en particulier (Colombie-Britannique et Nouveau-Brunswick) utilisent une méthode élément par élément. Quatre provinces (Manitoba, Île-du-Prince-Édouard, Nouvelle-Écosse, Terre-Neuve) recourent à la méthode de la discrétion ministérielle. Deux provinces (Alberta et Saskatchewan) suivent une méthode fondée sur la population pour le financement des dépenses de fonctionnement, tandis que deux autres (Ontario et Québec) se servent de budgets globaux. La méthode fondée sur la politique est la plus utilisée comme méthode de financement secondaire dans quatre provinces (Colombie-Britannique, Alberta, Ontario et Québec). Deux provinces (Ontario et Québec) utilisent également une méthode fondée sur la population conjointement avec la méthode principale<sup>25</sup>. Actuellement seule l'Ontario se sert d'une méthode fondée sur les services pour financer certains services hospitaliers.

### **2.1.1 Financement élément par élément**

La budgétisation élément par élément était auparavant la méthode de prédilection pour financer les hôpitaux au Canada. Selon cette méthode des montants précis sont négociés pour des éléments particuliers (ou des intrants), comme les services infirmiers dispensés aux hospitalisés ou les fournitures médicales/chirurgicales. L'affectation budgétaire totale d'un hôpital est simplement la somme des éléments. La Colombie-Britannique et le Nouveau-Brunswick utilisent toujours une budgétisation élément par élément (conjointement avec une méthode fondée sur la population) comme principale méthode de budgétisation.

<sup>25</sup> Bien que la méthode de classification du financement peut être la même pour plusieurs administrations, la façon dont la méthode est mise en oeuvre peut varier.

Dans la budgétisation élément par élément, les ministères provinciaux de la Santé peuvent lier des activités particulières à des objectifs stratégiques au moyen de dépenses directes. Par exemple, une province qui désire promouvoir la chirurgie d'un jour peut augmenter le financement par ligne affecté à cette activité par un facteur plus grand que celui qui est affecté aux soins infirmiers dispensés aux hospitalisés. Plus que certaines autres méthodes, le financement élément par élément permet aux hôpitaux de fonctionner avec une plus haute constance financière.

Toutefois, cette méthode de financement présente plusieurs inconvénients qui ont incité plusieurs ministères provinciaux à y renoncer. D'une part, la méthode élément par élément empêche la réaffectation entre les secteurs, ce qui réduit la souplesse dans la gestion des fonds. D'autre part, elle n'est pas liée au rendement et, par conséquent, n'encourage pas l'efficacité. De plus, la budgétisation élément par élément ne renseigne que sur le coût des intrants et non sur le coût ou la qualité des produits. En outre, l'examen attentif d'un budget élément par élément nécessite un effort notable. Toutefois, l'inconvénient le plus important, c'est que cette méthode a tendance à réduire la capacité des conseils d'administration et des gestionnaires des hôpitaux de lier les activités des hôpitaux aux besoins de la collectivité qu'ils servent.

### **2.1.2 Discrétion ministérielle**

Le financement selon cette méthode est fondé sur les décisions prises par le ministère provincial de la Santé en réponse à des demandes particulières faites par l'hôpital concerné. Elle est la principale méthode de financement au Manitoba, en Nouvelle-Écosse, à l'Île-du-Prince-Édouard et à Terre-Neuve.

La méthode de la discrétion ministérielle est hautement subjective, mais elle présente plusieurs avantages. Du point de vue du gouvernement, elle laisse une très grande latitude; les décisions ministérielles ne sont pas limitées par des formules ou d'autres méthodes de financement prédéterminées.

Le principal inconvénient de cette méthode de financement, c'est qu'elle risque d'être à courte vue, incohérente et ouvertement « politique ». Des changements importants peuvent être et sont apportés au financement à la suite de l'élection d'un nouveau gouvernement ou d'un changement de politique. En outre – et c'est un point essentiel pour le Comité – cette méthode manque certainement de transparence. Les témoins ont répété au Comité qu'il importe de dépolitiser le financement des hôpitaux. Par exemple, Mark Rochon, de l'Association des hôpitaux de l'Ontario, a déclaré :

*Nous devons étudier et promouvoir les mécanismes qui, [...] autant que possible, mettent à l'abri du jeu politique les décisions relatives à la prestation des services de santé<sup>26</sup>.*

### **2.1.3 Financement fondé sur la population**

Pour prévoir la demande de services hospitaliers, le financement fondé sur la population se base sur les renseignements démographiques comme l'âge, le sexe, la situation

---

<sup>26</sup> Mark Rochon, Association des hôpitaux de l'Ontario (56:42).

socioéconomique et les taux de mortalité. Les prévisions de dépenses des hôpitaux (ou des régions régionales de la santé) sont calculées à partir de la demande prévue de certains services de santé et des coûts estimatifs de la prestation de ces services. Actuellement, l'Alberta et la Saskatchewan utilisent principalement cette méthode, tandis que la Colombie-Britannique et le Nouveau-Brunswick se servent de cette méthode conjointement avec la budgétisation élément par élément. Terre-Neuve, la Nouvelle-Écosse, l'Ontario et le Québec envisagent d'adopter une démarche fondée sur la population comme méthode de financement principale.

Le Comité a appris que la méthode fondée sur la population, étant donné qu'elle fait appel à des formules strictement pour répartir les fonds, peut être objective et équitable et répondre aux besoins particuliers des régions et des hôpitaux. En outre, le PDG de la région régionale de la santé de Calgary, Jack Davis, a indiqué au Comité qu'en Alberta le système de financement fondé sur la population avait aidé à dépolitiser l'allocation des ressources<sup>27</sup>.

Cependant, il est complexe et difficile d'appliquer une formule fondée sur la population qui tienne compte de tous les facteurs ayant une incidence sur les soins de santé que reçoit une population. Une telle méthode nécessite de bons systèmes d'information qui sont exigeants en termes de ressources (matériel, bases de données, personnel).

Cette méthode de budgétisation peut devenir trop complexe et créer un manque de transparence lorsque les utilisateurs ne sont pas en mesure de comprendre ou de prédire comment le montant des fonds a été déterminé. D'après Les Vertesi, chef du département de médecine d'urgence du Royal Columbian Hospital (Vancouver), un modèle de financement fondé sur la population ne permet que d'estimer où les ressources en matière de soins de santé seront nécessaires; il n'encourage pas la prestation d'un meilleur service<sup>28</sup>.

### **2.1.4 Financement par budget global**

La méthode du budget global consiste à ajuster les dépenses antérieures (comme l'allocation de base de l'année précédente) pour établir le niveau de financement proposé pour l'année qui vient. Cette méthode met l'accent sur le budget total de l'hôpital plutôt que sur des activités de service individuelles ou des centres de coûts au sein de l'hôpital. Des ajustements peuvent être apportés au montant de base à l'aide d'un multiplicateur (comme le taux d'inflation) ou d'un montant forfaitaire pour établir le niveau de financement pour les périodes futures. Le Québec a mis en place des budgets globaux comme méthode de financement principale en 1994, tandis que l'Ontario utilise cette méthode depuis 1969<sup>29</sup>.

Le Comité a appris que, comme les activités hospitalières changent peu d'année en année, il est plus facile pour les administrations provinciales de simplement répéter l'allocation de l'année précédente en apportant un rajustement pour tenir compte de l'inflation ou de la croissance démographique. Par conséquent, les budgets globaux sont faciles à calculer pour les administrations provinciales et prévisibles pour l'hôpital. Le Dr Vertesi a expliqué que les budgets globaux sont de plus en plus utilisés, surtout parce qu'ils permettent aux

---

<sup>27</sup> Jack Davis, région régionale de la santé de Calgary (53:40).

<sup>28</sup> Les Vertesi (2001), *op. cit.*, p. 117.

<sup>29</sup> Barer, M.L. (1995), « Hospital Financing in Canada », chapitre deux de *Hospital Funding in Seven Countries*, Office of Technology Assessment: U.S. Congress, p. 23.  
(<http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1995/9525/952504.PDF>)

gouvernements de limiter les coûts tout en accordant à la gestion hospitalière une grande discrétion quant à la répartition des fonds entre les diverses activités<sup>30</sup>.

De plus, l'Association canadienne des soins de santé a fait valoir dans son mémoire que les budgets globaux favorisent l'efficacité en permettant aux hôpitaux de distribuer leurs économies d'un secteur d'activité à un autre secteur où un besoin se fait sentir. L'Association est également d'avis que le financement global permet la prestation de soins de santé complets et intégrés qui, à longue échéance, peuvent réduire les coûts d'ensemble des soins de santé<sup>31</sup>.

Malgré ces avantages, de nombreux témoins ont fait valoir que le budget global présente de nombreux inconvénients et, d'après le D<sup>r</sup> Vertesi, ce mode de rémunération des hôpitaux est archaïque<sup>32</sup>. Premièrement, un budget global n'est pas lié aux services qui sont réellement dispensés dans un hôpital. Deuxièmement, toute iniquité qui existe entre les hôpitaux est perpétuée par les budgets globaux. Troisièmement, les budgets globaux n'encouragent pas les hôpitaux à améliorer leur rendement; en effet, ils peuvent perpétuer et récompenser les hôpitaux inefficaces et pénaliser ceux qui sont plus efficaces. Quatrièmement, le financement par budget global ne peut pas s'adapter aux changements de la population et des structures de gestion. Cinquièmement, point peut-être le plus important, les budgets globaux entraînent une perte d'information progressive et permanente quant à ce que coûtent des services hospitaliers donnés. Les hôpitaux ne sont pas encouragés à mesurer de tels coûts unitaires.

Dans l'ensemble, la majorité des témoins ont convenu que, après des années de budgets globaux dans plusieurs provinces, personne ne sait plus le coût de quoi que ce soit et que, par conséquent, il est difficile de savoir, même approximativement, ce que le public reçoit pour son argent dans les hôpitaux. Le Comité est d'avis que la pénurie de données sur les coûts des services hospitaliers va à l'encontre de notre vision de ce que devrait être un secteur de services du XXI<sup>e</sup> siècle, c'est-à-dire un secteur capable de dispenser en temps opportun des soins de haute qualité en se fondant sur une prise de décision bien éclairée et un secteur dont on peut exiger des comptes, les gouvernements (et la population) sachant exactement quels services dans quels hôpitaux sont dispensés de façon efficiente et lesquels ne le sont pas.

***Le Comité est d'avis que la pénurie de données sur les coûts des services hospitaliers va à l'encontre de notre vision de ce que devrait être un secteur de services du XXI<sup>e</sup> siècle, c'est-à-dire un secteur capable de dispenser en temps opportun des soins de haute qualité en se fondant sur une prise de décision bien éclairée et un secteur dont on peut exiger des comptes, les gouvernements (et la population) sachant exactement quels services dans quels hôpitaux sont dispensés de façon efficiente et lesquels ne le sont pas.***

<sup>30</sup> Les Vertesi (2001), *op. cit.*, p. 31.

<sup>31</sup> Association canadienne des soins de santé, mémoire présenté au Comité en juin 2002, p. 6.

<sup>32</sup> Les Vertesi (53:44).

### **2.1.5 Financement fondé sur les politiques**

Selon la méthode fondée sur les politiques, le financement est distribué en fonction d'objectifs stratégiques particuliers. Contrairement à la méthode de la discrétion ministérielle, où le ministère (ou le ministre) de la Santé répond à des demandes de financement individuelles, une décision relative au financement prise au moyen de la méthode fondée sur les politiques a le même effet sur tous les établissements qui dispensent les services encouragés par une politique en particulier (comme un séjour post-partum de 48 heures dans les maisons des naissances).

Du point de vue du gouvernement, cette méthode permet au ministère de s'assurer que les hôpitaux adoptent ses politiques. Néanmoins, de nombreux responsables d'hôpitaux considèrent que ce mode de financement porte atteinte à leurs activités et aux services qu'ils dispensent. En outre, ce n'est pas une source très prévisible de financement puisque la distribution des fonds varie au gré des changements de gouvernement ou de politique.

### **2.1.6 Financement fondé sur les établissements**

Le financement fondé sur les établissements permet d'estimer les coûts de fonctionnement d'après les caractéristiques de l'hôpital, comme la taille, l'importance de l'activité d'enseignement, le taux d'occupation, la distance par rapport à l'établissement tertiaire le plus près (centres de soins spécialisés, etc.). Cette méthode reconnaît que la structure des différents hôpitaux peut influencer le coût de la prestation de services identiques.

Le financement fondé sur les établissements tient compte de la structure organisationnelle (les hôpitaux en milieu rural et les hôpitaux en milieu urbain, les hôpitaux d'enseignement et les hôpitaux communautaires, etc.). Toutefois, cette méthode ne tient pas suffisamment compte des changements démographiques ni de la distribution des maladies. Elle en outre le défaut de ne pas récompenser l'efficacité.

### **2.1.7 Financement par projet**

Le financement par projet permet de distribuer les fonds selon des besoins ponctuels. Cette méthode est souvent utilisée par les administrations provinciales et territoriales pour financer des dépenses d'immobilisations (par exemple la construction d'une aile d'hôpital). Le financement par projet est différent du financement fondé sur les politiques : la première méthode dirige des fonds vers un hôpital en particulier pour un besoin déterminé, tandis que la deuxième répartit une réserve de fonds entre divers hôpitaux pour appliquer une politique gouvernementale.

### **2.1.8 Financement fondé sur les services dispensés**

Le financement fondé sur les services dispensés est souvent appelé financement fondé sur la clientèle dans les ouvrages canadiens et étrangers; les deux expressions sont interchangeables dans le présent chapitre.

Le financement fondé sur la clientèle ou sur les services dispensés dépend du nombre et du type de cas traités (par exemple, le nombre de dialyses, de pontages, de remplacements de genoux ou de hanches) par un hôpital. Il comporte deux éléments essentiels : 1) le classement des malades dans des groupes cliniques qui utilisent des niveaux semblables de

ressources hospitalières et 2) l'utilisation d'un facteur de pondération pour chaque groupe pour estimer l'utilisation relative des ressources. Ces facteurs de pondération témoignent habituellement du coût moyen de traitement des patients de chaque groupe; ils sont utilisés pour établir, par établissement, des indices pour chaque groupe-client qui donnent une idée de la consommation moyenne de ressources, habituellement par rapport à une norme nationale. Plus l'indice est élevé, plus la consommation est grande. Les hôpitaux touchent un paiement pour chaque cas, en fonction du type de service ou d'intervention.

La documentation actuelle sur les méthodes de financement fondées sur la clientèle porte à croire que ces méthodes sont plus équitables que d'autres méthodes. Une caractéristique particulièrement attrayante des méthodes fondées sur la clientèle, c'est qu'elles encouragent l'efficacité et le rendement. Les données internationales indiquent une nette tendance dans le sens de telles méthodes.

Au Canada, l'Ontario a utilisé une méthode de financement fondée sur les services dispensés au cours de l'été 2001 pour distribuer un financement forfaitaire de 95 millions de dollars aux hôpitaux. Le nouveau mode de financement a été mis au point par le Joint Policy and Planning Committee (JPPC). Le JPPC a recommandé que cette méthodologie soit mise en oeuvre graduellement au cours des trois prochaines années et que ses répercussions soient surveillées<sup>33</sup>.

## **2.2 Financement fondé sur les services dispensés : Examen de l'expérience internationale**

### **2.2.1 États-Unis**

Comme au Canada, les hôpitaux constituent le principal poste de dépenses du secteur des soins de santé aux États-Unis. Toutefois, l'organisation du secteur hospitalier américain est l'une des plus complexes au monde, avec un ensemble hétérogène d'hôpitaux, de payeurs et de méthodes de financement<sup>34</sup>. En 1998, 28 % des hôpitaux étaient classés publics (État ou administration locale), 58 % étaient des hôpitaux privés sans but lucratif et 14 % étaient des hôpitaux privés à but lucratif<sup>35</sup>. Les services hospitaliers sont payés par des assureurs privés, par les patients eux-mêmes et par les programmes Medicaid et Medicare<sup>36</sup>.

En 1983, la Health Care Financing Administration (maintenant appelée Centers for Medicare and Medicaid Services) a mis en place un système de paiements préétablis (Prospective Payment System) dans le cadre duquel les hôpitaux sont payés selon une approche fondée sur la clientèle, à savoir sur des groupes homogènes de patients (Diagnostic Related Groups classification, ou DRG). Quarante-deux pour cent des hôpitaux sont maintenant

---

<sup>33</sup> Ontario Joint Policy and Planning Committee, *Hospital Funding Report Using 2000/01 Data*, document de référence n° RD 9-12, octobre 2001 ([www.jppc.org](http://www.jppc.org)).

<sup>34</sup> Mary Laschober et James Vertrees (1995), « Hospital Financing in the United States », chapitre huit de *Hospital Funding in Seven Countries*, Office of Technology Assessment: U.S. Congress, p. 136. (<http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1995/9525/952510.PDF>)

<sup>35</sup> Comité Bédard (2001), p. 38.

<sup>36</sup> Medicaid est un programme conjoint fédéral-État qui assure les soins de santé aux Américains à faible revenu. Medicare est un programme fédéral d'assurance-santé chargé d'assurer les personnes de 65 ans et plus. Ensemble, ces deux programmes assurent environ 30 % de la population américaine.



rémunérés selon ce système<sup>37</sup>. Les taux versés aux hôpitaux sont fondés sur le coût moyen d'un traitement donné et sont indépendants de la durée réelle du séjour à l'hôpital<sup>38</sup>. Les taux peuvent être rajustés à la hausse si un hôpital sert une population comptant un nombre disproportionné de personnes à faible revenu. La plupart des hôpitaux utilisent une méthode commune d'établissement des taux, mais les taux réels sont déterminés par chacun des États. Tous les taux sont revus annuellement par le Congrès des États-Unis. Les compagnies d'assurance privées et les régimes de soins gérés sont libres d'établir leurs propres taux hospitaliers selon les lignes directrices de l'État, le cas échéant.

La vaste gamme de payeurs et de taux de paiement selon la classification DRG a incité les hôpitaux à établir des systèmes d'information détaillés comportant des coûts administratifs élevés. Néanmoins, les DRG permettent de comparer l'utilisation des ressources entre les divers hôpitaux américains et, par conséquent, encouragent la concurrence entre les établissements. Dans son témoignage au Comité, le Dr Duncan Sinclair, ancien président de la Commission de restructuration des services de santé de l'Ontario, a déclaré ce qui suit :

*[...] ce n'est pas une mauvaise idée de payer les hôpitaux sur la base de diagnostics repères et des volumes y afférents, comme cela se fait dans certaines provinces et aussi aux États-Unis. C'est une très bonne idée<sup>39</sup>.*

D'après la documentation, le surclassement des DRG est devenu un problème courant parmi les hôpitaux américains. Ce problème survient lorsque les hôpitaux tentent de maximiser leurs remboursements en choisissant les codes de diagnostic qui entraînent des paiements plus élevés, qui ne sont pas nécessairement justifiés sur le plan médical<sup>40</sup>. Toutefois, le Comité a également reçu des témoignages selon lesquels des vérifications rigoureuses de la catégorie DRG dans laquelle un patient est placé ont permis de réduire le problème de façon substantielle, particulièrement depuis que des firmes de soins de santé et leurs cadres supérieurs ont été reconnus coupables de fraude relativement à cette pratique, affaires qui ont fait couler beaucoup d'encre.

### **2.2.2 Royaume-Uni**

La Grande-Bretagne a remanié de fond en comble son National Health Service (NHS) en 1991. On a alors mis en place un système de concurrence interne en séparant « l'acheteur » du « fournisseur » de services de santé. Les hôpitaux ont été établis comme des « fiduciaires » et devaient négocier des contrats avec les acheteurs – les médecins et les régies régionales de la santé détenteurs d'une enveloppe budgétaire. Pour faciliter l'utilisation de ce modèle, des systèmes fondés sur des DRG ont été mis en place comme méthode de paiement. Toutefois, les réformes du NHS ont été vivement critiquées parce qu'elles ont entraîné des hausses importantes des coûts administratifs.

---

<sup>37</sup> Comité Bédard (2001), p. 38.

<sup>38</sup> Deux listes de taux sont utilisés selon qu'un hôpital est situé dans un secteur urbain (comptant plus d'un millions d'habitants) ou dans secteur non urbain.

<sup>39</sup> Dr Duncan Sinclair (50:12).

<sup>40</sup> PricewaterhouseCoopers Healthcare (2000) « Health Care Fraud and Abuse: DRG Creep », *Issues*. (<http://www.pwcglobal.com/extweb/manissue.nsf/DocID/80FFF2EE2B921FC9852566D7004D5BC>)

D'autres réformes ont eu lieu en 1997 remplaçant par la coopération l'accent qui était mis auparavant sur la concurrence, mais le financement des hôpitaux est resté inchangé. Actuellement, les régies régionales de la santé de district sont financées en fonction de leur population. Les hôpitaux sont ensuite financés par les régies selon les méthodes fondées sur les groupes qui composent la clientèle.

### **2.2.3 France**

Le secteur hospitalier en France se divise en deux. Il y a, d'une part, les hôpitaux publics, responsables d'environ 75 % de l'activité hospitalière et, d'autre part, les hôpitaux privés qui justifient les 25 % restants. Par conséquent, les deux types d'hôpitaux sont rémunérés différemment. Tous les hôpitaux publics reçoivent des budgets d'exploitation globaux qui sont fondés sur le montant de l'année précédente augmenté annuellement par un taux fixé par le gouvernement. Les hôpitaux privés par contre sont rémunérés selon des taux quotidiens pour le nombre de cas traités.

La France envisage actuellement de financer les hôpitaux publics selon une méthode fondée sur la clientèle. Depuis presque 20 ans, le secteur hospitalier français met au point des systèmes d'information fondés sur des groupes homogènes de patients inspirés des DRG. En 1996, le Programme de Médicalisation du Système d'Information (PMSI) permettait de publier pour la première fois des données fiables sur les patients conçues particulièrement pour les conditions françaises. Lorsque les données du PMSI ont été utilisées pour mesurer le rendement des hôpitaux français, elles ont révélé des écarts au niveau du rendement et de la capacité des institutions et des régions. Les analystes français croient que le système actuel fondé sur les budgets globaux perpétue ces disparités.

### **2.2.4 Danemark<sup>41</sup>**

La majorité des hôpitaux du Danemark sont des hôpitaux publics appartenant aux conseils de comté et sont financés par ces derniers. Moins de 1 % du nombre total de lits sont fournis par des hôpitaux privés à but lucratif. Dans la région de Copenhague, les hôpitaux appartenant aux municipalités et financés par ces dernières sont regroupés dans une compagnie publique, la société hospitalière de Copenhague. La société est gérée par un conseil dont les membres sont nommés par les municipalités et le gouvernement national, et qui compte notamment des représentants du secteur privé.

Jusqu'à récemment, l'affectation des ressources aux hôpitaux se faisait principalement au moyen de budgets globaux prospectifs établis par les conseils de comté. Les investissements en immobilisations importants font l'objet d'une décision conjointe des conseils et des hôpitaux de comté et sont financés ponctuellement.

La budgétisation globale s'est avérée efficace pour gérer les dépenses des hôpitaux, mais elle présente peu d'encouragements financiers à améliorer l'efficacité aux points de service et à accroître l'activité en réponse à la demande, de sorte que les listes d'attente pour certaines interventions allongent. En réponse à ces lacunes, des fonds ont été alloués aux comtés en 1997 pour leur permettre de mettre à l'essai un système de financement fondé sur les services

---

<sup>41</sup> Les renseignements contenus dans cette section sont fondés sur un document du European Observatory on Health Care Systems : *Health Care Systems in Transition – Denmark*, 2001. (<http://www.euro.who.int/observatory/TopPage>)

dispensés. Pour encourager davantage le traitement de patients provenant d'autres comtés, le gouvernement national a mis en place en 1999 un système complet de paiement en fonction de DRG à l'égard de ces patients. Les taux ont été fixés à un niveau délibérément élevé pour stimuler la concurrence entre les hôpitaux.

En 2000, le gouvernement national a mis en place officiellement un système qui conjugue budgets globaux et DRG, assortis de cibles d'activité négociées pour chaque hôpital. Selon le nouveau système, chaque hôpital reçoit un budget initial correspondant à 90 % des taux DRG correspondant à la distribution de la clientèle dans la cible d'activité négociée, et les 10 % restants sont affectés en fonction de l'activité réelle. Les hôpitaux qui dispensent plus de traitements que leur cible négociée reçoivent des fonds supplémentaires. Le gouvernement national prévoit encourager des projets-pilotes où plus de 10 % du revenu de l'hôpital est fondé sur l'activité.

### **2.2.5 Norvège<sup>42</sup>**

Moins de 1 % de tous les lits d'hôpital et 5 % des services externes de la Norvège sont privés. Les comtés de la Norvège sont responsables du financement de tous les hôpitaux publics à l'exception d'un hôpital régional que possède et exploite le gouvernement national.

De 1980 à 1997, les hôpitaux norvégiens ont reçu des budgets globaux de leur comté. Bien qu'il ait été convenu que ce système permettait aux gouvernements de maîtriser les coûts et la distribution des ressources, une commission royale nommée en 1987 a révélé que les budgets globaux encourageaient certains hôpitaux à réduire leurs services pour éviter les dépassements de budget.

À la suite des recommandations de la commission, le gouvernement national s'est mis à accorder directement des subventions aux comtés pour le compte des hôpitaux, subventions dont le montant est fondé sur un système de DRG conjugué à des budgets globaux. La réforme mise en place en 1997 devait accroître les services aux patients hospitalisés, augmenter la productivité et réduire les listes d'attente. La nouvelle méthode de paiement a été mise en place graduellement : en 1997, 70 % des subventions aux comtés ont été accordées selon une formule fondée sur les besoins, tandis que les 30 % restants ont été versés en fonction de l'activité hospitalière de l'année précédente, sur la base des taux DRG nationaux normalisés. En 1998, la rémunération était fondée à 55 % sur la formule et à 45 % sur l'activité et, enfin, elle est passée à 50-50 en 1999. Depuis 1999, les chirurgies d'un jour sont financées en fonction du système des DRG. Les hôpitaux d'enseignement reçoivent deux subventions supplémentaires : l'une s'applique à l'enseignement et à la recherche et l'autre sert à financer le traitement de patients dont le cas est complexe et cher.

### **2.2.6 Examen de l'expérience internationale par le comité Bédard**

En juin 2000, le ministère de la Santé du Québec a établi un groupe de travail pour examiner le financement des hôpitaux dans la province. Ce groupe de travail, appelé *Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et spécialisés*, était présidé par Denis Bédard. Le comité Bédard a publié son rapport en décembre 2001. Une

---

<sup>42</sup> Les renseignements contenus dans cette section sont fondés sur un document du European Observatory on Health Care Systems: *Health Care Systems in Transition – Norway*, 2000. (<http://www.euro.who.int/document/e68950.pdf>)

section du rapport portait sur la budgétisation des hôpitaux aux États-Unis, au Royaume-Uni, en France, en Belgique et en Norvège. Le comité Bédard a fait plusieurs observations intéressantes fondées sur cet examen international :

- Les méthodes de financement des hôpitaux fondées sur la population sont largement utilisées et reconnues comme équitables.
- On observe une tendance allant de la budgétisation globale vers des systèmes d'information fondés sur le modèle des DRG.
- Les pays cherchent des mécanismes qui permettent de faire le lien entre la production et la consommation de services hospitaliers.
- On observe une tendance vers des méthodes d'évaluation plus perfectionnées de la performance financière des hôpitaux.
- Les pays mettent davantage l'accent sur la qualité des soins dans la prestation des services hospitaliers.

Dans l'ensemble, le comité Bédard a recommandé d'axer la méthode de budgétisation des hôpitaux du Québec sur les DRG et sur le rendement. Il est reconnu que des rajustements devront être apportés pour les hôpitaux d'enseignement. Le comité Bédard a également recommandé que le ministère de la Santé du Québec s'appuie sur le travail de l'Institut canadien d'information sur la santé (ICIS) plutôt que de tenter d'élaborer sa propre base de données sur les groupes qui composent la clientèle (le travail de l'ICIS est décrit plus en détails ci-dessous).

### **2.3 Justification du financement fondé sur les services dispensés au Canada**

Il est reconnu, autant au Canada qu'à l'étranger, que l'information sur l'utilisation des ressources hospitalières (et autres) est essentielle pour obtenir les résultats escomptés en matière de soins de santé, et ce, de façon efficiente. Dans les méthodes actuelles de financement des hôpitaux au Canada, les décisions ne sont généralement pas fondées sur des données détaillées sur les coûts puisque le financement est dicté par des considérations politiques ou fondé sur les tendances historiques et que, de toute façon, l'information nécessaire n'existe tout simplement pas.

***Le Comité est convaincu de la nécessité de réviser les mécanismes actuels de financement des hôpitaux qui reposent sur les intrants financiers et non sur les résultats finaux, afin de mettre l'accent sur le rendement de la prestation des services hospitaliers.***

Comme il est expliqué à la section 2.1, les provinces ont tenté récemment d'améliorer leur capacité de prise de décisions en mettant en place des modèles de financement, comme le financement fondé sur la population, qui exigent une information meilleure et plus détaillée, mais cette méthode d'établissement des budgets ne permet d'établir que des estimations très approximatives des besoins des hôpitaux. De plus, il n'est pas garanti que chaque hôpital saura exploiter efficacement les ressources qui lui sont ainsi attribuées pour dispenser les services voulus avec les résultats escomptés. Par conséquent, le Comité est convaincu de la nécessité de réviser les mécanismes actuels de financement des hôpitaux qui reposent sur les intrants

financiers et non sur les résultats finaux, afin de mettre l'accent sur le rendement de la prestation des services hospitaliers.

La majorité des témoins que le Comité a entendus souscrivent à l'adoption d'une formule de financement fondée sur les services dispensés. Par exemple, Michael Decter, ancien sous-ministre de la Santé du Manitoba et de l'Ontario et actuellement président du conseil d'administration de l'Institut canadien d'information sur la santé (ICIS), a déclaré :

*À mon avis, la bonne façon de financer les hôpitaux, c'est de les financer pour ce qu'ils font, pour les résultats qu'ils obtiennent<sup>43</sup>.*

Les avantages suivants du financement fondé sur les services dispensés ont été soulignés au Comité :

- Une meilleure information – Des témoins ont dit au Comité que le financement fondé sur les services dispensés exige de meilleurs renseignements, ce que le Comité considère comme essentiel pour mesurer le rendement du système de soins de santé sur les plans de la qualité et des résultats<sup>44</sup>. En fait, le manque de données cruciales entrave actuellement le travail des fournisseurs de soins de santé et celui des décideurs gouvernementaux. Dans son mémoire, l'Association canadienne des soins de santé a indiqué que ses membres croient fermement qu'il faut mettre en place des services d'établissement des coûts et améliorer les mécanismes de mesure du rendement et les repères<sup>45</sup>.
- Transparence et reddition de comptes – Des témoins ont souligné qu'étant donné que la méthode fondée sur les services lie le financement aux services effectivement dispensés, la reddition de comptes relativement à l'utilisation de fonds et la transparence des coûts s'en trouveraient grandement améliorées. Par exemple, dans le mémoire qu'elle a présenté au Comité, l'Association des hôpitaux de l'Ontario a affirmé que la population pourrait ainsi constater le lien direct entre le niveau de financement et le nombre et le type d'interventions pratiquées<sup>46</sup>.
- Équité dans la distribution du financement – Comme il repose sur la formule du « prix multiplié par le volume », le financement fondé sur les services dispensés est, pour beaucoup de témoins, un mécanisme plus équitable que les méthodes actuelles<sup>47</sup>. En outre, en attachant un prix à des services hospitaliers donnés, le financement fondé sur les services permet au bailleur de fonds de susciter des changements en modifiant la valeur attachée à des services particuliers.
- Investissement en capital – Le Dr Les Vertesi a informé le Comité que le système de soins de santé au Canada manque d'investissements dans les

---

<sup>43</sup> Michael Decter (52:12).

<sup>44</sup> Mark Rochon, Association des hôpitaux de l'Ontario (56:43).

<sup>45</sup> Association canadienne des soins de santé, mémoire présenté au Comité en juin 2002, p. 6.

<sup>46</sup> Association des hôpitaux de l'Ontario, mémoire présenté au Comité le 22 mai 2002, p. 36.

<sup>47</sup> Cette opinion a également été exprimée par Ladak (1998), *op. cit.*, p. 3.

immobilisations. Il a imputé cette situation à l'utilisation de budgets globaux qui n'attirent pas de capitaux et a fait valoir que le financement fondé sur les services dispensés, par contre, attire des capitaux extérieurs qui servent à construire des établissements.

- Indépendance – De nombreux témoins croient que le passage au financement fondé sur les services dispensés rendra les hôpitaux plus indépendants du gouvernement. Cela contribuera à dépolitiser la prise de décisions en matière de services hospitaliers. L'Association canadienne des soins de santé n'était pas d'accord avec ce point et elle a fait valoir que le financement fondé sur les services dispensés donnerait lieu très probablement à une plus grande microgestion par les gouvernements et non le contraire<sup>48</sup>. Le Comité ne partage pas ce point de vue. Comme la majorité des témoins, nous croyons que le financement fondé sur les services dispensés confèrera aux hôpitaux la latitude dont ils ont besoin pour affecter les ressources financières et humaines en se fondant sur les pratiques exemplaires, en respectant les considérations d'efficience et en tenant compte des besoins observés au niveau local.
- Réduction de la taille des ministères provinciaux de la Santé – Le Comité estime en effet que le financement fondé sur les services dispensés réduira énormément la microgestion descendante par contrôle et commandement dans les hôpitaux, qui caractérise actuellement tous les ministères provinciaux de la Santé. L'atténuation du rôle que jouent ces ministères entraînera une diminution correspondante du nombre d'employés.
- Prestation des services axée sur le patient – Le D<sup>r</sup> Vertesi a affirmé que lorsque les hôpitaux sont payés en fonction des services effectivement dispensés, les patients deviennent une source de revenu plutôt qu'un fardeau pour l'établissement. Le financement fondé sur les services dispensés encourage les fournisseurs à accroître l'efficacité, le volume des services et la satisfaction des patients, ce qui est nécessaire actuellement<sup>49</sup>.
- Efficience et rendement – Les mécanismes de financement des hôpitaux actuels n'encouragent pas les bons résultats et produisent souvent des résultats pervers sur le plan de la gestion financière. En fait, une étude de 1998 menée par l'Ontario Joint Policy and Planning Committee a révélé que les budgets globaux ne permettent pas d'établir de corrélation entre les déficits/surplus des hôpitaux et le rapport coût-efficacité dans le secteur hospitalier de l'Ontario. De façon plus précise, l'étude a conclu que plusieurs hôpitaux ontariens inefficaces affichent des surplus budgétaires et qu'un nombre encore plus grand d'hôpitaux qui sont considérés comme ayant un bon rapport coût-efficacité accusent des déficits<sup>50</sup>. Le financement fondé sur les services dispensés change la perspective financière puisque les hôpitaux sont payés en fonction de ce qu'ils font réellement plutôt que de toucher tel

---

<sup>48</sup> Association canadienne des soins de santé, mémoire présenté au Comité, p. 7.

<sup>49</sup> Les Vertesi (2001), *op. cit.*, p. 118.

<sup>50</sup> Ontario Joint Policy and Planning Committee Financial Issues Advisory Group (1998), *Understanding the Financial Pressures of Ontario Hospitals: Short and Long Term Solutions*, document n° RD 7-10. ([www.jppc.org](http://www.jppc.org))

ou tel montant qui répond à leurs besoins prévus. Comme c'est le cas aussi ailleurs dans le domaine économique, ceci favorise à la fois l'efficacité et le rendement.

- Structures de propriété multiple – Avec un bailleur de fonds/assureur unique, un financement fondé sur les services dispensés et la séparation de la fonction de financement de la fonction de prestation des services, on aboutit à un système dans lequel la question de la propriété de l'hôpital et sans importance. Le bailleur de fonds/assureur achète les services voulus à l'établissement qui offre le meilleur prix, pourvu que celui-ci réponde aux normes de qualité nécessaires. Il peut s'agir d'un établissement public ou d'un hôpital privé sans but lucratif ou à but lucratif. Comme il l'indique dans le volume cinq, le Comité croit que le patient et le bailleur de fonds/assureur recevront un service égal, peu importe la structure de propriété de l'établissement de soins de santé, pourvu que les deux conditions suivantes soient remplies : 1) tous les établissements d'une province reçoivent le même montant pour une intervention ou un service médical donné; 2) tous les établissements, indépendamment de leur structure de propriété, sont soumis au même système rigoureux et indépendant de contrôle de la qualité et d'évaluation. Le Comité tient à préciser qu'il ne prône pas la création d'établissements privés à but lucratif, mais il ne pense pas pour autant qu'il faille les interdire. D'ailleurs, ils ne sont pas interdits actuellement en vertu de la *Loi canadienne sur la santé*<sup>51</sup>. En fait, nous nous attendons à ce qu'une majorité écrasante des fournisseurs institutionnels continuent d'être des établissements privés sans but lucratif<sup>52</sup>.
- Souplesse pour changer les priorités – Le financement fondé sur les services permet au gouvernement de changer les priorités relativement à des interventions et des services donnés en modifiant le montant qu'il versera pour ces derniers.
- Concurrence pour dispenser les meilleurs services – Le financement fondé sur les services dispensés fera en sorte que des services donnés seront dispensés dans les hôpitaux les plus efficaces et qui dispensent le plus grand nombre (les volumes les plus élevés) de ces services. La concurrence dans la prestation de ces services améliorera la qualité et forcera les hôpitaux qui désirent continuer de fournir des services donnés de le faire de façon encore plus efficace.

***Le Comité tient à préciser qu'il ne prône pas la création d'établissements privés à but lucratif, mais il ne pense pas pour autant qu'il faille les interdire. D'ailleurs, ils ne sont pas interdits actuellement en vertu de la Loi canadienne sur la santé.***

---

<sup>51</sup> Ce point a été énoncé clairement dans une étude effectuée pour la Commission sur l'avenir des soins de santé au Canada par Colleen Flood et Sujit Choudhry, *Consolider les fondements : la modernisation de la Loi canadienne sur la santé*, étude n° 13, août 2002.

<sup>52</sup> Volume cinq, p. 41-42.

- Centres d'excellence – Le Comité a entendu dire à de nombreuses reprises qu'une méthode de financement fondée sur les services dispensés donnerait lieu à l'établissement de centres de spécialisation – ou « centres d'excellence », comme les ont appelés plusieurs témoins – qui effectuent certains traitements ou chirurgies. Un tel changement devrait être encouragé parce qu'il entraîne des économies dans la prestation des services hospitaliers. Cette façon de faire contribuerait à améliorer la qualité des services. En effet, des articles récents parus dans le *New England Journal of Medicine* révèlent que le meilleur indicateur de la qualité est le volume, qu'il s'agisse d'une chirurgie ou d'une procédure de diagnostic. Les avantages de la spécialisation pour certains services hospitaliers ont été reconnus par les premiers ministres des provinces et des territoires, qui ont convenu à leur réunion de janvier 2002 de partager les ressources humaines et le matériel en établissant des « sites d'excellence » pour un certain nombre d'interventions chirurgicales complexes<sup>53</sup>. Le concept des centres d'excellence comporte bien entendu des limites souhaitables, par exemple lorsque l'accessibilité aux services est compromise à cause de l'éloignement de l'hôpital qui offre un service donné. Il importe donc de trouver un juste équilibre entre les principes de qualité et d'efficience (rapport coût-efficacité) et celui d'accessibilité<sup>54</sup>.

La plupart des témoins étaient en faveur de l'adoption d'une formule de financement des hôpitaux fondée sur les services dispensés, mais ont précisé au Comité que la mise en place d'une telle formule présentait plusieurs difficultés de taille, que nous résumons ci-dessous.

### **2.3.1 Pertinence du choix de services**

Le financement fondé sur les services dispensés est attrayant pour les gestionnaires d'hôpitaux parce que ce sont eux qui déterminent quels services seront dispensés par leur établissement et à quels niveaux. Avec cette latitude, les hôpitaux choisiront l'éventail de services qui leur rapportera le plus tout en répondant aux besoins de la population qu'ils servent. Les hôpitaux seront encouragés à se spécialiser dans les services qu'ils sont le plus aptes à dispenser, ceux pour lesquels les taux de rémunération sont les plus attrayants; ils réduiront les services de façon à ne plus dispenser les services à faible volume qui ne sont pas bien subventionnés pour eux. Toutefois, on a mentionné au Comité que dans les petites localités rurales, particulièrement celles qui sont situées un peu loin des grands centres urbains, la priorité pourrait bien être de préserver l'accessibilité à des services donnés. Dans ce cas, les hôpitaux pourront choisir de continuer de fournir les services nécessaires malgré des taux de rémunération relativement faibles. Il est donc essentiel d'examiner ces taux et de les revoir périodiquement. Il est question à la section 2.5 des hôpitaux communautaires de petite taille et situés en milieu rural.

---

<sup>53</sup> Les services hospitaliers spécialisés comprennent, entre autres, la chirurgie cardiaque pédiatrique et la neurochirurgie par scalpel gamma.

<sup>54</sup> Par exemple, dans le cas de la chirurgie coronarienne pédiatrique, compte tenu du petit nombre d'enfants atteints et du fait qu'il s'agit généralement d'opérations réparatrices (par opposition à celles où l'enfant est en danger de mort), il serait avisé de concentrer les interventions dans quelques centres (comme c'est le cas actuellement en Ontario). Par contre, dans le cas des pontages coronariens chez l'adulte par exemple, il ne serait pas logique qu'un seul centre les pratique en Ontario.



### 2.3.2 Services excessifs et surévaluation

Le fait de financer un hôpital en fonction du volume et de la variété des services qu'il dispense incite à améliorer l'efficacité et la productivité. On peut cependant craindre que cette forme de rémunération à l'acte n'entraîne un excès de services et une facturation inappropriée (surclassement des DRG). La question de l'excès de services concerne les médecins rémunérés à l'acte. Le Comité est d'avis que cette méthode de rémunération a porté certains médecins à mettre l'accent sur le nombre de patients qu'ils examinent plutôt que sur la qualité de leurs soins. On a toutefois mentionné au Comité que, même si la possibilité d'un excès de services existe toujours en milieu hospitalier, le problème risque moins de se produire parce que de nombreux «joueurs», notamment les médecins orienteurs et les médecins-conseils et, bien sûr, les patients eux-mêmes, participent à chaque décision prise de dispenser tel service à une personne donnée à l'hôpital.

Voici l'avis du D<sup>r</sup> Duncan Sinclair, ancien membre de la Commission de restructuration des services de santé de l'Ontario :

*Le danger est bien moindre dans le cas des hôpitaux, car ceux-ci ne sont pas les contrôleurs de l'accès. Cependant, il faudrait soigneusement prévenir la collusion entre les contrôleurs d'accès à la fonction hospitalière et les hôpitaux eux-mêmes<sup>55</sup>.*

Certains témoins ont souligné que l'excès de services était particulièrement dangereux dans un système comme le système canadien, où les spécialistes qui travaillent à l'hôpital sont eux aussi rémunérés à l'acte. Toutefois, le problème peut être grandement atténué si les spécialistes des hôpitaux sont assujettis à un régime de rémunération différent, comme c'est le cas en Suède et au Royaume-Uni.

Dans un système de financement fondé sur les services dispensés, les cas sont pondérés selon leur gravité et l'utilisation correspondante des ressources : plus le cas est lourd, plus la rémunération est élevée. Par conséquent, les hôpitaux sont incités à surclasser les cas, c'est-à-dire attribuer le poids le plus élevé à chaque cas, que cette surévaluation soit ou non justifiée.

Michael Decter a soulevé la crainte suivante relativement à une facturation incorrecte ou à une surévaluation en ce qui concerne le financement fondé sur les services dispensés :

*Je crois que le financement fondé sur les services est la bonne marche à suivre, avec quelques réserves. Le système doit être suffisamment bien documenté et les données doivent être suffisamment solides pour ne pas se faire jouer. Vous vous rappellerez qu'une chaîne hospitalière d'importance aux États-Unis – HCA Columbia – a été poursuivie par le gouvernement des États-Unis pour l'avoir trompé de plusieurs millions, sinon milliards de dollars en exagérant les coûts<sup>56</sup>.*

---

<sup>55</sup> Duncan Sinclair (50:12).

<sup>56</sup> Michael Decter (52:13).

Il faudra peut-être envisager la mise en place de vérifications, d'amendes et de pénalités pour prévenir tout abus du système de paiement. Un tarif d'établissement des coûts détaillé et exact permettra également de réduire la tentation du surclassement.

### **2.3.3 Taux, information et données**

Avant de pouvoir mettre en oeuvre un système de financement fondé sur les services, il faut disposer de renseignements et de méthodologies fiables sur l'établissement des coûts selon les cas. Sharon Scholzberg-Gray, présidente et présidente-directrice générale de l'Association canadienne des soins de santé, a informé le Comité que le passage à un système de financement fondé entièrement sur les services dispensés exige que l'on dispose de données sur les coûts qui n'existent pas encore. Dans son mémoire, l'Association a indiqué que :

*Les données sur l'établissement des coûts ont été établies en Ontario et il a fallu 10 ans pour ce faire. Ce fut une initiative importante et nécessaire, mais il reste toujours des questions opérationnelles importantes à régler, notamment : le fait que ce processus ne porte que sur 50 à 60 % des services hospitaliers (il est utile pour les services et les chirurgies en milieu hospitalier, mais pas pour les services externes); la nécessité d'ajouter des « facteurs de complexité » (notamment pour reconnaître la situation unique des hôpitaux éloignés et des hôpitaux d'enseignement); et la tendance à affecter des coûts administratifs à des services qui ne sont pas couverts par le processus, pour donner ainsi l'apparence d'une grande efficacité. Compte tenu des défis continus que présente l'établissement d'un système en Ontario, on peut imaginer l'ampleur et la complexité des questions qui doivent être résolues pour établir un système d'établissement des coûts à l'échelle pancanadienne<sup>57</sup>.*

L'Institut canadien d'information sur la santé (ICIS) est actuellement responsable de la collecte, de l'établissement et de la révision des taux des services. Le travail de collecte des données sur les coûts au Canada a commencé en 1983, année où le Hospital Medical Records Institute a commencé à établir une base de données canadienne sur les groupes qui composent la clientèle, base de données qui est maintenant administrée par l'ICIS. Au moment de la mise en oeuvre, puisqu'il n'y avait pas de données exhaustives sur les coûts associés aux groupes de pathologies, il a fallu importer les données sur les coûts des États-Unis (États de New York et du Maryland) qui ont été adaptées aux durées de séjour canadiennes. Maintenant, l'ICIS utilise les données de certains hôpitaux de l'Alberta et de l'Ontario pour estimer les coefficients de pondération des groupes qui composent la clientèle.

Kevin Empey, directeur financier du University Health Network à Toronto, a souligné qu'un plus grand nombre d'hôpitaux doivent soumettre des données sur les coûts pour que des taux de rémunération exacts puissent être établis. Il a indiqué par exemple qu'en 2000, seulement deux des treize hôpitaux d'enseignement de l'Ontario et trois des soixante-neuf hôpitaux communautaires de cette province, de même qu'une poignée seulement d'hôpitaux de l'Alberta, ont fourni des données sur les coûts pour permettre de fixer les taux des cas canadiens<sup>58</sup>. Pour établir des taux suffisamment détaillés et à jour, il est essentiel que la majorité

---

<sup>57</sup> Association canadienne des soins de santé, mémoire présenté au Comité, p. 7.

<sup>58</sup> Kevin Empey (56:45).

des hôpitaux soient tenus de produire et de soumettre des données sur les coûts. Kevin Empey a également souligné ce qui suit :

*Nous devons adopter un système qui crée un incitatif ou une sanction, de façon à motiver les établissements à fournir des données et à participer à la compilation d'une base de données. Cela permettra d'avoir une meilleure structure et de meilleures données<sup>59</sup>.*

### **2.3.4 Innovation**

Dans son mémoire, l'Association canadienne des soins de santé a fait valoir que le financement fondé sur les services dispensés, qui met l'accent sur la prestation de services au coût le plus bas, découragerait l'innovation, autant en ce qui a trait aux nouvelles interventions qu'à la nouvelle technologie<sup>60</sup>. Cela préoccupe particulièrement les centres universitaires des sciences de la santé et les hôpitaux d'enseignement. Les établissements d'enseignement doivent être en mesure d'essayer de nouveaux traitements hautement spécialisés mais très chers sans avoir à subir les contrecoups d'un système fondé sur des taux. Il est donc important que les méthodes de financement axées sur la clientèle ne créent pas d'effets pervers en décourageant ce type (ou tout autre type) d'innovation. Les préoccupations soulevées relativement aux hôpitaux d'enseignement sont présentées à la section 2.4.

### **2.3.5 Soins de santé complets**

Les membres de l'Association canadienne des soins de santé ont fait remarquer que le financement fondé sur les services dispensés met l'accent sur une forme de soins axée davantage sur les interventions thérapeutiques que sur la prestation de soins complets intégrés. Autrement dit, il ne ferait qu'encourager les fournisseurs de soins à réagir à la maladie au lieu d'adopter une approche plus large qui tient compte notamment de la promotion de la santé et de la prévention de la maladie. Pour l'Association, la formule des budgets globaux favorise la prestation d'un éventail de soins plus vaste que le financement fondé sur les services dispensés. D'ailleurs, Mark Rochon de l'Association des hôpitaux de l'Ontario, qui est en faveur de l'adoption du financement fondé sur les services dispensés, a fait le commentaire suivant :

*Nous devons aussi reconnaître que certains volets du système de santé devraient être financés autrement. Je pense par exemple aux services liés à la promotion de la santé et à la prévention. De même, les services dont on a un besoin permanent tels que les salles d'urgence pourraient faire l'objet d'un financement global<sup>61</sup>.*

### **2.3.6 Escalade des coûts**

D'après l'Association canadienne des soins de santé, c'est exactement ce type de médecine axée sur les interventions thérapeutiques – le type même que favoriserait encore plus le financement fondé sur les services dispensés – qui a fait grimper les coûts :

*L'escalade des coûts qui se produit actuellement dans notre système de santé est presque entièrement imputable aux coûts des « actes » des médecins et aux coûts des*

---

<sup>59</sup> Ibid.

<sup>60</sup> Association canadienne des soins de santé, mémoire présenté au Comité, p. 6.

<sup>61</sup> Mark Rochon, Association des hôpitaux de l'Ontario (56:43).

*médicaments. Le financement fondé sur les services encouragerait la poursuite des pratiques actuelles<sup>62</sup>.*

Le Comité n'est pas de cet avis. Comme nous l'indiquons dans le volume cinq, nous croyons que le financement fondé sur les services dispensés change fondamentalement les incitatifs sous-jacents du système, de sorte que l'escalade des coûts s'estompera à longue échéance<sup>63</sup>.

### **2.3.7 Manque de simplicité**

De nombreux témoins ont indiqué au Comité que si le financement fondé sur les services dispensés était mis en oeuvre, plusieurs rajustements devraient être apportés aux taux afin de tenir compte des établissements comme les hôpitaux d'enseignement et les petits hôpitaux ruraux. Sharon Sholzberg-Gray, présidente-directrice générale de l'Association canadienne des soins de santé, a fait remarquer que même si la grande majorité des témoins appuient le financement fondé sur les services dispensés, ils ont chacun suggéré des modifications qui, ensemble, pourraient donner lieu à un système de financement extrêmement complexe :

*À l'examen de certains témoignages de personnes qui ont comparu devant le comité pour parler du financement fondé sur les services dispensés, nous avons constaté qu'elles [...] souhaitent toutes des formules tenant compte de complications particulières — une formule pour les hôpitaux universitaires, une approche différente pour les régions éloignées et encore une autre pour les établissements qui font ceci ou cela<sup>64</sup>.*

Le Comité a déjà reconnu dans le volume cinq qu'il serait nécessaire d'apporter certains rajustements au financement fondé sur les services dispensés pour tenir compte de la diversité des hôpitaux<sup>65</sup>. Les rajustements à envisager pour les centres d'enseignement et les petits hôpitaux ruraux sont décrits aux sections 2.4 et 2.5.

### **2.3.8 Commentaires du Comité**

Le Comité est d'accord avec les témoins pour dire que, dans la mesure du possible, les hôpitaux doivent être financés en fonction des services particuliers qu'ils offrent. Le financement fondé sur les services dispensés est la meilleure méthode de financement des dépenses de fonctionnement des hôpitaux,

***Le Comité croit que le financement fondé sur les services dispensés présente de nombreux avantages par rapport aux méthodes actuelles de financement des hôpitaux du Canada.***

même s'il faut éventuellement prévoir par ailleurs un financement additionnel distinct pour les dépenses en immobilisations (voir la section 2.6 ci-dessous). Le Comité croit que le financement fondé sur les services dispensés présente de nombreux avantages par rapport aux méthodes actuelles de financement des hôpitaux du Canada. Nous croyons que cette formule sera extrêmement avantageuse pour les Canadiens du point de vue de la qualité et de la promptitude

<sup>62</sup> Association canadienne des soins de santé, mémoire présenté au Comité, p. 6.

<sup>63</sup> Volume cinq, p. 36-39.

<sup>64</sup> Sharon Sholzberg-Gray (60:27).

<sup>65</sup> Volume cinq, p. 38-42.

des soins hospitaliers, et en ce qui concerne la transparence, la reddition de comptes et les rapports sur le rendement.

Le Comité reconnaît que le financement des hôpitaux est une question qui relève principalement des provinces; néanmoins, le gouvernement fédéral pourrait être extrêmement utile pour promouvoir le financement fondé sur les services. Nous croyons que le gouvernement fédéral doit assurer une partie du financement nécessaire pour permettre aux provinces de mettre en oeuvre le financement fondé sur les services dispensés dans le cadre du rôle qu'il doit jouer pour soutenir l'infrastructure des soins de santé et l'infrastructure de la santé (voir le volume quatre)<sup>66</sup>. Ce financement fédéral doit faire partie de l'investissement fédéral dans les systèmes d'information sur la santé, que le Comité recommande au chapitre dix. De plus, le Comité croit que l'ICIS a un rôle d'importance à jouer dans l'estimation des groupes qui composent la clientèle et de leur valeur pondérée, opérations nécessaires à la mise en oeuvre du financement fondé sur les services dispensés.

Si l'on veut que les Canadiens tirent le maximum de notre système de services hospitaliers financés ou assurés par le secteur public, il faut mettre en oeuvre le financement fondé sur les services dispensés. De plus, les hôpitaux aussi ont beaucoup à gagner avec ce mode de financement, qui leur permettra de repérer les pratiques inefficaces et, par conséquent, d'améliorer leur productivité. Ils seront ainsi en mesure de se faire concurrence au niveau de la qualité des soins.

Le Comité reconnaît que la mise en oeuvre d'un financement fondé sur les services dispensés prendra du temps. L'expérience des pays européens témoigne d'ailleurs de l'importance de procéder à petits pas. Aux premiers stades, les hôpitaux seraient rémunérés suivant une méthode mixte combinant le financement fondé sur les services et leur mode de financement habituel. Ensuite, les parts relatives des deux méthodes évolueraient en proportion inverse jusqu'à ce que, au terme de la période de transition, les hôpitaux soient rémunérés intégralement sur la base des services dispensés.

On pourrait par exemple s'inspirer du cas de la Norvège et utiliser initialement 70 % de financement classique et 30 % de financement fondé sur les services dispensés pour ensuite passer à 50 % partout, puis à 70 % de financement fondé sur les services et 30 % de financement classique pour aboutir finalement à un financement intégralement fondé sur les services dispensés.

Par conséquent, le Comité recommande:

**Que l'on adopte pour les hôpitaux un mode de financement fondé sur les services dispensés. Ce mode de financement convient particulièrement aux hôpitaux communautaires situés dans les grands centres urbains. Il faut pour cela :**

- **qu'un nombre suffisant d'hôpitaux soient tenus de soumettre à l'Institut canadien d'information sur la**

---

<sup>66</sup> Volume quatre, p. 103-114.

**santé des données sur leurs tarifs par cas et leurs coûts;**

- **que l'Institut canadien d'information sur la santé établisse, en collaboration avec les provinces et les territoires, une tarification détaillée afin de réduire la tentation du surclassement;**
- **que le gouvernement fédéral octroie à l'Institut canadien d'information sur la santé des crédits permanents qui seront consacrés à la collecte et à l'estimation des données nécessaires à la mise en œuvre du financement fondé sur les services dispensés;**
- **que l'on passe assez rapidement au financement fondé sur les services dispensés. Le Comité estime raisonnable de prévoir une période de transition de cinq ans.**

#### **2.4 Les centres universitaires des sciences de la santé et la complexité des hôpitaux d'enseignement**

Les hôpitaux d'enseignement du Canada font partie des centres universitaires des sciences de la santé (CUSS). Ces derniers sont composés d'un hôpital d'enseignement, d'une faculté de médecine, d'instituts de recherche et d'autres établissements hospitaliers (on trouvera à l'annexe 2.1 la liste des CUSS et de leurs hôpitaux affiliés). Puisque ces centres sont responsables de l'enseignement et de la recherche en plus de dispenser des soins aux patients, ils sont beaucoup plus complexes que les hôpitaux communautaires. Ils offrent également les services les plus modernes et les plus élaborés et traitent les cas complexes les plus difficiles.

***Les CUSS sont composés d'un hôpital d'enseignement, d'une faculté de médecine, d'instituts de recherche et d'autres établissements hospitaliers. Puisque ces centres sont responsables de l'enseignement et de la recherche en plus de dispenser des soins aux patients, ils sont beaucoup plus complexes que les hôpitaux communautaires.***

Les hôpitaux qui comptent un volet d'enseignement et de recherche ont des coûts plus élevés par cas pondéré que les hôpitaux communautaires, parce qu'il leur faut une infrastructure d'enseignement et des programmes spécialisés, et parce qu'ils font une plus grande utilisation des tests diagnostiques et consomment des ressources associées à des traitements plus novateurs et plus audacieux :

*Les études ont révélé que les coûts des interventions dans les centres universitaires des sciences de la santé sont plus élevés que dans les hôpitaux communautaires. Ce n'est pas seulement imputable aux coûts des soins complexes dispensés ou de la mise en place et de l'évaluation de méthodes ultra-modernes. Du fait de la vocation d'enseignement et de recherche de ces établissements, certaines procédures cliniques coûtent plus cher qu'ailleurs*

*et entraînent des séjours plus longs que la moyenne. De plus, un grand centre de recherche et d'enseignement doit assumer des coûts d'installation et de fonctionnement particuliers pour fournir espace et services de soutien au personnel médical<sup>67</sup>.*

Étant donné les volets d'enseignement et de recherche des CUSS, le financement provient traditionnellement d'au moins deux ministères provinciaux et, au sein de ces ministères, d'une variété de sources. Bien qu'il soit presque impossible d'établir avec précision la distinction entre la mission d'enseignement et la mission de prestation de soins de santé, les fonds du gouvernement peuvent être rangés dans trois grandes catégories<sup>68</sup>.

Premièrement, le ministère de l'Éducation verse des subventions d'exploitation aux universités qui, à leur tour, accordent des budgets aux facultés des sciences de la santé qui couvrent notamment les salaires du personnel universitaire. Deuxièmement, le ministère de la Santé octroie aux hôpitaux des budgets pour la formation clinique afin de payer les salaires des stagiaires des études supérieures et une partie des salaires du personnel d'enseignement clinique. Troisièmement, les hôpitaux reçoivent des subventions de fonctionnement des ministères de la Santé provinciaux qui les aident à payer les coûts additionnels des activités de recherche et de formation.

Vu cette complexité, le financement fondé sur les services pose plusieurs problèmes aux CUSS. Les patients des CUSS ont souvent besoin de traitements de pointe dont le coût ne peut pas être saisi avec exactitude dans des systèmes reposant sur des groupes de cas. Par exemple, S. Kevin Empey, vice-président des services financiers et de gestion au University Health Network (Toronto), a déclaré ce qui suit :

*[...] l'implantation d'un stimulateur cardiaque ou d'un défibrillateur relève du même groupe de cas et appelle donc des facteurs de pondération et un financement identiques. Or, cette méthode ne tient aucunement compte de la différence de coût considérable entre les deux appareils. En effet, l'implantation d'un défibrillateur coûte environ deux fois et demie plus cher que l'implantation d'un stimulateur cardiaque<sup>69</sup>.*

Dans le même ordre d'idées, on estime que le coût d'une greffe d'organes multiples est de 213 000 \$ par patient. Or, à cause de la complexité et de la rareté de cette intervention, les taux n'ont pas été déterminés au Canada pour ces greffes, si bien que les hôpitaux d'enseignement de Toronto touchent la même chose que pour une greffe d'organe unique, soit un montant bien inférieur au coût réel de ce type d'intervention<sup>70</sup>. Ainsi, le D<sup>r</sup> Hugh Scott, du Centre de santé de l'Université McGill, a déclaré ceci :

*Si vous voulez mettre en place une formule, elle doit inclure différents facteurs. À chaque fois que nous essayons d'appliquer une formule magique intégrant la chirurgie cardiaque et la psychothérapie, cela pose des problèmes. Si vous ajoutez à cela le contexte de*

---

<sup>67</sup> S. Kevin Empey, mémoire présenté au Comité le 22 mai 2002, p. 12.

<sup>68</sup> Lozon et Fox (2002), *op. cit.*, p. 16.

<sup>69</sup> S. Kevin Empey, mémoire présenté au Comité le 22 mai 2002, p. 6.

<sup>70</sup> S. Kevin Empey, *op. cit.*, p. 10.

*l'enseignement, les problèmes sont encore plus grands. Je recherche la simplicité et l'élégance. Il faut parfois tenir compte de facteurs multiples<sup>71</sup>.*

Le D<sup>r</sup> Jeffrey Lozon, de l'hôpital St. Michael à Toronto, a discuté de la complexité du financement des hôpitaux d'enseignement à cause de la diversité de leurs activités :

*[...] l'outil de financement le mieux approprié est celui qui établit le lien le plus étroit entre la responsabilité du centre de santé universitaire et ses résultats dans le cadre d'un système de financement équitable. Nos centres rendent compte de leurs résultats. Toutefois, il faut bien comprendre que nos résultats vont être différents de ceux d'un hôpital communautaire ou d'un hôpital en milieu rural. Ils seront plus complexes. Nous avons divers niveaux de résultats : les résultats relatifs au savoir que nous créons et les résultats relatifs au nombre d'étudiants qui reçoivent une formation.*

*Il nous serait sans doute difficile d'accepter une formule de financement uniformisé qui part du principe que mon hôpital a aussi peu de frais que celui de Yorkton, en Saskatchewan. Les hôpitaux mènent des activités diverses et leurs frais varient donc en conséquence. Nous devons évaluer nos activités et rendre des comptes au même titre que l'hôpital de Yorkton. Toutefois, cela ne consiste pas simplement à compter des dollars<sup>72</sup>.*

Les spécialistes des CUSS qui ont témoigné devant le Comité appuient la méthode de financement fondé sur les services dispensés pourvu que les groupes de cas et les facteurs de pondération soient établis pour les CUSS et qu'ils soient différents de ceux qui s'appliquent aux hôpitaux communautaires. Une telle méthode de financement pour les CUSS doit tenir compte de divers facteurs, y compris la complexité des interventions et des traitements, l'utilisation de nouvelles technologies et le recours à des médicaments qui coûtent cher. Les spécialistes ont également souligné qu'il importe d'envisager de financer les coûts des infrastructures d'enseignement et de recherche à partir d'une enveloppe distincte assortie de ses propres incitatifs à l'efficience.

Dans un article récent intitulé « Academic Health Sciences Centres Laid Bare », Jeffrey Lozon et Robert Fox ont indiqué que les CUSS devraient être considérés comme une ressource nationale dans le système de soins de santé et que le gouvernement fédéral devrait accroître sa part de financement des CUSS. Les auteurs ont indiqué que les CUSS ne peuvent plus se battre pour solliciter des fonds auprès de divers fournisseurs et se passer du soutien du gouvernement fédéral<sup>73</sup>.

Le Comité est d'accord avec les témoins pour dire que les centres universitaires des sciences de la santé sont différents des hôpitaux communautaires dans la mesure où ils exécutent une vaste gamme d'activités complexes, y compris la prestation de services, l'enseignement et la recherche. Par conséquent, le Comité recommande :

---

<sup>71</sup> D<sup>r</sup> Hugh Scott (63:17).

<sup>72</sup> D<sup>r</sup> Jeffrey Lozon (63:16-17).

<sup>73</sup> Jeffrey Lozon et Robert Fox (2002), « Academic Health Sciences Centres Laid Bare », article vedette dans *Healthcare Papers*, vol. 2, n<sup>o</sup> 3, p. 30.



**Que le financement fondé sur les services dispensés soit complété par une méthode de financement additionnelle qui tiendrait compte des services uniques qu'offrent les centres universitaires des sciences de la santé, y compris l'enseignement et la recherche.**

De plus, le Comité croit fermement que, puisqu'ils jouent un rôle essentiel au chapitre de l'enseignement, de la recherche et de la prestation de soins perfectionnés, les CUSS constituent une ressource nationale dans le système de soins de santé canadien; ils font par ailleurs partie intégrante de l'infrastructure de soins de santé du Canada. Par conséquent, le gouvernement fédéral est particulièrement bien placé pour soutenir les CUSS à l'échelle du pays, en assumant le rôle bien reconnu qu'il joue pour financer l'enseignement postsecondaire, la recherche en santé, la prestation des soins de santé, la technologie relative aux soins de santé et pour planifier les ressources humaines en soins de santé. Ces questions sont traitées dans les chapitres suivants du présent rapport.

**Le Comité croit que les CUSS constituent une ressource nationale dans le système de soins de santé. Le gouvernement fédéral est particulièrement bien placé pour soutenir les CUSS à l'échelle du pays.**

## **2.5 Petits hôpitaux et hôpitaux communautaires ruraux**

Puisque les hôpitaux communautaires de grande taille ou de taille moyenne ne sont pas aux prises avec les mêmes difficultés que les petits hôpitaux et les hôpitaux communautaires ruraux, des problèmes peuvent se présenter si la même formule de financement est appliquée aux deux types d'hôpitaux. Par exemple, Raisa Deber, professeure à l'Université de Toronto, a déclaré ce qui suit :

*[...] sur des problèmes liés au financement axé sur les services, notamment pour les hôpitaux des petites provinces ou collectivités, [...] le financement prévu ne sera pas suffisant pour supporter les dépenses d'infrastructure et d'administration<sup>74</sup>.*

En outre, l'Association canadienne des soins de santé a indiqué dans son mémoire :

*La mise en oeuvre du financement fondé sur les services serait difficile dans les régions rurales et éloignées, particulièrement si un seul fournisseur ou une seule organisation est en mesure de dispenser les services<sup>75</sup>.*

À l'examen des témoignages présentés au Comité, il semblerait que, dans la plupart des cas, les petits hôpitaux et les hôpitaux communautaires en milieu rural sont aux prises avec les problèmes suivants :

---

<sup>74</sup> Raisa Deber (59:12).

<sup>75</sup> Association canadienne des soins de santé, mémoire présenté au Comité, p. 7.

1. Des économies d'échelle limitées – Les petits hôpitaux situés en milieu rural doivent souvent assumer des coûts fixes et des volumes de patients faibles ou imprévisibles. Il en résulte des coûts par patient plus élevés.
2. Isolement – Un hôpital rural est considéré comme isolé si l'hôpital suivant le plus proche est situé à plus de 150 km. Cet hôpital devient alors le principal fournisseur de soins de santé pour l'ensemble de la région géographique. Un hôpital qui est responsable d'une grande région doit être en mesure de dispenser un plus vaste éventail de services malgré des volumes de patients faibles et sporadiques.
3. Éloignement – Par éloignement on entend la distance entre un hôpital et le centre de soins hospitaliers tertiaires le plus proche. Les hôpitaux peuvent être éloignés mais pas isolés (plusieurs hôpitaux peuvent servir une région donnée mais être situés à une distance considérable d'un centre de soins tertiaires). Toutefois, comme les hôpitaux isolés, les hôpitaux éloignés sont souvent aux prises avec des coûts fixes relativement élevés et doivent dispenser une gamme plus vaste de soins que les hôpitaux communautaires situés près des centres de soins tertiaires. Tous ces facteurs font en sorte que les coûts par patient sont plus élevés.
4. Population ayant des besoins spéciaux – De nombreux hôpitaux éloignés doivent s'occuper d'une population ayant des besoins spéciaux, comme les résidents des réserves des Premières nations. L'état de santé de ces personnes est souvent moins bon que la moyenne provinciale, ce qui donne lieu à des taux d'admission plus élevés<sup>76</sup>.

Par conséquent, la formule de financement utilisée pour les grands hôpitaux communautaires ne convient pas toujours aux petits hôpitaux et aux hôpitaux situés en milieu rural. Il est donc important que la formule tienne compte des défis particuliers que doivent relever les petits hôpitaux, les hôpitaux ruraux et les hôpitaux éloignés.

Un certain nombre de témoins ont exprimé leur inquiétude relativement à l'effet qu'aurait sur les services offerts par les petits hôpitaux ou les hôpitaux ruraux une méthode de financement fondée sur les services dispensés. Par exemple, Mark Rochon de l'Association des hôpitaux de l'Ontario a déclaré :

*Nous devons aussi nous assurer que le financement axé sur les services n'encourage pas les fournisseurs de services à cesser d'offrir les services nécessaires aux collectivités. Il faudra établir quels sont les besoins de chaque collectivité et déterminer si les services offerts sont suffisants<sup>77</sup>.*

Le président-directeur général du University Health Network, Kevin Empey, a ajouté :

---

<sup>76</sup> Ladak (1998), *op. cit.*, p. 31.

<sup>77</sup> Mark Rochon (56:43).

*Si on passe d'un financement global à un financement axé sur les services, certains fournisseurs décideront de se spécialiser davantage ou d'abandonner certaines choses. [...] les petites localités ne peuvent se permettre de voir leur hôpital cesser d'offrir certains services tout simplement en raison des tarifs<sup>78</sup>.*

Le Comité convient avec les témoins que, pour préserver l'accès aux services les plus demandés, le financement fondé sur les services dispensés doit être rajusté pour tenir compte de la situation particulière des petits hôpitaux et des hôpitaux communautaires en milieu rural. Par conséquent, le Comité recommande :

**Que, dans l'élaboration d'une formule de rémunération fondée sur les services dispensés pour le financement des hôpitaux communautaires, l'on tienne compte des facteurs suivants :**

- **Isolement : les hôpitaux ruraux ou éloignés doivent assumer des coûts plus élevés que ceux des grands centres urbains.**
- **Taille : les petits hôpitaux assument des coûts plus élevés par cas pondéré que les grands hôpitaux. Un rajustement devrait être apporté pour tenir compte de ces réalités.**

## **2.6 Financement des besoins en immobilisations des hôpitaux canadiens**

Comme nous l'indiquons à la section 2.1.7, les provinces et les territoires utilisent une méthode de financement des dépenses en immobilisations qui diffère de la méthode de financement utilisée relativement aux coûts de fonctionnement en ce qu'elle repose sur les projets et est, de ce fait, bien adaptée aux projets ponctuels à grande échelle.

Le Comité a entendu des témoignages selon lesquels les besoins en immobilisations des hôpitaux canadiens étaient importants. Des témoins ont affirmé que le niveau actuel d'investissement de capital des gouvernements provinciaux et territoriaux et des fondations des hôpitaux n'étaient pas suffisants pour assurer la viabilité du secteur hospitalier au Canada. D'après l'information qui a été présentée au Comité :

- Entre 1982 et 1998, les dépenses publiques réelles par habitant affectées à la construction de nouveaux hôpitaux ont diminué, passant de 50 à 2 \$, soit une baisse de 5,3 % par an<sup>79</sup>.
- Depuis 1998, les dépenses publiques réelles par habitant affectées à l'équipement des hôpitaux reculent de 1,8 % annuellement<sup>80</sup>.

---

<sup>78</sup> S. Kevin Empey (56:45).

<sup>79</sup> Association canadienne des institutions de santé universitaires, mémoire présenté au Comité le 13 juin 2002, p. 17.

<sup>80</sup> *Ibid.*

On observe par conséquent un écart substantiel entre le besoin d'installations et de matériel neufs et la capacité d'un hôpital de financer des immobilisations. Ainsi, plusieurs témoins ont proposé que le gouvernement fédéral accorde un financement. L'Association canadienne des institutions de santé universitaires (ACISU) a indiqué au Comité qu'un précédent existe à cet égard :

*Il convient également de noter qu'il existe un précédent quant au rôle que le gouvernement fédéral joue à cet égard. En 1948, le gouvernement fédéral a lancé un programme de subventions pour la construction d'hôpitaux – qui a été financé à frais partagés avec les provinces<sup>81</sup>.*

L'Association médicale canadienne a affirmé qu'en plus de l'investissement gouvernemental en immobilisations hospitalières, il pourrait être nécessaire que les hôpitaux mettent en place des approches novatrices au financement de l'infrastructure physique. D'après l'Association, il importe d'explorer le concept de partenariats publics-privés pour répondre aux besoins plutôt que de ne compter que sur les subventions gouvernementales<sup>82</sup>.

Bien que le Comité ait soutenu la consolidation du secteur hospitalier qui a eu lieu ces dernières années dans toutes les provinces, nous craignons que le nombre de lits dans certains hôpitaux ne soit pas suffisant pour répondre à la forte augmentation de la demande dans certaines régions où la population croît rapidement. Le problème touche en particulier certaines régions métropolitaines de l'Alberta (Calgary), de la Colombie-Britannique (Abbotsfort, Vancouver), de la Nouvelle-Écosse (Halifax), de l'Ontario (Oshawa, Toronto), du Québec (Montréal, Sherbrooke) et de la Saskatchewan (Saskatoon)<sup>83</sup>.

Par conséquent, le Comité croit que le gouvernement fédéral doit intervenir encore une fois, comme il l'a fait en 1948, pour soutenir financièrement les hôpitaux dont les besoins en immobilisations sont les plus grands. Cette participation fédérale ne toucherait pas le financement courant, mais serait plutôt considérée comme une mesure de « rattrapage ». Il s'agirait de mesures ponctuelles dont le financement pourrait cependant s'étendre sur plusieurs années.

Ainsi, le gouvernement fédéral pourrait par exemple décider de participer de façon ponctuelle au financement de l'expansion de la capacité hospitalière lorsque la croissance démographique d'une région donnée dépasse la moyenne provinciale de 50 %, et ce dans le contexte d'un programme d'investissement à coûts partagés avec la province concernée. Ainsi, armé de la promesse du gouvernement fédéral de verser une somme donnée tous les ans pendant dix ans, l'hôpital pourrait contracter un emprunt auprès d'une institution financière et faire démarrer les travaux.

Le Comité croit également que les gouvernements provinciaux et territoriaux devraient envisager d'établir des partenariats entre le secteur public et l'entreprise privée pour obtenir un investissement additionnel en immobilisations hospitalières. Par conséquent, le Comité recommande :

---

<sup>81</sup> *Ibid.*

<sup>82</sup> Association médicale canadienne, *For Commissioner Romanow: A Prescription for Sustainability*, 6 juin 2002, p. 26.

<sup>83</sup> Selon les données du recensement de 2001 de Statistique Canada. (<http://geodepot2.statcan.ca/Diss/Highlights/>)

**Que le gouvernement fédéral participe aux dépenses en immobilisations associées à l'expansion des hôpitaux situés dans des endroits où la croissance démographique est exceptionnellement élevée, c'est-à-dire les régions où la croissance démographique dépasse la moyenne provinciale de 50% ou plus. Cet apport devrait représenter 50 % du total de l'investissement en immobilisations nécessaire. En tout, le gouvernement fédéral devrait consacrer 1,5 milliard de dollars à cette initiative sur une période de dix ans ou 150 millions de dollars annuellement.**

**Que le gouvernement fédéral devrait encourager les provinces et les territoires à explorer des partenariats entre le secteur public et l'entreprise privée en vue d'obtenir un investissement supplémentaire dans la capacité hospitalière.**

Les investissements en immobilisations préoccupent aussi les CUSS. L'Association canadienne des institutions de santé universitaires a informé le Comité que le remplacement des immeubles est sous-financé et que la dépréciation n'est pas pleinement reconnue par les gouvernements fédéral et provinciaux aux fins du financement. En outre, la plupart des décisions d'investissement de capital semblent fondées sur des réactions à court terme plutôt que sur une perspective de planification à long terme. Dans certains cas, des annexes ou des rénovations sont apportées à des structures médiocres, lorsqu'une reconstruction complète aurait pu être une meilleure décision stratégique.

Bien qu'il y ait des variations dans les exigences en capital des hôpitaux d'enseignement, il est clair qu'un investissement important est nécessaire. Par exemple :

- Le Centre de santé de l'Université de Montréal a évalué les installations existantes (certains des immeubles ont entre 40 et 100 ans) et déterminé qu'il en coûtera 475 millions de dollars pour les rénover.
- Le University Health Network de Toronto estime que ses besoins en immobilisations pour les dix prochaines années s'élèveront à plus de 500 millions de dollars (soit plus de 50 millions de dollars par année).
- La St. John's Healthcare Corporation (Terre-Neuve) a terminé récemment l'aménagement d'un centre de pédiatrie et de réadaptation au coût de 70 millions de dollars.

D'après les renseignements qu'on lui a fournis, le Comité a conclu que le gouvernement fédéral doit consacrer quelque 4 milliards de dollars au renouvellement des infrastructures aux 16 sites des CUSS. Nous estimons que ces fonds fédéraux doivent être fournis en réponse à des demandes formulées par les CUSS eux-mêmes, sous réserve d'un examen par un groupe d'experts spécial indépendants, ce qui, à notre avis, serait gage de transparence.

Plus précisément, les CUSS devront présenter avec leur demande une justification solide des ressources additionnelles réclamées. Le bien-fondé de chaque demande sera évalué par un groupe d'experts indépendants qui fera rapport au ministre de la Santé. De plus, les CUSS retenus feront rapport de leur utilisation des fonds reçus, dans un esprit de reddition de comptes.

Par conséquent, le Comité recommande :

**Que le gouvernement fédéral verse 4 milliards de dollars au cours des dix prochaines années (soit 400 millions de dollars par année) aux centres universitaires des sciences de la santé pour leurs dépenses en immobilisations.**

**Que les centres universitaires des sciences de la santé soient tenus de faire rapport de leur utilisation de ces fonds fédéraux.**

## **2.7 Établissements de soins de santé publics ou privés?**

Dans la section 2.3 ci-dessus, le Comité a fait valoir les nombreux avantages du financement fondé sur les services dispensés, dont l'un a trait à la structure de propriété des établissements de soins de santé. Nous avons dit que le financement fondé sur les services signifie que l'assureur (le gouvernement) serait *neutre* relativement à la structure de propriété d'un hôpital. Le bailleur de fonds/assureur achèterait des services auprès d'un établissement à la condition que ceux-ci respectent les normes de qualité en vigueur. Puisque des établissements comparables recevraient le même montant pour une intervention donnée et puisque tous les établissements seraient soumis avec la même rigueur au contrôle de la qualité et au système d'évaluation, la structure de propriété ne serait pas importante sur le plan de la politique publique. Ainsi, le Comité est *neutre* face à la question de la structure de propriété.

***Le Comité tient à préciser qu'il ne prône pas la création d'établissements privés à but lucratif, mais il ne pense pas pour autant qu'il faille les interdire. D'ailleurs, ils ne sont pas interdits actuellement en vertu de la Loi canadienne sur la santé. En fait, nous nous attendons à ce qu'une majorité écrasante de fournisseurs institutionnels continuent, comme maintenant, d'être des établissements publics ou privés sans but lucratif.***

Comme il l'indique dans le volume cinq, le Comité croit que le patient et le bailleur de fonds/assureur recevront le même service quelle que soit la structure de propriété d'un établissement de soins de santé, pourvu que les deux conditions précitées relativement aux tarifs et à la qualité des services soient respectées. Le Comité tient à préciser qu'il ne prône pas la création d'établissements privés à but lucratif, mais il ne pense pas pour autant qu'il faille les interdire. D'ailleurs, ils ne sont pas interdits actuellement en vertu de la *Loi canadienne sur la santé*. En fait, nous nous attendons à ce qu'une majorité écrasante de

***Le financement fondé sur les services signifie que l'assureur (le gouvernement) serait neutre relativement à la structure de propriété d'un hôpital.***

fournisseurs institutionnels continuent, comme maintenant, d'être des établissements publics ou privés sans but lucratif.

De plus, le Comité tient à souligner qu'il n'y a pas de raison pour que des services de santé financés par le gouvernement et dispensés par des établissements privés à but lucratif donnent lieu à une structure de soins de santé à « deux vitesses », tant que le financement de ces services reste *public* et que les renvois aux établissements continuent d'être déterminés par le besoin clinique. Cette situation relativement aux hôpitaux n'est pas différente de celle que l'on observe dans le cas des soins de santé primaires, de la plupart des services diagnostiques et des chirurgies d'un jour – services qui sont actuellement dispensés au Canada par des entrepreneurs et des établissements privés à but lucratif.

***De plus, le Comité tient à souligner qu'il n'y a pas de raison pour que des services de santé financés par le gouvernement et dispensés par des établissements privés à but lucratif donnent lieu à une structure de soins de santé à « deux vitesses », tant que le financement de ces services reste public et que les renvois aux établissements continuent d'être déterminés par le besoin clinique.***

Dans le système canadien de soins de santé à l'heure actuelle, 5 % seulement des services hospitaliers sont dispensés par des entreprises à but lucratif. Par exemple, l'hôpital Shouldice, en Ontario, est un établissement privé à but lucratif qui a bénéficié d'une clause de droits acquis lorsque le régime d'assurance-maladie est entré en vigueur dans la province. Les établissements comme celui-ci sont réglementés selon un taux de rendement pour réduire le risque de surfacturation aux patients. En Alberta, les établissements privés à but lucratif sont autorisés en vertu d'une loi provinciale (loi 11) à faire concurrence aux hôpitaux publics et privés sans but lucratif pour la prestation d'un ensemble de services chirurgicaux assurés. Le Canada compte également plusieurs établissements de soins de santé à but lucratif (« cliniques privées ») qui soignent uniquement des patients qui paient à titre privé les services qu'ils reçoivent.

Malgré la présence au Canada de ces établissements de soins de santé privés à but lucratif, qui semblent dispenser la même qualité de soins que les établissements sans but lucratif et les établissements publics, un grand débat se poursuit quant au rôle potentiel et à l'incidence des hôpitaux et des cliniques à but lucratif dans le système de soins de santé. Ce débat a culminé en mai 2002 avec la publication de l'étude de méta-analyse de P. J. Devereaux et coll. publiée dans le *Journal de l'Association médicale canadienne*. Les auteurs de cette étude ont remarqué, en se fondant sur l'examen de 15 études par observation, que la propriété privée à but lucratif des hôpitaux comparée à la propriété privée sans but lucratif aux États-Unis entraîne un risque plus élevé de décès pour les patients<sup>84</sup>. Les auteurs en concluent que la recherche de profit inhérente aux hôpitaux privés à but lucratif pouvait entraîner un plafonnement des soins éventuellement fâcheux pour les patients.

*Pourquoi observe-t-on une plus grande mortalité dans les établissements à but lucratif?  
En général, les investisseurs attendent un rendement de 10 à 15 % sur leur*

---

<sup>84</sup> P.J. Devereaux et coll., « A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-for-Profit Hospitals », dans le *Journal de l'Association médicale canadienne*, vol. 166, n° 11, 28 mai 2002, p. 1399-1406.

*investissement. Les administrateurs des hôpitaux privés à but lucratif sont récompensés quand ils atteignent ou dépassent la marge bénéficiaire anticipée. Les établissements privés à but lucratif doivent générer des bénéfices, mais aussi payer des impôts et assumer parfois des coûts élevés associés aux remboursements dont bénéficient les cadres supérieurs, dépenses que n'ont pas les établissements privés sans but lucratif. En conséquence, quand ils servent des groupes de patients pour lesquels les remboursements sont similaires (comme ceux du programme Medicare), les hôpitaux privés à but lucratif doivent relever un défi de taille dans la mesure où ils doivent obtenir les mêmes résultats que les établissements privés sans but lucratif en consacrant cependant moins de ressources au soin des patients<sup>85</sup>.*

Lorsqu'il a témoigné devant le Comité, le D<sup>r</sup> Arnold Relman, ancien rédacteur en chef du *New England Journal of Medicine*, a exprimé des vues analogues :

*J'en suis arrivé à la conclusion que la plupart, sinon la totalité, des problèmes que connaît actuellement le système de soins de santé des États-Unis, et ils sont nombreux, résultent de l'empiètement croissant des entreprises privées à but lucratif et des marchés concurrentiels sur un secteur de notre vie nationale qui est à juste titre du domaine public. Ce n'est pas une coïncidence si aucun autre système de soins de santé dans le monde industrialisé n'est autant commercialisé que le nôtre, et si aucun n'est aussi onéreux, inefficace, inéquitable ou impopulaire. À dire vrai, les seules personnes qui sont satisfaites aux États-Unis de notre système actuel de soins de santé soumis aux lois du marché sont les propriétaires et les investisseurs des industries à but lucratif qui vivent des produits du système<sup>86</sup>.*

Ces résultats font dire à de nombreux observateurs qu'il n'est pas exclu que la même chose se produise au Canada si l'on décide « d'ouvrir la porte » aux hôpitaux privés à but lucratif.

Toutefois, le Comité a appris que l'étude Devereaux et coll. appelait plusieurs réserves. Premièrement, Brian S. Ferguson, professeur au département d'économie de l'Université de Guelph (Ontario), a informé le Comité dans un document récent que les auteurs de la méta-analyse avait exclu de façon systématique les hôpitaux publics de leur étude sous prétexte que les hôpitaux canadiens sont techniquement des établissements privés sans but lucratif se comportant plus ou moins comme les hôpitaux américains privés sans but lucratif<sup>87</sup>. Le professeur Ferguson fait valoir toutefois que les hôpitaux privés sans but lucratif américains ne fonctionnent pas du tout dans le même contexte que les hôpitaux privés sans but lucratif canadiens : ils fonctionnent dans un contexte très concurrentiel et jouissent de beaucoup plus de liberté en ce qui concerne la prise de décisions que leurs homologues canadiens.

---

<sup>85</sup> *Ibid.*, p. 1404-1405.

<sup>86</sup> D<sup>r</sup> Arnold Relman (48:8-9).

<sup>87</sup> Pour plus de renseignements, prière de consulter le document récent de Brian S. Ferguson, *A Comment on the Devereaux et al. Meta-Analysis of Mortality in Private American Hospitals*, ébauche, département d'économie, Université de Guelph (Ontario), juin 2002.



À cet égard, le professeur Ferguson a soutenu que les hôpitaux canadiens privés sans but lucratif ressemblent davantage aux hôpitaux publics américains qu'aux hôpitaux privés sans but lucratif américains. Dans cette optique, l'inclusion des hôpitaux publics dans la méta-analyse de Devereaux et coll. pourrait avoir donné des résultats bien différents<sup>88</sup>. En effet, plusieurs études ont révélé que les hôpitaux publics américains ont une mortalité (de 30 jours rajustée en fonction des risques) plus élevée que les hôpitaux à but lucratif, qui à leur tour affichent une mortalité supérieure à celle des hôpitaux sans but lucratif<sup>89</sup>.

Deuxièmement, le professeur Ferguson a également critiqué la méthodologie utilisée par Devereaux et coll. sur plusieurs points : les paramètres d'inclusion de la documentation pertinente; la sélection des résultats à inclure dans l'analyse; le choix de la variable dépendante; l'omission de certaines variables, etc.<sup>90</sup>. Enfin, dans un autre document, le professeur Ferguson a indiqué qu'il est presque impossible de tirer des conclusions valables sur le rôle potentiel des hôpitaux privés à but lucratif au Canada en se fondant sur des documents américains<sup>91</sup>. Le système de soins de santé aux États-Unis est composé de plusieurs assureurs publics et privés, comprend une multiplicité de fournisseurs publics et privés (sans but lucratif et à but lucratif) et fonctionne dans un contexte hautement concurrentiel, situation qui n'est pas susceptible de se présenter au Canada où prévaut un système d'assureur unique.

De plus, le cadre réglementaire qui régit la prestation des soins hospitaliers aux États-Unis est différent de celui du Canada. C'est pourquoi nous ne pouvons pas transposer simplement au Canada ce qui se passe aux États-Unis. Par exemple, le D<sup>r</sup> Arnold Relman a déclaré au Comité :

*À l'échelle du système américain de soins de santé, on trouve une réglementation insuffisante dans les établissements privés à but lucratif, tout autant que dans les établissements privés sans but lucratif. En ce qui concerne le système à but lucratif, il y a tellement d'argent en jeu dans les services de soins infirmiers, hospitaliers, ambulatoires et pharmaceutiques que les organismes réglementaires ont été persuadés, et j'irais jusqu'à dire intimidés, par l'influence politique et financière des propriétaires.*

*[...] Aux États-Unis, la prestation des soins de santé dans les établissements à but lucratif représente beaucoup d'argent. Cet argent est utilisé en partie pour faire en sorte que la réglementation demeure déficiente. Cela s'applique à la Food and Drug Administration ainsi qu'à toutes sortes d'organismes réglementaires. J'ai travaillé durant six ans pour un organisme public qui étudiait la qualité des soins dans les hôpitaux du Massachusetts. Il est clair pour moi que les considérations financières jouent un rôle important.*

---

<sup>88</sup> *Ibid.*

<sup>89</sup> Ces études sont résumées dans un article de Stephen Duckett, « Does it Matter Who Own Health Facilities », paru dans *Journal of Health Services Research Policy*, vol. 6, n° 1, janvier 2001, p. 59-62.

<sup>90</sup> Brian S. Ferguson, *op. cit.*, juin 2002.

<sup>91</sup> Brian S. Ferguson, « *Profits and the Hospital Sector: What Does the Literature Really Say?* », document de travail sur la santé rédigé pour l'Atlantic Institute for Market Studies, février 2002.

[...] *Si nous avons une réglementation solide, énergique et non discriminatoire, bon nombre des problèmes que j'ai mentionnés en rapport avec la qualité seraient résolus. Malheureusement, il n'en est rien*<sup>92</sup>.

Les observations de Devereaux et coll. sont aussi en contradiction avec celles d'une étude canadienne publiée en 1999 dans le *Journal de l'Association médicale canadienne* sur la qualité des soins dispensés dans des foyers pour personnes âgées autorisés et non autorisés de la région des Cantons de l'Est du Québec<sup>93</sup>. Les auteurs ont par exemple constaté que la qualité des soins dispensés aux résidents âgés dans les grands centres non autorisés de soins de longue durée (privés à but lucratif) étaient analogues à ceux que l'on retrouvait dans les grands centres autorisés de soins de longue durée (privés sans but lucratif)<sup>94</sup>. Ils ont observé en outre que la majorité des établissements étudiés (indépendamment de la taille et du type) fournissaient des soins d'une qualité relativement bonne.

**Compte tenu de l'information disponible, le Comité croit qu'en laissant la Loi canadienne sur la santé en l'état – c'est-à-dire en continuant d'autoriser le fonctionnement des hôpitaux et des cliniques privés à but lucratif dans le cadre du régime d'assurance-santé (puisque la loi n'interdit pas actuellement de tels établissements) – on ne détruira pas, comme certains critiques le soutiennent, le système de soins de santé tel que nous le connaissons maintenant.**

Dans l'ensemble, le Comité reconnaît que les textes sur les coûts comparatifs, la qualité, l'efficacité et le comportement général des établissements privés à but lucratif et privés sans but lucratif ne manquent pas. Nous reconnaissons également que ces études ont abouti à des conclusions mixtes. D'après certaines conclusions, les établissements à but lucratif ont un meilleur rendement, tandis que d'autres ce sont les établissements sans but lucratif ou les hôpitaux privés qui ont un meilleur rendement. D'après d'autres études encore, il n'y a pas de différence entre le rendement des deux types d'établissements.

Compte tenu de l'information disponible, le Comité croit qu'en laissant la *Loi canadienne sur la santé* en l'état – c'est-à-dire en continuant d'autoriser le fonctionnement des hôpitaux et des cliniques privés à but lucratif dans le cadre du régime d'assurance-santé (puisque la loi n'interdit pas actuellement de tels établissements) – on ne détruira pas, comme certains critiques le soutiennent, le système de soins de santé tel que nous le connaissons maintenant. D'autres pays avancés, où prévaut un système de soins de santé organisé public, universel et qui fonctionne parfaitement bien (comme l'Australie, le Danemark, l'Allemagne, les Pays-Bas, la Suède et le Royaume-Uni), permettent déjà l'existence d'hôpitaux à but lucratif; leur présence n'a pas causé de problèmes ou de difficultés insurmontables.

Le débat sur les avantages comparatifs des établissements publics, des établissements privés sans but lucratif et des établissements privés à but lucratif ne semble pas soulever le même type de passion partout. En fait, le Comité a passé en revue les activités du

<sup>92</sup> Dr Arnold Relman (48:23).

<sup>93</sup> Gina Bravo et coll., « Quality of Care in Unlicensed Homes for the Aged in the Eastern Townships of Quebec », *Journal de l'Association médicale canadienne*, vol. 160, n° 10, 18 mai 1999, p. 1441-1445.

<sup>94</sup> L'interprétation des résultats en fonction du type d'établissement (à but lucratif ou sans but lucratif) a été facilitée par l'information fournie par la statisticienne qui a participé à la réalisation de cette étude, Marie-France Dubois.

système de soins de santé de sept pays (voir le volume trois) et a visité trois pays (Danemark, Suède, Royaume-Uni). Il a constaté qu'il n'existe pas d'articles ou d'études dans les pays européens et en Australie qui comparent la qualité ou les résultats des hôpitaux à but lucratif, des hôpitaux sans but lucratif et des hôpitaux publics. Dans ce sens, ce débat est uniquement nord-américain.

Le Comité pense qu'il est peu probable que la mise en oeuvre du financement fondé sur les services dispensés fasse apparaître au Canada des hôpitaux généraux privés à but lucratif comme ceux qui sont exploités en Australie et au Royaume-Uni : dans ces deux pays, l'assurance privée des soins de santé fonctionne en parallèle avec le système public, et les médecins sont autorisés à exercer en pratique privée à grande échelle, un système qui a peu de chance d'être mis en place au Canada. Il est plus probable que les cliniques privées resteront petites et spécialisées. De telles cliniques apparaîtraient dans les créneaux où les bailleurs de fonds croient pouvoir faire un profit en fonctionnant à un coût inférieur à celui du système public, en réalisant des économies d'échelle ou, plus probablement, en profitant de l'économie de la spécialisation. Ces cliniques apporteraient un capital supplémentaire dans le système de soins de santé, puisqu'elles seraient financées par le secteur privé. C'est une autre raison pour laquelle il est peu probable qu'elles deviennent des hôpitaux généraux complètement équipés : le financement privé d'une entreprise si ambitieuse et risquée serait plus difficile à obtenir que le financement de cliniques spécialisées.

Enfin, le Comité est convaincu de la nécessité d'améliorer le rendement des hôpitaux et d'établir des rapports sur les hôpitaux du Canada, peu importe qui en est propriétaire, ce qui pourra se faire grâce au processus d'évaluation indépendant recommandé aux chapitres un et dix du présent volume. L'application d'un processus réglementaire unique à *tous* les établissements de soins de santé contribuerait grandement à assurer la prestation de soins de qualité, où que ce soit.

**Annexe 2.1 :**  
**Centres universitaires des sciences de la santé et hôpitaux et régies  
régionales de la santé affiliés**

**1. Memorial University of Newfoundland and Labrador**

Healthcare Corporation of St. John's  
The General Hospital  
St. Clare's Mercy Hospital  
Janeway Children's Health and Rehabilitation Centre  
Waterford Hospital  
Dr. L.A. Miller Centre  
Dr. Walter Templeman Health Centre

**2. Dalhousie University**

Capital Health  
IWK Health Centre  
Queen Elizabeth Health Sciences Centre II  
Dartmouth General Hospital  
East Coast Forensic Hospital  
Eastern Shore Memorial Hospital  
Hants Community Hospital  
The Nova Scotia Hospital  
Twin Oaks Memorial Hospital  
Musquodoboit Valley Memorial Hospital  
Atlantic Health Sciences Corporation\*  
Saint John Regional Hospital  
St. Joseph's Hospital  
Sussex Health Centre  
Charlotte County Hospital  
Grand Manan Facility

**3. Université Laval**

Centre hospitalier universitaire de Québec  
Hôpital Laval, Institut universitaire de cardiologie et de pneumologie

**4. Université de Sherbrooke**

Centre universitaire de santé de l'Estrie  
Institut universitaire de gériatrie de Sherbrooke

**5. Université de Montréal**

Centre hospitalier de l'Université de Montréal  
Hôpital Sainte-Justine  
Institut de cardiologie de Montréal  
Hôpital Maisonneuve-Rosemont  
Hôpital du Sacré-Coeur de Montréal  
Institut universitaire de gériatrie de Montréal

**6. McGill University**

Centre universitaire de santé McGill  
Hôpital général juif  
Hôpital St. Mary's  
Hôpital Douglas

**7. Université d'Ottawa**

Services de santé des Soeurs de la charité d'Ottawa  
Hôpital d'Ottawa  
Centre hospitalier pour enfants de l'Est de l'Ontario

**8. Queen's University**

Kingston General Hospital  
Hotel Dieu Hospital  
Providence Continuing Care Centre

**9. University of Toronto**

University Health Network  
St. Michael's Hospital  
The Hospital for Sick Children  
Sunnybrook Health Sciences Corporation  
Mount Sinai Hospital  
Toronto Rehabilitation Institute  
Baycrest Centre for Geriatric Care  
Centre for Addiction and Mental Health

**10. McMaster University**

Hamilton Health Sciences Centre  
St. Joseph's Hospital

**11. University of Western Ontario**

London Health Sciences Centre  
St. Joseph's Health Centre

**12. Université du Manitoba**

Office régional de la santé de Winnipeg  
Hôpital général de St-Boniface  
Centre des sciences de la santé

**13. University of Saskatchewan**

Saskatoon District Health Board  
Royal University Hospital  
Saskatoon City Hospital  
St. Paul's Hospital  
Regina Health District  
Regina General Hospital  
Pasqua Hospital

**14. University of Calgary**

Calgary Health Authority  
Rockyview Hospital  
Foothills Hospital  
Alberta Children's Hospital  
Peter Lougheed Hospital

**15. University of Alberta**

Capital Health Authority  
Royal Alexandra Hospital  
University of Alberta Hospital  
Grey Nuns and Misericordia Hospital

**16. University of British Columbia**

Provincial Health Services Authority  
Children's and Women's Health Centre  
BC Cancer Agency  
Vancouver Coastal Health Authority  
Vancouver Hospital and Health Science Centre  
Providence Health Care/St. Paul's Hospital

Source: renseignements fournis par Glenn Brimacombe, directeur général, Association canadienne des institutions de santé universitaires.

\*Le CUSS fait office de principal campus au Nouveau-Brunswick de l'Université Dalhousie et de l'Université Memorial de Terre-Neuve et Labrador.



## CHAPITRE TROIS

### DÉLÉGUER PLUS DE RESPONSABILITÉS AUX RÉGIES RÉGIONALES DE LA SANTÉ

---

Dans le volume cinq de son étude sur les soins de santé, le Comité soutient que la restructuration majeure du système médical et hospitalier entraînerait un transfert de la responsabilité opérationnelle à l'égard des dépenses en soins de santé des gouvernements provinciaux (ministères de la Santé) aux régies régionales de la santé (RRS). En vertu de cette réforme, les RRS seraient responsables de l'achat des services de santé auprès des hôpitaux et des autres établissements de santé au nom de la population qu'elles desservent. Si une province le souhaite, les régies régionales de la santé pourraient également être chargées de l'achat des soins de santé primaires et des médicaments de prescription<sup>95</sup>. Le transfert de la responsabilité de l'ensemble des services de santé des ministères provinciaux de la santé aux RRS faciliterait l'intégration et la coordination du système de prestation des soins de santé et permettrait de vraiment l'orienter vers les besoins des patients.

Ce type de réforme, déjà implantée à différents degrés dans plusieurs pays, notamment en Suède et au Royaume-Uni, est également proposé dans le rapport du Conseil consultatif sur la santé du premier ministre de l'Alberta, le rapport Mazankowski<sup>96</sup>. Le Comité croit que les RRS ont accompli un travail digne de mention en intégrant et en organisant les services de santé pour la population de leur région au cours des dix dernières années et qu'il faudrait leur confier davantage de responsabilités et de pouvoirs en ce qui a trait à la prestation de l'ensemble des services de santé assurés par l'État et/ou à la passation de contrats à cette fin.

***Le Comité croit que les RRS ont accompli un travail digne de mention en intégrant et en organisant les services de santé pour la population de leur région au cours des dix dernières années et qu'il faudrait leur confier davantage de responsabilités et de pouvoirs en ce qui a trait à la prestation de l'ensemble des services de santé assurés par l'État et/ou à la passation de contrats à cette fin.***

Le Comité croit de plus que cette réforme favorisera la concurrence entre les fournisseurs de soins de santé (tant les particuliers que les établissements) et contribuera à la rentabilité et à l'efficacité des services offerts. Comme il le mentionne dans le volume cinq, le Comité sait qu'une réforme de ce genre doit être adaptée à la situation particulière des différentes régions du pays, afin de tenir compte autant du nombre et du type de fournisseurs de soins de santé desservant chaque région que des facteurs comme le mélange urbain/rural. Nous sommes aussi conscients qu'en Ontario, au Yukon et au Nunavut, il faudra recourir à d'autres moyens

---

<sup>95</sup> Volume cinq, pp. 39-40.

<sup>96</sup> Premier's Advisory Council on Health, (le très honorable Don Mazankowski, président), *A Framework for Reform*, décembre 2001 (<http://www.premiersadvisory.com/>).



pour atteindre les objectifs visés par cette réforme puisqu'il n'y a pas de RRS dans ces provinces et territoires<sup>97</sup>.

Ce chapitre est divisé en cinq sections. La section 3.1 brosse un tableau général des régies régionales de la santé au Canada, à savoir leur structure actuelle, leur taille ainsi que l'ampleur de leurs responsabilités et de leur financement. La section 3.2 passe en revue les objectifs ayant mené à leur création et résume les répercussions qu'elles ont eues à la lumière de ces objectifs. La section 3.3 traite des obstacles qui empêchent actuellement les RRS de s'acquitter pleinement de leurs responsabilités. La section 3.4 explique en quoi les réformes axées sur certaines approches de « marché interne » pourraient permettre de remédier à ces préoccupations grâce à la délégation d'un plus grand nombre de responsabilités aux RRS. Enfin, dans la section 3.5, le Comité énonce sa position au sujet du rôle des RRS au Canada.

### **3.1 Un tableau des RRS au Canada<sup>98</sup>**

Au Canada, les régies régionales de la santé jouent un rôle de plus en plus grand dans les soins de santé. Au cours des quatorze dernières années, toutes les provinces, à l'exception de l'Ontario et des Territoires du Nord-Ouest, ont transféré en grande partie la responsabilité de la gestion du réseau de soins de santé des gouvernements provinciaux et territoriaux aux RRS. Au Canada, la définition courante de RRS est la suivante :

*Les régies régionales de la santé sont des organismes de soins de santé autonomes qui sont chargés de l'administration de la santé dans une région géographique clairement définie au sein d'une province ou d'un territoire. Elles sont dotées de conseils de gouvernance nommés ou élus et sont responsables du financement et de la prestation des services de santé communautaires et en établissement de leurs régions<sup>99</sup>.*

Malgré cette définition commune, il existe des différences considérables entre les régies régionales de la santé au Canada quant à l'ampleur, à la structure, à l'étendue des responsabilités et au nombre par province ou territoire. Le tableau 3.1 contient des

---

<sup>97</sup> Le Comité a appris que l'absence de RRS en Ontario s'explique par le fait que la Région du Grand Toronto est trop vaste pour une seule RRS. La solution consisterait peut-être à adopter le modèle de la RRS ailleurs dans la province et à recourir à un autre modèle d'intégration des soins dans la RGT.

<sup>98</sup> À moins d'indication contraire, l'information contenue dans cette section est fondée sur les documents suivants : Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, document de travail, janvier 2002. ([www.oha.com](http://www.oha.com))

Centre de recherche sur la régionalisation. *La régionalisation*. (<http://www.regionalization.org/>)

Ian McKillop, George H. Pink et Lina M. Johnson. *La gestion financière des soins de courte durée au Canada – Revue du financement, du suivi du rendement et des pratiques d'établissement des rapports financiers*, Institut Canadien d'information sur la santé, mars 2001 ([http://www.cihi.ca/dispPage.jsp?cw\\_page=GR\\_32\\_E](http://www.cihi.ca/dispPage.jsp?cw_page=GR_32_E)).

Peggy Leatt, George H. Pink et Michael Guerriere, « Towards a Canadian Model of Integrated Health Care », *HealthCare Papers*, vol. 1, no. 2, printemps 2000, pp. 13-35. (<http://www.longwoods.com/hp/spring00/Papers2.pdf>)

British Columbia Medical Association, *Regionalization of Health Care*, BCMA Policy and Reports, 1997 (<http://www.bcma.org/IssuesPolicy/PolicyPapersReports/regionalization/default.asp>).

Jonathan Lomas, *Regionalization and Devolution: Transforming Health, Reshaping Politics?* Occasional Paper No. 2, octobre 1997. (<http://www.regionalization.org/OP2.pdf>)

Jonathan Lomas, « Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the issues », *Journal de l'Association médicale canadienne*, vol. 156, no 3, février 1997, pp. 371-377. (<http://www.cmaj.ca/>)

<sup>99</sup> Définition fournie par le Centre de recherche sur la régionalisation.

renseignements sur le nombre actuel et la date approximative de constitution des RRS dans chaque province ou territoire ainsi que des données sur la population desservie. La régionalisation des soins de santé est un phénomène récent dans beaucoup de provinces. Alors que certaines provinces ont réduit dernièrement leur nombre de RRS (par exemple, leur nombre est passé de 52 à 6 en Colombie-Britannique), d'autres l'ont augmenté (une de plus au Nouveau-Brunswick et 5 de plus en Nouvelle-Écosse). De plus, la taille de la population desservie par une RRS varie d'une province à l'autre et à l'intérieur de chaque province.

**TABLEAU 3.1**  
**RÉGIES RÉGIONALES DE LA SANTÉ (RRS)**

	<b>DATE DE CONSTITUTION</b>	<b>NOMBRE DE RRS</b>	<b>POPULATION DESSERVIE (plage ou moyenne)</b>
Colombie-Britannique	1997	6	320 000 à 1,3 million
Alberta	1994	17	20 000 à 900 000
Saskatchewan	1992	12	30 000 à 50 000
Manitoba	1997-1998	12	7 000 à 650 000
Ontario	-	-	-
Québec	1989-1992	18	411 000
Nouvelle-Écosse	1996	9	34 000 à 384 000
Nouveau-Brunswick	1992	8	95 000
Île-du-Prince-Édouard	1993-1994	5	143 000
Terre-Neuve	1994	6	143 000
Yukon	-	-	-
Territoires du Nord-Ouest	1988-1997	9	386 à 17 897
Nunavut	-	-	-

Source: Association des hôpitaux de l'Ontario, *Regional Health Authorities in Canada – Lessons for Ontario*, document de travail, janvier 2002 ([www.oha.com](http://www.oha.com)).

Le tableau 3.2 contient l'information sur l'étendue des services dont les RRS sont responsables dans chaque province et territoire. Il existe de grandes variations à ce chapitre. Les services hospitaliers sont communs aux RRS de toutes les provinces. De plus, dans certaines provinces, les services de laboratoire, les soins de longue durée et les soins à domicile sont souvent dispensés par les régies régionales au moyen de contrats avec des organismes du secteur privé sans but lucratif ou à but lucratif. Au Québec, l'intégration d'une vaste gamme de services de santé, de services sociaux et de services de santé mentale par les RRS a été particulièrement réussie. Toutefois, les services médicaux, les médicaments de prescription et les soins aux personnes atteintes de cancer n'ont pas été délégués aux régions et sont toujours administrés et financés principalement par les gouvernements provinciaux et territoriaux.

**TABLEAU 3.2**  
**SERVICES ADMINISTRÉS PAR LES RÉGIES RÉGIONALES DE LA SANTÉ**

	Hôpitaux	Soins de longue durée	Soins à domicile	Santé publique	Santé mentale	Réhab	Services sociaux	Ambulance locale	Labos
C.-B.	X	X	X	X	X	X			X
Alb.	X	X	X	X		X			X
Sask.	X	X	X	X	X	X		X	
Man.	X	X	X	X		X		X	X
Qc	X	X	X	X	X	X	X	X	X
N.-B.	X		X					X	X
N.É.	X			X	X	X			X
Î.-P.É.	X	X	X	X	X	X	X		
T.-N.	X	X	X	X	X	X	X		
T.N.-O.	X	X	X	X		X	X		X

Source : Association des hôpitaux de l'Ontario, *Régional Health Authorities in Canada – Lessons for Ontario*, document de travail, janvier 2002 ([www.oha.com](http://www.oha.com)).

L'étendue du pouvoir décisionnel des régies régionales de la santé varie de l'une à l'autre. Dans certaines provinces, les RRS sont soumises à des restrictions budgétaires et administratives particulières déterminées à l'échelle provinciale (Nouvelle-Écosse, Manitoba, Colombie-Britannique), tandis qu'elles ont plus d'autonomie dans d'autres (Alberta, Saskatchewan, Île-du-Prince-Édouard). Les RRS sont dotées d'un conseil d'administration élu seulement dans quelques provinces (en Alberta, par exemple, les RRS ont des conseils dont les membres sont en partie élus). Et seulement quelques conseils comptent dans leurs rangs des représentants des fournisseurs de soins de santé (comme en Colombie-Britannique). Aucun des conseils n'intervient dans la génération de recettes, mais tous sont chargés de la planification, de l'établissement des priorités, de l'attribution des fonds et de la gestion des services au niveau local en vue d'assurer une meilleure intégration et d'améliorer l'efficacité et l'efficience, dans le respect des lignes directrices de la politique établie par la province. Bon nombre jouent également un rôle direct dans la prestation de services, ou du moins emploient des fournisseurs de soins autres que les médecins.

Les RRS reçoivent des fonds du gouvernement provincial/territorial habituellement au moyen de budgets globaux fondés sur les niveaux de dépenses antérieurs pour la population desservie. Certaines provinces (comme l'Alberta, la Colombie-Britannique et la Saskatchewan) ont opté pour un financement par tête basé sur les besoins de la population (ajusté en fonction des indicateurs de population, d'âge, de sexe et de besoin).

### **3.2 RRS : Objectifs et réalisations<sup>100</sup>**

À l'origine, la délégation aux régions des décisions relatives aux soins de santé comportait de nombreux objectifs. Selon la documentation canadienne, elle visait notamment : 1) la compression des coûts; 2) la satisfaction des besoins locaux; 3) le contrôle local du processus décisionnel; 4) la coordination et l'intégration des services; 5) l'utilisation efficiente des ressources en santé; 6) l'amélioration de l'accès; 7) la gestion efficace; 8) la responsabilisation

<sup>100</sup> Pour de plus amples renseignements, voir par exemple les documents suivants : 1) Robert Bear, « Can Medicare Be Saved? Reflections from Alberta », dans *Healthcare Papers*, été 2000, p. 60-67; 2) le rapport Mazankowski (décembre 2001).

accrue; 9) l'accent sur la santé et le bien-être de la population et 10) de meilleurs résultats cliniques.

Il y a eu peu d'évaluations de la régionalisation pour vérifier dans quelle mesure ces objectifs ont été atteints ou sont maintenant en voie de l'être. Les témoignages recueillis par le Comité et les renseignements fournis dans différents ouvrages donnent toutefois à penser que les RRS ont très bien tiré leur épingle du jeu à de nombreux égards :

- Les RRS fournissent des services moyennant des frais administratifs réduits. Par exemple, l'organisme Capital Health Region situé à Edmonton consacre moins de 3 % de son budget total aux frais administratifs.
- Les RRS axent principalement leur intervention sur la prévention de la maladie et la santé publique et veillent à maintenir des liens interactifs avec leur collectivité.
- Les RRS sont bien placées pour assurer l'intégration et la coordination des établissements offrant des services de santé. Ce faisant, elles arrivent à accroître l'efficacité et la qualité du service de façon durable.
- Une meilleure intégration et coordination au niveau régional permet de recourir aux fournisseurs de soins les moins coûteux, compte tenu des objectifs de chaque consommateur en matière d'accessibilité et de qualité des soins.
- La prestation intégrée des services de santé au niveau des RRS permet de mieux répondre aux demandes de services, par exemple, lorsque les services d'urgence sont débordés, grâce aux réponses intégrées faisant appel à des ressources spécialisées en soins à domicile, soins prolongés et soins actifs.
- Les RRS ont une plus grande marge de manœuvre pour réaffecter et regrouper les services cliniques entre les fournisseurs de soins de santé et les établissements.

Dans l'ensemble, les RRS jouent un rôle crucial dans le système de soins de santé en agissant comme intermédiaires 1) entre le patient et le fournisseur, 2) entre le gouvernement et la population locale et 3) entre l'assureur (gouvernement) et les différents fournisseurs. À cet égard, le Comité voit les RRS comme des intervenants clés dans la réforme du système de soins de santé. Elles offrent de formidables possibilités aux fins du renouvellement et de la viabilité des soins de santé au Canada.

**À cet égard, le Comité voit les RRS comme des intervenants clés dans la réforme du système de soins de santé. Elles offrent de formidables possibilités aux fins du renouvellement et de la viabilité des soins de santé au Canada.**

### **3.3 Obstacles qui empêchent les RRS de mettre pleinement à profit leur potentiel<sup>101</sup>**

Au cours de son étude, le Comité a appris qu'un certain nombre d'obstacles empêchaient actuellement les RRS de mettre pleinement à profit leur potentiel. Ils sont résumés ci-dessous :

- Même s'il incombe aux RRS d'offrir des services de santé en fonction des besoins de leur population, leurs budgets sont, dans certaines provinces, presque entièrement déterminés par le gouvernement, tout comme leurs objectifs de rendement. Dans ces provinces, les RRS disposent de peu d'options si elles ne peuvent répondre aux besoins de leurs citoyens en matière de santé avec les ressources financières à leur disposition. Des observateurs ont fait remarquer que les conseils des RRS doivent consacrer une grande partie de leur énergie à exercer des pressions sur la province pour obtenir plus de financement. Ils croient qu'il serait préférable d'investir ces efforts dans l'établissement de leurs propres priorités et dans la réalisation de leurs propres objectifs plutôt que dans l'adoption de mesures visant à satisfaire aux priorités et aux objectifs qui leur sont imposés par le gouvernement.
- Il existe des faiblesses dans la planification des ressources et l'établissement des budgets par les RRS, ainsi que des écarts dans les rapports de rendement. Actuellement, les RRS sont tenues de présenter des plans d'activités et des budgets à la province. Dans certains cas, cependant, il s'agit de plans très généraux. Il n'y a pas d'objectifs précis établis et acceptés par les deux parties, et les budgets s'apparentent plus à des lignes directrices et ne fixent aucune limite officielle quant aux montants qui peuvent être dépensés et à quelles fins. Certains analystes ont proposé de préciser dans les accords avec le gouvernement provincial ce qui arrive quand les RRS ne parviennent pas à respecter leur budget ou n'atteignent pas leurs objectifs de rendement. Cette obligation contribuerait grandement à accroître la transparence et la responsabilisation.
- Un exemple utile de la façon dont l'établissement d'objectifs peut être mis en pratique a été porté à l'attention du Comité. Le ministère de la Santé et du Bien-être de l'Alberta, de concert avec les organismes Capital Health des régions d'Edmonton et de Calgary, fixe annuellement des objectifs de volume pour ce qui est des services dispensés dans l'ensemble de la province (comme les transplantations d'organes, les chirurgies à cœur ouvert, les soins aux accidentés graves et aux grands brûlés et les neurochirurgies complexes). Ces objectifs sont établis en fonction de l'état de santé, de l'incidence des conditions sanitaires et des données conjoncturelles. La capacité de ces deux

---

<sup>101</sup> À moins d'indication contraire, l'information présentée dans cette section est fondée sur les documents suivants : Le rapport Mazankowski (décembre 2001).

Glenn G. Brimacombe et Lorraine Pigeon, *A Review of the Funding Flows of Regional Health Authorities in British Columbia*, The Conference Board of Canada, 2001.

Cam Donaldson, Gillian Currie et Craig Mitton, "Integrating Canada's Disintegrated Health Care System – Lessons from Abroad", *C.D. Howe Institute Commentary*, avril 2001. ([www.cdhowe.org](http://www.cdhowe.org))

RRS albertaines d'atteindre les objectifs fixés et le degré d'efficacité des soins qui en découle font l'objet d'un suivi annuel.

- Même si la majorité des décisions en matière de soins de santé relèvent des médecins, la rémunération de ces derniers est indépendante des RRS. À titre d'exemple, lorsqu'un médecin demande un test de laboratoire ou un rayon-X, c'est la RRS qui assume le fardeau financier, non le médecin. Voici ce que David Kelly, ancien sous-ministre adjoint de la Santé en Alberta et en Colombie-Britannique, avait à dire au Comité à ce sujet :

*En place depuis près de dix ans dans l'ouest du Canada, les régions sanitaires ont un mandat et des ressources pour fournir les services de santé payés par les fonds publics. Cependant, jusqu'ici on ne leur a pratiquement pas délégué de responsabilités relatives à la prestation de services médicaux. La rémunération des médecins demeure une responsabilité des ministères de la Santé, qui négocient des contrats provinciaux avec les associations de médecins. À ce jour, ces contrats, à mon avis, ont bien peu contribué à l'intégration des services médicaux aux services de santé régionaux ou à la promotion de la réforme des soins primaires. La décision prise par l'Alberta en 1994 constitue une exception remarquable. Cette province a transféré aux régions sanitaires la responsabilité et les ressources pour la prestation de tous les services de laboratoire, tant ceux des hôpitaux que des laboratoires privés. Cette décision, qui a suscité le transfert d'environ 10 % du budget des médecins aux régions, a produit des économies substantielles et un service de laboratoire intégré à l'échelle régionale. Les rapports Fyke et Mazankowski recommandent qu'au moins une partie de la responsabilité pour le paiement des services médicaux soit transférée aux régions (...) <sup>102</sup>.*

La situation pourrait être considérablement améliorée si le coût des services médicaux était inclus dans le budget des RRS plutôt que ce soit les gouvernements provinciaux et territoriaux qui assument séparément la rémunération des médecins. Plus important encore peut-être, le transfert de la pharmacothérapie et des soins de santé primaires au budget des RRS permettrait, du point de vue des patients, la pleine intégration du système (c'est-à-dire la mise en place d'un « système homogène »).

*(...) le transfert aux régies régionales a probablement réduit certains problèmes de manque de coordination des soins entre les organismes mais il n'est pas certain qu'il a amélioré l'intégration des nombreux processus de soins aux patients. Les composantes essentielles des soins intégrés ont été exclues du mandat des régies régionales – les médicaments et les soins médicaux étant les plus importantes. Sans responsabilité à l'égard des médecins et des produits pharmaceutiques, une régie régionale de la santé ne peut pas fournir des soins de santé intégrés <sup>103</sup>.*

À la lumière de ce fait, le Comité croit que l'attribution de responsabilités accrues en matière de prise de décisions concernant l'ensemble des services de santé et en matière de planification ainsi que l'exercice d'un plus grand contrôle sur l'attribution des ressources

---

<sup>102</sup> David Kelly, mémoire au Comité, pp. 7-8.

<sup>103</sup> Peggy Leatt *et coll.* (printemps 2000), p. 18.

faciliteraient l'intégration des services de santé. Or, ce sont toutes là des responsabilités que les RRS sont en mesure d'assumer dans le système de soins de santé financé par l'État, maintenant et dans l'avenir.

Cela exige que les gouvernements renoncent aux approches « descendantes » et privilégient plutôt le transfert à l'échelon régional de la responsabilité de la gestion et de la régie des soins de santé. Le rôle du gouvernement devrait se limiter à assurer la régie globale du système, à établir les politiques en matière de santé de la population, à négocier des plans stratégiques et des budgets et à financer les RRS pour atteindre ces objectifs.

***Le Comité croit que l'attribution de responsabilités accrues en matière de prise de décisions concernant l'ensemble des services de santé et en matière de planification ainsi que l'exercice d'un plus grand contrôle sur l'attribution des ressources faciliteraient l'intégration des services de santé. Or, ce sont toutes là des responsabilités que les RRS sont en mesure d'assumer dans le système de soins de santé financé par l'État, maintenant et dans l'avenir.***

L'adoption d'une politique fondée sur certains principes d'une approche de « marché interne » est une forme possible de réforme qui faciliterait la délégation d'un plus grand nombre de responsabilités aux RRS, dépolitiserait les décisions relatives aux soins de santé, accroîtrait la concurrence et l'éventail de choix offerts dans le secteur des soins de santé et ferait en sorte que les Canadiens aient accès à un système de soins de santé véritablement homogène.

### **3.4 Les RRS et le potentiel des marchés internes<sup>104</sup>**

Le concept de « marchés internes » peut paraître complexe, mais il réfère simplement à l'introduction des mécanismes de marché dans le système public de soins de santé. Des stimulants de ce type auraient une incidence sur les aspects *prestation* et *attribution* des systèmes de soins de santé, mais non sur l'aspect *financement*. Les réformes de type « marché interne » visent à accroître l'efficacité de la prestation des soins et des mécanismes d'attribution servant à répartir les recettes entre les fournisseurs de soins et les établissements.

Les marchés sont « internes » parce qu'ils supposent l'intervention, tant du côté de la demande que de l'offre, d'entités faisant partie du système public de soins de santé lui-même. Du côté de la demande, il y a un acheteur public qui agit à titre d'agent représentant la population de patients desservis. Du côté de l'offre, se trouve une autre entité qui offre le service. Dans ce contexte, l'acheteur serait la RRS, tandis que le fournisseur pourrait être un hôpital, un spécialiste, un laboratoire, un médecin de soins primaires, etc.

Des observateurs ont fait remarquer que le système canadien de soins de santé comporte déjà un certain nombre de caractéristiques propres aux marchés internes. Par exemple,

---

<sup>104</sup> L'information fournie dans cette section est fondée sur les documents suivants : European Observatory on Health Care Systems, *Health Care Systems in Eight Countries: Trends and Challenges*, avril 2002. (<http://www.euro.who.int/observatory/TopPage>)  
Volume trois, chapitre quatre et cinq, janvier 2002.  
Volume cinq, avril 2002.

dans la plupart des provinces, les RRS achètent les services hospitaliers au nom de leurs citoyens ou allouent des contrats à cet égard. Au préalable, un budget global ou un financement basé sur la population est négocié séparément entre le gouvernement et chaque RRS.

Au Canada, les gouvernements n'ont pas encore 1) délégué aux RRS, de façon claire et explicite, la responsabilité de l'achat de l'ensemble des services de santé, et n'ont pas non plus 2) établi de cadre de résultats cohérent qui permettrait l'établissement d'une concurrence équitable entre différents fournisseurs pour l'obtention de financement, et serait assorti de responsabilités claires énoncées dans un modèle-type de contrat d'affaires ou de rendement. Dans certains cas, les RRS se contentent actuellement de transmettre aux hôpitaux le budget reçu de leur gouvernement provincial ou territorial et fondé sur les niveaux de dépenses antérieurs. En outre, aucune RRS au Canada n'est responsable du budget des médecins (spécialistes rattachés à un hôpital et ou médecins de soins primaires) ni des dépenses en médicaments de prescription. En conséquence, il ne peut y avoir de concurrence (ni d'orientation de marché) entre les fournisseurs et les établissements de soins de santé, ni de réelle intégration des différents services de santé financés par l'État.

Certains spécialistes canadiens prétendent qu'une approche de marché interne où les RRS joueraient le rôle d'acheteurs favoriserait la gestion efficace des services de santé et améliorerait la qualité des soins dans leur région :

*Dans un marché interne, les régies régionales de la santé tiennent les cordons de la bourse et choisissent les fournisseurs en fonction de la qualité et des prix, au lieu de financer simplement les décisions de ceux qui utilisent les ressources<sup>105</sup>.*

L'application au niveau régional de principes de réforme axée sur les marchés internes ne signifie pas que les hôpitaux relevant actuellement des RRS doivent se tourner vers le secteur privé. Il est possible d'appliquer la logique des réformes de marché interne au Canada grâce à la passation de contrats à caractère concurrentiel entre les RRS et les différents hôpitaux publics (relevant des RRS). La concurrence peut être plus vive encore si les fournisseurs du secteur privé sont autorisés à faire concurrence aux fournisseurs de l'État pour offrir certains services de santé assurés par l'État (comme les chirurgies d'un jour et les soins de longue durée). En plus de favoriser une concurrence accrue, ces contrats entre les RRS et leurs hôpitaux permettraient de fixer des objectifs de rendement précis, de sorte que la responsabilisation des hôpitaux et des autres fournisseurs de soins s'en trouverait grandement améliorée.

Le Comité est d'avis que les réformes axées sur des approches de marché interne peuvent éventuellement favoriser la concurrence entre les hôpitaux, les autres établissements et les différents fournisseurs de soins. Elles peuvent aussi inciter les fournisseurs à être plus efficaces et plus conscients des coûts et à prendre des décisions quant aux services à offrir, à leurs destinataires et aux normes de service à respecter.

Le Comité croit de plus que de telles réformes conférerait aux RRS la marge de manœuvre nécessaire pour réorganiser les services afin de mieux

***Selon le Comité, une réforme de marché interne peut contribuer à la réorganisation des services en fonction des besoins de la population.***

<sup>105</sup> Cam Donaldson *et coll.* (avril 2001), p. 8.



les adapter aux besoins de la population. Plus important encore peut-être, l'adoption de réformes fondées sur des principes de marché interne permet de remédier au problème actuel de certaines provinces dont les ministères de la Santé appliquent un mode de gestion descendante. De plus, une approche de marché interne contribuerait à accroître considérablement la transparence et la responsabilisation dans toutes les parties du système.

Des réformes de marché interne impliquant la délégation claire de responsabilités aux organismes régionaux de santé ont été implantées en Suède et au Royaume-Uni. En Suède, avant l'adoption des réformes, les hôpitaux appartenaient aux conseils de comté qui étaient chargés de l'administration ainsi que du financement et de la prestation des services de santé et qui employaient la plupart des médecins, ceux qui étaient rattachés à un hôpital et les médecins de soins primaires. Les réformes ont donné lieu à de nouveaux accords contractuels et à de nouveaux modes de rémunération.

Ainsi, la gestion des hôpitaux publics a été transférée des conseils de comté à des conseils d'administration indépendants. La rémunération hospitalière a été remplacée par les diagnostics regroupés pour la gestion (DRG), une forme de financement en fonction du service (comme celle recommandée au chapitre deux du présent rapport). Des réformes du secteur des soins primaires ont aussi été instaurées pour permettre aux conseils de comté d'acheter les services des médecins. Un grand nombre de médecins de soins primaires se trouvent maintenant en pratique privée sous contrat avec les conseils de comté; ils sont remboursés par les conseils de comté selon la formule de rémunération à l'acte. D'autres conseils de comté ont instauré la rémunération par capitation pour les médecins de soins primaires. Dans l'ensemble, les estimations montrent que les conseils de comté ayant instauré des réformes de marché interne ont pu réduire les coûts de 13 % de plus que ceux qui avaient maintenu le *statu quo*.

Dans le système en vigueur avant la réforme, les hôpitaux du Royaume-Uni appartenaient à l'État et étaient administrés par le National Health Service (NHS), soit le service de santé national par l'entremise de ses RRS. Le budget de chaque RRS était établi par le gouvernement central selon une formule de capitation pondérée. Le budget de chaque hôpital était ensuite préparé selon un processus administratif comprenant des négociations entre la direction de l'hôpital et la RRS concernée. Les spécialistes des hôpitaux étaient des employés salariés du NHS. Ce système faisait l'objet de critiques, principalement parce que les RRS achetaient les services au nom de leur population locale et, qu'en même temps, elles dirigeaient les hôpitaux locaux. Elles se trouvaient donc en conflit d'intérêt puisqu'elles cherchaient à protéger ces hôpitaux.

Lorsque les réformes de marché interne ont été implantées, les RRS ont cessé de gérer directement leurs propres hôpitaux et sont devenues responsables, à titre d'acheteurs, de la passation de contrats avec les hôpitaux du NHS et les fournisseurs privés en vue de fournir les services requis par leurs populations résidentes. Les hôpitaux, de leur côté, ont été transformés en fiducies du NHS (NHS Trusts), c'est-à-dire, des organismes sans but lucratif à l'intérieur du NHS mais ne relevant pas directement des RRS. Un système de DRG a été mis en place pour payer les hôpitaux.

Un examen de la documentation laisse supposer qu'au Royaume-Uni, il n'y a guère eu d'évaluation rigoureuse du rôle d'acheteur de soins assumé par les RRS. Le fait que toutes les RRS sont devenues des acheteurs au début de la réforme a réduit les possibilités

d'analyse comparative. Selon certains spécialistes, les marchés internes n'ont pas fonctionné comme prévu car les deux parties en cause n'ont pas pris de mesures incitatives pour favoriser la restructuration.

Plus important encore peut-être, la responsabilité des soins de santé primaires n'a jamais été déléguée aux RRS. Les médecins de soins primaires ont été encouragés à adhérer au système des enveloppes budgétaires pour les omnipraticiens (« GP Fundholdings »). Ceux participant à ce régime recevaient un fonds pour l'achat, au nom de leurs patients, de médicaments de prescription, de services de spécialistes rattachés à un hôpital et de certains soins hospitaliers. Ainsi, la plupart des médecins de soins primaires qui ont adhéré au régime sont devenus des acheteurs rivaux pour les RRS. En fait, le régime est devenu si populaire que le gouvernement central a décidé de transférer les responsabilités d'achat jusque-là dévolues aux RRS aux médecins fonctionnant selon le régime des enveloppes budgétaires (qui ont par la suite formé les groupes de soins primaires (Primary Care Trusts)).

D'après Donaldson, Currie et Mitton (2001), la transformation des RRS en acheteurs est possible au Canada. Il y a maintenant des RRS dans la plupart des provinces et territoires et le fait que la plupart des soins de santé au Canada sont dispensés dans les grandes villes et à proximité de celles-ci ouvre, selon eux, toute grande la voie à une possible concurrence entre les fournisseurs. Ils insistent cependant sur les défis à relever.

- Premièrement, il faudrait modifier le mode de rémunération des hôpitaux pour que les stimulants de marché fonctionnent. Ainsi, les hôpitaux seraient rémunérés selon une formule de financement fondée sur les services dispensés. C'est l'une des raisons pour lesquelles le Comité en a recommandé l'adoption dans le chapitre deux.
- Deuxièmement, si les hôpitaux devaient s'engager dans des contrats avec les RRS, il leur faudrait exercer un contrôle plus rigoureux sur le personnel à leur emploi. En bout de ligne, il faudrait que la responsabilité du budget pour les spécialistes rattachés à un hôpital soit déléguée aux RRS.
- Troisièmement, pour réaliser l'intégration complète du système de soins de santé, le budget pour les médecins de soins primaires devrait être attribué aux RRS, qui seraient chargées de négocier des contrats avec les médecins de leur région. Les médecins ou les groupes de médecins devraient avoir le choix de s'engager par contrat avec une RRS ou de travailler à l'extérieur du système. Cela exigerait une révision du mode actuel de rémunération des médecins.
- Quatrièmement, il faudrait songer sérieusement à confier aux RRS le pouvoir de dépenser pour l'achat de médicaments de prescription.

D'après le rapport Mazankowski, les RRS sont prêtes à relever ces défis. De façon précise, voici ce que dit le rapport :

- Les RRS devraient envisager autant la passation de contrats avec les hôpitaux de leur région que d'autres ententes de prise en charge et mécanismes de paiement.

- Il faudrait inciter les RRS à signer des contrats avec différents fournisseurs y compris les cliniques, les fournisseurs privés et sans but lucratif, les groupes de fournisseurs de soins de santé (notamment les médecins de soins primaires) et les autres régions.
- Il faudrait encourager les RRS à faciliter la création de centres de spécialisation. Les RRS dotées d'une expertise spécialisée devraient être en mesure de vendre ces services à d'autres régions et de négocier des contrats avec elles pour en assurer la prestation. De cette manière, les régions généreraient un volume de services suffisant pour leur permettre d'atteindre de meilleurs résultats.

Le Comité reconnaît le fait que les marchés internes peuvent améliorer l'efficacité dans les grands centres urbains et les zones où la population est dense, mais il n'en va pas de même dans les régions à faible densité de population. Ce point a également été soulevé par Michael Decter, actuel président du conseil d'administration de l'ICIS et ancien sous-ministre de la Santé en Ontario, lorsqu'il a affirmé :

*(...) la densité de la population est sous-estimée en tant que facteur de la capacité d'implanter un marché interne. C'est un des dangers de l'expérience européenne appliquée au Canada. Les scissions acheteur/fournisseur fonctionnent bien lorsque la densité de la population et celle des fournisseurs sont suffisantes pour susciter la compétition.*

*(...) Nous avons deux réalités au Canada. Une grande partie de la population, peut-être 70 %, vit dans une poignée de grandes villes où je crois que ce modèle devrait fonctionner. La compétition serait une bonne chose en fonction de l'obtention de meilleurs prix et de meilleure qualité au fil du temps. Pour le reste, vous avez besoin de stratégies afin d'avoir suffisamment de services pour répondre aux besoins. Il ne s'agit pas de compétition. C'est plus une question de stabilité du financement et de stratégies pour permettre aux fournisseurs de s'installer réellement<sup>106</sup>.*

Le Comité est également conscient du fait qu'il n'y a pas de RRS en Ontario, au Yukon et au Nunavut à l'heure actuelle. En conséquence, la mise en œuvre de réformes fondées sur des principes de marché interne en vertu desquelles les RRS seraient responsables de l'ensemble des services de santé n'est pas possible dans ces provinces et territoires. Il faudrait donc songer à d'autres moyens pour intégrer la prestation des services de santé et en améliorer l'efficacité.

### **3.5 Commentaires du Comité**

Le Comité croit que la délégation d'un plus grand nombre de responsabilités aux régions régionales de la santé constitue une étape importante de la réforme des soins de santé au Canada. En réalité, les RRS sont présentes dans la

***Le Comité est persuadé qu'il est maintenant temps que les RRS puissent exercer un plus grand contrôle sur l'ensemble des dépenses de soins de santé de leur région.***

<sup>106</sup> Michael Decter (52:12).

plupart des provinces et un fort pourcentage des dépenses en soins de santé se concentre dans les grandes villes et à proximité de celles-ci, d'où l'instauration possible d'une concurrence entre les différents fournisseurs et établissements. Nous sommes persuadés qu'il est maintenant temps que les RRS puissent exercer un plus grand contrôle sur l'ensemble des dépenses de soins de santé de leur région.

Le Comité reconnaît que l'établissement de mécanismes de marché pour stimuler la concurrence entre les établissements de soins de santé exige un nombre suffisant de fournisseurs et une population importante. Bien que bon nombre de régions du Canada sont en mesure d'entreprendre une réforme de marché interne, certaines petites provinces et certaines régions à l'intérieur de grandes provinces en sont incapables. À notre avis, les réformes de marché interne devraient être mises en œuvre dans les secteurs géographiques où elles seraient avantageuses sur le plan de l'efficacité et de l'efficience.

Le Comité croit aussi qu'une réforme axée sur les principes de marché interne est la solution pour surmonter les différents obstacles qui empêchent les RRS de mettre pleinement à profit leur potentiel. Par ailleurs, il y aura moins d'interférence politique lorsque les RRS auront la liberté et la responsabilité pour atteindre les objectifs et se conformer aux normes de rendement. Les RRS auront la marge de manœuvre nécessaire pour attribuer leurs ressources financières de manière plus rentable et mieux adaptée aux besoins de la population qu'elles desservent. De plus, en confiant l'enveloppe budgétaire des soins primaires aux RRS, on s'assure qu'elles auront les moyens d'en contrôler les coûts. En outre, la délégation de la responsabilité financière à l'égard des services hospitaliers, des médecins rattachés à un hôpital et des soins de santé primaires favorisera la concurrence et permettra aux RRS d'offrir les services les plus efficaces et les plus rapides qui soient ou d'allouer des contrats à cette fin. Enfin, la prise en charge par une seule entité de l'ensemble des services de santé fera en sorte que le système de soins de santé sera mieux intégré et davantage orienté vers les besoins des patients.

Le Comité est conscient que l'application des principes de marché interne dans un système public de soins de santé oblige à modifier la méthode de rémunération des hôpitaux. Nous croyons que le financement en fonction des services est la méthode la plus pertinente et notre recommandation à cet effet est énoncée en détail au chapitre deux.

Le Comité sait aussi que pour porter fruit, les réformes de marché interne nécessitent de l'information détaillée et fiable sur les coûts. Nous croyons aussi que les recommandations que nous formulons concernant la mise en place d'un système national de dossiers de santé électroniques ainsi que l'évaluation indépendante du rendement et des résultats (voir le chapitre 10) faciliteront grandement ces réformes.

***Malgré le fait que la gestion et la prestation des services de santé soit d'abord une question de compétence provinciale, le Comité croit que le gouvernement fédéral peut jouer un rôle important dans l'amélioration de la prestation des soins de santé à l'échelle régionale en investissant de façon durable dans l'infrastructure des soins de santé, dans l'évaluation des résultats du système de soins et dans le bassin de ressources humaines affectées au secteur de la santé.***

Il semble qu'il n'y a eu que très peu d'évaluations rigoureuses des réformes de marché interne entreprises dans d'autres pays. Nous croyons que l'intervention de nombreux facteurs, tels que la mise en œuvre simultanée de différentes réformes, a rendu difficile l'établissement de leur réelle portée. Pour cette raison, le Comité pense qu'il est important de surveiller et d'évaluer l'incidence que les réformes fondées sur des principes de marché interne peuvent avoir au Canada sur la productivité, l'efficacité du système de soins de santé, l'accès aux services couverts par le régime d'assurance public, les délais d'attente, etc., et de communiquer ces renseignements à la population canadienne.

Malgré le fait que la gestion et la prestation des services de santé soit d'abord une question de compétence provinciale, le Comité croit que le gouvernement fédéral peut jouer un rôle important pour améliorer la prestation des soins de santé à l'échelle régionale en investissant de façon durable dans l'infrastructure des soins de santé (notamment dans la création de systèmes d'information pour permettre le passage à une formule de financement fondée sur les services dans le cas des hôpitaux), dans l'évaluation des résultats du système de soins de santé et dans le bassin de ressources humaines affectées au secteur de la santé.

En conséquence, le Comité recommande :

**Que les régies régionales de la santé des grands centres urbains puissent exercer un contrôle sur le coût des services médicaux en plus d'assumer leur responsabilité à l'égard des services hospitaliers dans leur région. Le pouvoir de dépenser pour l'achat de médicaments de prescription devrait également leur être délégué.**

**Que les régies régionales de la santé puissent choisir entre différents fournisseurs (particulier ou établissement) en fonction de la qualité et des coûts et récompenser les meilleurs fournisseurs par un volume accru. Ainsi, les RRS seraient dans l'obligation d'établir des contrats clairs où le volume des services et les objectifs de rendement seraient précisés.**

**Que le gouvernement fédéral encourage le transfert des responsabilités des gouvernements provinciaux et territoriaux aux régies régionales de la santé et participe à l'évaluation de la portée des réformes de marché interne menées à l'échelle régionale.**

## CHAPITRE QUATRE

### RÉFORME DES SOINS DE SANTÉ PRIMAIRES

---

#### 4.1 Pourquoi une réforme des soins de santé primaires est-elle nécessaire?

Les services de soins de santé primaires constituent le premier point de contact avec le système de soins de santé. D'après l'Association médicale canadienne, les soins de santé primaires comprennent « le diagnostic, le traitement et la gestion des problèmes de santé, la prévention et la promotion de la santé, de même qu'un soutien constant combiné à des interventions familiales ou communautaires, s'il y a lieu »<sup>107</sup>.

À l'heure actuelle, la prestation des soins primaires au Canada s'articule principalement autour de médecins de famille et d'omnipraticiens exerçant seuls ou en petits groupes. Environ 33% des médecins de soins primaires travaillent seuls et moins de 10% d'entre eux exercent dans des cliniques pluridisciplinaires. La grande majorité des cabinets de soins primaires appartiennent à des médecins qui les gèrent. Les honoraires à l'acte constituent la forme de rémunération des médecins la plus courante.

On a noté diverses lacunes et divers problèmes dans la façon dont les soins primaires sont généralement dispensés au Canada, à savoir :

- la fragmentation des soins et des services;
- l'utilisation inefficace des fournisseurs de soins de santé;
- le manque d'importance accordée à la promotion de la santé;
- les obstacles à l'accès (les soins ne sont pas offerts après les heures ouvrables et les fins de semaine);
- la piètre qualité du partage, de la collecte et de la gestion de l'information;
- le décalage des mesures d'incitation, en particulier de la rémunération à l'acte, qui récompense les soins ponctuels davantage que les soins prolongés et la promotion de la santé/prévention de la maladie<sup>108</sup>.

La création de groupes de soins primaires (GSP) comme étape essentielle de la réforme des soins primaires fait l'objet d'un assez vaste consensus, et presque tous les rapports provinciaux importants publiés ces dernières années renferment une recommandation en faveur d'une forme quelconque de réforme des soins primaires (voir la section 4.2.1). Comme Michael Decter, ex-sous-ministre de la Santé de l'Ontario, l'a indiqué au Comité :

---

<sup>107</sup> Citée dans Ann L. Mable et John Marriott, *Le Fonds pour l'adaptation des services de santé – Série de rapports de synthèse – Les soins primaires*, juin 2002, p. 15.

<sup>108</sup> *Ibid.*, p. 16.

*Le plus difficile, c'est de passer d'un modèle qui ne peut plus véritablement fonctionner – c'est-à-dire la pratique isolée – à un modèle collectif. Les groupes pourraient avoir de nombreuses configurations<sup>109</sup>.*

Les groupes de soins primaires sont des cabinets de groupe composés de médecins auxquels peuvent se joindre également d'autres fournisseurs de soins de santé (éventuellement des infirmières, des infirmières praticiennes, des physiothérapeutes, des diététistes, des sages-femmes, des psychologues, etc.).

Dans presque tous les types actuels de groupes de soins primaires, les patients doivent s'inscrire auprès d'un groupe ou d'un médecin précis pour une période de temps bien définie. Le GSP doit ensuite assurer l'accès aux soins primaires aux patients inscrits, et ce, 24 heures sur 24 et sept jours sur sept. Une fois inscrits, les patients doivent habituellement demeurer avec leur

***La création de groupes de soins primaires (GSP) comme étape essentielle de la réforme des soins primaires fait l'objet d'un assez vaste consensus, et presque tous les rapports provinciaux importants publiés ces dernières années renferment une recommandation en faveur d'une forme quelconque de réforme des soins primaires.***

groupe de soins primaires désigné pendant une période de temps bien précise, généralement de six mois à un an, à moins qu'ils ne changent de lieu de résidence. Le médecin ou l'équipe de soins primaires joue le rôle de portier pour le reste du système, aiguillant les patients inscrits vers des spécialistes. Comme maintenant, le choix du spécialiste ferait l'objet d'une négociation entre le patient et le médecin de soins primaires concerné. Toutefois, le patient inscrit n'aurait pas directement accès à un spécialiste (comme c'est théoriquement le cas à l'heure actuelle), ni à un autre médecin de famille à l'extérieur du groupe, sauf bien sûr, dans des situations urgentes.

Un système fondé sur des GSP présente plusieurs avantages, notamment :

- une garantie d'accès pour le patient à sa propre *équipe* de médecins et d'autres fournisseurs de services, 24 heures sur 24, sept jours sur sept;
- une meilleure utilisation de la gamme de fournisseurs de soins de santé et une meilleure coordination des services aux patients, grâce au travail d'une équipe interdisciplinaire;
- des possibilités d'économies à plus long terme grâce à une réduction de la demande à l'égard de services coûteux comme les salles d'urgence et les spécialistes, et grâce à l'adoption de mesures pour faire en sorte que chaque tâche soit confiée au professionnel le plus qualifié pour s'en occuper;
- des mesures de promotion de la santé et de prévention de la maladie à l'intention des patients.

---

<sup>109</sup> 52:9.

Dans le volume cinq, le Comité a reconnu qu'il n'existera jamais de modèle unique de prestation des soins de santé primaires pouvant s'appliquer exactement de la même façon dans chaque région et dans chaque province du pays, mais il s'est inspiré de divers rapports (voir la section 4.2.1) pour dresser une liste d'attributs souhaitables pour tous les modèles d'équipes pluridisciplinaires de soins de santé primaires, à savoir :

- la prestation d'une vaste gamme de services 24 heures sur 24, sept jours sur sept;
- la prestation des services par le professionnel de la santé le plus compétent pour s'en charger;
- l'adoption d'autres modes de rémunération que les honoraires à l'acte, par exemple la capitation, soit exclusivement, soit dans le cadre d'une formule de financement mixte;
- l'intégration de stratégies de promotion de la santé et de prévention de la maladie dans leur travail quotidien;
- la pleine intégration des dossiers de santé électroniques (DES) des patients à la prestation des soins.

L'une des questions soulevée lors des plus récentes audiences du Comité visait à savoir si la réforme des soins primaires allait entraîner des réductions de coûts perceptibles. Certains témoins sont d'avis qu'il devrait être possible de réaliser des économies si chaque service est dispensé par le fournisseur le plus compétent pour s'en charger, puisque les GSP offrent à tous les fournisseurs de soins la possibilité de mettre pleinement en valeur les compétences liées à leur champ de pratique. Ces témoins voient une source possible d'économies dans le fait que jusqu'à 60 à 70 % des interventions faites par des médecins pourraient être confiées à des infirmières ou à des infirmières praticiennes (des infirmières possédant des titres professionnels de niveau supérieur). Ils estiment que le transfert de ces tâches à d'autres membres qualifiés du personnel qui ne sont pas payés autant que les médecins, peut être avantageux à deux égards : il permet de réaliser des économies à court terme et de faire en sorte que les médecins consacrent une plus grande part de leur temps aux tâches pour lesquelles ils sont les seuls qualifiés et dont bon nombre sont actuellement assumées par des spécialistes parce que les médecins de soins primaires ne peuvent s'en occuper eux-mêmes faute de temps<sup>110</sup>.

Tous les témoins conviennent qu'on réaliserait des gains d'efficacité en permettant aux médecins de se concentrer sur les interventions qui requièrent leurs compétences uniques, mais plusieurs doutent en fait qu'on réaliserait les économies prévues.

---

<sup>110</sup> Ce phénomène est bien illustré par les faits suivants tirés d'un rapport de 1999 de la Commission de restructuration des services de santé de l'Ontario et cités dans le volume quatre de l'étude du Comité (p. 118). Le tiers des services médicaux facturés par des spécialistes ontariens en 1997 (ayant coûté 1,4 milliard de dollars en tout) auraient pu être rendus par des omnipraticiens. En 1997, les cinq codes de facturation les plus fréquents chez les omnipraticiens ontariens représentaient environ 69 % du montant total facturé par ceux-ci (1,2 milliard de dollars). Les voici : évaluations intermédiaires (pédiatrie), évaluations générales, évaluations mineures, psychothérapie individuelle et counselling. D'après les cliniciens conseillant la Commission de restructuration, la plupart de ces services, voire tous, auraient pu être rendus par des infirmières praticiennes, des infirmières et de nombreux professionnels de la santé bien formés.



À titre d'exemple, voici ce qu'a noté à ce sujet le D Peter Barrett, ancien président de l'AMC :

*[...] quoique souhaitable, l'élargissement de l'équipe de prestation de soins pour y inclure les infirmières, les pharmaciens, les diététistes et d'autres intervenants occasionnera une augmentation, et non pas une réduction, des coûts; il faut donc envisager autrement la réforme des soins primaires. Il faut y voir un investissement et non une façon de faire des économies, une façon rentable de répondre aux nouveaux besoins des Canadiens<sup>111</sup>.*

Néanmoins, le Comité estime que certains facteurs contribueraient effectivement à réduire les coûts. Les remarques du D Barrett se fondent sur l'hypothèse voulant qu'il y ait beaucoup de besoins auxquels le système ne répond pas et que la réforme des soins de santé primaires permettrait de combler, puisqu'un plus grand nombre de professionnels de la santé offrirait davantage de services. Avec une formule de rémunération à l'acte, il en coûterait évidemment plus cher. Par contre, si les médecins de soins primaires offraient des services selon la pleine mesure de leurs compétences, il y aurait également moins de patients dirigés vers des spécialistes<sup>112</sup>.

Tous les témoins soutiennent cependant que même s'il n'y a pas d'économies à réaliser à court terme, cela ne réduit en rien l'importance d'une réforme des soins primaires, mais fait au contraire ressortir d'autres raisons de la faire progresser. D'après le professeur Brian Hutchison, de l'Université McMaster :

*L'obsession de la réduction des coûts nous a amenés à envisager de recourir aux infirmières praticiennes comme remplaçantes des médecins. L'autre dimension qu'il faut explorer, c'est leur potentiel pour ce qui est d'étendre la palette des soins primaires et d'insister davantage sur la promotion de la santé, la prévention et le counselling, domaines dans lesquels elles ont beaucoup à offrir, probablement plus que les médecins. Nous devrions envisager pour les infirmières praticiennes un rôle complémentaire, au lieu de les voir principalement comme un moyen d'économiser de l'argent. Nous devrions voir dans cette profession un outil d'amélioration de la santé<sup>113</sup>.*

Le Comité est tout à fait d'accord avec ce point de vue. De fait, le rapport de synthèse sur divers projets de soins de santé primaires entrepris sous les auspices du Fonds pour l'adaptation des services de santé de Santé Canada fournit d'autres preuves en ce sens. Voici ce que dit ce rapport au sujet d'un projet d'évaluation du rôle d'un(e) infirmière praticienne dans le contexte d'une équipe pluridisciplinaire travaillant à partir d'une clinique de Calgary :

---

<sup>111</sup> 56:12.

<sup>112</sup> La recherche effectuée par la Commission de restructuration des services de santé de l'Ontario montre que la baisse la plus spectaculaire à ce chapitre concerne les renvois à des dermatologues et à des oto-rhino-laryngologistes.

<sup>113</sup> 58:13.

*Au départ, les médecins ne savaient pas très bien quel serait le rôle des infirmières praticiennes, mais ils ont vite constaté qu'elles facilitaient la communication entre différents fournisseurs de soins, qu'elles amélioreraient sensiblement l'accès aux soins et leur qualité, et qu'elles prenaient en main des cas, permettant ainsi aux médecins de passer plus de temps avec des patients qui avaient besoin de leurs services. Quelque 95 p. 100 des patients ont été satisfaits de cette initiative<sup>114</sup>.*

## **4.2 Les provinces et la réforme des soins primaires**

Dans la présente section, nous examinons brièvement les points saillants de six rapports provinciaux qui renferment des recommandations de réforme des soins primaires. Nous passons ensuite en revue différentes initiatives récentes de mise en œuvre dans trois provinces, soit l'Ontario, le Québec et le Nouveau-Brunswick, qui ont dépassé le stade de la rédaction de rapports et de la création de projets pilotes.

### **4.2.1 Rapports récents**

Le *tableau 4.1* (fin de chapitre) présente un aperçu des différentes propositions énoncées dans les six rapports, le plus ancien datant de décembre 1999<sup>115</sup>, et les regroupe en fonction d'un certain nombre d'éléments clés d'une éventuelle réforme des soins primaires. Il y a beaucoup de similitudes importantes et un certain nombre de différences notables de l'un à l'autre.

Tous les rapports préconisent de recourir à une forme quelconque d'équipe pluridisciplinaire fonctionnant habituellement 24 heures sur 24 et sept jours sur sept, pour assurer la prestation de soins primaires complets. Les modalités de réalisation de cet objectif varient cependant considérablement, tout comme les détails fournis dans les divers rapports. Il importe de noter que tous insistent sur la nécessité de créer une forme quelconque de dossier de santé électronique (DSE – voir le chapitre dix), même s'ils n'en font pas tous une condition inhérente à la mise en œuvre de leurs propositions de réforme des soins primaires.

Les descriptions des équipes pluridisciplinaires proposées dans les rapports diffèrent, tout comme la façon dont les liens entre les groupes de soins primaires et les autres

---

<sup>114</sup> Marriott Mable, *op. cit.*, p. 20

<sup>115</sup> Ces rapports sont les suivants :

1. Commission de restructuration des services de santé (Duncan Sinclair, président), *Primary Health Care Strategy – Advice and Recommendations to the Honourable Elizabeth Witmer, Minister of Health*, gouvernement de l'Ontario, décembre 1999.
2. Commission d'étude sur les services de santé et les services sociaux (Michel Clair, commissaire), *Les solutions émergentes – Rapport et recommandations*, janvier 2001.
3. Saskatchewan Commission on Medicare (Kenneth Fyke, commissaire), *Caring for Medicare – Sustaining a Quality System*, avril 2001.
4. Premier's Advisory Council on Health (le très honorable Don Mazankowski, président), *A Framework for Reform*, rapport au premier ministre de l'Alberta, décembre 2001, p. 52 et 53.
5. Primary Care Advisory Committee (Kathy LeGrow, présidente), *The Family Physician's Role in a Continuum of Care Framework for Newfoundland and Labrador*, un cadre pour le renouvellement des soins primaires, ministère de la Santé et des Services communautaires, Terre-Neuve et Labrador, décembre 2001.
6. Rapport du Conseil du premier ministre sur la qualité des soins de santé, *Renouvellement du système de santé*, gouvernement du Nouveau-Brunswick, janvier 2002.

fournisseurs de soins de santé, comme les hôpitaux, y sont envisagés. Seule une minorité des rapports préconisent l'adoption de mécanismes de financement de rechange bien précis, et deux seulement comportent des propositions explicites concernant l'inscription de patients.

Même s'il est trop tôt pour dire si les recommandations formulées dans ces différents rapports seront mises en œuvre, l'exemple de l'Ontario est peut-être instructif à cet égard. Premier à être publié, le rapport de la Commission de restructuration des services de santé (rapport Sinclair) est celui qui donne la description la plus détaillée de la façon dont la réforme des soins primaires devrait être mise en œuvre. Comme l'Ontario a été la première province à entreprendre une réforme des soins primaires sur l'ensemble de son territoire, il est intéressant de noter que le modèle effectivement adopté à cette fin semble moins uniforme et d'application plus souple et facultative que celui proposé dans le rapport.

#### **4.2.2 Le Réseau santé-famille de l'Ontario**

Le Réseau santé-famille de l'Ontario (RSFO) a été créé en mars 2001. Il s'agit d'un organisme semi-autonome qui relève du ministère de la Santé et des Soins de longue durée (MSSLD) de l'Ontario. Le RSFO fournit aux médecins de famille de l'information, un soutien administratif et des fonds pour les technologies afin d'appuyer la création volontaire dans leurs communautés de réseaux santé-famille (RSF).

Le modèle des RSF incite les groupes de médecins de famille et les membres des professions paramédicales comme les infirmières praticiennes à collaborer pour fournir des soins accessibles et coordonnés aux patients qui sont inscrits auprès de leurs services. Le RSFO fournit des fonds, des lignes directrices et des services de soutien, mais ce sont les médecins qui décident de leur propre gré de former un RSF local et qui planifient de quelle façon ils collaboreront pour offrir à leurs patients les meilleurs services possibles.

Il faut au moins cinq médecins (dont un doit jouer le rôle de chef de groupe) et 4 000 patients inscrits pour former un RSF, qui peut s'étendre à plus d'un endroit. En plus d'offrir des services pendant les heures ouvrables, l'un des bureaux d'un RSF doit être ouvert de 17 h à 20 h, du lundi au jeudi, et trois heures par jour la fin de semaine. En dehors des heures ouvrables, les patients inscrits sur la liste du RSF ont accès à une ligne téléphonique où des infirmières répondent aux appels, avec l'aide d'un médecin de garde du réseau santé-famille.

On a créé en 1998 des réseaux pilotes, appelés réseaux de soins primaires. Entre 1998 et 2000, on en a mis sur pied 14 dans sept communautés, si bien qu'aujourd'hui, ils regroupent plus de 178 médecins et environ 270 000 patients inscrits. En novembre 2001, l'Ontario Medical Association (OMA) s'est prononcée par vote en faveur de l'idée de permettre au RSFO d'offrir aux médecins du nord et des régions rurales de la province de conclure des ententes avec les réseaux santé-famille. En janvier 2002, les membres de l'OMA ont également donné leur accord à la signature d'un accord contractuel de portée générale avec les médecins de famille de toute la province. Un groupe de six médecins des Dorval Medical Associates à Oakville a formé en 2002 le premier réseau santé-famille de l'Ontario.

Les patients qui adhèrent à un RSF acceptent de contacter d'abord le médecin de leur réseau santé-famille lorsqu'ils ont besoin d'un service de santé, à moins d'être en voyage ou de se trouver dans une situation d'urgence. Ils acceptent également de

permettre au MSSLD de fournir au médecin du RSF certains renseignements au sujet des services de santé qui leur ont été dispensés par des médecins de famille n'appartenant pas leur réseau. Le MSSLD peut, en outre, communiquer au réseau santé-famille les dates d'immunisations et les résultats de tests de dépistage du cancer du col utérin et de mammographies.

C'est le médecin du réseau santé-famille qui, en consultation avec chaque patient, effectue les renvois vers des spécialistes ou d'autres médecins de famille pour obtenir une contre-expertise. Les patients peuvent continuer à utiliser les services de leur médecin sans joindre les rangs du RSF dont celui-ci fait partie. De même, s'ils décident d'annuler leur inscription auprès du RSF de leur médecin, ils n'ont pas à changer de médecin de famille. Celui-ci peut continuer à les recevoir selon les mêmes conditions qu'avant leur adhésion au réseau. Les patients peuvent changer de médecin attitré jusqu'à deux fois par an. Cependant, s'ils consultent régulièrement un autre omnipraticien, leur médecin attitré peut supprimer leur nom de la liste des patients inscrits auprès de son réseau santé-famille.

Le degré de satisfaction des médecins à l'égard des réseaux pilotes est élevé et aucun ne s'est encore retiré. Les ententes que signent les médecins afin de créer un RSF portent sur les droits et les responsabilités des patients et des médecins eux-mêmes, leur rémunération et le soutien administratif.

Les montants versés pour les patients inscrits, montants qui sont pondérés suivant l'âge et le sexe (voir le tableau 4.2) et qui englobent un éventail de 57 services de soins primaires courants, sont censés correspondre à environ 60 % des revenus d'un RSF. Le reste est constitué d'autres montants pour la prestation de services préventifs comme les vaccinations, les tests de Papanicolaou et les mammographies; de bonis pour le rapatriement de patients ayant déjà consulté d'autres médecins pour recevoir des soins primaires essentiels; d'honoraires de visite et de primes pour des services non essentiels, comme les accouchements et les soins aux patients hospitalisés.

**TABLEAU 4.2**  
**COEFFICIENT APPLICABLE AU VERSEMENT DU PAIEMENT AU TAUX DE BASE**  
**ET DU PAIEMENT SPÉCIAL SUIVANT L'ÂGE ET LE SEXE**

Âge	Homme	Femme	Moyenne
00-04	1,05	1,00	1,03
05-09	0,55	0,54	0,55
10-14	0,44	0,46	0,45
15-19	0,46	0,82	0,64
20-24	0,46	1,03	0,74
25-29	0,50	1,07	0,79
30-34	0,58	1,08	0,83
35-39	0,72	1,17	0,95
40-44	0,80	1,20	1,01
45-49	0,88	1,30	1,11
50-54	1,02	1,46	1,25
55-59	1,16	1,47	1,33
60-64	1,27	1,50	1,40
65-69	1,43	1,58	1,52
70-74	1,66	1,69	1,69
75-79	1,99	2,01	2,00
80-84	2,08	2,08	2,08
85-89	2,34	2,37	2,36
90+	2,64	2,68	2,67

Nota : Le multiplicateur pour le paiement au taux de base est 96,85 \$.

Source : Matt Borsellino, "Primary Care Payment Options Become Available," *The Medical Post*, 4 décembre 2001, p. 8.

Les médecins peuvent aussi facturer leur formation médicale continue et chaque réseau a droit annuellement à une somme pouvant aller jusqu'à 25 000 \$ pour acquitter ses frais d'administration supplémentaires. Les RSF ont également droit à des fonds pour se doter d'un système de technologies de l'information, notamment pour les dossiers électroniques de leurs patients, les avertissements concernant les interactions médicamenteuses, le suivi des mesures liées aux soins préventifs et la facturation électronique.

Avec une charge « moyenne » de travail de bureau et de garde à l'hôpital, en obstétrique et en salle d'urgence, et une liste de 1 480 patients, un médecin peut recevoir 254 846 \$ en vertu du modèle de rémunération mixte. La rémunération annuelle d'un médecin qui ne fait que du travail de bureau et qui a une liste de 1 423 patients peut atteindre 204 256 \$. Sa rémunération brute s'élève à 105 455 \$ s'il a une liste de 598 patients seulement.

Selon le D<sup>r</sup> Elliot Halparin, médecin de famille de Georgetown (Ontario) et président de l'OMA, la rémunération moyenne d'un médecin rattaché à un RSF en milieu

urbain, en vertu du modèle mixte, est évaluée à 244 500 \$, pour une liste de 1 600 patients, contre 210 700 \$ en vertu de la formule traditionnelle de rémunération à l'acte. Ces chiffres reposent sur la facturation moyenne des 6 500 à 7 000 médecins de famille ontariens qui assurent des soins complets.

Même s'il est trop tôt pour tenter d'évaluer le projet de RSFO lui-même, Price Waterhouse Coopers a effectué en octobre 2001 pour le compte du MSSLD une évaluation des projets pilotes (des réseaux de soins primaires ou RSP) avant leur pleine mise en œuvre. Certaines de ses conclusions sont dignes de mention :

- Les cinq principaux avantages dont bénéficient les médecins adhérant à un RSP sont les suivants : effets positifs de la rémunération par capitation sur le mode de vie et le style de pratique; amélioration des soins aux patients; technologies de l'information (TI); accroissement du revenu; partage des appels et remplacement en cas d'absence.
- Les principaux défis auxquels les médecins sont confrontés lorsqu'ils adhèrent à un RSP concernent les exigences administratives, les TI, la liste de patients et les relations avec le ministère.
- La participation d'infirmières praticiennes et d'autres fournisseurs de soins de santé aux réseaux a jusqu'ici été limitée, même si les patients déclarent être très satisfaits des infirmières praticiennes.
- La définition des rôles et l'intégration aux équipes posent des défis lorsque vient le temps d'inclure des infirmières praticiennes dans les RSP; le nombre d'infirmières praticiennes par rapport au nombre de médecin est extrêmement faible dans beaucoup de ces réseaux.
- Le recrutement d'infirmières praticiennes pourrait avoir une incidence sur la rentabilité des RSP, mais il n'existe aucune preuve définitive à cet effet.
- Les médecins sont très satisfaits de la capitation et certaines données préliminaires montrent que ce mode de rémunération a pour effet d'encourager des changements de comportements.
- Le service de télétriage semble avoir eu des répercussions positives sur l'utilisation des salles d'urgence. Selon les données émanant du fournisseur de ce service, s'il n'y avait pas eu de télétriage, les demandeurs auraient effectué 1 874 consultations auprès des salles d'urgence d'hôpitaux. Or, seuls 871 demandeurs se sont fait conseiller de se rendre à l'urgence, ce qui représente 1 003 consultations de moins.

On a aussi noté dans le rapport trois catégories d'obstacles qui entravent les progrès des réseaux :

- *Les obstacles à la mise en œuvre.* Exemples : les retards pour diverses composantes des TI, l'insuffisance des ressources pluridisciplinaires, l'incapacité d'absorber le volume plus élevé que prévu d'appels adressés au service de télétriage, le manque de sensibilisation des patients et du public au sujet de la réforme.

- *Les obstacles liés au modèle.* Exemples : une approche centrée sur les médecins à l'égard de la réforme, les problèmes posés par les codes de bonis et les taux de capitation, le peu de rétroaction donnée aux médecins au sujet de l'utilisation des services externes, la nécessité de recourir à des mesures de rendement précises pour évaluer les RSP.
- *Les obstacles systémiques.* Exemples : les pénuries de médecins, la structure de financement des soins de santé, le degré insuffisant d'intégration aux réformes adoptées dans d'autres secteurs de la santé et les lacunes sur le plan du service.

Le Comité trouve important de souligner que le modèle adopté en Ontario diffère énormément de celui préconisé par la Commission de restructuration des services hospitaliers. La Commission aurait voulu que les gouvernements cessent de payer les services offerts individuellement par les médecins et adoptent plutôt un modèle en vertu duquel ils financeraient le GSP dans son ensemble principalement au moyen d'une formule de capitation. De l'avis du Comité, cette proposition aurait entraîné la création de véritables pratiques de groupe au lieu du genre de pratique qui semble vouloir voir le jour en Ontario et en vertu duquel des médecins praticiens travaillent sous un même toit tout en conservant l'essentiel de leur autonomie. Le Comité souscrit à l'approche recommandée par la Commission de restructuration des services hospitaliers.

Deux autres provinces ont toutefois annoncé récemment des initiatives de réforme des soins primaires qui s'apparentent plus étroitement aux recommandations contenues dans les rapports commandés par leurs instances gouvernementales respectives.

### **4.2.3 Québec**

Le 4 juin 2002, le ministre québécois de la Santé et le président de la Fédération des médecins omnipraticiens du Québec ont annoncé qu'ils en étaient arrivés à une entente sur des modalités d'établissement des 20 premiers groupes de médecine de famille (GMF). Cette initiative fait partie d'un plan visant à créer plus de 300 de ces groupes au cours des quatre prochaines années, au terme desquelles ceux-ci devraient fournir des services de soins primaires à 75 % de la population de la province, comme l'a recommandé la Commission Clair<sup>116</sup>.

La création de GMF ne sera pas obligatoire, pas plus que l'inscription des patients. Chaque GMF englobera 6 à 10 médecins et infirmières et fournira une gamme complète de services de soins primaires à une population de 10 000 à 20 000 patients<sup>117</sup>. Durant la phase de transition initiale, les médecins continueront d'être rémunérés pour leur activité clinique de la même façon qu'ils le sont actuellement (à l'acte, au moyen d'un salaire, etc.), mais recevront aussi une rémunération horaire pour leurs activités associées au fonctionnement du GMF, comme la coordination des services destinés aux patients inscrits

<sup>116</sup> Communiqué de presse du ministère de la Santé et des Services sociaux (MSSS), 4 juin 2002.

<sup>117</sup> *Health Edition*, vol. 6 n° 23, 7 juin 2002, p. 4.

ou leur collaboration interdisciplinaire avec d'autres fournisseurs, de même qu'une prime annuelle pour chaque patient inscrit sur leur liste<sup>118</sup>.

Les patients s'inscriront auprès du médecin de leur choix à l'intérieur d'un GMF. Une inscription sera valide pendant une année et automatiquement renouvelée à moins que le patient ne l'annule par écrit. Les patients inscrits auront accepté de consulter d'abord leur médecin (ou quelqu'un d'autre au sein du même GMF), à moins qu'ils ne se trouvent dans une situation d'urgence ou qu'ils ne soient en voyage. Les GMF auront des heures d'ouverture prolongées et garantiront la prestation de soins 24 heures sur 24, sept jours sur sept, grâce à un service d'urgence téléphonique<sup>119</sup>.

Pour financer la création des 20 premiers GMF, le gouvernement québécois a engagé 15 millions de dollars, répartis en trois enveloppes : 5 millions de dollars pour verser une rémunération additionnelle aux médecins, 5 millions de dollars également pour la bureautique et le matériel de bureau et enfin 5 millions de dollars pour recruter des infirmières<sup>120</sup>. La création de chaque GMF devra être approuvée par le ministre; chaque groupe de médecine de famille devra également avoir conclu un contrat avec un CLSC (un centre de santé communautaire), ainsi qu'une entente avec le conseil régional de la santé.

Le gouvernement du Québec a aussi récemment présenté un projet de loi, parrainé conjointement par les ministères de la Santé et de la Justice, qui redéfinit les rôles des médecins pour leur permettre de déléguer plus de responsabilités aux infirmières. Ce groupe se spécialisera dans des domaines comme la chirurgie, la cardiologie et les soins intensifs néonataux, de même que dans l'exécution de tâches additionnelles dans divers contextes, notamment les salles d'urgence<sup>121</sup>.

#### **4.2.4 Nouveau-Brunswick**

Le gouvernement du Nouveau-Brunswick a récemment annoncé deux mesures connexes qui font suite aux recommandations relatives à une réforme des soins primaires contenues dans le rapport du Conseil du premier ministre sur la qualité des soins. Le 8 mai, il a déposé un projet de loi visant à intégrer des infirmières praticiennes au système de santé de la province et à permettre aux infirmières agréées de faire davantage usage de leurs compétences et de leur formation. Ce projet de loi prévoit la création et l'agrément d'infirmières praticiennes et habilite les infirmières de première ligne oeuvrant dans les soins de santé primaires à traiter elles-mêmes certains patients n'exigeant pas des soins urgents, sans l'intervention directe d'un médecin<sup>122</sup>. Elles pourront commander des tests en laboratoire et diverses procédures de diagnostic et délivrer des ordonnances pour certains médicaments.

Le ministre de la Santé a annoncé plus tôt que le gouvernement consacra 2,1 millions de dollars à la création dans la province d'au moins deux centres de santé

---

<sup>118</sup> Fiche technique du MSSS, « Résumé de l'entente particulière entre la FMOQ et le MSSS relative aux groupes de médecine de famille. »

<sup>119</sup> Fiche technique du MSSS, « Le groupe de médecine de famille ».

<sup>120</sup> *Health Edition, op. cit.*

<sup>121</sup> *Medical Post*, 14 mai 2002.

<sup>122</sup> Communiqué de presse 453, 8 mai 2002.



communautaire durant l'exercice en cours<sup>123</sup>. Ces centres feront appel à des équipes pluridisciplinaires de professionnels de la santé, notamment à des infirmières praticiennes.

Ce projet de loi a reçu l'appui tant des organisations représentant les médecins que de celles représentant les infirmières. En avril 2002, la Société médicale du Nouveau-Brunswick a de fait proposé la facturation directe de certains services de soins infirmiers au régime d'assurance-maladie de façon à permettre aussi bien aux médecins qu'aux infirmières de voir des patients. Elle a alors fait valoir que cette mesure allait permettre aux cabinets de médecins de famille d'accepter plus de patients, réduire les listes d'attente pour la consultation de spécialistes et même inciter certaines infirmières à retourner à l'exercice de leur profession.

### **4.3 Surmonter les obstacles au changement**

Le Comité accueille favorablement ces initiatives provinciales. Nous notons que, pour la première fois, la réforme des soins de santé primaires est passé du stade des études préliminaires à celui de la mise en application concrète. Ces progrès nous autorisent à entretenir un optimisme prudent quant à l'éventualité d'une vaste réforme des soins primaires au Canada. Il faudra cependant surmonter un certain nombre d'obstacles au changement.

En ce qui concerne l'Ontario par exemple, un certain nombre de témoins ont exprimé des doutes au sujet du caractère « centré sur les médecins » du RSFO. L'un d'eux, le professeur Hutchison, a déclaré au Comité que le modèle ontarien était :

*... un modèle très limité qui reflète le processus par lequel il a été négocié : des négociations bilatérales entre le gouvernement et l'Ontario Medical Association. Aucun intervenant non médecin n'a participé à la discussion. C'était des négociations privées, derrière des portes closes.*

*Bien qu'il comporte certains éléments intéressants, c'est un modèle plutôt traditionnel. On a changé le mode de financement (de rémunération des médecins), mais pas grand-chose d'autre. Chose certaine, ce modèle ne donne pas beaucoup de possibilités aux fournisseurs de soins pour ce qui est de mettre au point et d'évaluer divers arrangements faisant appel à des fournisseurs non médecins comme des infirmières praticiennes, travailleurs sociaux, sages-femmes, etc. C'est un modèle axé sur le médecin<sup>124</sup>.*

Abondant dans le même sens, le D<sup>r</sup> Peter Barrett a insisté sur le fait qu'« afin de garantir des soins complets et intégrés, le médecin de famille doit demeurer le prestataire et le coordonnateur central de l'accès opportun aux services médicaux financés par l'État »<sup>125</sup>. La D<sup>re</sup> Ruth Wilson, présidente du RSFO, a reconnu dans son témoignage que le modèle ontarien actuel constituait un point de départ. Elle espère « que les relations avec les autres professionnels se resserreront quand nous aurons mis en place des réseaux de santé

---

<sup>123</sup> *Medical Post*, vol. 38, n° 21, 21 mai 2002.

<sup>124</sup> 58:23.

<sup>125</sup> 56:10.

familiale »<sup>126</sup>, et ajoute que « nous avons beaucoup de choses à changer si nous voulons convaincre les milliers de médecins de famille de l'Ontario d'accepter ce modèle »<sup>127</sup>.

À cet égard, le président de l'OMA, le D<sup>r</sup> Elliott Halparin, a souligné qu'il faudrait du temps avant que les médecins n'y adhèrent en grand nombre :

*On peut comparer l'intérêt qu'il suscite à du maïs à éclater : au début, quelques grains éclatent seulement et ensuite il y en a de plus en plus. L'intérêt pour le système augmentera de la même façon à mesure que des gens se rendront compte que c'est la meilleure façon d'offrir un ensemble complet de services et que le système profite tant aux patients qu'aux médecins*<sup>128</sup>.

De façon plus générale, des témoins ont fait état de divers obstacles qui entravent encore la mise en œuvre d'une réforme des soins primaires, en l'occurrence :

- les droits acquis de divers groupes professionnels;
- les pénuries de personnel qualifié;
- le fait que les honoraires à l'acte soient la méthode de rémunération des médecins la plus courante;
- les coûts élevés de démarrage;
- l'absence d'une infrastructure d'information électronique.

Le premier de ces points est celui qui a semblé susciter le plus de controverse chez les témoins entendus par le Comité. Certains estiment qu'il faut une intervention ferme, de la part du gouvernement si nécessaire, pour sortir de l'impasse créée par des groupes professionnels qui défendent leur chasse gardée. Claude Forget, ancien ministre de la Santé du Québec, a affirmé que « le fonctionnement du secteur n'est pas très différent de celui d'une guilde médiévale au sens où il est rigide et ne permet pas d'aller chercher quelqu'un qui évolue dans une profession connexe, en cas de pénurie »<sup>129</sup>.

Graham Scott, ancien sous-ministre de la Santé de l'Ontario, a exprimé une opinion similaire, faisant remarquer que « nous sommes confrontés à un monstre très bien financé, bien organisé et puissant caché sous les traits des organisations qui représentent les professionnels de la santé »<sup>130</sup>. Toujours selon ses dires, il faut « la menace de dispositions législatives forcées »<sup>131</sup> pour amener les parties à la table des négociations afin de réviser la réglementation qui régit actuellement les champs de pratique.

D'autres témoins ont cependant fait valoir que la réforme des soins primaires ne pourra être imposée aux fournisseurs de soins de santé et qu'elle ne portera fruit que si elle est adoptée volontairement. Le D<sup>r</sup> Les Vertesi, directeur médical au Royal Columbian

---

<sup>126</sup> 57:7.

<sup>127</sup> 57:17.

<sup>128</sup> 56:22.

<sup>129</sup> 53:54.

<sup>130</sup> 53:47.

<sup>131</sup> 53:49.

Hospital de Vancouver, a ainsi affirmé « [qu']il y a des choses, comme la réforme des soins de santé primaires, qui doivent être effectuées par les fournisseurs, car le souci du détail est incroyablement important »<sup>132</sup>. Le professeur Hutchison a également souligné que « les chances sont très minces d'imposer des réformes à des fournisseurs récalcitrants, en partie parce que je ne crois pas qu'aux yeux du public, une réforme des soins primaires apporterait des avantages énormes »<sup>133</sup>.

Au sujet des champs de pratique, M<sup>me</sup> Kelly Kay de l'Association canadienne des infirmières auxiliaires, a souligné ce qui suit :

*[...] le fait que les infirmières auxiliaires autorisées rencontrent toujours des obstacles artificiels à l'exercice de leur profession, que les infirmières praticiennes doivent lutter pour être reconnues et rémunérées et que d'autres professionnels, comme les physiothérapeutes, ne bénéficient toujours pas d'un accès direct illustre bien les obstacles que rencontrent encore certains groupes professionnels*<sup>134</sup>.

Par ailleurs, des représentants des médecins ont noté les progrès réalisés par les organisations de professionnels lorsqu'elles ont convenu de principes communs pour déterminer les champs de pratique. Voici ce qu'à dit à ce sujet le D<sup>r</sup> Barrett :

***[...] le Comité s'est dit favorable à la révision des règles qui régissent les champs de pratique afin de permettre à tous les fournisseurs de soins de santé de fournir la gamme complète des services pour lesquels ils ont été formés. Le Comité est d'avis qu'il faudrait uniformiser autant que possible ces règles dans tout le pays.***

*L'Association médicale canadienne a adopté une politique sur les « champs de pratique » qui appuie clairement la collaboration et la coopération. L'Association des infirmières et infirmiers du Canada et l'Association des pharmaciens du Canada ont donné leur accord de principe à cette politique. Nous avons d'ailleurs signé un document à cet effet*<sup>135</sup>.

Dans le volume cinq, le Comité s'est dit favorable à la révision des règles qui régissent les champs de pratique afin de permettre à tous les fournisseurs de soins de santé de fournir la gamme complète des services pour lesquels ils ont été formés<sup>136</sup>. Le Comité est d'avis qu'il faudrait uniformiser autant que possible ces règles dans tout le pays. Le rapport de synthèse des projets touchant les soins primaires du Fonds pour l'adaptation des services de santé en arrive à une conclusion semblable, notamment pour ce qui est des soins infirmiers :

---

<sup>132</sup> 53:90.

<sup>133</sup> 58:12.

<sup>134</sup> 61:4.

<sup>135</sup> 56:12.

<sup>136</sup> Voir également au chapitre onze d'autres observations sur la nécessité de modifier les règles régissant les champs de pratique.

*Il faudrait une initiative fédérale, provinciale et territoriale pour définir des normes nationales en ce qui concerne la terminologie et la portée de la pratique. Cette initiative devrait comprendre des prescriptions légales favorables à l'élargissement du rôle des infirmières et des infirmières praticiennes<sup>137</sup>.*

Le Comité souscrit à cette conclusion et croit que le gouvernement fédéral devrait prendre l'initiative à cet égard.

Certains témoins ont laissé entendre que ce qui manque surtout pour faire progresser la réforme des soins primaires plus rapidement, c'est la volonté politique. Dans cet esprit, Michael Decter a déclaré au Comité :

*La question n'est pas de trouver le bon modèle, mais plutôt de déplacer des balises. Nous avons passé beaucoup de temps à chercher le modèle parfait de réforme des soins primaires. À certains endroits, cela a fonctionné en grande partie parce que quelqu'un a tout simplement eu la volonté de changer les choses<sup>138</sup>.*

Des témoins ont réitéré l'argument formulé par le Comité dans le volume cinq à l'effet qu'il ne peut y avoir de modèle unique applicable de la même façon dans toutes les régions du pays. Mme Kelly Kay a affirmé que « celle-ci [la prestation des soins de santé primaires] variera d'un endroit à l'autre », puisque « chaque ville doit adapter ses services à ses besoins »<sup>139</sup>. Pour sa part, la D<sup>e</sup> Susan Hutchison, présidente du Forum des médecins omnipraticiens de l'Association médicale canadienne, a déclaré au Comité :

*La composition des équipes de soins de santé varie selon les besoins de la population. Il n'existe pas de composition idéale. Ce qui fonctionne le mieux, ce sont des ressources humaines adéquates pour répondre aux besoins de la population. La composition du personnel soignant s'établit en fonction des services nécessaires pour répondre aux besoins des malades. La gamme idéale des services offerts par une équipe dépend des besoins de la population et du bassin de professionnels de la santé disponibles. Il peut y avoir une variation considérable entre les besoins de diverses populations, comme c'est le cas pour les populations autochtones, par exemple<sup>140</sup>.*

Les auteurs du rapport de synthèse sur les projets du Fonds pour l'adaptation des services de santé (FASS) dans le domaine des soins primaires (juin 2002) en arrivent à une conclusion semblable lorsqu'ils soulignent que « le système de santé s'est déjà montré capable de soutenir des variations organisationnelles et il pourrait encore le faire dans le cadre déterminant de l'intégration des soins de santé primaires »<sup>141</sup>. Ils tirent aussi un certain nombre de leçons qui corroborent les recommandations formulées par le Comité dans le volume cinq en ce qui concerne les caractéristiques fondamentales d'un système de soins primaires réformé, l'élaboration d'une stratégie nationale en matière de ressources humaines

---

<sup>137</sup> Marriott Mable, *op. cit.*, p. 45.

<sup>138</sup> 52:16.

<sup>139</sup> 61:5.

<sup>140</sup> 56:15.

<sup>141</sup> Marriott Mable, *op. cit.*, p. 40.

en santé et la mise en oeuvre d'un système national de dossiers de santé électroniques. Ainsi, ils concluent que :

*L'expérience directe acquise par le biais des projets du FASS apporte un nouvel éclairage et renforce les connaissances de longue date sur certains aspects des soins de santé primaires, comme les avantages de la médecine de groupe et des équipes pluridisciplinaires, le potentiel inexploité des infirmières, et les liens entre les déterminants, la promotion de la santé et la maladie, et la prévention des blessures<sup>142</sup>.*

Ils affirment également que certaines conditions sont nécessaires au succès de la réforme des soins primaires et soutiennent à cet égard qu'« il est essentiel, si l'on veut de bons soins de santé primaires, de prêter attention à des éléments sous-jacents tels que la création d'un dossier médical électronique commun et l'accès à des ordinateurs et à d'autres technologies pour les services, l'information et la recherche »<sup>143</sup>.

#### **4.4 Le rôle du gouvernement fédéral**

Dans le volume cinq, le Comité recommande :

**Que le gouvernement fédéral continue de travailler avec les provinces et les territoires à la réforme de la prestation des soins primaires et qu'il assure un soutien financier permanent aux projets de réforme entraînant la création d'équipes de soins de santé primaires pluridisciplinaires qui :**

- **visent à offrir une large gamme de services 24 heures sur 24, sept jours sur sept;**
- **veillent à faire en sorte que les services soient dispensés par les professionnels de la santé compétents qui conviennent le mieux;**
- **utilisent à leur pleine mesure les capacités et les compétences d'un éventail de professionnels de la santé;**
- **adoptent d'autres modes de rémunération que les honoraires à l'acte, par exemple la capitation, soit exclusivement, soit dans le cadre d'une formule de financement mixte;**
- **cherchent à intégrer des stratégies de promotion de la santé et de prévention de la maladie dans leur travail quotidien;**

---

<sup>142</sup> *Ibid.*, p. 39.

<sup>143</sup> *Ibid.*, p. 40.

- **assument progressivement une plus grande part de responsabilité à l'égard des besoins en santé et en bien-être de la population desservie.**

Un appui financier permanent à l'égard des initiatives de réforme qui entraînent la création d'équipes de soins de santé primaires pluridisciplinaires constituerait un prolongement de l'engagement dont le gouvernement fédéral a fait preuve à l'égard de la réforme des soins primaires en allouant 150 millions de dollars au Fonds pour l'adaptation des services de santé, dont 60 millions de dollars ont servi à financer des projets reliés à la réforme des soins primaires. Le gouvernement fédéral a également affecté 560 des 800 millions de dollars consentis au titre du Fonds pour l'adaptation des soins de santé primaires (FASSP), créé en 2002 à l'issue de la Conférence des premiers ministres, pour aider les provinces et les territoires à élargir la portée des mesures envisagées dans le secteur des soins primaires et en accélérer la mise en oeuvre. Cette somme est allouée au prorata de la population. Pour y avoir accès, chaque gouvernement provincial et territorial doit élaborer une proposition sur la façon dont leur part du FASSP servira à absorber les frais de transition occasionnés par la réforme des soins de santé primaires.

Le FASSP n'est toutefois pas un programme permanent. Le Comité reconnaît que les coûts de démarrage pour les groupes de soins primaires peuvent être considérables. Si l'on se fie aux coûts réels de mise en oeuvre de la réforme des soins primaires au Québec, ceux-ci pourraient atteindre jusqu'à 750 000 \$ par groupe, mais on avait évalué au départ qu'ils pourraient aussi atteindre un million de dollars par groupe.

Le Comité recommande donc :

**Que le gouvernement fédéral puise 50 millions de dollars par année dans les nouvelles recettes que le Comité lui a recommandé de générer, pour aider les provinces à mettre sur pied des groupes de soins primaires.**

Cet argent, qui s'ajoutera aux sommes provenant du FASSP, devrait permettre la création de 50 à 65 groupes de soins primaires par année.

Le Comité est persuadé que, pour pouvoir fonctionner efficacement, les groupes de soins primaires doivent jouer le rôle de portiers pour le reste du système de soins de santé. Il faut, par exemple, trouver des moyens pour inciter les patients inscrits auprès d'un GSP à consulter le médecin de leur groupe plutôt que de faire eux-mêmes des démarches pour obtenir les soins de spécialistes. Ce devrait donc être au fournisseur de soins primaires de faire les renvois à des spécialistes, en consultation avec le patient.

***Le Comité est persuadé que, pour pouvoir fonctionner efficacement, les groupes de soins primaires doivent jouer le rôle de portiers pour le reste du système de soins de santé.***

Néanmoins, le Comité ne croit pas qu'il y a lieu d'interdire aux patients de consulter d'autres médecins, particulièrement des spécialistes, s'ils le désirent. Il croit par contre que les patients qui choisissent de solliciter ailleurs des soins qui pourraient être

fournis adéquatement par le GSP auprès duquel ils sont inscrits devraient assumer les conséquences financières de leur décision. En d'autres termes, les patients devraient être assujettis à des frais, lorsqu'ils consultent d'autres médecins, notamment des spécialistes, de leur propre initiative.

Dans le volume cinq, le Comité recommande aussi l'établissement d'un cadre permanent pour l'étude des questions touchant les ressources humaines, en particulier grâce à la création d'un organisme national permanent de coordination des ressources humaines en santé composé de représentants des principaux intervenants et des différents ordres de gouvernement. Le mandat de cet organisme consisterait à coordonner des projets visant à assurer un nombre suffisant de diplômés pour réaliser l'objectif d'autonomie du Canada en matière de ressources humaines en santé<sup>144</sup>.

Au sujet de la création de dossiers de santé électroniques, le Comité recommande dans le volume cinq de prolonger le mandat actuel d'Inforoute Santé du Canada, au-delà des 3 à 5 ans initialement prévus, pour qu'elle mette au point, de concert avec les provinces et territoires, un système national de DSE. Plusieurs témoins ont fait valoir que la création de dossiers de santé électroniques est non seulement essentielle à la réforme des soins de santé primaires, mais que c'est un domaine dans lequel le gouvernement fédéral peut exercer un leadership.

D'après Jack Davis, président-directeur général de la Calgary Health Region, « le seul domaine où je vois un réel potentiel d'investissement fédéral est la création du dossier médical électronique »<sup>145</sup>. Le D Kenneth Sky, ex-président de l'Ontario Medical Association, a mentionné que « pour les médecins, l'élément de la réforme des soins primaires qui est lié à l'utilisation de la technologie de l'information constitue un gros incitatif »<sup>146</sup>. Michael Decter estime pour sa part que les dossiers de santé électroniques sont si importants qu'« on devrait soudoyer les médecins. Je leur offrirais de l'argent pour qu'ils informatisent leur système »<sup>147</sup>.

Le Comité admet que le gouvernement fédéral devrait assumer un rôle de premier plan pour accélérer d'un système national de dossiers de santé électroniques et présente des recommandations précises en ce sens au chapitre dix.

---

<sup>144</sup> Voir également le chapitre onze du présent volume.

<sup>145</sup> 53:88.

<sup>146</sup> 56:22.

<sup>147</sup> 52:14.

## **Annexe 4.1 :** **Régime d'enveloppes budgétaires pour les omnipraticiens en Grande-Bretagne**

Lors des discussions sur la réforme des soins primaires, il est souvent question de l'expérience britannique avec la création de marchés internes durant les années 90. Avant 1990, il était exact de décrire le service national de santé britannique (le British National Health Service, habituellement appelé le NHS) comme une entité dirigée par une bureaucratie monolithique qui contrôlait tous les aspects du système. À l'époque, les services de soins de santé communautaires et les hôpitaux du NHS appartenaient à l'État et étaient exploités par les régies régionales de la santé du NHE. On déterminait le budget de chaque hôpital suivant un processus administratif qui supposait des négociations entre la direction hospitalière et celle du NHS. La prestation des soins par les omnipraticiens était assujettie à un système d'établissement de listes (« rostering ») qui obligeait les patients à s'inscrire auprès d'un omnipraticien en particulier, qui tenait lieu par la suite de portier (« gatekeeper ») pour le reste du système. Les omnipraticiens travaillaient à contrat pour le NHS et étaient rémunérés selon un système mixte de salaire et de capitation établie selon le nombre de patients inscrits sur leur liste.

Avec la réforme des soins primaires et la création de marchés internes, certains cabinets de médecine générale ont pu choisir volontairement d'adhérer au régime des enveloppes budgétaires (autrement dit, de devenir des « fundholders »). Les cabinets de médecine familiale qui desservaient un nombre suffisant de patients sont devenus des acheteurs et ont alors été autorisés à passer des contrats avec des hôpitaux et avec d'autres fournisseurs communautaires (des infirmières de district, par exemple) pour obtenir certains services. Les enveloppes budgétaires ne devaient servir qu'à l'achat de services hospitaliers et communautaires; elles ne pouvaient être utilisées pour arrondir les revenus des omnipraticiens concernés. Le NHS a toujours rémunéré les omnipraticiens participant au régime comme des professionnels indépendants travaillant à leur compte. Les diverses réformes adoptées durant les années 90, comme la mise en place du régime d'enveloppes budgétaires (« fundholding ») et, plus récemment, la création de groupes de soins primaires, n'ont pas fondamentalement modifié la façon dont les omnipraticiens britanniques gagnent leur argent.

Au début des années 90, on s'attendait à ce que le régime d'enveloppes budgétaires ne représente qu'une infime partie du processus général de réforme mais contre toute attente, il a rapidement gagné en popularité pour diverses raisons. Il est vite devenu évident que les participants au régime pouvaient offrir de meilleurs services à leurs patients. Ceci a créé un effet d'entraînement, peu de médecins voulant être laissés pour compte. Le gouvernement conservateur a renforcé cette tendance en offrant d'autres avantages (comme des ordinateurs) uniquement aux cabinets participant au régime. En plus, le fait de fonctionner selon le régime des enveloppes budgétaires conférait aux omnipraticiens concernés un rôle central et une plus grande autorité dans l'ensemble du système. Les consultants (des spécialistes) ont été obligés de faire preuve d'une plus grande souplesse et de rendre davantage de comptes aux omnipraticiens, puisque ceux-ci pouvaient décider de renvoyer leurs patients à d'autres professionnels dans le cadre de leur pratique.



Élu pour la première fois en 1997, le gouvernement travailliste dirigé par Tony Blair était critique à l'égard d'un certain nombre d'aspects de la réforme axée sur les marchés internes. Il estimait, en particulier, que le régime d'enveloppes budgétaires avait favorisé l'apparition en Grande-Bretagne d'une forme de système à deux vitesses (« two-tierism »), parce que les patients des omnipraticiens participant au régime pouvaient souvent se faire soigner plus rapidement que ceux des autres omnipraticiens. Comme ils estimaient que cela allait à l'encontre des principes fondamentaux du NHS, les travaillistes ont cherché à restreindre les formes de concurrence qui, selon eux, étaient la cause des inégalités en train de se créer.

En avril 1999, le gouvernement a obligé tous les omnipraticiens à joindre les rangs d'un groupe de soins primaires (GSP), c'est-à-dire un regroupement de cabinets de médecine générale à l'intérieur de régions géographiques bien plus grandes que celles délimitées en vertu du régime des enveloppes budgétaires, pouvant englober de 50 000 à 250 000 personnes. Les GSP ont réuni des fournisseurs de soins primaires locaux sous l'autorité d'un conseil principalement dirigé par des omnipraticiens, mais comptant également des infirmières et d'autres fournisseurs de soins communautaires locaux. On s'attendait à ce que les GSP évoluent petit à petit et deviennent des « fiducies » (« trusts ») de soins primaires capables d'assumer l'entière responsabilité de la mise en service (par l'octroi de contrats) et de la prestation de services de santé communautaires à leur population. Dès avril 2002, presque tous les GSP étaient devenus des fiducies.

En principe, cette évolution conférait dorénavant à tous les omnipraticiens les avantages offerts par le régime des enveloppes budgétaires, c'est-à-dire un seul budget régional englobant tous les services de médecine générale, les médicaments de prescription et les soins hospitaliers et spécialisés. Une évaluation récemment effectuée par le King's Fund donne toutefois à penser qu'il y aura encore certaines étapes à franchir avant que les fiducies de soins primaires puissent réaliser leur indéniable potentiel. Les auteurs de cette étude ont conclu que les fiducies de soins primaires se développent actuellement à des rythmes différents et que même si elles ont fait des progrès au chapitre de l'établissement et de l'intégration des soins primaires et communautaires, leur portée demeure jusqu'ici limitée pour ce qui est de la mise en service et de l'amélioration de la santé<sup>148</sup>.

Il y a lieu de souligner que les omnipraticiens ont conservé le monopole de la prestation des soins primaires jusqu'à la mise en œuvre des réformes du marché dans les années 90 grâce à leur rôle de portiers pour tous les autres volets du système. Un certain nombre de réformes apportées par le gouvernement travailliste a permis aux cabinets dirigés par des infirmières d'assumer un rôle croissant à cet égard. On a notamment créé une ligne téléphonique de consultation dont des infirmières assurent la surveillance 24 heures sur 24 (NHS Direct) et ouvert un certain nombre de cliniques sans rendez-vous où des infirmières font une première évaluation et peuvent ensuite diriger les patients au besoin vers des omnipraticiens locaux.

Il est très difficile, en raison d'un certain nombre de facteurs, de tirer des conclusions définitives de l'expérience britannique, qui puissent facilement s'appliquer au contexte canadien. On n'a pas toujours disposé de données suffisantes et la rapidité des

---

<sup>148</sup> John Appleby et Anna Coote, *Five Year Health Check*, King's Fund, avril 2002, p. 47.

changements n'a pas facilité la réalisation d'une étude approfondie. En plus, compte tenu de la structure très différente des deux systèmes, il est difficile d'appliquer les leçons tirées du système britannique au système canadien de soins de santé. Un certain nombre de points sont toutefois dignes de mention :

- Premièrement, malgré son opposition à la forme prise par les marchés internes sous le gouvernement conservateur sortant, le gouvernement travailliste a néanmoins conservé des éléments clés du principe de la séparation « payeur-fournisseur » adopté par les conservateurs.
- Deuxièmement, la transition opérée par le gouvernement Blair pour passer du régime des enveloppes budgétaires aux GSP et aux FSP semble mettre davantage en évidence les succès du régime plutôt que ses lacunes. On s'est mis à craindre l'instauration d'un système à deux vitesses parce que les omnipraticiens participant au régime ont réussi à négocier avec les fiduciaires hospitalières au nom de leurs patients.
- Troisièmement, le fait d'octroyer un plus grand rôle aux infirmières et à d'autres fournisseurs de soins dans la prestation des soins primaires n'est pas sans rappeler les recommandations en ce sens qui reviennent constamment sur le tapis dans le débat en cours au Canada à propos de la réforme des soins primaires.



**TABLEAU 41**  
**EXAMEN DE RAPPORTS PROVINCIAUX RÉCENTS COMPORTANT DES RECOMMANDATIONS DE RÉFORME DES SOINS**  
**DE SANTÉ PRIMAIRES**

<b>Rapport</b>	<b>Étendue des services</b>	<b>Composition des équipes</b>	<b>Rémunération</b>	<b>Taille d'un cabinet</b>	<b>DSE*</b>	<b>Inscription</b>	<b>Relations externes</b>
Sinclair (Ont.) Déc. 1999	Des soins primaires complets seraient fournis 24 heures sur 24, sept jours sur sept grâce à l'ouverture des cabinets après les heures ouvrables (ou à la prolongation de leurs heures d'ouverture) et à un triage téléphonique qui serait aussi effectué 24 heures sur 24 jour.	Des médecins et des infirmières praticiennes jouant le rôle de « fournisseurs principaux », à l'intérieur d'une équipe interdisciplinaire qui inclurait des infirmières agréées, des sages-femmes, des psychologues et des travailleurs sociaux, des pharmaciens, des physiothérapeutes et des diététistes. Chacun des fournisseurs de soins de santé exercerait la gamme complète des compétences liées à son champ de pratique.	Il s'agirait d'un financement de groupe plutôt que d'un financement individuel, principalement au moyen d'une formule de capitation à laquelle s'ajouteraient d'autres méthodes; le groupe déterminerait les montants qui seraient remboursés aux fournisseurs de services qui en seraient membres. Il ne s'agirait pas simplement d'un partage des bureaux.	Trois modèles distincts : <u>Régions urbaines</u> - 6 médecins et 2 infirmières praticiennes pour environ 1 680 patients; <u>Régions rurales</u> - 2 médecins et 2 infirmières praticiennes pour 1 293 patients; <u>Régions éloignées</u> - 1 médecin et 3 infirmières praticiennes/infirmiers praticiens pour 1 142 patients.	Oui	Oui	Chaque cabinet serait chargé d'élaborer des ententes avec d'autres organismes et fournisseurs de soins de santé (des hôpitaux, des spécialistes, des services de santé publics, des centres de réadaptation, des établissements de soins de longue durée, des services de soins à domicile et des services communautaires).
Clair (Qué.) Janv. 2001	Des cabinets de groupe assureraient les services 24 heures sur 24, sept jours sur sept. Les services incluraient la promotion de la santé et la prévention, le diagnostic et le traitement des maladies, les renvois vers des hôpitaux et des spécialistes, la coordination du continuum des soins et les renvois vers des organismes de services sociaux.	Les cabinets ne comprendraient que des médecins et des infirmières praticiennes, mais ceux-ci travailleraient en collaboration avec le réseau actuel de CLSC (des travailleurs sociaux, des diététistes, des psychologues, des physiothérapeutes, etc.).	Un système mixte de rémunération incluant des éléments de capitation, une somme forfaitaire pour la participation à certains programmes et des honoraires à l'acte à des fins de prévention ou pour stimuler la productivité.	6 à 10 médecins travaillant à l'intérieur d'une polyclinique ou d'un CLSC, bénéficiant de la collaboration de deux à trois infirmières praticiennes et responsables de 1 000 à 1 800 personnes.	Oui	Oui	Contrat avec la régie régionale de la santé et entre le cabinet de soins primaires de groupe et le CLSC. Les régies régionales de la santé seraient chargées de coordonner le réseau de cabinets de soins primaires de groupe avec d'autres fournisseurs de services.

Rapport	Étendue des services	Composition des équipes	Rémunération	Taille d'un cabinet	DSE*	Inscription	Relations externes
Fyke (Sask.) Avril 2001	Des cabinets de groupe offrirait les services 24 heures sur 24. En dehors des heures ouvrables, les appels téléphoniques seraient transmis à un membre du groupe qui se trouverait à proximité; un service d'appoint serait assuré en permanence grâce à un centre d'appel provincial. Il n'y aurait pas de liste explicite des services.	Les cabinets de soins primaires de groupe comprendraient divers fournisseurs, notamment des médecins, des infirmières praticiennes, des sages-femmes, des physiothérapeutes, des diététistes, des préposés aux soins à domicile et des professionnels dans les domaines de la santé mentale, de la réadaptation, de la lutte contre la toxicomanie et de la santé publique.			Oui		Les régies régionales de la santé organiseraient et gèreraient les cabinets de soins primaires de groupe, en recrutant tous les fournisseurs de services, notamment les médecins, par contrat ou autrement.
Mazan- kowski (Alb.) Déc. 2001	L'auteur de ce rapport approuve de façon très générale l'idée d'une réforme des soins de santé primaires. Des équipes pluridisciplinaires assureraient la prestation de soins complets.	Les équipes pourraient comprendre un médecin de famille, une infirmière ou une infirmière praticienne, des travailleurs en santé mentale, des travailleurs sociaux et d'autres intervenants.	L'auteur estime que les honoraires à l'acte font obstacle au changement. Il est d'avis qu'un modèle mixte de financement serait la meilleure solution et trouve que le Réseau santé-famille de l'Ontario constitue un excellent exemple à cet égard.		Oui		Les médecins devraient avoir la possibilité de conclure des contrats avec les régies régionales de la santé pour une partie de leurs revenus.
T.-N. Déc. 2001	Un réseau d'équipes de soins primaires assurant un « continuum de soins » (incluant des soins préventifs, des soins axés sur la promotion de la santé, des soins curatifs, des soins de soutien et de réadaptation).	Les médecins de soins primaires collaboreraient avec d'autres fournisseurs de soins de santé et d'autres médecins. À l'intérieur de chacune des équipes, chaque fournisseur de soins de santé exercerait ses compétences à leur plus haut niveau.	L'auteur ne recommande pas de méthode précise de financement (un modèle universel), mais semble être favorable à une forme quelconque de financement souple et mixte. Il ne fait pas mention de la capitation.		Oui		Les conseils régionaux dresseraient à l'intention des médecins un aperçu des services médicaux nécessaires pour leur région. Des groupes de médecins concluraient des ententes officielles avec les conseils pour assurer la prestation de l'ensemble des services énumérés dans lesdites ententes.

Rapport	Étendue des services	Composition des équipes	Rémunération	Taille d'un cabinet	DSE*	Inscription	Relations externes
N.-B. Janv. 2002	Accès à une gamme complète de services ambulatoires 24 heures sur 24, sept jours sur sept, qui seraient coordonnés à partir d'un seul endroit, de préférence, un centre de santé communautaire. Là où les centres ne sont pas ouverts 24 heures sur 24, les appels téléphoniques seraient redirigés vers un centre de service fonctionnant en permanence.	Un modèle axé sur la collaboration et une approche d'équipe vis-à-vis de la prestation des soins primaires. Les médecins de famille ne verraient pas chaque patient et d'autres membres de l'équipe pourraient fournir des services de consultation et/ou se charger du traitement. L'objectif consisterait à faire pleinement appel à tous les fournisseurs de soins en fonction de leurs connaissances, compétences et aptitudes respectives.		Dans la mesure du possible, tous les services de soins primaires seraient assurés ou coordonnés par un réseau de centres de santé communautaires. Ces centres seraient considérés comme le « noyau » physique des soins primaires offerts dans la communauté.	Oui		D'autres fournisseurs de soins pourraient être consultés par l'intermédiaire de télésanté et/ou, sur place, au centre de santé communautaire lui-même.

\*Dossier de santé électronique  
Source : Bibliothèque du Parlement



# **Partie III :**

# **La garantie de**

# **soins de santé**

A thick, dark grey L-shaped line that starts as a vertical bar on the right side of the text and then extends horizontally to the left, underlining the text.





## CHAPITRE CINQ

### DES SOINS DE SANTE EN TEMPS OPPORTUN

---

La plus grande partie du volume six est consacrée à des aspects particuliers de la prestation des soins de santé. La restructuration des hôpitaux, le financement des soins, la réforme des soins de santé primaires et l'élargissement du système public d'assurance-médicaments, de même que certains types de soins de santé à domicile et de soins palliatifs sont autant d'éléments cruciaux d'un régime de soins de santé viable. Toutefois, le présent chapitre abordera une question qui, si elle est moins débattue, reste pourtant très importante : le droit de recevoir des soins de santé et l'incidence de la *Charte canadienne des droits et libertés* (la Charte) sur la prestation *en temps opportun* des soins de santé nécessaires sur le plan médical.

L'accès *en temps opportun* à des soins médicaux ne signifie pas nécessairement un accès immédiat, pas plus que la question de la rapidité d'accès ne s'applique qu'aux affections graves. Cela veut plutôt dire que le service est offert en conformité avec les lignes directrices des pratiques cliniques garantissant que le délai d'attente n'entraîne pas d'effet nocif sur l'état de santé du patient.

***Le Comité estime important de souligner que l'accès en temps opportun ne signifie pas nécessairement un accès immédiat, pas plus que la question de la rapidité d'accès ne s'applique qu'aux affections graves. Cela veut plutôt dire que le service est offert en conformité avec les lignes directrices des pratiques cliniques garantissant que le délai d'attente n'entraîne pas d'effet nocif sur l'état de santé du patient.***

La question de l'accès en temps opportun aux soins de santé revêt une importance particulière à l'heure actuelle, pour les raisons suivantes. En premier lieu, de multiples sondages d'opinion ont révélé que, de plus en plus, la principale inquiétude des Canadiens vis-à-vis du système public de soins de santé concerne les délais d'attente pour l'obtention d'un diagnostic, de soins hospitaliers et des services d'un spécialiste. Ces sondages mettent tous en lumière l'absence fréquente d'un accès rapide aux soins de santé, tel que le définissent les patients.

Ensuite, l'impossibilité d'obtenir en temps opportun des soins nécessaires peut nuire de façon significative à l'état de santé et au bien-être du patient. Par conséquent, les pressions vont probablement s'intensifier sur les gouvernements, les hôpitaux et les médecins pour qu'ils s'assurent que les soins de santé médicalement nécessaires sont fournis en temps opportun dans le cadre du système public. Il est aussi fort probable qu'à défaut d'améliorations importantes, les Canadiens vont insister auprès du gouvernement pour qu'il prenne les mesures législatives qui leur permettront de recevoir rapidement des soins dans un système privé parallèle de services hospitaliers et de services fournis par les médecins.

Enfin, si ces pressions s'avèrent inefficaces, pour les raisons précisées plus loin, le Comité croit que les tribunaux vont probablement déclarer inconstitutionnelles les lois actuelles qui empêchent effectivement les Canadiens d'acheter au secteur privé, au Canada, des services couverts par l'assurance-santé.

Par conséquent, il est essentiel de trouver une solution au problème de la rapidité d'accès aux soins afin de préserver, au Canada, le modèle de l'assureur unique du système public de soins hospitaliers et de soins dispensés par les médecins, que les Canadiens – et le Comité – appuient si fortement.

Les soins de santé constituent-ils un droit pour les Canadiens? Peut-on empêcher les Canadiens de prendre des mesures pour obtenir rapidement des soins que le système public ne parvient pas à leur assurer dans les délais voulus? Ces questions sont abordées dans le présent chapitre.

## 5.1 Le droit aux soins de santé – Perception du public ou droit reconnu par la loi?

D'abord, il importe d'établir une distinction entre un droit aux soins de santé reconnu par la loi et l'opinion du public quant à l'existence de ce droit. Dans le volume quatre, le Comité signale que des sondages d'opinion publique révèlent que les Canadiens, confortés dans cette opinion par les politiciens et les médias, estiment jouir du droit constitutionnel de recevoir des soins de santé, bien que la Charte n'en fasse pas mention de façon explicite<sup>149</sup>. En fait, aucune loi canadienne ne confère explicitement ce droit, bien que les gouvernements aient mis en place des programmes établissant un régime de soins de santé financé par l'État<sup>150</sup>.

**Le Comité a signalé que des sondages d'opinion publique révèlent que les Canadiens estiment jouir du droit constitutionnel de recevoir des soins de santé, bien que la Charte n'en fasse pas mention de façon explicite.**

Le préambule de la *Loi canadienne sur la santé*<sup>151</sup> (la Loi) indique ce qui suit :

*[...] l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens.*

De même, l'article 3 de la Loi énonce l'objectif premier de la politique canadienne de la santé, soit :

*de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.*

Ces énoncés de la *Loi canadienne sur la santé*, aussi favorables soient-ils, n'établissent pas le droit aux soins de santé.

<sup>149</sup> Volume quatre, p. 38.

<sup>150</sup> Colleen Flood et Tracy Epps, *Can a Patients' Bill of Rights Address Concerns About Waiting Lists?* document de travail provisoire, Groupe du droit de la santé, faculté de droit, Université de Toronto, 9 octobre 2001, p. 7.

<sup>151</sup> L.R. (1985), ch. 6.

De même, des instruments internationaux comme la Déclaration universelle des droits de l'homme de 1948, dont le Canada est signataire, font état du droit à un niveau de vie assurant la santé et le bien-être, y compris les soins de santé et le droit à la sécurité en cas de maladie ou d'invalidité, mais ils ne constituent pas le fondement d'un droit constitutionnel, ni même juridique, aux soins de santé<sup>152</sup>.

Il est clair que le public est convaincu de jouir d'un droit juridique aux soins de santé qui, dans les faits, n'existe pas.

Malgré l'absence d'un droit juridique aux soins de santé, les effets de la *Charte canadienne des droits et libertés* dans le contexte des soins de santé font l'objet d'une documentation et d'une jurisprudence toujours plus considérables. Il est particulièrement intéressant d'examiner l'incidence de l'article 7 de la Charte sur la prestation en temps opportun de soins de santé au Canada.

## **5.2 Disponibilité des services couverts par le régime public à l'extérieur du système public de soins de santé**

Dans le volume quatre, le Comité examine l'incidence de la *Loi canadienne sur la santé* sur la prestation de soins de santé privés. Nous avons souligné le fait que la Loi n'interdit pas la prestation de services de santé privés. Elle fixe plutôt les conditions dans lesquelles les provinces et les territoires recevront ou non la contribution totale du gouvernement fédéral pour le paiement des services hospitaliers ou fournis par les médecins jugés médicalement nécessaires que reçoivent leurs résidents<sup>153</sup>.

Pour recevoir la pleine contribution du gouvernement fédéral, les régimes publics d'assurance-santé des provinces et des territoires doivent respecter cinq conditions essentielles : gestion publique, intégralité, universalité, transférabilité et accessibilité. La *Loi canadienne sur la santé* incite fortement les provinces et les territoires à décourager les médecins et les hôpitaux d'imposer aux patients des frais additionnels ou des frais d'utilisation pour la prestation de services nécessaires sur le plan médical. La contribution pécuniaire versée par le gouvernement fédéral dans le cadre du TCSPS peut être réduite du montant correspondant à la surcharge ou aux frais d'utilisation.

La *Loi canadienne sur la santé* n'interdit pas aux fournisseurs de soins de santé d'offrir des soins couverts par les régimes d'assurance-santé provinciaux et de facturer le secteur privé plutôt que le régime d'assurance provincial. De plus, elle ne limite aucunement la prestation, par des établissements privés (à but lucratif ou non lucratif), de services couverts par le régime public d'assurance-santé. D'ailleurs, à l'heure actuelle, des établissements privés offrent ce type de services dans toutes les provinces. Cependant, la Loi impose des sanctions pécuniaires considérables aux provinces qui permettent le paiement, à titre privé, de services couverts par le régime public d'assurance-santé, surtout si cela suppose l'imposition d'une surcharge ou de frais d'utilisation.

---

<sup>152</sup> Association du Barreau canadien, Groupe de travail sur les soins de santé, *What's Law Got To Do With It? Health Care Reform in Canada*, (Ottawa, Association du Barreau canadien, août 1994) p. 24.

<sup>153</sup> Volume quatre p. 41-42.

De concert avec la *Loi canadienne sur la santé*, les lois provinciales et territoriales tentent de décourager et de prévenir la prestation, à l'extérieur du régime public d'assurance-santé, de services jugés médicalement nécessaires. Les médecins peuvent choisir de fournir leurs services en marge du régime public et de facturer les services directement au patient, mais divers règlements provinciaux découragent cette pratique. Bon nombre de provinces interdisent aux médecins qui ont choisi de se retirer du régime d'assurance-santé d'imposer aux patients un tarif supérieur à celui que prévoit le régime. Certaines provinces refusent de rembourser les patients qui reçoivent des services de santé assurés de médecins qui se sont retirés du régime d'assurance-santé. De plus, la majorité des provinces interdisent l'achat de régimes privés d'assurance-santé en vue de services couverts par le système provincial, bien que toutes les provinces permettent à leurs résidents d'acheter une assurance privée pour les services médicaux et hospitaliers ou fournis par les médecins exclus des services jugés nécessaires sur le plan médical<sup>154</sup>.

Comme l'indique le Comité dans le volume quatre de son étude:

*La Loi canadienne sur la santé, tout comme les lois provinciales et territoriales, a empêché l'émergence d'un système privé de soins de santé qui ferait directement concurrence au système public. Il n'est tout simplement pas possible, sur le plan économique, pour les patients, les médecins ou les établissements de soins de santé de participer à un système parallèle<sup>155</sup>.*

**Le Comité déplore le fait que les Canadiens n'ont guère de possibilités, s'il en est, de pallier au Canada l'incapacité du système public de soins de santé de leur offrir les soins requis en temps voulu. Ceux qui en ont les moyens peuvent obtenir des soins aux États-Unis, mais la plupart des patients se contentent d'attendre, parfois en vain, que le régime public puisse les accueillir.**

En définitive, les Canadiens n'ont guère de possibilités, s'il en est, de pallier au Canada l'incapacité du système public de soins de santé de leur offrir les soins requis en temps voulu. Ceux qui en ont les moyens peuvent obtenir des soins aux États-Unis, mais la plupart des patients se contentent d'attendre, parfois en vain, que le régime public puisse les accueillir.

### **5.3 Prestation de soins de santé en temps opportun et article 7 de la Charte canadienne des droits et libertés**

La réalité des longues listes d'attente pour l'obtention de certains traitements jugés nécessaires sur le plan médical – donc, l'impossibilité de recevoir des soins en temps opportun – soulève diverses questions, et les droits des patients en attente de soins n'est certainement pas la moindre. À cet égard, le Comité pose les questions suivantes, dans le volume quatre :

*Si un droit aux soins de santé est reconnu en vertu de l'article 7 de la Charte et si l'accès à des services de santé financés par les fonds publics n'est pas obtenu en temps opportun, est-ce que les gouvernements peuvent continuer à décourager la prestation de services de santé privés en interdisant les assurances privées?*

<sup>154</sup> Colleen M. Flood, Tom Archibald, « The illegality of private health care in Canada », *Journal de l'Association médicale canadienne*, 20 mars 2001, 164 (6), p. 825-830.

<sup>155</sup> Volume quatre, p. 42.

*Est-il juste et raisonnable dans une société libre et démocratique que le gouvernement rationne l'offre de services de santé financés par l'État (au moyen d'affectations budgétaires aux soins de santé) et que, simultanément, il empêche les particuliers d'obtenir ces services au Canada, même à leurs propres frais<sup>156</sup>?*

Ces questions ont fait l'objet de vives discussions qui, de l'avis du Comité, ont des conséquences importantes pour le système canadien de soins de santé, sous sa forme actuelle. En fait, le Comité a soulevé ces questions à la fois pour stimuler la discussion et pour indiquer aux gouvernements qu'il sera de plus en plus difficile, sinon impossible, de maintenir des politiques et des lois qui limitent ou découragent l'accès aux soins de santé privés si le régime public ne fournit pas les soins médicalement nécessaires en temps opportun.

Par conséquent, le Comité estime que l'incapacité du système public de soins de santé à fournir les soins en temps opportun, démontrée par les longues listes d'attente pour l'obtention des services, ouvre vraisemblablement la porte à une contestation judiciaire en vertu de la Charte; cette contestation pourrait réussir à abroger les lois qui empêchent ou dissuadent les Canadiens de payer personnellement pour obtenir, au Canada, des services jugés nécessaires sur le plan médical, même quand ces derniers sont couverts par le régime public d'assurance-santé.

***Le Comité estime que l'incapacité du système public de soins de santé à fournir les soins, démontrée par les longues listes d'attente pour l'obtention des services, ouvre vraisemblablement la porte à une contestation judiciaire en vertu de la Charte; cette contestation pourrait réussir à abroger les lois qui empêchent ou dissuadent les Canadiens de payer personnellement pour obtenir, au Canada, des services jugés nécessaires sur le plan médical, même quand ces derniers sont couverts par le régime public d'assurance-santé.***

La *Charte canadienne des droits et libertés* garantit certains droits et libertés fondamentaux. L'article 7 énonce ce qui suit :

*Chacun a droit à la vie, à la liberté et à la sécurité de sa personne; il ne peut être porté atteinte à ce droit qu'en conformité avec les principes de justice fondamentale.*

Bien que la Charte ne mentionne pas explicitement les soins de santé, certains commentateurs estiment que l'article 7 a une signification particulière à ce chapitre. Ce n'est pas que l'article 7 garantisse la prestation de soins de santé dans le cadre d'un régime public; mais il assure le droit à la liberté et à la sécurité de la personne, droit qui, selon certains, pourrait subir un préjudice si le système public de soins de santé ne peut offrir des soins adéquats en temps opportun.

Ce droit permettrait l'interprétation suivante : si les citoyens ne peuvent pas obtenir des soins en temps opportun au sein du régime public, les gouvernements ne sauraient les empêcher de payer pour les obtenir ailleurs au Canada. Autrement dit, même si l'obtention de soins de santé ne constitue pas un droit, il reste que les citoyens ont le droit de ne pas être

<sup>156</sup> *Ibid.*

empêchés par le gouvernement d'obtenir des soins ailleurs au Canada, si le service ne peut être fourni en temps opportun dans le cadre du régime public.

En 1994, le Groupe de travail sur les soins de santé de l'Association du Barreau canadien a jugé que la Charte ne garantit pas le droit aux soins de santé. Il en est venu à cette conclusion en faisant sienne l'idée voulant que la Charte est souvent interprétée comme un instrument négatif plutôt que positif, qui n'oblige généralement pas les gouvernements à adopter un comportement en particulier, mais qui protège plutôt les Canadiens contre les actions gouvernementales coercitives<sup>157</sup>.

Ainsi, dans le contexte des soins de santé, la Charte n'exige peut-être pas des gouvernements qu'ils veillent à ce que le système public offre un certain niveau de soins, mais elle pourrait être invoquée pour les empêcher d'imposer des mesures coercitives refusant aux citoyens la liberté d'obtenir, à leurs frais, des soins de santé au Canada, lorsque le régime public ne peut leur offrir ces soins en temps opportun.

D'ailleurs, d'après le Groupe de travail, des particuliers pourraient faire valoir en cour que l'article 7 comprend un droit de recourir à des services de santé privés lorsque le gouvernement ne peut pas ou ne veut pas assurer la prestation de services adéquats (ce qui, de toute évidence, pourrait comprendre l'incapacité d'un gouvernement à offrir le service en temps opportun)<sup>158</sup>.

Des juristes ont expliqué au Comité que l'article 7 a des implications en matière de soins de santé et que ce n'est qu'une question de temps avant que ses paramètres ne soient examinés plus en détail par les tribunaux. Des jugements récents laissent entrevoir que la Charte prendra sans doute plus de place dans le domaine des soins de santé. Certaines causes fondées sur l'article 15 de la Charte, soit le droit à l'égalité, ont été gagnées<sup>159</sup>. Cependant, les tribunaux n'ont pas encore été saisis de toutes les implications de l'article 7 pour ce qui est de la prestation des soins de santé en temps opportun.

Dans un commentaire rédigé récemment par l'Institut C.D. Howe, intitulé *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*<sup>160</sup>, Stanley Hartt et Patrick Monahan tentent de déterminer si les gouvernements peuvent empêcher ou dissuader les Canadiens de payer eux-mêmes des services de santé jugés médicalement nécessaires lorsqu'il est impossible d'obtenir ces services dans le système public.

Dans leur analyse fondée sur l'article 7<sup>161</sup> de la Charte, Hartt et Monahan concluent que, dans le cas où le système public ne fournit pas, en temps opportun, des soins de

---

<sup>157</sup> *What's Law Got To Do With It? Health Care Reform in Canada*, (1994), p. 26.

<sup>158</sup> *Ibid.*, p. 94.

<sup>159</sup> Dans *Eldridge c. Colombie-Britannique (Procureur général)* [1997] 3 RCS 624, la Cour suprême du Canada a établi que le défaut du gouvernement provincial de payer les services d'interprètes gestuels dans les hôpitaux dans le cadre de son régime public d'assurance-santé était discriminatoire à l'égard des patients sourds en vertu de leur incapacité physique et violait leur droit à l'égalité établi à l'article 15 de la Charte.

<sup>160</sup> Stanley H. Hartt, c.r., et Patrick J. Monahan, *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*, Institut C.D. Howe, commentaire n° 164, mai 2002.

<sup>161</sup> Selon Hartt et Monahan (p. 9), une revendication présentée au regard de l'article 7 de la Charte comporte trois éléments :

santé jugés nécessaires sur le plan médical, les restrictions concernant le paiement des soins à titre personnel ou l'achat d'une assurance-santé privée violent le droit de la personne à la liberté et à la sécurité garanti par l'article 7 et vont à l'encontre des principes de justice fondamentale. Puisque ce commentaire est probablement l'étude la plus détaillée effectuée à ce jour sur l'application de l'article 7 dans le contexte des soins de santé, le Comité estime qu'il convient d'examiner plus avant l'argumentation des auteurs.

Hartt et Monahan soutiennent que les décisions individuelles en matière de soins de santé sont des décisions personnelles fondamentales concernant la santé, la vie et la mort; à ce titre, elles sont couvertes par la garantie de liberté établie à l'article 7. Par conséquent, les gouvernements qui empêchent les particuliers d'obtenir des soins à l'extérieur du régime public ont l'obligation concomitante de veiller à ce que des soins soient fournis en temps opportun dans le cadre de ce système.

Ainsi, lorsque le régime public ne peut pas ou ne veut pas offrir les soins en temps opportun, Hartt et Monahan affirment que les particuliers doivent être libres d'obtenir les soins nécessaires ailleurs. Par conséquent, dans ces circonstances, les restrictions quant à la capacité d'obtenir des soins en dehors du régime public, y compris celles qui concernent le droit d'acheter une assurance-santé privée, violent le droit de la personne de prendre des décisions personnelles qui concernent sa vie et sa santé, garanti à l'article 7<sup>162</sup>.

Le droit à la sécurité de la personne garanti à l'article 7 comporte un aspect à la fois physique et psychologique qui, selon Hartt et Monahan, invoquent la décision prise en 1988 par la Cour suprême du Canada dans la cause *Morgentaler*, engloberait les préjudices physiques et psychologiques associés à l'attente excessive du patient pour obtenir des soins. Ils écrivent :

*Lorsque les gouvernements adoptent des mesures qui retardent ou freinent l'accès aux services jugés nécessaires sur le plan médical ou lorsque ce délai augmente concrètement les risques médicaux ou entraîne d'autres préjudices en matière de santé, il y a manifestement violation de la sécurité de la personne<sup>163</sup>.*

Toutefois, même en cas de restriction du droit à la liberté et à la sécurité, il n'y a pas de violation de l'article 7 à moins qu'il ne soit prouvé que la restriction va à l'encontre des « principes de justice fondamentale ». Bien que les tribunaux aient conclu que la justice fondamentale comporte un aspect de procédure et un aspect de fond, ce terme n'a pas été défini explicitement. Hartt et Monahan estiment qu'il est manifestement injuste, et donc contraire aux principes de justice fondamentale, d'établir un système dans lequel les services jugés médicalement nécessaires ne sont, à tous égards, accessibles que par le biais du système public de soins de santé, mais ne sont pas offerts en temps opportun<sup>164</sup>.

---

1) L'action d'une législature ou d'un gouvernement prive une personne d'au moins un des droits « à la vie, à la liberté et à la sécurité ». 2) Cette dépossession doit être contraire aux principes de justice fondamentale. 3) La violation ne peut être justifiée en vertu de l'article 1 de la Charte, qui prescrit qu'un droit garanti ne peut être limité que dans des « limites raisonnables et dont la justification puisse se démontrer dans le cadre d'une société libre et démocratique ».

<sup>162</sup> *Ibid.*, p. 17.

<sup>163</sup> *Ibid.*, p. 15.

<sup>164</sup> *Ibid.*, p. 20-21.



Par conséquent, Hartt et Monahan soutiennent que, si les services de soins de santé ne sont pas offerts en temps opportun, les gouvernements provinciaux ne peuvent légalement interdire aux Canadiens d'obtenir ces services au Canada, pas plus que le gouvernement fédéral ne peut user des sanctions financières prévues dans la *Loi canadienne sur la santé* pour forcer les provinces à appliquer des restrictions qui sont inconstitutionnelles<sup>165</sup>. Autrement dit, les gouvernements ne peuvent se trouver dans l'incapacité d'assurer la prestation en temps opportun des services de santé jugés médicalement nécessaires, tout en interdisant aux Canadiens d'obtenir ces services en marge du système public de soins de santé. Cela suppose donc que les gouvernements ne peuvent empêcher les Canadiens de souscrire une assurance-santé privée pour couvrir le coût de ces services reçus à l'extérieur du système public de soins.

**Hartt et Monahan soutiennent que, si les services de soins de santé ne sont pas offerts en temps opportun, les gouvernements provinciaux ne peuvent légalement interdire aux Canadiens d'obtenir ces services au Canada, pas plus que le gouvernement fédéral ne peut user des sanctions financières prévues dans la Loi canadienne sur la santé pour forcer les provinces à appliquer des restrictions qui sont inconstitutionnelles.**

Il s'ensuit, si Hartt et Monahan voient juste, que la Charte interdit à un gouvernement de refuser à un particulier le droit d'obtenir des soins de santé privés lorsque le gouvernement n'offre pas ces services en temps opportun :

*Les dispositions qui interdisent le paiement, à titre personnel, de services jugés nécessaires sur le plan médical sont tout à fait justifiables lorsque le système public est en mesure de fournir ces services en temps opportun [...]*<sup>166</sup>

*Dans le cas où le système public de soins de santé n'offre pas les soins nécessaires en temps opportun, les gouvernements vont à l'encontre de la loi en interdisant aux Canadiens d'utiliser leurs propres ressources pour acheter ces services à titre personnel, dans leur pays. Dans ces circonstances, en appliquant des limites au paiement de soins de santé à titre personnel et aux régimes privés d'assurance-santé, les lois de différentes provinces imposent aux Canadiens un système qui, à tout le moins, compromet leur santé et pourrait mettre leur vie en danger*<sup>167</sup>.

---

<sup>165</sup> *Ibid.*, p. 5.

<sup>166</sup> *Ibid.*, p. 3.

<sup>167</sup> *Ibid.*, p. 4.

Toutefois, l'analyse de Hartt et Monahan ne conclut pas que l'unique solution au problème est que le gouvernement assouplisse les restrictions quant à la capacité d'un particulier d'acquiescer une assurance-santé privée. Les auteurs de l'étude estiment que le gouvernement a deux options : financer et structurer le système

**Le gouvernement a deux options : financer et structurer le système public de soins de santé de façon à ce qu'il puisse offrir, en temps opportun, les soins de santé jugés nécessaires sur le plan médical, ou permettre aux Canadiens de payer eux-mêmes ces soins s'ils ne peuvent les obtenir en temps opportun dans le cadre du système public.**

public de soins de santé de façon à ce qu'il puisse offrir, en temps opportun, les soins de santé jugés nécessaires sur le plan médical, ou permettre aux Canadiens de payer eux-mêmes ces soins s'ils ne peuvent les obtenir en temps opportun dans le cadre du système public<sup>168</sup>.

Le Comité trouve convaincante cette analyse de Hartt et Monahan. Cependant, il convient de noter que la Cour supérieure du Québec en est venue à une conclusion différente dans une cause [*Chaoulli c. Québec (Procureure générale)*]<sup>169</sup> dans laquelle on a invoqué l'article 7 de la Charte pour contester la décision du gouvernement du Québec d'interdire à un particulier de souscrire un régime privé d'assurance-santé dans le but de payer, à titre personnel, des soins de santé couverts par le régime provincial d'assurance-maladie. La cause *Chaoulli* portait sur le désir du plaignant de souscrire un régime privé d'assurance-santé pour des soins et des traitements futurs auxquels il *aurait pu* ne pas avoir accès en temps opportun. Autrement dit, la cause *Chaoulli* portait sur des événements futurs hypothétiques et non sur des événements qui s'étaient déjà produits; par conséquent, la cause *Chaoulli* ne concerne pas directement la question examinée dans l'étude de Hartt et Monahan.

La Cour supérieure du Québec a rejeté la requête *Chaoulli* et a conclu que, bien que l'interdiction de souscrire un régime privé d'assurance-santé puisse violer les droits de liberté et de sécurité de la personne en vertu de l'article 7 de la Charte, il était toutefois conforme aux principes de justice fondamentale évoqués à l'article 7 de refuser la possibilité de souscrire un régime privé d'assurance-santé au regard de services couverts par le régime public d'assurance-maladie du Québec<sup>170</sup>.

Pour déterminer si les restrictions du gouvernement québécois respectaient les « principes de justice fondamentale » et, donc, ne violaient pas l'article 7, la Cour a pesé le pour et le contre entre le droit de souscrire un régime privé d'assurance-santé et l'objectif collectif d'assurer à tous les résidents du Québec l'égalité d'accès aux services jugés médicalement nécessaires. De l'avis de la Cour, le fait de souscrire un régime privé aurait pour effet de compromettre l'intégrité, le bon fonctionnement et la viabilité du système public de soins de santé<sup>171</sup>. En examinant ce jugement, il importe de se rappeler qu'il s'agit d'une décision d'un tribunal de première instance, qui n'a pas encore été commentée par une cour d'appel ni par la Cour suprême du Canada.

<sup>168</sup> *Ibid.*

<sup>169</sup> [2000] J. Q. No. 470 (QL) (C.S.Q., juge Piché).

<sup>170</sup> *Ibid.*, paragr. no. 243.

<sup>171</sup> *Ibid.*, paragr. no. 261-263.

Il convient aussi de signaler que cette décision a été rendue malgré le fait que certains pays d'Europe et l'Australie, qui disposent d'un système public de soins de santé, n'interdisent pas la souscription à un régime privé d'assurance-santé et que cette pratique ne semble pas avoir causé de torts irréparables au fonctionnement ou à la viabilité de leur système public.

Il faut aussi souligner que l'expérience de ces pays affaiblit considérablement l'argument voulant que, même si l'interdiction de souscrire une assurance-santé viole le droit de la personne à recevoir des soins de santé en temps opportun, une telle violation peut se justifier en vertu de l'article 1 de la Charte. Pour que cet argument soit valide, il doit s'agir d'une violation respectant «des limites qui soient raisonnables et dont la justification puisse se démontrer dans le cadre d'une société libre et démocratique». Puisque d'autres sociétés démocratiques et libres ont un régime universel de soins de santé et permettent à des particuliers de souscrire une assurance-santé pouvant servir à couvrir les coûts de ces services en marge du régime public, et puisque les systèmes de soins de santé de ces pays semblent fonctionner efficacement, les tribunaux pourraient réfuter l'argument voulant que la violation du droit de la personne à recevoir des soins de santé en temps opportun (soit l'interdiction d'établir un système privé parallèle) constitue une limite raisonnable «et dont la justification puisse se démontrer».

***L'incapacité de régler efficacement la question de l'accès aux soins en temps opportun mènera très vraisemblablement à l'apparition d'un régime parallèle de soins hospitaliers et de soins dispensés par les médecins.***

Une autre cause québécoise (*Stein c. Québec (Régie de l'Assurance-maladie)*), plutôt que de se fonder sur la Charte, a suivi une approche différente et exigé du gouvernement provincial qu'il rembourse les dépenses médicales engagées par un patient aux États-Unis pour le traitement d'une affection grave, qu'il ne pouvait recevoir en temps opportun au Québec<sup>172</sup>. Dans l'affaire *Stein*, le patient avait été informé qu'il devait subir une intervention chirurgicale pour un cancer grave au plus tard quatre à huit semaines après le diagnostic. Après avoir dépassé la période d'attente prescrite pour recevoir son traitement, le patient s'est rendu à New York pour y recevoir des soins. Par la suite, il a contesté le refus de la Commission de l'assurance-maladie du Québec de rembourser ses dépenses médicales. Le tribunal a tranché en faveur de Stein, en indiquant que, puisque chaque jour de retard augmentait les risques de décès, il n'était pas raisonnable d'obliger le patient à attendre d'être opéré à Montréal. Dans cette cause, il importe de noter l'insistance du tribunal sur l'accès aux soins en temps opportun.

***Les membres du Comité croient fermement que les gouvernements ne peuvent attendre passivement que les tribunaux décident comment les Canadiens recevront les soins jugés nécessaires sur le plan médical. Il est temps pour eux de prendre des mesures pour régler le problème des périodes d'attente.***

<sup>172</sup> *Stein c. Québec (Régie de l'Assurance-maladie)*, [1999] QJ No. 2724.

## 5.4 Commentaires du Comité

Bien que les tribunaux canadiens n'aient pas encore établi l'existence d'un droit aux soins de santé en vertu de la Charte, il apparaît clairement au Comité que, lorsque le système public de soins de santé n'est pas en mesure d'offrir des soins adéquats en temps opportun, il devient de plus en plus difficile, voire impossible, de justifier l'interdiction de recourir au secteur privé. Il est vraisemblable que l'impossibilité d'obtenir des soins de santé en temps opportun dans le cadre du système public et l'interdiction concomitante, pour les Canadiens, d'obtenir ces soins ailleurs au Canada violent le droit à la liberté et à la sécurité de la personne établi à l'article 7 de la Charte.

L'incapacité de régler efficacement la question de l'accès aux soins en temps opportun mènera très vraisemblablement à l'apparition d'un régime parallèle de soins hospitaliers et de soins dispensés par les médecins. Par conséquent, il est crucial de régler le problème des délais d'attente, ou du manque d'accès en temps opportun, afin de préserver, au Canada, le modèle du payeur unique des soins de santé, que les Canadiens – et le Comité – appuient si vivement.

Les membres du Comité croient fermement que les gouvernements ne peuvent attendre passivement que les tribunaux décident comment les Canadiens recevront les soins jugés nécessaires sur le plan médical. Il est temps pour eux de prendre des mesures pour régler le problème des périodes d'attente.

Les gouvernements ne peuvent plus faire abstraction du problème croissant que pose l'accès aux soins de santé en temps opportun. Ils *doivent* – comme les fournisseurs de soins eux-mêmes, particulièrement les hôpitaux et les médecins – trouver une solution afin d'offrir un accès rapide à des soins appropriés.

L'approche que favorise le Comité pour régler le problème des longs délais d'attente et, ainsi, éviter l'émergence d'un système privé parallèle, comporte deux volets : d'abord, investir davantage dans les soins de santé en fonction des objectifs décrits dans les autres chapitres du rapport; ensuite, faire en sorte que les gouvernements offrent une garantie nationale de soins de santé, c'est-à-dire un ensemble de normes nationales assurant un accès rapide aux principaux soins de santé, dont les paramètres seront examinés dans le prochain chapitre.



#### 6.1 Le problème des listes d'attente : la perception du public

Le principe d'accessibilité de la *Loi canadienne sur la santé* établit que les Canadiens doivent jouir d'un « accès satisfaisant » aux services de santé assurés. Cependant, la Loi ne définit pas ce qui constitue un accès satisfaisant. Depuis quelque temps, l'accès aux soins de santé a été mis en cause par le problème des listes d'attente et des délais pour l'obtention des soins : la difficulté d'obtenir des soins en temps opportun est de plus en plus perçue comme un problème majeur du système de soins de santé. Bien sûr, la notion de prestation de services « en temps opportun » est subjective : ce qui semble un délai acceptable pour une personne peut paraître une éternité pour quelqu'un d'autre, surtout lorsque la santé est en jeu. Quoi qu'il en soit, le Comité estime que l'expression « accès en temps opportun » décrit mieux que le terme « accès satisfaisant » les attentes du public au regard du système public de soins de santé.

Les résultats d'une étude menée par Statistique Canada et publiée en juillet 2002<sup>173</sup> donnent, pour la première fois, une indication fiable de la mesure dans laquelle les Canadiens voient dans la prolongation des délais d'attente une lacune majeure du système public de soins de santé. Le sondage révèle que « près d'un Canadien sur cinq ayant eu recours à des soins de santé en 2001, soit pour lui-même ou pour un membre de sa famille, s'est heurté à certaines difficultés, allant de la difficulté à obtenir un rendez-vous à une longue attente avant d'obtenir les soins »<sup>174</sup>.

**Le Comité a appris que près d'un Canadien sur cinq ayant eu recours à des soins de santé en 2001, soit pour eux-mêmes ou pour un membre de leur famille, s'est heurté à certaines difficultés, allant de la difficulté à obtenir un rendez-vous à une longue attente avant d'obtenir les soins.**

Sur les quelque cinq millions de personnes qui ont consulté un spécialiste, environ 18 %, soit 900 000 personnes, ont indiqué que le fait d'avoir attendu pour obtenir les soins avait eu des répercussions sur leur vie. La majorité d'entre elles (59 %) ont dit avoir éprouvé de l'inquiétude, de l'anxiété ou du stress. Environ 37 % de ces personnes ont affirmé avoir ressenti de la douleur.

Les auteurs de l'étude en arrivent à la conclusion suivante :

*Les renseignements nouveaux les plus importants en ce qui concerne l'accès aux services de soins de santé sont peut-être ceux recueillis au sujet des périodes d'attente. Selon les données de l'enquête, les Canadiens et Canadiennes ont clairement indiqué que de devoir attendre pour obtenir les soins est manifestement une barrière à l'obtention des soins. [...] De toute évidence, les Canadiens et Canadiennes jugent ces longues périodes*

---

<sup>173</sup> *Accès aux services de soins de santé au Canada, 2001*, Claudia Sanmartin, Christian Houle, Jean-Marie Berthelot et Kathleen White, Statistique Canada, juin 2002.

<sup>174</sup> Statistique Canada, *Le Quotidien*, 15 juillet 2002.

*d'attente inacceptables, surtout lorsque celles-ci ont des effets indésirables sur leur vie, comme l'inquiétude, l'anxiété ou la douleur éprouvée durant l'attente*<sup>175</sup>.

Ces nouvelles données de Statistique Canada incitent fortement à penser que les preuves empiriques tendant à démontrer l'ampleur croissante du problème des listes d'attente, dont le Comité a déjà fait mention, témoignent d'un problème réel et de plus en plus répandu dans le système public de soins de santé au Canada. Les membres du Comité sont convaincus de la nécessité de résoudre ce problème. Le statu quo est tout simplement inacceptable. Avant d'exposer les recommandations du Comité, le présent chapitre examine l'expérience canadienne et internationale du problème des périodes d'attente.

## **6.2 Le problème des listes d'attente : la situation réelle**

Pour le Comité, l'un des aspects les plus troublants du dossier des listes d'attente réside dans l'absence de données précises sur le nombre de Canadiens qui doivent attendre avant de pouvoir consulter un spécialiste, obtenir un diagnostic ou recevoir un traitement à l'hôpital, sur la durée de la période d'attente ainsi que sur les services en cause (maladies, états et signes). Ce

***Pour le Comité, l'un des aspects les plus troublants du dossier des listes d'attente réside dans l'absence de données précises sur le nombre de Canadiens qui doivent attendre avant de pouvoir consulter un spécialiste, obtenir un diagnostic ou recevoir un traitement à l'hôpital, sur la durée de la période d'attente ainsi que sur les services en cause (maladies, états et signes).***

manque de données pose un sérieux problème aux décideurs. Dans l'esprit du public, la gravité du problème des listes d'attente ne fait aucun doute, mais il existe peu ou pas de données qui permettent d'en mesurer l'ampleur et il n'y a pratiquement pas de normes ou de protocoles auxquels se reporter pour établir un ordre de priorité en fonction des besoins pour ceux qui sont en attente de traitement.

D'une part, les gouvernements vont naturellement chercher à se montrer sensibles à un problème social, que celui-ci soit réel ou soit simplement perçu comme tel. D'autre part, si, du point de vue des besoins cliniques réels (et non des attentes du patient), le délai d'attente pour obtenir un traitement ou un diagnostic ne met pas en péril la santé du patient, il est peu justifié alors de dépenser beaucoup d'argent pour augmenter l'offre de ressources de santé en question. Il est essentiel de pouvoir mesurer la véritable portée du problème des listes d'attente et son impact sur la santé et le bien-être des patients pour être en mesure d'adapter la politique gouvernementale en conséquence.

Nous savons qu'il existe au Canada deux excellents exemples de listes d'attente dont le classement par ordre de priorité est fait de façon objective – le Réseau de soins cardiaques de l'Ontario et le projet de rationalisation des listes d'attente dans l'Ouest canadien. Ces exemples montrent qu'il est possible, avec un régime rigoureux de gestion des listes d'attente, grâce auquel les patients sont traités en fonction du degré de priorité de leur cas et dans un délai fixé à partir de lignes directrices cliniques, d'atténuer et même d'éliminer, dans bien des cas, le problème de l'attente et la perception selon laquelle les délais sont trop longs.

---

<sup>175</sup> Accès aux services de soins de santé au Canada, p. 24.

Ces exemples montrent aussi que l'application de lignes directrices cliniques fondées sur les besoins pour gérer les listes d'attente permet d'établir clairement le besoin réel de nouvelles ressources, c'est-à-dire lorsque la gestion des listes d'attente ne suffit pas à elle seule à assurer aux patients dont les besoins sont prioritaires un accès aux soins en temps opportun et que le recours à de nouvelles ressources s'impose. Dans un cas semblable, un mode de gestion des listes d'attente axé sur les besoins permet en outre de déterminer clairement le genre et la quantité des différentes ressources nécessaires – qu'il s'agisse d'argent, d'équipement, de fournisseurs de soins ou de lits d'hôpitaux.

Par conséquent, du point de vue stratégique, il est essentiel que le Canada commence dès que possible à établir une base de données précises sur les listes d'attente ainsi que des critères de service en fonction des besoins pour les personnes en attente de soins, du genre de ceux décrits à la section suivante. D'ailleurs, l'une des raisons pour lesquelles le Comité insiste sur la nécessité d'améliorer radicalement les systèmes d'information sur la santé et d'accélérer la mise en œuvre (voir le chapitre dix) réside précisément dans la possibilité ainsi offerte d'établir des listes d'attente par ordre de priorité et de produire des données sur leur application.

Cependant, le Comité estime que les Canadiens ne devraient pas devoir attendre qu'on en ait fini avec cette étape essentielle au règlement d'un problème auquel il aurait fallu s'attaquer il y a des années. Déjà, les patients et leurs familles doivent avoir des signes évidents de la volonté d'agir des gouvernements et des progrès accomplis dans la recherche d'une solution au problème des listes d'attente. C'est pourquoi le Comité recommande, à la section 6.5, l'établissement *immédiat* d'une garantie de soins de santé, c'est-à-dire l'adoption d'un barème de périodes d'attente maximales, établies en fonction des besoins.

### **6.3 L'expérience canadienne**

Comme nous l'avons mentionné, il existe au Canada deux exemples d'initiatives qui montrent de façon probante qu'il est possible de s'attaquer au problème des listes d'attente.

#### **6.3.1 Réseau de soins cardiaques de l'Ontario (RSCO)**

Le Réseau de soins cardiaques de l'Ontario (RSCO) est reconnu depuis longtemps comme un modèle de gestion des périodes d'attente qui repose principalement sur l'établissement d'un ordre de priorité en fonction des besoins. Créé en 1990 pour coordonner, faciliter et surveiller l'accès aux soins cardiaques spécialisés et pour conseiller le Ministère sur les questions touchant les soins cardiaques dispensés aux adultes, le RSCO a, depuis, mis au point des méthodes permettant de faciliter et de surveiller l'accessibilité des soins, une grande variété de lignes directrices concernant les services cardiaques ainsi qu'un système provincial d'information en cardiologie, afin d'appuyer la prestation des soins, la recherche et l'amélioration continue des services. Axées au départ sur la chirurgie cardiaque, les priorités du RSCO ont été élargies pour englober le cathétérisme, l'angioplastie et les endoprothèses, ainsi que les stimulateurs cardiaques, les défibrillateurs internes et la réadaptation cardiologique.

Le RSCO utilise les renseignements sur les patients et leur état pathologique pour calculer l'indice d'urgence (URS – *Urgency Rating Score*). L'URS est un outil de référence servant à établir l'ordre de priorité des besoins des patients, c'est-à-dire à dresser une liste d'attente de façon rigoureuse, en fonction des besoins relatifs des patients pour l'obtention des services



concernés. Il sert aussi à surveiller l'accessibilité des soins en temps voulu dans l'ensemble de la province. Quel que soit le service requis, le patient présentant l'état pathologique le plus sérieux (selon son URS) reçoit les soins en priorité. Les efforts du RSCO ont réduit considérablement les périodes d'attente pour les pontages coronariens depuis le milieu des années 90. Les périodes d'attente médianes des cas considérés comme urgents se maintiennent autour de trois jours, sans égard aux fluctuations dans le nombre total de patients inscrits sur la liste<sup>176</sup>.

### **6.3.2 Projet de rationalisation des listes d'attente dans l'Ouest canadien**

Les résultats du projet de rationalisation des listes d'attente dans l'Ouest canadien (*Western Canada Waiting List – WCWL*), publiés en mars 2001<sup>177</sup>, indiquent qu'il est possible d'appliquer le type de système utilisé par le RSCO à d'autres maladies et interventions graves. Le projet WCWL est mené conjointement par divers organismes, comme les régies régionales de la santé, les associations médicales provinciales, les ministères provinciaux de la Santé ainsi que les centres de recherche en santé. Ce projet a été lancé dans le but de trouver une solution à ce qui est perçu comme un problème important et persistant d'accessibilité des soins de santé dans l'Ouest canadien, et d'influencer la façon dont les listes d'attente sont structurées, gérées et perçues par le public.

Au Canada, il n'existe aucune norme pour l'établissement d'un ordre de priorité des patients en ce qui a trait aux différents services médicaux (à l'exception du RSCO, en Ontario). Cela signifie qu'il n'existe pas de méthode provinciale ou nationale de mesure ou de détermination des périodes d'attente pour les services médicaux, ni de normes et de critères universels quant aux délais jugés « acceptables » au Canada pour l'obtention de la grande majorité des services de santé. Il est donc impossible de déterminer si, d'un point de vue clinique, les patients ont attendu durant une période raisonnable ou déraisonnable pour recevoir des soins. L'absence de critères et de méthodes uniformes permettant d'établir l'ordre de priorité des patients en attente de soins signifie que l'ordre des patients sur les listes d'attente dépend de critères cliniques et non cliniques qui varient selon le médecin traitant d'un établissement, d'une régie régionale de la santé et d'une province à l'autre.

Le but premier du projet WCWL a été de produire des outils permettant d'établir l'ordre de priorité des patients sur les listes d'attente en fonction de points attribués par des médecins. Cette tâche a été menée dans cinq domaines cliniques présentant des différences appréciables : chirurgie de la cataracte, interventions chirurgicales générales, arthroplastie de la hanche et du genou, examen IRM et santé mentale des enfants. Un ensemble de critères permettant de déterminer le degré de priorité et un système de pointage ont été élaborés en étroite collaboration avec un groupe d'experts. Les critères et le système de pointage ont été soumis aux diverses étapes des travaux empiriques visant à en évaluer la validité et la fiabilité. Les cliniciens qui ont mis à l'essai les outils servant à établir l'ordre de priorité ont généralement conclu qu'ils pouvaient s'avérer utiles dans un contexte clinique.

---

<sup>176</sup> Voir la présentation du Réseau de soins cardiaques de l'Ontario à la Commission sur l'avenir des soins de santé au Canada, 29 octobre 2001.

<sup>177</sup> *Du chaos à l'ordre : Rationaliser les listes d'attente au Canada*, rapport final, projet de rationalisation des listes d'attente dans l'Ouest canadien, mars 2001.

Les résultats du projet WCWL établissent que les cliniciens, les administrateurs et le public croient qu'une meilleure gestion des listes d'attente est à la fois nécessaire, possible et bienvenue. Ce qu'il reste à faire maintenant, c'est d'élaborer des normes et des critères pour établir des délais d'attente convenables et acceptables, en fonction des différents degrés de priorité des besoins. Le projet WCWL n'a pu s'attaquer à cette tâche puisqu'elle dépassait le mandat pour lequel il était financé.

Quoi qu'il en soit, les auteurs du rapport final du projet WCWL soutiennent qu'il est tout à fait possible d'établir un certain ordre dans les priorités de traitement et d'accès aux soins facultatifs. L'expérience d'autres instances a montré qu'il est possible de recourir à des approches systématiques et à des techniques de détermination des priorités pour améliorer la gestion des périodes d'attente. Les recherches menées pour le projet WCWL<sup>178</sup> mettent en lumière un certain nombre de méthodes pour y parvenir, entre autres :

- veiller à ce que le processus d'établissement des normes régissant les périodes d'attente soit de portée nationale;
- faire porter les normes régissant les périodes d'attente sur quatre principaux types d'intervention : consultation pour soins primaires, première consultation d'un spécialiste, test diagnostique et chirurgie.

Comme le montrent les expériences du RSCO et du WCWL, il est possible d'atténuer grandement le problème des listes d'attente – tel qu'il se pose en réalité et tel qu'il est perçu – en adoptant une méthode fondée sur les besoins cliniques des patients inscrits sur une liste d'attente. Puisqu'il n'y a encore que peu ou pas de données permettant d'établir dans quelle mesure il est possible d'atténuer le problème au moyen de ces nouvelles techniques de gestion des listes, certains sont d'avis qu'il serait prématuré d'agir avant de connaître pleinement la portée du problème réel – et non perçu – des listes d'attente. Ils sont d'avis qu'il est trop tôt pour mettre en œuvre des mesures telles que la garantie de soins de santé (voir la section 6.5) proposée par le Comité. Le Comité réfute ce point de vue et estime que les Canadiens méritent qu'on applique *maintenant* la garantie de soins de santé. À tout le moins, cette garantie aiguillonnerait la création des normes, critères et systèmes d'information nécessaires. Nul doute aussi que la garantie de soins de santé soulagerait aussi en grande partie l'anxiété actuelle des patients et de leurs familles.

***Le Comité estime que les Canadiens méritent qu'on applique maintenant la garantie de soins de santé.***

#### **6.4 Expérience internationale**

Bien qu'on ne puisse tirer de conclusions définitives de l'expérience internationale, des indices permettent de croire que l'établissement de périodes d'attente maximales au regard de certaines interventions peut contribuer à réduire les périodes d'attente. Plusieurs facteurs restreignent les conclusions qu'il est possible de tirer de l'expérience internationale. D'abord, les systèmes de soins de santé sont extrêmement complexes et ancrés dans l'histoire et la culture de chaque pays. En ce qui concerne l'établissement de périodes d'attente maximales – ce que le Comité appelle la « garantie de soins de santé » –, l'expérience est très récente et se limite à une poignée de pays. De plus, les périodes d'attente maximales ont fait

---

<sup>178</sup> Sanmartin, Claudia, *Toward Standard Definitions of Waiting Times for Health Care Services*, p. 361.

l'objet de révisions. Malgré ces réserves, le Comité estime que l'expérience internationale peut éclairer la recherche de solutions pour réduire les périodes d'attente au Canada.

#### **6.4.1 Suède**

Dans ses rapports précédents<sup>179</sup>, le Comité a mentionné que la Suède a expérimenté une forme de « garantie de soins de santé » au début des années 90. Cette garantie fixait un temps d'attente maximal pour les tests diagnostiques (90 jours), pour certains types de chirurgies électives (90 jours) ainsi que pour les consultations de médecins de soins primaires (8 jours) et de spécialistes (90 jours). La Suède a aussi mis en place un système grâce auquel les temps d'attente des interventions majeures sont affichés tous les jours sur un site Web. Les patients peuvent consulter ce site et choisir l'hôpital ayant les délais les plus courts ou s'adresser au premier médecin ou chirurgien libre.

En 1997, un nouveau système est entré en vigueur : la garantie de soins de santé « 0/7/90 ». Ce système établit que le patient doit recevoir les soins d'un infirmier praticien dans un centre de soins primaires le jour même de la consultation et obtenir un rendez-vous avec un médecin dans les sept jours. Enfin, le cas échéant, le patient doit se voir offrir un rendez-vous avec un spécialiste dans les trois mois. S'il ne peut obtenir de rendez-vous, le patient a le droit de recevoir des soins dans un autre pays sans devoir assumer de frais additionnels. La garantie stipule que les traitements nécessaires doivent être fournis dans les meilleurs délais, sans toutefois fixer de période d'attente maximale à cet égard.

Dans l'ensemble, il semble que la garantie de soins offerte en Suède contribue davantage à accroître la liberté de choix des patients qu'à réglementer les périodes d'attente. Dans le conseil de comté de Stockholm, par exemple, les patients ont le choix entre de nombreux fournisseurs de soins et établissements, mais en pratique relativement peu d'entre eux exercent cette liberté de choix et un bon nombre ne sont même pas conscients qu'ils peuvent. En général, les Suédois accordent beaucoup d'importance à la proximité d'accès aux soins; une grande majorité des patients préfèrent en effet recevoir des soins dans leur pays plutôt qu'à l'étranger, même s'il leur faut pour cela attendre plus longtemps.

#### **6.4.2 Danemark<sup>180</sup>**

Au Danemark, le ministre de la Santé et l'Association des conseils de comté, qui sont conjointement responsables du financement et de la prestation des services de santé, se sont fixé comme objectif en 1993 de ramener à trois mois, au plus tard à la fin de 1995, la période d'attente maximale pour tout traitement chirurgical non urgent. Cette garantie s'accompagnait d'encouragements financiers pour inciter les comtés à atteindre cet objectif. Cependant, malgré l'intensification de l'activité et la réduction générale des périodes d'attentes, les comtés n'ont pas été en mesure de respecter cette garantie et celle-ci a par la suite été révoquée en 1997.

Jusqu'à tout récemment, on a eu recours à une approche « politique » pour faciliter la réduction des périodes d'attente et l'on a augmenté en conséquence le budget des

---

<sup>179</sup> Voir, par exemple, vol. 5, p. 59, et vol. 3, p. 31.

<sup>180</sup> On trouvera une description détaillée du régime de soins de santé danois dans *Health Care Systems in Transition: Denmark*, Signild Vallgarda, Allan Krasnik et Karsten Vrangbaek, Observatoire européen des systèmes de soins de santé, 2001.

soins de santé. Des objectifs différenciés ont été établis en fonction de l'évaluation de l'incidence des périodes d'attente sur les différents groupes de patients. Dès mars 2000, on avait fixé des objectifs pour les troubles cardiaques graves (deux, trois ou cinq semaines, selon le diagnostic et le traitement offert), le cancer du sein, le cancer du poumon, le cancer de l'utérus et le cancer de l'intestin (attente de deux semaines, entre le renvoi du patient et l'examen préliminaire, entre l'acceptation du patient en chirurgie et l'intervention chirurgicale ainsi qu'entre la chirurgie et le début du traitement postchirurgical).

Un rapport du gouvernement central, publié en 2000, indique que, dans l'ensemble, le pourcentage de patients devant attendre plus de trois mois est tombé de 32 % à 28 % en 1997 et à 21 % en 1998. Cette même année, 71 % des patients ont été traités immédiatement, 14 % ont reçu un traitement le même mois et 8 % ont dû attendre plus de trois mois. La période d'attente moyenne pour les interventions chirurgicales est passée de 93 jours en 1995 à 87 en 1997.

Depuis 1997, le ministère de la Santé affiche sur Internet les périodes d'attente prévues à différents hôpitaux au regard de 24 types de diagnostic. Cette mesure vise à élargir le choix des patients parmi les hôpitaux du pays. En juin 2001, le gouvernement social-démocrate a annoncé un investissement de 500 millions de couronnes (environ 100 M\$ CAN) afin de réduire encore davantage le temps d'attente pour obtenir un traitement contre le cancer, et a ensuite promulgué une loi visant à garantir à tous les patients atteints de cancer une période d'attente minimale.

Malgré tout, l'inquiétude concernant la prolongation des périodes d'attente dans les hôpitaux publics a été l'un des facteurs qui a mené à la défaite des sociaux-démocrates aux mains du Parti libéral, formation politique de droite. Depuis, le nouveau gouvernement a annoncé un nouvel investissement de 1,5 milliard de couronnes (environ 290 M\$ CAN) réparti dans l'ensemble du réseau hospitalier public à seule fin de réduire les listes d'attente.

Le gouvernement a aussi déclaré que les patients qui doivent attendre plus de deux mois pour recevoir un traitement de quelque nature que ce soit dans le système public pourront, à compter du 1<sup>er</sup> juillet, choisir de se faire soigner dans un hôpital privé ou dans un autre pays, sans frais additionnels. Comme en Suède, les Danois voient cette mesure comme un élargissement du choix du patient plutôt que comme une véritable « garantie de soins de santé ». Dans le témoignage qu'il a livré au Comité par conférence téléphonique, M. John Erik Petersen, chef du ministère de la Santé et de l'Intérieur, gouvernement du Danemark, a fourni l'explication suivante :

*Il y a une dizaine d'années, nous avons lancé le concept du libre choix des hôpitaux, parmi les hôpitaux publics. Toutefois, il n'y a toujours pas de liberté de choix à l'égard des quelques hôpitaux privés au Danemark, ni à l'égard des hôpitaux à l'étranger.*

*Au 1<sup>er</sup> juillet, cependant, nous élargissons ce concept de liberté de choix pour inclure les hôpitaux privés et les hôpitaux d'autres pays dans des cas où le malade ne peut être traité dans un hôpital public dans son propre pays ou dans un pays avoisinant en moins de deux mois. C'est là qu'intervient cette notion de garantie. Il ne s'agit pas vraiment*

*d'une garantie, mais disons qu'après un délai d'attente de deux mois, le libre choix est élargi.*

*Nous avons également une garantie de soins, mais seulement dans les cas limités, par exemple lorsqu'il s'agit de cancer ou de maladies cardio-vasculaires très graves où la vie du malade est en danger. Cette garantie existe depuis un an. Et c'est une garantie en ce sens que les conseils et les hôpitaux sont tenus de trouver les soins requis pour le malade dans le délai fixé, qui est inférieur au délai de deux mois. Ils ont donc l'obligation de lui trouver les soins dont il a besoin, ce qui n'est pas le cas pour le libre choix élargi. Dans ce dernier cas, vous pouvez choisir librement de vous faire soigner dans un hôpital privé ou un hôpital à l'étranger si vous attendez plus de deux mois, mais rien ne garantit que l'hôpital privé que vous choisirez pourra vous soigner<sup>181</sup>.*

Il est intéressant de noter que les Danois, à l'instar des Suédois, ne s'attendent pas à ce que beaucoup de patients se prévalent de ces nouvelles garanties. M. Petersen a poursuivi en ces termes :

*En ce qui concerne le délai de deux mois, nous ne prévoyons pas que les périodes d'attente de plus de deux mois vont disparaître au Danemark. Nous savons déjà que depuis l'introduction du concept de la liberté de choix parmi les hôpitaux publics, les patients décident souvent d'attendre plus longtemps pour être traités à leur hôpital local, plutôt que d'avoir à se faire soigner en Europe ou dans d'autres régions du pays, bien que le Danemark soit un assez petit pays. Par conséquent, nous ne pensons pas que beaucoup de citoyens voudront profiter de cette offre<sup>182</sup>.*

Les témoins danois ont indiqué au Comité que la décision de fixer à deux mois la période au terme de laquelle les patients ont le libre choix de l'hôpital se fonde davantage sur la dynamique politique que sur des conclusions cliniques et scientifiques. Cette situation tranche nettement avec les périodes d'attente maximales fixées pour les cancers et les maladies cardiaques, qui ont été décidées en fonction de critères cliniques. Quoi qu'il en soit, la garantie de deux mois représente, selon le D<sup>r</sup> Steen Friberg Nielsen, président-directeur général, de la *Top Management Academy*, gouvernement du Danemark, « une décision politique qui était fondée sur le niveau de service »<sup>183</sup> que le gouvernement désirait offrir aux citoyens.

## **6.5 Recommandations du Comité**

Le Comité estime que deux facteurs alimentent la perception selon laquelle le problème des délais d'attente va en s'aggravant au Canada.

Le premier est la pénurie apparente de personnel et d'équipement de diagnostic. Selon le Comité, ces carences ont été gravement exacerbées ces dix dernières années par les décisions successives des gouvernements de tous ordres, qui ont cherché à tout prix à réduire de façon drastique les coûts des soins de santé (et d'autres dépenses publiques). Ces compressions ont créé une situation dans laquelle certaines composantes du système de soins de santé sont de

---

<sup>181</sup> Compte rendu des délibérations du Comité, 17 juin 2002, 64:4.

<sup>182</sup> *Ibid.*

<sup>183</sup> *Ibid.*

moins en moins aptes à répondre à la demande. Dans un système qui vise l'égalité de traitement pour tous, ce déséquilibre entre l'offre et la demande de services a allongé les périodes d'attente et, comme en font foi les données de Statistique Canada, a alimenté l'inquiétude du public à ce sujet.

Toutefois, l'absence de listes d'attente établies avec rigueur selon un ordre de priorité dicté par des critères et des données cliniques fondés sur les besoins, qui permettent de bien évaluer l'état des patients en attente de traitement, aggrave sensiblement le problème. L'absence de données complique certes la recherche de solutions. En fait, dans le système de soins de santé canadien, il est impossible d'établir une distinction valable entre, d'une part, les véritables besoins du patient, établis selon des critères cliniques, et, d'autre part, le désir du patient et de son médecin traitant d'obtenir des soins immédiats (lorsque le fait de devoir attendre ne compromet en rien la santé du principal intéressé).

Ce ne sont pas toujours les pénuries qui sont à l'origine des listes d'attente. Comme nous l'avons mentionné, tout indique qu'il est possible de réduire les périodes d'attente en s'attaquant directement au problème, comme l'a fait le RSCO en Ontario. Nous sommes convaincus que l'un des principaux facteurs à l'origine de la prolongation des périodes d'attente réside dans la lenteur des « intervenants » du système – les hôpitaux et leurs médecins spécialistes et chirurgiens en particulier – à systématiser la gestion des listes d'attente pour l'ensemble des interventions importantes, tests diagnostiques et consultations. Tout comme il appuie les mesures visant à rendre le système de soins de santé plus efficace, le Comité accueille favorablement les efforts pour améliorer la gestion des listes d'attente, comme le projet WCWL, qui font que les patients qui en ont le plus besoin reçoivent les soins en premier et que, dans la mesure du possible, les périodes d'attentes sont réduites au minimum pour tout le monde. Le Comité croit toutefois qu'il est fort peu probable qu'une meilleure gestion puisse, à elle seule, résoudre le problème des listes d'attente, qui est sans doute en partie attribuable aux pénuries.

***Fidèle à sa philosophie voulant que le meilleur moyen de réformer un système complexe comme le régime de soins de santé consiste à mettre en œuvre des mesures d'encouragement pour tous les intervenants en cause, le Comité est convaincu qu'il faut faire assumer aux gouvernements la responsabilité de leurs décisions. Il estime donc que ce sont les vrais responsables du problème des listes d'attente qui doivent en porter le blâme, à savoir, les gouvernements, qui n'ont pas fourni les ressources financières suffisantes; les gouvernements et les fournisseurs de services, qui n'ont pas élaboré de systèmes de gestion des listes d'attente en fonction des besoins et des évaluations cliniques; enfin, les gouvernements, qui n'ont pas demandé et financé la mise en place de ces systèmes pour rationaliser les listes d'attente, notamment celles attribuables au sous-financement du système. Le Comité est donc d'avis qu'il revient aux gouvernements d'assumer le coût des mesures de redressement, c'est-à-dire le traitement des patients dans un autre territoire, d'ici à ce que l'élaboration et la mise en place de systèmes de gestion des listes d'attente se concrétisent.***

On peut ensuite se demander pourquoi on a laissé la situation se détériorer au point que près d'un Canadien sur cinq dit avoir éprouvé des difficultés à obtenir des services de santé en temps opportun. Selon le Comité, cela s'explique en partie par le fait que la compression des coûts – ou plus précisément le refus de continuer à accroître le financement au même rythme que la hausse des coûts des soins de santé – était une solution attrayante pour le gouvernement. Elle a pu être mise en œuvre avec relativement de facilité, la raison étant que jusqu'ici, le gouvernement n'a pas eu à subir le contrecoup de ses mesures de compression. À la place, ce sont les patients surtout qui ont écopé, puisqu'ils doivent maintenant attendre plus longtemps pour obtenir des services de santé.

Fidèle à sa philosophie voulant que le meilleur moyen de réformer un système complexe comme le régime de soins de santé consiste à mettre en œuvre des mesures d'encouragement pour tous les intervenants en cause, le Comité est convaincu qu'il faut faire assumer aux gouvernements la responsabilité de leurs décisions. Il estime donc que ce sont les vrais responsables du problème des listes d'attente qui doivent en porter le blâme, à savoir, les gouvernements, qui n'ont pas fourni les ressources financières suffisantes; les gouvernements et les fournisseurs de services, qui n'ont pas élaboré de systèmes de gestion des listes d'attente en fonction des besoins et des évaluations cliniques; enfin, les gouvernements, qui n'ont pas demandé et financé la mise en place de ces systèmes pour rationaliser les listes d'attente, notamment celles attribuables au sous-financement du système. Le Comité est donc d'avis qu'il revient aux gouvernements d'assumer le coût des mesures de redressement, c'est-à-dire le traitement des patients dans un autre territoire, d'ici à ce que l'élaboration et la mise en place de systèmes de gestion des listes d'attente se concrétisent.

Par conséquent, le Comité recommande :

**Qu'un délai d'attente maximum tenant compte des besoins soit fixé et rendu public pour chaque type d'intervention ou de traitement majeur;**

**Qu'une fois ce délai expiré, l'assureur (le gouvernement) paie pour que le patient puisse immédiatement faire des démarches pour subir l'intervention ou le traitement en question ailleurs au Canada ou, au besoin, à l'étranger (par exemple, aux États-Unis). C'est ce qu'on appelle la garantie de soins de santé.**

Le Comité est conscient que les gouvernements pourront fort bien tenter de faire valoir que si un patient ne reçoit pas en temps opportun un service médicalement nécessaire et est autorisé en conséquence à s'adresser ailleurs pour obtenir le service en question en vertu de la garantie de soins de santé, la responsabilité (ou le blâme) repose peut-être sur les épaules de l'hôpital ou de ses médecins, qui n'ont pas bien utilisé les ressources existantes ou n'ont pas bien géré les listes d'attente. Dans ces circonstances, il se peut qu'ils cherchent à recouvrer les frais subis au titre de la garantie de soins auprès des hôpitaux ou des médecins concernés. En d'autres termes, il se peut que les gouvernements imputent la responsabilité de respecter les délais d'attente maximums à ceux qui doivent effectivement gérer le système. C'est là une mesure

raisonnable, s'il peut être démontré que le sous-financement est la seule ou même la principale raison à l'origine du délai d'attente trop long.

C'est toutefois là une question qui doit être résolue entre les gouvernements et les établissements et médecins faisant partie du système public de soins de santé. Les patients ne devraient pas avoir à subir de conséquences. Leur seul souci devrait être d'obtenir les traitements dont ils ont besoin en temps opportun et d'en faire assumer le coût par l'État. C'est donc, au départ, aux gouvernements que devrait incomber, en tant qu'assureurs du patient, la responsabilité de respecter la garantie de soins de santé.

***Le moment où cette garantie de soins de santé s'appliquerait pour chaque intervention serait établi en fonction d'une évaluation du moment à partir duquel une prolongation de l'attente risquerait de compromettre sensiblement la santé ou la qualité de vie du patient. Les périodes d'attente seraient établies par des organismes scientifiques, à partir de données cliniques et scientifiques.***

Le moment où cette garantie de soins de santé s'appliquerait pour chaque intervention serait établi en fonction d'une évaluation du moment à partir duquel une prolongation de l'attente risquerait de compromettre sensiblement la santé ou la qualité de vie du patient. Les périodes d'attente seraient établies par des organismes scientifiques, à partir de données cliniques et scientifiques. À cette fin, le Comité recommande :

**Que le processus d'établissement des normes régissant les périodes d'attente soit de portée nationale ;**

**Qu'un organisme indépendant, chargé d'examiner les données scientifiques et cliniques pertinentes, soit mis sur pied;**

**Que les normes régissant les périodes d'attente portent sur quatre principaux types d'intervention : consultation pour soins primaires, première consultation d'un spécialiste, test diagnostique et chirurgie.**

Le Comité reconnaît la nécessité d'aborder simultanément les deux groupes de facteurs susmentionnés. Premièrement, il faut appliquer les techniques de gestion efficace des listes d'attente fondées sur de saines méthodes cliniques, afin de gérer les périodes d'attente de façon efficace et équitable. Deuxièmement, l'accès aux ressources suffisantes pour y arriver exigera une volonté politique et il faudra donc encourager le gouvernement à agir en conséquence.

Puisque le gouvernement a la responsabilité d'assurer le financement d'un éventail suffisant de services essentiels offerts par les hôpitaux et les médecins, il a l'obligation de les aider à respecter des normes acceptables de service aux patients. C'est là l'essence d'un système axé sur le patient et du « contrat » conclu entre les Canadiens et leurs gouvernements en matière de soins de santé.



Une période d'attente maximale garantie constitue une représentation concrète de cette obligation. En offrant une telle garantie, le gouvernement devra assumer la responsabilité si les soins requis ne sont pas fournis en temps opportun, dans la mesure, bien sûr, où les hôpitaux et les médecins du régime public respectent leur part du contrat en établissant et en appliquant des critères cliniques de priorisation des listes d'attente en fonction des besoins et en utilisant leurs ressources le plus efficacement possible. Les gouvernements n'auront plus le loisir de laisser les périodes d'attente se prolonger sans devoir subir de conséquences financières. Il en sera de même pour les hôpitaux et les médecins, lorsque le sous-financement n'est pas le principal facteur responsable de la prolongation des délais d'attente, puisqu'il incombera à l'assureur d'assumer les frais nécessaires pour permettre aux patients d'aller se faire traiter ailleurs.

D'autres rapports produits au Canada ont recommandé des solutions semblables au problème des périodes d'attente. Après avoir examiné l'expérience suédoise, le conseil consultatif sur la santé de l'Alberta a présenté un rapport (le rapport Mazankowski) recommandant l'établissement d'une garantie de soins de 90 jours pour certains services. Selon le conseil, cette garantie encouragerait les fournisseurs de soins et les régies régionales de la santé à prendre les mesures nécessaires pour gérer et raccourcir les listes d'attente. Le rapport précise que le patient pourra devoir renoncer au choix du médecin ou de l'hôpital s'il veut être traité dans le délai de 90 jours. De plus, si les régies régionales de la santé ne peuvent fournir le service dans ce délai, d'autres options devront être envisagées, comme celle d'obtenir le service dans une autre région. Les services pourraient être offerts par un fournisseur public ou privé.

Plus récemment, l'Association médicale canadienne a appuyé le concept de garantie de soins de santé proposé par le Comité et l'a inclus dans son document intitulé *Ordonnance pour la viabilité*, publié le 6 juin 2002. L'AMC propose que soient établies, « au sujet de la qualité et des périodes d'attente, des lignes directrices et des normes claires »<sup>184</sup> au regard d'un ensemble bien défini de services de base, et estime que « si le système public de santé ne réussit pas à se conformer aux normes convenues et prescrites relativement à l'accès aux services de base en temps opportun, les patients doivent alors avoir accès à d'autres options qui leur permettent d'obtenir les soins requis par d'autres moyens »<sup>185</sup>. Le Comité se réjouit que l'AMC ait fait sienne sa proposition.

## **6.6 Les conséquences possibles d'une non-application de la garantie de soins de santé**

Deux éléments doivent se conjuguer pour qu'il y ait des progrès significatifs au chapitre de la réduction des périodes d'attente, du renouvellement du contrat conclu entre les Canadiens et leurs gouvernements en matière de soins de santé et du rétablissement de la confiance du public canadien dans son système de soins de santé. D'abord, les gouvernements de tous ordres doivent joindre le geste à la parole et appliquer une garantie de soins de santé établissant le droit des Canadiens à recevoir les soins nécessaires dans les meilleurs délais. Ensuite, cet engagement doit reposer sur le meilleur système de gestion des périodes d'attente qu'il soit possible de mettre en œuvre.

---

<sup>184</sup> Association médicale canadienne, *Ordonnance pour la viabilité*, p. 16.

<sup>185</sup> *Ibid.*, p. 16-17.

Puisque la prestation des soins de santé est une responsabilité provinciale au Canada, la garantie de soins de santé ne peut s'appliquer sans l'adhésion des provinces et des territoires. Le Comité estime que le principal apport du gouvernement fédéral à la mise en œuvre de la garantie de soins de santé consiste à veiller à ce que les gouvernements fédéral et provinciaux s'entendent sur les moyens d'assurer la stabilité et la prévisibilité du financement au titre du système public de soins de santé. Le Comité est persuadé de la nécessité de maintenir la contribution financière du gouvernement fédéral à un niveau suffisant et prévisible. Les questions touchant le financement sont examinées en détail aux chapitres 14 et 15 du présent rapport.

Il importe néanmoins de mesurer les conséquences d'un refus de la part des provinces d'adhérer à la garantie de soins de santé. Au chapitre précédent, le Comité a fait valoir que les gouvernements ne peuvent plus jouer sur deux tableaux, c'est-à-dire ne pas offrir l'accès en temps opportun aux soins médicalement nécessaires par l'intermédiaire du système public de soins de santé et empêcher par ailleurs les Canadiens d'obtenir ces services auprès d'établissements privés. Ainsi, l'une des conséquences du refus d'appliquer une garantie de soins de santé serait de rendre hautement probable l'accueil favorable par les tribunaux d'une éventuelle contestation de la loi interdisant la création parallèle d'un régime privé de soins de santé et d'assurance-maladie.

Une deuxième conséquence serait qu'il incomberait au gouvernement fédéral d'envisager de promulguer lui-même une loi pour faire appliquer la garantie de soins de santé. Il pourrait, par exemple, fixer lui-même des périodes maximales d'attente applicables à l'échelle nationale pour diverses interventions, à l'issue desquelles la garantie de soins de santé s'appliquerait. À l'expiration du délai, le gouvernement fédéral pourrait assumer les coûts subis pour permettre au patient de se faire traiter ailleurs, notamment aux États-Unis, et en déduire le montant des sommes versées à la province de résidence du patient au titre du TCSPS.

Ainsi, la pénalité imposée dans le cas d'une violation de la garantie de soins de santé serait comparable à celle assumée par les provinces qui dérogent à la *Loi canadienne sur la santé*. Actuellement, lorsqu'il établit qu'une province a imposé des frais modérateurs ou une surcharge interdite par la *Loi canadienne sur la santé*, le gouvernement fédéral peut retenir des fonds qu'il aurait normalement transférés à la province une somme équivalant à celle qu'elle a perçue.

Évidemment, l'adoption d'une telle mesure législative par le gouvernement fédéral ne manquerait pas de soulever des protestations. Cependant, elle permettrait la mise en œuvre d'une garantie nationale de soins de santé pour limiter les délais d'attente, mesure qui, de l'avis du Comité, est absolument nécessaire et serait largement approuvée par le public canadien.

## **6.7 Quelques réflexions sur la garantie de soins de santé**

Le Comité estime que les gouvernements fédéral et provinciaux - territoriaux devraient pouvoir s'entendre sur un ensemble national de périodes d'attente maximales pour diverses interventions. Il espère vivement que le gouvernement fédéral n'aura pas à intervenir unilatéralement, ni qu'aucun système parallèle de soins financé par un régime d'assurance privé ne verra le jour à la suite de décisions judiciaires. Si le Comité a souligné les conséquences possibles d'une non-application de la garantie de soins de santé, c'est qu'il rejette catégoriquement le statu quo : les Canadiens qui en ont besoin *doivent* avoir accès *en temps opportun* aux services médicalement nécessaires.

Il importe également de noter que la recommandation du Comité concernant la mise en œuvre de la garantie de soins de santé se superpose à d'autres recommandations importantes formulées dans le présent rapport. Par exemple, les systèmes d'information sur la santé et les méthodes permettant d'évaluer le rendement et les résultats, qui font l'objet de recommandations au chapitre dix, doivent être mis en place pour assurer le suivi des périodes d'attente d'un bout à l'autre du pays et ainsi veiller à ce que les patients soient traités en temps opportun et à ce que les normes imposées par la garantie de soins de santé soient respectées. De plus, la réforme des soins de santé primaires, que propose le Comité au chapitre quatre, est essentielle à la prestation efficace et rapide des soins de santé au XXI<sup>e</sup> siècle.



The Standing Senate Committee on Social Affairs, Science and Technology

Final Report on  
the state of the health care system in Canada

*The Health of Canadians - The Federal Role*  
*Volume Six:*  
*Recommendations for Reform*

*Chair*

The Honourable Michael J. L. Kirby

*Deputy Chair*

The Honourable Marjory LeBreton

OCTOBER 2002



# TABLE OF CONTENTS

---

<b>TABLE OF CONTENTS</b> .....	<b>i</b>
<b>ORDER OF REFERENCE</b> .....	<b>vii</b>
<b>SENATORS</b> .....	<b>viii</b>
<b>LIST OF ABBREVIATIONS</b> .....	<b>ix</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>xi</b>
<b>FOREWORD</b> .....	<b>xiii</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>PART I: ACCOUNTABILITY</b> .....	<b>3</b>
<b>CHAPTER ONE</b> .....	<b>5</b>
THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS.....	5
1.1 Summary of Some Key Points from Volumes One through Five.....	5
1.1.1 <i>The role of the federal government</i> .....	5
1.1.2 <i>Objectives of federal health care policy</i> .....	6
1.1.3 <i>The current system is not fiscally sustainable</i> .....	8
1.1.4 <i>A national health care guarantee is critical to successful reform</i> .....	10
1.2 Improving Governance – The Need for a National Health Care Commissioner.....	11
1.2.1 <i>Canadian Medical Association (CMA)</i> .....	13
1.2.2 <i>Colleen Flood and Sujit Choudry</i> .....	14
1.2.3 <i>Tom Kent</i> .....	15
1.2.4 <i>Duane Adams</i> .....	15
1.2.5 <i>Lawrence Nestman</i> .....	16
1.3 The Committee’s Proposal.....	17
<b>PART II: EFFICIENCY MEASURES</b> .....	<b>23</b>
<b>CHAPTER TWO</b> .....	<b>25</b>
HOSPITAL RESTRUCTURING AND FUNDING IN CANADA.....	25
2.1 Funding Methods for Hospitals in Canada: Advantages and Disadvantages.....	27
2.1.1 <i>Line-by-line</i> .....	28
2.1.2 <i>Ministerial discretion</i> .....	29
2.1.3 <i>Population-based</i> .....	29
2.1.4 <i>Global budget</i> .....	30
2.1.5 <i>Policy-based</i> .....	31
2.1.6 <i>Facility-based</i> .....	32

2.1.7	<i>Project-based</i>	32
2.1.8	<i>Service-based</i>	32
2.2	Service-Based Funding: Review of International Experience	33
2.2.1	<i>United States</i>	33
2.2.2	<i>United Kingdom</i>	34
2.2.3	<i>France</i>	34
2.2.4	<i>Denmark</i>	35
2.2.5	<i>Norway</i>	35
2.2.6	<i>Review of international experience by the Comité Bédard</i>	36
2.3	The Rationale for Service-Based Funding in Canada	36
2.3.1	<i>Appropriateness of service mix</i>	40
2.3.2	<i>Over-servicing and up-coding</i>	40
2.3.3	<i>Rates, information and data</i>	41
2.3.4	<i>Innovation</i>	42
2.3.5	<i>Comprehensive health care</i>	43
2.3.6	<i>Escalation of costs</i>	43
2.3.7	<i>Lack of simplicity</i>	43
2.3.8	<i>Committee commentary</i>	44
2.4	Academic Health Sciences Centres and the Complexity of Teaching Hospitals	46
2.5	Small and Rural Community Hospitals	48
2.6	Financing the Capital Needs of Canadian Hospitals	50
2.7	Public Versus Private Health Care Institutions	53
Appendix 2.1 Academic Health Sciences Centres in Canada and their Affiliated Hospitals and Regional Health Authorities		59

### **CHAPTER THREE ..... 63**

DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES.....		63
3.1	RHAs Across Canada: A Portrait.....	64
3.2	RHAs: Goals and Achievements.....	66
3.3	Barriers that Prevent RHAs from Functioning to Their Fullest Potential.....	67
3.4	RHAs and the Potential for Internal Markets.....	70
3.5	Committee Commentary .....	74

### **CHAPTER FOUR..... 77**

PRIMARY HEALTH CARE REFORM.....		77
4.1	Why is Primary Health Care Reform Needed?.....	77
4.2	The Provinces and Primary Care Reform.....	80
4.2.1	<i>Recent reports</i> .....	80
4.2.2	<i>The Ontario Family Health Network</i> .....	81
4.2.3	<i>Quebec</i> .....	85
4.2.4	<i>New Brunswick</i> .....	85
4.3	Overcoming the Barriers to Change.....	86
4.4	The Federal Role.....	90
Appendix 4.1: GP Fundholding in Great Britain.....		93



**PART III: THE HEALTH CARE GUARANTEE ..... 97**

**CHAPTER FIVE ..... 99**

TIMELY ACCESS TO HEALTH CARE..... 99

5.1 The Right to Health Care – Public Perception or Legal Right?..... 100

5.2 The Extent to which Publicly Insured Health Services are Available Outside the Publicly Funded Health Care System..... 101

5.3 Timely Health Care and Section 7 of the Canadian Charter of Rights and Freedoms..... 102

5.4 Committee Commentary ..... 108

**CHAPTER SIX.....109**

THE HEALTH CARE GUARANTEE..... 109

6.1 The Public Perception of the Problem of Waiting Lists..... 109

6.2 The Reality of the Waiting List Problem..... 110

6.3 Canadian Experience ..... 111

6.3.1 *Cardiac Care Network of Ontario*..... 111

6.3.2 *The Western Canada Waiting List Project*..... 111

6.4 International Experience..... 113

6.4.1 *Sweden*..... 113

6.4.2 *Denmark*..... 114

6.5 Committee Recommendations..... 116

6.6 The Potential Consequences of Not Implementing a Health Care Guarantee ..... 119

6.7 Concluding Thoughts on the Health Care Guarantee..... 120

**PART IV: CLOSING THE GAPS IN THE SAFETY NET..... 123**

**CHAPTER SEVEN .....125**

EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS..... 125

7.1 Trends in Drug Spending ..... 126

7.2 International Comparisons..... 128

7.3 Coverage for Prescription Drugs in Canada..... 130

7.3.1 *Public prescription drug insurance plans*..... 130

7.3.2 *Private prescription drug insurance plans*..... 131

7.3.3 *Plan features and their relation to protection from severe drug expenses* ..... 132

7.4 An Emerging Issue: Catastrophic Prescription Drug Expenses..... 132

7.5 Protecting Canadians Against Catastrophic Prescription Drug Expenses..... 137

7.5.1 *How the plan would work*..... 138

7.5.2 *The benefits of the plan*..... 140

7.5.3 *How much would the plan cost?*..... 141

7.5.4 *Committee’s Proposal for a Catastrophic Prescription Drug Insurance Plan*..... 142

7.6 The Need for a National Drug Formulary..... 143

**CHAPTER EIGHT .....145**

EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE ..... 145

8.1 Brief Review of Key Points about Home Care from Volumes Two and Four..... 145

8.2 Other Options ..... 147

8.3	The Extra-Mural Program in New Brunswick.....	148
8.3.1	<i>Building on the New Brunswick example: direct referrals to home care.....</i>	<i>150</i>
8.4	Organizing and Delivering Post-Acute Home Care.....	151
8.4.1	<i>Definition of post-acute home care.....</i>	<i>151</i>
8.4.1.1	<i>When does Post-Acute Home Care (PAHC) servicing start?.....</i>	<i>151</i>
8.4.1.2	<i>When does PAHC servicing end?.....</i>	<i>152</i>
8.4.2	<i>Organizational arrangements for PAHC.....</i>	<i>153</i>
8.4.3	<i>Who provides PAHC?.....</i>	<i>155</i>
8.5	The Cost of a National Post-Acute Home Care Program.....	156
8.5.1	<i>How to calculate the cost of a national PAHC program.....</i>	<i>156</i>
8.5.2	<i>What about hidden costs?.....</i>	<i>157</i>
8.5.3	<i>How much will a national PAHC program cost?.....</i>	<i>158</i>
8.6	Paying for Post-Hospital Home Care.....	158
<b>CHAPTER NINE.....</b>		<b>163</b>
EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE.....		163
9.1	The Need for a National Palliative Home Care Program.....	163
9.2	Financial Assistance to Caregivers Providing Palliative Care at Home.....	164
9.3	Caregiver Tax Credit.....	166
9.4	Job Protection.....	167
9.5	Concluding Remarks.....	167
<b>PART V: EXPANDING CAPACITY AND BUILDING INFRASTRUCTURE .....</b>		<b>169</b>
<b>CHAPTER TEN.....</b>		<b>171</b>
THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE.....		171
10.1	Health Care Technology.....	171
10.2	Electronic Health Records.....	175
10.3	Evaluation of Quality, Performance and Outcomes.....	177
10.4	Protection of Personal Health Information.....	179
<b>CHAPTER ELEVEN.....</b>		<b>185</b>
HEALTH CARE HUMAN RESOURCES.....		185
11.1	The Extent of Health Human Resource Shortages.....	185
11.2	Health Human Resources: The Need for a National Strategy.....	188
11.3	Increasing the Number of Physicians Trained in Canada.....	191
11.4	Integrating International Medical Graduates.....	193
11.5	Alleviating the Shortage of Nurses.....	194
11.6	Allied Health Professionals .....	197
11.7	Funding Post-Graduate Training.....	198
11.8	Health Human Resources: Scope of Practice Rules Review .....	198
11.9	Committee Commentary .....	199
<b>CHAPTER TWELVE.....</b>		<b>201</b>
NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH.....		201
12.1	Assuming Leadership in Canadian Health Research.....	202
12.2	Engaging the Scientific Revolution.....	205
12.3	Securing a Predictable Environment for Health Research .....	208
12.3.1	<i>Federal funding for health research.....</i>	<i>209</i>

12.3.2	<i>Federal in-house health research</i> .....	212
12.4	Enhancing Quality in Health Services and in Health Care Delivery.....	213
12.5	Improving the Health Status of Vulnerable Populations.....	215
12.6	Commercializing the Outcomes of Health Research.....	217
12.7	Applying the Highest Standards of Ethics to Health Research.....	221
12.7.1	<i>Research involving human subjects</i> .....	222
12.7.2	<i>Issues with respect to research involving human subjects</i> .....	224
12.7.3	<i>Animals in research</i> .....	227
12.7.4	<i>Privacy of personal health information</i> .....	229
12.7.5	<i>Genetic privacy</i> .....	234
12.7.6	<i>Potential situations of conflict of interest</i> .....	235

**PART VI: HEALTH PROMOTION AND DISEASE PREVENTION..... 237**

**CHAPTER THIRTEEN..... 239**

	HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE.....	239
13.1	Trends in Diseases.....	242
13.1.1	<i>Infectious diseases</i> .....	243
13.1.2	<i>Chronic diseases</i> .....	243
13.1.3	<i>Injury</i> .....	244
13.1.4	<i>Mental health</i> .....	244
13.2	The Economic Burden of Illness.....	245
13.3	The Need for a National Chronic Disease Prevention Strategy.....	246
13.4	Strengthening Public Health and Health Promotion.....	249
13.5	Toward Healthy Public Policy: The Need for Population Health Strategies.....	250

**PART VII: FINANCING REFORM..... 253**

**CHAPTER FOURTEEN..... 255**

	HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED.....	255
14.1	More Money Is Needed for Health Care.....	256
14.2	The Financing Role of the Federal Government.....	260
14.3	How New Federal Funding for Health Care Should Be Managed.....	262

**CHAPTER FIFTEEN..... 265**

	HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED.....	265
15.1	The Amount of Increased Federal Funding Required.....	267
15.2	Potential Sources of Increased Federal Funding.....	270
15.3	General Taxation.....	271
15.4	Earmarked Taxation.....	275
15.5	Payroll Taxes.....	278
15.6	National Health Care Premiums.....	280
15.7	User Charges.....	282
15.8	Medical Savings Accounts.....	284
15.9	Pre-Funding for Health Care.....	285
15.10	Committee Commentary.....	286
15.11	Current Federal Funding for Health Care.....	291

<b>CHAPTER SIXTEEN .....</b>	<b>295</b>
THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE .....	295
16.1 Private Health Care Insurance in Canada and Selected OECD Countries.....	297
16.2 Review of Recent Literature on the Impact of Private Health Care Insurance and Private For-Profit Delivery.....	299
16.3 Committee Commentary .....	302
 <b>PART VIII: THE CANADA HEALTH ACT.....</b>	 <b>305</b>
 <b>CHAPTER SEVENTEEN .....</b>	 <b>307</b>
THE CANADA HEALTH ACT.....	307
17.1 Universality.....	308
17.2 Comprehensiveness.....	309
17.3 Accessibility .....	313
17.4 Portability .....	315
17.5 Public Administration.....	316
17.6 Committee Commentary .....	319
 <b>CONCLUSION.....</b>	 <b>321</b>
 <b>APPENDIX A .....</b>	 <b>A-1</b>
LIST OF RECOMMENDATIONS BY CHAPTER.....	A-1
 <b>APPENDIX B.....</b>	 <b>A-19</b>
LIST OF PRINCIPLES FROM VOLUME FIVE (APRIL 2002).....	A-19
 <b>APPENDIX C.....</b>	 <b>A-23</b>
LIST OF WITNESSES.....	A-23

# **Part IV: Closing the Gaps in the Safety Net**

---



## CHAPTER SEVEN

### EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS

---

In previous volumes, the Committee highlighted a number of critical issues with respect to prescription drug insurance coverage in Canada and the cost of prescription drugs:

- In recent years, the cost of prescription drugs has escalated faster than all other elements in health care. Spending on prescription drugs accounts for a very significant and increasing share of public sector health care expenditures. The expectation is that the upward pressures on prescription drug costs will continue as new, effective, but very costly, drugs (particularly those genetically tailored to the individual) enter the Canadian market in the next decade.
- The *Canada Health Act* does not apply to prescription drugs used outside the hospital setting, and publicly funded drug coverage varies considerably from province to province. This contrasts sharply with the policy in many OECD countries, in which publicly funded coverage is provided for prescription drugs as well as hospital and doctor services.
- Private insurance coverage for prescription drugs provided through employer-sponsored plans or individual insurance policies varies significantly in terms of design, eligibility and out-of-pocket costs to plan members.
- Despite the availability of both public and private drug insurance plans, many Canadians have no coverage at all for prescription drugs. Moreover, among those with some form of coverage (either public or private), there is substantial variation in its nature and quality.
- Financial hardship due to high prescription drug expenses is increasingly a real risk – indeed, it is a reality – for many individual and families in Canada.

This chapter reviews trends in drug costs and examines the current level of insurance coverage for prescription drugs in Canada. Particular attention is devoted to the absence and insufficiency of coverage for very high prescription drug expenses. The chapter presents the Committee's observations on Canadians' need for enhanced protection against severe or "catastrophic" prescription drug expenses, and its recommendations on how the federal government should contribute to achieving this goal.

***The Committee strongly supports the view that no Canadian should suffer undue financial hardship as a result of having to pay health care bills. It is essential that this principle be applied to prescription drug expenses.***

As stated in previous volumes, as well as in the present volume, the Committee strongly supports the view that no Canadian should suffer undue financial hardship as a result of

having to pay health care bills. This basic principle at the root of Canadian health care policy should be applied to prescription drug expenses.

## **7.1 Trends in Drug Spending<sup>186</sup>**

The Canadian Institute for Health Information reports that since 1997 spending on drugs (both prescription and non-prescription) has been the second-largest category of health care spending in Canada, behind hospitals but now ahead of spending on physician services. It is expected that final figures will show that in 2001, spending on drugs was equivalent to almost 50% of the amount spent on hospitals.

Spending on drugs has grown from \$3.8 billion in 1985 to \$15.5 billion in 2001. During this 16-year period, data from CIHI show that spending on drugs has grown faster than inflation and beyond the rate attributable to population growth. More precisely, from 1985 to 1992, drug expenditures increased on average by 12% annually. Between 1992 and 1996, they grew by an average of 5% annually. The growth rate then rose to around 10% in 1997 and 1998, and dropped to around 8% in 1999. Although the data have not yet been finalized, the average growth rate of drug spending is expected to have been about 7% in 2000 and 9% in 2001.

Prescription drugs make up the largest component of the total spending on drugs (79% in 2001, up from 67% in 1985). Non-prescription drugs accounted for the remaining 21% of drug spending in 2001 (compared to 33% in 1985). For the most part, non-prescription drugs are purchased directly by consumers and paid for out-of-pocket. By contrast, many payers are involved in the financing of prescription drugs. They include both the public sector (provincial/territorial Pharmacare programs, federal government plans for specific groups and Workers' Compensation Boards) and the private sector (private insurance plans and individuals).

---

<sup>186</sup> Most of the information provided in this section is based on data from the Canadian Institute for Health Information, *Drug Expenditure in Canada, 1985-2001*, Ottawa, April 2002. The media release for this report is available on CIHI's Website at [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=media\\_24apr2002\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_24apr2002_e)



**TABLE 7.1**  
**SPENDING ON PRESCRIPTION DRUGS BY SOURCE OF FINANCE**  
**(PERCENTAGE)**

	<b>1985</b>	<b>1988</b>	<b>1999</b>	<b>2001</b>
P/T Governments	40.6	42.6	38.2	42.0
Federal Government	2.3	1.9	2.4	2.4
Workers' Compensation Boards <sup>1</sup>	0.5	0.6	3.1	4.8
<b>Sub-Total Public Sector</b>	<b>43.4</b>	<b>45.1</b>	<b>43.7</b>	<b>49.2</b>
Private Insurers	N/A	30.5	33.5	29.9
Out-of-Pocket	N/A	24.4	22.8	20.9
<b>Sub-Total Private Sector</b>	<b>56.6</b>	<b>54.9</b>	<b>56.3</b>	<b>50.8</b>
<b>Total All Sources</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

1) Data from 1997 and beyond include spending by WCBs as well as the Quebec Drug Insurance Fund.  
N/A: not available.

Source: CIHI (April 2002), *Drug Expenditure in Canada, 1985-2001*, and Economics Division, Parliamentary Research Branch, Library of Parliament.

In 1985, 57% of prescription drug spending came from the private sector (see Table 7.1). By 2001, it had decreased to 51%. Correspondingly, the share of prescription drugs financed from public sources increased steadily from 43% to 49%. Table 7.1 also shows that the total proportion of prescription drugs paid out-of-pocket by individual Canadians has decreased from 24.4% in 1988 to 20.9% in 2001. That is, an increasing share of total prescription drug spending in Canada is being picked up by public sector drug coverage plans.

CIHI data on drug spending do not include drugs dispensed in hospitals, which it classifies as hospital expenditure. Estimates provided by CIHI in its April 2002 report suggest that drug expenditures in hospitals amounted to \$1.1 billion in 2001. In addition, the share of total hospital expenditures spent on drugs has consistently increased between 1985 and 2001, from 2.8% to 3.4%. CIHI notes, however, that the rate of growth in drug expenditures in hospitals has been slower than that of out-of-hospital drug spending. Although there may have been some shift in drug spending from hospitals to the community, CIHI stresses that more research is required to examine the relationship between drug utilization in and out-of-hospital.

Many observers expect out-of-hospital costs of prescription drugs to grow substantially in the coming years, for a number of reasons:

- The cost of developing and marketing new drug therapies has risen rapidly as pharmaceutical companies tackle more challenging diseases and face more stringent drug approval processes around the world.
- Rapid scientific progress has introduced the possibility of developing new genetically tailored drugs, applicable to a small number of patients suffering with chronic degenerative conditions, that are potentially extremely effective and also enormously costly.

- Many of the newer drug therapies are targeted at chronic conditions treated at home, as opposed to acute conditions treated in hospital.
- Changes in medical practice and new technology have replaced some hospital-based treatment with home care, which is now being provided for a number of conditions with high drug therapy costs.

The net effect is that many Canadians now incur high levels of prescription drug costs that were inconceivable only a few years ago.

## 7.2 International Comparisons

In comparison to selected OECD countries, Canada allocates a large proportion of its total health care spending to drugs, ranking second in 1998 to the United Kingdom. In the same year, Canada ranked fourth for the level of drug spending per capita, after the United States, Germany and Sweden. Spending on drugs varies greatly across countries and is influenced by numerous factors, including specific public policy traditions and institutional characteristics (reimbursement systems for users and providers, prescribing habits, etc.).<sup>187</sup>

***Many Canadians now incur high levels of prescription drug costs that were inconceivable only a few years ago.***

---

<sup>187</sup> Stephane Jacobzone, *Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals*, Occasional Paper No. 40, Labour Market and Social Policy, OECD, April 2000 ([www.oecd.org](http://www.oecd.org)).

**TABLE 7.2  
PUBLIC INSURANCE COVERAGE FOR PRESCRIPTION DRUGS**

	<b>Formulary</b>	<b>Cost Sharing</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>▪ National formulary listing only drugs that receive a positive assessment with respect to safety, quality, clinical efficacy and cost-effectiveness.</li> <li>▪ Therapeutic reference-based pricing.<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary.</li> <li>▪ Exemptions for some segments of the population.</li> <li>▪ Higher cost sharing for brand-name drugs when generic copies are available.</li> <li>▪ Individuals must pay for drugs not listed on the formulary.</li> </ul>
<b>Germany</b>	<ul style="list-style-type: none"> <li>▪ The federal government maintains a “negative list” of drugs that are not entitled to public reimbursement.</li> <li>▪ Therapeutic reference-based pricing.<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed co-payment per prescription. Co-payment varies by type of beneficiary and size of prescription.</li> </ul>
<b>Netherlands</b>	<ul style="list-style-type: none"> <li>▪ National formulary.</li> <li>▪ Therapeutic reference-based-pricing.<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary.</li> <li>▪ Exemptions for some segments of the population.</li> </ul>
<b>Sweden</b>	<ul style="list-style-type: none"> <li>▪ There is no national formulary, but each county council has developed its own list.</li> <li>▪ All drugs prescribed by doctors and hospitals are purchased by a single national agency, Apotekbolaget, a state-owned company that owns all pharmacies in Sweden..</li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary.</li> <li>▪ Exemptions for some segments of the population.</li> </ul>
<b>United Kingdom</b>	<ul style="list-style-type: none"> <li>▪ National formulary under the NHS.</li> <li>▪ There is also a negative list , that excludes some drugs from NHS prescription on the grounds of poor therapeutic value or excessive cost.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed amount per prescription.</li> <li>▪ Exemptions for some segments of the population.</li> </ul>

<sup>1)</sup> Therapeutic reference-based pricing ensures that the government pays only up to the price of a lower-priced drug that is therapeutically interchangeable with, or equivalent to, the prescribed drug.

Source: Stéphane Jacobzone, *Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals*, Occasional Paper No. 40, Labour Market and Social Policy, OECD, April 2000; Donald Willison et al., *International Experience with Pharmaceutical Policy: Common Challenges and Lessons for Canada*, Project funded under Health Canada’s Health Transition Fund, 30 April 2001; Senate Committee on Social Affairs (Volume Three); and Economics Division Parliamentary Research Branch, Library of Parliament.

In contrast, Canada and the United States exhibit a much lower public share of spending on drugs, which is largely explained by the fact that the entire population of other countries is covered for prescription drugs by public insurance. Also, the countries with which Canada and the United States are compared have formularies restricting the number of drugs

covered under public insurance, and they impose cost sharing (co-payments, co-insurance and deductibles) with waivers for certain groups of beneficiaries (see Table 7.2).

### **7.3 Coverage for Prescription Drugs in Canada<sup>188</sup>**

Currently, coverage for prescription drugs in Canada is offered through a mixture of public and private insurance plans described briefly below.

#### **7.3.1 Public prescription drug insurance plans**

With respect to public plans it is worth noting that:

1. All provinces have public prescription drug programs that cover virtually all the drug costs of low-income seniors (those receiving GIS, the Guaranteed Income Supplement), a group that constitutes about 5% of Canada's adult population. This group is thus fully protected from catastrophic prescription drug expenses. All provinces except Newfoundland also offer coverage to higher-income seniors as well.
2. All provinces also have programs that provide prescription drug coverage for recipients of social assistance, a group that comprised 6.8% of the population in 2000, protecting them also from catastrophic prescription drug expenses.
3. The federal government assumes the full cost of providing prescription drugs (as well as other health services) for some Aboriginal populations and certain armed forces veterans. These groups, which account for approximately 2% of the Canadian population, are thereby fully protected against catastrophic prescription drug expenses.
4. Provincial governments in British Columbia, Saskatchewan, Manitoba, and Ontario have prescription drug plans targeted to the general population that provide a protective cap (in some cases based on family income) on the personal cost of drug expenses borne by individuals.
5. Quebec mandates prescription drug coverage with an out-of-pocket cap no greater than \$750 for all residents, whether under employer-sponsored programs or the provincial program.

---

<sup>188</sup> This section is based on information provided by Fraser Group/Tristat Resources, *Drug Expenses Coverage in the Canadian Population: Protection From Severe Drug Expenses*, August 2002. This study was sponsored by the Canadian Life and Health Insurance Association at the request of the Committee.

6. Alberta offers to all residents a public, voluntary, premium-based prescription drug insurance plan that provides significant drug expense coverage after a three month waiting period.

In summary, a significant number of public drug plans provide a significant degree of protection against personal financial hardship to Canadians who face very high expenses for prescription drugs. However, the federal government does not directly contribute to any of the provincial plans.

### **7.3.2 Private prescription drug insurance plans**

Private sector drug insurance plans contribute significantly to Canadians' prescription drug coverage:

1. They are an entirely voluntary initiative, sponsored mostly by employers but also by unions, joint union/employer entities and educational institutions. In addition, about 1% of Canadians are covered by health insurance policies purchased individually.
2. An estimated 2.4 million Canadians belong to private-sector plans that cover 100% of prescription drug expenses, thus completely protecting their members from financial hardship attributable to very high drug costs. An additional 300,000 have plans that, in combination with public prescription drug coverage, provide 100% coverage.
3. An estimated 9.7 million Canadians (the 2.4 million mentioned above plus an additional 7.3 million Canadians, totalling 55% of those in private-sector plans) have private-sector plans that include an overall protective cap on the out-of-pocket costs of individual plan members.
4. The remaining 8.1 million Canadians in private-sector plans (45% of those in private-sector plans) have coverage that, for the most part, provides substantial – but not complete – protection from catastrophic prescription drug expenses.

In Volume Four, the Committee recounted the real-life experience of one Atlantic Canadian whose experience illustrated this last point. A professional librarian and member of a good-quality employer-sponsored plan, the individual in question faced personal out-of-pocket costs of \$17,000 annually attributable to his wife's requirement for prescription drugs that cost \$50,000 a year.

The Committee recently heard of another Atlantic Canadian resident whose medication for pulmonary hypertension (a life-threatening condition) costs more than \$100,000 a year. The individual in question's current expenses are over \$4,600 monthly (or \$55,000 annually) in order to cover the insurance premium, the drug, the peripherals needed to administer the drug, additional necessary medications and oxygen tanks. An anticipated increase

in dosage within the next year will increase the monthly bill to approximately \$5,150, or \$61,800 annually. People become eligible for government assistance in this province only once they have exhausted all their savings, including RRSPs.

### **7.3.3 Plan features and their relation to protection from severe drug expenses**

While prescription drug insurance plans have many different features and attributes, only four relate to the extent of protection such plans offer against catastrophic drug expenses. These are: deductibles, co-payments/co-insurance, annual or lifetime maximums, and out-of-pocket caps.

A *deductible* is the amount of drug expense that must be paid initially by an individual before the drug insurance plan reimburses any expense. The deductible is normally applied to a calendar or plan year. Deductibles are commonly expressed as fixed dollar amounts, but some legislated public drug insurance programs use amounts related to family income. Deductibles, unless they are extraordinarily high, usually have minimal impact on the degree of protection a plan provides against catastrophic drug expenses.

*Co-payments and co-insurance* correspond to the portion of the cost of each prescription that must be paid by the individual. Co-payments take the form of a flat amount per prescription (e.g., \$5), while co-insurance requires a fixed percentage per prescription (e.g. 5%). Co-payments can also include the pharmacist's professional dispensing fee (as opposed to the cost of the drug itself). They do not protect individuals, as in the professional librarian example cited above, from very high personal expenses resulting from the prolonged use of very expensive drugs.

An *annual or lifetime maximum* restricts to a specific amount the total amount of prescription drug expenses that a plan will pay on behalf of a plan member. Expenses in excess of this amount are to be paid out-of-pocket. For instance, a plan with a \$5,000 annual maximum would pay no more than that in a given year. The higher the maximum, the greater the protection. It is highly unusual for public prescription drug insurance plans to impose maxima. Some private-sector plans do, but most have unlimited coverage or specify very high annual or lifetime maxima such as a million dollars.

Finally, *out-of-pocket caps* are provisions of plans that restrict the total amount of deductibles, co-payments and co-insurance to be imposed on an individual during a given year. These may be expressed either as a fixed upper limit (e.g., \$1,500) or as an amount related to family income (e.g., 3%). Many prescription drug insurance plans, particularly private-sector plans, do not have explicit caps on out-of-pocket drug expenses. This feature in a drug plan guarantees the insured individual protection against catastrophic prescription drug expenses. The lower this limit, the higher the degree of protection.

## **7.4 An Emerging Issue: Catastrophic Prescription Drug Expenses**

Generally, the direct financial impact of the rise in drug spending described above is relatively modest because the proportion of average household expenditures spent on

prescription drugs remains small in absolute terms. CIHI data show that in 1999 the annual per capita expenditure on prescription drugs was \$331.38, of which \$75.49 was paid for out-of-pocket.

Nonetheless, some individuals and families can and *do* incur much more substantial expenses. While it is important to recognize that this affects relatively few people for the moment, the Committee believes that the problem warrants careful attention because:

1. Most important, some individuals do experience substantial personal financial hardship in paying for drug expenses, thereby frustrating the fundamental objective of Canadian health policy referred to above.
2. Those facing a significant personal financial burden may discontinue (or not begin) treatment requiring expensive medications.
3. Physicians may admit patients to more costly hospital based treatment so they are spared the high costs for drugs dispensed for use out of hospital.
4. Doctors may prescribe and patients may demand cheaper but less effective drugs.
5. Individuals may stay on social assistance rather than seek employment in order to maintain drug coverage.
6. The drug plan to which the affected individual belongs may experience sufficient financial expenditures that it prompts the plan sponsor to limit or discontinue it, thereby reducing or eliminating drug expense protection for all members of the plan. Other drug plan sponsors may take pre-emptive action to reduce the financial risk of catastrophic drug costs to their own plans

Estimates by Fraser Group/Tristat Resources show that currently 98% of the Canadian population is covered by one or more public and/or private prescription drug coverage plans (see Table 7.3). Two percent of Canadians (some 600,000 individuals) have no prescription drug coverage whatsoever and must assume full personal financial exposure in the event they require expensive prescription drugs.

***Two percent of Canadians (some 600,000 individuals) have no prescription drug coverage whatsoever and must assume full personal financial exposure in the event they require expensive prescription drugs.***

**TABLE 7.3**  
**PRESCRIPTION DRUG EXPENSE COVERAGE IN THE CANADIAN POPULATION**

Covered by	Percent of Population
Public Plans	53%
Private Plans	58%
Both Public and Private	13%
No Coverage	2%

Source: Fraser Group/Tristat Resources, Drug Expense Coverage in the Canadian Population: Protection From Severe Drug Expenses, August 2002, p. 11.

Fraser Group/Tristat Resources also analyzed the variations in the current levels of protection from severe drug expenses by province. Tables 7.4 and 7.5 show the percentage of the population of each province that would face various levels of out-of-pocket expenses when confronted with total prescription drug expenses of either \$5,000 (Table 7.4) or \$20,000 (Table 7.5). Each table divides the population of the province into four groups according to how much they would each pay out-of-pocket: (a) those who would pay up to \$750; (b) those who would pay between \$751 and \$2,000; (c) those who would pay over \$2,000; (d) those with no coverage at all.

Thus, for example, Table 7.4 indicates that 70% of B.C. residents with drug expenses of \$5,000 pay no more than \$750 out of pocket, while the remaining 30% of B.C. residents pay between \$751 and \$2,000. In Newfoundland, only 48% of the population who spend \$5,000 on prescription drugs pay up to \$750, while 24% of population of that province pay between \$751 and \$2,000. However, there are also 28% of Newfoundlanders who have no coverage at all and therefore have to pay the full \$5,000.

For those with \$20,000 in prescription drug expenses (Table 7.5), the percentages of B.C. residents with each level of out of pocket expenses remain the same. In Newfoundland, 48% of the population still pay only up to \$750, and the same 28% of the population have no coverage and must pay the full \$20,000. The 24% of the population that paid between \$751 and \$2,000 when faced with drug expenses of \$5,000, now has to pay over \$2000.

While the lack of coverage for a substantial proportion of Atlantic Canada residents remains a striking feature of the national pattern, the tables also point to significant variations in out-of-pocket levels among provinces that have programs covering their entire population. Quebec stands out as having the least variation in protection levels, followed by British Columbia, Manitoba and Saskatchewan.



**TABLE 7.4  
OUT-OF-POCKET COSTS FOR PRESCRIPTION DRUG EXPENSES OF \$5,000  
(PERCENTAGE OF POPULATION)**

	<b>Up to \$750</b>	<b>\$751 - \$2,000</b>	<b>Over \$2,000</b>	<b>No coverage</b>	<b>Total</b>
BC	70%	30%	0%	0%	100%
ALTA	43%	57%	0%	0%	100%
SASK	68%	24%	8%	0%	100%
MAN	84%	13%	3%	0%	100%
ONT	70%	25%	5%	0%	100%
QC	100%	0%	0%	0%	100%
NB	45%	28%	0%	27%	100%
NS	47%	29%	0%	24%	100%
PEI	48%	25%	0%	27%	100%
NFLD	48%	24%	0%	28%	100%
<b>Canada</b>	<b>73%</b>	<b>23%</b>	<b>2%</b>	<b>2%</b>	<b>100%</b>

**TABLE 7.5  
OUT-OF-POCKET COSTS FOR PRESCRIPTION DRUG EXPENSES OF \$20,000  
(PERCENTAGE OF POPULATION)**

	<b>Up to \$750</b>	<b>\$751 - \$2,000</b>	<b>Over \$2,000</b>	<b>No coverage</b>	<b>Total</b>
BC	70%	30%	0%	0%	100%
ALTA	43%	0%	57%	0%	100%
SASK	67%	25%	8%	0%	100%
MAN	84%	13%	3%	0%	100%
ONT	70%	12%	18%	0%	100%
QC	100%	0%	0%	0%	100%
NB	45%	0%	28%	27%	100%
NS	47%	0%	29%	24%	100%
PEI	48%	0%	25%	27%	100%
NFLD	48%	0%	24%	28%	100%
<b>Canada</b>	<b>73%</b>	<b>20%</b>	<b>5%</b>	<b>2%</b>	<b>100%</b>

Source: Fraser Group/Tristat Resources, Drug Expense Coverage in the Canadian Population: Protection From Severe Drug Expenses, August 2002, pp. 48-49.

Data from the same group also indicate that coverage for the great majority of Canadians (89%) provides a protective cap on out-of-pocket costs regardless of the amount of high prescription drug expenses. However, 9% of the Canadian population have drug coverage plans without such protective caps, that require co-payments or have reimbursement limits. For these individuals, out-of-pocket costs increase as their prescription drug expenses increase.

In total, 11% of Canadians are at substantial risk of significant financial hardship from high prescription drug expenses paid out of their own pockets. Table 7.6 illustrates the out-of-pocket costs for an individual requiring prescription medications costing \$20,000 per year.<sup>189</sup>

**TABLE 7.6**

Plan Type	Plan Parameters		Out-of-Pocket Cost (\$)
	Deductible	Co-payment	
A common employee benefit plan	0	0	0
Social assistance in many provinces	0	0	0
Indian Affairs NIHB	0	0	0
Another common employee benefit plan	\$25	0	25
Alberta Seniors Plan	0	30% not to exceed \$25 per prescription	About 900 (assuming 3 prescriptions per month)
Quebec RAMQ for individuals under age 65	\$100	25% out-of-pocket (capped at \$750)	750
British Columbia Pharmacare	\$800	0	800
Ontario Trillium Plan (for family income of \$60,000)	4% of adjusted family income		2,400
Most common employee benefit plan	0	20%	4,000
Federal Civil Service	\$60	20%	4,048
Alberta Non-Group Program	0	30%	6,000
No Coverage	N/A	N/A	20,000

In a separate analysis of claims data from a large number of employer sponsored drug plans (approximately half of all plans in Canada), research presented to the Committee showed that for the year 2000:

<sup>189</sup> While this is not a common occurrence, approximately 4,000 individuals in private plans exceeded this level of expense in 2000. A comparable figure for public plans is not available.

- A few individuals had drug expenses exceeding \$200,000.
- About one person per thousand insured had personal medical expenses (supplemental to medicare) exceeding \$10,000. The great majority of these expenses were for prescription drugs.

From these data, it is estimated that some three persons per thousand or about 53,000 persons covered by private-sector plans experienced drug expenses exceeding \$5,000 in the year 2000.

***It is possible to say, therefore, with some confidence that more than 100,000 Canadians experience annual drug expenses exceeding \$5,000; that number is virtually certain to increase in the years ahead.***

Published data from the Ontario Drug Benefit program suggest that the frequency of drug expenses exceeding \$5,000 may be several times higher (between 10 and 20 per thousand) within public plans covering seniors and those unable to work. This is not particularly surprising since public plans cover all seniors, who represent the age segment of the population most likely to make high use of prescription drugs.

It is possible to say, therefore, with some confidence that more than 100,000 Canadians experience annual drug expenses exceeding \$5,000; that number is virtually certain to increase in the years ahead. How these heavy expenses are paid – that is, how much is paid by a private insurance plan, how much by a public insurance plan and how much by the individual out-of-pocket – will, of course, vary from individual to individual.

## **7.5 Protecting Canadians Against Catastrophic Prescription Drug Expenses**

In developing its proposal to expand the federal government’s role in health care to include protection against the impact of severe or “catastrophic” prescription drug expenses, the Committee has sought to accomplish two objectives.

First, and foremost, the Committee wants to make sure that no Canadian individual or family is exposed to undue financial hardship as a result of having to pay all, or even a significant fraction, of the costs of extremely expensive and/or prolonged prescription drug treatments. This is entirely consistent with the basic public policy objectives underpinning the system of public health care insurance in Canada.

Second, the Committee wants to create the conditions for long-term sustainability of current prescription drug coverage programs, both provincial public and private supplementary drug insurance plans, in the face of escalating prescription drug costs and the anticipated introduction of increasingly expensive and effective drug therapies.

***Specifically, the Committee’s proposal calls for the federal government to take over responsibility for 90% of prescription drug expenses that exceed a certain limit that qualifies them as “catastrophic.”***

The Committee’s proposed plan therefore builds on, rather than replaces, Canada’s extensive current systems of provincial prescription drug coverage and private

supplementary drug insurance plans. The Committee's intent, therefore, is to present a feasible and realistic program that will inject new federal money into expanding available coverage in ways that will protect Canadians against undue financial hardship resulting from severe or catastrophic prescription drug expenses.

Specifically, the Committee's proposal calls for the federal government to take over responsibility for 90% of prescription drug expenses that exceed a certain limit that qualifies them as "catastrophic." The federal government should establish criteria and conditions that private and provincial/territorial public plans would have to meet to be eligible to receive this federal assistance. In exchange, the federal government would assume 90% of the expense of protecting Canadian individuals and families against catastrophic drug expenses. In order to ensure uniformity of coverage throughout the country, and in order to be able to control which drugs are eligible to be covered under this program, it will also be necessary to establish a national drug formulary (see section 7.6, below).

***In order to ensure uniformity of coverage throughout the country, and in order to be able to control which drugs are eligible to be covered under this program, it will also be necessary to establish a national drug formulary.***

The Committee is aware that the final parameters of the catastrophic prescription drug insurance plan would have to be established through negotiations between all the concerned parties – the federal and provincial/territorial governments as well as supplementary drug plan sponsors and carriers. However, the Committee feels that the basic contours of the plan it has worked out constitute a realistic and acceptable framework for implementation.

### **7.5.1 How the plan would work**

To qualify for federal assistance, provinces/territories would have to put in place a program that would ensure that residents of the province/territory would never be obliged to pay out-of-pocket more than 3% of their family income for prescription drugs. That is, personal prescription drug expenses for any family of the province/territory would be capped at 3% of the individual's total family income. The federal government would agree to pay 90% of prescription drug expenditures in excess of \$5,000 for individuals for whom the combined total of their out-of-pocket expenses and the provincial contribution for which they were eligible was greater than \$5,000 in a single year. Thus, the participating provincial/territorial governments would have to pay only 10% of the cost that exceeded \$5,000 of supplying prescription drugs to families who incurred catastrophic drug expenses (i.e., those whose total drug expenses exceeded \$5,000 for the year).

***To qualify for federal assistance, provinces/territories would have to put in place a program that would ensure that residents of the province/territory would never be obliged to pay out-of-pocket more than 3% of their family income for prescription drugs.***

To qualify for federal assistance, sponsors of private supplementary prescription drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out-of-pocket expenses that exceed \$1,500 per year. That is, for private-sector plans, out-of-pocket costs for plan members would be capped at \$1,500 in any given year. For plans that meet this criterion, the federal government would then agree to pay 90% of prescription drug costs in excess of \$5,000 for individual plan members whose total prescription drug costs exceed \$5,000 per year, with the plan paying the remaining 10%. Thus, each individual plan member's out-of-pocket costs would be capped at either 3% of family income or \$1,500, whichever is less.

***To qualify for federal assistance, sponsors of private supplementary drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out of pocket expenses that exceed \$1500 per year. Private supplementary drug plans would retain responsibility for drug expenses up to \$5000.***

Private supplementary drug plans would retain responsibility for drug expenses up to \$5,000, and would be strongly encouraged to put in place a pooling mechanism to assist all plans in dealing with costs in the \$1,500 – \$5,000 range. Private plan sponsors would, of course, be able to offer additional benefits and enhancements beyond the minimum requirements to be eligible for federal assistance.

The net result of this new program to protect Canadian individuals and families against the consequences of severe prescription drug expenses would be that no one would ever be obliged to pay more than 3% of their family income for prescription drugs. Those who are members of a private plan that participates in the federal program would never pay more than \$1,500 or 3% of their family income for prescription drugs, whichever is lower. Depending on whether or not an individual is a member of a private plan, the first \$5,000 in total prescription drug expenses would be paid by some combination of individual out-of-pocket spending, public and private insurance. The federal government would then pay 90% of the prescription drug costs over \$5,000 incurred by any individual in the course of a single year, with the remaining 10% of the costs over \$5,000 being paid by either a provincial or a private supplementary plan.

To illustrate how this program would work in practice, consider the following example. Three individuals each incur \$10,000 in prescription drug expenses in the course of a given year. One of them, Jane, earns \$60,000 annually. Another, Bob, earns \$30,000. Both Jane and Bob are enrolled in supplementary private insurance plans that meet the federal eligibility criteria for catastrophic prescription drug coverage. The third, Anne, is self-employed and also earns \$60,000 a year, but does not have private supplementary drug insurance. All three live in a province that participates in the federal plan.

In Anne's case, she would seek assistance from the provincial prescription drug insurance plan. Since 3% of Anne's income is \$1,800, she would be entitled to receive \$8,200 from the provincial plan to meet her total cost of \$10,000.

In Bob's case, his out-of-pocket expenses would be capped at \$1,500 under his private supplementary drug insurance plan. However, 3% of his income is only \$900. Bob

would therefore be entitled to a \$600 rebate from his insurance plan, so his total out-of-pocket expenditure does not exceed 3% of his income.<sup>190</sup>

In Jane's case, her out-of-pocket expenses would, like Bob, be capped at \$1,500 by her private supplementary plan, but since 3% of her income (\$1,800) is greater than her out-of-pocket costs (\$1,500), she would not be entitled to additional assistance.

Let's now suppose that Jane and Bob get married. They still each incur \$10,000 in prescription drug expenses annually, for a total of \$20,000. Their family income is now \$90,000 (\$60,000+\$30,000). Their private supplementary insurance plan caps their out-of-pocket expenses at \$1,500 each, for a total of \$3,000. However, 3% of their family income is only \$2,700. Jane and Bob, therefore, are entitled to receive a \$300 rebate from the provincial government.

The federal government's contribution would be paid either to the provinces or to the supplementary private insurance plans, but not directly to individuals. These payments would be made at regular pre-determined intervals (quarterly, semi-annually or annually) and claims submitted to the federal program would, of course, be subject to periodic audit to ensure that they corresponded to expenses that were actually incurred.

## **7.5.2 The benefits of the plan**

Taken together, these measures would provide effective protection against catastrophic prescription drug expenses for all Canadians and offer additional benefits to those with lower incomes by capping out-of-pocket expenses at 3% of family income. The plan also contains incentives for both the provincial/territorial governments and private supplementary plan sponsors to participate.

For the provinces and territories, the Committee's plan is structured so that the federal government provides financial assistance for some coverage that all provinces/territories already offer, such as paying the costs of catastrophic prescription drug expenses of seniors and people on social assistance. The federal contribution would therefore free up provincial money and enable provinces to pay for whatever improvements to provincial prescription drug plans are required to put in place the guarantee that no resident incur out-of-pocket costs in excess of 3% of his/her income. Furthermore, it shifts the onus from the provinces to the federal government to deal with the increasing incidence of very high (catastrophic) drug costs attributable to escalation in the cost of drugs themselves and the introduction of new, more sophisticated, and particularly expensive drug therapies.

Thus, even those provinces/territories that do not currently provide any coverage against catastrophic expenses for the working population under the age of 65 (and that

***The net result would be, of course, a real step forward for those Canadians (roughly 600,000 people) who currently have no protection whatsoever against catastrophic prescription drug expenses.***

<sup>190</sup> Note that it should be possible to work out a payment plan that enables people who are not in a position to wait for a rebate from the government at the end of the year to benefit from a credit at the point of purchase, or some similar scheme to reduce their actual out of pocket expenses to a manageable limit.

might also have difficulty participating in a traditional federal cost-sharing program because of a lack of available provincial money to match the federal dollars) are likely to derive sufficient financial benefit under this program to allow them to meet the federal eligibility criterion. The net result would be, of course, a real step forward for those Canadians (roughly 600,000 people) who currently have no protection whatsoever against catastrophic prescription drug expenses.

The Committee's proposal would also help ensure the long-term sustainability of private supplementary drug insurance plans for those that agree to cap their members' out-of-pocket expenses at \$1,500 per year. It would remove the spectre of extreme volatility in plan costs due to catastrophic drug expenses. Moreover, potential plan sponsors who have hesitated to adopt supplementary prescription drug benefit plans in the past out of fear of potentially facing catastrophic drug costs may now be more inclined to introduce them. This is particularly important for small and new businesses, enabling them to offer more competitive benefits packages to prospective employees than would otherwise be possible.

### **7.5.3 How much would the plan cost?**

It is estimated that implementing this federal initiative to protect all Canadians against catastrophic prescription drug costs would cost approximately \$500 million per year. At the request of the Committee, this cost estimate was prepared using a large-scale micro-simulation model of national drug coverage constructed by the Fraser Group and Tristat Resources, researchers who have authored several major studies of prescription drug coverage in Canada. Their most recent study, *Drug Expense Coverage in the Canadian Population: Protection from Severe Drug Expenses*, was presented to the Senate Committee on June 12, 2002.

The model by the Fraser Group and Tristat Resources is built on four key data files:

- The Statistics Canada Survey of Labour Income Dynamics (SLID) sample of approximately 60,000 Canadian households provides the basic demographic characteristics.
- The Statistics Canada Survey of Work Arrangements is used to establish supplementary drug coverage status.
- The Plan Parameter File, which establishes the terms of the public and private plans, was developed from an analysis of public plan provisions and records of 80,000 employer-sponsored plans.
- The Drug Need File, containing the estimated average annual drug expense for each age and gender group as well as the probability distribution by size of expense, is based on an analysis of supplementary drug plan claims data as well as published data from some public programs.

The entire model is balanced to aggregate benchmarks derived from macro statistics provided by the Canadian Institute for Health Information for the year 2000, adjusted for the characteristics of the sample frame used by the Statistics Canada surveys.

The Committee has added an additional cushion to the raw output from the model with a view to providing a prudent and robust estimate that is believed to overestimate somewhat the likely costs.

#### **7.5.4 Committee's Proposal for a Catastrophic Prescription Drug Insurance Plan**

In summary, then, the Committee recommends that:

**The federal government introduce a program to protect Canadians against catastrophic prescription drug expenses.**

**For all eligible plans, the federal government would agree to pay:**

- **90% of all prescription drug expenses over \$5,000 for those individuals for whom the combined total of their out-of-pocket expenses and the contribution that a province/territory incurs on their behalf exceeds \$5000 in a single year;**
- **90% of prescription drug expenses in excess of \$5,000 for individual private supplementary prescription drug insurance plan members for whom the combined total of their out-of-pocket expenses and the contribution that the private insurance plan incurs on their behalf exceeds \$5,000 in a single year.**
- **the remaining 10 % would be paid by either a provincial/territorial plan or a private supplementary plan.**

**In order to be eligible to participate in this federal program:**

- **provinces/territories would have to put in place a program that would ensure that no family of the province/territory would be obliged to pay more than 3% of family income for prescription drugs;**
- **sponsors of existing private supplementary drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out-of-pocket expenses that exceed \$1,500 per year; this would cap each individual plan member's out-of-pocket costs at either 3% of family income or \$1,500, whichever is less.**



## **7.6 The Need for a National Drug Formulary**

It is clear to the Committee that, in order to implement its plan to protect Canadian individuals and families from catastrophic prescription drug costs in a uniform and equitable manner across the country, it will be necessary to establish a national drug formulary. The concept of a national drug formulary was brought to the Committee's attention by a number of witnesses during its study.

A drug formulary refers to a list of prescription drugs that are supplied under public drug insurance plans. A "national" drug formulary does not mean that the federal government alone would be responsible for determining which prescription drugs would be on it. Rather, a national formulary is best conceived in terms of harmonization among the federal, provincial and territorial participants together with the participation of other interested stakeholders.

As the Committee noted in Volume Four of its study, the benefits of a national drug formulary include the following:

- Elimination of the potential for log-rolling, or pressuring one province to add a drug to its formulary because another has already done so;
- Enhanced ability to undertake and make available nationally the research needed to understand whether the benefits of a new (and costlier) drug genuinely represent a significant improvement on existing (and cheaper) drugs.<sup>191</sup>

The establishment of a national drug formulary could lead the way to the creation of a single national buying agency – one that covers all provincial/territorial/federal jurisdictions. The substantial buying power of such an agency would strengthen the ability of public prescription drug insurance plans to negotiate the lowest possible purchase prices from drug companies.

Given the plan to protect Canadians against catastrophic prescription drug costs, a national drug formulary would mean that all Canadians would receive comparable coverage and access to drugs regardless of where they lived. It would also enable the funders of the program to exercise control over which drugs were eligible for coverage. The Committee believes that, since the federal government will be funding 90% of the cost, it is essential that the federal government be at the table when these decisions are made. Moreover, given the potential for exponential growth in the costs of new drug therapies, the funders of the program will have to agree jointly which drugs are covered under the plan. The Committee therefore recommends that:

**The federal government work closely with the provinces and territories to establish a single national drug formulary.**

---

<sup>191</sup> Volume Four, p. 71.



## CHAPTER EIGHT

### EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE

---

#### 8.1 Brief Review of Key Points about Home Care from Volumes Two and Four

Spending on home care in Canada (both public and private) has increased continually over the past two decades (see Figures 8.1 and 8.2). In previous Volumes, the Committee noted that there is no consensus about what services should be included in the definition of home care. Home health care services can cover some acute care (intravenous therapy and dialysis, for example), long-term care (for individuals with degenerative diseases such as Alzheimer's or chronic physical or mental disabilities), and end-of-life care for those with terminal conditions. In addition to health care, home care can include social support services such as monitoring, homemaking, nutritional counselling and meal preparation. It extends along a wide continuum of care.

There are two basic kinds of home care providers: formal caregivers such as nurses, therapists, and personal support workers; and informal caregivers, usually family members or friends. The 1998/99 Population Health Survey found that the majority of those who reported needing care in the home due to aging, chronic illness or disability received no formal, publicly funded care whatsoever. Between 80% and 90% of all home care provided to people with these needs is unpaid. The survey did not report the extent to which needs not paid for from public funds are being paid for privately, met by informal caregivers, or simply not met.

The need for home care will become a major challenge as the baby boomers age, average life expectancy rises, health care delivery becomes both more de-institutionalized and more technologically complex, and as work and social patterns decrease the availability of informal care-giving by family members. The Committee heard that home care can fulfill a number of functions, notably:

***The need for home care will become a major challenge as the baby boomers age, average life expectancy rises, health care delivery becomes both more de-institutionalized and more technologically complex, and as work and social patterns decrease the availability of informal care-giving by family members.***

- it substitutes for services provided by hospitals and long-term care facilities;
- it maintains clients' capacity to remain in their current environment, usually their homes, as an alternative to moving to another and often more costly venue such as a long-term care facility; and
- it reduces dependency, primarily by providing monitoring at additional short-run but lower long-run costs.

Many witnesses contended that when home care is substituted for acute care – usually hospital-based care – it should be considered the same as acute care delivered in other settings and, accordingly, should be encompassed under the *Canada Health Act*.

Currently, each province and territory offers some form of home care program, but not as a “medically necessary” service under the *Canada Health Act*. Therefore, publicly funded home care programs vary greatly across the country in terms of eligibility, scope of coverage and applicable user charges. Although its provision has increased in most provinces in recent years, public spending on home care still represents a small proportion of overall provincial health care budgets.

Recent studies suggest that although home care is generally cost-effective, it is clear that in many cases institutionalized care remains more efficient, particularly for the frail elderly. Of course, institutionalized care is always more convenient for service providers.

But cost and the ease of service delivery are not the only factors to be taken into account. Many people want to receive care if it is available to them in their homes, rather than in institutions.

In Volume Four (section 8.10), the Committee outlined four options for federal contributions to the financing of home care:

1. *A National Home Care Program*

Under this option, the federal government would increase its transfers to assist the provinces and territories to develop home care programs in their respective jurisdictions. The federal government would work closely with the provinces and territories to develop national home care standards, a critical issue if home care is to become a fully integrated component of Canada’s health care delivery system.

2. *Tax Credit and Tax Deduction to Home Care Consumers*

The federal government could offer enhanced financial assistance to home care consumers through tax changes that build upon existing income tax provisions. Alternatively new tax incentives could be created to encourage people to put money aside for their long-term care needs.

3. *Creating a Dedicated Insurance Fund to Cover the Need for Home Care*

Using a dedicated, capitalized insurance fund approach such as that suggested by the Clair Commission in Quebec, home care could be offered as benefits in kind or as monetary benefits.

#### 4. *Specific Measures Aimed at Informal Caregivers*

The reduction in in-patient hospital services has increased the burden of care on families and friends of home care patients. Currently, more than 3 million Canadians – mostly women – provide unpaid care to ill family members in the home. This option would provide further financing support for Canada’s informal caregivers, using the Canada Pension Plan (CPP) and/or Employment Insurance programs to assist those who leave the workforce temporarily to provide informal care.

### **8.2 Other Options**

These options were focused on federal involvement in all three aspects of home care (substitution, maintenance and prevention). The only specific aspect that was raised in Volume Five was in relation to the development of a national health info-structure and concerned the need to invest in tele-homecare. In Volume Five, the Committee also announced its intention to produce a thematic study on the issue of home care in the near future.

In subsequent testimony, the Committee heard that it is important to consider devising a national home care strategy in stages, beginning with the function of home care as a substitute for acute care.

Health Canada showed in 1999<sup>192</sup> that on a national basis, one-third of home care’s clientele has acute needs and two-thirds employ its long-term services (Table 8.1). The latter are recipients of continuing care, while the former are post-acute care recipients, usually those requiring services for a short period following hospitalization. Recent hospital transformations through closures, mergers, reductions in lengths of stay, and changes to the size and function of hospitals have shifted the traditional home care caseload, putting greater emphasis on post-acute home care recipients.

Home care is no longer the preserve of the elderly. Forty-five percent of home care recipients in Ontario are under 65 years of age and 15 percent are children.<sup>193</sup> Moreover, the services profiles are distinct for the two main groups of home care clients. The post-acute care group receives care for a short period, generally less than 90 days; the other, made up primarily of elderly and disabled people, receives care on a continuing basis. For short-term recipients, nursing services make up the lion’s share (63.0%) of home care received; the remaining services are divided between personal support (20.6%) and various other therapies (16.4%). In contrast, for continuing care recipients,

***Recent hospital transformations through closures, mergers, reductions in lengths of stay, and changes to the size and function of hospitals have shifted the traditional home care caseload, putting a heavier emphasis on post-acute home care recipients.***

<sup>192</sup> “Provincial and Territorial Home Care Programs: A Synthesis for Canada,” Health Canada, June 1999.

<sup>193</sup> Laporte A, Croxford R, Coyte PC: Access to home care services The role of socio-economic status. Presentation at the Canadian Health Economics Research Association Conference, Halifax, May 2002.

personal support is the most prevalent service (59.2%), followed by nursing care (35.5%); therapeutic services are rarely necessary.<sup>194</sup>

**TABLE 8.1**  
**PERCENTAGE OF ACUTE, LONG-TERM, AND OTHER CLIENTS, 1996-97**  
**(JURISDICTIONS WHERE DATA ARE AVAILABLE)**

<b>Province/ Territory</b>	<b>Acute Care Clients</b>	<b>Long-Term Care Clients</b>	<b>Others</b>	<b>Total</b>
B.C.	56.4	34.5	N/A	90.9
Alta.	41.0	52.0	7.0	100.0
Sask.	22.9	70.5	6.6	100.0
Que.	21.1	63.7	15.2	100.0
N.B.	53.3	46.6	N/A	99.9
P.E.I.	20.0	75.0	5.0	100.0
Y.T.	16.6	73.7	9.6	99.9
<b>Canada</b>	<b>33.0</b>	<b>58.0</b>	<b>8.7</b>	<b>99.7</b>

The Committee believes the model of home care delivery pioneered in New Brunswick should be highlighted.

### **8.3 The Extra-Mural Program in New Brunswick**

Founded in 1981, under then Health Minister, now Senator, Brenda Robertson (a member of this Committee), the New Brunswick Extra-Mural Hospital (NBEMH) was Canada's first government-funded home-hospital program. It is often cited as a possible model for other jurisdictions. Designated as a Hospital Corporation under the New Brunswick Hospital Act, its services were eligible to be insured by the province. "The mission of the NBEMH was to provide a comprehensive range of coordinated healthcare services for individuals of all ages for the purpose of promoting, maintaining and/or restoring health within the context of their daily lives."<sup>195</sup>

In 1996, a major restructuring of the NBEMH took place. A change in legislation changed the status of the NBEMH from that of a Hospital Corporation to its current status as an Extra-Mural Program (EMP). Management of the existing service delivery units devolved to the eight Region Hospital Corporations (RHCs). The RHCs manage hospital facilities, community health care centres (four sites in the province), and the Extra-Mural Service Delivery Units located in their territory. While management of service delivery has been decentralized, overall direction, including development, standard setting, funding, and monitoring of the EMP

<sup>194</sup> Ibid.

<sup>195</sup> Brief to the Committee, p. 3.

is the responsibility of the Hospital Services Division of the New Brunswick Department of Health and Community Services.

Thirty service delivery sites provide for the delivery of EMP services to clients across the entire province. Staff includes clinical coordinators, liaison nurses, support staff, and field staff representing the disciplines of clinical nutrition, nursing, occupational therapy, physiotherapy, speech language pathology, social work, and respiratory therapy. All professional staff members are employees of the EMP who work in interdisciplinary teams. Support services such as homemaking and meals-on-wheels are contracted. Direct care staff provides the case-management function as well. Nursing services are available 24 hours a day, seven days a week, while all other disciplines deliver services Monday to Friday.

Clients of the program fall into one of four categories or groupings:

- **Acute Care:** The objective is to facilitate early discharge or prevent admissions to more costly facilities, including hospitals; to improve or restore function through the provision of assessment and intervention in clients' natural environments. Services include, but are not limited to, selective chemotherapy, oxygen therapy, diabetes management, IV therapy, wound care, intravenous hydration and medication administration, and post-operative rehabilitation.
- **Continuing Care:** the objective is to maintain and prevent further deterioration in health/function so that individuals can remain in their current environments for as long as possible. Services include, but are not limited to, oxygen therapy; medication assessment, management, and monitoring; seating and positioning; adaptive equipment aids/prescription; support for individuals on mechanical ventilation; and group therapy.
- **Promotive/Preventive Care:** The purpose is to provide information, advice, or any planned combination of educational and organizational supports to maintain or enhance health; to prevent the occurrence of injuries, illnesses, chronic conditions and their resulting disabilities.
- **Palliative Care:** the objective is to provide interventions that help alleviate pain and manage the symptoms of a terminal illness; to provide support and respite to individuals and their informal support networks so individuals may die at home or delay admission to a medical care facility for as long they so choose.

Assessment, treatment, education, and consultation are a component of each type of care. The services provided are intended to promote client independence for as long as possible. At its inception the budget for the EMP was \$250,000. As shown in Table 8.2, in a province with a total population of just over 750,000 it has grown into a program with a budget around \$40 million. It offers an example of how it is possible to phase in a comprehensive home care program over time.

### 8.3.1 Building on the New Brunswick example: direct referrals to home care

The Committee took particular note of the fact that the New Brunswick EMP enabled doctors to refer patients directly to the program. Cheryl Hansen, Provincial Director of the EMP, told the Committee that “between 50 to 60 per cent of the EMP total caseload is for acute care services or is the acute care replacement and substitution function of hospitals.” In her brief to the Committee she further indicated that “approximately 55% of acute care clients are admitted directly from the community,”<sup>196</sup> without having been admitted to a hospital. The Committee highlights this aspect of the EMP in the hope that other jurisdictions will consider developing similar programs that offer the possibility of extending the range of services available to Canadians under the *Canada Health Act* in an effective and cost-efficient fashion.

**[...] “approximately 55% of acute care clients are admitted directly from the community,” without having been admitted to a hospital. The Committee highlights this aspect of the EMP in the hope that other jurisdictions will consider developing similar programs that offer the possibility of extending the range of services available to Canadians under the Canada Health Act in an effective and cost-efficient fashion.**

**TABLE 8.2  
EXTRA-MURAL PROGRAM – ASSORTED DATA**

	1996-97	1997-98	1998-99†	1999-00†	2000-01*‡
Staff (FTE)	527	590	592	608	668
Separations <sup>3</sup>	10,866	11,972	12,680	13,924	19,941
Nursing Visits <sup>1, 3</sup>	270,145	275,586	295,817	326,630	282,813
Rehab. Visits <sup>2, 3</sup>	34,107	64,080	93,459	87,946	78,609
Other Visits <sup>3</sup>	40,457	42,587	43,522	45,040	39,148
Total Visits	344,709	382,253	432,720	459,616	400,570
Gross Expenditures (\$M)	\$28.6	\$31.7	\$35.0	\$37.2	\$39.7
Average Cost / Visit <sup>3</sup>	\$83	\$83	\$81	\$81	\$99
Average Cost / Separation <sup>3</sup>	\$2,632	\$2,662	\$2,758	\$2,674	\$1,990

Source: New Brunswick Department of Health and Wellness, Annual Report 2000-2001.

Notes:

1. Includes occupational therapy, physiotherapy and speech language pathology visits.
2. Includes social work, clinical nutrition, and respiratory therapy visits .
3. For 1999-2000 fiscal year only, due to the implementation of a new EMP information system, statistics are estimated based on activity data collected from April to September 1999.

† Staffing and volume increases attributed to the Rehabilitation Services Plan

\* Preliminary data

‡ Statistics may vary from previous years as EMP went live with a new information system in 2000-01 (EMP Information System). Collection of statistics is according to New Brunswick MIS guidelines in 2000-01.

<sup>196</sup> Brief to the Committee, p. 3.



## **8.4 Organizing and Delivering Post-Acute Home Care**

In this section and the two that follow, the Committee outlines its specific proposal for a national program to provide publicly funded insurance coverage for post-acute home care, that is, for people requiring treatment at home following an episode of hospitalization.<sup>197</sup> We describe mechanisms for the financing, delivery and organization of home care following hospitalization.

Although other types of home care services are also important contributors to good health, the Committee believes it is important to focus at this time on the financing, organizing, and delivery of post-acute home care. The Committee's objective is to stimulate the development of a new national program that provides public insurance coverage for services that are now delivered to Canadians in their own residences and are not therefore covered under the provisions of the *Canada Health Act*. Although we do not now propose a comprehensive home care program, the Committee is convinced that it is important to begin with what we believe to be a fiscally feasible expansion of the health care safety net in Canada.

***...the Committee believes it is important to focus at this time on the financing, organizing, and delivery of post-acute home care.***

### **8.4.1 Definition of post-acute home care**

Post-acute home care refers to the provision of home care services to patients who have experienced an episode of hospital care. The first challenge to face in developing a national program for post-acute home care is in the identification and classification of home care following hospital care and linking relevant home care services to an initial episode of hospital care, whether in-patient care or same-day surgery.

***...the Committee is convinced that it is important to begin now a fiscally feasible expansion of the health care safety net in Canada. We believe our proposed program meets the test of fiscal feasibility.***

#### **8.4.1.1 When does Post-Acute Home Care (PAHC) servicing start?**

Fortunately, studies have explored the definition of post-acute home care (PAHC) in the context of health service restructuring.<sup>198</sup> Most experts have defined post-acute home care recipients as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date. Initiation of home care beyond 30 days of

---

<sup>197</sup> The Committee wishes to acknowledge the invaluable assistance of Dr. Peter Coyte in the preparation of its proposal for the development of a national publicly funded program for post-acute home care. Professor Coyte is Professor of Health Economics and CHSRF/CIHR Health Services Chair at the University of Toronto. He is also the Co-Director of the Home and Community Care Evaluation and Research Centre, and the President of Canadian Health Economics Research Association. Many of the specific recommendations were developed by Professor Coyte in a background paper prepared at the request of the Committee.

<sup>198</sup> Coyte PC, Young W: Regional variations in the use of home care services in Ontario, 1993/1995. *Canadian Medical Association Journal*, 161:4, 376-380, 1999; Coyte PC, Young W: *Reinvestment in and use of home care services*, Technical Report No. 97-05-TR, Institute for Clinical Evaluative Studies: Toronto, Ontario, November, 1997; Coyte PC, Young W, DeBoer D: *Home care report for the Health Services Restructuring Commission*. Report to the Health Services Restructuring Commission, Health Services Restructuring Commission: Toronto, 1997.

discharge is unlikely to be directly related to previous hospitalization.<sup>199</sup> An interval shorter than 30 days might exclude episodes of home care that were related to the prior hospitalization but were postponed because of scheduling or other difficulties.

***The Committee therefore proposes that post-acute home care recipients should be defined as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date.***

The Committee therefore proposes that post-acute home care recipients should be defined as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date.

#### **8.4.1.2 When does PAHC servicing end?**

While there appears to be consensus in the literature on the definition of who should initially qualify as a PAHC recipient, the identification of those home care services that are relevant or attributable to the original hospitalization represents a greater challenge. The current ad hoc solution has usually been to impose an arbitrary date beyond which further in-home servicing may be presumed to be unrelated to the original reason(s) for hospitalization. In some instances this cut-off date has been one year after discharge;<sup>200</sup> in other cases it has been 60 days. One rationale for use of the 60 day limit is that it is consistent with the short stay (or short term) classification of home care episodes; episodes of home care that extend beyond 60 days are then classified as long stay (or continuing care).

It is important to note, that over 50% of PAHC recipients are discharged from home care before 30 days of home care have elapsed, and almost 70% before 60 days; only 12.7% receive PAHC past six months. The Committee has decided to adopt a cut-off date of three months, that is a period inbetween 60 days and six months. Hence, somewhere in the range of 75-80% of PAHC recipients will have been discharged from home care before the three months have elapsed.

The Committee therefore recommends that:

**An episode of PAHC should be defined as all home care services received between the first date of service provision following hospital discharge, if that date occurs within 30 days of discharge, and up to three months following hospital discharge.**

---

<sup>199</sup> Hollander M: *The costs, and cost-effectiveness of continuing care services in Canada*. Queen's-University of Ottawa Economic Projects Ottawa, 1-113, 1994; Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997); Kenney GM: How access to long-term care affects home health transfers. *Journal of Health Politics Policy and Law*, 83: 412-414, 1993.

<sup>200</sup> Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997).

## 8.4.2 Organizational arrangements for PAHC

The national estimates of the total cost of the Committee's PAHC program will be derived below. The manner in which such funds are allocated and the mechanisms used to assign responsibility for the organization and delivery of such care are tremendously important. This section outlines mechanisms for the finance, organization and delivery of PAHC.

Control and responsibility for the organization and delivery of PAHC varies across Canada but is usually the responsibility of organizations that are distinct from hospitals. This has created parallel sets of entrenched interests, pitting organizations responsible for hospital care against those responsible for home care, and creating conflict that has foreclosed on or restricted opportunities for service integration, stifled innovation and put unnecessary limits on service cost-effectiveness.

Therefore the Committee believes that it would be a mistake to continue to fund those organizations charged with the distinct responsibility to negotiate, select, approve, and evaluate (internal or external) contractual arrangements with home care providers. The development (or perpetuation) of a separate program for PAHC that entails another set of vested interests would do little to ensure that funding follows the care recipient. The financing of PAHC should be first directed to hospitals, and the Committee recommends that:

### **Financing for post-acute home care should be first directed to hospitals.**

There is an abundance of evidence to indicate that hospitals respond in predictable ways to financial incentives. The introduction of service-based reimbursement, whereby hospitals are reimbursed at a fixed rate for each type of service delivered (in keeping with the Committee's recommendations on hospital funding in

Chapter Two), would provide incentives to shorten lengths of stay and to shift the hospital caseload toward day surgery and away from in-patient care.<sup>201</sup> Furthermore, given the relationship between PAHC and hospital care, the introduction of service-based reimbursement for hospitals would increase their demand for PAHC.<sup>202</sup>

***Directing the funding for the provision of PAHC to hospitals will allow them to benefit from the potential cost-savings associated with shorter lengths of stay, thereby encouraging the uptake of home care and greater use of PAHC.***

---

<sup>201</sup> A variety of studies have explored the classification of linked episodes of hospital care and PAHC. Based on the work performed for the Health Services Restructuring Commission in Ontario, for example, each inpatient and same day surgery hospitalization could be assigned to one of twenty-five mutually exclusive and exhaustive Major Clinical Categories (MCCs) in the case of inpatient care, and one of six Day Procedure Groups (DPGs) in the case of same day surgery. [Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997); Kenney (1993); Canadian Institute for Health Information: *Length of stay database by CMG*. Ottawa. Canadian Institute for Health Information, 1994. Canadian Institute for Health Information: *DPG booklet*. Ottawa. Canadian Institute for Health Information, 1996.]

<sup>202</sup> Kenney (1993); Kenney GM: Understanding the effects of PPS on Medicare home health use. *Inquiry*, 28: 129-139, 1991.

Directing funding for the provision of PAHC to hospitals will allow them to benefit from the potential cost-savings associated with shorter lengths of stay, thereby encouraging the uptake of home care and greater use of PAHC.<sup>203</sup> In contrast, if a separate organization were financed for the provision of in-home care, the potential cost-savings achieved through either shorter hospital stays or the use of day surgery would be much less likely to be captured, and hence, would not have a direct impact on decisions regarding service provision.

Consequently, the Committee believes that efficiency gains in the provision of both hospital care and PAHC are better advanced through the vertical integration and joint financing of these services, and recommends that:

**In order to encourage innovation and service integration, and to enhance the efficient and effective provision of necessary health care irrespective of the setting in which such care is received, a service-based method of reimbursement for PAHC should be developed in conjunction with service-based arrangements for each episode of hospital care.**

Furthermore, in the Committee's view, PAHC programs should not be restricted only to nursing and therapy services. This could lead to distorted patterns of practice because PAHC recipients, like many patients using other forms of home care, utilise a full array of home care services. Limiting the scope of services covered under the program might encourage hospitals to substitute nursing services for other kinds of personal support services that would be more cost effective, raising, rather than lowering, the aggregate cost of care.

This point was reinforced by the experience of the New Brunswick Extra-Mural Program. In her brief to the Committee, Cheryl Hansen indicated that one of the lessons they learned was that:

*The acute care substitute function of homecare requires a comprehensive team working collaboratively to meet the needs of the client and family. An essential component of acute care services is the provision of appropriate short term home support services e.g., homemaking.[...]The funding and provision of adequate short term support needs to be addressed in order for the replacement/ substitution function of homecare to occur in a fashion that ensures quality service for the client and family.<sup>204</sup>*

For these reasons the Committee believes that the reimbursement arrangements for the provision of home care following hospital care should be flexible in order to encourage innovation and efficiency and recommends that:

---

<sup>203</sup> Kenney (1993).

<sup>204</sup> Brief to the Committee, June 17, 2002, p. 7.

**The range of services, products and technologies (including prescription drugs) that may be used to facilitate the use of home care following hospital care not be restricted.**

### **8.4.3 Who provides PAHC?**

The Committee recognizes that the methods by which PAHC is organized and delivered is a separate question from how these services are funded, and that many different forms of service delivery are feasible. In some circumstances, hospitals may provide the services themselves; in others, hospitals may contract with not-for-profit or for-profit home care service providers; in yet other circumstances, hospitals may contract with third-party agencies that sub-contract with home care service providers.

***In some circumstances, hospitals may provide the services themselves; in other situations hospitals may contract with not-for-profit or for-profit home care service providers, or in other circumstances hospitals may contract with third party agencies that sub-contract with home care service providers.***

The organizational options for PAHC are many and offer a variety of potential benefits. First, the establishment of separate third party home care agencies may present some hospitals with an opportunity to pool resources and gain economies of scale in service provision, despite the potential to incur additional contracting and other administrative costs.

Second, hospitals may develop dedicated in-home service teams to deal with the particular community circumstances faced by care recipients.

Finally, hospitals may contract-out (or out-source) the provision of PAHC to home care service providers. This arrangement has a number of advantages. It can permit service specialization by providers familiar with circumstances in the community; it offers the prospect of service integration between hospital and PAHC; and it yields opportunities to take advantage of cost savings associated with improvements in patterns of care.

The Committee therefore recommends that:

**Hospitals have the option to develop contractual relationships directly with home care service providers or with transfer agencies that may provide case management and service provision arrangements.**

Regardless of the organizational arrangement selected, the providers of PAHC should receive service-based reimbursement. As described in detail in Chapter 2, the amount of money a provider is paid under service-based funding depends on the acuity of the case being

***Regardless of the organizational arrangement selected, the providers of PAHC should receive service-based reimbursement.***

treated. Thus, service-based funding levels would be determined by clinical guidelines. This method ensures that the PAHC service providers receive a flat rate for their services to a specific patient, thereby encouraging service innovation and integration, and enhancing the efficient and effective allocation of health care services.

Reimbursing home care service providers with a fixed, predetermined payment offers a number of incentives. First, providers may retain residual income and therefore have the incentive to select the most efficient ways of delivering services. Second, to take advantage of economies of scale and scope, both vertical and horizontal service integration may occur. Such integrated organizations may be in a better position than other organizations to delegate tasks cost-effectively and improve the continuity of care. Third, to the extent to which payment exceeds the costs incurred in service provision, incentives exist for such organizations to compete for additional care recipients.<sup>205</sup>

However, there is a negative incentive given that this reimbursement method also tends to encourage the avoidance of care recipients with high service needs, i.e., “cherry-picking.” Also, in the absence of a vigilant program of evaluation, organizations may be tempted to skimp on service provision, potentially leading to diminished quality of care. Consequently, the determination of an appropriate risk-adjusted service-based payment that closely reflects the service needs of PAHC recipients and the introduction of a systematic program of outcome performance, are policies that must be developed in concert with modified funding schemes to ensure cost-effective and uniformly accessible PAHC of high quality.

The Committee therefore recommends that:

**Contracts formed with home care service providers should include, in addition to service-based reimbursement arrangements, mechanisms to monitor service quality, performance and outcome.**

## **8.5 The Cost of a National Post-Acute Home Care Program**

### **8.5.1 How to calculate the cost of a national PAHC program**

As shown in Figure 8.3 (at the end of this chapter), there are wide interprovincial variations in per capita public home care expenditures in Canada, variations that persist even after adjusting for the age-sex composition of the underlying population. While the average per capita public funding for home care in fiscal year 2000 was \$87.51, there was a four-fold variation in such expenditures, ranging from the highest in New Brunswick (\$193.76) to the lowest in Prince Edward Island (\$47.85) and Quebec (\$51.89).<sup>206</sup> These variations are due, in

---

<sup>205</sup> Valdeck BC, Miller NA: The Medicare home health initiative. *Health Care Financing Review*, 16:1, 7 – 16, 1994; Phillips BR, Brown RS, Bishop CE, et al: Do preset per visit payments affect home health agency behaviour? *Health Care Financing Review*, 16:1, 91- 107, 1994.

<sup>206</sup> Health Canada: *Health expenditures in Canada by age and sex 1980-81 to 2000-01*. Health Policy and Communications Branch, Health Canada: Ottawa, August, 2001.

part, to the extent to which the provincial publicly funded home care program is extensive (as it is in New Brunswick) or quite restricted (as it is in Prince Edward Island and Quebec).

Nationally, public home care expenditures were \$2,690.9 million in fiscal year 2000.<sup>207</sup> In order to identify the proportion associated with PAHC, the Committee used methods based on previous work in Ontario for the Health Services Restructuring Commission.<sup>208</sup> All home care recipients were identified for fiscal year 1997 and assigned to one of four mutually exclusive categories, as shown in Figure 8.4 (at the end of this chapter), based on their use of home care in relation to an episode of hospital care.

Home care recipients were first classified according to whether they had had an episode of hospital care, whether inpatient or same-day surgery, during fiscal year 1997.<sup>209</sup> If they had had an episode of hospital care, the pattern of home care provision within 30 days of discharge was analyzed. If the first home care visit following hospital discharge took place within thirty days, the pattern of use of home care services in the 30 days prior to hospitalization was analyzed. Accordingly, the four home care recipient categories were: no hospitalization; no PAHC; PAHC without prior home care; and PAHC with prior home care.

The use of home care services and the average cost of such services were analyzed for one year following either the first home care service date (for recipients who did not receive PAHC) or the first home care service date following hospital discharge (for recipients who received PAHC).

Two estimates are offered for the proportion of total home care costs attributable to PAHC. The first (high) estimate is based on the proportion of home care *recipients* that received PAHC, while the second (low) estimate is based on the proportion of *expenditures* attributable to such care. While 42.8% of home care recipients received PAHC services, only 26.5% of total home care expenditures were attributable to such care. The use of both estimates on which to base the cost of a national PAHC program recognizes the uncertainty associated with developing cost estimates for a program of this kind, given the absence of a health information system relating to the use of home care services.

### **8.5.2 What about hidden costs?**

In addition to home care service costs, other costs associated with the provision of PAHC are hidden in other provincial spending categories. Drug costs are a major item that is hidden. For fiscal year 2001, the Ontario Drug Benefit (ODB) program expenditure attributable to home care recipients was estimated at \$86.8 million.<sup>210</sup> While this amount probably underestimates provincial drug program costs associated with the provision of home care, it may be used to approximate the hidden costs associated with the provision of PAHC.<sup>211</sup>

---

<sup>207</sup> *Ibid*.

<sup>208</sup> Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997).

<sup>209</sup> See Figure 8.4.

<sup>210</sup> Peter Coyte, Personal Communication, Mr. Carl Marshall, Associate Director, Administration, Finance and Eligibility, Drug Programs Branch, Ontario Ministry of Health and Long -Term Care, 2002.

<sup>211</sup> Suppose the identified ODB program expenditures attributable to home care only represents the hidden costs incurred by those under sixty-five years of age during their home care episode. Under this assumption, estimates of

### **8.5.3 How much will a national PAHC program cost?**

A calculation done for the Committee combined estimates of the hidden costs with those for the direct service costs and, converting to 2002 dollars, used the growth in home care funding in Ontario between fiscal years 2000 and 2002 of 11.9% and estimated the cost of providing post-acute home care for a one-year period following hospitalization. This yielded a total cost estimate for a national PAHC program of between \$1,021.1 million and \$1,511.8 million for fiscal year 2002.<sup>212</sup> Given that the Committee has recommended a period of three months' coverage, it is legitimate to fix the estimated cost of the program at approximately \$1,100 million per year. The Committee recognizes that this estimate is probably somewhat high.

### **8.6 Paying for Post-Hospital Home Care**

The Committee believes the cost of a national PAHC program should be shared equally between the provincial and federal governments. It therefore recommends that:

**The federal government establish a new National Post-Acute Home Care Program, to be jointly financed with the provinces and territories on a 50:50 basis.**

This brings the total cost (in fiscal year 2002 dollars) of a National PAHC Program to be borne by the federal government to approximately \$550 million per year.

It is also necessary to ask, however, whether the person receiving the home care – the patient – should also contribute to the cost of this expansion of publicly insured health care services. There are two ways of looking at this question.

The first is that the need for this expanded service arises as a result of the individual's having been in hospital and that the service is therefore simply an extension of hospital care which, under Medicare, should be "free" to the patient and paid entirely out of public funds. Moreover, one advantage of implementing this option of providing first-dollar coverage is that, since the full cost of home care coverage will be paid by the PAHC program, there is no reason for patients to object to shorter hospital stays. That is, no disincentive is introduced to the transfer of patients from high-cost hospital care to less expensive non-hospital care. This increases the likelihood of realizing efficiency gains for the health care system as a whole.

The second approach is that since patients are, for the most part, paying currently for at least some aspects of this home care service, it is reasonable that patients

---

the hidden costs associated with an episode of home care are \$627.97 (in 2001 dollars). Since these costs are assumed to be uniform across all categories of home care recipients, they may be used to compute a "hidden cost" inflation factor for PAHC. This inflation factor may be defined as one plus the ratio of the hidden costs (\$627.97) to the cost per PAHC recipient. The latter depends on the home care costs attributable to PAHC recipients divided by the number of such recipients (137,915 from Figure 4). Using figures from Ontario, in conjunction with the high estimate for PAHC costs, the hidden cost inflation factor is (1.1731), while this factor is (1.2796) when using the low estimate for PAHC costs.

<sup>212</sup> The low estimate was calculated as \$2,690.9 million \* 1.119 \* 0.265 \* 1.2796, while the high estimate was derived as \$2,690.9 million \* 1.119 \* 0.428 \* 1.1731.



continue to pay a small part of the cost, provided that the actual dollar amount paid by the patient is adjusted in proportion to his or her income. The amount paid by the individual patient should be small enough to meet the test of the Committee's second objective for publicly funded health care, namely, that no Canadian should suffer undue financial hardship as a result of having to pay health care bills.

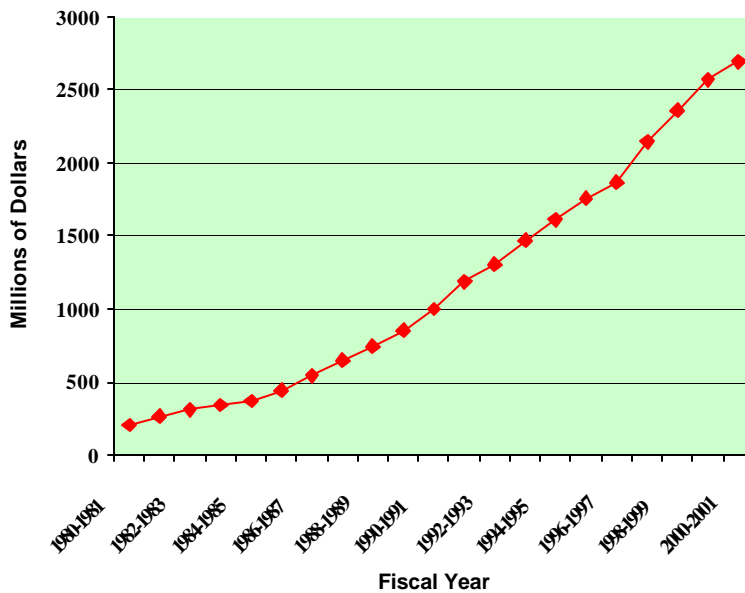
One method that has been suggested for implementing this second approach involves treating insured services as taxable benefits. Using this model, at the end of each year, people who had received services under the PAHC program would be sent a statement from the provincial government indicating the total cost of the home care services obtained. This cost would then become a taxable benefit. Patients could be protected against undue financial hardship as a result of having to pay this increased tax by capping the maximum amount of additional income tax any individual would have to pay at 3% of the individual's income.

This second view holds also that any new public money spent for expanded health care services should benefit those Canadians who can least afford to pay for these services; those who can afford to make a financial contribution to the cost should do so. Only by adopting this approach to the expansion of the public health care system, this argument continues, can Canada afford to close the widening gaps in the health care safety net. Indeed, this is one of the reasons the Committee's proposal for an insurance program to protect Canadians against catastrophic drug costs includes an element of "patient pay."

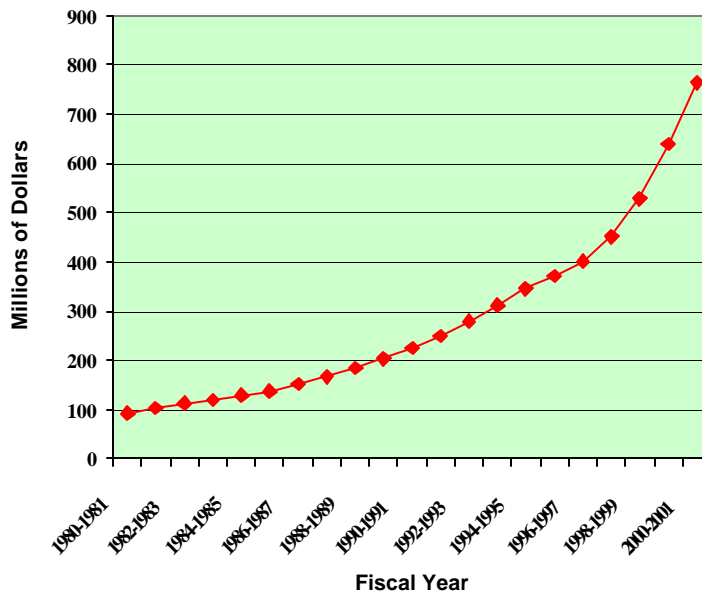
Nevertheless, with respect to its proposed new PAHC program, the Committee, after considerable reflection, agrees with the first view. Although it is concerned about the precedent of first-dollar coverage for expanded publicly funded services, the Committee believes that the advantages in terms of encouraging efficiency – encouraging the transfer of patients from higher-cost hospital beds to lower-cost home care beds – and equity, outweigh the disadvantages. With respect to the expansion of public health insurance to include post-acute home care, the Committee therefore recommends that:

**The PAHC program be treated as an extension of medically necessary coverage already provided under the *Canada Health Act*, and that therefore the full cost of the program should be borne by government (shared equally by the provincial/territorial and federal levels).**

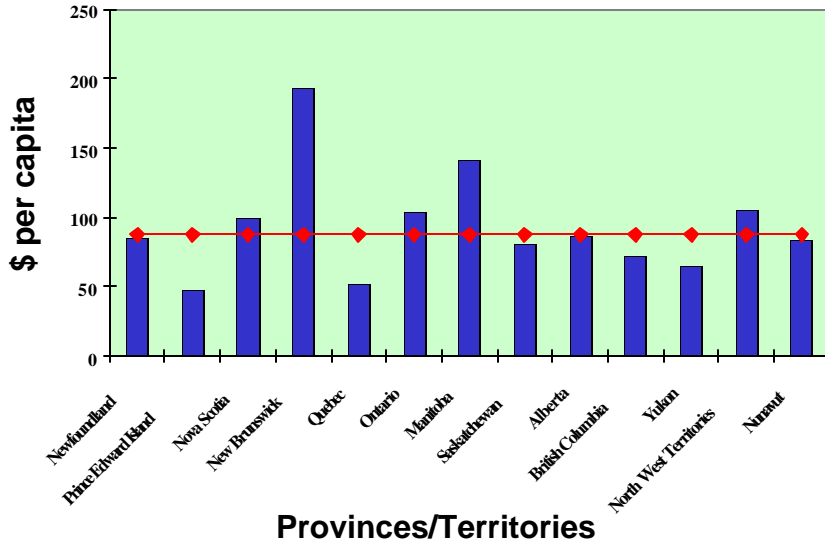
**Figure 8.1: Public Home Care Expenditures in Canada  
1980-81 to 2000-01**



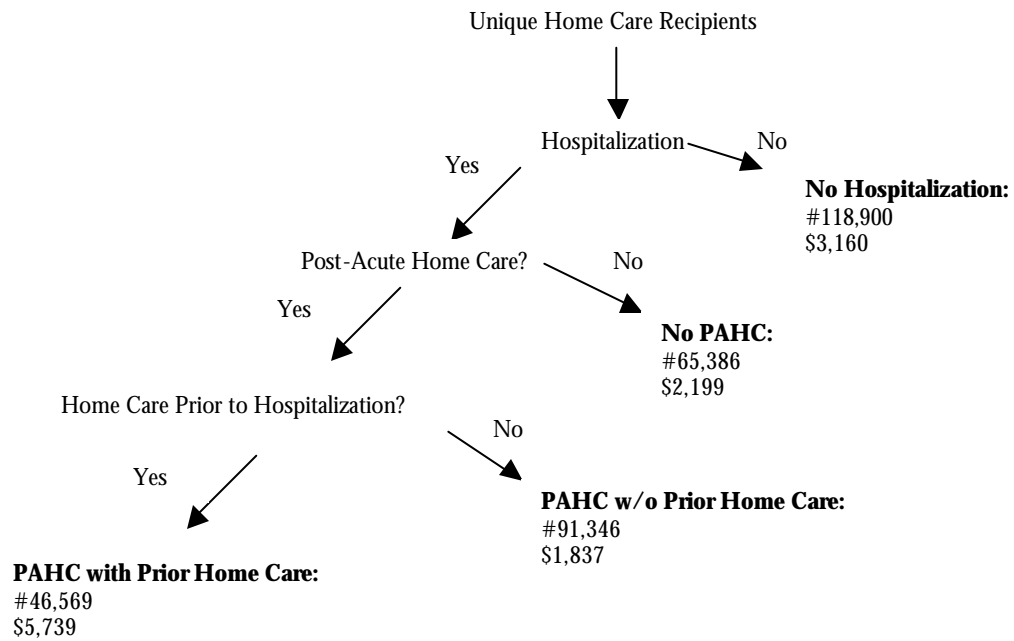
**Figure 8.2: Private Home Care Expenditures in Canada  
1980-81 to 2000-01**



**Figure 8.3: Per Capita Public Home Care Expenditures for Canadian Provinces and Territories, 2000-01**



**Figure 8.4: Home Care Recipients and Mean Expenditures (in 2002 Dollars)**





## CHAPTER NINE

### **EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE**

Throughout the different phases of the hearings, the importance of palliative and end-of-life care was brought to the Committee's attention. Palliative care is a special kind of health care for individuals and families who are living with a life-threatening illness that has reached such an advanced stage that death is on the horizon.

The goal of palliative care is to provide the best possible quality of life for the terminally ill by ensuring their comfort and dignity and relieving pain and other symptoms. Palliative care is designed to meet not only the dying person's physical needs but also his or her psychological, social, cultural, emotional and spiritual needs and those of his or her family as well.

#### **9.1 The Need for a National Palliative Home Care Program**

Palliative care can be offered in a variety of places — at home, in hospitals, in long-term care facilities, and occasionally in hospices. As was reported by the Senate Subcommittee to Update *Of Life and Death* in June 2000, palliative care services in Canada are often fragmented and frequently nonexistent. Patients may not have access to palliative care services until very close to death and in many cases not at all. The report also indicated that palliative care in hospitals is usually paid for by a provincial health plan, which typically covers professional care and drugs, medical supplies, and equipment while the person remains in the hospital. In long-term care facilities, however, residents may be required to pay varying amounts for their care and supplies.

***The Committee believes that there is a clear need to ensure that proper palliative care is universally available, and that it is provided in a manner that respects the wishes of the dying person and his or her loved ones.***

The Committee believes that there is a clear need to ensure that proper palliative care is universally available, and that it is provided in a manner that respects the wishes of the dying person and his or her loved ones.

Different components of the health care system are involved in the many facets of palliative, end-of-life care. From a policy perspective, it is important that the federal and provincial/territorial governments work together to ensure that Canadians are well cared for and have choice in care at the end of their lives.

The Committee recognizes the importance of providing access to palliative care services for Canadians of all ages and across all relevant sectors of the health care system, hospitals, hospices, community services, as well as non-governmental organizations. It also recognizes that enabling universal access to palliative care services at all of these sites would require major changes that would be very hard to implement.

Recent studies have estimated that while over 80% of Canadians die in hospital, fully 80-90% of Canadians would prefer to die at home, close to their families, living as normally as possible. But the services necessary in the home are often not available. Where they do exist it is usually as result of initiatives taken at the community level or by local institutions and regional health authorities, rather than as a consequence of government policy intended to reach the whole Canadian population.

The Committee is convinced that it is essential for the federal government to make a substantial contribution to making palliative care services available to Canadians in their homes. However, it has proven impossible to obtain the data that would permit accurate estimates of the cost of a national palliative home care program. None of the experts or potential sources of accurate statistical information on palliative care with whom the Committee consulted had detailed costs on palliative home care. Nonetheless, the Committee believes the federal government should set aside the funds now to cover the initial costs of a program that should be developed in conjunction with the provinces and territories and paid for on a 50:50 cost-sharing basis. The Committee therefore recommends that:

***While the Committee is aware that there are important limits to what the federal government can achieve directly in this area, it is nonetheless convinced that it is essential for the federal government to make a substantial contribution to making palliative care services available to Canadians in their homes.***

**The federal government agree to contribute \$250 million per year towards a National Palliative Home Care Program to be designed with the provinces and territories and co-funded by them on a 50:50 basis.**

## **9.2 Financial Assistance to Caregivers Providing Palliative Care at Home**

In addition to helping establish a national program to pay the costs of end-of-life care for Canadians who choose to die in their own homes, there are also other measures that the federal government should consider in order to alleviate the burden that now falls on the shoulders of thousands of informal caregivers.

***In addition to helping to establish a national program to pay the costs of end-of-life care for Canadians who choose to die in their own homes, there are also other measures that the federal government should consider in order to alleviate the burden that now falls on the shoulders of thousands of informal caregivers.***

These are discussed in this section and the ones that follow.

Most of the costs of care in the home are currently assumed by the dying person's family. During Phase Two of its study, the Committee was told that, in general, the majority of informal caregivers are women who must often simultaneously manage responsibility

both for aging parents and their own children while also holding down full-time paid work. This combination of responsibilities can not only lead to stress-related illness and loss of work time for the caregiver, but may also increase the risk of neglect and mistreatment of those receiving care.

In its 1999 report, *Caring about Caregiving: The Eldercare Responsibilities of Canadian Workers and the Impact on Employers*, the Conference Board of Canada found that 48% of those providing personal care in the home said it was very difficult to balance their personal and job responsibilities; 42% of them experienced a great deal of stress in trying to juggle their various roles; 57% felt that they did not have enough time for themselves; 53% cut back on sleep; and 44% had experienced minor health problems in the past six months.

These statistics, which apply to all caregivers at home and not just those delivering palliative care, illustrate how reliance on informal caregivers imposes costs on Canadians, while at the same time saving the health care system money. If care were not provided informally, in all likelihood greater costs would be incurred by hospitals and other providers.

In Volume Four, the Committee insisted on the importance of providing support to informal caregivers. It recognized that current tax provisions are inadequate to compensate informal caregivers for the time and resources they provide. The Committee highlighted the fact that the National Advisory Committee on Aging (NACA) had recommended that the Canada Pension Plan (CPP) and the Employment Insurance (EI) program be adjusted to accommodate individuals who leave the workforce temporarily to provide informal care.

With increased support in the form of a policy to provide caregivers with financial and information resources, dying Canadians would have access to quality care and would be able to choose where they wished to spend their final days. Increased assistance to caregivers would ensure that they 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 dying and grieving process.

***Many working Canadians are faced with stark choices as they try to balance the need to provide for their family with caring for a terminally ill family member. Minimizing the amount of lost income during this temporary but very difficult period would be an important first step toward improving the situation facing family caregivers of dying individuals.***

Many working Canadians are faced with stark choices as they try to balance the need to provide for their family with caring for a terminally ill family member. Minimizing the amount of lost income during this temporary but very difficult period would be an important first step toward improving the situation facing family caregivers of dying individuals.

In Volume Four, the Committee referred to statistics from NACA that estimated that providing benefits through the EI system to persons leaving the workforce to care for an ailing relative would increase the overall cost of EI by about \$670 million per year. This estimate was based on the total number of caregivers and a 10-week period of benefit payment. Using

figures from Statistics Canada on the actual number of palliative care patients, and reducing slightly the period of eligibility for benefits, the Committee has determined that the overall cost to the EI system for providing benefits to informal caregivers who were caring for palliative care patients would be significantly less than NACA had calculated.

In 1999, 219,530 Canadians died. Not all, however, required palliative care. By eliminating accidental deaths and certain types of illness, the Committee has determined that approximately 160,000 Canadians can be expected to require palliative care in any given year. Using the average EI rate of \$257 per week and a period of 6 weeks (instead of the 10-week period used by the National Council on Aging), providing EI benefits to individuals providing palliative care in the home would cost approximately \$240 million per year. The Committee believes that up to six weeks of leave should be granted to employees who provide palliative care to a dying relative at home, and that the federal government should consider allowing employees who take advantage of this leave to be eligible to receive EI benefits. 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.**

### **9.3 Caregiver Tax Credit**

The Employment Insurance system is not the only avenue that exists for providing support to caregivers. Tax credits are another option. The 1998 budget recognized that families caring for an ill loved one required government assistance, and implemented a tax credit that applies to individuals residing with, and providing in-home care for, an elderly parent or grandparent or an infirm, dependent relative. This credit reduces combined federal-provincial tax by up to \$600.

The federal government also provides a medical expense tax credit. This credit allows Canadians to deduct the cost of certain medical devices, aids or equipment. A number of other tax credits also exist, including the disability tax credit and the attendant care expense deduction.

The Committee recommends that:

**The federal government examine the feasibility of expanding the tax measures already available to people providing care to dying family members or to those who purchase such services on their behalf.**



## 9.4 Job Protection

Under the Constitution, the provinces have the primary responsibility for labour legislation, including job protection. However, there are areas that fall under federal jurisdiction, including the federal public service, military personnel, and individuals working in federal penitentiaries. People employed in these areas are governed by the Canada Labour Code and the Treasury Board assumes responsibility for employees of the federal government.

With regard to job protection, it would be possible for the federal government to take a leadership role in ensuring that people under its jurisdiction who take time off from work in order to care for a dying relative not endanger their employment status. The Committee therefore recommends that:

**The federal government amend the Canada Labour Code to allow employee leave for family crisis situations, such as care of a dying family member, and that the federal government work with the provinces to encourage similar changes to provincial labour codes.**

Furthermore, the federal government could take additional steps with regard to its own employees. The Committee recommends that:

**The federal government take a leadership role as an employer and enact changes to Treasury Board legislation to ensure job protection for its own employees caring for a dying family member.**

## 9.5 Concluding Remarks

The federal government can provide strong leadership and support for dying Canadians and their families, in particular by ensuring that Canadians who choose to die at home have access to the services that they need to do so with dignity. A new cost-shared palliative home care program would represent a major step toward making this possible.

As well, the additional measures recommended in this chapter would significantly improve the situation confronting family members who care for the dying at home. The Employment Insurance option would provide immediate financial assistance. Moreover, it would likely trigger job protection legislation in the provinces, as did extended maternity benefit legislation.

The disadvantage of this option is that it is only available to insured workers. Tax credits, on the other hand, have the advantage of providing broader

***The federal government is in a position to provide strong leadership and support for dying Canadians and their families, in particular by ensuring that Canadians who choose to die at home have access to the services that they need to do so with dignity.***

coverage. However, such credits do not offer earnings replacement during the time of need, nor would they likely help to initiate job protection legislation.

Taken together, all the measures recommended in this chapter constitute a package that, if implemented, would mark real progress towards making quality end-of-life care for Canadians a reality.

**Part V:**  
**Expanding Capacity and**  
**Building Infrastructure**



## CHAPTER TEN

### THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE

---

In Volume Five, the Committee presented its findings and general recommendations with respect to the role of the federal government in health care infrastructure.<sup>213</sup> These recommendations were based on the third of the roles the Committee spelled out in Volume Four for the federal government in health and health care, a role intended to “support health care infrastructure and health infostructure.”<sup>214</sup>

In this chapter, the Committee provides more specific details on its recommendations relating to health care technology (Section 10.1), electronic health records (Section 10.2) and evaluation of quality, performance and outcomes (Section 10.3) – three areas of Canadian health care infrastructure which the Committee strongly feels must be given priority by the federal government.

***The Committee strongly believes that health care technology, electronic health records and the evaluation of quality, performance and outcomes are three areas of Canadian health care infrastructure that must be given priority by the federal government.***

The collection of patient information under a system of EHR and the related use of such information for the purpose of 1) clinical practice, 2) system management, 3) performance and outcome evaluation, and 4) health research, raise a number of important and complex issues with respect to the protection of personal health information; these are reviewed in Section 10.4

#### 10.1 Health Care Technology

In Volume Five, the Committee noted that, despite the importance of health care technology in delivering timely and high-quality health services, the availability of many new technologies continues to be disproportionately low in Canada in comparison with other OECD countries. More specifically, Canada ranks 21<sup>st</sup> of 28 OECD countries in the availability of CT scanners, 19<sup>th</sup> of 22 in availability of lithotriptors, and 19<sup>th</sup> of 27 in availability of MRIs. Its only acceptable ranking is in the availability of radiation equipment, where it ranks 6<sup>th</sup> out of 17.

Data also show that this technology gap is widening. For example, the availability of MRIs in Canada worsened between 1986 and 1995 relative to other OECD countries, including Australia, France, the Netherlands and the United States.<sup>215</sup>

In addition, we noted in Volume Five that the aging of health care technology is also of concern. For example, information provided to the Committee indicated that between 30% and 63% of imaging technology currently used in Canada is outdated. Not only can the

---

<sup>213</sup> Volume Five, pp. 69-89.

<sup>214</sup> Volume Four, p. 9.

<sup>215</sup> Volume Five, pp. 69-70.

outdated nature of health care technology negatively affect the health of a patient, but it also raises concerns about the legal liability of health care providers.<sup>216</sup>

The Committee is concerned that the shortage of health care technology and the use of outdated equipment impede exact diagnosis and inhibit high-quality treatment. Moreover, we are concerned that the deficit in health care technology has been translated into limited access to needed care and lengthened waiting times. In our view, health care technologies are key to providing Canadians with timely and high-quality health care.

***The Committee is concerned that the shortage of health care technology and the use of outdated equipment impede exact diagnosis and inhibit high-quality treatment. Moreover, we are concerned that the deficit in health care technology has translated into limited access to needed care and lengthened waiting times.***

In September 2000, the federal government responded to the deficit in health care technology by establishing the Medical Equipment Fund (MEF). The MEF allocated \$1 billion (transferred on a per capita basis over a two-year period) to the provinces and territories for the purchase of health care technology. The Committee has welcomed this injection of new federal funds. However, we raised a number of concerns in Volume Five about the MEF:

- First, some provinces have not applied for their share of this fund, possibly because the federal government requires matching grants that some of the poorer provinces have difficulty financing.
- Second, additional resources are required to operate the new equipment. Even if provinces can afford their share of the capital investment, they may have difficulty funding the additional ongoing operating costs.
- Third, the investment did not address the problem of old equipment that needs to be upgraded.
- Fourth, even with this new funding, Canada still does not rank at a level comparable to other OECD countries.
- And finally, there are apparently no mechanisms to ensure accountability on the part of the provinces/territories as to exactly where money targeted to purchasing new equipment is actually spent.

In July 2002, the Canadian Medical Association gave the Committee a report on the Medical Equipment Fund that addressed many of these concerns.<sup>217</sup> This background paper made the following observations:

- Because of the lack of a transparent accountability mechanism, it is very difficult to determine whether the MEF reached its intended destination.

---

<sup>216</sup> Volume Five, p. 70.

<sup>217</sup> Canadian Medical Association, *Whither the Medical Equipment Fund?*, Background paper and technical notes, July 2002.

- Of the \$1 billion allocated through the MEF, approximately 60% was used for new (incremental) spending on health care technology, while 40% was used to pay for already planned expenditures.
- The MEF resulted in a modest to significant improvement in the availability of health care technology in Canada compared to other OECD countries. For example, the gap in health care technology has been reduced significantly in terms of radiation equipment and MRIs since the introduction of the MEF, while a substantial gap remains with respect to CT scans, PET scans and lithotriptors.
- An estimated investment of \$1.15 billion is still needed to bring Canada up to the 1997 level of the 7-OECD country average. Of this amount, \$650 million is required for the purchase of new medical equipment and \$500 million is required for additional operating costs. The latter amount is critical to ensure that the purchasing funds can in fact be used by all provinces/territories; otherwise, the investments may not be made due to the lack of fiscal capacity of some provinces/territories.

The overall estimate by the Canadian Medical Association is very conservative; the calculation rests on only selective technologies (CT scans, MRIs, lithotriptors, PET scans and linear accelerators). Moreover, the \$1.15 billion investment in health care technology would bring Canada only to the level in 1997 of the other OECD countries for these five specific technologies.<sup>218</sup>

***The Committee believes that additional funding is required for the purchase of health care technology. We also believe that the federal government should support the provinces and territories to purchase new medical equipment.***

Other calculations by the Association of Canadian Academic Healthcare Organizations suggest that between \$1.7 and \$2.5 billion (or some \$420 million per year over five years) is required by Academic Health Sciences Centres (AHSCs) for the purchase and operation of advanced medical equipment.

The findings in the papers by both the Canadian Medical Association and the Association of Canadian Academic Healthcare Organizations reinforce the observations and conclusions made by the Committee in Volume Five. Accordingly, we believe that additional funding is required for the purchase of health care technology. We also believe that the federal government should support the provinces and territories to purchase new medical equipment.

It is the view of the Committee that the federal government should ensure that any new funding for health care technology be spent on *incremental* purchases of medical equipment and not to offset already planned expenditures. Moreover, we strongly feel that a better accountability mechanism is needed for

***The Committee strongly feels that a better accountability mechanism is needed for targeted federal funds such as the Medical Equipment Fund.***

<sup>218</sup> Association of Canadian Academic Healthcare Organizations, *Background Information in Support of a National Teaching Centre Health Infrastructure Fund*, Draft Submission to the Committee, 6 August 2002.

targeted federal funds such as the MEF.

The Committee also noted in Volume Five that there is a need to perform more health care technology assessment (HTA) when considering the introduction of a new technology or the replacement of existing medical equipment.<sup>219</sup> HTA provides information on safety, clinical effectiveness and economic efficiency and also considers the social, legal and ethical implications of the use of health care technology. The Committee stressed that all levels of government invest less than \$8 million in total in Canada on HTA, whereas the United Kingdom provides some \$100 million to its national HTA body, the National Institute for Clinical Evidence. Accordingly, we recommended in Volume Five that the federal government provide additional funding to HTA agencies for the purpose of assessing new and existing health care technology.

Finally, the Committee believes that a significant portion of the funding for the purchase of health care technology should be provided to AHSCs that currently house a large proportion of advanced medical equipment. AHSCs are also well suited, given their physical and clinical infrastructure, to undertake state-of-the-art HTA activities. It is the view of the Committee that federal funding for health care technology should not be provided to privately owned and operated clinics since they do not perform teaching, assessment and research activities.

The Committee acknowledges the important role of AHSCs in introducing and assessing new health care technology. We also recognize that community hospitals require additional investment in new medical equipment as well. It is our view that the federal government must play a leading role in sustaining long-term investment in needed health care technology.

The Committee does not believe, however, that a program such as the MEF is the means by which such a goal should be achieved. We agree with witnesses that federal funding should be provided within a multi-year fiscal framework, responding to requests initiated by health care institutions themselves with review by a group of independent experts. This would, in our view, provide a more *effective* and *accountable* model of governance.

***The Committee agrees with witnesses that federal funding should be provided within a multi-year fiscal framework, responding to requests initiated by health care institutions themselves with review by a group of independent experts.***

More precisely, under this model, teaching hospitals, community hospitals and regional health authorities would be required to accompany a request with a sound rationale for additional resources. Each application would be evaluated on its own merits by an independent expert group that would report to the Minister of Health. Moreover, in order to ensure accountability, successful applicants would have to report on their disposition of the funds received. Therefore, the Committee recommends that:

---

<sup>219</sup> Volume Five, pp. 72-75.



**The federal government provide funding to hospitals for the express purpose of purchasing and assessing health care technology. The federal government should devote a total of \$2.5 billion over a five-year period (or \$500 million annually) to this initiative. Of this funding, \$400 million should be allocated annually to Academic Health Sciences Centres, while \$100 million should be provided annually to community hospitals. The community hospital funding should be cost-shared on a fifty-fifty basis with the provinces, while the Academic Health Sciences Centre funding should be 100% federal.**

**The institutions benefiting from this program be required to report on their use of such funding.**

## **10.2 Electronic Health Records**

The electronic health record (EHR) is based on an automated provider-based system within an electronic network that provides complete patients' health records including visits to physicians, hospital stays, prescription drugs, laboratory tests, and so on. In Volume Five, the

***The electronic health record (EHR) is based on an automated provider-based system within an electronic network that provides complete patients' health records including visits to physicians, hospital stays, prescription drugs, laboratory tests, and so on.***

Committee stressed that an EHR system is the first step in gathering health-related information that will allow for evidence-based decision making throughout the whole health care system. An EHR system also offers tremendous opportunities to integrate the various components of Canada's health care system that currently work in silos.<sup>220</sup>

An important characteristic of an EHR system is that it can make patient data available to health care providers and institutions anywhere on a need-to-know basis by connecting interoperable databases that have adopted the required data and technical standards. Not only can an EHR system greatly improve quality and timeliness in health care delivery; it can also enhance health care system management, efficiency and accountability. Moreover, the data collected from an EHR system can provide very useful information for the purpose of health research.

The benefits of an EHR system are numerous:

---

<sup>220</sup> Volume Five, pp. 78-80.

*National, interoperable EHR solutions that bring comprehensive and portable information to health providers and their patients will empower Canadians and help to significantly improve the quality, safety, accessibility, timeliness and efficiency of services.*

*Furthermore, EHR solutions will enable the creation, analysis and dissemination of the best possible evidence from across Canada and around the world as a basis for more informed decisions by patients, citizens and caregivers; by health professionals and providers; and by health managers and policymakers. They will also help maximize the return on ICT investments through alignment, and drive the development of common standards and interoperability.<sup>221</sup>*

All levels of government in Canada have recognized the importance of developing and deploying EHR systems. On September 11, 2000, the First Ministers agreed to work together to develop an interlinked EHR system over the next three years and to work collaboratively to develop common data standards to ensure compatibility and interoperability of provincial health information networks together with stringent protection of personal health information.

In support of the agreement reached by the First Ministers, the federal government committed \$500 million in 2000-01 to a private not-for-profit corporation known as Canada Health Infoway Inc. (or *Infoway*). *Infoway* is not a federal agency or a Crown corporation, nor is it controlled by the federal government. The members of *Infoway* are the Deputy Ministers of Health of the provincial, territorial and federal governments. *Infoway* is governed by a Board of Directors who are representatives of regions of Canada.<sup>222</sup> The Board also involves some independent directors.

In July 2002, *Infoway* forwarded a copy of its business plan to the Committee. As part of its business plan, *Infoway* intends to invest in projects that enhance patient care, build on the existing base of information management, ensure leverage of financial investments and align federal, provincial and territorial priorities in a sustained fashion in order to achieve a pan-Canadian EHR system.

The Committee recognizes that the cost of building a pan-Canadian, interoperable EHR system will greatly exceed the initial \$500-million investment contributed by the federal government. Indeed, data from *Infoway* suggest that implementing a coordinated system of EHR throughout Canada will require \$2.2 billion. Without coordination, that is if jurisdictions implement EHR in isolation from each other, the one-time costs of EHR

***The Committee believes that both Canadians and their publicly funded health care system will benefit greatly if the system of electronic health records is national in scope. Indeed, a national EHR system is critical. To achieve this, the federal government must provide leadership and the necessary resources.***

<sup>221</sup> Linda Lizotte-MacPherson, President and CEO of *Infoway*, Letter to the Committee, 24 July 2002, p. 7.

<sup>222</sup> To date, Quebec has elected not to participate as a member and as such has not availed itself of its right to appoint a representative to *Infoway's* Board of Directors.

deployment would reach \$3.8 billion. Accordingly, achieving the full deployment of an EHR system will require a significant alignment of effort on the part of all jurisdictions, a pooling of resources, partnerships with the private sector and new sources of funding.

Overall, the Committee is very enthusiastic about the work undertaken by *Infoway* in deploying a national system of EHR. We believe that both Canadians and their publicly funded health care system will benefit greatly if the system of electronic health records is national in scope. Indeed, a *national* EHR system is critical. It is our view that, to achieve this, the federal government must provide leadership and the necessary resources. Therefore, the Committee reiterates its recommendation from Volume Five that:

**The federal government provide additional financial support to Canada Health Infoway Inc. so that *Infoway* develop, in collaboration with the provinces and territories, a national system of electronic health records.**

Furthermore, the Committee recommends that:

**Additional federal funding to *Infoway* amount to \$2 billion over a five-year period, or an annual allocation of \$400 million.**

The issue of privacy, confidentiality and protection of personal health information in the context of an EHR system is perhaps the most sensitive one raised during the Committee's hearings on this question. We address this question in detail in Section 10.4 below. However, it is worth noting here that an EHR system has the potential to actually improve the present situation with respect to the privacy of patients' health information. Currently, the privacy of individual health records is not secure. Moreover, patients do not have effective access to their own records and, in fact, don't even know where those records are. The Committee is of the view that, in the absence of a common EHR, both privacy and health care are substantially at risk from the wide dispersal of fragments of a patient's record here and there in doctor's offices, hospitals, public health units, home care providers' files, nursing homes, etc.

***The Committee is of the view that, in the absence of a common EHR, both privacy and health care are substantially at risk from the wide dispersal of fragments of a patient's record here and there in doctors' offices, hospitals, public health units, home care providers, nursing homes, etc.***

### **10.3 Evaluation of Quality, Performance and Outcomes**

In Volume Five,<sup>223</sup> the Committee stated that long-term investment in information and communication technology, including an HER system, will allow the collection

---

<sup>223</sup> Volume Five, pp. 80-83.

of more timely and better information on access to care, quality delivery, system performance and patients' outcomes. We also indicated that while governments must finance the HER system, they should not be responsible for assessing health data and evaluating quality and outcomes. We agreed with witnesses that, currently, collection and evaluation of health-related information is done by the same people who are responsible for paying for, and for providing, health services – that is, governments.

Accordingly, we noted the fact that there is no independent assessment of outcomes and no external audit of the impact of various procedures on patients. This concern was also raised by various provincial commissions on health care. Based on the testimony and provincial reports, the Committee concluded that the role of the evaluator of the health care system must be separated from that of the insurer and provider in order to obtain an independent assessment of health care system performance and outcomes.

***The Committee is convinced that the role of the evaluator of the health care system must be separated from that of the insurer and provider in order to obtain an independent assessment of health care system performance and outcomes.***

As explained in great detail in Chapter One, the Committee believes that such independent evaluation should be performed at the national (not federal) level. This would allow for the pooling of expertise, thereby making the most effective use of the limited human resources currently available in Canada, and result in major economies of scale. This is why we have recommended in Chapter One the appointment of a National Health Care Commissioner charged with providing comments and recommendations on health care system performance, health status and health outcomes.

***The Committee believes that such independent evaluation should be performed at the national (not federal) level by the National Health Care Commissioner recommended in Chapter One.***

Moreover, the Committee believes that the work of the National Health Care Commissioner in evaluating health care system performance and outcomes should build on those national organizations that are currently devoted to the task of performing independent health care system evaluation.

One organization that the Committee believes strongly should collaborate in a national system of independent evaluation is the Canadian Institute for Health Information (CIHI). In our view, CIHI has a credible history in collecting standardized data and developing indicators for the health care system. Its work has been developed through a cooperative process involving various jurisdictions and multiple stakeholders.

In addition, CIHI already has extensive data holdings that serve to support monitoring of the health care system (in a variety of fields such as human resources, adverse events, waiting times, Case Mix Groups (CMGs), system performance, health status indicators, financial

***It is the view of the Committee that CIHI has a credible history in developing indicators for the health care system.***

management, and so on). Furthermore, CIHI has already established credible mechanisms for reporting to the public.

Since its inception, CIHI has been providing the Canadian public, health care managers and policy makers with excellent information. However, its budget, which is currently set at \$95 million over four years (2001-2005), falls short of the investment necessary to provide the information required to plan, manage and report on the impact on the health care system changes recommended by the Committee. Thus, we believe strongly that CIHI's budget must be augmented considerably.

Another national organization, the Canadian Council on Health Services Accreditation (CCHSA), has built a solid foundation on the basis of a voluntary accreditation process for health care institutions. The Committee learned that its strength derives from its primary focus on continuous quality improvement, a strength that should be preserved.

The Committee believes that, as part of a national system of evaluation, the mandate of CCHSA should be expanded to require regular accreditation, at regular intervals, for all sectors of health care (RHAs, public and private hospitals, primary health care settings, etc.). Accreditation should be based on well recognized national standards. If standards are not met and remediation is inadequate, then accreditation should not be given. The accreditation process would be supportive of a transparent accountability process.

Therefore, the Committee recommends that:

**The federal government provide additional annual funding of \$50 million to the Canadian Institute for Health Information. In addition, an annual investment of \$10 million should be provided to the Canadian Council on Health Services Accreditation. This new federal investment will help establish a national system of evaluation of health care system performance and outcomes, and hence facilitate the work of the National Health Care Commissioner.**

#### **10.4 Protection of Personal Health Information**

Electronic health records will likely affect the application of fair information principles in a number of ways. As compatible EHR systems are developed and implemented across the country, the traditional, bilateral relationship between patient and provider will be transformed into a more complex web of interactions between the patient and the health care system.

By their very nature, paper records are limited to discrete pieces of personal information that could feasibly be gathered in paper form, contained in a specific physical location, often collected by a single provider and accessible to that same provider in the context of one individual encounter at a time. This contrasts with EHRs, which can assemble a more complete, comprehensive and longitudinal record of a person's health information originating

from multiple sources, captured in electronic form that is readily available and potentially accessible to multiple authorized users, in real-time, irrespective of location.

This transformation will inevitably affect how patients can meaningfully and practically exercise their right to protection of personal health information. Likewise, this transformation will affect how responsibility and accountability are coordinated and shared among the multiple users of that information.

For these reasons, advancements in health information technology, including the development and implementation of EHRs, are often perceived as threats to individual privacy. This is in part due to the potential for increased access by multiple users and the seeming lack of patient control over personal health information. This being said, however, health information technology also provides a real opportunity for increased protection of privacy, as compared to paper records, through more effective security safeguards to restrict access and enhanced tracking features to audit all transactions. It also offers the opportunity for increased, rather than diminished, personal access to and control of health information by patients. These potential advantages balance the potential threats of EHRs.

***Health information technology provides a real opportunity for increased privacy protection through more effective security safeguards to restrict access and enhanced tracking features to audit all transactions.***

A system of EHRs is planned as the first critical phase in the development of an eventual pan-Canadian health info-structure. The immediate and obvious benefits of EHRs in the context of primary health care include improved efficiency of the system through more effective management of patients' health records and integrated health services delivery. EHRs also promise improved

***EHRs also promise improved health care by giving providers access to a more comprehensive understanding of their patients' health status as an essential aid for proper diagnosis, effective treatment and safe prescriptions, particularly in situations of emergency or out-of-province care.***

health care by giving providers access to a more comprehensive understanding of their patients' health status as an essential aid for proper diagnosis, effective treatment and safe prescriptions, particularly in situations of emergency or out-of-province care.

Moreover, the pan-Canadian health info-structure promises to empower patients with better health information as well. This will allow patients to make more informed choices about their own health, the health of others and the health care system. A health infostructure will allow health care managers to evaluate service providers better and will enhance accountability of the system. It will also provide researchers with the evidentiary bases needed to continue to improve health care and better understand the determinants of health.<sup>224</sup>

---

<sup>224</sup> Canada Health Infoway, *Paths to Better Health*, Final Report of the Advisory Council on Health Infostructure, December 1999

Currently, there are three main privacy issues that must be addressed for EHRs to become a reality in Canada in the next five to seven years. These are:

1. The need for a more harmonized approach to privacy across all jurisdictions to allow for more consistent conditions for sharing personal health information among users and more consistent protection of personal health information for patients.
2. The need to develop robust and effective privacy safeguards, policies and procedures that can be implemented in a pragmatic, practical and cost-effective manner.
3. The need to build public confidence that personal health information will be protected in an electronic world.<sup>225</sup>

Currently, there is significant variation in privacy laws and data access policies across the country that poses a challenge for EHR systems that are dependent on inter-sectoral and inter-jurisdictional flows of personal health information. Differences in rules on how the scope of purpose is defined, the form of consent required, the conditions for substitute decision-making, the criteria for non-consensual access to personal health information, periods for retention of data and requirements for destruction, to name but a few, must be seriously addressed in order to enable the development of EHR systems.

In addition, existing oversight bodies in different sectors and jurisdictions have varying delegated legislative authority over some parts of an EHR system, but not others. Without some overarching coordination, this piecemeal approach will render very difficult, in practice, any system of review and oversight, process for approval, procedure for investigation and application of sanctions.

The Committee encourages ongoing federal/provincial/territorial efforts to develop a harmonized approach to protecting personal health information. In particular, the Committee recommends that:

**The federal government work to achieve greater consistency and/or coordination across federal/provincial/territorial jurisdictions on the following key issues:**

- **Need-to-know rules restricting access to authorized users based on their purposes;**

---

<sup>225</sup> See Advisory Council on Health Infostructure, *Canada Health Infoway, Paths to Better Health*, Final Report, December 1999; Federal/Provincial/Territorial Advisory Committee on Health Infostructure, *Tactical Plan for a Pan-Canadian Health Infostructure*, 2001 Update; discussions of Regional Fora held by Canada Health Infoway Inc. summarized at <http://www.canadahealthinfoway.ca/sub.php?lang=en&secLoc=frm>).

- **Consent rules governing the form and criteria of consent in order to be valid;**
- **Conditions authorizing non-consensual access to personal health information in limited circumstances and for specific purposes;**
- **Rules governing the retention and destruction of personal health information;**
- **Mechanisms for ensuring proper oversight of cross-jurisdictional electronic health record systems.**

Another major challenge facing EHR development is the need to find ways of implementing compatible EHR systems in a manner that both protects people's right to privacy of personal health information and is feasible and workable in practice. While there may be ways of introducing the most stringent physical, technological and organizational safeguards possible, these may simply not work in practice or be cost-effective. Moreover, safeguards change significantly over time as technology and customary practice evolves, requiring constant updating and upgrading. Organizations must distinguish passing trends from well-tested and proven state-of-the-art measures and make realistic investment choices accordingly.

In an EHR environment, many players will be involved in the collection of personal health information for inclusion in the common record. There will be many authorized users that can potentially gain rightful access to the EHR, adding information and collectively participating in the development of the record. As control will be shared among various players and users, so too shall accountability be shared. A real challenge lies in coordinating and apportioning responsibilities so that patients' rights do not fall between the cracks. Despite the seemingly amorphous environment of an EHR system, patients must be able to direct their questions and concerns to an identifiable, responsible entity and exercise, in a meaningful way, their rights to access, correction and redress in the event of non-compliance.

Therefore, the Committee recommends that:

**Canada Health Infoway Inc. and other key investors structure their investment criteria in such a way as to create incentives for developers of EHR systems to ensure practical and pragmatic privacy solutions for implementing the following:**

- **State-of-the-art security safeguards for protecting personal health information and auditing transactions;**
- **Shared accountability among various custodians accessing and using EHRs;**



- **Coordination among custodians to give meaningful effect to patients' rights to access their EHR, rectify any inaccuracy and challenge non-compliance.**

In order to enable the development and implementation of EHRs, public trust and confidence are indispensable. There is currently little research on understanding the determinants of Canadians' attitudes about the use of their personal health information for different purposes. Such research is vital if EHRs are to be developed and implemented in a manner that takes into account these determinants and respects people's underlying concerns in specific contexts.

While the advantages of EHRs may be obvious to those who are in the business of developing them, these advantages must also be made obvious to individual Canadians. The promise of an eventual pan-Canadian health info-structure belongs to everyone. An informed and meaningful dialogue should occur, engaging all key stakeholders, including patient groups and consumer representatives. Providers will be better equipped to improve the quality of the care they deliver and integrate their services; policy-makers and managers will be better informed and able to ensure access to health care and accountability for actions throughout the system; researchers will be able to evaluate the effectiveness of health care products and services and better understand the determinants of Canadians' health; members of the public will be better empowered to make informed choices about their own health, their health care and about health-related policy. An open, transparent, and iterative public communication strategy would go a long way to bring home the many benefits of EHRs and the truly inclusive vision of an eventual pan-Canadian health info-structure. Therefore, the Committee recommends that:

**Key stakeholders, including the federal, provincial and territorial Ministries of Health, Canada Health Infoway Inc., the Canadian Institute for Health Information and Canadian Institutes of Health Research, undertake the following:**

- **Rigorous research into the determinants affecting Canadian attitudes regarding acceptable and unacceptable uses of their personal health information;**
- **Informed and meaningful dialogue with key stakeholders, including patient groups and consumer representatives;**
- **An open, transparent and iterative public communication strategy about the benefits of EHRs.**



## CHAPTER ELEVEN

### HEALTH CARE HUMAN RESOURCES

---

#### 11.1 The Extent of Health Human Resource Shortages

Over the course of its hearings the Committee has heard overwhelming evidence of a persistent human resource shortage in all sectors of the health care system, affecting specialist physicians as well as family practitioners, registered nurses as well as licensed practical nurses, laboratory technologists as well as pharmacists. Addressing the supply of professionals in all health care disciplines and finding ways to increase their individual and collective productivity are two of the most pressing, yet complex, problems facing health care policy makers.

***Addressing the shortage of professionals in all health care disciplines and finding ways to increase their individual and collective productivity are two of the most pressing, yet complex, problems facing health care policy makers.***

Hardly a month goes by without the release of a new study or report that further documents the breadth and the gravity of the situation. A number of these that have appeared since the release of the Committee's last report tell a familiar story.

According to a new report issued by the Canadian Institute for Health Information (CIHI) in June 2002, physician supply in Canada peaked in 1993 and has suffered a 5% decline since then, bringing the ratio of physicians to population down to the level it was 15 years ago.<sup>226</sup> This report provided one more graphic illustration of the extent of the human resource shortage and its consequences, including fewer family doctors, fewer younger physicians and heavier workloads for doctors.

Two recent provincial documents on physician supply also lend further support to the view expressed by the Committee in its previous reports that the human resource question is one area where it is increasingly legitimate to speak in terms of a crisis confronting the system. The Quebec College of Physicians examined the numbers of doctors actually in practice, rather than relying on raw registration numbers, and found that the province would need more than 1,400 additional physicians to provide necessary services to the population.<sup>227</sup>

For its part, the Ontario Medical Association estimated that there was a further net loss of 110 physicians from that province between 1999-2000, bringing the total shortfall to an estimated 1,585 physicians. The report indicates that there are now over 100 underserved communities in the province.<sup>228</sup>

---

<sup>226</sup> Dr. Benjamin TB Chan, *From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s?*, Canadian Institute for Health Information, June 2002.

<sup>227</sup> *Medical Post*, June 4, 2002.

<sup>228</sup> Ontario Medical Association "Position paper on physician workforce policy and planning", April 2002.

At the same time, the Committee is concerned that all of the studies referred to above focus on the number of practising physicians, and do not address the problem of productivity. Clearly, improving physician productivity would reduce the numbers of additional physicians required in Canada.

For example, most surgeons say that they could increase their productivity if they were given more operating time, and greater access to short term beds for their patients, who could then complete their recovery at home.<sup>229</sup> This fact raises the following policy question: is it better to remove the existing roadblocks to improved surgeon productivity, or to produce more surgeons who will, like their predecessors, not be as productive as they could be or want to be because institutional constraints prevent them from increasing their productivity? Policy questions like these cannot be properly answered without a much better understanding of the current level of productivity of physicians and the barriers to increasing that productivity.

*...the Committee is concerned that all of the studies referred to above focus on the number of practising physicians, and do not address the problem of productivity.*

The Committee believes that it is essential that independent research organizations, not affiliated with the medical profession, undertake detailed studies of physician productivity and of the barriers that impede increases in productivity. Government, as the funder of the system, and those who actually provide health services must understand the factors that influence productivity in health care and how the productivity of the key personnel in the system can be improved.

*The Committee believes that it is essential that independent research organizations not affiliated to the medical profession (such as CIHI or the CIHR), undertake detailed studies of physician productivity.*

In other fields, the availability of, for example, information technology has increased the productivity of other professionals over the past 20 years. Surely better diagnostic equipment, more effective drugs, improved out-of-hospital treatments, combined with the improved health status of Canadians over the past 20 years should have made physicians more productive. But whether this has actually happened is not known. This is why the proposed research is needed.

The Committee believes that similar observations to those about physician productivity could also be made about other health care professionals. The Committee therefore recommends that:

**Studies be done to determine how the productivity of health care professionals can be improved. These studies should be either undertaken or commissioned by the National Coordinating Committee on Health Human Resources that the Committee recommends be created.**

---

<sup>229</sup> See Chapter 8 of this volume for the Committee's proposal for a post-hospital home care program

Three recently issued reports provide additional data on the extent of the shortage of nurses. CIHI reported in June 2002 that although there was a slight increase (1.2%) in the number of nurses employed in Canada between 1997 and 2001, it was not sufficient to keep pace with population growth. There are thus fewer nurses per capita in the country today than five years ago. The report also indicated that the nursing workforce is aging rapidly, with the average age of RNs employed in nursing going from 42.4 years in 1997 to 43.7 years in 2001.<sup>230</sup>

A study conducted for the Canadian Nurses Association that examined trends since 1966 noted “throughout the entire 35 years covered by the data series, the nursing workforce has seen the age composition shift to older age groups.”<sup>231</sup> The CNA report also made projections with regard to nursing supply and demand for the next 10 to 15 years, concluding that “there will be a shortage of 78,000 RNs in 2011 and 113,000 RNs by 2016.”<sup>232</sup>

The Final Report of the Canadian Nursing Advisory Committee, chaired by Mr. Michael Decter, was released in August 2002. It identified three barriers to a quality workplace for Canadian nurses,<sup>233</sup> namely:

- the need for an increased number of nurses;
- the need to improve the education and maximize the scope of practice of nurses;
- the need to improve working conditions of nurses.

Amongst its 51 recommendations designed to help eliminate these barriers, the Advisory Committee advocated that the number of new, first-year seats in schools of nursing for Registered Nurses be increased by 25% (roughly 1,100 new seats) in September 2004 and that this number be adjusted upward by a further 20% in each of the subsequent four years.

Still, not enough is known about the productivity of nurses and what could be done to improve it. For example, in its report, the Canadian Nursing Advisory Committee endorses the need for “provincial and federal resources [...] to be directed toward the development of accurate and manageable strategies to measure and report on workload.”<sup>234</sup> The Committee believes that the same type of productivity research that is proposed with respect to physicians is also needed in order to understand better how nurses spend their time at work, and what institutional barriers stand in the way of improved productivity. This is why the recommendation made above includes all health care professionals.

Although allied health professionals receive less public attention, the Committee has repeatedly drawn attention to the fact that the human resource shortage is not limited to doctors and nurses. For example, the Committee noted in previous Volumes that over 20

---

<sup>230</sup> Canadian Institute for Health Information, *Supply and Distribution of Registered Nurses in Canada, 2001 Report*, June 2002.

<sup>231</sup> Canadian Nurses Association, *Planning for the Future: Nursing Human Resource Projections*, June 2002, p. 20.

<sup>232</sup> *Ibid.*, p. 1.

<sup>233</sup> *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses*, Advisory Committee on Health Human Resources, 2002, p. 3.

<sup>234</sup> p. 36

disciplines reported experiencing important shortages, ranging from physical and occupational therapists to radiography and medical laboratory technologists to public health inspectors.

Moreover, witnesses indicated that despite these shortages, enrolments in training programs are being cut. One example was medical laboratory technology in Alberta, where places in training schools had been cut from 40 to 20 students. Witnesses also referred to other disturbing figures, considering the ever-increasing demand for technical and professional employees attributable both to new technologies and to a growing population. For example, there has been a 42% decrease in the number of graduates from medical laboratory technology programs across the country since 1987, while diagnostic imaging produced 15% fewer graduates over the same period. The Canadian Society for Medical Laboratory Science has predicted a nation-wide shortage of general medical laboratory technologists within the next 5 to 15 years.

A further illustration was provided by the Canadian Pharmacists Association. It noted that a shortage of pharmacists is a problem in many countries including Canada, the United Kingdom and the United States. The under-supply of pharmacists translates into increased vacancies, longer delays in filling vacancies, increases in overtime hours, and market-based wage increases that exceed the cost of living. Another recent study suggests that well over 2,000 additional pharmacists could readily find work in Canada.

The decline in the number of graduates has also been compounded by what has been called “credential creep.” This refers to the gradual increase in the educational levels required to gain employment in a particular field, said to be driven by increasing complexity of the work involved. Among the consequences of “credential creep” are that it takes longer to train new graduates, thereby exacerbating the existing shortages of all health care professionals.

Credential creep also has other consequences. On the one hand, it can lead to the transfer of some programs from community colleges to universities; on the other, it can lead to graduates seeking higher levels of compensation they believe are justified by the additional training they have undergone.

The Committee is concerned that these developments occur without sufficient independent study to verify that the changes in the level of qualification and remuneration are warranted. The Committee believes that a review of the length of time required to train various health care professionals is needed, as well as an examination of what is the most appropriate educational institution to provide the needed training.

## **11.2 Health Human Resources: The Need for a National Strategy**

The Committee believes strongly that one of the major consequences of the growing world-wide shortage of health human resources is that Canada must develop a strategy to enable the country to become self-sufficient in health human resources.

***The Committee believes strongly that one of the major consequences of the growing world-wide shortage of health human resources is that Canada must develop a strategy to enable the country to become self-sufficient in health human resources.***

In the Committee's view, moving forward in this regard entails recognizing that such a strategy cannot be a "federal" one but must rather involve all stakeholders, bearing in mind that the training and education of health care professionals is a provincial responsibility. For Canada to attain the objective of self-sufficiency in health human resources, long-term cooperation and coordination among all stakeholders in the health care field are essential.

In the Committee's opinion, problems relating to interprovincial competition for graduates in health-related fields further highlight the necessity to develop a national health human resources strategy. Competition among different jurisdictions for scarce human resources, whether interprovincial or international, can lead to severe regional disparities in the ability to provide health care services.

The Committee believes that the federal government must play a much stronger role than it has to date in coordinating efforts to develop and implement a national health human resource strategy and to deal with shortages. Given that it is clear that there can be no "quick fix" to the crisis in health human resources, and that a wide range of interests and concerns must be considered in the search for long-term solutions, it seems to the Committee appropriate to recommend the establishment of an ongoing framework to deal with human resource issues. The Committee therefore recommended in Volume Five that:

***The Committee believes that the federal government must play a much stronger role than it has to date in coordinating efforts to deal with health human resources shortages.***

**The federal government work with other concerned parties to create a permanent National Coordinating Committee for Health Human Resources, to be composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include:**

- **disseminating up-to-date data on human resource needs;**
- **coordinating initiatives to ensure that adequate numbers of graduates are being trained to meet the goal of self-sufficiency in health human resources;**
- **sharing and promoting best practices with regard to strategies for retaining skilled health care professionals and coordinating efforts to repatriate Canadian health care professionals who have emigrated to other countries;**
- **recommending strategies for increasing the supply of health care professionals from under-represented groups, such as Canada's Aboriginal peoples, and in**

**under-serviced regions, particularly the rural and remote areas of the country;**

- **examining the possibilities for greater coordination of licensing and immigration requirements between the various levels of government.**

As noted earlier, the Committee also believes that the National Coordinating Committee on Health Human Resources should assume responsibility for studying how the productivity of health care professionals can be improved. It is also clear to the Committee that no single group of professionals, nor any single level of government, should predominate in the deliberations of the proposed National Coordinating Committee.

The Committee also recommends that the federal government undertake a number of specific initiatives designed to increase the supply of health care professionals, namely that:

**The federal government:**

- **Work with provincial governments to ensure that all medical schools and schools of nursing receive the funding increments required to permit necessary enrolment expansion;**
- **Put in place mechanisms by which direct federal funding could be provided to support expanded enrolment in medical and nursing education, and ensure the stability of funding for the training and education of allied health professionals;**
- **Review federal student loan programs available to health care professionals and make modifications to ensure that the impact of inevitable increases in tuition fees does not lead to denial of opportunity to students in lower socio-economic circumstances;**
- **Work with provincial governments to ensure that the relative wage levels paid to different categories of health professionals reflect the real level of education and training required of them.**

In previous volumes, the Committee had noted that there was a serious shortage of health care providers from Aboriginal backgrounds. In order to help to address this problem the Committee also recommended in Volume Five that:

**The federal government work with the provinces and medical and nursing faculties to finance places for students**



**from Aboriginal backgrounds over and above those available to the general population.**

Moreover, since all the measures described in the above recommendations take time to implement, various shorter-term measures are required to deal with the health human resources crisis. One such avenue involves the tax system. Short-term tax incentives were used in the late 1960s and early 1970s to attract university professors to Canada at a time when the country faced a severe shortage of qualified university faculty members. The Committee believes a similar approach should be considered at this time with respect to health care professionals. It therefore further recommends that:

**In order to facilitate the return to Canada of Canadian health care professionals who are working abroad, the federal government should work with the provinces and professional associations to inform expatriate Canadian health professionals of emerging job opportunities in Canada, and explore the possibility of adopting short-term tax incentives for those prepared to return to Canada.**

The following sections of this chapter contain additional observations related to the health human resources shortage in Canada, as well as a number of further recommendations to help alleviate it.

### **11.3 Increasing the Number of Physicians Trained in Canada**

The recent CIHI report referred to above has made a new contribution to the discussion of physician supply in Canada by assigning weights to the various factors that have contributed to the decline in the ratio of physicians to population:

- about 25% of the decline can be attributed to longer postgraduate training for doctors, both because family doctors now require two years of postgraduate training instead of one before entering independent practice, and because a higher proportion of doctors are choosing to become specialists, which requires much longer training periods;
- 22% of the drop was attributable to fewer foreign doctors entering Canada;
- 17% was caused by increased physician retirement;
- to date, only 11% of the decline can be attributed to decreased enrolment in medical schools, but the full effect of the cuts of the 1990s will only be felt in coming years.

The author of the report, Dr. Ben Chan, notes that several key mistakes were made in policy design during the 1990s. In the first place, unintended consequences were not taken into account. For example, it was not fully appreciated that increasing the length of training (e.g., two rather than one year of postgraduate training for family physicians) permanently reduces the supply of physicians. Second, policies were not reviewed frequently

enough, so the effects of a number of policies combined in unexpected ways to generate a larger shortage than was anticipated. Finally, measures that gave the system flexibility were eliminated; for example, students were forced to lock into career choices at very early stages in their undergraduate education without the benefit of practical experience or the possibility of changing their minds at a later date.<sup>235</sup>

The Committee remains convinced that the only long-term solution to the human resources crisis remains the development of a national strategy that focuses on training enough physicians and other health professionals in Canada to meet the country's needs, as well as on increasing physician productivity. A recent estimate provided to the Committee by Dr. Abraham Fuks, President of the Association of Canadian Medical Colleges (ACMC), indicated that simply to maintain the current physician to population ratio, 2,500 students would have to enter medical school by 2005, an increase of 640 students from the 2001 first-year enrolment of 1,860.<sup>236</sup>

***The Committee remains convinced that the only long-term solution to the human resources crisis remains the development of a national strategy that focuses on training enough physicians and other health professionals in Canada to meet the country's needs, as well as on increasing physician productivity.***

In Volume Five, the Committee recommended that the federal government provide ongoing financial assistance to the provinces to increase enrolments in Canadian medical schools. According to the ACMC, the cost per place in a Canadian medical school is currently estimated at \$260,000 over a four-year period. An additional 640 students would therefore cost approximately \$160 million per year once the new levels of enrolment were attained.<sup>237</sup> The Committee believes that this would be money well spent, and therefore recommends that:

**The federal government contribute \$160 million per year, starting immediately, so that Canadian medical colleges can enrol 2,500 first-year students by 2005.**

Moreover, it is important to bear in mind Dr. Chan's conclusion that it is necessary to review regularly the levels of enrolment to ensure that they remain in accord with evolving circumstances. Dr. Fuks estimated that in order to offset current physician shortages (rather than merely maintaining the current physician to population ratio) it would be necessary to increase enrolments further to 3,000 first-year students by 2009. It is important to note, however, that such forecasts do not take into account the impact of potential improvements in productivity. The Committee believes it necessary to keep a careful watch on the situation, and recommends that:

---

<sup>235</sup> Dr. Ben Chan, "How Canada can better manage its MD supply," *Medical Post*, June 25, 2002.

<sup>236</sup> Dr. Abraham Fuks, Brief to the Committee, July 23, 2002.

<sup>237</sup> The cost per student, per year is one quarter of the total of \$260,000, that is \$65,000. However, once there are the desired number of new students enrolled in each year of the four-year medical degree program, this \$65,000 per student per year must be multiplied by four, so that the total cost of the new places is \$260,000 per year.

**The proposed National Coordinating Committee for Health Human Resources be charged with monitoring the levels of enrolment in Canadian medical schools and make recommendations to the federal government on whether these are appropriate.**

Clearly, however, it will take time to raise the levels of enrolment, and it will be even longer before these increases translate into greater numbers of doctors in the field. In the short term, then, measures should also be taken to relieve some of the pressure. The Committee has already reiterated its recommendation from Volume Five that the federal government explore the possibility of adopting short-term tax incentives in order to repatriate health care professionals working abroad.

There are also a number of highly skilled and well-trained Canadians who are completing their basic medical education outside Canada, notably in Australia, Ireland and the UK. Dr. Fuks told the Committee that many of these students, who are receiving their training in high-quality medical faculties, are eager to return to Canada. The Committee believes that there should, therefore, be a robust policy of recruitment for such expatriate Canadians to return to Canada for post-graduate training and practice in this country.

In order to accommodate these returning students, as well as the international medical graduates discussed below, it will also be necessary to increase the number of post-graduate residency positions. Based on figures provided by the Association of Canadian Medical Colleges,<sup>238</sup> the Committee therefore recommends that:

**The federal government should contribute financially to increasing the number of post-graduate residency positions in medicine to a ratio of 120 per 100 graduates of Canadian medical schools.**

As the Committee noted in Volume Five, this will also allow Canadian physicians who are already in practice greater opportunity to re-enter postgraduate training and pursue additional qualifications.

#### **11.4 Integrating International Medical Graduates**

Another measure specific to dealing with the shortage of physicians is the development of a national plan to make better use of international medical graduates (IMGs) already here. In the past, Canada has been able to rely on recruitment from abroad to fill some of the gaps. For example, over 50% of doctors practising in Saskatchewan are international medical graduates who have been trained elsewhere and recruited to Saskatchewan later in their careers. However, other countries now face many of the same shortages that confront our system. There does not seem to make much sense for all developed countries to poach endlessly each other's highly trained health care professionals.

---

<sup>238</sup> Dr. Fuks, *op. cit.*

Most experts estimate that there are currently at least 2,000 international medical graduates in Canada who are not licensed to work as physicians.<sup>239</sup> There is no common program for issuing credentials to IMGs, and each province has a limited program for admitting IMGs to residency programs. For example, Ontario reserves 40 spots for IMG training, but despite 1,000 applications last year only 25 were admitted.

There are some signs of progress, however. In April 2001, Manitoba launched the first permanent program in Canada to assist IMGs to obtain medical licences. It relies on a three-stage Clinicians Assessment and Professional Enhancement (CAPE) process, an evaluation tool developed by the University of Manitoba's faculty of medicine, to assess the medical knowledge and clinical skill of foreign-trained doctors. The CAPE program has proved so successful that the College of Physicians and Surgeons of Nova Scotia refers IMG applicants who do not have licensed North American training or clinical practice experience to the Manitoba program for assessment.<sup>240</sup>

Members of the Association of Canadian Medical Colleges recently concluded that there is a pressing need for a national strategy, incorporating national standards, to assist in integrating IMGs into the Canadian medical workforce. They proposed that there be a common evaluation program that would allow IMGs to be classified in one of four categories: their education and training is equivalent and they should be licensed practise in Canada; they need some extra training; their medical education is equivalent but they need to do postgraduate training here; or neither their education nor training is adequate and they have to begin again at a medical school in Canada.

The Committee therefore recommends that:

**The federal government work with the provinces to establish national standards for the evaluation of international medical graduates, and provide ongoing funding to implement an accelerated program for the licensing of qualified IMGs and their full integration into the Canadian health care delivery system.**

## **11.5 Alleviating the Shortage of Nurses**

As noted earlier in this chapter, a study conducted for the Canadian Nurses Association indicated that the country would be short 78,000 RNs in 2011 and that this shortfall could reach 113,000 by 2016. The study reached these conclusions despite using what it calls relatively optimistic assumptions with regard to the number of nursing graduates that can be anticipated in the coming five years. The report estimates that "the output from Canada's nursing schools is expected to grow from 4,599 graduates in the year 2000 to more than 9,000 per annum by the year 2007."<sup>241</sup> (See Table 11.1, below).

---

<sup>239</sup> *Medical Post*, June 11, 2002.

<sup>240</sup> Pamela Clarke, "The Foreign Question," *Medical Post*, May 28, 2002.

<sup>241</sup> CNA, *op. cit.*, p. 1.

**TABLE 11.1**  
**NUMBER OF NURSING GRADUATES, 1999-2008\***

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Canada	5,221	4,599	5,499	6,782	7,578	7,678	7,834	8,829	9,182	9,382

Source: Projections by Eva Ryten for the Canadian Nurses Association, June, 2002.

\* 1999-2001, actual data; 2002-2008, projections

But even with almost doubling the number of graduates, and an expected influx of 1,200 nurses trained abroad every year from 2002 onwards, the study categorically affirmed that it will not be possible to meet the anticipated demand for nursing services. Nor is there a sufficiently large pool of trained nurses who are not currently employed in nursing who could be enticed back into the profession in order to help deal with the shortfall. In fact, the report points out that:

*It is particularly relevant to note that in both 2000 and 2001, there were fewer than 3,000 RNs who were not working as nurses but looking for jobs in nursing. This is a tiny number compared with the total stock of RNs in the country.<sup>242</sup>*

Nonetheless, the Committee believes that everything possible should be done to entice those qualified nurses who have left the profession to return to active nursing. This is all the more important since, even if it were deemed advisable to substitute licensed practical nurses (LPNs) for RNs, the report notes that there are not enough qualified LPNs to make up the shortfall either.

*For licensed practical nurses to meet a significant portion of nursing service requirements that cannot be met by RNs due to the nursing shortage, the LPN complement would have to be growing at an extremely rapid rate. But, in fact, the number of LPNs has been stagnant or decreasing for nearly 20 years. In 1983, there were 83,539 LPNs in Canada. By 1999, this number was down to 66,100.<sup>243</sup>*

At the same time, Ms. Kelly Kay of the Canadian Practical Nurses Association told the Committee that:

*In most jurisdictions, licensed practical nurses are in short supply. However, there are still situations such as in the province of Ontario where 1,400 registered practical nurses reported on their last registration data form that they were seeking employment in nursing.<sup>244</sup>*

---

<sup>242</sup> *Ibid.*, p. 13.

<sup>243</sup> *Ibid.*, p. 74.

<sup>244</sup> 61:25

Although in 1997 it appeared that the trend was towards a decline in the number of applications to nursing schools, this no longer seems to be true. Ms. Ginette Lemire-Rodger, outgoing president of the CAN, explained to the Committee that:

*In Canada, this year alone, thousands of well-qualified students have been turned away. The universities reject them because there are only 70 places for every 800 applications across the country. There is no lack of young people and not-so-young people wanting to take up nursing, but the governments are not funding the seats in the universities.*<sup>245</sup>

Clearly, then, everything points to the need to increase the number of nursing graduates in fairly dramatic fashion. The committee noted in Volume Five that Human Resources Development Canada (HRDC) has undertaken a major sector study in order to make recommendations with regard to the supply of nurses. However, as Michael Decter remarked to the Committee:

**Clearly, then, everything points to the need to increase the number of nursing graduates in fairly dramatic fashion.**

*I know the Government of Canada through HRDC is funding two large studies. To paraphrase David Sackett, you do not need a double blind, random clinical trial to apply common sense. Common sense would say we need more nurses in this country and we need them urgently.*<sup>246</sup>

In calculating how many new places should be allotted, the CNA report cautions that in the long run it is important to avoid

*periods of either very sharp increases or decreases in output over short spaces of time. Doing this repeatedly over long periods of time leads to a roller coaster of surpluses and shortages in supply. Ideally, levels of output would increase gradually each year in line with increased needs.*<sup>247</sup>

Had there not been a serious underfunding of nursing positions during the nineties, the CNA estimates that the number of graduates needed would still have been of the order of 10,000 per annum. The CNA report explained that this is because “even if the crisis of the 90s had never occurred, Canada would be facing nursing shortages in both 2011 and 2016, albeit of a smaller magnitude, because of the impending retirement of the larger graduating cohorts who are being replaced by smaller ones.”<sup>248</sup> Taking the consequences of the erroneous decisions of the nineties into account, the CNA felt it prudent to recommend that nursing programs be expanded in order to attain an annual output of 12,000 graduates.

---

<sup>245</sup> 61:16

<sup>246</sup> 52:8

<sup>247</sup> CNA, *op. cit.*, p. 76.

<sup>248</sup> *Ibid.*, p. 73.

The Committee endorses this estimate. Table 11.1 gives the projections contained in the report for current and projected provincial output of graduates until 2008. The Committee recommends that:

**The federal government phase in funding over the next five years so that by 2008 there are 12,000 graduates from nursing programs across the country, and that the federal government continue to provide full additional funding to the provinces for all nursing school places over and above 10,000, for as long as is necessary to eliminate the shortage of nurses in the country.**

Using the figures given in Table 11.1 that indicate the anticipated levels of nursing graduates, this means that by 2008 it will be necessary to graduate an additional 2,618 nurses. The numbers could be increased as follows to build towards this figure:

**TABLE 11.2**

	2004	2005	2006	2007	2008
Current anticipated number of graduates	7,678	7,834	8,829	9,182	9,382
Projected number of graduates given additional federal funding	8,000	9,000	10,000	11,000	12,000

The Committee was told by the CNA that each additional nursing position in Ontario cost \$7,700 per year. Based on a four-year program, this translates into approximately \$30,000 to train each new nurse. Extending this estimate to all nursing places across the country, it would cost approximately \$80 million per year to bring the number of nursing graduates to the 12,000 level recommended by the CNA.<sup>249</sup> To be sure that sufficient funds are available, and in light of the seriousness of the nursing shortage, the Committee believes that it would be prudent to set aside a further \$10 million in the hope that more nurses could graduate even sooner. The Committee therefore recommends that:

**The federal government commit \$90 million per year from the additional revenue the Committee recommends that it raise in order to enable Canadian nursing schools to graduate 12,000 nurses by 2008.**

## **11.6 Allied Health Professionals**

The Committee was not able to obtain sufficient data to work out a detailed proposal with regard to the precise numbers of new graduates that would be needed to respond

<sup>249</sup> This calculation was done on the same basis as for the medical students (i.e. 2,618. x \$30,000)

to the shortages of allied health professionals discussed earlier in this chapter. Nonetheless, the Committee believes that it is essential for the federal government to commit funds to addressing these pressing needs. The Committee therefore recommends that:

**The federal government commit \$40 million per year from the new revenues that the Committee has recommended it raise in order to assist the provinces in raising the number of allied health professionals who graduate each year.**

**The exact allocation of these funds be determined by the proposed National Coordinating Committee for Health Human Resources.**

### **11.7 Funding Post-Graduate Training**

The cost of training new health care professionals does not end the moment they graduate from university or college. There are additional costs that are borne in large part by academic health sciences centres, not only for physicians but for the full range of health care professionals. The Association of Canadian Academic Healthcare Organizations (ACAHO) has estimated the additional costs associated with increases in health care training positions for all the health care professions to be in the range of \$300 – \$550 million over the course of their training cycle (or between \$60 and \$110 million per year). These costs include funding for instructors, space, overhead and supplies. The Committee therefore recommends that:

**The federal government devote \$75 million per year of the new money the Committee recommends be raised to assisting Academic Health Sciences Centres to pay the costs associated with expanding the number of training slots for the full range of health care professionals.**

### **11.8 Health Human Resources: Scope of Practice Rules Review**

The final area of the Committee's human resource recommendations involves the need for a thorough independent review of the scope of practice rules for the various health care professions. This review needs to focus on removing the barriers to fruitful collaboration that now exist among health care professionals and that prevent some health care professionals (e.g., nurse practitioners) from using the full set of skills for which they have been trained.

***The final area of the Committee's human resource recommendations involves the need for a thorough independent review of the scope of practice rules for the various health care professions.***



The importance of dealing with this problem on an urgent basis was clearly stated by Dr. Duncan Sinclair, the Chair of the Ontario Health Service Restructuring Commission, in his testimony to the Committee:

*Having a doctor do work that a nurse practitioner or nurse could do is like calling an electrician to change a light bulb or a licensed mechanic out of the garage to fill your tank and check the oil and tire pressure – would they do a good job? They would do an excellent job! But would it be a good use of their time, training and expertise? It would not! It would constitute an expensive and inefficient use of scarce resources, both of money and the expertise of very talented people.<sup>250</sup>*

The Committee believes that such expensive and inefficient use of scarce human resources needs to cease *now*. As noted in Chapter Four on Primary Health Care Reform, the synthesis report of the Health Transition Fund's primary care projects concluded with regard to nurse practitioners that:

*A federal/provincial/territorial initiative should develop national standards for terminology and scope of practice. It should include legislative requirements that support an expanded role for nurses and nurse practitioners.<sup>251</sup>*

The Committee therefore recommends that:

**An independent review of scope of practice rules and other regulations affecting what individual health professionals can and cannot do be undertaken for the purpose of developing proposals that would enable the skills and competencies of diverse health care professionals to be utilized to the fullest and enable health care services to be delivered by the most appropriately qualified professionals.**

## **11.9 Committee Commentary**

The Committee acknowledges that there needs to be an increase in the number of people employed in each of the health care professions, and our recommendations are designed to address this problem.

But the Committee is also very concerned about the overall costs that this increase in human resource supply will entail for the system as a whole. The Committee is keenly aware, for example, that physicians are the major cost-drivers in the system.<sup>252</sup> Since increasing

---

<sup>250</sup> See Volume Four of the Committee's study, *Issues and Options*, p. 110-11.

<sup>251</sup> Ann L. Mable and John Marriott, *Health Transition Fund Synthesis Series – Primary Health Care*, June 2002, p. 29.

<sup>252</sup> There is also evidence to suggest that Canadian physicians are well remunerated compared to physicians in other countries. OECD data indicates that the ratio of average physician income to average employee compensation in Canada was 3.2. Only ratios in the United States (5.5) and Germany (3.4) were higher than Canada's, while the ratio

the supply of physicians does not decrease the average cost that each physician imposes on the system, as the number of practising physicians increases the only way in which the system could remain fiscally sustainable is for significant productivity improvements also to occur.

The Committee therefore feels that it is necessary for the increase in the numbers of educational positions to be accompanied by detailed studies of how to improve the productivity of each of the health care professions. If these studies are not done, and if productivity is not substantially improved, the Committee is concerned that this could lead to an unsustainable escalation of overall health care costs.

***The Committee therefore feels that it is necessary for the increase in the numbers of educational positions to be accompanied by detailed studies of how to improve the productivity of each of the health care professions.***

---

was much lower in a number of other countries such as Australia (2.1), France (1.9) and the UK (1.4). See, Reinhardt, Uwe E., Peter S. Hussey and Gerard F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999" in *Health Affairs*, May-June, 2002, p. 175.

## CHAPTER TWELVE

### NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH<sup>253</sup>

---

Health research is about creating and applying new knowledge with respect to health and health care. Health research encompasses a full spectrum of activities that range from biomedical research, to clinical research, to health services research, and to population health research:

- **Biomedical research** pertains to biological organisms, organs, and organ systems. For example, this type of research would use animal or human tissues or cell culture to understand how the body controls the production of blood cells in the bone marrow, how those controls break down in leukemia, and how normal controls might be reinstated by treatment with drugs.
- **Clinical research** relates to studies involving human participants, healthy or ill. An example would include clinical trials on humans to test the toxicity and effectiveness of a possible new treatment for leukemia that has shown promising results in basic biomedical research, and then to compare the new drug with other drugs in terms of their net benefit to patients.
- **Health services research** embraces health care delivery, administration, organization and financing. An example might be research into the mechanisms for handling patients with leukemia, from the means for diagnosis, through their treatment in hospital, on an out-patient basis, or at home, to their long-term follow-up through hospital or community care.
- **Population health research** focuses on the broad factors that influence health status (socio-economic conditions, gender, culture, literacy, etc.). An example might be a study using large databases of personal health information gained from a number of sources to learn whether the incidence of leukemia is associated with environmental or other factors.

Health research is the source of new knowledge about human health, how to maintain optimal health, how to prevent, diagnose and treat disease, and how to manage our health care system. Health research leads to the development of new or improved drug therapy, treatment, medical equipment and devices, and new ways of organizing and delivering health care. Health research also contributes to a better understanding of the complex interplay of the social, economic, environmental, biological and genetic determinants that affect our health and our susceptibility to disease.

The Committee was told that health research fosters the creation of knowledge-based employment, which in turn contributes to reversing the brain drain observed in the country. Overall, witnesses stressed that health research improves the personal and economic health of Canadians and enhances our international competitiveness:

---

<sup>253</sup> This chapter is an updated version of Chapter Five included in Volume Five, pp. 91-125.

*Health research provides enormous economic, social and health care rewards to society. The jobs that are created by these investments are high-quality, well-paying, knowledge-based positions that generate worldwide recognition for Canadians. These investments also support the rejuvenation of academic institutions across the country. They help train new health professionals in the latest technologies and techniques and they provide important support for the health care delivery system in Canada. Most importantly, the results of these activities lead directly to better ways to treat patients, which ensures a healthier and more productive population.*<sup>254</sup>

The Committee also heard that health research could serve as a catalyst to regional economic development and that the health services innovations generated through health research activities could greatly contribute to enhancing the quality and sustainability of Canada's health care system. As health research activity spreads out from the academic health sciences centres and government and into more community-based settings, we can anticipate that standards of care will improve, as health care providers engaged in health research will be better connected with the most recent information. Overall, health research provides tremendous opportunities for both economic and health care progress.

The Committee believes that Canada must actively engage in health research to capture its share of benefits. The Committee also strongly believes that the federal government has a critical role to play as a facilitator, catalyst, performer, consensus builder and coordinator in the overall effort to nurture excellence in health research. This chapter addresses a series of issues, including funding, partnerships and ethics, which we believe deserve close attention if Canada is to achieve the highest standard of excellence in health research.<sup>255</sup>

***The Committee believes that Canada must actively engage in health research to capture its share of benefits.***

## **12.1 Assuming Leadership in Canadian Health Research**

As Table 12.1 shows, health research in Canada is characterized by a complex network that involves a wide range of disciplines and a multiplicity of performers carrying out their research activities in a variety of locations. In Canada, health research is performed by universities, teaching hospitals, business enterprises, government, and non-profit organizations. This research is financed from a variety of public, private, Canadian and foreign sources.

---

<sup>254</sup> Dr. Barry D. McLennan, Chair of the Coalition for Biomedical and Health Research (CBHR), *The Improving Climate for Health Research in Canada*, Brief to the Committee, 9 May 2001, p. 2.

<sup>255</sup> The Committee wishes to say that sections 12.1 and 12.2 of this chapter were inspired by a speech given by Dr. Kevin Keough, Chief Scientist at Health Canada, at the third annual Amyot Lecture organized by Health Canada. We found his lecture very useful in highlighting some of the challenges and opportunities facing health research.

**TABLE 12.1**  
**THE CANADIAN HEALTH RESEARCH NETWORK**

DISCIPLINES	LOCATIONS	SOURCES OF FUNDING
<ul style="list-style-type: none"> <li>▪ Clinical Disciplines</li> <li>▪ Social Sciences and Humanities</li> <li>▪ Epidemiology</li> <li>▪ Life Sciences</li> <li>▪ Cellular and Molecular Biology</li> <li>▪ Chemistry</li> <li>▪ Engineering</li> <li>▪ Computing and Mathematical Sciences</li> <li>▪ Health Services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Academia (Universities, Teaching Hospitals, Research Institutes)</li> <li>▪ Industry</li> <li>▪ Government</li> <li>▪ Physicians' Practices</li> <li>▪ Community Organizations</li> <li>▪ Community Hospitals</li> <li>▪ Others</li> </ul>	<ul style="list-style-type: none"> <li>▪ Governments (Federal, Provincial, Departments, Funding Agencies)</li> <li>▪ Non-Government Organizations and National Voluntary Organizations</li> <li>▪ International Sources</li> <li>▪ Industry</li> <li>▪ Universities</li> <li>▪ Others</li> </ul>

The different stakeholders in health research collaborate with each other in various ways: government-university, university-industry, government-industry. In fact, the Committee was told that science is a continuum and the multiple components of health research cannot exist independently of the others. Each component has an important, albeit changing, research role to play in ensuring maximum health benefits for Canadians.

The federal government has always played an important role in health research as a funder, performer and user of research. The federal government financially supports health research carried out in universities, teaching hospitals and research institutes (extramural research); it performs health research in its own laboratories (intramural or in-house research); and it utilizes the outcomes of health research carried out elsewhere. Moreover, the federal government has an important role to play in setting national priorities for health research.

The Committee believes that, in a country as vast as Canada, the federal government has a catalytic leadership role in working with the provincial and territorial governments to ensure that our health care system is driven by research and innovation. To be successful, the federal government needs to have a close collaboration with the provinces and territories to sustain a culture that supports the creation and use of knowledge generated by health research.

In addition, the Committee agrees with a 1999 report of the Council of Science and Technology Advisors that health research performed, funded and used by the federal government must be of the highest quality. It must be demonstrated to meet or

***The Committee agrees that health research performed, funded and used by the federal government must be of the highest quality. It must be demonstrated to meet or exceed international standards of excellence in science, technology and ethics.***

exceed international standards of excellence in science, technology and ethics.<sup>256</sup>

The Committee was informed that, as the cost, complexity and pace of advancement in health research accelerate, individual organizations no longer have the resources or expertise to work in a vacuum:

*Traditionally, investigators have worked in isolation, pursuing their own research agendas and living grant-to-grant. This scattered, ad hoc approach simply won't work in today's world when the complexity of science requires the pooling of resources.*<sup>257</sup>

At the third annual Amyot Lecture organized by Health Canada, Dr. Kevin Keough, Chief Scientist at Health Canada, stated that it is necessary to adopt an inclusive (or horizontal) approach to health research and to find new ways to partner – that is, to bring together multidisciplinary teams of scientists from across the whole health research system to combine their intellectual, financial and physical resources in conducting the research required to better understand the complex and highly interconnected world in which we live.<sup>258</sup>

The Committee agrees with Dr. Keough that it is critical to sustain effective partnerships and to distribute the effort of individual partners in a manner that will maximize the output of Canadian health research. In our view, complementary and collaborative approaches to health research are not only feasible and cost-effective, but also contribute to better research outcomes for all stakeholders. This overarching goal can only be met if the role of the federal government continues to adapt to the changing health research environment. In addition to being a performer, funder and user of health research, the federal government must become more active as a catalyst and a facilitator.

***The Committee agrees that it is critical to sustain effective partnerships and to distribute the effort of individual partners in a manner that will maximize the output of Canadian health research.***

The Committee strongly believes that the federal government should assume leadership in Canadian health research and, therefore, we recommend that:

**Health research and its translation into the health care system be routinely on the agendas of meetings of federal and provincial/territorial Ministers and Deputy Ministers of Health, and that the Canadian Institute of Health Research be represented and be involved in setting the agendas for health research at those meetings. This would greatly help to sustain a culture that supports the creation and use of**

---

<sup>256</sup> Council of Science and Technology Advisors, *Building Excellence in Science and Technology (BEST): The Federal Roles in Performing Science and Technology*, December 1999, p. 5.

<sup>257</sup> The Western Canadian Task Force on Health Research and Economic Development, *Seizing the Future – Health as an Engine of Economic Growth for Western Canada*, Summary of the Report, August 2001, p. 2.

<sup>258</sup> Dr. Kevin Keough, Amyot Lecture, October 2001.

**knowledge generated by health research throughout Canada.**

**The federal government set, on a regular basis, national goals and priorities for health research in collaboration with all stakeholders.**

**The federal government foster multi-stakeholder collaborations when performing, funding and using health research. This should contribute to capitalizing on the best available resources while minimizing overlap and duplication.**

Dr. Keough stressed that, as a starting point, the federal government should encourage the interchange of health research scientists between government, academia and the private sector. A freer flow of scientists would enhance the quality of Canadian health research, improve science and research advice to government, maximize the contribution of Canadian scientists to the whole health research community, and contribute to the renewal of the science base in all sectors. The Committee shares similar views and, therefore, recommends that:

**The federal government take a leadership role, through the Canadian Institutes of Health Research and Health Canada, in developing a strategy to encourage the interchange of research scientists between government, academia and the private sector, including national voluntary organizations.**

The Committee wishes to acknowledge the important role played by national voluntary organizations in health research. These organizations act as a key bridge at the national level between health research and its application through knowledge transfer of information to researchers, health care providers and the general public. It is the view of the Committee that, given the knowledge and experience these national voluntary organizations bring, as well as the significant proportion of the health research enterprise which they support, they must be included in the multistakeholders collaboration in health research.

## **12.2 Engaging the Scientific Revolution**

Witnesses told the Committee that health research in Canada and throughout the world is currently undergoing a scientific revolution. They explained that this revolution in health research is fuelled by the ongoing advances in genomics, engineering and cell biology. Research in these scientific disciplines will have a profound effect on the detection, diagnosis and treatment of various genetically linked diseases. Elucidation of the physiological processes associated with various conditions will require years of efforts to identify the relevant genes and to determine how they interact.

*We are in the midst of a profound global revolution being driven by our rapidly emerging understanding of the molecular basis of life, of human biology and of disease. Like prior revolutions in science, this revolution is being driven by the collision of diverse disciplines and approaches: genetics, molecular biology, the broader bio-sciences, [information technology] and computational methodologies, small molecules and surface chemistry, bioethics, epidemiology, health economics, and the social sciences and humanities. The pace of this health research revolution is still accelerating, driven by significant global investments by governments, industry and philanthropy.<sup>259</sup>*

As the human genome project approaches completion, the next challenge is to understand the function of the 30,000-40,000 genes that humans appear to possess. These genes encode the entire protein set or proteome estimated at 2 million. Thus, the next frontier in biology appears to be proteomics, the cataloging and functional description of all proteins in living organisms, which is far more complex and promising than genomics.

Similarly, advances in biomedical engineering and miniaturization on the molecular scale will push development of more sophisticated devices for diagnosis and therapy – targeted delivery of drugs, biological testing, molecular imaging, and tissue and organ repair. Canada has a real opportunity to become a world leader in this field of “nanotechnology” or “nanomedicine.”

The study and use of stem cells is another good example of the potential impact that health research can have on health and health care. Stem cells have the unique property, whatever their origin, of becoming specialized cells. Currently, both the research community and related stakeholders are very enthusiastic about the potential of stem cells, both from embryonic and adult sources. It is anticipated that research on these cells will lead to treatments for serious diseases such as Parkinson’s, Alzheimer’s, diabetes and spinal cord injuries. It is also widely believed that these cells can ultimately be manipulated to grow into virtually any tissue or organ thus providing much needed organs for transplant.

Recent research has been successful in programming human embryonic stem cells into producing insulin. Normally, this function is performed by specialized pancreatic islet cells. Should this treatment prove to be able to provide a cure for diabetes, which is presently being treated by regular injection of insulin, it will not only improve the quality of life for the individual, but will also ease the economic burden of disease. In a different study, stem cells isolated from the skin of animals were coaxed into becoming neural, muscular and fat cells.

Other areas where the scientific revolution has a definite impact are chemistry and computer science where advances in molecular modelling combined with synthetic chemistry change the way novel drugs are discovered. Bioinformatics and robotics are also areas that will benefit health research.

The scientific revolution in health research is not limited to basic and biomedical research; it is also creating tremendous opportunities for research into health services and population health. More than ever before, research is undertaken in Canada and abroad to find

---

<sup>259</sup> Dr. Alan Bernstein, president of the CIHR, *Health Research Revolution – Innovation Will Shape This Century*.



new ways of delivering quality care and to understand the implications of the interaction of the determinants that affect the health of a population.

At the third Amyot Lecture, Dr. Keough stressed that advances in health research, and the need for governments and individuals to accommodate them, will continue to accelerate. This means that governments must be able to both perform and rely on good science, which is based on sound research harnessed for the public good. The government's effectiveness in integrating progresses from emerging areas such as biotechnology and nanotechnology depends on this principle.

The Committee agrees with Dr. Keough that it is imperative for Canada to take up the challenges wrought by the scientific revolution. We are convinced that countries with a strong health research network are more capable of translating advances and innovations into cost-effective health services, modern and internationally competitive policy and regulatory frameworks, new or adaptive products, and new health promotion activities. An energetic health research environment contributes to improved health, higher quality of life, and an efficient health care system. This in turn engenders public confidence, a vibrant business environment and a strong economy.

Along with Dr. Keough, the Committee believes that good science is good economics and that the government has a crucial role in maximizing the gains for Canada and its citizens. Clearly, the costs of doing good science are high; but the costs of not doing it are even higher. These scientific developments are rapidly expanding and there is fierce competition in the field. Along with numerous witnesses, the Committee is convinced that Canada cannot afford to fall behind. The potential pay-off is a fast and economically beneficial transfer of knowledge and its conversion into tangible benefits for the Canadian population.

***The Committee believes that good science is good economics and that the government has a crucial role in maximizing the gains for Canada and its citizens.***

It is the opinion of the Committee that such a formidable challenge can be met only through a concerted effort by government, industry, academia, non-governmental organizations and international organizations. Each of these partners has its own specific role. However, coordination and support should be provided by the federal government, through its agencies and departments, especially CIHR and Health Canada. Therefore, the Committee recommends that:

**The federal government, through both Health Canada and the Canadian Institutes of Health Research, coordinate and provide resources to ensure that Canada contributes to and benefits from the scientific revolution to maximize the economic, health and social gains for Canadians.**

The Committee strongly believes that Canada can be a world leader in health research, building on our strengths in human genetics, stem cell biology, population health, bioethics, proteomics, and health economics. We have a tremendous opportunity to apply the

knowledge generated from genomics and proteomics research to the study of human populations and human research. For example, the CIHR through its institutes of Genetics and Health Services and Policy Research are partnering with the Federal/Provincial/Territorial Coordinating Committee on Genetics and Health to identify and prioritize emerging issues that can be addressed through research.

The field of genomics and proteomics in Canada could benefit from a more integrated investment approach. For example, with a long-standing record of excellence in protein science research and training, Canada is well positioned to make a significant contribution in proteomics. The Canadian Proteomics Initiative – a partnership between CIHR’s Institute of Genetics and the Protein Engineering Network of Centres of Excellence (PENCE) – is working to build on the federal government’s investments to date in infrastructure to build a large-scale national program that will ensure that Canada’s remains internationally competitive. Therefore, the Committee recommends that:

**The Canadian Institutes of Health Research and Genome Canada fund research that positions Canada as a world leader in the new area of genomics and human genetics so that the health care system can take appropriate advantage of this new technology to improve the health of Canadians.**

**The Canadian Institutes of Health Research play a leadership role in establishing best practices for addressing the complex ethical issues raised by the use of this new technology in health research and health care.**

### **12.3 Securing a Predictable Environment for Health Research**

As indicated in Volume Two, the federal government has had a long tradition in financing health research.<sup>260</sup> The most recent estimates by Statistics Canada indicate that the majority (some 79%) of federally funded health research is “extramural” as it takes place in universities and hospitals (68%), private non-profit organizations (6%), and business enterprises (4%).<sup>261</sup>

The principal federal funding body for health research is the Canadian Institutes of Health Research (CIHR). In fact, CIHR is the only federal entity whose budget is entirely devoted to health research. Its creation in 2000 involved a major evolution of the mandate of the Medical Research Council of Canada (MRC) and incorporation of the National Health Research and Development Program (NHRDP), formerly Health Canada’s main financing instrument for extramural health research. Despite the creation of CIHR, Health Canada is still involved in the financing of some extramural health research in a wide range of fields (children’s health, women’s health, Aboriginal health, etc.).

---

<sup>260</sup> Volume Two, pp. 93-104.

<sup>261</sup> Statistics Canada, *Estimates of Total Expenditures on Research and Development in the Health Field in Canada, 1988 to 2000*, Catalogue No. 88F0006XIE01006, April 2001.

There are also a number of federal research-oriented bodies whose funding focuses entirely on health-related research. These include namely the Canadian Health Services Research Foundation (CHSRF) and the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). Many feel that for a country of the size of Canada, there are too many federal funding organizations.

In addition, there are several secondary sources of extramural federal health research funding. More precisely, the federal government is responsible for a number of research councils, agencies and programs that devote (to various extents) a portion of their budget for health-related research. These include the Natural Sciences and Engineering Research Council (NSERC), the Social Sciences and Humanities Research Council (SSHRC), the Canada Foundation for Innovation (CFI), the Canada Research Chairs (CRCs), and the Networks of Centres of Excellence.<sup>262</sup> The federal government has also funded Genome Canada, a not-for-profit corporation dedicated to developing and implementing a national strategy in genomics research.

The remainder of the federally funded health research (some 21%) is “intramural” or “in-house” research, that is research conducted in federal government facilities. Federal facilities in which health-related research is performed include Health Canada, Statistics Canada, the National Research Council, Human Resources Development Canada, Agriculture Canada, Environment Canada (in partnership with Health Canada) and the Canadian Food Inspection Agency.

### **12.3.1 Federal funding for health research**

The federal government has, on many occasions, demonstrated its commitment to health research. The Committee applauds the high priority for research given in the 2001 Speech from the Throne and particularly its announcement to increase funding for health research:

*Our government's overriding goal is nothing less than branding Canada as the most innovative country in the world – as the place to be for knowledge creation; where our best and brightest can make their discoveries; where the global research stars of today and tomorrow are born; becoming the magnet for new investments and new ventures.*

*(...) The Government of Canada will (...) provide a further major increase in funding to the Canadian Institutes of Health Research, to enhance their research into disease*

---

<sup>262</sup> The NCEs are supported and overseen by the three Canadian granting agencies (CIHR, NSERC and SSHRC). It is worth noting that eight networks, of the currently funded 22 NCEs, conduct health research in the fields of: arthritis, bacterial diseases, vaccines and immunotherapeutics for cancer and viral diseases, stroke, health evidence application, genetic diseases, stem cells and protein engineering. Some of the other NCEs may have impact on health and health care (e.g. Institute for Robotics and Intelligent Systems or Canadian Water Network).

*prevention and treatment, the determinants of health, and the effectiveness of the health care system.*<sup>263</sup>

The Committee also recognizes the creation of CIHR as a major achievement in health research. We laud the increased funding for CIHR announced in the December 2001 Budget Speech, despite the severe financial pressures the federal government faces. In addition, the creation of, and funding for, the Canada Foundation for Innovation in 1997, followed by the Millennium Scholarships, the Canada Research Chairs, and Genome Canada, are clear indications that health research and innovation are integral to public health-related policy in Canada.

Throughout its study, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other industrialized countries in this regard. In fact, the role of national government in financing health research, expressed in purchasing power parity (PPP) per capita, is much higher in the United States, the United Kingdom, France and Australia than in Canada. For example, as stated in Volume Two, the American government provided in 1998 four times more funding per capita to health research than did the Canadian government.<sup>264</sup>

***Throughout its study, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other industrialized countries in this regard.***

Witnesses unanimously recommended that the federal government's share of total spending on extramural health research be increased to 1% of total health care spending in Canada, from its current level of approximately 0.5%. This could involve increasing CIHR's current budget to \$1 billion from the current level of \$560 million. Additional resources should also be devoted to federally performed health research (discussed in the following section). Overall, increased investment in extramural and in-house health research would bring the level of the federal contribution to health research more in line with that of national governments in other OECD countries. More importantly, this would help maintain a vibrant, innovative and leading edge health research industry.

Another concern brought to the attention of the Committee related to the long-term nature of research in contrast to existing budgetary program planning. High quality research is very competitive internationally and requires long-term commitments. Young researchers, on whom Canada's future in research depends, commit their careers on the basis of their perceptions of the long-term environment for research. Canada will not attract or keep excellent people without providing an excellent environment for research. Research pays little attention to national borders. The world

***The Committee strongly supports the view that health research money is money to support the best and brightest minds. Ultimately, Canada's challenge in health research is a challenge to attract and retain outstanding people.***

<sup>263</sup> Government of Canada, *Speech from the Throne*, First Session of the 37<sup>th</sup> Parliament, 30 January 2001.

<sup>264</sup> Volume Two, p. 97.

recognizes excellence, and competes vigorously for it.

The Committee strongly supports the view that health research money is money to support the best and the brightest minds. At least two-thirds of funds for health research go to salaries and training stipends for highly qualified and motivated researchers, research assistants, technicians, research trainees, etc. Ultimately, Canada's challenge in health research is a challenge to attract and retain outstanding people.

The role of the federal government is central to this competition for excellent researchers. In particular, CIHR is the long-term source of research funds for the health research activities stimulated by the Research Chairs, the Canadian Foundation for Innovation, and Genome Canada, all of which are adding greatly to Canada's capacity for excellence in research. CIHR is also an essential partner for research stimulated by the many health research charities.

Overall, the Committee believes that the federal government must establish and maintain long-term stability in the Canadian health research environment. Providing an adequate and predictable level of funding is a necessary prerequisite. We agree with witnesses that the federal government must increase its investment in health research so that federal extramural funding accounts for 1% of total health care spending.

In our view, such additional federal funding should be directed to research projects that can have a significant impact on health status or that contribute substantially to improvements in health care quality and delivery. Research in such fields as population health, public health, health services delivery, clinical practice guidelines, early child development, and women's and Aboriginal health should be given the highest priority.

The Committee also believes that the establishment of CIHR has resulted in the creation of a broad platform upon which to launch bold new initiatives in health research. Moreover, we believe that CIHR and its 13 Institutes must insist on the translation of knowledge generated by research; this will ensure that the results of health research are translated into action including changes in clinical practice, health care policy, and individual behaviours.

Health research is a long-term investment; many research projects span a researcher's whole career, and grants are usually awarded for three- to five-year terms, which are simply not consistent with the one-year-at-a-time budget allocation to CIHR. Overall, the Committee recommends that

#### **The federal government:**

- **Increase, within a reasonable timeframe, its financial contribution to extramural health research to achieve the level of 1% of total Canadian health care spending. This requires an additional investment of \$440 million by the federal government;**

- **Recognize that health research is a long term proposition, and therefore set and adhere to clear long-term plans for funding health research, particularly through the Canadian Institutes of Health Research. More precisely, the federal government should commit to a five-year planning horizon for the CIHR budget;**
- **Provide predictable and appropriate investment for in-house health research.**

### **12.3.2 Federal in-house health research**

A report by the Council of Science and Technology Advisors identified a clear need for the federal government to perform in-house research. This report stressed that the federal government must have an adequate research capacity to deliver the following key roles:

- Support for decision making, policy development and regulations.
- Development and management of standards.
- Support for public health, safety, environment and/or defence needs.
- Enabling economic and social development.<sup>265</sup>

In other words, the ability of the federal government to set policy and enforce regulations requires it to have an appropriate in-house research capacity. In addition, the government needs to have access to the highest possible quality scientific and technological information in a time frame that meets its needs. Failure to use the best available data and analysis could expose the government to liabilities for damages caused by those decisions.

The major key player in federal intramural health research is Health Canada, for which this function is critical to the fulfillment of its mandate. The department is mandated to help the people of Canada maintain and improve their health and to ensure their safety. Thus, in addition to access to top-quality scientific and technological information, Health Canada must obtain advice to set policy and enforce regulations. The required in-house research capacity includes expertise in:

- the state and spread of disease;
- ensuring the safety of food, water and health products, including pharmaceuticals;
- air quality issues; and,
- fulfilling health promotion obligations.

---

<sup>265</sup> Council of Science and Technology Advisors (CSTA), *Building Excellence in Science and Technology (BEST): The Federal Role in Performing Science and Technology*, 16 December 1999, p. 12. The CSTA consists of a group of external experts providing the federal government with on science and technology issues.

To undertake these responsibilities, Health Canada's researchers must possess independent knowledge and skills over a wide range of scientific disciplines, ranging from the behavioural sciences to cellular and molecular biology. In addition, Health Canada must have an adequate in-house capacity to assimilate, interpret and extrapolate the knowledge obtained from other health research partners. Finally, the department must be able to draw widely on expertise and facilities that are not available in-house.

Overall, the Committee learned that Health Canada has a unique role. In order to meet its mandate, the department must be able to provide the best possible independent science advice related to its legislated responsibilities, to undertake a wide range of scientific activities related to its role as regulator and policy advisor, and to provide evidence-based health services and programs. This unique obligation requires Health Canada to have the necessary science and research capacity to fulfill these three functions.

The Committee feels it is important to acknowledge that Health Canada has taken an important step in ensuring, through the appointment in 2001 of a Chief Scientist, that it possess the ability to meet its mandate. The Chief Scientist and his office play a pivotal role in bringing leadership and coherence to Health Canada's scientific responsibilities and activities by championing the principles of alignment, linkages and excellence espoused by the Council of Science and Technology Advisors.

The Committee strongly believes that there is a clear need for the federal government to perform health research and that it must have the capacity to deliver its mandate. The Committee also acknowledges the importance for Health Canada of partnering with stakeholders outside of government when necessary. Therefore, the Committee recommends that:

***The Committee strongly believes that there is a clear need for the federal government to perform health research and that it must have the capacity to deliver its mandate.***

#### **Health Canada:**

- **Be provided with the financial and human resources in health research that are required to fulfill its mandate and obligations;**
- **Engage actively in the establishment of linkages and partnerships with other health research stakeholders.**

#### **12.4 Enhancing Quality in Health Services and in Health Care Delivery**

As indicated on numerous occasions in this report, the Canadian health care delivery system is facing a very serious situation, marked by rising costs, a high degree of dissatisfaction and high expectations. While many recommendations for change to the publicly funded health care system have been made over the years, most of them have not been based on

scientific evidence, but rather have been grounded on anecdotal evidence or political posturing. For these reasons, research on all aspects of Canada's publicly funded health care system is, at the present time, very critical for health care policy makers and managers.

Areas in need of more research are varied and include:

- health promotion policies
- disease and injury prevention strategies (at both the individual and population levels)
- determinants of health
- approaches to primary care management
- new modes of remuneration for health care providers and institutions
- decision-making by health care providers and users
- organizational care delivery models
- health care policy management
- health care resources allocation
- impact of selected areas of privatized health care
- pharmaco-economics
- assessment and utilization of health care technology and equipment.

Clinical research and the involvement of health care providers themselves in health research are key elements in ensuring that fundamental research is translated into better health and health care. Clinical trials and large-cohort population health research studies are under-supported in Canada, in part due to the large, long-term financial commitment that is required before such studies can be launched. Urgent investment in training and subsequent career support is needed for clinician investigators in Canada. Harassed by ever increasing demands for clinical service, they find it increasingly difficult to remain competitive in competitions for grants and awards.

In Canada, a wide range of organizations are involved in health services research. It is the view of the Committee that, at this critical time for our health care delivery system, it is essential that this type of research be well funded and that these research centres and their investigators take part in the present debate about the future structure of the Canadian hospital and doctor system and about how the growing gaps in health care coverage can be closed.

Moreover, many studies have shown that there is a major gap between new knowledge and its application in every day medicine. For example, only 46% of elderly

***The Committee believes that the federal government, given its unique role in health research, should commit a significant investment in promoting in partnership with the provinces and territories, the adoption of research findings in clinical practice.***



patients were given pneumococcal vaccine, though it is the group most at risk for suffering from such infections. Aspirin, although recommended for all adult diabetic patients, was prescribed in only 20% of cases, and counselling on HIV transmission was given to less than 3% of adolescents during physician's office visits.<sup>266</sup> In addition, wide variations in practice patterns and outcomes persist across regions as well as across provinces. The Committee believes that the federal government, given its unique role in health research, should commit a significant investment to promoting, in partnership with the provinces and territories, the adoption of research findings in clinical practice. This must be done while continuing to support new research on priority health issues and the development of new tools, so that in the future this knowledge and the new tools can be translated into and implemented to produce improved health and enhanced health care.

Overall, the Committee acknowledges that more health research should be undertaken in order to enhance quality in health services and in health care delivery. Therefore, we recommend that:

**The federal government, through the Canadian Institutes of Health Research, Health Canada and the Canadian Health Services Research Foundation, devote additional funding to health services research and clinical research and that it collaborate with the provinces and territories to ensure that the outcomes of such research are broadly diffused to health care providers, managers and policy-makers.**

## **12.5 Improving the Health Status of Vulnerable Populations**

There are many groups in Canadian society that have, for numerous reasons, less immediate access to health services appropriate to their specific needs. Examples include individuals with mental health problems, individuals with addiction problems, people with physical disabilities, some ethnic minorities, women in difficult circumstances, people living in rural and remote communities, the homeless and the poor. The Committee acknowledges that there is an urgent need in Canada to support cross-disciplinary health research that will provide new evidence on the diverse factors that influence health status, and on approaches to improving access to needed health care for vulnerable groups. CIHR has recently set up a strategic plan through three of its Institutes to study this crucial problem, but more resources are needed. Therefore, the Committee recommends that:

**The federal government, through the Canadian Institutes of Health Research and Health Canada, provide additional funding to health research aimed at the health of particularly vulnerable segments of Canadian society.**

---

<sup>266</sup> *JAMA*, vol. 286, p. 1834 (2001).

In Volume Four of its health care study, the Committee stated that the health of Aboriginal Canadians is a national disgrace. There is a disproportionately, and completely unacceptable, large gap in health indicators between Aboriginal and non-Aboriginal Canadians. Aboriginal peoples experience much higher incidence of many health problems, including: significantly higher rates of cancer, diabetes and arthritis; heart disease among men; suicide among young men; HIV/AIDS; and morbidity and mortality related to injuries. Infant mortality rates are twice to three times the national average, with high rates of fetal alcohol syndrome and fetal alcohol effects (FAS/FAE), and poor nutrition. Approximately 12% of Aboriginal children have asthma, in comparison with 5% of all Canadian children. This last trend is attributable, at least in part, to environmental health issues, such as the presence of moulds in houses.<sup>267</sup>

The Committee believes that research is perhaps the most important element that will help improve the health status of Aboriginal Canadians. In our view, the creation of CIHR's Institute of Aboriginal Peoples' Health is an important step in this direction. Health Canada, which delivers numerous programs and services to First Nations and Inuit communities, needs to strengthen its research capacity as well as its capacity to translate health research into effective public policy. In particular, Health Canada requires a strong research capacity to:

***The Committee believes that research is perhaps the most important element that will help improve the health status of Aboriginal Canadians.***

- compile and analyze available population-based information to identify trends, emerging issues, and differences across geographic regions or communities;
- review programs and services to identify the most effective practices in First Nations and Inuit communities and to assess timely progress in addressing key health issues; and
- maintain and augment the capacity to analyze research both nationally and internationally, and integrate best practice into policy and program development, implementation and evaluation.

Therefore, the Committee recommends as a matter of urgency that:

**The federal government provide additional funding to CIHR in order to increase participation of Canadian health researchers, including Aboriginal peoples themselves, in research that will improve the health of Aboriginal Canadians.**

**Health Canada be provided with additional resources to expand its research capacity and to strengthen its research translation capacity in the field of Aboriginal health.**

---

<sup>267</sup> Volume Four, pp. 129-135.

Research into the field of health in developing countries is also of concern. The Committee learned that very little research activity is directed towards health problems that affect developing countries. In fact, data suggest that less than 10% of health research is devoted to diseases or conditions that account for 90% of the global disease burden.

The primary causes of morbidity and mortality in developing countries can be grouped under four general areas: malnutrition, poor sexual and reproductive health, communicable diseases, and non-communicable diseases including injuries. A recent report by the World Health Organization shows that long-term economic growth is impossible where large numbers of people are malnourished, sick or dying.

It is the view of the Committee that, given its expertise and excellence in health research, Canada should assume a leadership role in this area. The federal government has taken a step in the right direction. In a first-ever collaborative effort, four Canadian government organizations have joined their forces to formalize a shared commitment to address the problems of global health through research. The Canadian International Development Agency (CIDA), CIHR, the International Development Research Centre (IDRC) and Health Canada have formed the Global Health Research Initiative. Not only will this joint undertaking allow the four partners to operate their programs and research more effectively, it will also contribute to a great humanitarian cause – the health protection of citizens of all countries, including Canadians. This is the beginning; much more needs to be done. Therefore, the Committee recommends that:

**The federal government provide increased resources to the Global Health Research Initiative.**

## **12.6 Commercializing the Outcomes of Health Research**

One outcome of health research is the creation of new knowledge. New knowledge is in itself of great value to society but the overall impact of health research is maximized when new knowledge is translated into social and economic benefits. Commercialization of health research outcomes represents one way to achieve this knowledge translation.

***New knowledge is in itself of great value to society but the overall impact of health research is maximized when new knowledge is translated into social and economic benefits. Commercialization of health research outcomes represents one way to achieve this knowledge translation.***

Commercialization of health research can happen at many different stages of research and each stage faces different challenges. For example, one of the main challenges facing commercialization of academic health research (occurring in universities and hospitals) is that their early stage of development makes the investment of capital by private sector very risky, thus speculative. By contrast, once a product is marketable, such as the late stage clinical trials (mainly performed by large research-based pharmaceutical firms), the main challenges relate to

intellectual property and the patent regime, as well as to approval and monitoring of drugs. Commercialization of health research outcomes brings numerous benefits including:

- improved health, resulting in a more productive workforce;
- enhanced health services quality;
- increased efficiency in health care system delivery;
- expanded research funding leveraged from commercialization and research partnerships;
- enhanced job creation with newly formed companies;
- and greater economic activity from the manufacturing, marketing and sales of new health care products and services.

In its brief to the Committee, the Council for Health Research in Canada indicated that spin-off biotechnology companies formed by CIHR-funded scientists are an important by-product of public investment in health research:

*For instance, 23 companies have been formed at the University of British Columbia employing 732 people. At McGill, 18 companies have been formed employing 392 people. At the University of Ottawa, 10 companies have been formed employing 459 people. Such companies cannot flourish without public investments to fund a steady discovery pipeline.<sup>268</sup>*

Visudyne is one example of Canadian health research that has produced some powerful advances in health care. The drug, which is approved for use in over 30 countries, is the only approved treatment for age-related macular degeneration, the leading cause of age-related blindness. This treatment was developed at the University of British Columbia (UBC) and was funded, in part, by the federal government. UBC assisted in the start-up of QLT Inc. to commercialize this product that has head offices in Vancouver, employs over 350 people and has a market capitalization of \$1.5US billion.

Another example is 3TC, the only inhibitor of HIV reverse transcriptase with few or no side effects and a common component of treatment for HIV/AIDS, which also arose out of federally funded research performed in Montreal. BioChem Pharma Inc., prior to its acquisition by Shire Pharmaceuticals plc. (based in the United Kingdom), had head offices in Montreal, employed 278 people, and had a market capitalization of \$3.7US billion.

These examples illustrate the potential of health research to treat disease, create employment and generate economic benefits for Canada. While many academic technologies are licensed to foreign companies, it is reasonable to expect that value should be created and retained in Canada wherever possible and appropriate when the federal government has made investments in health research.

---

<sup>268</sup> Council for Health Research in Canada, *Health Research: The Engine of Innovation*, Brief to the Committee, 30 December 2001, p. 2.

As stated in Section 12.2, “good science is good economics.” However, during his testimony, Dr. Henry Friesen, Team Leader of the Western Canadian Task Force on Health Research and Economic Development, told the Committee that the conditions are not presently in place to enable publicly funded health research to maximize the returns to Canadian taxpayers.<sup>269</sup> In the opinion of this Task Force, the capacity for research commercialization is sub-optimal and clearly unacceptable.<sup>270</sup>

Similar findings were presented in a 1999 report published by the Advisory Council on Science and Technology (ACST) and prepared by its Expert Panel on the Commercialization of University Research.<sup>271</sup> The Expert Panel made the case that research results from federal funding of university research, where there is commercialization potential, should be managed as an asset that can return benefits to the Canadian economy and Canadian taxpayers. The Expert Panel also showed that the United States has a much better track record in commercialization of university-based research than Canada, despite a growing private sector involvement in funding research at Canadian universities.

Most major research institutions (universities and research hospitals) in Canada have in-house technology commercialization offices that are funded by university sources and, in cases of successful offices, by revenue derived from operation. Currently, the expenses associated with commercialization activities are not covered by direct federal research funding. The Committee learned that the vast majority of these technology commercialization offices have costs that exceed their revenue. They are operated as a cost centre and not as a profit centre for the institution. However, while their function is not critical to the research enterprise (creation of new knowledge), an argument could be made to include costs of operating these offices in the calculation of indirect research costs since technology commercialization is a research-related activity.

The question of funding indirect costs in Canadian research by the federal granting agencies has been one of contention in recent years. It has been recognized as one element to explain the lower level of competitiveness of Canadian researchers. Indirect costs are those expenses associated with administration, maintenance, commercialization and the salary of the principal investigator that is attributable to the research project. The ACST in its 1999 report<sup>272</sup> and subsequent publications has made the recommendation that the federal government increase its investment by supporting the indirect costs of sponsored research. Similarly, the brief of the Council for Health Research in Canada stressed:

*[The] indirect costs of research must be funded in order to provide a cutting-edge research environment that will fully realize the benefits of the government’s Innovation Agenda.*

---

<sup>269</sup> See Committee Proceedings, Issue No. 30.

<sup>270</sup> Western Canadian Task Force on Health Research and Development, *Shaping the Future of Health Research and Economic Development in Western Canada*, August 2001, pp. 19-20.

<sup>271</sup> Expert Panel on the Commercialization of University Research, *Public Investments in University Research: Reaping the Benefits*, Advisory Council on Science and Technology, 4 May 1999.

<sup>272</sup> *Ibid.*

(...) *The Council believes it should be a priority for the government to develop a specific, long-term plan to address this issue as soon as possible.*<sup>273</sup>

The Committee acknowledges that, in its December 2001 Budget, the federal government provided a one-time investment of \$200 million through the granting councils to help alleviate the financial pressures that are associated with the rising indirect costs of research activities, including commercialization. We both hope that universities and research hospitals will use some of these funds to improve their commercialization abilities, and that the federal government will make this investment permanently recurrent.

The Committee agrees with witnesses and recent reports that there is a need to find ways to maximize the returns to Canadians from the commercialization of federally funded health research. We believe that the federal government should establish the necessary conditions to enable researchers and those technology commercialization offices providing support and services to researchers to perform to their full potential in commercializing the results of federally funded health research.

***The Committee agrees with witnesses and recent reports that there is a need to find ways to maximize the returns to Canadians from the commercialization of federally funded health research. We believe that the federal government should establish the necessary conditions to enable researchers and those technology commercialization offices providing support and services to researchers to perform to their full potential in commercializing the results of federally funded health research.***

Further, the Committee believes that CIHR, Canada's premier vehicle for funding health research with a legislated mandate to translate knowledge into improved health, is uniquely positioned to assess the recommendations made by the Western Canadian Task Force, the ACST's Expert Panel and other studies on technology commercialization as they apply to health research. We believe that CIHR should use these reports as the basis for developing and delivering on an innovation strategy that considers programs, policies and people. In our view, such a strategy would see CIHR support and strengthen the capacity of academic technology commercialization offices to maximize the transfer of technologies to market, thereby creating of Canadian companies and jobs and enhancing Canada's innovation capacity. In addition, we believe that this innovation strategy must be developed within a framework that includes governing principles of public good and benefit to Canada so that any strategy to maximize the social and economic impact does not threaten academic freedom or influence the direction of research or the delivery of health care. Therefore, the Committee recommends that:

**The federal government require an explicit commitment from all recipients of federally funded health research that they will obtain the greatest possible benefit to Canada, whenever the results of their federally funded research are used for commercial gain.**

---

<sup>273</sup> Council for Health Research in Canada, Brief to the Committee, p. 5.

**The Canadian Institutes of Health Research, while not ignoring the social value of health research that does not result in commercial gain, seek to facilitate appropriate economic returns within Canada from the investments it makes in Canadian health research, whenever the results of investments in Canadian health research are used for commercial gain. In doing so, CIHR should develop an innovation strategy aimed at accelerating and facilitating the commercialization of health research outcomes.**

**The federal government invest additional resources to enhance the output of Canadian health researchers and strengthen the commercialization capacity of performers of federally funded health research through CIHR's innovation strategy. This new funding would be additional to the current health research investment. In particular, the funding of the indirect costs of research by the Canadian granting agencies should be made permanent. Health research performers should be made accountable for the use of these commercialization funds.**

One aspect of the commercialization of health research outcomes that generated controversy recently is the issuance of patents for higher life forms. This subject goes deeply into ethical, intellectual property, and economical issues. Although these questions are highly relevant to Canadian health research and the work of this Committee, they are debated elsewhere. Indeed, the Canadian Biotechnology Advisory Committee (CBAC) has been mandated by the federal government to provide advice on this crucial issue. The CBAC published an interim report on the subject at the end of 2001 where it recommended that human beings at all stages of development, are not patentable.<sup>274</sup> Further, the report recommended that a systematic research program be undertaken to assess the impact of biotechnology patents on various aspects of health services. It is clearly an issue that deserves serious consideration, but is beyond the scope of this report.

## **12.7 Applying the Highest Standards of Ethics to Health Research**

The preceding sections have demonstrated Canada's growing excellence in, and high priority for, health research. However, history has shown that the pursuit of new knowledge in health research can lead, for example, to abuse of the people who are involved as the subjects of research, to invasions of privacy, and to abuse of animals. In various ways, numerous reports have emphasized that new knowledge must not be gained at the expense of abuse of humans and other life forms, and that excellence in health research requires excellence in ethics.

---

<sup>274</sup> Canadian Biotechnology Advisory Committee, *Biotechnology and intellectual property: patenting of higher life forms and related issues*, Interim report to the Government of Canada Biotechnology Ministerial Coordinating Committee, Ottawa, November 2001.

But what is ethics? Laura Shanner, Professor at the University of Alberta, told the Committee that “ethics” is a “systematic, reasoned attempt to understand and make the best possible decisions about matters of fundamental human importance.”<sup>275</sup> When we refer to ethical issues informed by biological knowledge in medicine, we refer to “bioethics.” Dr. Nuala Kenny, Professor of Pediatrics at Dalhousie University (Nova Scotia), defined bioethics as follows:

*Bioethics is a particular understanding of ethics that brings the discipline of philosophy to assist in making value-laden decisions. It is about the right and the good. It is a practical discipline. Bioethics is ethics in the realm of the biosphere, human biology. It is actually broader than human health, but most people use it in that context.*

*It asks how, in a pluralistic society, do you lay out the values, the issues and the interests at stake when making a decision about the right and the good, generally about an individual patient situation. Then, how do you assist the relevant parties in establishing some kind of priority, so that if there are competing goods or competing harms, you make your choices in a responsible way.*<sup>276</sup>

In many fields, difficult decisions often involve consideration of numerous factors, each implicating different – and often conflicting – values, principles, viewpoints, beliefs, expectations, fears, hopes, etc. When facing such difficult decisions, people may reach different conclusions not only because they consider different factors, but also because they weigh them against each other in different ways. The practical effect of the discipline of ethics is to help those who face complex decisions to identify the inherent values and principles, to weigh them against each other, and to come to the best possible decision. Though based on strong theoretical foundations, ethics in health care and health research deals with real life situations.

Because research seeks constantly to expand the forefront of knowledge, it poses the most challenging questions of ethics. The purpose of this section is to survey some of the major areas of research ethics in terms of the policies and mechanisms now present and/or needed in Canada, to ensure that health research is carried out in a manner that meets the ethical standards of Canadians.

### **12.7.1 Research involving human subjects**

Health research must involve humans as research subjects. While research with other life forms can provide much essential knowledge, in the end only research directly on human beings can tell us, for example, whether a potential new approach to prevention, diagnosis or treatment of disease is safe enough to use in humans, whether it actually helps patients, what its side effects are, and whether it is better than a treatment that is already available.

---

<sup>275</sup> Laura Shanner, *Ethical Theories in Bioethics and Health Law*, University of Alberta, Brief to the Committee, 2000, p. 1.

<sup>276</sup> Dr. Nuala Kenny (42:59-60).



Research subjects, often patients with diseases whose treatment is under study, bear the risks of the research so that others may gain from the knowledge that research is intended to provide. Research involving humans poses many risks: abuse of people, misuse, exploitation, breaches of privacy, confidentiality, etc. Because health research raises such a wide range of issues, an international consensus has developed over the last 50 years or so. This international consensus, which started with the Nuremberg Code (1947) and the Declaration of Helsinki (1964, revised in 2000), requires that the ethical aspects of any research project involving humans be reviewed and approved, with modifications if needed, by an appropriately constituted ethics committee (in Canada called “Research Ethics Board” or REB) before the research project is started.

***Research subjects, often patients with diseases whose treatment is under study, bear the risks of the research so that others may gain from the knowledge that research is intended to provide.***

The Research Ethics Board “is a societal mechanism to ensure the protection of research participants.”<sup>277</sup> REBs are multidisciplinary local institution-based boards, independent of the investigator and research sponsor, established to review the ethical standards of research projects within their institutions. They have the power to approve, reject, request modifications to, or terminate any proposed or ongoing research involving human subjects. In effect, the REB attests, for each research protocol, that the proposed research, if it is carried out in the manner agreed to by the REB, meets or exceeds standards of ethics that Canadians expect.

The dominant national policy for the ethics of research involving humans, the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS), was published by CIHR, the SSHRC and NSERC in 1998. The TCPS followed earlier policies (MRC, 1978, 1987, and SSHRC, 1976). The Panel and Secretariat on Research Ethics, launched in November 2001 by the three federal research funding agencies, are responsible for coordinating the evolution and interpretation of the TCPS. The objective is to keep the TCPS up-to-date in response to the rapidly evolving advances in knowledge, research and technology.

The *Tri-Council Policy Statement* has been adopted by academic institutions (where the majority of health research involving humans is carried out) and by some governmental departments and agencies, including the Department of National Defence (DND) and the National Research Council (NRC).

Health Canada is establishing its own Research Ethics Board, which will also use the TCPS, to assess the ethical acceptability of in-house research, research that is contracted to non-Health Canada researchers which requires ethical review and research applications to CIHR or other funding agencies. Health Canada has also adopted the International Conference on Harmonization (ICH) guidelines applying to clinical trials involving the participation of human subjects.<sup>278</sup>

---

<sup>277</sup> National Council on Ethics in Human Research, *Protecting Human Research Subjects: Case-Based Learning for Canadian Research Ethics Boards and Researchers*, Ottawa, 2000, p. 7.

<sup>278</sup> Despite the care taken by the three federal granting agencies and Health Canada in the international harmonization of guidelines applying to clinical trials involving human subjects, the Committee would like to be in no doubt that any Canadian participating in clinical trials from outside Canada be protected by ethical standards that are at least as stringent as those applying here.

Since the 1970s, in accord with national policies governing ethics in research involving humans, some 300 local REBs in Canada have been established in a variety of settings including universities, government laboratories, community organizations and teaching and community hospitals. In many teaching hospitals, at least 50% of the research protocols reviewed by REBs are clinical trials that are sponsored by industry for purposes of testing new pharmaceutical interventions in human health so as to meet the regulatory licensing requirements of Health Canada and the USA Food and Drug Administration. In addition, some company-based and private for-profit REBs have developed over the last few years to allow REB review of privately sponsored research outside academic institutions, and hence without access to local REBs. In Alberta, all physicians who are not covered by an institutional REB are required to use the REB of the Alberta College of Physicians and Surgeons. Newfoundland is moving towards establishing a single REB for all health research in the province.

In 1989, the National Council on Ethics in Human Research (NCEHR) was created by the MRC with the support of Health Canada and the Royal College of Physicians and Surgeons of Canada. NCEHR works to foster high ethical standards for the conduct of research involving humans across the country by offering advice on the implementation of the TCPS, primarily through educational activities and site visits to local REBs. NCEHR is now funded by CIHR, SSHRC, NSERC, Health Canada and the Royal College of Physicians and Surgeons.

### **12.7.2 Issues with respect to research involving human subjects<sup>279</sup>**

The *Tri-Council Policy Statement*, in effect Canada's national statement of policy for ethical conduct in health research involving humans, appears to be consistent with world standards. For the most part, REBs in Canada seem to operate to a high standard, building on more than two decades of experience and the dedication of many people across the country. However, the Committee learned that serious gaps have been identified in a number of reports released in recent years by NCEHR and CIHR, as well as by the Law Commission of Canada.<sup>280</sup> A summary of the main issues or gaps identified in these reports is presented below:

- Although the *Tri-Council Policy Statement* sets very high standards, there is currently no oversight mechanism to ensure compliance with these standards. On the one hand, there is no process of certification, accreditation or regular inspection of the research ethics review procedures performed by REBs. On the other hand, and though more REBs are starting to address this issue, few monitor the conduct of research once a research protocol has been approved.

---

<sup>279</sup> The following section does not deal with the ethical boundaries surrounding research into human reproductive health as federal legislation is expected to be tabled soon in the House of Commons. The Committee recognizes that this area is at the cutting edge of applied research and evolves rapidly. In our view, all research involving human reproductive material, human organisms derived from such material, other human cell lines, or part of any of them (including human genes) should be subject to full ethical review by REBs and application of the TCPS and other applicable legislation.

<sup>280</sup> More specifically, see the following four reports: 1) NCEHR (formerly National Council on Bioethics in Human Research or NCBHR), "Protecting and Promoting the Human Research Subject: A Review of the Function of Research Ethics Boards in Canadian Faculties of Medicine", *NCBHR Communiqué*, Volume 6 (1), 1995, pp 3-28; 2) Draft report of the Task Force established by the NCEHR to study models of accreditation for human research protection programs in Canada, September 28, 2001; 3) McDonald, Michael (Principal Investigator), *The Governance of Health Research Involving Human Subjects*, research sponsored by the Law Commission of Canada, Ottawa, May 2000; 4) Draft Report of the Task Force on Continuing Review, CIHR, 2001.

In other words, REBs often have limited knowledge of what happens after they have approved a research protocol.

- Some concerns were raised about real or perceived conflicts of interest by researchers or institutions. Though international consensus suggests that REBs would be established within research institutions, and that the work of REBs requires close collaboration with other institutional responsibilities, REBs must be able to operate free from institutional or researcher pressures.
- Similarly, a lack of public oversight of private REBs that act independently or through Contract Research Organizations hired by drug companies raises concerns about their independence and conflicts of interest.
- There is a basic need for more resources for REBs. As the work becomes increasingly complicated with globalization, technology and commercialization, REBs are struggling to find committee chairs or even members.
- There are currently no standard training requirements for Canadian REB members and researchers in research ethics. However, in the absence of similar Canadian standards, Canadian researchers must meet American educational standards for American funded health research involving human subjects.
- The current ethics review processes are “producer-driven” rather than “consumer-driven.” In other words, there is a lack of representative participation in governance on the part of research subjects.
- There is an urgent need for empirical research on the effects of health research on human subjects as well as on the effectiveness of the ethics governance procedures.

To sum up, the governance, transparency and accountability of the ethics review processes in Canada need to be improved:

*(...) we were surprised to see how substantial the gaps were between the ideals expressed in policy and the ground arrangements for accountability, effectiveness and the other criteria for good governance.<sup>281</sup>*

The Committee agrees with many reports that the central concern for Canada is the public accountability of the overall processes for assuring the ethics of research involving humans. We recognize the excellent work that has been done across Canada by dedicated people in many environments who have strived to ensure that health research involving human subjects meets the highest standards of ethics, and we are confident that the standards

***The Committee agrees with many reports that the central question for Canada is the public accountability of the overall processes for assuring the ethics of research involving humans.***

---

<sup>281</sup> Professor Michael MacDonald, Law Commission of Canada.

achieved in Canada are as good as any in the world. Indeed, the report released by the Law Commission of Canada stated:

*We are also very much impressed with the calibre of scholarly, ethics and legal expertise represented on many REBs. And, at a general level, Canadian scholars are prominent internationally in research regarding legal and ethical aspects of human subjects research.<sup>282</sup>*

However, the Committee believes that the present varied structures and approaches to health research ethics are inconsistent with the public accountability that an area of this importance requires. Accordingly, we urge the various leading stakeholders of health research involving human subjects to work

***We urge the various leading stakeholders of health research involving human subjects to work together to develop a governance system for health research involving human subjects that can meet the following objectives: the promotion of socially beneficial research; the protection of research participants; and the maintenance of trust between the research community and society as a whole.***

together to develop a governance system for health research involving human subjects that can meet the following objectives: the promotion of socially beneficial research; the protection of research participants; and the maintenance of trust between the research community and society as a whole.<sup>283</sup> This initiative should involve Health Canada, CIHR, other federal funding agencies, the Panel and Secretariat on Research Ethics, industrial research sponsors, research institutes, health professional licensing bodies and associations, NCEHR, the newly created Canadian Association of Research Ethics Boards, etc. Therefore, the Committee recommends:

**Health Canada initiate, in collaboration with stakeholders, the development of a joint governance system for health research involving human subjects for all research that the federal government performs, that it funds, and that it uses in its regulatory activities.**

**Health Canada, in the development of this ethics governance system, regard the following components as essential to progress:**

- **Work initially on all (health) research that the federal government performs, funds, or uses in its regulatory activities, to develop an effective and efficient system of governance that will become accepted as the standard of care across Canada;**

---

<sup>282</sup> *Ibid.*, p. 300.

<sup>283</sup> These objectives correspond to those that were identified in the McDonald report cited in the previous footnote.

- **Give prime importance in the governance system to effective education and training mechanisms for all who are involved in research and research ethics, with certification appropriate to their different responsibilities;**
- **Develop standards, based on the *Tri-Council Policy Statement*, the International Conference on Harmonization guidelines applying to clinical trials involving human subjects, and other relevant Canadian and foreign standards, against which research ethics functions or Research Ethics Boards can be accredited or certified as meeting the levels of function that are consistent with the expectations of Canadians and with those in other countries;**
- **Ensure that the *Tri-Council Policy Statement* is updated and is maintained at the forefront of international policies for the ethics or research involving humans;**
- **Remove inconsistencies between the various policies under which research involving humans is now governed, and make Canadian standards consistent with those of other countries that affect Canadian research;**
- **Establish an accreditation or certification process for research ethics functions that is at arm's length from government, but clearly accountable to government;**
- **Develop the governance system through open, transparent and meaningful consultation with stakeholders.**

### **12.7.3 Animals in research**

Because animals are biologically very similar to humans, animals are used in research to develop new biological knowledge that has a high chance of applicability to the human condition. However, because animals are not identical to humans, new knowledge that arises from research with animals must be tested in humans before it is applied to human health.

Ethical concerns about the use of animals by humanity, particularly their use in research, have been recognized since the 19<sup>th</sup> century, especially in England. In Canada, these concerns caused MRC and NRC to undertake studies leading in 1968 to the creation of the Canadian Council on Animal Care (CCAC). Currently, CCAC receives 87% of its \$1.2 million budget from CIHR and NSERC to cover CCAC services to the research institutions that they

fund. CCAC obtains the rest of its revenues from fees for service charged to governmental and private institutions.

CCAC awards the Certificate of Good Animal Practice<sup>®</sup> to institutions that it determines are in compliance with its standards. Compliance is determined through site visits by assessment panels. CIHR and NSERC make participation in the CCAC program mandatory for all those who wish to receive their research funding and inform institutions that they will withdraw funds from institutions that CCAC states are not in compliance with its standards. The CCAC reports that institutions generally comply with its recommendations.<sup>284</sup>

In its brief to the Committee, the Coalition for Biomedical Health Research stated that CCAC standards are recognized both nationally and internationally:

*(...) research that complies with CCAC guidelines and policies constitutes ethically sound and responsible activity.*

*(...) CCAC's nationally and internationally accepted standards (...) provide the needed balance between the protection of animals and the benefits that are gained by the use of animals in science.<sup>285</sup>*

The formal structure of the CCAC, along with its monitoring program, is regarded by many, in Canada and abroad, as an optimal model enabling it to work effectively at arm's length from and with government.<sup>286</sup> In addition, recent report suggested that such a model could be considered in the field of research involving human subjects. For example:

*An interesting model in Canada and one, which I think we need to look at seriously with regard to an accreditation process for human research, is the Canadian Council on Animal Care. (...) it now has remarkable credibility with international recognition. (...) It remains a very interesting and almost uniquely Canadian model. It has federal fiscal support and yet, functioning on its own, setting standards and having a very respected accreditation process for animal research.<sup>287</sup>*

The Committee acknowledges that CCAC performs a world class service to Canadians in a cost-effective manner. Though there is no doubt that some Canadians will disagree, mainly those who reject any use of animals in research, the Committee believes that the CCAC offers clear evidence that a very sensitive

***The Committee acknowledges that CCAC performs a world class service to Canadians at a remarkably low cost.***

<sup>284</sup> Louis-Nicolas Fortin and Thérèse Leroux, "Reflections on Monitoring Ethics Review of Research with Human Subjects in Canada", *NCEHR Communiqué*, Summer 1997.

<sup>285</sup> Coalition for Biomedical and Health Research, Brief to the Committee, p. 8.

<sup>286</sup> Sub-Committee on Ethics, *The Ethics Mandate of the Canadian Institutes of Health Research: Implementing a Transformative Vision*, Working Paper prepared for the Interim Governing Council of the CIHR, 10 November 1999, pp. 18-19.

<sup>287</sup> Dr. Henry Dinsdale, Speech to the National Workshop of the NCEHR, March 2001, p. 5.

area that requires minute by minute attention and care can be effectively managed by an approach based on:

- Belief, until proven wrong, that institutions and individuals are seeking to work in a manner that reflects the values of Canadians;
- A firm foundation in increasing awareness and training of individuals on issues and standards;
- An assessment approach that is based on internationally recognized standards and that leads to certification of facilities and processes, that involves experts and lay persons, and that operates in a collegial manner until the point when there is evidence of wrongdoing and failure to take the necessary corrective measures.

While not advocating simply copying CCAC's mechanisms into the challenge of governance of research involving humans, the Committee believes that much can be learned from CCAC's experience. The Committee, however, identifies a gap in the interactions between the CCAC and the federal government. Though numerous departments and agencies place themselves under CCAC's assessment program for research involving animals that is carried out in their own facilities, and CIHR and NSERC require compliance with CCAC's standards as a condition of receiving research funds, we believe that this is not enough. Therefore, we recommend that:

**All federal departments and agencies require compliance with the standards of the Canadian Council on Animal Care for:**

- **All research that is carried out in federal facilities, and**
- **All research that is funded by federal departments or agencies but performed outside federal facilities, and**
- **All research that is carried out without federal funding or facilities, but that is submitted to or used by the federal government for purposes of exercising its legislated functions.**

#### **12.7.4 Privacy of personal health information**

All personal information is precious to individuals, but information about personal health is probably the most sensitive to most people. Health information goes to a person's most intimate identity, not only because it directly affects the individual him or herself, but also because it can affect family members and others, as well as other aspects of the person's life, such as his/her employment or insurability.

The right to privacy and confidentiality of personal health information is a very important value for Canadians. Now more than ever, Canadians need reassurance that their privacy and confidentiality will be respected in this era of rapidly advancing technology. However, the quality of their health and health care is also a value that Canadians cherish very dearly. Health care providers, health care managers and health researchers need access to personal health information to improve the health of Canadians, strengthen health services and sustain a high quality health care system. The present challenge for Canadians is to set acceptable limits around the right to privacy, on the one hand, and the need for access to information (by health care providers, managers and researchers) on the other, in order to achieve an appropriate balance between them.

***The right to privacy and confidentiality of personal health information is a very important value for Canadians.***

The *Personal Information Protection and Electronic Documents Act* or PIPEDA, promulgated in June 2000, has stimulated intensive debate and study of this question in the past two years. The health sector had not recognized the potential effects of this legislation on health research and health care management until the legislative review of the Bill was well advanced through the House of Commons. Representatives from various parts of the health sector therefore intervened strongly in hearings before this Senate Committee in late 1999. Their testimony clearly demonstrated that the health sector was not part of the broad consensus supporting the bill, and also that there was no consensus within the health sector itself as to an appropriate solution to the issues about privacy of health information which are raised by the bill. As a result, the Committee concluded that there was a significant degree of uncertainty surrounding the application of PIPEDA to personal health information that required clarification. In response to the Committee's recommendation<sup>288</sup>, therefore, the federal government decided to delay the application of PIPEDA to personal health information until January 1, 2002. This delay would allow one extra year from the time of proclamation to motivate government and relevant stakeholders in the health sector to resolve these uncertainties and formulate a solution that is appropriate for the protection of personal health information.

The Committee is pleased that several groups in the health sector have seriously addressed many of the concerns raised by PIPEDA, and in particular, the need to protect personal health information, while at the same time allow restricted use of such information for essential purposes such as health research and health care management (which includes the provision, management, evaluation and quality assurance of health services).

Over the past two years, CIHR has undertaken a wide-range analysis of the privacy issues and initiated a broad consultation process with various stakeholders, culminating in recommendations for the interpretation and application of PIPEDA to health research.<sup>289</sup>

CIHR's recommendations set out precise legal wording in the form of proposed regulations under PIPEDA that, without changing the Act, would facilitate its interpretation and application in the area of health research. These recommendations were presented to the

---

<sup>288</sup> Second report of the Standing Senate Committee on Social Affairs, Science and Technology, 36<sup>th</sup> Parliament, 2<sup>nd</sup> Session, 6 December 1999.

<sup>289</sup> CIHR, *Recommendations for the Interpretation and Application of the Personal Information Protection and Electronic Documents Act in the Health Research Context*, 30 November 2001. CIHR's proposed regulations are available on the CIHR Website at [http://www.cihr.ca/about\\_cihr/ethics/recommendations\\_e.pdf](http://www.cihr.ca/about_cihr/ethics/recommendations_e.pdf).



Committee as the most realistic, short-term solution, recognizing that PIPEDA would not likely be amended before January 1, 2002. CIHR emphasizes that its proposed regulations, though significantly limited by the current wording of PIPEDA, could nevertheless provide the necessary guidance to help clarify certain ambiguous terms in a manner that will achieve the objectives of the Act without impeding vitally important research. CIHR is also of the view that regulations, as legally binding instruments, are necessary to enable researchers, and Canadians in general, to understand what the law expects of them and how to govern their conduct accordingly. Furthermore, such regulations could provide the necessary basis on which provinces and territories could develop substantially similar legislation before January 1, 2004, as provided for by PIPEDA.<sup>290</sup>

Finally, CIHR recognizes the need for further work with various stakeholders and the provinces to establish an overall, more coherent, comprehensive and harmonized legal or policy framework for the health sector. Ultimately, whatever law or policy governs this area needs to be interpreted and applied in a flexible and feasible manner, and users need to develop more detailed guidelines for promoting best information practices in their daily work.

The Committee has considered the regulations proposed by CIHR and we commend CIHR for its efforts in this regard. We fully support the intent of the proposed regulations. As stated in its Fourteenth Report dated December 14, 2001<sup>291</sup>, the Committee believes that these regulations should be given serious consideration and, therefore, we recommend that:

**Regulations such as those proposed by the Canadian Institutes of Health Research receive their fullest and fairest consideration in discussions about providing greater clarity and certainty of the law with the view to ensure that its objectives will be met without preventing important research to continue to better the health of Canadians and improve their health services.**

A second and parallel initiative was undertaken by a Privacy Working Group composed of representatives from the Canadian Dental Association, the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, and the Consumers Association of Canada. The Privacy Working Group addressed the need to access personal health information for the purposes of health care management. In a report submitted to Health Canada, the Privacy Working Group enunciated the following principles.<sup>292</sup>

- Confidentiality of information in health care delivery is of great importance to Canadians. Fear of disclosure to others of personal health information is

---

<sup>290</sup> Indeed, the Act gives provinces and territories until January 1, 2004, to develop substantially similar legislation.

<sup>291</sup> Standing Senate Committee on Social Affairs, Science and Technology, *Fourteenth Report*, 37<sup>th</sup> Parliament, 1<sup>st</sup> Session, 14 December 2001.

<sup>292</sup> Privacy Working Group, *Privacy Protection and Health Information: Understanding the Implementation Issues*, report submitted to Health Canada, December 2000.

likely to harm the trust that is essential in the relationship between patients and providers, and hence limits the willingness to seek care, or to impart information that is important to patient care.

- While an individual's right to privacy of personal health information is of great importance, it is not absolute. This right is subject to reasonable limits, prescribed by law, to appropriately balance the individual's right to privacy and societal needs, as can be reasonably justified in a free and democratic society.
- Individuals have the right to: privacy of their personal health information; decide whether and under what conditions they want such information collected, used or disclosed; know about and have access to their health records and ensure their accuracy; and have recourse when they suspect a breach of their privacy.
- In parallel, health care providers and organizations have obligations to: treat personal health information as confidential; safeguard privacy and confidentiality using appropriate security methods; use identifiable information only with the individual's consent except when the law requires disclosure or there is compelling evidence for societal good under strict conditions; restrict the collection, use and disclosure of personal health information to de-identified information, unless the need for identifiable information is demonstrated; and, implement policies, procedures and practices to achieve privacy protection.

When the Committee met in December 2001 to examine progress made with respect to the application of PIPEDA to health care, we were informed that, while the members of the Privacy Working Group agreed on many issues, they had not yet achieved a definitive and unified position. The Privacy Working Group was of the view that progress towards achieving consensus would require the active involvement and leadership of the federal government. The federal government, however, has taken the position that the concerns of the Privacy Working Group should be resolved between the members of the group and the Privacy Commissioner.

The Committee believes that further guidance and direction is needed in respect of the provision, management, evaluation and quality assurance of health services. For this purpose, constructive and collective efforts by *all* affected parties must be made to address the relevant issues, and government must lead by example. As stated in its 14<sup>th</sup> Report, the Committee recommends that:

**Discussions continue among stakeholders, the Privacy Commissioner, and those federal and provincial government departments involved with the provision, management, evaluation and quality assurance of health services.**

Like other Canadians, the members of the Committee place a very high priority on the protection of personal health information. Though protection of personal health information is understandably of very high importance, we must recognize what else is at risk if access is summarily rejected because of perceived threats to the privacy and confidentiality. Rather than give absolute status to the right to privacy, the Committee believes that Canadians must engage in a careful and thoughtful consideration of the reasons why personal information is needed for health research and health care management purposes, the social benefits that accrue to Canadians individually and collectively as a result, and the conditions that must be met before access is allowed. Because of its long-standing responsibility in funding health care and financing health research, the federal government should play a major role in promoting greater public awareness and facilitating greater debate in regard to these issues.

***The Committee believes that Canadians must engage in a careful and thoughtful consideration of the reasons why personal information is needed for health research and health care management purposes, the social benefits that accrue to Canadians individually and collectively as a result, and the conditions that must be met before access is allowed.***

CIHR's *Draft Case Studies Involving Secondary Use of Personal Information in Health Research* (December 2001) constitutes an excellent model for encouraging discussion and broader understanding through very concrete examples of real health research projects involving secondary use of personal information. Parallel efforts by others to develop similar case studies illustrating why and how personal information is used for health care management purposes would also be extremely valuable. In light of the above, the Committee recommends that:

**The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, design and implement a program of public awareness to foster in Canadians a broad understanding of:**

- **the nature of, and reasons for, the extensive databases containing personal health information that must be maintained to operate a publicly financed health care system, and**
- **the critical need to make secondary use of such databases for health research and health care management purposes.**

This being said, the Committee believes that if Canadians are to allow restricted access to personal health information for essential functions, such as health research and health care management, it is imperative that their personal health information be adequately protected. We wish to emphasize the importance of ensuring, all the while, that Canadians remain confident that the privacy of their personal health information is being respected. We see here, once again, a major federal role to promote a fulsome discussion of the relevant ethical issues

and examination of the control and review mechanisms necessary for ensuring that the secondary use of personal information for health care management and health research purposes is conducted in an open, transparent and accountable manner. Therefore, the Committee recommends that:

**The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, be responsible for promoting:**

- **thoughtful discussion and consideration of the ethical issues, particularly informed consent issues, involved in the secondary use of personal health information for health care management and health research purposes;**
- **thorough examination of the control and review mechanisms needed for ensuring that databases containing personal health information are effectively created, maintained and safeguarded and that their use for health care management and health research purposes is conducted in an open, transparent and accountable manner.**

### **12.7.5 Genetic privacy**

The discussion above has addressed issues of privacy of personal health information arising from databases from the existing health care system. The Committee recognizes that new technologies allowing analysis of genes is also introducing new considerations into the management of personal health information. The exploding abilities to link DNA sequences to disease offer the potential both to greatly increase the health care of the individual but also to intrude into the privacy of both the individual and his or her relatives. In addition, these technologies allow the prediction of diseases that have not yet become evident. However, a majority of these predictions represent increased probability of the incidence of the disease, the test being often statistical in nature (e.g., the likelihood is twice that of the general population) rather than absolute (as for Huntington's disease, for example).

The application of the new genetic technologies to human health is as yet in its infancy, but at least some of the potential benefits and harms are becoming evident. The concerns include the fear that access to genetic information on individuals might affect their employability or insurability.

***The Committee is pleased that interdepartmental discussions are underway within the federal government on this wide range of issues, and encourages their pursuit to provide guidance and advice on means of addressing these complex issues in the best interests of Canadians.***

The Committee is pleased that interdepartmental discussions are underway within the federal government on this wide range of issues, and encourages their pursuit to provide guidance and advice on means of addressing these complex issues in the best interests of Canadians.

### **12.7.6 Potential situations of conflict of interest**

Advances in human health often involve participation of researchers in academia, in government and in industry. The boundaries between these are becoming increasingly blurred, and much mutual trust and collaboration is required between them. For example:

- The large majority of published health research in Canada is done by researchers in academic institutions, who obtain funding from government, philanthropic and industrial sources.
- Academic researchers are increasingly entrepreneurial, and are the source of many start-up companies that are providing fast economic growth in the biological revolution.
- Industries obtain many of their ideas for new commercial entities, including new interventions in health, from academic research, and are starting to establish research centres in academia in exchange for right of first refusal on intellectual property.
- Government regulates health interventions, as well as contributing to knowledge through its in-house research. Regulations depend on research carried out by industry, often in academic institutions, which is assessed by governmental scientists, who may call on academic scientists for advice and other assistance.

The potential for conflicts of interest are obvious, as are the concerns that, for example, industrial interests in protecting intellectual property and commercial interests might adversely affect the performance or publication of research carried out in public institutions or with public funds. Media attention has rightly focused on instances when these fears appear to have been realised.

The Committee acknowledges that industrial research is an essential component of health research and health care. In fact, our growing abilities to promote health and to prevent, diagnose or treat disease are very largely due to industry. In addition, despite a number of publicized cases with evidence of conflict of interest, the Committee is of the view that the majority of industry works to high standards of ethics, fully consistent with the expectations of Canadians. Indeed, companies cannot expect to survive in today's world if they flout society's expectations.

***The Committee is of the view that the majority of industry works to high standards of ethics, fully consistent with the expectations of Canadians. Indeed, companies cannot expect to survive in today's world if they flout society's expectations.***

However, the Committee understands that the growing role of industry in Canada's health research spectrum, particularly in clinical trials, is a cause for concern. This was highlighted in a recent editorial by the International Committee on Medical Journal Editors, which laid out the ground rules for avoiding conflict of interest in publications.<sup>293</sup> In particular, there is a need to find an appropriate balance between clinical research performed in the academic sector, the ability to compare different treatments for the same disease, the focus of research on diseases in which profits are most likely, (e.g., diseases of wealthy as opposed to poor nations), the publication of negative results (e.g., the need for a registry of all clinical trials), and related areas.

The Committee welcomes the work of CIHR in expanding the collaborative health research programs between academic and industrial research through the University-Industry Program and the CIHR/Rx&D<sup>294</sup> Program. We understand that CIHR partnerships with industry need to be encouraged. However, there is a need to consider whether explicit guidelines should be developed; these guidelines could assist in determining the impact of ethically problematic areas in CIHR's relations with industry. We have learned that CIHR has set up a working group to study this issue. Therefore, the Committee recommends that:

**The Canadian Institutes of Health Research, in partnership with industry and other stakeholders, continue to explore the ethical aspects of the interface between the sectors with a view to ensuring that the collaborations and partnerships function in the best interests of all Canadians.**

---

<sup>293</sup> See *Canadian Medical Association Journal*, 18 September 2001, Vol. 165, pp. 786-788.

<sup>294</sup> Partnership between CIHR and Canada's Research-Based Pharmaceutical Companies.

**Part VI:  
Health Promotion and  
Disease Prevention**

---





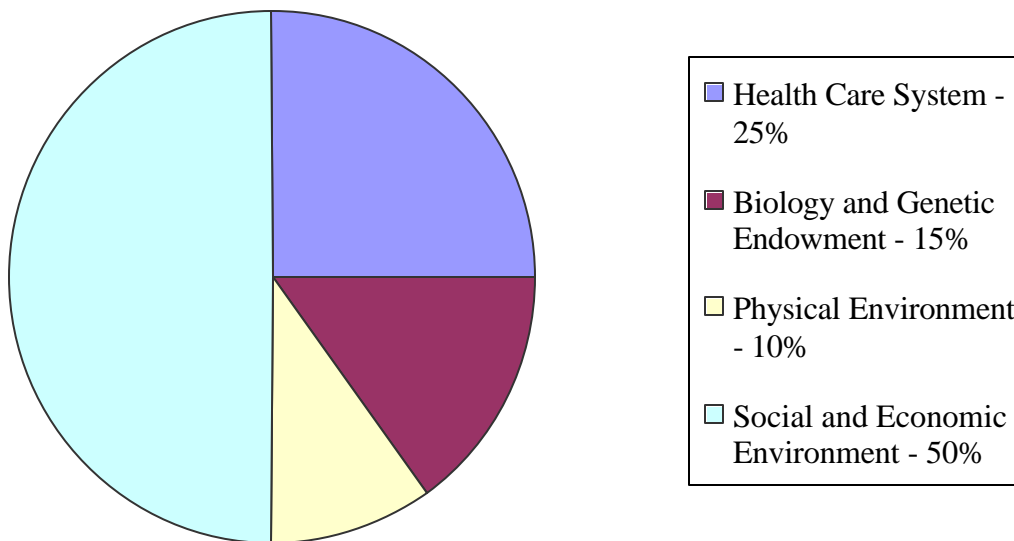
## CHAPTER THIRTEEN

### **HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE**

---

As the Committee has noted in Volume One, it is clear that the health care system is an important contributor to good health. Services as widely varied as childhood immunization, medications to reduce high blood pressure or prevent asthma, and heart surgery all contribute to health and well-being. In fact, the Canadian Institute for Advanced Research estimates that 25% of the health of the population is attributable to the health care system alone (see Chart 13.1).<sup>295</sup> Obviously, it is important that the health care sector is fiscally sustainable and continually strives to provide timely services of high quality. Many of the recommendations made by the Committee in this report are designed specifically to achieve sustainability, timeliness, quality and efficiency in health care delivery, all with the objective of improving the health and well-being of Canadians.

**CHART 13.1**  
**ESTIMATED IMPACT OF DETERMINANTS OF HEALTH ON THE**  
**HEALTH STATUS OF THE POPULATION**



Source: Estimation by the Canadian Institute for Advanced Research, Graph available on Health Canada's Website.

---

<sup>295</sup> Volume One, p. 81.

The remaining 75% of the health of the Canadian population is determined by a multiplicity of factors outside the health care system. These factors, which are often referred to as the “non-medical determinants of health,” include: biology and genetic endowment; income and social support; education and literacy; employment and working conditions; physical environment; personal health practices and skills; early childhood development; gender; and culture.

Throughout its study, the Committee was told repeatedly that, to maintain and improve health status, governments should, in addition to sustaining a good health care system, develop public policies and programs that address these non-medical determinants of health. Such policies and programs encompass a wide spectrum of interrelated activities, ranging from health and wellness promotion, through illness and injury prevention and public health and health protection, to broader population health strategies. These are all components of a healthy public policy:

- **Health and Wellness Promotion:** these activities are designed to encourage Canadians to take a more active role in improving their health through, for example, exercise and healthy food and lifestyle choices.
- **Illness and Injury Prevention:** consists of activities directed toward decreasing the probability of individuals, families and communities contracting specific diseases and injuries. Prevention activities seek to reduce unwanted health outcomes by reducing or eliminating associated risk factors. Immunization, early detection of disease through screening programs and reduction of exposure to potentially injurious activities (use of seat belts in the car, fences around pools, safer roads, etc.) are examples of illness and injury prevention.
- **Public Health and Health Protection:** are intended to protect the health of Canadians against current and emerging health threats. This includes the surveillance and control of disease outbreaks and trends (in both infectious and chronic illnesses) and the monitoring of safety and effectiveness of a variety of products (such as food, drugs and medical devices), as well as environmental health assessments.
- **Population Health Strategies:** include a wide range of government policies and programs that can influence income redistribution, access to education, housing, water quality, workplace safety, and so on – all major determinants of the health of a population.
- **Healthy Public Policy:** is a concept that encompasses health and wellness promotion, disease and injury prevention, public health and health protection, as well as population health. Under a healthy public policy strategy, every major action, program and policy of government is evaluated in terms of its implications for the health of Canadians. Healthy public policy requires an intersectoral approach – one that engages the several sectors that are responsible for, or affect, each of the determinants of health.

There is increasing evidence that investing more human and financial resources in promotion, prevention, protection and population health can significantly improve the health

outcomes for a given population. In the end, this can reduce the demand for health services and the pressures on the publicly funded health care system.

The Committee was told and is aware, however, that promotion, prevention, protection and population health activities do not claim anything like the close focus and high status that health care has in the eyes of the Canadian public and, obviously, public policy decision makers. Although it is clear that, collectively, the non-medical determinants of health have far greater impact on the health of the population than health care, the fact is that the very positive outcomes from promotion, prevention, protection and population health activities are generally visible only over the longer term, and thus they are less newsworthy. Because they are less likely to capture the attention of the general public, they are less attractive politically.

The Committee believes that there are enormous potential benefits to be derived from health and wellness promotion, disease and injury prevention, public health and health protection and population health strategies, measured primarily in terms of improving the health of Canadians, but also in terms of their positive long-term financial impact on the health care system.

***The Committee believes that there are enormous potential benefits to be derived from health and wellness promotion, disease and injury prevention, public health and health protection and population health strategies, measured primarily in terms of improving the health of Canadians, but also in terms of their positive long-term financial impact on the health care system.***

The focus on wellness was recently addressed by the Government of Newfoundland and Labrador in its five-year strategic health plan. The first goal of this plan incorporates a wellness strategy built on health promotion, illness and injury prevention, health protection and early child development.<sup>296</sup> The Committee applauds such initiative.

The Committee strongly supports the opinion of many witnesses that additional funding in these fields is essential for Canada to develop healthy public policies that focus on improving the health and well-being of the population, rather than concentrating only on curing people when they get sick. Moreover, the Committee believes that the federal government can and must play a leadership role in this area.

In this chapter, the Committee sets out its findings and recommendations with respect to the role of the federal government in promoting healthy public policies. Section 13.1 provides information on trends in disease and injury in Canada. Section 13.2 presents data on the economic burden of disease and injury. Section 13.3 discusses the need for a national chronic disease prevention strategy. Section 13.4 examines the concerns raised with respect to public health, health protection and health and wellness promotion. Section 13.5 discusses the broader context of the determinants of health, and highlights the possibilities of moving toward healthy public policy in Canada.

---

<sup>296</sup> Minister of Health and Community Services, *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador*, September 2002 ([www.gov.nf.ca/health/strategichealthplan](http://www.gov.nf.ca/health/strategichealthplan)).

### 13.1 Trends in Diseases<sup>297</sup>

During the twentieth century, the application of new knowledge and technology in two key areas – public health (through the provision of clean water and sanitation) and health care – has significantly altered the pattern of disease. The causes of mortality have shifted away from acute, infectious diseases to non-communicable (chronic) diseases (see Table 13.1).

Chronic diseases, such as cancer and cardiovascular disease, are now the leading causes of death and disability in Canada, with accidental injuries the third most common. However, some infectious diseases once thought conquered – such as tuberculosis – are re-emerging as the infectious agents that cause them have developed resistance to antibiotics. Rapid international transport of foods and people also increases the opportunities for the spread of infectious diseases.

**TABLE 13.1**  
**LEADING CAUSES OF DEATH (AGE-STANDARDIZED)**  
**RATE PER 100,000**

<b>1921-25</b>	
Cardiovascular and renal disease	221.9
Influenza, bronchitis and pneumonia	141.1
Diseases of early infancy	111.0
Tuberculosis	85.1
Cancer	75.9
Gastritis, duodenitis, enteritis and colitis	72.2
Accidents	51.5
Communicable diseases	47.1
<b>All causes</b>	<b>1,030.0</b>
<b>1996-97</b>	
Cardiovascular diseases (heart disease and stroke)	240.2
Cancer	184.8
Chronic obstructive pulmonary diseases	28.4
Unintentional injuries	27.7
Pneumonia and influenza	22.1
Diabetes mellitus	16.7
Hereditary/degenerative diseases of the central nervous system	14.7
Diseases of the arteries, arterioles and capillaries	14.3
<b>All causes</b>	<b>654.4</b>

Source: Susan Crompton, "100 Years of Health", *Canadian Social Trends*, Statistics Canada, Catalogue 11-008, No. 59, Winter 2000, p. 13.

<sup>297</sup> Most of the information contained in this section can be found in Volume Two, Chapter Four, "Disease Trends", pp. 45-55.

### 13.1.1 Infectious diseases

In the early 1920s, heart and kidney diseases were the leading causes of death, followed by influenza, bronchitis and pneumonia, and diseases of early infancy. Tuberculosis took more lives than cancer. Intestinal illnesses such as gastritis, enteritis and colitis, and communicable diseases such as diphtheria, measles, whooping cough and scarlet fever, were also common causes of death.

Public health programs, combined with the large-scale introduction of vaccines and antibiotics, have led to a major shift in the pattern of diseases, with a move away from infectious diseases to chronic diseases. Many infectious diseases persist, however. Indeed, Dr. Paul Gully, Director General at the Centre for Infectious Disease Prevention and Control (Health Canada), told the Committee that the death rate from infectious diseases in Canada has increased since 1980.<sup>298</sup> He pointed to seven infectious disease trends that, in his view, threaten Canadians:

- Many infectious diseases, such as AIDS and hepatitis C, persist;
- There are new and emerging infectious disease threats, including mad cow disease and *E. coli*, as well as the West Nile Virus;
- Global travel and migration can quickly introduce new diseases into the population;
- Environmental changes, such as global warming, deforestation, and tainted water, may increase the spread of infections;
- Behavioural changes, particularly high-risk sexual practices and drug use, can foster the spread of HIV and other infectious diseases;
- Public resistance to immunization could cause a resurgence in, for example, polio and measles;
- Anti-microbial resistance in infectious organisms may reduce the effectiveness of traditional curative measures, such as antibiotics.<sup>299</sup>

### 13.1.2 Chronic diseases

According to the National Population Health Survey, in 1998-1999, more than half of all Canadians, or 16 million people, reported suffering from a chronic condition. The most common were allergies, asthma, arthritis, back problems, and high blood pressure.<sup>300</sup>

Cardiovascular disease is the leading cause of death in Canada, accounting for 37% of all deaths. Mortality from cardiovascular disease has been declining in Canada since 1970 among both men and women, although more slowly in women. Cancer in its major forms

---

<sup>298</sup> Dr. Paul Gully, Brief to the Committee, 4 April 2001, p. 2.

<sup>299</sup> Dr. Paul Gully, *op. cit.*, p. 5.

<sup>300</sup> Dr. Christina Mills, Brief to the Committee, 4 April 2001, p. 4.

is the second-leading cause of death and is the leading cause of potential years of life lost<sup>301</sup> before age 70 (accounting for over one-third of all potential years of life lost). Cancer is primarily a disease of older Canadians; 70% of new cancer cases and 83% of deaths due to cancer occur among those who are 60 or older. Death rates from cancer have declined slowly for men since 1990, but have remained relatively stable among women over the same period. However, lung cancer rates for women are now four times higher than they were in 1971.

### **13.1.3 Injury**

In 1995-1996, injuries accounted for 217,000 hospital admissions in Canada. By far the highest rates of hospital admissions due to injuries were among Canadians over the age of 65. Falls remain an important cause of injury among seniors and children under 12. Among children, poisoning was the next most important cause of injury-related admission to hospital in 1996. For adolescents and adults under the age of 65, motor vehicle accidents constituted the second most important cause. The vast majority of injuries are accidental (about 66%).<sup>302</sup>

### **13.1.4 Mental health**

The National Population Health Survey of 1994-1995 found that approximately 29% of Canadians experienced a high level of stress; 6% of Canadians felt depressed; 16% of Canadians reported that their lives were adversely affected by stress; and 9% had some cognitive impairment such as difficulties thinking and remembering. Work prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health estimated that about 3% of Canadians suffer from severe and chronic mental disorders that can cause serious functional limitations and social and economic impairment, such as bipolar personality and schizophrenia. This translates into approximately one in every 35 Canadians over 15 years of age.<sup>303</sup>

Mental stress and disorders leading to mental illness can strike at different periods in life. Autism, behavioural problems and attention deficit disorder most commonly affect children. Adolescence is the typical onset of eating disorders and schizophrenia. Adulthood is a time when depression may manifest itself more obviously. Senior years are marred by Alzheimer's and other forms of dementia, although depression is also often identified in the elderly.

Because of the importance of mental health among Canadians, the Committee will hold specific hearings and table a separate report to present its findings and recommendations to the federal government.

---

<sup>301</sup> The internationally recognized indicator of "potential years of life lost" refers to the number of years of life lost when a person dies before a specified age, say age 75. A person dying at age 25, for example, has lost 50 years of life.

<sup>302</sup> Federal/Provincial/Territorial Advisory Committee on Population Health, *Toward a Healthy Future – Second Report on the Health of Canadians*, Ottawa, 1999, p. 19.

<sup>303</sup> Kimberly McEwan and Elliot Goldner, *Accountability and Performance Indicators for Mental Health Services and Supports: A Resource Kit*, prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Ottawa, 2000, p. 30.

### 13.2 The Economic Burden of Illness

The only available estimates on the economic burden of illness and injury in Canada were published in 1997 by Health Canada; they apply to 1993. That year, the total cost of illness and injury was estimated to be \$156.9 billion, or 22% of GDP. Direct costs (such as hospital care, physician services and health research) amounted to \$71.7 billion, while indirect costs (such as lost productivity) accounted for \$85.1 billion.

As Table 13.2 shows, the diagnostic categories with the highest total costs were cardiovascular diseases (\$19.7 billion or 15.3% of total costs), musculoskeletal diseases (\$17.8 billion or 13.8%), injuries (\$14.3 billion or 11.1%), cancer (\$13.1 billion or 10.1%), respiratory diseases (\$12.2 billion or 9.4%), diseases of the nervous system (\$9.6 billion or 7.4%), and mental illness (\$7.8 billion or 6%). Infectious diseases accounted for 2.0% of the total economic burden of illness (\$2.6 billion).

**TABLE 13.2**  
**ECONOMIC BURDEN OF ILLNESS BY DIAGNOSTIC CATEGORY, 1993**  
**(IN MILLIONS OF DOLLARS)**

	DIRECT COSTS <sup>1</sup>		INDIRECT COSTS		TOTAL COST	
	Percent	Cost	Percent	Cost	Percent	Cost
Infectious/Parasitic	1.8	786	2.2	1,857	2.0	2,643
Cancer	7.3	3,222	11.6	9,845	10.1	13,067
Endocrine/Related	3.0	1,334	2.5	2,086	2.6	3,419
Blood Diseases	0.6	274	0.2	173	0.3	447
Mental Disorders	11.4	5,051	3.3	2,787	6.1	7,839
Nervous System/Sense	5.1	2,252	8.6	7,321	7.4	9,573
Cardiovascular	16.7	7,354	14.5	12,368	15.3	19,722
Respiratory	8.6	3,787	9.9	8,393	9.4	12,181
Digestive	7.5	3,326	3.4	2,920	4.8	6,247
Genitourinary	5.1	2,248	0.9	786	2.3	3,034
Pregnancy	4.6	2,025	0.8	690	2.1	2,715
Skin/Related	2.0	892	0.1	122	0.8	1,014
Musculoskeletal	5.6	2,460	18.0	15,328	13.8	17,788
Birth Defects	0.7	305	0.4	334	0.5	639
Perinatal Conditions	1.2	551	0.4	332	0.7	883
Ill-defined Conditions	4.2	1,851	3.0	2,517	3.4	4,368
Injuries	7.1	3,122	13.2	11,222	11.1	14,343
Well-Patient Care	6.2	2,741	0.0	0	2.1	2,741
Other	1.2	549	7.1	6,040	5.1	6,589
<b>TOTAL</b>	<b>100.0</b>	<b>44,130</b>	<b>100.0</b>	<b>85,123</b>	<b>100.0</b>	<b>129,253</b>

A total of \$27.6 billion in direct costs were not classifiable by diagnostic category.

Source: Laboratory Centre for Disease Control (Health Canada), *Economic Burden of Illness in Canada, 1993*. 1997, pp. 10-11.

### 13.3 The Need for a National Chronic Disease Prevention Strategy

These statistics suggest that chronic diseases are not only the leading cause of death and disability in Canada but account for the largest proportion of the economic burden of illness. Moreover, information given to the Committee indicates that about two-thirds of total deaths in Canada are due to the following chronic diseases: cardiovascular disease (heart and stroke), cancer, chronic obstructive lung disease (bronchitis and emphysema) and diabetes.<sup>304</sup> More specifically:

- Cardiovascular diseases, including coronary artery disease and stroke, are responsible for 38% of all deaths among Canadians each year, and are one of the leading reasons for hospitalization.
- Cancer is the second most important cause of death in Canada, responsible for 29% of all deaths each year, and accounting for almost one third of potential years of life lost.
- Chronic obstructive lung disease is the fifth most common cause of death in Canada and is the only cause of death that is increasing in prevalence. Asthma is the most common chronic respiratory disease of children; it is the leading cause of hospital admission and school absenteeism among children in Canada.
- Over one million Canadians live with diabetes. It is a major cause of coronary heart disease and a leading cause of blindness and limb amputations. Among Aboriginal Canadians, the prevalence of diabetes is three times as high as among other Canadians. In total, diabetes accounts annually for about 25,000 potential years of life lost.

During its study, the Committee was told repeatedly that most chronic diseases are entirely preventable. Moreover, a report prepared by Terrence Sullivan, Vice President and Head, Division of Preventive Oncology, Cancer Care Ontario, indicates that many chronic diseases – particularly cardiovascular disease, cancer, chronic obstructive lung disease and diabetes – share common causes. More specifically, poor diet, lack of exercise, smoking, stress and excessive alcohol intake – all lifestyle issues – are recognized as the leading social/behavioural risk factors for these diseases. These risk factors are also often associated with other physical and physiological states that elevate the risk of chronic disease – including overweight/obesity, high blood pressure/hypertension, high blood cholesterol/hypercholesterolemia, and glucose intolerance/diabetes.<sup>305</sup> If reduced or eliminated, these common lifestyle risk factors would greatly lessen the prevalence and economic burden of these chronic diseases.

The fact that the vast majority of Canadians are exposed to one or more of these common risk factors<sup>306</sup> suggests that the overall health status of the population could be

---

<sup>304</sup> Advisory Committee on Population Health, *Advancing Integrated Prevention Strategies in Canada: An Approach to Reducing the Burden of Chronic Diseases*, Discussion Paper, 10 June 2002.

<sup>305</sup> Terrence Sullivan, *Preventing Chronic Disease and Promoting Public Health: An Agenda for Health System Reform*, August 2002.

<sup>306</sup> An analysis from the 2000 Canadian Community Health Survey indicated that 65% of Canadians showed more than one risk factor for chronic disease.



substantially improved by a stronger focus on chronic disease prevention, in parallel with controlling infectious diseases. In recognition of this fact and the potential for joint action, major national health organizations (Canadian Cancer Society, Canadian Diabetes Association, Heart and Stroke Foundation of Canada, Canadian Council for Tobacco Control, Coalition for Active Living, and Dieticians of Canada) have recently come together with Health Canada to form the Chronic Disease Prevention Alliance of Canada (CDPAC).

In addition to this new strategic alliance, there are also several important nation-wide chronic disease initiatives, such as: the Canadian Diabetes Strategy, Canadian Heart Health Initiative, Canadian Cardiovascular Disease Action Plan, Canadian Strategy for Cancer Control, and many other federal/provincial/territorial joint initiatives.

However, the Committee was told that there is a need to integrate, coordinate and strengthen all these diverse initiatives into a national chronic disease prevention strategy. According to Sullivan, Canada should build from the knowledge, success and failure of the existing initiatives to push the agenda forward with renewed vigour.<sup>307</sup>

In addition to better integration of the various current initiatives, there is a need for:

- Increased federal leadership, including political leadership and sustained financial and human resources.
- Development of a common vision across all the major chronic disease organizations, leading to a set of specific goals and objectives.
- Partnerships with the provinces/territories and stakeholders in private sector and non-government organizations.
- Surveillance systems for chronic disease and associated risk factors that will also track progress toward the attainment of strategic goals.
- Greater investment in prevention initiatives that are tailored to regional differences.

The national chronic disease prevention strategy should incorporate a combination of public education efforts, mass media programs and policy interventions. These interventions should be implemented through multiple settings (primary health care, education system, workplace, community) and address the need of various priority populations (e.g., Aboriginal Canadians, rural communities, women, etc.).

The direct benefits of a national chronic disease prevention strategy would be substantial, encompassing the avoidance of unnecessary premature disease, enhanced population health status, improved productivity and reduced health care costs. Estimates are that over a ten year period the decreased health care costs resulting from reduced utilization of hospital and doctor services could be as much as 10%.<sup>308</sup>

---

<sup>307</sup> Terrence Sullivan, *op. cit.*, p. 7.

<sup>308</sup> Terrence Sullivan, *op. cit.*, p. 10.

The Committee agrees with many witnesses that now is the time for the federal government to lead a national initiative to reduce the prevalence and economic burden of chronic disease in Canada. In our view, the federal government is particularly well suited to assume such leadership, given its long-standing role in health promotion and disease prevention and its legislative authority with respect to health surveillance and health protection.

A national chronic disease prevention strategy will improve the health of Canadians and contribute to the sustainability of the publicly funded health care system. The Committee believes that the Chronic Disease Prevention Alliance of Canada can assist with the design and implementation of this strategy.

While we feel that the federal government must act as a leader, it is important to collaborate with provincial/territorial governments, the private sector, and voluntary health sector partners – if we are to effect the needed changes. Therefore, the Committee recommends that:

***The Committee agrees with many witnesses that now is the time for the federal government to lead a national initiative to reduce the prevalence and economic burden of chronic disease in Canada. In our view, the federal government is particularly well-suited to assume such leadership, given its longstanding role in health promotion and disease prevention and its legislative authority with respect to health surveillance and health protection.***

**The federal government, in collaboration with the provinces and territories and in consultation with major stakeholders (including the Chronic Disease Prevention Alliance of Canada), implement a National Chronic Disease Prevention Strategy.**

**The National Chronic Disease Prevention Strategy build on current initiatives through better integration and coordination.**

**The federal government contribute \$125 million annually to the National Chronic Disease Prevention Strategy.**

**Specific goals and objectives should be set under the National Chronic Disease Prevention Strategy. The outcomes of the strategy should be evaluated against these goals and objectives on a regular basis.**

### **13.4 Strengthening Public Health and Health Promotion**

A report produced for the Committee by Dr. Joseph Losos, Director of the Institute of Population Health (University of Ottawa), states that public health/health protection often functions silently as the sentinel for health – through monitoring, testing, analyzing, intervening, informing, promoting and preventing – until something happens unexpectedly. In such instances (such as: Walkerton, food-borne outbreaks, infectious disease outbreaks, increasing chronic disease clusters), the crisis and profile of public health incidents quickly reach major proportions. Perhaps most important, often this occurs at a great cost in human suffering, possibly death and financial expense for often preventable occurrences.<sup>309</sup>

According to the *Canadian Medical Association Journal*, a major problem with public health interventions is that funding is low, often unstable or inconsistent. The result is that the public health care infrastructure in Canada is under considerable stress.<sup>310</sup>

Another major barrier to effective public health is fragmentation: all provinces and territories have separate public health legislation. The federal government also has direct statutory responsibilities for regulatory aspects of public health (e.g., disease surveillance, food and drugs, devices, biologics, some environmental health, consumer products). This welter of regulatory authority results in complex negotiations among the various “players” and less than optimal coordinated activity. Such fragmentation limits the effectiveness of public health efforts and results in a lack of clear accountability and leadership. In the view of many experts, there is an immediate need for strong federal leadership to rectify this unhappy and less-than-productive situation.<sup>311</sup>

Similarly, government funding for health promotion is very low relative to spending on health care. In addition, health promotion is practised both by governments and non-government organizations. While most of these efforts have proven effective, their fragmentation has resulted in a poorly coordinated or integrated health promotion infrastructure. More important, no health goals have been set nationally for health promotion as there have been in the United States.<sup>312</sup>

The Committee believes strongly that programs and policies with respect to public health, health protection and health and wellness promotion are critical to enhancing the health of Canadians. We believe that a coordinated and integrated approach is needed and that, once again, the federal government can and should play a leadership role. We believe also that more funding is needed in this area. Given its statutory authority with respect to health protection and its long-standing role in health promotion, the federal government should devote more funding to health protection and promotion. Therefore, the Committee recommends that:

**The federal government ensure strong leadership and provide additional funding to sustain, better coordinate and**

---

<sup>309</sup> Dr. Joseph Losos, *Promotion and Protection of the Health and Wellbeing of the Population – Vision of Federal/National Roles*, 4 September 2002, p.1.

<sup>310</sup> “Public Health on the Ropes”, Editorial, and Richard Schabas, “Public Health: What is to be done?”, *Canadian Medical Association Journal*, Vol. 166, No. 10, 14 May 2002.

<sup>311</sup> Dr. Losos, *op. cit.*

<sup>312</sup> Dr. Losos, *op. cit.*, p. 1.

**integrate the public health infrastructure in Canada as well as relevant health promotion efforts. An amount of \$200 million in additional federal funding should be devoted to this very important undertaking.**

### **13.5 Toward Healthy Public Policy: The Need for Population Health Strategies**

As described above, the term “population health” is used to describe the multiplicity and range of factors that all contribute to health. These many factors encompass both the medical and the non-medical determinants of health. The concept of population health is not new. Indeed, for almost 30 years, Canada has played a leading role worldwide in elaborating the concept of population health:

- In 1974, the then federal Minister of Health, Marc Lalonde, released a working document entitled *A New Perspective on the Health of Canadians*. This report stressed that a high quality health care system was only one component of a healthy public policy, which should take into account human biology (research), lifestyle and the physical, social and economic environments. The Lalonde report was extremely influential in shaping broader approaches to health both in Canada and internationally. At the federal level, it led, among other things, to a variety of social marketing campaigns such as ParticipAction, Dialogue on Drinking, and the Canada Food Guide.
- In 1986, the report *Achieving Health for All*, released by the then federal Minister of Health, Jake Epp, led to the initiatives related to Canada’s Drug Strategy, the Heart Health Initiative, Healthy Communities, the National AIDS Strategy, etc.
- In 1989, the Canadian Institute for Advanced Research (CIAR), then headed by Dr. Fraser Mustard, proposed that the determinants of health do not work in isolation but that it is the complex interaction among determinants that can have the most significant effect on health. This work, along with more recent findings by Dr. Mustard, has, among other things, led to the development of the joint federal and provincial/territorial initiative on early childhood development.
- In 1994, the population health approach was officially endorsed by the federal, provincial and territorial Ministers of Health in a report entitled *Strategies for Population Health: Investing in the Health of Canadians*.
- In September 2000, all Ministers of Health agreed to give priority to action on the broader, underlying conditions that make Canadians healthy or unhealthy.

There is increasing evidence on the impact of the determinants of health on the health status of Canadians, particularly with respect to the socio-economic determinants. For example, the *Second Report on the Health of Canadians*<sup>313</sup> pointed out that:

- Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes;
- Large disparities in income distribution lead to increases in social problems and poorer health among the population as a whole;
- Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy;
- Canadians with high levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier food;
- Studies in neurobiology have confirmed that experiences from conception to age 6 have the greatest influence of any time in the life cycle on the connecting and conditioning of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health right throughout the lifespan;
- Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning are particularly important in maintaining health and cognitive capacity in old age;
- Despite reductions in infant mortality rates, improvements in education levels, and reductions in substance abuse in many Aboriginal communities, First Nations and Inuit people remain at higher risk than the Canadian population as a whole for illness and early death;
- Men are more likely to die prematurely than women, largely as a result of heart disease, fatal accidental injuries, cancer and suicide. Women are more likely to suffer from depression, stress, chronic conditions, and injuries and deaths resulting from family violence;
- Older Canadians are far more likely than younger Canadians to have physical illnesses, but young people report the lowest levels of psychological well-being.

Despite the available evidence, no jurisdiction in Canada and no country in the world has designed and implemented programs and policies firmly based on a population health approach. The fact is that there remain significant practical obstacles to the design of concrete programs that can be sustained over the long haul.

In the first place, the multiplicity of factors that influence health status means that it is extremely difficult to associate cause and effect, especially since the effects of a given

---

<sup>313</sup> Federal/Provincial/Territorial Advisory Committee on Population Health, *Toward a Healthy Future - Second Report on the Health of Canadians*, Ottawa, 1999.

intervention are often obvious only after many years. Because political horizons are often of a shorter-term nature, the long timeframe for judging the impact of policy in this area can be a serious disincentive to the elaboration and implementation of population health strategies.

Furthermore, it is very difficult to coordinate government activity across the diverse factors that influence health status. The structure of most governments does not easily lend itself to inter-ministerial responsibility for tackling complex problems. This difficulty is compounded several times over when various levels of governments, together with many non-governmental players, are taken into account, as they must be if population health strategies are to be truly effective.

Although many difficulties are associated with developing an effective population health approach, the Committee believes it is important for Canada to continue to strive to set an example by exploring innovative ways to turn good theory into sound practice that will contribute to improving the population's health status.

Moreover, the Committee believes, along with many witnesses, that, given its clear responsibility for so many policies and programs that affect health (health, environment, agriculture, finance, etc.), the federal government should lead the way in population health by coordinating the activities of the different departments concerned. Along with Dr. Losos, we believe the best coordinator would be the federal Minister of Health. As a first step, all policies and programs established by the federal government should be assessed in terms of their impact on the health status of Canadians. Health impact assessment should become a routine component of all new public policies and programs at the federal level.<sup>314</sup>

***The Committee believes, along with many witnesses, that given its clear responsibility for so many policies and programs that impact on health (health, environment, agriculture, finance, etc.), the federal government should lead the way in population health by coordinating the activities of the different concerned departments.***

Ideally, the Ministers of Health in all Canadian jurisdictions would take on the role of “champions for population health” and advocate health as the major consideration in all initiatives, irrespective of sector. This would lead to the development throughout Canada of a truly “healthy public policy.”

In a subsequent report, the Committee will set out its findings and recommendations on the potential for, and the implications of, healthy public policy in Canada.

---

<sup>314</sup> Dr. Losos, *op. cit.*, p. 5.

Comité sénatorial permanent des affaires sociales,  
des sciences et de la technologie

Rapport final sur  
l'état du système de soins de santé au Canada

*La santé des Canadiens – Le rôle du gouvernement fédéral*  
*Volume Six :*  
*Recommandations en vue d'une réforme*

*Président*  
L'honorable Michael J. L. Kirby

*Vice-présidente*  
L'honorable Marjory LeBreton

OCTOBRE 2002





# TABLE DES MATIÈRES

---

<b>TABLE DES MATIÈRES</b> .....	<b>i</b>
<b>ORDRE DE RENVOI</b> .....	<b>vii</b>
<b>SÉNATEURS</b> .....	<b>viii</b>
<b>LISTE DES ABRÉVIATIONS</b> .....	<b>ix</b>
<b>REMERCIEMENTS</b> .....	<b>xi</b>
<b>AVANT-PROPOS</b> .....	<b>xiii</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>PARTIE I : RESPONSABILISATION</b> .....	<b>5</b>
<b>CHAPITRE UN</b> .....	<b>7</b>
LA NÉCESSITÉ D'UN RAPPORT ANNUEL SUR L'ÉTAT DU SYSTÈME DE SOINS DE SANTÉ ET SUR L'ÉTAT DE SANTÉ DES CANADIENS .....	7
1.1 Résumé de quelques points saillants des volumes un à cinq .....	7
1.1.1 <i>Le rôle du gouvernement fédéral</i> .....	7
1.1.2 <i>Objectifs de la politique fédérale en matière de soins de santé</i> .....	8
1.1.3 <i>L'actuel système n'est pas financièrement viable</i> .....	10
1.1.4 <i>Une garantie nationale de soins de santé est essentielle au succès de la réforme</i> .....	12
1.2 Améliorer la gouvernance — La nécessité d'un commissaire national aux soins de santé.....	14
1.2.1 <i>Association médicale canadienne (AMC)</i> .....	16
1.2.2 <i>Colleen Flood et Sujit Choudry</i> .....	16
1.2.3 <i>Tom Kent</i> .....	17
1.2.4 <i>Duane Adams</i> .....	18
1.2.5 <i>Lawrence Nestman</i> .....	19
1.3 La proposition du Comité .....	19
<b>PARTIE II : MESURES VISANT L'EFFICIENCE</b> .....	<b>25</b>
<b>CHAPITRE DEUX</b> .....	<b>27</b>
RESTRUCTURATION ET FINANCEMENT DES HÔPITAUX AU CANADA .....	27
2.1 Méthodes de financement des hôpitaux au Canada : Avantages et inconvénients .....	29
2.1.1 <i>Financement élément par élément</i> .....	30
2.1.2 <i>Discretion ministérielle</i> .....	31
2.1.3 <i>Financement fondé sur la population</i> .....	31
2.1.4 <i>Financement par budget global</i> .....	32
2.1.5 <i>Financement fondé sur les politiques</i> .....	34
2.1.6 <i>Financement fondé sur les établissements</i> .....	34
2.1.7 <i>Financement par projet</i> .....	34
2.1.8 <i>Financement fondé sur les services dispensés</i> .....	34
2.2 Financement fondé sur les services dispensés : Examen de l'expérience internationale.....	35

2.2.1	<i>États-Unis</i> .....	35
2.2.2	<i>Royaume-Uni</i> .....	36
2.2.3	<i>France</i> .....	37
2.2.4	<i>Danemark</i> .....	37
2.2.5	<i>Norvège</i> .....	38
2.2.6	<i>Examen de l'expérience internationale par le comité Bédard</i> .....	38
2.3	Justification du financement fondé sur les services dispensés au Canada.....	39
2.3.1	<i>Pertinence du choix de services</i> .....	43
2.3.2	<i>Services excessifs et surévaluation</i> .....	44
2.3.3	<i>Taux, information et données</i> .....	45
2.3.4	<i>Innovation</i> .....	46
2.3.5	<i>Soins de santé complets</i> .....	46
2.3.6	<i>Escalade des coûts</i> .....	46
2.3.7	<i>Manque de simplicité</i> .....	47
2.3.8	<i>Commentaires du Comité</i> .....	47
2.4	Les centres universitaires des sciences de la santé et la complexité des hôpitaux d'enseignement.....	49
2.5	Petits hôpitaux et hôpitaux communautaires ruraux.....	52
2.6	Financement des besoins en immobilisations des hôpitaux canadiens .....	54
2.7	Établissements de soins de santé publics ou privés?.....	57
	Annexe 2.1 : Centres universitaires des sciences de la santé et hôpitaux et régies régionales de la santé affiliés.....	63

## **CHAPITRE TROIS..... 67**

	DÉLÉGUER PLUS DE RESPONSABILITÉS AUX RÉGIES RÉGIONALES DE LA SANTÉ.....	67
3.1	Un tableau des RRS au Canada.....	68
3.2	RRS : Objectifs et réalisations .....	70
3.3	Obstacles qui empêchent les RRS de mettre pleinement à profit leur potentiel.....	72
3.4	Les RRS et le potentiel des marchés internes.....	74
3.5	Commentaires du Comité.....	78

## **CHAPITRE QUATRE..... 81**

	RÉFORME DES SOINS DE SANTÉ PRIMAIRES.....	81
4.1	Pourquoi une réforme des soins de santé primaires est-elle nécessaire? .....	81
4.2	Les provinces et la réforme des soins primaires.....	85
4.2.1	<i>Rapports récents</i> .....	85
4.2.2	<i>Le Réseau santé-famille de l'Ontario</i> .....	86
4.2.3	<i>Québec</i> .....	90
4.2.4	<i>Nouveau-Brunswick</i> .....	91
4.3	Surmonter les obstacles au changement.....	92
4.4	Le rôle du gouvernement fédéral.....	96
	Annexe 4.1 : Régime d'enveloppes budgétaires pour les omnipraticiens en Grande-Bretagne .....	99

**PARTIE III : LA GARANTIE DE SOINS DE SANTÉ..... 107**

**CHAPITRE CINQ.....109**

DES SOINS DE SANTE EN TEMPS OPPORTUN..... 109

5.1 Le droit aux soins de santé – Perception du public ou droit reconnu par la loi?..... 110

5.2 Disponibilité des services couverts par le régime public à l'extérieur du système public de soins de santé..... 111

5.3 Prestation de soins de santé en temps opportun et article 7 de la *Charte canadienne des droits et libertés*..... 112

5.4 Commentaires du Comité..... 119

**CHAPITRE SIX ..... 121**

LA GARANTIE DE SOINS DE SANTÉ ..... 121

6.1 Le problème des listes d'attente : la perception du public..... 121

6.2 Le problème des listes d'attente : la situation réelle..... 122

6.3 L'expérience canadienne ..... 123

6.3.1 Réseau de soins cardiaques de l'Ontario (RSCO)..... 123

6.3.2 Projet de rationalisation des listes d'attente dans l'Ouest canadien ..... 124

6.4 Expérience internationale ..... 125

6.4.1 Suède..... 126

6.4.2 Danemark..... 126

6.5 Recommandations du Comité..... 128

6.6 Les conséquences possibles d'une non-application de la garantie de soins de santé ..... 132

6.7 Quelques réflexions sur la garantie de soins de santé ..... 133

**PARTIE IV : RESSERRER LES MAILLES DU FILET DE SÉCURITÉ..... 135**

**CHAPITRE SEPT .....137**

ÉTENDRE LA COUVERTURE POUR INCLURE LA PROTECTION CONTRE LES COÛTS EXORBITANTS DES MÉDICAMENTS DE PRESCRIPTION ..... 137

7.1 Tendances des dépenses au titre des médicaments..... 138

7.2 Comparaisons avec d'autres pays..... 140

7.3 L'assurance pour les médicaments de prescription au Canada..... 142

7.3.1 Régimes publics d'assurance-médicaments..... 142

7.3.2 Régimes privés d'assurance-médicaments..... 143

7.3.3 Les caractéristiques des régimes d'assurance et leur incidence sur la protection contre les frais élevés de médicaments..... 144

7.4 Un phénomène nouveau : Les dépenses exorbitantes en médicaments de prescription..... 145

7.5 Protéger les Canadiens contre les frais exorbitants de médicaments de prescription..... 149

7.5.1 Comment fonctionnerait le régime..... 150

7.5.2 Avantages du régime proposé..... 152

7.5.3 Combien coûterait le régime?..... 153

7.5.4 Proposition du Comité relative à un régime d'assurance contre les frais exorbitants de médicaments de prescription..... 154

7.6 Nécessité d'une liste nationale des médicaments admissibles..... 155

<b>CHAPITRE HUIT.....</b>	<b>157</b>
ÉLARGIR LA COUVERTURE POUR INCLURE LES SOINS ACTIFS À DOMICILE.....	157
8.1 Bref aperçu des principaux points relevés dans les volumes deux et quatre à propos des soins à domicile.....	157
8.2 Autres options.....	159
8.3 Le programme extra-mural au Nouveau-Brunswick.....	160
8.3.1 <i>S'inspirer de l'exemple du Nouveau-Brunswick : renvois directs aux soins à domicile</i> .....	162
8.4 Organiser et fournir des soins actifs à domicile.....	163
8.4.1 <i>Définition des soins actifs à domicile</i> .....	164
8.4.1.1 <i>Quand les services de soins actifs à domicile (SAD) commencent-ils?</i> .....	164
8.4.1.2 <i>Quand les SAD se terminent-ils?</i> .....	165
8.4.2 <i>Dispositions organisationnelles pour les SAD</i> .....	165
8.4.3 <i>Qui fournit des SAD?</i> .....	167
8.5 Le coût d'un programme national de soins actifs à domicile.....	169
8.5.1 <i>Comment calculer le coût d'un programme national de SAD</i> .....	169
8.5.2 <i>Et les coûts cachés?</i> .....	170
8.5.3 <i>Combien coûtera un programme national de SAD?</i> .....	171
8.6 Payer les soins post-hospitaliers à domicile .....	171
<b>CHAPITRE NEUF.....</b>	<b>175</b>
ÉTENDRE LA COUVERTURE POUR INCLURE LES SOINS PALLIATIFS À DOMICILE.....	175
9.1 Nécessité d'un programme national de soins palliatifs.....	175
9.2 Aide financière aux fournisseurs de soins palliatifs à domicile.....	176
9.3 Crédit d'impôt pour fournisseurs de soins.....	178
9.4 Protection des emplois.....	179
9.5 Conclusion.....	179
<b>PARTIE V : ACCROÎTRE LA CAPACITÉ ET CONSTRUIRE L'INFRASTRUCTURE 181</b>	
<b>CHAPITRE DIX.....</b>	<b>183</b>
LE RÔLE DU GOUVERNEMENT FÉDÉRAL DANS L'INFRASTRUCTURE DE SOINS DE SANTÉ .....	183
10.1 Technologies de la santé .....	183
10.2 Dossiers de santé électroniques .....	187
10.3 Évaluation de la qualité, de l'efficacité et des résultats .....	190
10.4 Protection des renseignements personnels sur la santé.....	192
<b>CHAPITRE ONZE.....</b>	<b>199</b>
LES RESSOURCES HUMAINES DE LA SANTÉ.....	199
11.1 La gravité de la pénurie de ressources humaines en santé.....	199
11.2 Les ressources humaines de la santé : Nécessité d'une stratégie nationale .....	203
11.3 Accroître le nombre de médecins formés au Canada.....	206
11.4 Intégration des diplômés en médecine étrangers.....	208
11.5 Réduire la pénurie d'infirmières .....	209
11.6 Professions paramédicales.....	213
11.7 Financement des études supérieures.....	213
11.8 Ressources humaines de la santé : Examen des règles relatives au champ de pratique.....	213
11.9 Commentaires du Comité.....	214

<b>CHAPITRE DOUZE.....</b>	<b>217</b>
FAVORISER L'EXCELLENCE DANS LA RECHERCHE CANADIENNE EN SANTÉ.....	217
12.1 Assumer le leadership dans la recherche en santé.....	219
12.2 S'engager dans la révolution scientifique.....	222
12.3 Garantir un environnement de recherche prévisible.....	225
12.3.1 <i>Le financement fédéral de la recherche en santé.....</i>	<i>226</i>
12.3.2 <i>La recherche fédérale interne en santé.....</i>	<i>229</i>
12.4 Rehausser la qualité des services de santé et de la prestation des soins.....	230
12.5 Améliorer l'état de santé des populations vulnérables.....	232
12.6 Commercialiser les résultats de la recherche en santé.....	234
12.7 Respecter les normes d'éthique les plus élevées dans la recherche en santé.....	239
12.7.1 <i>La recherche sur des sujets humains.....</i>	<i>240</i>
12.7.2 <i>Questions suscitées par la recherche sur des sujets humains.....</i>	<i>242</i>
12.7.3 <i>L'utilisation d'animaux dans la recherche.....</i>	<i>245</i>
12.7.4 <i>La confidentialité des renseignements médicaux personnels.....</i>	<i>247</i>
12.7.5 <i>La confidentialité de l'information génétique.....</i>	<i>252</i>
12.7.6 <i>Les situations possibles de conflit d'intérêts.....</i>	<i>253</i>
 <b>PARTIE VI : PROMOTION DE LA SANTÉ ET PRÉVENTION DE LA MALADIE ..</b>	 <b>257</b>
<b>CHAPITRE TREIZE.....</b>	<b>259</b>
UNE POLITIQUE PUBLIQUE « PRO-SANTÉ » – LA SANTÉ AU-DELÀ DES SOINS DE SANTÉ.....	259
13.1 Tendances de la maladie.....	262
13.1.1 <i>Maladies infectieuses.....</i>	<i>263</i>
13.1.2 <i>Maladies chroniques.....</i>	<i>264</i>
13.1.3 <i>Blessures.....</i>	<i>265</i>
13.1.4 <i>Problèmes de santé mentale.....</i>	<i>265</i>
13.2 Fardeau économique de la maladie.....	265
13.3 Nécessité d'une stratégie nationale de prévention des maladies chroniques.....	267
13.4 Renforcer la santé publique et la promotion de la santé.....	270
13.5 Vers une politique publique pro-santé – Nécessité d'élaborer des stratégies d'amélioration de la santé de la population.....	271
 <b>PARTIE VII : FINANCER LA REFORME.....</b>	 <b>275</b>
<b>CHAPITRE QUATORZE.....</b>	<b>277</b>
COMMENT ADMINISTRER IES FONDS SUPPLÉMENTAIRES QUE LE GOUVERNEMENT FÉDÉRAL CONSACRERA À LA SANTÉ.....	277
14.1 Il faut investir davantage dans le système de soins de santé.....	278
14.2 Le rôle du gouvernement fédéral en matière de financement.....	283
14.3 Comment gérer les nouveaux fonds que le gouvernement fédéral destinera aux soins de santé.....	285

<b>CHAPITRE QUINZE.....</b>	<b>289</b>
COMMENT GÉNÉRER DES FONDS ADDITIONNELS POUR LES SOINS DE SANTÉ .....	289
15.1 Ampleur du financement fédéral additionnel requis.....	291
15.2 Sources possibles de financement fédéral accru.....	294
15.3 Impôts généraux.....	295
15.4 Impôts spécifiques .....	300
15.5 Charges sociales.....	303
15.6 Prime nationale d'assurance-santé.....	305
15.7 Frais d'utilisation.....	307
15.8 Comptes d'épargne-santé.....	309
15.9 Financement anticipé des soins de santé .....	310
15.10 Commentaires du Comité.....	312
15.11 Financement fédéral actuel des soins de santé.....	317
 <b>CHAPITRE SEIZE .....</b>	 <b>321</b>
VIABILITÉ FINANCIÈRE DU SYSTÈME DE SOINS DE SANTÉ : LES CONSÉQUENCES DE L'INACTION.....	321
16.1 L'assurance-santé privée au Canada et dans certains pays de l'OCDE.....	323
16.2 Examen de la documentation récente sur les effets d'un système privé d'assurance-santé et de prestation de soins à but lucratif .....	326
16.3 Commentaires du Comité.....	328
 <b>PARTIE VIII : LA LOI CANADIENNE SUR LA SANTÉ.....</b>	 <b>331</b>
 <b>CHAPITRE DIX-SEPT.....</b>	 <b>333</b>
LA LOI CANADIENNE SUR LA SANTÉ.....	333
17.1 Universalité.....	334
17.2 Intégralité .....	335
17.3 Accessibilité .....	339
17.4 Transférabilité .....	341
17.5 Gestion publique.....	342
17.6 Commentaires du Comité.....	345
 <b>CONCLUSION.....</b>	 <b>347</b>
 <b>ANNEXE A.....</b>	 <b>A-1</b>
LISTE DES RECOMMANDATIONS PAR CHAPITRE .....	A-1
 <b>ANNEXE B.....</b>	 <b>A-21</b>
LIST DES PRINCIPES DU VOLUME CINQ (AVRIL 2002).....	A-21
 <b>ANNEXE C.....</b>	 <b>A-23</b>
LISTE DES TÉMOINS.....	A-23

# **Partie IV : Resserrer les mailles du filet de sécurité**





## CHAPITRE SEPT

### ÉTENDRE LA COUVERTURE POUR INCLURE LA PROTECTION CONTRE LES COÛTS EXORBITANTS DES MÉDICAMENTS DE PRESCRIPTION

---

Dans les volumes précédents de son étude, le Comité a mis en lumière plusieurs questions cruciales touchant la couverture de l'assurance-médicaments au Canada et le coût des médicaments de prescription :

- Ces dernières années, le coût des médicaments de prescription a grimpé plus rapidement que celui de tous les autres éléments du système de santé. Les dépenses en médicaments de prescription représentent une part très importante et sans cesse croissante des coûts de la santé dans le secteur public. On s'attend à ce que la hausse des frais de médicaments de prescription persiste à mesure que de nouveaux médicaments efficaces mais très coûteux (spécialement ceux qui sont adaptés génétiquement au patient) apparaîtront sur le marché canadien au cours de la prochaine décennie.
- La *Loi canadienne sur la santé* ne s'applique pas aux médicaments de prescription utilisés hors du milieu hospitalier, et la couverture des régimes publics d'assurance-médicaments varie considérablement d'une province à l'autre. Il s'agit là d'un net contraste avec la politique qui existe dans de nombreux pays de l'OCDE, où les médicaments de prescription sont assurés par l'État aussi bien que les services hospitaliers et les services fournis par les médecins.
- La couverture privée offerte par les régimes d'assurance de l'employeur ou les polices d'assurance individuelle pour les médicaments de prescription varie beaucoup quant à la conception, à l'admissibilité et aux frais que les participants doivent payer de leur poche (soit les dépenses personnelles non remboursables).
- Malgré l'accessibilité des régimes publics et des régimes privés d'assurance-médicaments, beaucoup de Canadiens ne bénéficient d'absolument aucune couverture pour leurs médicaments de prescription. De plus, dans le cas de ceux qui en ont une (publique ou privée), la nature et la qualité de la couverture varient considérablement.
- Le fardeau financier excessif attribuable aux dépenses élevées en médicaments de prescription devient de plus en plus un risque réel – et même une réalité – pour beaucoup de particuliers et de familles au Canada.

Dans le présent chapitre, nous examinons les tendances des coûts des médicaments et le niveau actuel de couverture offert par les régimes d'assurance pour les médicaments de prescription au Canada. Nous accordons une attention particulière à l'absence et à l'insuffisance de protection contre les coûts très élevés des médicaments. Le Comité formule des observations sur la nécessité pour les Canadiens de bénéficier d'une meilleure protection

contre les frais très élevés et même exorbitants de médicaments de prescription, de même que des recommandations sur la façon dont le gouvernement fédéral devrait contribuer à cet objectif.

Comme il l'a fait remarquer dans des rapports antérieurs et précédemment dans le présent volume, le Comité est fermement convaincu qu'aucun Canadien ne devrait avoir à porter un fardeau financier excessif parce qu'il est obligé d'acquitter ses factures de soins de santé. Ce principe fondamental, qui est à la base de la politique canadienne en matière de santé, devrait s'appliquer aux frais de médicaments de prescription.

***Le Comité est fermement convaincu qu'aucun Canadien ne devrait avoir à porter un fardeau financier excessif parce qu'il est obligé d'acquitter ses factures de soins de santé. Il est essentiel que ce principe fondamental, qui est à la base de la politique canadienne en matière de santé, s'applique aux frais de médicaments de prescription.***

## **7.1 Tendances des dépenses au titre des médicaments<sup>186</sup>**

L'Institut canadien d'information sur la santé (ICIS) signale que, depuis 1997, les dépenses consacrées aux médicaments (de prescription et en vente libre) forment la deuxième catégorie en importance de dépenses de santé au Canada, venant derrière les coûts hospitaliers mais maintenant devant ceux des services fournis par les médecins. On prévoit que les chiffres définitifs indiqueront qu'en 2001, les dépenses en médicaments équivalaient à près de 50 % des dépenses hospitalières.

Les dépenses au titre des médicaments sont passées de 3,8 milliards de dollars en 1985 à 15,5 milliards de dollars en 2001. Les données de l'ICIS montrent qu'au cours de cette période de 16 ans, elles ont augmenté plus rapidement que l'inflation et à un rythme supérieur à celui de la croissance démographique. Plus précisément, de 1985 à 1992, elles ont augmenté à un taux annuel moyen de 12 % et de 1992 à 1996, à un taux de 5%. Par la suite, le taux de croissance est passé à environ 10 % en 1997 et en 1998, pour tomber à environ 8 % en 1999. Bien que les données ne soient pas encore au point, on s'attend à ce que le taux moyen de croissance des dépenses en médicaments ait été d'environ 7 % en 2000 et de 9 % en 2001.

Les médicaments de prescription constituent l'élément le plus important des dépenses totales en médicaments (79 % en 2001, en hausse par rapport à 67 % en 1985). Les médicaments en vente libre comptaient pour les 21 % restants des dépenses en médicaments en 2001 (contre 33 % en 1985). Dans la plupart des cas, les consommateurs achètent eux-mêmes et paient de leur poche les médicaments en vente libre. Par contraste, plusieurs payeurs contribuent au financement des médicaments de prescription. Ils appartiennent au secteur public (les régimes provinciaux/territoriaux d'assurance-médicaments, les régimes d'assurance du gouvernement fédéral pour certains groupes et les commissions de la sécurité professionnelle et de l'assurance contre les accidents du travail/Workers' Compensation Boards) et au secteur privé (les régimes d'assurance privés et les particuliers).

---

<sup>186</sup> La plus grande partie de l'information fournie dans cette section provient d'un document de l'Institut canadien d'information sur la santé: *Drug Expenditure in Canada, 1985-2001*, Ottawa, avril 2002. On trouvera le communiqué annonçant ce rapport sur le site Web de l'ICIS: [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=media\\_24apr2002\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_24apr2002_e)

**TABLEAU 7.1**  
**DÉPENSES AU TITRE DES MÉDICAMENTS DE PRESCRIPTION**  
**SELON LA SOURCE DE FINANCEMENT**  
**(POURCENTAGE)**

	<b>1985</b>	<b>1988</b>	<b>1999</b>	<b>2001</b>
Gouvernements prov. et terr.	40,6	42,6	38,2	42,0
Gouvernement fédéral	2,3	1,9	2,4	2,4
CSPAAT/WCB1	0,5	0,6	3,1	4,8
<b>Total partiel - Secteur public</b>	<b>43,4</b>	<b>45,1</b>	<b>43,7</b>	<b>49,2</b>
Assureurs privés	n. d.	30,5	33,5	29,9
Dépenses personnelles non remboursables	n. d.	24,4	22,8	20,9
<b>Total partiel - Secteur privé</b>	<b>56,6</b>	<b>54,9</b>	<b>56,3</b>	<b>50,8</b>
<b>Total – Ensemble des sources</b>	<b>100,0</b>	<b>100,0</b>	<b>100,0</b>	<b>100,0</b>

1) Les données portant sur 1997 et les années suivantes englobent les dépenses faites par les CSPAAT/WCB de même que par le Fonds de l'assurance-médicaments du Québec.  
n. d. : données non disponibles.

Source : ICIS (avril 2002), *Drug Expenditure in Canada, 1985-2001*, et Division de l'économie, Direction de la recherche parlementaire, Bibliothèque du Parlement.

En 1985, 57 % des dépenses en médicaments de prescription ont été payées par le secteur privé (voir le tableau 7.1). En 2001, la proportion avait baissé à 51 %. En conséquence, la proportion financée par des sources publiques a augmenté progressivement, passant de 43 % à 49 %. Le tableau 7.1 montre également que la proportion totale des médicaments de prescription que les citoyens canadiens ont payés de leur poche a diminué entre 1998 et 2001, passant de 24,4 % à 20,9 %. Ces chiffres révèlent qu'une part croissante des dépenses totales en médicaments de prescription au Canada est payée par les régimes d'assurance-médicaments du secteur public.

Les données de l'ICIS sur les dépenses en médicaments n'incluent pas les médicaments distribués dans les hôpitaux, que l'Institut considère comme des dépenses hospitalières. D'après les estimations fournies par l'ICIS dans son rapport d'avril 2002, les dépenses en médicaments des hôpitaux se sont élevées à 1,1 milliard de dollars en 2001. En outre, la proportion des dépenses hospitalières totales consacrée aux médicaments n'a cessé d'augmenter entre 1985 et 2001, passant de 2,8 % à 3,4 %. L'ICIS fait cependant observer que le taux de croissance des dépenses en médicaments des hôpitaux a été plus lent que celui des dépenses en médicaments faites à l'extérieur des hôpitaux. Bien qu'il ait pu y avoir un déplacement des dépenses des hôpitaux vers la collectivité, l'ICIS fait remarquer qu'il faut effectuer davantage de recherche pour connaître le rapport entre la consommation de médicaments à l'hôpital et la consommation hors de l'hôpital.

Beaucoup d'observateurs s'attendent à ce que le coût des médicaments de prescription consommés à l'extérieur des hôpitaux augmente beaucoup dans les années à venir, et ce pour plusieurs raisons :

- Le coût de la mise au point et de la commercialisation de nouvelles pharmacothérapies a augmenté rapidement à mesure que les sociétés pharmaceutiques s'attaquent à des maladies plus difficiles à soigner et doivent se soumettre à des processus plus rigoureux d'approbation des médicaments partout dans le monde.
- Les progrès scientifiques rapides ont donné lieu à la possibilité d'élaborer de nouveaux médicaments génétiquement personnalisés, applicables à un petit nombre de patients souffrant de maladies dégénératives chroniques, médicaments qui peuvent être à la fois extrêmement efficaces et extrêmement coûteux.
- Bon nombre des nouvelles pharmacothérapies visent à soigner des maladies chroniques traitées à domicile plutôt que des maladies aiguës traitées à l'hôpital.
- Des changements dans la pratique médicale et la nouvelle technologie ont remplacé le traitement en milieu hospitalier par des soins à domicile qui sont maintenant offerts pour plusieurs maladies dont les coûts de pharmacothérapie sont élevés.

Par conséquent, beaucoup de Canadiens doivent aujourd'hui payer des frais élevés de médicaments de prescription, ce qui était impensable il y a quelques années à peine.

## 7.2 Comparaisons avec d'autres pays

En comparaison avec certains pays de l'OCDE, le Canada consacre aux médicaments une forte proportion de ses dépenses totales en soins de santé, venant au deuxième rang en 1998, après le Royaume-Uni. La même année, le Canada s'est classé au quatrième rang pour ce qui est du montant des dépenses en médicaments par habitant, derrière les États-Unis, l'Allemagne et la Suède. Les dépenses en médicaments varient énormément d'un pays à l'autre en fonction de nombreux facteurs, notamment le caractère traditionnel des politiques gouvernementales et les caractéristiques institutionnelles (systèmes de remboursement pour les consommateurs et les fournisseurs, habitudes de prescription, etc.)<sup>187</sup>.

**(...) beaucoup de Canadiens doivent aujourd'hui payer des frais élevés de médicaments de prescription, ce qui était impensable il y a quelques années à peine.**

<sup>187</sup> Stéphane Jacobzone, *Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals*, étude hors-série n° 40, Politique du marché du travail et politique sociale, OCDE, avril 2000 ([www.oecd.org](http://www.oecd.org)).

**TABLEAU 7.2**  
**COUVERTURE DES RÉGIMES PUBLICS D'ASSURANCE POUR LES MÉDICAMENTS DE PRESCRIPTION**

	<b>Liste des médicaments admissibles</b>	<b>Partage des coûts</b>
<b>Australie</b>	<ul style="list-style-type: none"> <li>• La liste nationale des médicaments admissibles contient uniquement les médicaments qui font l'objet d'une évaluation positive quant à la sécurité, à la qualité, à l'efficacité clinique et au rapport coût-efficacité.</li> <li>• Établissement du coût en fonction du produit thérapeutique de référence<sup>1</sup>.</li> </ul>	<ul style="list-style-type: none"> <li>• Quote-part fixe par ordonnance, sous réserve d'un plafond annuel. La quote-part varie selon le type de bénéficiaire.</li> <li>• Exemptions pour certains segments de la population.</li> <li>• Partage des coûts plus élevé pour les médicaments de marque déposée lorsqu'il existe des médicaments génériques.</li> <li>• Les particuliers doivent payer les médicaments ne figurant pas sur la liste.</li> </ul>
<b>Allemagne</b>	<ul style="list-style-type: none"> <li>• Le gouvernement fédéral tient une « liste négative » contenant les médicaments non admissibles au remboursement par le régime public.</li> <li>• Établissement du coût en fonction du produit thérapeutique de référence<sup>1</sup>.</li> </ul>	<ul style="list-style-type: none"> <li>• Quote-part fixe par ordonnance. La quote-part varie selon le type de bénéficiaire et l'importance de l'ordonnance.</li> </ul>
<b>Pays-Bas</b>	<ul style="list-style-type: none"> <li>• Liste nationale des médicaments.</li> <li>• Établissement du coût en fonction du produit thérapeutique de référence<sup>1</sup>.</li> </ul>	<ul style="list-style-type: none"> <li>• Quote-part fixe par ordonnance, sous réserve d'un plafond annuel. La quote-part varie selon le type de bénéficiaire.</li> <li>• Exemptions pour certains segments de la population.</li> </ul>
<b>Suède</b>	<ul style="list-style-type: none"> <li>• Il n'existe pas de liste nationale, mais chaque conseil de comté a sa propre liste.</li> <li>• Tous les médicaments prescrits par les médecins et les hôpitaux sont achetés par un organisme national unique, Apotekbolaget, société d'État propriétaire de toutes les pharmacies de Suède.</li> </ul>	<ul style="list-style-type: none"> <li>• Quote-part fixe par ordonnance, sous réserve d'un plafond annuel. La quote-part varie selon le type de bénéficiaire.</li> <li>• Exemptions pour certains segments de la population.</li> </ul>
<b>Royaume-Uni</b>	<ul style="list-style-type: none"> <li>• Liste nationale des médicaments admissibles sous le régime du NHS.</li> <li>• Il existe aussi une « liste négative » des médicaments qui ne peuvent être prescrits par le NHS à cause de leur piètre valeur thérapeutique ou de leur coût excessif.</li> </ul>	<ul style="list-style-type: none"> <li>• Quote-part fixe par ordonnance.</li> <li>• Exemptions pour certains segments de la population.</li> </ul>

1) L'établissement du coût en fonction du produit thérapeutique de référence fait en sorte que le gouvernement ne paie que jusqu'à concurrence du coût d'un médicament à prix abordable qui est interchangeable du point de vue thérapeutique avec le médicament prescrit ou qui en est l'équivalent. Source : Stephane Jacobzone (avril 2000), *Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals*, étude hors-série n° 40, Politique du marché du travail et politique sociale, OCDE, avril 2000; Donald Willison et coll., *L'expérience internationale en matière de politique pharmaceutique : défis communs et leçons à tirer pour le Canada*, projet financé par le Fonds pour l'adaptation des services de santé de Santé Canada, 30 avril 2001; Comité sénatorial des affaires sociales (volume trois) et Division de l'économie, Direction de la recherche parlementaire, Bibliothèque du Parlement.

Par contraste, la part publique des dépenses en médicaments est beaucoup plus faible au Canada et aux États-Unis, ce qui s'explique surtout par le fait que l'ensemble de la population des autres pays bénéficie d'une couverture pour les médicaments de prescription. Par ailleurs, les pays avec lesquels sont comparés le Canada et les États-Unis ont des listes limitant le nombre des médicaments admissibles à la couverture par les régimes d'assurance publics, imposent le partage des coûts (quote-parts, coassurance et franchises) et prévoient des exemptions pour certains groupes de bénéficiaires (voir le tableau 7.2).

### **7.3 L'assurance pour les médicaments de prescription au Canada<sup>188</sup>**

À l'heure actuelle, la protection à l'égard des médicaments de prescription au Canada est offerte au moyen d'un mélange de régimes d'assurance publics et privés, que nous décrivons ci-après.

#### **7.3.1 Régimes publics d'assurance-médicaments**

En ce qui a trait aux régimes publics, il convient de noter ce qui suit :

1. Toutes les provinces ont des régimes d'assurance-médicaments qui couvrent presque tous les frais de médicaments des personnes âgées à faible revenu (celles qui touchent le Supplément de revenu garanti, ou SRG), qui forment environ 5 % de la population adulte du Canada. Ainsi, ce groupe est entièrement protégé contre les frais exorbitants de médicaments de prescription. Toutes les provinces sauf Terre-Neuve offrent également cette protection aux personnes âgées mieux nanties.
2. Toutes les provinces ont aussi des régimes qui assurent une protection aux bénéficiaires de l'aide sociale, groupe qui constituait 6,8 % de la population en 2000 et qui, ainsi, se trouve à l'abri des frais exorbitants de médicaments de prescription.
3. Le gouvernement fédéral assume entièrement le coût des médicaments de prescription (et d'autres services de santé) fournis à certaines populations autochtones et à certains anciens combattants. Ces groupes, qui comptent pour environ 2 % de la population canadienne, sont ainsi entièrement protégés contre les frais exorbitants de médicaments de prescription.
4. Les gouvernements de la Colombie-Britannique, de la Saskatchewan, du Manitoba et de l'Ontario ont des régimes d'assurance-médicaments destinés à l'ensemble de la population et qui prévoient un plafond (fondé dans certains cas sur le revenu familial) pour les dépenses personnelles non remboursables.
5. Le Québec prévoit pour tous ses résidents une assurance-médicaments assortie d'un plafond de 750 \$ pour les dépenses personnelles non remboursables, qu'il s'agisse des régimes d'assurance de l'employeur ou du régime provincial.

---

<sup>188</sup> Cette section se fonde sur des données fournies par Fraser Group/Tristat Resources : *Drug Expenses Coverage in the Canadian Population: Protection From Severe Drug Expenses*, août 2002. Cette étude a été commandée par l'Association canadienne des compagnies d'assurances de personnes, à la demande du Comité.

6. L'Alberta offre à tous ses résidents un régime facultatif d'assurance-médicaments, à base de cotisations, qui assure une couverture étendue pour les médicaments de prescription au bout d'une période d'attente de trois mois.

En somme, un grand nombre de régimes publics d'assurance-médicaments offrent une protection financière importante aux Canadiens qui ont des frais très élevés de médicaments de prescription. Cependant, le gouvernement fédéral ne contribue directement à aucun des régimes provinciaux.

### **7.3.2 Régimes privés d'assurance-médicaments**

Les régimes d'assurance-médicaments du secteur privé contribuent de façon importante à protéger les Canadiens contre les coûts des médicaments de prescription :

1. Ces régimes résultent entièrement de l'initiative de leurs promoteurs, qui sont pour la plupart des employeurs, mais aussi des syndicats, des entités mixtes syndicales-patronales et des établissements d'enseignement. De plus, environ 1 % des Canadiens sont protégés par des polices d'assurance-santé qu'ils ont achetées eux-mêmes.
2. Environ 2,4 millions de Canadiens adhèrent à un régime privé qui couvre la totalité des frais de médicaments de prescription, les protégeant ainsi entièrement contre un fardeau financier excessif attribuable à des coûts pharmaceutiques très élevés. Environ 300 000 autres bénéficient de régimes qui, en combinaison avec un régime public d'assurance-médicaments, leur assurent une couverture totale.
3. Environ 9,7 millions de Canadiens (les 2,4 millions dont nous venons de parler, plus 7,3 millions d'autres, soit au total 55 % des participants aux régimes privés) adhèrent à un régime privé qui prévoit un plafond global pour les dépenses personnelles non remboursables.
4. Les 8,1 millions de Canadiens restants qui souscrivent à un régime privé (45 % des participants aux régimes privés) bénéficient, dans la plupart des cas, d'une protection substantielle, mais incomplète, contre les frais exorbitants de médicaments de prescription.

Dans le volume quatre de son étude, le Comité a évoqué le cas d'un Canadien de la région de l'Atlantique dont la situation illustre bien ce dernier point. Cet homme, bibliothécaire de profession et cotisant pourtant à un bon régime d'assurance de son employeur, doit déboursier de sa poche 17 000 \$ chaque année pour payer une partie des médicaments dont son épouse a besoin et qui coûtent environ 50 000 \$ par année.

Le Comité a entendu parler dernièrement du cas d'un autre résident de la région de l'Atlantique qui souffre d'hypertension artérielle pulmonaire (une maladie parfois mortelle) et dont les médicaments coûtent 100 000 \$ par année. Cette personne paie actuellement plus de 4 600 \$ par mois (55 000 \$ par année) pour sa cotisation d'assurance, le médicament, les instruments nécessaires à la prise du médicament, d'autres médicaments dont elle a besoin et des bonbonnes d'oxygène. L'augmentation prévue de la dose d'ici un an fera passer sa facture mensuelle à environ 5 150 \$, soit 61 800 \$ par année. Or, les résidents de la province où habite

cette personne ne deviennent admissibles à l'aide gouvernementale qu'une fois épuisées toutes leurs épargnes, y compris leurs REER.

### **7.3.3 Les caractéristiques des régimes d'assurance et leur incidence sur la protection contre les frais élevés de médicaments**

Les régimes d'assurance-médicaments présentent de nombreuses caractéristiques et particularités différentes, mais seulement quatre d'entre elles ont une incidence sur le degré de protection qu'ils offrent contre les frais exorbitants de médicaments. Ce sont la franchise, la quote-part/coassurance, le maximum annuel ou à vie et le plafond appliqué aux dépenses personnelles non remboursables.

La *franchise* est le montant que l'assuré doit payer au départ avant d'avoir droit à un remboursement de son régime d'assurance-médicaments. Elle s'applique normalement à l'année civile ou l'année du régime. La franchise est habituellement un montant fixe, mais certains régimes publics établis par la loi la calculent en fonction du revenu familial. À moins d'être extraordinairement élevée, la franchise a ordinairement une incidence minimale sur le degré de protection qu'offre le régime contre les frais exorbitants de médicaments.

La *quote-part* et la *coassurance* sont la partie du coût de chaque ordonnance que doit payer l'assuré. La quote-part représente un montant fixe par ordonnance (p. ex. 5 \$), tandis que la coassurance est un pourcentage fixe par ordonnance (p. ex. 5 %). La quote-part peut aussi inclure les frais d'exécution de l'ordonnance (par opposition au coût du médicament lui-même). Comme nous l'avons vu dans l'exemple du bibliothécaire ci-dessus, la quote-part et la coassurance ne protègent pas l'assuré contre les dépenses personnelles très élevées résultant de la consommation prolongée de médicaments très chers.

Le *maximum annuel* ou *à vie* limite à un certain montant le total des dépenses en médicaments de prescription que paiera le régime à l'égard d'un assuré. Ce dernier doit payer de sa poche les frais excédant ce montant. Par exemple, un régime assorti d'un maximum annuel de 5 000 \$ ne paiera pas plus que ce montant au cours d'une année donnée. Plus le maximum est élevé, plus grande est la protection. Il est très inhabituel qu'un régime public d'assurance-médicaments impose un maximum. Certains régimes privés le font, mais la plupart offrent une couverture illimitée ou fixent un maximum annuel ou à vie très élevé, par exemple un million de dollars.

Enfin, le *plafond appliqué aux dépenses personnelles non remboursables* est une disposition qui limite le montant total de la franchise, de la quote-part et de la coassurance que devra payer l'assuré au cours d'une année donnée. Il peut s'agir d'un montant fixe (p. ex. 1 500 \$) ou d'une proportion du revenu familial (p. ex. 3 %). Beaucoup de régimes, surtout des régimes du secteur privé, ne fixent pas de plafond explicite pour les dépenses personnelles non remboursables. Le plafond appliqué aux dépenses personnelles garantit à l'assuré une protection contre les frais exorbitants de médicaments de prescription. Plus cette limite est basse, plus le degré de protection est élevé.



#### **7.4 Un phénomène nouveau : Les dépenses exorbitantes en médicaments de prescription**

Généralement, les répercussions financières directes de l'augmentation des frais de médicaments, que nous décrivons plus haut, sont relativement modestes, car la proportion des dépenses moyennes d'un ménage au titre des médicaments de prescription est faible en termes absolus. Les données de l'ICIS montrent qu'en 1999, les dépenses annuelles par habitant s'élevaient à 331,38 \$; de ce montant, l'assuré a payé 75,49 \$ de sa poche.

Malgré cela cependant, certains particuliers et certaines familles peuvent dépenser des sommes beaucoup plus élevées et les dépensent effectivement. Il est important de reconnaître que, pour le moment, c'est le cas de relativement peu de gens, mais le Comité croit que le problème justifie un examen attentif, car :

1. Chose la plus importante, certaines personnes portent effectivement un lourd fardeau financier en payant elles-mêmes leurs frais de médicaments, ce qui va à l'encontre de l'objectif fondamental de la politique canadienne de santé, dont nous parlons plus haut.
2. Les personnes qui portent un lourd fardeau financier peuvent abandonner (ou ne pas entreprendre) un traitement nécessitant des médicaments coûteux.
3. Les médecins peuvent admettre un patient à un traitement plus coûteux à l'hôpital de manière à lui éviter les coûts élevés des médicaments de prescription qu'il aurait à payer hors du milieu hospitalier.
4. Les médecins peuvent prescrire, et les patients exiger, des médicaments moins chers mais moins efficaces.
5. Certaines personnes peuvent choisir de demeurer assistées sociales au lieu de chercher un emploi, afin de conserver leur droit à l'assurance-médicaments.
6. Le régime d'assurance-médicaments auquel participe l'assuré peut avoir des déboursés financiers si grands qu'ils amènent le promoteur à limiter ou à abandonner le régime, réduisant ou supprimant ainsi pour tous les participants la protection contre les frais de médicaments. D'autres promoteurs peuvent prendre des mesures préventives afin de réduire le risque financier de coûts exorbitants de médicaments dans leur propre régime.

D'après les calculs de Fraser Group/Tristat Resources, 98 % de la population canadienne bénéficie actuellement de la couverture d'un ou de plusieurs régimes publics et/ou privés d'assurance-médicaments (voir le tableau 7.3). Deux pour cent des Canadiens (environ 600 000 personnes) n'ont absolument aucune couverture pour les médicaments de prescription et doivent

***Deux pour cent des Canadiens (environ 600 000 personnes) n'ont absolument aucune couverture pour les médicaments de prescription et doivent assumer eux-mêmes le risque financier que suppose le recours éventuel à des médicaments coûteux.***

assumer eux-mêmes le risque financier que suppose le recours éventuel à des médicaments coûteux.

**TABLEAU 7.3**  
**PROTECTION DE LA POPULATION CANADIENNE CONTRE LES FRAIS DE**  
**MÉDICAMENTS DE PRESCRIPTION**

<b>Couverture assurée par</b>	<b>Pourcentage de la population</b>
les régimes publics	53 %
les régimes privés	58 %
les deux types de régimes	13 %
Aucune couverture	2 %

Source : Fraser Group/Tristat Resources, Drug Expense Coverage in the Canadian Population: Protection From Severe Drug Expenses, août 2002, p. 11.

La firme Fraser Group/Tristat Resources a également analysé les variations par province des niveaux actuels de protection contre les frais élevés de médicaments. Les tableaux 7.4 et 7.5 indiquent le pourcentage de résidents de chaque province qui auraient à payer telles ou telles dépenses personnelles non remboursables si leurs frais totaux de médicaments de prescription s'élevaient à 5 000 \$ (tableau 7.4) ou à 20 000 \$ (tableau 7.5). Dans chaque tableau, la population de la province est divisée en quatre groupes, selon le montant à payer de sa poche : a) les personnes qui paieraient jusqu'à 750 \$; b) celles qui paieraient entre 751 \$ et 2 000 \$; c) celles qui paieraient plus de 2 000 \$; d) celles qui ne bénéficient d'aucune protection.

Par exemple, le tableau 7.4 indique que 70 % des résidents de la Colombie-Britannique dont les frais de médicaments de prescription se chiffrent à 5 000 \$ ne paient pas plus de 750 \$ de leurs poches, alors que les 30 % restants de la population de la province paient entre 751 \$ et 2 000 \$. À Terre-Neuve, seulement 48 % des résidents qui ont eu des frais de médicaments de 5 000 \$ paient jusqu'à 750 \$ de leurs poches, alors que 24 % de la population de la province paient entre 751 \$ et 2 000 \$. Cependant, 28 % des Terre-Neuviens ne bénéficient d'aucune protection et doivent donc payer la somme totale de 5 000 \$.

Dans le cas des personnes dont les frais de médicaments s'élèvent à 20 000 \$ (tableau 7.5), les pourcentages de résidents de la Colombie-Britannique qui ont à payer telles ou telles dépenses personnelles non remboursables sont les mêmes. À Terre-Neuve, 48 % de la population ne paient encore que jusqu'à 750 \$, et les mêmes 28 % des résidents ne bénéficient d'aucune protection et doivent donc payer la somme totale de 20 000 \$. Les 24 % de la population qui payaient entre 751 \$ et 2 000 \$ lorsque leurs frais de médicaments se chiffraient à 5 000 \$ doivent maintenant déboursier plus de 2 000 \$.

Il est frappant de voir qu'une proportion importante des résidents de la région de l'Atlantique ne bénéficie encore d'aucune protection, mais les tableaux indiquent aussi que les dépenses personnelles non remboursables varient beaucoup entre les provinces qui offrent des régimes d'assurance à l'ensemble de la population. C'est au Québec que les niveaux de protection varient le moins, puis en Colombie-Britannique, au Manitoba et en Saskatchewan.

**TABLEAU 7.4**  
**DÉPENSES PERSONNELLES NON REMBOURSABLES DES PERSONNES DONT LES**  
**FRAIS DE MÉDICAMENTS DE PRESCRIPTION S'ÉLÈVENT À 5000 \$**  
**(POURCENTAGE DE LA POPULATION)**

	Jusqu'à 750\$	751 \$ - 2 000 \$	Plus de 2 000 \$	Aucune protection	Total
<b>C.-B.</b>	70 %	30 %	0 %	0 %	100 %
<b>ALB.</b>	43 %	57 %	0 %	0 %	100 %
<b>SASK.</b>	68 %	24 %	8 %	0 %	100 %
<b>MAN.</b>	84 %	13 %	3 %	0 %	100 %
<b>ONT.</b>	70 %	25 %	5 %	0 %	100 %
<b>QUÉBEC</b>	100 %	0 %	0 %	0 %	100 %
<b>N.-B.</b>	45 %	28 %	0 %	27 %	100 %
<b>N.-É.</b>	47 %	29 %	0 %	24 %	100 %
<b>Î.-P.-É.</b>	48 %	25 %	0 %	27 %	100 %
<b>T.-N.</b>	48 %	24 %	0 %	28 %	100 %
<b>Canada</b>	<b>73 %</b>	<b>23 %</b>	<b>2 %</b>	<b>2 %</b>	<b>100 %</b>

**TABLEAU 7.5**  
**DÉPENSES PERSONNELLES NON REMBOURSABLES DES PERSONNES DONT LES**  
**FRAIS DE MÉDICAMENTS DE PRESCRIPTION S'ÉLÈVENT À 20 000 \$**  
**(POURCENTAGE DE LA POPULATION)**

	Jusqu'à 750\$	751 \$ - 2 000 \$	Plus de 2 000 \$	Aucune protection	Total
<b>C.-B.</b>	70 %	30 %	0 %	0 %	100 %
<b>ALB.</b>	43 %	0 %	57 %	0 %	100 %
<b>SASK.</b>	67 %	25 %	8 %	0 %	100 %
<b>MAN.</b>	84 %	13 %	3 %	0 %	100 %
<b>ONT.</b>	70 %	12 %	18 %	0 %	100 %
<b>QUÉBEC</b>	100 %	0 %	0 %	0 %	100 %
<b>N.-B.</b>	45 %	0 %	28 %	27 %	100 %
<b>N.-É.</b>	47 %	0 %	29 %	24 %	100 %
<b>Î.-P.-É.</b>	48 %	0 %	25 %	27 %	100 %
<b>T.-N.</b>	48 %	0 %	24 %	28 %	100 %
<b>Canada</b>	<b>73 %</b>	<b>20 %</b>	<b>5 %</b>	<b>2 %</b>	<b>100 %</b>

Source : Fraser Group/Tristat Resources, Drug Expense Coverage in the Canadian Population : Protection From Severe Drug Expenses, août 2002, p. 48-49.

Des données provenant toujours de Fraser Group/Tristat Resources révèlent également que la couverture dont bénéficient la grande majorité des Canadiens (89 %) prévoit un plafond protecteur pour les dépenses personnelles non remboursables, quelle que soit l'importance des frais de médicaments de prescription. Cependant, 9 % de la population canadienne participe à des régimes d'assurance-médicaments dépourvus d'un tel plafond

protecteur, régimes qui imposent des quote-parts ou limitent le remboursement. Pour ces personnes, les dépenses personnelles non remboursables s'accroissent à mesure qu'augmentent les frais de médicaments.

Au total, 11 % des Canadiens courent un risque important d'éprouver de graves difficultés financières parce qu'ils devront payer de leur poche des frais élevés de médicaments de prescription. Le tableau 7.6 montre les dépenses personnelles non remboursables d'une personne ayant besoin de médicaments de prescription qui coûtent 20 000 \$ par année<sup>189</sup>.

**TABLEAU 7.6**

Type de régime d'assurance	Paramètres du régime		Dépenses personnelles non remboursables (\$)
	Franchise	Quote-part	
Régimes ordinaires de prestations aux employés	0	0	0
Aide sociale dans beaucoup de provinces	0	0	0
SSNA (Affaires indiennes)	0	0	0
Autre régime ordinaire de prestations aux employés	25 \$	0	25 \$
Alberta Seniors Plan	0	30 %, sans dépasser 25 \$ par ordonnance	Environ 900 \$ (en supposant 3 ordonnances par mois)
RAMQ (Québec), pour les personnes de moins de 65 ans	100 \$	25 % de dépenses personnelles non remboursables (limite de 750 \$)	750 \$
Régime d'assurance-médicaments de la Colombie-Britannique	800 \$	0	800 \$
Programme de médicaments Trillium de l'Ontario (pour un revenu familial de 60 000 \$)	4 % du revenu familial rajusté		2 400 \$
Régime ordinaire de prestations aux employés le plus courant	0	20 %	4 000 \$
Régime de la fonction publique fédérale	60 \$	20 %	4 048 \$
Programme pour assurés ne faisant partie d'aucun groupe en Alberta	0	30 %	6 000 \$
Aucune protection	n. d.	n. d.	20 000 \$

Dans une analyse distincte des données relatives aux demandes de remboursement d'un grand nombre de régimes d'assurance-médicaments offerts par l'employeur

<sup>189</sup> Bien que cela ne se produise pas couramment, environ 4000 participants à des régimes privés ont dépassé ce montant en 2000. Nous ne disposons pas d'un chiffre comparable pour les régimes publics.

(environ la moitié de tous les régimes au Canada), la recherche présentée au Comité a révélé que, pour l'année 2000 :

- Quelques personnes ont eu des frais de médicaments dépassant 200 000 \$.
- Environ un assuré sur 1 000 a eu des frais médicaux personnels (en sus de l'assurance-santé) dépassant 10 000 \$. Il s'agissait en grande majorité de frais de médicaments de prescription.

D'après ces données, on estime qu'environ trois personnes sur 1 000 participant à des régimes privés, soit environ 53 000, ont eu des frais de médicaments dépassant 5 000 \$ en 2000.

Selon des données publiées émanant du Programme de médicaments de l'Ontario, la fréquence des frais de médicaments excédant 5 000 \$ peut être plusieurs fois supérieure (entre 10 et 20 personnes sur 1 000) dans le cadre de régimes publics couvrant les personnes âgées et les personnes incapables de travailler. Cela n'est pas particulièrement étonnant puisque les régimes publics couvrent toutes les personnes âgées, qui forment le groupe d'âge le plus susceptible de faire une forte consommation de médicaments de prescription.

***On peut donc dire avec une certaine assurance que plus de 100 000 Canadiens ont chaque année des frais de médicaments dépassant 5 000 \$, et il est presque certain que ce nombre augmentera dans les années à venir.***

On peut donc dire avec une certaine assurance que plus de 100 000 Canadiens ont chaque année des frais de médicaments dépassant 5 000 \$, et il est presque certain que ce nombre augmentera dans les années à venir. Le paiement de ces lourdes dépenses – c'est-à-dire la part payée par un régime d'assurance privé, celle payée par un régime d'assurance public et celle payée par le consommateur lui-même – variera évidemment d'une personne à l'autre.

## **7.5 Protéger les Canadiens contre les frais exorbitants de médicaments de prescription**

En proposant d'élargir le rôle du gouvernement fédéral dans le domaine de la santé de façon à inclure la protection contre les dépenses élevées ou « exorbitantes » en médicaments de prescription, le Comité vise deux objectifs.

Tout d'abord, il veut faire en sorte qu'aucun particulier, ni aucune famille au Canada n'ait à supporter un fardeau financier excessif parce qu'il doit payer la totalité ou même une fraction importante des coûts d'un traitement extrêmement long et/ou coûteux faisant appel à des médicaments de prescription. Voilà qui est tout à fait conforme aux objectifs fondamentaux sur lesquels repose le régime public d'assurance-santé au Canada.

Ensuite, le Comité veut créer les conditions nécessaires pour assurer la viabilité à long terme des régimes actuels d'assurance-médicaments et des régimes d'assurance-médicaments complémentaire, tant publics que privés, devant la montée en flèche des coûts des médicaments de prescription et l'avènement prévu de pharmacothérapies de plus en plus coûteuses et efficaces.

Le régime que propose le Comité s'inspire donc des régimes provinciaux d'assurance-médicaments et des régimes privés d'assurance-médicaments complémentaire qui existent déjà au Canada; il ne les remplace pas. Le Comité entend donc présenter un programme réalisable et réaliste qui permettra d'injecter des fonds fédéraux nouveaux pour élargir la couverture actuelle de façon à protéger les Canadiens contre un fardeau financier excessif résultant de dépenses élevées ou exorbitantes en médicaments de prescription.

Plus précisément, le Comité propose que le gouvernement fédéral assume la responsabilité de 90 % des frais de médicaments de prescription dépassant un seuil au-delà duquel ils deviennent « exorbitants ». Le gouvernement fédéral devrait établir des critères et des conditions auxquels les régimes privés et les régimes publics des provinces et territoires devraient répondre pour être admissibles à l'aide fédérale. En échange, il assumerait 90 % de ce qu'il en coûte pour protéger les particuliers et les familles contre les frais exorbitants de médicaments. Afin d'assurer une couverture uniforme partout au Canada et de contrôler l'admissibilité des médicaments dans le cadre du régime, il sera également nécessaire d'établir liste nationale des médicaments admissibles (voir la section 7.6 plus loin).

***Plus précisément, le Comité propose que le gouvernement fédéral assume la responsabilité de 90 % des frais de médicaments de prescription dépassant un seuil au-delà duquel ils deviennent « exorbitants ».***

Le Comité reconnaît que les paramètres définitifs du régime d'assurance contre les dépenses exorbitantes en médicaments de prescription devront être arrêtés lors de négociations entre toutes les parties concernées : le gouvernement fédéral, les gouvernements provinciaux et territoriaux, les promoteurs des régimes privés d'assurance-médicaments complémentaire et les assureurs. Il est cependant d'avis que le profil général du régime qu'il propose forme un cadre de mise en oeuvre à la fois réaliste et acceptable.

***Afin d'assurer une couverture uniforme partout au Canada et de contrôler l'admissibilité des médicaments dans le cadre du régime, il sera également nécessaire d'établir une liste nationale des médicaments admissibles.***

### **7.5.1 Comment fonctionnerait le régime**

Pour avoir droit à l'aide fédérale, il faudrait que les provinces et les territoires mettent en place un régime garantissant que les résidents n'auront jamais à payer de leur poche plus de 3 % de leur revenu familial pour acheter des médicaments de prescription. En d'autres mots, un plafond de 3 % du revenu familial serait appliqué aux dépenses personnelles non remboursables des familles de la province ou du territoire au titre des médicaments de prescription. Le gouvernement fédéral accepterait de payer 90 % des frais dépassant 5 000 \$ dans le cas de personnes dont le total combiné des dépenses personnelles non

***Pour avoir droit à l'aide fédérale, il faudrait que les provinces et les territoires mettent en place un régime garantissant que les résidents n'auront jamais à payer de leur poche plus de 3 % de leur revenu familial pour acheter des médicaments de prescription.***

remboursables et de la contribution provinciale à laquelle elles avaient droit est supérieur à 5 000 \$ au cours d'une année. Ainsi, les provinces et les territoires participants n'auraient à payer que 10 % des coûts supérieurs à 5 000 \$ dans le cas des familles dont les frais sont exorbitants (c'est-à-dire ceux dont le total des frais de médicaments dépassent 5 000 \$ pour l'année).

Pour avoir droit à l'aide fédérale, il faudrait que les promoteurs des régimes privés d'assurance complémentaire pour les médicaments de prescription garantissent qu'aucun participant n'aura à payer de sa poche plus de 1 500 \$ par année. En d'autres termes, dans le cas des régimes privés, les coûts que les participants auraient à payer de leur poche seraient plafonnés à 1 500 \$ pour une année donnée. Pour les régimes qui respectent ce critère, le gouvernement fédéral s'engagerait à payer 90 % des coûts de médicaments de prescription dépassant 5 000 \$ à l'égard des participants dont le total des frais de médicaments de prescription s'élève à plus de 5 000 \$ par année, les régimes privés assument les 10 % restantes. Ainsi, les dépenses personnelles non remboursables de chaque participant seraient plafonnées à 3 % de son revenu familial ou à 1 500 \$, selon le plus petit des deux montants.

***Pour avoir droit à l'aide fédérale, il faudrait que les promoteurs des régimes privés d'assurance-médicaments complémentaire garantissent qu'aucun participant n'aura à payer de sa poche plus de 1 500 \$ par année pour acheter des médicaments de prescription. [...] Les régimes privés d'assurance-médicaments complémentaire conserveraient la responsabilité des frais de médicaments jusqu'à concurrence de 5 000 \$.***

Les régimes privés d'assurance-médicaments complémentaire conserveraient la responsabilité des frais de médicaments jusqu'à concurrence de 5 000 \$ et seraient fortement encouragés à mettre en place une caisse commune pour s'aider les uns les autres à absorber les coûts se situant entre 1 500 \$ et 5 000 \$. Bien entendu, les promoteurs de régimes privés pourraient offrir des avantages et des améliorations additionnels allant au-delà des exigences minimales nécessaires pour être admissible à l'aide fédérale.

Le nouveau régime visant à protéger les familles et les particuliers canadiens contre les conséquences de frais très élevés de médicaments de prescription ferait en sorte que personne ne serait obligé de consacrer plus de 3 % de son revenu familial à l'achat de médicaments de prescription. Les adhérents aux régimes privés qui participent au programme fédéral ne paieraient jamais plus de 1 500 \$ ou 3 % de leur revenu familial au titre de médicaments de prescription, selon le moins élevé des deux montants. Suivant que la personne est membre ou non d'un régime privé, la première tranche de 5 000 \$ de ses frais de médicaments de prescription serait payée grâce à une combinaison de dépenses personnelles non remboursables, d'assurance publique et d'assurance privée. Le gouvernement fédéral paierait 90 % des frais de médicaments de prescription d'une personne qui dépassent 5 000 \$ au cours d'une année donnée, et un régime provincial ou un régime privé d'assurance complémentaire assumerait les 10 % restants.

Pour comprendre comment fonctionnerait concrètement ce programme, voyons l'exemple suivant. Comparons trois personnes qui dépensent chacune 10 000 \$ en médicaments de prescription au cours d'une année donnée. Jeanne gagne 60 000 \$ par année. Robert en gagne 30 000 \$. Jeanne et Robert souscrivent tous deux à des régimes privés d'assurance-médicaments

complémentaire qui répondent au critère fédéral d'admissibilité à la couverture pour dépenses exorbitantes en médicaments de prescription. La troisième personne, Anne, travaille à son compte et gagne elle aussi 60 000 \$ par année, mais elle n'adhère pas à un régime privé d'assurance-médicaments complémentaire. Ces trois personnes vivent dans une province qui participe au programme fédéral.

Pour sa part, Anne, aurait recours au régime provincial d'assurance-médicaments. Comme 3 % de son revenu se chiffre à 1 800 \$, elle aurait droit à un remboursement de 8 200 \$ du régime provincial pour payer ses dépenses totales de 10 000 \$.

Quant à Robert, ses dépenses personnelles non remboursables seraient limitées à 1 500 \$ en vertu de son régime privé d'assurance-médicaments complémentaire. Mais comme 3 % de son revenu se chiffre à seulement 900 \$, il aurait droit à un remboursement de 600 \$ de son régime d'assurance, de manière que le total des frais payés de sa poche ne dépassent pas 3 % de son revenu<sup>190</sup>.

Dans le cas de Jeanne, les dépenses à payer de sa poche seraient, comme pour Robert, limitées à 1 500 \$ en vertu de son régime privé d'assurance complémentaire. Mais comme 3 % de son revenu (1 800 \$) représente un montant plus élevé que ses dépenses personnelles non remboursables (1 500 \$), elle n'aurait droit à aucune aide additionnelle.

Supposons maintenant que Jeanne et Robert se marient. Leurs dépenses personnelles en médicaments de prescription s'élèvent toujours à 10 000 \$ par année, soit 20 000 \$ au total pour les deux. Leur revenu familial est maintenant 90 000 \$ (60 000 \$ + 30 000 \$). Leur régime privé d'assurance-médicaments complémentaire limite le montant des dépenses personnelles non-remboursables à 1 500 \$ chacun, soit 3 000 \$ au total pour les deux. Toutefois, comme la part correspondant à 3 % de leur revenu familial n'est plus que 2 700 \$, Robert et Jeanne ont droit à un remboursement de 300 \$ du gouvernement provincial.

La contribution du gouvernement fédéral serait versée soit aux provinces, soit aux régimes privés d'assurance complémentaire, mais pas directement aux particuliers. Les versements seraient effectués à des intervalles réguliers établis à l'avance (chaque trimestre, chaque semestre ou chaque année) et les demandes de remboursement seraient évidemment soumises à une vérification périodique pour s'assurer qu'elles correspondent à des dépenses réelles.

### **7.5.2 Avantages du régime proposé**

Prises ensemble, ces mesures assureraient une protection efficace contre les frais exorbitants de médicaments de prescription pour tous les Canadiens et offriraient des avantages additionnels aux personnes à faible revenu en plafonnant les dépenses personnelles non remboursables à 3 % du revenu familial. Le régime proposé comporte également des incitatifs pour encourager les gouvernements provinciaux et territoriaux et les promoteurs des régimes privés d'assurance complémentaire à participer.

---

<sup>190</sup> Notons qu'il serait possible de mettre au point des modalités de paiement pour permettre aux personnes qui ne sont pas en mesure d'attendre le remboursement du gouvernement à la fin de l'année de bénéficier d'un crédit sur le lieu de vente, ou quelque autre mécanisme similaire pour réduire à une limite raisonnable les dépenses payées de leur poche.



Pour les provinces et les territoires, le régime que propose le Comité est structuré de façon que le gouvernement fédéral fournira une aide financière pour une partie de la couverture que les provinces et les territoires offrent tous déjà, par exemple le paiement des coûts exorbitants de médicaments de prescription que doivent acheter les personnes âgées et les assistés sociaux. La contribution fédérale libérerait par conséquent des fonds provinciaux et permettrait aux provinces d'apporter les améliorations nécessaires à leurs régimes d'assurance-médicaments afin de mettre en oeuvre la garantie qu'aucun résident n'aura à payer de sa poche plus de 3 % de son revenu. De plus, la contribution fédérale se trouve à transposer des provinces au gouvernement fédéral l'obligation de faire face à l'incidence croissante des frais de médicaments très élevés (exorbitants) attribuables à la montée en flèche des coûts des médicaments eux-mêmes et à l'apparition de nouvelles pharmacothérapies plus perfectionnées et particulièrement coûteuses.

Ainsi, même les provinces et les territoires qui n'offrent pas actuellement de protection contre les frais exorbitants de médicaments aux travailleurs de moins de 65 ans (et qui pourraient également avoir du mal à participer à un programme fédéral à frais partagés ordinaire parce qu'ils n'ont pas l'argent nécessaire pour égaler la contribution fédérale) sont susceptibles de tirer un avantage financier suffisant de ce programme pour leur permettre de répondre au critère d'admissibilité fédéral. Cela constituerait bien sûr

***Cela constituerait bien sûr un net progrès pour les Canadiens qui ne bénéficient actuellement d'aucune protection contre les frais exorbitants de médicaments de prescription (au nombre d'environ 600 000).***

un net progrès pour les Canadiens qui ne bénéficient actuellement d'aucune protection contre les frais exorbitants de médicaments de prescription (au nombre d'environ 600 000).

La proposition du Comité contribuerait également à assurer la viabilité à long terme des régimes privés d'assurance-médicaments complémentaire qui accepteraient de plafonner à 1 500 \$ par année les dépenses personnelles non remboursables des participants. Elle éliminerait aussi le spectre de l'extrême volatilité des coûts du régime résultant des dépenses exorbitantes en médicaments. De plus, les promoteurs potentiels qui hésitaient dans le passé à mettre sur pied des régimes d'assurance-médicaments de prescription complémentaire de crainte d'avoir à absorber des coûts pharmaceutiques exorbitants seront peut-être dorénavant plus enclins à le faire. Cet avantage est particulièrement important dans le cas des nouvelles PME, car celles-ci pourraient offrir à leurs futurs employés des ensembles d'avantages sociaux plus compétitifs que cela n'aurait été possible autrement.

### **7.5.3 Combien coûterait le régime?**

On estime que la mise en oeuvre de cette mesure fédérale, visant à protéger tous les Canadiens contre les frais exorbitants de médicaments de prescription, coûterait environ 500 millions de dollars par année. À la demande du Comité, cette estimation a été établie à l'aide d'un modèle de micro-simulation à grande échelle de la couverture nationale pour les médicaments de prescription, modèle élaboré par Fraser Group/Tristat Resources, chercheurs qui ont effectué plusieurs études importantes sur l'assurance-médicaments au Canada. Leur étude la plus récente, *Drug Expense Coverage in the Canadian Population: Protection from Severe Drug Expenses*, a été présentée au Comité sénatorial le 12 juin 2002.

Le modèle élaboré par Fraser Group/Tristat Resources est fondé sur quatre fichiers de données de base :

- L'échantillon d'environ 60 000 ménages canadiens utilisé pour l'Enquête sur la dynamique du travail et du revenu (EDTR) de Statistique Canada fournit les caractéristiques démographiques de base.
- L'Enquête sur les horaires et les conditions de travail de Statistique Canada sert à établir l'état de la protection complémentaire à l'assurance-médicaments.
- Le fichier des paramètres des régimes d'assurance-médicaments, qui établit les conditions des régimes publics et des régimes privés, a été élaboré à partir d'une analyse des dispositions des régimes publics et des dossiers de 80 000 régimes offerts par l'employeur.
- Le fichier des besoins en médicaments, renfermant les moyennes annuelles des dépenses en médicaments calculées selon les groupes d'âge et le sexe de même que la distribution théorique selon la taille des dépenses, se fonde sur une analyse des demandes de remboursement présentées aux régimes d'assurance-médicaments complémentaire ainsi que sur des données publiées par certains régimes publics.

L'ensemble du modèle est équilibré à l'aide de normes globales découlant de macro-statistiques fournies par l'Institut canadien d'information sur la santé pour l'année 2000, rajustées pour tenir compte des caractéristiques de la base de sondage utilisée par Statistique Canada.

Le Comité a ajouté aux résultats bruts du modèle un coussin additionnel afin de fournir une estimation prudente et solide qui, croyons-nous, surestime quelque peu les coûts probables.

#### **7.5.4 Proposition du Comité relative à un régime d'assurance contre les frais exorbitants de médicaments de prescription**

En résumé, donc, le Comité recommande :

**Que le gouvernement fédéral mette en place un programme visant à protéger les Canadiens contre les dépenses exorbitantes en médicaments de prescription.**

**Pour tous les régimes admissibles, le gouvernement fédéral accepterait de payer :**

- **90 % des dépenses en médicaments de prescription dépassant 5 000 \$ dans le cas des personnes dont le total combiné des dépenses personnelles non remboursables et de la contribution de la province ou du territoire à leur égard est supérieur à 5 000 \$ au cours d'une année;**

- **90 % des dépenses en médicaments de prescription dépassant 5000 \$ dans le cas des participants à un régime privé d'assurance-médicaments complémentaire dont le total combiné des dépenses personnelles non remboursables et de la contribution du régime d'assurance privé à leur égard est supérieur à 5 000 \$ au cours d'une année.**
- **Les 10 % restants seraient assumés par un régime provincial/territorial ou par un régime privé complémentaire.**

**Pour être admissibles à ce programme fédéral :**

- **les provinces et les territoires devront mettre en place un programme garantissant qu'aucune famille n'aura à payer de sa poche plus de 3 % de son revenu familial pour acheter des médicaments de prescription;**
- **les promoteurs des régimes privés d'assurance-médicaments complémentaire existants devront garantir qu'aucun participant n'aura à payer de sa poche plus de 1500 \$ par année; ainsi, les dépenses personnelles non remboursables de chaque participant seraient plafonnées à 3 % de son revenu familial ou à 1500 \$, selon le moins élevé des deux montants.**

## **7.6 Nécessité d'une liste nationale des médicaments admissibles**

Bien entendu, le Comité reconnaît qu'il faudra établir une liste nationale des médicaments admissibles si l'on veut mettre en oeuvre un régime visant à protéger les familles et les particuliers canadiens, de façon uniforme et équitable partout au Canada, contre les dépenses exorbitantes en médicaments de prescription. L'idée d'une liste nationale a été évoquée plusieurs fois au cours de l'étude du Comité.

Il s'agit d'une liste des médicaments de prescription fournis en vertu d'un régime public d'assurance-médicaments. Le terme «national» ne signifie pas que le gouvernement fédéral serait la seule instance chargée de déterminer les médicaments de prescription qui y figureraient. Au contraire, la liste serait le fruit de la collaboration du gouvernement fédéral et des gouvernements provinciaux et territoriaux, avec le concours d'autres intervenants intéressés.

Comme le Comité le fait observer dans le volume quatre de son étude, une liste nationale des médicaments admissibles présenterait les avantages suivants :

- elle éliminerait la possibilité qu'une province se sente obligée d'ajouter un médicament à sa liste parce qu'une autre province l'a déjà fait;

- elle accroîtrait la capacité d'effectuer et de diffuser à l'échelle nationale les recherches nécessaires pour démontrer que les avantages d'un médicament nouveau (et plus cher) constituent vraiment un progrès important par comparaison à des médicaments existants (et moins chers)<sup>191</sup>.

La création d'une liste nationale des médicaments admissibles pourrait conduire à la création d'un organisme acheteur unique qui servirait tous les gouvernements provinciaux et territoriaux et le gouvernement fédéral. Le pouvoir d'achat d'un tel organisme serait colossal, ce qui aiderait probablement les régimes publics à obtenir les meilleurs prix possibles auprès des sociétés pharmaceutiques.

Puisque l'objectif est de protéger les Canadiens contre les frais exorbitants de médicaments de prescription, une liste nationale des médicaments admissibles permettrait d'accorder à tous les Canadiens une protection uniforme et un accès comparable aux médicaments où qu'ils habitent. Elle permettrait aussi à ceux qui financent le régime d'exercer un contrôle sur les médicaments admissibles. Le Comité juge essentiel que le gouvernement fédéral soit présent à la table quand les décisions se prendront, puisqu'il paiera 90 % des coûts. De plus, comme les coûts des nouvelles pharmacothérapies risquent d'augmenter de façon exponentielle, ceux qui financent le régime devront s'entendre sur les médicaments qui seront couverts. Le Comité recommande par conséquent :

**Que le gouvernement fédéral travaille en étroite collaboration avec les provinces et les territoires afin d'établir une liste nationale unique des médicaments admissibles.**

---

<sup>191</sup> Volume quatre, p. 75-76.

## CHAPITRE HUIT

### ÉLARGIR LA COUVERTURE POUR INCLURE LES SOINS ACTIFS À DOMICILE

---

#### 8.1 Bref aperçu des principaux points relevés dans les volumes deux et quatre à propos des soins à domicile

Les dépenses au titre des soins à domicile au Canada (dans les secteurs public et privé) ont sans cesse augmenté au cours des vingt dernières années (voir les graphiques 8.1 et 8.2). Dans ses rapports précédents, le Comité a noté qu'aucun consensus ne se dégage à propos des services à inclure dans la définition des soins à domicile. Ils peuvent comprendre certains soins de courte durée tels que l'intraveineothérapie et la dialyse, les soins de longue durée aux personnes atteintes d'affections dégénératives telles que la maladie d'Alzheimer ou des incapacités chroniques physiques ou mentales, et les soins de fin de vie pour les personnes en phase terminale. Outre les soins de santé, les soins à domicile peuvent inclure les services sociaux de soutien tels que la surveillance, l'aide ménagère, les conseils nutritionnels et la préparation de repas. Les soins à domicile couvrent donc un large spectre de soins.

Les fournisseurs de soins à domicile se répartissent en deux groupes : les soignants professionnels – infirmières, thérapeutes et préposés au soutien personnel – et les aidants naturels – généralement des membres de la famille ou des amis. L'enquête 1998-1999 sur la santé de la population a révélé que la plupart des personnes ayant besoin de soins à domicile en raison du vieillissement, d'une incapacité ou d'une maladie chronique, n'ont reçu aucune aide des services de santé publics. Entre 80 et 90 % de la totalité des soins à domicile sont prodigués sans rémunération. L'enquête n'indique pas dans quelle mesure les services non financés par les fonds publics ont été payés de source privée, ou quels besoins ont été comblés par des aidants naturels ou sont demeurés insatisfaits.

***La satisfaction des besoins de soins à domicile deviendra un problème croissant à mesure que les baby-boomers vieillissent, qu'augmente l'espérance de vie, que les soins sont désinstitutionnalisés et gagnent en complexité technologique et que les régimes de travail et les modèles sociaux réduisent la possibilité que des membres de la famille puissent offrir des soins en tant qu'aidants naturels.***

La satisfaction des besoins de soins à domicile deviendra un problème croissant à mesure que les baby-boomers vieillissent, qu'augmente l'espérance de vie, que les soins sont désinstitutionnalisés et gagnent en complexité technologique et que les régimes de travail et les modèles sociaux réduisent la possibilité que des membres de la famille puissent offrir des soins en tant qu'aidants naturels. Le Comité a été informé que les soins à domicile peuvent remplir plusieurs fonctions, notamment :

- ils remplacent les services fournis par les hôpitaux et les établissements de soins de longue durée;

- ils permettent au client de demeurer dans son environnement, généralement son domicile, ce qui lui évite de déménager dans un nouvel endroit souvent plus dispendieux, tel un établissement de soins de longue durée;
- ils préviennent la dépendance, surtout par la surveillance qu'ils assurent, au prix d'un coût supplémentaire à court terme mais moins élevé à long terme.

Selon de nombreux témoins, lorsque les soins à domicile remplacent les soins de courte durée (habituellement en milieu hospitalier), ils devraient être considérés comme des soins de courte durée fournis dans un autre cadre et, par conséquent, tomber sous le régime de la *Loi canadienne sur la santé*.

Actuellement, chaque province ou territoire offre un éventail de soins à domicile, mais ceux-ci ne sont pas considérés comme services « médicalement nécessaires » aux termes de la *Loi canadienne sur la santé*. Par conséquent, les programmes publics de soins à domicile varient considérablement d'un bout à l'autre du pays en ce qui concerne l'admissibilité, l'étendue de la couverture et les frais d'utilisation. Bien que les services de soins à domicile fournis aient augmenté dans la plupart des provinces au cours des dernières années, les dépenses publiques en soins à domicile constituent toujours une faible proportion du budget global des soins de santé des provinces.

Des études récentes indiquent que les soins à domicile sont souvent économiques; toutefois, dans bien des cas, les soins en établissement demeurent plus efficaces, particulièrement pour les personnes âgées en perte d'autonomie. Bien entendu, il est toujours plus commode pour les fournisseurs de soins de santé d'offrir les soins en établissement.

Toutefois, le coût des services et la facilité de prestation ne sont pas les seuls facteurs dont il faut tenir compte : bien des gens préféreront recevoir des soins à domicile, dans la mesure du possible, plutôt qu'en établissement.

Dans le volume quatre (section 8.10), le Comité propose quatre solutions pour la contribution fédérale au financement des soins à domicile.

#### 1. *Programme national de soins à domicile*

En vertu de cette solution, le gouvernement fédéral augmente ses paiements de transfert afin d'aider les provinces et les territoires à élaborer des programmes de soins à domicile sur leur territoire. Le gouvernement fédéral travaille en étroite collaboration avec les provinces et les territoires pour élaborer des normes nationales de soins à domicile, condition absolument essentielle si l'on veut que les soins à domicile fassent partie du système canadien de soins de santé.

#### 2. *Crédit d'impôt et déduction fiscale pour les consommateurs de soins à domicile*

Le gouvernement fédéral pourrait accroître l'aide financière aux consommateurs de soins à domicile grâce à des changements fiscaux, pouvant s'ajouter aux prestations fiscales existantes. Ou alors, il pourrait créer des nouvelles mesures fiscales afin d'encourager les gens à épargner en prévision des soins à long terme dont ils auront besoin.

### 3. *Créer une caisse d'assurance pour les soins à domicile*

La création d'une caisse d'assurance capitalisée réservée à cette fin, sur le modèle proposé par la Commission Clair au Québec, permettrait d'offrir les soins à domicile sous forme de prestations en nature ou de paiements.

### 4. *Mesures spécifiques destinées aux aidants naturels*

La réduction des services aux malades hospitalisés a alourdi le fardeau des membres de la famille et des amis des patients. Actuellement, plus de trois millions de Canadiens – principalement des femmes – soignent des membres malades de leur famille, à la maison, sans être rémunérés. La solution présentée en rubrique augmenterait l'aide financière apportée aux aidants naturels au Canada : le Régime de pensions du Canada (RPC) et les programmes d'assurance-emploi soutiendraient les personnes qui quittent temporairement le marché du travail pour prodiguer des soins à un proche.

## **8.2 Autres options**

Ces options étaient centrées sur la participation du gouvernement fédéral aux trois aspects des soins à domicile (substitution, maintien et prévention). Dans le volume cinq, le Comité a abordé, comme seul élément, l'élaboration d'une infostructure nationale de la santé et la nécessité d'investir dans les télésoins à domicile. Il y a aussi annoncé son intention de produire une étude thématique sur la question des soins à domicile prochainement.

Par la suite, le Comité a entendu des témoins souligner l'importance d'envisager l'élaboration d'une stratégie nationale de soins à domicile en étapes, en abordant d'abord les soins à domicile en tant que remplacement des soins de courte durée.

En 1999<sup>192</sup>, Santé Canada a montré qu'à l'échelle nationale, le tiers des personnes recevant des soins à domicile présentent des besoins de courte durée et que les deux tiers utilisent des services à long terme (tableau 1). Ceux-ci reçoivent des soins prolongés tandis que le premier groupe reçoit des soins actifs à domicile, généralement pour une courte période suivant l'hospitalisation. Les transformations qu'a subies récemment le milieu hospitalier en raison des fermetures et des fusions, des réductions marquées des durées de séjour et de la modification radicale de la taille et de la fonction des hôpitaux ont accru la proportion de soins à domicile puisqu'elles ont augmenté les soins actifs à domicile après une hospitalisation.

***Les transformations qu'a subies récemment le milieu hospitalier en raison des fermetures et des fusions, des réductions marquées des durées de séjour et de la modification radicale de la taille et de la fonction des hôpitaux ont accru la proportion de soins à domicile, puisqu'elles ont augmenté les soins actifs à domicile après une hospitalisation.***

Les soins à domicile ne sont plus réservés aux personnes âgées. Quarante-cinq pour cent des consommateurs de soins à domicile en Ontario ont moins de 65 ans, et quinze

---

<sup>192</sup> Programmes provinciaux et territoriaux de soins à domicile : Une synthèse pour le Canada, Santé Canada, juin 1999.

pour cent sont des enfants<sup>193</sup>. De plus, les profils de services sont distincts pour les deux groupes principaux formant la clientèle des soins à domicile. Les bénéficiaires de soins actifs à domicile reçoivent des soins pour une courte période, généralement inférieure à 90 jours; l'autre groupe, composé principalement de personnes âgées ou handicapées, reçoit des soins de façon permanente ou continue. Pour ce qui est des soins à court terme, la plus grande part est dispensée par des services infirmiers (63 %), le reste étant réparti entre les services de soutien personnel (20,6 %) et les autres thérapies (16,4 %). À l'opposé, chez les bénéficiaires de soins prolongés, les services de soutien personnel viennent en premier (59,2 %), suivis des soins infirmiers (35,5 %); les services thérapeutiques sont rarement nécessaires<sup>194</sup>.

**TABLEAU 81**  
**POURCENTAGES DE CLIENTS DES SERVICES À COURT TERME, À LONG TERME ET AUTRES , 1996-1997 (TERRITOIRES OÙ DES DONNÉES SONT DISPONIBLES)**

Province / Territoire	Clients – soins de courte durée	Clients – soins de longue durée	Autres	Total
C.-B.	56,4	34,5	Non disp.	90,9
Alb.	41,0	52,0	7,0	100,0
Sask.	22,9	70,5	6,6	100,0
Québec	21,1	63,7	15,2	100,0
N.-B.	53,3	46,6	Non disp.	99,9
Î.-P.-É.	20,0	75,0	5,0	100,0
Yukon	16,6	73,7	9,6	99,9
<b>Canada</b>	<b>33,0</b>	<b>58,0</b>	<b>8,7</b>	<b>99,7</b>

Le Comité estime que le modèle de prestation de soins à domicile mis de l'avant par le Nouveau-Brunswick mérite d'être souligné.

### **8.3 Le programme extra-mural au Nouveau-Brunswick**

Fondé en 1981, sous la direction de Brenda Robertson (alors ministre de la Santé et maintenant sénatrice et membre du Comité), l'Hôpital extra-mural du Nouveau-Brunswick a été le premier programme public d'hospitalisation à domicile au pays, souvent cité comme modèle possible pour les autres territoires. Les services de l'Hôpital, désigné corporation hospitalière en vertu de la *Loi hospitalière du Nouveau-Brunswick*, étaient admissibles aux fins d'assurance par la province. La mission de l'Hôpital extra-mural du Nouveau-Brunswick consistait à fournir une gamme complète de services de soins de santé coordonnés pour les personnes de tout âge en vue de promouvoir, de maintenir et/ou de restaurer la santé, dans le contexte de leur vie quotidienne<sup>195</sup>.

<sup>193</sup> Laporte, A., Croxford, R., Coyte, P.C., *Access to home care services The role of socio-economic status*, Présentation à la conférence de l'Association canadienne pour la recherche en économie de la santé, Halifax, mai 2002.

<sup>194</sup> *Ibid*

<sup>195</sup> Mémoire présenté au Comité, p. 3.



En 1996, l'Hôpital extra-mural du Nouveau-Brunswick a subi une importante restructuration. En effet, un changement législatif a modifié le statut de l'Hôpital extra-mural qui, de corporation hospitalière, est devenu le programme extra-mural (PEM) actuel. La gestion des unités existantes de prestation de services a été déléguée aux huit corporations hospitalières régionales (CHR). Les CHR gèrent les établissements hospitaliers, les centres de santé communautaires (quatre dans la province) et les unités de prestation de services extra-muraux situées dans leur territoire. Bien que la gestion de la prestation des services ait été décentralisée, la direction globale, y compris le développement, l'établissement de normes, le financement et la surveillance du programme extra-mural (PEM), relève de la division des services hospitaliers du ministère de la Santé et des Services communautaires.

Trente centres de prestation de services dispensent les services du PEM partout dans la province. Le personnel comprend des coordonnateurs cliniques, des infirmières de liaison, des employés de soutien et du personnel sur place spécialisé en nutrition, en soins infirmiers, en ergothérapie, en physiothérapie, en orthophonie, en service social et en inhalothérapie. Tous les professionnels sont des employés du PEM et travaillent dans des équipes interdisciplinaires. Les services de soutien, tels l'aide ménagère et la « popote roulante », sont fournis à contrat. Le personnel de soins directs assure aussi la gestion des cas. Les services infirmiers sont disponibles 24 heures sur 24, 7 jours sur 7; tous les autres services sont fournis du lundi au vendredi.

Les clients du programme sont classés en quatre catégories ou groupes :

- **Soins de courte durée** – Objectifs : permettre la sortie de l'hôpital plus tôt ou prévenir des admissions à l'hôpital ou dans des établissements plus coûteux; fournir une évaluation et intervenir dans l'environnement naturel des clients afin d'améliorer ou de restaurer les fonctions. Les services offerts sont, entre autres, la chimiothérapie sélective, l'oxygénothérapie, la gestion du diabète, la thérapie intraveineuse, les soins des plaies, l'hydratation par intraveineuse, l'administration de médicaments ainsi que la réadaptation postopératoire.
- **Soins prolongés** – Objectifs : maintenir la santé/les fonctions ou prévenir une détérioration supplémentaire de la santé/des fonctions, ce qui permet aux personnes de demeurer dans leur environnement aussi longtemps que possible. Les services comprennent, entre autres, l'oxygénothérapie, l'évaluation, la gestion et la surveillance de la médication, le contrôle de la position assise et de la posture, les aides ou ordonnances en équipement d'adaptation, le soutien aux personnes utilisant un dispositif de ventilation artificielle et la thérapie de groupe.
- **Soins de promotion/de prévention** – Objectifs: fournir des renseignements, des conseils ou toute combinaison prévue de soutiens éducationnel et organisationnel dans le but de maintenir ou d'améliorer la santé, prévenir les blessures, les maladies, les affections chroniques et les incapacités qui en résultent.
- **Soins palliatifs** – Objectifs : intervenir afin d'aider à atténuer la douleur et à gérer les symptômes d'une maladie en phase terminale; fournir du soutien et

un répit aux clients et à leurs aidants naturels, afin que ces personnes puissent mourir à la maison ou retarder, aussi longtemps qu'elles le souhaitent, leur admission dans un établissement de soins médicaux.

Chaque catégorie de soins comporte des éléments d'évaluation, de traitement, de formation et de consultation. Les services fournis servent à favoriser le plus longtemps possible l'autonomie du client. Au moment de la création du PEM, son budget s'établissait à 250 000 \$. Comme le montre le tableau 8.2, le budget du programme s'élève maintenant à quelque 40 millions de dollars, dans une province dont la population dépasse à peine 750 000 personnes, illustrant comment il est possible de mettre en œuvre progressivement un programme complet de soins à domicile.

### **8.3.1 S'inspirer de l'exemple du Nouveau-Brunswick : renvois directs aux soins à domicile**

Le Comité a relevé en particulier le fait que le PEM du Nouveau-Brunswick permet aux médecins de diriger les patients directement vers le programme. Cheryl Hansen, directrice provinciale du PEM, a signalé dans son mémoire au Comité qu'entre 50 et 60 % des clients du PEM reçoivent des services de courte durée ou des soins actifs qui remplacent les soins hospitaliers. Mme Hansen a en outre signalé qu'environ 55 % des bénéficiaires de soins de courte durée sont admis directement à partir de leur collectivité<sup>196</sup> et ne sont pas hospitalisés au préalable. Le Comité souligne cet aspect du PEM dans l'espoir que d'autres compétences voudront élaborer des programmes semblables, offrant la possibilité d'élargir la gamme de services offerts aux Canadiens en vertu de la *Loi canadienne sur la santé*, de façon efficace et économique.

***[...] environ 55 % des bénéficiaires de soins de courte durée sont admis directement à partir de la collectivité<sup>1</sup> et ne sont pas hospitalisés au préalable. Le Comité souligne cet aspect du PEM dans l'espoir que d'autres compétences voudront élaborer des programmes semblables, offrant la possibilité d'élargir la gamme de services offerts aux Canadiens en vertu de la Loi canadienne sur la santé de façon efficace et économique.***

---

<sup>196</sup> Mémoire présenté au Comité, p. 3.

**TABLEAU 8.2**  
**PROGRAMME EXTRA-MURAL – DONNÉES VARIÉES**

	<b>1996-1997</b>	<b>1997-1998</b>	<b>1998-1999†</b>	<b>1999-2000†</b>	<b>2000-2001*‡</b>
Personnel (ETP)	527	590	592	608	668
Séparations <sup>3</sup>	10 866	11 972	12 680	13 924	19 941
Visites – soins infirmiers <sup>1, 3</sup>	270 145	275 586	295 817	326 630	282 813
Visites – réadaptation <sup>2, 3</sup>	34 107	64 080	93 459	87 946	78 609
Autres visites <sup>3</sup>	40 457	42 587	43 522	45 040	39 148
Total des visites	344 709	382 253	432 720	459 616	400 570
Dépenses brutes (M \$)	28,6	31,7	35,0	37,2	39,7
Coût moyen / visite <sup>3</sup>	83 \$	83 \$	81 \$	81 \$	99 \$
Coût moyen / séparation <sup>3</sup>	2 632 \$	2 662 \$	2 758 \$	2 674 \$	1 990 \$

Source: ministère de la Santé et du Mieux-être du Nouveau-Brunswick, Rapport annuel 2000-2001.

Notes :

1. Comprend les visites en ergothérapie, en physiothérapie et en orthophonie.
2. Comprend les visites en travail social, en nutrition clinique et en inhalothérapie.
3. Pour l'exercice 1999-2000 seulement, en raison de la mise en œuvre d'un nouveau système d'information pour le PEM, les statistiques sont des estimations basées sur les données relatives aux activités d'avril à septembre 1999.

† Hausses de recrutement et de volume attribuables au Plan de services de réadaptation.

\* Données provisoires.

‡ Les données peuvent varier par rapport aux années précédentes car, en 2000-2001, le PEM a commencé à utiliser un nouveau système d'information (EMP Information System). La cueillette des statistiques est effectuée en conformité avec les directives du système d'information de gestion du Nouveau-Brunswick pour l'année 2000-2001.

#### **8.4 Organiser et fournir des soins actifs à domicile**

Dans la présente section, ainsi que dans les deux sections suivantes, le Comité expose sa proposition visant l'établissement d'un programme national d'assurance publique pour les soins actifs à domicile, c'est-à-dire à l'intention des personnes ayant besoin de traitements à domicile à la suite d'une hospitalisation<sup>197</sup>. Il décrit les mécanismes de financement, de prestation et d'organisation en vue de ce type de soins.

***[...] le Comité croit qu'il importe, pour le moment, de se concentrer sur le financement, l'organisation et la prestation de services de soins actifs à domicile.***

<sup>197</sup> Le Comité désire souligner l'aide précieuse fournie par le Dr Peter Coyte afin de préparer sa proposition visant l'élaboration d'un programme national public de soins actifs à domicile. M. Coyte est professeur en économie de la santé et président des services de santé CIHR/FCRSS à l'Université de Toronto. Il est également co-directeur du Home and Community Care Evaluation and Research Centre et président de l'Association canadienne pour la recherche en économie de la santé. Plusieurs recommandations ont été élaborées par le professeur Coyte dans un document d'appui préparé à la demande du Comité.

Bien que d'autres types de services de soins à domicile soient actuellement disponibles, le Comité croit qu'il importe, pour le moment, de se concentrer sur le financement, l'organisation et la prestation de services de soins actifs à domicile. L'objectif du Comité est de promouvoir la création d'un nouveau programme national d'assurance publique pour les services qui, parce qu'ils sont fournis à domicile, ne tombent pas sous le régime de la *Loi canadienne sur la santé*. Bien qu'il ne propose pas un programme complet de soins à domicile, le Comité est convaincu de l'importance d'amorcer dès maintenant, dans la mesure où la situation financière le permet, l'élargissement du « filet de sécurité » en matière de soins de santé au Canada. Or, le Comité estime que le programme qu'il propose est réalisable sur le plan financier.

#### **8.4.1 Définition des soins actifs à domicile**

Les soins actifs à domicile désignent les soins prodigués aux patients à domicile, à la suite d'une période d'hospitalisation. Le premier défi que pose l'élaboration d'un programme national de soins actifs à domicile consiste à définir et à classer les soins à domicile suivant une période d'hospitalisation et à décrire comment il est possible de les relier à une période initiale de soins hospitaliers, en tant que services aux patients hospitalisés ou aux patients en chirurgie d'un jour.

**[...] le Comité est convaincu de l'importance d'amorcer dès maintenant, dans la mesure où la situation financière le permet, l'élargissement du « filet de sécurité » en matière de soins de santé au Canada. Or, le Comité estime que le programme qu'il propose est réalisable sur le plan financier.**

##### **8.4.1.1 Quand les services de soins actifs à domicile (SAD) commencent-ils?**

Heureusement, il y a eu des études sur la définition des soins actifs à domicile dans le contexte de la restructuration des services de santé<sup>198</sup>. Pour la plupart des spécialistes, le bénéficiaire de soins actifs à domicile est défini comme étant une personne ayant reçu sa première visite de soins à domicile dans les trente jours après avoir été hospitalisée ou après avoir reçu son congé à la suite d'une hospitalisation d'un jour. Il est peu probable que, passé ce délai, les soins à domicile soient directement liés à l'hospitalisation<sup>199</sup>. Un intervalle plus court que trente jours risque d'exclure les soins actifs à domicile reportés à cause de problèmes d'horaire ou autres.

**Le Comité propose donc que le bénéficiaire de soins actifs à domicile soit défini comme étant une personne ayant reçu sa première visite de soins à domicile dans les trente jours après avoir été hospitalisée ou après avoir reçu son congé à la suite d'une hospitalisation d'un jour.**

<sup>198</sup> Coyte, P.C., Young, W., Regional variations in the use of home care services in Ontario, 1993/1995. *Canadian Medical Association Journal*, 161:4, 376-380, 1999; Coyte, P.C., Young, W., *Reinvestment in and use of home care services*, Rapport technique n° 97-05-TR, Institute for Clinical Evaluative Studies, Toronto (Ontario), novembre 1997; Coyte, P.C., Young, W., DeBoer, D., *Home care report for the Health Services Restructuring Commission*. Rapport à la Commission de restructuration des services de santé, Toronto, 1997.

<sup>199</sup> Hollander, M., *The costs, and cost-effectiveness of continuing care services in Canada*. Queen's-University of Ottawa Economic Projects Ottawa, 1-113, 1994; Coyte et Young (1999); Coyte et Young (1997); Coyte, Young et DeBoer

Le Comité propose donc que le bénéficiaire de soins actifs à domicile soit défini comme étant une personne ayant reçu sa première visite de soins à domicile dans les trente jours après avoir été hospitalisée ou après avoir reçu son congé à la suite d'une hospitalisation d'un jour.

#### **8.4.1.2 Quand les SAD se terminent-ils?**

Bien qu'il semble y avoir consensus quant à la définition de bénéficiaire des SAD, il est plus difficile de définir quels services sont directement liés à l'hospitalisation. Généralement, la solution a été de fixer une date arbitraire au-delà de laquelle on pouvait considérer que la poursuite des services à domicile était sans lien avec les motifs ayant nécessité l'hospitalisation. Dans certains cas, la date limite a été fixée à un an après le congé<sup>200</sup> et dans d'autres cas, à soixante jours. L'une des raisons invoquées pour justifier la période de soixante jours est le fait qu'elle correspond à la classification de soins de court séjour (ou de courte durée), les périodes de soins à domicile de plus de soixante jours étant alors classées comme périodes de long séjour (ou soins prolongés).

Il importe de souligner que, pour la plus de la moitié des bénéficiaires de SAD, les soins à domicile se terminent avant 30 jours; pour presque 70 % des bénéficiaires de SAD, les soins prennent fin avant 60 jours, et seulement 12,7 % reçoivent des SAD pendant plus de 6 mois. Le Comité a donc décidé d'adopter une période limite de 3 mois, soit un compromis entre 60 jours et 6 mois. Ainsi, pour 75 % à 80 % des bénéficiaires de SAD, les soins auront pris fin avant la fin des trois premiers mois.

Par conséquent, le Comité recommande :

**Qu'une période de SAD désigne l'ensemble des services de soins à domicile reçus entre la première date de prestation de services suivant le congé d'hospitalisation, si cette date survient moins de trente jours après le congé, jusqu'à concurrence de trois mois après le congé de l'hôpital.**

#### **8.4.2 Dispositions organisationnelles pour les SAD**

Nous établissons plus loin l'estimation nationale du coût total du programme SAD. Cependant, l'affectation des fonds et les mécanismes d'attribution des responsabilités en matière d'organisation et de prestation de tels soins sont des questions extrêmement importantes. La présente section expose donc les mécanismes de financement, d'organisation et de prestation des SAD.

Le contrôle et la responsabilité de l'organisation et de la prestation des SAD sont confiés à diverses instances au Canada, mais ils relèvent généralement d'organismes distincts des hôpitaux. Cette situation a créé des courants d'intérêts parallèles bien arrêtés, opposant les organismes responsables des soins hospitaliers à ceux ayant charge des soins à domicile et

---

(1997); Kenney, G.M., How access to long-term care affects home health transfers. *Journal of Health Politics Policy and Law*, 83: 412-414, 1993.

<sup>200</sup> Coyte et Young (1999); Coyte et Young (1997); Coyte, Young et DeBoer (1997).

entraînant un conflit qui a réduit les possibilités d'intégrer les services, freiné l'innovation et limité inutilement la rentabilité des services.

Par conséquent, le Comité croit que ce serait une erreur de continuer à financer les organismes chargés en propre de négocier, de choisir, d'approuver et d'évaluer (à l'interne ou à l'externe) les dispositions contractuelles avec les fournisseurs de soins à domicile. La création d'un nouveau programme distinct, d'un autre ensemble d'intérêts particuliers, ne contribuera pas à garantir que les ressources financières servent le bénéficiaire des soins. Pour ce qui est des SAD, les ressources financières devraient être dirigées d'abord vers les hôpitaux. C'est pourquoi le Comité recommande :

**Que le financement des soins actifs à domicile soit d'abord dirigé vers les hôpitaux.**

Il a été souvent démontré que les hôpitaux réagissent de façon prévisible aux encouragements fiscaux. L'introduction d'un remboursement basé sur les services, en vertu duquel les hôpitaux seraient remboursés à un tarif fixe pour chaque type de service fourni (conformément aux recommandations

***Le fait de diriger les ressources financières associées aux SAD vers les hôpitaux leur permettra de bénéficier des économies potentielles associées aux séjours plus courts, favorisant ainsi l'utilisation des soins à domicile et des SAD.***

formulées par le Comité au chapitre deux, au sujet du financement hospitalier), inciterait à raccourcir la durée des séjours et à déplacer l'ensemble des cas hospitaliers vers la chirurgie d'un jour et à les détourner des soins à l'hôpital<sup>201</sup>. De plus, étant donné la relation entre les SAD et les soins hospitaliers, l'introduction pour les hôpitaux du remboursement basé sur les services augmenterait leurs besoins en SAD<sup>202</sup>.

Le fait de diriger les ressources financières associées aux SAD vers les hôpitaux permettra à ces derniers de bénéficier des économies potentielles associées aux séjours plus courts, favorisant ainsi l'utilisation des soins à domicile et des SAD<sup>203</sup>. Par contre, si les fonds pour la prestation de services de soins à domicile sont versés à un organisme distinct, l'économie potentielle due aux séjours plus courts ou au recours à la chirurgie d'un jour ne serait pas récupérée et, par conséquent, elle n'aurait pas un impact direct sur les décisions relatives à la prestation de services.

<sup>201</sup> Plusieurs études ont exploré la classification des périodes d'hospitalisation et des SAD connexes. En se basant sur le travail accompli par la Commission de restructuration des services de santé en Ontario, par exemple, il serait possible d'assigner chaque hospitalisation et chaque cas de chirurgie d'un jour soit à l'une des vingt-cinq catégories cliniques principales, de type exclusif et exhaustif, dans le cas de soins à l'hôpital (hospitalisation), soit à un des six groupes de chirurgie d'un jour. [Coyte et Young (1999); Coyte et Young (1997); Coyte, Young et DeBoer (1997); Kenney (1993); Institut canadien d'information sur la santé : *Length of stay database by CMG*. Institut canadien d'information sur la santé, Ottawa, 1994. Institut canadien d'information sur la santé, *DPG booklet*. Institut canadien d'information sur la santé, Ottawa, 1996.]

<sup>202</sup> Kenney (1993); Kenney, G.M., Understanding the effects of PPS on Medicare home health use. *Inquiry*, 28: 129-139, 1991.

<sup>203</sup> Kenney (1993).

Par conséquent, le Comité croit que les gains d'efficacité, en matière de prestation de soins hospitaliers et de SAD, sont favorisés par l'intégration verticale de ces services et de leur financement conjoint. Il recommande donc ce qui suit :

**Afin d'encourager l'innovation et l'intégration de services et d'améliorer l'efficacité et l'efficacités des services de soins de santé nécessaires, indépendamment du cadre dans lequel ces services sont reçus, que soit élaborée une méthode de remboursement pour les SAD, basée sur les services, conjointement avec les arrangements fondés sur les services pour chaque période de soins hospitaliers.**

De plus, le Comité estime qu'il faut éviter de réserver les programmes de SAD aux services infirmiers et thérapeutiques, si l'on ne veut pas déformer les modèles de pratique; en effet, les bénéficiaires de SAD, comme les autres consommateurs de soins à domicile, utilisent la gamme complète des services offerts. Le fait de limiter l'étendue des services couverts par le programme pourrait encourager les hôpitaux à substituer des services infirmiers à d'autres services de soutien personnel qui auraient été plus efficaces en matière de coûts. Or, en agissant ainsi, les hôpitaux risquent d'augmenter les coûts des soins au lieu de les réduire.

C'est ce qu'a confirmé l'expérience du Programme extra-mural du Nouveau-Brunswick. Dans son exposé au Comité, Cheryl Hansen a mentionné qu'une des leçons apprises était que :

*Le remplacement des soins actifs par des soins à domicile exige une équipe complète qui travaille en collaboration pour satisfaire aux besoins du client et de la famille. Un élément essentiel des services de soins actifs réside dans la prestation de services de soutien à domicile à court terme adaptés (p. ex., les services d'un auxiliaire familial). [...] La question du financement et de la prestation d'un soutien suffisant à court terme doit être réglée pour que le recours aux soins à domicile en guise de remplacement/substitution permette d'assurer des services de qualité au client et à la famille<sup>204</sup>.*

Pour ces raisons, le Comité croit que les dispositions de remboursement pour la prestation de soins à domicile à la suite d'une hospitalisation devraient être suffisamment souples afin d'encourager l'innovation et l'efficacité. C'est pourquoi il recommande :

**Que la gamme de services, de produits et de technologies pouvant être utilisée pour faciliter les soins à domicile après une hospitalisation ne fasse pas l'objet de restrictions.**

#### **8.4.3 Qui fournit des SAD?**

Le Comité reconnaît que la question de l'organisation et de la prestation des SAD est une question distincte du financement; il sait aussi que la prestation de ces services peut prendre différentes formes. Dans certains cas, les hôpitaux peuvent fournir les services eux-mêmes; dans d'autres cas, ils peuvent établir des contrats avec des fournisseurs de soins à

<sup>204</sup> Mémoire présenté au Comité, 17 juin 2002, p. 7.

domicile à but lucratif ou non; les hôpitaux peuvent aussi établir des contrats avec des agences intermédiaires qui concluent des contrats de sous-traitance avec les fournisseurs de soins de santé à domicile.

Les SAD peuvent donc être organisés de multiples façons, offrant chacune ses avantages. Premièrement, l'établissement d'agences intermédiaires pour les soins à domicile fournit l'occasion aux hôpitaux de mettre en commun des ressources et de réaliser des économies d'échelle dans la prestation des services, malgré le risque d'engendrer des coûts supplémentaires d'administration et de gestion des contrats.

***Dans certains cas, les hôpitaux peuvent fournir les services eux-mêmes; dans d'autres cas, ils peuvent établir des contrats avec des fournisseurs de soins à domicile à but lucratif ou non; les hôpitaux peuvent aussi établir des contrats avec des agences intermédiaires qui concluent des contrats de sous-traitance avec les fournisseurs de soins de santé à domicile.***

Deuxièmement, les hôpitaux peuvent mettre sur pied des équipes de service à domicile adaptées aux conditions particulières que connaissent les bénéficiaires dans leur collectivité.

Enfin, les hôpitaux peuvent passer des contrats de sous-traitance avec les fournisseurs de services de soins à domicile. Ce genre d'arrangement comporte certains avantages, soit: permettre la prestation de services spécialisés par des fournisseurs qui connaissent bien les conditions du milieu; offrir une possibilité d'intégrer les services hospitaliers et les SAD; permettre des économies en raison des améliorations apportées aux modèles de soins.

Par conséquent, le Comité recommande :

**Que les hôpitaux aient la possibilité d'établir des liens contractuels directement avec les fournisseurs de soins à domicile ou avec des agences intermédiaires pouvant prendre des dispositions en matière de prestation de services et de gestion de cas.**

Indépendamment de l'arrangement organisationnel choisi, le fournisseur de SAD devrait recevoir un remboursement en fonction des services fournis. Comme le montre en détail le chapitre deux, la somme que reçoit le fournisseur dans un régime de financement en fonction des services offerts dépend de la gravité du cas traité.

***Indépendamment de l'arrangement organisationnel choisi, le fournisseur de SAD devrait recevoir un remboursement en fonction des services fournis.***

Par conséquent, le niveau de financement devrait être dicté par des facteurs cliniques. Cette méthode garantit que les fournisseurs de SAD reçoivent un taux fixe pour les services offerts à un patient donné, soutenant ainsi l'innovation et l'intégration des services et améliorant l'efficacité et l'efficacités de la répartition des services de soins de santé.



Le fait de rembourser les fournisseurs de services de soins à domicile selon un mode de paiement fixe et prédéterminé offre un certain nombre d'incitatifs. Premièrement, s'ils peuvent conserver les résultats résiduels nets, les fournisseurs sont encouragés à choisir les moyens les plus efficaces pour des services. Deuxièmement, les efforts visant à profiter des économies d'échelle et de gamme peuvent favoriser l'intégration verticale et horizontale des services. Des organismes ainsi intégrés peuvent être en meilleure position que d'autres pour déléguer les tâches de façon rentable et améliorer la continuité des soins. Troisièmement, dans la mesure où le paiement dépasse les coûts engagés pour la prestation de services, ce système incite les organismes à se faire concurrence pour obtenir de nouveaux bénéficiaires<sup>205</sup>.

Toutefois, ce système comporte un désavantage en ce qu'il peut inciter les fournisseurs de soins à se désintéresser des bénéficiaires présentant des besoins élevés, c'est-à-dire à choisir les clients. De plus, en l'absence d'un programme d'évaluation vigilant, les organismes seront tentés de lésiner sur la prestation des services, entraînant une réduction de la qualité des soins<sup>34</sup>. Par conséquent, la détermination d'un juste paiement basé sur les services, ajusté aux risques et adapté aux besoins des bénéficiaires de SAD, et l'introduction d'un programme systématique d'évaluation du rendement en fonction des résultats attendus doivent faire l'objet de politiques élaborées dans le contexte des nouveaux modes de financement afin d'assurer la rentabilité et l'uniformité d'accès de SAD de qualité.

Le Comité recommande donc :

**Que les contrats établis avec les fournisseurs de services de soins à domicile incluent, en plus des ententes de remboursement en fonction des services, des mécanismes pour surveiller la qualité et le rendement des services, ainsi que les résultats prévus.**

## **8.5 Le coût d'un programme national de soins actifs à domicile**

### **8.5.1 Comment calculer le coût d'un programme national de SAD**

Comme le montre la figure 3, il existe de larges variations interprovinciales dans les dépenses publiques par personne pour les soins à domicile au Canada, qui persistent même après l'ajustement relatif aux variations de composition âge-sexe de la population visée. Le financement public moyen par personne pour les soins à domicile pour l'exercice 2000 s'élevait à 87,51 \$. Cependant, on note un écart de quatre pour un dans ces dépenses entre le niveau le plus élevé, le Nouveau-Brunswick (193,76 \$), et le plus bas, l'Île-du-Prince-Édouard (47,85 \$) et le Québec (51,89 \$)<sup>206</sup>. Ces écarts sont en partie attribuables à la portée du programme public de soins à domicile, qui peut être vaste (comme au Nouveau-Brunswick) ou assez restreinte (comme à l'Île-du-Prince-Édouard et au Québec).

---

<sup>205</sup> Valdeck, B.C., Miller, N.A., The Medicare home health initiative. *Health Care Financing Review*, 16:1, 7 – 16, 1994; Phillips, B.R., Brown, R.S., Bishop, C.E., et autres, Do preset per visit payments affect home health agency behaviour? *Health Care Financing Review*, 16:1, 91- 107, 1994.

<sup>206</sup> Santé Canada, *Dépenses de santé au Canada selon l'âge et le sexe, 1980-1981 à 2000-2001*. Politique de la santé et communications, Santé Canada, Ottawa, août 2001.

À l'échelle nationale, les dépenses publiques en soins à domicile s'élevaient à 2 690,9 millions de dollars pour l'exercice 2000<sup>207</sup>. Afin d'établir la proportion de ces dépenses associée aux SAD, le Comité a utilisé des méthodes basées sur des travaux effectués auparavant en Ontario pour la Commission de restructuration des services de santé<sup>208</sup>. Tous les bénéficiaires de soins à domicile ont été identifiés pour l'exercice 1997 et assignés à l'une des quatre catégories mutuellement exclusives, comme le montre la figure 4, en fonction de leur utilisation des soins à domicile relativement à toute période de soins hospitaliers.

Les bénéficiaires de soins à domicile ont tout d'abord été classés selon qu'ils ont ou non vécu une période de soins hospitaliers, soit en tant que patient hospitalisé ou lors d'une chirurgie d'un jour, durant l'exercice 1997<sup>209</sup>. S'ils avaient été hospitalisés, la prestation de services de soins à domicile moins de 30 jours après le congé était analysée. Si la visite de soins à domicile à la suite de l'hospitalisation avait eu lieu dans une période de trente jours, l'utilisation de services de soins à domicile dans les trente jours avant l'hospitalisation était analysée. Les quatre catégories de bénéficiaires de soins à domicile étaient donc établies comme suit : pas d'hospitalisation; pas de SAD; SAD sans soins à domicile antérieurs; et SAD avec soins à domicile antérieurs.

L'utilisation de services de soins à domicile et le coût moyen de ces services ont été analysés pour une année à partir de la date des premiers services de soins à domicile (pour les bénéficiaires qui n'ont pas reçu de SAD), ou de la date des premiers soins à domicile suivant le congé de l'hôpital (pour les bénéficiaires qui ont reçu des SAD).

Deux estimations sont proposées pour la proportion du coût total des soins à domicile imputable aux SAD. La première estimation (la plus élevée) a été établie en fonction de la proportion de *bénéficiaires* de soins à domicile ayant reçu des SAD, tandis que la deuxième estimation (la plus basse), a été établie en fonction de la proportion de *dépenses* attribuables à ces soins. Bien que 42,8 % des bénéficiaires de soins à domicile aient reçu des SAD, seulement 26,5 % des dépenses totales de soins à domicile étaient attribuables à ces soins. Conséquemment, l'utilisation des deux estimations du coût national du programme de SAD tient compte de l'incertitude associée à l'estimation de coûts d'un programme de ce genre, dans l'absence d'un système d'information sur la santé relatif à l'utilisation des services de soins à domicile.

### **8.5.2 Et les coûts cachés?**

En plus du coût des services de soins à domicile, il existe d'autres coûts associés à la prestation de SAD, cachés dans d'autres catégories de dépenses provinciales. Le coût des médicaments constitue une composante majeure des coûts cachés. Pour l'exercice 2001, les dépenses du programme de médicaments de l'Ontario attribuables aux bénéficiaires de soins à domicile étaient évaluées à 86,8 millions de dollars<sup>210</sup>. Bien que ces données reflètent probablement une sous-estimation des coûts du programme de médicaments provinciaux associés

---

<sup>207</sup> *Ibid.*

<sup>208</sup> Coyte et Young (1999); Coyte et Young (1997); Coyte, Young et DeBoer (1997).

<sup>209</sup> Voir la figure 8.4.

<sup>210</sup> Peter Coyte, Communication personnelle, M. Carl Marshall, directeur associé, Administration, finance et admissibilité, programmes de médicaments, Ministère de la santé et des soins de longue durée de la province de l'Ontario, 2002.

à la prestation de soins à domicile, elles peuvent servir à estimer les coûts cachés liés à la prestation de SAD<sup>211</sup>.

### **8.5.3 Combien coûtera un programme national de SAD?**

Dans un calcul effectué pour le Comité, on a combiné les estimations de coûts cachés à celles des coûts directs liés aux services, convertis en dollars 2002, en utilisant la croissance de 11,9 % du financement dans le domaine des soins à domicile en Ontario entre les exercices 2000 et 2002, et on a estimé le coût des soins actifs à domicile pour une période d'un an à la suite d'une hospitalisation. D'après ce calcul, un programme national de SAD coûterait, au total, entre 1 021,1 millions et 1 511,8 millions de dollars pour l'exercice 2002<sup>212</sup>. Puisqu'il a été établi qu'une couverture de trois mois serait plus appropriée, le Comité juge légitime d'évaluer le coût total du programme à environ 1,100 millions par année, tout en reconnaissant que même cette évaluation est probablement élevée.

## **8.6 Payer les soins post-hospitaliers à domicile**

Le Comité croit que le coût d'un tel programme devrait être partagé à parts égales entre les gouvernements provinciaux et le gouvernement fédéral. Il recommande donc :

**Que le gouvernement fédéral établisse un nouveau programme national de soins actifs à domicile, qu'il financera à parts égales avec les provinces et territoires (50 / 50).**

Cela ramènerait les dépenses totales (en dollars de l'exercice 2002) du gouvernement fédéral au regard d'un programme national de SAD à environ 550 millions de dollars.

Cependant, on doit aussi se demander si la personne recevant les soins à domicile (le patient) devrait aussi aider à couvrir le coût de cette expansion des services publics de soins assurés. On peut examiner cette question sous deux angles.

D'une part, on peut concevoir que ce service prolongé vient de ce que le patient a effectué un séjour à l'hôpital. Par conséquent, le service sera un prolongement des soins hospitaliers qui, dans le régime d'assurance-maladie, doivent être « gratuits » pour le patient et entièrement payés par les fonds publics. De plus, l'un des avantages de cette option offrant une

---

<sup>211</sup> Supposons que les dépenses du programme de médicaments de l'Ontario attribuables aux soins de santé à domicile représentent seulement les coûts cachés engagés par les personnes de moins de soixante-cinq ans durant la période de soins à domicile reçus. Selon cette hypothèse, l'estimation des coûts cachés liés à cette période de soins à domicile s'élève à 627,97 \$ (en dollars 2001). Étant donné que ces coûts sont supposés être uniformes dans toutes les catégories de bénéficiaires de soins à domicile, ils peuvent servir à calculer un facteur d'inflation des « coûts cachés » pour les SAD. Ce facteur tenant compte de l'inflation peut être défini comme étant la valeur un plus le ratio des coûts cachés (627,97 \$) par rapport aux coûts par bénéficiaire de SAD. Ces derniers dépendent des coûts attribuables aux soins de santé à domicile pour les bénéficiaires de SAD divisés par le nombre de bénéficiaires (137 915 d'après la figure 4). En utilisant les chiffres de l'Ontario, conjointement avec l'estimation élevée des coûts de SAD, le facteur d'inflation des coûts cachés s'élève à 1,1731 tandis qu'il s'élève à 1,2796 en utilisant l'estimation plus basse des coûts de SAD.

<sup>212</sup> L'estimation basse a été calculée en utilisant la formule  $2\ 690,9\ M\ \$ * 1,119 * 0,265 * 1,2796$  tandis que l'estimation élevée a été dérivée de:  $2\ 690,9\ M\ \$ * 1,119 * 0,428 * 1,1731$ .

couverture au premier dollar est que, puisque le coût entier de la couverture des soins à domicile sera payé par le programme SAD, les patients n'ont pas de raison de s'objecter à de plus courts séjours à l'hôpital. Cela signifie que rien ne s'oppose au transfert de patients recevant des soins hospitaliers coûteux vers des services extra-hospitaliers moins chers, ce qui augmente les possibilités de gain en efficacité pour l'ensemble du système de soins de santé.

Par contre, étant donné que la plupart des patients paient actuellement le coût d'au moins une partie de ce genre de service, il est raisonnable qu'ils continuent de payer une petite partie des coûts, à la condition que les sommes versées par le patient soient ajustées à son revenu. Le montant payé par le patient devra être suffisamment modeste pour satisfaire le second objectif établi par le Comité au regard des soins de santé publics, c'est-à-dire qu'aucun Canadien ne doit subir de difficultés financières excessives en raison de la nécessité de payer des factures de soins de santé.

Pour appliquer cette deuxième approche, on a proposé de traiter les services assurés comme avantage imposable. Selon ce modèle, à la fin de l'année, les bénéficiaires du programme de SAD recevraient du gouvernement provincial un état des coûts totaux des services à domicile reçus. Ces coûts constitueraient un avantage imposable pour le patient. On pourrait protéger le patient contre les difficultés financières excessives associées au paiement de cette hausse d'impôt en limitant le niveau d'impôt sur le revenu additionnel à 3 % du revenu personnel.

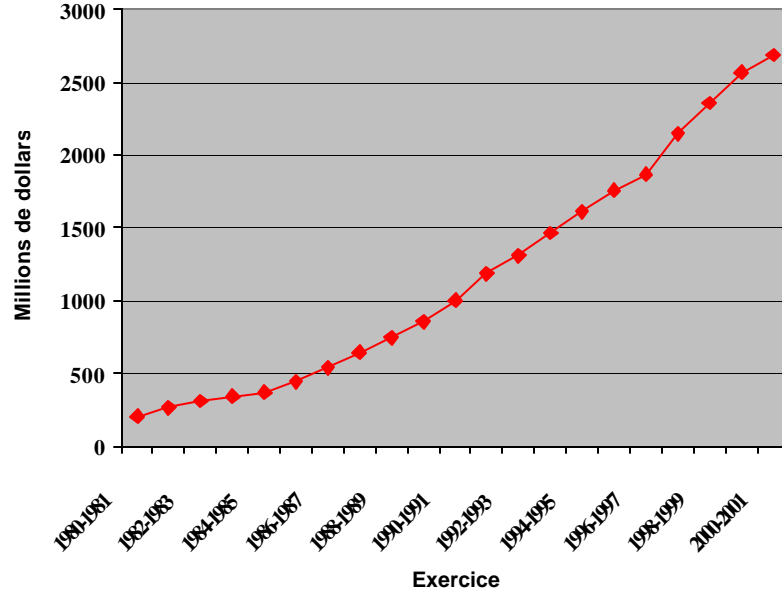
Cette approche suppose aussi que les nouvelles ressources financières publiques investies dans les services étendus de soins de santé doivent profiter aux Canadiens et Canadiennes les moins en mesure de payer ces services; ceux qui ont les moyens de le faire devront apporter une contribution financière pour aider à couvrir le coût de ces services. Nous maintenons que ce n'est qu'en adoptant cette approche d'expansion du système public de soins de santé que le Canada se donnera les moyens de fermer les écarts grandissants dans le « filet de sécurité » des soins de santé. En fait, c'est l'une des raisons pour lesquelles le programme d'assurance destiné à protéger les Canadiens contre le paiement de coûts vertigineux de médicaments, proposé par le Comité, comporte une contribution financière du patient.

Quoi qu'il en soit, en ce qui concerne l'adoption d'un nouveau programme de soins actifs à domicile, le Comité, après mûre réflexion, appuie la première des deux approches. Bien qu'il s'inquiète du précédent que constitue l'assurance au premier dollar de services étendus, le Comité estime que les avantages qu'offre cette approche en favorisant l'efficacité – puisqu'elle promeut le transfert de patients recevant des soins hospitaliers coûteux vers des soins à domicile moins chers – et l'équité, l'emportent sur les inconvénients.

En ce qui concerne l'expansion du régime public d'assurance-maladie pour y inclure les soins actifs à domicile, le Comité recommande donc :

**Que le programme des SAD soit considéré comme un prolongement de la couverture médicale nécessaire déjà prévue par la *Loi canadienne sur la santé* et que, par conséquent, le coût intégral du programme soit couvert par le gouvernement (à parts égales entre le gouvernement fédéral et les gouvernements provinciaux-territoriaux).**

Graphique 8.1 : Dépenses publiques en matière de soins à domicile au Canada, 1980-1981 à 2000-2001



Graphique 8.2 : Dépenses privées en matière de soins à domicile au Canada, 1980-1981 à 2000-2001

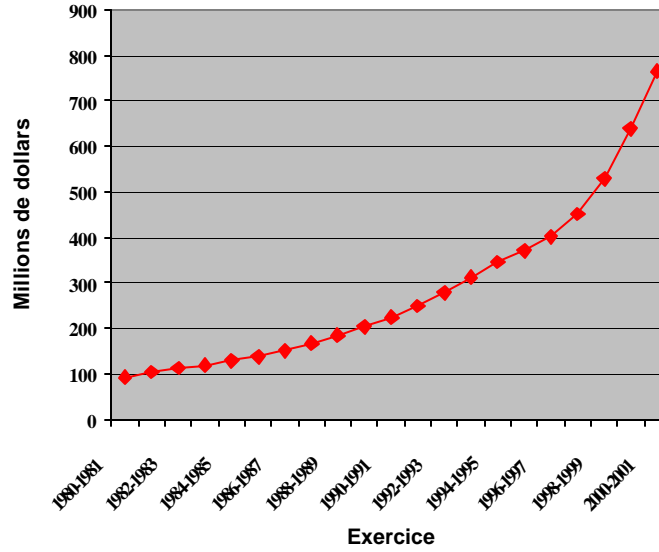


Figure 8.3: Dépenses publiques par personne en soins à domicile, pour les provinces et les territoires du Canada, 2000-2001

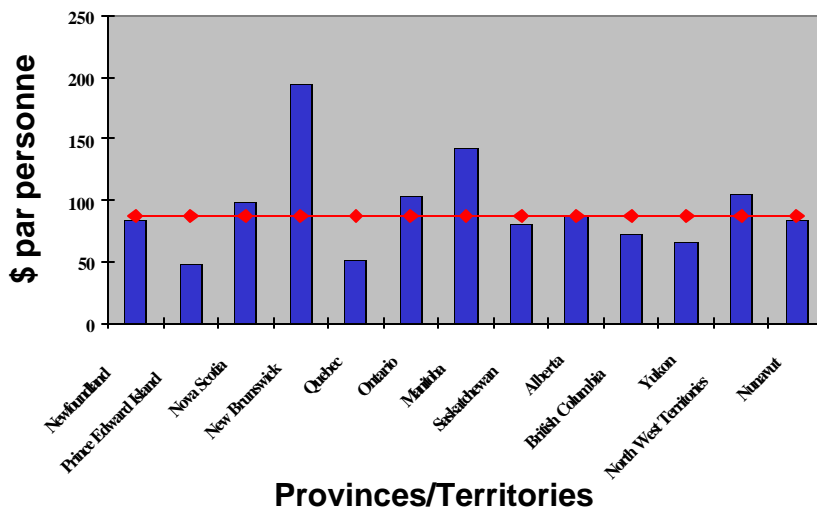
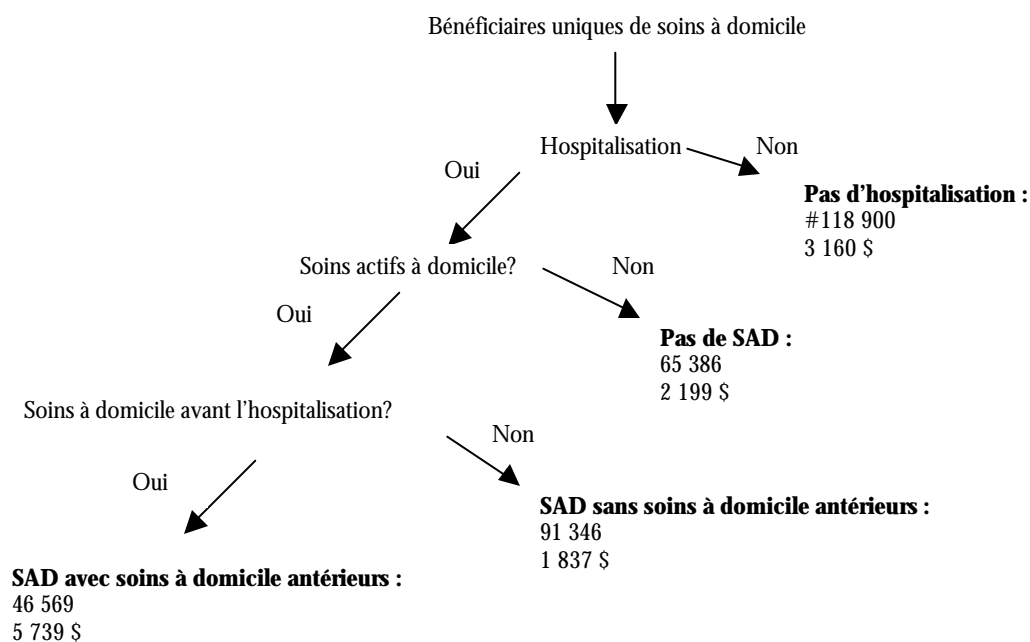


Figure 8.4 : Bénéficiaires de soins à domicile et dépenses moyennes (en dollars 2002)



## CHAPITRE NEUF

### ÉTENDRE LA COUVERTURE POUR INCLURE LES SOINS PALLIATIFS À DOMICILE

---

Au cours des différentes phases des audiences, on a porté à l'attention du Comité l'importance des soins palliatifs et des soins de fin de vie. Les soins palliatifs constituent un genre spécial de soins de santé qui s'adressent aux personnes atteintes d'une maladie mortelle en phase terminale, ainsi qu'à leur famille.

Les soins palliatifs ont pour but d'améliorer le plus possible la qualité de vie des malades en phase terminale en leur assurant confort et dignité et en soulageant leur douleur et leurs autres symptômes. Les soins palliatifs sont conçus pour répondre non seulement aux besoins physiques du malade, mais aussi à ses besoins psychologiques, sociaux, culturels, émotionnels et spirituels et à ceux de sa famille.

#### 9.1 Nécessité d'un programme national de soins palliatifs

Les soins palliatifs sont dispensés à divers endroits : à domicile, dans les hôpitaux, dans les établissements de soins de longue durée et, à l'occasion, dans les hospices. Comme l'a mentionné le sous-comité sénatorial chargé de mettre à jour le rapport *De la vie et de la mort* au mois de juin 2000, les services de soins palliatifs au Canada sont souvent fragmentés ou inexistantes. Il arrive que les malades n'y aient accès que peu de temps avant la mort ou même, dans bien des cas, qu'ils n'en bénéficient jamais. Le rapport indique aussi que les soins palliatifs dispensés dans les hôpitaux sont habituellement payés par les régimes d'assurance-santé provinciaux, qui couvrent en général les soins professionnels et les médicaments, les fournitures médicales et l'équipement dont le malade a besoin pendant son séjour à l'hôpital. Par contre, dans les établissements de soins de longue durée, les résidents doivent parfois payer divers montants pour leurs soins et leurs fournitures.

***Selon le Comité, il est clair qu'on doit assurer des soins palliatifs adéquats et universels et que ceux-ci doivent être dispensés de façon à respecter les volontés du mourant et des êtres qui lui sont chers.***

Selon le Comité, il est clair qu'on doit assurer des soins palliatifs adéquats et universels et que ceux-ci doivent être dispensés de façon à respecter les volontés du mourant et des êtres qui lui sont chers.

Diverses composantes du système de soins de santé interviennent dans les nombreux aspects des soins palliatifs de fin de vie. En ce qui touche les grandes orientations, il est important que le gouvernement fédéral et les provinces et territoires travaillent ensemble pour veiller à ce que les Canadiens reçoivent des soins adéquats et puissent faire des choix en matière de soins de fin de vie.

Le Comité reconnaît qu'il est important d'assurer l'accès aux services de soins palliatifs aux Canadiens de tous âges et dans tous les secteurs concernés du système de soins de santé, à savoir les hôpitaux, les hospices, les services communautaires et les organisations non

gouvernementales. Il est également conscient que permettre l'accès universel aux services de soins palliatifs dans tous ces secteurs exigerait des changements importants qu'il serait très difficile de mettre en œuvre.

Selon des études récentes, plus de 80 % des Canadiens meurent à l'hôpital, alors que pas moins de 80 à 90 % préféreraient finir leurs jours à la maison, auprès de leur famille et dans des conditions de vie aussi normales que possible. Cependant, il arrive souvent que les services nécessaires à domicile n'existent pas. Ceux qui existent sont habituellement le fruit d'initiatives prises au niveau communautaire ou par des instances locales et les régies régionales de la santé, et non pas d'une politique gouvernementale destinée à l'ensemble de la population canadienne.

Le Comité est convaincu qu'il est essentiel que le gouvernement fédéral contribue dans une large mesure à procurer aux Canadiens des soins palliatifs à domicile. Cependant, il lui a été impossible d'obtenir des données qui permettraient d'estimer d'une façon assez exacte le coût d'un programme national de soins palliatifs à domicile. Ni les experts que le Comité a consultés ni les sources susceptibles de détenir des statistiques exactes sur les soins palliatifs n'ont pu lui fournir des détails sur les coûts des soins palliatifs à domicile. Quoi qu'il en soit, le Comité estime que le gouvernement fédéral devrait réserver dès maintenant les fonds nécessaires pour payer les coûts initiaux d'un programme qui devrait être élaboré conjointement avec les provinces et les territoires et financé selon une formule de partage à parts égales. Par conséquent, le Comité recommande :

***Le Comité est convaincu qu'il est essentiel que le gouvernement fédéral contribue dans une large mesure à procurer aux Canadiens des soins palliatifs à domicile.***

**Que le gouvernement fédéral s'engage à verser 250 millions de dollars par année au titre d'un programme national de soins palliatifs à domicile, élaboré de concert avec les provinces et les territoires et financé à 50 % par chacune des deux parties.**

## **9.2 Aide financière aux fournisseurs de soins palliatifs à domicile**

En plus d'aider à établir un programme national de financement des soins de fin de vie pour les Canadiens qui choisissent de mourir à la maison, le gouvernement fédéral devrait prendre d'autres mesures pour alléger le fardeau qui incombe actuellement à des milliers d'aidants naturels. Il est question de ces mesures dans la présente section et dans celles qui suivent.

Les coûts des soins de fin de vie à domicile sont présentement assumés en grande partie par la famille du malade. Dans la deuxième phase de son étude, le Comité a appris qu'en général, la majorité des aidants naturels sont des femmes qui, bien souvent, doivent s'occuper à la fois de leurs parents vieillissants et de leurs propres enfants, en plus de travailler à l'extérieur à

***En plus d'aider à établir un programme national de financement des soins de fin de vie pour les Canadiens qui choisissent de mourir à la maison, le gouvernement fédéral devrait prendre d'autres mesures pour alléger le fardeau qui incombe actuellement à des milliers d'aidants naturels.***



plein temps. Ce cumul de responsabilités peut entraîner des maladies liées au stress et des absences du travail pour le soignant, et accroître le risque de négligence et de mauvais traitements pour le malade.

Dans le rapport intitulé *Caring about Caregiving: The Eldercare Responsibilities of Canadian Workers and the Impact on Employers*, qu'il a publié en 1999, le Conference Board du Canada signale que 48 % des personnes qui dispensent des soins personnels à domicile ont déclaré qu'il leur était très difficile de concilier leurs obligations personnelles et leur vie professionnelle; 42 % ont dit vivre énormément de stress en essayant de concilier leurs divers rôles; 57 % ont affirmé ne pas avoir suffisamment de temps pour elles-mêmes; 53 % ont réduit leurs heures de sommeil et 44 % avaient eu des problèmes de santé mineurs au cours des six derniers mois.

Ces statistiques, qui s'appliquent à tous les fournisseurs de soins à domicile et pas seulement à ceux qui prodiguent des soins palliatifs, montrent que la dépendance à l'égard de soignants naturels coûte cher aux Canadiens, même si cela permet au système de santé de faire des économies. Si ce n'était des soignants naturels, les coûts des hôpitaux et des autres fournisseurs de soins seraient fort probablement plus élevés.

Dans le volume quatre de son étude, le Comité insiste sur l'importance d'accorder un soutien aux soignants naturels. Il reconnaît que les dispositions fiscales actuelles ne permettent pas de rémunérer ces personnes dans une juste mesure pour le temps et les ressources qu'elles consacrent à un membre de la famille malade. Il souligne le fait que le Conseil consultatif national sur le troisième âge (CCNTA) avait recommandé qu'on modifie le Régime de pensions du Canada (RPC) et le programme d'assurance-emploi afin de tenir compte des personnes qui quittent temporairement leur emploi pour assumer des responsabilités d'aidant naturel.

Si l'on soutenait mieux les aidants naturels en leur fournissant des ressources financières et documentaires, les mourants pourraient recevoir des soins de qualité et choisir l'endroit où ils veulent passer leurs derniers jours. Un soutien accru permettrait aux soignants de bénéficier des connaissances, des compétences, de la sécurité de revenu, de la protection d'emploi et d'autres formes d'appui dont ils ont besoin pour s'occuper d'un être cher mourant sans compromettre leur santé et leur bien-être au cours du passage de la vie à la mort et de la période de deuil.

Bien des travailleurs canadiens sont confrontés à des choix difficiles lorsqu'ils doivent subvenir aux besoins de leur famille tout en s'occupant d'un parent atteint d'une maladie en phase terminale. Limiter la perte de revenus durant cette période très difficile serait un premier pas important pour améliorer la situation des soignants naturels.

***Bien des travailleurs canadiens sont confrontés à des choix difficiles lorsqu'ils doivent subvenir aux besoins de leur famille tout en s'occupant d'un parent atteint d'une maladie en phase terminale. Limiter la perte de revenus durant cette période très difficile serait un premier pas important pour améliorer la situation des soignants naturels.***

Dans le volume quatre, le Comité cite des statistiques du CCNTA selon lesquelles on augmenterait le coût global de l'assurance-emploi d'environ 670 millions de dollars par année si l'on versait des prestations aux personnes qui quittent leur emploi pour s'occuper d'un parent malade. Cette estimation repose sur le nombre total de soignants et sur une période de prestations de dix semaines. Si l'on se fie aux données de Statistique Canada sur le nombre réel de malades bénéficiant de soins palliatifs, et si l'on réduit légèrement la période d'admissibilité aux prestations, le Comité est d'avis qu'il en coûterait beaucoup moins que la somme avancée par le CCNTA pour verser des prestations d'assurance-emploi aux aidants naturels qui donnent des soins palliatifs à domicile.

En 1999, 219 530 Canadiens sont décédés, mais ils n'ont pas tous eu besoin de soins palliatifs. En éliminant les décès dus à des accidents et à certains types de maladies, le Comité estime qu'environ 160 000 Canadiens pourraient avoir besoin de soins palliatifs au cours d'une année donnée. Si l'on utilise des prestations moyennes d'assurance-emploi de 257 \$ par semaine et une période de prestations de six semaines (au lieu des dix semaines préconisées par le CCNTA), le Comité est d'avis qu'il en coûterait environ 240 millions de dollars par année pour verser des prestations aux personnes qui dispensent des soins palliatifs à domicile. Selon le Comité, il faudrait accorder jusqu'à six semaines de congé aux employés qui veulent prodiguer des soins palliatifs à domicile à parent mourant, et le gouvernement fédéral devrait envisager de permettre aux employés qui se prévalent de ce congé d'avoir droit à des prestations d'assurance-emploi. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral étudie la possibilité de permettre que des prestations d'assurance-emploi soient versées pendant une période de six semaines aux salariés canadiens qui choisissent de s'absenter du travail pour prodiguer des soins palliatifs à domicile à un parent mourant.**

### **9.3 Crédit d'impôt pour fournisseurs de soins**

Le programme d'assurance-emploi n'est pas le seul moyen d'aider les soignants. Les crédits d'impôt en sont un autre. Dans le budget de 1998, on reconnaissait que les familles s'occupant d'un être cher malade avaient besoin d'une aide gouvernementale et l'on prévoyait un crédit d'impôt pour les personnes qui vivent avec leur mère ou leur père âgé, un grand-parent ou un parent handicapé à charge et qui lui dispensent des soins à domicile. Ce crédit réduit l'impôt fédéral-provincial combiné d'un montant pouvant atteindre 600 \$.

Le gouvernement fédéral accorde également un crédit d'impôt pour frais médicaux. Ce crédit permet aux Canadiens de déduire de leur revenu le coût de certains appareils, soins ou équipements médicaux. Il existe également d'autres crédits d'impôt, dont le crédit d'impôt pour personnes handicapées et la déduction pour frais de soins auxiliaires.

Le Comité recommande :

**Que le gouvernement fédéral étudie la possibilité d'étendre l'application des mesures fiscales déjà existantes aux personnes qui s'occupent d'un membre d'un proche**

**mourant ou à celles qui paient pour obtenir ces services au nom du mourant.**

#### **9.4 Protection des emplois**

En vertu de la Constitution, ce sont les provinces qui assument la responsabilité première en matière de législation du travail, notamment en matière de protection des emplois. Cependant, certains secteurs relèvent de la compétence du gouvernement fédéral, soit les fonctionnaires fédéraux, le personnel militaire et les employés des pénitenciers fédéraux. Ces personnes sont régies par le *Code canadien du travail* et c'est le Conseil du Trésor qui est responsable des employés du gouvernement fédéral.

En ce qui concerne la protection des emplois, le gouvernement fédéral pourrait prendre l'initiative de voir à ce que les employés qui s'absentent du travail pour s'occuper d'un parent mourant ne risquent pas de perdre leur emploi. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral modifie le *Code canadien du travail* de façon à permettre aux employés de s'absenter dans les situations de crise familiale, par exemple pour s'occuper d'un proche mourant, et qu'il collabore avec les provinces afin de favoriser de telles modifications aux codes provinciaux du travail.**

De plus, le gouvernement fédéral pourrait prendre d'autres mesures en ce qui concerne ses propres fonctionnaires. Le Comité recommande :

**Que le gouvernement fédéral prenne l'initiative en tant qu'employeur en modifiant la législation du Conseil du Trésor afin de protéger les emplois de ses propres employés qui s'occupent d'un proche mourant.**

#### **9.5 Conclusion**

Le gouvernement fédéral peut agir comme chef de file et appuyer les Canadiens en fin de vie et leur famille, notamment en veillant à offrir à ceux qui le désirent les services dont ils ont besoin pour mourir à la maison avec dignité. Un nouveau programme national à frais partagés assurant la prestation de soins palliatifs à domicile représenterait un pas important dans ce sens.

***Le gouvernement fédéral peut agir comme chef de file et appuyer les Canadiens en fin de vie et leur famille, notamment en veillant à offrir à ceux qui le désirent les services dont ils ont besoin pour mourir à la maison avec dignité.***

De plus, les autres mesures recommandées dans le présent chapitre amélioreraient sensiblement la situation des personnes qui choisissent de prodiguer des soins à un parent malade à la maison. On pourrait offrir une aide financière immédiate aux soignants par le biais du programme d'assurance-emploi. De plus, cette solution mènerait probablement à l'adoption de lois sur la protection des emplois dans les provinces, comme dans le cas des

dispositions relatives aux prestations de maternité complémentaires. Cette option présente cependant un inconvénient puisqu'elle ne vise que les travailleurs assurés. Les crédits d'impôt, quant à eux, ont l'avantage de procurer une couverture plus large, mais ils ne permettent pas de remplacer le revenu en période de besoin et ne contribueraient probablement pas à l'adoption de mesures législatives pour protéger les emplois.

Prises globalement, toutes les recommandations du présent chapitre forment un ensemble de mesures qui, si elles sont mises en œuvre, marqueront un véritable progrès vers la prestation de soins de fin de vie de qualité aux Canadiens.

# **Partie V :** **Accroître la capacité et** **construire l'infrastructure**



## CHAPITRE DIX

### LE RÔLE DU GOUVERNEMENT FÉDÉRAL DANS L'INFRASTRUCTURE DE SOINS DE SANTÉ

---

Dans le volume cinq, le Comité a présenté ses conclusions et ses recommandations d'ensemble en ce qui a trait au rôle du gouvernement fédéral dans l'infrastructure des soins de santé<sup>213</sup>. Ces recommandations étaient fondées sur le troisième des rôles que le Comité a attribués au gouvernement fédéral, dans le volume quatre, au sujet des soins de santé et de la santé en général, en l'occurrence celui touchant le « soutien de l'infrastructure des soins de santé et de l'infrastructure de la santé »<sup>214</sup>.

Dans le présent chapitre, le Comité précise ses recommandations relatives aux technologies de la santé (section 10.1), aux dossiers de santé électroniques (section 10.2) et à l'évaluation de la qualité, de l'efficacité et des résultats (section 10.3). Ce sont là les trois aspects de l'infrastructure canadienne des soins de santé auxquels, selon le Comité, le gouvernement fédéral doit accorder la priorité.

***Le Comité est intimement convaincu que les technologies de la santé, les dossiers de santé électroniques ainsi que l'évaluation de la qualité, de l'efficacité et des résultats sont les trois aspects de l'infrastructure canadienne des soins de santé auxquels le gouvernement fédéral doit accorder la priorité.***

La collecte de renseignements sur les patients aux fins d'un système de dossiers de santé électroniques (DES) et l'utilisation de ces renseignements aux fins 1) de la pratique clinique, 2) de la gestion du système, 3) de l'évaluation de l'efficacité et des résultats et 4) des recherches en santé soulève un certain nombre de questions importantes et complexes touchant la protection des renseignements personnels en matière de santé. Celles-ci sont abordées à la section 10.4.

#### 10.1 Technologies de la santé

Dans le volume cinq, le Comité constate que, malgré l'importance que revêtent les technologies de la santé dans la prestation de services de qualité supérieure en temps opportun, le Canada traîne encore très nettement de l'arrière par rapport aux autres pays de l'OCDE sur le plan de l'accès aux nouvelles technologies. En effet, il est au 21<sup>e</sup> rang des 28 pays de l'OCDE pour ce qui est de l'accès à un tomodensitomètre, au 19<sup>e</sup> rang (sur 22) pour l'accès à un lithotriporteur et 19<sup>e</sup> (sur 27) pour l'accès à un IRM. Il n'est en bonne place qu'au chapitre de l'accès aux appareils de radiologie (6<sup>e</sup> sur 17).

Pire encore, les chiffres montrent que l'écart se creuse. Ainsi, la position du Canada par rapport aux autres pays de l'OCDE, notamment l'Australie, la France, les Pays-Bas et les États-Unis, pour ce qui est de l'accès à l'IRM, a reculé entre 1986 et 1995<sup>215</sup>.

---

<sup>213</sup> Volume cinq, p. 73-94.

<sup>214</sup> Volume quatre, p. 11.

En outre, toujours dans le volume cinq, nous faisons remarquer que le « vieillissement » des appareils pose aussi problème. D'après des informations communiquées au Comité, 30 à 63 % des appareils d'imagerie médicale actuellement utilisés au Canada sont désuets. Cette situation risque non seulement d'affecter la santé des patients, mais elle suscite des préoccupations quant à la responsabilité des professionnels de la santé<sup>216</sup>.

Le Comité craint que le manque d'équipement et l'utilisation d'appareils désuets ne nuisent à l'établissement de diagnostics précis et à la qualité des traitements. En outre, nous craignons que le déficit sur le plan des technologies de la santé n'ait eu pour effet de limiter l'accès aux soins nécessaires et d'allonger les périodes d'attente. À notre avis, les technologies de la santé sont essentielles pour pouvoir offrir aux Canadiens des soins de santé de qualité supérieure en temps opportun.

***Le Comité craint que le manque d'équipement et l'utilisation d'appareils désuets ne nuisent à l'établissement de diagnostics précis et à la qualité des traitements. En outre, nous craignons que le déficit sur le plan des technologies de la santé n'ait pour effet de limiter l'accès aux soins nécessaires et d'allonger les périodes d'attente.***

En septembre 2000, le gouvernement fédéral a décidé de remédier au déficit sur le plan des technologies de la santé en créant le Fonds pour l'acquisition de matériel médical (FAMM). Il a versé un milliard de dollars aux provinces et territoires (au prorata de leurs populations, sur une période de deux ans) afin de leur permettre d'acheter des technologies de la santé. Le Comité se réjouit de cette injection de nouveaux fonds fédéraux. Cependant, nous avons soulevé plusieurs préoccupations dans le volume cinq relativement au FAMM :

- Premièrement, toutes les provinces n'ont pas encore réclamé la part qui leur revient, sans doute parce que le gouvernement fédéral exige qu'elles fournissent une subvention de contrepartie, ce qui est difficile pour certaines d'entre elles.
- Deuxièmement, l'exploitation de nouveaux équipements entraîne de nouvelles dépenses, qui peuvent être difficiles à assumer même pour les provinces qui ont les moyens de s'équiper.
- Troisièmement, cet investissement ne règle en rien le problème de la modernisation des équipements désuets.
- Quatrièmement, même les nouvelles sommes investies dernièrement ne porteront pas le Canada à un niveau comparable à celui des autres pays de l'OCDE.
- Enfin, il n'existe apparemment pas de mécanisme de reddition de comptes qui permette de savoir ce que font exactement les provinces et les territoires des sommes qui leur sont accordées pour acheter de l'équipement neuf.

---

<sup>215</sup> Volume cinq, p. 73-74.

<sup>216</sup> Volume cinq, p. 74.



En juillet 2002, l'Association médicale canadienne a remis un rapport sur le Fonds pour l'acquisition de matériel médical qui traite d'un grand nombre de ces préoccupations<sup>217</sup>. Voici ce que l'on apprend à la lecture de ce document d'information :

- Comme il n'existe pas de mécanismes de reddition de comptes transparents, il est difficile de déterminer si les objectifs ultimes du FAMM ont été atteints.
- Près de 60 % du milliard de dollars versé par l'intermédiaire du FAMM ont servi à absorber de nouvelles dépenses (supplémentaires) dans le domaine des technologies de la santé, tandis que 40 % ont alimenté des dépenses déjà prévues.
- Le FAMM a permis d'apporter des améliorations allant de modestes à importantes dans l'accès aux technologies de la santé au Canada par rapport aux autres pays de l'OCDE. Par exemple, l'écart dans ce domaine a été considérablement réduit dans le cas des appareils de radiologie et d'IRM depuis l'adoption du FAMM, mais cet écart demeure important dans le cas des tomodescripteurs, des tomographes par émission de positrons et des lithotripteurs.
- On estime à quelque 1,15 milliard de dollars l'investissement qui est encore nécessaire pour permettre au Canada de se hisser au niveau moyen établi pour sept pays de l'OCDE en 1997. Sur cette somme, 650 millions de dollars devront servir à l'achat de nouveaux équipements médicaux et 500 millions de dollars au financement des frais de fonctionnement supplémentaires. Il faudra à tout prix que les provinces et territoires disposent de cette somme pour être en mesure de se prévaloir des fonds destinés à l'achat de matériel, faute de quoi l'investissement pourrait ne pas se réaliser, certaines provinces et certains territoires risquant de ne pas avoir les moyens financiers d'exploiter le nouvel équipement.

Les estimations d'ensemble de l'Association médicale canadienne sont très prudentes; elles se limitent à quelques appareils seulement (tomodescripteurs, IRM, lithotripteurs, tomographes par émission de positrons et accélérateurs linéaires). Qui plus est, l'investissement de 1,15 milliard de dollars dans les technologies de la santé ne permettrait au Canada que de se hausser au niveau atteint en 1997 par les autres pays de l'OCDE pour ce qui est de ces cinq appareils en particulier<sup>218</sup>.

D'après d'autres calculs effectués par l'Association canadienne des institutions de santé universitaires, les centres universitaires des sciences de la santé (CUSS) auront besoin de 1,7 à 2,5 milliards de dollars (soit quelque 420 millions de dollars par an sur cinq

**Le Comité croit que l'achat de technologies de la santé exige l'injection de nouveaux fonds. Nous croyons aussi que le gouvernement fédéral devra soutenir financièrement les provinces et les territoires pour leur permettre d'acquérir du nouveau matériel médical.**

<sup>217</sup> Association médicale canadienne, *Whither the Medical Equipment Fund?*, document d'information et notes techniques, juillet 2002.

<sup>218</sup> Association canadienne des institutions de santé universitaires, *Background Information in Support of a National Teaching Centre Health Infrastructure Fund*, projet de mémoire présenté au Comité, 6 août 2002.

ans) pour acheter et exploiter du matériel médical de pointe.

Les constats auxquels parviennent l'Association médicale canadienne et l'Association canadienne des institutions de santé universitaires dans leurs documents confortent le Comité dans ses observations et conclusions du volume cinq. Nous croyons donc que l'achat de technologies de la santé exige l'injection de nouveaux fonds. Nous croyons aussi que le gouvernement fédéral devra soutenir financièrement les provinces et les territoires pour leur permettre d'acquérir du nouveau matériel médical.

Le Comité estime que le gouvernement fédéral doit veiller à ce que tous les nouveaux fonds destinés aux technologies de la santé soient consacrés à l'achat de matériel médical plutôt qu'au financement de dépenses déjà prévues. Nous sommes en outre intimement convaincus qu'il faudrait resserrer les mécanismes de reddition de comptes pour ce qui est de l'utilisation des fonds fédéraux ciblés, comme le FAMM.

***Le Comité est intimement convaincu qu'il faudrait resserrer les mécanismes de reddition de comptes pour ce qui est de l'utilisation des fonds fédéraux ciblés, comme le FAMM.***

Le Comité fait par ailleurs remarquer, dans le volume cinq, qu'il convient d'effectuer davantage d'évaluations des technologies de la santé (ETS) au moment de décider de l'adoption de technologies nouvelles ou du remplacement des appareils médicaux<sup>219</sup>. L'ETS permet d'obtenir des informations sur la sûreté des technologies, leur efficacité clinique et leur rentabilité et elle prend en compte les aspects sociaux, juridiques et éthiques du recours aux technologies de la santé. Le Comité insiste sur le fait que, tous ordres de gouvernement confondus, le Canada investit annuellement moins de 8 millions de dollars au total dans l'ETS, comparativement aux quelque 100 millions de dollars que le Royaume-Uni consacre à son National Institute for Clinical Evidence (NICE). Forts de ce constat, nous recommandons, dans le volume cinq, que le gouvernement fédéral accroisse le montant des fonds destinés aux organismes chargés de l'ETS afin de favoriser l'évaluation des technologies de la santé courantes et nouvelles.

Enfin, le Comité croit qu'une part importante du financement destiné à l'achat de technologies de la santé devrait aller aux CUSS qui possèdent actuellement une grande partie du matériel médical de pointe. De plus, les CUSS sont bien placés, compte tenu de leur infrastructure matérielle et clinique, pour se lancer dans des activités d'ETS de pointe. Le Comité estime que le financement fédéral consacré aux technologies de la santé ne devrait pas être consenti à des cliniques privées puisqu'elles n'exercent aucune activité d'enseignement, d'évaluation ou de recherche.

Le Comité prend acte du rôle important que jouent les CUSS dans la mise en place et l'évaluation des nouvelles technologies de la santé. Nous reconnaissons que les hôpitaux communautaires doivent, eux aussi, pouvoir investir davantage dans l'achat de nouveau matériel médical. Nous croyons que le gouvernement fédéral doit jouer un rôle de premier plan pour maintenir l'investissement à long terme dans les technologies de la santé nécessaires.

---

<sup>219</sup> Volume cinq, p. 77-79.

Le Comité ne croit cependant pas qu'un programme comme le FAMM soit le moyen à utiliser pour atteindre cet objectif. Nous sommes d'accord avec la position des témoins à l'effet que le financement fédéral doit s'inscrire dans un cadre financier pluriannuel et viser à satisfaire aux demandes émanant des établissements de santé eux-mêmes, dont l'examen serait confié à un groupe d'experts indépendants. À nos yeux, cette formule correspond à un modèle de gouvernance plus *efficace* et *responsable*.

Ainsi, en vertu de ce modèle, les hôpitaux universitaires et communautaires ainsi que les régies régionales de la santé (RRS) seraient tenus d'assortir leurs demandes de solides justifications quant aux ressources supplémentaires requises. Le bien-fondé de chaque demande serait évalué par un groupe d'experts indépendants qui ferait ensuite rapport au ministre de la Santé. En outre, afin de garantir la reddition de comptes, les candidats retenus devraient faire rapport de la façon dont ils dépensent les fonds perçus. Le Comité recommande donc :

***Le Comité est d'accord avec la position des témoins à l'effet que le financement fédéral doit s'inscrire dans un cadre financier pluriannuel, et viser à satisfaire aux demandes émanant des établissements de santé eux-mêmes, dont l'examen serait confié à un groupe d'experts indépendants.***

**Que le gouvernement fédéral verse aux hôpitaux des fonds expressément destinés à l'achat et à l'évaluation de technologies de la santé. Le gouvernement fédéral devrait consacrer à cette fin 2,5 milliards de dollars au total sur cinq ans (ou 500 millions de dollars par année). De ce montant, 400 millions de dollars seraient alloués annuellement aux centres universitaires des sciences de la santé, et 100 millions de dollars aux hôpitaux communautaires. Le financement des hôpitaux communautaires serait partagé à parts égales avec les provinces, tandis que la financement des centres serait assuré intégralement par le gouvernement fédéral.**

**Que les établissements bénéficiant de ce programme fassent rapport de la façon dont ils utilisent les fonds reçus.**

## **10.2 Dossiers de santé électroniques**

Le dossier de santé électronique (DSE) s'appuie sur un système automatisé alimenté par les fournisseurs de soins de santé, à l'intérieur d'un réseau électronique donnant accès au dossier de santé complet du patient, notamment aux renseignements concernant les visites chez le médecin, les séjours à l'hôpital, les médicaments prescrits, les analyses de laboratoire, etc. Dans

***Le dossier de santé électronique (DSE) s'appuie sur un système automatisé alimenté par les fournisseurs de soins de santé, à l'intérieur d'un réseau électronique donnant accès au dossier de santé complet du patient, notamment aux renseignements concernant les visites chez le médecin, les séjours à l'hôpital, les médicaments prescrits, les analyses de laboratoire, etc.***

le volume cinq, le Comité rappelait que le système de DSE représente la première étape d'un processus de collecte de renseignements sur la santé qui permettra de prendre des décisions fondées sur des données probantes dans l'ensemble du système de soins de santé. Un système de DSE offre d'énormes possibilités pour réaliser l'intégration des divers éléments du système de soins de santé du Canada, actuellement cloisonné<sup>220</sup>.

Tout système de DSE possède l'importante caractéristique suivante : il permet aux fournisseurs de soins de santé et aux établissements, où qu'ils se trouvent, d'accéder au besoin à des renseignements sur les patients, grâce à l'interconnexion de bases de données interopérables qui respectent les normes nécessaires en matière de technique et de données. Un tel système permet non seulement d'accroître sensiblement la qualité de la prestation et la rapidité d'accès aux soins, mais il permet aussi d'améliorer la gestion et l'efficacité du système de soins de santé de même que la reddition de comptes à son égard. De plus, les données recueillies grâce à un système de DSE peuvent être très utiles aux fins de la recherche en santé.

Les avantages d'un tel système sont nombreux :

*La mise en œuvre à l'échelle nationale de solutions de DSE interopérables, qui permettent aux fournisseurs de soins et à leurs patients de disposer de données complètes et transférables, habiliteront les Canadiens et permettront d'améliorer la qualité, la sécurité, l'accessibilité, la rapidité et l'efficacité des services.*

*De plus, leur mise en œuvre permettra de créer, d'analyser et de diffuser, à l'échelle du Canada et du monde, des données grâce auxquelles les patients, les citoyens et les aidants, de même que les professionnels de la santé, les fournisseurs de soins, les administrateurs du réseau de la santé ainsi que les responsables des orientations politiques pourront prendre des décisions plus informées. Grâce aux DSE, il sera possible de maximiser le rendement des investissements dans les TIC, grâce à l'harmonisation des systèmes, et de favoriser l'interopérabilité de même que l'élaboration de normes communes<sup>221</sup>.*

Tous les ordres de gouvernement du Canada ont reconnu l'importance d'élaborer et de mettre en œuvre des systèmes de DSE. En effet, le 11 septembre 2000, les premiers ministres provinciaux ont convenu de collaborer à l'établissement d'un système intégré au cours des trois prochaines années et à la formulation de normes communes de données destinées à assurer la compatibilité et l'interopérabilité des réseaux provinciaux d'information sur la santé, de même qu'à garantir une stricte protection des renseignements médicaux personnels.

À l'appui de l'accord conclu par les premiers ministres, le gouvernement fédéral a engagé 500 millions de dollars en 2000-2001 afin de mettre sur pied une société sans but lucratif du nom d'Inforoute Santé du Canada Inc. (ou *Inforoute*). *Inforoute* n'est ni un organisme fédéral, ni une société d'État et elle n'est pas non plus contrôlée par le gouvernement fédéral. *Inforoute* regroupe les sous-ministres de la Santé des gouvernements fédéral, provinciaux et territoriaux et

---

<sup>220</sup> Volume cinq, p. 82-84.

<sup>221</sup> Linda Lizotte-MacPherson, présidente et présidente-directrice-générale d'*Inforoute*, lettre au Comité, 24 juillet 2002, p. 7.

elle est régie par un conseil d'administration dont les membres représentent les différentes régions du Canada<sup>222</sup> et comptent aussi quelques administrateurs indépendants.

En juillet 2002, *Inforoute* a transmis au Comité un exemplaire de son plan d'activités. L'organisme y indique son intention d'investir dans des projets susceptibles d'améliorer les soins dispensés aux patients, à partir de la base de gestion de l'information existante, de multiplier les investissements et d'harmoniser les priorités fédérales, provinciales et territoriales de façon durable pour parvenir à mettre en œuvre un système pancanadien de DSE.

Le Comité est conscient que les coûts associés à la mise en œuvre d'un système pancanadien et interopérable de DSE dépasseront de loin l'investissement initial de 500 millions de dollars du gouvernement fédéral. En fait, d'après les données d'*Inforoute*, la mise en place d'un système coordonné de DSE à l'échelle du Canada coûtera 2,2 milliards de dollars. S'il devait ne pas y avoir de coordination, autrement dit si les instances responsables travaillaient chacune de leur côté, les coûts ponctuels de mise en œuvre atteindraient alors 3,8 milliards de dollars. Force est de constater que la mise en place d'un système de DSE exigera de gros efforts de coordination de la part de toutes les instances concernées, de même que la mise en commun des ressources, la collaboration du secteur privé et le recours à de nouvelles sources de financement.

Dans l'ensemble, le Comité se réjouit du travail entrepris par *Inforoute* en vue de la mise en œuvre d'un système national de DSE. Nous croyons qu'un tel système sera grandement profitable aux Canadiens et à leur système public de soins de santé si sa portée est nationale. En fait, l'établissement d'un système *national* de DSE est crucial. En conséquence, nous estimons que le gouvernement fédéral

***Le Comité croit qu'un tel système sera grandement profitable aux Canadiens et à leur système public de soins de santé si sa portée est nationale. En fait, l'établissement d'un système national de DSE est crucial. En conséquence, nous estimons que le gouvernement fédéral doit faire preuve de leadership et débloquer les ressources nécessaires à cette fin.***

doit faire preuve de leadership et débloquer les ressources nécessaires à cette fin. Le Comité réitère donc la recommandation qu'il avait formulée dans le volume cinq, à savoir :

**Que le gouvernement fédéral accorde un financement additionnel à Inforoute Santé du Canada Inc. pour permettre à cette entreprise de créer, de concert avec les provinces et les territoires, un système national de dossiers de santé électroniques.**

De plus, le Comité recommande :

**Que le financement fédéral supplémentaire versé à Inforoute s'élève à 2 milliards de dollars sur cinq ans, soit une enveloppe annuelle de 400 millions de dollars.**

---

<sup>222</sup> Le Québec a préféré, jusqu'ici, s'abstenir de participer en qualité de membre et ne s'est donc pas prévalu de son droit de nommer un représentant au conseil d'administration d'*Inforoute*.

La question de la protection de la vie privée, de la confidentialité et de la sécurité des renseignements personnels sur la santé dans le contexte d'un système de DSE est probablement l'aspect le plus délicat soulevé lors des audiences du Comité à ce sujet. Nous y reviendrons plus en détail à la section 10.4. Il convient toutefois de souligner ici qu'un système de DSE offre de réelles possibilités d'amélioration de la

***Le Comité est d'avis que l'absence de DSE communs met en péril la protection des renseignements personnels et la qualité des soins de santé en raison de la dispersion de parcelles de renseignements ici et là dans les dossiers des cabinets de médecin, des hôpitaux, des services de santé publique, des fournisseurs de soins à domicile, des centres d'hébergement et de soins de longue durée, etc.***

protection des renseignements médicaux personnels. À l'heure actuelle, rien ne garantit la protection des dossiers médicaux personnels. De plus, les patients n'ont pas facilement accès à leurs propres dossiers et, en fait, ne savent même pas où ceux-ci se trouvent. Le Comité est d'avis que l'absence de DSE communs met en péril la protection des renseignements personnels et la qualité des soins de santé en raison de la dispersion de parcelles de renseignements ici et là dans les dossiers des cabinets de médecin, des hôpitaux, des services de santé publique, des fournisseurs de soins à domicile, des centres d'hébergement et de soins de longue durée, etc.

### **10.3 Évaluation de la qualité, de l'efficacité et des résultats**

Dans le volume cinq<sup>223</sup>, le Comité affirme qu'un investissement à long terme dans les technologies de l'information et des communications, notamment dans un système de DSE, permettra de recueillir des renseignements plus pertinents et plus opportuns sur l'accès aux soins, la qualité de leur prestation, l'efficacité du système de soins et ses résultats pour le patient. Nous indiquons aussi que les gouvernements doivent financer le système de DSE sans toutefois se charger d'évaluer les données sur la santé, la qualité des soins et les résultats. À l'instar des témoins, nous reconnaissons que la collecte et l'évaluation des renseignements sur la santé sont actuellement effectuées par ceux qui financent et assurent la prestation des soins de santé, à savoir les gouvernements.

Nous avons ainsi constaté que les résultats ne font l'objet d'aucune évaluation indépendante et qu'il n'existe pas de vérification externe de l'impact des diverses interventions sur les patients. Cette même préoccupation a été soulevée dans les rapports des différentes commissions provinciales sur les soins de santé. À la lumière des témoignages et des rapports provinciaux, le Comité a conclu

***Le Comité est convaincu que le rôle d'évaluation du système de soins de santé doit être dissocié de celui qui est lié au financement et à la prestation des soins afin de permettre une évaluation indépendante de l'efficacité et des résultats du système de soins de santé.***

que le rôle d'évaluation du système de soins de santé doit être dissocié de celui qui est lié au financement et à la prestation des soins afin de permettre une évaluation indépendante de l'efficacité et des résultats du système de soins de santé.

---

<sup>223</sup> Volume cinq, p. 84-87.

Comme cela est expliqué en détail au chapitre un, le Comité est d'avis qu'une telle évaluation indépendante doit être menée à l'échelle nationale (et non fédérale). Ce genre d'approche permettrait une mise en commun des compétences de nature à optimiser l'emploi des ressources humaines limitées dont dispose actuellement le Canada, d'où la réalisation d'importantes économies d'échelle. C'est pourquoi nous recommandons la création d'un poste de commissaire national aux soins de santé chargé de formuler des observations et des recommandations sur l'efficacité du système de soins de santé, l'état de santé de la population et les résultats obtenus.

***Le Comité est d'avis qu'une telle évaluation indépendante doit être menée à l'échelle nationale (et non fédérale) par le commissaire national aux soins de santé, poste dont le Comité recommande la création au chapitre un.***

De plus, le Comité croit que le travail du commissaire national aux soins de santé aux fins de l'évaluation de l'efficacité et des résultats du système de soins de santé devrait reposer sur celui des organismes nationaux actuellement chargés de procéder à des évaluations indépendantes du système.

Le Comité est intimement convaincu que l'Institut canadien de l'information sur la santé (ICIS) devrait être appelé à collaborer à un système national d'évaluation indépendante. Nous estimons que l'ICIS a fait ses preuves dans la collecte de données normalisées et l'élaboration d'indicateurs applicables au système de soins de santé. Le fruit de ses travaux est le résultat d'une collaboration avec divers ordres de gouvernement et de multiples intervenants.

De plus, l'ICIS dispose déjà d'imposantes données d'archives de nature à faciliter la surveillance du système de soins de santé (dans différents domaines comme les ressources humaines, les effets indésirables, les délais d'attente, les groupes homogènes de patients (DRG), l'efficacité du système, les indicateurs de l'état de santé, la gestion financière, etc.). Qui plus est, l'ICIS dispose déjà de mécanismes de production de rapports publics dignes de foi.

***Nous estimons que l'ICIS a fait ses preuves dans la collecte de données normalisées et l'élaboration d'indicateurs applicables au système de soins de santé.***

Depuis sa création, l'ICIS fournit une excellente information à la population canadienne, aux gestionnaires des soins de santé et aux décideurs. Cependant, son budget, qui est actuellement de 95 millions de dollars sur quatre ans (2001-2005), ne suffit pas pour investir comme il le faudrait pour être en mesure de produire l'information nécessaire pour prévoir et gérer les effets des changements recommandés par le Comité sur le système de soins de santé et en faire rapport. Nous sommes donc fermement convaincus de la nécessité d'augmenter considérablement le budget de l'ICIS.

Un autre organisme national, le Conseil canadien d'agrément des services de santé (CCASS) s'est doté d'une solide assise grâce au processus d'agrément volontaire des établissements de soins de santé. Le Comité a appris que cet organisme a bâti sa crédibilité sur son désir de viser, en permanence, l'amélioration de la qualité; c'est là une orientation qu'il faudra préserver.

Selon nous, il conviendrait, dans le cadre d'un système national d'évaluation, d'élargir le mandat du CCASS pour qu'il puisse imposer à tous les secteurs des soins de santé (RRS, hôpitaux publics et hôpitaux privés, établissements de soins de santé primaires, etc.) un agrément ordinaire, renouvelable à intervalles réguliers. L'agrément doit reposer sur des normes nationales reconnues. Si ces normes ne sont pas respectées et que les mesures prises pour corriger la situation sont insatisfaisantes, l'agrément ne doit pas être accordé. Le processus d'agrément contribuerait à la mise en œuvre d'un mécanisme de reddition de comptes transparent.

Le Comité recommande donc :

**Que le gouvernement fédéral accorde un financement annuel supplémentaire de 50 millions de dollars à l'Institut canadien d'information sur la santé et verse en outre une somme annuelle de 10 millions de dollars au Conseil canadien d'agrément des services de santé. Ce nouvel investissement fédéral contribuera à l'établissement d'un système national d'évaluation de l'efficacité et des résultats du système de soins de santé et facilitera ainsi la tâche au commissaire national aux soins de santé.**

#### **10.4 Protection des renseignements personnels sur la santé**

Les dossiers de santé électroniques modifieront vraisemblablement l'application des principes de traitement équitable de l'information à bien des égards. L'élaboration et la mise en œuvre de systèmes de DSE d'un bout à l'autre du pays transformeront les rapports bilatéraux qu'entretiennent habituellement le patient et le fournisseur en un ensemble d'interactions plus complexes entre le patient et le système de soins de santé.

En raison de leur nature même, les documents sur papier sont essentiellement des éléments distincts d'information personnelle qui peuvent être colligés sur papier et placés dans un endroit précis, souvent sur l'initiative d'un seul fournisseur et accessibles à lui seul dans le contexte d'une rencontre individuelle. Il en va différemment des DSE qui peuvent être regroupés dans un fichier d'information personnelle sur la santé de portée longitudinale plus complète et détaillée, et dont le contenu est établi à partir de sources multiples, puis saisi dans un format électronique facilement accessible et auquel de multiples utilisateurs autorisés peuvent avoir accès, en temps réel, où qu'ils se trouvent.

Cette transformation se répercutera inévitablement sur la façon dont les patients peuvent exercer de façon concrète et pratique leur droit à la protection des renseignements personnels en matière de santé. De même, elle aura une incidence sur la façon dont les responsabilités et les obligations de rendre compte sont

***Les technologies de l'information sur la santé offrent malgré tout de réelles possibilités d'améliorer la protection de la vie privée grâce à des dispositifs de sécurité plus efficaces qui restreignent l'accès et à des mécanismes améliorés de suivi qui permettent de vérifier toutes les opérations.***



coordonnées et partagées entre les multiples utilisateurs.

C'est ce qui explique que l'évolution des technologies de l'information sur la santé, notamment l'élaboration et la mise en œuvre de DSE, est souvent perçue comme menaçante pour le respect de la vie privée. Cette réserve est attribuable en partie à l'élargissement possible de l'accès à de multiples utilisateurs et au manque apparent de contrôle exercé par le patient sur les renseignements concernant sa propre santé. Cela étant dit, les technologies de l'information sur la santé offrent malgré tout de réelles possibilités d'améliorer la protection de la vie privée grâce à des dispositifs de sécurité plus efficaces qui restreignent l'accès et à des mécanismes améliorés de suivi qui permettent de vérifier toutes les opérations. Ces avantages possibles sont aussi inhérents aux DSE que les éventuelles menaces qu'ils peuvent poser.

La mise en place d'un système de DSE est censée être la première étape cruciale de l'élaboration d'une éventuelle infostructure pancanadienne de la santé. Les avantages immédiats et évidents des DSE dans le contexte des soins de santé primaires concernent notamment les gains d'efficacité découlant d'une gestion plus efficace des dossiers de santé

***Les DSE devraient aussi accroître la qualité des soins de santé dispensés étant donné que les fournisseurs pourront acquérir une connaissance plus approfondie de l'état de santé de leur patient, ce qui est essentiel pour pouvoir poser un bon diagnostic et prescrire un traitement efficace et des médicaments sûrs, en particulier dans les situations d'urgence ou lorsque des soins sont dispensés à l'extérieur de la province de résidence.***

des patients et de l'intégration des services de santé offerts. Les DSE devraient aussi accroître la qualité des soins de santé dispensés étant donné que les fournisseurs pourront acquérir une connaissance plus approfondie de l'état de santé de leur patient, ce qui est essentiel pour pouvoir poser un bon diagnostic et prescrire un traitement efficace et des médicaments sûrs, en particulier dans les situations d'urgence ou lorsque des soins sont dispensés à l'extérieur de la province de résidence.

De plus, l'infostructure pancanadienne de la santé devrait responsabiliser les patients puisqu'ils auront accès eux aussi à une information sur la santé de meilleure qualité. Il leur sera ainsi possible de faire des choix éclairés au sujet de leur santé, de la santé d'autrui et du système de soins de santé. Une infostructure de la santé offrira aux gestionnaires des soins de santé les outils nécessaires pour mieux évaluer les fournisseurs de services et permettra une meilleure reddition de comptes. De même, elle fournira aux chercheurs les assises nécessaires pour continuer à améliorer les soins de santé et mieux comprendre les déterminants de la santé<sup>224</sup>.

À l'heure actuelle, il y a trois principaux enjeux en matière de protection des renseignements personnels qui doivent être pris en compte si nous voulons que les DSE deviennent une réalité au Canada au cours des cinq à sept prochaines années. Ce sont, en l'occurrence :

---

<sup>224</sup> *Inforoute Santé du Canada: Voies vers une meilleure santé*, Rapport final du Conseil consultatif sur l'infostructure de la santé, décembre 1999.

1. La nécessité de mieux harmoniser l'approche adoptée à l'égard de la protection des renseignements personnels d'un territoire de compétence à l'autre afin d'uniformiser les conditions régissant le partage de renseignements personnels sur la santé entre les utilisateurs et d'assurer la même protection à tous les patients.
2. La nécessité d'élaborer des balises, des politiques et des procédures rigoureuses et efficaces en matière de protection de la vie privée, qui peuvent être mises en œuvre de façon pratique et rentable.
3. La nécessité de convaincre le public que les renseignements personnels sur la santé seront protégés dans un monde électronique<sup>225</sup>.

À l'heure actuelle, il y a d'énormes variations dans les lois sur la protection des renseignements personnels et les politiques en matière d'accès aux données en vigueur d'un bout à l'autre du pays. Ces écarts sont autant de défis posés aux systèmes de DSE, dont le fonctionnement est tributaire de l'acheminement des renseignements personnels sur la santé d'un secteur à l'autre et d'une province ou d'un territoire à l'autre. Le manque d'uniformité des règles régissant la définition des fins autorisées, la forme de consentement exigé, les conditions applicables à la prise de décisions pour autrui, les critères d'accès sans consentement à des renseignements personnels sur la santé, les périodes de conservation des données et les exigences en matière de destruction, pour n'en nommer que quelques-uns, doivent être examinés attentivement si nous voulons être en mesure d'élaborer des systèmes de DSE.

De plus, les organismes de surveillance actuellement en place dans les différents secteurs et au sein des différentes instances peuvent exercer des pouvoirs législatifs délégués de portée variable sur certains aspects des systèmes de DSE, mais non sur d'autres. Sans une certaine coordination globale, cette approche fragmentaire rendra très difficile en pratique l'adoption d'un système d'examen et de surveillance, d'un processus d'approbation, d'une procédure d'enquête et de sanctions.

Le Comité se réjouit des efforts constants déployés par les instances fédérales-provinciales-territoriales pour mettre au point une approche harmonisée à l'égard de la protection des renseignements personnels sur la santé. De façon précise, le Comité recommande :

**Que les enjeux clés suivants fassent l'objet d'une plus grande harmonisation et coordination entre les instances fédérales, provinciales et territoriales :**

- **des règles d'accès sélectif restreignant l'accès aux utilisateurs autorisés en fonction des fins pour lesquelles ceux-ci ont besoin des renseignements;**

---

<sup>225</sup> Voir Conseil consultatif sur l'infrastructure de la santé, *Inforoute Santé du Canada : Voies vers une meilleure santé*, Rapport final, décembre 1999; Comité consultatif fédéral-provincial-territorial sur l'infrastructure de la santé, *Plan tactique pour une infrastructure pancanadienne de la santé*, Mise à jour de 2001; résumé des discussions du forum régional organisé par Inforoute Santé du Canada à l'adresse suivante : <http://www.canadahealthinfoway.ca/sub.php?lang=en?secLoc=frm>.

- **des règles de consentement régissant la forme et les critères à respecter pour qu'un consentement soit valide;**
- **des conditions autorisant l'accès sans consentement à des renseignements personnels sur la santé dans des circonstances exceptionnelles et pour des fins précises;**
- **des règles régissant la conservation et la destruction des renseignements personnels sur la santé;**
- **des mécanismes permettant d'assurer une surveillance suffisante des systèmes de DSE d'un organisme à l'autre.**

L'autre défi important qui se pose aux DSE réside dans la nécessité de trouver une façon de mettre en œuvre des systèmes de DSE compatibles qui permettent à la fois de préserver le droit des personnes à la protection des renseignements personnels sur leur santé et de satisfaire aux critères de faisabilité et d'efficacité. Peut-être est-il possible d'adopter des mesures matérielles, technologiques et organisationnelles très strictes, mais il se peut que leur application ne soit tout simplement pas pratique ou rentable. De plus, les mesures de protection évoluent sensiblement au fil du temps, à mesure que les technologies et les pratiques habituelles changent, d'où la nécessité d'une mise à jour et d'une modernisation constantes. Les organisations devront faire la différence entre les tendances passagères et les mesures d'avant-garde qui ont fait leur preuve, puis décider en conséquence des investissements à faire.

Dans un environnement de DSE, de nombreux dépositaires interviendront dans la collecte de renseignements personnels sur la santé devant être versés dans un fichier. De multiples utilisateurs autorisés pourront éventuellement avoir légitimement accès aux DSE, pour y ajouter d'autres renseignements et participer collectivement à l'enrichissement du fichier. Comme la responsabilité du contrôle sera partagée entre plusieurs dépositaires et utilisateurs, il devra en être de même de l'obligation de rendre compte. La réelle difficulté résidera donc dans la nécessité de coordonner et de répartir les responsabilités de façon que les droits des patients ne soient pas relégués au second rang. Malgré le caractère apparemment vague du cadre de fonctionnement d'un système de DSE, les patients devront pouvoir adresser leurs questions et leurs préoccupations à une entité identifiable et exercer de façon concrète leur droit d'accès, de correction et de recours en cas de non-conformité.

Le Comité recommande donc :

**Qu'Inforoute Santé du Canada Inc. et d'autres investisseurs clés structurent leurs critères d'investissement de façon à créer des conditions de nature à encourager les concepteurs de systèmes DSE à trouver des solutions utiles et pratiques en matière de protection des renseignements personnels pour permettre :**

- **l'adoption de mesures de sécurité d'avant-garde pour protéger les renseignements personnels sur la santé et soumettre les opérations à une vérification;**
- **un partage entre les différents dépositaires qui ont accès aux DSE et les utilisent de la responsabilité en matière de reddition de comptes;**
- **une coordination entre les dépositaires de façon que les patients puissent concrètement exercer leur droit d'accès à leur DSE pour y rectifier une inexactitude et contester en cas de non-conformité.**

L'obtention de la confiance du public sera absolument indispensable pour permettre l'élaboration et la mise en œuvre de DSE. Peu d'études ont été menées jusqu'ici pour tenter de mieux comprendre les éléments qui déterminent l'attitude des Canadiens à l'égard de l'utilisation à différentes fins des renseignements personnels concernant leur santé. Or, elles sont essentielles si nous voulons que les DSE soient élaborés et mis en œuvre de façon à tenir compte de ces éléments et à respecter les préoccupations sous-jacentes de la population dans des contextes précis.

Les avantages des DSE sont peut-être évidents pour ceux dont le travail est de les concevoir, mais ils doivent aussi l'être aux yeux des Canadiens. Le projet d'infrastructure pancanadienne de la santé engage tout le monde. Un dialogue éclairé et valable doit avoir lieu pour permettre la participation de tous les intervenants clés, notamment les groupes de patients et les représentants des consommateurs. Les fournisseurs seront mieux équipés pour améliorer la qualité des soins qu'ils dispensent et réaliser l'intégration de leurs services; les décideurs et les gestionnaires seront mieux informés pour assurer l'accessibilité aux soins de santé et une reddition de comptes plus serrée; les chercheurs seront mieux en mesure d'évaluer l'efficacité des produits et services médicaux et de comprendre les déterminants de la santé des Canadiens; le grand public sera mieux habilité à faire des choix éclairés au sujet de sa propre santé, des soins de santé et des politiques en matière de santé. Une stratégie de communication publique ouverte, transparente et itérative contribuerait beaucoup à convaincre la population des nombreux avantages des DSE et de la vision véritablement inclusive d'une éventuelle infrastructure pancanadienne de la santé. Le Comité recommande donc :

**Que les principaux intervenants, notamment les ministères de la Santé fédéral, provinciaux et territoriaux, Inforoute Santé du Canada Inc., l'Institut canadien d'information sur la santé et les Instituts de recherche en santé du Canada, veillent à :**

- **entreprendre une étude rigoureuse des facteurs qui déterminent l'attitude des Canadiens à l'égard de ce qui leur paraît être une utilisation acceptable ou non acceptable des renseignements personnels concernant leur santé;**

- **amorcer un dialogue éclairé et valable avec les principaux intervenants, notamment les groupes de patients et les représentants des consommateurs;**
- **mettre en œuvre une stratégie de communication publique ouverte, transparente et itérative pour expliquer les avantages des DSE.**



# CHAPITRE ONZE

## LES RESSOURCES HUMAINES DE LA SANTÉ

---

### 11.1 La gravité de la pénurie de ressources humaines en santé

Au cours de ses audiences, le Comité a entendu des témoignages accablants relativement à une pénurie persistante de ressources humaines dans tous les secteurs du système de soins de santé. Cette pénurie touche tout autant les médecins spécialistes que les omnipraticiens, les infirmières autorisées que les infirmières auxiliaires autorisées, les technologues de laboratoire que les pharmaciens. S'occuper de la question de l'offre de professionnels dans toutes les disciplines des soins de santé et trouver des moyens d'accroître leur productivité individuelle et globale constituent deux des problèmes les plus pressants et les plus complexes auxquels sont confrontés les décideurs de la santé.

***S'occuper de la question de l'offre de professionnels dans toutes les disciplines des soins de santé et trouver des moyens d'accroître leur productivité individuelle et globale constituent deux des problèmes les plus pressants et les plus complexes auxquels sont confrontés les décideurs de la santé.***

Il se passe rarement un mois sans qu'on publie une nouvelle étude ou un nouveau rapport confirmant l'ampleur et la gravité de la situation. Plusieurs de ces ouvrages ont paru depuis la publication du dernier rapport du Comité, et ils abondent malheureusement dans le même sens.

Selon un nouveau rapport publié par l'Institut canadien d'information sur la santé (ICIS) en juin 2002, le nombre de médecins a atteint un sommet au Canada en 1993; il a diminué de 5% depuis, ce qui a fait baisser le ratio médecin-population au niveau d'il y a 15 ans<sup>226</sup>. Le document de l'ICIS illustre une fois de plus la grave pénurie de ressources humaines ainsi que ses conséquences, notamment le moins grand nombre d'omnipraticiens et de jeunes médecins et la charge de travail plus lourde des médecins.

Deux documents provinciaux récents portant sur l'offre de médecins (médecins disponibles) viennent à leur tour appuyer le point de vue exprimé par le Comité dans ses rapports antérieurs, à savoir qu'il est de plus en plus justifié de parler d'une crise des ressources humaines en santé. Le Collège des

***[...] le Comité s'inquiète du fait que toutes les études dont il est question plus haut ne parlent que du nombre de médecins et passent sous silence le problème de la productivité.***

---

<sup>226</sup> Dr Benjamin T.B. Chan, *Du surplus perçu à la pénurie perçue : l'histoire des médecins canadiens dans les années 1990*, Institut canadien d'information sur la santé, juin 2002.

médecins du Québec a étudié le nombre de médecins qui exercent actuellement leur profession, plutôt que de se fier simplement au nombre de médecins inscrits, et a constaté que la province aurait besoin de 1 400 médecins de plus pour desservir la population<sup>227</sup>.

Pour sa part, l'Ontario Medical Association estime qu'il y a eu une perte nette additionnelle de 110 médecins en Ontario entre les années 1999 et 2000, portant le manque à gagner total à environ 1 585. Le rapport de l'OMA révèle que plus de 100 localités sont actuellement mal desservies dans la province<sup>228</sup>.

De son côté, le Comité s'inquiète du fait que toutes les études dont il est question plus haut parlent uniquement du nombre de médecins et passent sous silence le problème de la productivité. Or il est clair que l'on pourrait réduire le nombre de médecins supplémentaires nécessaires au Canada si l'on augmentait la productivité des médecins.

Par exemple, la plupart des chirurgiens affirment qu'ils seraient plus productifs si on leur accordait plus d'heures en salle d'opération et un meilleur accès à des lits de soins de courte durée pour leurs patients, lesquels pourraient poursuivre leur convalescence à la maison<sup>229</sup>. Ce fait soulève la question suivante en matière de politique gouvernementale : vaut-il mieux éliminer les obstacles à une productivité accrue chez les chirurgiens ou produire un plus grand nombre de chirurgiens qui, comme leurs prédécesseurs, ne seront pas aussi productifs qu'ils pourraient l'être ou voudraient l'être à cause de contraintes institutionnelles? On ne peut répondre à de telles questions de politique sans connaître beaucoup mieux le niveau actuel de productivité des médecins et les obstacles à l'accroissement de leur productivité.

Le Comité estime essentiel que des organismes de recherche indépendants de la profession médicale étudient attentivement la productivité des médecins et les obstacles qui empêchent son accroissement. Le gouvernement, en tant que source de financement du système de santé, et les fournisseurs de soins de santé eux-mêmes doivent comprendre les facteurs qui influent sur la productivité dans le domaine des soins de santé et la façon dont on peut améliorer la productivité du personnel clé du système.

***Le Comité estime essentiel que des organismes de recherche indépendants de la profession médicale (comme l'ICIS ou les IRSC) étudient attentivement la productivité des médecins.***

Dans d'autres secteurs, la disponibilité de nouvelles technologies de l'information, par exemple, a permis d'accroître la productivité des professionnels au cours des 20 dernières années. Il est certain qu'on aurait pu rendre les médecins plus productifs grâce à de meilleurs appareils de diagnostic, à des médicaments plus efficaces et à de meilleurs traitements externes, sans compter l'effet qu'aurait pu avoir sur leur productivité l'amélioration de l'état de santé des Canadiens depuis 20 ans. Or, rien ne nous dit si cela s'est effectivement produit. C'est pourquoi la recherche proposée s'impose.

---

<sup>227</sup> *Medical Post*, 4 juin 2002.

<sup>228</sup> Ontario Medical Association, *Position Paper on Physician Workforce Policy and Planning*, avril 2002.

<sup>229</sup> Voir, au chapitre huit du présent volume, la proposition du Comité relativement à un programme de soins à domicile dispensés après hospitalisation.



Selon le Comité, des observations semblables à celles qui ont été faites au sujet de la productivité des médecins valent également pour d'autres professionnels de la santé. Le Comité recommande donc :

**Que l'on effectue des études pour trouver des moyens d'améliorer la productivité des professionnels de la santé. Ces études devraient être effectuées ou commandées par le comité national de coordination des ressources humaines en santé dont le Comité recommande la création.**

Trois rapports parus dernièrement fournissent des données supplémentaires sur l'importance de la pénurie d'infirmières. L'ICIS a révélé qu'en juin 2002, la légère hausse du nombre d'infirmières actives au Canada (1,2 %) entre 1997 et 2001 n'a pas été suffisante par rapport à l'accroissement démographique. Il y a donc moins d'infirmières par habitant aujourd'hui qu'il y a cinq ans. Le rapport de l'ICIS indique également que l'effectif infirmier vieillit rapidement, la moyenne d'âge chez les infirmières autorisées étant passée de 42,4 ans en 1997 à 43,7 ans en 2001<sup>230</sup>.

Une étude de l'Association des infirmières et infirmiers du Canada portant sur les tendances observées depuis 1996 signale qu'au cours des 35 années étudiées, on remarque un déplacement de la composition par âge de l'effectif infirmier vers les groupes d'âge plus avancé<sup>231</sup>. Le rapport de l'AIIIC établit aussi des projections de l'offre et de la demande d'infirmières au cours des 10 à 15 prochaines années et conclut qu'il y aura une pénurie de 78 000 infirmières autorisées en 2011 et de 113 000 en 2016<sup>232</sup>.

Le rapport final du Comité consultatif canadien sur les soins infirmiers, présidé par M. Michael Decter, a paru en août 2002. On y énumère trois façons d'améliorer la qualité de vie au travail des infirmières canadiennes<sup>233</sup> :

- augmenter le nombre d'infirmières;
- améliorer la formation et élargir le champ de pratique des infirmières;
- améliorer les conditions de travail des infirmières.

Parmi ses 51 recommandations destinées à réaliser ces améliorations, le Comité consultatif propose qu'on augmente de 25 % le nombre de nouvelles places de première année du diplôme d'infirmière autorisée dans les écoles de sciences infirmières (c'est-à-dire qu'on ajoute environ 1 100 nouvelles places) en septembre 2004, et qu'on accroisse encore le nombre de 20 % à chacune des quatre années subséquentes.

---

<sup>230</sup> Institut canadien d'information sur la santé, *Nombre et répartition des infirmières et infirmiers autorisés au Canada, rapport 2001*, juin 2002.

<sup>231</sup> Association des infirmières et infirmiers du Canada, *Planning for the Future: Nursing Human Resource Projections*, juin 2002, p. 20.

<sup>232</sup> *Ibid.*, p. 1.

<sup>233</sup> *Notre santé, notre avenir : un milieu de travail de qualité pour les infirmières canadiennes*, Comité consultatif des ressources humaines en santé, 2002, p. 3.

Cependant, on n'en sait pas encore assez sur la productivité des infirmières et sur ce qu'on pourrait faire pour l'améliorer. Dans son rapport, par exemple, le Comité consultatif canadien sur les soins infirmiers confirme la nécessité d'« orienter les ressources provinciales et fédérales vers l'élaboration de stratégies précises et pratiques visant à mesurer la charge de travail et à en faire rapport »<sup>234</sup>. Le Comité estime qu'il faudrait effectuer le même genre d'études de productivité que celles qu'il propose plus haut dans le cas des médecins, afin de mieux comprendre à quelles tâches les infirmières consacrent leur temps et quels sont les obstacles institutionnels qui nuisent à l'amélioration de leur productivité. C'est la raison pour laquelle la recommandation ci-dessus porte sur tous les professionnels de la santé.

Même si les membres des professions paramédicales ne sont pas autant le point de mire du public, le Comité a plusieurs fois attiré l'attention sur le fait que la pénurie de ressources humaines ne se limite pas aux médecins et aux infirmières. Par exemple, il a indiqué dans des volumes antérieurs que plus de 20 disciplines ont déclaré connaître des pénuries importantes, dont les physiothérapeutes et les ergothérapeutes, les technologues en radiographie et les technologues de laboratoire médical ainsi que les inspecteurs sanitaires.

De plus, des témoins ont fait savoir que, malgré ces pénuries, on réduit le recrutement dans les programmes de formation. On a donné l'exemple des programmes de techniques de laboratoire médical, en Alberta, où le nombre de places de formation est passé de 40 à 20. Des témoins ont cité d'autres chiffres troublants, compte tenu de la demande toujours croissante de personnel technique et professionnel, à la fois en raison des nouvelles technologies et de l'accroissement de la population. Par exemple, le nombre de diplômés des programmes de techniques de laboratoire médical a diminué de 42 % dans l'ensemble du pays depuis 1987, et le nombre de diplômés en imagerie diagnostique a baissé de 15 %. La Société canadienne de science de laboratoire médical a prédit une pénurie de technologues généraux de laboratoire médical partout au pays d'ici 5 à 15 ans.

L'Association des pharmaciens du Canada a également témoigné à ce sujet. Elle a fait remarquer que la pénurie de pharmaciens ne touche pas seulement le Canada, mais aussi de nombreux autres pays, dont le Royaume-Uni et les États-Unis. Un nombre insuffisant de pharmaciens signifie davantage de postes vacants, de plus longues périodes d'attente pour combler ces postes, un plus grand nombre d'heures supplémentaires et des augmentations de salaire excessives par rapport au coût de la vie. Une autre étude récente indique que bien au-delà de 2 000 pharmaciens supplémentaires pourraient facilement trouver du travail au Canada.

À la baisse du nombre de diplômés s'ajoute ce que l'on pourrait appeler « une progression insidieuse des compétences », c'est-à-dire l'augmentation graduelle du niveau d'études nécessaire pour occuper un emploi dans un domaine donné, attribuable à la complexité croissante des tâches à exécuter. Cette progression insidieuse des compétences a pour effet, entre autres, d'allonger la durée de formation des nouveaux diplômés, ce qui aggrave la pénurie de tous genres de professionnels de la santé.

La progression insidieuse des compétences a aussi d'autres conséquences. D'une part, elle peut mener au transfert de certains programmes des collèges communautaires aux

---

<sup>234</sup> *Ibid.*, p. 40.

universités et, de l'autre, elle peut faire en sorte que les diplômés demandent des salaires plus élevés, qu'ils justifient par la formation additionnelle qu'ils ont reçue.

Le Comité s'inquiète que ces phénomènes se produisent sans qu'on les ait suffisamment étudiés afin de vérifier si les changements apportés aux niveaux de compétence et de rémunération sont justifiés. Il est d'avis que l'on devrait déterminer la durée de la formation nécessaire aux divers professionnels de la santé et l'établissement d'enseignement le plus apte à offrir cette formation.

## **11.2 Les ressources humaines de la santé : Nécessité d'une stratégie nationale**

Le Comité croit fermement que l'une des principales conséquences de la pénurie mondiale croissante de ressources humaines en santé, c'est qu'elle force le Canada à élaborer une stratégie qui lui permettra de réaliser l'autosuffisance à cet égard.

Selon le Comité, pour aller de l'avant dans ce dossier, il faut d'une part reconnaître qu'une telle stratégie ne saurait être « fédérale », mais plutôt qu'elle devra mettre à contribution tous les intervenants; d'autre part, il faut garder à l'esprit que la formation des professionnels de la santé incombe aux provinces. Pour que le Canada puisse devenir autosuffisant sur le plan des ressources humaines en santé, une collaboration et une coordination à long terme sont essentielles entre tous les intervenants du secteur de la santé.

***Le Comité croit fermement que l'une des principales conséquences de la pénurie mondiale croissante de ressources humaines en santé, c'est qu'elle force le Canada à élaborer une stratégie qui lui permettra de réaliser l'autosuffisance à cet égard.***

De l'avis du Comité, les problèmes causés par la concurrence interprovinciale pour obtenir les diplômés dans les divers domaines de la santé ne font qu'accentuer la nécessité d'élaborer une stratégie nationale des ressources humaines en santé. La concurrence que se livrent les provinces ou les pays, se disputant de maigres ressources humaines, risque de créer de graves disparités régionales dans la capacité de dispenser des services de soins de santé.

Le Comité estime que le gouvernement fédéral doit dorénavant jouer un rôle beaucoup plus important pour coordonner les efforts visant à élaborer et à mettre en œuvre une stratégie nationale relative aux ressources humaines en santé et à lutter contre les pénuries. Puisqu'il n'y a pas de solution miracle et qu'il faut tenir compte d'une foule d'intérêts et de préoccupations dans la formulation de solutions à long terme, le Comité estime souhaitable de recommander l'élaboration d'un cadre de travail permanent. Il a par conséquent recommandé dans le volume cinq de son rapport :

***Le Comité estime que le gouvernement fédéral doit dorénavant jouer un rôle beaucoup plus important pour coordonner les efforts de lutte contre la pénurie de ressources humaines en santé.***

**Que le gouvernement fédéral travaille avec d'autres parties intéressées afin de créer un comité national permanent de coordination des ressources humaines de la santé, composé**

**de représentants des principaux intervenants et des différents ordres de gouvernement. Son mandat serait le suivant :**

- **diffuser des renseignements à jour sur les besoins en ressources humaines;**
- **coordonner des projets visant à assurer un nombre suffisant de diplômés pour réaliser l'objectif d'autosuffisance en matière de ressources humaines;**
- **partager et promouvoir les pratiques exemplaires quant aux stratégies servant à retenir des professionnels de la santé compétents, et coordonner les efforts de rapatriement des professionnels de la santé canadiens qui ont émigré;**
- **recommander des stratégies pour accroître le nombre de professionnels de la santé provenant de groupes sous-représentés, comme les peuples autochtones, ainsi que dans les régions mal desservies, particulièrement les régions rurales et éloignées;**
- **examiner les possibilités en vue d'une meilleure coordination, entre les divers ordres de gouvernement, des exigences en matière d'accréditation et d'immigration.**

Comme il a déjà été signalé, le Comité est d'avis que le comité national de coordination des ressources humaines en santé devrait se charger d'étudier les moyens d'améliorer la productivité des professionnels de la santé. Il est également clair pour le Comité qu'aucun groupe de professionnels ni aucun ordre de gouvernement ne devrait prédominer dans les délibérations du comité national de coordination dont il propose la création.

Le Comité a aussi recommandé que le gouvernement fédéral prenne un certain nombre de mesures précises destinées à augmenter le nombre de professionnels de la santé, notamment :

**Que le gouvernement fédéral :**

- **Travaille avec les gouvernements provinciaux pour faire en sorte que toutes les écoles de médecine et de sciences infirmières reçoivent les augmentations de financement nécessaires pour leur permettre d'accroître le nombre d'inscriptions.**
- **Mette en place des mécanismes permettant un financement fédéral direct afin de soutenir un plus grand nombre d'inscriptions dans les écoles de**

**médecine et de sciences infirmières, et assure la stabilité du financement en vue de la formation de professionnels paramédicaux.**

- **Examine les programmes fédéraux de prêts étudiants offerts aux professionnels de la santé et y apporte les modifications nécessaires afin que les augmentations inévitables de frais de scolarité ne nuisent pas aux étudiants défavorisés sur le plan socioéconomique.**
- **Travaille avec les gouvernements provinciaux pour faire en sorte que la rémunération des différentes catégories de professionnels de la santé tienne compte du niveau de formation réel exigé d'eux.**

Dans les volumes précédents, le Comité a signalé un grave manque de fournisseurs de soins de santé d'origine autochtone. Pour aider à solutionner ce problème, il a aussi recommandé dans le volume cinq :

**Que le gouvernement fédéral travaille avec les provinces et les facultés de médecine et de sciences infirmières afin de financer des places à l'intention des étudiants d'origine autochtone, en plus des places offertes à la population générale.**

De plus, étant donné que la mise en œuvre de toutes les mesures énumérées dans les recommandations ci-dessus prendra du temps, il faut prévoir diverses mesures à court terme pour régler la crise des ressources humaines. L'une d'elles consiste en des incitatifs fiscaux. De tels incitatifs fiscaux à court terme ont été utilisés à la fin des années 60 et au début des années 70 pour attirer des professeurs d'université au Canada à une époque où le pays connaissait une grave pénurie d'universitaires qualifiés. Le Comité est d'avis qu'une approche semblable devrait être envisagée à l'heure actuelle en ce qui concerne les professionnels de la santé. Il recommande par conséquent :

**Que, pour faciliter le retour au Canada des professionnels de la santé canadiens travaillant à l'étranger, le gouvernement fédéral travaille avec les provinces et les associations professionnelles afin d'informer ces professionnels des nouvelles perspectives d'emploi au Canada, et qu'il étudie la possibilité d'adopter des incitatifs fiscaux à court terme pour ceux qui sont prêts à rentrer au Canada.**

Les sections suivantes du présent chapitre contiennent d'autres observations sur la pénurie de ressources humaines en santé au Canada, ainsi qu'un certain nombre de recommandations additionnelles pour aider à la réduire.

### 11.3 Accroître le nombre de médecins formés au Canada

Le rapport publié récemment par l'ICIS, dont nous parlons plus haut, a enrichi l'étude portant sur l'offre de médecins au Canada, en attribuant un poids aux divers facteurs qui ont contribué à la baisse du ratio médecin-population :

- environ 25 % de la baisse est attribuable à la formation postdoctorale plus longue des médecins, parce que les omnipraticiens doivent maintenant faire deux années de formation postdoctorale au lieu d'une avant de se joindre à un cabinet indépendant, et parce qu'une plus forte proportion de médecins choisissent de devenir spécialistes, ce qui exige une formation beaucoup plus longue;
- 22 % est attribuable au fait qu'un moins grand nombre de médecins étrangers viennent au Canada;
- 17 % est attribuable au nombre plus élevé de médecins qui prennent leur retraite;
- jusqu'à maintenant, seulement 11 % est attribuable à la baisse du nombre d'inscriptions dans les écoles de médecine, mais les pleines répercussions des compressions des années 90 ne se feront sentir qu'au cours des prochaines années.

L'auteur du rapport, le D<sup>r</sup> Ben Chan, fait remarquer que plusieurs erreurs importantes ont été commises dans les décisions stratégiques prises au cours des années 90. Premièrement, on n'a pas tenu compte des conséquences non intentionnelles de ces décisions. Par exemple, on n'a pas pleinement pesé le fait que le prolongement de la formation des omnipraticiens (deux années de formation postdoctorale au lieu d'une) réduirait de façon permanente le nombre de médecins. Deuxièmement, on n'a pas revu les politiques assez fréquemment, de sorte que les effets de plusieurs politiques se sont combinés de façon inattendue, créant une pénurie plus grave que prévu. Enfin, on a éliminé des mesures qui donnaient au système une certaine souplesse. Par exemple, les étudiants étaient obligés de faire un choix de carrière très tôt dans leurs études universitaires sans pouvoir profiter d'une expérience pratique ou de la possibilité de changer d'idée plus tard<sup>235</sup>.

Le Comité demeure convaincu que la seule solution à long terme à la crise des ressources humaines en santé est l'élaboration d'une stratégie nationale visant, d'une part, à former un nombre suffisant de médecins et d'autres professionnels de la santé au Canada pour répondre aux besoins du pays, et, d'autre part, à accroître la productivité des médecins.

***Le Comité demeure convaincu que la seule solution à long terme à la crise des ressources humaines en santé est l'élaboration d'une stratégie nationale visant, d'une part, à former un nombre suffisant de médecins et d'autres professionnels de la santé au Canada pour répondre aux besoins du pays, et, d'autre part, à accroître la productivité des médecins.***

<sup>235</sup> D<sup>r</sup> Ben Chan, « How Canada can better manage its MD supply », *Medical Post*, 25 juin 2002.

(AFMC), indique que, seulement pour maintenir le ratio médecin-population actuel, il faudrait que 2 500 étudiants entrent en faculté de médecine d'ici 2005, ce qui représente 640 de plus que les 1 860 inscriptions de première année enregistrées en 2001<sup>236</sup>.

Dans le volume cinq, le Comité a recommandé que le gouvernement fédéral accorde un soutien financier continu aux provinces afin d'accroître le nombre d'inscriptions dans les écoles de médecine canadiennes. Selon l'AFMC, le coût par place dans une école de médecine au Canada se chiffre actuellement à 260 000 \$ pour une période de quatre ans. Par conséquent, 640 étudiants de plus coûteraient environ 160 millions de dollars par année une fois atteints les nouveaux niveaux d'inscription<sup>237</sup>. Le Comité estime que cet argent serait bien dépensé. Il recommande donc :

**Que le gouvernement fédéral verse dès maintenant 160 millions de dollars par année afin que les écoles de médecine canadiennes puissent recruter 2500 étudiants de première année d'ici 2005.**

De plus, il est également important de garder à l'esprit la conclusion du D<sup>r</sup> Chan, à savoir qu'il faudra revoir régulièrement les niveaux d'inscription pour s'assurer qu'ils sont en tout temps conformes à l'évolution de la situation. Le D<sup>r</sup> Fuks estime que, pour compenser les pénuries actuelles de médecins (plutôt que seulement maintenir le ratio médecin-population), il faudrait augmenter davantage les inscriptions pour atteindre l'objectif de 3000 étudiants de première année en 2009. Il importe toutefois de signaler que ces prévisions ne tiennent pas compte de l'effet des augmentations possibles de productivité. Le Comité est d'avis qu'il faut surveiller la situation de près. Il recommande :

**Que le comité national de coordination des ressources humaines en santé dont le Comité propose la création soit chargé de surveiller les niveaux d'inscription des écoles de médecine du Canada et qu'il conseille le gouvernement fédéral à cet égard.**

Cependant, il est clair qu'il faudra du temps pour accroître les niveaux d'inscription et encore plus de temps pour que ces augmentations se traduisent par un plus grand nombre de médecins actifs. On devra alors, à court terme, prendre certaines mesures pour réduire un peu la pression. Le Comité a déjà réitéré sa recommandation du volume cinq, à savoir que le gouvernement fédéral devrait étudier la possibilité d'adopter des incitatifs fiscaux à court terme pour rapatrier les professionnels de la santé qui travaillent à l'étranger.

De plus, un certain nombre de Canadiens hautement qualifiés et spécialisés terminent actuellement leurs études médicales de base à l'extérieur du Canada, notamment en Australie, en Irlande et au Royaume-Uni. Le D<sup>r</sup> Fuks a déclaré au Comité que beaucoup de ces

---

<sup>236</sup> D<sup>r</sup> Abraham Fuks, mémoire présenté au Comité le 23 juillet 2002.

<sup>237</sup> Le coût par étudiant par année représente le quart de la somme totale de 260 000 \$, c'est-à-dire 65 000 \$. Toutefois, une fois le nombre souhaité de nouveaux étudiants inscrits dans chacune des années du programme de quatre ans en médecine, il faut multiplier par quatre la somme de 65 000 \$ par étudiant par année, ce qui porte le coût total des nouvelles places à 260 000 \$ par année.

étudiants, qui fréquentent des facultés de médecine de renom, ont hâte de revenir au Canada. Le Comité croit donc que l'on devrait établir une politique de recrutement vigoureuse pour encourager ces Canadiens expatriés à rentrer au Canada pour recevoir une formation postdoctorale et exercer leur profession au pays.

Afin d'accueillir ces étudiants qui reviennent, de même que les diplômés en médecine étrangers dont il est question plus bas, il faudra aussi augmenter le nombre de postes de médecins résidents. S'inspirant des chiffres fournis par l'Association des facultés de médecine du Canada<sup>238</sup>, le Comité recommande donc :

**Que le gouvernement fédéral contribue financièrement à accroître le nombre de postes de médecins résidents afin d'atteindre un ratio de 120 pour 100 diplômés des écoles de médecine canadiennes.**

Comme le Comité l'a déjà fait remarquer, cette mesure permettra aussi aux médecins canadiens déjà en place d'accéder plus facilement à la formation supérieure et d'acquérir des compétences additionnelles.

#### **11.4 Intégration des diplômés en médecine étrangers**

Une autre mesure visant tout particulièrement à réduire la pénurie de médecins consiste à élaborer un plan national qui permettra de mieux utiliser les diplômés en médecine étrangers qui sont déjà ici. Par le passé, le Canada a pu compter sur le recrutement étranger pour combler certains de ses besoins. Par exemple, plus de 50 % des médecins de la Saskatchewan sont des diplômés étrangers qui ont été formés ailleurs et ont été recrutés par cette province plus tard au cours de leur carrière. Cependant, d'autres pays sont maintenant confrontés aux mêmes pénuries que le Canada. Il semble insensé que tous les pays développés fassent sans cesse du maraudage les uns chez les autres pour recruter des professionnels de la santé hautement qualifiés.

La plupart des experts estiment actuellement à au moins 2000 le nombre de diplômés en médecine étrangers au Canada qui ne détiennent pas de licence pour pratiquer la médecine<sup>239</sup>. Il n'existe pas de programme uniforme pour accorder les attestations d'études aux diplômés étrangers, et chaque province dispose d'un programme limité pour leur admission aux programmes de résidence. Par exemple, l'Ontario réserve 40 places pour la formation de diplômés étrangers, et sur les 1 000 demandes reçues l'année dernière, 25 seulement ont été acceptées.

On note cependant des signes d'amélioration. En avril 2001, le Manitoba a lancé le premier programme permanent au Canada pour aider les diplômés étrangers à obtenir une licence de médecine. Ce programme se fonde sur un processus d'évaluation clinique et de perfectionnement professionnel (CAPE) en trois étapes, outil élaboré par la faculté de médecine de l'Université du Manitoba pour évaluer les connaissances médicales et les compétences cliniques des médecins formés à l'étranger. Le programme CAPE a connu un tel succès que le College of Physicians and Surgeons of Nova Scotia y réfère les diplômés étrangers candidats qui

---

<sup>238</sup> Dr Fuks, *op. cit.*

<sup>239</sup> *Medical Post*, 11 juin 2002.



n'ont pas reçu de formation autorisée ou acquis d'expérience clinique pratique en Amérique du Nord<sup>240</sup>.

Les membres de l'Association des facultés de médecine du Canada ont conclu récemment qu'il faut d'urgence élaborer une stratégie nationale, comportant des normes nationales, pour favoriser l'intégration des diplômés en médecine étrangers au personnel médical canadien. Ils ont proposé un programme d'évaluation commun qui permettrait de classer les diplômés dans l'une des quatre catégories suivantes : la personne a fait des études et reçu une formation équivalente et elle devrait être autorisée à exercer la profession au Canada; la personne a besoin d'une formation complémentaire; la personne a fait des études en médecine équivalentes, mais elle doit suivre une formation postdoctorale au Canada; la personne n'a pas d'études ni de formation suffisantes et elle doit recommencer des études en médecine au Canada.

Par conséquent, le Comité recommande :

**Que le gouvernement fédéral travaille avec les provinces afin d'établir des normes nationales pour l'évaluation des diplômés en médecine étrangers, et qu'il fournisse un financement continu pour mettre en œuvre un programme accéléré visant à délivrer des licences aux diplômés étrangers qualifiés et à intégrer complètement ces derniers au système canadien de soins de santé.**

### **11.5 Réduire la pénurie d'infirmières**

Comme nous l'avons indiqué plus haut dans le présent chapitre, une étude menée par l'Association des infirmières et infirmiers du Canada a révélé qu'il manquerait 78 000 infirmières autorisées au pays en 2011 et que l'écart pourrait atteindre 113 000 en 2016. Les auteurs de l'étude arrivent à ces conclusions malgré les hypothèses relativement optimistes qu'ils posent à l'égard du nombre de diplômés en sciences infirmières auquel on peut s'attendre au cours des cinq prochaines années. Selon eux, le nombre de diplômés des écoles de sciences infirmières du Canada passera de 4 599 en 2000 à plus de 9 000 par année en 2007<sup>241</sup>. (Voir le tableau 11.1 ci-dessous.)

---

<sup>240</sup> Pamela Clarke, « The Foreign Question », *Medical Post*, 28 mai 2002.

<sup>241</sup> AIIC, *op. cit.*, p. 1.

**TABLEAU 11.1**  
**NOMBRE DE DIPLÔMÉS EN SCIENCES INFIRMIÈRES, 1999-2008\***

Année	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Canada	5 221	4 599	5 499	6 782	7 578	7 678	7 834	8 829	9 182	9 382

*Source* : Projections établies par Eva Ryten pour le compte de l'Association des infirmières et infirmiers du Canada, juin 2002.

\* 1999-2001 : données réelles; 2002-2008 : projections

Cependant, même si le nombre de diplômés augmente de près du double et que l'on s'attend à un apport de 1 200 infirmières formées à l'étranger chaque année à compter de 2002, les auteurs affirment de façon catégorique qu'il sera impossible de répondre à la demande prévue de services de soins infirmiers. Il n'existe pas non plus de bassin suffisamment large d'infirmières qualifiées qui ne travaillent pas actuellement en soins infirmiers et qui pourraient être incitées à revenir à la profession pour aider à réduire la pénurie. En fait, le rapport fait remarquer :

*Il convient tout particulièrement de noter qu'en 2000 et 2001, moins de 3 000 infirmières autorisées ne travaillaient pas en soins infirmiers et cherchaient un emploi dans ce domaine. C'est un bien petit nombre en comparaison du nombre total d'infirmières autorisées au pays<sup>242</sup>.*

Néanmoins, le Comité estime qu'il faudrait tout faire pour inciter les infirmières qualifiées qui ont quitté la profession à revenir travailler en soins infirmiers. Cela est d'autant plus important que, même si l'on jugeait souhaitable de remplacer les infirmières autorisées par des infirmières auxiliaires autorisées, les auteurs du rapport signalent que ces dernières ne sont pas en nombre suffisant pour combler la pénurie.

*Pour que les infirmières auxiliaires autorisées puissent répondre à une partie importante des besoins en services infirmiers qui ne peuvent être comblés à cause de la pénurie d'infirmières autorisées, il faudrait que leur nombre augmente à un rythme extrêmement rapide. Or le nombre d'infirmières auxiliaires autorisées ne bouge pas ou diminue depuis près de 20 ans. En 1983, il y avait 83 539 infirmières auxiliaires au Canada. En 1999, le nombre était tombé à 66 100<sup>243</sup>.*

En même temps, Mme Kelly Kay, de l'Association des infirmiers et infirmières auxiliaires du Canada, a déclaré au Comité :

*Dans la plupart des provinces, on manque d'infirmières auxiliaires autorisées. Il reste toutefois des situations comme en Ontario où 1 400 infirmières auxiliaires autorisées*

<sup>242</sup> *Ibid.*, p. 13.

<sup>243</sup> *Ibid.*, p. 74.

*ont indiqué dans leur dernier formulaire de renseignements qu'elles cherchaient un emploi en soins infirmiers*<sup>244</sup>.

En 1997, le nombre de demandes d'inscription dans les écoles de sciences infirmières était à la baisse, mais il semble que ce ne soit plus le cas maintenant. Mme Ginette Lemire-Rodger, présidente sortante de l'AIIC, a donné au Comité l'explication suivante :

*Au Canada, cette année seulement, on a refusé des milliers d'étudiants très bien formés. Les universités les refusent parce qu'il n'existe que 70 sièges pour 800 demandes au pays. Nous ne vivons pas une pénurie de jeunes et de moins jeunes personnes voulant entreprendre une carrière dans les soins infirmiers. Nous sommes dans une situation où les gouvernements ne financent pas les sièges pour accepter ces étudiants*<sup>245</sup>.

En somme, tout indique qu'il faudrait accroître de manière assez radicale le nombre de diplômés en sciences infirmières. Le Comité a fait remarquer dans le volume cinq que Développement des ressources humaines Canada (DRHC) a entrepris une importante étude de secteur afin de formuler des recommandations au sujet du nombre d'infirmières. Toutefois, Michael Decter a signalé au Comité :

**En somme, tout indique qu'il faudrait accroître de manière assez radicale le nombre de diplômés en sciences infirmières.**

*Je sais que le gouvernement du Canada, par l'entremise de DRHC, finance actuellement deux grandes études. Pour reprendre ce que disait David Sackett, il n'est pas nécessaire de faire un essai clinique à double insu pour faire preuve de bon sens. Le bon sens veut que nous ayons besoin de plus d'infirmiers et d'infirmières au Canada et que ce besoin est urgent*<sup>246</sup>.

Dans son rapport, l'AIIC précise qu'en calculant le nombre de places qui devraient être allouées, il est important d'éviter à long terme

*des périodes de fortes hausses ou de fortes baisses sur de courts intervalles. De telles fortes hausses et fortes baisses répétées sur de longues périodes mènent à une suite d'excédents et de déficits dans la profession. L'idéal serait que les niveaux augmentent graduellement chaque année en fonction de l'accroissement des besoins*<sup>247</sup>.

Même s'il n'y avait pas eu un sérieux problème de sous-financement des postes en soins infirmiers dans les années 90, l'AIIC estime que le nombre de diplômés requis aurait été de toute façon de l'ordre de 10 000 par année. L'AIIC explique cela en disant que même sans la crise des années 90, le Canada serait confronté à des pénuries d'infirmières en 2011 et 2016, bien que moins fortes, à cause de la retraite imminente des grandes cohortes de diplômés qui seront remplacées par de plus petites<sup>248</sup>. En tenant compte des conséquences des décisions erronées

<sup>244</sup> 61:25.

<sup>245</sup> 61:16.

<sup>246</sup> 52:8.

<sup>247</sup> AIIC, *op. cit.*, p. 76.

<sup>248</sup> *Ibid.*, p. 73.

prises dans les années 90, l'AIIIC a cru prudent de recommander l'élargissement des programmes de sciences infirmières pour atteindre le nombre cible de 12 000 diplômés par année.

Le Comité appuie cette estimation. Le tableau 11.1 présente les chiffres contenus dans le rapport au sujet du nombre actuel et projeté de nouveaux diplômés jusqu'en 2008. Le Comité recommande :

**Que le gouvernement fédéral introduise graduellement du financement au cours des cinq prochaines années de façon que le nombre de diplômés des programmes de sciences infirmières atteigne 12 000 en 2008 dans l'ensemble du Canada, et qu'il continue à fournir un financement supplémentaire complet aux provinces pour toutes les places dans les écoles de sciences infirmières au-delà de 10 000 inscriptions, et ce, aussi longtemps qu'il sera nécessaire pour enrayer la pénurie d'infirmières au pays.**

Si l'on examine les chiffres du tableau 11.1, qui indiquent le nombre prévu de diplômés en sciences infirmières, on constate qu'en 2008 il nous faudra 2 618 diplômés de plus. Les effectifs pourraient être augmentés de la façon suivante afin d'en arriver à ce nombre cible :

**TABLEAU 11.2**

	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>
Nombre prévu de diplômés à l'heure actuelle	7 678	7 834	8 829	9 182	9 382
Nombre projeté de diplômés en tenant compte du financement fédéral additionnel	8 000	9 000	10 000	11 000	12 000

L'AIIIC a informé le Comité que chaque poste additionnel en soins infirmiers en Ontario coûte 7 700 \$ par année. Pour un programme de quatre ans, cela signifie qu'il faudrait environ 30 000 \$ pour former chaque nouvelle infirmière. Si l'on étend cette estimation à toutes les places en soins infirmiers au Canada, il en coûterait environ 880 millions de dollars par année pour atteindre le niveau de 12 000 diplômés en sciences infirmières recommandé par l'AIIIC<sup>249</sup>. Pour s'assurer de disposer de fonds suffisants, et vu la gravité de la pénurie d'infirmières, le Comité juge qu'il serait prudent de réserver la somme additionnelle de 10 millions de dollars dans l'espoir qu'un plus grand nombre de diplômés puissent terminer leurs études plus tôt. Le Comité recommande donc :

**Que le gouvernement fédéral verse 90 millions de dollars par année tirés des recettes supplémentaires dont le Comité recommande le prélèvement, afin de permettre aux écoles d'infirmières du Canada de produire 12 000 diplômés d'ici 2008.**

<sup>249</sup> Le calcul a été fait de la même manière que pour les étudiants en médecine (soit (2 618 x 30 000 \$)).

## **11.6 Professions paramédicales**

Le Comité n'a pu obtenir suffisamment de données pour élaborer une proposition détaillée relativement au nombre précis de diplômés qu'il faudrait produire pour composer avec la pénurie de personnel des professions paramédicales, dont nous avons parlé plus haut dans le présent chapitre. Il croit néanmoins essentiel que le gouvernement fédéral engage des fonds pour répondre à ces besoins pressants. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral verse 40 millions de dollars par année tirés des recettes supplémentaires dont le Comité recommande le prélèvement, afin d'aider les provinces à accroître le nombre de diplômés des professions paramédicales chaque année.**

**Que l'allocation exacte de ces fonds soit déterminée par le comité national de coordination des ressources humaines en santé.**

## **11.7 Financement des études supérieures**

Les coûts de formation des nouveaux professionnels de la santé ne s'arrêtent pas au moment où ceux-ci obtiennent leur diplôme d'université ou de collège. Les centres universitaires de sciences de la santé, surtout, ont des coûts additionnels à payer, pas seulement pour les médecins mais aussi pour tous les autres professionnels de la santé. Selon l'Association canadienne des institutions de santé universitaires (ACISU), les coûts additionnels liés à l'augmentation des places de formation pour toutes les professions de la santé sont de l'ordre de 300 millions à 550 millions de dollars au cours du cycle de formation (soit entre 60 et 110 millions de dollars par année). Les coûts comprennent la rémunération des formateurs, la location des locaux, les frais généraux et les fournitures. Le Comité recommande donc :

**Que le gouvernement fédéral consacre 75 millions de dollars par année des nouveaux fonds que recommande de recueillir le Comité afin d'aider les centres universitaires des sciences de la santé à payer les coûts liés à l'accroissement du nombre de places de formation pour l'ensemble des professions de la santé.**

## **11.8 Ressources humaines de la santé : Examen des règles relatives au champ de pratique**

La dernière question sur laquelle portent les recommandations du Comité en matière de ressources humaines est la nécessité d'effectuer un examen indépendant complet des règles relatives au champ de pratique des diverses professions de la santé. Cet examen doit être axé sur l'élimination des obstacles qui nuisent actuellement à une collaboration fructueuse entre professionnels de la santé et qui empêchent certains d'entre eux (les infirmières praticiennes, par exemple) d'utiliser l'ensemble des compétences pour lesquelles ils ont été formés.

Dans son témoignage devant le Comité, le D'Duncan Sinclair, président de la Commission de restructuration des services de santé de l'Ontario, a été clair sur l'importance de résoudre ce problème de façon urgente :

*Faire faire par un médecin le travail qu'une infirmière praticienne ou une infirmière pourrait effectuer, c'est comme faire venir un électricien pour changer une ampoule ou demander à un mécanicien breveté de faire le plein et de vérifier le niveau d'huile et la pression des pneus. Ces spécialistes feraient-ils du bon travail? Certainement! Mais est-ce que ce serait utiliser judicieusement leur temps, leur formation et leur expertise? Pas du tout! Ce serait une utilisation coûteuse et inefficace de ressources déjà limitées que sont l'argent et le savoir de gens très doués<sup>250</sup>.*

**La dernière question sur laquelle portent les recommandations du Comité en matière de ressources humaines est la nécessité d'effectuer un examen indépendant complet des règles relatives au champ de pratique des diverses professions de la santé.**

Le Comité est d'avis que cette utilisation coûteuse et inefficace de ressources humaines rares doit cesser dès *maintenant*. Comme nous le soulignons dans le chapitre quatre, qui porte sur la réforme des soins de santé primaires, le rapport de synthèse sur les projets liés aux soins primaires du Fonds pour l'adaptation des services de santé concluait, pour ce qui est des infirmières praticiennes :

*Il faudrait une initiative fédérale, provinciale et territoriale pour définir des normes nationales en ce qui concerne la terminologie et la portée de la pratique. Cette initiative devrait comprendre des prescriptions légales favorables à l'élargissement du rôle des infirmières et des infirmières praticiennes<sup>251</sup>.*

Le Comité recommande donc :

**Qu'un examen indépendant des règles relatives au champ de pratique et des autres règlements concernant ce que chaque professionnel de la santé peut ou ne peut pas faire soit effectué dans le but d'élaborer des propositions qui feraient en sorte qu'on utilise pleinement les compétences des divers professionnels de la santé et que les soins de santé soient fournis par le professionnel qualifié qui convient le mieux.**

## **11.9 Commentaires du Comité**

Le Comité reconnaît qu'il faut accroître les effectifs de chacune des professions de la santé, et c'est l'objectif qu'il vise par ses recommandations.

<sup>250</sup> Voir le volume quatre de l'étude du Comité, *Questions et options*, p. 118-119.

<sup>251</sup> Ann L. Mable et John Marriott, *Health Transition Fund Synthesis Series – Primary Health Care*, juin 2002, p. 29.

Cependant, il s'inquiète beaucoup des coûts globaux que l'accroissement des ressources humaines supposera pour l'ensemble du système. Il est tout à fait conscient, par exemple, que ce sont les médecins qui sont le principal facteur de coût<sup>252</sup>. Puisque le fait d'accroître le nombre de médecins ne fait pas baisser le coût moyen qu'impose chaque médecin au système, le seul moyen de faire en sorte que le système demeure financièrement viable au fur et à mesure qu'augmentera le nombre de médecins actifs serait d'améliorer sensiblement la productivité.

Par conséquent, le Comité estime nécessaire que l'accroissement du nombre de places dans les programmes d'enseignement s'accompagne d'études approfondies sur la façon d'améliorer la productivité dans chacune des professions de la santé. En l'absence de telles études et d'une amélioration importante de la productivité, le Comité craint que les coûts globaux des soins de santé ne connaissent une escalade intolérable.

***Par conséquent, le Comité estime nécessaire que l'accroissement du nombre de places dans les programmes d'enseignement s'accompagne d'études approfondies sur la façon d'améliorer la productivité dans chacune des professions de la santé.***

---

<sup>252</sup> Des chiffres montrent également que les médecins canadiens sont bien rémunérés en comparaison de ceux d'autres pays. Des données de l'OCDE indiquent que le ratio du revenu moyen des médecins à la rémunération moyenne des salariés au Canada s'établit à 3.2. Seuls les ratios observés aux États-Unis (5.5) et en Allemagne (3.4) sont plus élevés que celui du Canada; ils sont beaucoup plus bas dans un certain nombre d'autres pays, comme l'Australie (2.1), la France (1.9) et le Royaume-Uni (1.4). Voir Reinhardt, Uwe E., Peter S. Hussey et Gerard F. Anderson, « Cross-National Comparisons of Health Systems Using OECD Data, 1999 », *Health Affairs*, mai-juin 2002, p. 175.





## CHAPITRE DOUZE

### FAVORISER L'EXCELLENCE DANS LA RECHERCHE CANADIENNE EN SANTÉ<sup>253</sup>

---

La recherche en santé a pour objet de créer et d'appliquer de nouvelles connaissances dans les domaines de la santé et des soins de santé. Elle englobe toute une gamme d'activités allant de la recherche biomédicale à la recherche clinique, en passant par la recherche sur les services de santé et sur la santé de la population.

- La **recherche biomédicale** porte sur les organismes biologiques, les organes et les systèmes d'organes. Dans des recherches de ce genre, on utilise par exemple des cultures de cellules ou des tissus animaux ou humains pour tenter de comprendre comment l'organisme contrôle la production de cellules sanguines dans la moelle osseuse, comment la leucémie dérègle ces mécanismes de contrôle et comment rétablir des mécanismes normaux par l'administration de médicaments.
- La **recherche clinique** consiste à étudier des personnes saines ou malades. Dans des recherches de ce genre, on pourrait par exemple faire des essais cliniques sur des humains pour déterminer l'efficacité et la toxicité d'un nouveau traitement possible de la leucémie qui s'est révélé prometteur au cours de recherches biomédicales de base, puis comparer le nouveau médicament à d'autres en fonction de ses avantages nets pour les patients.
- La **recherche sur les services de santé** englobe la prestation, l'administration, l'organisation et le financement des soins de santé. On peut citer comme exemple la recherche portant sur les processus de traitement des leucémiques : moyens de diagnostic, hospitalisation, traitement en consultation externe ou à domicile et suivi à long terme à l'hôpital ou dans des services de santé communautaire.
- La **recherche sur la santé de la population** est centrée sur les grands facteurs qui influent sur l'état de santé (conditions socio-économiques, sexe, culture, niveau d'instruction, etc.). On peut citer comme exemple les études fondées sur de grandes bases de données contenant des renseignements médicaux personnels tirés de différentes sources afin de déterminer si l'incidence de la leucémie est liée à des facteurs environnementaux ou autres.

La recherche en santé est la source de nouvelles connaissances sur la santé humaine : comment maintenir un état de santé optimal, comment prévenir, diagnostiquer et traiter les maladies, comment gérer notre système de soins de santé. Elle permet de mettre au point des pharmacothérapies nouvelles ou améliorées, des traitements, des équipements et des dispositifs médicaux et de nouveaux moyens d'organiser et de dispenser les soins de santé. La recherche en santé contribue également à une meilleure compréhension de l'interaction

---

<sup>253</sup> Le présent chapitre est une version mise à jour du chapitre cinq du volume cinq, p. 95-131.

complexe des facteurs déterminants sociaux, économiques, environnementaux, biologiques et génétiques qui influent sur la santé et sur la prédisposition aux maladies.

D'après les témoignages reçus par le Comité, la recherche en santé favorise la création d'emplois axés sur le savoir, ce qui peut contribuer à l'inversion de l'exode des cerveaux observé dans le pays. Dans l'ensemble, les témoins ont souligné que cette recherche améliore la santé personnelle et économique des Canadiens et renforce notre compétitivité à l'échelle internationale :

*La recherche en santé procure à la société des retombées énormes sur les plans économique, social et des soins de santé. Les emplois créés par ces investissements sont des emplois de grande qualité, bien rémunérés et qui font appel à la matière grise et procurent aux Canadiens une reconnaissance mondiale. Ces investissements favorisent par ailleurs le renouvellement des établissements universitaires partout au pays. Ils aident à former de nouveaux professionnels dans les plus récentes techniques et technologies et apportent un soutien important au système de soins de santé au Canada. Enfin et surtout, les résultats de ces activités entraîneront directement une amélioration du traitement des patients, contribuant ainsi à une population en meilleure santé et plus productive<sup>254</sup>.*

Le Comité a également entendu des témoignages selon lesquels la recherche en santé peut servir de catalyseur du développement économique régional et les innovations qui en découlent peuvent beaucoup contribuer à améliorer la qualité et la viabilité du système canadien de soins de santé. À mesure que les activités de recherche en santé sortent des centres universitaires et des laboratoires du gouvernement pour s'étendre à des milieux plus proches de la collectivité, nous pouvons nous attendre à ce que la qualité des soins s'améliore parce que les fournisseurs de soins participant à des recherches sur la santé seront davantage branchés sur l'information la plus récente dans le domaine. Dans l'ensemble, la recherche en santé offre des perspectives extraordinaires de progrès tant sur le plan économique que sur celui des soins.

Le Comité est d'avis que le Canada doit participer activement à la recherche en santé pour en retirer sa part d'avantages. Il croit fermement aussi que le gouvernement fédéral a un rôle essentiel à jouer comme facilitateur, catalyseur, intervenant, conciliateur et coordonnateur de l'ensemble des efforts déployés pour favoriser l'excellence dans la recherche en santé. Le présent chapitre aborde une série de questions, comprenant le financement, les partenariats et l'éthique, qui méritent à notre avis, beaucoup d'attention, si le Canada veut parvenir aux degrés les plus élevés de l'excellence dans la recherche en santé<sup>255</sup>.

**Le Comité croit que le Canada doit participer activement à la recherche en santé pour en retirer sa part d'avantages.**

---

<sup>254</sup> Dr Barry D. McLennan, président de la Coalition pour la recherche biomédicale et en santé (CRBS), *L'amélioration du climat de la recherche en santé au Canada*, mémoire présenté au Comité le 9 mai 2001, p. 2.

<sup>255</sup> Le Comité signale que les sections 12.1 et 12.2 du présent chapitre sont inspirées d'un discours prononcé par le Dr Kevin Keough, expert scientifique en chef à Santé Canada, lors de la troisième Conférence annuelle Amyot organisée par le Ministère. Le Comité a trouvé que cette conférence expliquait d'une manière très utile les défis et les perspectives de la recherche en santé.

## 12.1 Assumer le leadership dans la recherche en santé

Comme le montre le tableau 1, la recherche en santé au Canada se caractérise par un réseau complexe comprenant un vaste éventail de disciplines et une multiplicité d'intervenants menant des activités de recherche à différents endroits. Au Canada, la recherche en santé est effectuée par les universités, les hôpitaux universitaires, des entreprises, des organismes gouvernementaux et des organismes sans but lucratif. Elle est financée par différentes sources publiques et privées, canadiennes et étrangères.

**TABLEAU 1  
LE RÉSEAU CANADIEN DE LA RECHERCHE EN SANTÉ**

DISCIPLINES	LIEUX	SOURCES DE FINANCEMENT
<ul style="list-style-type: none"> <li>▪ Disciplines cliniques</li> <li>▪ Sciences sociales et humanités</li> <li>▪ Épidémiologie</li> <li>▪ Sciences de la vie</li> <li>▪ Biologie cellulaire et moléculaire</li> <li>▪ Chimie</li> <li>▪ Génie</li> <li>▪ Informatique et mathématiques</li> <li>▪ Services de santé</li> </ul>	<ul style="list-style-type: none"> <li>▪ Milieu universitaire (universités, hôpitaux universitaires, instituts de recherche)</li> <li>▪ Secteur privé</li> <li>▪ Gouvernement</li> <li>▪ Cabinets de médecins</li> <li>▪ Organismes communautaires</li> <li>▪ Hôpitaux communautaires</li> <li>▪ Autres</li> </ul>	<ul style="list-style-type: none"> <li>▪ Gouvernements (fédéral, provinciaux, ministères, organismes de financement)</li> <li>▪ Organisations non gouvernementales et organismes bénévoles nationaux</li> <li>▪ Sources internationales</li> <li>▪ Secteur privé</li> <li>▪ Universités</li> <li>▪ Autres</li> </ul>

Les différents intervenants dans la recherche en santé collaborent entre eux de diverses manières, établissant des relations gouvernement-université, université-secteur privé et gouvernement-secteur privé. En fait, le Comité a appris des témoins que la science est un continuum et que les multiples composantes de la recherche en santé ne peuvent pas exister indépendamment les unes des autres. Chaque composante a un rôle important, quoique changeant, à jouer dans la recherche pour procurer le maximum d'avantages aux Canadiens.

Le gouvernement fédéral a toujours joué un rôle important dans le financement, l'exécution et l'utilisation de la recherche en santé. Il soutient financièrement la recherche effectuée dans les universités, les hôpitaux universitaires et les instituts de recherche (recherche extra-muros), il mène lui-même des recherches sur la santé dans ses

***Le Comité convient que la recherche en santé effectuée, financée et utilisée par le gouvernement fédéral doit être de la plus haute qualité. Elle doit, preuves à l'appui, satisfaire aux normes internationales d'excellence en sciences, en technologie et en éthique, ou les dépasser.***

propres laboratoires (recherche intra-muros) et il utilise les résultats des recherches faites ailleurs. De plus, le gouvernement fédéral a un rôle important à jouer dans la définition des priorités nationales de la recherche en santé.

Le Comité estime que, dans un pays aussi vaste que le Canada, le gouvernement fédéral a un rôle de chef de file catalyseur à jouer auprès des gouvernements provinciaux et territoriaux pour faire en sorte que notre système de soins de santé soit axé sur la recherche et l'innovation. Pour réussir, le gouvernement fédéral doit travailler en étroite collaboration avec les provinces et les territoires afin de soutenir une culture qui appuie la création et l'utilisation de connaissances générées par la recherche en santé.

En outre, le Comité convient, avec les auteurs d'un rapport publié en 1999 par le Conseil d'experts en sciences et en technologie, que la recherche en santé effectuée, financée et utilisée par le gouvernement fédéral doit être de la plus haute qualité. Elle doit, preuves à l'appui, satisfaire aux normes internationales d'excellence en sciences, en technologie et en éthique, ou les dépasser<sup>256</sup>.

Le Comité a été informé qu'au fur et à mesure de l'augmentation du coût, de la complexité et du rythme de progression de la recherche en santé, les organismes de recherche n'ont, à eux seuls, ni les ressources ni l'expertise nécessaires pour travailler indépendamment :

*Les chercheurs ont de tout temps travaillé dans l'isolement, menant leurs propres programmes de recherche et vivant de subventions successives. Cette approche fragmentaire, au jour le jour, n'est tout simplement plus envisageable dans un monde où la complexité des sciences impose de mettre en commun les ressources disponibles<sup>257</sup>.*

Lors de la troisième Conférence annuelle Amyot organisée par Santé Canada, le Dr Kevin Keough, expert scientifique en chef du Ministère, a déclaré qu'il est nécessaire d'adopter une approche inclusive (ou horizontale) de la recherche en santé et de trouver de nouveaux moyens de former des partenariats, c'est-à-dire de regrouper des équipes pluridisciplinaires de scientifiques recrutés dans l'ensemble du système de la recherche en santé et de réunir leurs ressources intellectuelles, financières et matérielles pour mener les recherches nécessaires, et ce, afin de mieux comprendre le monde complexe et hautement interdépendant dans lequel nous vivons<sup>258</sup>.

Le Comité convient avec le Dr Keough qu'il est de la plus haute importance de maintenir des partenariats efficaces et de répartir les efforts des partenaires individuels de façon à maximiser les résultats de la recherche en santé. À notre avis, des approches complémentaires et conjointes de la recherche en santé sont non seulement réalisables et

***Le Comité convient qu'il est de la plus haute importance de maintenir des partenariats efficaces et de répartir les efforts des partenaires individuels de façon à maximiser les résultats de la recherche canadienne en santé.***

<sup>256</sup> Conseil d'experts en sciences et en technologie, *Vers l'excellence en sciences et en technologie (VEST) : Les rôles du gouvernement fédéral dans les activités liées aux sciences et à la technologie*, décembre 1999, p. 5.

<sup>257</sup> The Western Canadian Task Force on Health Research and Economic Development, *Seizing the Future – Health as an Engine of Economic Growth for Western Canada*, résumé du rapport, août 2001, p. 2.

<sup>258</sup> Dr Kevin Keough, Conférence Amyot, octobre 2001.

économiques, mais elles contribuent aussi à de meilleurs résultats pour tous les intervenants. Cet objectif fondamental ne peut être atteint que si le rôle du gouvernement fédéral continue à s'adapter à l'environnement changeant de la recherche en santé. À part son rôle dans l'exécution, le financement et l'utilisation de la recherche, le gouvernement fédéral doit devenir plus actif comme catalyseur et facilitateur.

Le Comité croit fermement que le gouvernement fédéral devrait assumer le leadership de la recherche canadienne en santé et, par conséquent, recommande :

**Que la recherche et sa concrétisation dans le système de soins de santé figurent régulièrement à l'ordre du jour des rencontres des ministres et sous-ministres fédéraux, provinciaux et territoriaux de la santé, et que l'Institut de recherche en santé du Canada soit représenté et participe à l'établissement des programmes de recherche en santé lors de ces réunions. Ces mesures aideront énormément à soutenir une culture d'appui à la création et à l'utilisation des connaissances générées par la recherche en santé partout au Canada.**

**Que le gouvernement fédéral établisse, sur une base régulière et en collaboration avec tous les intervenants, des objectifs et des priorités nationaux pour la recherche en santé.**

**Que le gouvernement fédéral favorise la collaboration entre différents intervenants lorsqu'il exécute, finance et utilise des recherches en santé. On pourrait ainsi disposer des meilleures ressources possibles, tout en réduisant au minimum le chevauchement et le double emploi.**

Le D<sup>r</sup> Keough a souligné que le gouvernement fédéral devrait, pour commencer, encourager l'échange de chercheurs en santé entre le gouvernement, le monde universitaire et le secteur privé. Une circulation plus libre des scientifiques rehausserait la qualité de la recherche en santé, améliorerait la qualité des conseils donnés au gouvernement en matière de sciences et de recherche, maximiserait la contribution des scientifiques canadiens à l'ensemble de la communauté de la recherche en santé et contribuerait au renouveau de la base scientifique dans tous les secteurs. Le Comité a des vues semblables à cet égard. Par conséquent, il recommande :

**Que le gouvernement fédéral assume un rôle de leadership, par l'entremise des Instituts de recherche en santé du Canada et de Santé Canada, dans l'élaboration d'une stratégie visant à encourager l'échange de chercheurs entre le gouvernement, le milieu universitaire et le secteur privé, y compris les organisations bénévoles nationales.**

Le Comité souhaite reconnaître le rôle important joué par les organisations bénévoles nationales dans la recherche en santé. Ces organisations sont des intermédiaires clés, au niveau national, entre la recherche et l'application de ses résultats par transfert de connaissances aux chercheurs, aux fournisseurs de soins et au public. Le Comité est d'avis que, compte tenu de leurs connaissances et de leur expérience, ainsi que de l'importance des activités de recherche en santé qu'elles appuient, les organisations bénévoles nationales doivent participer à la collaboration entre les intervenants dans la recherche en santé.

## **12.2 S'engager dans la révolution scientifique**

Les témoins ont dit au Comité que la recherche en santé, aussi bien au Canada qu'ailleurs dans le monde, subit actuellement les effets d'une révolution scientifique. Ils ont expliqué que cette révolution est due aux progrès réalisés en génomique, en ingénierie et en biologie cellulaire. La recherche dans ces disciplines aura de profonds effets sur la détection, le diagnostic et le traitement de différentes maladies liées à la génétique. L'explication des processus physiologiques associés aux diverses affections exigera des années d'efforts pour identifier les gènes en cause et déterminer leur interaction.

*Nous sommes au milieu d'une profonde révolution mondiale alimentée par notre compréhension toujours croissante du fondement moléculaire de la vie, de la biologie humaine et de la maladie. Comme les révolutions antérieures de la science, celle-ci est menée par la collision entre diverses disciplines et approches : génétique, biologie moléculaire, l'ensemble des sciences de la vie, [l'informatique] et les méthodes de calcul, les petites molécules et la chimie de surface, la bioéthique, l'épidémiologie, l'économie de la santé, les sciences sociales et les humanités. Le rythme de cette révolution de la recherche en santé n'a pas encore cessé de s'accélérer sous l'effet d'importants investissements mondiaux des gouvernements, du secteur privé et de philanthropes<sup>259</sup>.*

À mesure que le projet du génome humain tire à sa fin, le prochain défi consistera à comprendre le rôle des quelque 30 000 à 40 000 gènes que les humains semblent posséder. Ces gènes codent tout l'ensemble des protéines ou protéome, qui en compterait 2 millions. Par conséquent, la prochaine frontière en biologie est probablement celle de la protéomique, catalogue et fonctions de toutes les protéines des organismes vivants, qui est beaucoup plus complexe et prometteuse que la génomique.

De même, les progrès en génie biomédical et en miniaturisation à l'échelle moléculaire favoriseront le développement de dispositifs diagnostiques et thérapeutiques de plus en plus perfectionnés qui permettront l'administration de médicaments à cible définie, les essais biologiques, l'imagerie moléculaire et les réparations de tissus et d'organes. Le Canada a des chances réelles de devenir un chef de file mondial dans le domaine de la *nanotechnologie* ou *nanomédecine*.

L'étude et l'utilisation des cellules souches sont un autre bon exemple des répercussions possibles de la recherche sur la santé et les soins. Les cellules souches, quelle que soit leur origine, ont la propriété très particulière de donner naissance à des cellules à fonction spécialisée. À l'heure actuelle, tant le monde de la recherche que les autres intervenants sont très

---

<sup>259</sup> Dr Alan Bernstein, président des IRSC, *Health Research Revolution – Innovation Will Shape This Century*.

enthousiastes quant aux possibilités des cellules souches provenant de tissus embryonnaires ou adultes. On s'attend à ce que la recherche sur ces cellules débouche sur des traitements d'affections graves telles que la maladie de Parkinson, la maladie d'Alzheimer, le diabète et les lésions de la moelle épinière. On croit aussi, en général, qu'il sera possible un jour de manipuler ces cellules pour produire presque n'importe quels tissus, ce qui permettra de disposer des organes dont on a tellement besoin pour les transplantations.

Des chercheurs ont récemment réussi à programmer des cellules souches tirées d'embryons humains pour qu'elles produisent de l'insuline, fonction normalement réalisée par les cellules spécialisées des îlots pancréatiques. Si ces recherches permettent de guérir le diabète, qui est actuellement traité par des injections régulières d'insuline, elles n'amélioreront pas seulement la qualité de vie des patients, mais réduiront aussi le fardeau économique de la maladie. Dans une étude différente, des chercheurs sont parvenus à utiliser des cellules souches prélevées sur la peau d'animaux pour produire des neurones, du tissu musculaire et des cellules adipeuses.

Parmi les autres domaines dans lesquels la révolution scientifique a des effets marqués, il y a lieu de mentionner la chimie et l'informatique, où les progrès de la modélisation moléculaire s'alliant à la chimie synthétique sont en train de changer la façon dont les nouveaux médicaments sont découverts. De plus, la bioinformatique et la robotique influenceront également sur la recherche en santé.

Dans cette recherche, la révolution scientifique ne se limite pas aux travaux de base et à la recherche biomédicale. Elle est en train de créer des perspectives extraordinaires dans les domaines de la recherche sur les services de santé et sur la santé de la population. Plus que jamais auparavant, des recherches sont effectuées au Canada et à l'étranger pour trouver de nouveaux moyens de dispenser des soins de qualité et de comprendre les effets de l'interaction des déterminants qui agissent sur la santé d'une population.

À la troisième Conférence annuelle Amyot, le D<sup>r</sup> Keough a souligné que les progrès de la recherche en santé et la nécessité pour les gouvernements et les particuliers de tenir compte de ces progrès continueront à s'accélérer. Cela signifie que les gouvernements doivent être en mesure d'exécuter et d'utiliser de bonnes recherches scientifiques axées sur le bien public. L'efficacité avec laquelle le gouvernement intégrera les progrès découlant de nouveaux secteurs tels que la biotechnologie et la nanotechnologie dépend de ce principe.

Le Comité convient avec le D<sup>r</sup> Keough qu'il est impératif pour le Canada de relever les défis qu'apporte la révolution scientifique. Nous sommes convaincus que les pays dotés d'un solide réseau de recherche en santé sont plus capables que les autres d'utiliser les progrès et les innovations pour créer des services de santé efficaces et économiques, des cadres stratégiques et réglementaires pouvant soutenir la concurrence internationale, des produits nouveaux ou adaptés et de nouvelles activités de promotion de la santé. Un milieu dynamique de recherche en santé contribue à l'amélioration de la santé, de la qualité de vie et du système des soins de santé. Cela, à son tour, suscite la confiance du public et engendre un milieu d'affaires dynamique et une économie forte.

***Comme le D<sup>r</sup> Keough, le Comité croit que les sciences et l'économie vont de pair et que le gouvernement a un rôle essentiel à jouer pour maximiser les avantages pour le Canada et ses citoyens.***

Comme le D<sup>r</sup> Keough, le Comité croit que les sciences et l'économie vont de pair et que le gouvernement a un rôle essentiel à jouer pour maximiser les avantages pour le Canada et ses citoyens. De toute évidence, le travail scientifique de qualité est coûteux, mais il est encore plus coûteux de ne pas le faire. Les développements scientifiques se multiplient rapidement, et une concurrence féroce règne dans ce domaine. Comme beaucoup de témoins, le Comité est persuadé que le Canada ne peut pas se permettre de prendre du retard. Les avantages possibles comprennent un transfert de connaissances rapide et rentable et la conversion de ces connaissances en avantages tangibles pour la population canadienne.

Le Comité est d'avis que, pour relever un défi de cette envergure, il faudra un effort concerté de la part du gouvernement, du secteur privé, du milieu universitaire, des organisations non gouvernementales et des organismes internationaux. Chacun de ces partenaires a un rôle précis à jouer. Toutefois, c'est le gouvernement fédéral qui doit assurer la coordination et le soutien, par l'entremise de ses ministères et organismes, et notamment les IRSC et Santé Canada. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral, par l'entremise aussi bien de Santé Canada que des Instituts de recherche en santé du Canada, assure la coordination et fournisse les ressources nécessaires pour que le Canada contribue à la révolution scientifique et en bénéficie, de façon à en maximiser les avantages économiques, sanitaires et sociaux pour les Canadiens.**

Le Comité est convaincu que le Canada peut être un chef de file mondial de la recherche en santé, grâce à ses forces en génétique humaine, en biologie des cellules souches, en santé de la population, en bioéthique, en protéomique et en économie de la santé. Nous avons une prodigieuse occasion d'appliquer les connaissances acquises en génomique et en protéomique à l'étude des populations humaines et à la recherche sur l'être humain. Par exemple, les IRSC, par l'entremise de l'Institut de génétique et de l'Institut des services et des politiques de la santé, travaillent en collaboration avec le Comité coordonnateur fédéral-provincial-territorial en matière de génétique et de santé afin de cerner les questions émergentes pouvant faire l'objet d'études et d'établir un ordre de priorité.

Une méthode d'investissement plus intégrée pourrait grandement favoriser les domaines de la génomique et de la protéomique. Ainsi, avec ses solides antécédents d'excellence en recherche et en formation en science protéique, le Canada est bien placé pour contribuer à la protéomique. L'initiative canadienne en protéomique – un partenariat entre l'Institut de génétique des IRSC et les centres d'excellence du Réseau en génie protéique – table sur les investissements du gouvernement fédéral dans l'infrastructure à ce jour pour établir un programme national d'envergure qui assurera le maintien de la compétitivité du Canada à l'échelle internationale. Par conséquent, le Comité recommande :

**Que les Instituts de recherche en santé du Canada et Génome Canada financent des projets de recherche qui assureront au Canada un rôle de chef de file mondial dans ce nouveau domaine de la génomique et de la génétique humaine afin que le système de soins de santé puisse**



**profiter de cette nouvelle technologie pour améliorer la santé des Canadiens.**

**Que les Instituts de recherche en santé du Canada jouent un rôle de chef de file dans l'établissement de pratiques exemplaires pour ce qui est questions éthiques complexes que soulève l'utilisation de cette nouvelle technologie en recherche et en soins de la santé.**

### **12.3 Garantir un environnement de recherche prévisible**

Comme le souligne le volume deux, le gouvernement fédéral a une longue tradition de financement de la recherche en santé<sup>260</sup>. Les estimations les plus récentes de Statistique Canada révèlent que la majorité (environ 79 %) des recherches en santé bénéficiant d'un financement fédéral sont « extérieures », en ce sens qu'elles ont lieu dans les universités et les hôpitaux (68 %), dans des organismes privés sans but lucratif (6 %) et dans des entreprises (4 %)<sup>261</sup>.

Les Instituts de recherche en santé du Canada, ou IRSC, constituent le principal organisme fédéral de financement de la recherche dans ce domaine. En fait, les IRSC sont la seule entité fédérale dont le budget soit intégralement consacré à la recherche en santé. Leur création, en 2000, représentait une importante évolution du mandat du Conseil de recherches médicales du Canada (CRM). Ils sont maintenant responsables du Programme national de recherche et de développement en matière de santé (PNRDS), qui était auparavant le principal instrument de financement de la recherche extérieure en santé. Malgré la création des IRSC, Santé Canada s'occupe encore du financement de certaines recherches extérieures dans une foule de domaines (santé des enfants, santé des femmes, santé des Autochtones, etc.).

Il y a en outre un certain nombre d'organismes fédéraux axés sur la recherche dont le financement est entièrement centré sur la recherche en santé. Il s'agit surtout de la Fondation canadienne de la recherche sur les services de santé (FCRSS) et de l'Office canadien de coordination de l'évaluation des technologies de la santé (OCCETS).

De plus, le Canada compte, plusieurs sources fédérales secondaires de financement de la recherche extérieure en santé. Plus précisément, le gouvernement fédéral est responsable de plusieurs conseils, agences et programmes de recherche qui consacrent (dans diverses mesures) une partie de leur budget à des recherches liées à la santé, comme le Conseil de recherches en sciences naturelles et en génie (CRSNG), la Fondation canadienne pour l'innovation (FCI), le Programme des chaires de recherche du Canada (PCRC) et les Réseaux de centres d'excellence (RCE)<sup>262</sup>. Le gouvernement fédéral a également financé Genome Canada,

---

<sup>260</sup> Volume deux, p. 97-108.

<sup>261</sup> Statistique Canada, *Estimations des dépenses totales au titre de la recherche et du développement dans le secteur de la santé au Canada, 1988 à 2000*, n° 88F0006XIB01006 au catalogue, avril 2001.

<sup>262</sup> Les RCE sont appuyés et supervisés par les trois organismes subventionnaires canadiens (les IRSC, le CRSNG et le CRSH). Il y a lieu de mentionner que huit réseaux, sur les 22 RCE actuellement financés, mènent des recherches dans les domaines suivants : arthrite, maladies bactériennes, vaccins et immunothérapie pour le cancer et les maladies virales, accidents vasculaires cérébraux, application de l'information sur la santé, maladies génétiques,

société sans but lucratif consacrée à l'élaboration et à la mise en œuvre d'une stratégie nationale de recherche sur le génome.

Les autres recherches en santé financées par le gouvernement fédéral (environ 21 %) sont internes, étant effectuées dans des installations fédérales. Celles-ci se trouvent à Santé Canada, Statistique Canada, le Conseil national de recherches, Développement des ressources humaines Canada, Agriculture Canada, Environnement Canada (en partenariat avec Santé Canada) et l'Agence canadienne d'inspection des aliments.

### **12.3.1 Le financement fédéral de la recherche en santé**

Le gouvernement fédéral a démontré à maintes reprises son engagement envers la recherche en santé. Le Comité se félicite de la haute priorité accordée à la recherche dans le discours du Trône de 2001 et, en particulier, de l'augmentation qui y est annoncée du financement de la recherche en santé :

*Notre objectif, audacieux s'il en est, doit être de nous faire reconnaître comme l'un des pays les plus novateurs du monde. [...] Nous devons voir à hisser le Canada au rang des cinq pays les plus avancés au chapitre de la recherche-développement, et ce, d'ici 2010.*

[...]

*Le gouvernement augmentera à nouveau de manière substantielle les fonds destinés aux Instituts de recherche en santé du Canada. Ces fonds additionnels leur permettront d'accroître la recherche sur la prévention et le traitement des maladies, les déterminants de la santé et l'efficacité du régime de soins<sup>263</sup>.*

Le Comité reconnaît également que la création des IRSC constituait une grande réalisation dans le domaine de la recherche en santé. Nous nous félicitons de l'augmentation du financement des IRSC annoncée dans l'exposé budgétaire de décembre 2001 en dépit des fortes pressions financières qui s'exerçaient sur le gouvernement fédéral. De plus, la création et le financement de la Fondation canadienne pour l'innovation en 1997, suivi par l'établissement des bourses d'études du millénaire, du Programme des chaires de recherche du Canada et de Génome Canada sont des indications claires du fait que la recherche et l'innovation en santé font partie intégrante de la politique publique du Canada relative à la santé.

Tout le long de l'étude, les témoins ont dit au Comité que, même si le financement fédéral assure un appui important à la recherche en santé, le Canada ne se compare toujours pas favorablement aux autres pays industrialisés à cet égard. En fait, le rôle du gouvernement national dans le financement de la recherche en santé, exprimé en parité de pouvoir d'achat (PPA) par habitant, est

***Tout le long de l'étude, les témoins ont dit au Comité que, même si le financement fédéral assure un appui important à la recherche en santé, le Canada ne se compare toujours pas favorablement aux autres pays industrialisés à cet égard.***

---

cellules souches et ingénierie des protéines. Certains autres RCE peuvent avoir des répercussions sur la santé et les soins de santé (par exemple l'Institut de robotique et d'intelligence des systèmes ou le Réseau canadien de l'eau).

<sup>263</sup> Gouvernement du Canada, *Discours du Trône*, première session de la 37<sup>e</sup> législature, 30 janvier 2001.

beaucoup plus important aux États-Unis, au Royaume-Uni, en France et en Australie qu'au Canada. Par exemple, comme le mentionne le volume deux, en 1998, le gouvernement américain a consacré à la recherche en santé, par habitant, quatre fois plus que le gouvernement canadien<sup>264</sup>.

Les témoins ont été unanimes à recommander que la part du gouvernement fédéral dans les dépenses de recherche extra-muros en santé soit portée de son niveau actuel d'environ 0,5 % à 1 % des dépenses consacrées aux soins de santé au Canada. Cela nécessiterait de porter le budget actuel des IRSC de son niveau actuel de 560 millions de dollars à 1 milliard de dollars. D'autres ressources devraient également aller à la recherche en santé réalisée dans les installations fédérales (que nous abordons dans la section suivante). Dans l'ensemble, l'augmentation des fonds affectés à la recherche extérieure et intérieure en santé rapprocherait la contribution fédérale du niveau des gouvernements nationaux d'autres pays de l'OCDE. Fait plus important, cela assurerait le maintien de la recherche en santé comme secteur de pointe dynamique et innovateur.

Les témoins ont porté une autre préoccupation à l'attention du Comité : le caractère à long terme de la recherche s'accommode mal de l'horizon limité de la planification budgétaire actuelle. À l'échelle internationale, la recherche de haut calibre est très concurrentielle et nécessite des engagements à long terme. Les jeunes chercheurs, dont dépend l'avenir de la recherche canadienne, engagent leur carrière sur la base de leur perception de l'environnement à long terme de la recherche. Le Canada ne pourra pas attirer et garder les éléments brillants sans leur ménager un excellent environnement de recherche. La recherche fait abstraction des frontières nationales. Le monde reconnaît l'excellence et livre une vigoureuse concurrence pour l'obtenir.

Le Comité appuie fortement le point de vue selon lequel les fonds consacrés à la recherche en santé doivent servir à encourager les esprits les plus brillants. Les deux tiers au moins de ces fonds vont aux salaires et aux allocations de formation de chercheurs, d'adjoints de recherche, de techniciens et de stagiaires aussi hautement qualifiés que motivés. En définitive, le défi du Canada dans la recherche en santé est d'attirer et de conserver des personnes aux talents exceptionnels.

***Le Comité appuie fortement le point de vue selon lequel les fonds consacrés à la recherche en santé doivent servir à encourager les esprits les plus brillants.[...] En définitive, le défi du Canada dans la recherche en santé est d'attirer et de conserver des personnes aux talents exceptionnels.***

Le rôle du gouvernement fédéral est essentiel dans cette concurrence livrée pour attirer les bons chercheurs. En particulier, les IRSC constituent la source de fonds à long terme pour les activités de recherche suscitées par les chaires de recherche, la Fondation canadienne pour l'innovation et Génome Canada, qui augmentent considérablement la possibilité pour le Canada d'exceller dans le domaine de la recherche. Les IRSC sont aussi un partenaire essentiel pour la recherche suscitée par les nombreux organismes caritatifs de recherche en santé.

---

<sup>264</sup> Volume deux, p. 101.

Dans l'ensemble, le Comité croit que le gouvernement fédéral doit établir et maintenir la stabilité à long terme de l'environnement canadien de la recherche en santé. Un financement prévisible d'un niveau suffisant constitue un préalable nécessaire. Nous sommes d'accord avec les témoins qui estiment que le gouvernement fédéral doit accroître ses investissements en recherche en santé afin que le financement fédéral de la recherche extra-muros s'élève à 1 % de toutes les dépenses consacrées aux soins de santé.

D'après le Comité, les fonds fédéraux supplémentaires devront être affectés à des projets de recherche pouvant influencer considérablement sur l'état de santé ou contribuer à améliorer grandement la qualité et la prestation des soins de santé. La priorité absolue doit être accordée à la recherche dans des domaines comme la santé de la population, l'hygiène publique, la prestation de services de santé, les directives pour la pratique clinique, le développement de la petite enfance et la santé des femmes et des Autochtones.

Le Comité estime également que la création des IRSC a donné une vaste tribune pouvant servir à lancer des nouveaux projets audacieux de recherche en santé. Il juge en outre que les IRSC et leurs 13 établissements doivent insister pour que les connaissances générées par la recherche se traduisent en mesures concrètes, notamment la modification de la pratique clinique, de la politique en matière de soins de santé et des comportements individuels.

La recherche en santé est un investissement à long terme : de nombreux projets s'étendent sur toute la carrière d'un chercheur et les subventions sont ordinairement accordées pour des périodes de trois à cinq ans, ce qui est tout simplement incompatible avec le principe d'une allocation budgétaire annuelle aux IRSC. Dans l'ensemble, le Comité recommande :

**Que le gouvernement fédéral :**

- **augmente, dans un laps de temps raisonnable, sa contribution financière à la recherche extérieure en santé, de façon à atteindre un niveau de 1% des dépenses totales consacrées aux soins de santé au Canada, ce qui signifie un investissement supplémentaire de 440 millions de dollars de la part du gouvernement fédéral;**
- **reconnaisse que la recherche en santé est un projet de longue haleine et, par conséquent, établisse des plans à long terme clairs pour le financement de la recherche en santé, et s'y conforme, particulièrement par l'entremise des Instituts de recherche en santé du Canada. Plus précisément, le gouvernement fédéral devrait adopter un horizon de planification de cinq ans pour le budget des IRSC;**
- **fasse un investissement prévisible et suffisant dans la recherche interne en santé.**

### **12.3.2 La recherche fédérale interne en santé**

Selon un rapport du Conseil d'experts en sciences et en technologie, le gouvernement fédéral doit clairement effectuer des recherches internes : il doit disposer de capacités suffisantes de recherche pour être en mesure de s'acquitter des grandes fonctions suivantes :

- soutenir la prise de décisions, l'élaboration des politiques et la réglementation;
- élaborer et gérer des normes;
- répondre aux besoins du public en matière de santé, de sécurité, d'environnement et/ou de défense;
- faciliter le développement économique et social<sup>265</sup>.

Autrement dit, pour que le gouvernement fédéral puisse élaborer des politiques et faire respecter des règlements, il a besoin de capacités de recherche internes. De plus, il doit avoir accès à une information scientifique et technique de la plus haute qualité dans des délais correspondant à ses besoins. À défaut d'utiliser les meilleures données et analyses disponibles, le gouvernement s'expose à être jugé responsable d'éventuels dommages causés par ses décisions.

Santé Canada est le principal intervenant au niveau fédéral dans le domaine de la recherche interne en santé, cette fonction étant essentielle à l'exécution de son mandat. Le Ministère a le devoir de préserver et d'améliorer la santé de la population du Canada et d'assurer sa sécurité. Santé Canada doit donc, en plus d'accéder à une information scientifique et technique de la plus haute qualité, obtenir des conseils lui permettant d'élaborer des politiques et de mettre en vigueur des règlements. La capacité de recherche interne nécessite des compétences dans les domaines suivants :

- la situation et la propagation des maladies;
- la sécurité des aliments, de l'eau et des produits de santé, y compris les produits pharmaceutiques;
- les questions liées à la qualité de l'air;
- le respect des obligations en matière de promotion de la santé.

Pour assumer ces responsabilités, les chercheurs de Santé Canada doivent posséder des connaissances et des compétences indépendantes dans tout un éventail de disciplines scientifiques, allant des sciences du comportement à la biologie cellulaire et moléculaire. De plus, Santé Canada doit posséder des capacités internes suffisantes pour assimiler, interpréter et extrapoler les connaissances obtenues par d'autres partenaires de la recherche en santé. Enfin, le Ministère doit pouvoir recourir facilement à des compétences et à des installations dont il ne dispose pas lui-même dans ses ressources internes.

---

<sup>265</sup> Conseil d'experts en sciences et en technologie, *Vers l'excellence en sciences et en technologie (VEST) : Les rôles du gouvernement fédéral dans les activités liées aux sciences et à la technologie*, 16 décembre 1999, p. 12. Le CEST est formé d'un groupe d'experts extérieurs qui conseillent le gouvernement fédéral sur les questions de sciences et de technologie.

Dans l'ensemble, le Comité a appris que Santé Canada joue un rôle unique. Pour remplir son mandat, le Ministère doit être en mesure de donner des conseils scientifiques indépendants de la plus haute qualité, dans le cadre des responsabilités que lui confère la loi, d'entreprendre une vaste gamme d'activités scientifiques liées à son rôle d'organisme de réglementation et de conseiller en matière de politique, et de dispenser des services et des programmes de santé fondés sur les résultats. Ces obligations sans pareille imposent à Santé Canada d'avoir les capacités scientifiques et de recherche nécessaires pour s'acquitter de ces trois fonctions.

Le Comité croit qu'il est important de reconnaître qu'en nommant un expert scientifique en chef en 2001, Santé Canada a agi d'une façon décisive en vue d'acquérir les capacités nécessaires pour s'acquitter de son mandat. L'expert scientifique en chef et ses collaborateurs jouent un rôle central en dirigeant et en coordonnant les responsabilités et les activités scientifiques de Santé Canada et en se faisant les champions des principes de l'alignement, des liens et de l'excellence que préconise le Conseil d'experts en sciences et en technologie.

Le Comité croit fermement qu'il est nécessaire pour le gouvernement fédéral de faire de la recherche en santé et d'avoir les moyens de s'acquitter de son mandat. Le Comité reconnaît également qu'il est important pour Santé Canada de former au besoin des partenariats avec des intervenants extérieurs au secteur public. Par conséquent, le Comité recommande :

***Le Comité croit fermement qu'il est nécessaire pour le gouvernement fédéral de faire de la recherche en santé et d'avoir les moyens de s'acquitter de son mandat.***

#### **Que Santé Canada :**

- **dispose des ressources financières et humaines de recherche en santé qu'il lui faut pour s'acquitter de son mandat et de ses obligations;**
- **entreprenne activement d'établir des liens et des partenariats avec d'autres intervenants du domaine de la recherche en santé.**

#### **12.4 Rehausser la qualité des services de santé et de la prestation des soins**

Comme nous l'avons mentionné à maintes reprises dans notre rapport, le système canadien de soins de santé se trouve dans une situation grave, marquée par des hausses des coûts, une grande insatisfaction et des attentes élevées. De nombreuses recommandations ont été formulées au fil des ans en vue de modifier le système public de soins de santé. La plupart se fondaient cependant non sur des faits scientifiques, mais sur des preuves anecdotiques ou des considérations politiques. Voilà pourquoi la recherche portant sur tous les aspects du système public de soins de santé revêt actuellement tant d'importance pour les décideurs et les gestionnaires de la politique des soins de santé.

D'autres recherches sont nécessaires dans différents secteurs, notamment :

- les politiques de promotion de la santé
- les stratégies de prévention des maladies et des blessures (tant au niveau des individus que de la population)
- les déterminants de la santé
- les approches de gestion des soins primaires
- les nouveaux modes de rémunération des fournisseurs et des établissements de soins de santé
- le processus décisionnel des fournisseurs et des utilisateurs de soins de santé
- les modèles organisationnels de prestation des soins
- la gestion de la politique en matière de soins de santé
- la répartition des ressources des soins de santé
- les répercussions de la privatisation de certains secteurs des soins de santé
- l'analyse pharmacoéconomique
- l'évaluation et l'utilisation de la technologie et du matériel de soins de santé.

La recherche clinique et la participation des fournisseurs de soins eux-mêmes à la recherche en santé jouent un rôle clé dans l'exploitation des résultats de la recherche fondamentale pour améliorer la santé et les soins. Les essais cliniques et les grandes études longitudinales sur la santé de la population ne reçoivent pas un financement suffisant au Canada, surtout parce que le lancement de telles études nécessite d'importants engagements financiers à long terme. Des investissements urgents sont nécessaires pour former des cliniciens-chercheurs et pour les appuyer par la suite dans leur carrière. Harcelés par une demande toujours plus grande de services cliniques, ces derniers trouvent de plus en plus difficile de rester compétitifs dans la course aux prix et aux subventions.

Au Canada, de nombreuses organisations s'occupent de recherche sur les services de santé. Le Comité est d'avis qu'en ce moment critique pour notre système de soins de santé, il est essentiel que ce genre de recherche reçoive un financement suffisant et que les centres de recherche et leur personnel participent au débat actuel sur la structure future du système canadien de services hospitaliers et de services dispensés par un médecin ainsi que sur les moyens de réduire les lacunes croissantes de la couverture du régime de soins.

De plus, de nombreuses études ont montré qu'il existe un important écart entre les nouvelles connaissances et leur application courante dans la médecine de tous les jours. Par exemple, seulement 46 % des patients âgés ont reçu le vaccin antipneumococcique, en dépit du fait qu'ils forment le groupe qui risque le plus d'être atteint par les infections pneumococcales. Bien que son administration soit

***Le Comité croit que le gouvernement fédéral, en raison de son rôle très particulier dans la recherche en santé, devrait consacrer des crédits substantiels pour favoriser, de concert avec les provinces et les territoires, l'adoption des résultats de la recherche dans la pratique clinique.***

recommandée pour tous les diabétiques adultes, l'aspirine n'est prescrite que dans 20 % des cas, et les conseils sur la transmission du VIH ne sont donnés qu'à moins de 3 % des adolescents qui passent par un cabinet de médecin<sup>266</sup>. De plus, d'importantes différences persistent dans les schémas de pratique et les résultats, aussi bien entre régions qu'entre provinces. Le Comité croit que le gouvernement fédéral, en raison de son rôle très particulier dans la recherche en santé, devrait consacrer des crédits substantiels pour favoriser, de concert avec les provinces et les territoires, l'adoption des résultats de la recherche dans la pratique clinique. Le gouvernement devrait le faire tout en continuant à appuyer les nouvelles recherches sur les questions de santé prioritaires et à mettre au point de nouveaux outils, pour qu'à l'avenir ces connaissances et ces outils servent à améliorer la santé et les soins de santé.

Dans l'ensemble, le Comité estime qu'il faudrait mener plus de recherches pour améliorer la qualité des services de santé et de la prestation des soins. Par conséquent, il recommande :

**Que le gouvernement fédéral, par l'entremise des Instituts de recherche en santé du Canada, de Santé Canada et de la Fondation canadienne de la recherche sur les services de santé, consacre des fonds supplémentaires à la recherche sur les services de santé et à la recherche clinique, et qu'il collabore avec les provinces et les territoires pour que les résultats de ces recherches soient largement diffusés parmi les fournisseurs, les gestionnaires et les décideurs du domaine des soins de santé.**

## **12.5 Améliorer l'état de santé des populations vulnérables**

De nombreux groupes de la société canadienne ont, pour diverses raisons, un accès moins immédiat que les autres à des services de santé correspondant à leurs besoins particuliers. On peut citer l'exemple des personnes atteintes de troubles mentaux, des toxicomanes, des personnes handicapées, de certaines minorités ethniques, des femmes en situation difficile, des habitants des collectivités rurales et isolées, des sans-abri et des pauvres. Le Comité reconnaît qu'il existe au Canada un besoin urgent d'appuyer des recherches pluridisciplinaires en santé afin d'acquérir de nouvelles connaissances sur les divers facteurs qui influencent l'état de santé ainsi que sur les moyens d'améliorer l'accès aux soins de santé dont les groupes vulnérables ont besoin. Les IRSC ont récemment élaboré un plan stratégique, par l'intermédiaire de trois de leurs instituts, en vue d'étudier cet important problème, mais des ressources supplémentaires sont nécessaires. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral, par l'entremise des Instituts de recherche en santé du Canada et de Santé Canada, affecte davantage de fonds à la recherche portant sur la santé de segments particulièrement vulnérables de la société canadienne.**

---

<sup>266</sup> JAMA, vol. 286, p. 1834 (2001).



Dans le volume quatre de son étude sur les soins de santé, le Comité a déclaré que l'état de santé des Autochtones canadiens est une honte nationale. Il y a un écart disproportionné et totalement inacceptable entre les indicateurs de santé des Autochtones et ceux des autres Canadiens. Les membres de nos Premières nations connaissent une incidence beaucoup plus élevée de nombreux problèmes de santé, comprenant notamment le cancer, le diabète et l'arthrite, les affections cardiaques parmi les hommes, le suicide parmi les jeunes hommes, le VIH-sida ainsi que la morbidité et la mortalité liées aux blessures. Les taux de mortalité infantile sont deux à trois fois supérieurs à la moyenne nationale, avec des proportions élevées de syndrome et d'effets d'alcoolisme fœtal et de mauvaise nutrition. Environ 12 % des enfants autochtones sont asthmatiques, par rapport à 5 % de l'ensemble des enfants canadiens. Cette dernière tendance est attribuable, du moins en partie, à des problèmes de santé environnementale, comme la présence de moisissures dans les maisons<sup>267</sup>.

Le Comité croit que c'est la recherche qui pourrait contribuer le plus à l'amélioration de l'état de santé des Autochtones canadiens. À notre avis, la création, aux IRSC, de l'Institut de la santé des Autochtones est un pas important dans la bonne direction. Santé Canada, qui dispense de nombreux services et programmes de santé dans les collectivités

***Le Comité croit que c'est la recherche qui pourrait contribuer le plus à l'amélioration de l'état de santé des Autochtones canadiens.***

des Premières nations et les collectivités inuites, devrait renforcer sa capacité de recherche et sa capacité d'intégration des résultats de la recherche dans la politique publique. En particulier, Santé Canada a besoin d'une forte capacité de recherche pour atteindre les objectifs suivants :

- compiler et analyser les renseignements démographiques disponibles pour déterminer les tendances, les nouveaux problèmes et les différences entre régions géographiques et collectivités;
- examiner les programmes et les services pour déterminer les pratiques les plus efficaces dans les collectivités des Premières nations et les collectivités inuites, et pour s'assurer que des progrès suffisants sont réalisés en vue de résoudre les grands problèmes de santé;
- maintenir et renforcer la capacité d'analyse de la recherche tant nationale qu'internationale, et intégrer les pratiques exemplaires dans l'élaboration, la mise en œuvre et l'évaluation des politiques et des programmes.

Par conséquent, le Comité recommande à titre urgent :

**Que le gouvernement fédéral affecte des fonds supplémentaires à l'Institut de la santé des Autochtones des IRSC, afin d'intensifier la participation des chercheurs canadiens en santé, et notamment des Autochtones eux-mêmes, aux recherches visant à améliorer la santé des Autochtones canadiens.**

---

<sup>267</sup> Volume quatre, p. 139-146.

**Que Santé Canada reçoive des ressources supplémentaires pour étendre sa capacité de recherche et renforcer sa capacité d'intégration des résultats de la recherche dans le domaine de la santé des Autochtones.**

La recherche sur les questions de santé intéressant les pays en développement est également importante. Le Comité a appris que ces recherches sont très rares. En fait, les données recueillies portent à croire que moins de 10 % de la recherche en santé est consacrée aux problèmes qui représentent 90 % du fardeau mondial des maladies.

Les principales causes de morbidité et de mortalité dans les pays en développement peuvent être regroupées sous quatre grands titres : la malnutrition, le manque d'hygiène sexuelle et reproductive, les maladies transmissibles et les maladies non transmissibles (y compris les blessures). Un récent rapport de l'Organisation mondiale de la santé révèle qu'en présence d'un grand nombre de malades, de mourants ou de personnes souffrant de malnutrition, la croissance économique est impossible à long terme.

Le Comité est d'avis qu'en raison de son expertise et de son excellence dans la recherche en santé, le Canada devrait assumer un rôle de leadership à cet égard. Le gouvernement fédéral a déjà franchi un premier pas dans la bonne direction. En effet, dans un effort conjoint sans précédent, quatre organismes gouvernementaux canadiens ont uni leurs forces pour prendre l'engagement commun de s'attaquer aux problèmes de santé mondiaux grâce à la recherche. L'Agence canadienne de développement international (ACDI), les IRSC, le Centre de recherches pour le développement international (CRDI) et Santé Canada ont ainsi lancé l'Initiative de recherche en santé mondiale (IRSM). Cette entreprise conjointe leur permettra non seulement d'exploiter plus efficacement leurs programmes et leurs recherches, mais aussi de contribuer à une grande cause humanitaire, la protection de la santé des citoyens de tous les pays, y compris les Canadiens. C'est un début, et il faudra en faire plus. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral affecte davantage de ressources à l'Initiative de recherche en santé mondiale.**

## **12.6 Commercialiser les résultats de la recherche en santé**

Les nouvelles connaissances découlant de la recherche en santé ont en elles-mêmes une grande valeur pour la société, mais les effets globaux de la recherche sont maximisés quand ces connaissances rapportent des avantages sociaux et économiques. La commercialisation des résultats de la recherche en santé est l'un des moyens de réaliser ces avantages.

***Les nouvelles connaissances découlant de la recherche en santé ont en elles-mêmes une grande valeur pour la société, mais les effets globaux de la recherche sont maximisés quand ces connaissances rapportent des avantages sociaux et économiques. La commercialisation des résultats de la recherche en santé est l'un des moyens de réaliser ces avantages.***

La commercialisation des résultats de la recherche en santé peut intervenir à de nombreuses étapes différentes de la

recherche, chacune de ces étapes faisant l'objet de problèmes distincts. Par exemple, l'une des principales difficultés de la commercialisation de la recherche universitaire en santé (recherche effectuée dans les universités et les hôpitaux) est qu'aux premiers stades des travaux, les investissements privés sont très risqués et sont donc d'un caractère spéculatif. Par contre, une fois que la recherche a débouché sur un produit commercialisable, comme aux derniers stades des essais cliniques (principalement réalisés par de grandes entreprises pharmaceutiques orientées vers la recherche), le principal problème réside dans le régime de propriété intellectuelle et de brevets, de même que dans l'approbation et la surveillance des médicaments. La commercialisation des résultats de la recherche en santé procure de nombreux avantages, notamment :

- amélioration de la santé, qui peut augmenter la productivité de la main-d'œuvre;
- amélioration de la qualité des services de santé;
- augmentation de l'efficacité de la prestation des soins de santé;
- financement accru de la recherche, découlant de la commercialisation et de la formation de partenariats de recherche;
- création d'emplois dans de nouvelles entreprises;
- intensification de l'activité économique grâce à la fabrication, à la commercialisation et à la vente de nouveaux produits et services liés aux soins de santé.

Dans son mémoire au Comité, le Conseil pour la recherche en santé au Canada mentionne que les nouvelles sociétés de biotechnologie établies par des scientifiques bénéficiant d'un financement des IRSC constituent une importante retombée des investissements publics dans la recherche en santé :

*Par exemple, 23 sociétés ont été créées à l'Université de la Colombie-Britannique, et 732 personnes y travaillent. À McGill, 18 entreprises ont été lancées; elles emploient 392 personnes. À l'Université d'Ottawa, 10 sociétés ont été mises sur pied et offrent du travail à 459 personnes. De telles entreprises ne peuvent s'épanouir sans investissements publics servant à financer régulièrement la machine à découverte<sup>268</sup>.*

Visudyne est un exemple de résultat de la recherche canadienne en santé ayant entraîné des progrès remarquables dans le domaine des soins. Ce médicament, dont l'utilisation a été autorisée dans plus de 30 pays, constitue le seul traitement approuvé de la dégénérescence maculaire liée à l'âge, principale cause de perte de la vue due au vieillissement. Le médicament a été mis au point à l'Université de la Colombie-Britannique, avec un financement provenant partiellement du gouvernement fédéral. L'Université a prêté son concours pour le démarrage de la société QLT Inc., chargée de la commercialisation du produit. L'entreprise, qui a son siège à Vancouver, emploie plus de 350 personnes et a une capitalisation boursière de l'ordre de 1,5 milliard de dollars américains.

---

<sup>268</sup> Conseil pour la recherche en santé au Canada, *Recherche en santé – Moteur de l'innovation*, mémoire présenté au Comité le 30 décembre 2001, p. 2-3.

Le 3TC est un autre exemple : seul inhibiteur de la reverse-transcriptase du VIH ayant peu ou pas d'effets secondaires, ce produit est un élément courant du traitement du VIH-sida, mis au point grâce à des recherches effectuées à Montréal avec un financement fédéral. Avant son acquisition par la société britannique Shire Pharmaceuticals plc., BioChem Pharma Inc. avait son siège à Montréal, employait 278 personnes et avait une capitalisation boursière de 3,7 milliards de dollars américains.

Ces exemples illustrent le potentiel de la recherche en santé pour le traitement des maladies, la création d'emplois et la production d'avantages économiques pour le Canada. Même si beaucoup de technologies développées dans les universités sont cédées sous licence à des sociétés étrangères, il est raisonnable de s'attendre à ce que le Canada conserve certains avantages quand le gouvernement fédéral a contribué au financement de la recherche en cause.

Comme nous l'avons dit à la section 12.2, les sciences et l'économie vont de pair. Toutefois, dans son témoignage devant le Comité, le D<sup>r</sup> Henry Friesen, chef d'équipe du Western Canadian Task Force on Health Research and Development, a déclaré que les conditions actuelles ne permettent pas aux contribuables canadiens de bénéficier au maximum des résultats de la recherche en santé financée par les deniers publics<sup>269</sup>. De l'avis du groupe de travail, loin d'être optimale, la capacité de commercialisation des résultats de la recherche est clairement inacceptable<sup>270</sup>.

Des conclusions semblables figurent dans un rapport daté de 1999 du Conseil consultatif des sciences et de la technologie (CCST), produit par son Groupe d'experts sur la commercialisation des résultats de la recherche universitaire<sup>271</sup>. Le Groupe d'experts défend la thèse selon laquelle les résultats tirés de la recherche universitaire financée par des fonds fédéraux devraient, s'il existe des possibilités de commercialisation, être gérés comme un bien pouvant rapporter des dividendes à l'économie et aux contribuables du Canada. Il démontre que les États-Unis ont beaucoup mieux réussi que le Canada à commercialiser les résultats de la recherche universitaire, en dépit d'une participation croissante du secteur privé au financement de la recherche dans les universités canadiennes.

La plupart des grands établissements de recherche du Canada (universités et hôpitaux de recherche) ont des bureaux internes de commercialisation de la technologie financés par des sources universitaires et, en cas de succès, par les recettes découlant de leur propre activité. À l'heure actuelle, les dépenses liées aux activités de commercialisation ne sont pas couvertes par le financement fédéral direct de la recherche. Le Comité a appris que, pour la grande majorité, ces bureaux de commercialisation de la technologie ne recouvrent pas leurs frais et constituent donc des centres de coûts plutôt que des centres de profit pour leur établissement. Même si leur fonction n'est pas essentielle à la recherche en soi (création de nouvelles connaissances), on peut soutenir qu'il existe de bonnes raisons d'inclure les frais d'exploitation de ces bureaux dans le calcul des coûts indirects de la recherche, puisque la commercialisation de la technologie est une activité liée à la recherche.

---

<sup>269</sup> Voir délibérations du Comité, fascicule n° 30.

<sup>270</sup> Western Canadian Task Force on Health Research and Development, *Shaping the Future of Health Research and Economic Development in Western Canada*, août 2001, p. 19-20.

<sup>271</sup> Groupe d'experts sur la commercialisation des résultats de la recherche universitaire, *Les investissements publics dans la recherche universitaire : Comment les faire fructifier*, Conseil consultatif des sciences et de la technologie, 4 mai 1999.

La question du financement des coûts de recherche indirects par les organismes subventionnaires fédéraux fait depuis quelques années l'objet d'une controverse. Selon certains, elle explique en partie la compétitivité moindre des chercheurs canadiens. Les coûts indirects sont les dépenses liées à l'administration, à l'entretien, à la commercialisation et à la rémunération du chercheur principal, qui sont attribuables à un projet de recherche. Le rapport de 1999 du CCST<sup>272</sup> ainsi que des publications postérieures recommandent que le gouvernement fédéral augmente son investissement en acceptant de financer les coûts indirects de la recherche qu'il appuie. De même, le mémoire du Conseil pour la recherche en santé au Canada insiste sur le point suivant :

*[Les] coûts indirects de recherche doivent être financés afin d'offrir un milieu de pointe en recherche, milieu qui permette la réalisation de tous les avantages du programme d'innovation du gouvernement. [...] Le Conseil croit que le gouvernement devrait avoir pour priorité d'élaborer le plus tôt possible un plan spécifique et à long terme s'attaquant à cette question<sup>273</sup>.*

Le Comité reconnaît que, dans son budget de décembre 2001, le gouvernement fédéral a prévu un investissement ponctuel de 200 millions de dollars, par l'entremise des conseils subventionnaires, pour réduire les pressions financières liées à la hausse des coûts indirects des activités de recherche, y compris la commercialisation. Nous espérons, d'une part, que les universités et les hôpitaux de recherche utiliseront une partie de ces fonds pour renforcer leur capacité de commercialisation et, de l'autre, que le gouvernement fédéral décidera de transformer cet investissement ponctuel en crédit annuel permanent.

Le Comité convient avec les témoins et les conclusions des rapports récents qu'il est nécessaire de trouver des moyens de faire profiter au maximum les contribuables canadiens de la commercialisation de la recherche en santé financée à l'aide de fonds fédéraux. Nous croyons que le gouvernement fédéral devrait établir les conditions nécessaires pour permettre aux chercheurs et aux bureaux de commercialisation de la technologie qui offrent de l'appui et des services aux chercheurs de maximiser les résultats de leurs efforts de commercialisation des résultats de la recherche en santé financée à l'aide de fonds fédéraux.

***Le Comité convient avec les témoins et les conclusions des rapports récents qu'il est nécessaire de trouver des moyens de faire profiter au maximum les contribuables canadiens de la commercialisation de la recherche en santé financée à l'aide de fonds fédéraux. Nous croyons que le gouvernement fédéral devrait établir les conditions nécessaires pour permettre aux chercheurs et aux bureaux de commercialisation de la technologie qui offrent de l'appui et des services aux chercheurs de maximiser les résultats de leurs efforts de commercialisation des résultats de la recherche en santé financée à l'aide de fonds fédéraux.***

De plus, le Comité estime qu'à titre de principal mécanisme canadien de financement de la recherche en santé ayant le mandat législatif d'utiliser la connaissance pour

<sup>272</sup> Ibid.

<sup>273</sup> Conseil pour la recherche en santé au Canada, mémoire présenté au Comité, p. 5.

améliorer la santé, les IRSC sont les mieux placés pour évaluer les recommandations relatives à la recherche en santé formulées par le Western Canadian Task Force, le Groupe d'experts du CCST et dans d'autres études sur la commercialisation de la technologie. Nous croyons que les IRSC devraient se servir de ces études comme base pour élaborer et mettre en œuvre une stratégie d'innovation tenant compte des programmes, des politiques et des personnes. À notre avis, une telle stratégie devrait permettre aux IRSC d'appuyer et de renforcer la capacité des bureaux universitaires de commercialisation de la technologie de maximiser les transferts de technologie au marché, favorisant ainsi l'innovation et la création d'entreprises et d'emplois au Canada. Nous croyons en outre que cette stratégie d'innovation doit se fonder sur un cadre comprenant des principes directeurs qui touchent le bien public et les avantages pour le Canada, afin que la recherche du maximum d'avantages sociaux et économiques ne menace ni la liberté universitaire, ni l'orientation de la recherche, ni la prestation des soins de santé. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral exige de tous les bénéficiaires de subventions fédérales à la recherche en santé l'engagement explicite d'obtenir le maximum d'avantages pour le Canada quand les résultats de la recherche subventionnée sont utilisés à des fins lucratives.**

**Que les Instituts de recherche en santé du Canada, sans faire abstraction de la valeur sociale de la recherche en santé n'ayant pas de résultats commerciaux lucratifs, cherchent à favoriser les retombées économiques au Canada découlant de leurs investissements dans la recherche canadienne en santé, quand les résultats de cette recherche sont utilisés à des fins lucratives. Ce faisant, les IRSC devraient élaborer une stratégie d'innovation visant à accélérer et à faciliter la commercialisation des résultats de la recherche en santé.**

**Que le gouvernement fédéral investisse des ressources supplémentaires, dans le cadre de la stratégie d'innovation des IRSC, pour valoriser la production des chercheurs canadiens en santé et renforcer la capacité de commercialisation des résultats de la recherche en santé financée par des fonds fédéraux. Le nouveau financement devrait s'ajouter aux investissements actuels dans la recherche en santé. Il faudrait en particulier rendre permanent le financement des coûts indirects de la recherche par les organismes subventionnaires du Canada. Les responsables de la recherche en santé devraient rendre compte de l'utilisation des fonds de commercialisation.**

La délivrance de brevets à l'égard de formes de vie supérieures est un aspect de la commercialisation des résultats de la recherche en santé qui a récemment suscité une certaine controverse. Ce sujet est étroitement lié à des questions d'éthique, de propriété intellectuelle et d'intérêts économiques. Même si ces questions s'inscrivent dans le cadre de la recherche

canadienne en santé et du travail du Comité, elles sont examinées ailleurs. En fait, le gouvernement fédéral a chargé le Comité consultatif canadien de la biotechnologie (CCCB) de le conseiller sur cette question de la plus haute importance. Le CCCB a publié un rapport provisoire fin 2001 dans lequel il recommande de refuser de breveter des êtres humains, quel que soit le stade de leur développement<sup>274</sup>. De plus, le rapport recommande d'entreprendre un programme de recherche systématique pour évaluer les répercussions des brevets de biotechnologie sur différents aspects des services de santé. C'est clairement là un sujet qui mérite un examen sérieux, mais qui déborde le cadre du présent rapport.

## **12.7 Respecter les normes d'éthique les plus élevées dans la recherche en santé**

Les sections qui précèdent ont démontré l'excellence croissante du Canada dans le domaine de la recherche en santé et la priorité élevée dont cette recherche bénéficie chez nous. L'histoire montre cependant que la découverte de nouvelles connaissances relatives à la santé peut, par exemple, occasionner des abus touchant les sujets de la recherche, la vie privée et le traitement des animaux. Des nombreux rapports ont souligné de diverses façons que l'acquisition de nouvelles connaissances ne devrait pas se faire au détriment d'êtres humains ou d'autres formes de vie et que l'excellence en santé exige l'excellence en matière d'éthique.

Mais qu'est-ce que l'éthique? Laura Shanner, professeure à l'Université de l'Alberta, a dit au Comité que l'éthique est « une tentative systématique et raisonnée de comprendre des questions d'une importance humaine fondamentale et de prendre les meilleures décisions possibles à leur sujet<sup>275</sup> ». Quand l'éthique est appliquée à des connaissances biologiques en médecine, on parle plutôt de « bioéthique ». La D<sup>re</sup> Nuala Kenny, professeure de pédiatrie à l'Université Dalhousie (Nouvelle-Écosse), a défini comme suit la bioéthique :

*La bioéthique est une compréhension particulière de l'éthique qui implique la discipline de la philosophie pour aider à prendre des décisions de valeur. C'est une question de déterminer ce qui est juste et bon. La bioéthique est l'éthique dans le domaine de la biosphère, la biologie humaine. Cela va également au-delà de la santé humaine, mais la majorité des gens l'utilisent dans ce contexte.*

*Cela revient à poser la question de savoir comment définir, dans une société multiculturelle, les valeurs, les problèmes et les intérêts en jeu pour décider de ce qui est juste et bon, généralement concernant la situation d'un patient. Puis, comment aider les parties en question à établir une sorte de priorité afin de se battre pour ce qui est bon ou contre ce qui est mauvais, et de faire des choix de manière responsable<sup>276</sup>.*

Dans beaucoup de domaines, les décisions difficiles nécessitent l'examen de multiples facteurs, mettant chacun en cause des valeurs, des principes, des points de vue, des convictions, des attentes, des craintes, des espoirs, etc., différents et souvent contradictoires.

---

<sup>274</sup> Comité consultatif canadien de la biotechnologie, *Biotechnologie et propriété intellectuelle : La brevetabilité des formes de vie supérieures et enjeux connexes*, rapport provisoire adressé au Comité de coordination ministérielle de la biotechnologie, gouvernement du Canada, Ottawa, novembre 2001.

<sup>275</sup> Laura Shanner, *Ethical Theories in Bioethics and Health Law*, Université de l'Alberta, mémoire présenté au Comité, 2000, p. 1.

<sup>276</sup> D<sup>re</sup> Nuala Kenny (42:59-60).

Face à de telles décisions, différentes personnes vont aboutir à différentes conclusions non seulement parce qu'elles considèrent des facteurs différents, mais aussi parce qu'elles les jugent les uns par rapport aux autres de façons différentes. L'effet pratique de l'éthique, comme discipline, est d'aider ceux qui doivent affronter des décisions complexes à en saisir les valeurs et les principes inhérents et à les peser les uns par rapport aux autres afin d'aboutir à la meilleure décision possible. Bien que fondée sur de solides bases théoriques, l'éthique des soins et de la recherche en santé traite de situations réelles de la vie.

Comme la recherche tente constamment de faire avancer le champ de la connaissance, elle pose les questions d'éthique les plus difficiles. L'objet de cette section est de passer en revue quelques-uns des grands secteurs de l'éthique de la recherche à la lumière des politiques et des mécanismes nécessaires ou actuellement en place au Canada, pour nous assurer que la recherche en santé est réalisée d'une manière conforme aux normes éthiques des Canadiens.

### 12.7.1 La recherche sur des sujets humains

La recherche en santé doit, à l'occasion, porter sur des humains comme sujets. Même si la recherche sur d'autres êtres vivants procure des connaissances essentielles, en définitive, seule la recherche sur des sujets humains peut nous dire, par exemple, si une approche possible de la prévention, du diagnostic ou du traitement d'une maladie est assez sûre, si elle aide vraiment les patients, quels sont ses effets secondaires et si elle est supérieure à un traitement qui existe déjà.

***Les sujets de recherche – il s'agit souvent de patients atteints de la maladie dont le traitement est à l'étude – assument des risques pour que d'autres puissent profiter des connaissances que la recherche est censée fournir.***

Les sujets de recherche – il s'agit souvent de patients atteints de la maladie dont le traitement est à l'étude – assument des risques pour que d'autres puissent profiter des connaissances que la recherche est censée fournir. La recherche sur des sujets humains comporte de nombreux risques : abus des personnes en cause, mauvaise utilisation des données, exploitation, violation de la vie privée, confidentialité, etc. Parce que la recherche en santé suscite tant de questions, un consensus international s'est développé au cours du dernier demi-siècle. Ce consensus, qui a commencé avec le Code de Nuremberg (1947) et la Déclaration de Helsinki (1964, révisée en 2000), préconise que les aspects éthiques de tout projet de recherche ayant des sujets humains soient examinés et approuvés, après modification si nécessaire, par un comité d'éthique constitué d'une manière appropriée (au Canada, il porte le titre de « comité d'éthique de la recherche » ou CER) avant le commencement des travaux.

Un comité d'éthique de la recherche (CER) «est un mécanisme que la société canadienne établit pour garantir la protection de ses membres participant à des travaux de recherche<sup>277</sup> ». Un CER est un groupe pluridisciplinaire indépendant des chercheurs et des commanditaires de la recherche, formé dans un établissement local pour examiner les normes éthiques des projets de recherche de l'établissement. Il est habilité à approuver ou à rejeter tout

<sup>277</sup> Conseil national d'éthique en recherche chez l'humain, *Protecting Human Research Subjects: Case-Based Learning for Canadian Research Ethics Boards and Researchers*, Ottawa, 2000, p. 7.



projet envisagé ou en cours ayant des sujets humains, à en demander la modification ou à y mettre fin. En fait, le CER atteste, pour chaque protocole de recherche, que les travaux envisagés, s'ils sont réalisés de la manière approuvée, satisfont aux normes d'éthique auxquelles les Canadiens s'attendent, ou les dépassent.

La principale politique nationale régissant l'éthique de la recherche sur des sujets humains, *Énoncé de politique des trois Conseils : Éthique de la recherche avec des êtres humains* (EPTC), a été publiée en 1998 par les IRSC, le CRSH et le CRSNG. L'EPTC a remplacé les politiques antérieures (CRM, 1978 et 1987; CRSH, 1976). Le Panel d'experts et le Secrétariat en éthique de la recherche, que les trois organismes subventionnaires fédéraux ont constitués en novembre 2001, sont chargés de coordonner l'évolution et l'interprétation de l'EPTC, l'objectif étant de le tenir à jour face à l'évolution rapide de la connaissance, de la recherche et de la technologie.

L'*Énoncé de politique des trois Conseils* a été adopté par les établissements universitaires (où se fait la plus grande partie de la recherche sur des sujets humains) et par un certain nombre de ministères et d'organismes fédéraux, y compris le ministère de la Défense nationale (MDN) et le Conseil national de recherches du Canada (CNRC).

Santé Canada est en train d'établir son propre comité d'éthique de la recherche, qui se servira aussi de l'EPTC, pour déterminer si la recherche interne, la recherche donnée à contrat à des chercheurs extérieurs et les demandes présentées aux IRSC et à d'autres organismes de financement sont acceptables sur le plan éthique. Santé Canada a également adopté les lignes directrices de la Conférence internationale d'harmonisation relatives aux essais cliniques auxquels participent des sujets humains<sup>278</sup>.

Depuis les années 70, conformément aux politiques nationales régissant l'éthique de la recherche sur les sujets humains, quelque 300 CER locaux ont été créés au Canada dans différents milieux : universités, laboratoires du gouvernement, organisations communautaires, hôpitaux universitaires et communautaires. Dans beaucoup d'hôpitaux universitaires, au moins 50 % des protocoles de recherche examinés par les CER portent sur des essais cliniques commandités par le secteur privé pour mettre à l'épreuve de nouvelles interventions pharmaceutiques dans la santé humaine, afin de satisfaire aux exigences réglementaires d'autorisation de Santé Canada et de la Food and Drug Administration des États-Unis. De plus, un certain nombre de CER d'entreprise et de CER privés à but lucratif ont été créés dans les dernières années pour examiner la recherche financée par des intérêts privés à l'extérieur des établissements universitaires, à des endroits sans accès à un CER local. En Alberta, tous les médecins qui ne relèvent pas d'un CER d'établissement sont tenus de recourir au CER du Collège des médecins et chirurgiens de l'Alberta. Pour sa part, Terre-Neuve envisage d'établir un CER unique chargé d'examiner toute la recherche en santé effectuée dans la province.

En 1989, le CRM a créé le Conseil national d'éthique en recherche chez l'humain (CNERH), avec l'appui de Santé Canada et du Collège royal des médecins et chirurgiens du Canada. Le CNERH s'efforce d'encourager le respect de normes d'éthique rigoureuses dans la recherche sur des sujets humains effectuée partout dans le pays, en donnant des conseils sur la

---

<sup>278</sup> Malgré le soin apporté par les trois organismes subventionnaires fédéraux et Santé Canada pour assurer l'harmonisation internationale des lignes directrices régissant les essais cliniques sur des sujets humains, le Comité tient à avoir l'assurance catégorique que tout Canadien participant à des essais cliniques d'origine étrangère est protégé par des normes éthiques au moins aussi strictes que celles qui s'appliquent au Canada.

mise en œuvre de l'EPTC, surtout dans le cadre d'activités éducatives et de visites sur place à des CER locaux. Le CNERH est actuellement financé par les IRSC, le CRSH, le CRSNG, Santé Canada et le Collège royal des médecins et chirurgiens du Canada.

### **12.7.2 Questions suscitées par la recherche sur des sujets humains<sup>279</sup>**

L'Énoncé de politique des trois Conseils, qui est en fait la politique nationale du Canada sur la conduite éthique de la recherche en santé sur des sujets humains, semble être compatible avec les normes mondiales. Pour la plupart, les CER du Canada semblent appliquer des normes élevées, fondées sur plus de vingt ans d'expérience et de dévouement de nombreuses personnes partout dans le pays. Toutefois, le Comité a appris que de sérieuses lacunes sont signalées dans quelques rapports récemment publiés par le CNERH et les IRSC ainsi que par la Commission du droit du Canada<sup>280</sup>. Nous présentons dans ce qui suit un résumé des principaux problèmes ou lacunes mentionnés dans ces rapports :

- Bien que l'Énoncé de politique des trois Conseils établisse des normes très élevées, il n'existe actuellement aucun mécanisme de surveillance permettant de vérifier la conformité à ces normes. D'une part, il n'existe aucun processus d'approbation, d'autorisation ou d'inspection régulière des procédures d'examen de l'éthique de la recherche appliquées par les CER. De l'autre, et malgré le fait qu'un nombre croissant de CER commencent à s'attaquer à ce problème, peu de comités d'éthique suivent les recherches effectuées après l'approbation du protocole correspondant. En d'autres termes, les CER n'ont le plus souvent qu'une connaissance limitée de ce qui se passe après l'approbation d'un protocole de recherche.
- Certaines préoccupations ont été exprimées au sujet de conflits d'intérêts réels ou perçus impliquant des chercheurs ou des établissements. Même si, par consensus international, les CER doivent être créés dans les établissements de recherche et si leur travail exige une collaboration étroite avec d'autres services de leur établissement, ils doivent pouvoir fonctionner à l'abri des pressions de l'établissement et des chercheurs.
- De même, l'absence de supervision publique des CER privés, qui agissent indépendamment ou par l'entremise d'organisations de recherche engagées à contrat par des sociétés de produits pharmaceutiques, suscite des

---

<sup>279</sup> La section qui suit ne traite pas des limites éthiques de la recherche sur la santé génésique humaine parce que des mesures législatives fédérales portant sur ce sujet doivent être déposées sous peu à la Chambre des communes. Le Comité reconnaît que ce secteur est à la fine pointe de la recherche appliquée et qu'il évolue rapidement. À notre avis, toute la recherche portant sur le matériel reproducteur humain, les organismes humains tirés de ce matériel, d'autres souches de cellules humaines ou toute partie de ce qui précède (y compris les gènes humains) devrait être assujettie à un examen éthique complet effectué par les CER compétents, ainsi qu'à l'EPTC et aux mesures législatives et réglementaires applicables.

<sup>280</sup> Pour plus de précisions, voir les quatre documents suivants : 1) CNERH (anciennement, le Conseil national de la bioéthique en recherche chez les sujets humains ou CNBRH), «Protéger et promouvoir le sujet de recherche humain : Un examen de la fonction des Comités de recherche d'éthique pour la recherche dans les facultés de médecine au Canada», dans *Communiqué CNBRH*, vol. 6(1), 1995; 2) Ébauche de rapport du Groupe de travail du CNERH chargé d'étudier les modèles d'accréditation des programmes de protection des sujets humains au Canada, 28 septembre 2001; 3) Michael MacDonald (chercheur principal), *Gouvernance de la recherche en santé avec des sujets humains*, recherche commanditée par la Commission du droit du Canada, Ottawa, mai 2000; 4) Projet de rapport du Groupe de travail sur l'examen continu, IRSC, 2001.

préoccupations au sujet de leur indépendance et des possibilités de conflit d'intérêts.

- Les CER ont besoin de ressources supplémentaires. Le travail devenant de plus en plus compliqué, du fait de la mondialisation, de l'évolution de la technologie et de la commercialisation, les CER ont de la difficulté à se trouver des présidents et même à recruter des membres.
- Il n'existe actuellement au Canada aucune norme sur les titres et l'expérience des membres des CER et des chercheurs en éthique de la recherche. En l'absence de normes canadiennes, les chercheurs doivent cependant satisfaire aux normes de formation américaines s'appliquant à la recherche en santé sur des sujets humains financée par des sources américaines.
- Les processus actuels d'examen éthique se fondent davantage sur les « producteurs » que sur les « consommateurs ». En d'autres termes, les sujets ne sont pas suffisamment représentés au niveau de la gestion de la recherche.
- Il est urgent d'entreprendre des recherches empiriques au sujet des effets de la recherche en santé sur les sujets humains, ainsi que de l'efficacité des procédures d'examen éthique.

Bref, il faut améliorer la gouvernance, la transparence et la responsabilité des processus d'examen éthique appliqués au Canada :

*[...] nous avons été surpris de constater l'importance des écarts entre les idéaux exprimés dans la politique et les dispositions pratiques de responsabilité, d'efficacité et d'autres critères de bonne gestion<sup>281</sup>.*

Le Comité convient avec les auteurs de nombreux rapports que la question centrale, pour le Canada, est de savoir qui est responsable envers le public de l'ensemble des processus mis en œuvre pour assurer le caractère éthique de la recherche effectuée sur des sujets humains. Nous reconnaissons l'excellent travail accompli dans différents milieux, partout au Canada, par des personnes dévouées qui se sont efforcées de veiller à ce que la recherche en santé effectuée sur des sujets humains satisfasse aux normes d'éthique les plus élevées. Nous sommes persuadés que les résultats obtenus au Canada sont aussi bons que partout ailleurs dans le monde. En fait, le rapport publié par la Commission du droit du Canada souligne :

***Le Comité convient avec les auteurs de nombreux rapports que la question centrale, pour le Canada, est de savoir qui est responsable envers le public de l'ensemble des processus mis en œuvre pour assurer le caractère éthique de la recherche effectuée sur des sujets humains.***

*Nous avons également été très impressionnés par le calibre des experts appartenant à de nombreux CER, sur les plans de l'érudition, de l'éthique et du droit. D'une façon générale, les chercheurs canadiens ont acquis une réputation internationale en ce qui*

---

<sup>281</sup> Michael MacDonald, Commission du droit du Canada.

concerne les aspects juridiques et éthiques de la recherche effectuée sur des sujets humains<sup>282</sup>.

Le Comité croit cependant que les structures et les approches variées qui caractérisent actuellement l'éthique de la recherche en santé sont incompatibles avec la responsabilité envers le public qu'exige un secteur de cette importance. Nous exhortons donc les différents grands intervenants de la recherche en santé sur des sujets humains à travailler ensemble pour élaborer un système de gouvernance pouvant atteindre les objectifs suivants : la promotion de la recherche présentant des avantages sociaux, la protection des chercheurs et le maintien de la confiance entre la communauté de la recherche et l'ensemble de la société<sup>283</sup>. Les intervenants suivants devraient participer à cette initiative : Santé Canada, les IRSC, les autres organismes subventionnaires fédéraux, le Panel d'experts et le Secrétariat en éthique de la recherche, les commanditaires du secteur privé, les instituts de recherche, les organisations et associations professionnelles de la santé, le CNERH, l'Association canadienne (nouvellement créée) des comités d'éthique de la recherche, etc. Par conséquent, le Comité recommande :

***Nous exhortons donc les différents grands intervenants de la recherche en santé sur des sujets humains à travailler ensemble pour élaborer un système de gouvernance pouvant atteindre les objectifs suivants : la promotion de la recherche présentant des avantages sociaux, la protection des chercheurs et le maintien de la confiance entre la communauté de la recherche et l'ensemble de la société.***

**Que Santé Canada prenne l'initiative, en collaboration avec les intervenants, de l'élaboration d'un système commun de gouvernance de la recherche en santé effectuée sur des sujets humains s'appliquant à toute la recherche que le gouvernement fédéral exécute, finance et utilise dans ses activités de réglementation.**

**Que, dans l'élaboration de ce système de gouvernance de l'éthique, Santé Canada considère les éléments suivants comme essentiels au progrès :**

- **travailler en premier sur toute la recherche (en santé) que le gouvernement fédéral exécute, finance ou utilise dans ses activités de réglementation, afin d'élaborer un système efficace et efficient de gouvernance qui sera adopté comme norme partout au Canada;**
- **accorder une grande importance, dans le système de gouvernance, à des mécanismes efficaces d'éducation et de formation, destinés à tous ceux qui s'occupent de recherche et d'éthique de la recherche**

<sup>282</sup> *Ibid.*, p. 300.

<sup>283</sup> Ces objectifs correspondent à ceux qui sont définis dans le rapport McDonald, cité dans la note précédente.

**et dotés d'un processus d'agrément correspondant aux responsabilités des différents participants;**

- **élaborer des normes, fondées sur l'*Énoncé de politique des trois Conseils*, les lignes directrices de la Conférence internationale d'harmonisation relatives aux essais cliniques sur des sujets humains et d'autres normes pertinentes canadiennes et étrangères, pouvant servir de base à l'autorisation ou à l'agrément des fonctions ou des comités d'éthique de la recherche à un niveau correspondant aux attentes des Canadiens et aux normes d'autres pays;**
- **veiller à l'actualisation de l'*Énoncé de politique des trois Conseils* et à son maintien à l'avant-garde des politiques internationales régissant l'éthique ou la recherche sur des sujets humains;**
- **faire disparaître les incohérences entre les différentes politiques qui régissent actuellement la recherche sur des sujets humains et faire concorder les normes canadiennes avec celles d'autres pays qui influent sur la recherche canadienne;**
- **établir un processus d'autorisation ou d'agrément des fonctions d'éthique de la recherche, qui soit indépendant du gouvernement, mais qui soit clairement tenu de lui rendre compte de son activité;**
- **élaborer le système de gouvernance dans le cadre de consultations de fond ouvertes et transparentes avec les intervenants.**

### **12.7.3 L'utilisation d'animaux dans la recherche**

Les animaux étant biologiquement très semblables aux humains, ils sont utilisés dans la recherche pour acquérir de nouvelles connaissances biologiques ayant de fortes chances de s'appliquer aux humains. Toutefois, comme ils ne sont pas identiques à ceux-ci, toute nouvelle connaissance découlant de la recherche sur les animaux doit faire l'objet d'essais sur des humains avant d'être appliquée à la santé humaine.

Des préoccupations éthiques au sujet de l'utilisation des animaux, notamment dans la recherche, ont été exprimées depuis le XIX<sup>e</sup> siècle, surtout en Angleterre. Au Canada, ces préoccupations ont amené le CRM et le CNRC à entreprendre des études qui ont abouti, en 1968, à la création du Conseil canadien de protection des animaux (CCPA). Aujourd'hui, le CCPA reçoit 87 % de son budget de 1,2 million de dollars des IRSC et du CRSNG, ce qui lui permet d'offrir ses services aux établissements de recherche qu'ils financent. Le CCPA tire le reste de ses revenus des honoraires qu'il facture aux établissements gouvernementaux et privés.

Le CCPA délivre le Certificat de bonnes pratiques animales<sup>®</sup> aux établissements qu'il juge conformes à ses normes. La conformité est déterminée par des équipes d'évaluation

qui effectuent des visites sur place. Les IRSC et le CRSNG imposent à tous ceux qui souhaitent recevoir des fonds de recherche de participer au programme du CCPA et informent les bénéficiaires qu'ils cesseront de recevoir ces fonds si le CCPA les déclare non conformes à ses normes. Le CCPA signale que les établissements respectent en général ses recommandations<sup>284</sup>.

Dans son mémoire au Comité, la Coalition pour la recherche biomédicale et en santé (CRBS) affirme que les normes du CCPA sont reconnues aussi bien au Canada qu'à l'échelle internationale :

*La CRBS estime que les recherches faisant appel à des animaux qui sont conformes aux lignes directrices et aux politiques du CCPA sont des activités éthiques et responsables.*

*En reconnaissant les normes du CCPA, qui sont acceptées à l'échelle nationale et internationale, le gouvernement fédéral sera en mesure d'établir l'équilibre nécessaire entre la protection des animaux et les bienfaits découlant de leur utilisation à des fins scientifiques<sup>285</sup>.*

La structure formelle du CCPA et son programme de surveillance constituent, pour beaucoup d'observateurs au Canada et à l'étranger, un modèle optimal qui permet au Conseil de travailler efficacement en toute indépendance du gouvernement, mais en collaboration avec lui<sup>286</sup>. De plus, un rapport récent envisage même l'utilisation d'un modèle du même genre dans la recherche sur des sujets humains. Par exemple :

*Il y a au Canada un modèle intéressant que nous devrions, je crois, considérer sérieusement dans notre recherche d'un processus d'approbation de la recherche sur des sujets humains. C'est celui du Conseil canadien de protection des animaux. [...] il a aujourd'hui une crédibilité remarquable et une réputation internationale. [...] Il s'agit d'un modèle très intéressant presque exclusivement canadien. Il bénéficie de subventions fédérales tout en fonctionnant d'une manière indépendante, définissant des normes et établissant un processus très respecté d'approbation de la recherche sur les animaux<sup>287</sup>.*

Le Comité reconnaît que le CCPA fournit des services de calibre mondial aux Canadiens d'une façon efficace et économique. Quoiqu'un certain nombre de Canadiens ne voudront pas en convenir – notamment ceux qui s'opposent à toute utilisation des animaux dans la recherche, le Comité croit que le CCPA a clairement prouvé qu'il est possible de gérer efficacement un secteur très délicat qui nécessite une attention de tous les instants en adoptant une approche fondée sur :

**Le Comité reconnaît que le CCPA fournit des services de calibre mondial aux Canadiens d'une façon très économique.**

<sup>284</sup> Louis-Nicolas Fortin et Thérèse Leroux, « Éléments de réflexion sur la surveillance du contrôle éthique de la recherche », dans *Communiqué CNBRH*, été 1997.

<sup>285</sup> Coalition pour la recherche biomédicale et en santé, mémoire présenté au Comité, p. 7.

<sup>286</sup> Sous-comité de l'éthique, *Mandat d'éthique d'IRSC : Mise en place d'une vision transformatrice*, document de travail établi à l'intention du conseil d'administration provisoire des IRSC, 10 novembre 1999, p. 18-19.

<sup>287</sup> Dr Henry Dinsdale, discours prononcé à la Conférence nationale du CNERH, mars 2001, p. 5.

- la conviction, jusqu'à preuve du contraire, que les établissements et les particuliers s'efforcent de travailler d'une manière qui reflète les valeurs des Canadiens;
- le renforcement de la sensibilisation et de la formation des personnes aux dossiers et aux normes;
- des méthodes d'évaluation qui sont basées sur des normes reconnues à l'échelle internationale, qui mènent à l'agrément des installations et des processus, font intervenir des experts et des profanes et sont appliquées d'une manière collégiale en l'absence de preuves d'écarts de conduite et d'omission de prendre les mesures correctives nécessaires.

Sans préconiser une simple transposition des mécanismes du CCPA dans la gestion, certes difficile, de la recherche sur des sujets humains, le Comité croit qu'il y a beaucoup d'enseignements à tirer de l'expérience du CCPA. Il estime cependant qu'il existe des lacunes dans l'interaction entre le CCPA et le gouvernement fédéral. Même si de nombreux ministères et organismes fédéraux ont adopté le programme d'évaluation du CCPA pour la recherche sur les animaux effectuée dans leurs propres installations et même si les IRSC et le CRSNG imposent le respect des normes du CCPA comme condition préalable à l'attribution de fonds de recherche, nous croyons que cela ne suffit pas. Par conséquent, le Comité recommande :

**Que tous les ministères et organismes fédéraux imposent le respect des normes du Conseil canadien de protection des animaux dans :**

- **toute la recherche effectuée dans des installations fédérales;**
- **toute la recherche financée par des ministères et organismes fédéraux, mais effectuée en dehors des installations fédérales;**
- **toute la recherche effectuée sans financement fédéral en dehors des installations fédérales, mais dont les résultats sont présentés au gouvernement fédéral ou sont utilisés par lui dans l'exercice de fonctions prévues par voie législative.**

**12.7.4 La confidentialité des renseignements médicaux personnels**

Tous les renseignements personnels sont importants, mais pour la plupart des gens les renseignements médicaux sont probablement les plus délicats. Les renseignements sur la santé revêtent un caractère très intime, non seulement parce qu'ils touchent directement la personne en cause, mais aussi parce qu'ils ont des effets sur les membres de la famille et d'autres, ainsi que sur différents aspects de la vie d'une personne, comme son emploi ou son assurabilité.

***Le droit à la vie privée et à la protection des renseignements médicaux personnels est très précieux pour les Canadiens.***

Le droit à la vie privée et à la protection des renseignements médicaux personnels est très précieux pour les Canadiens. Plus que jamais auparavant, ceux-ci ont aujourd'hui besoin de l'assurance que leur vie privée et leurs renseignements personnels seront respectés en cette ère de progrès technologiques rapides. En même temps, l'état de santé et la qualité des soins ont aussi une très grande valeur pour eux. Les fournisseurs de services de santé, les gestionnaires des soins de santé et les chercheurs en santé doivent avoir accès aux renseignements médicaux personnels pour améliorer la santé des Canadiens, renforcer les services et maintenir la qualité du système de soins. Pour les Canadiens, le défi actuel est de trouver un juste milieu entre leur droit à la vie privée et les besoins d'accès à l'information (des fournisseurs de services de santé, des gestionnaires des soins et des chercheurs).

La *Loi sur la protection des renseignements personnels et les documents électroniques* (LPRPDE), promulguée en juin 2000, a suscité un débat animé et un important examen de cette question ces deux dernières années. Le secteur de la santé ne s'est rendu compte des effets possibles de cette mesure législative sur la recherche en santé et la gestion des soins qu'assez tard dans le processus d'examen du projet de loi à la Chambre des communes. Des représentants de différentes parties du secteur de la santé sont donc intervenus énergiquement au cours des audiences tenues par le Comité fin 1999. Leur témoignage a clairement démontré, d'une part, que le secteur de la santé ne participait pas au large consensus qui s'était formé en faveur du projet de loi et, de l'autre, que les diverses entités du secteur de la santé ne s'entendaient pas entre elles sur une solution aux problèmes de confidentialité de l'information médicale que soulevait la mesure législative. En conséquence, le Comité a conclu que beaucoup d'incertitude entourait l'application de la LPRPDE aux renseignements médicaux personnels et que des éclaircissements étaient donc nécessaires. En réponse à la recommandation du Comité<sup>288</sup>, le gouvernement fédéral a décidé de reporter jusqu'au 1<sup>er</sup> janvier 2002 l'application de la Loi aux renseignements médicaux personnels. Cette période d'un an après la proclamation de la LPRPDE devait permettre au gouvernement et aux intervenants en cause du secteur de la santé de régler les points d'incertitude et de proposer une solution assurant la protection des renseignements médicaux personnels.

Le Comité est heureux de constater que plusieurs groupes du secteur de la santé se sont sérieusement occupés de beaucoup des préoccupations soulevées par la LPRPDE, et notamment la nécessité de protéger les renseignements médicaux personnels tout en permettant une utilisation limitée à des fins essentielles, telles que la recherche en santé et la gestion des soins (qui comprend la prestation, la gestion, l'évaluation et l'assurance de la qualité des services de santé).

Au cours des deux dernières années, les IRSC ont procédé à une vaste analyse de cette question et ont lancé un important processus de consultation avec différents intervenants, qui a abouti à des recommandations sur l'interprétation et l'application de la LPRPDE à la recherche en santé<sup>289</sup>.

---

<sup>288</sup> Deuxième rapport du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, 36<sup>e</sup> législature, 2<sup>e</sup> session, 6 décembre 1999.

<sup>289</sup> IRSC, *Recommandations pour l'interprétation et l'application de la Loi sur la protection des renseignements personnels et les documents électroniques dans le contexte de la recherche en santé*, 30 novembre 2001. Le règlement proposé par les IRSC peut être consulté à [http://www.cihr.ca/about\\_cihr/ethics/recommendations\\_f.pdf](http://www.cihr.ca/about_cihr/ethics/recommendations_f.pdf).



Les recommandations des IRSC présentent, sous forme d'un projet de règlement établi en vertu de la LPRPDE, des dispositions exprimées dans un langage juridique précis, qui, sans modifier la Loi, en faciliteraient l'interprétation et l'application dans le domaine la recherche en santé. Les IRSC ont présenté ces recommandations au Comité comme solution réaliste à court terme fondée sur l'hypothèse que la LPRPDE ne serait vraisemblablement pas modifiée avant le 1<sup>er</sup> janvier 2002. Les IRSC ont souligné que leur projet de règlement, quoique sensiblement limité par le libellé actuel de la LPRPDE, peut néanmoins servir de guide utile pour aider à clarifier certains termes ambigus d'une manière qui permettrait d'atteindre les objectifs de la Loi sans pour autant entraver des recherches d'une importance vitale. Les IRSC sont également d'avis que le règlement, comme instrument exécutoire, est nécessaire pour permettre aux chercheurs et à l'ensemble des Canadiens de comprendre ce que la loi attend d'eux et de choisir en conséquence leur ligne de conduite. De plus, il pourrait servir de base aux mesures législatives sensiblement équivalentes que les provinces et les territoires pourraient élaborer avant le 1<sup>er</sup> janvier 2004, comme le prévoit la LPRPDE<sup>290</sup>.

Enfin, les IRSC reconnaissent que d'autres travaux doivent être réalisés de concert avec différents intervenants et les provinces pour établir un cadre juridique ou stratégique d'ensemble plus cohérent, plus complet et mieux harmonisé pour le secteur de la santé. En définitive, la loi ou la politique qui régira ce domaine doit admettre une certaine souplesse et un certain réalisme dans son interprétation et son application. De plus, les utilisateurs devront élaborer des lignes directrices plus détaillées pour favoriser l'adoption des meilleures pratiques d'information dans leur travail quotidien.

Le Comité a examiné le projet de règlement proposé par les IRSC, qu'il tient à féliciter de leurs efforts dans ce domaine. Nous appuyons pleinement l'intention de ce document. Comme nous l'avons mentionné dans notre quatorzième rapport daté du 14 décembre 2001<sup>291</sup>, le Comité croit que ce texte devrait faire l'objet d'une étude sérieuse. Par conséquent, il recommande :

**Que des règlements comme celui que proposent les Instituts de recherche en santé du Canada fassent l'objet de l'étude la plus complète et la plus équitable possible dans le cadre des discussions qui se tiendront sur les moyens de clarifier et de préciser la loi, afin d'en atteindre les objectifs sans entraver d'importantes recherches destinées à améliorer la santé des Canadiens et à leur assurer de meilleurs services de santé.**

Une deuxième initiative parallèle a été entreprise par un Groupe de travail sur la protection de la vie privée composé de représentants de l'Association dentaire canadienne, l'Association canadienne des soins de santé, l'Association médicale canadienne, l'Association des infirmières et infirmiers du Canada, l'Association des pharmaciens du Canada et l'Association des consommateurs du Canada. Le groupe de travail s'est occupé des besoins d'accès aux

---

<sup>290</sup> C'est un fait que la Loi donne aux provinces et aux territoires jusqu'au 1<sup>er</sup> janvier 2004 pour élaborer des mesures législatives sensiblement équivalentes.

<sup>291</sup> Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, *Quatorzième rapport*, 37<sup>e</sup> législature, 1<sup>re</sup> session, 14 décembre 2001.

renseignements médicaux personnels à des fins de gestion des soins de santé. Dans un rapport présenté à Santé Canada, il énonce les principes suivants<sup>292</sup> :

- Le caractère confidentiel de l'information, dans le domaine de la prestation des soins de santé, revêt une grande importance pour les Canadiens. La crainte que des renseignements médicaux personnels soient divulgués à d'autres peut nuire à la confiance qui est essentielle dans les relations entre patients et fournisseurs et amener donc les patients à hésiter à obtenir des soins ou à donner des renseignements que les fournisseurs ont besoin de connaître pour administrer un traitement approprié.
- Même si le droit individuel à la protection des renseignements médicaux personnels est d'une grande importance, il n'est pas absolu. Ce droit doit s'exercer dans des limites raisonnables, prescrites par la loi, de façon à réaliser l'équilibre entre le droit à la vie privée et les besoins sociaux dont la justification peut se démontrer dans le cadre d'une société libre et démocratique.
- Toute personne a droit à la protection de ses renseignements médicaux personnels, peut décider des conditions dans lesquelles ces renseignements sont recueillis, utilisés ou divulgués, a le droit de connaître l'existence de ses dossiers médicaux, d'y avoir accès et d'en vérifier l'exactitude, et doit avoir des recours quand elle soupçonne une violation de sa vie privée.
- En contrepartie, les fournisseurs et les organisations de soins de santé ont l'obligation de considérer les renseignements médicaux personnels comme confidentiels; de prendre des mesures de sécurité adéquates pour préserver la vie privée et la confidentialité des renseignements personnels; de n'utiliser des renseignements identifiables qu'avec le consentement de la personne en cause, sauf si la loi impose le contraire ou, dans des conditions strictes, s'il existe des preuves concluantes que le bien public l'exige; de limiter la collecte, l'utilisation et la divulgation des renseignements médicaux personnels à l'information non identifiable, sauf s'il est possible de démontrer la nécessité de renseignements identifiables; et de mettre en œuvre les politiques, procédures et pratiques nécessaires pour assurer la protection des renseignements personnels.

Lorsque le Comité s'est réuni en décembre 2001 pour examiner les progrès réalisés au sujet de l'application de la LPRPDE aux soins de santé, il a appris qu'en dépit du fait que les membres du Groupe de travail sur la protection de la vie privée s'entendaient sur de nombreuses questions, ils n'étaient pas encore parvenus à une position finale commune. Le Groupe de travail était d'avis que la formation d'un consensus nécessiterait la participation active et le leadership du gouvernement fédéral. Pour sa part, le gouvernement fédéral estimait que les préoccupations des membres du Groupe de travail devaient être réglées entre eux-mêmes et le commissaire à la protection de la vie privée.

---

<sup>292</sup> Groupe de travail sur la protection de la vie privée, *Principes de protection des renseignements personnels en matière de santé au Canada*, rapport présenté à Santé Canada, décembre 2000.

Le Comité croit que d'autres conseils et lignes directrices sont nécessaires pour guider la prestation, la gestion, l'évaluation et l'assurance de la qualité des services de santé. À cette fin, *toutes* les parties en cause doivent participer à un effort collectif constructif pour résoudre les problèmes qui se posent, et le gouvernement devrait donner l'exemple. Comme il l'a mentionné dans son quatorzième rapport, le Comité recommande :

**Que des discussions se poursuivent entre les intervenants, le commissaire à la protection de la vie privée et les ministères fédéraux et provinciaux qui s'occupent de la prestation, de la gestion, de l'évaluation et de l'assurance de la qualité des services de santé.**

Comme beaucoup d'autres Canadiens, les membres du Comité accordent une très grande importance à la protection des renseignements médicaux personnels. Ils reconnaissent en même temps l'étendue du risque couru si l'accès à ces renseignements est sommairement refusé par suite de menaces perçues pour la vie privée et la confidentialité des renseignements personnels. Au lieu d'accorder une valeur absolue au

***le Comité croit que les Canadiens doivent procéder à un examen soigneux et réfléchi des raisons pour lesquelles l'accès à des renseignements personnels est nécessaire aux fins de la recherche en santé et de la gestion des soins, des avantages sociaux dont profitent les Canadiens en conséquence, à titre individuel et collectif, et des conditions auxquelles il faut satisfaire pour obtenir cet accès.***

droit à la vie privée, le Comité croit que les Canadiens doivent procéder à un examen soigneux et réfléchi des raisons pour lesquelles l'accès à des renseignements personnels est nécessaire aux fins de la recherche en santé et de la gestion des soins, des avantages sociaux dont profitent les Canadiens en conséquence, à titre individuel et collectif, et des conditions auxquelles il faut satisfaire pour obtenir cet accès. Par suite de ses responsabilités de longue date dans le financement des soins et de la recherche en santé, le gouvernement fédéral devrait jouer un rôle de premier plan pour sensibiliser le public et favoriser un débat élargi sur ces questions.

Le projet d'*Études de cas sur l'utilisation secondaire des renseignements personnels dans la recherche en santé* (décembre 2001) des IRSC constitue un excellent modèle pour encourager la discussion et favoriser une meilleure compréhension grâce à des exemples très concrets de projets réels de recherche en santé faisant une utilisation secondaire de renseignements personnels. Des efforts parallèles déployés par d'autres pour présenter des études de cas semblables illustrant pourquoi et comment des renseignements personnels sont utilisés à des fins de gestion des soins de santé seraient extrêmement précieux. Compte tenu de ce qui précède, le Comité recommande :

**Que le gouvernement fédéral, par l'entremise des Instituts de recherche en santé du Canada et de Santé Canada et de concert avec d'autres intervenants intéressés, élabore et mette en œuvre un programme de sensibilisation du public destiné à assurer une meilleure compréhension :**

- **de la nature et de la raison d'être des grandes bases de données contenant des renseignements médicaux personnels, qui doivent être tenues pour assurer le fonctionnement d'un système public de soins de santé;**
- **du besoin essentiel de faire une utilisation secondaire de telles bases de données aux fins de la recherche en santé et de la gestion des soins.**

Cela étant dit, le Comité croit que si les Canadiens autorisaient une utilisation limitée des renseignements médicaux personnels dans des fonctions essentielles, comme la recherche en santé et la gestion des soins, il serait impératif de protéger adéquatement ces renseignements. Nous tenons à insister sur l'importance de veiller, en même temps, à ce que les Canadiens soient persuadés du respect du caractère privé de leurs renseignements médicaux personnels. Une fois de plus, nous considérons que le gouvernement fédéral a un grand rôle à jouer à cet égard pour susciter une pleine discussion des questions éthiques qui se posent et une étude des mécanismes de contrôle et d'examen nécessaires pour s'assurer que l'utilisation secondaire de renseignements personnels aux fins de la recherche en santé et de la gestion des soins se fait d'une manière ouverte, transparente et responsable. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral, par l'entremise des Instituts de recherche en santé du Canada et de Santé Canada et de concert avec d'autres intervenants intéressés, se charge de favoriser :**

- **une discussion et un examen réfléchis des questions éthiques, concernant notamment le consentement éclairé, que pose l'utilisation secondaire des renseignements médicaux personnels aux fins de la recherche en santé et de la gestion des soins;**
- **une étude approfondie des mécanismes de contrôle et d'examen nécessaires pour s'assurer que les bases de données contenant des renseignements médicaux personnels sont efficacement créées, tenues et protégées et que leur utilisation aux fins de la recherche en santé et de la gestion des soins est faite d'une manière ouverte, transparente et responsable.**

#### **12.7.5 La confidentialité de l'information génétique**

Nous avons examiné, dans la section précédente, le caractère confidentiel des renseignements médicaux personnels tirés de bases de données faisant partie du système actuel de soins de santé. Le Comité reconnaît que les nouvelles technologies d'analyse des gènes introduisent de nouveaux aspects dans la gestion des renseignements médicaux personnels. La capacité en pleine expansion d'établir des liens entre des séquences d'ADN et certaines maladies promet d'améliorer considérablement les soins qu'il sera possible de donner, mais augmente les

possibilités d'atteinte à la vie privée de l'individu et de ses proches. De plus, les technologies permettent de prédire des maladies dont les symptômes ne sont pas encore évidents. Toutefois, la majorité de ces prédictions représentent surtout une probabilité accrue d'incidence de la maladie, le test étant souvent de nature plus statistique (révélant, par exemple, deux ou trois fois plus de chances de contracter la maladie par rapport à l'ensemble de la population) qu'absolue (comme dans le cas de la maladie de Huntington).

L'application des nouvelles techniques génétiques à la santé humaine en est encore à ses premiers balbutiements, mais certains de leurs avantages et inconvénients possibles sont déjà évidents. On peut craindre, par exemple, que l'accès à l'information génétique d'une personne ne puisse influencer sur ses chances d'obtenir un emploi ou de l'assurance.

Le Comité a été heureux d'apprendre que des discussions interministérielles portant sur une vaste gamme de sujets sont en cours au sein du gouvernement fédéral. Il encourage la poursuite de ces discussions en vue d'aboutir à des conseils et des lignes directrices sur les moyens de régler ces questions complexes au mieux des intérêts des Canadiens.

***Le Comité a été heureux d'apprendre que des discussions interministérielles portant sur une vaste gamme de sujets sont en cours au sein du gouvernement fédéral. Il encourage la poursuite de ces discussions en vue d'aboutir à des conseils et des lignes directrices sur les moyens de régler ces questions complexes au mieux des intérêts des Canadiens.***

### **12.7.6 Les situations possibles de conflit d'intérêts**

Dans le domaine de la santé humaine, les progrès réalisés dépendent souvent de la participation de chercheurs du monde universitaire, du gouvernement et du secteur privé. Les limites entre ces groupes s'estompent de plus en plus, tandis qu'augmentent la confiance mutuelle et la collaboration entre eux. Par exemple :

- En grande majorité, la recherche en santé dont les résultats sont publiés au Canada est l'œuvre de chercheurs d'établissements universitaires qui obtiennent du financement du gouvernement, de sources philanthropiques et du secteur privé.
- Les chercheurs du milieu universitaire sont, de plus en plus souvent, animés de l'esprit d'entreprise. Ils fondent souvent de nouvelles sociétés qui assurent une croissance économique rapide dans la révolution biologique.
- Les sociétés privées tirent de la recherche universitaire beaucoup de leurs idées commerciales, y compris de nouvelles interventions en santé. Elles commencent à créer des centres de recherche en milieu universitaire en contrepartie d'un droit de premier refus sur la propriété intellectuelle des résultats obtenus.
- Le gouvernement réglemente les interventions en santé, tout en contribuant à la création de nouvelles connaissances grâce à ses recherches internes. Les règlements dépendent de recherches effectuées par le secteur privé, souvent

dans des établissements universitaires, qui sont évaluées par les scientifiques du gouvernement, parfois avec l'aide et les conseils de scientifiques du milieu universitaire.

Les possibilités de conflit d'intérêts sont évidentes. On peut craindre en outre que le souci de protéger la propriété intellectuelle et les intérêts commerciaux dans le secteur privé ne nuise à l'exécution ou à la publication de la recherche effectuée dans des établissements publics ou à l'aide de fonds publics. Les médias ont à juste titre concentré leur attention sur des cas où ces craintes s'étaient concrétisées.

Le Comité reconnaît que la recherche industrielle est un élément essentiel de la recherche en santé et des soins de santé. En fait, notre capacité croissante de favoriser la santé et de prévenir, diagnostiquer ou traiter les maladies est, pour une grande part, attribuable au secteur privé. De plus, malgré un certain nombre de cas de conflit d'intérêts qui

***Le Comité est d'avis que la majorité des travaux du secteur privé reflètent des normes élevées d'éthique et répondent pleinement aux attentes des Canadiens à cet égard. Il n'y a pas de doute d'ailleurs que les entreprises ne peuvent pas espérer survivre dans le monde actuel en faisant fi des aspirations de la société.***

ont fait les manchettes, le Comité est d'avis que la majorité des travaux du secteur privé reflètent des normes élevées d'éthique et répondent pleinement aux attentes des Canadiens à cet égard. Il n'y a pas de doute d'ailleurs que les entreprises ne peuvent pas espérer survivre dans le monde actuel en faisant fi des aspirations de la société.

Le Comité comprend cependant que le rôle de plus en plus important assumé par le secteur privé dans la recherche canadienne en santé, surtout sur le plan des essais cliniques, suscite des préoccupations. Cela ressort d'un récent éditorial de l'International Committee of Medical Journal Editors, qui exposait les règles de base à observer pour éviter les conflits d'intérêts dans les publications<sup>293</sup>. Il est nécessaire, en particulier, de trouver un équilibre approprié entre la recherche clinique effectuée en milieu universitaire, la possibilité de comparer différents traitements de la même maladie, l'importance accordée dans la recherche aux maladies assurant les bénéfices les plus importants (par exemple les maladies des pays riches, par opposition à celles des pays pauvres), la publication de résultats négatifs (nécessité d'établir un registre de tous les essais cliniques) et d'autres domaines connexes.

Le Comité se réjouit du travail accompli par les IRSC en vue de resserrer la collaboration entre le monde universitaire et le secteur privé dans le domaine de la recherche en santé grâce au Programme Université-industrie et au Programme Rx&D<sup>294</sup>. Nous comprenons qu'il est important d'encourager les partenariats des IRSC avec l'industrie. Nous nous rendons compte en même temps qu'il faut déterminer s'il convient d'établir des lignes directrices explicites, qui contribueraient à l'examen des aspects des relations des IRSC avec l'industrie pouvant poser des problèmes d'éthique. Par conséquent, le Comité recommande :

**Que les Instituts de recherche en santé du Canada, en partenariat avec le secteur privé et d'autres intervenants,**

<sup>293</sup> Voir *Journal de l'Association médicale canadienne*, 18 septembre 2001, vol. 165, p. 786-788.

<sup>294</sup> Partenariat entre les IRSC et les sociétés pharmaceutiques canadiennes axées sur la recherche.

**continuent d'étudier les aspects éthiques des relations entre les secteurs afin de veiller à ce que la collaboration et les partenariats jouent dans l'intérêt de tous les Canadiens.**





# **Partie VI : Promotion de la santé et prévention de la maladie**



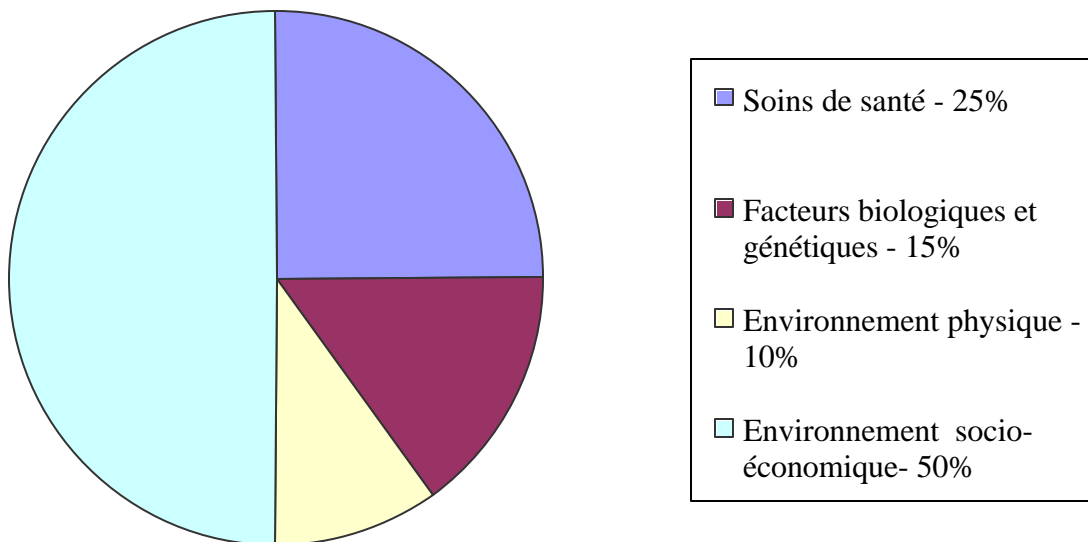
## CHAPITRE TREIZE

### UNE POLITIQUE PUBLIQUE « PRO-SANTÉ » – LA SANTÉ AU-DELÀ DES SOINS DE SANTÉ

---

Comme l'a souligné le Comité dans le volume un de son étude, il est clair que le système de soins de santé joue un rôle important dans la santé des Canadiens. Des services aussi divers que la vaccination des enfants, les médicaments pour soigner l'hypertension artérielle ou l'asthme de même que la chirurgie cardiaque sont autant d'éléments qui contribuent à la santé et au mieux-être de la population. En fait, selon les estimations de l'Institut canadien de recherches avancées, la santé de la population repose dans une proportion de 25 % sur les soins de santé (graphique 13.1)<sup>295</sup>. De toute évidence, il est important que le secteur de la santé soit financièrement viable et cherche continuellement à offrir des services de haute qualité en temps opportun. Bon nombre des recommandations formulées par le Comité dans le présent rapport sont destinées précisément à réaliser la viabilité, l'opportunité, la qualité et l'efficacité de la prestation des soins de santé, et ce, dans le but d'améliorer la santé et le mieux-être des Canadiens.

**GRAPHIQUE 13.1**  
**ESTIMATION DE L'INCIDENCE DES DÉTERMINANTS DE LA SANTÉ SUR**  
**L'ÉTAT DE SANTÉ DE LA POPULATION**



source : Estimations de l'Institut canadien de recherches avancées; graphique disponible sur le site web de Santé Canada

---

<sup>295</sup> Volume un, p. 88.

Par ailleurs, la santé des Canadiens est déterminée dans une proportion de 75 % par une multiplicité de facteurs indépendants du système de soins de santé. Parmi ces facteurs, qu'on appelle souvent les «déterminants non médicaux de la santé», on trouve le patrimoine biologique et génétique, le revenu et le soutien social, le niveau d'instruction et l'alphabétisation, l'emploi et les conditions de travail, l'environnement physique, l'hygiène, les habitudes de vie et les compétences d'adaptation personnelles, le développement de la petite enfance, le sexe et la culture.

Tout au long de son étude, le Comité s'est fait dire à maintes reprises que, pour maintenir et améliorer la santé des Canadiens, les gouvernements doivent, en plus de maintenir un bon système de soins de santé, élaborer des politiques et des programmes publics qui touchent également les déterminants non médicaux de la santé. Ces politiques et ces programmes englobent un vaste éventail d'activités liées entre elles, allant de la promotion de la santé et du mieux-être à l'adoption de stratégies plus larges relatives à la santé de la population, en passant par la prévention de la maladie et des blessures et la protection de la santé. Tous ces éléments font partie intégrante d'une politique publique «pro-santé».

- **Promotion de la santé et du mieux-être** – Ces activités visent à encourager les Canadiens à jouer un rôle plus actif dans l'amélioration de leur santé, notamment en faisant de l'exercice, en ayant une alimentation saine et en faisant des choix de vie sains.
- **Prévention de la maladie et des blessures** – Il s'agit d'activités destinées à réduire la probabilité que les personnes, les familles et les collectivités contractent des maladies particulières ou subissent des blessures. Les activités de prévention ont pour but de réduire les effets non désirés sur la santé en atténuant ou éliminant les facteurs de risque connexes. La vaccination, le dépistage précoce de la maladie, grâce à des programmes de dépistage, et la réduction de l'exposition à des activités potentiellement préjudiciables (utilisation de la ceinture de sécurité en voiture, pose de clôtures autour des piscines, amélioration de la sécurité des routes, etc.) sont autant de mesures de prévention de la maladie et des blessures.
- **Santé publique et protection de la santé** – Les activités dans ce domaine visent à protéger la santé des Canadiens contre les menaces connues et nouvelles. Il s'agit, par exemple, de la surveillance et de la lutte contre les flambées de cas de maladies et les tendances de la maladie (maladies infectieuses et chroniques), la surveillance de la sûreté et de l'efficacité de divers produits (notamment les aliments, les médicaments et les appareils médicaux) ainsi que l'évaluation de l'hygiène du milieu.
- **Stratégies relatives à la santé de la population** – On trouve dans cette catégorie un large éventail de politiques et de programmes gouvernementaux qui peuvent influencer sur la redistribution du revenu, l'accès à l'éducation, le logement, la qualité de l'eau, la sécurité au travail, etc., autant de déterminants importants de la santé de la population.
- **Politique publique «pro-santé»** – Il s'agit d'un concept qui englobe la promotion de la santé et du mieux-être, la prévention de la maladie et des

blessures, la santé publique et la protection de la santé ainsi que l'amélioration de la santé de la population. Une politique publique pro-santé exige que le gouvernement évalue les répercussions sur la santé des Canadiens de chaque mesure, politique ou programme d'importance. Une politique publique pro-santé nécessite une démarche intersectorielle, c'est-à-dire une démarche mobilisant les divers secteurs qui sont responsables des déterminants de la santé ou qui ont une incidence sur eux.

De plus en plus, les recherches montrent qu'on peut améliorer grandement la santé d'une population en consacrant davantage de ressources humaines et financières à la promotion de la santé, à la prévention de la maladie et à la protection et l'amélioration de la santé. En bout de ligne, cela peut réduire la demande de services de santé ainsi que les pressions exercées sur le système public de soins de santé.

On a toutefois dit au Comité – et il en est d'ailleurs conscient – que les activités liées à la promotion, à la prévention, à la protection et à l'amélioration de la santé de la population sont loin d'égaliser les soins de santé en popularité et en visibilité chez le public canadien et, manifestement aussi, chez les décideurs. S'il est clair que, collectivement, les déterminants non médicaux de la santé ont une incidence bien plus grande sur la santé de la population que les soins de santé, il n'en demeure pas moins que les résultats très positifs des activités de promotion, de prévention, de protection et d'amélioration de la santé de la population ne sont généralement perceptibles qu'à long terme, ce qui explique qu'on en parle moins dans les médias. Et comme ils sont peu susceptibles d'attirer l'attention du public, ils sont moins intéressants du point de vue politique.

Le Comité est d'avis que l'on peut retirer d'énormes avantages de la promotion de la santé et du mieux-être, de la prévention de la maladie et des blessures, de la santé publique, de la protection de la santé et des stratégies touchant la santé de la population, principalement pour ce qui est d'améliorer la santé des Canadiens, mais aussi pour ce qui est des répercussions financières positives à long terme de ces activités sur le système de santé public.

***Le Comité est d'avis que l'on peut retirer d'énormes avantages de la promotion de la santé et du mieux-être, de la prévention de la maladie et des blessures, de la santé publique, de la protection de la santé et des stratégies touchant la santé de la population, principalement pour ce qui est d'améliorer la santé des Canadiens, mais aussi pour ce qui est des répercussions financières positives à long terme de ces activités sur le système de santé public.***

Le gouvernement de Terre-Neuve et du Labrador a récemment élaboré une vision axée sur le mieux-être dans son plan stratégique quinquennal en matière de santé. Le premier objectif en est l'élaboration d'une stratégie relative au bien-être qui repose sur la promotion de la santé, la prévention de la maladie et des blessures, la protection de la santé et le développement de la petite enfance<sup>296</sup>. Le Comité applaudit à cette initiative.

<sup>296</sup> Ministre de la Santé et des Services communautaires, *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador*, septembre 2002 ([www.gov.nf.ca/health/strategiehealthplan](http://www.gov.nf.ca/health/strategiehealthplan)).

Le Comité se rallie de plus en plus à l'opinion des nombreux témoins qui jugent essentiel d'augmenter le financement dans ces domaines pour que le Canada puisse se doter de politiques publiques visant à améliorer la santé et le mieux-être de la population plutôt qu'à uniquement soigner les gens quand ils sont malades. De plus, le Comité croit que le gouvernement fédéral peut et doit faire œuvre de chef de file dans ce domaine.

Dans le présent chapitre, le Comité énonce ses constatations et ses recommandations sur le rôle du gouvernement fédéral dans la promotion de politiques publiques pro-santé. La section 13.1 fournit de l'information sur les tendances de la maladie et des blessures au Canada. La section 13.2 présente des données sur le fardeau économique de la maladie et des blessures. Dans la section 13.3, il est question de la nécessité d'une stratégie nationale de prévention des maladies chroniques. La section 13.4 étudie les préoccupations soulevées relativement à la santé publique, à la protection de la santé et à la promotion de la santé et du bien-être. Dans la section 13.5, nous analysons le cadre plus large des déterminants de la santé et évoquons les avantages de l'adoption d'une politique publique pro-santé au Canada.

### **13.1 Tendances de la maladie**<sup>297</sup>

Au cours du XX<sup>e</sup> siècle, l'application de nouvelles connaissances et de nouvelles technologies dans deux grands secteurs - la santé publique (plus particulièrement la disponibilité d'eau propre et les techniques sanitaires) et les soins de santé - a grandement modifié les tendances de la maladie. Les causes de mortalité se sont déplacées des maladies infectieuses aiguës aux maladies non transmissibles (chroniques) (voir le tableau 13.1).

Les maladies chroniques telles que le cancer et les maladies cardiovasculaires sont aujourd'hui les deux principales causes de décès et d'invalidité au Canada, les blessures accidentelles constituant la troisième. Cependant, certaines maladies infectieuses qu'on croyait vaincues, comme la tuberculose, refont surface parce que les agents infectieux qui les causent développent une résistance aux antibiotiques. Le transport international rapide des aliments et des personnes contribue également à augmenter les risques de propagation des maladies infectieuses.

---

<sup>297</sup> La plupart des informations présentées dans cette section se trouvent au volume deux, chapitre quatre, « Tendances de la maladie », p. 47 à 57.

**TABLEAU 13.1**  
**PRINCIPALES CAUSES DE MORTALITÉ (NORMALISÉES SELON L'ÂGE)**  
**(TAUX POUR 100 000 PERSONNES)**

<b>1921-1925</b>	
Maladies cardiovasculaires et rénales	221,9
Grippe, bronchite et pneumonie	141,1
Maladies de la petite enfance	111,0
Tuberculose	85,1
Cancer	75,9
Gastrite, duodénite, entérite et colite	72,2
Accidents	51,5
Maladies transmissibles	47,1
<b>Ensemble des causes</b>	<b>1 030,0</b>
<b>1996-1997</b>	
Maladies cardiovasculaires (maladies du cœur et ACV)	240,2
Cancer	184,8
Maladies pulmonaires obstructives chroniques	28,4
Blessures non intentionnelles	27,7
Pneumonie et grippe	22,1
Diabète sucré	16,7
Affections héréditaires et dégénératives du système nerveux central	14,7
Maladies des artères, des artérioles et des capillaires	14,3
<b>Ensemble des causes</b>	<b>654,4</b>

Source : Susan Crompton, « Cent ans de santé », *Tendances sociales canadiennes*, Statistique Canada, publication n° 11—008 au catalogue, n° 59, hiver 2000.

### **13.1.1 Maladies infectieuses**

Au début des années 20, les maladies du cœur et du rein étaient les principales causes de décès. Venaient ensuite la grippe, la bronchite et la pneumonie, suivies par les maladies de la petite enfance. La tuberculose a fauché plus de vies que le cancer. Les maladies intestinales, comme la gastrite, l'entérite et la colite, ainsi que les maladies transmissibles telles que la diphtérie, la rougeole, la coqueluche et la scarlatine étaient aussi des causes de mortalité courantes.

Les programmes de santé publique et l'utilisation massive de vaccins et d'antibiotiques ont entraîné un bouleversement important des tendances de la maladie : les maladies chroniques ont gagné du terrain au détriment des maladies infectieuses. Toutefois, de nombreuses maladies infectieuses persistent. Le D<sup>r</sup> Paul Gully, directeur général du Centre de prévention et de contrôle des maladies infectieuses de Santé Canada, a dit au Comité que, depuis

1980 au Canada, le taux de décès attribuables aux maladies infectieuses a augmenté<sup>298</sup>. Il relève sept tendances de maladies infectieuses qui menacent les Canadiens :

- De nombreuses maladies infectieuses, telles que le sida et l'hépatite C, persistent.
- On relève de nouvelles menaces de maladie infectieuses, notamment la maladie de la vache folle et le colibacille ainsi que le virus du Nil occidental.
- Les voyages et les migrations mondiales peuvent faire apparaître rapidement de nouvelles maladies parmi la population.
- Les changements environnementaux, comme le réchauffement climatique, le déboisement et la contamination de l'eau, peuvent favoriser la propagation des infections.
- Les modifications du comportement, notamment les pratiques sexuelles à risque et la toxicomanie, peuvent favoriser la propagation du VIH et d'autres maladies infectieuses.
- La résistance de la population à l'immunisation pourrait causer la réapparition de la polio et de la rougeole, par exemple.
- La résistance antimicrobienne des agents pathogènes peut réduire l'efficacité des mesures curatives traditionnelles comme les antibiotiques<sup>299</sup>.

### **13.1.2 Maladies chroniques**

Selon l'Enquête nationale sur la santé de la population effectuée en 1998-1999, plus de la moitié des Canadiens, à savoir 16 millions de personnes, ont déclaré avoir une maladie chronique. Les maladies les plus fréquentes sont les allergies, l'asthme, l'arthrite, les maux de dos et l'hypertension<sup>300</sup>.

Les maladies cardiovasculaires constituent la principale cause de mortalité au Canada, représentant 37 % de tous les décès. La mortalité attribuable aux maladies cardiovasculaires est en régression depuis 1970 tant chez les hommes que chez les femmes, quoique moins rapidement chez les femmes. Le cancer sous ses principales formes est la deuxième cause de mortalité et la principale cause de perte d'années potentielles de vie<sup>301</sup> avant 70 ans (il est à l'origine de plus du tiers de la perte d'années potentielles de vie). Le cancer touche principalement les Canadiens âgés : 70 % des nouveaux cas et 83 % des décès attribuables au cancer surviennent chez les personnes de 60 ans et plus. Les taux de décès attribuables au cancer diminuent lentement chez les hommes depuis 1990, tandis qu'ils sont demeurés relativement stables chez les femmes pendant la même période. Toutefois, les taux de cancer du poumon chez les femmes sont présentement quatre fois plus élevés qu'en 1971.

---

<sup>298</sup> Dr Paul Gully, mémoire présenté au Comité le 4 avril 2000, p. 2.

<sup>299</sup> Dr Paul Gully, *op. cit.*, p. 5.

<sup>300</sup> Dre Christina Mills, mémoire présenté au Comité le 4 avril 2001, p. 4.

<sup>301</sup> L'indicateur des « années potentielles de vie perdues », reconnu à l'échelle internationale, représente le nombre d'années de vie perdues quand une personne décède avant un âge donné, disons 75 ans. Ainsi, une personne qui meurt à 25 ans a perdu 50 ans de vie.



### **13.1.3 Blessures**

En 1995-1996, il y a eu 217 000 admissions à l'hôpital attribuables à des blessures. Les taux d'admission à l'hôpital en raison de blessures étaient de loin les plus élevés chez les personnes de 65 ans et plus. Les chutes demeurent une cause importante de blessure chez les aînés et les enfants de moins de 12 ans. Chez les enfants, en 1996, l'empoisonnement constituait la deuxième cause en importance des admissions à l'hôpital en raison de traumatismes. Chez les adolescents et les adultes de moins de 65 ans, les collisions de véhicules automobiles constituaient la deuxième cause en importance. La grande majorité des blessures sont accidentelles (environ 66 %)<sup>302</sup>.

### **13.1.4 Problèmes de santé mentale**

L'Enquête nationale sur la santé de la population de 1994-1995 révèle que 29 % des Canadiens connaissent un niveau élevé de stress, 6 % se sentent déprimés, 16 % indiquent que le stress a des effets nuisibles sur leur vie et 9 % ont une déficience cognitive telle que des difficultés à réfléchir et à se souvenir. Selon un rapport rédigé à l'intention du Réseau de consultation sur la santé mentale fédéral, provincial et territorial, environ 3% des Canadiens souffrent de troubles mentaux graves et chroniques pouvant engendrer des limitations fonctionnelles graves et une mésadaptation sociale et économique, par exemple la maladie affective bipolaire et la schizophrénie. Autrement dit, environ un Canadien de 15 ans et plus sur 35 en est atteint<sup>303</sup>.

Le stress et les troubles mentaux qui aboutissent à la maladie mentale peuvent se manifester à différentes périodes de la vie. L'autisme, les problèmes de comportement et le trouble déficitaire d'attention affectent plus communément les enfants. Les troubles de l'alimentation et la schizophrénie apparaissent surtout à l'adolescence. L'âge adulte est la période au cours de laquelle la dépression se manifeste de manière plus évidente. Les personnes âgées sont touchées par la maladie d'Alzheimer et d'autres types de démence, mais la dépression est également fréquente chez elles.

En raison de l'importance de la maladie mentale chez les Canadiens, le Comité tiendra des audiences spéciales et produira un rapport distinct dans lequel il présentera ses constatations et ses recommandations au gouvernement fédéral.

## **13.2 Fardeau économique de la maladie**

Les seules estimations dont nous disposons sur le fardeau économique de la maladie et des blessures au Canada ont été publiées en 1997 par Santé Canada et portent sur l'année 1993. Cette année-là, on estimait à 156,9 milliards de dollars le coût total de la maladie et des blessures, soit 22 % du PIB. Les coûts directs (soins hospitaliers, services dispensés par les médecins et recherches sur la santé, etc.) s'élevaient à 71,7 milliards de dollars et les coûts indirects (perte de productivité, etc.), à 85,1 milliards de dollars.

---

<sup>302</sup> Comité consultatif fédéral-provincial-territorial sur la santé de la population, *Pour un avenir en santé: Deuxième rapport sur la santé de la population canadienne*, Ottawa, 1999, p. 19.

<sup>303</sup> Kimberley McEwan et Elliot Goldner, *Indicateurs de rendement et de reddition de comptes pour les services de soins et de soutien en santé mentale*, trousse d'information préparée pour le Réseau de consultation sur la santé mentale fédéral, provincial et territorial, Ottawa, 2000, p. 30.

Comme le montre le tableau 13.2, les catégories diagnostiques affichant les coûts totaux les plus élevés étaient les maladies cardiovasculaires (19,7 milliards de dollars - 15,3 % des coûts totaux), les maladies musculo-squelettiques (17,8 milliards - 13,8 %), les blessures (14,3 milliards - 11,1 %), le cancer (13,1 milliards - 10,1 %), les maladies respiratoires (12,2 milliards - 9,4 %), les maladies du système nerveux (9,6 milliards - 7,4 %) et les troubles mentaux (7,8 milliards - 6 %). Les maladies infectieuses représentaient 2,0 % du fardeau économique total de la maladie (2,6 milliards de dollars).

**TABLEAU 13.2**  
**FARDEAU ÉCONOMIQUE DE LA MALADIE**  
**PAR CATÉGORIE DIAGNOSTIQUE, 1993**  
**(EN MILLIONS DE DOLLARS)**

	COÛTS DIRECTS <sup>1</sup>		COÛTS INDIRECTS		COÛT TOTAL	
	%	Coût	%	Coût	%	Coût
Mal. infectieuses/parasit.	1,8	786	2,2	1 857	2,0	2 643
Cancer	7,3	3 222	11,6	9 845	10,1	13 067
Mal. endocriniennes/conn.	3,0	1 334	2,5	2 086	2,6	3 419
Maladies sanguines	0,6	274	0,2	173	0,3	447
Troubles mentaux	11,4	5 051	3,3	2 787	6,1	7 839
Syst. nerveux/org. des sens	5,1	2 252	8,6	7 321	7,4	9 573
Affect. cardiovasculaires	16,7	7 354	14,5	12 368	15,3	19 722
Affect. respiratoires	8,6	3 787	9,9	8 393	9,4	12 181
Appareil digestif	7,5	3 326	3,4	2 920	4,8	6 247
Aff. génito-urinaires	5,1	2 248	0,9	786	2,3	3 034
Grossesse	4,6	2 025	0,8	690	2,1	2 715
Aff. cutanées/connexes	2,0	892	0,1	122	0,8	1 014
Aff. musculo-squelettiques	5,6	2 460	18,0	15 328	13,8	17 788
Anomalies congénitales	0,7	305	0,4	334	0,5	639
Affections périnatales	1,2	551	0,4	332	0,7	883
Affections mal définies	4,2	1 851	3,0	2 517	3,4	4 368
Blessures	7,1	3 122	13,2	11 222	11,1	14 343
Soins aux bien-portants	6,2	2 741	0,0	0	2,1	2 741
Autres	1,2	549	7,1	6 040	5,1	6 589
<b>TOTAL</b>	<b>100,0</b>	<b>44 130</b>	<b>100,0</b>	<b>85 123</b>	<b>100,0</b>	<b>129 253</b>

Des coûts directs s'élevant à 27,6 milliards de dollars n'ont pu être ventilés par catégorie diagnostique.

Source : Laboratoire de lutte contre la maladie (Santé Canada), *Le fardeau économique de la maladie au Canada 1993, 1997.*

### 13.3 Nécessité d'une stratégie nationale de prévention des maladies chroniques

Les chiffres présentés ci-dessus indiquent que les maladies chroniques non seulement sont la première cause de décès et d'invalidité au Canada, mais aussi qu'elles représentent la plus grande part du fardeau économique de la maladie. De plus, des informations fournies au Comité indiquent qu'environ les deux tiers de l'ensemble des décès au Canada sont attribuables aux maladies chroniques suivantes : maladies cardiovasculaires (maladies du cœur et accidents vasculaires cérébraux), cancer, maladies respiratoires obstructives chroniques (bronchite et emphysème) et diabète<sup>304</sup>. Plus précisément,

- les maladies cardiovasculaires, y compris les coronaropathies et les accidents vasculaires cérébraux, sont responsables de 38 % de tous les décès enregistrés au Canada chaque année et elles sont l'une des principales causes d'hospitalisation;
- le cancer est la deuxième cause de décès au Canada, intervenant pour 29 % dans le nombre total de décès et pour près du tiers des années potentielles de vie perdues;
- les maladies respiratoires obstructives chroniques représentent la cinquième cause de décès au Canada et la seule en voie d'augmentation; l'asthme est la maladie respiratoire chronique la plus courante chez les enfants et la première cause d'admission à l'hôpital et d'absentéisme scolaire chez les enfants au Canada;
- plus d'un million de Canadiens sont aux prises avec le diabète; le diabète est une cause importante de maladies coronariennes, de cécité et d'amputations. Chez les Autochtones canadiens, la prévalence du diabète est trois fois plus élevée que chez le reste de la population. Au total, le diabète représente chaque année quelque 25 000 années potentielles de vie perdues.

Au cours de son étude, le Comité a entendu dire à maintes reprises que la plupart des maladies chroniques sont parfaitement évitables. De plus, un rapport rédigé par Terrence Sullivan, vice-président et directeur de la Division de l'oncologie préventive d'Action cancer Ontario, indique que de nombreuses maladies chroniques – en particulier les maladies cardiovasculaires, le cancer, les maladies pulmonaires obstructives chroniques et le diabète – ont les mêmes causes. En effet, une mauvaise alimentation, le manque d'exercice, le tabagisme, le stress et la consommation excessive d'alcool (autant de comportements liés au mode de vie) sont reconnus comme les principaux facteurs de risque sociaux et comportementaux pour ces maladies. Ces facteurs de risque sont également souvent associés à d'autres troubles physiques ou physiologiques qui accroissent le risque de maladies chroniques, notamment l'excès de poids ou l'obésité, l'hypertension artérielle, un taux de cholestérol élevé (hypercholestérolémie) et l'intolérance au glucose (diabète)<sup>305</sup>. Si l'on parvenait à atténuer ou à éliminer ces facteurs de

---

<sup>304</sup> Comité consultatif sur la santé de la population, *Advancing Integrated Prevention Strategies in Canada: An Approach to Reducing the Burden of Chronic Diseases*, document de travail, 10 juin 2002.

<sup>305</sup> Terrence Sullivan, *Preventing Chronic Disease and Promoting Public Health: An Agenda for Health System Reform*, août 2002.

risque liés au mode de vie, on réduirait énormément la prévalence de ces maladies chroniques et le fardeau économique qu'elles représentent.

Le fait que la grande majorité des Canadiens sont exposés à l'un ou plusieurs de ces facteurs de risque courants<sup>306</sup> donne à penser que l'état de santé général de la population pourrait être grandement amélioré si l'on mettait davantage l'accent sur la prévention des maladies chroniques tout en continuant de lutter contre les maladies infectieuses. Conscients de cette réalité et de la possibilité d'une action commune, de grands organismes de santé nationaux (Société canadienne du cancer, Association canadienne du diabète, Fondation des maladies du cœur du Canada, Conseil canadien pour le contrôle du tabac, Coalition for Active Living et Les Diététistes du Canada) se sont récemment associés à Santé Canada pour former l'Alliance pour la prévention des maladies chroniques au Canada (APMCC).

En plus de cette nouvelle alliance stratégique, plusieurs autres mesures importantes ont été prises relativement à la prévention des maladies chroniques, notamment la Stratégie canadienne sur le diabète, l'Initiative canadienne en santé cardiovasculaire, le Plan d'action canadien contre les maladies cardiovasculaires, la Stratégie canadienne de lutte contre le cancer, sans nommer les nombreuses autres initiatives fédérales-provinciales-territoriales conjointes.

Cependant, certains ont dit au Comité qu'il faudrait intégrer, coordonner et renforcer ces différentes initiatives afin d'élaborer une stratégie nationale de prévention des maladies chroniques. Selon M. Sullivan, le Canada devrait utiliser les connaissances acquises et s'inspirer des réussites et des échecs des initiatives passées pour faire avancer le dossier de façon encore plus résolue<sup>307</sup>.

En plus de mieux intégrer les diverses initiatives en cours, il faudrait :

- assurer un leadership fédéral plus fort, notamment sur le plan politique et sur celui du maintien des ressources humaines et financières;
- élaborer une vision commune parmi tous les grands organismes qui travaillent dans le domaine des maladies chroniques, afin d'élaborer un ensemble d'objectifs précis;
- créer des partenariats avec les gouvernements provinciaux et territoriaux, les intervenants de l'entreprise privée et les organisations non gouvernementales;
- mettre en place des systèmes de surveillance des maladies chroniques et des facteurs de risque connexes, systèmes qui permettront également de surveiller la réalisation d'objectifs stratégiques précis;
- investir davantage dans des initiatives préventives adaptées aux particularités régionales.

La stratégie nationale de prévention des maladies chroniques devrait faire appel à l'éducation du public, à des programmes de communication de masse et à des interventions

---

<sup>306</sup> Une analyse de l'Enquête sur la santé dans les collectivités canadiennes, enquête effectuée en 2000, révèle que 65 % des Canadiens sont exposés à plus d'un facteur de risque lié aux maladies chroniques.

<sup>307</sup> Terrence Sullivan, *op. cit.*, p. 7.

stratégiques. Ces interventions devraient porter sur plusieurs fronts (soins de santé primaires, système d'enseignement, milieu du travail, collectivité) et répondre aux besoins de certaines populations prioritaires (Autochtones, collectivités rurales, femmes, etc.).

Une stratégie nationale de prévention des maladies chroniques procurerait de grands avantages. Elle permettrait notamment d'éviter l'occurrence prématurée et inutile de la maladie, d'améliorer l'état de santé de la population, d'accroître la productivité et d'abaisser les coûts des soins de santé. Selon les estimations, sur une période de 10 ans, on pourrait réduire jusqu'à 10 % les coûts des soins de santé parce que la population recourrait moins aux hôpitaux et aux services des médecins<sup>308</sup>.

Le Comité convient, avec de nombreux témoins, qu'il est temps que le gouvernement fédéral lance une initiative nationale visant à réduire la prévalence et le fardeau économique des maladies chroniques au Canada. À notre avis, le gouvernement fédéral est particulièrement bien placé pour jouer ce rôle de chef de file, étant donné ses longs antécédents en matière de promotion de la santé et de prévention de la maladie ainsi que son pouvoir législatif à l'égard de la surveillance et de la protection de la santé.

Une stratégie nationale de prévention des maladies chroniques améliorera la santé des Canadiens et contribuera à la viabilité du système de santé public. Le Comité croit que l'Alliance pour la prévention des maladies chroniques au Canada peut contribuer à la conception et à la réalisation de cette stratégie.

Nous sommes d'avis que le gouvernement fédéral doit faire preuve de leadership, mais il est important qu'il collabore avec les gouvernements provinciaux et territoriaux, le secteur privé et les partenaires bénévoles du secteur de la santé, pour que les changements nécessaires soient apportés. C'est pourquoi le Comité recommande :

***Le Comité convient, avec de nombreux témoins, qu'il est temps que le gouvernement fédéral lance une initiative nationale visant à réduire la prévalence et le fardeau économique des maladies chroniques au Canada. À notre avis, le gouvernement fédéral est particulièrement bien placé pour jouer ce rôle de chef de file, étant donné ses longs antécédents en matière de promotion de la santé et de prévention de la maladie ainsi que son pouvoir législatif à l'égard de la surveillance et de la protection de la santé.***

**Que le gouvernement fédéral, de concert avec les gouvernements provinciaux et territoriaux et en consultation avec les principaux intervenants (dont l'Alliance pour la prévention des maladies chroniques au Canada), mette en œuvre une stratégie nationale de prévention des maladies chroniques;**

**Que cette stratégie s'inspire des initiatives en cours, mais qu'elle prévoie aussi une meilleure intégration et une meilleure coordination;**

---

<sup>308</sup> Terrence Sullivan, *op. cit.*, p. 10.

**Que le gouvernement fédéral consacre 125 millions de dollars par année à la stratégie nationale de prévention des maladies chroniques;**

**Que des objectifs précis soient fixés dans le cadre de la stratégie et que les résultats soient évalués régulièrement en fonction de ces objectifs.**

### **13.4 Renforcer la santé publique et la promotion de la santé**

Dans un rapport rédigé par Joseph Losos, directeur de l'Institut de la santé de la population (Université d'Ottawa), l'auteur affirme que la santé publique et la protection de la santé jouent souvent le rôle de « sentinelles » de la santé – grâce à leurs fonctions de surveillance, de test, d'analyse, d'intervention, d'information, de promotion et de prévention – jusqu'à ce qu'un événement imprévu se produise. Lorsqu'un tel événement survient (affaire de l'eau contaminée à Walkerton, intoxications alimentaires, flambées de cas de maladies infectieuses, augmentation ponctuelle des cas de maladies chroniques, etc.), la crise et la visibilité de l'événement prennent rapidement des proportions considérables. Mais, par-dessus tout, ces crises entraînent de grandes souffrances, voire des décès et des coûts énormes, alors qu'on aurait pu les éviter au départ<sup>309</sup>.

Selon le *Journal de l'Association médicale canadienne*, les interventions en santé publique comportent une grande lacune en ce que leur financement est modeste, instable et irrégulier. Il en découle que l'infrastructure des soins de santé au Canada subit d'énormes pressions<sup>310</sup>.

La fragmentation est un autre obstacle à l'efficacité en matière de santé publique. En effet, chaque gouvernement provincial et territorial possède sa propre législation en la matière. Le gouvernement fédéral assume également, de par la loi, des responsabilités en matière de réglementation de la santé publique (surveillance épidémiologique, aliments et drogues, appareils, produits biologiques, santé environnementale, produits de consommation). Ce fouillis de pouvoirs réglementaires et législatifs donne lieu à des négociations complexes entre les différents intervenants et à une coordination des activités qui laisse à désirer. Une telle fragmentation limite l'efficacité des efforts en santé publique et aboutit à l'absence d'une responsabilité et d'un leadership clairs. De l'avis de nombreux experts, il faut dès maintenant que le gouvernement fédéral prenne résolument l'initiative de corriger cette situation déplorable qui nuit à la productivité<sup>311</sup>.

De même, les sommes qu'affecte le gouvernement à la promotion de la santé sont très modestes quand on les compare aux dépenses en santé. De plus, tant les gouvernements que les organisations non gouvernementales s'occupent de promotion de la santé. La plupart des efforts en ce sens se sont révélés efficaces, mais leur fragmentation a donné

---

<sup>309</sup> Joseph Losos, *Promotion and Protection of the Health and Wellbeing of the Population – Vision of Federal/National Roles*, 4 septembre 2002, p. 1.

<sup>310</sup> « Public Health on the Ropes », éditorial, et Richard Schabas, « Public Health: What is to be done? », *Journal de l'Association médicale canadienne*, vol. 166, n° 10, 14 mai 2002.

<sup>311</sup> Joseph Losos, *op.cit.*

lieu à une infrastructure de promotion de la santé mal coordonnée et mal intégrée. Chose plus importante encore, il n'existe pas au Canada d'objectifs nationaux en matière de promotion de la santé, comme c'est le cas aux États-Unis<sup>312</sup>.

Le Comité croit fermement qu'il est absolument nécessaire d'établir des programmes et des politiques en matière de santé publique, de protection de la santé et de promotion de la santé et du mieux-être si l'on veut améliorer la santé des Canadiens. Nous croyons qu'il faut adopter une démarche coordonnée et intégrée dans ce domaine et, encore une fois, que le gouvernement fédéral peut et doit y jouer un rôle prépondérant. Nous pensons aussi qu'il faut consacrer davantage d'argent à ce secteur. Étant donné son pouvoir légal en matière de protection de la santé et le rôle qu'il joue depuis longtemps dans la promotion de la santé, le gouvernement fédéral devrait accroître son financement dans ce domaine. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral assure un leadership fort en matière de soutien, de coordination et d'intégration de l'infrastructure de la santé publique et des efforts de promotion de la santé au Canada et qu'il y affecte davantage de fonds. Il devrait consacrer 200 millions de dollars de plus à cette entreprise très importante.**

### **13.5 Vers une politique publique pro-santé – Nécessité d'élaborer des stratégies d'amélioration de la santé de la population**

Comme nous l'avons vu plus haut, l'expression « santé de la population » est employée pour décrire la multiplicité et l'étendue des facteurs qui contribuent à la santé. Ces nombreux facteurs englobent les déterminants médicaux et non médicaux de la santé. La notion de santé de la population n'est pas nouvelle. En fait, depuis près de 30 ans, le Canada joue un rôle prépondérant dans le monde aux fins de l'élaboration du concept de santé de la population.

- En 1974, le ministre de la Santé, Marc Lalonde, a publié un document de travail intitulé *Nouvelle perspective de la santé des Canadiens*. On y soulignait qu'un système de soins de santé de haute qualité n'est que l'une des composantes d'une politique publique pro-santé, laquelle devrait tenir compte des facteurs biologiques humains (recherche), du mode de vie et des environnements physique, social et économique. Le rapport Lalonde a énormément contribué à façonner des approches plus larges de la santé, tant au Canada qu'ailleurs dans le monde. À l'échelon fédéral, le rapport a donné lieu, entre autres, à diverses campagnes de marketing social comme ParticipAction, Dialogue sur l'alcool et le *Guide alimentaire canadien*.
- En 1986, le rapport *La santé pour tous*, publié par le ministre de la Santé d'alors, Jake Epp, a donné lieu à des initiatives comme la Stratégie antidrogue canadienne, l'Initiative canadienne en santé cardiovasculaire, Villes et villages en santé, la Stratégie canadienne sur le VIH/sida, etc.

---

<sup>312</sup> Joseph Losos, *op.cit.*, p. 1.

- En 1989, l'Institut canadien de recherches avancées (ICRA), dirigé à l'époque par Fraser Mustard, a posé comme hypothèse que les déterminants de la santé ne fonctionnent pas en vase clos, mais que ce sont les interactions complexes entre eux qui influent le plus sur la santé. Ces travaux, de même que les dernières constatations du D Mustard, ont conduit entre autres à l'élaboration de l'initiative fédérale-provinciale-territoriale sur le développement de la petite enfance.
- En 1994, l'approche de la santé de la population a officiellement été entérinée par les ministres fédéral, provinciaux et territoriaux de la Santé dans un rapport intitulé *Stratégies d'amélioration pour la santé de la population : investir dans la santé des Canadiens*.
- En septembre 2000, tous les ministres de la Santé ont convenu d'intervenir en priorité sur le plan des conditions sous-jacentes et plus larges qui influent sur la santé des Canadiens.

On dispose de plus en plus de preuves que les déterminants de la santé ont un effet sur l'état de santé des Canadiens, surtout les déterminants socio-économiques. Par exemple, le deuxième *Rapport sur la santé des Canadiens*<sup>313</sup> signalait ceci :

- Les Canadiens à faible revenu risquent davantage de mourir plus tôt et de souffrir de maladies que les Canadiens à revenu plus élevé.
- Les écarts importants dans la répartition des revenus font augmenter les problèmes sociaux et contribuent à une moins bonne santé chez l'ensemble de la population.
- Les gens peu alphabétisés sont plus susceptibles d'être sans emploi et pauvres, d'être en mauvaise santé et de mourir plus tôt que les Canadiens plus instruits.
- Les Canadiens plus instruits ont davantage accès à des environnements physiques sains et sont plus aptes, que les personnes moins scolarisées, à préparer leurs enfants à l'école. Ils ont aussi tendance à moins fumer, à être plus actifs physiquement et à avoir accès à des aliments santé.
- Des études en neurobiologie ont confirmé que, plus que toutes les autres, ce sont les expériences vécues entre la conception et l'âge de six ans qui influent le plus sur la connexion et le conditionnement des neurones du cerveau. La stimulation positive en début de vie améliore l'apprentissage, le comportement et la santé tout au long de la vie.
- Le vieillissement n'est pas synonyme de mauvaise santé. Une vie active et l'accès à des possibilités d'apprentissage tout au long de la vie sont des facteurs particulièrement importants pour conserver la santé et la capacité cognitive à un âge avancé.

---

<sup>313</sup>Comité consultatif fédéral-provincial-territorial sur la santé de la population, *Pour un avenir en santé - Deuxième rapport sur la santé de la population canadienne*, Ottawa, 1999.



- Malgré la diminution de la mortalité infantile, l'augmentation des niveaux d'instruction et la baisse de la consommation excessive d'alcool et de drogues dans bien des collectivités autochtones, les membres des Premières nations et les Inuits courent plus de risques que le Canadien moyen de tomber malades ou de mourir prématurément.
- Les hommes sont plus susceptibles que les femmes de mourir prématurément, surtout de maladies cardiaques, de blessures accidentelles mortelles, de cancers et par suicide. Les femmes sont plus sujettes à la dépression, au stress, aux maladies chroniques, aux blessures et plus susceptibles de mourir par suite de violence familiale.
- Les Canadiens âgés sont beaucoup plus susceptibles que les jeunes de souffrir de maladies physiques, mais les jeunes affichent les taux de bien-être psychologique les plus faibles.

Malgré ces réalités, aucun ordre de gouvernement au Canada et aucun pays n'a conçu ni mis en place des programmes et des politiques solidement ancrés dans une approche axée sur la santé de la population. Le fait est qu'il y a encore, sur le plan pratique, d'importants obstacles qui empêchent l'élaboration de programmes concrets pouvant être maintenus sur de longues périodes.

Tout d'abord, en raison de la multiplicité des facteurs qui influent sur l'état de santé, il est extrêmement difficile d'associer causes et effets, d'autant plus que les effets d'une intervention donnée ne deviennent souvent visibles qu'au bout de nombreuses années. Comme les horizons politiques sont habituellement plus courts, la longue période nécessaire à l'observation des conséquences d'une politique dans ce domaine peut décourager sérieusement l'élaboration et la mise en œuvre de stratégies axées sur la santé de la population.

Par ailleurs, il est très difficile de coordonner les activités gouvernementales de façon à tenir compte de la multiplicité des facteurs qui influent sur l'état de santé. En fait, la structure de la plupart des gouvernements ne se prête pas facilement à une responsabilité interministérielle face à des problèmes complexes. La difficulté s'aggrave lorsque plusieurs ordres de gouvernement et de nombreux intervenants non gouvernementaux sont en jeu, comme ce doit être le cas si l'on veut que les stratégies relatives à la santé de la population soient vraiment efficaces.

L'élaboration d'une approche axée sur la santé de la population comporte certes de nombreuses embûches mais, selon le Comité, il est important que le Canada s'efforce de donner l'exemple en explorant des façons pratiques et novatrices d'appliquer une théorie sensée afin d'aider à améliorer la santé de la population.

De plus, comme de nombreux témoins, le Comité croit que, vu sa responsabilité à l'égard d'un si grand

***Comme de nombreux témoins, le Comité croit que, vu sa responsabilité à l'égard d'un si grand nombre de programmes et de politiques ayant une incidence sur la santé (santé, environnement, agriculture, finances, etc.), le gouvernement fédéral devrait ouvrir la voie en matière de santé de la population en coordonnant les activités des différents ministères intéressés.***

nombre de programmes et de politiques ayant une incidence sur la santé (santé, environnement, agriculture, finances, etc.), le gouvernement fédéral devrait montrer la voie à suivre en matière de santé de la population en coordonnant les activités des différents ministères intéressés. Comme le D<sup>r</sup> Losos, nous croyons que le ministre fédéral de la Santé serait le mieux placé pour assurer cette coordination. Dans un premier temps, le gouvernement fédéral devrait évaluer la portée de tous les programmes et politiques existants sur la santé des Canadiens. Il faudrait que des études d'impact sur la santé fassent partie intégrante du processus d'élaboration des politiques et des programmes au gouvernement fédéral.<sup>314</sup>

Idéalement, les ministres de la Santé de tous les ordres de gouvernement au Canada devraient jouer le rôle de « champions de la santé de la population » et faire en sorte que la santé soit la principale considération dans toutes les initiatives, quel que soit le secteur. On aurait alors une véritable politique publique pro-santé au Canada.

Dans un rapport à venir, le Comité présentera ses constatations et ses recommandations sur les avantages et les répercussions de l'instauration de politiques publiques pro-santé au Canada.

---

<sup>314</sup> D<sup>r</sup> Losos, *op. cit.* p. 5.

The Standing Senate Committee on Social Affairs, Science and Technology

Final Report on  
the state of the health care system in Canada

*The Health of Canadians - The Federal Role*  
*Volume Six:*  
*Recommendations for Reform*

*Chair*

The Honourable Michael J. L. Kirby

*Deputy Chair*

The Honourable Marjory LeBreton

OCTOBER 2002



# TABLE OF CONTENTS

---

<b>TABLE OF CONTENTS</b> .....	<b>i</b>
<b>ORDER OF REFERENCE</b> .....	<b>vii</b>
<b>SENATORS</b> .....	<b>viii</b>
<b>LIST OF ABBREVIATIONS</b> .....	<b>ix</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>xi</b>
<b>FOREWORD</b> .....	<b>xiii</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>PART I: ACCOUNTABILITY</b> .....	<b>3</b>
<b>CHAPTER ONE</b> .....	<b>5</b>
THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS.....	5
1.1 Summary of Some Key Points from Volumes One through Five.....	5
1.1.1 <i>The role of the federal government</i> .....	5
1.1.2 <i>Objectives of federal health care policy</i> .....	6
1.1.3 <i>The current system is not fiscally sustainable</i> .....	8
1.1.4 <i>A national health care guarantee is critical to successful reform</i> .....	10
1.2 Improving Governance – The Need for a National Health Care Commissioner .....	11
1.2.1 <i>Canadian Medical Association (CMA)</i> .....	13
1.2.2 <i>Colleen Flood and Sujit Choudry</i> .....	14
1.2.3 <i>Tom Kent</i> .....	15
1.2.4 <i>Duane Adams</i> .....	15
1.2.5 <i>Lawrence Nestman</i> .....	16
1.3 The Committee’s Proposal.....	17
<b>PART II: EFFICIENCY MEASURES</b> .....	<b>23</b>
<b>CHAPTER TWO</b> .....	<b>25</b>
HOSPITAL RESTRUCTURING AND FUNDING IN CANADA .....	25
2.1 Funding Methods for Hospitals in Canada: Advantages and Disadvantages.....	27
2.1.1 <i>Line-by-line</i> .....	28
2.1.2 <i>Ministerial discretion</i> .....	29
2.1.3 <i>Population-based</i> .....	29
2.1.4 <i>Global budget</i> .....	30
2.1.5 <i>Policy-based</i> .....	31
2.1.6 <i>Facility-based</i> .....	32

2.1.7	<i>Project-based</i> .....	32
2.1.8	<i>Service-based</i> .....	32
2.2	<b>Service-Based Funding: Review of International Experience</b> .....	33
2.2.1	<i>United States</i> .....	33
2.2.2	<i>United Kingdom</i> .....	34
2.2.3	<i>France</i> .....	34
2.2.4	<i>Denmark</i> .....	35
2.2.5	<i>Norway</i> .....	35
2.2.6	<i>Review of international experience by the Comité Bédard</i> .....	36
2.3	<b>The Rationale for Service-Based Funding in Canada</b> .....	36
2.3.1	<i>Appropriateness of service mix</i> .....	40
2.3.2	<i>Over-servicing and up-coding</i> .....	40
2.3.3	<i>Rates, information and data</i> .....	41
2.3.4	<i>Innovation</i> .....	42
2.3.5	<i>Comprehensive health care</i> .....	43
2.3.6	<i>Escalation of costs</i> .....	43
2.3.7	<i>Lack of simplicity</i> .....	43
2.3.8	<i>Committee commentary</i> .....	44
2.4	<b>Academic Health Sciences Centres and the Complexity of Teaching Hospitals</b> .....	46
2.5	<b>Small and Rural Community Hospitals</b> .....	48
2.6	<b>Financing the Capital Needs of Canadian Hospitals</b> .....	50
2.7	<b>Public Versus Private Health Care Institutions</b> .....	53
	<b>Appendix 2.1 Academic Health Sciences Centres in Canada and their Affiliated Hospitals and Regional Health Authorities</b> .....	59

## **CHAPTER THREE ..... 63**

	<b>DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES</b> .....	63
3.1	<i>RHAs Across Canada: A Portrait</i> .....	64
3.2	<i>RHAs: Goals and Achievements</i> .....	66
3.3	<i>Barriers that Prevent RHAs from Functioning to Their Fullest Potential</i> .....	67
3.4	<i>RHAs and the Potential for Internal Markets</i> .....	70
3.5	<i>Committee Commentary</i> .....	74

## **CHAPTER FOUR..... 77**

	<b>PRIMARY HEALTH CARE REFORM</b> .....	77
4.1	<i>Why is Primary Health Care Reform Needed?</i> .....	77
4.2	<i>The Provinces and Primary Care Reform</i> .....	80
4.2.1	<i>Recent reports</i> .....	80
4.2.2	<i>The Ontario Family Health Network</i> .....	81
4.2.3	<i>Quebec</i> .....	85
4.2.4	<i>New Brunswick</i> .....	85
4.3	<i>Overcoming the Barriers to Change</i> .....	86
4.4	<i>The Federal Role</i> .....	90
	<b>Appendix 4.1: GP Fundholding in Great Britain</b> .....	93

**PART III: THE HEALTH CARE GUARANTEE ..... 97**

**CHAPTER FIVE ..... 99**

TIMELY ACCESS TO HEALTH CARE..... 99

5.1 The Right to Health Care – Public Perception or Legal Right?..... 100

5.2 The Extent to which Publicly Insured Health Services are Available Outside the Publicly Funded Health Care System..... 101

5.3 Timely Health Care and Section 7 of the Canadian Charter of Rights and Freedoms..... 102

5.4 Committee Commentary ..... 108

**CHAPTER SIX.....109**

THE HEALTH CARE GUARANTEE..... 109

6.1 The Public Perception of the Problem of Waiting Lists..... 109

6.2 The Reality of the Waiting List Problem..... 110

6.3 Canadian Experience ..... 111

6.3.1 *Cardiac Care Network of Ontario*..... 111

6.3.2 *The Western Canada Waiting List Project*..... 111

6.4 International Experience..... 113

6.4.1 *Sweden*..... 113

6.4.2 *Denmark*..... 114

6.5 Committee Recommendations..... 116

6.6 The Potential Consequences of Not Implementing a Health Care Guarantee ..... 119

6.7 Concluding Thoughts on the Health Care Guarantee..... 120

**PART IV: CLOSING THE GAPS IN THE SAFETY NET..... 123**

**CHAPTER SEVEN .....125**

EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS..... 125

7.1 Trends in Drug Spending ..... 126

7.2 International Comparisons..... 128

7.3 Coverage for Prescription Drugs in Canada..... 130

7.3.1 *Public prescription drug insurance plans*..... 130

7.3.2 *Private prescription drug insurance plans*..... 131

7.3.3 *Plan features and their relation to protection from severe drug expenses* ..... 132

7.4 An Emerging Issue: Catastrophic Prescription Drug Expenses..... 132

7.5 Protecting Canadians Against Catastrophic Prescription Drug Expenses..... 137

7.5.1 *How the plan would work*..... 138

7.5.2 *The benefits of the plan*..... 140

7.5.3 *How much would the plan cost?*..... 141

7.5.4 *Committee's Proposal for a Catastrophic Prescription Drug Insurance Plan*..... 142

7.6 The Need for a National Drug Formulary..... 143

**CHAPTER EIGHT .....145**

EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE ..... 145

8.1 Brief Review of Key Points about Home Care from Volumes Two and Four..... 145

8.2 Other Options ..... 147

8.3	The Extra-Mural Program in New Brunswick.....	148
8.3.1	<i>Building on the New Brunswick example: direct referrals to home care.....</i>	<i>150</i>
8.4	Organizing and Delivering Post-Acute Home Care.....	151
8.4.1	<i>Definition of post-acute home care.....</i>	<i>151</i>
8.4.1.1	<i>When does Post-Acute Home Care (PAHC) servicing start?.....</i>	<i>151</i>
8.4.1.2	<i>When does PAHC servicing end?.....</i>	<i>152</i>
8.4.2	<i>Organizational arrangements for PAHC.....</i>	<i>153</i>
8.4.3	<i>Who provides PAHC?.....</i>	<i>155</i>
8.5	The Cost of a National Post-Acute Home Care Program.....	156
8.5.1	<i>How to calculate the cost of a national PAHC program.....</i>	<i>156</i>
8.5.2	<i>What about hidden costs?.....</i>	<i>157</i>
8.5.3	<i>How much will a national PAHC program cost?.....</i>	<i>158</i>
8.6	Paying for Post-Hospital Home Care.....	158
<b>CHAPTER NINE.....</b>		<b>163</b>
EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE.....		163
9.1	The Need for a National Palliative Home Care Program.....	163
9.2	Financial Assistance to Caregivers Providing Palliative Care at Home.....	164
9.3	Caregiver Tax Credit.....	166
9.4	Job Protection.....	167
9.5	Concluding Remarks.....	167
<b>PART V: EXPANDING CAPACITY AND BUILDING INFRASTRUCTURE .....</b>		<b>169</b>
<b>CHAPTER TEN.....</b>		<b>171</b>
THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE.....		171
10.1	Health Care Technology.....	171
10.2	Electronic Health Records.....	175
10.3	Evaluation of Quality, Performance and Outcomes.....	177
10.4	Protection of Personal Health Information.....	179
<b>CHAPTER ELEVEN.....</b>		<b>185</b>
HEALTH CARE HUMAN RESOURCES.....		185
11.1	The Extent of Health Human Resource Shortages.....	185
11.2	Health Human Resources: The Need for a National Strategy.....	188
11.3	Increasing the Number of Physicians Trained in Canada.....	191
11.4	Integrating International Medical Graduates.....	193
11.5	Alleviating the Shortage of Nurses.....	194
11.6	Allied Health Professionals.....	197
11.7	Funding Post-Graduate Training.....	198
11.8	Health Human Resources: Scope of Practice Rules Review.....	198
11.9	Committee Commentary.....	199
<b>CHAPTER TWELVE.....</b>		<b>201</b>
NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH.....		201
12.1	Assuming Leadership in Canadian Health Research.....	202
12.2	Engaging the Scientific Revolution.....	205
12.3	Securing a Predictable Environment for Health Research.....	208
12.3.1	<i>Federal funding for health research.....</i>	<i>209</i>



12.3.2	<i>Federal in-house health research</i> .....	212
12.4	Enhancing Quality in Health Services and in Health Care Delivery.....	213
12.5	Improving the Health Status of Vulnerable Populations.....	215
12.6	Commercializing the Outcomes of Health Research.....	217
12.7	Applying the Highest Standards of Ethics to Health Research.....	221
12.7.1	<i>Research involving human subjects</i> .....	222
12.7.2	<i>Issues with respect to research involving human subjects</i> .....	224
12.7.3	<i>Animals in research</i> .....	227
12.7.4	<i>Privacy of personal health information</i> .....	229
12.7.5	<i>Genetic privacy</i> .....	234
12.7.6	<i>Potential situations of conflict of interest</i> .....	235

**PART VI: HEALTH PROMOTION AND DISEASE PREVENTION..... 237**

**CHAPTER THIRTEEN..... 239**

	HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE.....	239
13.1	Trends in Diseases.....	242
13.1.1	<i>Infectious diseases</i> .....	243
13.1.2	<i>Chronic diseases</i> .....	243
13.1.3	<i>Injury</i> .....	244
13.1.4	<i>Mental health</i> .....	244
13.2	The Economic Burden of Illness.....	245
13.3	The Need for a National Chronic Disease Prevention Strategy.....	246
13.4	Strengthening Public Health and Health Promotion.....	249
13.5	Toward Healthy Public Policy: The Need for Population Health Strategies.....	250

**PART VII: FINANCING REFORM..... 253**

**CHAPTER FOURTEEN..... 255**

	HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED.....	255
14.1	More Money Is Needed for Health Care.....	256
14.2	The Financing Role of the Federal Government.....	260
14.3	How New Federal Funding for Health Care Should Be Managed.....	262

**CHAPTER FIFTEEN..... 265**

	HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED.....	265
15.1	The Amount of Increased Federal Funding Required.....	267
15.2	Potential Sources of Increased Federal Funding.....	270
15.3	General Taxation.....	271
15.4	Earmarked Taxation.....	275
15.5	Payroll Taxes.....	278
15.6	National Health Care Premiums.....	280
15.7	User Charges.....	282
15.8	Medical Savings Accounts.....	284
15.9	Pre-Funding for Health Care.....	285
15.10	Committee Commentary.....	286
15.11	Current Federal Funding for Health Care.....	291

<b>CHAPTER SIXTEEN .....</b>	<b>295</b>
THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE .....	295
16.1 Private Health Care Insurance in Canada and Selected OECD Countries.....	297
16.2 Review of Recent Literature on the Impact of Private Health Care Insurance and Private For-Profit Delivery.....	299
16.3 Committee Commentary .....	302
 <b>PART VIII: THE CANADA HEALTH ACT.....</b>	 <b>305</b>
 <b>CHAPTER SEVENTEEN .....</b>	 <b>307</b>
THE CANADA HEALTH ACT.....	307
17.1 Universality.....	308
17.2 Comprehensiveness.....	309
17.3 Accessibility .....	313
17.4 Portability .....	315
17.5 Public Administration.....	316
17.6 Committee Commentary .....	319
 <b>CONCLUSION.....</b>	 <b>321</b>
 <b>APPENDIX A .....</b>	 <b>A-1</b>
LIST OF RECOMMENDATIONS BY CHAPTER.....	A-1
 <b>APPENDIX B.....</b>	 <b>A-19</b>
LIST OF PRINCIPLES FROM VOLUME FIVE (APRIL 2002).....	A-19
 <b>APPENDIX C.....</b>	 <b>A-23</b>
LIST OF WITNESSES.....	A-23

# **Part VII: Financing Reform**

---



## CHAPTER FOURTEEN

### HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED

---

In Volume Five, the Committee stressed its conclusion that, as currently structured, Canada's publicly funded health care system is not fiscally sustainable.<sup>315</sup> Accordingly, there is a need to undertake major reform in the way physician and hospital services are funded in order to preserve and enhance the publicly funded health care system, a system to which Canadians are committed and that has served them so well over the last few decades.

In Volume Five, the Committee stated its view that a *fiscally sustainable health care system* is one upon which Canadians can rely both today and in the future. When considering the system's fiscal sustainability, two interrelated constraints must be taken into account. The first is the willingness of taxpayers to pay for the system. The second is the need for continued economic growth and the corresponding need for governments to keep tax rates at levels that do not diminish Canada's ability to generate investment, create jobs and keep Canada competitive with other OECD countries, and particularly with the United States.<sup>316</sup>

***It is the view of the Committee that a fiscally sustainable health care system is one upon which Canadians can rely both today and in the future. When considering the system's fiscal sustainability, two interrelated constraints must be taken into account. The first is the willingness of taxpayers to pay for the system. The second is the need for continued economic growth and the corresponding need for governments to keep tax rates at levels that do not damage Canada's ability to invest, create jobs and keep us relatively competitive with other OECD countries, and particularly with the United States.***

To address the question about the fiscal sustainability of the publicly funded health care system, the Committee examined, in its Volume Five, current and projected trends in health care spending.<sup>317</sup> We documented the continuing upward pressures on health care costs due to the rapidly rising costs of drugs and new technology, Canada's aging population, the high and increasing cost of health care human resources and growing public expectations. Based on this information and numerous studies and reports on the increasing costs of health care in Canada, the Committee concluded that Canada's publicly funded health care system, as it is currently operated, is *not* fiscally sustainable given current funding levels.

This chapter examines the implications of this conclusion. Section 14.1 summarizes the multidimensional pressures that, in the view of the Committee, will put considerable additional strain on governments' budgets for health care both in the short and in

---

<sup>315</sup> Volume Five, p. 7.

<sup>316</sup> *Ibid.*

<sup>317</sup> Volume Five, pp. 7-9.

the long term, and that led us to conclude that more money is needed to sustain the publicly funded health care system and particularly to effect changes to improve its effectiveness and efficiency. Section 14.2 provides the Committee's view on the financing role of the federal government in sustaining a national health care insurance system. Section 14.3 describes a new management system that the Committee believes strongly should be applied to new federal funding for health care.

### 14.1 More Money Is Needed for Health Care

In Volume Five<sup>318</sup>, the Committee examined current and projected trends in health care spending. They are summarized, once again, below.

Data from the Canadian Institute for Health Information (CIHI) show that health care spending in Canada topped \$95 billion in 2000, an increase of 6.9% over the previous year. After adjusting for inflation and population growth, there was a real increase in spending of 4.1% between 1999 and 2000.

Data show also that the pace of growth in health care spending is increasing. In fact, real spending per capita is rising faster today than at any time since the 1980s. There are real, continuing upward pressures on Canada's health care costs:

- **Drug Costs:** The cost of drugs currently accounts for over 15% of total (public and private) health care spending. It is forecast to have climbed to \$14.7 billion in 2000, up 9% from the year before. The Committee noted in Volume Two that, between 1990 and 2000, drug spending per capita increased by almost 93%, more than twice the average increase for health care spending in total (40%).<sup>319</sup> New, effective, but very costly, drugs are expected to enter the Canadian market in the next decade (vaccine against AIDS, new immunological cure for juvenile diabetes, etc.), further exacerbating upward pressures on overall drug costs.
- **New Technology:** Canada needs to invest more in health care technology and health information systems. The Committee's Volume Two indicated that every \$1-billion capital investment in new medical equipment requires an additional \$700 million to cover related operating and maintenance costs.<sup>320</sup> In fact, an estimated \$2.5 billion in capital is required to bring Canada's investment in health care technology to a level equivalent to that of other OECD countries (see Chapter Ten). Similarly, estimates suggest that between \$6 and \$10 billion (over a six- to eight-year period) is required to achieve full implementation of a Canadian health info-structure, or between \$1 to \$1.25 billion annually (see Chapter Ten).
- **Ageing Population:** In 1998, 12% of Canadians were 65 or older. That year, more than 43% of provincial and territorial government spending on health care went to services for seniors. According to Statistics Canada, by 2010

---

<sup>318</sup> Volume Five, pp. 6-12.

<sup>319</sup> Volume Two, p. 20.

<sup>320</sup> Volume Two, p. 41 and p. 114.

seniors will represent 14.6% of the population, a percentage that rises to 23.6% as the peak of the baby boom generation enters retirement by 2031. Expensive procedures, rarely if ever previously performed on elderly patients, are increasingly available to them.<sup>321</sup> Estimates suggest that the impact of population aging will account for an additional 1% of total health care costs each year. Although this percentage appears to be quite small in the larger scheme of things, in dollar terms it amounts to approximately \$1 billion annually in increased health care costs, continuing for decades.

- **Cost of Health Care Human Resources:** Labour costs account for about 75% of spending on health care. According to the report of Premier's Advisory Council on Health in Alberta (the Mazankowski report), in 2001-02 over half the budget increase for health care went to salary increases in that province. This trend is likely to be maintained throughout Canada.
- **Health Research:** Unprecedented support for health research will lead to the development of many new technologies and drugs. This year, some US\$40 billion will be spent on health research in the G7 countries, leading to effective, but costly, technologies in the fields of genomics, proteomics, nanotechnology, etc.
- **Growing Public Expectations:** Many observers have noted that increasing public demand for physician and hospital services will have a major impact on future costs. In his interim report, Roy Romanow puts this point very well: "One of the most significant cost drivers is how our own expectations have grown over the past few decades. We expect the best in terms of technology, treatments, facilities, research and drugs, and as a consequence, we may be placing demands on our governments that are not sustainable over time."<sup>322</sup> Canadians are more like North Americans than Europeans when it comes to public expectations. More precisely, 64% of Canadians are very interested in new medical discoveries, compared to 66% of Americans and 44% of Europeans.
- **Health Care Restructuring:** Restructuring, renewing and reforming health care will cost a considerable amount of money. For example, it has been estimated that establishing primary health care teams in Quebec would cost, on average, \$750,000 per team (see Chapter Four).
- **Gaps in the Health Care Safety Net** As pointed out in Chapters Seven, Eight and Nine of this report, currently there are serious gaps in our health care safety net, particularly with respect to prescription drugs, home care and palliative care. Expanding public coverage to reduce or close these gaps in insurance coverage will require additional government funding.

---

<sup>321</sup> For example, cardiac procedures (e.g. PTCA) performed on the elderly are increasing by 12% annually; joint surgery (e.g. knee replacement) is increasing at an annual rate of 8%; renal dialysis is increasing by 14% a year (at a cost of \$50,000 annually per patient).

<sup>322</sup> Commission on the Future of Health Care in Canada (Roy J. Romanow Commissioner), *Shape the Future of Health Care, Interim Report*, February 2002, p. 25.

The Committee was told that even conservative projections of future health care costs estimate that those costs will increase by at least one percentage point over the increase in GDP for the indefinite future. Given the publicly funded nature of Canada's health care system, these cost pressures will put considerable strain on governments' budgets, both in the short and in the long term. This has been well documented by provincial and territorial ministers of health in their 2000 report of cost drivers as well as by many reports tabled with the Committee.

For example, a report prepared for the Ontario Hospital Association estimated that close to 38% of total provincial program spending went to health care in 2000-2001, up from 33% in 1992-1993.<sup>323</sup> For its part, the Canadian Taxpayers Federation projected that this proportion will hit 50% as early as 2007 in British Columbia and New Brunswick.<sup>324</sup> Similarly, the Conference Board of Canada estimated that over the period 2000-2020, public per capita spending on health care (adjusted for inflation) will increase by 58%, compared to an increase of only 17% in public per capita spending on all other government services and programs.<sup>325</sup>

This increase in the percentage of government spending devoted to health care provides the clearest indication of the financial pressures felt by governments charged with funding health care. A wide range of witnesses, including health care managers, providers and consumers, expressed deep concerns about rising health care costs and their impact on governments' budgets, both in terms of crowding out other government programs such as education and social services, and imperilling the governments' overall fiscal stability. This testimony and many related reports have persuaded the Committee that, in addition to other necessary reforms, it is essential to invest additional money into Canada's health care system in order to renew and sustain it.

In contrast, a recent report by University of Waterloo Professor Gerard Boychuk contended that there is no fiscal crisis in health care.<sup>326</sup> In his view, there is no fiscal crisis in the sense that Canada's spending on health care has remained relatively constant when taken as a percentage of GDP or as a percentage of overall government revenues. This analysis, however, is presented with a number of caveats. First, it does not consider the projections in health care costs that clearly indicate that health care spending will increase at a rate higher than the growth in either GDP or government revenue. Second, Professor Boychuk recognized the fact that health care is crowding out the provision of other public goods, but considered this as a serious problem only from the provincial perspective, not from the national perspective. This argument avoids the fact that although there are two levels of government involved in funding health care, there is only one set of taxpayers who, no matter where they live, must bear the burden of increasing health care costs. Third, Professor Boychuk argued that the federal government took advantage of the switch from the Established Programs Financing (EPF) to the CHST to reduce its share of health care spending. In his view, publicly funded health care is no longer affordable from a provincial perspective as a result of reduced federal transfers. The logical conclusion to

---

<sup>323</sup> TEAQ Associates, *Getting the Right Balance: A Review of Federal-Provincial Fiscal Relations and the Funding of Public Services*, prepared for the Ontario Hospital Association, December 2001, p. 21.

<sup>324</sup> Walter Robinson, *The Patient, The Condition, The Treatment – A CTF Research and Position Paper on Health Care*, Canadian Taxpayers Federation, September 2001, p. 59.

<sup>325</sup> Glenn G. Brimacombe, Pedro Antunes and Jane McIntyre, *The Future Cost of Health Care in Canada, 2000 to 2020 – Balancing Affordability and Sustainability*, The Conference Board of Canada, 2001, p. 21.

<sup>326</sup> Gerard Boychuk, *The Changing Political and Economic Environment of Health Care in Canada*, Discussion Paper, Commission on the Future of Health Care in Canada, July 2002.



this argument would seem, therefore, to be that the federal government should provide more money for health care.

The Committee does not support Professor Boychuk's view that the source of the sustainability crisis is political rather than fiscal. We received overwhelming evidence to support our conclusion that the publicly funded health care system is not fiscally sustainable given current funding levels and that, consequently, more money is needed to restructure and renew Medicare and to close the gaps in the existing health care safety net.

Some individuals and organizations disagree with this conclusion. They claim that operating the health care system more efficiently would save enough money so that no new sources of funding would be required. The Committee has always acknowledged the critical importance of improving effectiveness and efficiency in the management and delivery of health services. In fact, the restructuring recommendations outlined in Chapters Two, Three, Four, Six, Ten and Eleven are designed to achieve this objective.

The Committee does not believe that there is sufficient evidence to support the hypothesis that efficiency gains alone will be enough to obviate the need for additional funding. Jack Davis, CEO of Calgary Regional Health Authority and former secretary to the Cabinet in the Government of Alberta echoed this view when he stated:

*The belief that some magical efficiency will come along that will generate productivity levels in our health care system that are beyond anything that exists anywhere on this planet is naive and unrealistic.<sup>327</sup>*

Canada's publicly funded health care system must be restructured and made much more effective and efficient. But the Committee believes, as it has stated previously, that responsible planning of public policy must include additional funding for health care, including funding the cost of restructuring the system.

Given the federal government's role in the financing of health care, the Committee believes strongly that the government has a critical role to play in sustaining and renewing health care in Canada. We acknowledge, however, that, given all the competing demands for federal government expenditures (e.g., agriculture, the armed forces, the environment, urban infrastructure and so on), any additional funding from federal sources will have to come from *new* money, not from revenue transferred into the health care envelope from existing sources.

***The Committee wishes to stress that, given all the competing demands for federal government expenditures (e.g. agriculture, the armed forces, the environment, urban infrastructure and so on), any additional funding from federal sources will have to come from new money, not from revenue transferred into the health care envelope from existing sources.***

---

<sup>327</sup> Jack Davis (53:59).

We turn, therefore, to confront the most difficult health care issue facing policy makers and indeed all Canadians: how should additional funds for health care be raised? Should these new revenues come from increases in existing taxes, or from new forms of taxation or other levies? Should they come from individuals and/or businesses and flow to government by way of taxes or health care insurance premiums or should they come directly from individuals and/or businesses directly into health care? Jack Mintz, President and CEO of the CD Howe Institute, raised this question eloquently:

*Governments will need more revenues because of the rising public share of health care costs over time. Therefore, we must think carefully about how we want to fund the public provision of health care. What is the appropriate way of financing that? This is an important question that Canadians should be asking themselves, because that will be an increasing burden for Canadians as a whole.*<sup>328</sup>

Furthermore, in considering how such additional funding ought to be raised, we must keep in mind that Canada's personal taxes are the highest of the G7 countries and among the highest in the OECD. The Committee believes therefore that Canadians must balance their desire for publicly funded health services against both their willingness to pay taxes to fund them publicly and the need for Canadian tax levels to be set so as to maintain our ability to invest and create new jobs, keeping us competitive with other OECD countries, particularly the United States. The Committee's recommendations on how to raise additional federal funding for health care are presented in Chapter Fifteen.

## **14.2 The Financing Role of the Federal Government**

Many witnesses emphasized the fact that historically the federal government has played a major role in financing publicly insured health services. Moreover, public opinion surveys show repeatedly that Canadians want and expect the federal government to continue to be a major player in Canada's publicly funded health care system.

The Committee believes that, to preserve the spirit of the Medicare program that it pioneered several decades ago, the federal government must play a major role in meeting the serious challenges now facing our publicly funded health care system. We reiterate Principle Three from Volume Five: "The federal government should play a major role in sustaining a national health care insurance system."<sup>329</sup>

***The Committee believes that the federal government, through its financing role, can facilitate, encourage and accommodate the provinces and territories in their efforts to restructure, reconfigure and renew their health care systems.***

The Committee believes that the federal government, through its financing role, can facilitate, encourage and accommodate the provinces and territories in their efforts to restructure, reconfigure and renew their health care systems. The Committee is convinced that

---

<sup>328</sup> Jack Mintz (62:5).

<sup>329</sup> Volume Five, p. 29.

the vast majority of Canadians are looking to the federal government to collaborate with, support and form partnerships with the provinces/territories and health care providers to effect needed changes in the health care system. In fact, as discussed in Volume Five, there are many reasons why the federal government's role is important<sup>330</sup>.

First, Canadians strongly support national principles in health care, and they look to the federal government to play a strong role in setting and maintaining them and to ensure their application throughout the country. As it now stands, the federal government's ability to participate in the development and application of nationwide standards and to recommend appropriate policies to provincial and territorial governments depends in large part on the size of its financial contribution.

Second, and some would say most important, only the federal government is in a position to make sure that all provinces and territories, regardless of the size of their economies, have at their disposal the financial resources to meet the health care needs of their citizens. This redistributive role of the federal government is fundamental to what many call "the Canadian way." From this perspective, Sharon Sholzberg-Gray, President and CEO, Canadian Healthcare Association, stated:

*(...) we would like to add leadership as an additional role for the federal government. After all, the federal government is the only level of government that can ensure access for Canadians to comparable services, wherever they live in this country. No one provincial or territorial government can ensure that. Only the federal government can do that, and it should take leadership in this area.*<sup>331</sup>

Third, federal funding for health care is particularly critical to reform and renewal of health care; making changes in the way the health care system is structured and operates will surely result in the requirement of more rather than less money, at least in the short term.

Fourth, interprovincial harmonization with respect to what services are insured and scope of practice rules is an important element of a truly national system. The federal government has an key role in facilitating such harmonization (such as, for example, using financial means to help provincial or territorial governments to meet national standards).

***The Committee believes strongly that the money that the federal government transfers to the provinces/territories for the purpose of health care should provide it a seat at the table when the restructuring of the health care system is discussed. In our view, the federal government should not give money without having a say on how that money is spent.***

Fifth, the Committee believes strongly that the money that the federal government transfers to the provinces/territories for the purpose of health care should provide it a seat at the table when the restructuring of the health care system is discussed. In our view, the federal government should not give money without having a say on how that money is

---

<sup>330</sup> Volume Five, pp. 12-14.

<sup>331</sup> Sharon Sholzberg-Gray (49:11).

spent. Canadians rightly expect that, when decisions are made about how their tax dollars are to be spent, the government to which they pay those taxes should be represented.

Finally, the Committee is also convinced that there must be stability of, and predictability in, federal funding for public health care insurance. No industry can be expected to operate effectively if, from year to year, its revenue is subject to significant fluctuations over which it has no control. In fact, effective planning, an essential element of an efficiently operated industry, is impossible unless stability and predictability of funding are assured. In other words, multi-year funding is essential if the publicly funded health care system is to be run effectively and efficiently.

### **14.3 How New Federal Funding for Health Care Should Be Managed**

Before turning to the Committee's recommendations with respect to how new additional federal funds for health care should be raised (see Chapter Fifteen), we first address the issue of how such new federal revenue should be managed. The Committee believes that Canadians will 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. This requires that the allocation of any new money that Canadians pay to the federal government for health care be subject to a process that is transparent and by which the government can be held accountable by taxpayers.

The Committee believes strongly that new federal funding for health care should be managed according to four distinct but inter-related parameters:

First, increased federal revenue for health care must go into an *earmarked fund* that is separate and distinct from the Consolidated Revenue Fund. We believe Canadians will not agree to pay increased health care contributions to the federal government unless they are assured that the money will be spent on health care, and that the money is truly incremental to the federal government's existing commitment to health care spending. This has been confirmed by a recent survey by Pollara,<sup>332</sup> which indicated that 75% of Canadians would be willing to pay more taxes if such revenue were directed to health care, and not flow into general revenue. Thus, it appears that, for Canadians, health care is unique, different from other publicly funded goods and services: earmarking funds for health care would ensure that public funding remains less susceptible to the vagaries of political decisions with respect to the allocation of government's financial resources.

***The Committee believes that increased federal revenue for health care must go into an earmarked fund that is separate and distinct from the Consolidated Revenue Fund.***

Second, increased federal revenue for health care must be *targeted*. The Committee is convinced that new federal funding must be used for the purposes outlined in this report, particularly those that would

***The Committee strongly believes that new federal money given to the provinces and territories must buy change or reform; additional money should not be used to fund the publicly funded health care system as it is presently structured.***

<sup>332</sup> Pollara, *Health Care in Canada Survey 2002*, June 2002.

expand public health care coverage (as described in Chapters Seven, Eight and Nine) and those that will improve the effectiveness and efficiency of the health care delivery system (such as service-based funding for hospitals, primary health care reform, health care technology, electronic health records, health research and evaluation, and so on). In other words, new federal money given to the provinces and territories must buy change or reform; new money should not be used to fund the operation of the publicly funded health care system as it is presently structured.

Third, and as a corollary to the second point, the Committee is strongly opposed to increased federal funding for health care being given to the provinces and territories under the mechanism of the Canada Health and Social Transfer (CHST). CHST transfers cannot be targeted for specific purposes, nor can the provinces and territories be held accountable for how the money is spent. Similarly, the Committee is equally strongly opposed to the transfer of additional tax points to the provinces and territories. In the first place, the transfer of tax points has a very unequal impact on different provinces. Second, once the tax points have been transferred, the federal government has no authority over how the resulting revenue is spent.

***The Committee is strongly opposed to increased federal funding for health care being given to the provinces and territories under the mechanism of the Canada Health and Social Transfer (CHST).***

Fourth, the Committee is convinced that the federal government should be advised annually on how the money in the earmarked fund should be spent. This advice should be given in the annual report produced by the National Health Care Council, as recommended in Chapter One. The advice given to the government should be made public to ensure transparency and accountability.

***The Committee is convinced that the federal government should be advised annually by the National Health Care Council on the priorities that should be attached to expenditures out of the earmarked fund.***

And fifth, it is imperative that all governments be made accountable for how additional federal funding for health care is spent. It is the view of the Committee that Canadians must be able to see that the money is being spent for its targeted purposes. Accordingly, both levels of government – federal and provincial/territorial governments – must therefore *share accountability*.

***It is the view of the Committee that, from a federal perspective, an annual audit by the Auditor General of Canada of the earmarked fund should detail how the money in the fund has been spent; the results of the audit should be made public.***

***Similarly, provincial and territorial governments should be required to report annually to Parliament and the Canadian public on their utilization of earmarked health care funds provided by the federal government.***

From a federal perspective, an annual audit by the Auditor General of Canada of the earmarked fund should specify how the money in the fund has been spent; the results of the audit should be made public. From a provincial/territorial perspective, their use of earmarked federal funds must be

coupled with a requirement for transparent accountability to show the public that the funds have indeed been spent for the specific health care purposes to which they were targeted. In order to do so, provincial and territorial governments should be required to report annually to the Canadian public on their utilization of earmarked health care funds provided by the federal government.

Therefore, the Committee recommends that:

**The federal government establish an Earmarked Fund for Health Care that is distinct and separate from the Consolidated Revenue Fund. The Earmarked Fund will contain the additional revenue raised by the federal government for investment in health care.**

**Money from the Earmarked Fund for Health Care be used solely for the purpose of health care. Moreover, such money must be used to buy change or reform: it must be utilized exclusively for expanding public health care coverage and for restructuring and renewal of the publicly funded hospital and doctor system.**

**The National Health Care Council be charged with the mandate of advising the federal government on how the money in the Earmarked Fund for Health Care should be spent. The Council's advice to the government should be made public through an annual report.**

**The federal government subject the Earmarked Fund for Health Care to an annual audit by the Auditor General of Canada. The result of such an audit should be made public.**

**The federal government 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.**

If Canadians are indeed willing (as we believe they are) to strengthen the investment by their federal government in health care, and if federal and provincial/territorial governments are willing to collaborate in restructuring and expanding Medicare, then the Committee believes Canada's publicly funded health care system can be made not only fiscally sustainable, but also capable of entering a new era based on its increased efficiency, quality, timeliness, transparency and accountability.

## CHAPTER FIFTEEN

### HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED <sup>333</sup>

---

As stated in Chapter One of Volume Five as well as earlier in this report, the Committee has received sufficient evidence, based on both the testimony of witnesses and various reports, to conclude that Canada's publicly funded health care system is not fiscally sustainable. It is, therefore, imperative to invest additional money into our health care system in order to renew and sustain it.

Additional funding for health care can come only from the people of Canada, either through the public purse or privately. As shown in Table 15.1, *public funding* can be drawn from general taxation (the primary form of health care financing in Canada, Australia and the United Kingdom) or from dedicated payroll taxes paid by employers and employees and based on labour earnings (as in Germany and the Netherlands). Public funding may also involve public health care insurance premiums (as in Alberta and British Columbia) or an earmarked health care tax (as in Australia). Finally, public funding for health care could be generated from taxable health care benefits, that is, making publicly funded health care benefits received by an individual subject to income tax.<sup>334</sup>

***In the view of the Committee, it is imperative to invest additional money into our health care system in order to renew and sustain it.***

***Additional funding for health care can only come from the people of Canada, through either the public purse or privately.***

*Private financing* sources discussed at the Committee's hearings 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. In contrast to Canada, user charges for publicly insured health services are required in Australia, Germany, the Netherlands, Sweden and the United Kingdom (amongst other countries). Systems of MSAs are currently in place in Singapore, South Africa and the United States.

---

<sup>333</sup> This chapter is based on the testimony received by the Committee as well as on a thorough review of the literature on this topic. In addition, a paper by Robert D. Brown and Michanne Haynes (July 2002) prepared at the request of the Committee, entitled *Financing Options for Funding and Incremental Increase in Federal Spending on the Health Sector*, provided useful guidance in the writing of this chapter.

<sup>334</sup> We are not aware of any country requiring that health care benefits for publicly insured services be taxable, although a number of proposals of this type have been put forward in Canada.

**TABLE 15.1  
SOURCES OF FUNDING FOR HEALTH CARE**

<b>SECTOR</b>	<b>SOURCE</b>
<b>PUBLIC</b>	<ul style="list-style-type: none"> <li>• General Taxation – which incorporates both direct taxation (personal and corporate income tax) and indirect taxes;</li> <li>• Earmarked Tax– a tax earmarked for a specific purpose, such as taxable health care benefits (whereby the health care costs incurred during a year are added to taxable income);</li> <li>• Payroll Taxes – contributions related to labour earnings and paid by employees and/or employers;</li> <li>• Public Health Care Insurance Premiums – an amount (flat or income-related) paid by everyone for the right to be covered under public health care insurance.</li> </ul>
<b>PRIVATE</b>	<ul style="list-style-type: none"> <li>• User Charges – which correspond to a form of payment made by a patient at the time a publicly funded health service is rendered;</li> <li>• Medical Savings Accounts – health care accounts set up to pay for the health care expenses of an individual or his/her family<sup>(a)(b)</sup>;</li> <li>• Private Health Care Insurance – purchased by individuals or through employers’ sponsored plans..</li> </ul>

(a) Some proposals suggest that MSAs be funded publicly or, as proposed by some in Canada, as a mixture of public and private sources.

(b) There exists also some other plans involving individual responsibility for some costs but not incurred at the point of service.

Source: Economics Division, Parliamentary Research Branch, Library of Parliament; Brown and Haynes (2002).

Private health care insurance could be used to supplement, complement or replace publicly funded health care. In the event that additional money is not invested into health care as the Committee recommends in this report, or that government fails to ensure timely access to needed care, it is likely that there would be great pressure and, as suggested in Chapter Five, probably a legal obligation on government, to let those Canadians who can afford to do so purchase private health care insurance to obtain privately delivered health services.

Private insurance would, however, move away from the single insurer model that the Committee strongly favours, and would lead to a parallel private delivery system. The potential implications for the publicly funded health care system of allowing private health care insurance in Canada are not discussed in this chapter but are reviewed thoroughly in Chapter Sixteen.

***Private insurance would move away from the single insurer model that the Committee strongly favours and would lead to a parallel private delivery system.***



## **15.1 The Amount of Increased Federal Funding Required**

The Committee believes that the federal government must provide additional funding for the reform and renewal of the publicly funded health care system. Based on our calculations, implementation of the recommendations given in Chapters Two through Thirteen, when combined with a significant contingency amount that reflects the considerable uncertainty involved in forecasting future costs in the health care field, will require an additional federal investment of approximately \$5 billion annually (see Table 15.2).

The amount of \$5 billion shown in Table 15.2 is the Committee's estimate of the annual increase in health care costs that would result from expanding public health care insurance to close the gaps in the existing plans (as described in Chapters Seven, Eight and Nine) and from investing in measures to make the current hospital and doctor system more effective and efficient (as described in Chapters Two, Three, Four, Ten, Eleven, Twelve and Thirteen). This amount is *in addition to* the current federal contribution to health care (through the CHST and other programs). It is also in addition to any increase in federal funding that may be required to support the *existing* hospital and doctor system, as a transition measure until the changes recommended in this report can come into full effect.

**TABLE 15.2**  
**ADDITIONAL ANNUAL FEDERAL INVESTMENT NEEDED TO IMPLEMENT**  
**THE RECOMMENDATIONS IN THIS REPORT**

<b>Expansion and Restructuring</b>	<b>Federal Share (in Millions \$)</b>	<b>Additional Information</b>
<b>Expansion of Coverage:</b>		
▪ Post-Hospital Home Care <sup>(b)</sup>	550	Annually
▪ Catastrophic Drugs <sup>(a)</sup>	500	Annually
▪ Palliative Care <sup>(b)</sup>	250	Annually
<b>Improving Efficiency and Effectiveness:</b>		
▪ Health Care Technology (AHSCs) <sup>(c)</sup>	400	\$2 billion over 5 years
▪ Capital Costs (AHSCs) <sup>(c)</sup>	400	\$4 billion over 10 years
▪ Infoway (EHRs) <sup>(c)</sup>	400	\$2 billion over 5 years
▪ Capital Costs (Community Hospitals) <sup>(b)</sup>	150	\$1.5 billion over 10 years
▪ Equipment for Community Hospitals <sup>(b)</sup>	100	\$500 million over 5 years
▪ Primary Health Care Reform <sup>(c)</sup>	50	\$250 million over 5 years
▪ CIHI <sup>(c)</sup>	50	Annually
<b>Promotion and Prevention:</b>		
▪ Health Promotion and Protection <sup>(c)</sup>	200	Annually
▪ Prevention of Chronic Diseases <sup>(c)</sup>	125	Annually
<b>Health Care Human Resources:</b>		
▪ Medical Schools <sup>(c)</sup>	160	Annually
▪ Nursing Schools and Allied Professions <sup>(c)</sup>	130	Annually
▪ AHSCs (Post-Graduate Training) <sup>(c)</sup>	70	Annually
<b>Research, Evaluation and Reporting:</b>		
▪ Research Funded by CIHR <sup>(c)</sup>	440	Annually
▪ Health Care Commissioner <sup>(c)</sup>	15	Annually
▪ National System (CCHSA) <sup>(c)</sup>	10	Annually
Contingency (20%)	1,000	Annually
<b>TOTAL</b>	<b>5,000</b>	<b>Annually</b>

(a) 90% federal funding.

(b) 50/50 federal and provincial/territorial cost-sharing program.

(c) 100% federal funding.

Source: See the previous chapters.

The Committee believes that the total amount of \$5 billion per year in new funding is a realistic sum and an acceptable amount that the federal government, and indeed Canadians through their taxes, ought to be willing to invest in health care on an ongoing basis.

The amounts shown against each purpose in Table 15.2 are estimates. The amount spent for the various purposes listed will vary somewhat from year to year depending on the priority attached to each purpose in any given year. These priorities, and the allocation of funds to each purpose, should be set on an annual basis by the federal government on the advice of the National Health Care Council, as described in Chapters One and Fourteen.

The new federal investment in health care recommended by the Committee *must* be used to support change. It is worthwhile noting that about 30% of the proposed new federal funding will be spent on expanding public health care coverage and on health promotion and disease prevention. About 40% will enhance effectiveness and efficiency of the doctor and hospital system and support increased enrolment in the various health care professions. Some 10% of the proposed expenditures will be invested in health research, outcome evaluation and performance reporting. We have incorporated a 20% annual contingency to provide the necessary flexibility in federal investment.

It is also worth pointing that, out of the \$5 billion in new federal investment, a large proportion is for transitional costs that will decrease as efficiency and effectiveness changes are put in place. Once the 5-year or 10-year period is over, the money used during the transition period will be available for other health care priorities.

The Committee acknowledges that some of its recommendations – particularly with respect to post-hospital home care, palliative care and investment in community hospitals – require cost-sharing with the provinces/territories. In our view, these additional costs will not constitute a significant additional financial burden for provincial/territorial governments under these programs, since the federal 50% investment recommended by the Committee would *replace* money which some of the provinces/territories are now spending in these areas. It is not possible, however, given the limited resources the Committee has at its disposal, to evaluate precisely the extent of these savings to the provinces/territories. Similarly, it is not possible for the Committee to calculate the increased cost to each jurisdiction for the proposed cost-shared programs.

***The Committee acknowledges that some of its recommendations – particularly with respect to post-hospital home care, palliative care and investment in community hospitals – require cost-sharing with the provinces/territories. In our view, these additional costs will not constitute a significant additional financial burden for provincial/territorial governments under these programs, since the federal 50% investment recommended by the Committee would replace money which some of the provinces/territories are now spending in these areas. (...) It is thus fair to say that the Committee's recommendations would generate savings of at least \$1.5 billion for the provinces and territories.***

More important, in some of the Committee's recommendations, the federal money directly replaces funds that the provinces/territories would otherwise have to spend. For example, the proposed new federal funding in the areas of health care technology, hospital capital, primary health care reform and human resources – which amounts to some \$1.5 billion – would entirely substitute for investment that provincial and territorial governments would have to make in order to reform and renew their health care system. It is thus fair to say that the Committee's recommendations would generate savings of *at least* \$1.5 billion for the provinces and territories. This would be in addition to any savings resulting from effectiveness and efficiency gains from our proposed reform, and the Committee expects these savings to be substantial once the changes we recommend are all in place and fully operational.

## 15.2 Potential Sources of Increased Federal Funding

From which source should the new federal investment in health care come? Should the federal government simply increase the rate of one or more of the existing direct and indirect taxes (general taxation)? Or should the government employ new taxation measures linked specifically to the funding of health care, such as an earmarked tax for health care, or make health care benefits taxable as income, or use earmarked payroll taxes or a national health care insurance premium? Should the federal government also consider an increase in private financing for health care through user charges, MSAs or other plans involving individual responsibility for some health care costs?

This chapter examines these questions in detail. It reviews the advantages and disadvantages of the full range of public and private methods of funding an incremental federal contribution to health care, including general taxation, earmarked taxation, taxable health care benefits, payroll taxes, and public health care insurance premiums. It also provides a discussion of user charges, MSAs and the concept of pre-funding health care.

In considering each of the potential federal revenue sources, the Committee evaluates each of them according to the same set of criteria. These criteria are equity, efficiency, intergenerational fairness, stability and visibility:

- *Equity* deals mainly with income redistribution and social justice. It may be defined as the extent to which contributions to the financing of health care insurance are based on ability to pay (income distribution) as well as the extent to which access to such insurance is based on need (social justice).
- *Efficiency* is concerned with the optimal allocation of resources. A system is efficient if it creates minimum distortions and disincentives in the rest of the economy (in terms, for example, of reduced business investment, lower consumption and living standards, damage to the labour market and job creation, deterioration in international competitiveness, and so on). Efficiency can also encompass cost-effectiveness, that is, the extent to which revenue for health care is generated at the lowest possible administrative and compliance cost.
- *Intergenerational fairness* compares the distribution of the cost burden between younger and older people or between workers and retirees.
- *Stability* refers to the degree of predictability of future funding levels.
- *Visibility* denotes the ability of citizens to link their contributions to government spending on health care (at each level of government) to the benefits that they receive.

These criteria have helped the Committee to decide which source(s) of funding appear(s) to be the most appropriate to raise additional federal revenue for health care.

At the outset, the Committee wishes to emphasize that new financing sources must ensure that the health care system will continue to meet the needs of Canadians in a way that will neither overwhelm other requirements for government finance nor give rise to an unacceptable tax burden on citizens or businesses. The additional revenue requirements must

also be structured so as to do the least damage to the economy in terms of job creation and income growth. Moreover, the new revenue sources must make Canadians better aware of the link between the public health care benefits they receive and the taxes that they incur to pay for them.

### **15.3 General Taxation**

Currently, federal funding for health care is derived from general taxation. General taxation is very broad and encompasses both direct and indirect taxes. Direct taxes, which can be levied on individuals, households or corporations, include personal income tax and corporate taxation. Indirect taxes, which are levied on transactions and commodities, include, for example, sales tax, value-added tax and excise taxes.

Currently, none of the direct or indirect taxes that make up federal general taxation offer much visibility or link between the taxes paid and the services received. Indeed, this is the primary reason that many Canadians describe Canada's health care system as being free. The various federal revenues generated through direct and indirect taxation are currently collected into one single fund – the Consolidated Revenue Fund. As a result, there is no direct link between taxation and public health care spending, despite the fact that a substantial part of government revenues are used to pay for health care costs. This contrasts greatly with earmarked taxation (see Section 15.4, below) in which the tax revenue corresponding to the “earmarked” service goes into a designated fund to be used only for that specific purpose.

All forms of direct and indirect taxation have varying implications for equity and efficiency. Direct taxes levied on individuals are frequently progressive: the amount paid rises with income so that high-income people pay proportionately more than low-income people. This leads to a redistribution of income from individuals with higher income to those with less.

Indirect taxes such as sales taxes are usually considered regressive, as the payments are related to consumption of the taxed good or service: high-income people pay proportionately less indirect tax as a percentage of their income (although they pay more in absolute terms). That is, because poorer individuals spend a larger proportion of their income on consumption than richer persons, the burden of a consumption tax falls more heavily on them. However, over a lifetime, consumption is roughly proportional to income over a broad range of earnings; hence, the regressiveness of a consumption tax is not as large as might be initially thought. Further, various offsetting measures, such as the GST Tax Credit, can reduce the regressiveness of a consumption tax.

In his brief to the Committee, Robert Evans, Professor of Health Economics at the University of British Columbia, explained:

*Taxes are described as progressive if an individual's tax liability rises more than proportionately as income rises, such that higher income individuals not only pay more,*

*but pay a larger share of their incomes. Conversely, regressive taxation results in lower income people paying a larger share of their incomes in tax.*<sup>335</sup>

The implication of general taxation on equity therefore depends on both the structure of a country's direct and indirect tax systems and the relative amounts of revenue raised by each form of tax.<sup>336</sup> Studies using OECD data suggest that, in countries in which general taxation funds most health care, the mix of direct and indirect taxes used renders the overall taxation mildly progressive.<sup>337</sup>

In 2000, Canada relied on direct taxes for 57% and indirect taxes for 43% of its total taxation revenue. Data also suggest that the Canadian tax system has become more progressive over the last decade: in 1993, Canada collected 49% of its tax revenues from indirect taxes.<sup>338</sup>

When compared with other OECD countries that use tax financing for health care, Canada is above average in its reliance on the personal income tax.<sup>339</sup> In fact, only Denmark, Australia and New Zealand rely to a greater extent on the personal income tax as a percentage of total tax revenues.<sup>340</sup> In terms of its reliance on the corporate income tax, Canada is again slightly above the average of countries with a health care system funded out of general taxation.<sup>341</sup> Finally, Canada is below the average in its use of consumption or indirect taxes, relative to all taxes.<sup>342</sup> Therefore, it could be said that Canada has one of the more progressive tax systems among OECD countries.

From another perspective, however, the fact that Canada has significantly higher personal income tax rates than the United States means that Canada is less attractive for skilled, high-income workers. The higher personal income tax rates also raise the cost of investment capital in Canada derived from personal savings, and therefore discourage investment, productivity and future growth. Indeed, the Committee was told:

*While a number of factors (higher government debt and social spending) are likely to mean that Canada will continue to have for some time higher personal tax rates than the U.S., it is nevertheless good policy to avoid increasing the spread between US and Canadian rates, and in the long term to reduce these differences. Accordingly, there are major policy reasons for not imposing a significant increase in personal tax rates and widening the personal tax gap with the U.S.*<sup>343</sup>

---

<sup>335</sup> Robert Evans, Brief to the Committee, 3 June 2002, p. 2.

<sup>336</sup> Derek Wanless, *Securing our Future Health: Taking a Long-Term View*, Interim Report, November 2001, p. 51. ([http://www.hm-treasury.gov.uk/Consultations\\_and\\_Legislation/wanless/consult\\_wanless\\_interimrep.cfm](http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_interimrep.cfm)).

<sup>337</sup> Elias Mossialos and Anna Dixon, "Funding Health Care in Europe: Weighing up the Options," Chapter Twelve in *Funding Health Care: Options for Europe*, 2002, pp. 272-300.

<sup>338</sup> According to Statistics Canada's data taken from CANSIM II, Table 380-0022.

<sup>339</sup> Caroline Chapain and François Vaillancourt, "Le financement des services de santé au Québec," in *Le système de santé québécois: Un modèle en transformation*, edited by C. Bégin, 1999, pp. 101-121.

<sup>340</sup> OECD (2000), *Revenue Statistics 1965-1999*, Table 11.

<sup>341</sup> OECD (2000), Table 13.

<sup>342</sup> OECD (2000), Table 27.

<sup>343</sup> Brown and Haynes (2002), p. 13.

Similarly, the Committee heard that it would be difficult and inadvisable to increase corporate income tax to support the incremental costs of increased federal spending on health care. The base for corporate taxation is smaller than the base for personal income tax or a payroll tax, and is also much more variable. Furthermore, increasing corporate tax rates would have a very negative impact on rates of return on capital investments in Canada, and therefore would discourage both investment and job creation. Even existing businesses could be influenced to relocate outside of Canada in response to what would be a very significant increase in tax burdens. Overall, many witnesses argued that the corporate tax is unsuitable for raising additional revenues to finance health care.

The Committee was told that with an increase in the federal personal income tax there would be significant costs to efficiency, measured in terms of labour supply, savings and investment. We were told that a tax on income imposes a “double tax” on savings, since the income out of which savings are made is subject to income tax, and then the returns on the savings are themselves subject to additional tax.

Nevertheless, because financing the health care system by general taxation draws revenue from a wide base, it helps to minimize the distortions taxation creates in the economy. Furthermore, financing health care through general taxation involves low administrative costs.<sup>344</sup>

Under general tax-financed systems, as opposed to those financed by earmarked taxes, decisions about how much should be spent on health care necessarily require trade-offs to be made among other government spending priorities, such as social programs or tax or debt reduction. As a result, funding health care through general taxation means that the allocation to health care is subject to spending negotiations within government. While this provides some element of accountability, it also greatly politicizes the decision-making process.

Another disadvantage of funding health care through general taxation is that it can leave the health care system vulnerable in times of economic slowdown or fiscal constraint. Economic slowdowns result in lower tax revenues and increased pressures to reduce public spending. This, therefore, negatively affects the stability of health care funding. It should be noted, however, that all tax revenues fluctuate with the economy and that general revenues tend to fluctuate less than many specific forms of taxes.

Finally, and perhaps most important, witnesses stressed that direct and indirect taxation do not have the same impact in terms of intergenerational fairness. Personal income tax extracts a greater proportion of government revenues from the younger working population than from retirees. Thus, Canada’s changing demographics, which reflect a rise in the proportion of retirees relative to the working population, would be associated with a decreasing tax base and smaller revenues for any given income tax rate. As a result, the use of direct taxation, particularly personal income tax, to finance the publicly funded health care system could involve significant subsidization of the health care needs of the elderly by the younger working population. In this perspective, Jack Mintz, President and CEO of the C.D. Howe Institute, told the Committee that:

---

<sup>344</sup> Derek Wanless (2001), p. 50.

*In fact, the OECD has estimated that, as the population ages, the tax/GDP ratio in Canada will fall by 1.5 points. This is because elderly people, once they retire, tend to have lower incomes and, therefore, pay less tax than workers. There may be some taxes that would be better if you were going to fund health care expenditures, because the majority of health care expenditures are weighted heavily toward the elderly in the last years of their lives. Therefore, as the population ages and the benefits paid out to the elderly increase, if you have taxes that are particularly falling on working Canadians they will have to bear a bigger responsibility for those benefits.*<sup>345</sup>

In contrast, the Committee was informed that demographic changes have less impact on government revenue generated through indirect taxation, such as a consumption tax. Moreover, consumption taxes may be preferable, on the grounds of economic efficiency, to corporate income tax. David Stewart-Patterson, Senior Vice-President, Policy, Canadian Council of Chief Executives, stressed that point when he stated:

*In considering tax policy, however, we must remember that not all taxes are equal in terms of their economic impact. As the Department of Finance has estimated, an extra dollar of revenue raised through corporate taxes may do nine times as much damage to economic growth as a dollar raised through sales tax. The more Canada chooses to spend on health care through the public system, therefore, the more it will have to shift its tax mix toward a consumption base in order to remain competitive.*<sup>346</sup>

Jack Mintz from the C.D. Howe Institute held similar views:

*(...) consumption taxes have been found to have lower distortionary costs to the economy and they tend to be more efficiently imposed. They are smoother than, for example, income taxes over the life cycle of individuals because working income tends to peak during working lives before falling off in retirement years. At the same time, consumption tends to be lower than income during the years in which people are accumulating savings, and consumption tends to be high in retirement years relative to income as that is when people are drawing down assets to consume during their retirement years. Consumption taxes also tend to be proportional to the consumption of individuals over a life cycle. One could make it progressive by having a tax credit, such as the GST tax credits which provides relief, particularly for lower income Canadians.*<sup>347</sup>

David Kelly, former Deputy Minister of Health in British Columbia, also suggested that consumption taxes generate less distortion in the economy:

---

<sup>345</sup> Jack Mintz (62:6).

<sup>346</sup> David Stewart-Patterson, Brief to the Committee, 17 June 2002, p. 4.

<sup>347</sup> Jack Mintz (62:7).



*If the decision has been taken to increase funding for health care and the question is what should be the revenue source, I would do exactly what the B.C. government did a few months ago when it discovered that it did not have sufficient revenue to cover rising health care costs – it increased the consumption tax.*

*(...) I say that for three reasons. First, it raises revenue quickly. Second, we have to keep our income tax, corporate tax, payroll tax and so on within shooting distance of the Americans, which significantly constraints our policy flexibility. Third, it is a visible tax. It would make consumers fully aware of the implications of health care cost increases. It might bring additional consumer pressure to bear on the cost side of the equation which, from my point of view, would be healthy.<sup>348</sup>*

To sum up, the decision to consider direct versus indirect taxation as a means of increasing federal revenue for the purpose of health care will necessarily require that some trade-off be made between equity, intergenerational fairness and efficiency. The testimony received by the Committee suggests that the objective should be first of all to ensure that any new tax is as efficient as possible so that it causes as little damage to the economy (including job creation and economic growth) as possible, and then subsequently to achieve whatever progressivity is desired in the system through supplementary measures such as low-income tax credits or high-income surtaxes.

#### **15.4 Earmarked Taxation**

Earmarked taxes are taxes from which the revenue is dedicated to a specific use. Earmarked taxes can be either direct or indirect. An earmarked tax for health care has several advantages over general taxation. For example, it may reduce public resistance to paying the tax because it is clearly associated with a use that provides benefits to the public. Establishing genuine linkage between taxation and spending makes the funding of health care more transparent and responsive. Another advantage of earmarking taxation is that it makes people feel more connected to the tax system which, in turn, may increase the pressures on health care providers and institutions to improve quality and access to services. Earmarked revenues may also be more stable since they are less susceptible to the vagaries of political decisions with respect to the allocation of the government's financial resources.

Many witnesses presented strong arguments in favour of earmarked taxes. In the view of these witnesses, earmarking taxes for health care is what Canadians want. For example, Dr. Les Vertesi, Chief of the Department of Emergency Medicine at the Royal Columbian Hospital (Vancouver), told the Committee:

*I believe that the public is prepared to put more money into their public health care system, but not into taxes that go into general revenue. It is a trust issue. The record on governments taxing people and then ensuring that money goes into designated services is not good, or at least certainly the perception is that it is not good. The trust has been*

---

<sup>348</sup> David Kelly (59:40-41).

*broken. People do not want to give money to governments and have it just disappear. They are prepared to do so if they are assured that the money will go into health care, and especially into health care in their local area (...).*<sup>349</sup>

There are, however, a number of disadvantages associated with earmarked taxes. Not all taxes that bear the name or appearance of an earmarked tax are strictly earmarked to an identified use in practice. This is particularly true if the revenue from the earmarked tax is merged together with other tax revenues. This weakens the connection between revenue and expenditure and consequently undermines the population's trust that the tax will be devoted to the named purpose. For a tax to be effectively earmarked, the revenue it generates must go into a specific, dedicated fund, and not into the Consolidated Revenue Fund.

Earmarking taxes also introduces rigidity into the government budgetary process, because expenditure on the program for which the tax is earmarked is determined by the revenue generated and not by policy decisions. Another disadvantage is that the revenue derived from a single earmarked tax can be cyclical and susceptible to variability in periods of economic expansion or slowdown.

Also, separating health care from other areas of public spending might lead to pressure to have other budget items funded separately by earmarked taxes. If this happened in a number of areas it would make it difficult for the government to generate a large enough Consolidated Revenue Fund to be able to pay the cost of necessary but less popular government programs, such as foreign aid. Thus, having a large number of earmarked taxes is simply not workable.

In Volume Four, the Committee presented an option under which the cost of publicly funded health care that an individual receives during a year be treated as a taxable benefit for that year. Thus, the individual would pay income tax on the cost of the health services provided, subject to an annual maximum. This method of taxation would raise additional revenue for health care and promote individual accountability for the use of health care.<sup>350</sup> Under this option, which corresponds to one form of earmarked tax, individuals would be required to add the cost of the health services that they received during the year to their taxable income. Such an option has been advocated in recent years, particularly by Jack Mintz *et al.* (1998),<sup>351</sup> Tom Kent (2000)<sup>352</sup> and most recently by Mintz, Aba, and Goodman (2002).<sup>353</sup>

Under the plan proposed by Mintz, Aba and Goodman, individuals would be charged a tax of 40% of the health care costs they incurred during the year, up to a maximum of 3% of the individual's annual income. Families with an income of less than \$10,000 would be exempt from paying tax on any service they received through the publicly funded health care system. Under this scheme, the more an individual used the services of the health care system,

---

<sup>349</sup> Dr. Les Vertesi (53:62).

<sup>350</sup> Volume Four, pp. 63-64.

<sup>351</sup> Jack Mintz, Michael Gordon and Duanjie Chen, "Funding Canada's Health Care System: A Tax-Based Alternative to Privatization," in *Canadian Medical Association Journal*, 8 September 1998, pp.493-496.

<sup>352</sup> Tom Kent, *What Should Be Done About Medicare*, The Caledon Institute of Social Policy, August 2000.

<sup>353</sup> Jack Mintz, S. Aba and W.D. Goodman (2002), "Funding Public Provision of Private Health: The Case for a Copayment Contribution through the Tax System," *C.D. Howe Institute Commentary – The Health Papers*, No. 163.

the higher the individual's contribution to the system would be in that year, up to the maximum 3% of income.

Mintz, Aba and Goodman argued that, by relating the individual's contribution to the actual health services that are used, and by encouraging users to consider the costs, efficiency would be gained in the use of health care resources. The authors also contended that limiting individual health care taxes to a maximum of 3% of annual income would ensure that the costs would remain affordable to the taxpayer and thus no one would be deprived of needed health services. This would also prevent the costs of health care from imposing a catastrophic burden on any taxpayer.

Using survey data on health care utilization rates, Mintz, Aba and Goodman estimated that 62% of Canadians would pay the maximum contribution of 3% of their annual income in any one year. Overall, this would generate \$6.6 billion annually in tax revenue (or about 16% of total public spending on physicians, hospitals and other health care institutions). They estimated that it would also lead to a decrease of 13.5% in the use of health services, the value of which they estimated to be \$6.3 billion. The authors believe that additional administrative costs would be minimal since the contribution would be collected through the provincial/territorial personal income tax system.

A number of witnesses discussed proposals such as the one by Mintz *et al.*. For example, Paul Darby, Director, Economic Forecasting, Conference Board of Canada, stated:

*It has a high degree of attractiveness in that it does remove some of the mystery surrounding the cost of health care to various users of the system. It does have the advantage of tying those costs, to some extent at least, to payment. I am not sure it completely gets around the issue of redistribution or the burden perhaps falling on the less advantaged members of society.*<sup>354</sup>

The option of a taxable health care benefit would help ensure visibility. It would also improve somewhat the stability of public health care funding. Such an option would have an impact that in some ways would be similar to direct taxation in terms of efficiency and distortion in the economy. However, it would increase Canada's reliance on the personal income tax, which is already well above that of other OECD countries.

But perhaps most important, the main argument presented to the Committee against a taxable health care benefit is that some people will have the perception that they would be paying for health care twice – once through general taxation and once through the additional income tax they would pay for the specific health services that they would receive during the year. The argument of “double payment” led the Alberta Premier's Advisory Council on Health to decide not to support making health care a taxable benefit.<sup>355</sup>

The Committee was told that a relatively efficient way of generating new federal revenue to pay for health care would be to use some portion of a general consumption tax, such

---

<sup>354</sup> Paul Darby (59:17).

<sup>355</sup> Mazankowski report, p. 55.

as the GST, and have it earmarked for health care. The GST is the major federal consumption tax in Canada and, according to many witnesses, it is a relatively efficient tax. Because of its broad and generally non-distorting coverage, many witnesses contended that it would be the most suitable consumption tax to increase to pay for additional federal spending on health care.

The GST option, however, would be somewhat more regressive than personal income taxation. Nonetheless, the proposal to earmark an increase in the GST for the purpose of health care received very broad support during the Committee's hearings. For example, Paul Darby explained that:

*(...) the Conference Board's position on how to address the financing issues over the next 30 years tends towards consumption taxes, such as the GST. We would tend to try to avoid taxes on working, which would include income and payroll taxes. We sense that, at this point, taxes on consumption would probably have the least disincentive effects among the various tax options one could consider. (...) We would want to see a specific link between the taxation and the spending on health care, in the hopes that those taxes would, as a result, be much more politically palatable to the general public.<sup>356</sup>*

Mr. Darby suggested that rebates for low-income Canadians through income tests, such as the current GST Tax Credit, could be provided for an earmarked and increased GST in order to improve equity and progressivity. In addition, if the rebates for the increase in the GST were similar in structure to the current GST rebates, they would add little to the scheme's administrative cost.

## **15.5 Payroll Taxes**

In many OECD countries (such as Germany and the Netherlands), public funding for health care is generated from an earmarked payroll tax. Contributions under this payroll tax are usually compulsory and shared between the employee and the employer. These contributions are levied on labour earnings and are held by a body operating at arm's length from government ("Sickness Funds"). The predominant attraction for earmarked payroll taxes (or "social insurance") in many OECD countries is the independence of the insurer or agency from government and the perceived greater responsiveness of the insurer to the patient or consumer.

In Canada, both the federal and provincial/territorial governments currently use earmarked payroll taxes in one form or another. At the federal level they include: premiums for Employment Insurance and Canada Pension Plan contributions (the CPP/QPP is both a federal and provincial responsibility). Provincial payroll taxes include: workers' compensation premiums (collected in all provinces) and health care/post-secondary education taxes (levied in Quebec, Manitoba, Ontario, Newfoundland and the Northwest Territories), with the latter not generally being firmly dedicated to any specific use.

---

<sup>356</sup> *Ibid.*, (59:5).

An earmarked payroll tax as a means of collecting revenue for the purpose of health care has the advantages previously mentioned for earmarked taxes. For example, it can be paid into a separate fund. It is highly visible and transparent and, therefore, usually more acceptable to the public. In other words, higher levels of transparency under a system of payroll taxes weaken resistance to contribution increases compared with general taxation increases. In addition, payroll tax revenue is, at least in theory, better protected from annual political interference, since budgetary and spending decisions can be devolved to independent bodies. Equally important, levying the tax only on labour income avoids distortions to savings and investment. Finally, revenue generated from payroll taxes also appears to be more stable. In this perspective, a recent report states:

*In Belgium, where health care is financed about equally from taxation and social insurance contributions, the deviation of average annual growth was greater for revenue from government sources than non-government sources. (...) In other words, annual government spending on health care fluctuated more than insurance-based revenue. (...) Consequently, relying more on funding from general taxation than on payroll contributions is likely to make revenue less stable.*<sup>357</sup>

Earmarking a payroll tax, however, has a number of disadvantages. Because employers are usually required to contribute to part of the cost of health care insurance, this results in higher labour costs, inhibits job creation and reduces the international competitiveness of a country's economy. Moreover, a payroll tax relies on a more narrow revenue base (labour earnings). Accordingly, it would require a higher rate of a payroll tax to raise a given amount of revenue than would a general income tax on all income. This may explain why general tax revenue is also used as an important revenue source in countries with health care payroll tax systems. In these countries, general tax funds are usually transferred to health care insurance funds to cover the contributions of the non-employed population. General tax revenues may also cover the deficits of public health care insurance funded by payroll taxes.

In contrast to general taxation, a payroll tax may also impede job mobility; employees may be unwilling to move to a non-covered job (such as self-employment) in some systems for fear of higher contribution payments or fewer benefits (as in the United States).

The potential negative impact of payroll taxes on industry was one of the justifications for diversifying funding sources from an employee/employer contribution system to an income-tax-based system under the Juppé Plan in France. More precisely, France significantly reduced the employee contribution rate (from 5.5% in 1997 to 0.75% in 2000) and dedicated its General Social Contribution Tax specifically to health care (the tax rate was increased from 3.4% to 7.5% of personal income). Italy and Spain went a step further by shifting completely from payroll tax to a general tax-revenue-financed health care system.

Another criticism of payroll taxes with respect to efficiency is that the various European Sickness Funds, which are responsible for collecting and managing the contributions made by employers and employees, have little incentive to control costs because they have the

---

<sup>357</sup> Mossialos and Dixon (2002), chapter twelve, p. 285.

ability to raise contribution rates. Also, the existence in some countries of multiple funds and the lack of integration in purchasing health services often results in high administration costs.

It could also be argued that health care financing via a payroll tax system is vulnerable to periods of economic downturn, since reduced revenues from lower employment and freezes in income levels would result in smaller contributions to Sickness Funds. Furthermore, with the financing burden concentrated on employers and employees, the negative impacts on certain labour-intensive sectors of the economy could be significant.

Finally, with respect to equity, available evidence from Germany and the Netherlands suggests that funding health care through payroll tax tends to be regressive. This is probably because the design of these two systems allows higher-income earners, who already possess private insurance, to opt out of the public health care insurance plan.

An important element of payroll tax, however, is the smaller impact it has on the overall Canadian economy when compared to other forms of taxation. Preliminary calculations by the Department of Finance showed that an extra dollar of tax revenue raised through payroll taxes cost the economy 27 cents in real loss of output. This is compared to \$1.55 in loss of output for every extra dollar of corporate income tax and 56 cents for personal income tax. Sales taxes were shown to be the least distorting source of tax revenue, creating only 17 cents of output loss.<sup>358</sup> In the context of international competitiveness, there is still some room for payroll taxes in Canada: OECD data show that Canada depends less on this form of taxation relative to other industrialized countries.<sup>359</sup>

However, a crucial factor with respect to payroll taxes is that, in terms of intergenerational fairness, payroll tax has an impact similar to but worse than income taxation: the burden is borne entirely by the younger and working population.

## 15.6 National Health Care Premiums

A public health care insurance premium is a fixed lump-sum amount paid by either an individual or a family for the purpose of financing publicly insured health services. In some systems, health care insurance premiums are fixed amounts paid *regardless* of income and *independent* of usage of the health care system. This form of premium is currently used in both British Columbia and Alberta, although there are some exemptions for low-income individuals and families in the two provinces.

This method of funding is considered to be quite efficient for two reasons. First, the financing burden is spread over a wide base (the entire population) rather than just the employed, as is the case with most payroll taxes. This means that all sectors of the economy are treated equally, and due to the flat nature of premium payments, individuals have little incentive to alter their behaviour (whether to consume more or less, whether to work more or less, etc). Second, health care insurance premiums do not differentiate between the younger and older segments of the population, thereby ensuring inter-generational fairness.

---

<sup>358</sup> Department of Finance. Data presented by the OECD, *OECD Economic Surveys – Canada 1997*, November 1997, p. 85.

<sup>359</sup> OECD, *Revenue Statistics 1965-2000*, 2001.

*Whether a person works or not they would still have to pay the amount. This would be the least distortionary of the types of taxes that could be levied, and the one most conducive to the demographic issues we will face down the road.<sup>360</sup>*

A flat health care insurance premium does not affect marginal income tax rates, as an increase in personal income taxation would, and therefore has a less distorting impact on the economy in terms of savings and investment.

In terms of equity, flat premiums for public health care insurance would tend to hit low-income Canadians the hardest, although some low-income relief could be used to soften that impact. Also, middle-income Canadians would have to pay the same health care premium as rich ones. Therefore flat premiums are clearly regressive, as they benefit most those with high incomes. They do, however, benefit those with high health care needs, since they pay the same amount of premium as those who use the health care system only slightly.

Overall, the equitable characteristics of a system financed by flat premiums appear to be quite limited. The Committee was informed that, for greater equity, premiums should be linked to income in some manner and some groups of the population should be exempted from paying them. The suggestion to use variable premiums adjusted to income levels was recently made in the Mazankowski report, *A Framework for Reform*, prepared for the Premier of Alberta in 2001.

In his brief to the Committee, David Kelly provided a lengthy statement on the benefits of a national health care insurance premium:

*There may well be need for additional federal revenues to support the Canadian health care system, and a federal health care premium would be one means of raising funds in a fashion which provides visibility for the federal financial contribution.*

*(...) The provincial premiums programs which operate in Alberta and British Columbia raise significant revenue for those provinces. Premiums are fixed amounts applied universally (payment is mandatory), income-related (reduced or eliminated for lower income earners), but unrelated to program eligibility (late or non payment does not result in termination of benefits to an individual or family). Premiums are collected where possible through payroll deduction, with the balance directly billed to provincial residents. The administrative costs of collecting premiums by a process separate from the income tax system are nontrivial.*

*(...) Were a federal health care premium to be introduced, it would certainly make sense to collect it through the income tax system, rather than through a separate administrative procedure. That is, one could provide for deduction at source, quarterly payments, and annual reconciliation through the existing tax collection structure, rather than invoicing*

---

<sup>360</sup> Jack Mintz (62:7).

*all Canadian families on a monthly or quarterly basis. There are many potential designs for the structure of a federal premium – it could be a flat rate applied equally to all residents, or a flat rate with relief for lower income earners as in the two provinces which levy their own premiums, or a surtax applied proportionally or in some other fashion on top of the income tax. All these options have their own equity implications. It should be kept in mind that there is a very substantial element of income redistribution associated with the financing of Canada’s universal health care program. Any move to finance the system in part through a premium which is less progressive than existing funding sources would affect the nature of that income distribution, and so add to the list of value issues which the Committee must sort through.*<sup>361</sup>

In conclusion, premiums could constitute a visible and equitable means of raising the money for the purpose of health care, provided that they are structured in a way to ensure progressivity (that is, premiums should vary in proportion to income).

## **15.7 User Charges**

User charges are usually defined as a form of payment (covering a portion of the cost of services) made by a patient at the time a health service is rendered. That is, they represent an up-front charge to the patient. In Volume Four of its health care study, the Committee described the different forms of user charges:

- Co-insurance, the simplest form of user charge, requires the patient to pay a fixed percentage (say, 5%) of the cost of services received. Thus, the higher the cost of the service, the larger the fee. Many private-sector drug insurance plans require this method of payment.
- Co-payment is an alternative to co-insurance. Instead of having to pay a share of costs, the patient is required to pay a nominal fee per service (for example \$5) which does not necessarily bear any relation to the cost of the service. The same amount is charged, no matter what the cost of the health care provided. This form of user charge exists in many countries, such as Sweden.
- Under a system of deductibles, the patient is required to pay the total costs of services received over a certain period up to a certain ceiling, the deductible. Above the ceiling, costs of services to the patient are covered by the insurance plan. All users must pay the deductible, which is independent of the quantity of services received. Again, this form of insurance-based user charge is required in some countries.<sup>362</sup>

Some commentators have suggested that user charges of relatively modest size can be a useful means of discouraging overuse of the health care system, and of creating some personal sense of responsibility for the use of the system. However, much of the literature with respect to user charges concludes that these charges deter some individuals from seeking

---

<sup>361</sup> David Kelly, Brief to the Committee, pp. 2-3.

<sup>362</sup> Volume Four, p. 62.



necessary as well as unnecessary care, and do so in a way that falls disproportionately on the poor. Professor Robert Evans told the Committee that user charges raise serious issues of access and equity:

*It is well-known and extensively documented that a relatively small proportion of the population use a very high proportion of health care services, both in any one time period and over longer times. A recent study in B.C., now being written up for publication, shows that the five percent of the adult population with the highest use of physicians' services (measured in dollars of billings) not only accounted for 33.7% of total billings, but made up 43.5% of hospital admissions and used 69.3% of inpatient days. These people were generally quite ill, typically with major and multiple problems. There were on average older – almost half were over 60 – came from poorer neighbourhoods, and had a death rate nearly eight times that of the general population. For most of them, there seems to be no realistic prospect of their paying over half of the costs that they generate, even if such an extraordinarily skewed distribution of financial burden were acceptable to the general population.<sup>363</sup>*

It is worth noting that Canada is the only industrialized country that prohibits user charges for publicly insured health services. Despite their use elsewhere, the Committee reviewed the evidence on user charges in Canada and concluded in Volume Five that access to publicly funded hospitals and doctors should not depend on the income or wealth of individual Canadians.<sup>364</sup> We explained that most of the spending and waste in the health care system are beyond patient control; the major expenses, and the decisions that give rise to these expenses, are incurred or influenced by health care providers on behalf of their patients. These decisions are not made by the patients themselves. Moreover, the Committee was told that implementing modest user charges could incur administrative costs that would nearly equal the revenue generated from such charges.

**The Committee reviewed the evidence on user charges in Canada and concluded that access to publicly funded hospitals and doctors should not depend on the income or wealth of individual Canadians.**

For all these reasons, the Committee enunciated in Volume Five Principle Eighteen, which states that while incentives need to be developed to encourage patients to use the hospital and doctor system as efficiently as possible, such incentives should *not* include up-front user charges.

Some form of patient payment, however, could be used in implementing the primary health care reform that the Committee is proposing in Chapter Four. It should not be labelled as a user charge, but rather as an “orientation fee.” When primary health care physicians make referrals to specialists, patients do not incur any costs. Should the patient decide to take an appointment to a medical specialist without any referral, he or she should be liable for part or all of the cost incurred by this visit. This form of patient payment is required in Denmark.

<sup>363</sup> Robert Evans, Brief to the Committee, 3 June 2002, p. 6.

<sup>364</sup> Volume Five, pp. 53-54.

## 15.8 Medical Savings Accounts

As described in Volume Three of the Committee's study on health care, Medical Savings Accounts (MSAs) are health care accounts, similar to bank accounts, set up to pay for the health care expenses of an individual (or family).<sup>365</sup> They are often established in conjunction with high-deductible (or catastrophic) health care insurance. Money contributed to an MSA belongs to, and is controlled by, the account holder, accumulates on a tax-free basis and is not taxed if used for health care purposes. Unused MSA funds can be utilized for other purposes to the benefit of the account holder.

MSAs usually involves three levels of payment. First, money in the account is used for normal medical expenses. Next, if the account is exhausted and the deductible has not been reached, the user pays the expenses personally. Third, public health care insurance covers expenses beyond the deductible.

MSA systems are operating in a few jurisdictions, including Singapore, South Africa and parts of the United States. The general theory behind MSAs is that consumers would make more judicious and cost-effective decisions if they were spending their own money, rather than relying on the "free" publicly funded services. As a result, MSAs would limit (if not eliminate) unnecessary utilization of health services, reduce the pressures on public health care funding and encourage efficiency.

A number of proposals for MSAs have been put forward in recent years in Canada.<sup>366</sup> Given the interest of a number of Canadians in MSAs, the Committee reviewed the literature on the topic and held discussions with various individuals and experts. Based on the evidence received, we believe that, although MSAs have some interesting elements, they would not be appropriate in our publicly funded hospital and doctor system.

First, there is no consensus among experts on the impact of MSAs on a country's health status and overall health care costs. On the one hand, some maintain that MSAs increase consumer choice, encourage patients to make more prudent use of health services and reduce health care spending. On the other hand, others contend that MSAs can realize only small health care savings at best, segment the risk in the insurance market, drive up costs and have an adverse impact on health as people, particularly the poor and unhealthy, cut back on necessary health care. Moreover, the most recent literature suggests that current knowledge of MSAs is too limited to recommend their incorporation into the Canadian health care system.<sup>367</sup>

However, the impact on equity is certainly the aspect that is of most concern to the Committee. Like user charges, MSAs transfer part of the responsibility for health care spending from government directly to patients. Furthermore, they do so in a manner that falls disproportionately on the poor and on those who are sick, whether rich or poor. In fact, MSAs

---

<sup>365</sup> Volume Three, Chapter Seven, pp. 53-63.

<sup>366</sup> See the following documents: 1) William McArthur, Cynthia Ramsay and Michael Walker ed., *Healthy Incentives: Canadian Health Reform in a Canadian Context*, The Fraser Institute, 1996; 2) Cynthia Ramsay, "Medical Savings Accounts", *Critical Issues Bulletin*, The Fraser Institute, 1998; 3) David Gratzer, *Code Blue – Reviving Canada's Health Care System*, ECW Press, 1999; 4) Dennis Owens and Peter Holle, *Universal Medical Savings Accounts*, Frontier Centre for Public Policy, Policy Series No. 5, July 2000.

<sup>367</sup> Samuel E.D. Shortt, "Medical Savings Accounts in Publicly Funded Health Care Systems: Enthusiasm versus Evidence", in *Canadian Medical Association Journal*, Vol. 167, No. 2, 23 July 2002, pp. 159-162.

reduce the subsidy that the well now pay to the poor. A recent study reports that, if MSAs were implemented in Manitoba for hospitals and physician services, then the sickest 20% of residents in that province would become personally responsible for over \$60 million of health care costs.<sup>368</sup>

In Volume Four, the Committee indicated that a system of MSAs might be contemplated for application in a limited sphere, such as paying for long-term care facilities, where there are already significant private out-of-pocket charges. However, MSAs should *not* be applied in the broader health care field involving presently insured services.

Therefore, the Committee strongly believes that funding for medically required hospital care and physician services must remain the responsibility of a publicly funded and administered health care insurance program. This is consistent with Principle Four in our Volume Five, which stated: “Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.”<sup>369</sup>

***The Committee strongly believes that funding for medically required hospital care and physician services must remain the responsibility of a publicly funded and administered health care insurance program.***

## **15.9 Pre-Funding for Health Care**

In the context of an aging population, the option of pre-funding health care is gaining some popularity. Pre-funding involves setting aside funds today to meet all or part of projected future cost increases in health care, so as to enable Canada to maintain a relatively stable (or at least more stable) annual ratio of health care spending to GDP. Excess revenues gathered now for such pre-funding would be placed in a special account, to be made available later for stabilization purposes.

Unfortunately, the costs of full pre-funding are high, even when the stabilization is attempted over a period of 30-40 years during which Canada’s population will be getting significantly older. Accordingly, there may not be the popular will to implement a long term pre-funding plan now when the need to meet immediate cost pressures in the system is seen to be urgent. And the question could be raised, as with earmarked taxation, as to why health care costs only should be pre-funded – what about other costs that will also vary with aging of the population?

It has been suggested that it may be more practical to consider the pre-funding of only some elements of overall health care costs, specifically those relating to health services for the elderly, such as home and institutional care, that are not now publicly funded. Such pre-funding might be accomplished through a government plan financed by current taxation or through private health care insurance coverage. Such a scheme (comparable to MSAs) would assist individuals to save for future health care costs on a tax-efficient basis, especially if the

<sup>368</sup> Evelyn L. Forget, Raisa Deber and Leslie L. Roos, “Medical Savings Accounts: Will They Reduce Costs?”, in *Canadian Medical Association Journal*, Vol. 167, No. 2, 23 July 2002, pp. 143-147.

<sup>369</sup> Volume Five, p. 30.

premiums are deductible and earnings on accumulated funds are exempt from tax. Ultimately, pre-funding would relieve the publicly funded health care system of some costs that it now incurs in subsidizing some of those who need such services.

A variant of this approach was proposed by the Clair Commission in Quebec, which recommended that a separately managed fund be established to pre-fund the costs of both home and institutional care for individuals no longer able to care for themselves. The Commission recommended that the fund be financed by a mandatory premium (tax) on personal income from all sources, and be for the benefit of those (particularly the elderly) whose inability to care for themselves was long-term (over six months). Such a plan would provide an improvement in and integration of existing services for long-term disability and yet avoid a rapid rise in health care costs for an aging population.

This approach has a number of advantages: its financing structure is highly visible and the funds generated are wholly dedicated. The degree of equity of this funding method, as well as its impact on efficiency and intergenerational fairness, would depend on the source of revenue used to raise the money – personal income tax, public premiums or private health care insurance.

Given that the need to raise additional revenue to fund health care is urgent, the Committee does not endorse pre-funding. In our view, it would be very difficult to justify setting aside funds for future needs while substantial sums of money are required now throughout the publicly funded health care system to undertake its restructuring, renewal and expansion.

### **15.10 Committee Commentary**<sup>370</sup>

Sections 15.3 to 15.9 above have described a wide variety of possible options for raising \$5 billion annually in new federal government revenue; they have also presented in some detail the advantages and disadvantages associated with each option in terms of five specific criteria – equity, efficiency, intergenerational fairness, stability and visibility. On the basis of this information, the Committee reached conclusions about the approaches it favours.

We wish to say, up front, that there is no such thing as a “good” tax. There are, however, specific objectives that a new tax or revenue-generating initiative designed to pay for a specific public benefit should meet:

- The tax should be apportioned fairly and reasonably over the groups that will be called upon to pay it;
- The tax should have the least possible adverse effect on economic activity and growth in relation to the revenues raised;
- The tax should involve modest administrative costs of compliance for taxpayers and collection costs to government;

---

<sup>370</sup> The Committee is indebted to Robert D. Brown, former chairman of Price Waterhouse, and his research assistant Michanne Haynes, for many of the calculations and revenue estimates presented in this chapter. The assistance of the Department of Finance in supplying statistical data is gratefully acknowledged.

- The justification for the tax should be clearly apparent to the public, preferably by associating the revenue directly with the benefits of the spending;
- The tax should produce revenues that are stable and robust (in the sense that they will grow at about the rate of GDP), enabling the funds raised to meet increasing costs in the future;
- To justify its collection, the tax should be perceived to result in some tangible improvements to the system and to health care coverage.

On balance, the evidence available on how different revenue sources affect equity shows that equity is best served when health care is funded through personal income taxation or consumption taxes, rather than through payroll taxes or fixed premiums. In addition, from an efficiency viewpoint, international experience indicates that payroll taxation may affect the labour market more negatively than general taxation, because contributions are levied only on wages and employers are liable for part of the contribution. Finally, research shows that, whatever the method of raising revenue, the level of economic activity at any given time significantly influences the ability of a country to raise money for health care (or for any other purpose). Moreover, spending on health care has an opportunity cost, and other sectors may take priority in times of economic contraction or military conflict.

However, a major advantage of both payroll taxation and premiums over existing income and other general taxation is that they are more visible, transparent and predictable sources of financing. Earmarked taxation would certainly help in bringing more visibility, and possibly even greater stability, to a tax-funded health care system.

The Committee is of the view that increased federal revenue for hospital and doctor services should not come disproportionately from those who are ill. These services are now perceived to be “free.” The method of raising revenue should not be perceived as a “tax on the sick.” For this reason, the Committee rejects all forms of financing that call for individuals to pay directly on the basis of their utilization of the hospital and doctor system.

***The Committee is of the view that increased federal revenue for hospital and doctor services should not come disproportionately from those who are ill. The method of raising revenue should not be perceived as a “tax on the sick.”***

Furthermore, the Committee believes that the increased federal revenue should be raised based on ability to pay; that is, to ensure equity, individuals with higher incomes should pay more than individuals with lower incomes. For this reason, the Committee rejects the option of a flat national health care insurance premium. But, as we discuss below, we are not opposed to the option of a progressive health care insurance premium structure.

With respect to direct taxation, calculations done on behalf of the Committee by Brown and Haynes indicate that it would be necessary to increase the rate applicable to each taxable income bracket of personal income tax by 1.1 percentage points in order to raise \$5 billion in additional federal revenue. Another way to finance an incremental annual federal spending on health care through the personal income tax would be to impose a 5.7% surtax on

all federal tax. The Committee was told that these two options would, however, reverse approximately one-third of the 2000 federal personal tax cuts provided under the five-year tax plan and raise marginal tax rates significantly.

Calculations by Brown and Haynes also indicate that it would be necessary to increase the general rate of corporate tax by 7 percentage points in order to raise an additional \$5 billion in federal revenue. This would, however, reverse all present and scheduled future cuts in corporate tax, leaving Canada's rates uncompetitive internationally. This would, therefore, severely affect the Canadian business sector, employment and the overall economy.

The Committee is convinced that the changes to the Canadian tax structure that lead to increased revenue should be done in a way that keeps Canada's tax rates, including personal income tax rates, relatively competitive with other OECD countries, particularly the United States. In addition, for the sake of intergenerational fairness, we believe that the working population should not bear a disproportionate burden of taxation relative to the retired population. For these reasons, and based on the estimates given above, the Committee rejects the option of raising funds by increasing personal income taxes or corporate income taxes.

Although there appears to be some room for a payroll tax from an international competitiveness perspective, the Committee rejects this option on the grounds of intergenerational fairness. It would be unfair to require one segment of the population – working Canadians – to bear the costs of increased investment in the publicly funded health care system. This is particularly true in the context of an aging population with a reducing proportion of that population in the workforce.

***It is the view of the Committee that it would be unfair to require one segment of the population – working Canadians – to bear the costs of increased investment in the publicly funded health care system. This is particularly true in the context of an aging population.***

Therefore, the Committee concludes that there are two possible ways in which \$5 billion could be raised annually from Canadians and which comply with the set of criteria and objectives listed above. The first option is a *National Health Care Sales Tax*. The testimony received by the Committee suggests that, although this option might be considered mildly regressive, the benefits gained from an efficiency point of view far outweigh the impact on equity. In addition, expanded tax credit rebates would greatly reduce the impact of sales tax on lower-income people. The tax would be collected using the same base as the Goods and Services Tax (GST) so that its collection would be straightforward. Calculations done for the Committee suggest that the rate of tax required to raise \$5 billion annually would be around 1.5% (precisely, 13%). Thus, under the National Health Care Sales Tax option, Canadians would pay a national sales tax of 8.5%, which would consist of a 7% GST and a 1.5% National Health Care Sales Tax. The GST tax credit rebate program would be expanded to parallel the increase in the rate to 8.5%.

The second option involves a *Variable National Health Care Insurance Premium*. Under this option, Canadians would pay, through the tax system, a national health care insurance premium the amount of which would vary with the individual's taxable income as shown in Table 15.3. For each taxable income bracket currently used for the purpose of calculating an

individual's federal personal income tax, a flat premium would be charged. The premium would then increase (indeed double) for individuals in the following income bracket.

**TABLE 15.3**  
**ANNUAL FEDERAL REVENUE GENERATED FROM A VARIABLE**  
**NATIONAL HEALTH CARE INSURANCE PREMIUM**

<b>Taxable Income Bracket (Federal Personal Income Tax Rate)</b>	<b>Number of Taxfilers Paying Premiums (Millions)</b>	<b>Level of Premium (Dollars)</b>	<b>Estimated Annual Federal Revenue (\$ Billion)</b>
<b>Up to \$31,677 (16%)</b>	7.9	<b>\$0.50/day (or \$185/year)</b>	1.341
<b>\$31,678 to \$63,354 (22%)</b>	5.8	<b>\$1/day (or \$370/year)</b>	2.096
<b>\$63,355 to \$103,000 (26%)</b>	1.4	<b>\$2/day (or \$740/year)</b>	0.968
<b>Over \$103,000 (29%)</b>	0.5	<b>\$4/day (or \$1,400/year)</b>	0.622
<b>ESTIMATED TOTAL FEDERAL REVENUE</b>			<b>5.027</b>

1. Taxfilers in the taxable income bracket from \$0 to \$31,677 with no net federal tax liability (net of non-refundable tax credits) will not be liable for any health care premium.
2. In addition, taxfilers in this first bracket who do have net federal tax will pay the lesser of \$185 or 10% of taxable income not offset by the income equivalent to the amount of the non-refundable tax credits. This provision is designed to prevent the premium payable by taxpayers in this bracket with only modest net federal tax from being disproportionate to their income tax. For example, suppose that a taxfiler has a taxable income of \$9,934. The federal tax on this taxable income is 16%, which amounts to \$1,590. But this taxfiler also has \$9,000 on which he/she can claim the 16% of non-refundable tax credits or \$1,440. Thus, the net federal tax for this taxfiler is \$150 (\$1,590 minus \$1,440). For taxfilers in this income bracket, the premium corresponds to 10% of the value obtained from the difference between the taxable income (e.g. \$9,934) and the amounts on which the non-refundable tax credits are claimed (e.g. \$9,000). The taxfiler in the above example has a \$150 net federal tax from taxable income of \$934 in excess of the amounts on which the refundable tax credits are calculated; this taxfiler would thus pay a premium of \$93.40 (that is, 10% of \$934) instead of \$185, the normal premium for this bracket.
3. There is a total of 15.4 million taxfilers with income less than \$31,677 of whom only 7.9 million pay net federal tax. The average premium for all taxfilers in this bracket is \$71. For the 7.9 million with net federal tax, the average premium is \$170.
4. Individual taxfilers in the 22%, 26% and 29% brackets are subject to "notch relief", so that their premium will not be more than the premium for the income bracket below theirs, plus 10% of their income exceeding the bracket threshold. This provision is designed to prevent a taxpayer who receives income that puts him/her just over the bottom of the next income bracket from facing an abrupt and steep increase in premium. For example, an individual with income of \$33,177 (\$1,500 in excess of the 22% bracket threshold of \$31,677) would pay \$185 (the premium of the previous bracket) plus \$150 (\$1,500 times 10%) for a total premium of \$335, instead of the normal premium of \$370 for this bracket.
5. Calculation based on 2001-2002 data.

Source: Robert D. Brown and Michanne Haynes. Based on data provided by the Department of Finance.

To ensure that individuals with taxable income only slightly in excess of the bottom of their bracket are not subject to a significant increase in their premiums, a “notch relief” provision has been incorporated into the calculation of premiums. This notch relief provides that the premiums of taxpayers will not be more than the premium of the income bracket below theirs plus 10% of income exceeding the income threshold for the bracket. Thus, the Variable National Health Care Insurance Premium is progressive across the entire income spectrum, but it is virtually flat within each income bracket.<sup>371</sup>

Although the Variable National Health Care Insurance Premium would be calculated through the income tax, it is *not* equivalent to an increase in personal income tax. The premium has some aspects of an income tax (because it is subject to some variation in incomes), but in fact it basically varies by taxable income bracket, not income. Moreover, the premium would have only a very moderate impact on marginal income tax rates, which would rise only at the “notch points” where the higher premium in the next bracket is phased in. Therefore, marginal rates would be relatively unchanged and, accordingly, would have much less impact on personal incentives to earn, save and invest than that which would result from an increase in personal income taxation.

The Committee understands that it is up to the federal government to decide which of the two options, either a National Health Care Sales Tax *or* a Variable National Health Care Insurance Premium, is most appropriate to raise the needed \$5 billion annually. Both options for raising \$5 billion annually in new federal health care revenue have advantages and disadvantages.

***Both options for raising \$5 billion annually in new federal health care revenue have advantages and disadvantages.***

On the one hand, the National Health Care Sales Tax would be simple to administer, as it would be based on the identical tax base to the GST. In addition, this option has a built-in growth factor, as sales tax revenue grows with the economy. Since health care spending is forecast to grow at a rate faster than the growth in GDP, having a built-in growth factor is important. Moreover, the National Health Care Sales Tax would not be significantly regressive, particularly since the GST tax credit rebate program would be extended to the new tax. Nonetheless, a major barrier to any sales tax increase is strong public opposition to such taxes in general, and the GST in particular.

On the other hand, the Variable National Health Care Insurance Premium has the advantage of being progressive as the amount of premium increases, in stages, with income. Such a

***The most important issue is for Canadians to agree to contribute \$5 billion annually in new federal revenue for health care.***

---

<sup>371</sup> As indicated in Section 15.4, the Committee rejects the option of a flat annual health care premium because it is clearly regressive. For example, calculations indicate that it would require an annual flat premium of \$425 for every taxfiler with income over \$20,000 to generate \$5 billion in revenue. But there are over 136,000 taxfilers who have income in excess of \$20,000 and who pay no tax because of the application of credits such as the Charitable Donation Credit. For this group, the payment of a flat premium would be a significant additional burden. If the flat rate premium were modified so that it could not exceed 5% of taxable income in excess of the \$20,000 threshold, then the required annual premium would increase to \$500, and there would still be some taxfilers with no net tax who would be required to pay some of the premium.



national premium would also be consistent with the way in which individuals usually buy insurance, namely by paying for it through an annual premium. However, the premium option has the significant disadvantage that the more steps there are in the premium structure, the closer the premium is to an income tax increase and, for reasons stated earlier in this chapter, the Committee is opposed to an income tax increase. Moreover, the fewer steps there are in the premium structure (hence the less it looks like an income tax), the more regressive this option becomes.

From the Committee's perspective, the most important issue is for Canadians to agree to contribute \$5 billion annually in new federal revenue for health care. This is the issue Canadians need to seriously consider, debate and then decide.

Which of the two options described above is eventually chosen as the revenue raising mechanism is less important than agreement to raise the \$5 billion. Nevertheless, in choosing between the two options, the Committee recommends the National Variable Health Care Insurance Premium. Therefore, the Committee recommends that:

***In choosing between the two options, the Committee recommends the National Variable Health Care Insurance Premium.***

**The federal government establish a National Variable Health Care Insurance Premium in order to raise the necessary federal revenue to finance implementation of the Committee's recommendations.**

### **15.11 Current Federal Funding for Health Care**

The Committee recognizes that the \$5 billion in increased spending is not the entire increase in federal health care spending that will be required in the years ahead. The cost of the hospital and doctor system to which the federal government now contributes will continue to grow. The increased revenues required to cover these increasing costs will have to be funded out of the efficiency savings that result from the restructuring recommendations proposed in this report, and from the general growth in federal revenues from existing tax sources.

This raises the question of whether, in order to substantially improve transparency and accountability in federal health care spending, the 62% of federal CHST cash transfers that are currently notionally attributed to health care (according to Finance Canada's estimation) ought to be paid for through an *earmarked* tax source (as described in Section 15.4 above). This would help the public considerably in understanding how much federal money is spent on health care.

***In order to substantially improve transparency and accountability in federal health care spending, the 62% of federal CHST cash transfers which are currently notionally attributed to health care ought to be paid for through an earmarked tax source.***

Canadians would thus see a more direct link between the taxes they pay and the health services

they receive. It would also greatly help to dispel the widely held perception that health care is “free.”

One way to do this would be to earmark some of the seven percentage points of the GST to health care. Calculations done for the Committee indicate that it would be necessary to earmark 3.1 of the 7 percentage points of the GST (or around 45% of the revenue generated through the GST) to obtain the 62% of current federal CHST cash transfers which are related to health care.

However, given the need for an increase in the current CHST funding (at least until the full impact of the Committee’s restructuring recommendations come into effect), it is probably appropriate that, if an earmarked source is to be used for the current federal cash contribution to health care, and if the earmarked source is to be the GST, then 3.5 (rather than the calculated current 3.1) of the 7 percentage points of GST revenue (or 50% of GST revenue) should be earmarked for health care. This would increase federal base funding for health care by \$1.5 billion. In addition, transparency would be enormously enhanced by earmarking half of GST revenue to be the federal cash contribution to health care, supplemented by the additional funding required for implementation of the reforms recommended in this report.

A significant advantage of using the GST revenue as the earmarked source is that it has a built-in escalator: as the economy goes, so does the GST revenue. Thus, using 3.5 of the 7 percentage points of the GST (rather than the calculated current 3.1 percentage points) to fund the federal cash contribution to the existing publicly funded hospital and doctor system would create the stable and predictable source of federal funding that the Committee called for in Principle Two in Volume Five<sup>372</sup> as well as lead to augmentation of this federal contribution. Therefore, the Committee recommends that:

***Using 3.5 of the 7 percentage points of the GST (rather than the calculated current 3.1 percentage points) to fund the cash federal contribution to the existing publicly funded hospital and doctor system would both create the stable and predictable source of federal funding the Committee called for in Principle Two in Volume Five as well as lead to augmentation of this federal contribution.***

**The federal government determine an earmarked revenue source which would fund the approximately 62% of CHST currently regarded as being the federal annual cash contribution to Canada’s national health care insurance program.**

If the GST is chosen as the earmarked revenue source for the current federal annual cash contribution to the national hospital and doctor insurance program, 3.1 of the 7 percentage points of the GST would be required to meet the current funding levels. In this case, the Committee further recommends that:

---

<sup>372</sup> Volume Five, pp. 25-28.

**If the GST is chosen as the earmarked revenue source for the current federal cash contribution to the national hospital and doctor insurance plan, then in order for the federal government to make a significant additional contribution to funding to the current hospital and doctor system, half of all GST revenue (or 3.5 of the 7 percentage points) should be earmarked for health care. (This would be in addition to the increased federal funding required to implement the recommendations in this report.)**

If the above two recommendations are accepted, then the federal government would be indirectly contributing *at least* an additional \$3.0 billion a year to the *existing* public hospital and doctor insurance program. \$1.5 billion would come from increasing to 3.5 percentage points the amount of GST revenue earmarked for health care, while another \$1.5 billion would, as discussed in Section 15.1, come from money that the provinces are now spending and that they would no longer have to spend once the recommendations in this report are implemented. This amount would then be reinvested in the existing health care system.

If the federal government also decided to invest the \$1-billion contingency (as discussed in Section 15.1) as a transitional payment into the existing hospital and doctor system while the efficiency measures proposed in this report are being put into effect, the total additional contribution of the federal government to the *existing* system would be *at least* \$4 billion.

***The Committee believes it is important to acknowledge the fact that the health care costs of the elderly are considerably higher than the health care costs of younger people, and that some provinces have a higher percentage of their population aged 70 and over than other provinces.***

Finally, CHST transfers are currently distributed to the provinces/territories on a per capita basis. If the health care portion of the CHST is paid from an earmarked revenue source as recommended above, the Committee believes that a variation should be made to the way a province's share of the fund is determined. More precisely, we believe it is important to acknowledge the fact that the health care costs of the elderly are considerably higher than the health care costs of younger people, and that some provinces have a much higher percentage of their population aged 70 and over than other provinces. Accordingly, the Committee recommends that:

**The share of the federal annual contribution to which a province/territory is entitled for the purpose of the existing national hospital and doctor program be not only based on the proportion of its population relative to Canada as a whole, but also weighted in some way by the percentage of its population aged 70 years and over.**

A variety of weighting formulae are possible, and should be explored in order to improve the fairness of current federal health care contributions to the provinces and territories. However, a simple formula would be to give triple the weight to each provincial resident aged 70 years and over. This would be of significant assistance to smaller provinces while not significantly hurting wealthier ones.

## CHAPTER SIXTEEN

### THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE

---

The previous chapter detailed the Committee's position with respect to how additional federal revenue should be raised and administered in order to implement our recommendations. We believe strongly that their implementation is essential if health care reform and renewal is to be undertaken, and if this is to be done in a manner that is effective, transparent and accountable. The Committee is convinced that an additional \$5 billion annually must be invested by the federal government to finance the changes necessary to secure a high-quality and fiscally sustainable health care system.

The Committee also realizes, however, that in a free and democratic society, Canadians may not be willing to pay more taxes to the federal government (through the National Health Care Insurance Premium as we recommend in this report) to support their national health care insurance system – Medicare. Conversely, the federal government may be unwilling to impose a tax increase on a reluctant population, even though the

***The Committee also realizes, however, that in a free and democratic society, Canadians may not be willing to pay more taxes to the federal government (through the National Health Care Insurance Premium as we recommend in this report) to support their national health care insurance system – Medicare. Conversely, the federal government may be unwilling to impose a tax increase on a reluctant population, even though the increased revenue would be spent on health care.***

increased revenue would be spent on health care. In this case, the question then arises as to what the consequences would be. They would include the following:

- No proposed expansion of public health care insurance coverage to include catastrophic prescription drug costs, some post hospital home care treatment and out-of-hospital palliative care would occur;
- No reform and renewal of the hospital and doctor system would take place and major health care cost pressures would continue to erode the system;
- Nor would the essential investments in infrastructure occur, particularly those in health information management, health care technology and expanded enrolment in medical and nursing schools;
- This, in turn, would make implementation of the National Health Care Guarantee impossible. Given Canada's relative deficiency in medical equipment and health care providers to deal with waiting queues, understandably provincial governments would be unwilling to legislate a care guarantee if its implementation meant they would have to pay the cost of sending an ever increasing number of patients to the United States or elsewhere for treatment;

- A Canadian health infostructure, along with the full deployment of a system of electronic health records and a system of service-based funding for hospitals, would not be developed, thus limiting Canada’s ability to evaluate the cost, effectiveness, quality, performance and outcomes of its health care system or to develop strategies to increase its productivity.

In short, in the absence of the additional investment the Committee recommends, the Canadian health care system will continue to deteriorate. The “health care contract”<sup>373</sup> between Canadians and their governments will break if Canadians are unwilling to pay an additional \$5 billion in taxes (the citizens’ part of the contract) so that government can finance adequately the changes necessary for the sustainability of our publicly funded, universal, comprehensive, accessible and portable hospital and doctor insurance plan (the government part of the contract), expanded to cover, in part, out-of-hospital prescription drugs, home care and palliative care as recommended.

Under these circumstances, it seems highly probable that, for the reasons discussed in Chapter Five, the courts would decide that under the *Charter of Rights and Freedoms*, government could no longer deny Canadians the right to purchase private health care insurance that would enable them to receive and pay for health services in Canada that are also included in the publicly insured set of services. Thus, a parallel private health care system is likely to emerge.

***The Committee has stated on numerous occasions, and we repeat it here again, that we are in favour of a single public funder/insurer for hospital and doctor services covered under the Canada Health Act.***

This is *not* the outcome preferred by the Committee. We have stated on numerous occasions, and we repeat it here again, that we are in favour of a single public funder/insurer for hospital and doctor services covered under the *Canada Health Act*. The single, public insurer model was, in fact, the first principle enunciated in Volume Five.<sup>374</sup> As a corollary, private insurance for publicly insured health services should continue to be disallowed, *provided* that such publicly insured services are delivered in a *timely* fashion.

Nonetheless, the Committee believes it is important to consider the implications of allowing private health care insurance to develop, together with its associated parallel privately funded hospital and doctor system. This is the purpose of this chapter. Section 16.1 describes briefly the role of private health care insurance in Canada and in selected OECD countries. Section 16.2 provides a summary of the findings of recent literature on the impact of private health care insurance on costs, access and quality in the publicly funded health care system. Finally, Section 16.3 sets out the Committee’s view on the possible development of a parallel private delivery system in Canada.

***It is the view of the Committee that private insurance for publicly insured health services should continue to be disallowed, provided that such services are delivered in a timely fashion.***

<sup>373</sup> Volume Five, p. 61.

<sup>374</sup> Volume Five, pp. 23-25.

## 16.1 Private Health Care Insurance in Canada and Selected OECD Countries

Currently, the *Canada Health Act* requires public health care insurance plans to be accountable to the provincial government and to be not-for-profit. Moreover, the majority of provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island and Quebec) prohibit private companies from insuring services that are covered under public health care insurance plans.<sup>375</sup> In these provinces, private insurers are limited to providing supplementary health care benefits, such as semi-private or private accommodation during hospital stay, prescription drugs, dental care and eyeglasses – all services that are not insured under provincial health care insurance plans.

Four provinces do permit private health care insurance for services that are also publicly insured (New Brunswick, Newfoundland, Nova Scotia and Saskatchewan). Thus, patients of opted-out physicians<sup>376</sup> in these provinces can substitute private for public health care coverage. However, provincial legislation that prohibits opted-out physicians from practising both in the publicly funded system and privately has meant that few opt out. Therefore, few people purchase private health care insurance.

For example, in Nova Scotia, opted-out physicians cannot bill privately in excess of the fee specified on the public insurance fee schedule. This creates a disincentive, as physicians cannot be paid more for equivalent cases working under private insurance than if they worked within the public plan. As a result, there are very few opted-out physicians and, consequently, there is little need for private health care insurance to cover publicly insured health services.

In Newfoundland, patients of opted-out physicians are entitled to public coverage up to the amount set out in the fee schedule (in other words, patients are entitled to public funds to subsidize the cost of buying their health services in the private for-profit sector). Out-of-pocket spending by patients is thus limited to the difference between the fee charged by the opted-out physician and the publicly scheduled fee; but few physicians have opted out in Newfoundland and, therefore, there is little demand for private health care insurance.

In New Brunswick and Saskatchewan, patients of opted-out physicians cannot be subsidized by the public plan as they would be in Newfoundland. Nonetheless, there has been no significant development of private-sector in health care insurance in these two provinces.

Overall, the *Canada Health Act*, together with provincial/territorial legislation, has prevented the emergence of private health care insurance in Canada that competes directly with public insurance. It is simply not economically feasible for patients, physicians or health care institutions to participate in a private parallel system.

---

<sup>375</sup> Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada", in *Canadian Medical Association Journal*, Vol. 164, No. 6, 20 March 2001, pp. 825-830.

<sup>376</sup> A physician opts out when he/she chooses to give up his/her rights to bill the public health care insurance plan and takes up practice in the private sector. Every provincial health care insurance legislation permits physicians to opt out.

This contrasts sharply with the situation in other OECD countries, in which private health care insurance can and does compete with public health care insurance, and physicians can work in and receive payments from both the public and the private sectors.<sup>377</sup> There are two different models of private insurance for health services in these countries. The first, prevalent in Germany and the Netherlands, involves a system of private insurance and service delivery that is totally separate from the public system. The second, in place in countries like Australia, Sweden and the United Kingdom, involves competition between public and private insurers and interaction between public and private providers.

In Germany and the Netherlands, private health care insurance is voluntary for those people with relatively high annual incomes (while public coverage is mandatory for those with middle and lower incomes). The private insurers must accept all those who apply for coverage and must provide benefits equivalent to those offered under the public plan. Thus, private insurers cannot “cherry-pick,” i.e., restrict coverage to patients who are healthy and wealthy, thereby leaving the public sector to pay for patients who are less healthy and wealthy. The premiums paid for private insurance are risk-related (but subject to strict regulation) and do not vary significantly for equivalent coverage.

In the United Kingdom, residents can purchase private insurance to cover the same health services provided in private hospitals as are offered in public hospitals. Although privately-insured patients in the United Kingdom usually obtain their health services outside the NHS; they can also be treated in NHS facilities in which “pay beds” are available. Physicians are permitted to earn up to 10% of their gross annual income from private practice.

In Australia, private health care insurance, as in the United Kingdom, competes with the public plan. Moreover, the Australian government actively encourages residents to acquire private health care insurance by subsidizing 30% of its cost. Premiums required under private health care insurance are strictly regulated and community-rated (i.e., a single premium applies to everyone, regardless of his/her health status). Privately insured patients may receive care in either a public or private hospital; in both cases, the public health care insurance plan subsidizes 75% of the hospital costs, while the remainder is covered by private insurance. Specialists working in public hospitals can treat patients privately and receive payment both from private and public health care insurance plans.

Private health care insurance is permitted even in Sweden, which is generally recognized as being amongst the most socialized of European countries. In Sweden, as in Australia, government legislation requires that premiums charged by private health care insurers must be community-rated. Private hospitals do not usually obtain payment from the publicly funded plan, unless care is provided through contracts with the county councils.<sup>378</sup> Physicians in Sweden are allowed to work in both the public and the private sectors.

The evidence summarized in the Committee’s Volume Three, as well as the findings of a Canadian study,<sup>379</sup> show that the vast majority of care delivered in private for-profit health care institutions in countries like Australia, New Zealand, the Netherlands, Sweden and

---

<sup>377</sup> For more information on health care systems elsewhere, consult the Committee’s Volume Three.

<sup>378</sup> This, in fact, is becoming more prevalent in Scandinavian countries under their new health care guarantee.

<sup>379</sup> Cam Donaldson and Gillian Currie, *The Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity*, Institute of Health Economics (Alberta), Working Paper 00-9, 2000.



the United Kingdom is funded through private health care insurance. Also, physicians practising in those countries are usually employed in the public sector and top up their incomes by working in the private sector on a fee-for-service basis. It should be noted, however, that in all these countries the private for-profit sector is quite small.

The restriction on the role of private health care insurance in Canada as well as on physician opted-out practice is unique among OECD countries. Pressures to loosen the restrictions and create a parallel system of private insurance and delivery will increase, however, if timely access to needed services cannot be assured in the publicly funded health care system. This observation was already noted in 1996 by Glouberman and Vining when they stated that:

*It is obvious that any significant initiatives (whether implicit or explicit) to further ration publicly-financed health care will encourage increased demand for privately-financed health care.<sup>380</sup>*

Jeffrey Lozon, President of St. Michael's Hospital in Toronto and former Deputy Minister of Health in Ontario, put this question to the Committee:

*When you take the notions of a private insurance system (...) out of the discussion, you are left inevitably with the question of tax increases, whether dedicated or not. I would like to raise this: Why not allow individuals to purchase health insurance that would provide them with another level of care (...)? Why not allow individuals who have the wherewithal to say, "I do not want to have to wait six months for my hip replacement", to buy that service?<sup>381</sup>*

## **16.2 Review of Recent Literature on the Impact of Private Health Care Insurance and Private For-Profit Delivery**

Advocates for a parallel private system argue that it will ensure the sustainability of the publicly funded system (by reducing public cost pressures), improve access to the public system (by reducing waiting times), and improve quality in the public system (through competition). They also argue that private health care insurance would give patients access to greater choice and higher-quality services without compromising the public system.

By contrast, opponents of a parallel private system contend that it will create "two-tier" health care, compromise equity, increase costs, and reduce quality and access to the publicly financed system, as those who have the financial means to purchase private insurance exit to private delivery institutions. They also argue that, with higher pay-per-unit activity in the privately funded system, personnel is likely to be drawn from the public system, making waiting times longer in the public system in the absence of an adequate supply of doctors and nurses. Moreover, they contend that the private for-profit sector "cherry picks" the relatively routine, uncomplicated (and therefore less expensive) care – elective surgery and the like – and leaves to

---

<sup>380</sup>Steven Glouberman and Aidan Vining, *Cure or Disease? Private Health Insurance in Canada*, University of Toronto, 1996, p. 61.

<sup>381</sup> Jeffrey Lozon (53:64).

the public system the complex, emergency and more expensive services, thereby increasing substantially the unit costs of the public system.

The Committee believes that the truth lies between those two extreme views. What does the international evidence suggest? A review of recent literature on the subject of private health care insurance and delivery indicates the following:<sup>382</sup>

- In the United Kingdom (as in New Zealand), private health care insurance has encouraged the development of private health care delivery. In both countries, physicians can work in the public as well as the private sector; physicians are usually employed in the public sector and top up their incomes by working in the private sector on a fee-for-service basis.
- In the United Kingdom (as in Germany and the Netherlands), private health care insurers pay much more than does public insurance for the same health service. For example, physicians can earn three to four times more in the private sector than in the National Health Service (NHS) for providing the same service.
- Private hospitals are well established in the United Kingdom and are regularly used by the NHS to pick up excess demand when public sector waiting times get too long (just as some provincial governments use the American private health care sector to relieve queues in Canada).
- Patients holding private health care insurance in Australia can select the physician of their choice for hospital care. Evidence suggests that these private patients get quicker access to treatments for which publicly insured patients face a queue. Queue-jumping by wealthy, privately insured patients is also prevalent in Sweden and in the United Kingdom.
- In Australia, there has been no change in public-sector waiting times following the subsidy policy to encourage private health care insurance. Similarly, evidence from New Zealand and the United Kingdom suggests that, although long public waiting times tend to fuel demand for private health care insurance, having it does not reduce the length of public waiting times.

---

<sup>382</sup> See the following documents:

Brian Lee Crowley, *Private Financing, Private Delivery. Two Tier Health Care?*, Presentation to the National Health Care Leadership Conference Panel, Halifax, 27 May 2002.

Stefan Greß et al., *Private Health Insurance in Social Health Insurance Countries – Market Outcomes and Policy Implications*, Discussion Paper, February 2002.

Jeremiah Hurley et al., *Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada*, Centre for Health Economics and Policy Research Analysis, McMaster University, Working Paper 01-12, December 2001.

Colleen M. Flood, Mark Stabile and Carolyn Hughes Tuohy, *Lessons From Away: What Canada Can Learn From Other Health Care Systems*, Document prepared for the Committee, 30 April 2001.

Colleen M. Flood and Tom Archibald (March 2001), *op. cit.*

Raisa Deber et al., "Why not Private Health Insurance? 1. Insurance Made Easy", *Canadian Medical Association Journal*, Vol. 161, No. 5, 7 September 1999, pp. 539-542.

Carolyn H. Tuohy, Colleen M. Flood and Mark Stabile, *How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence From OECD Countries*, Paper submitted to the Journal of Health Politics, Policy and Law, University of Toronto.

- Evidence from Australia and the United Kingdom suggests that private parallel delivery systems tend to offer a limited range of services for niche markets; they focus on relatively simple, less complex, elective procedures, shifting the burden of the most expensive cases and patients requiring more comprehensive care to the public system.
- In the Netherlands, the government regulates the maximum fees physicians may charge for the treatment of privately insured patients. This has reduced the incentives for preferential treatment of privately insured patients compared to those publicly insured.
- In the Netherlands, two factors help prevent the health care system from becoming a “two-tier” system. First, those who purchase private health care insurance cannot fall back on the public system for some of their health care needs. Private insurers cannot just skim off the easier kinds of care like elective surgery (as happens in the United Kingdom); they must cover all needs. Second, having private insurance does not enable Dutch citizens to jump queues in the public system. It is seen as contrary to a physician’s ethical code to select patients with private insurance over other patients; patients of both kinds are treated side-by-side in the same hospitals.
- In Germany, privately insured people tend to receive more comprehensive and faster treatment than do people with public health care insurance.
- In both Germany and the Netherlands, governments quite extensively regulate private health care insurance in order to ensure affordable premiums and limit risk selection by private insurers.
- In Australia, Sweden and the United Kingdom, people who purchase private health care insurance do so out of after-tax income and must continue to pay the same rate of income tax. That is, they pay doubly for health care insurance through general taxation and private premiums. This contrasts with the situation in both Germany and the Netherlands, where residents holding private health care insurance do not contribute to any Sickness Funds.
- Data from 22 OECD countries indicate that increases in private spending on health care are associated over time with decreases in public health care funding. There appears, then, to be some justification for the concern that increasing the proportion of private financing will substitute for and dilute rather than supplement public funding.

On the basis of the evidence from other countries presented above, the Committee has concluded that no country in which a parallel private health care insurance and delivery system coexists with a public health care insurance scheme can serve as a model

***On the basis of the evidence available from other countries, the Committee has concluded that no country in which a parallel private health care insurance and delivery system coexists with a public health care insurance scheme can serve as a model that should be adopted, without change, by Canada.***

that should be adopted, without change, by Canada.

Countries in which parallel private systems compete with publicly funded health care coverage exhibit a number of problems, including: risk selection and cream skimming; no reduction in waiting lists in the public sector; queue jumping; and preferential treatment. These concerns must be appropriately addressed if governments fail, for whatever reason, to provide funding sufficient to assure timely access to care in our publicly funded Canadian health care system.

### **16.3 Committee Commentary**

It is the view of the Committee that, in the absence of governments providing adequate funding, and providers delivering effective and timely health services, to paraphrase section 1 of the Charter, it would no longer be just and reasonable in a free and democratic society to deny Canadians the right to purchase private health care insurance. They should not be denied the right to purchase private supplementary insurance to pay for services they are unable to access in a timely fashion in the publicly funded health care system.

While the Committee would regard such a development as very regrettable, and while many Canadians would strongly oppose it, it is important to recognize two facts:

- first, as indicated in Section 16.2, Canada is the *only* major industrialized country which does not have some element of a parallel private hospital and doctor system;
- second, the *current* Canadian system is not nearly as “one tier” as popular mythology would have Canadians believe.

As a matter of fact, people who can afford it can, and do, go out of Canada (usually to the United States) to access the health services they want if their only alternative is a long queue for those services in Canada.

There is also strong anecdotal evidence to suggest that the situation in Canada is similar to that in Australia, where, in the words of one of the Australian witnesses who testified before the Committee; “access to public (health) services is usually more easily obtained by wealthier and more powerful individuals who understand how the system works and have appropriate contacts in hospital service delivery and administration.”

In addition, provincial Workers’ Compensation Boards in most provinces receive preferred access to treatment for their clients based on the argument it is necessary to ensure the client gets back to work quickly (which, of course, saves the Workers’ Compensation Board money). Moreover, in some provinces, Workers’ Compensation Boards have contracts with hospitals for a specified number of beds and diagnostic procedures, thus ensuring quick access to services for WCB patients. They also make direct payments to physicians for services performed, and such payments do not count toward any provincial cap on a physician’s income.

All these facts are important for Canadians to reflect on as they consider whether they want the federal government to support or reject the Committee’s recommendation for an additional \$5-billion investment in health care.

The Committee realizes that some people will be offended by the Committee's raising the potential development of a parallel private system of health care. They are likely to claim that it is possible for Canadians to maintain the current publicly funded system without their having to put more money into the system (e.g., the \$5 billion proposed by the Committee). Such critics will probably say that:

- The current system is inefficient and that restructuring will save sufficient money to cover the increasing costs of the system. The Committee has repeatedly acknowledged the critical importance of improving the effectiveness and efficiency of the management and delivery of health care (see Chapter 2 of Volume Five and Chapters 2, 3 and 4 of this report). But the Committee has also repeatedly stated that there is *not* enough evidence to support the hypothesis that efficiency gains alone will be sufficient to avoid having to put large amounts of new funds into the system, particularly if the growing gaps in the system are to be closed. Furthermore, there is widespread to near-universal agreement that substantial amounts of additional money are required to achieve the massive and fundamental changes necessary to create a genuine health care system, capable of achieving acceptable standards of efficiency and effectiveness together with the quality of outcomes we in Canada can, and should, demand.
- In addition, those who hold the view that efficiency measures only are required to refinance the health care system gloss over the key fact that restructuring in any industry costs money - money that has to be spent before the resulting efficiency savings are realized.
- The argument will also be made that the additional \$5 billion can come from the federal surplus anticipated over time. This argument, however, completely ignores the fact that there are several other compelling demands on any federal surplus, such as agriculture, the Canadian Armed Forces, infrastructure for Canada's major cities, and so on. The Committee believes that the majority of any federal surplus should *not* be devoted only to health care or even primarily to health care. More important, since surpluses rise and fall (as now) with the state of the economy, it would be irresponsible for government to base the future of the Canadian health care system on the vagaries of the economic cycle.

Therefore, the Committee categorically rejects the position that the problems of Canada's health care system can be solved in a way that is cost-free to individual Canadians. We believe that Canadians, through their federal government, must confront head-on the choice between putting considerably more money into the health care system or having the courts rule in favour of the emergence of a parallel private system.

***The Committee believes that Canadians, through their federal government, must confront head-on the choice between putting considerably more money into the health care system or having the courts rule in favour of the emergence of a parallel private system.***



**Part VIII:**  
***The Canada Health Act***

---





## CHAPTER SEVENTEEN

### THE CANADA HEALTH ACT

---

In Volume One, the Committee traced the evolution of the nation-wide principles of the Canadian health care system. We stressed the fact that although the delivery of health care is primarily within provincial/territorial jurisdiction, it does not mean that national interests are absent. For its part, the federal government established national principles and contributed to meeting the cost of health care, first through cost-sharing (from 1966 to 1977) and subsequently by block-funding.<sup>383</sup>

These national principles are currently set out in the *Canada Health Act* (the Act), which was *unanimously* enacted by Parliament in April 1984. The five national principles of the Act are:

- The principle of **universality**, which means that public health care insurance must be provided to all Canadians;
- The principle of **comprehensiveness**, which means that medically necessary hospital and doctor services are covered by public health care insurance;
- The principle of **accessibility**, which means that financial or other barriers to the provision of publicly funded health services are discouraged, so that health services are available to all Canadians when they need them;
- The principle of **portability**, which means that all Canadians are covered under public health care insurance, even when they travel within Canada and internationally or move from one province to another;
- The principle of **public administration**, which requires provincial and territorial health care insurance plans to be managed by a public agency on a not-for-profit basis. (This principle says nothing about the ownership structure of a health service *delivery* institution.)

As explained in Volume One, the Committee considers the first four principles of the *Canada Health Act* to be patient-oriented. The fifth principle – that of **public administration** – is of a completely different character. It is not patient-focussed but “is rather the means of achieving the end to which the other four principles are directed.”<sup>384</sup> The public administration condition of the *Canada Health Act* is the basis for the single insurer/funder model that the Committee endorsed in Volume Five under Principle One.<sup>385</sup>

Altogether, the five principles of the *Canada Health Act* flow from two overarching objectives for federal health care policy – objectives that the Committee strongly supports as the primary federal health care objectives. As indicated in Volume Four, these two objectives are:

---

<sup>383</sup> See Volume One, Chapter Two, pp. 31-44.

<sup>384</sup> Volume One, p. 41.

<sup>385</sup> Volume Five, pp. 23-25.

- To ensure that every Canadian has *timely* access to all medically necessary health services *regardless* of his or her ability to pay for those services.
- To ensure that *no* Canadian suffers *undue* financial hardship as a result of having to pay health care bills.<sup>386</sup>

Each recommendation made in this report with respect to 1) restructuring of the hospital and doctor system, 2) establishment of a national health care guarantee, 3) improvement of the health care infrastructure, and 4) enhancement of federal funding for health care, is designed to make progress toward achieving these two overarching public policy objectives in ways that are consistent with the principles of the *Canada Health Act*. Adopted together, these recommendations will ensure the long-term sustainability of Canadian Medicare.

***All recommendations put forward by the Committee in this report are designed to make progress toward achieving the two overarching public objectives of federal health care policy in ways that are consistent with the principles of the Canada Health Act.***

The Committee's recommendations relating to the expansion of public health care coverage are also intended to preserve the primary objectives of federal health care policy, although we recognize that some of the program characteristics proposed for such expansion do not comply with the *Canada Health Act*. This is particularly true with respect to the out-of-pocket payment provisions up to an annual cap/maximum of 3% of family income proposed for catastrophic prescription drug coverage.

This chapter provides a description and interpretation of the principles of the Act in light of the Committee's recommendations. It is against the principles set out in the *Canada Health Act* and the potential for achieving the two federal health care policy objectives that the Committee's recommendations should be judged.

***It is against the principles set out in the Canada Health Act and the potential for achieving the two federal health care policy objectives that the recommendations of the Committee should be judged.***

## **17.1 Universality**

The principle of universality of the *Canada Health Act* requires that *all* residents of a province or territory be entitled, on uniform terms and conditions, to the publicly funded health services covered by provincial/territorial plans. Universality is often considered by Canadians as a fundamental value that ensures national health care insurance for everyone wherever they live in the country.

Universality does not dictate a particular source of funding for the health care insurance plan. As a matter of fact, the provinces/territories can and do fund their universal plans as they wish, through premiums, dedicated or general taxation. By contrast, universal health care coverage in both Germany and the Netherlands is provided through a system of dedicated payroll taxes.

---

<sup>386</sup> Volume Four, p. 16.

Moreover, universality is not necessarily achieved only through public funding. For example, universal coverage for health services is guaranteed by both Sickness Funds (public plans) and private insurers in Germany and the Netherlands. Similarly, the Quebec Pharmacare program provides universal coverage through a combination of public and private insurance.

Perhaps more important, the principle of universal coverage does *not* necessarily mean first-dollar coverage. In fact, countries that provide universal health care coverage, like Australia, Germany, the Netherlands and Sweden, permit user charges and extra-billing for publicly insured services. In Canada, first-dollar coverage for publicly funded hospital and doctor services is required under the provisions of the *Canada Health Act* that explicitly prohibit user charges and extra-billing (see Section 17.3, below).

***The Committee feels it is important to stress that the principle of universal coverage does not necessarily mean first dollar coverage.***

The principle of universality is one the Committee holds dear. It ensures that access to publicly funded health services is available to everyone, everywhere, and that no one is discriminated against on the basis of such factors as income, age, and health status. We believe that universal insurance coverage and the access it provides to the publicly funded hospital and doctor system has served Canadians extremely well. Accordingly, it should be preserved.

Similarly, the Committee believes strongly that the broadening of public coverage recommended in this report should rest on the principle of universality. In our view, coverage for catastrophic prescription drug costs, post-hospital home care and out-of-hospital palliative care must be provided to *all* Canadians, when they need them.

***The Committee is of the view that coverage for catastrophic prescription drug costs, post-hospital home care and out-of-hospital palliative care must be provided to all Canadians, when they need them.***

## **17.2 Comprehensiveness**

Health services that must be covered under the *Canada Health Act* are determined on the basis of the “medical necessity” concept under the principle of comprehensiveness. All medically necessary health services provided by hospitals and doctors must be covered under provincial/territorial health care insurance plans.

The determination of what services ought to be considered “medically necessary” is a difficult task. Most Canadians would agree that life-saving cardiac procedures are medically necessary. Most Canadians would also agree that most cosmetic surgery procedures do not meet that criterion. The difficulty comes with those services that lie between these two extremes.

Deciding what health services are to be insured and excluded has always been part of the way Canadian Medicare has functioned. These decisions are made in each province/territory by the government after negotiation with the medical profession. That is why there are differences in what is covered publicly in different provinces/territories. For example, as reviewed in Volume One, the removal of warts is no longer covered in Nova Scotia, New Brunswick, Ontario, Manitoba, Alberta, Saskatchewan and British Columbia, but remains

publicly insured in Newfoundland, Quebec and Prince Edward Island. Similarly, stomach stapling is covered in most provinces, but it is not insured in New Brunswick, Nova Scotia or the Yukon, where patients (or their private supplementary health care insurance) must pay for this procedure.<sup>387</sup>

The Committee was told repeatedly that the current process for determining what is and what is not covered under provincial/territorial health care insurance plans is conducted in secret by governments, acting with the provincial/territorial medical associations, with no public input. It is not an open and transparent process. For example, the Canadian Healthcare Association pointed that:

*Unilateral pronouncements from governments of the delisting of services are certainly not in the best interest of Canadians.*

*(...) Any discussions or decisions regarding the “basket of services” must be evidence based and involve an open and transparent process that meaningfully involves all stakeholders.*<sup>388</sup>

The Committee shares the view of the Canadian Healthcare Association and many other witnesses that transparency requires that the process of deciding what is, and what is not, to be publicly insured should be much more open than it has been historically and is now.

***The Committee shares the view of many witnesses that transparency requires that the process of deciding what is, and what is not, to be publicly insured should be much more open than it has been historically and is now.***

For this reason, the Committee enunciated Principle Four in Volume Five, which states that the determination of what should be covered under public health care insurance should be done through an open and transparent process.<sup>389</sup> This principle also reflects the views expressed in the report of the Clair Commission in Quebec and the Mazankoski report in Alberta, both of which recommended that consideration should be given to reviewing the principle of comprehensiveness of the *Canada Health Act*. Both recommended the establishment of a permanent committee, made up of citizens, ethicists, health care providers and scientists, to review and make decisions on the range of services that should be covered publicly. Such a review would set the boundaries between publicly insured and privately funded health services; it would also lead to evidence-based (as opposed to the current negotiated process) decision making with respect to what services should be covered under public health care insurance.

The Committee believes strongly that the permanent committee charged with revising the set of publicly funded health services should be broad-based in membership and not be composed entirely of experts. We believe that input from those who would be directly

---

<sup>387</sup> Volume One, pp. 98-99.

<sup>388</sup> Canadian Healthcare Association, Brief to the Committee, May 2002, pp. 3-4.

<sup>389</sup> Volume Five, pp. 30-32.

affected by the committee's decisions – namely, citizens – is essential if the process is to be truly open and is to have public credibility and acceptability.

The Committee also believes that there should be rational standards to define those services covered publicly in each province/territory. This would bring more uniformity to public health care coverage across the country. Therefore, the Committee recommends that:

**The federal government, in collaboration with the provinces and territories, establish a permanent committee – the Committee on Public Health Care Insurance Coverage – made up of citizens, ethicists, health care providers and scientists.**

**The Committee on Public Health Care Insurance Coverage be given the mandate to review and make recommendations on the set of services that should be covered under public health care insurance.**

**The Committee on Public Health Care Insurance Coverage report its findings and recommendations to the National Health Care Council.**

**As its first task, the Committee on Public Health Care Insurance Coverage be charged with developing national standards upon which decisions for public health care coverage will be made.**

It must be recognized that revising the comprehensive basket of publicly insured health services is not intended to reduce costs. It is intended to improve both transparency and evidence-based decisions with respect to comprehensiveness of publicly funded health services. The purpose of such a review is to use clinical, evidence-based, research to ensure that publicly insured health services are those that are most clinically effective in preventing disease, restoring and maintaining health, and alleviating pain and suffering.

Another important critique raised with respect to the principle of comprehensiveness of the *Canada Health Act* relates to its limited scope of coverage. In Volume One, the Committee stated that the *Canada Health Act* is very limited: it is centred on medically necessary health services provided by hospitals and doctors. Moreover, the Act applies to a shrinking range because fewer services are provided now in hospitals. Thanks to new knowledge and technologies, many more health services can be provided safely and effectively on an ambulatory basis or at home. Hospital stays are shorter; drug therapy often enables people to avoid hospital-based care altogether.

As shown in Volume Three, there is a sharp contrast between Canada and other OECD countries in terms of the scope of its public health care coverage. Many countries with a similar share of public spending in total health care expenditures provide coverage that is much broader than Canada's, encompassing such items as prescription drugs (Australia, Germany, Sweden, the United Kingdom), home care (Germany, Sweden), and long-term care (Germany, the Netherlands).

As described elsewhere in this report, when services and prescription drugs are provided outside hospitals, they fall outside the ambit of the *Canada Health Act*. As a result, these services are not usually provided cost-free to the patients, nor are they necessarily provided in accordance with the principles of accessibility, comprehensiveness and universality.<sup>390</sup> Moreover, testimony received by the Committee suggests that, more and more often, individual Canadians bear heavy financial burdens as a result of incurring very high out-of-pocket expenditures to obtain these services.

Based on the evidence it gathered throughout its hearings, and as set out in Chapters Seven, Eight and Nine of this report, the Committee has come to the conclusion that there is a need to expand public health care insurance coverage to encompass three new applications: catastrophic prescription drug costs, post-hospital home care costs, and palliative home care costs.

It is the view of the Committee that broadening public health care coverage to encompass catastrophic prescription drug costs, post-hospital home care costs and palliative home care costs is consistent with the primary objectives of federal health care policy. This is particularly true with respect to catastrophic prescription drug costs if we are to meet the second objective of federal health care policy – that no Canadian suffers undue financial hardships as a result of having to pay health care bills.

***It is the view of the Committee that broadening public health care coverage to encompass catastrophic drug costs, post-hospital home care costs and palliative home care costs is consistent with the primary objectives of federal health care policy.***

The Committee acknowledges that national parameters will have to be developed for both post-hospital home care and palliative care delivered out-of-hospital. This would be consistent with the original intent of the national health care insurance program. The Committee on Public Health Care Insurance Coverage could play a major role in this area. Therefore, the Committee recommends that:

**The Committee on Public Health Care Insurance Coverage be charged with determining the national parameters applicable to post-hospital home care and palliative care delivered in the home.**

---

<sup>390</sup> Volume One, pp. 35-36.

### 17.3 Accessibility

The principle of accessibility in the *Canada Health Act* stipulates that Canadians should have “reasonable access” to insured hospital and doctor services. However, the Act does not provide a clear definition as to what constitutes reasonable access. Although originally the primary concern was to eliminate financial barriers, lately the concern over access to health care has been associated primarily with the problem of waiting times. There is no doubt that a major problem of the current health care system is one of *timely* access. As stated earlier, it is the view of the Committee that “timely access” describes more accurately what Canadians expect from the publicly funded health care system than “reasonable access.”

The Committee believes that, since governments have the responsibility of providing funding sufficient to ensure an adequate supply of the essential services of hospitals and doctors, this responsibility carries with it the obligation to ensure reasonable standards of access. This is the essence of a patient-oriented system and of the health care “contract” between Canadians and their governments.

***In the view of the Committee, the National Health Care Guarantee is the essence of a patient-oriented system and of the health care “contract” between Canadians and their governments.***

It is the view of the Committee that a maximum waiting time guarantee for publicly insured health services would meet this obligation. For this reason, we have, in Chapter Six, recommended establishment of a National Health Care Guarantee.

How (and where) does a National Health Care Guarantee fit in the context of the *Canada Health Act*? There are a number of possibilities:

1. The health care guarantee could be added as a sixth principle to the Act. As such, provincial and territorial governments that failed to comply with the National Health Care Guarantee would be subject to the financial penalties currently present in the *Canada Health Act*.
2. The health care guarantee could be appended to the *Canada Health Act* or expressed in the preamble of the Act. This excludes the possibility of enforcement or penalty by the federal government.
3. The National Health Care Guarantee could be introduced in new legislation, similar to the *Canada Health Act*, but subject to different principles, different enforcement mechanisms and different penalties.

***The Committee has concluded that the National Health Care Guarantee would be most effective if implemented through legislation distinct from the Canada Health Act.***

The Committee has concluded that the National Health Care Guarantee would be most effective if implemented through legislation *distinct* from the *Canada Health Act*. A new Act giving effect to the National Health Care Guarantee would ensure that the definition of *timely* access to needed hospital and doctor services is set uniformly across the country and that the

federal government plays a major role in this guarantee. Therefore, the Committee recommends that:

**The federal government enact new legislation establishing the National Health Care Guarantee. The new legislation should include a definition of the concept of “timely access” that will relate to such a guarantee.**

Another important provision of the *Canada Health Act* relating to the accessibility criterion is that insured people have uniform access to hospital and doctor services without any financial barrier. It is for this reason that user charges and extra-billing are not permitted for services covered under the *Canada Health Act*.

However, the question of whether patients should make a financial contribution with respect to the new publicly insured health services we recommend is one that should be addressed. The Committee believes that Canada’s public purse cannot afford first dollar coverage for the broader range of health services the Committee is recommending. We have suggested, therefore, in our proposal for catastrophic prescription drug cost coverage that individuals make a financial contribution to the cost of the prescription drugs they take.

***The question of whether patients should make a financial contribution with respect to new publicly insured health services is one that should be addressed. The Committee believes that Canada’s public purse cannot afford first-dollar coverage for the broader range of health services the Committee is recommending.***

Requiring some financial contribution from patients for the expanded set of publicly insured services is not consistent with the *Canada Health Act*. Therefore, it is not possible simply to add “catastrophic prescription drugs” to the current list of medically required services set out in the *Canada Health Act*.

The Committee’s proposal to expand public health care coverage to post-hospital home care for a three-month period and to insure at home palliative care costs appears to be consistent with both the spirit and the letter of the *Canada Health Act*. However, the Committee is recommending that this expansion in coverage be funded through a new cost-sharing mechanism totally different from the CHST. This additional federal funding will be subject to a number of conditions (including accountability and transparency) that are not currently found under the CHST or the *Canada Health Act*. Federal funding for coverage of catastrophic prescription drugs will also be provided through the new funding mechanism, not the CHST.

***The Committee believes that the expansion of public coverage to include catastrophic prescription drugs, post-hospital home care and palliative care in the home must be authorized through new federal legislation, and not under the Canada Health Act.***

For all these reasons, the Committee believes that the expansion of public coverage to include catastrophic prescription drugs, post-hospital home care and palliative care



in the home must be authorized through new federal legislation, and not under the *Canada Health Act* (see Section 17.6 below).

## 17.4 Portability

The portability criterion of the *Canada Health Act* requires that the provinces and territories extend medically necessary hospital and physician coverage to their residents during temporary absences (business or vacation) from the province or territory. This allows individuals to travel away from their home province or territory and yet retain their public health care insurance coverage. This portability requirement applies to emergency health services: residents must seek prior approval from their home province health care insurance plan for non-emergency (elective) health services provided out-of-province.

The principle of portability also applies when residents move from one province or territory to another: they must retain their coverage for insured health services by the “home” province during a minimum waiting period in the “host” province that does not exceed three months. After the waiting period, the new province or territory of residence assumes the responsibility for public health care coverage.

Canadians are also entitled to portable public health care insurance coverage when they are temporarily out of the country. Most provinces, however, limit the reimbursement of the cost of emergency health services obtained outside Canada under their public health care insurance. For this reason, Canadians are strongly encouraged to purchase supplementary private health care insurance when they travel in another country.

Within Canada, the portability provision of the *Canada Health Act* is generally implemented through bilateral reciprocal billing agreements among the provinces and territories for hospital and physician services. These agreements are interprovincial, not federal, and signing them is not a requirement of the *Canada Health Act*.<sup>391</sup> The rates prescribed within these agreements are those of the host province (apart from Quebec, which pays home-province rates), and the agreements are meant to ensure that Canadian residents travelling in another province/territory, for the most part, will not face any user charges at the point of service for medically required hospital and physician services.

Reciprocal billing is a convenient administrative arrangement. However, it is but one method of satisfying the portability criterion of the Act. A requirement for patients to pay “up front” and seek reimbursement from their home province or territory also satisfies the portability criterion of the Act as long as access to a medically necessary insured service is not denied based on the patient’s inability to pay.<sup>392</sup>

Overall, the principle of portability under the *Canada Health Act* provides Canadians with peace of mind when they travel within Canada or when they move from one province/territory to another. Perhaps more important, the principle of portability is closely

---

<sup>391</sup> The Government of Quebec has not always been signatory to these agreements.

<sup>392</sup> At present, portability does not always apply to Quebec residents as many providers in other provinces will not treat Quebec residents if they do not pay the medical fees upfront. In many cases, this is not possible and Quebec residents have been transferred in ambulance for long distances in difficult circumstances back to Quebec.

linked to that of universality and it certainly encourages uniformity in public health care coverage.

The Committee believes that portability is an important national principle that should be maintained when expanding public coverage to catastrophic prescription drug costs, post-hospital home care and palliative care costs.

***The Committee believes that portability is an important national principle that should be maintained when expanding public coverage to catastrophic prescription drug costs, post-hospital home care and palliative care costs.***

## **17.5 Public Administration**

The public administration criterion of the *Canada Health Act* relates to the *administration* of provincial/territorial health care insurance plans for medically necessary health services. It stipulates that provincial/territorial health care insurance plans must be administered by a public agency on a not-for-profit basis. The principle of public administration was underlined in Volume Five under Principle One, which states that there should be a single funder/insurer – the government – for hospital and doctor services covered under the *Canada Health Act*.<sup>393</sup>

In the view of the Committee, a single funder system yields considerable efficiencies over any form of multi-funder arrangement, including administrative, economic and informational economies of scale. Furthermore, since a publicly funded hospital and doctor system has become a fundamental element of Canadian society, the Committee believes that the single funder should be government.

***In the view of the Committee, a single funder system yields considerable efficiencies over any form of multi-funder arrangement, including administrative, economic and informational economies of scale. Furthermore, since a publicly funded hospital and doctor system has become a fundamental element of Canadian society, the Committee believes that the single funder should be government.***

In Volume Five, we explained that a compelling argument for the retention of a single public funder or insurer for the hospital and doctor system is that Canadians support it strongly. The Committee agrees that this central element of our system must be maintained, *provided* that the system meets appropriate standards for high-quality services delivered in a timely manner.

Many witnesses told the Committee that giving primary financial responsibility to a single funder provides the Canadian health care system with a more efficient administration of health care insurance than is possible under a multi-funder system. They also testified that Canada's publicly financed single insurer system for medically necessary health services eliminates costs associated with the marketing of competitive health care insurance policies, billing for and collecting premiums, and evaluating insurance risks.

---

<sup>393</sup> Volume Five, pp. 23-25.

Another strong argument in favour of public health care insurance is the fact that very few Canadians can afford not to be covered. It therefore makes sense to have everyone covered by a single plan. A single insurer system providing universal coverage also means that no one will deny themselves needed health care because they have what they feel to be a more pressing use for their money (perhaps for food, shelter, clothing, etc.). Nor will anyone be denied necessary care due to their inability to pay.

Yet another important advantage relates to the principle of risk sharing. The more who share the risk (all Canadians), the lower the cost of insuring against all risks.

The Committee also heard that a single insurer makes a lot of economic sense for Canadian industry and is an important element of Canadian competitiveness. This point was put eloquently by Paul Darby, Director of Economic Forecasting and Analysis, Conference Board of Canada, when he stated:

*(...) our largely single payer system has significant efficiency advantages, in general, and that these in turn help improve our industrial competitiveness. We should not lose these advantages.*<sup>394</sup>

A single funder model implies that there will not be, within Canada, a parallel, private insurance sector that competes with public insurance for the funding of hospital and doctor services under the *Canada Health Act*, at least in those hospitals and with those doctors that care for publicly insured patients.

Up to now, the single insurer model has discouraged the growth of a second tier of health care that many claim would pose a significant threat to Canada's publicly funded health care system. We point out, however, that parallel public and private health care systems exist in most other industrialized countries.

In Chapters Five, Six and Sixteen, the Committee has raised the concern that laws that, in effect, prevent the development of a parallel private system, and hence help preserve the principle of public administration of the *Canada Health Act*, may be struck down by the courts if the publicly funded and insured health care system fails to provide *timely* and quality care. Should this happen, the principle of public administration would have to be revisited. The Committee believes that, Through implementation of its recommendations, our publicly funded health care system can provide timely access to services of very high quality and that Canada's single insurer model for hospitals and doctors will be preserved.

***It is the hope of the Committee that Canada's single insurer model for hospitals and doctors will be preserved.***

As noted in Volume One, it is equally important to understand clearly what the public administration principle of the *Canada Health Act* does not mean. This principle refers to the *administration* of health care insurance coverage; it does not deal with the *delivery* of publicly insured health services. The Act does not prevent provinces and territories from allowing

---

<sup>394</sup> Paul Darby, Brief to the Committee, 3 June 2002, p. 2.

private (for-profit and not-for-profit) health care providers, whether individual or institutional, to deliver, and be reimbursed for, provincially insured health services, so long as extra-billing or user charges are not involved. This is, in fact, what Canadian Medicare has been from the start – a national health care insurance program based primarily on the *private* (both for-profit and not-for-profit) *delivery of publicly insured* hospital and doctor services.

The Committee is concerned that the principle of public administration is poorly understood, particularly because of the confusion between administering public health care insurance and delivering publicly insured health services. We believe that the federal government, namely through Health Canada, should clearly articulate the meaning of “public administration” and make it clear that the *Canada Health Act* does not prohibit in any way the private delivery, either for-profit or not-for-profit, of publicly funded health services. This would greatly improve the current debate about health care in this country. Therefore, the Committee recommends that:

***In Volume One, the Committee noted that it is important to understand clearly what the public administration principle of the Canada Health Act does not mean. This principle refers to the administration of health care insurance coverage; it does not deal with the delivery of publicly insured health services.***

**The principle of public administration of the *Canada Health Act* be maintained for publicly insured hospital and doctor services. That is, there should be a single insurer – the government – for publicly insured hospital and doctor services delivered by either public or private health care providers and institutions.**

**The federal government, through Health Canada, clarify the meaning of the concept of public administration under the *Canada Health Act* so as to recognize explicitly that this principle applies to the administration of public health care insurance, not to the delivery of publicly insured health services.**

While the Committee is convinced that the principle of public administration must be maintained for the hospital and doctor system, it would be very difficult in our view to extend it to the broader range of health services recommended in this report. This is particularly true with respect to the expansion of public coverage against catastrophic prescription drug costs.

***The Committee believes that the expansion of coverage to include catastrophic prescription drug costs should be based on a partnership between the public and the private sectors. This is why the recommendations made in Chapter Seven are based on the collaboration of public and private insurers to ensure universal coverage for catastrophic prescription drug costs.***

Prescription drug coverage is currently provided by many insurers, ranging from governments to private insurance companies. In fact, the private drug insurance industry is already well established in Canada and it appears to be functioning well. The Committee believes, and has recommended in Chapter Seven, that the expansion of coverage to include catastrophic prescription drug costs should be based on a partnership between the public and the private sectors to ensure universal coverage for catastrophic drug costs.

## **17.6 Committee Commentary**

The Committee has no hesitation in saying that in-depth reform of the publicly funded hospital and doctor system can take place within the five national principles of the *Canada Health Act*. We believe that the Act has served Canadians relatively well in terms of providing universal and uniform coverage for hospital and doctor services. We feel that the four patient-oriented principles of the Act should be maintained for hospital and doctor services, while the principle of public administration should be clarified.

However, the Committee believes that Canadian Medicare and the *Canada Health Act* must be supplemented by two new pieces of legislation. First, as explained in Section 17.3, new federal legislation must be enacted to implement the National Health Care Guarantee. This legislated health care guarantee will improve access to the set of hospital and doctor services that are currently insured under the *Canada Health Act*. Second, the Committee's proposal to expand public coverage also requires the enactment of new legislation:

- Coverage for catastrophic prescription drug costs requires the financial participation of both public plans and private insurers (collaboration that is not consistent with the principle of public administration of the *Canada Health Act*).
- Coverage for catastrophic prescription drug costs requires that individuals make a financial contribution to cover part of the cost of the insured service (this is not consistent with the first-dollar coverage contained under the principle of accessibility of the Act).
- Coverage for catastrophic prescription drugs, post-hospital home care for a period of three months and palliative home care costs will be funded through a federal funding mechanism that is distinct from the current CHST (the principles of the *Canada Health Act* relate to the CHST only).
- The Committee believes strongly that additional federal funding provided for the expansion of public coverage must be based on specific conditions related to transparency and accountability (these principles are totally absent from the *Canada Health Act*).

While principles other than those of the *Canada Health Act* are needed for the new programs proposed in the report, the underlying value related to those services, namely, providing high-quality services on the basis of need, should remain. Similarly, access to reasonably comparable

***The Committee believes that, while principles other than those of the Canada Health Act are needed, the underlying value of receiving services on the basis of need should remain.***

services for all Canadians everywhere in the country must be assured under the legislation covering the new programs. This comparability requires the development of national standards. These should apply to all publicly funded services, whether delivered by private for-profit, private not-for-profit or public health care providers and institutions. Therefore, the Committee recommends that:

**The federal government enact new legislation instituting health care coverage for catastrophic prescription drugs, post-hospital home care and some palliative care in the home. This new legislation should explicitly spell out conditions relating to transparency of decision making and accountability.**

## CONCLUSION

---

Two years ago, at the outset of the Committee's work, the Committee endorsed two major public policy objectives for Canada's health care system:

- To ensure that every Canadian has timely access to medically necessary health services regardless of his or her ability to pay for those services, and
- To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.

Implicit in these two objectives, particularly the first, is the requirement that the medically necessary services provided under Medicare be of high quality. Clearly, providing access to services of inferior quality would defeat the purpose of Canada's health care system.

In addition, the Committee recognized that the value of fairness is also an important component of Canadians' views of the health care system. This value of fairness underlies the patient-oriented principles of a universal, comprehensive, portable and accessible system that the Committee – and Canadians – strongly support.

But, to Canadians, fairness also means equity of access to the system – wealthy Canadians should not be able to buy their way to the front of waiting lists in Canada. Repeated public opinion polling data have shown that having to wait months for diagnostic or hospital treatment is the greatest concern and complaint that Canadians have about the health care system. The solution to this problem is not, as some have suggested, to allow wealthy Canadians to pay for services in a private health care institution. Such a solution would violate the principle of equity of access. The solution is the care guarantee as recommended in this report.

Based on evidence presented at Committee hearings over the past two years as well as on public opinion polling data, the Committee is also aware that Canadians believe that the current system is inefficient. Moreover, Canadians are not prepared to invest additional money into the system until these inefficiencies are eliminated. The Committee realizes that changing this public perception of an inefficient system will not be easy. It will require the introduction of *incentives* to encourage all the components of the system to function more efficiently. It will also require that the system function in a much more transparent and accountable fashion, including in the ways in which public money is spent.

In formulating its recommendations, the Committee also took account of two additional factors. First, the Committee believes that if the second public policy objective given above – the no undue financial hardship objective – is to be met, steps must be taken *now* to begin to close the major gaps in the health care safety net. While the Committee believes that Canadians who are genuinely in need of help, and cannot afford to pay for it, should receive the assistance they need from public funds, this does not mean that what is needed are new first-dollar coverage programs in areas such as pharmacare or home care. In the Committee's view prudence requires that any expansion of the current system to begin to close the gaps in it must be done in small, manageable steps.

The second factor that is reflected in the Committee's recommendations is the belief that anyone proposing a plan to reform and renew the health care system has an obligation to say how their plan of reform will be paid for. Moreover, the payment method must be described in terms that are meaningful to individual Canadians.

The only way Canadians can develop an informed opinion on the merits of a proposed plan of reform is if they can clearly understand the benefits that will result from the plan, and what it will cost them to have the plan implemented.

***Anyone proposing a plan to reform and renew the health care system has an obligation to say how their plan of reform will be paid for. The only way Canadians can develop an informed opinion on the merits of a proposed plan of reform is if they can clearly understand the benefits that will result from the plan, and what it will cost them to have the plan implemented.***

It is for this reason that the Committee has taken the extremely unusual (some have even described it as unique) step of both costing our recommendations *and* putting forward a recommended option for raising the new federal revenue required to implement fully our recommendations. To fail to do this would, in our view, perpetuate the myth that health care is a "free" good. This would play directly into the hands of those who oppose reform. Not to give a revenue-raising plan would also mean that the Committee had failed to meet the test of transparency and accountability, which it has insisted throughout its recommendations must apply to the health care system as a whole.

***Not to give a revenue-raising plan would also mean that the Committee had failed to meet the test of transparency and accountability, which it has insisted throughout its recommendations must apply to the health care system as a whole.***

The Committee understands that the implementation of its set of recommendations will require considerable *behavioral change on the part of all participants* in the health care system. For example:

- The change to service-based funding will alter the way in which hospitals are managed. It will make hospital management, and the health care professionals working in a hospital, much more conscious of which procedures they do efficiently and which they do inefficiently. It will also mean that hospitals in large urban areas will face competition from other hospitals and specialist clinics.
- The changes involved in primary health care reform will require family physicians to accept changes to the way they are remunerated (by replacing straight fee-for-service by a remuneration model that is primarily capitation with an added component of fee-for-service). It will also require that modifications be made to the scope of practice rules for all health care professionals in order to ensure that such rules are not barriers to health care professionals being able to use their skills to the fullest extent for which they have been trained.



- The changes involved in primary health care reform will also require that patients agree to stay with their choice of family physician for a year, unless they move to a different community. The recommendation to set up a system of electronic health records will require that patients agree to give the necessary approval to enable an efficient use of patient electronic health records. (As explained in Chapter 10, the Committee believes that a system of electronic health records can be built, and the resulting information system operated, in a manner that is entirely consistent with the spirit as well as the letter of privacy laws.)
- Provincial/territorial governments will need to change a significant aspect of their approach to the health care system by agreeing to a health care guarantee, thus accepting responsibility for the consequences of their past decisions to cut budgets and ration the supply of health care services.
- Provincial/territorial governments will also have to move away from their current command-and-control approach to health care by giving regional health authorities sufficient autonomy and by allowing the system of incentives, with its associated behavioral change, to generate the desired results.
- The federal government will have to agree to the creation of an arms-length fund, overseen by a Health Care Commissioner and a National Health Care Council who will advise the government on how money in the fund should be spent. This advice should be made public, and there should also be an annual public accounting of how funds earmarked for health care are actually spent. This is an essential step in restoring public confidence in the system.
- The federal government will also have to accept that it has a major leadership role to play in financially sustaining the infrastructure that is essential to a successful national health care system. Included in this infrastructure are the nation's 16 Academic Health Sciences Centres, the national supply of human resources in the health care sector, technology, information systems and research.
- The federal government will also have to accept that it has a major role to play in financing, and marketing, programs of health promotion and chronic disease prevention.

Finally, it is important to stress how critical the objectives of greater accountability and transparency are to the Committee's views on the kinds of reform that are needed in the health care system, and the critical role that improved information, at all levels of the system, must play in implementing these objectives. This increased information is needed for the following reasons:

- first, to make more transparent the processes by which resource allocation decisions are made – principally with regard to money, but also including human resources;
- second, to enhance the accountability of the people, institutions and governments that decide what types of services will be covered by public health care insurance and how much of any particular service will be provided;
- third, and perhaps most important, to change the public debate from a debate about dollars to a debate about services and service levels.

Canadians have a right to debate the question of whether they are willing to pay more for improved levels of service, and they have a right to understand the linkages between funding levels and service levels. Changing the nature of the public debate about health care will mark a significant step towards gaining public support for restructuring and renewing the publicly funded hospital and doctor system.

The Committee fully recognizes that its set of recommendations will be subject to close critical scrutiny. This is entirely understandable in such a value-laden public policy issue as health care. In fact, it is likely that each reader of this report will support his or her own unique subset of recommendations.

We ask readers, however, to keep in mind that no major reform of any large system, particularly one as complex as the health care system, is ever perfect. There is no perfect solution. Everyone involved will have to be prepared to compromise in order to make reform work for the benefit of all Canadians. Insisting on perfection, or attempting to obtain everything one wants, will doom reform to failure.

***There is no perfect solution. Everyone involved will have to be prepared to compromise in order to make reform work for the benefit of all Canadians. Insisting on perfection, or attempting to obtain everything one wants, will doom reform to failure.***

Similarly, reform will fail if people insist on addressing all health care problems before beginning to make progress on some of them, particularly on the hospital and doctor system. These tendencies, along with a focus on self-interest by those employed in the system, explain why reform has failed in the past.

Recognizing these dangers, we have worked hard to develop a set of recommendations we believe to be pragmatic, middle-of-the-road in ideological terms, workable and that will lead to substantial improvements in the hospital and doctor sectors of the health care system. We believe that a steady pace of reform is the way to make the restructuring and renewal of Canada's health care system possible.

We trust that those involved in all aspects of the country's health care system, and indeed all Canadians, will consider the recommendations with the same pragmatic approach as the Committee, and that everyone will be prepared to make some compromises in order to meet our common goal: having a fiscally sustainable health care system of which Canadians can be truly proud.

***We trust that those involved in all aspects of the country's health care system, and indeed all Canadians, will consider the recommendations with the same pragmatic approach as the Committee, and that everyone will be prepared to make some compromises in order to meet our common goal: having a fiscally sustainable health care system of which Canadians can be truly proud.***



## **APPENDIX A**

### **LIST OF RECOMMENDATIONS BY CHAPTER**

---

#### **The Committee recommends that:**

#### **CHAPTER ONE:**

#### **THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS**

#### **A National Health Care Commissioner and National Health Care Council**

New federal/provincial/territorial committee made up of five provincial/territorial and five federal representatives be struck. Its mandate would be to appoint a National Health Care Commissioner and the other eight members of a National Health Care Council from among the Commissioner's nominees;

The National Health Care Commissioner be charged with the following responsibilities:

- To put nominations for members to a National Health Care Council before the F/P/T committee and to chair the Council once the nominees have been ratified;
- To oversee the production of an annual report on the state of the health care system and the health status of Canadians. The report would include findings and recommendations on improving health care delivery and health outcomes in Canada, as well as on how the federal government should allocate new money raised to reform and renew the health care system;
- To work with the National Health Care Council to advise the federal government on how it should allocate new money raised to reform and renew the health care system in the ways recommended in this report;
- To hire such staff as is necessary to accomplish this objective and to work closely with existing independent bodies to minimize duplication of functions.

The federal government provide \$10 million annually for the work of the National Health Care Commissioner and the National Health Care Council that relates to producing an annual report on the state of the health care system and the health status of Canadians, and to advising the federal government on the allocation of new money raised to reform and renew the health care system.

## **CHAPTER TWO:**

### **HOSPITAL RESTRUCTURING AND FUNDING IN CANADA**

#### **Service Based Funding**

Hospitals should be funded under a service-based remuneration scheme. This method of funding is particularly well suited for community hospitals located in large urban centres. In order to achieve this, a number of steps must be undertaken:

- A sufficient number of hospitals should be required to submit information on case rates and costing data to the Canadian Institute for Health Information;
- The Canadian Institute for Health Information, in collaboration with the provinces and territories, should establish a detailed set of case rates to reduce incentives to up-code.
- The federal government should devote ongoing funding to the Canadian Institute for Health Information for the purpose of collecting and estimating the data needed to establish service-based funding.
- The shift to service-based funding should occur as quickly as possible. The Committee considers a five-year period to be a reasonable timeframe for the full implementation of the new hospital funding.

Service-based funding should be augmented by an additional funding method that would take into account the unique services provided by Academic Health Sciences Centres, including teaching and research.

In developing a service-based remuneration scheme for financing of community hospitals, consideration be given to the following factors:

- Isolation: hospitals located in rural and remote areas are expected to incur higher costs than those in large urban centres. An adjustment should reflect this fact.
- Size: small hospitals are expected to incur higher costs per weighted case than larger hospitals. An adjustment should recognize this fact.

#### **Capital Support for Hospitals**

The federal government provide capital financial support for the expansion of hospitals located in areas of exceptionally high population growth; that is, areas in which the population growth exceeds the average rate of growth in the province by 50% or more. Such federal financial support should account for 50% of the total capital investment needed. In total, the federal government should devote \$1.5 billion to this initiative over a 10-year period, or \$150 million annually.

The federal government should encourage the provinces and territories to explore public-private partnerships as a means of obtaining additional investment in hospital capacity.

The federal government contribute \$4 billion over the next 10 years (or \$400 million annually) to Academic Health Sciences Centres for the purpose of capital investment.

Academic Health Sciences Centres be required to report on their use of this federal funding.

## **CHAPTER THREE**

### **DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES**

Regional health authorities in major urban centres be given control over the cost of physician services in addition to their responsibility for hospital services in their regions. Authority for prescription drug spending should also be devolved to RHAs.

Regional health authorities should be able to choose between providers (individual or institutional) on the basis of quality and costs, and to reward the best providers with increased volume. As such, RHAs should establish clear contracts specifying volume of services and performance targets.

The federal government should encourage the devolution of responsibility from provincial/territorial governments to regional health authorities, and participate in evaluating the impact of internal market reforms undertaken at the regional level.

## **CHAPTER FOUR**

### **PRIMARY HEALTH CARE REFORM**

The federal government continue to work with the provinces and territories to reform primary care delivery, and that it provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care teams that:

- are working to provide a broad range of services, 24 hours a day, 7 days a week;
- strive to ensure that services are delivered by the most appropriately qualified health care professional;
- utilise to the fullest the skills and competencies of a diversity of health care professionals;
- adopt alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae;
- seek to integrate health promotion and illness prevention strategies in their day-to-day work;

- progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.

The federal government commit \$50 million per year of the new revenue the Committee has recommended it raise to assist the provinces in setting up primary care groups.

## **CHAPTER FIVE**

### **TIMELY ACCESS TO HEALTH CARE**

There are no recommendations in this chapter.

## **CHAPTER SIX**

### **THE HEALTH CARE GUARANTEE**

For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public.

When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country (e.g., the United States). *This is called the Health Care Guarantee.*

The process to establish standard definitions for waiting times be national in scope.

An independent body be created to consider the relevant scientific and clinical evidence.

Standard definitions focus on four key waiting periods – waiting time for primary health care consultation; waiting time for initial specialist consultation; waiting time for diagnostic tests; waiting time for surgery.

## **CHAPTER SEVEN**

### **EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS**

The federal government introduce a program to protect Canadians against catastrophic prescription drug expenses.

For all eligible plans, the federal government would agree to pay:

- 90% of all prescription drug expenses over \$5,000 for those individuals for whom the combined total of their out-of-pocket expenses and the contribution that a province/territory incurs on their behalf exceeds \$5000 in a single year;



- 90% of prescription drug expenses in excess of \$5,000 for individual private supplementary prescription drug insurance plan members for whom the combined total of their out-of-pocket expenses and the contribution that the private insurance plan incurs on their behalf exceeds \$5,000 in a single year.
- the remaining 10 % would be paid by either a provincial/territorial plan or a private supplementary plan.

In order to be eligible to participate in this federal program:

- provinces/territories would have to put in place a program that would ensure that no family of the province/territory would be obliged to pay more than 3% of family income for prescription drugs;
- sponsors of existing private supplementary drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out-of-pocket expenses that exceed \$1,500 per year; this would cap each individual plan member's out-of-pocket costs at either 3% of family income or \$1,500, whichever is less.

The federal government work closely with the provinces and territories to establish a single national drug formulary.

## **CHAPTER EIGHT**

### **EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE (PAHC)**

#### **When Does PAHC Coverage Begin and End**

An episode of PAHC should be defined as all home care services received between the first date of service provision following hospital discharge, if that date occurs within 30 days of discharge, and up to three months following hospital discharge.

#### **PAHC Financing Directed to Hospitals**

Financing for post-acute home care should be first directed to hospitals.

In order to encourage innovation and service integration, and to enhance the efficient and effective provision of necessary health care irrespective of the setting in which such care is received, a service-based method of reimbursement for PAHC should be developed in conjunction with service-based arrangements for each episode of hospital care.

#### **Range of Services Covered**

The range of services, products and technologies (including prescription drugs) that may be used to facilitate the use of home care following hospital care not be restricted.

## **PAHC Funded Through Service Based Funding**

Hospitals have the option to develop contractual relationships directly with home care service providers or with transfer agencies that may provide case management and service provision arrangements.

Contracts formed with home care service providers should include, in addition to service-based reimbursement arrangements, mechanisms to monitor service quality, performance and outcome.

## **PAHC Programs Should Be Cost-Shared**

The federal government establish a new National Post-Acute Home Care Program, to be jointly financed with the provinces and territories on a 50:50 basis.

The PAHC program be treated as an extension of medically necessary coverage already provided under the *Canada Health Act*, and that therefore the full cost of the program should be borne by government (shared equally by the provincial/territorial and federal levels).

## **CHAPTER NINE**

### **EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE**

The federal government agree to contribute \$250 million per year towards a National Palliative Home Care Program to be designed with the provinces and territories and co-funded by them on a 50:50 basis.

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 federal government examine the feasibility of expanding the tax measures already available to people providing care to dying family members or to those who purchase such services on their behalf.

The federal government amend the Canada Labour Code to allow employee leave for family crisis situations, such as care of a dying family member, and that the federal government work with the provinces to encourage similar changes to provincial labour codes.

The federal government take a leadership role as an employer and enact changes to Treasury Board legislation to ensure job protection for its own employees caring for a dying family member.

## **CHAPTER TEN**

### **THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE**

#### **Health Care Technology**

The federal government provide funding to hospitals for the express purpose of purchasing and assessing health care technology. The federal government should devote a total of \$2.5 billion over a five-year period (or \$500 million annually) to this initiative. Of this funding, \$400 million should be allocated annually to Academic Health Sciences Centres, while \$100 million should be provided annually to community hospitals. The community hospital funding should be cost-shared on a fifty-fifty basis with the provinces, while the Academic Health Sciences Centre funding should be 100% federal.

The institutions benefiting from this program be required to report on their use of such funding.

#### **Electronic Health Records**

The federal government provide additional financial support to Canada Health Infoway Inc. so that *Infoway* develop, in collaboration with the provinces and territories, a national system of electronic health records.

Additional federal funding to *Infoway* amount to \$2 billion over a five-year period, or an annual allocation of \$400 million.

#### **Evaluation of System Performance**

The federal government provide additional annual funding of \$50 million to the Canadian Institute for Health Information. In addition, an annual investment of \$10 million should be provided to the Canadian Council on Health Services Accreditation. This new federal investment will help establish a national system of evaluation of health care system performance and outcomes, and hence facilitate the work of the National Health Care Commissioner.

#### **Protection of Personal Health Information**

The federal government work to achieve greater consistency and/or coordination across federal/provincial/territorial jurisdictions on the following key issues:

- Need-to-know rules restricting access to authorized users based on their purposes;
- Consent rules governing the form and criteria of consent in order to be valid;
- Conditions authorizing non-consensual access to personal health information in limited circumstances and for specific purposes;
- Rules governing the retention and destruction of personal health information;

- Mechanisms for ensuring proper oversight of cross-jurisdictional electronic health record systems.

Canada Health Infoway Inc. and other key investors structure their investment criteria in such a way as to create incentives for developers of EHR systems to ensure practical and pragmatic privacy solutions for implementing the following:

- State-of-the-art security safeguards for protecting personal health information and auditing transactions;
- Shared accountability among various custodians accessing and using EHRs;
- Coordination among custodians to give meaningful effect to patients' rights to access their EHR, rectify any inaccuracy and challenge non-compliance.

Key stakeholders, including the federal, provincial and territorial Ministries of Health, Canada Health Infoway Inc., the Canadian Institute for Health Information and Canadian Institutes of Health Research, undertake the following:

- Rigorous research into the determinants affecting Canadian attitudes regarding acceptable and unacceptable uses of their personal health information;
- Informed and meaningful dialogue with key stakeholders, including patient groups and consumer representatives;
- An open, transparent and iterative public communication strategy about the benefits of EHRs.

## **CHAPTER ELEVEN**

### **HEALTH CARE HUMAN RESOURCES**

#### **The Need for Productivity Studies**

Studies be done to determine how the productivity of health care professionals can be improved. These studies should be either undertaken or commissioned by the National Coordinating Committee on Health Human Resources that the Committee recommends be created.

#### **The National Coordinating Committee for Health Human Resources**

The federal government work with other concerned parties to create a permanent National Coordinating Committee for Health Human Resources, to be composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include:

- disseminating up-to-date data on human resource needs;

- coordinating initiatives to ensure that adequate numbers of graduates are being trained to meet the goal of self-sufficiency in health human resources;
- sharing and promoting best practices with regard to strategies for retaining skilled health care professionals and coordinating efforts to repatriate Canadian health care professionals who have emigrated to other countries;
- recommending strategies for increasing the supply of health care professionals from under-represented groups, such as Canada's Aboriginal peoples, and in under-serviced regions, particularly the rural and remote areas of the country;
- examining the possibilities for greater coordination of licensing and immigration requirements between the various levels of government.

### **Increasing the Supply of Health Human Resources**

The federal government:

- Work with provincial governments to ensure that all medical schools and schools of nursing receive the funding increments required to permit necessary enrolment expansion;
- Put in place mechanisms by which direct federal funding could be provided to support expanded enrolment in medical and nursing education, and ensure the stability of funding for the training and education of allied health professionals;
- Review federal student loan programs available to health care professionals and make modifications to ensure that the impact of inevitable increases in tuition fees does not lead to denial of opportunity to students in lower socio-economic circumstances;
- Work with provincial governments to ensure that the relative wage levels paid to different categories of health professionals reflect the real level of education and training required of them.

The federal government work with the provinces and medical and nursing faculties to finance places for students from Aboriginal backgrounds over and above those available to the general population.

In order to facilitate the return to Canada of Canadian health care professionals who are working abroad, the federal government should work with the provinces and professional associations to inform expatriate Canadian health professionals of emerging job opportunities in Canada, and explore the possibility of adopting short-term tax incentives for those prepared to return to Canada.

The federal government contribute \$160 million per year, starting immediately, so that Canadian medical colleges can enrol 2,500 first-year students by 2005.

The proposed National Coordinating Committee for Health Human Resources be charged with monitoring the levels of enrolment in Canadian medical schools and make recommendations to the federal government on whether these are appropriate.

The federal government should contribute financially to increasing the number of post-graduate residency positions in medicine to a ratio of 120 per 100 graduates of Canadian medical schools.

The federal government work with the provinces to establish national standards for the evaluation of international medical graduates, and provide ongoing funding to implement an accelerated program for the licensing of qualified IMGs and their full integration into the Canadian health care delivery system.

The federal government phase in funding over the next five years so that by 2008 there are 12,000 graduates from nursing programs across the country, and that the federal government continue to provide full additional funding to the provinces for all nursing school places over and above 10,000, for as long as is necessary to eliminate the shortage of nurses in the country.

The federal government commit \$90 million per year from the additional revenue the Committee recommends that it raise in order to enable Canadian nursing schools to graduate 12,000 nurses by 2008.

The federal government commit \$40 million per year from the new revenues that the Committee has recommended it raise in order to assist the provinces in raising the number of allied health professionals who graduate each year.

The exact allocation of these funds be determined by the proposed National Coordinating Committee for Health Human Resources.

The federal government devote \$75 million per year of the new money the Committee recommends be raised to assisting Academic Health Sciences Centres to pay the costs associated with expanding the number of training slots for the full range of health care professionals.

### **Review Scope of Practice Rules**

An independent review of scope of practice rules and other regulations affecting what individual health professionals can and cannot do be undertaken for the purpose of developing proposals that would enable the skills and competencies of diverse health care professionals to be utilized to the fullest and enable health care services to be delivered by the most appropriately qualified professionals.

## **CHAPTER TWELVE**

### **NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH**

#### **Assuming Leadership in Health Research**

Health research and its translation into the health care system be routinely on the agendas of meetings of federal and provincial/territorial Ministers and Deputy Ministers of Health, and that the Canadian Institute of Health Research be represented and be involved in setting the agendas for health research at those meetings. This would greatly help to sustain a culture that supports the creation and use of knowledge generated by health research throughout Canada.

The federal government set, on a regular basis, national goals and priorities for health research in collaboration with all stakeholders.

The federal government foster multi-stakeholder collaborations when performing, funding and using health research. This should contribute to capitalizing on the best available resources while minimizing overlap and duplication.

The federal government take a leadership role, through the Canadian Institutes of Health Research and Health Canada, in developing a strategy to encourage the interchange of research scientists between government, academia and the private sector, including national voluntary organizations.

#### **Funding Health Research**

The federal government, through both Health Canada and the Canadian Institutes of Health Research, coordinate and provide resources to ensure that Canada contributes to and benefits from the scientific revolution to maximize the economic, health and social gains for Canadians.

The Canadian Institutes of Health Research and Genome Canada fund research that positions Canada as a world leader in the new area of genomics and human genetics so that the health care system can take appropriate advantage of this new technology to improve the health of Canadians.

The Canadian Institutes of Health Research play a leadership role in establishing best practices for addressing the complex ethical issues raised by the use of this new technology in health research and health care.

The federal government:

- Increase, within a reasonable timeframe, its financial contribution to extramural health research to achieve the level of 1% of total Canadian health care spending. This requires an additional investment of \$440 million by the federal government;
- Recognize that health research is a long term proposition, and therefore set and adhere to clear long-term plans for funding health research, particularly through the Canadian

Institutes of Health Research. More precisely, the federal government should commit to a five-year planning horizon for the CIHR budget;

- Provide predictable and appropriate investment for in-house health research.

Health Canada:

- Be provided with the financial and human resources in health research that are required to fulfill its mandate and obligations;
- Engage actively in the establishment of linkages and partnerships with other health research stakeholders.

The federal government, through the Canadian Institutes of Health Research, Health Canada and the Canadian Health Services Research Foundation, devote additional funding to health services research and clinical research and that it collaborate with the provinces and territories to ensure that the outcomes of such research are broadly diffused to health care providers, managers and policy-makers.

### **Health Research on Vulnerable Populations**

The federal government, through the Canadian Institutes of Health Research and Health Canada, provide additional funding to health research aimed at the health of particularly vulnerable segments of Canadian society.

The federal government provide additional funding to CIHR in order to increase participation of Canadian health researchers, including Aboriginal peoples themselves, in research that will improve the health of Aboriginal Canadians.

Health Canada be provided with additional resources to expand its research capacity and to strengthen its research translation capacity in the field of Aboriginal health.

The federal government provide increased resources to the Global Health Research Initiative.

### **Commercializing the Results of Health Research**

The federal government require an explicit commitment from all recipients of federally funded health research that they will obtain the greatest possible benefit to Canada, whenever the results of their federally funded research are used for commercial gain.

The Canadian Institutes of Health Research, while not ignoring the social value of health research that does not result in commercial gain, seek to facilitate appropriate economic returns within Canada from the investments it makes in Canadian health research, whenever the results of investments in Canadian health research are used for commercial gain. In doing so, CIHR should develop an innovation strategy aimed at accelerating and facilitating the commercialization of health research outcomes.

The federal government invest additional resources to enhance the output of Canadian health researchers and strengthen the commercialization capacity of performers of federally funded



health research through CIHR's innovation strategy. This new funding would be additional to the current health research investment. In particular, the funding of the indirect costs of research by the Canadian granting agencies should be made permanent. Health research performers should be made accountable for the use of these commercialization funds.

### **Ethics in Health Research**

Health Canada initiate, in collaboration with stakeholders, the development of a joint governance system for health research involving human subjects for all research that the federal government performs, that it funds, and that it uses in its regulatory activities.

Health Canada, in the development of this ethics governance system, regard the following components as essential to progress:

- Work initially on all (health) research that the federal government performs, funds, or uses in its regulatory activities, to develop an effective and efficient system of governance that will become accepted as the standard of care across Canada;
- Give prime importance in the governance system to effective education and training mechanisms for all who are involved in research and research ethics, with certification appropriate to their different responsibilities;
- Develop standards, based on the *Tri-Council Policy Statement*, the International Conference on Harmonization guidelines applying to clinical trials involving human subjects, and other relevant Canadian and foreign standards, against which research ethics functions or Research Ethics Boards can be accredited or certified as meeting the levels of function that are consistent with the expectations of Canadians and with those in other countries;
- Ensure that the *Tri-Council Policy Statement* is updated and is maintained at the forefront of international policies for the ethics or research involving humans;
- Remove inconsistencies between the various policies under which research involving humans is now governed, and make Canadian standards consistent with those of other countries that affect Canadian research;
- Establish an accreditation or certification process for research ethics functions that is at arm's length from government, but clearly accountable to government;
- Develop the governance system through open, transparent and meaningful consultation with stakeholders.

All federal departments and agencies require compliance with the standards of the Canadian Council on Animal Care for:

- All research that is carried out in federal facilities, and
- All research that is funded by federal departments or agencies but performed outside federal facilities, and

- All research that is carried out without federal funding or facilities, but that is submitted to or used by the federal government for purposes of exercising its legislated functions.

### **The Protection of Personal Health Information**

Regulations such as those proposed by the Canadian Institutes of Health Research receive their fullest and fairest consideration in discussions about providing greater clarity and certainty of the law with the view to ensure that its objectives will be met without preventing important research to continue to better the health of Canadians and improve their health services.

Discussions continue among stakeholders, the Privacy Commissioner, and those federal and provincial government departments involved with the provision, management, evaluation and quality assurance of health services.

The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, design and implement a program of public awareness to foster in Canadians a broad understanding of:

- the nature of, and reasons for, the extensive databases containing personal health information that must be maintained to operate a publicly financed health care system, and
- the critical need to make secondary use of such databases for health research and health care management purposes.

The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, be responsible for promoting:

- thoughtful discussion and consideration of the ethical issues, particularly informed consent issues, involved in the secondary use of personal health information for health care management and health research purposes;
- thorough examination of the control and review mechanisms needed for ensuring that databases containing personal health information are effectively created, maintained and safeguarded and that their use for health care management and health research purposes is conducted in an open, transparent and accountable manner.

The Canadian Institutes of Health Research, in partnership with industry and other stakeholders, continue to explore the ethical aspects of the interface between the sectors with a view to ensuring that the collaborations and partnerships function in the best interests of all Canadians.

## **CHAPTER THIRTEEN**

### **HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE**

#### **National Chronic Disease Prevention Strategies**

The federal government, in collaboration with the provinces and territories and in consultation with major stakeholders (including the Chronic Disease Prevention Alliance of Canada), implement a National Chronic Disease Prevention Strategy.

The National Chronic Disease Prevention Strategy build on current initiatives through better integration and coordination.

The federal government contribute \$125 million annually to the National Chronic Disease Prevention Strategy.

Specific goals and objectives should be set under the National Chronic Disease Prevention Strategy. The outcomes of the strategy should be evaluated against these goals and objectives on a regular basis.

#### **Public Health Infrastructure**

The federal government ensure strong leadership and provide additional funding to sustain, better coordinate and integrate the public health infrastructure in Canada as well as relevant health promotion efforts. An amount of \$200 million in additional federal funding should be devoted to this very important undertaking.

## **CHAPTER FOURTEEN**

### **HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED**

The federal government establish an Earmarked Fund for Health Care that is distinct and separate from the Consolidated Revenue Fund. The Earmarked Fund will contain the additional revenue raised by the federal government for investment in health care.

Money from the Earmarked Fund for Health Care be used solely for the purpose of health care. Moreover, such money must be used to buy change or reform: it must be utilized exclusively for expanding public health care coverage and for restructuring and renewal of the publicly funded hospital and doctor system.

The National Health Care Council be charged with the mandate of advising the federal government on how the money in the Earmarked Fund for Health Care should be spent. The Council's advice to the government should be made public through an annual report.

The federal government subject the Earmarked Fund for Health Care to an annual audit by the Auditor General of Canada. The result of such an audit should be made public.

The federal government 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.

## **CHAPTER FIFTEEN**

### **HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED**

#### **Funding the Recommendations in this Report**

The federal government establish a National Variable Health Care Insurance Premium in order to raise the necessary federal revenue to finance implementation of the Committee's recommendations.

#### **Funding Current Federal Expenditures on Health Care**

The federal government determine an earmarked revenue source which would fund the approximately 62% of CHST currently regarded as being the federal annual cash contribution to Canada's national health care insurance program.

If the GST is chosen as the earmarked revenue source for the current federal cash contribution to the national hospital and doctor insurance plan, then in order for the federal government to make a significant additional contribution to funding to the current hospital and doctor system, half of all GST revenue (or 3.5 of the 7 percentage points) should be earmarked for health care. (This would be in addition to the increased federal funding required to implement the recommendations in this report.)

The share of the federal annual contribution to which a province/territory is entitled for the purpose of the existing national hospital and doctor program be not only based on the proportion of its population relative to Canada as a whole, but also weighted in some way by the percentage of its population aged 70 years and over.

## **CHAPTER SIXTEEN**

### **THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE**

There are no recommendations in this chapter.

## **CHAPTER SEVENTEEN**

### **THE CANADA HEALTH ACT**

The federal government, in collaboration with the provinces and territories, establish a permanent committee – the Committee on Public Health Care Insurance Coverage – made up of citizens, ethicists, health care providers and scientists.

The Committee on Public Health Care Insurance Coverage be given the mandate to review and make recommendations on the set of services that should be covered under public health care insurance.

The Committee on Public Health Care Insurance Coverage report its findings and recommendations to the National Health Care Council.

As its first task, the Committee on Public Health Care Insurance Coverage be charged with developing national standards upon which decisions for public health care coverage will be made.

The Committee on Public Health Care Insurance Coverage be charged with determining the national parameters applicable to post-hospital home care and palliative care delivered in the home.

The federal government enact new legislation establishing the National Health Care Guarantee. The new legislation should include a definition of the concept of “timely access” that will relate to such a guarantee.

The principle of public administration of the *Canada Health Act* be maintained for publicly insured hospital and doctor services. That is, there should be a single insurer – the government – for publicly insured hospital and doctor services delivered by either public or private health care providers and institutions.

The federal government, through Health Canada, clarify the meaning of the concept of public administration under the *Canada Health Act* so as to recognize explicitly that this principle applies to the administration of public health care insurance, not to the delivery of publicly insured health services.

The federal government enact new legislation instituting health care coverage for catastrophic prescription drugs, post-hospital home care and some palliative care in the home. This new legislation should explicitly spell out conditions relating to transparency of decision making and accountability.



## APPENDIX B

### LIST OF PRINCIPLES FROM VOLUME FIVE (APRIL 2002)

---

The following principles, enunciated in Volume Five, have guided the Committee in developing the detailed plan of action outlined in this report.

#### THE INSURER:

1. There should be a single funder (insurer) – the government either directly or through an arm's length agency – for hospital and doctor services covered under the *Canada Health Act*.
2. There should be stability of, and predictability in, government funding for public health care insurance.
3. The federal government should play a major role in sustaining a national health care insurance system.
4. The determination of what should be covered under public health care insurance should be done through an open and transparent process. Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.
5. The federal government should contribute on an ongoing basis to fund health care technology.
6. The federal government should increase its investment in those areas of health and health care for which it already has a major responsibility.
7. The consequences arising from changes in the level or amount of government funding for hospital and medical care should be clearly understood by government and explained to the public, in as much detail as possible, at the time such changes are made and announced.

## **THE PROVIDER:**

8. In the first stage of health care reform, the method for remunerating hospitals should be changed from the current annual global budget to service-based funding.
9. Regional health authorities should have the responsibility for purchasing hospital services provided by institutions within their region.
10. Primary care renewal should lead to the provision of primary care by group practices, or clinics, which operate twenty-four hours a day, seven days a week.
11. To facilitate primary care reform, the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards.
12. New scope of practice rules and other measures need to be developed in order to enable all health care providers in the primary care sector to provide the full range of services for which they have been trained.
13. In the second stage of health care reform, an “internal market” should probably be created in which primary health care teams would purchase health services provided by hospitals and other health care institutions on behalf of their patients.
14. A national (not exclusively federal) strategy must be developed to achieve both an adequate supply and optimal use of health care providers.

## **THE EVALUATOR:**

15. Accountability and transparency in health care financing and delivery require the deployment of a system of electronic health records (EHR) that can capture and translate information on system performance and outcomes.
16. Measuring treatment outcomes and system performance must become an essential part of the health information system. Such monitoring and evaluation of the health care delivery system should be performed independently at the national (not federal) level and be funded by government.



**THE PATIENT:**

17. Canada's publicly funded health care system should be patient-oriented.
18. Incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees for services that are deemed to be medically necessary.
19. Programs that enable people to be responsible for their own health and to stay healthy must be given high priority. The federal government can play a leadership role in this regard.
20. For each type of major procedure or treatment a maximum waiting time should be established, and made public. When this maximum time is reached, the insurer (government) shall pay for the patient to receive immediately the procedure or treatment in another jurisdiction including, if necessary, another country



# APPENDIX C

## LIST OF WITNESSES

---

### 1<sup>ST</sup> SESSION OF THE 37<sup>TH</sup> PARLIAMENT

#### **Wednesday, April 24, 2002**

*Ontario Health Services Restructuring Commission:*  
Dr. Duncan Sinclair, Former Commissioner

#### **Thursday, April 25, 2002**

*Health Canada:*  
Marcel Nouvet, Assistant Deputy Minister, Information Analysis and Connectivity Branch  
Michel Léger, Executive Director, Strategic Alliances and Priorities Division, Information Analysis and Connectivity Branch

#### **Wednesday, May 1, 2002**

*Canadian Institute for Health Information:*  
Michael Decter, Chairman, Board of Directors

#### **Monday, May 6, 2002**

*Calgary Health Region:*  
Jack Davis, President and CEO

*As an individual:*  
Claude Forget, Former Minister of Health, Province of Quebec

*Dalhousie University:*  
Dr. Nuala Kenny, Professor of Pediatrics and Chair, Department of Bioethics

*St. Michael's Hospital:*  
Jeffrey Lozon, President and CEO

*As an individual:*  
Graham Scott, Former Deputy Minister of Health, Province of Ontario

*Royal Columbian Hospital:*  
Dr. Les Vertesi, Medical Director

#### **Wednesday, May 8, 2002**

*As an individual:*  
The Honourable Monique Bégin, P.C.

#### **Thursday, May 9, 2002**

*Dalhousie University:*  
Professor Lawrence Nestman, School of Health Services Administration

**Wednesday, May 22, 2002**

*Canadian Medical Association:*

Dr. Peter Barrett, Past President  
Dr. Susan Hutchison, Chair, GP Forum

*Ontario Medical Association:*

Dr. Elliot Halparin, President  
Dr. Kenneth Sky, Past President

*Ontario Hospital Association:*

Mark Rochon, Member, Advocacy Committee

*Association of Canadian Academic Health Care Organizations:*

Glenn G. Brimacombe, CEO

*University Health Network:*

Kevin Empey, Chief Financial Officer

**Wednesday, May 29, 2002**

*Capital Health Authority:*

Dr. Ken Gardener, Vice-President, Medical Affairs

*Ontario Family Health Network:*

Dr. Ruth Wilson, Chair  
Donna Segal, CEO

**Thursday, May 30, 2002**

*McMaster University – Centre for Health Economics and Policy Analysis (CHEPA):*

Dr. Brian Hutchison

*University of Guelph:*

Professor Brian Ferguson, Department of Economics

**Monday, June 3, 2002**

*University of Toronto, Department of Health Policy, Management and Evaluation:*

Professor Raisa Deber

*University of British Columbia:*

Professor Roberts G. Evans

*Canadian Taxpayers Federation:*

Walter Robinson, Federal Director

*The Conference Board of Canada:*

Paul Darby, Director, Economic Forecasting

*As an individual:*

David Kelly

**Wednesday, June 5, 2002**

*Canadian Healthcare Association:*  
Sharon Sholzberg-Gray, President and CEO  
Larry Odegard, CEO, Forum

*Canadian Association of Chain Drug Stores:*  
Lori Turik, Vice-President, Public Affairs  
Deb Saltmarche, Director of Pharmacy

**Thursday, June 6, 2002**

*Canadian Nurses Association:*  
Ginette Lemire Rodger, President  
Robert Calnan, President-Elect

*Canadian Practical Nurses Association:*  
Kelly Kay, Representative

**Wednesday, June 12, 2002**

*C.D. Howe Institute:*  
Jack Mintz, President and CEO

**Thursday, June 13, 2002**

*Association of Canadian Academic Health Care Organizations:*  
Glenn Brimacombe, CEO

*St. Michael's Hospital:*  
Jeffrey Lozon, President and CEO

*McGill University Health Centre:*  
Dr. Hugh Scott, Executive Director

*Applied Management:*  
Bryan Ferguson, Partner

*Fraser Group:*  
Ken Fraser

*Tristat Resources:*  
Richard Shillington, Principal

**Monday, June 17, 2002 (9:00 a.m.)**

(By videoconference)

*Government of Denmark:*  
John Erik Petersen, Head of Department, Ministry of Health and the Interior  
Dr. Steen Friberg Nielsen, CEO, Top Management Academy  
Morten Hjulsgaard, Head of Department, National Informatics, National Board of Health  
Dr. Arne Kverneland, Head of Division of Medical Informatics, National Board of Health

**Monday, June 17, 2002 (12:30 p.m.)**

*Government of New Brunswick, Department of Health and Wellness:*  
Cheryl Hansen, Director, Extra-Mural Program

*University of Toronto, Home Care Evaluation Research Centre:*  
Peter Coyte, Co-Director

*Hollander Analytical Services:*  
Marcus Hollander

*Canadian Council of Chief Executives:*  
David Stewart-Patterson, Senior Vice President, Policy

**VOLUME FIVE (October 15, 2001 – March 7, 2002)**

**Monday, October 15, 2001**

*University of Manitoba:*  
Linda West, Professor, Asper School of Business

*Frontier Centre for Public Policy:*  
Peter Holle, President

*Western Canadian Task Force on Health Research and Economic Development:*  
Dr. Henry Friesen, Team Leader  
Dr. John Foerster  
Dr. Audrey Tingle  
Chuck Laflèche

*Regional Health Authorities of Manitoba*  
Bill Bryant, Chair, Council of Chairs  
Kevin Beresford, Chair, Council of CEOs  
Randy Lock, Executive Director

*Manitoba Centre for Health Policy and Evaluation:*  
Dr. Nora Lou Roos

*Women's Health Clinic:*  
Madeline Boscoe, Advocacy Coordinator

*Hospice and Palliative Care Manitoba:*  
Dr. Paul Henteleff, Chair, Advocacy Committee  
John Bond, Member of Advocacy Committee  
Margaret Clarke, Executive Director

*Canadian Union of Public Employees in Manitoba (CUPE):*  
Paul Moist, President  
Lorraine Sigurdson, Health Care Coordinator

*Société franco-manitobaine:*  
Daniel Boucher, Chief Executive Officer

*As a walk-on:*  
Barry Shtatleman

**Tuesday, October 16, 2001**

*Saskatchewan Registered Nurses' Association:*

June Blau, President

*Victorian Order of Nurses:*

Bob Layne, Vice-President, Planning and Government Relations (Western Region)

Lois Clark, Executive Director, VON North Central Saskatchewan

Brenda Smith, National Board Member (Saskatchewan)

*Community Health Services (Saskatoon) Association:*

Kathleen Storrie, Vice-President

Ingrid Larson, Director, Member Relations

*As an individual:*

Dr. John Bury

*Canadian Union of Public Employees (CUPE) Saskatchewan:*

Tom Graham, President, CUPE Saskatchewan

Stephen Foley, President, Health Care Council

John Welden, Health Care Coordinator, Health Care Council

*Saskatoon Chamber of Commerce:*

Dave Ductchak, President

Kent Smith-Windsor, Executive Director

Jodi Blackwell, Research and Operations Director

*Arthritis Society of Saskatchewan:*

Sherry McKinnon, Executive Director

Joy Tappin, Board Member

*Canadian Parks and Recreation:*

Randy Goulden, Executive Director, Tourism Yorkton

*Métis National Council:*

Gerald Morin, President

Don Fidler, Director, Health Care

**Wednesday, October 17, 2001**

*Premier's Advisory Council on Health (Alberta):*

The Right Honourable Don Mazankowski, P.C., Chair

Peggy Garritty

*Department of Health and Social Services (Nunavut):*

The Hon. Edward Picco, Minister

*Calgary Health Region:*

Jack Davis, CEO

*Capital Health Authority:*

Sheila Weatherill, President and CEO

*Canadian Practical Nurses Association:*

Pat Fredrickson, President

*University of Alberta - Faculty of Nursing:*  
Dr. Donna Wilson

*Health Sciences Association of Alberta:*  
Elisabeth Ballermann, President

*Alberta Association of Registered Nurses:*  
Sharon Richardson, President

*United Nurses of Alberta:*  
Heather Smith, President

*Friends of Medicare:*  
Christine Burdett, Provincial Chair  
Tammy Horne, Member

*As an individual:*  
Kevin Taft, MLA

*Western Canada Waiting List Project:*  
John McGurran, Project Director

*Primary Care Initiative:*  
Dr. June Bergman

*Alberta Consumers Association:*  
Wendy Armstrong

*Fédération des communautés francophones et acadiennes du Canada :*  
George Arès, President

*National Advisory Council on Aging:*  
Pat Raymaker, Chairwoman

*Alberta Council on Aging:*  
Neil Reimer, Secretary/Treasurer

*Nechi Institute:*  
Ruth Morin, Chief Executive Officer  
Richard Jenkins, Director of Marketing and Health Promotion

*Executive of the Alberta and Northwest Conference of the United Church of Canada - Health Advisory Committee:*  
Louise Rogers  
Kent Harold  
Don Junk

*As a walk-on:*  
Noel Somerville

**Thursday, October 18, 2001**

*Commission on Medicare, Saskatchewan:*  
Ken Fyke, Former Chair

*Tommy Douglas Research Institute:*  
Dave Barrett, Chair  
Marc Eliesen, Co-Chair



*Market-Media International Corporation:*  
Joan Gadsby, President

*University of British Columbia, Family Practice Residency Program:*  
Dr. J. Galt Wilson, Program Director - Prince George Site

*University of British Columbia:*  
Dr. John A. Cairns, Dean of Medicine  
Dr. Joanna Bates, Associate Dean, Admissions

*Health Professions Council:*  
Dianne Tingey, Member  
Gerry Fahey, Research Director

*Cambie Surgery Centre:*  
Dr. Brian Day, Founder

*As an individual:*  
Cynthia Ramsay, Health Economist

*Health Association of British Columbia:*  
Lorraine Grant, Chair of the Board of Directors  
Lisa Kallstrom, Executive Director

*University of British Columbia:*  
Dr. John H. V. Gilbert, Coordinator of Health Sciences

*University of British Columbia - Vancouver Hospital and Health Sciences Centre:*  
Professor Charles Wright, Director, Centre for Clinical Epidemiology and Evaluation

*University of British Columbia – Centre for Health Services and Policy Research:*  
Professor Barbara Mintzes

*Professional Association of Residents of British Columbia:*  
Dr. Kristina Sharma

**Friday, October 19, 2001**

*Canadian Medical Association:*  
Dr. Peter Barrett, Past President  
Dr. Arun Garg, Chair, Council on Health Policy and Economics

*British Columbia Medical Association:*  
Dr. Heidi Oetter, President  
Darrell Thomson, Director, Economics and Policy Analysis

*University of British Columbia, Anxiety Disorders Unit, Department of Psychiatry:*  
Dr. Peter D. McLean, Professor and Director

*Maples Surgical Centre (Manitoba)*  
Dr. Mark Godley

**Monday, October 29, 2001**

*Canadian Radiation Oncology Services:*

Dr. Thomas McGowan, President and Medical Director

*Canadian Taxpayers Federation:*

Walter Robinson, Federal Director

*Canadian Council of Churches:*

Stephen Allen, Member of Commission for Justice and Peace and Co-Chair of the Commission's Ecumenical Health Care

*Buffett Taylor Employee Benefits and Workplace Wellness Consultants:*

Edward Buffett, President and CEO

*As an individual:*

Michael Rachlis

*Medical Reform Group:*

Dr. Joel Lexchin

*At Work Health Solutions Inc.:*

Dr. Arif Bhimji, Founder and President; Medical Director of Liberty Health  
Gery Barry, President and CEO of Liberty Health

*Consumers' Association of Canada:*

Jean Jones, Chair of the Health Committee  
Mel Fruitman, President

*Ontario Association of Optometrists:*

Dr. Joseph Chan

*Medical Devices Canada (MEDEC):*

Peter Goodhand, President

*AstraZeneca:*

Gerry McDole, President and CEO

*Comcare Health Services:*

Mary Jo Dunlop

*Saint Michael's Hospital:*

Jeffrey Lozon, President and CEO

*Association of Ontario Health Centres:*

Gary O'Connor, Executive Director

*Ontario Medical Association:*

Kenneth Sky, President

*The Arthritis Society:*

Denis Morrice, President and CEO

*SMARTRISK:*

Dr. Robert Conn, President and CEO

*Canadian Cancer Society:*

Dr. Barbara Whyllie, Director, Cancer Control Policy

Cheryl Mayer, Director, Cancer Control Programs, Alcohol and Drug Recovery Association of Ontario, and  
Addiction Intervention Association

Jeff Wilbee, Executive Director

**Tuesday, October 30, 2001**

*Canadian Institute for Health Information:*

Michael Decter, Chairman, Board of Directors

*Ontario Hospital Association:*

David MacKinnon, President and CEO

*Registered Nurses Association of Ontario:*

Doris Grinspun, Executive Director

*McMaster University Department of Economics:*

Jeremiah Hurley, Professor

*University of Toronto Public Health Science Department:*

Dr. Cameron Mustard, Professor

*University of Toronto:*

Colleen Flood, Professor

*Drug Trading Company Limited:*

Larry Latowsky, President and CEO

Jane Farnharm, Vice President, Pharmacy

*Canadian Pharmacists Association:*

Ron Elliott, President

*GlaxoSmithKline:*

Geoffrey Mitchinson, Vice-president, Public Affairs

*Medtronic:*

Donald A. Hurley, President

*Canadian Association for the Fifty Plus:*

Dr. Bill Gleberzon, Associate Executive Director

Lilian Morgenthal, President

*Canadian Association for Community:*

Cheryl Gulliver, President

Connie Laurin-Bowie

Margot Easton

*Roeher Institute:*

Cameron Crawford, President

*As individuals:*

Clement Edwin Babb

Robert S.W. Campbell

**Wednesday, October 31, 2001**

*As individuals:*

The Honourable Claude Forget  
The Honourable Claude Castonguay  
André-Pierre Contandriopoulos, Professor, Faculty of Medicine, University of Montreal

*Hôtel Dieu Hospital:*

Dr. Serge Boucher

*Conseil du patronat du Québec:*

Gilles Taillon, President

*Canadian Chamber of Commerce:*

Nancy Hughes-Anthony, President and Chief Executive Officer  
Michael N. Murphy, Senior Vice-President, Policy

*As individuals:*

Jean-Luc Migué  
Lee Soderstrom, Professor, Department of Economics, McGill University

*Montreal Economic Institute:*

Michel Kelly-Gagnon, Executive Director  
Dr. Edwin Coffey, Retired Associate Professor, Faculty of Medicine, McGill University, and Former President of the Quebec Medical Association

*Frosst Health Care Foundation:*

Dr. Monique Camerlain, President of the Board of Directors  
Janet Dunbrack, Executive Director.

**Thursday, November 1, 2001**

*Association des optométristes du Québec:*

Dr. Langis Michaud, President  
Marie-Josée Crête, Deputy Director General  
Clairmont Girard, Advisor

*Collège des médecins du Québec:*

Dr. Yves Lamontagne, President  
Dr. André Garon, Deputy Secretary General

*As an individual:*

Robert Dorion

*Canadian Life and Health Insurance Association:*

Mark Daniels, President  
Greg Traversy, Executive Vice-President  
Yves Millette, Senior Vice-President, Quebec Affairs  
Frank Fotia, Vice-President, Group Insurance.

*As individuals:*

Dr. Margaret Somerville, Acting Director, McGill Centre for Medicine, Ethics and Law, McGill University  
Dr. Robyn Tamblyn, Associate Professor, Department of Economics, McGill University

*Merck Frosst Canada Ltd.:*

Kevin Skilton, Director, Policy Planning  
Dr. Terrance Montague, Executive Director, Patient Health

*Association québécoise des droits des retraités (AQDR):*  
Ann Gagnon, Advisor on Health  
Yollande Richer, Vice-President, Communications  
Myroslaw Smereka, Director General

**Monday, November 5, 2001**

*Department of Health and Community Services, Newfoundland:*  
Robert C. Thompson, Deputy Minister  
Beverly Clarke, Assistant Deputy Minister

*Victorian Order of Nurses (VON Canada):*  
Patricia Pilgrim, President, St. John's Branch  
Bernice Blake Dibblee, Executive Director, St. John's Branch

*Association of Registered Nurses of Newfoundland and Labrador:*  
Sharon Smith, President

*Canadian Union of Public Employees, Newfoundland:*  
Wayne Lucas, President

*As an individual:*  
Maud Peach

*National Cancer Institute of Canada:*  
Dr. Roy West, President

*Health and Community Services, Newfoundland:*  
Dr. Catherine Donovan

*Weight Watchers:*  
Marlene Bayers, Regional Manager

*Newfoundland Cancer Treatment and Research Foundation:*  
Bertha H. Paulse, Chief Executive Officer

*As an individual:*  
Karen McGrath, Executive Director of Health and Community Services St. John's Region

**Tuesday, November 6, 2001**

*Canadian Auto Workers (CAW):*  
Cecil Snow, President, Nova Scotia Health Care Council

*Nova Scotia Association of Health Organizations:*  
Robert Cook, President and CEO

*Insurance Bureau of Canada:*  
George Anderson, President and CEO  
Paul Kovacs, Senior Vice-President, Policy, and Chief Economist

*Canadian Coalition Against Insurance Fraud:*  
Mary Lou O'Reilly, Executive Director

*Atlantic Institute for Market Studies:*  
Dr. David Zitner, Fellow on Health Policy

*Dalhousie University:*

Nuala Kenny, Professor of Pediatrics and Chair, Department of Bioethics  
Dr. Vivek Kusumakar, Head, Mood Disorders Research Group, Department of Psychiatry  
Lawrence Nestman, Professor, School of Health Services Administration

*Nova Scotia Valley Caregivers Support Group:*

Maxine Barrett

*Elizabeth May Chair in Women's Health and the Environment, Dalhousie University:*

Sharon Batt, Chair

*Feminists for Just and Equitable Public Policy:*

Ms. Georgia MacNeil, Chair Person

*Cape Breton Regional Health Care Complex:*

John Malcom, CEO

Dr. Mahmood Naqvi, Medical Director, Cape Breton Regional Facility

*Capital District Health Authority:*

Dr. John Ruedy, Vice-President, Academic Affairs

*Dalhousie University:*

Thomas Rathwell, Professor and Director, School of Health Services Administration

*Canadian Medical Association:*

Dr. Henry Haddad, MD, President

Bill Tholl, Secretary General

Dr. Bruce Wright, President of the Medical Society of Nova Scotia

Dr. Dana W. Hanson, President-Elect

*Dalhousie University:*

Dr. Desmond Leddin, Head, Division of Gastroenterology

Dr. George Kephart, Director, Population Health Research Unit, Department of Community and Epidemiology

Dr. Kenneth Rockwood, Faculty of Medicine, Division of Geriatric Medicine

*Cobequid Community Health Board:*

Ryan Sommers

*Health Canada:*

Anne-Marie Leger, Policy Analyst

### **Wednesday, November 7, 2001**

*Department of Health and Social Services, Prince Edward Island:*

The Honourable Jamie Ballem, Minister

*PEI Seniors Advisory Council:*

Heather Henry-MacDonald, Chair

*Canadian Union of Public Employees, PEI Division:*

Bill A. McKinnon, National Representative

Ms. Donalda MacDonald, President

Raymond Léger, Research Representative

*Department of Health and Social Services:*

Mary Hughes-Power, Director of Acute and Continuing Care

Deborah Bradley, Manager of Public Health Policy

*College of Family Physicians of Canada:*  
Dr. Peter MacKean, Chairman of the Board

*Queen Elizabeth Hospital:*  
Iain Smith, Drug Utilization Coordinator

*PEI Pharmacy Board:*  
Neila Auld, Executive Director, PEI

*Queen's Regional Health Authority:*  
Sylvia Poirier, Chair

*West Prince Regional Health Authority:*  
Ken Ezeard, Chief Executive Officer

*Department of Health and Social Services:*  
Dr. Don Ling, Director of Medical Services

*Department of Health and Social Services, Prince Edward island:*  
Rory Francis, Deputy Minister  
Bill Harper, Assistant Deputy Minister  
Jean Doherty, Communications Coordinator

*Southern Kings Health Authority:*  
Betty Fraser, Chief Executive Officer

*Department of Health and Social Services:*  
Susan Maynard, Senior Health Planner  
Kathleen Flanagan-Rochon, Community Services Coordinator

*Evangeline Health Centre:*  
Elise Arsenault, Coordinator

*East Prince Regional Health Authority:*  
David Riley, Chief Executive Officer

*Dalhousie University:*  
Dr. Stan Kutcher, Department Head of the Community Health and Epidemiology/ Psychiatry

**Thursday, November 8, 2001**

*Faculty of Nursing, University of New Brunswick:*  
Dr. Margaret Dykeman

*New Brunswick Health Care Association:*  
Robert Simpson, Chief Executive Officer

*Canadian Association of Chain Drug Stores:*  
Sherry Porter, Atlantic Canada Representative  
Sandra Aylward, Vice President, Pharmacy Services

*As individuals:*

Dr. Russell King, Former Minister of Health, Province of New Brunswick  
William Morrissey, Former Deputy Minister of Health, Province of New Brunswick

*Applied Management:*

Bryan Ferguson, Partner

*Société des Acadiens et Acadiennes du Nouveau-Brunswick:*

Daniel Thériault, Director General

*Canadian Snowbird Association:*

Bob Jackson, President

*New Brunswick Senior Citizens Federation Inc.:*

Helen Ladouceur, Member

Eilleen Malone, Member

*Catholic Health Association of Canada:*

Sandra Keon, Secretary Treasurer; and Vice-President of Clinical Programs, Pembroke Hospital

*Miramichi Police Force:*

Michael Gallagher, Corporal, Drug Section

*Canadian Union of Public Employees, New Brunswick:*

Raymond Léger, Research Representative

*Federal Superannuates National Association:*

Rex G. Guy, National President

Roger Heath, Research and Communications Officer

*Union of New Brunswick Indians:*

Nelson Solomon, Director of Health

Wanda Paul Rose, Coordinator

Norville Getty, Consultant

*Nurses Association of New Brunswick:*

Roxanne Tarjan, Director General

**Thursday, February 21, 2002**

*Canadian Federation of Nurses Unions:*

Kathleen Connors, President

*Canadian Health Coalition:*

Dr. Arnold Relman, Former editor of *New England Journal of Medicine*

Michael McBane, National Coordinator

*Federal Superannuates National Co-ordinator:*

Rex G. Guy, National President

Roger Heath, Research and Communications Officer



**Thursday, March 7, 2002**

*Canadian Healthcare Association:*

Sharon Sholzberg-Gray, President and CEO  
Kathryn Tregunna, Director, Policy Development

*Canadian Labour Congress:*

Kenneth V. Georgetti, President  
Cindy Wiggins, Senior Researcher, Social and Economic Policy Department

**VOLUME THREE (May 28, 2001 – June 14, 2001)**

**Monday, May 28, 2001**

*(By videoconference)*

*From the Ministry of Health, Welfare and Sports of the Netherlands:*

Dr. Hugo Hurts, Deputy Director, Health Insurance Division, Ministry of Health, Welfare and Sports of the Netherlands

*From the International Institute of Social Studies of the Netherlands:*

Professor James Bjorkman

**Thursday, June 7, 2001 (9:00 a.m.)**

*(by videoconference)*

*Swedish Parliament (Riksdag):*

Lars Elinderson, Deputy member, Committee on Health and Welfare

**Monday, June 11, 2001**

*(By videoconference)*

*German Health Ministry:*

Georg Baum, Director General, Head of Directorate Health Care  
Dr. Margot Faelker, Deputy-Director, Section Financial Issues of Statutory Health Insurance  
Dr. Rudolf Vollmer, Director-General, Head of Directorate Long-Term Nursing Care Insurance

*Department of Health – Economic and Operational Research Division of the United Kingdom:*

Clive Smee, Chief Economic Adviser

*University of Birmingham:*

Professor Chris Ham, Director, Health Services Management Centre

*London School of Economics:*

Professor Julien LeGrand, Richard Titmuss Professor of Social Policy, LSE Health & Social Care

**Tuesday, June 12, 2001**

*(By videoconference)*

*Australian Institute of Health and Welfare:*

Dr. Richard Madden, Director

*Australian Health Insurance Association:*

Russel Schneider, CEO

*National Centre for Epidemiology and Population Health – Australian National University*  
Dr. Tony Adams, Professor of Public Health

*Health Insurance Commission:*  
Dr. Brian Richards

*Australian Medical Association:*  
Dr. Carmel Martin, Director  
Dr. Roger Kilham

**Wednesday, June 13, 2001**

*Health Canada:*  
Ake Blomqvist, Visiting Academic, Applied Research and Analysis Directorate, Information, Analysis and Connectivity Branch and Professor, University of Western Ontario

*University of Calgary:*  
Professor Cam Donaldson, Department of Economics

*University of Toronto (by videoconference):*  
Professor Colleen Flood, Faculty of Law

*As an individual:*  
Claude Forget

*University of Toronto:*  
Professor Mark Stabile, Department of Economics  
Professor Carolyn Tuohy, Department of Political Science

**Thursday, June 14, 2001**

*(by videoconference)*

*U.S. Department of Health and Human Services:*  
Christine Schmidt, Deputy to the Deputy Assistant Secretary for Health Policy, Office of the Assistant Secretary for Planning and Evaluation  
Ariel Winter, Analyst  
Tanya Alteras, Analyst

**VOLUME TWO (March 21 2001 - June 7 2001)**

**Wednesday, March 21, 2001**

*Statistics Canada:*  
Réjean Lachapelle, Director, Demography Division  
Jean-Marie Berthelot, Manager, Health Analysis and Modeling Group, Social and Economic Studies Division  
Brian Murphy, Senior Research Analyst, Socio-Economic Modeling Group

*Canadian Institute of Actuaries:*  
David Oakden, President  
Rob Brown, Manager of Task Force on Health Care Financing  
Daryl Leech, Chair, Committee on Health Care

*National Advisory Council on Aging:*  
Dr. Michael Gordon, Member

*Conference Board of Canada:*  
James G. Frank, Ph.D., Chief Economist and Vice-President  
Glenn Brimacombe, Director of Health Program

**Thursday, March 22, 2001**

*C.D. Howe Institute:*  
William B.P. Robson, Vice-President and Director of Research

*McMaster University:*  
Byron G. Spencer, Professor

*University of Ottawa:*  
Dr. William Dalziel

**Wednesday, March 28, 2001**

*IMS Health Canada:*  
Dr. Roger A. Korman, President

*Canadian Association of Pharmacists:*  
Dr. Jeff Poston, Executive Director

*Health Promotion Research:*  
Dr. Robert Coombs, President and CEO

*Health Canada:*  
Barbara Ouellet, Director of Home Care and Pharmaceuticals, Health Care Directorate, Policy and Consultation Branch

**Thursday, March 29, 2001**

*Canadian Association of Radiologists:*  
Dr. John Radomsky

**Thursday, March 29, 2001 (cont'd)**

*Canadian Coordinating Office for Health Technology Assessment (CCHOTA):*  
Dr. Jill Sanders, President and CEO

*The Fraser Institute:*  
Martin Zelder, Director of Health Policy Research

*As an individual:*  
Professor David Feeny

**Wednesday, April 4, 2001**

*Health Canada:*  
Dr. Christina Mills, Director General, Centre for Chronic Disease Prevention and Control – Population Public Health Branch

Dr. Paul Gully, Acting Director General, Centre for Infectious Disease Prevention and Control

Dr. Clarence Clotney, Acting Director, Diabetes Division, Bureau of Cardio-Respiratory Diseases and Diabetes, Centre for Chronic Disease prevention and Control

Nancy Garrard, Director, Division of Aging and Seniors

*Dalhousie University:*

Dr. David MacLean, Departmental Head, Community Health and Epidemiology

**Thursday, April 5, 2001**

*Health Canada:*

Abby Hoffman, Director General, Health Care Directorate – Health Policy and Communications Branch

Cliff Halliwell, Director General, Applied Research & Analysis Directorate, Information, Analysis and Connectivity Branch

Nancy Garrard, Director, Division of Aging and Seniors

**Thursday, April 26, 2001**

*Canadian Institute of Health Research:*

Dr. Alan Bernstein, President

*Health Canada:*

Kimberly Elmslie, Acting Executive Director, Health Research Secretariat

*Statistics Canada:*

T. Scott Murray, Director General, Institutions and Social Statistics Branch

**Wednesday, May 9, 2001**

*Canada's Research-Based Pharmaceutical Companies:*

Murray Elston, President

*Coalition for Biomedical and Health Research:*

Dr. Barry McLennan, Chairman

Charles Pitts, Executive Director

*Centre for Excellence for Women's Health:*

Dr. Pat Armstrong

*Canadian Genetic Diseases Network:*

Dr. Ronald Worton, CEO & Scientific Director

**Thursday, May 10, 2001**

*Health Canada:*

William J. Pascal, Director General, Office of Health and Information Highway, Information, Analysis and Connectivity Branch

*Canadian Institute for Health Information:*

Dr. John S. Millar, Vice-President, Research and Analysis

*Canadian Society of Telehealth:*

Dr. Robert Filler, President

*Department of Health and Wellness of New Brunswick*

David Cowperthwaite, Director of Information System

**Wednesday, May 16, 2001**

*Canadian Medical Association:*  
Dr. Peter Barrett, President

*Canadian Medical Forum Task Force 1:*  
Dr. Hugh Scully, President

*Federal Provincial Territorial Advisory Committee on Health Human Resources:*  
Dr. Thomas Ward, Chair

*Canadian Nurses Association:*  
Sandra MacDonald-Remecz, Director of Policy, Regulation and Research

*Canadian Federation of Nurses Unions:*  
Kathleen Connors, President

*Ordre des infirmières et infirmiers auxiliaires du Québec:*  
Régis Paradis, President

*Nurse Practitioners Association of Ontario:*  
Linda Jones

*Canadian Radiation and Imaging Societies in Medicine (CRISM):*  
Dr. Paul C. Johns, Past Chair

*The Canadian Chiropractic Association:*  
Dr. Tim St. Dennis, President

*Canadian Society for Medical Laboratory Science:*  
Kurt Davis, Executive Director

**Thursday, May 17, 2001**

*Canadian Home Care Association (CHCA):*  
Nadine Henningsen, Executive Director

*Canadian Association for Community Care (CACC):*  
Dr. Taylor Alexander, President

*Victorian Order of Nurses for Canada (VON Canada):*  
Diane McLeod, Vice-President, Policy, Planning and Government Relations, Central Region

**Wednesday, May 30, 2001**

*Health Canada:*  
Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch  
Jerome Berthelette, Special Advisor, Office of the Special Advisor Aboriginal Health, First Nations Inuit Health Branch  
Dr. Peter Cooney, Acting Director General, Non-Insured Health Benefits, First Nations and Inuit Health

*Indian and Northern Affairs Canada:*  
Chantal Bernier, Assistant Deputy Minister, Socio-economic Development Policy and Programs  
Terry Harrison, Director, Social Services and Justice

*Assembly of First Nations:*  
Elaine Johnston, Director of Health

*Métis National Council:*  
Gerald Morin, President

*Native Women's Association of Canada:*  
Michelle Audette, Interim Speaker and President of the Native Women Association of Quebec

*Congress of Aboriginal Peoples:*  
Scott Clark, President, United Native Nations

*Inuit Tapirisat of Canada:*  
Larry Gordon, Member ITC, Health Committee

*Pauktuutit Inuit Women's Association:*  
Veronica N. Dewar, President

*National Aboriginal Health Organization:*  
Dr. Judith Bartlett, Chair  
Richard Jock, Executive Director

*Canadian Institutes of Health Research:*  
Dr. Jeff Reading, Scientific Director, Institute of Aboriginal People's Health

*Wikwemikong Health Centre:*  
Ron Wakegijig, Healer

*National Indian and Inuit Community Health Representatives Organization:*  
Margaret Horn, Executive Director

**Thursday, May 31, 2001**

*Health Canada:*  
Dr. John Wooton, Special Advisor on Rural Health, Population and Public Health Branch

*Canadian Medical Association:*  
William Tholl, Secretary General and Chief Executive Officer

*Society of Rural Physicians of Canada:*  
Dr. Peter-Hutten-Czapski, President

*Consortium for Rural Health Research:*  
Dr. Judith Kulig

**Wednesday, June 6, 2001**

*University of Ottawa:*  
Professor Martha Jackman, Faculty of Law

*University of Calgary: (by videoconference)*  
Professor Sheila Martin, Faculty of Law

**Thursday, June 7, 2001 (11:00 a.m.)**

*Health Canada:*

Nancy Garrard, Acting Director General, Centre for Healthy Human Development, Population and Public Health Branch

Tom Lips, Senior Policy Advisor for Mental Health, Population and Public Health Branch

Carl Lakaski, Senior Analyst, Mental Health, Health Human Resources Strategies Division, Health Policy and Communications Branch

*Canadian Psychological Association:*

Dr. John Service, Executive Director

*Canadian Alliance on Mental Illness and Mental Health:*

Phil Upshall, Coordinator

*Canadian Mental Health Association:*

Bonnie Pape

*Department of Health and Wellness of New Brunswick:*

Ken Ross, Assistant Deputy Minister, Mental Health Services

**VOLUME ONE (March 2 200 – September 21, 2001)  
(2<sup>nd</sup> Session, 36<sup>th</sup> Parliament)**

**Thursday, March 2, 2000**

University of Toronto, Department of Health Administration:

Raisa Deber, Professor

Health Canada:

Dr. Robert McMurtry, *G.D.W. Cameron Visiting Chair*

*Health Action Lobby (HEAL):*

Sharon Sholzberg-Gray, Co-Chair

Dr. Mary Ellen Jeans, *Co-Chair*

Canadian Policy Research Network:

Sholom Glouberman, Director, Health Network

**Wednesday, March 22, 2000**

Founder's Network :

Dr. Fraser Mustard

Goldfarb Consultants:

Dr. Scott Evans, Senior Statistical Consultant

Environics Research Group :

Chris Baker, Vice-President

*Health Canada:*

Wendy Watson-Wright, Director General, Policy and Major Projects Directorate, Health Promotion and Programs Branch

**Thursday, March 23, 2000**

Health Canada:

Sylvain Paradis, Acting Policy Group Manager, Policy and Major Projects Directorate, Quantitative Analysis and Research Section, Health Promotion and Programs Branch

Liz Kusey, Policy Analyst, Policy and Major Projects Directorate, Health Promotion and Programs Branch

Monique Charon, Acting Director, Program Policy and Planning, Program Policy, Transfer Secretariat and Planning Directorate, Medical Services Branch

Mary Johnston, Education Consultant, Strategic Policy and Systems Coordination Section, Childhood and Youth Division – Health Promotion and Programs Branch

Julie MacKenzie, Senior Research Analyst, Strategic Policy and Systems Coordination Section, Childhood and Youth Division – Health Promotion and Programs Branch

Queens University – School of Policy Studies:

Keith Banting, Director

**Thursday, April 6, 2000**

*University of British Columbia:*

Robert G. Evans, Director, Population Health Program

Canadian Centre for Policy Alternatives:

Colleen Fuller

The Fraser Institute:

Martin Zelder, Director of Health Policy Research

**Wednesday, May 3, 2000**

*Health Canada:*

Cliff Halliwell, Director General, Applied Research & Analysis Directorate, Information, Analysis and Connectivity Branch

Abby Hoffman, Senior Policy Advisor

Frank Fedyk, Acting Director, Canada Health Act Directorate, Policy and Consultation Branch

**Thursday, May 4, 2000**

*As an individual:*

Tom Kent

*University of Toronto:*

Michael Bliss, Professor

**Wednesday, May 10, 2000**

*University of Western Ontario:*

Ake Blomqvist, Professor

*University of Toronto:*

Colleen Flood, Professor

Mark Stabile, Professor



**Thursday, May 11, 2000**

*Canadian Institute for Health Information:*

John S. Millar, Vice-President, Research and Analysis

*McGill University:*

Margaret Somerville, Professor

*Alberta University:*

Laura Shanner, Professor

**Wednesday, May 17, 2000**

*As an individual:*

The Honourable Marc Lalonde, P.C.

**Wednesday, May 31, 2000**

*As an individual:*

The Honourable Monique Bégin, P.C.

**Wednesday, June 7, 2000**

*Department of Finance:*

Guillaume Bissonnette, General Director, Federal-Provincial Relations and Social Policy Branch

Barbara Anderson, Director, Federal-Provincial Relations Division - Federal-Provincial Relations and Social Policy Branch

**Thursday, September 21, 2000**

*As an individual:*

Graham Scott, Former Deputy Minister of Health, Province of Ontario



**OTHER WRITTEN SUBMISSIONS RECEIVED:**

Abell Medical Clinic

Alberta Centre for Injury Control and Research

Amgen Canada Inc.

Ancaster-Dundas-Flamborough-Aldershot New Democratic Party Riding Association Executive Committee

Association of Canadian Medical Colleges (ACMC)

Patricia Baird

B.C. Better Care Pharmacare Coalition

Bruce Bigham

Brain Injury Association of Nova Scotia

Robert D. Brown and Michanne Haynes

Canada Health Infoway

Canada's Research-Based Pharmaceutical Companies

Canada West Foundation

Canadian Association of Emergency Physicians (CAEP)

Canadian Association of Internes and Residents

Canadian Blood Services

Canadian Caregiver Coalition

Canadian Cochrane Network and Centre

Canadian Council on Integrated Healthcare  
Canadian Dental Hygienists Association  
Canadian Drug Manufacturers Association (CDMA)  
Canadian Strategy for Cancer Control  
Cancer Care Ontario, Division of Preventive Oncology  
Chemical Sensitivities Information Exchange Network Manitoba (CSIENM)  
Conestoga College (Pat Bower, Course instructor)  
Laurent Desjardins  
Faith Partners (Ottawa)  
Federation of Medical Women in Canada  
Sandra Finley  
Dr. Michael Gordon, Baycrest Centre for Geriatric Care  
Serena Grant  
Health Care Corporation of St.John's  
Heart and Stroke Foundation of New Brunswick  
Home-based Spiritual Care  
Kidney Foundation of Canada  
Kids First Parent Association of Canada  
Dr. Lee Kurisko  
Caterine Lindman  
Jim Ludwig  
Dr. Keith Martin  
Dr. Ross McElroy  
Dr. Malcom S. McPhee  
Meals on Wheels of Calgary  
Medbuy Corporation  
Verna Milligan  
Moose Jaw-Thunder Creek District Health Board  
Dr. Earl B. Morris  
Fran Morrison  
Multiple Sclerosis Society of Canada  
John Neilson  
Ontario Chamber of Commerce  
Ontario Psychological Association  
Roy L. Piepenburg (Liberation Consulting)  
Red Deer Network in Support of Medicare  
Dr. Robert S. Russell  
Society of Obstetricians and Gynaecologists of Canada  
Christa Streicher  
Thames Valley District Health Council  
Elaine Tostevin  
University of Ottawa Heart Institute  
University of Ottawa Institute of Population Health (Dr. Joseph Losos, Director)

Comité sénatorial permanent des affaires sociales,  
des sciences et de la technologie

Rapport final sur  
l'état du système de soins de santé au Canada

*La santé des Canadiens – Le rôle du gouvernement fédéral*  
*Volume Six :*  
*Recommandations en vue d'une réforme*

*Président*  
L'honorable Michael J. L. Kirby

*Vice-présidente*  
L'honorable Marjory LeBreton

OCTOBRE 2002



# TABLE DES MATIÈRES

---

<b>TABLE DES MATIÈRES</b> .....	<b>i</b>
<b>ORDRE DE RENVOI</b> .....	<b>vii</b>
<b>SÉNATEURS</b> .....	<b>viii</b>
<b>LISTE DES ABRÉVIATIONS</b> .....	<b>ix</b>
<b>REMERCIEMENTS</b> .....	<b>xi</b>
<b>AVANT-PROPOS</b> .....	<b>xiii</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>PARTIE I : RESPONSABILISATION</b> .....	<b>5</b>
<b>CHAPITRE UN</b> .....	<b>7</b>
LA NÉCESSITÉ D'UN RAPPORT ANNUEL SUR L'ÉTAT DU SYSTÈME DE SOINS DE SANTÉ ET SUR L'ÉTAT DE SANTÉ DES CANADIENS .....	7
1.1 Résumé de quelques points saillants des volumes un à cinq .....	7
1.1.1 <i>Le rôle du gouvernement fédéral</i> .....	7
1.1.2 <i>Objectifs de la politique fédérale en matière de soins de santé</i> .....	8
1.1.3 <i>L'actuel système n'est pas financièrement viable</i> .....	10
1.1.4 <i>Une garantie nationale de soins de santé est essentielle au succès de la réforme</i> .....	12
1.2 Améliorer la gouvernance — La nécessité d'un commissaire national aux soins de santé.....	14
1.2.1 <i>Association médicale canadienne (AMC)</i> .....	16
1.2.2 <i>Colleen Flood et Sujit Choudry</i> .....	16
1.2.3 <i>Tom Kent</i> .....	17
1.2.4 <i>Duane Adams</i> .....	18
1.2.5 <i>Lawrence Nestman</i> .....	19
1.3 La proposition du Comité .....	19
<b>PARTIE II : MESURES VISANT L'EFFICIENCE</b> .....	<b>25</b>
<b>CHAPITRE DEUX</b> .....	<b>27</b>
RESTRUCTURATION ET FINANCEMENT DES HÔPITAUX AU CANADA .....	27
2.1 Méthodes de financement des hôpitaux au Canada : Avantages et inconvénients .....	29
2.1.1 <i>Financement élément par élément</i> .....	30
2.1.2 <i>Discretion ministérielle</i> .....	31
2.1.3 <i>Financement fondé sur la population</i> .....	31
2.1.4 <i>Financement par budget global</i> .....	32
2.1.5 <i>Financement fondé sur les politiques</i> .....	34
2.1.6 <i>Financement fondé sur les établissements</i> .....	34
2.1.7 <i>Financement par projet</i> .....	34
2.1.8 <i>Financement fondé sur les services dispensés</i> .....	34
2.2 Financement fondé sur les services dispensés : Examen de l'expérience internationale.....	35

2.2.1	<i>États-Unis</i> .....	35
2.2.2	<i>Royaume-Uni</i> .....	36
2.2.3	<i>France</i> .....	37
2.2.4	<i>Danemark</i> .....	37
2.2.5	<i>Norvège</i> .....	38
2.2.6	<i>Examen de l'expérience internationale par le comité Bédard</i> .....	38
2.3	Justification du financement fondé sur les services dispensés au Canada.....	39
2.3.1	<i>Pertinence du choix de services</i> .....	43
2.3.2	<i>Services excessifs et surévaluation</i> .....	44
2.3.3	<i>Taux, information et données</i> .....	45
2.3.4	<i>Innovation</i> .....	46
2.3.5	<i>Soins de santé complets</i> .....	46
2.3.6	<i>Escalade des coûts</i> .....	46
2.3.7	<i>Manque de simplicité</i> .....	47
2.3.8	<i>Commentaires du Comité</i> .....	47
2.4	Les centres universitaires des sciences de la santé et la complexité des hôpitaux d'enseignement.....	49
2.5	Petits hôpitaux et hôpitaux communautaires ruraux.....	52
2.6	Financement des besoins en immobilisations des hôpitaux canadiens .....	54
2.7	Établissements de soins de santé publics ou privés?.....	57
	Annexe 2.1 : Centres universitaires des sciences de la santé et hôpitaux et régies régionales de la santé affiliés.....	63

## **CHAPITRE TROIS..... 67**

	DÉLÉGUER PLUS DE RESPONSABILITÉS AUX RÉGIES RÉGIONALES DE LA SANTÉ.....	67
3.1	Un tableau des RRS au Canada.....	68
3.2	RRS : Objectifs et réalisations .....	70
3.3	Obstacles qui empêchent les RRS de mettre pleinement à profit leur potentiel.....	72
3.4	Les RRS et le potentiel des marchés internes.....	74
3.5	Commentaires du Comité.....	78

## **CHAPITRE QUATRE..... 81**

	RÉFORME DES SOINS DE SANTÉ PRIMAIRES.....	81
4.1	Pourquoi une réforme des soins de santé primaires est-elle nécessaire? .....	81
4.2	Les provinces et la réforme des soins primaires.....	85
4.2.1	<i>Rapports récents</i> .....	85
4.2.2	<i>Le Réseau santé-famille de l'Ontario</i> .....	86
4.2.3	<i>Québec</i> .....	90
4.2.4	<i>Nouveau-Brunswick</i> .....	91
4.3	Surmonter les obstacles au changement.....	92
4.4	Le rôle du gouvernement fédéral.....	96
	Annexe 4.1 : Régime d'enveloppes budgétaires pour les omnipraticiens en Grande-Bretagne .....	99

**PARTIE III : LA GARANTIE DE SOINS DE SANTÉ..... 107**

**CHAPITRE CINQ.....109**

DES SOINS DE SANTE EN TEMPS OPPORTUN..... 109

5.1 Le droit aux soins de santé – Perception du public ou droit reconnu par la loi?..... 110

5.2 Disponibilité des services couverts par le régime public à l'extérieur du système public de soins de santé..... 111

5.3 Prestation de soins de santé en temps opportun et article 7 de la *Charte canadienne des droits et libertés*..... 112

5.4 Commentaires du Comité..... 119

**CHAPITRE SIX ..... 121**

LA GARANTIE DE SOINS DE SANTÉ ..... 121

6.1 Le problème des listes d'attente : la perception du public..... 121

6.2 Le problème des listes d'attente : la situation réelle..... 122

6.3 L'expérience canadienne ..... 123

6.3.1 Réseau de soins cardiaques de l'Ontario (RSCO)..... 123

6.3.2 Projet de rationalisation des listes d'attente dans l'Ouest canadien ..... 124

6.4 Expérience internationale ..... 125

6.4.1 Suède..... 126

6.4.2 Danemark..... 126

6.5 Recommandations du Comité..... 128

6.6 Les conséquences possibles d'une non-application de la garantie de soins de santé ..... 132

6.7 Quelques réflexions sur la garantie de soins de santé ..... 133

**PARTIE IV : RESSERRER LES MAILLES DU FILET DE SÉCURITÉ..... 135**

**CHAPITRE SEPT .....137**

ÉTENDRE LA COUVERTURE POUR INCLURE LA PROTECTION CONTRE LES COÛTS EXORBITANTS DES MÉDICAMENTS DE PRESCRIPTION ..... 137

7.1 Tendances des dépenses au titre des médicaments..... 138

7.2 Comparaisons avec d'autres pays..... 140

7.3 L'assurance pour les médicaments de prescription au Canada..... 142

7.3.1 Régimes publics d'assurance-médicaments..... 142

7.3.2 Régimes privés d'assurance-médicaments..... 143

7.3.3 Les caractéristiques des régimes d'assurance et leur incidence sur la protection contre les frais élevés de médicaments..... 144

7.4 Un phénomène nouveau : Les dépenses exorbitantes en médicaments de prescription..... 145

7.5 Protéger les Canadiens contre les frais exorbitants de médicaments de prescription..... 149

7.5.1 Comment fonctionnerait le régime..... 150

7.5.2 Avantages du régime proposé..... 152

7.5.3 Combien coûterait le régime?..... 153

7.5.4 Proposition du Comité relative à un régime d'assurance contre les frais exorbitants de médicaments de prescription..... 154

7.6 Nécessité d'une liste nationale des médicaments admissibles..... 155

<b>CHAPITRE HUIT.....</b>	<b>157</b>
ÉLARGIR LA COUVERTURE POUR INCLURE LES SOINS ACTIFS À DOMICILE.....	157
8.1 Bref aperçu des principaux points relevés dans les volumes deux et quatre à propos des soins à domicile.....	157
8.2 Autres options.....	159
8.3 Le programme extra-mural au Nouveau-Brunswick.....	160
8.3.1 <i>S'inspirer de l'exemple du Nouveau-Brunswick : renvois directs aux soins à domicile</i> .....	162
8.4 Organiser et fournir des soins actifs à domicile.....	163
8.4.1 <i>Définition des soins actifs à domicile</i> .....	164
8.4.1.1 <i>Quand les services de soins actifs à domicile (SAD) commencent-ils?</i> .....	164
8.4.1.2 <i>Quand les SAD se terminent-ils?</i> .....	165
8.4.2 <i>Dispositions organisationnelles pour les SAD</i> .....	165
8.4.3 <i>Qui fournit des SAD?</i> .....	167
8.5 Le coût d'un programme national de soins actifs à domicile.....	169
8.5.1 <i>Comment calculer le coût d'un programme national de SAD</i> .....	169
8.5.2 <i>Et les coûts cachés?</i> .....	170
8.5.3 <i>Combien coûtera un programme national de SAD?</i> .....	171
8.6 Payer les soins post-hospitaliers à domicile .....	171
<b>CHAPITRE NEUF.....</b>	<b>175</b>
ÉTENDRE LA COUVERTURE POUR INCLURE LES SOINS PALLIATIFS À DOMICILE.....	175
9.1 Nécessité d'un programme national de soins palliatifs.....	175
9.2 Aide financière aux fournisseurs de soins palliatifs à domicile.....	176
9.3 Crédit d'impôt pour fournisseurs de soins.....	178
9.4 Protection des emplois.....	179
9.5 Conclusion.....	179
<b>PARTIE V : ACCROÎTRE LA CAPACITÉ ET CONSTRUIRE L'INFRASTRUCTURE</b>	<b>181</b>
<b>CHAPITRE DIX.....</b>	<b>183</b>
LE RÔLE DU GOUVERNEMENT FÉDÉRAL DANS L'INFRASTRUCTURE DE SOINS DE SANTÉ .....	183
10.1 Technologies de la santé .....	183
10.2 Dossiers de santé électroniques .....	187
10.3 Évaluation de la qualité, de l'efficacité et des résultats .....	190
10.4 Protection des renseignements personnels sur la santé.....	192
<b>CHAPITRE ONZE.....</b>	<b>199</b>
LES RESSOURCES HUMAINES DE LA SANTÉ.....	199
11.1 La gravité de la pénurie de ressources humaines en santé.....	199
11.2 Les ressources humaines de la santé : Nécessité d'une stratégie nationale .....	203
11.3 Accroître le nombre de médecins formés au Canada.....	206
11.4 Intégration des diplômés en médecine étrangers.....	208
11.5 Réduire la pénurie d'infirmières .....	209
11.6 Professions paramédicales.....	213
11.7 Financement des études supérieures.....	213
11.8 Ressources humaines de la santé : Examen des règles relatives au champ de pratique.....	213
11.9 Commentaires du Comité.....	214



<b>CHAPITRE DOUZE.....</b>	<b>217</b>
FAVORISER L'EXCELLENCE DANS LA RECHERCHE CANADIENNE EN SANTÉ.....	217
12.1 Assumer le leadership dans la recherche en santé.....	219
12.2 S'engager dans la révolution scientifique.....	222
12.3 Garantir un environnement de recherche prévisible.....	225
12.3.1 <i>Le financement fédéral de la recherche en santé.....</i>	<i>226</i>
12.3.2 <i>La recherche fédérale interne en santé.....</i>	<i>229</i>
12.4 Rehausser la qualité des services de santé et de la prestation des soins.....	230
12.5 Améliorer l'état de santé des populations vulnérables.....	232
12.6 Commercialiser les résultats de la recherche en santé.....	234
12.7 Respecter les normes d'éthique les plus élevées dans la recherche en santé.....	239
12.7.1 <i>La recherche sur des sujets humains.....</i>	<i>240</i>
12.7.2 <i>Questions suscitées par la recherche sur des sujets humains.....</i>	<i>242</i>
12.7.3 <i>L'utilisation d'animaux dans la recherche.....</i>	<i>245</i>
12.7.4 <i>La confidentialité des renseignements médicaux personnels.....</i>	<i>247</i>
12.7.5 <i>La confidentialité de l'information génétique.....</i>	<i>252</i>
12.7.6 <i>Les situations possibles de conflit d'intérêts.....</i>	<i>253</i>
 <b>PARTIE VI : PROMOTION DE LA SANTÉ ET PRÉVENTION DE LA MALADIE ..</b>	 <b>257</b>
<b>CHAPITRE TREIZE.....</b>	<b>259</b>
UNE POLITIQUE PUBLIQUE « PRO-SANTÉ » – LA SANTÉ AU-DELÀ DES SOINS DE SANTÉ.....	259
13.1 Tendances de la maladie.....	262
13.1.1 <i>Maladies infectieuses.....</i>	<i>263</i>
13.1.2 <i>Maladies chroniques.....</i>	<i>264</i>
13.1.3 <i>Blessures.....</i>	<i>265</i>
13.1.4 <i>Problèmes de santé mentale.....</i>	<i>265</i>
13.2 Fardeau économique de la maladie.....	265
13.3 Nécessité d'une stratégie nationale de prévention des maladies chroniques.....	267
13.4 Renforcer la santé publique et la promotion de la santé.....	270
13.5 Vers une politique publique pro-santé – Nécessité d'élaborer des stratégies d'amélioration de la santé de la population.....	271
 <b>PARTIE VII : FINANCER LA REFORME.....</b>	 <b>275</b>
<b>CHAPITRE QUATORZE.....</b>	<b>277</b>
COMMENT ADMINISTRER IES FONDS SUPPLÉMENTAIRES QUE LE GOUVERNEMENT FÉDÉRAL CONSACRERA À LA SANTÉ.....	277
14.1 Il faut investir davantage dans le système de soins de santé.....	278
14.2 Le rôle du gouvernement fédéral en matière de financement.....	283
14.3 Comment gérer les nouveaux fonds que le gouvernement fédéral destinaera aux soins de santé.....	285

<b>CHAPITRE QUINZE</b> .....	<b>289</b>
COMMENT GÉNÉRER DES FONDS ADDITIONNELS POUR LES SOINS DE SANTÉ .....	289
15.1 Ampleur du financement fédéral additionnel requis.....	291
15.2 Sources possibles de financement fédéral accru.....	294
15.3 Impôts généraux.....	295
15.4 Impôts spécifiques .....	300
15.5 Charges sociales.....	303
15.6 Prime nationale d'assurance-santé.....	305
15.7 Frais d'utilisation.....	307
15.8 Comptes d'épargne-santé.....	309
15.9 Financement anticipé des soins de santé .....	310
15.10 Commentaires du Comité.....	312
15.11 Financement fédéral actuel des soins de santé.....	317
 <b>CHAPITRE SEIZE</b> .....	 <b>321</b>
VIABILITÉ FINANCIÈRE DU SYSTÈME DE SOINS DE SANTÉ : LES CONSÉQUENCES DE L'INACTION.....	321
16.1 L'assurance-santé privée au Canada et dans certains pays de l'OCDE.....	323
16.2 Examen de la documentation récente sur les effets d'un système privé d'assurance-santé et de prestation de soins à but lucratif .....	326
16.3 Commentaires du Comité.....	328
 <b>PARTIE VIII : LA LOI CANADIENNE SUR LA SANTÉ</b> .....	 <b>331</b>
 <b>CHAPITRE DIX-SEPT</b> .....	 <b>333</b>
LA LOI CANADIENNE SUR LA SANTÉ.....	333
17.1 Universalité.....	334
17.2 Intégralité .....	335
17.3 Accessibilité .....	339
17.4 Transférabilité .....	341
17.5 Gestion publique.....	342
17.6 Commentaires du Comité.....	345
 <b>CONCLUSION</b> .....	 <b>347</b>
 <b>ANNEXE A</b> .....	 <b>A-1</b>
LISTE DES RECOMMANDATIONS PAR CHAPITRE .....	A-1
 <b>ANNEXE B</b> .....	 <b>A-21</b>
LIST DES PRINCIPES DU VOLUME CINQ (AVRIL 2002).....	A-21
 <b>ANNEXE C</b> .....	 <b>A-23</b>
LISTE DES TÉMOINS.....	A-23

# **Partie VII : Financer la réforme**

---



## CHAPITRE QUATORZE

### COMMENT ADMINISTRER LES FONDS SUPPLÉMENTAIRES QUE LE GOUVERNEMENT FÉDÉRAL CONSACRERA À LA SANTÉ

---

Le Comité a conclu le volume cinq de son étude en rappelant que, dans sa structure actuelle, le système public de soins de santé au Canada n'est pas financièrement viable<sup>315</sup>. Autrement dit, le mécanisme de financement du système de soins hospitaliers et de soins dispensés par les médecins payé par les deniers publics n'est plus conforme aux exigences du XXI<sup>e</sup> siècle. On devra par conséquent entreprendre une vaste réforme des mécanismes de financement des services hospitaliers et des services dispensés par les médecins si l'on veut préserver et améliorer le système de santé public auquel tiennent les Canadiens et qui les a si bien servis au cours des dernières décennies.

Toujours dans le volume cinq, le Comité indiquait ce qu'est pour lui un *système de soins de santé financièrement viable* : un système sur lequel les Canadiens peuvent compter maintenant et pourront compter dans l'avenir. S'agissant de sa viabilité, il convient de tenir compte de deux contraintes corrélées. D'une part, les contribuables doivent être disposés à payer pour l'entretenir. D'autre part, les gouvernements se doivent de favoriser l'expansion économique et donc de maintenir les taux d'imposition à un niveau ne risquant pas de nuire à la capacité du Canada

***Pour le Comité, un système de soins de santé financièrement viable est un système sur lequel les Canadiens peuvent compter maintenant et pourront compter dans l'avenir. S'agissant de sa viabilité, il convient de tenir compte de deux contraintes corrélées. D'une part, les contribuables doivent être disposés à payer pour l'entretenir. D'autre part, les gouvernements se doivent de favoriser l'expansion économique et donc de maintenir les taux d'imposition à un niveau ne risquant pas de nuire à la capacité du Canada de stimuler l'investissement, de créer des emplois et de demeurer compétitif par rapport aux autres membres de l'OCDE, en particulier les États-Unis.***

de stimuler l'investissement, de créer des emplois et de demeurer compétitif par rapport aux autres membres de l'OCDE, en particulier les États-Unis<sup>316</sup>.

Dans le volume cinq, le Comité s'est penché sur les tendances actuelles et projetées des dépenses de santé pour répondre à la question de la viabilité du système public canadien de soins de santé<sup>317</sup>. Il a recueilli des données sur les pressions continues qu'exercent sur les budgets de la santé la hausse rapide et marquée du coût des médicaments et des nouvelles technologies, le vieillissement de la population, les coûts déjà élevés et sans cesse croissants des ressources humaines dans le domaine de la santé et l'augmentation des attentes du public. En s'inspirant de ces données et de nombreux rapports et études sur l'augmentation des coûts de la

---

<sup>315</sup> Volume cinq, p. 7.

<sup>316</sup> *Ibid.*

<sup>317</sup> Volume cinq, p. 7-9.

santé au Canada, le Comité a déduit que le système public canadien de soins de santé *n'est pas* financièrement viable dans sa structure actuelle.

Dans le présent chapitre, nous allons examiner les répercussions d'un tel constat. La section 14.1 dresse un état des multiples facteurs qui, selon le Comité, exercent des pressions considérables sur les budgets de santé des gouvernements, à court comme à long terme. C'est d'ailleurs cette situation qui nous a amenés à conclure à la non-viabilité financière du système de santé du Canada et à la nécessité de lui consacrer davantage de fonds afin d'en assurer la survie et, en particulier, de le modifier pour en améliorer l'efficacité et l'efficience. La section 14.2 examine le rôle que le gouvernement fédéral devrait jouer en matière de financement, du moins selon le Comité, afin de garantir la pérennité du régime national d'assurance-santé. À la section 14.3, enfin, nous décrivons le système d'administration que le gouvernement fédéral devrait, selon nous, appliquer à tous les nouveaux fonds destinés aux soins de santé.

### **14.1 Il faut investir davantage dans le système de soins de santé**

Dans le volume cinq<sup>318</sup>, le Comité s'était penché sur les tendances actuelles et projetées en matière de dépenses de santé. Nous les résumons à nouveau ci-après.

Selon des données provenant de l'Institut canadien d'information sur la santé (ICIS), les dépenses de santé publiques et privées au Canada ont dépassé 95 milliards de dollars en 2000, soit une progression de 6,9 % par rapport à l'année précédente. Même après correction pour tenir compte de l'inflation et de l'accroissement démographique, on observe une augmentation de 4,1 % en termes réels entre 1999 et 2000.

Les données montrent que la progression des dépenses de santé s'accélère. En fait, les dépenses réelles par habitant n'ont jamais augmenté aussi rapidement depuis les années 80. En outre, les projections témoignent de l'existence de facteurs qui tendent à faire grimper les dépenses de santé :

- **Coûts des médicaments** : Les coûts des médicaments comptent actuellement pour plus de 15 % dans les dépenses totales (publiques et privées) en soins de santé. On prévoit qu'ils auront grimpé de 14,7 milliards de dollars en 2000, une hausse de 9 % par rapport à 1999. Dans le volume deux de son étude, le Comité avait fait remarquer qu'entre 1990 et 2000, les dépenses de médicaments par habitant avaient progressé de près de 93 %, soit plus du double de l'augmentation de l'ensemble des dépenses de santé (40 %) <sup>319</sup>. Or des médicaments nouveaux et efficaces mais extrêmement coûteux feront leur apparition sur le marché canadien dans les dix prochaines années (vaccin contre le sida, nouvelle cure immunologique contre le diabète juvénile, etc.), ce qui fera monter encore plus le coût total des médicaments.
- **Technologies nouvelles** : Le Canada doit investir davantage dans les technologies de la santé et les systèmes d'information sur la santé. Dans le volume deux, le Comité précisait que chaque tranche d'un milliard de dollars d'investissement dans l'achat d'appareils neufs exige une somme

---

<sup>318</sup> Volume cinq, p. 6-13.

<sup>319</sup> Volume deux, p. 20.

supplémentaire de l'ordre de 700 millions de dollars pour couvrir les coûts connexes de fonctionnement et d'entretien des machines<sup>320</sup>. Il faudrait en fait augmenter les dépenses en capital de 2,5 milliards de dollars pour parvenir à un niveau d'équipement en nouvelles technologies analogue à celui des autres pays de l'OCDE (voir le chapitre dix). De même, on estime qu'il faudrait entre 6 et 10 milliards de dollars sur six à huit ans (ou 1 à 1,25 milliard de dollars annuellement) pour instituer une infrastructure de la santé complète au Canada (voir le chapitre dix).

- **Viellissement de la population** : En 1998, 12 % des Canadiens avaient 65 ans ou plus, et plus de 43 % des dépenses de santé des provinces et des territoires concernaient les personnes âgées. D'après des chiffres de Statistique Canada, les personnes âgées représenteront 14,6 % de la population en 2010 et 23,6 % lorsque le gros de la génération du baby-boom aura pris sa retraite en 2031. Des interventions coûteuses qu'on ne pratiquait pas autrefois sur les personnes âgées leur sont maintenant offertes de plus en plus couramment<sup>321</sup>. On estime que le vieillissement de la population fera, à lui seul, augmenter de 1 % par an les dépenses totales en soins de santé. Si le pourcentage paraît faible, il équivaut tout de même à environ un milliard de dollars de plus par an pendant des dizaines d'années.
- **Coût des ressources humaines** : Les coûts de main-d'œuvre représentent environ 75 % des dépenses de soins de santé. Selon le Conseil consultatif du premier ministre de l'Alberta sur la santé (dont le rapport est mieux connu sous le nom de « rapport Mazankowski »), plus de la moitié de l'accroissement du budget de la santé en 2001-2002 a été consacré aux augmentations salariales dans cette province. Cette tendance devrait se confirmer partout au Canada.
- **Recherche en santé** : Un niveau sans précédent de financement de la recherche en santé va entraîner l'élaboration d'un grand nombre de technologies et de médicaments nouveaux. Cette année, les pays du G-7 consacreront l'équivalent d'une quarantaine de milliards de dollars américains à la recherche en santé, ce qui aboutira à des technologies efficaces mais chères dans des domaines comme la génomique, la protéomique et les nanotechnologies.
- **Augmentation des attentes de la population** : De nombreux analystes ont affirmé que les attentes de la population en ce qui a trait aux soins hospitaliers et aux soins dispensés par les médecins vont avoir un impact considérable sur les coûts futurs. D'ailleurs, Roy Romanow le fait bien remarquer dans son rapport provisoire : « L'un des principaux facteurs d'augmentation au cours des dernières décennies a été l'évolution de nos attentes. De nos jours, nous voulons ce qu'il y a de mieux en matière de technologie, de traitements, d'installations, de recherche et de médicaments, et, par conséquent, nous

---

<sup>320</sup> Volume deux, p. 43 et 118.

<sup>321</sup> Certaines interventions cardiaques (comme l'ACTP) progressent de 12 % par an chez les personnes âgées, les chirurgies des articulations (comme le remplacement du genou) augmentent à un rythme de 8 % par an et la dialyse rénale est en hausse de 14 % par an dans ce groupe d'âge (à un coût de 50 000 \$ par an par patient).

dictons à nos gouvernements des impératifs qu'il leur est impossible de maintenir au fil des ans »<sup>322</sup>. Les Canadiens ont une attitude plus nord-américaine qu'européenne en matière d'attentes. Plus précisément, 64 % des Canadiens sont très intéressés par les nouvelles découvertes médicales, contre 66 % des Américains et 44 % des Européens.

- **Restructuration des soins médicaux** : La restructuration, le renouvellement et la réforme du système de soins de santé vont coûter extrêmement cher. On estime, par exemple, que l'établissement d'équipes de soins de santé primaires au Québec coûtera en moyenne 750 000 \$ par équipe (voir le chapitre quatre).
- **Lacunes du système** : Comme nous l'avons signalé aux chapitres sept, huit et neuf du présent rapport, la couverture du régime d'assurance-santé comporte d'importantes lacunes, notamment pour ce qui est des médicaments, des soins à domicile et des soins palliatifs. Il va manifestement falloir que le gouvernement affecte plus d'argent au régime pour en élargir la couverture et en combler les lacunes.

Des témoins ont indiqué au Comité que, même d'après les projections les plus prudentes, les coûts des soins de santé progresseront de un point de pourcentage, voire davantage, de plus que l'augmentation du PIB et ce, pour un avenir indéfini. Étant donné le caractère public du système canadien de santé, ces tensions sur les coûts vont peser très lourd dans les budgets des administrations publiques à court et à long terme. Il en est d'ailleurs question dans le rapport (2000) des ministres provinciaux et territoriaux de la Santé sur les facteurs de coût ainsi que dans de nombreux documents remis au Comité.

Par exemple, dans un rapport rédigé pour l'Association des hôpitaux de l'Ontario, on apprend que près de 38 % des dépenses totales au titre des programmes ont été consacrées aux soins de santé en 2000-2001, soit une hausse de 33 % par rapport à 1992-1993<sup>323</sup>. Pour sa part, la Fédération des contribuables canadiens prévoit que la proportion atteindra 50 % dès 2007 en Colombie-Britannique et au Nouveau-Brunswick<sup>324</sup>. De son côté, le Conference Board du Canada estime qu'entre 2000 et 2020 les dépenses publiques en santé par habitant (corrigées en fonction de l'inflation) croîtront de 58 %, tandis que les dépenses publiques par habitant au titre de tous les autres programmes et services gouvernementaux n'augmenteront que de 17 %<sup>325</sup>.

Cette augmentation du pourcentage des dépenses publiques consacrées à la santé est la meilleure indication des pressions financières qui s'exercent sur les gouvernements chargés de financer la santé. Une foule de témoins, notamment des administrateurs, des fournisseurs et

---

<sup>322</sup> Commission sur l'avenir des soins de santé au Canada (Roy Romanow, président), *Préparer l'avenir des soins de santé*, rapport provisoire, février 2002, p. 25.

<sup>323</sup> TEAQ Associates, *Getting the Right Balance : A Review of Federal-Provincial Fiscal Relations and the Funding of Public Services*, document rédigé pour l'Association des hôpitaux de l'Ontario, décembre 2001, p. 21.

<sup>324</sup> Walter Robinson, *The Patient, The Condition, The Treatment – A CTF Research and Position Paper on Health Care*, Fédération des contribuables canadiens, septembre 2001, p. 59.

<sup>325</sup> Glenn G. Brimacombe, Pedro Antunes et Jane McIntyre, *The Future Cost of Health Care in Canada, 2000 to 2020 – Balancing Affordability and Sustainability*, Conference Board du Canada, 2001, p. 21.



des consommateurs de services de santé, ont exprimé de vives inquiétudes au sujet de l'augmentation des coûts des soins de santé et de ses répercussions sur les budgets des pouvoirs publics, que ce soit parce que les autres programmes gouvernementaux (comme l'éducation et les services sociaux) risquent d'être relégués au second plan ou que les finances publiques risquent d'être déstabilisées. Ces témoignages ainsi que de nombreux rapports abondant dans le même sens ont convaincu le Comité qu'en plus des autres réformes nécessaires, il est essentiel d'investir davantage dans le système canadien de soins de santé pour le renouveler et en assurer la pérennité.

Par contraste, dans un rapport récent, le professeur Gerard Boychuk de l'Université de Waterloo soutient qu'il n'existe pas de crise financière dans les soins de santé<sup>326</sup>. Selon lui, on ne peut parler de crise en ce sens que les dépenses canadiennes en matière de santé, exprimées en pourcentage du PIB ou en pourcentage des recettes générales de l'État, sont demeurées relativement constantes. Cependant, d'aucuns voient un certain nombre de lacunes dans cette analyse. D'abord, elle ne tient pas compte des projections relatives aux coûts de la santé, qui indiquent que les dépenses de santé vont augmenter à un rythme supérieur à la fois à la croissance du PIB et à celle des recettes de l'État. Ensuite, le professeur Boychuk reconnaît que les soins de santé occupent trop de terrain par rapport aux autres services publics, mais il dit que le problème n'est grave que du point de vue provincial et non à l'échelle nationale. Dans cet argument, il oublie que, même si deux ordres de gouvernement participent au financement de la santé, les contribuables sont seuls à assumer la totalité du fardeau de l'augmentation des coûts de la santé, où qu'ils habitent. Enfin, le professeur Boychuk soutient que le gouvernement fédéral a profité du passage du Financement des programmes établis (FPE) au TCSPS, car il a ainsi pu réduire sa part des dépenses en santé. Selon lui, le système public de soins de santé n'est plus viable du point de vue provincial à cause de la réduction des transferts fédéraux. La conclusion logique de cet argument semble par conséquent être que le gouvernement fédéral doit injecter davantage de fonds dans les soins de santé.

Le Comité n'est pas d'accord avec le professeur Boychuk pour dire que la crise touchant la viabilité du système de soins de santé est d'ordre politique plutôt que financier. Nous avons reçu un nombre écrasant de témoignages qui nous confortent dans notre conclusion que le système de santé public n'est pas financièrement viable aux niveaux de financement actuels et que, par conséquent, il faudra y investir davantage d'argent pour restructurer et renouveler l'assurance-santé, de même que pour combler les lacunes du filet de sécurité de la santé.

Certaines personnes et organisations ne sont pas du même avis. Elles pensent qu'on pourrait économiser suffisamment d'argent simplement en améliorant l'efficacité du système, de sorte qu'on n'aurait pas besoin de chercher de nouvelles sources de financement. Le Comité a toujours reconnu l'importance d'améliorer l'efficacité et l'efficience de la gestion et de la prestation des services de santé. D'ailleurs, bien des recommandations de restructuration contenues dans les chapitres deux, trois, quatre, six, dix et onze vont dans le sens de cet objectif.

Le Comité estime qu'on ne lui a pas fourni de preuves suffisantes pour confirmer l'hypothèse que des gains d'efficacité permettraient, à eux seuls, d'éviter d'avoir à injecter des fonds supplémentaires. Dans son témoignage, Jack Davis, président-directeur

---

<sup>326</sup> Gerard Boychuk, *The Changing Political and Economic Environment of Health Care in Canada*, document de travail, Commission sur l'avenir des soins de santé au Canada, juillet 2002.

général de la régie régionale de la santé de Calgary, a repris la position du Comité en déclarant ceci :

*Il est naïf et irréaliste de croire qu'une mesure magique viendra améliorer les niveaux de productivité dans notre réseau de la santé, au-delà de tout ce qui existe ailleurs sur la planète<sup>327</sup>.*

Il faut restructurer le système public de soins de santé du Canada et le rendre beaucoup plus efficace et efficient. Toutefois, le Comité estime, et il l'a d'ailleurs déjà dit, que toute planification responsable des politiques publiques doit prévoir des fonds supplémentaires pour les soins de santé, notamment pour en financer la restructuration.

Le Comité est convaincu qu'étant donné ses responsabilités en matière de financement des soins de santé, le gouvernement fédéral a un rôle capital à jouer dans tout ce qui touche au maintien et au renouvellement des soins de santé au Canada. Toutefois, vu la multiplicité des besoins concurrents en matière de dépenses fédérales (agriculture, forces armées, environnement, infrastructure urbaine, etc.), le Comité est d'avis qu'on ne pourra pas se contenter de transférer à la santé des sommes provenant d'une autre enveloppe budgétaire, mais qu'il faudra trouver des fonds *additionnels*.

***Vu la multiplicité des besoins concurrents en matière de dépenses fédérales (agriculture, forces armées, environnement, infrastructure urbaine, etc.), le Comité est d'avis qu'on ne pourra pas se contenter de transférer à la santé des sommes provenant d'une autre enveloppe budgétaire, mais qu'il faudra trouver des fonds additionnels.***

On doit dès lors se poser la question la plus difficile à laquelle sont confrontés les décideurs et même tous les Canadiens : où doit-on aller chercher les fonds additionnels pour le secteur de la santé? Doivent-ils provenir d'une augmentation des impôts ou de nouveaux prélèvements fiscaux? Les particuliers et les entreprises doivent-ils les verser au gouvernement par la voie des impôts ou de cotisations au régime d'assurance-santé, ou directement au secteur de la santé? Jack Mintz, président-directeur général de l'Institut C.D. Howe, a d'ailleurs fort bien formulé la question :

*(...) les gouvernements auront besoin de recettes supplémentaires parce que la part publique du coût des soins de santé augmente avec le temps. Par conséquent, nous devons réfléchir soigneusement aux moyens de financer la prestation publique des soins. Quels sont les moyens adéquats de financement? Voilà une importante question que les Canadiens devraient se poser, parce qu'il y aura un fardeau de plus en plus lourd que tous les Canadiens devront assumer<sup>328</sup>.*

De plus, en cherchant de nouvelles ressources, il ne faut pas oublier que le fardeau fiscal des particuliers canadiens est le plus élevé des pays du G-7 et qu'il est parmi les plus élevés des pays de l'OCDE. Le Comité croit, par conséquent, que les Canadiens doivent concilier, d'une part, leur désir de disposer de services de santé financés par les deniers publics

<sup>327</sup> Jack Davis (53:59).

<sup>328</sup> Jack Mintz (62.5).

et, d'autre part, leur volonté de payer des impôts pour que le gouvernement puisse les financer et la nécessité de fixer les impôts à des niveaux raisonnables de façon à soutenir la capacité du Canada d'investir, de créer des emplois et de continuer de faire concurrence aux autres pays de l'OCDE, surtout les États-Unis. Les recommandations du Comité sur la façon de trouver des fonds fédéraux supplémentaires pour les soins de santé sont présentées au chapitre quinze.

## **14.2 Le rôle du gouvernement fédéral en matière de financement**

Beaucoup de témoins ont tenu à rappeler que le gouvernement fédéral a toujours joué un rôle important dans le financement des services de santé. De plus, les sondages d'opinion montrent que les Canadiens s'attendent à ce que le gouvernement fédéral continue de jouer un rôle de premier plan dans le système public de soins de santé.

Le Comité estime que, s'il veut préserver l'esprit du programme d'assurance-santé qu'il a lancé il y a déjà plusieurs dizaines d'années, le gouvernement fédéral doit jouer un rôle important dans la résolution des graves problèmes auquel est présentement confronté le système de santé public. Nous rappelons, à cet égard, le troisième principe énoncé dans le volume cinq de notre étude : « Le gouvernement fédéral joue un rôle de premier plan dans le maintien d'un système national d'assurance-santé »<sup>329</sup>.

Par le rôle qu'il joue dans le financement du secteur de la santé, le gouvernement fédéral peut encourager les provinces et les territoires à restructurer, reconfigurer et renouveler leur système de soins de santé et les aider à le faire. Le Comité est convaincu que la grande majorité des Canadiens souhaitent que le gouvernement fédéral soutienne les efforts des provinces, des territoires et des fournisseurs de soins de santé et forme des partenariats avec eux en vue d'apporter les changements voulus au système. En fait, comme nous l'avons précisé dans le volume cinq, la participation du gouvernement fédéral à ce processus est importante pour bien des raisons.<sup>330</sup>

***Par le rôle qu'il joue dans le financement du secteur de la santé, le gouvernement fédéral peut encourager les provinces et les territoires à restructurer, reconfigurer et renouveler leur système de soins de santé et les aider à le faire.***

Premièrement, les Canadiens tiennent à ce que des principes nationaux régissent le système de soins de santé; ils s'attendent à ce que le gouvernement fédéral veille à les établir et à les maintenir et à ce qu'il les applique d'un bout à l'autre du pays. Actuellement, la capacité du gouvernement fédéral de participer à l'élaboration et à l'application de normes nationales et de recommander des politiques aux provinces et aux territoires dépend, pour une large part, de l'importance de sa contribution financière.

Deuxièmement, et certains verront là l'argument le plus important, seul le gouvernement fédéral est en mesure de veiller à ce que toutes les provinces et tous les territoires disposent des ressources financières nécessaires pour répondre aux besoins de leur population en matière de soins de santé, quelle que soit la taille de leur économie. Le rôle de redistribution du gouvernement fédéral est fondamental dans ce que beaucoup appellent « la manière

<sup>329</sup> Volume cinq, p. 31.

<sup>330</sup> Volume cinq, p. 13-15.

canadienne » de faire. À cet égard, voici la position de Sharon Sholzberg-Gray, présidente-directrice générale de l'Association canadienne des soins de santé :

*(...) nous souhaiterions ajouter aux responsabilités du gouvernement fédéral celle de jouer un rôle de chef de file. Après tout, le fédéral est le seul ordre de gouvernement qui puisse garantir à tous les Canadiens l'accès à des services comparables, quelle que soit la région qu'ils habitent. Aucune administration provinciale ou territoriale n'est en mesure de faire cela. Seul le gouvernement fédéral peut offrir cette garantie, et il devrait donc assumer un rôle de direction dans ce domaine<sup>331</sup>.*

Troisièmement, le financement fédéral est crucial pour la réforme et le renouvellement du système de soins de santé. Il est certain que les changements à apporter à la structure et au fonctionnement du système vont exiger des fonds additionnels, du moins dans un premier temps.

Quatrièmement, un système véritablement national exige une certaine harmonisation entre les provinces pour ce qui est des services assurés et des règles relatives au champ de pratique. Le gouvernement fédéral a un rôle important à jouer pour faciliter cette harmonisation; il peut, par exemple, employer des moyens financiers pour persuader les provinces et les territoires de se conformer aux normes nationales.

Cinquièmement, le Comité croit fermement que les sommes que le gouvernement fédéral verse aux provinces et aux territoires au titre des soins de santé doivent lui garantir voix au chapitre lorsqu'il s'agira de restructurer le système de soins de santé. Le gouvernement fédéral ne doit pas simplement accorder des fonds; il doit aussi avoir son mot à dire sur la façon dont ils sont dépensés. Les Canadiens s'attendent, avec raison, à ce que le gouvernement auquel ils paient leurs impôts soit représenté lorsque se prennent les décisions sur la façon dont cet argent sera dépensé.

***Le Comité croit fermement que les sommes que le gouvernement fédéral verse aux provinces et aux territoires au titre des soins de santé doivent lui garantir voix au chapitre lorsqu'il s'agira de restructurer le système de soins de santé. Le gouvernement fédéral ne doit pas simplement accorder des fonds; il doit aussi avoir son mot à dire sur la façon dont ils sont dépensés.***

Enfin, le Comité est persuadé que le financement gouvernemental doit être stable et prévisible. Aucun secteur de l'économie ne peut fonctionner efficacement si, d'une année à l'autre, ses recettes sont soumises à d'importantes fluctuations indépendantes de sa volonté. En fait, il est impossible de bien planifier – tâche essentielle dans tout secteur qui se veut efficient – si le financement n'est pas stable et prévisible. Autrement dit, un financement pluriannuel est essentiel au fonctionnement efficace et efficient du système public de soins de santé.

---

<sup>331</sup> Sharon Sholzberg-Gray (49:11)

### 14.3 Comment gérer les nouveaux fonds que le gouvernement fédéral destinera aux soins de santé

Avant de passer aux recommandations du Comité sur la façon de trouver de nouveaux fonds fédéraux destinés à la santé (voir le chapitre quinze), parlons d'abord de leur gestion. Le Comité croit que les Canadiens ne seront disposés à contribuer davantage aux dépenses publiques en santé qu'à *condition* d'être convaincus que ces sommes iront effectivement au système de santé et qu'elles seront dépensées judicieusement. Cela revient à dire que l'attribution des sommes additionnelles que les Canadiens verseront au gouvernement fédéral au titre des soins de santé devra faire l'objet d'un processus transparent grâce auquel le gouvernement sera tenu de rendre des comptes aux contribuables.

Le Comité croit fermement que les nouveaux fonds fédéraux destinés à la santé devront être gérés en fonction de quatre paramètres distincts mais interdépendants.

Premièrement, les recettes fédérales supplémentaires destinées à la santé devront être versées dans un *fonds réservé*, distinct du Trésor public. Nous croyons que les Canadiens n'accepteront pas de verser des cotisations de santé plus élevées s'ils n'ont pas la garantie que cet argent ira effectivement aux soins de santé et qu'il viendra véritablement s'ajouter aux sommes que le gouvernement fédéral s'est déjà engagé à consacrer à la santé. Cette position est d'ailleurs confirmée par un récent sondage Pollara<sup>332</sup> selon lequel 75 % des Canadiens seraient disposés à payer davantage sous forme d'impôts et de taxes si cet argent allait directement aux soins de santé plutôt qu'au Trésor. Ainsi il semble que, pour les Canadiens, les soins de santé soient un cas unique et qu'ils diffèrent des autres biens et services financés par le secteur public : réserver des fonds aux soins de santé permettrait de soustraire davantage le financement public aux aléas des décisions politiques relatives à l'attribution des ressources financières du gouvernement.

***Le Comité est d'avis que les recettes fédérales supplémentaires destinées à la santé devront être versées dans un fonds réservé, distinct du Trésor public.***

Deuxièmement, il faudra *cibler* les dépenses additionnelles que le gouvernement fédéral consacrera à la santé. Le Comité est convaincu que les nouveaux fonds fédéraux devront effectivement servir aux fins décrites dans le présent rapport, c'est-à-dire surtout à étendre la couverture de l'assurance-santé publique (comme nous l'expliquons aux chapitres sept, huit et neuf) et à améliorer l'efficacité et l'efficience du système de prestation de soins (financement des hôpitaux fondé sur les services dispensés, réforme des soins de santé primaires, technologie de la santé, informatisation des dossiers de santé, recherche et évaluation en santé, etc.). Autrement dit, les nouvelles sommes accordées aux provinces et aux territoires doivent servir à opérer de véritables changements et une vraie réforme, et non pas à financer le système de santé public dans sa forme actuelle.

***Le Comité croit fermement que les nouvelles sommes accordées aux provinces et aux territoires doivent servir à opérer de véritables changements et une vraie réforme, et non pas à financer le système de santé public dans sa forme actuelle.***

<sup>332</sup> Pollara, *Health Care in Canada Survey 2002*, juin 2002.

Troisièmement, et comme corollaire au deuxième point, le Comité s'oppose fermement à ce que le gouvernement fédéral verse ces fonds supplémentaires aux provinces et aux territoires dans le cadre du Transfert canadien en matière de santé et de programmes sociaux (TCSPS). En effet, les fonds du TCSPS ne peuvent être réservés à des fins précises et les provinces et les territoires ne sont pas tenus d'en rendre compte. Le Comité s'oppose aussi résolument au transfert de points d'impôt additionnels aux provinces et aux territoires. D'abord, l'effet du transfert de points d'impôt varie beaucoup d'une province à l'autre. Ensuite, une fois les points d'impôt transférés, le gouvernement fédéral n'a pas son mot à dire sur la façon dont les sommes sont dépensées.

***Le Comité s'oppose fermement à ce que le gouvernement fédéral verse ces fonds supplémentaires aux provinces et aux territoires dans le cadre du Transfert canadien en matière de santé et de programmes sociaux (TCSPS).***

Quatrièmement, le Comité est convaincu qu'il faudrait conseiller chaque année le gouvernement fédéral sur la façon de dépenser les fonds réservés. Ces conseils devraient figurer dans le rapport annuel rédigé par le conseil national des soins de santé dont le Comité propose la création au chapitre un. Ils devraient également être rendus publics dans un souci de transparence et de reddition de comptes.

***Le Comité est convaincu que le conseil national des soins de santé devrait conseiller chaque année le gouvernement fédéral sur les priorités à respecter dans l'attribution des fonds réservés.***

Cinquièmement, il est essentiel que tous les ordres de gouvernement rendent compte de la façon dont ils dépensent les fonds fédéraux additionnels au titre des soins de santé. Le Comité estime que les Canadiens doivent pouvoir constater que l'argent est bel et bien dépensé aux fins désignées. Par conséquent, les deux ordres de gouvernement – fédéral et provincial-territorial – doivent assumer une *responsabilité* commune.

À l'échelle fédérale, le Bureau du vérificateur général devrait vérifier chaque année comment les fonds réservés ont été dépensés et rendre publics les résultats de cette vérification. Les provinces et les territoires, de leur côté, devraient rendre compte de façon transparente que les fonds fédéraux réservés à des fins données ont bel et bien été dépensés à ces fins. Pour ce faire, ils devraient faire rapport annuellement au Parlement et au public canadien sur l'utilisation des fonds fédéraux réservés à la santé.

***Le Comité est d'avis qu'à l'échelle fédérale, le Bureau du vérificateur général devrait vérifier chaque année comment les fonds réservés ont été dépensés et rendre publics les résultats de cette vérification.***

***Les provinces et les territoires, de leur côté, devraient faire rapport annuellement au Parlement et au public canadien sur l'utilisation des fonds fédéraux réservés à la santé.***

Par conséquent, le Comité recommande :

**Que le gouvernement fédéral crée un fonds réservé aux soins de santé, distinct du Trésor. Ce fonds contiendra les recettes supplémentaires qu'il destine aux soins de santé.**

**Que les sommes réservées aux soins de santé ne soient consacrées qu'à la santé. De plus, qu'elles servent à opérer de véritables changements et une vraie réforme, c'est-à-dire exclusivement à étendre la couverture de l'assurance-santé et à restructurer et renouveler le système public de soins hospitaliers et de soins fournis par les médecins.**

**Que le conseil national des soins de santé soit chargé de conseiller le gouvernement fédéral sur la façon de dépenser les fonds réservés aux soins de santé, et que ses conseils soient rendus publics dans un rapport annuel.**

**Que le gouvernement fédéral soumette le fonds réservé aux soins de santé à des vérifications annuelles confiées au Bureau du vérificateur général du Canada. Que les résultats de ces vérifications soient rendus publics.**

**Que le gouvernement fédéral exige que les provinces et les territoires fassent rapport annuellement à la population canadienne quant à l'utilisation des sommes fédérales provenant du fonds réservé aux soins de santé.**

Si les Canadiens se montrent disposés (comme nous le croyons) à contribuer à l'effort du gouvernement fédéral visant à augmenter les investissements dans le domaine de la santé, et si le gouvernement fédéral et les gouvernements provinciaux et territoriaux sont prêts à collaborer à la restructuration et à l'expansion du régime d'assurance-santé, le Comité est d'avis que non seulement le système canadien de santé pourra devenir viable, mais aussi qu'il pourra entrer dans une nouvelle ère grâce à son efficacité, à sa qualité, à sa pertinence, à sa transparence et à son imputabilité accrues.





## CHAPITRE QUINZE

### COMMENT GÉNÉRER DES FONDS ADDITIONNELS POUR LES SOINS DE SANTÉ<sup>333</sup>

---

Comme nous l'avons indiqué au chapitre un du volume cinq et plus haut dans le présent rapport, les témoignages qu'il a entendus et les documents qu'il a consultés ont permis au Comité de réunir suffisamment d'informations pour conclure que le système public de soins de santé du Canada n'est pas viable financièrement. Il est donc impérieux d'y consacrer davantage d'argent dans le but de le renouveler et de le soutenir.

***Le Comité estime qu'il est impérieux de consacrer davantage d'argent au système de soins de santé, pour le renouveler et le soutenir.***

***Cet argent supplémentaire n'a que deux sources possibles : le Trésor ou le secteur privé.***

Les sommes additionnelles nécessaires ne peuvent provenir que des Canadiens, de sources publiques ou privées. Comme on le voit au tableau 15.1, les sources publiques comprennent notamment les impôts (principale source de financement des soins de santé au Canada, en Australie et au Royaume-Uni) ou encore les charges sociales réservées, payées par les employeurs et les salariés, et fondées sur les gains des travailleurs (comme c'est le cas en Allemagne et aux Pays-Bas). On peut aussi penser à des primes d'assurance-santé publique (comme c'est le cas en Alberta et en Colombie-Britannique) ou à un impôt spécifique au titre du système de santé (comme en Australie). Enfin, le financement public des soins de santé pourrait se faire par le truchement de prestations de soins de santé imposables, c'est-à-dire que l'on considérerait comme un revenu imposable les soins publics reçus par un particulier<sup>334</sup>.

Parmi les sources privées de financement dont il a été question au cours des audiences du Comité, on relève différentes formes de frais d'utilisation des services assurés, des cotisations à des comptes d'épargne-santé (CES) et à d'autres régimes similaires et des régimes privés d'assurance-santé. Contrairement au Canada, des frais d'utilisation des services publics sont exigés en Australie, en Allemagne, aux Pays-Bas, en Suède et au Royaume-Uni (entre autres pays). Il existe des régimes de CES à Singapour, en Afrique du Sud et aux États-Unis.

---

<sup>333</sup> Le présent chapitre est fondé sur les témoignages reçus par le Comité et sur une analyse approfondie de la documentation disponible sur ce sujet. De plus, un document signé par Robert D. Brown et Michanne Haynes (juillet 2002), préparé à la demande du Comité, intitulé *Financing Options for Funding and Incremental Increase in Federal Spending on the Health Sector*, a fourni de précieuses balises pour la rédaction du présent chapitre.

<sup>334</sup> Nous ne connaissons aucun pays qui exige un impôt sur les services de santé assurés; toutefois, un certain nombre de propositions en ce sens ont été formulées au Canada.

**TABLEAU 15.1**  
**SOURCES DE FINANCEMENT DES SOINS DE SANTÉ**

SECTEUR	SOURCE
<b>PUBLIC</b>	<ul style="list-style-type: none"> <li>▪ Impôts généraux – Cela comprend les impôts directs (impôt sur le revenu des particuliers et impôt des sociétés) et les impôts indirects.</li> <li>▪ Impôt spécifique – Impôt destiné à une utilisation spécifique, par exemple des services de santé imposables (formule selon laquelle les coûts de santé engendrés au cours d'un exercice s'ajoutent au revenu imposable).</li> <li>▪ Charges sociales – Cotisations liées aux gains des employés et versées par les employés et (ou) les employeurs.</li> <li>▪ Primes d'assurance-santé publique – Montant (fixe ou lié au revenu) versé par chaque citoyen et lui donnant droit à l'assurance-santé publique.</li> </ul>
<b>PRIVÉ</b>	<ul style="list-style-type: none"> <li>▪ Frais d'utilisation – Correspondent à une forme de paiement effectué par un patient au moment où est fourni un service assuré.</li> <li>▪ Comptes d'épargne-santé (CES) – Comptes d'épargne-santé constitués pour couvrir les dépenses de santé d'une personne ou de sa famille <sup>a)b)</sup>.</li> <li>▪ Assurance-santé privée – Souscrite par des particuliers ou par le truchement de régimes parrainés par l'employeur.</li> </ul>

a) Certains souhaiteraient que les CES soient financés par les deniers publics ou, selon certains Canadiens, par une combinaison de fonds publics et privés.

b) Il existe également quelques autres régimes en vertu desquels le particulier assume certains coûts, mais pas nécessairement au point de service.

Source : Division de l'économie, Direction de la recherche parlementaire, Bibliothèque du Parlement; Brown et Haynes (2002).

L'assurance-santé privée pourrait servir à compléter ou à remplacer le système public de soins de santé ou à combler ses lacunes. Si l'on décidait de ne pas investir de crédits additionnels dans le système public de soins de santé comme le recommande le Comité, ou encore si le gouvernement ne garantissait pas l'accès aux soins nécessaires en temps opportun, la pression serait sans doute grande pour que le gouvernement autorise les Canadiens qui en ont les moyens à souscrire des assurances-santé privées dans le but d'obtenir des services de santé fournis par des établissements privés et, comme nous le disons au chapitre cinq, le gouvernement serait peut-être même légalement tenu de le faire.

***Toutefois, l'assurance privée forcerait à renoncer au modèle de l'assureur unique, fortement prôné par le Comité, ce qui conduirait à l'instauration d'un régime privé parallèle de prestation de soins.***

Toutefois, l'assurance privée forcerait à renoncer au modèle de l'assureur unique, fortement prôné par le Comité, ce qui conduirait à l'instauration d'un régime privé parallèle de prestation de soins. Nous n'aborderons pas ici les conséquences d'une éventuelle légalisation de l'assurance-santé privée au Canada sur le système public de soins de santé; cette question est analysée en profondeur au chapitre seize.

### **15.1 Ampleur du financement fédéral additionnel requis**

Le Comité croit que le gouvernement fédéral a le devoir de consacrer davantage d'argent au régime public. Sur la foi de nos calculs, la réalisation des recommandations présentées aux chapitres deux à treize nécessitera que le gouvernement fédéral consacre environ cinq milliards de dollars de plus à la santé, chaque année, cette somme comprenant une provision pour éventualités importante vu la très grande difficulté de prévoir l'évolution des coûts dans le secteur de la santé (voir le tableau 15.2).

Le montant de cinq milliards de dollars indiqué dans le tableau 15.2 représente l'estimation faite par le Comité de l'augmentation annuelle des coûts de santé qui découlerait de l'élargissement du régime public de manière à combler les lacunes constatées (aux chapitres sept, huit et neuf) et d'un investissement dans des mesures destinées à rendre plus efficaces et efficaces le régime hospitalier et l'utilisation des médecins (comme il est proposé aux chapitres deux, trois, quatre, cinq, six, dix, onze, douze et treize). Ce montant *s'ajoute* aux sommes déjà affectées par le gouvernement fédéral à la santé (par le truchement du TCSPS et d'autres programmes). Il s'additionne également à toute hausse de la contribution fédérale requise pour soutenir le système *actuel* de services hospitaliers et de services fournis par les médecins à titre de mesure transitoire jusqu'à ce que les changements recommandés dans le présent rapport soient pleinement mis en oeuvre.

**TABLEAU 15.2**  
**FONDS FÉDÉRAUX ADDITIONNELS REQUIS POUR LES SOINS DE SANTÉ**

<b>Élargissement et restructuration</b>	<b>Part fédérale (M \$)</b>	<b>Détails</b>
<b>Élargissement de la couverture</b>		
▪ Soins à domicile post-hospitalisation <sup>b)</sup>	550	Chaque année
▪ Médicaments dont le coût est exorbitant <sup>a)</sup>	500	Chaque année
▪ Soins palliatifs <sup>b)</sup>	250	Chaque année
<b>Amélioration de l'efficacité et de l'efficacé</b>		
▪ Technologie de la santé (CUSS) <sup>o)</sup>	400	2 milliards sur 5 ans
▪ Immobilisations (CUSS) <sup>o)</sup>	400	4 milliards sur 10 ans
▪ Inforoute (DSE) <sup>o)</sup>	400	2 milliards sur 5 ans
▪ Immobilisations (hôpitaux communautaires) <sup>b)</sup>	150	1,5 milliard sur 10 ans
▪ Équipement (hôpitaux communautaires) <sup>b)</sup>	100	500 millions sur 5 ans
▪ Réforme des soins primaires <sup>c)</sup>	50	250 millions sur 5 ans
▪ ICIS <sup>c)</sup>	50	Chaque année
<b>Promotion et prévention</b>		
▪ Promotion et protection de la santé <sup>c)</sup>	200	Chaque année
▪ Prévention des maladies chroniques <sup>b)</sup>	125	Chaque année
<b>Ressources humaines en santé</b>		
▪ Écoles de médecine <sup>c)</sup>	160	Chaque année
▪ Écoles de sciences infirmières et professions connexes <sup>c)</sup>	130	Chaque année
▪ CUSS (études supérieures) <sup>o)</sup>	70	Chaque année
<b>Recherche, évaluation et rapports</b>		
▪ Recherche financée par l'ICIS <sup>c)</sup>	440	Chaque année
▪ Commissaire aux soins de santé <sup>c)</sup>	15	Chaque année
▪ Système national (CCASS) <sup>o)</sup>	10	Chaque année
Provision pour éventualités (20 %)	1 000	Chaque année
<b>TOTAL PARTIEL</b>	<b>5 000</b>	<b>Chaque année</b>

a) Financement fédéral à 90 %.

b) Programme à partage égal des coûts entre le gouvernement fédéral et les provinces et territoires.

c) Financement fédéral intégral.

Source : Voir les chapitres précédents.

Le Comité estime réaliste et raisonnable que le gouvernement fédéral, et donc les Canadiens par la voie de leurs impôts, consacrent cinq milliards de dollars par année, en crédits nouveaux, aux soins de santé de manière continue.

Les montants présentés en regard des différents postes au tableau 15.2 sont des estimations. Les sommes véritablement affectées à la réalisation de différentes fins varieront

sensiblement d'année en année en fonction de l'importance accordée à chaque poste, chaque année. Ces priorités et les montants qui seront affectés à chaque poste devront être établis chaque année par le gouvernement fédéral, sur avis du conseil national des soins de santé décrit aux chapitres un et quatorze.

Les fonds additionnels que le Comité recommande au gouvernement fédéral de consacrer aux soins de santé *doivent impérativement* servir à soutenir le changement. Il convient de souligner qu'environ 30 % des dépenses fédérales additionnelles proposées seront consacrées à l'élargissement de la couverture des services de santé, à la promotion de la santé et à la prévention des maladies. Une autre tranche de 40 % environ servira à optimiser les services des médecins et du réseau hospitalier et à stimuler l'intérêt pour les différentes professions de la santé. Quelque 10 % des dépenses proposées seront affectés à la recherche en santé, à l'évaluation des résultats et à la production de rapports sur le rendement. Pour donner de la souplesse à l'exercice d'investissement fédéral, nous avons prévu une tranche annuelle de 20 % en guise de provision pour éventualités.

Il est également utile de souligner qu'une grande partie des cinq milliards de dollars en argent neuf fédéral couvrira les coûts de transition, lesquels diminueront à mesure que seront mis en œuvre les changements visant à améliorer l'efficacité et l'efficacéité du régime. Après cinq ou dix ans, les sommes affectées à la transition pourront être redirigées vers d'autres priorités en soins de santé.

Le Comité reconnaît que certaines des mesures qu'il recommande – notamment en ce qui concerne les soins post-hospitaliers à domicile, les soins palliatifs et l'investissement dans les hôpitaux communautaires – nécessitent un partage des coûts avec les provinces et les territoires. Selon nous, ces coûts additionnels ne constitueront pas un fardeau financier supplémentaire important pour les gouvernements provinciaux et territoriaux relativement à ces programmes, étant donné que la part de 50 % que représentent les nouveaux investissements fédéraux recommandés par le Comité *remplacera* des sommes que certaines provinces et certains territoires dépensent actuellement à cet égard. Cependant, les ressources

dont dispose le Comité ne lui permettent pas d'évaluer avec précision l'ampleur exacte des économies pour les provinces et les territoires, ni de calculer l'augmentation des coûts que représentent, pour ceux-ci, les programmes à frais partagés qu'il propose.

***Le Comité reconnaît que certaines des mesures qu'il recommande – notamment en ce qui concerne les soins post-hospitaliers à domicile, les soins palliatifs et l'investissement dans les hôpitaux communautaires – nécessitent un partage des coûts avec les provinces et les territoires. Selon nous, ces coûts additionnels ne constitueront pas un fardeau financier supplémentaire important pour les gouvernements provinciaux et territoriaux relativement à ces programmes, étant donné que la part de 50 % que représentent les nouveaux investissements fédéraux recommandés par le Comité remplacerait des sommes que certaines provinces et certains territoires dépensent actuellement à cet égard. (...) Il est donc juste de dire que les recommandations du Comité généreraient au moins 1,5 milliard de dollars d'économies pour les provinces et les territoires.***

Qui plus est, dans certaines des recommandations du Comité, les crédits fédéraux remplaceront directement des sommes que les provinces et les territoires seraient autrement forcés de déboursier. Par exemple, les crédits neufs fédéraux proposés dans les secteurs des technologies de la santé, des immobilisations des hôpitaux, de la réforme des soins primaires et des ressources humaines – qui représentent quelque 1,5 milliard de dollars – se substituerait en totalité à des investissements que devraient autrement consentir les provinces et les territoires pour réformer et renouveler leur système de soins de santé. Il est donc juste de dire que les recommandations du Comité généreraient *au moins* 1,5 milliard de dollars d'économies pour les provinces et les territoires. Cette somme s'ajoute aux économies issues des gains d'efficacité et d'efficience réalisés grâce à la réforme que nous proposons. Le Comité s'attend d'ailleurs que ces économies soient substantielles une fois que les changements qu'il recommande seront entièrement opérationnels.

## **15.2 Sources possibles de financement fédéral accru**

De quelle source devraient provenir les nouveaux fonds fédéraux en santé? Le gouvernement fédéral devrait-il simplement augmenter le taux de l'un ou de plusieurs des impôts directs et indirects déjà en place (imposition générale)? Devrait-il prendre de nouvelles mesures fiscales liées spécifiquement au financement des soins de santé, par exemple créer un impôt spécifique pour les soins de santé, imposer les services reçus au même titre que le revenu, percevoir des charges sociales spéciales ou instaurer une prime nationale d'assurance-santé? Le gouvernement fédéral devrait-il également envisager une hausse du financement privé des soins de santé, par l'imposition de droits d'utilisation, la constitution de CES ou d'autres régimes chargeant le particulier d'une partie des coûts des soins qu'il reçoit?

Ces questions sont examinées en détail dans le présent chapitre. Nous y analysons les avantages et les inconvénients de tous les modes envisageables de financement public et privé d'un relèvement de la contribution du gouvernement fédéral aux soins de santé : impôt général, impôt spécifique, prestations de santé imposables, charges sociales et primes d'assurance-santé publique. Nous y abordons également les frais d'utilisation, les CES et le principe du pré-financement des soins de santé.

Pour l'analyse de chacune des sources potentielles de recettes pour le gouvernement fédéral, le Comité utilise le même ensemble de critères : équité, efficience, équité entre les générations, stabilité et visibilité.

- *L'équité* porte principalement sur la redistribution du revenu et la justice sociale. On peut dire qu'il s'agit de la mesure dans laquelle les cotisations au financement de l'assurance-santé sont fondées sur la capacité de payer (redistribution du revenu) et de la mesure dans laquelle l'accès à l'assurance-santé est fondé sur le besoin (justice sociale).
- *L'efficience* a trait à la répartition optimale des ressources. Est efficient un système qui fausse ou inhibe le moins possible les décisions dans le reste de l'économie (il pourrait s'agir par exemple d'une réduction des investissements commerciaux, d'une baisse de la consommation et du niveau de vie, de préjudices causés au marché du travail et à la création d'emplois, de la détérioration de la compétitivité internationale, etc.). L'efficience porte aussi sur le rapport coût-efficacité qui permet de déterminer si les revenus destinés

aux soins de santé sont générés au moindre coût possible, en matière d'administration et de contrôle de la conformité.

- *L'équité entre les générations* compare la distribution des coûts entre les jeunes et les personnes âgées et entre les personnes retraitées et celles qui sont sur le marché du travail.
- *La stabilité* porte sur la prévisibilité du financement futur.
- *La visibilité* renvoie à la capacité des citoyens de faire le lien entre leurs cotisations aux dépenses publiques en santé (pour chaque ordre de gouvernement) et les avantages qu'ils en retirent.

Ces critères ont aidé le Comité à choisir les sources de financement qui semblent le mieux convenir au but recherché, à savoir permettre au gouvernement fédéral de générer des recettes additionnelles à consacrer aux soins de santé.

Le Comité tient à préciser d'entrée de jeu que les nouvelles sources de financement doivent garantir que le système de soins de santé pourra continuer de répondre aux besoins des Canadiens sans empiéter sur le financement d'autres besoins et sans faire porter aux citoyens ou aux entreprises un fardeau fiscal intolérable. Toute nouvelle forme de ponction envisagée doit nuire le moins possible à l'économie, notamment à la création d'emplois et à la croissance des revenus. De plus, les nouvelles sources de recettes doivent rendre les Canadiens plus conscients du lien entre les soins de santé qu'ils reçoivent du régime public et les impôts et taxes qu'ils paient pour les financer.

### **15.3 Impôts généraux**

Actuellement, les crédits fédéraux affectés à la santé proviennent des recettes fiscales générales, lesquelles sont issues des impôts directs et indirects. Les impôts directs, perçus auprès des particuliers, des ménages ou des sociétés, comprennent l'impôt sur le revenu des particuliers et l'impôt des sociétés. Les impôts indirects, perçus sur les transactions et les biens et services vendus, comprennent notamment les taxes de vente, les taxes sur la valeur ajoutée et les taxes d'accise.

Actuellement, aucun des impôts directs et indirects qui sont à la source des recettes fiscales générales du gouvernement fédéral ne fait ressortir le lien entre les impôts payés et les services reçus. C'est d'ailleurs en grande partie pour cette raison que tant de Canadiens considèrent leur système de soins de santé comme gratuit. Les diverses recettes fédérales engendrées par les impôts directs et indirects sont actuellement versées dans un seul fonds : le Trésor. Cela explique qu'il n'existe pas de lien direct entre les impôts payés et les dépenses en santé, malgré le fait qu'une importante part des recettes gouvernementales sert à payer les soins de santé. Ce régime diffère grandement de l'imposition spécifique (voir la section 15.4, ci-dessous), où les recettes fiscales destinées au service visé sont versées dans un fonds particulier réservé à cette fin.

Toutes les formes d'imposition directe et indirecte ont des conséquences diverses en matière d'équité et d'efficacité. Les impôts directs perçus auprès des particuliers sont souvent progressifs, c'est-à-dire que le montant à verser augmente avec le revenu, de sorte que les mieux

nantis paient proportionnellement plus que les petits salariés. Il en découle une redistribution des revenus des riches vers les moins fortunés.

Les impôts indirects, comme la taxe de vente, sont habituellement jugés régressifs, étant donné que les sommes versées sont liées à la consommation de biens et services taxables; ainsi, les personnes qui ont des revenus élevés paient proportionnellement moins d'impôts indirects par rapport à leur revenu (mais elles en paient plus, en termes absolus). En effet, les personnes moins fortunées consacrent une part plus grande de leurs revenus à l'achat de biens et services que les plus fortunés, de sorte que le fardeau des taxes à la consommation est plus lourd pour les moins nantis. Cependant, sur l'espace d'une vie, la consommation est à peu près proportionnelle au revenu, pour une large fourchette de revenus; par conséquent, les taxes à la consommation ne sont pas aussi régressives qu'on pourrait le croire à première vue. De plus, diverses mesures de compensation, par exemple le crédit d'impôt pour TPS, peuvent réduire le caractère régressif d'une taxe à la consommation.

Dans son mémoire au Comité, Robert Evans, professeur d'économie de la santé à l'Université de la Colombie-Britannique, donne l'explication suivante :

*Un impôt est dit progressif lorsque l'obligation fiscale du contribuable augmente plus vite que son revenu, de sorte que les personnes à revenu élevé paient plus d'impôt que les autres en termes absolus et en proportion de leur revenu. Inversement, une imposition régressive fait en sorte que les personnes à faible revenu versent une part plus élevée de leurs revenus en impôts et taxes<sup>335</sup>.*

Par conséquent, les répercussions éventuelles de l'imposition générale sur le plan de l'équité dépendent, d'une part, de la structure des régimes d'imposition directe et indirecte du pays et, d'autre part, des recettes relatives perçues par chaque type de taxe<sup>336</sup>. Des études fondées sur des données de l'OCDE indiquent que, dans les pays où les recettes fiscales générales financent la plupart des soins de santé, la combinaison de taxes et d'impôts directs et indirects tend à rendre l'imposition générale légèrement progressive<sup>337</sup>.

En 2000, les recettes fiscales du Canada étaient constituées pour 57 % d'impôts directs et pour 43 % d'impôts indirects. Des données montrent également que le régime fiscal canadien est devenu plus progressif au cours de la dernière décennie : en 1993, 49 % des recettes fiscales du Canada provenaient d'impôts indirects<sup>338</sup>.

Par rapport à la moyenne dans les autres pays de l'OCDE qui financent leurs soins de santé à même les recettes fiscales, le Canada compte beaucoup sur l'impôt sur le revenu des particuliers<sup>339</sup>. En fait, seuls le Danemark, l'Australie et la Nouvelle-Zélande tirent une part

---

<sup>335</sup> Robert Evans, mémoire présenté au Comité le 3 juin 2002, p. 2.

<sup>336</sup> Derek Wanless, *Securing our Future Health: Taking a Long-Term View*, Interim Report, novembre 2001, p. 51. ([http://www.hm-treasury.gov.uk/Consultations\\_and\\_Legislation/wanless/consult\\_wanless\\_interimrep.cfm](http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_interimrep.cfm))

<sup>337</sup> Elias Mossialos et Anna Dixon, « Funding Health Care in Europe: Weighing up the Options », chapitre douze de *Funding Health Care: Options for Europe*, 2002, p. 272-300.

<sup>338</sup> Selon les données de Statistique Canada provenant du CANSIM II, tableau 380-0022.

<sup>339</sup> Caroline Chapain et François Vaillancourt, « Le financement des services de santé au Québec », dans *Le système de santé québécois: Un modèle en transformation*, C. Bégin édit., 1999, p. 101-121.



plus grande de leurs recettes fiscales de cet impôt<sup>340</sup>. En ce qui concerne la part relative de l'impôt des sociétés dans les recettes fiscales, le Canada se situe encore là au-dessus de la moyenne des pays qui financent leur système de soins de santé à même les recettes fiscales générales<sup>341</sup>. Enfin, le Canada est légèrement sous la moyenne pour ce qui est de la part des impôts indirects dans les recettes fiscales<sup>342</sup>. Par conséquent, on peut dire que le Canada dispose de l'un des systèmes fiscaux les plus progressifs des pays de l'OCDE.

D'un autre point de vue, cependant, le fait que les taux de l'impôt sur le revenu des particuliers soient significativement plus élevés au Canada qu'aux États-Unis signifie que le Canada est moins intéressant pour les travailleurs qualifiés à hauts revenus. Cette situation a aussi pour effet de faire grimper le coût au Canada des capitaux d'investissement provenant de l'épargne personnelle, ce qui nuit à l'investissement, à la productivité et à la croissance. Voici ce qui a été dit au Comité :

*Un certain nombre de facteurs (dette publique et dépenses sociales plus élevées) sont susceptibles de faire en sorte que le Canada continuera pendant un certain temps encore à avoir des taux d'imposition du revenu des particuliers plus élevés que les États-Unis, mais il vaudrait mieux éviter de creuser l'écart entre les taux américains et canadiens et, à terme, chercher à réduire cet écart. Par conséquent, on a de bonnes raisons de ne pas trop augmenter l'impôt sur le revenu des particuliers et d'élargir l'écart à ce chapitre entre le Canada et les États-Unis<sup>343</sup>.*

De même, on a expliqué au Comité pourquoi il serait difficile et malavisé d'augmenter l'impôt des sociétés pour financer l'augmentation des dépenses fédérales en santé. L'assiette d'imposition des sociétés est non seulement plus petite que l'assiette de l'impôt sur le revenu des particuliers ou que celle des cotisations sociales, mais aussi beaucoup moins stable. Par ailleurs, la hausse des taux d'imposition des sociétés nuirait gravement au rendement des capitaux investis au Canada, ce qui découragerait non seulement l'investissement mais aussi la création d'emplois. Même des entreprises établies pourraient être tentées de quitter le Canada devant une hausse considérable du fardeau fiscal. En général, de nombreux témoins ont fait valoir que l'impôt des sociétés est un véhicule qui ne convient pas pour générer des recettes additionnelles destinées à financer les soins de santé.

Il a été dit au Comité qu'une augmentation de l'impôt fédéral sur le revenu des particuliers nuirait considérablement à l'efficience, au niveau de l'offre de main-d'œuvre, de l'épargne et de l'investissement. Des témoins ont affirmé qu'un impôt sur le revenu est une « double taxe » sur l'épargne, puisque le revenu d'où provient l'épargne est imposé et qu'ensuite l'intérêt gagné sur l'épargne est également frappé d'un impôt.

Quoi qu'il en soit, étant donné que le financement du système de soins de santé par les recettes fiscales générales tire ses revenus d'une large assiette, il contribue à réduire les

---

<sup>340</sup> OCDE (2000), *Revenue Statistics 1965–1999*, tableau 11.

<sup>341</sup> OCDE (2000), tableau 13.

<sup>342</sup> OCDE (2000), tableau 27.

<sup>343</sup> Brown et Haynes (2002), p. 13.

inégalités créées dans l'économie. De plus, le financement des soins de santé par les recettes fiscales générales coûte peu en administration<sup>344</sup>.

Dans le cadre d'un système de soins de santé financé à même les recettes fiscales générales, par opposition à un régime financé par des impôts spécifiques, les décisions relatives aux montants à consacrer à la santé nécessitent obligatoirement des compromis avec les autres priorités de dépenses du gouvernement, par exemple les programmes sociaux ou la réduction des impôts et de la dette. Donc, le financement des soins de santé à même les recettes fiscales engendre des négociations sur les dépenses publiques au sein même du gouvernement. Ce processus permet une certaine transparence, mais il a le défaut de lourdement politiser la prise de décisions.

Le financement de la santé à même les recettes fiscales présente l'autre inconvénient de rendre le système de santé vulnérable en période de ralentissement économique ou de compressions budgétaires. Lorsque l'économie ralentit, les recettes fiscales diminuent et les gouvernements sont incités à réduire les dépenses publiques. Cela nuit naturellement à la stabilité du financement des soins de santé. Il convient toutefois de souligner que toutes les recettes fiscales fluctuent au rythme des variations de l'économie et que les recettes générales varient moins que bien des taxes et impôts spécifiques.

Enfin, ce qui pourrait être l'argument le plus important, des témoins ont fait valoir que les impôts directs et indirects n'ont pas le même impact sur les différentes générations, d'où la question de l'équité entre générations. L'impôt sur le revenu prélève une part plus grande des recettes gouvernementales auprès des jeunes actifs que des retraités. Donc, l'augmentation prévue du rapport des retraités à la population active au Canada devrait réduire l'assiette de l'impôt et donc les recettes fiscales. Par conséquent, dans un système de santé financé par des impôts directs, et en particulier par l'impôt sur le revenu des particuliers, les besoins des personnes âgées pourraient être largement subventionnés par la population active plus jeune. À ce sujet, voici ce qu'avait à dire au Comité Jack Mintz, président-directeur-général de l'Institut C.D. Howe :

*En fait, l'OCDE a estimé qu'avec le vieillissement de la population, le ratio impôts/PIB du Canada baissera de 1,5 point. C'est parce qu'une fois à la retraite, les personnes âgées tendent à gagner un revenu moindre et, par conséquent, à payer moins d'impôts que les travailleurs. Il y a peut-être de meilleures sources de financement des soins de santé parce que la majorité des dépenses qui y sont consacrées sont attribuables aux dernières années de vie des personnes âgées. Par conséquent, à mesure que la population vieillit et que les prestations versées à l'égard des aînés augmentent, les impôts frappant les travailleurs devront augmenter aussi pour financer ces prestations<sup>345</sup>.*

Inversement, d'autres intervenants ont dit au Comité que les changements démographiques ont moins d'effet sur les recettes gouvernementales issues de l'imposition indirecte, comme les taxes à la consommation. De plus, l'utilisation des taxes à la consommation pourrait être préférable, du point de vue de l'efficacité économique, à l'utilisation de l'impôt sur

---

<sup>344</sup> Derek Wanless (2001), p. 50.

<sup>345</sup> Jack Mintz (62:6).

le revenu des sociétés. David Stewart-Patterson, vice-président principal du Conseil canadien des chefs d'entreprise, a insisté sur ce point :

*Quiconque examine la politique fiscale doit se rappeler que les taxes et les impôts n'ont pas tous les mêmes incidences économiques. Comme l'évalue le ministère des Finances, un dollar additionnel prélevé en impôt des sociétés peut faire neuf fois plus de dommages à la croissance économique qu'un dollar issu de la taxe de vente. Ainsi, plus le Canada choisira de consacrer d'argent au système public de soins de santé, plus il devra compter sur les taxes à la consommation afin de demeurer compétitif<sup>346</sup>.*

Jack Mintz, de l'Institut C.D. Howe, a tenu des propos similaires :

*[...] les taxes à la consommation [...] n'ont pas trop d'effets de distorsion sur l'économie et [...] tendent à être imposées d'une façon assez efficace. Elles s'appliquent d'une façon plus progressive que l'impôt sur le revenu, par exemple, pendant le cycle de vie parce que le revenu tend à atteindre son maximum pendant la vie active, puis à diminuer progressivement après la retraite. En même temps, la consommation est généralement moindre que le revenu dans les années où les gens économisent, tandis qu'elle augmente par rapport au revenu à la retraite, lorsque les gens puisent dans leur actif pour vivre. Les taxes à la consommation tendent également à être proportionnelles à la consommation des individus pendant leur cycle de vie. On pourrait les rendre progressives au moyen d'un crédit d'impôt semblable au crédit pour TPS qui assure un certain allègement fiscal aux Canadiens à faible revenu<sup>347</sup>.*

David Kelly, un ancien sous-ministre de la Santé en Colombie-Britannique, croit également que les taxes à la consommation perturbent moins l'économie :

*Si la décision a déjà été prise d'augmenter le financement en matière de santé et si la question consiste à déterminer quelle devrait être la source des recettes, j'agis exactement comme le gouvernement de la Colombie-Britannique lorsqu'il a découvert il y a quelques mois qu'il ne disposait pas des revenus suffisants pour couvrir les coûts des soins de santé en pleine expansion — il a tout simplement augmenté la taxe à la consommation.*

*[...]Premièrement, elle permet d'augmenter rapidement les recettes. Deuxièmement, il faut maintenir l'impôt sur le revenu, l'impôt des sociétés, les charges sociales et ainsi de suite à distance raisonnable des impôts et taxes américains, ce qui impose des restrictions considérables à notre politique. Troisièmement, c'est une taxe visible. Elle forcerait les consommateurs à réaliser les répercussions des augmentations des coûts des soins de santé. Elle pourrait également inciter davantage les consommateurs à tenir compte du facteur coûts, ce qui à mon point de vue serait sain<sup>348</sup>.*

---

<sup>346</sup> David Stewart-Patterson, mémoire présenté au Comité le 17 juin 2002, p. 4.

<sup>347</sup> Jack Mintz (62:7).

<sup>348</sup> David Kelly (59:40-41).

Pour résumer, le choix entre l'imposition directe et l'imposition indirecte, comme moyen d'accroître les recettes fédérales destinées à la santé, entraîne obligatoirement des compromis entre l'équité, la justice entre les générations et l'efficacité. À la lumière des témoignages reçus, le Comité conclut que le premier objectif devrait être de faire en sorte que tout nouvel impôt soit le plus efficace possible de manière à nuire le moins possible à l'économie (notamment à la création d'emplois et à la croissance économique), puis d'assurer la progressivité du système par des mesures additionnelles comme des crédits d'impôt pour les faibles revenus et des impôts additionnels pour les revenus élevés.

#### **15.4 Impôts spécifiques**

Les impôts spécifiques sont des impôts affectés à un usage déterminé. Ils peuvent être directs ou indirects. Un impôt réservé aux soins de santé présente plusieurs avantages par rapport aux recettes fiscales générales. Il a des chances d'être mieux accepté que d'autres ponctions fiscales puisqu'il est clairement rattaché à une utilisation qui profite à la population. Le fait de créer un lien véritable entre la perception d'un impôt et une dépense rend le financement de la santé plus transparent et plus souple. De plus, le prélèvement d'un impôt spécifique permet aux gens de se sentir davantage interpellés par le régime fiscal, chose qui peut inciter les fournisseurs de soins et les établissements à améliorer la qualité et l'accessibilité des services. Enfin, les recettes d'impôts spécifiques pourraient être plus stables, car elles sont moins exposées aux aléas des décisions politiques relativement à l'affectation des ressources financières de l'État.

De nombreux témoins ont présenté de solides arguments pour l'instauration d'impôts spécifiques. Selon eux, c'est la solution que souhaitent les Canadiens. Par exemple, le docteur Les Vertesi, directeur du service de médecine d'urgence au Royal Columbian Hospital de Vancouver, a dit ceci au Comité :

*Je crois que le public est prêt à investir plus d'argent dans son réseau public de la santé, mais pas pour des taxes qui se retrouvent dans les recettes générales. C'est une question de confiance. Le bilan des administrations gouvernementales qui imposent le revenu des gens, puis garantissent que l'argent recueilli sera consacré à certains services désignés n'est pas reluisant — tout au moins c'est la perception. Le lien de confiance a été rompu. Les gens ne veulent pas donner de l'argent aux pouvoirs publics et constater que celui-ci ne fait que disparaître. Ils sont prêts à le faire si on les rassure sur le fait que l'argent ira aux soins de santé, et surtout aux soins de santé locaux<sup>349</sup>.*

Les impôts spécifiques présentent un certain nombre d'inconvénients. En effet, tous les impôts qualifiés de spécifiques ou présentés comme tels ne sont pas nécessairement destinés à un usage concret. Cela est particulièrement vrai lorsque les recettes d'un impôt spécifique sont groupées avec d'autres recettes fiscales. Cette fusion de recettes affaiblit le lien entre les recettes et les dépenses et, par voie de conséquence, mine l'assurance qu'a la population de voir son argent servir à la fin prévue. Pour qu'un impôt soit efficacement spécifique ou affecté à une fin, il faut que les recettes qu'il génère soient versées dans un fonds spécifique et non pas au Trésor.

---

<sup>349</sup> Dr Les Vertesi (53:62).

Le fait d'affecter des impôts à des fins particulières rigidifie le processus budgétaire du gouvernement, car les dépenses affectées au programme visé sont déterminées par les recettes réalisées et non pas par des décisions stratégiques. Un autre inconvénient tient au fait que les recettes tirées d'un seul impôt spécifique peuvent être cycliques et sujettes à des variations suivant les accélérations et les ralentissements de l'économie.

Également, le fait de séparer les soins de santé des autres postes de dépense pourrait constituer un encouragement à financer distinctement d'autres postes budgétaires au moyen d'impôts spécifiques. Si une telle tendance touchait un certain nombre de domaines, le gouvernement finirait par avoir du mal à entretenir un Trésor suffisant pour acquitter les coûts des programmes gouvernementaux nécessaires mais moins populaires, notamment l'aide à l'étranger. Il serait donc irréaliste d'instaurer un grand nombre d'impôts spécifiques.

Dans le volume quatre, le Comité présente une solution en vertu de laquelle les coûts des soins de santé reçus par un particulier au cours d'une année sont considérés comme un avantage imposable pour cet exercice. Ainsi, un particulier paierait de l'impôt sur le coût des services de santé qu'il a reçus, à concurrence d'un certain montant annuel. Ce mode d'imposition générerait des recettes additionnelles pour les soins de santé et favoriserait une responsabilisation des gens vis-à-vis de la consommation des soins de santé<sup>350</sup>. Selon cette solution, qui est une forme d'impôt spécifique, un particulier devrait ajouter le coût des services de santé qu'il a reçus au cours de l'exercice à son revenu imposable. Cette option est préconisée depuis quelques années, notamment par Jack Mintz et coll. (1998)<sup>351</sup>, Tom Kent (2000)<sup>352</sup> et, tout dernièrement, par Mintz, Aba et Goodman (2002)<sup>353</sup>.

Selon le plan proposé par Mintz, Aba et Goodman, les particuliers paieraient un impôt de 40 % sur les coûts des soins de santé qu'ils engendrent au cours d'un exercice, jusqu'à un plafond équivalant à 3 % de leur revenu annuel. Les familles dont les revenus sont inférieurs à 10 000 \$ par année seraient exemptées de cet impôt pour les coûts des services reçus du système public de soins de santé. Dans ce type de système, un particulier cotise proportionnellement à l'utilisation qu'il fait des services de santé, jusqu'à concurrence de 3 % de son revenu.

Mintz, Aba et Goodman font valoir que, en établissant un rapport entre la cotisation du particulier et les services qu'il utilise effectivement, et en encourageant les utilisateurs à penser aux coûts, on pourrait utiliser les ressources en santé de manière plus efficiente. Les auteurs estiment également que le fait de limiter les cotisations du particulier à 3 % de son revenu annuel garantirait que les coûts demeurent abordables pour le contribuable et donc que personne ne risque d'être privé de services de santé nécessaires. En outre, ce système éviterait que les coûts de la santé ne constituent pour un contribuable donné un fardeau excessif.

En s'inspirant de données sur l'utilisation des soins de santé, Mintz, Aba et Goodman ont estimé que 62 % des Canadiens paieraient la cotisation maximale de 3 % de leur

---

<sup>350</sup> Volume quatre, p. 63-64.

<sup>351</sup> Jack Mintz, Michael Gordon et Duanjie Chen, « Funding Canada's Health Care System: A Tax-Based Alternative to Privatization », dans le *Journal de l'Association médicale canadienne*, 8 septembre 1998, p. 493-496.

<sup>352</sup> Tom Kent, *What Should Be Done About Medicare*, The Caledon Institute of Social Policy, août 2000.

<sup>353</sup> Jack Mintz, S. Aba et W.D. Goodman (2002), « Funding Public Provision of Private Health: The Case for a Copayment Contribution through the Tax System », *C.D. Howe Institute Commentary – The Health Papers*, no. 163.

revenu annuel. Mises ensemble, ces cotisations généreraient des recettes additionnelles de 6,6 milliards de dollars (soit environ 16 % du total des dépenses publiques affectées aux médecins, aux hôpitaux et aux autres établissements de santé). Selon leurs calculs, la perception de cet impôt ferait diminuer de 13,5 % l'utilisation des services de santé, ce qui représente une économie de 6,3 milliards de dollars. Les auteurs croient que les coûts administratifs additionnels seraient minimes, car les cotisations seraient prélevées par le truchement du système de perception des impôts provinciaux et territoriaux.

Un certain nombre de témoins ont présenté de propositions semblables à celle de Mintz et coll. Par exemple, Paul Darby, directeur des prévisions économiques au Conference Board du Canada, a dit ceci :

*[Cette solution] est très intéressante en ce sens qu'elle fait comprendre aux utilisateurs du système ce que coûtent les soins de santé. Elle présente aussi l'avantage de lier ces coûts à un paiement — du moins jusqu'à un certain point. Je ne suis pas sûr qu'elle règle le problème de la redistribution ou du transfert du fardeau aux membres les plus défavorisés de la société<sup>354</sup>.*

La solution consistant à prélever un impôt sur les services de santé serait garante de visibilité, sans compter qu'elle améliorerait sensiblement la stabilité du financement du système de soins de santé. Une telle solution aurait un impact semblable, d'une certaine manière, à l'imposition directe pour ce qui est de l'efficacité et des distorsions économiques. Cependant, elle amènerait le Canada à dépendre davantage de l'impôt sur le revenu des particuliers, lequel est déjà bien plus lourd ici que dans les autres pays de l'OCDE.

L'argument le plus probant présenté au Comité contre les services de santé imposables veut que certaines personnes auront l'impression de payer deux fois les soins qu'elles reçoivent : une fois par l'imposition générale et une autre fois par l'impôt qu'elles doivent verser au titre des services de santé consommés durant l'année. L'argument du « double paiement » a convaincu le conseil consultatif du premier ministre de l'Alberta sur la santé de ne pas retenir cette solution<sup>355</sup>.

On a proposé au Comité une manière relativement efficace de générer de nouvelles recettes fédérales pour les soins de santé : réserver une partie d'une taxe à la consommation, par exemple la TPS. La TPS est la principale taxe à la consommation fédérale au Canada. Selon de nombreux témoins, il s'agit d'une taxe relativement efficace; en raison de son champ d'application large et généralement neutre, la TPS est l'impôt à la consommation que l'on pourrait le plus facilement relever pour payer les dépenses additionnelles du gouvernement fédéral en santé.

Cependant, cette solution serait sensiblement plus régressive que l'imposition des services de santé. Quoiqu'il en soit, le projet d'affecter une hausse de la TPS au paiement des soins de santé a été accueilli favorablement par un grand nombre d'intervenants au cours des audiences du Comité. Par exemple, Paul Darby a expliqué ce qui suit :

---

<sup>354</sup> Paul Darby (59:17).

<sup>355</sup> Rapport Mazankowski, p. 55.

*[...] la position du Conference Board en ce qui concerne la façon d'assurer le financement du système de soins au cours des 30 prochaines années a tendance à favoriser le recours accru aux taxes de consommation, comme la TPS. À notre avis, il faut essayer d'éviter des taxes et impôts qui touchent le travail, c'est-à-dire l'impôt sur le revenu et les charges sociales. Pour nous, les taxes de consommation auraient sans doute l'effet démobilisateur le moins important de toutes les options qu'on pourrait envisager en matière de fiscalité. [...] Nous souhaitons qu'il y ait une corrélation directe entre l'impôt et les dépenses engagées au titre des soins de santé, dans l'espoir que ce type d'impôt soit beaucoup plus facile, sur le plan politique, à faire accepter par la population<sup>356</sup>.*

M. Darby a dit que des remises aux Canadiens à faible revenu, comme le crédit pour la TPS, pourraient être offertes dans le cadre d'une TPS spécifique et majorée, afin d'améliorer l'équité et la progressivité du régime. De plus, si ces remises étaient structurées sur le modèle du crédit pour TPS, elles feraient peu augmenter les coûts d'administration.

## **15.5 Charges sociales**

Dans beaucoup de pays de l'OCDE (notamment en Allemagne et aux Pays-Bas), le financement public des soins de santé se fait par le truchement de charges sociales spécifiques. Les cotisations sont habituellement obligatoires et concernent les salariés et les employeurs. Elles sont prélevées sur les salaires et conservées (dans une «caisse d'assurance-maladie») par un organisme indépendant du gouvernement. Le principal intérêt des charges sociales spécifiques (ou «caisses d'assurance sociale») qui existent dans bon nombre de pays de l'OCDE tient à l'indépendance de l'assureur vis-à-vis du gouvernement et à l'impression de souplesse qu'il donne au patient ou consommateur.

Au Canada, les gouvernements fédéral, provinciaux et territoriaux utilisent déjà des charges sociales spécifiques sous une forme ou une autre. À l'échelon fédéral, il s'agit des cotisations à l'assurance-emploi et au Régime de pensions du Canada (le RPC et la RRQ sont de responsabilité fédérale et provinciale). Les charges sociales provinciales comprennent les cotisations aux commissions de la sécurité professionnelle et de l'assurance contre les accidents du travail (dans chaque province) et les impôts au titre du système de santé et de l'éducation postsecondaire (au Québec, au Manitoba, en Ontario, à Terre-Neuve et dans les Territoires du Nord-Ouest), quoi que le produit de ces derniers ne soit pas réservé à un usage spécifique.

Une charge sociale dont le produit est réservé au financement des soins de santé offre les avantages déjà cités pour les impôts spécifiques. Par exemple, elle peut être versée dans un fonds distinct. Elle est très visible et transparente, de sorte qu'elle est mieux acceptée par la population. En d'autres mots, en raison de la plus grande transparence inhérente à un régime de charges sociales, les gens résistent moins à une hausse des cotisations qu'à une hausse des impôts généraux. De plus, les recettes issues des charges sociales sont, du moins en théorie, davantage protégées de l'ingérence politique annuelle, étant donné que les décisions budgétaires et de dépenses peuvent être confiées à des organismes indépendants. Il est tout aussi important de souligner que, en n'imposant que le revenu du travail, on évite de nuire à l'épargne et à l'investissement. Enfin, les recettes issues des charges sociales semblent plus stables. À ce point de vue, voici ce qu'indique un rapport publié récemment :

---

<sup>356</sup> *Ibid.*, (59:5).

*En Belgique, où les soins de santé sont financés à parts presque égales par les impôts et les cotisations à l'assurance sociale, la variation de la croissance annuelle moyenne a été plus grande pour les recettes de source gouvernementale que pour les autres. [...] En d'autres mots, les dépenses gouvernementales en santé ont fluctué davantage que les recettes de l'assurance sociale. [...] Par conséquent, si l'on compte davantage sur l'impôt général que sur les cotisations sociales, les recettes seront moins stables<sup>357</sup>.*

Cependant, l'affectation de charges sociales à une fin précise présente un certain nombre d'inconvénients. Les employeurs sont habituellement tenus de cotiser à une partie des coûts de l'assurance-santé, ce qui fait monter les coûts de main-d'œuvre, nuit à la création d'emplois et réduit la compétitivité internationale de l'économie nationale. De plus, les charges sociales reposent sur une assiette relativement petite (le revenu du travail des salariés). Par conséquent, il faudrait porter le taux des charges sociales à un niveau relativement élevé pour obtenir le même produit que l'impôt général sur tous les revenus. Cela explique sans doute pourquoi les recettes fiscales générales sont une importante source complémentaire de revenus dans les pays disposant d'un régime à charges sociales affectées à la santé. Dans ces pays, une partie du produit des impôts généraux est habituellement virée à des caisses d'assurance-santé pour couvrir les cotisations des inactifs. Les recettes fiscales générales peuvent également couvrir les déficits des caisses publiques d'assurance-santé constituées à même les charges fiscales.

Contrairement à l'impôt général, les charges sociales peuvent aussi nuire à la mobilité des travailleurs; en effet, les salariés peuvent hésiter à passer à un emploi non couvert (par exemple un travail autonome) par crainte d'avoir à verser des cotisations plus élevées ou de recevoir moins d'avantages (comme c'est le cas aux États-Unis).

Dans le cadre du Plan Juppé, en France, on a entre autres invoqué l'effet néfaste possible des charges sociales sur l'industrie pour justifier la diversification des sources de financement et réduire les cotisations employeur-salariés au profit d'un système reposant sur l'impôt sur le revenu. Plus précisément, le gouvernement français a considérablement abaissé le taux de cotisation des salariés (de 5,5 % en 1997, il est passé à 0,75 % en 2000) et a affecté la totalité de la contribution sociale généralisée aux soins de santé (le taux de ce prélèvement est passé de 3,4 à 7,5 % du revenu des particuliers). Les gouvernements de l'Italie et de l'Espagne sont allés encore plus loin en abandonnant complètement le financement du système de santé par les charges sociales au profit des recettes fiscales générales.

Une autre critique formulée à l'encontre des charges sociales, eu égard à l'efficacité, veut que les différentes caisses maladie européennes chargées de percevoir et de gérer les cotisations des employeurs et des salariés soient peu encouragées à limiter les coûts, car elles ont la possibilité de hausser les taux de cotisation. Par ailleurs, l'existence dans certains pays de caisses multiples et le manque d'intégration à l'achat des services de santé engendrent souvent des coûts d'administration élevés.

On peut également faire valoir que le financement des soins de santé par les charges sociales est aléatoire en période de ralentissement économique du fait que les réductions de revenus associées à la baisse de l'emploi et au gel des salaires font baisser les cotisations aux caisses d'assurance-maladie. En outre, le fait que le fardeau du financement reposerait sur les

---

<sup>357</sup> Mossialos et Dixon (2002), chapitre douze, p. 285.



employeurs et les salariés pourrait avoir des effets néfastes graves sur certains secteurs de l'économie à forte intensité de main-d'œuvre.

Enfin, en ce qui concerne l'équité, des informations provenant d'Allemagne et des Pays-Bas indiquent que le financement des soins de santé par les charges sociales tend à être régressif. Cela s'explique probablement par la nature des deux systèmes, qui permettent aux personnes qui gagnent plus et qui possèdent déjà une assurance-santé privée de ne pas cotiser au régime public.

Les charges sociales ont aussi ceci de particulier qu'elles ont un moindre impact sur l'économie canadienne dans son ensemble que les autres types de prélèvements. Des calculs préliminaires effectués par le ministère des Finances indiquent qu'un dollar additionnel en recettes fiscales perçu par le truchement des charges sociales coûte à l'économie 0,27 \$ en production perdue. Par comparaison, la perte de production est de 1,55 \$ pour chaque dollar additionnel d'impôt sur les sociétés et de 0,56 \$ pour chaque dollar additionnel d'impôt sur le revenu des particuliers. Il est prouvé que la taxe de vente est le véhicule qui a le moins d'effet sur la production, à savoir seulement 0,17 \$ pour chaque dollar additionnel perçu<sup>358</sup>. Dans le contexte de la compétitivité internationale, il reste une certaine marge de manœuvre au Canada pour l'imposition d'autres charges sociales : des données de l'OCDE indiquent que cette forme d'imposition est moins exploitée au Canada que dans d'autres pays industrialisés<sup>359</sup>.

Cependant, les charges sociales ont un impact semblable à celui causé par l'imposition des revenus sur le plan de l'équité entre générations, sauf que l'effet est encore pire, car le fardeau est porté entièrement par les jeunes travailleurs.

## **15.6 Prime nationale d'assurance-santé**

Une prime d'assurance-santé est un montant forfaitaire fixe versé par une personne ou une famille afin de financer des services de santé assurés. Dans certains régimes, les primes d'assurance-santé sont des montants fixes versés indépendamment du revenu et de l'utilisation du système de soins de santé. Ce genre de cotisation est en usage en Colombie-Britannique et en Alberta; à noter qu'il existe dans ces deux provinces des exemptions pour les personnes et les familles à faible revenu.

Ce mode de financement est jugé relativement efficient pour deux raisons : le fardeau financier est réparti sur une large base (l'ensemble de la population) plutôt que parmi les personnes qui ont un emploi, comme c'est le cas de la plupart des régimes de charges sociales. Cela signifie que toutes les branches de l'économie sont traitées également; de plus, comme les primes sont les mêmes pour tous, les gens ont peu de raisons de modifier leur comportement (que ce soit de consommer plus ou moins ou de travailler plus ou moins). En outre, les primes d'assurance-santé ne font pas de distinction entre jeunes et vieux, d'où leur équité entre les générations.

---

<sup>358</sup> Ministère des Finances, données présentées par l'OCDE (*OECD Economic Surveys – Canada 1997*), novembre 1997.

<sup>359</sup> OCDE, *Revenue Statistics 1965-2000*, 2001.

*[...] Que les gens travaillent ou non, tout le monde paierait la prime. Cette forme d'imposition entraînerait le moins de distorsions et tiendrait le plus compte des effets démographiques attendus à l'avenir<sup>360</sup>.*

Une prime forfaitaire d'assurance-santé n'a pas d'effet sur les taux marginaux d'imposition du revenu, comme en aurait une hausse de l'impôt sur le revenu des particuliers; elle a par conséquent moins d'effet sur l'épargne et l'investissement.

Pour ce qui est de l'équité, des primes forfaitaires d'assurance-santé publique auraient tendance à frapper plus durement les personnes à faible revenu, bien qu'il soit possible d'envisager des mesures d'atténuation des impacts. Également, les salariés moyens verseraient les mêmes primes que les riches, de sorte que les primes forfaitaires sont manifestement régressives, car elles profitent davantage aux personnes à revenu élevé. En revanche, elles profitent aux personnes qui ont de grands besoins en soins de santé, lesquelles versent les mêmes primes que les personnes qui utilisent peu le système de soins de santé.

Dans l'ensemble, les caractéristiques équitables d'un système financé par des primes forfaitaires semblent plutôt limitées. On a dit au Comité que, pour plus d'équité, il faudrait que les primes soient liées aux revenus d'une manière ou d'une autre et que certaines tranches de la population en soient exemptées. Il a été proposé récemment dans le rapport Mazankowski (2001), *A Framework for Reform*, produit pour le premier ministre de l'Alberta, d'utiliser des primes variables adaptées aux niveaux de revenus.

Dans son mémoire au Comité, David Kelly présente un long exposé sur les avantages d'un régime de cotisations nationales d'assurance-santé.

*Il se pourrait que le gouvernement fédéral doive générer des recettes additionnelles pour soutenir le système des soins de santé, et un régime fédéral de primes d'assurance-santé constituerait un moyen de percevoir de l'argent d'une manière qui rende visible la contribution financière du gouvernement fédéral.*

*(...) Les régimes provinciaux en vigueur en Alberta et en Colombie-Britannique génèrent d'importantes recettes pour ces gouvernements. Les primes sont fixes et leur paiement est obligatoire et universel; elles sont réduites ou éliminées pour les petits revenus, mais n'ont pas de lien avec l'admissibilité à un programme (un paiement omis ou en retard n'entraîne pas la cessation des services à la personne ou à la famille). Les primes sont perçues dans la mesure du possible par retenues à la source, le solde étant entièrement facturé aux résidents de la province. Les coûts administratifs de la perception des primes par un mécanisme distinct du régime de l'impôt sur le revenu ne sont pas négligeables.*

*(...) Dans l'éventualité d'un régime fédéral de primes d'assurance-santé, il serait certainement judicieux de percevoir les primes par le truchement du système de l'impôt sur le revenu, plutôt qu'au moyen d'une procédure administrative distincte. Autrement dit, la perception se ferait à la source, au moyen de paiements trimestriels et un*

---

<sup>360</sup> Jack Mintz (62:7).

*rapprochement annuel pourrait être fait dans le cadre de la structure existante de perception des impôts; cela vaudrait mieux que d'envoyer à toutes les familles une facture mensuelle ou trimestrielle. Cette prime peut prendre différentes formes; il peut s'agir d'un montant forfaitaire identique pour tout le monde ou encore d'un montant forfaitaire avec mesures d'atténuation pour les petits revenus, comme c'est le cas dans les deux provinces qui disposent d'un tel régime; il peut également s'agir d'un impôt additionnel imposé proportionnellement ou autrement, après l'impôt sur le revenu. Ces différentes formules ont chacune leurs conséquences en matière d'équité. Il convient de se rappeler que le financement du programme universel des soins de santé au Canada comporte un important élément de redistribution du revenu. Toute mesure destinée à financer le système en partie au moyen d'une prime moins progressive que les sources actuelles de financement affecterait la nature de cette répartition des revenus et allongerait de ce fait la liste des critères dont le Comité doit tenir compte<sup>361</sup>.*

En conclusion, les primes pourraient constituer un moyen visible et équitable de générer des recettes pour les fins du financement des soins de santé, à condition qu'elles soient structurées de manière à assurer leur progressivité (c'est-à-dire, qu'elles varient en fonction du revenu).

### **15.7 Frais d'utilisation**

Les frais d'utilisation sont habituellement définis comme une forme de paiement (couvrant une portion du coût du service) effectué par le consommateur d'un service de santé au moment où le service est fourni. Il s'agit donc d'un coût initial imposé au patient. Dans le volume quatre de son étude sur les soins de santé, le Comité a décrit les différentes formes de frais d'utilisation :

- La coassurance, la façon la plus simple d'imposer des frais d'utilisation, consiste pour le patient à payer un pourcentage fixe (disons 5 %) du coût des services reçus. Plus le coût du service est élevé, plus le montant à déboursier est élevé. De nombreux régimes privés d'assurance-médicaments optent pour cette formule.
- La quote-part est une autre option. Au lieu de payer une partie des coûts, le patient doit payer pour chaque service un montant fixe (par exemple 5 \$) qui n'a pas nécessairement de rapport avec le coût du service. Le montant perçu demeure uniforme quel que soit le coût du service fourni. Cette formule existe dans bien des pays, dont la Suède.
- Dans un régime de franchises, le patient doit payer le coût total des services reçus pendant une période donnée jusqu'à concurrence d'un plafond, la franchise. Au-delà de ce plafond, les coûts des services fournis sont couverts par le régime d'assurance. Tous les utilisateurs doivent payer une franchise minimale uniforme qui ne dépend pas de la quantité de services reçus. Cette forme de frais d'utilisation est utilisée dans certains pays<sup>362</sup>.

---

<sup>361</sup> David Kelly, mémoire présenté au Comité, p. 2-3.

<sup>362</sup> Volume quatre, p. 65.

Certains commentateurs ont indiqué que des frais d'utilisation d'un montant relativement modeste pourraient être un moyen utile de dissuader la consommation excessive de services de santé et de responsabiliser des gens à l'égard de l'utilisation du système. Toutefois, la plupart des auteurs de documents sur le sujet concluent que les frais d'utilisation dissuadent certaines personnes de se procurer des soins même nécessaires, phénomène qui s'observe surtout chez les pauvres. Le professeur Robert Evans a déclaré au Comité que les frais d'utilisation soulèvent d'importantes questions d'accessibilité et d'équité :

*Un fait est bien connu et amplement recensé : une proportion relativement faible de la population consomme une forte proportion des services de santé, observation qui vaut tant pour les périodes ponctuelles que pour les longues périodes. Une étude récente menée en Colombie-Britannique qui paraîtra bientôt montre que la tranche de cinq pour cent de la population adulte qui fait le plus grand usage des services des médecins (mesuré en termes de facturation en dollars) non seulement était à la source de 33,7 % de la facturation totale, mais faisait aussi l'objet de 43,5 % des admissions dans les hôpitaux et se voyait attribuer 69,3 % des journées d'hospitalisation. Ces personnes étaient en général assez malades, le plus souvent atteintes d'affections graves et multiples. Elles étaient aussi en moyenne plus vieilles – près de la moitié avaient plus de 60 ans –, provenaient des quartiers les plus pauvres et affichaient un taux de mortalité neuf fois plus élevé que celui de la population en général. Pour la plupart d'entre elles, il ne semblait pas y avoir de possibilité réaliste qu'elles puissent payer plus de la moitié des coûts dont elles étaient à l'origine, en supposant qu'une distribution aussi asymétrique du fardeau financier soit acceptable pour le reste de la population<sup>363</sup>.*

Il importe de souligner que le Canada est le seul pays industrialisé qui interdit l'imposition de frais d'utilisation relativement à des services de santé couverts par l'assurance-santé publique. Bien que cette forme de financement soit utilisée ailleurs, après étude de la situation au Canada, le Comité a conclu, dans le volume cinq de son étude, que l'accès aux services hospitaliers et aux services fournis par les médecins ne devrait pas dépendre du revenu ou de la richesse de chacun<sup>364</sup>.

**Le Comité a examiné les témoignages relatifs aux frais d'utilisation au Canada et a conclu que l'accès aux services hospitaliers et aux services fournis par les médecins ne devrait pas dépendre du revenu ou de la richesse de chacun.**

Nous avons expliqué que la plupart des dépenses et des pertes imputables au système de soins de santé n'étaient pas le fait des patients, car les décisions qui donnent lieu à ces dépenses sont prises par les prestataires de soins de santé pour le compte de leurs patients; elles ne sont pas prises par les patients eux-mêmes. De plus, le Comité a été informé du fait que l'adoption de frais d'utilisation minimales pourrait donner lieu à des coûts administratifs qui seraient quasi égaux aux revenus générés par ces frais.

Pour toutes ces raisons, le Comité a énoncé dans le volume cinq le Principe dix-huit, selon lequel s'il faut certes instituer des mécanismes pour encourager les patients à faire

<sup>363</sup> Robert Evans, mémoire présenté au Comité le 3 juin 2002, p. 6.

<sup>364</sup> Volume cinq, p. 57.

un usage aussi efficace que possible des services hospitaliers et des services des médecins, ces mécanismes *excluent* l'imposition de frais d'utilisation.

Certaines formes de paiement pourraient toutefois être imposées aux patients dans le cadre de la mise en oeuvre de la réforme des soins de santé primaires proposée par le Comité au chapitre quatre. Elles ne seraient pas étiquetées comme des frais d'utilisation mais plutôt comme des « frais d'orientation ». Lorsque les médecins de soins primaires renvoient des patients à des spécialistes, les patients n'ont aucun frais à payer. Si un patient décide de lui-même de prendre rendez-vous avec un médecin spécialiste sans lui avoir été renvoyé, il devrait être responsable d'une partie ou de la totalité des frais associés à cette consultation. Cette formule de paiement par le patient est en vigueur au Danemark.

### **15.8 Comptes d'épargne-santé**

Comme l'explique le Comité dans le volume trois de son étude, les comptes d'épargne-santé (CES) sont des comptes analogues à un compte en banque, mais ils servent à payer les dépenses de soins de santé d'une personne ou d'une famille<sup>365</sup>. Ils sont souvent établis conjointement à une assurance-santé servant à couvrir des coûts exorbitants (avec franchise élevée). Les sommes investies dans un CES appartiennent au titulaire du compte, qui en dispose comme il l'entend, s'accumulent en franchise d'impôt et ne sont pas imposées si elles sont utilisées pour fins de soins de santé. Le titulaire du compte peut employer à d'autres fins les sommes inutilisées.

Les CES nécessitent trois niveaux de paiement. Tout d'abord, l'argent contenu dans le compte est utilisé pour couvrir des dépenses de santé normales. Par la suite, si le compte est épuisé mais que la franchise n'est pas atteinte, l'intéressé paie ses dépenses lui-même. Enfin, le régime public d'assurance-santé couvre les dépenses qui excèdent la franchise.

Quelques pays, notamment Singapour, l'Afrique du Sud et certaines parties des États-Unis, ont recours à ce système. La théorie générale qui sous-tend les CES veut que les consommateurs prennent des décisions plus judicieuses et rentables s'ils ont à dépenser leur propre argent, plutôt que de se fier aux services « gratuits » financés par l'État. Par conséquent, les CES limiteraient (ou élimineraient) l'utilisation inutile des services de santé, freineraient l'augmentation des dépenses publiques au chapitre de la santé et encourageraient l'efficacité.

Ces dernières années, plusieurs formules de comptes d'épargne-santé (CES) ont été proposées au Canada<sup>366</sup>. Vu l'intérêt d'un grand nombre de Canadiens pour les CES, le Comité a examiné la documentation à ce sujet et s'est entretenu avec un certain nombre de personnes et de spécialistes. Selon l'information recueillie, nous sommes d'avis qu'un tel mécanisme ne conviendrait pas à notre système public de soins de santé dispensés par les hôpitaux et les médecins.

---

<sup>365</sup> Volume trois, chapitre sept, p. 62.

<sup>366</sup> Voir les documents suivants : 1) William McArthur, Cynthia Ramsay et Michael Walker, éd., *Healthy Incentives: Canadian Health Reform in a Canadian Context*, The Fraser Institute, 1996; 2) Cynthia Ramsay, « Medical Savings Accounts », *Critical Issues Bulletin*, The Fraser Institute, 1998; 3) David Gratzner, *Code Blue – Reviving Canada's Health Care System*, ECW Press, 1999; 4) Dennis Owens et Peter Holle, *Universal Medical Savings Accounts*, Frontier Centre for Public Policy, Policy Series No. 5, juillet 2000.

D'abord, les spécialistes ne s'entendent pas sur l'incidence des CES sur l'état de santé de la population et sur les coûts des soins. Certains soutiennent que les CES augmentent le choix offert aux consommateurs, encouragent les patients à faire un usage plus prudent des services et réduisent les dépenses de santé. D'autres avancent que les CES ne procurent au mieux que de petites économies, segmentent le risque sur le marché de l'assurance, font augmenter les coûts et ont une incidence négative sur la santé, puisque les gens, en particulier les pauvres et les malades, se priveront de soins de santé nécessaires. De plus, les études les plus récentes révèlent que les connaissances actuelles sur les CES sont trop limitées pour qu'on puisse recommander leur adoption dans le système canadien de soins de santé<sup>367</sup>.

Toutefois, c'est la question de l'incidence sur l'équité qui préoccupe le plus le Comité. Tout comme les frais d'utilisation, les CES transfèrent directement du gouvernement aux patients une partie de la responsabilité des dépenses de santé et ce, d'une manière qui impose un fardeau disproportionné aux pauvres et aux personnes malades, qu'elles soient riches ou pauvres. En fait, les CES réduisent le subventionnement actuel des démunis par les nantis. Une étude récente montre que si les CES étaient mis en oeuvre au Manitoba, 20 % des résidents les plus malades de cette province devraient assumer personnellement des coûts de plus de 60 millions de dollars en soins de santé<sup>368</sup>.

Dans le volume quatre, le Comité a indiqué qu'on pourrait d'abord envisager l'application des CES dans une sphère limitée, par exemple pour le paiement des services dans des établissements de soins de longue durée, où les bénéficiaires assument déjà eux-mêmes une large part des frais. Toutefois, les CES *ne doivent pas* être mis en application dans le champ plus large des soins de santé actuellement couverts par l'assurance-santé.

Par conséquent, le Comité croit fermement que le financement des services hospitaliers et des services fournis par les médecins qui sont nécessaires d'un point de vue médical doit continuer de relever d'un programme d'assurance-santé financé et géré par l'État, ce qui est conforme au Principe quatre énoncé dans le volume cinq : « Les services de santé couverts par la *Loi canadienne sur la santé* sont assurés par l'État. Les autres services de santé continuent d'être financés à partir de sources publiques et privées, comme c'est déjà le cas<sup>369</sup>. »

***Le Comité croit fermement que le financement des services hospitaliers et des services dispensés par les médecins qui sont nécessaires d'un point de vue médical doit continuer de relever d'un programme d'assurance-santé financé et géré par l'État.***

## **15.9 Financement anticipé des soins de santé**

Dans le contexte du vieillissement de la population, l'option du financement anticipé des soins de santé gagne en popularité. Le financement anticipé consiste à mettre dès aujourd'hui des fonds de côté pour couvrir en totalité ou en partie l'augmentation prévue des

<sup>367</sup> Samuel E.D. Shortt, « Medical Savings Accounts in Publicly Funded Health Care Systems: Enthusiasm versus Evidence », *Journal de l'Association médicale canadienne*, vol. 167, n° 2, 23 juillet 2002, p. 159-162.

<sup>368</sup> Evelyn L. Forget, Raisa Deber et Leslie L. Roos, « Medical Savings Accounts: Will They Reduce Costs? », *Journal de l'Association médicale canadienne*, vol. 167, n° 2, 23 juillet 2002, p. 143-147.

<sup>369</sup> Volume cinq, p. 21.

coûts de santé, afin de maintenir le rapport des dépenses de santé au PIB à un niveau relativement stable. Le surplus des recettes accumulées maintenant grâce à ce financement anticipé serait placé dans un compte spécial, auquel on aurait accès plus tard à des fins de stabilisation.

Malheureusement, le financement intégral du régime par anticipation coûte très cher, même lorsque la stabilisation est étalée sur une période de 30 à 40 ans. En outre, comme la population du Canada est en plein processus de vieillissement, il pourrait être difficile dans l'immédiat de faire accepter la mise en oeuvre d'un plan de financement anticipé à long terme à l'heure où l'on sent l'urgence de faire face à l'augmentation imminente des coûts du régime. Par ailleurs, comme dans le cas des prélèvements fiscaux à affectation déterminée, on pourrait aussi se demander pourquoi seuls les coûts des soins de santé devraient faire l'objet d'un financement anticipé, puisque d'autres coûts aussi sont affectés par le vieillissement de la population.

Certains pensent qu'il vaudrait peut-être mieux envisager un financement anticipé partiel, limité par exemple aux coûts des services de santé destinés aux personnes âgées, comme les soins à domicile et les soins en établissement qui ne sont pas assumés par l'État actuellement. On pourrait pour ce faire instituer un régime public financé à même les recettes fiscales courantes ou confier le tout à des régimes privés d'assurance-santé. Un tel mécanisme (comparable aux CES) aiderait les gens à économiser en vue de leurs dépenses de santé futures en maximisant leurs avantages fiscaux, surtout si les cotisations sont déductibles et si les revenus tirés des fonds accumulés demeurent à l'abri de l'impôt. En bout de ligne, le financement anticipé économiserait de l'argent au système public de soins de santé du fait que celui-ci n'aurait plus à subventionner une partie des consommateurs de ces services.

Au Québec, une variante de cette approche a été proposée par la commission Clair, qui recommandait qu'un fonds à gestion distincte soit créé en vue du financement anticipé des coûts liés aux soins à domicile et en établissement fournis aux personnes en perte d'autonomie. La commission a recommandé que ce fonds soit financé par un prélèvement fiscal obligatoire sur les revenus de toutes sources des particuliers et soit mis à la disposition des personnes (en l'occurrence, surtout des personnes âgées) frappées de perte d'autonomie de longue durée (plus de six mois). Ce régime faciliterait l'amélioration et l'intégration des services actuels consacrés à l'invalidité de longue durée et éviterait une hausse rapide des coûts liés aux soins de santé dans le contexte du vieillissement de la population.

Cette approche offre de nombreux avantages : sa structure de financement est très visible et les fonds générés sont entièrement consacrés aux fins prévues. Le degré d'équité de cette méthode de financement ainsi que son incidence sur l'efficacité et sur l'équité entre les générations dépendraient de la source de revenu servant à recueillir les fonds – impôt sur le revenu des particuliers, cotisations à un régime public ou assurance-santé privée.

Vu l'urgence de générer des recettes additionnelles pour financer les soins de santé, le Comité ne cautionne pas le financement anticipé. À notre avis, il serait très difficile de justifier la mise de côté de fonds en vue de besoins futurs alors qu'on a besoin d'injecter dès maintenant des sommes substantielles dans le système public de soins de santé pour en assurer la restructuration, le renouvellement et l'expansion.

## 15.10 Commentaires du Comité<sup>370</sup>

Nous avons présenté, aux sections 15.3 à 15.9 ci-dessus, plusieurs solutions possibles pour générer cinq milliards de dollars de plus par an en recettes fédérales, avec les avantages et les inconvénients de chacune en regard de critères précis, soit l'équité, l'efficacité, l'équité entre les générations, la stabilité et la visibilité. À la lumière de cette information, le Comité a tiré ses conclusions quant aux approches qu'il privilégie.

Nous soulignons, tout d'abord, qu'il n'existe pas en soi de « bonne » taxe. Il existe, par contre, des objectifs précis auxquels doit répondre toute nouvelle taxe ou mesure génératrice de recettes conçue pour financer un service public précis :

- la taxe doit être répartie équitablement et raisonnablement entre les groupes auxquels on fait appel pour la payer;
- la taxe doit avoir le moins d'effets négatifs possibles sur l'activité et la croissance économique relativement aux recettes générées;
- la taxe ne doit entraîner que de modestes coûts administratifs pour les contribuables et peu de frais de recouvrement pour le gouvernement;
- la justification de la taxe doit être évidente pour la population et de préférence établie par un rapport direct entre les recettes générées et les services qu'elles permettent de financer;
- la taxe doit générer des recettes stables et robustes (en se sens qu'elles croîtront au rythme du PIB ou à peu près), de manière que son produit permette de faire face aux augmentations futures des coûts;
- pour en justifier la perception, la taxe doit être perçue comme donnant lieu à des améliorations tangibles du régime et de la couverture de l'assurance-santé.

Tout bien considéré, le principe de l'équité est mieux servi quand les soins de santé sont financés par ponction fiscale sur le revenu des particuliers ou par la voie de taxes à la consommation plutôt que par des charges sociales ou des primes forfaitaires. En outre, du point de vue de l'efficacité, l'expérience internationale indique que les charges sociales peuvent nuire au marché du travail encore plus que l'imposition générale, puisque les contributions ne sont perçues que sur les salaires et que les employeurs sont responsables d'une partie de celles-ci. Finalement, les recherches montrent que, quelle que soit la méthode de génération des recettes retenue, le niveau d'activité économique influence grandement la capacité d'un pays à amasser les fonds nécessaires au financement des soins de santé (ou à d'autres fins) et ce, n'importe quand dans le temps. De plus, les dépenses de santé ont un coût d'option, et d'autres secteurs peuvent devenir prioritaires en période de récession ou de conflit armé.

Toutefois, les charges sociales et les primes ont un avantage important sur l'impôt sur le revenu et les autres formes d'imposition générale en ce qu'elles constituent une source de financement plus visible, transparente et prévisible. Les impôts spécifiques, pour leur

---

<sup>370</sup> Le Comité tient à exprimer ses remerciements à Robert D. Brown, ancien président de Price Waterhouse, et à son adjointe de recherche, Michanne Haynes, pour bon nombre des calculs et des estimations de recettes contenus dans le présent chapitre. Il est par ailleurs reconnaissant au ministère des Finances pour les données statistiques qu'il lui a fournies.



part, contribuent certainement à une meilleure visibilité, voire à une stabilité accrue, dans un système de soins de santé financé à partir du régime fiscal.

Le Comité est d'avis que les recettes fédérales accrues destinées au financement des services hospitaliers et des services fournis par les médecins ne doivent pas provenir de manière disproportionnée des personnes malades. Les services de santé sont actuellement perçus comme étant « gratuits ». La méthode de perception ne doit pas être perçue comme une « taxe sur les malades ». Pour cette raison, le Comité a rejeté toutes les formes de financement qui font appel à une participation financière proportionnelle à la consommation de services hospitaliers et des médecins.

***Le Comité est d'avis que les recettes fédérales accrues destinées au financement des services hospitaliers et des services fournis par les médecins ne doivent pas provenir de manière disproportionnée des personnes malades. La méthode de perception ne doit pas être perçue comme une « taxe sur les malades ».***

En outre, le Comité croit que l'accroissement des recettes fédérales doit reposer sur la capacité de payer des contribuables, c'est-à-dire que, pour garantir l'équité, les hauts salariés doivent payer proportionnellement plus que les petits salariés. Pour cette raison, le Comité rejette l'option d'une prime nationale d'assurance-santé uniforme mais, comme nous l'indiquons plus loin, nous ne sommes pas contre la possibilité d'une structure progressive de prime d'assurance-santé.

En ce qui a trait à l'imposition directe, les calculs effectués au nom du Comité par Brown et Haynes indiquent qu'il faudrait relever de 1,1 point de pourcentage le taux d'imposition de chaque fourchette de revenu imposable des particuliers pour générer cinq milliards de dollars de recettes fédérales additionnelles. On obtiendrait le même résultat au moyen d'une surtaxe de 5,7 % sur la totalité de l'impôt fédéral. Il a été signalé au Comité que ces deux solutions auraient comme conséquence d'amputer du tiers environ les réductions de l'impôt sur le revenu des particuliers annoncées en 2000 dans le plan fiscal quinquennal et de hausser considérablement les taux marginaux d'imposition.

Les calculs effectués par Brown et Haynes indiquent par ailleurs qu'il faudrait augmenter de 7 % le taux d'imposition des revenus des sociétés pour générer cinq milliards de dollars de plus en recettes fédérales. Cette mesure annulerait toutes les réductions actuelles et annoncées de l'impôt des sociétés et porterait le fardeau fiscal des sociétés établies au Canada à un niveau bien supérieur à celui qu'on observe chez nos concurrents étrangers. L'entreprise, l'emploi et, en fait, toute l'économie canadienne, en souffriraient grandement.

Le Comité est convaincu que, si l'on modifie la structure du régime fiscal canadien pour générer un surcroît de recettes, il faut se garder de porter les taux d'imposition des revenus des particuliers et de ceux des sociétés à un niveau indûment supérieur à ceux qui se pratiquent dans les autres pays de l'OCDE, et en particulier aux États-Unis. De plus, dans un souci d'équité entre les générations, nous croyons que la population active ne doit pas assumer un fardeau fiscal disproportionné par comparaison avec celui des retraités. Pour ces raisons, et compte tenu des estimations mentionnées plus haut, le Comité rejette l'idée d'une augmentation de l'impôt sur le revenu des particuliers et de l'impôt des sociétés.

Si l'alourdissement des charges sociales ne nuit pas indûment à la compétitivité internationale des entreprises canadiennes, cette solution pêche contre l'équité entre les générations. Il serait en effet injuste d'exiger qu'un segment de la population – les travailleurs – assume les coûts d'un investissement accru dans le système public de soins de santé, d'autant plus que, en l'occurrence, le vieillissement démographique amenuise la part relative des travailleurs dans la population.

***Le Comité est d'avis qu'il serait injuste d'exiger qu'un segment de la population – les travailleurs – assume les coûts d'un investissement accru dans le système public de soins de santé, d'autant plus que, en l'occurrence, le vieillissement démographique amenuise la part relative des travailleurs dans la population.***

Par conséquent, le Comité conclut qu'il n'existe que deux solutions possibles pour aller chercher cinq milliards de dollars par an de plus auprès des Canadiens en respectant les conditions et objectifs précités. La première consiste à créer une *taxe de vente nationale au titre des soins de santé*. Selon les témoignages présentés au Comité, bien que cette option puisse être considérée comme quelque peu régressive, les avantages qui en découlent du point de vue de l'efficacité compensent largement son incidence sur l'équité. En outre, une augmentation des crédits d'impôt en atténuerait grandement l'impact sur les personnes à faible revenu. Cette taxe serait perçue au moyen du même mécanisme que la taxe sur les produits et services (TPS), donc simplement. Les calculs effectués pour le compte du Comité indiquent que le taux à fixer pour générer cinq milliards de dollars par année se situerait autour de 1,5 % (plus précisément à 1,3 %). Ainsi, si l'on adoptait la solution d'une taxe de vente nationale au titre des soins de santé, les Canadiens paieraient une taxe de vente nationale de 8,5 %, formée d'une TPS de 7 % et d'une taxe de vente au titre des soins de santé de 1,5 %. Le crédit pour TPS serait accru proportionnellement à la hausse de la taxe de vente.

La deuxième solution réside dans la perception d'une *prime nationale variable d'assurance-santé*. Dans ce cas, les Canadiens paieraient, par le truchement du régime fiscal, une prime nationale d'assurance-santé dont le montant varierait selon le revenu imposable de chacun, comme on peut le voir au tableau 15.3. En fait, le montant de la prime doublerait à chacune des tranches de revenu utilisées pour les fins du calcul de l'impôt fédéral sur le revenu des particuliers.

**TABLEAU 15.3**  
**RECETTES FÉDÉRALES ANNUELLES ENGENDRÉES PAR UNE PRIME NATIONALE**  
**VARIABLE D'ASSURANCE-SANTÉ**

<b>Fourchette de revenus (taux fédéral d'imposition du revenu des particuliers)</b>	<b>Millions de déclarants qui paient une prime</b>	<b>Montant de la prime</b>	<b>Recettes fédérales annuelles estimatives (en milliards de dollars)</b>
<b>Jusqu'à 31 677 \$ (16 %)</b>	7,9	<b>0,50 \$/jour (ou 185 \$/année)</b>	1,341
<b>De 31 678 à 63 354 \$ (22 %)</b>	5,8	<b>1 \$/jour (ou 370 \$/année)</b>	2,096
<b>De 63 355 à 103 000 \$ (26 %)</b>	1,4	<b>2 \$/jour (ou 740 \$/année)</b>	0,968
<b>Plus de 103 000 \$ (29 %)</b>	0,5	<b>4 \$/jour (ou 1 400 \$/année)</b>	0,622
<b>RECETTES FÉDÉRALES TOTALES (ESTIMATION)</b>			<b>5,027</b>

Notes

- Les déclarants de la première fourchette de revenu imposable (jusqu'à 31 677 \$) qui n'ont pas d'impôt fédéral net à payer (compte tenu des crédits d'impôt non remboursables) ne seront pas tenus de payer la prime.
- Les déclarants de la première fourchette de revenu imposable qui ont un impôt fédéral net à payer devront régler le moindre des deux montants suivants : 185 \$ ou 10 % du revenu imposable au-delà du montant de leur revenu imposable leur donnant droit à des crédits d'impôt non remboursables. Cette disposition évite qu'un contribuable de cette tranche d'imposition assujéti à un impôt fédéral net modeste ne paie une prime d'un montant disproportionné par rapport à son impôt sur le revenu. Prenons l'exemple d'un contribuable dont le revenu imposable s'élève à 9 934 \$. Le taux d'imposition associé à la première tranche d'imposition est de 16 %, ce qui donne 1 590 \$. Cependant, le contribuable peut réclamer des crédits d'impôt non remboursables de 16 % à l'égard de 9 000 \$, soit 1 440 \$. Le contribuable a donc un impôt fédéral net à payer de 150 \$ (1 590 \$ moins 1 440 \$). Pour les contribuables de cette tranche d'imposition, la prime correspond à 10 % de la différence entre le revenu imposable (9 934 \$) et le montant à l'égard duquel le contribuable réclame des crédits d'impôt non remboursables (9 000 \$). Le contribuable de notre exemple a un impôt fédéral net à payer de 150 \$ sur un revenu imposable qui dépasse de 934 \$ le montant servant de base au calcul des crédits d'impôt non remboursables; il paierait donc une prime de 93,40 \$ (c'est-à-dire 10 % de 934 \$) au lieu de la prime normale de 185 \$ associée à cette tranche d'imposition.
- En tout, 15,4 millions de Canadiens déclarent un revenu inférieur à 31 677 \$; parmi eux, seulement 7,9 millions ont un impôt fédéral net à payer. La prime moyenne de tous les contribuables de cette fourchette serait de 71 \$; pour les 7,9 millions qui ont un impôt fédéral net à payer, la prime moyenne serait de 170 \$.
- Les déclarants visés par les fourchettes d'imposition de 22 %, 26 % et 29 % bénéficient d'une disposition limitative en vertu de laquelle la prime qu'ils auront à verser ne sera pas supérieure à la prime prévue pour la fourchette qui précède la leur, plus 10 % du revenu qui dépasse le seuil de leur tranche d'imposition. Cette disposition est conçue pour éviter qu'un contribuable dont le revenu imposable dépasse de très peu le seuil d'une tranche d'imposition n'ait à payer la totalité de la prime normalement prévue pour cette tranche de revenu imposable. Par exemple, un contribuable dont le revenu imposable s'établit à 33 177 \$ (1 500 \$ au-delà du seuil de 31 677 \$ de la tranche de revenu frappée d'un impôt de 22 %) paierait 185 \$ (la prime de la fourchette qui précède la sienne), plus 150 \$ (1 500 x 10 %), soit 335 \$ au total au lieu de la prime de 370 \$ qui serait normalement payable à l'égard de cette tranche de revenu.
- Les calculs sont fondés sur les données de l'exercice 2001-2002.

Source : Robert D. Brown et Michanne Haynes, sur la base de données provenant du ministère des Finances.

Cependant, pour éviter que les personnes dont le revenu imposable dépasse à peine le seuil de leur tranche d'imposition ne voient leur prime doubler d'un coup, une disposition spéciale de limitation a été intégrée au calcul : ainsi, la prime d'un contribuable ne peut pas dépasser le montant de la prime associée à la tranche d'imposition immédiatement inférieure, plus 10 % du revenu imposable qui dépasse le seuil de la tranche d'imposition du contribuable. La prime nationale variable d'assurance-santé est donc progressive sur l'ensemble de l'éventail des revenus, mais presque fixe à l'intérieur de chaque fourchette de revenu imposable<sup>371</sup>.

La prime nationale variable d'assurance-santé serait calculée à partir du régime de l'impôt sur le revenu, mais *il ne faut pas* y voir une augmentation de l'impôt sur le revenu des particuliers. Certes, la prime présente certains aspects d'un impôt sur le revenu (du fait qu'elle varie avec le revenu), mais en fait elle varie selon la tranche d'imposition et non avec le revenu. En outre, la prime aurait un impact très modeste seulement sur les taux d'imposition marginaux, qui n'augmenteraient qu'aux points d'application progressive de la cotisation supérieure de la tranche d'imposition suivante. En conséquence, les taux marginaux d'imposition demeureraient relativement inchangés et auraient donc peu d'impact sur l'incitation à gagner, à économiser et à investir, par comparaison avec une augmentation de l'impôt sur le revenu des particuliers.

C'est bien sûr au gouvernement fédéral qu'il appartiendra de décider laquelle des deux solutions – soit une taxe de vente nationale au titre des soins de santé, soit une prime nationale variable d'assurance-santé – est la meilleure. Les deux solutions envisagées pour permettre au gouvernement fédéral de générer les cinq milliards de dollars de plus par an nécessaires au secteur de la santé ont leurs avantages et leurs inconvénients.

***Les deux solutions envisagées pour permettre au gouvernement fédéral de générer les cinq milliards de dollars de plus par an nécessaires au secteur de la santé ont leurs avantages et leurs inconvénients.***

D'une part, la taxe de vente nationale au titre des soins de santé serait facile à administrer, car son application bénéficierait du système en place de la TPS. De plus, cette solution comporte un facteur de croissance, car les revenus des taxes de vente augmentent avec l'économie. Comme il est prévu que les dépenses en santé augmenteront plus rapidement que le PIB, il est important de disposer d'un tel facteur de croissance. De plus, la taxe de vente nationale au titre des soins de santé ne serait pas substantiellement régressive, d'autant plus que le crédit pour TPS s'appliquerait à la nouvelle taxe. Il reste cependant que l'opposition du public aux taxes de vente en général et à la TPS en particulier constitue un important obstacle à l'augmentation de ce type de taxe.

---

<sup>371</sup> Comme il est indiqué à la section 15.4, le Comité écarte la solution d'une cotisation annuelle uniforme en raison de son caractère régressif évident. Par exemple, les calculs indiquent qu'il faudrait imposer une cotisation annuelle fixe de 425 \$ à chaque Canadien déclarant un revenu supérieur à 20 000 \$ pour générer cinq milliards de recettes additionnelles. À noter que plus de 136 000 Canadiens déclarent des revenus de plus de 20 000 \$ et ne paient pas d'impôt sur le revenu en raison de crédits comme le crédit d'impôt pour enfants, le crédit pour dons de bienfaisance, etc. Pour ce groupe, l'imposition d'une cotisation uniforme constituerait vraisemblablement un fardeau additionnel lourd à porter. Si la cotisation uniforme était modifiée de manière à la faire plafonner à 5 % du revenu imposable dépassant 20 000 \$, la cotisation annuelle à payer passerait à 500 \$ et certains déclarants n'ayant pas d'impôt à payer seraient quand même tenus d'en verser une partie.

En revanche, la prime variable nationale d'assurance-santé a l'avantage d'être progressive puisqu'elle augmente par paliers en fonction du revenu. Une telle prime nationale correspondrait en plus à la manière dont les particuliers achètent normalement de l'assurance, c'est-à-dire en versant une prime annuelle. Cependant, plus on trouve de paliers dans la structure de la prime, plus elle risque d'être assimilée à une surtaxe sur le revenu; or, pour les raisons déjà énoncées, le Comité réprovoque toute augmentation de l'impôt sur le revenu. Enfin, moins la structure de la prime comporte de paliers (moins elle ressemble à un impôt sur le revenu), plus elle devient régressive.

***L'important, c'est que les Canadiens consentent à fournir au gouvernement fédéral cinq milliards de dollars additionnels pour les soins de santé.***

L'important, pour le Comité, c'est que les Canadiens consentent à fournir au gouvernement fédéral cinq milliards de dollars additionnels pour les soins de santé. C'est l'enjeu sur lequel les Canadiens devront se pencher sérieusement afin d'en débattre et de prendre une décision.

***Des deux solutions, le Comité recommande celle de la prime nationale variable au titre des soins de santé.***

En bout de ligne, la décision de consentir un effort supplémentaire de cinq milliards de dollars est plus importante que la manière dont on s'y prendra. Néanmoins, des deux solutions, le Comité préfère celle de la prime nationale variable au titre des soins de santé. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral institue une prime nationale variable au titre de la santé pour générer les recettes nécessaires au financement de la mise en œuvre des recommandations du Comité.**

### **15.11 Financement fédéral actuel des soins de santé**

Le Comité admet que la somme de cinq milliards ne correspond pas à l'augmentation totale des dépenses fédérales en soins de santé qui sera nécessaire au cours des années à venir. Le coût du système de services hospitaliers et des services fournis par les médecins auquel le gouvernement fédéral contribue déjà ne cessera de s'accroître. Les sommes additionnelles requises pour couvrir ces dépenses accrues devront provenir des économies d'efficacité résultant de la mise en œuvre des recommandations énoncées dans le présent rapport en matière de restructuration ainsi que de la croissance générale des recettes fédérales tirées de l'assiette fiscale actuelle.

Cela soulève la question suivante : afin d'améliorer substantiellement la transparence et la reddition des comptes en matière de dépenses de santé fédérales, les 62 % des transferts pécuniaires au titre du Transfert canadien en matière de santé et de programmes

***Pour améliorer substantiellement la transparence et la reddition des comptes en matière de dépenses de santé fédérales, les 62 % des transferts pécuniaires du gouvernement fédéral au titre du TCSPS actuellement destinés aux soins de santé devraient être financés par la voie d'une source de recettes fiscales réservées.***

sociaux (TCSPS) actuellement destinés aux soins de santé (selon l'évaluation de Finances Canada), devraient-ils être financés par la voie d'une source de recettes fiscales réservées (comme nous l'expliquons à la section 15.4)? En effet, cela aiderait beaucoup le public à bien comprendre comment les deniers fédéraux sont dépensés en ce qui a trait aux soins de santé. Les Canadiens verraient ainsi un lien plus direct entre ce qu'ils versent au fisc et les services de santé qu'ils reçoivent. Cela contribuerait largement à réfuter la perception largement répandue selon laquelle les soins de santé sont « gratuits ».

Une manière d'y arriver consisterait à affecter quelques-uns des 7 points de pourcentage de la TPS aux soins de santé. Les calculs effectués pour le Comité indiquent qu'il serait nécessaire de réserver 3,1 des 7 points de pourcentage de la TPS (soit près de 45 % des recettes issues de cette taxe) pour obtenir un montant équivalant aux 62 % des transferts pécuniaires fédéraux au titre du TCSPS actuellement consacrés à la santé.

Cependant, vu la nécessité de relever le niveau actuel du TCSPS (à tout le moins jusqu'à ce que le plein effet des recommandations du Comité en matière de restructuration se fasse sentir), il vaudrait sans doute mieux, si l'on décide de recourir à une source de recettes réservées et si l'on choisit la TPS, réserver à la santé 3,5 (au lieu des 3,1 points actuels calculés) des 7 points de la TPS (soit la moitié du produit de la TPS), ce qui permettrait d'allonger de 1,5 milliard de dollars le financement de base de la santé par le gouvernement fédéral. Si l'on réservait la moitié des recettes tirées de la TPS au paiement de l'apport pécuniaire du gouvernement fédéral au financement du système de soins de santé, en plus des fonds supplémentaires qu'exigera la mise en œuvre des réformes recommandées dans le présent rapport, on bénéficierait par ailleurs de l'avantage d'une transparence considérablement accrue.

Un des avantages important du recours à la TPS comme source de recettes réservées est qu'elle comporte un facteur de progression intégré : si l'économie se porte bien, il en va de même des revenus générés par la TPS. Donc, l'affectation de 3,5 des 7 points de pourcentage de la TPS (au lieu des 3,1 points actuels calculés) au financement de la contribution fédérale pécuniaire aux services hospitaliers et aux services fournis par les médecins permettrait à la fois de disposer d'une source stable et prévisible de fonds publics, comme le recommande le Comité dans le Principe deux énoncé dans le volume cinq<sup>372</sup>, et de faire augmenter cette contribution.

***L'affectation de 3,5 des 7 points de pourcentage de la TPS (au lieu des 3,1 points actuels calculés) au financement de la contribution fédérale pécuniaire aux services hospitaliers et aux services fournis par les médecins permettrait à la fois de disposer d'une source stable et prévisible de fonds publics, comme le recommande le Comité dans le Principe deux énoncé dans le volume cinq, et de faire augmenter cette contribution.***

Par conséquent, le Comité recommande :

**Que le gouvernement fédéral procède au choix d'une source de recettes réservées qu'il affectera au financement de sa contribution annuelle au programme national canadien**

<sup>372</sup> Volume cinq, p. 28-31.

**d'assurance-santé, laquelle est actuellement évaluée à environ 62 % du TCSPS.**

Si le gouvernement fédéral choisit la TPS comme source de recettes réservées pour sa contribution annuelle pécuniaire au régime national d'assurance des soins hospitaliers et des soins dispensés par les médecins, il faudrait 3,1 des 7 points actuels pour générer des recettes équivalant au niveau de financement actuel. En conséquence, le Comité recommande :

**Que, si l'on retient la TPS comme source de recettes réservées au financement de la contribution pécuniaire actuelle du gouvernement fédéral au régime national d'assurance des soins hospitaliers et des soins dispensés par les médecins, la moitié du produit de la TPS (3,5 des 7 points de la taxe) soit réservé au secteur de la santé, de manière à permettre au gouvernement fédéral de faire une contribution additionnelle au financement du système actuel de soins hospitaliers et de soins dispensés par les médecins. (Cela viendrait s'ajouter aux crédits fédéraux nécessaires à la mise en œuvre des recommandations énoncées dans le présent rapport.)**

Si les deux recommandations ci-dessus sont acceptées, le gouvernement fédéral injectera indirectement *au moins* 3,0 milliards de dollars de plus par année dans le régime public d'assurance-santé *courant*, soit 1,5 milliard de dollars obtenus en portant à 3,5 les points de la TPS dont le produit est réservé à la santé et 1,5 milliard de dollars d'économies pour les provinces résultant de la mise en œuvre des recommandations du présent rapport (voir la section 15.1) qui seront réinvestis ailleurs dans le système actuel de soins de santé.

Si le gouvernement fédéral décidait aussi d'investir la provision pour éventualités de un milliard de dollars (dont nous parlons à la section 15.1) dans le système de soins hospitaliers et de soins dispensés par des médecins à titre de paiement de transition en attendant que l'on commence à cueillir les fruits, en gains d'efficience, des mesures proposées dans le présent rapport, l'apport additionnel total du gouvernement fédéral au système actuel s'élèverait à *au moins* quatre milliards de dollars.

Enfin, les transferts au titre du TCSPS versés aux provinces et aux territoires sont établis au prorata de la population. Si la part du TCSPS visant les soins de santé est financée à même une source de recettes réservées, comme nous le recommandons plus haut, le Comité est d'avis qu'il faudrait modifier légèrement le mode de calcul de la part de chaque province. Plus précisément, nous croyons important de reconnaître que les

***Le Comité estime important de reconnaître que les personnes âgées coûtent bien plus cher au système de soins de santé que les jeunes, et que certaines provinces affichent une bien plus forte proportion de personnes de plus de 70 ans que les autres.***

personnes âgées coûtent bien plus cher au système de soins de santé que les jeunes, et que certaines provinces affichent une bien plus forte proportion de personnes de plus de 70 ans que les autres. Par conséquent, le Comité recommande :

**Que la part de chaque province et territoire de la contribution annuelle du gouvernement fédéral au financement du régime courant de soins hospitaliers et de soins dispensés par les médecins soit calculée au prorata de la population, mais corrigée pour tenir compte, d'une manière ou d'une autre, du poids démographique de la population âgée de 70 ans et plus.**

Plusieurs formules de pondération sont possibles et doivent être envisagées pour rendre plus équitable la distribution entre les provinces et les territoires de la contribution actuelle du gouvernement fédéral au titre des soins de santé. Une solution simple consisterait à tripler le poids des personnes de 70 ans et plus. Cette solution aiderait grandement les provinces peu peuplées sans vraiment nuire aux provinces riches.



## CHAPITRE SEIZE

### VIABILITÉ FINANCIÈRE DU SYSTÈME DE SOINS DE SANTÉ : LES CONSÉQUENCES DE L'INACTION

---

Au chapitre précédent, le Comité a exposé son point de vue sur la façon dont il conviendra de réunir et d'administrer des fonds supplémentaires au niveau fédéral afin de mettre en œuvre ses recommandations. Le Comité croit fermement que la mise en œuvre de ces recommandations est essentielle pour entreprendre une réforme et un renouvellement efficaces, transparents et responsables du système de soins de santé. Il est convaincu que le gouvernement fédéral doit absolument investir cinq milliards de dollars de plus par an dans le secteur de la santé pour financer les changements qui permettront d'assurer la qualité et la viabilité du système.

Le Comité se rend compte cependant que, dans une société libre et démocratique, les Canadiens pourraient ne pas vouloir payer plus d'impôts au gouvernement fédéral (dans le cadre de la prime nationale d'assurance-santé que nous recommandons dans le présent rapport) pour le financement de l'assurance-santé. Pour sa part, le gouvernement fédéral pourrait refuser d'imposer une augmentation de taxe à une population réticente à accepter cette surcharge, même si les sommes recueillies étaient consacrées au secteur de la santé. Il convient donc de déterminer quelles seraient les conséquences d'une telle décision. Le Comité croit que ces conséquences comprendraient ce qui suit :

***Le Comité se rend compte cependant que, dans une société libre et démocratique, les Canadiens pourraient ne pas vouloir payer plus d'impôts au gouvernement fédéral (dans le cadre de la prime nationale d'assurance-santé que nous recommandons dans le présent rapport) pour le financement de l'assurance-santé. Pour sa part, le gouvernement fédéral pourrait refuser d'imposer une augmentation de taxe à une population réticente à accepter cette surcharge, même si les sommes recueillies étaient consacrées au secteur de la santé.***

- Il deviendrait impossible d'étendre l'assurance-santé publique aux frais exorbitants de médicaments de prescription, à certains soins à domicile après l'hospitalisation et aux soins palliatifs hors-hôpital.
- La réforme et le renouvellement du système de soins hospitaliers et de soins dispensés par un médecin n'auraient pas lieu et des pressions financières considérables continueraient à affaiblir le système.
- Il serait également impossible de procéder aux investissements nécessaires dans l'infrastructure, notamment au niveau de la gestion de l'information sur la santé et des technologies de la santé, et d'augmenter le nombre d'inscriptions dans les écoles de médecine et de sciences infirmières.
- Il deviendrait en outre impossible de mettre en place une garantie de soins de santé par suite du manque d'équipement médical et de fournisseurs de soins

nécessaires pour réduire les files d'attente. Les gouvernements provinciaux refuseraient à juste titre de légiférer pour établir une telle garantie si cela devait les forcer à assumer le prix du traitement aux États-Unis ou ailleurs d'un nombre toujours croissant de patients.

- Il faudrait renoncer à une infrastructure canadienne de la santé ainsi qu'à un plein déploiement de systèmes de dossiers de santé électroniques et d'un régime de financement des hôpitaux fondé sur les services dispensés, ce qui limiterait la possibilité pour le Canada d'évaluer le coût, l'efficacité, la qualité, le rendement et les résultats du système de soins de santé ou d'élaborer des stratégies propres à en améliorer la productivité.

***Le Comité a déclaré à maintes reprises – et nous le répétons ici – qu'il préfère une source publique unique de financement et d'assurance des services hospitaliers et des services dispensés par un médecin couverts par la Loi canadienne sur la santé.***

Bref, si les investissements additionnels que le Comité recommande ne sont pas consentis, le système canadien de soins de santé continuera à se détériorer. Le « contrat d'assurance-santé<sup>373</sup> » entre les Canadiens et leurs gouvernements sera rompu si les Canadiens refusent de payer cinq milliards de dollars de plus en impôts (obligation contractuelle des citoyens) pour permettre au gouvernement de financer adéquatement les changements nécessaires afin d'assurer la pérennité de notre système public, universel, complet, accessible et transférable d'assurance des soins hospitaliers et des soins dispensés par un médecin, élargi pour couvrir aussi en partie, comme nous le recommandons, les coûts des médicaments de prescription, des soins à domicile et des soins palliatifs dispensés en dehors des hôpitaux.

Dans ces circonstances, il est très probable, pour les raisons indiquées au chapitre cinq, que les tribunaux décideraient, en application de la *Charte canadienne des droits et libertés*, que le gouvernement ne peut plus nier aux Canadiens le droit d'acheter de l'assurance-santé privée pour obtenir au Canada, contre rémunération, des services de santé faisant partie du groupe des services assurés par le régime public. Un système parallèle de soins de santé privés ferait ainsi probablement son apparition.

Ce n'est *pas* là le résultat privilégié par le Comité. Nous avons déclaré à maintes reprises – et nous le répétons ici – que nous préférons une source publique unique de financement et d'assurance des services hospitaliers et des services dispensés par un médecin couverts par la *Loi canadienne sur la santé*. Le modèle axé sur un assureur public unique

***Le Comité est d'avis que l'assurance privée des services de santé assurés par le régime public doit continuer d'être interdite, pourvu que ces services puissent être dispensés en temps opportun.***

---

<sup>373</sup> Volume cinq, p. 61.

constituait en fait le premier des principes énoncés dans le volume cinq<sup>374</sup>. En corollaire, l'assurance privée des services de santé assurés par le régime public doit continuer d'être interdite, *pourvu* que ces services puissent être dispensés *en temps opportun*.

Le Comité croit néanmoins important de savoir ce qui se passerait si l'assurance-santé privée était autorisée à se développer, avec son système parallèle de services hospitaliers et de services dispensés par un médecin financés par des fonds privés. C'est ce que nous nous proposons de faire dans ce chapitre. La section 16.1 décrit brièvement le rôle de l'assurance-santé privée au Canada et dans certains autres pays de l'OCDE. À la section 16.2, nous présentons un résumé des conclusions d'études récentes concernant les incidences d'un système privé d'assurance-santé sur les coûts, l'accessibilité et la qualité du régime public de soins de santé. Enfin, le Comité présente, à la section 16.3, son point de vue sur l'apparition possible d'un système parallèle privé de soins de santé au Canada.

### **16.1 L'assurance-santé privée au Canada et dans certains pays de l'OCDE**

Conformément à la *Loi canadienne sur la santé*, les régimes publics d'assurance-santé doivent rendre compte de leurs activités à leur gouvernement provincial et fonctionner comme organismes à but non lucratif. De plus, la majorité des provinces (Alberta, Colombie-Britannique, Manitoba, Ontario, Île-du-Prince-Édouard et Québec) interdisent aux compagnies privées d'assurer des services déjà couverts par un régime public d'assurance-santé<sup>375</sup>. Dans ces provinces, les assureurs privés ne peuvent couvrir que des services de santé complémentaires, comme la chambre privée ou à deux lits durant un séjour à l'hôpital, les médicaments de prescription, les soins dentaires et les lunettes, c'est-à-dire des services non couverts par le régime provincial d'assurance-santé.

Quatre provinces (Nouveau-Brunswick, Terre-Neuve, Nouvelle-Écosse et Saskatchewan) permettent à des compagnies d'assurance privées de couvrir des services assurés par le régime public. Dans ces provinces, les patients des médecins déconventionnés<sup>376</sup> peuvent substituer une assurance privée à leur assurance-santé publique. Toutefois, comme les lois provinciales interdisent à ces médecins de pratiquer à la fois dans le secteur public et dans le secteur privé, en définitive, il y a peu de médecins déconventionnés et peu de gens achètent de l'assurance-santé privée.

En Nouvelle-Écosse, par exemple, les médecins déconventionnés ne sont pas autorisés à facturer à leurs clients plus que les taux prévus dans les barèmes du régime public. Cela constitue un facteur de désincitation, puisque les médecins ne peuvent pas gagner davantage, dans des cas équivalents, en travaillant pour un régime privé que pour un régime public. Ainsi, il n'y a finalement que très peu de médecins déconventionnés, ce qui fait que le besoin d'assurance-santé privée n'est pas grand.

---

<sup>374</sup> Volume cinq, p. 25-27.

<sup>375</sup> Colleen M. Flood et Tom Archibald, «The Illegality of Private Health Care in Canada», dans le *Journal de l'Association médicale canadienne*, vol. 164, n° 6, 20 mars 2001, p. 825-830.

<sup>376</sup> Un médecin est déconventionné lorsqu'il décide de renoncer à son droit de facturer le régime public d'assurance-santé et s'établit dans le secteur privé. Tous les régimes provinciaux d'assurance-santé permettent aux médecins de se déconventionner.

À Terre-Neuve, les patients des médecins déconventionnés ont droit à l'assurance-santé publique jusqu'à concurrence du montant fixé dans les barèmes du régime public (autrement dit, ils peuvent obtenir des fonds publics pour subventionner le coût des services de santé du secteur privé à but lucratif). Leurs déboursés sont ainsi limités à la différence entre les honoraires facturés par les médecins déconventionnés et les honoraires prévus dans les barèmes publics. Comme il y a peu de médecins déconventionnés à Terre-Neuve, la demande d'assurance-santé privée est faible.

Au Nouveau-Brunswick et en Saskatchewan, les patients des médecins déconventionnés ne reçoivent pas de subventions publiques comme à Terre-Neuve. Le secteur de l'assurance-santé privée n'a cependant pas connu un développement sensible dans ces deux provinces.

Dans l'ensemble, la *Loi canadienne sur la santé* a permis, de concert avec la législation provinciale et territoriale correspondante, d'empêcher le développement au Canada d'un secteur d'assurance-santé privée pouvant directement concurrencer le régime public. Il n'est tout simplement pas rentable pour les patients, les médecins et les établissements de soins de faire partie d'un régime privé parallèle.

La situation est très différente dans d'autres pays de l'OCDE, où l'assurance-santé privée peut faire concurrence au régime public et où les médecins peuvent être rémunérés par les deux secteurs<sup>377</sup>. Il existe en fait deux modèles distincts d'assurance-santé privée dans ces pays. Le premier, qu'on retrouve principalement en Allemagne et aux Pays-Bas, comporte un système privé d'assurance et de prestation de services qui est complètement distinct du régime public. Le second, établi dans des pays tels que l'Australie, la Suède et le Royaume-Uni, fait jouer la concurrence entre les assureurs et les fournisseurs de soins des secteurs public et privé.

En Allemagne et aux Pays-Bas, l'accès à l'assurance privée est facultative pour les gens qui disposent d'un revenu relativement élevé (l'assurance-santé publique étant obligatoire pour les personnes à revenu moyen ou à faible revenu). Les assureurs privés ont l'obligation d'accepter tous ceux qui demandent à être couverts et d'offrir des prestations au moins égales à celles du régime public. Ainsi, ils ne peuvent pas « écrémer le marché », c'est-à-dire se réserver exclusivement les patients les plus riches et les mieux portants en laissant le régime public financer les patients les moins aisés et les plus malades. Les primes facturées pour l'assurance privée sont liées au risque (mais sont soumises à une réglementation stricte) et ne varient pas sensiblement pour une couverture équivalente.

Au Royaume-Uni, les résidents peuvent acheter de l'assurance-santé privée couvrant des soins dispensés par des hôpitaux privés même si les mêmes soins sont offerts par les hôpitaux publics. Les patients ayant une assurance privée obtiennent ordinairement des services en dehors du système national de soins de santé (NHS), mais ils peuvent aussi recevoir des traitements dans des établissements publics ayant des « lits payants ». Les médecins britanniques sont autorisés à tirer au plus 10 % de leur revenu annuel brut de clients privés.

En Australie, l'assurance-santé privée peut concurrencer le régime public, comme au Royaume-Uni. De plus, le gouvernement encourage les résidents à acheter de l'assurance

---

<sup>377</sup> Pour de plus amples renseignements sur les systèmes de santé d'autres pays, voir le volume trois de l'étude du Comité.

privée en en subventionnant le coût à 30 %. Les primes de l'assurance-santé privée sont soumises à des règles de tarification strictes qui ne permettent aucune distinction (ce qui revient à dire que le taux des primes est le même pour tout le monde, indépendamment de l'état de santé). Les patients qui ont une assurance privée peuvent obtenir des soins dans un hôpital public ou privé : dans les deux cas, le régime public finance 75 % des coûts d'hospitalisation, le reste étant couvert par l'assurance privée. Les spécialistes travaillant dans les hôpitaux publics peuvent donc avoir une clientèle privée et recevoir des paiements de source aussi bien publique que privée.

L'assurance-santé privée est autorisée même en Suède, pays généralement reconnu comme étant parmi les plus socialisés d'Europe. En Suède, comme en Australie, la loi impose aux assureurs privés de fixer des primes uniformes indépendantes de l'état de santé. Les hôpitaux privés ne reçoivent ordinairement pas de paiements du régime public, à moins de dispenser des services dans le cadre de contrats signés avec les conseils de comté<sup>378</sup>. Les médecins suédois sont autorisés à travailler pour les secteurs public et privé.

Les renseignements présentés dans le volume trois de l'étude du Comité et les conclusions d'une étude canadienne<sup>379</sup> montrent qu'en grande majorité, les soins dispensés par les établissements privés à but lucratif de pays tels que l'Australie, la Nouvelle-Zélande, les Pays-Bas, la Suède et le Royaume-Uni sont financés par de l'assurance-santé privée. De plus, dans ces pays, les médecins travaillent habituellement pour le secteur public et gagnent un revenu supplémentaire en dispensant à une clientèle privée des services facturés à l'acte. Il y a lieu de noter cependant que, dans tous ces pays, le secteur privé à but lucratif est assez petit.

Les restrictions imposées au Canada sur le rôle de l'assurance-santé privée et sur le déconventionnement des médecins n'ont pas d'équivalent dans les autres pays de l'OCDE. Toutefois, des pressions croissantes s'exerceront en faveur du relâchement de ces restrictions et de la création d'un système privé parallèle d'assurance-santé et de prestation de soins si le régime public ne peut pas offrir les services nécessaires en temps opportun. Glouberman et Vining avaient déjà fait cette observation en 1996 lorsqu'ils ont dit ceci :

*Il est évident que toute initiative importante (qu'elle soit implicite ou explicite) pour rationner encore plus les soins de santé dispensés par le régime public augmentera la demande de soins financés par des sources privées<sup>380</sup>.*

Jeffrey Lozon, président-directeur général de l'Hôpital St. Michael's de Toronto et ancien sous-ministre de la Santé de l'Ontario, a posé la question suivante au Comité :

*S'il n'est plus question d'une assurance privée [...], inévitablement, il reste la question des augmentations d'impôt, que ce soit un impôt spécialement affecté ou non. Je soulèverais la question suivante : pourquoi ne pas permettre aux gens qui le veulent de contracter une assurance-santé qui leur accorderait un niveau de soins autre [...]?*

---

<sup>378</sup> Le cas est en fait de plus en plus fréquent dans les pays scandinaves du fait de leur nouvelle garantie de soins de santé.

<sup>379</sup> Cam Donaldson et Gillian Currie, *The Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity*, Institute of Health Economics (Alberta), document de travail 00-9, 2000.

<sup>380</sup> Steven Glouberman et Aidan Vining, *Cure or Disease? Private Health Insurance in Canada*, Université de Toronto, 1996, p. 61.

*Pourquoi ne pas permettre aux personnes qui ont ce qu'il faut pour dire: «Je ne veux pas attendre pendant six mois pour un remplacement de la hanche» d'acheter le service en question<sup>381</sup>?*

## **16.2 Examen de la documentation récente sur les effets d'un système privé d'assurance-santé et de prestation de soins à but lucratif**

D'après les partisans d'un système privé parallèle, un tel système peut favoriser la viabilité du système public (en réduisant les pressions causées par la hausse des coûts publics), améliorer l'accès au système public (en réduisant les délais d'attente) et en augmenter la qualité (grâce à la concurrence). De plus, l'assurance-santé privée donnerait aux patients un plus grand choix et une meilleure qualité de services sans compromettre le système public.

Par contre, les adversaires d'un système privé parallèle soutiennent que ce système créerait «deux niveaux» de soins, compromettrait l'équité, ferait monter les coûts et réduirait la qualité et l'accessibilité du système public au fur et à mesure que les gens qui ont les moyens de payer une assurance privée quitteraient le système public pour s'adresser à des établissements privés. Ils estiment par ailleurs que la rémunération supérieure obtenue pour un travail équivalent dans le système privé attirera probablement beaucoup de membres du personnel du système public, ce qui allongera les délais d'attente du régime public tant que le pays ne disposera pas d'un nombre suffisant de médecins et d'infirmières. En outre, ils affirment que le secteur privé à but lucratif se livre à un «écrémage», c'est-à-dire qu'il choisit les cas simples (et donc moins coûteux à traiter) – les interventions chirurgicales non urgentes et les autres cas du genre – en laissant au régime public les cas urgents, complexes et coûteux, ce qui a pour effet de relever substantiellement les coûts unitaires du régime public.

La réalité se situe quelque part entre ces deux points de vue extrêmes. Que révèlent les données internationales? Voici les résultats d'un examen de la documentation récente relative aux systèmes privés d'assurance-santé et de prestation de soins<sup>382</sup> :

- Au Royaume-Uni (comme en Nouvelle-Zélande), l'assurance-santé privée a favorisé le développement d'un système privé de prestation de soins. Dans les deux pays, les médecins sont autorisés à travailler pour les secteurs public et

---

<sup>381</sup> Jeffrey Lozon (53:64).

<sup>382</sup> Voir les documents suivants :

Brian Lee Crowley, *Private Financing Private Delivery. Two Tier Health Care?*, communication présentée à la Conférence nationale sur le leadership dans les soins de santé, Halifax, 27 mai 2002.

Stefan Greß et coll., *Private Health Insurance in Social Health Insurance Countries – Market Outcomes and Policy Implications*, document de travail, février 2002.

Jeremiah Hurley et coll., *Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada*, Centre for Health Economics and Policy Research Analysis, Université McMaster, document de travail 01-12, décembre 2001.

Colleen M. Flood, Mark Stabile et Carolyn Hughes Tuohy, *Lessons From Away: What Canada Can Learn From Other Health Care Systems*, document produit pour le Comité, 30 avril 2001.

Colleen M. Flood et Tom Archibald (mars 2001), *op. cit.*

Raisa Deber et coll., « Why not Private Health Insurance? 1. Insurance Made Easy », *Journal de l'Association médicale canadienne*, vol. 161, n° 5, 7 septembre 1999, p. 539-542.

Carolyn H. Tuohy, Colleen M. Flood et Mark Stabile, *How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence From OECD Countries*, document présenté au *Journal of Health Politics, Policy and Law*, Université de Toronto.

privé. Ils travaillent habituellement pour le secteur public et gagnent un revenu supplémentaire en dispensant à une clientèle privée des services facturés à l'acte.

- Au Royaume-Uni (comme en Allemagne et aux Pays-Bas), les assureurs privés paient beaucoup plus cher que le régime public pour les mêmes services de santé. Ainsi, les médecins gagnent trois à quatre fois plus dans le secteur privé que dans le cadre du Système national de soins de santé (NHS) en dispensant le même service.
- Les hôpitaux privés sont bien établis au Royaume-Uni, au point où le NHS fait appel à eux lorsque les temps d'attente du secteur public deviennent trop longs (tout comme certains gouvernements provinciaux du Canada font appel à des services de santé privés des États-Unis pour réduire les files d'attente).
- En Australie, les patients ayant une assurance privée peuvent choisir leur médecin lorsqu'ils sont hospitalisés. D'après les données recueillies, ces patients accèdent plus rapidement aux traitements que les patients du régime public, qui doivent attendre leur tour. C'est la même chose en Suède et au Royaume-Uni dans le cas des patients aisés qui ont une assurance privée.
- En Australie, les délais d'attente du régime public n'ont pas changé après l'adoption de la politique subventionnant l'achat de polices privées d'assurance-santé. De même, les données recueillies en Nouvelle-Zélande et au Royaume-Uni permettent de croire que, même si les longues périodes d'attente font monter la demande d'assurance-santé privée, l'existence d'une telle assurance ne réduit pas les délais d'attente du régime public.
- D'après les données recueillies en Australie et au Royaume-Uni, les systèmes privés parallèles de prestation de soins tendent à offrir une gamme de services limitée dans des créneaux particuliers axés le plus souvent sur des interventions relativement simples, peu complexes et sans urgence, ce qui laisse au régime public les cas les plus coûteux et ceux qui nécessitent des soins polyvalents.
- Aux Pays-Bas, le gouvernement fixe le plafond des honoraires que les médecins peuvent facturer aux patients ayant une assurance privée, ce qui réduit la tentation d'accorder un traitement privilégié à ces derniers par rapport aux patients du régime public.
- Également aux Pays-Bas, deux facteurs empêchent la transition vers un système « à deux niveaux ». D'abord, ceux qui décident de souscrire une assurance-santé privée ne peuvent pas s'en remettre au régime public pour certains de leurs besoins de santé. Les assureurs privés doivent assumer tous les besoins. Ils ne peuvent pas limiter leurs services à certains soins, par exemple les interventions chirurgicales non urgentes (comme c'est le cas au Royaume-Uni). Ensuite, le fait d'avoir une assurance privée ne permet pas aux Néerlandais d'accéder plus rapidement aux traitements : il est jugé contraire au code d'éthique médical d'accorder la préférence à des patients

ayant une assurance privée. Les clients privés et publics sont traités en même temps dans les mêmes hôpitaux.

- En Allemagne, une assurance-santé privée assure en général des soins plus complets et plus rapides que l'assurance-santé publique.
- En Allemagne et aux Pays-Bas, le gouvernement contrôle de très près l'assurance-santé privée pour que les primes soient abordables et pour empêcher les assureurs de limiter à leur gré les risques à couvrir.
- En Australie, en Suède et au Royaume-Uni, les gens qui souscrivent une assurance-santé privée ne peuvent pas déduire les primes de leur revenu dans le calcul de leurs impôts et sont soumis aux mêmes taux d'imposition que les autres. Ainsi, ils doivent payer double, en finançant l'assurance-santé publique à titre de contribuables et en versant des primes privées. Ce n'est pas le cas en Allemagne et aux Pays-Bas, où les personnes ayant une assurance privée ne sont pas tenues de cotiser aux fonds publics d'assurance-santé.
- Les données recueillies dans 22 pays de l'OCDE montrent que l'augmentation des dépenses privées consacrées aux soins de santé se traduit avec le temps par des baisses du financement des services publics de santé. Cela tend à confirmer, dans une certaine mesure, la crainte que le financement privé ne se substitue au financement public et le réduise au lieu de s'y ajouter.

Compte tenu des données recueillies dans d'autres pays présentées ci-dessus, le Comité est d'avis qu'aucun pays doté de systèmes parallèles public et privé d'assurance-santé et de prestation de soins ne peut offrir au Canada un modèle à adopter tel quel.

***Compte tenu des données recueillies dans d'autres pays, le Comité est d'avis qu'aucun pays doté de systèmes parallèles public et privé d'assurance-santé et de prestation de soins ne peut offrir au Canada un modèle à adopter tel quel.***

Les pays dans lesquels un système privé parallèle fait concurrence à un régime public d'assurance-santé connaissent un certain nombre de problèmes : choix des risques à assumer et « écrémage », listes d'attente aussi longues dans le secteur public, traitement préférentiel des personnes ayant une assurance privée. Ces préoccupations devront être prises en compte si les gouvernements ne réussissent pas, pour une raison ou une autre, à fournir un financement suffisant pour assurer des soins en temps opportun dans le contexte de notre système de soins de santé public.

### **16.3 Commentaires du Comité**

Si les gouvernements n'assurent pas un financement suffisant qui permette la prestation de services de santé efficaces et opportuns, le Comité est d'avis que, pour paraphraser l'article 1<sup>er</sup> de la *Charte canadienne des droits et libertés*, il ne serait ni juste ni raisonnable, dans une société libre et démocratique, de nier aux Canadiens le droit de souscrire de l'assurance-santé privée. Les citoyens doivent pouvoir acheter une assurance complémentaire privée couvrant les services que le financement public ne permet pas de leur fournir dans des délais raisonnables.



Tout en considérant qu'une telle évolution serait très regrettable et en reconnaissant que beaucoup de Canadiens s'y opposeraient fermement, le Comité estime important de noter deux faits :

- d'abord, comme l'indique la section 16.2, le Canada est le *seul* grand pays industrialisé qui n'ait pas au moins quelques éléments d'un système privé parallèle de services hospitaliers et de services fournis par les médecins;
- ensuite, le système canadien *actuel* n'est pas aussi uniforme et équitable que certains l'affirment.

En réalité, les gens qui en ont les moyens vont déjà à l'étranger (habituellement aux États-Unis) pour obtenir les soins qu'ils jugent nécessaires s'ils trouvent les files d'attente trop longues au Canada.

De plus, d'après des données anecdotiques dignes de foi, la situation au Canada est assez semblable à celle qui existe en Australie où, selon l'un des témoins australiens qui a déposé devant le Comité, « l'accès aux services publics [de santé] est ordinairement plus facile pour les gens riches et puissants qui connaissent les rouages du système et ont les contacts voulus dans les services opérationnels et administratifs des hôpitaux ».

De plus, dans la plupart des provinces, les Commissions des accidents du travail obtiennent un accès préférentiel aux soins pour leurs clients en affirmant que ceux-ci doivent pouvoir reprendre leurs fonctions le plus rapidement possible (ce qui, bien entendu, permet aux Commissions de réaliser des économies). Certaines commissions provinciales ont d'ailleurs passé avec des hôpitaux des contrats leur assurant un nombre prescrit de lits et d'interventions diagnostiques, ce qui accélère l'accès de leurs patients aux services de santé. Les Commissions versent aussi directement à des médecins, pour les services qu'elles obtiennent, des paiements qui ne font pas partie du plafond de revenu que pourrait imposer la province.

Les Canadiens doivent tenir compte de tous ces faits avant de décider s'ils veulent que le gouvernement fédéral appuie ou rejette la recommandation du Comité relative à un investissement annuel supplémentaire de cinq milliards de dollars dans le système de soins de santé.

Le Comité se rend compte qu'il risque de vexer des gens en soulevant l'éventualité de la création d'un système privé parallèle de soins de santé. Ces personnes affirmeront probablement qu'il est possible pour les Canadiens de garder le régime public actuel d'assurance-santé sans avoir à y injecter d'importantes sommes (comme les cinq milliards de dollars que le Comité propose). Ces gens diront, par exemple, ce qui suit :

- Le système actuel étant inefficace, la restructuration permettra d'économiser suffisamment de fonds pour compenser la hausse des coûts. Le Comité est souvent revenu sur l'importance d'augmenter l'efficacité et l'efficience de la gestion et de la prestation de soins de santé (voir volume cinq, chapitre 2, et les chapitres 2, 3 et 4 du présent volume). En même temps, il a soutenu à maintes reprises que les renseignements réunis *ne permettent pas* de croire que les gains d'efficacité seront suffisants à eux seuls pour éviter d'avoir à injecter d'importantes sommes supplémentaires dans le système, surtout s'il faut

comblent les fossés de plus en plus nombreux qui s'y creusent. En même temps, il est très couramment sinon universellement reconnu qu'il faut d'importants fonds additionnels afin de réaliser les changements massifs et fondamentaux nécessaires pour que le système de soins de santé puisse vraiment répondre à des normes acceptables d'efficacité et d'efficience et parvenir aux résultats auxquels les Canadiens sont en droit de s'attendre.

- De plus, ceux qui affirment que seules des mesures d'amélioration de l'efficacité sont nécessaires pour rétablir le système de soins de santé font abstraction de deux faits importants. D'abord, la restructuration coûte de l'argent dans n'importe quel secteur, de l'argent qu'il faut dépenser avant de pouvoir réaliser des économies grâce aux gains d'efficacité obtenus. Ensuite, il est probable qu'il faudra une dizaine d'années pour terminer la restructuration. De toute évidence, on ne pourra pas attendre aussi longtemps sans trouver de nouveaux fonds.
- On soutiendra aussi que les cinq milliards de dollars additionnels peuvent être prélevés dans l'excédent budgétaire fédéral. Cet argument fait cependant abstraction du fait qu'il existe d'autres secteurs qui ont un besoin urgent de fonds, comme l'agriculture, les Forces canadiennes, l'infrastructure des grandes villes du Canada, etc. Le Comité *ne croit pas* qu'il conviendrait de consacrer la majorité d'un excédent budgétaire fédéral exclusivement ou même principalement aux soins de santé. De plus, comme les excédents augmentent et diminuent (comme maintenant) selon la conjoncture économique, il ne serait pas sage que le gouvernement fonde l'avenir du système canadien de soins de santé sur les fluctuations du cycle économique.

Par conséquent, le Comité rejette catégoriquement le point de vue selon lequel les problèmes du système canadien de soins de santé peuvent être résolus sans qu'il en coûte rien aux Canadiens. Nous croyons que les Canadiens, par l'entremise de leur gouvernement fédéral, doivent absolument faire le choix entre consacrer beaucoup plus d'argent au système de soins de santé ou laisser les tribunaux trancher en faveur de la création d'un système privé parallèle.

***Le Comité croit que les Canadiens, par l'entremise de leur gouvernement fédéral, doivent absolument faire le choix entre consacrer beaucoup plus d'argent au système de soins de santé ou laisser les tribunaux trancher en faveur de la création d'un système privé parallèle.***

**Partie VIII :**  
**La *Loi canadienne***  
***sur la santé***



## CHAPITRE DIX-SEPT

### LA LOI CANADIENNE SUR LA SANTÉ

---

Dans le volume un, le Comité a décrit l'évolution des principes pancanadiens du système de soins de santé du Canada. Nous avons souligné que même si la prestation des soins de santé est principalement un secteur de compétence provinciale-territoriale, il ne fallait pas conclure à l'absence d'intérêts nationaux. Le gouvernement fédéral, pour sa part, a établi des principes nationaux et a aidé à payer le coût des soins de santé, d'abord selon une formule de partage des frais (de 1966 à 1977) et ensuite par financement global<sup>383</sup>.

Ces principes nationaux figurent dans la *Loi canadienne sur la santé* (la Loi), qui a été adoptée à l'unanimité par le Parlement en avril 1984. Les cinq principes nationaux contenus dans la Loi sont :

- le principe **d'universalité**, qui signifie que tous les Canadiens ont droit à un régime public d'assurance-santé;
- le principe **d'intégralité**, qui signifie que tous les services médicalement nécessaires fournis par des hôpitaux ou des médecins sont couverts par l'assurance-santé publique;
- le principe **d'accessibilité**, qui décourage le recours à des mesures financières ou autres pouvant faire obstacle à la prestation des services de santé publics, afin que tous les Canadiens aient accès aux services de santé quand ils en ont besoin;
- le principe de **transférabilité**, qui signifie que tous les Canadiens sont couverts par l'assurance-santé publique, même quand ils voyagent au Canada ou à l'étranger, ou qu'ils déménagent dans une autre province;
- le principe de **gestion publique**, qui exige que les régimes d'assurance-santé provinciaux et territoriaux soient gérés par un organisme public sans but lucratif. (Ce principe ne précise rien au sujet de la nature des établissements de *prestation* de services de santé.)

Comme il l'a expliqué dans le volume un, le Comité considère que les quatre premiers principes de la *Loi canadienne sur la santé* sont axés sur le patient. Le cinquième principe – soit celui de **gestion publique** – est d'une toute autre nature. Il ne met pas l'accent sur le patient, mais « plutôt sur les moyens de réaliser les objectifs visés par les quatre autres principes<sup>384</sup> ». C'est ce principe qui constitue la base du modèle de la source unique d'assurance ou de financement que le Comité prône comme principe premier, dans le volume cinq<sup>385</sup>.

---

<sup>383</sup> Voir le volume un, chapitre deux, p. 33-48.

<sup>384</sup> Volume un, p. 43.

<sup>385</sup> Volume cinq, p. 25-27.

Ensemble, les cinq principes de la *Loi canadienne sur la santé* visent deux objectifs primordiaux de la politique fédérale en matière de soins de santé, objectifs que le Comité appuie sans réserve. Ces deux objectifs, déjà présentés dans le volume quatre, sont :

- Tous les Canadiens doivent avoir accès *en temps opportun* aux services de santé médicalement nécessaires *sans égard* à leur capacité de payer;
- Aucun Canadien ne doit subir de difficultés financières excessives du fait du coût des soins de santé<sup>386</sup>.

Chaque recommandation faite dans le présent rapport concernant 1) la restructuration du système hospitalier et médical, 2) l'établissement d'une garantie nationale en matière de soins de santé, 3) l'amélioration de l'infrastructure des soins de santé et 4) la bonification du financement fédéral des soins de santé, vise à favoriser la réalisation de ces deux objectifs primordiaux d'intérêt public, par des moyens qui sont conformes aux principes de la *Loi canadienne sur la santé*. Adoptées ensemble, ces recommandations garantiront la viabilité à long terme du régime d'assurance-santé canadien.

**Toutes les recommandations faites par le Comité dans le présent rapport visent à favoriser la réalisation des deux objectifs primordiaux d'intérêt public, par des moyens qui sont conformes aux principes de la Loi canadienne sur la santé.**

Les recommandations du Comité touchant l'élargissement de la couverture publique des soins de santé visent en outre à préserver les objectifs primordiaux de la politique fédérale en matière de santé, mais nous reconnaissons que quelques-unes des caractéristiques du programme d'expansion proposé ne sont pas conformes à la *Loi canadienne sur la santé*. Soulignons tout particulièrement à cet égard la proposition qui fixerait à un maximum de 3 % du revenu familial les coûts que les particuliers doivent payer de leur poche pour l'achat de médicaments de prescription au coût exorbitant.

Dans le présent chapitre, les principes de la Loi sont décrits et interprétés à la lumière des recommandations du Comité. Celles-ci doivent être jugées en fonction des principes établis dans la *Loi canadienne sur la santé* et du potentiel de réalisation des deux objectifs stratégiques fédéraux en matière de soins de santé.

**Les recommandations du Comité doivent être jugées en fonction des principes établis dans la Loi canadienne sur la santé et du potentiel de réalisation des deux objectifs stratégiques fédéraux en matière de soins de santé.**

## 17.1 Universalité

Le principe d'universalité de la *Loi canadienne sur la santé* exige que *tous* les résidents d'une province ou d'un territoire aient droit, selon des modalités uniformes, aux services de santé financés par l'État couverts par les régimes provinciaux-territoriaux. Les Canadiens considèrent souvent l'universalité comme une valeur fondamentale qui garantit un régime national d'assurance-santé pour tout le monde, peu importe le lieu de résidence au pays.

---

<sup>386</sup> Volume quatre, p. 18.

L'universalité ne dicte pas une source en particulier pour le financement du régime d'assurance-santé. En fait, les provinces et territoires peuvent financer leurs régimes universels comme ils le veulent, et c'est ce qu'ils font, au moyen de primes ou d'un impôt spécial ou général. Par contraste, l'assurance-santé universelle en Allemagne et aux Pays-Bas est offerte au moyen d'un système de charges sociales spécifiques.

De plus, l'universalité n'est pas nécessairement assurée uniquement à l'aide de fonds publics. Par exemple, en Allemagne et aux Pays-Bas, la couverture universelle des services de santé est garantie à la fois par les caisses maladie (régimes publics) et les assureurs privés. De même, le programme d'assurance-médicaments du Québec assure une couverture universelle à l'aide du recours combiné à l'assurance privée et à l'assurance publique.

Avant tout, le principe de couverture universelle *ne signifie pas* nécessairement une couverture au premier dollar. En fait, les pays qui offrent une assurance-santé universelle, comme l'Australie, l'Allemagne, les Pays-Bas et la Suède, permettent les frais d'utilisation et la surfacturation pour les services assurés à même les fonds publics.

Au Canada, la couverture au premier dollar pour les services médicaux et hospitaliers financés par l'État est obligatoire en vertu des dispositions de la *Loi canadienne sur la santé* qui interdit explicitement les frais d'utilisation et la surfacturation (voir la section 17.3 ci-dessous).

***Le Comité estime important de souligner que le principe de couverture universelle ne signifie pas nécessairement une couverture au premier dollar.***

Le principe d'universalité tient à cœur au Comité. Il fait en sorte que tout le monde a accès aux services de santé publics partout et que personne n'est exclu en raison de facteurs comme le revenu, l'âge ou l'état de santé. Nous croyons que l'assurance universelle et l'accès qu'elle offre à un système médical et hospitalier public a extrêmement bien servi les Canadiens. Il faut donc la conserver.

Dans le même ordre d'idées, le Comité croit fermement que l'élargissement de la couverture publique recommandé dans le présent rapport doit reposer sur le principe d'universalité. Le Comité est d'avis que la couverture des coûts exorbitants de médicaments de prescription, des soins à domicile post-hospitaliers et des soins palliatifs externes doit être fournie à *tous* les Canadiens lorsqu'ils en ont besoin.

***Le Comité est d'avis que la couverture des coûts exorbitants de médicaments de prescription, des soins à domicile post-hospitaliers et des soins palliatifs externes doit être fournie à tous les Canadiens lorsqu'ils en ont besoin.***

## **17.2 Intégralité**

Les services de santé qui doivent être couverts en vertu de la *Loi canadienne sur la santé* sont déterminés selon la notion de « nécessité médicale » que comporte le principe d'intégralité. Tous les services hospitaliers et les services médicaux médicalement nécessaires doivent être couverts par les régimes d'assurance-santé provinciaux-territoriaux.

Il est difficile de déterminer ce que l'on doit considérer comme « médicalement nécessaire ». La plupart des Canadiens s'accordent pour dire qu'une chirurgie cardiaque essentielle à la survie est médicalement nécessaire. La plupart des Canadiens s'accordent

également pour dire que la majorité des cas de chirurgie esthétique ne répondent pas aux critères de nécessité médicale. La difficulté réside dans les services qui se situent entre ces deux extrêmes.

Depuis la création du régime d'assurance-santé canadien, il a toujours fallu décider quels services devaient être assurés et lesquels devaient être exclus. Ces décisions sont prises par chaque province et territoire, après négociation avec la profession médicale. C'est pourquoi il existe des différences entre les provinces et territoires relativement à ce qui est couvert par les fonds publics. Par exemple, comme nous l'avons indiqué dans le volume un, l'enlèvement des verrues n'est plus couvert en Nouvelle-Écosse, au Nouveau-Brunswick, en Ontario, au Manitoba, en Alberta, en Saskatchewan et en Colombie-Britannique, mais ce service reste assuré à Terre-Neuve, au Québec et à l'Île-du-Prince-Édouard. Dans le même ordre d'idées, la gastroplastie est couverte dans la plupart des provinces, mais elle n'est pas assurée au Nouveau-Brunswick, en Nouvelle-Écosse ou au Yukon, où les patients doivent payer pour recevoir ce traitement (ou recourir à leur assurance-santé privée complémentaire)<sup>387</sup>.

Le Comité s'est fait dire à maintes reprises que les gouvernements procèdent à huis clos, de concert avec les associations médicales provinciales et territoriales mais sans participation du public, pour déterminer quels services sont couverts par les régimes d'assurance-santé provinciaux et territoriaux. Le processus n'est ni ouvert ni transparent. Par exemple, l'Association canadienne des soins de santé a fait remarquer que :

*Les radiations unilatérales de services par les gouvernements ne sont certainement pas au mieux des intérêts des Canadiens.*

*(...) Toute discussion ou décision concernant l'ensemble de services offerts doit reposer sur des faits et suivre un processus ouvert et transparent qui fait intervenir de façon significative tous les intervenants<sup>388</sup>.*

Le Comité est d'accord avec l'Association canadienne des soins de santé et de nombreux autres témoins selon lesquels la transparence exige que le processus de décision concernant l'étendue de la couverture publique soit beaucoup plus ouvert qu'il ne l'a été jusqu'à présent.

**Le Comité est d'accord avec de nombreux témoins selon lesquels la transparence exige que le processus de décision concernant l'étendue de la couverture publique soit beaucoup plus ouvert qu'il ne l'a été jusqu'à présent.**

Le Comité a donc, pour cette raison, énoncé au volume cinq le principe quatre, qui stipule que la détermination des services couverts par l'assurance-santé publique doit se faire d'une façon ouverte et transparente<sup>389</sup>. Ce principe correspond également aux points de vue exprimés dans le rapport de la Commission Clair au Québec et dans le rapport Mazankowski en Alberta, qui recommandent tous les deux de revoir le principe d'intégralité de la *Loi canadienne sur la santé*. Les deux rapports recommandent l'établissement d'un comité permanent, composé de citoyens, d'éthiciens, de fournisseurs de soins de santé et de scientifiques, et chargé d'examiner les services et de décider lesquels doivent être assurés par l'État. Cet examen servira à décider du

<sup>387</sup> Volume un, p. 108-109.

<sup>388</sup> Association canadienne des soins de santé, mémoire présenté au Comité en mai 2002, p. 3-4.

<sup>389</sup> Volume cinq, p. 32-33.



mode de financement – public ou privé – des divers services de santé; il permettra en outre de se fonder sur des faits (au lieu de suivre l'actuel processus de négociation) pour choisir les services qui seront couverts par l'assurance-santé publique.

Le Comité croit fermement que le comité permanent chargé d'examiner l'ensemble des services de santé financés par l'État doit être diversifié et ne pas être composé exclusivement de spécialistes. Nous croyons que la participation des personnes qui sont touchées directement par les décisions, c'est-à-dire les citoyens, est essentielle pour que le processus soit vraiment ouvert et qu'il soit crédible et accepté par la population.

Le Comité croit également qu'il doit y avoir des normes nationales pour définir les services publics couverts dans chaque province et territoire. De telles normes assureront une plus grande uniformité dans la couverture publique des soins de santé à l'échelle du pays. Par conséquent, le Comité recommande :

**Que le gouvernement fédéral, en collaboration avec les provinces et territoires, établisse un comité permanent – soit le comité sur la couverture de l'assurance-santé publique – constitué de citoyens, d'éthiciens, de fournisseurs de soins de santé et de scientifiques.**

**Que ce comité ait pour mandat d'examiner les services et de recommander ceux qui doivent être couverts par l'assurance-santé publique.**

**Que le comité sur la couverture de l'assurance-santé publique rende compte de ses constatations et recommandations au conseil national des soins de santé.**

**Que, en premier lieu, le comité sur la couverture de l'assurance-santé publique soit chargé d'élaborer des normes nationales pour orienter les décisions relatives à la couverture publique des soins de santé.**

Il faut reconnaître que l'examen de l'ensemble des services de santé publics assurés ne vise pas à réduire les coûts, mais à améliorer la transparence et à permettre des décisions fondées sur les faits relativement à l'intégralité de ces services. Un tel examen a pour objet d'utiliser la recherche clinique reposant sur des données probantes pour assurer que les services de santé financés par l'État sont les plus efficaces sur le plan clinique pour ce qui est de prévenir la maladie, de rétablir et de conserver la santé et de soulager la douleur et la souffrance.

Une autre critique importante relativement au principe d'intégralité de la *Loi canadienne sur la santé* a trait à la portée limitée de la couverture. Dans le volume un, le Comité a indiqué que la *Loi canadienne sur la santé* était très limitée : elle est centrée sur les services de santé médicalement nécessaires dispensés par les hôpitaux et les médecins. De plus, la Loi s'applique à une gamme décroissante de soins, puisque les hôpitaux dispensent maintenant moins de services. Grâce aux nouvelles connaissances et technologies, un nombre croissant de services de santé

peuvent être dispensés à domicile ou comme soins ambulatoires, de façon sûre et efficace. Les séjours à l'hôpital sont de plus courte durée, et la pharmacothérapie permet souvent d'éviter complètement les soins hospitaliers.

Comme l'a souligné le Comité dans le volume trois, le Canada est très différent des autres pays de l'OCDE en ce qui concerne l'envergure de la couverture publique d'assurance-santé. De nombreux pays qui consacrent une part comparable de leurs dépenses publiques aux soins de santé offrent une couverture beaucoup plus large que le Canada, englobant les médicaments de prescription (Australie, Allemagne, Suède, Royaume-Uni), les soins à domicile (Allemagne, Suède) et les soins de longue durée (Allemagne, Pays-Bas).

Comme le Comité l'a indiqué ailleurs dans le présent rapport, lorsque les services et les médicaments de prescription sont dispensés à l'extérieur des hôpitaux, ils ne sont pas régis par la *Loi canadienne sur la santé*. Par conséquent, ces services ne sont d'habitude pas fournis gratuitement aux patients et ils ne sont pas nécessairement dispensés en fonction des principes d'accessibilité, d'intégralité et d'universalité<sup>390</sup>. De plus, d'après les témoignages présentés au Comité, de plus en plus souvent, des citoyens canadiens portent de lourds fardeaux financiers parce qu'ils doivent déboursier de leur poche des frais très élevés pour obtenir ces services.

Le Comité s'est fondé sur les témoignages recueillis au cours de ses audiences pour conclure, comme il l'a expliqué en détail dans les chapitres sept, huit et neuf du présent rapport, qu'il faut élargir la couverture du régime d'assurance-santé public pour englober trois nouveaux éléments : les coûts exorbitants de médicaments de prescription, le coût des soins à domicile post-hospitaliers et le coût des soins palliatifs à domicile.

Le Comité est d'avis que l'élargissement de la couverture publique des soins de santé pour inclure les coûts exorbitants de médicaments de prescription, le coût des soins à domicile post-hospitaliers et le coût des soins palliatifs à domicile est conforme aux objectifs premiers de la politique fédérale en matière de soins de santé. L'inclusion des coûts exorbitants de médicaments de prescription est particulièrement importante si nous voulons atteindre le deuxième objectif de la politique fédérale, soit qu'aucun Canadien ne subisse de difficultés financières excessives du fait du coût des soins de santé.

***Le Comité est d'avis que l'élargissement de la couverture publique des soins de santé pour inclure les coûts exorbitants de médicaments de prescription, le coût des soins à domicile post-hospitaliers et le coût des soins palliatifs à domicile est conforme aux objectifs premiers de la politique fédérale en matière de soins de santé.***

Le Comité reconnaît qu'il faudra établir des paramètres nationaux pour les soins à domicile post-hospitaliers et les soins palliatifs externes, dont l'inclusion serait conforme à l'intention première du programme national d'assurance-santé. Le comité sur la couverture de l'assurance-santé publique pourrait jouer un rôle important à cet égard. Par conséquent, le Comité recommande :

---

<sup>390</sup> Volume un, p. 36-39.

**Que le comité sur la couverture de l'assurance-santé publique soit chargé de déterminer les paramètres nationaux applicables aux soins à domicile post-hospitaliers et aux soins palliatifs dispensés à domicile.**

### **17.3 Accessibilité**

Le principe d'accessibilité de la *Loi canadienne sur la santé* stipule que les Canadiens doivent avoir un « accès satisfaisant » aux services hospitaliers et médicaux assurés. Cependant, la Loi ne définit pas clairement ce qui constitue un accès satisfaisant. Au début, on a voulu éliminer les obstacles financiers, mais récemment, la question de l'accès aux soins de santé a été liée principalement aux problèmes de périodes d'attente. Le système de santé actuel vit sans contredit un important problème d'accès *en temps opportun*. Comme il l'a indiqué précédemment, le Comité est d'avis que l'expression « accès en temps opportun » décrit plus exactement ce que la population canadienne attend du régime public d'assurance-santé que l'expression « accès satisfaisant ».

Le Comité croit que puisque les gouvernements ont la responsabilité de prévoir le financement nécessaire pour assurer la prestation adéquate des services hospitaliers et médicaux essentiels, cette responsabilité comporte l'obligation d'établir des normes d'accès satisfaisant. Il s'agit de l'essence d'un système axé sur le patient et du « contrat » de soins de santé passé entre les Canadiens et leurs gouvernements. Le Comité est d'avis qu'une garantie fixant une période d'attente maximale pour les services couverts par l'assurance-santé publique répondrait à cette obligation. Par conséquent, nous avons recommandé au chapitre six l'établissement d'une garantie nationale de soins de santé.

**Le Comité est d'avis que la garantie nationale de soins de santé constitue l'essence d'un système axé sur le patient et du « contrat » passé entre les Canadiens et leurs gouvernements.**

Comment (et où) une garantie nationale de soins de santé s'inscrit-elle dans le contexte de la *Loi canadienne sur la santé*? Il existe plusieurs possibilités :

1. La garantie de soins de santé pourrait être ajoutée comme sixième principe à la Loi. Les gouvernements provinciaux et territoriaux qui ne respectent pas la garantie nationale de soins de santé seraient passibles des pénalités financières déjà prévues dans la *Loi canadienne sur la santé*.
2. La garantie de soins de santé pourrait être annexée à la *Loi canadienne sur la santé* ou énoncée dans le préambule de la Loi. Le gouvernement fédéral ne disposerait alors d'aucun moyen pour appliquer la garantie ou imposer des pénalités.
3. La garantie nationale de soins de santé pourrait figurer dans une nouvelle loi, semblable à la *Loi canadienne sur la santé*, mais assujettie à des principes différents et prévoyant d'autres mécanismes d'application et des pénalités différentes.

Le Comité a conclu que le mieux serait que la garantie nationale de soins de santé soit mise en œuvre au moyen de mesures législatives *distinctes* de la *Loi canadienne sur la santé*. Une

nouvelle loi portant création de la garantie assurera que la définition d'un accès *en temps opportun* aux services hospitaliers et médicaux nécessaires est établie de façon uniforme à l'échelle du pays et que le gouvernement fédéral joue un rôle important à l'égard de cette garantie. Par conséquent, le Comité recommande :

***Le Comité a conclu que le mieux serait que la garantie nationale de soins de santé soit mise en œuvre au moyen de mesures législatives distinctes de la Loi canadienne sur la santé.***

**Que le gouvernement fédéral adopte une nouvelle loi portant création de la garantie nationale de soins de santé. La nouvelle loi comprendra une définition de la notion d'« accès en temps opportun » que prévoit une telle garantie.**

La *Loi canadienne sur la santé* comporte une autre disposition importante relativement à l'accessibilité, soit que les gens assurés aient accès aux services hospitaliers et médicaux selon des modalités uniformes et sans obstacle financier. C'est pour cette raison que les frais d'utilisation et la surfacturation ne sont pas autorisés pour les services couverts en vertu de la *Loi canadienne sur la santé*.

Toutefois, il faut décider si les patients devront contribuer financièrement aux nouveaux services de santé publics que nous proposons. Le Comité croit que le Canada n'a pas les moyens d'offrir une couverture au premier dollar pour la vaste gamme de services de santé que le Comité recommande. C'est pourquoi nous avons suggéré dans notre proposition relative aux coûts exorbitants de médicaments de prescription que les particuliers contribuent financièrement au coût des médicaments de prescription dont ils ont besoin.

***Toutefois, il faut décider si les patients devront contribuer financièrement aux nouveaux services de santé publics que nous proposons. Le Comité croit que le Canada n'a pas les moyens d'offrir une couverture au premier dollar pour la vaste gamme de services de santé que le Comité recommande.***

Mais on déroge à la *Loi canadienne sur la santé* si l'on exige des patients une contribution financière à l'égard d'un ensemble élargi de services assurés par l'État. Il n'est donc pas possible d'ajouter tout simplement « les coûts exorbitants des médicaments de prescription » à la liste actuelle des services médicalement nécessaires établie par la *Loi canadienne sur la santé*.

La proposition du Comité d'élargir la couverture publique des soins de santé afin d'inclure les soins à domicile post-hospitaliers pour une période de trois mois et le coût des soins palliatifs à domicile semble conforme à l'esprit et à la lettre de la *Loi canadienne sur la santé*. Toutefois, le Comité recommande que l'élargissement de la couverture soit financé à l'aide d'un nouveau mécanisme de partage des frais complètement différent du TCSPS. Ce financement fédéral supplémentaire sera assujéti à plusieurs conditions (y compris la reddition de comptes et la transparence) qui ne sont pas imposées actuellement dans le cadre du TCSPS ou par la *Loi canadienne sur la santé*. Les fonds fédéraux pour couvrir des coûts exorbitants de médicaments de

prescription seront également versés par le truchement du nouveau mécanisme de financement et non dans le cadre du TCSPS.

Par conséquent, le Comité croit que l'élargissement de la couverture publique pour comprendre les coûts exorbitants de médicaments de prescription, les soins à domicile post-hospitaliers et les soins palliatifs à domicile doit être autorisé en vertu d'une nouvelle loi fédérale et non de la *Loi canadienne sur la santé* (voir la section 17.6 ci-après).

***Le Comité croit que l'élargissement de la couverture publique pour comprendre les coûts exorbitants de médicaments de prescription, les soins à domicile post-hospitaliers et les soins palliatifs à domicile doit être autorisé en vertu d'une nouvelle loi fédérale et non de la Loi canadienne sur la santé.***

#### **17.4 Transférabilité**

Le critère de transférabilité de la *Loi canadienne sur la santé* exige que les provinces et les territoires assurent la couverture des services hospitaliers et médicaux médicalement nécessaires à leurs résidents même quand ceux-ci quittent temporairement la province ou le territoire (pour les affaires ou des vacances). Ainsi, les personnes peuvent s'absenter de leur province ou territoire de résidence et conserver leur couverture d'assurance-santé publique. Cette exigence de transférabilité s'applique aux services de santé d'urgence : les résidents doivent demander au préalable l'autorisation de leur régime provincial d'assurance-santé pour les services de santé non urgent (ou facultatifs) dispensés à l'extérieur de la province.

Le principe de la transférabilité s'applique également aux résidents qui quittent une province ou un territoire pour s'installer ailleurs au Canada : la province d'origine doit continuer d'offrir la couverture des services de santé assurés durant une période d'attente dans la province d'accueil ne dépassant pas trois mois. Après la période d'attente, la nouvelle province ou le nouveau territoire de résidence assume la responsabilité de la couverture de l'assurance-santé publique.

Les Canadiens ont également droit à la couverture de l'assurance-santé publique lorsqu'ils s'absentent temporairement du pays. Toutefois, la plupart des provinces limitent le remboursement du coût des services de santé d'urgence obtenus à l'extérieur du Canada dans le cadre de leur assurance-santé publique. Ainsi, les Canadiens sont fortement encouragés à acheter une assurance-santé privée complémentaire lorsqu'ils voyagent à l'étranger.

Au Canada, le principe de transférabilité que prévoit la *Loi canadienne sur la santé* est généralement appliqué au moyen d'ententes réciproques entre les provinces et territoires en vue de la facturation des services hospitaliers et médicaux. Ces ententes sont de nature interprovinciale et non fédérale et ne sont pas imposées par la *Loi canadienne sur la santé*<sup>391</sup>. Les taux prescrits dans ces ententes sont ceux de la province hôte (sauf pour le Québec qui paie ses taux provinciaux), et les ententes visent à assurer que les résidents canadiens qui se rendent dans une autre province ou un autre territoire n'auront pas à payer, dans la plupart des cas, des frais d'utilisation imposés au point de service pour des services médicaux ou hospitaliers médicalement nécessaires.

<sup>391</sup> Le gouvernement du Québec n'est pas toujours signataire de ces ententes.

La facturation réciproque est une mesure administrative commode, mais ce n'est pas la seule façon de répondre au critère de la Loi relatif à la transférabilité. Le principe de transférabilité est respecté si les patients sont priés de payer à l'avance et demandent un remboursement à leur province ou territoire de résidence, pourvu que l'accès à un service assuré médicalement nécessaire ne soit pas refusé à cause de l'incapacité de payer du patient<sup>392</sup>.

Dans l'ensemble, le principe de transférabilité que prévoit la *Loi canadienne sur la santé* permet aux Canadiens d'avoir l'esprit tranquille lorsqu'ils voyagent au Canada ou lorsqu'ils déménagent pour s'installer dans une autre province ou un autre territoire. Avant tout peut-être, le principe de transférabilité est étroitement lié à celui d'universalité et encourage certainement l'uniformité de la couverture publique des soins de santé.

Le Comité croit que la transférabilité est un principe national important qui doit être maintenu si la couverture publique est élargie pour comprendre les coûts exorbitants de médicaments de prescription, les coûts des soins à domicile post-hospitaliers et ceux des soins palliatifs.

***Le Comité croit que la transférabilité est un principe national important qui doit être maintenu si la couverture publique est élargie pour comprendre les coûts exorbitants de médicaments de prescription, les coûts des soins à domicile post-hospitaliers et ceux des soins palliatifs.***

## **17.5 Gestion publique**

Le principe de gestion publique contenu dans la *Loi canadienne sur la santé* concerne la *gestion* des régimes provinciaux et territoriaux d'assurance-santé couvrant les services de santé médicalement nécessaires. Il stipule que les régimes d'assurance-santé des provinces et des territoires doivent être gérés par un organisme public sans but lucratif. Le principe de gestion publique a été souligné dans le volume cinq, au principe premier, selon lequel un assureur-bailleur de fonds unique – en l'occurrence le gouvernement – doit payer les services hospitaliers et médicaux couverts en vertu de la *Loi canadienne sur la santé*<sup>393</sup>.

De l'avis du Comité, un système à bailleur de fonds unique est beaucoup plus efficace que n'importe quel mode de financement à sources multiples et permet de réaliser des économies d'échelle sur les plans administratif, économique et informationnel. En outre, puisque le système public de services hospitaliers et médicaux fait déjà partie intégrante

***De l'avis du Comité, un système à bailleur de fonds unique est beaucoup plus efficace que n'importe quel mode de financement à sources multiples et permet de réaliser des économies d'échelle sur les plans administratif, économique et informationnel. En outre, puisque le système public de services hospitaliers et médicaux fait déjà partie intégrante de la société canadienne, le Comité croit que le bailleur de fonds unique doit être le gouvernement.***

<sup>392</sup> À l'heure actuelle, les résidents du Québec ne jouissent pas toujours de la transférabilité puisque de nombreux fournisseurs dans d'autres provinces refusent de les traiter s'ils ne paient pas les frais médicaux à l'avance. Cela est souvent impossible, et des résidents du Québec ont été transportés en ambulance sur de longues distances, dans des conditions difficiles, pour être ramenés au Québec.

<sup>393</sup> Volume cinq, p. 25-27.

de la société canadienne, le Comité croit que le bailleur de fonds unique doit être le gouvernement.

Dans le volume cinq, nous avons expliqué qu'un argument probant en faveur du maintien d'une source unique de financement ou d'assurance pour le système hospitalier et médical public est le vif appui que lui accordent les Canadiens. Le Comité convient que cet élément central de notre système doit être maintenu, *pourvu que* le système réponde aux normes de services de qualité élevée dispensés sans délai.

De nombreux témoins ont affirmé au Comité que d'accorder la responsabilité financière première à un seul bailleur de fonds donne lieu à une administration de l'assurance-santé plus efficace qu'elle ne le serait dans le cadre d'un système à plusieurs sources de fonds. Les témoins ont ajouté que le système public à assureur unique pour les services de santé médicalement nécessaires élimine les coûts liés à la mise en marché de polices d'assurance-santé concurrentielles, à la facturation et à la collecte de primes, ainsi qu'à l'évaluation des risques d'assurance.

Un autre argument solide en faveur de l'assurance-santé publique est que très peu de Canadiens peuvent se permettre de ne pas être assurés. Il est donc logique que tous soient couverts par un régime unique. Un système à assureur unique offrant une couverture universelle signifie également que personne ne se refusera les soins de santé nécessaires afin de satisfaire un autre besoin perçu comme plus urgent (peut-être s'alimenter, se loger, se vêtir, etc.). Et personne ne se verra refuser des soins nécessaires à cause de son incapacité de payer.

Mais le principe de partage des risques comporte un avantage important : plus le nombre de participants est élevé (tous les Canadiens), plus le coût d'assurance tous risques baisse.

Des témoins ont également indiqué au Comité qu'un assureur unique est très logique sur le plan économique pour l'industrie canadienne et que c'est un élément important de la capacité concurrentielle du Canada. Cet argument a été formulé de façon éloquente par Paul Darby, directeur des prévisions économiques et de l'analyse du Conference Board of Canada, qui a déclaré :

*(...) notre système, qui est en grande partie à payeur unique, présente des avantages importants sur le plan de l'efficacité en général, et ces avantages aident à accroître notre compétitivité industrielle. Nous devons éviter de les perdre<sup>394</sup>.*

Un modèle à bailleur unique veut dire qu'il n'y aura pas au Canada un secteur d'assurance privé parallèle qui fait concurrence à l'assurance publique pour le financement des services hospitaliers et médicaux dans le cadre de la *Loi canadienne sur la santé*, du moins dans les hôpitaux et chez les médecins qui dispensent des soins aux patients assurés par l'État.

Jusqu'à présent, le modèle à assureur unique a empêché l'émergence d'un système à deux vitesses qui, de l'avis de bien des gens, pourrait mettre en péril le système de

---

<sup>394</sup> Paul Darby, mémoire présenté au Comité le 3 juin 2002, p. 2.

santé public au Canada. Nous tenons toutefois à souligner qu'il existe des systèmes de soins de santé parallèles publics et privés dans la plupart des autres pays industrialisés.

Dans les chapitres cinq, six et seize, le Comité a exprimé la crainte que les lois qui empêchent l'avènement d'un système privé parallèle et qui donc aident à préserver le principe de gestion publique de la *Loi canadienne sur la santé* puissent être rejetées par les tribunaux si le système d'assurance-santé public ne réussit pas à dispenser *en temps opportun* des soins de qualité. Le cas échéant, le principe de gestion publique devra être revu. Mais le Comité estime que la mise en œuvre de ses recommandations permettra que notre système public de soins de santé assure des services de très haute qualité en temps opportun et fera que le modèle d'assureur unique pour les services hospitaliers et médicaux soit préservé.

***Le Comité souhaite que le modèle d'assureur unique pour les services hospitaliers et médicaux soit préservé.***

Comme nous l'avons indiqué dans le volume un, il est également important de comprendre clairement ce que le principe de gestion publique contenu dans la *Loi canadienne sur la santé* ne signifie pas. Ce principe vise la *gestion* de l'assurance-santé et non la *prestation* des services de santé assurés par l'État. La Loi n'interdit pas aux provinces ou territoires d'autoriser des fournisseurs de soins de santé privés (à but lucratif ou sans but lucratif), qu'ils soient des fournisseurs individuels ou institutionnels, à dispenser des services de santé assurés par la province et à se faire rembourser, tant qu'il n'y a pas surfacturation ni frais d'utilisation. C'est en fait ce que le régime d'assurance-santé canadien a toujours été – un programme d'assurance-santé national reposant principalement sur la *prestation privée* (dans un but lucratif ou non) de services hospitaliers et médicaux assurés par l'État.

***Dans le volume un, le Comité a indiqué qu'il était également important de comprendre clairement ce que le principe de la gestion publique de la Loi canadienne sur la santé ne signifie pas. Ce principe vise la gestion de l'assurance-santé et non la prestation des services de santé assurés par l'État.***

Le Comité craint que le principe de gestion publique soit mal compris, particulièrement à cause de la confusion qui existe entre la gestion de l'assurance-santé publique et la prestation des services de santé assurés par l'État. Nous croyons que le gouvernement fédéral, par l'intermédiaire de Santé Canada, doit bien préciser le sens de l'expression « gestion publique » et expliquer clairement que la *Loi canadienne sur la santé* n'interdit nullement la prestation par un organisme privé, à but lucratif ou sans but lucratif, de services de santé publics. Le niveau du débat qui fait rage actuellement sur les soins de santé au Canada s'en trouverait grandement rehaussé. Par conséquent, le Comité recommande :

**Que le principe de gestion publique contenu dans la *Loi canadienne sur la santé* soit maintenu à l'égard des services hospitaliers et médicaux assurés par l'État, c'est-à-dire qu'un seul assureur – soit le gouvernement – paie les services publics hospitaliers et médicaux dispensés par des fournisseurs ou des établissements de soins de santé publics ou privés.**



**Que le gouvernement fédéral, par l'intermédiaire de Santé Canada, précise la notion de gestion publique en vertu de la *Loi canadienne sur la santé* de façon à reconnaître explicitement que ce principe s'applique à la gestion de l'assurance-santé publique et non à la prestation des services de santé assurés par l'État.**

Bien que le Comité soit convaincu que le principe de gestion publique doit être maintenu pour les services hospitaliers et médicaux, il serait très difficile à notre point de vue de l'étendre à la gamme plus large de services de santé recommandée dans le présent rapport. Il serait particulièrement difficile d'inclure dans l'assurance-santé publique les coûts exorbitants de médicaments de prescription.

La couverture des médicaments d'ordonnance est offerte actuellement par de nombreux assureurs allant des gouvernements aux compagnies d'assurance privées. En fait, l'industrie privée d'assurance-médicaments est déjà bien établie au Canada et semble bien fonctionner. Le Comité croit que l'expansion de la couverture pour comprendre les coûts exorbitants de médicaments de prescription doit reposer sur un partenariat entre les secteurs public et privé afin d'assurer une couverture universelle de ces coûts, et il a formulé au chapitre sept une recommandation à cet égard.

***Le Comité croit que l'expansion de la couverture pour comprendre les coûts exorbitants de médicaments de prescription doit reposer sur un partenariat entre les secteurs public et privé. Pour cette raison, les recommandations faites au chapitre sept supposent la collaboration entre les assureurs publics et privés pour assurer la couverture universelle des coûts exorbitants des médicaments d'ordonnance.***

## **17.6 Commentaires du Comité**

Le Comité est convaincu qu'il est possible d'opérer une réforme approfondie du système public de services hospitaliers et médicaux tout en appliquant les cinq principes nationaux de la *Loi canadienne sur la santé*. Nous croyons que la Loi a relativement bien servi les Canadiens pour ce qui est d'assurer une couverture universelle et uniforme des services hospitaliers et médicaux. Nous estimons que les quatre principes de la Loi axés sur les patients doivent être maintenus pour les services hospitaliers et médicaux, tandis que le principe de gestion publique doit être précisé.

Toutefois, le Comité croit qu'il faut ajouter à l'assurance-santé canadienne et à la *Loi canadienne sur la santé* deux nouvelles mesures législatives. En premier lieu, comme on l'explique à la section 17.3, il faut adopter une nouvelle loi fédérale portant création de la garantie nationale de soins de santé. Cette garantie améliorera l'accès aux services hospitaliers et médicaux qui sont actuellement assurés en vertu de la *Loi canadienne sur la santé*. En deuxième lieu, la proposition du Comité d'élargir la couverture publique exige aussi l'adoption d'une nouvelle loi :

- La couverture des coûts exorbitants de médicaments de prescription exige la participation financière des assureurs publics et privés (une collaboration qui

n'est pas en conformité avec le principe de gestion publique contenu dans la Loi).

- La couverture des coûts exorbitants de médicaments de prescription exige que les particuliers contribuent financièrement en assumant une partie du coût du service assuré (ce qui déroge à la couverture au premier dollar que prévoit le principe d'accessibilité de la Loi).
- La couverture des coûts exorbitants de médicaments de prescription, des soins à domicile post-hospitaliers pour une période de trois mois et des soins palliatifs à domicile sera assurée au moyen d'un mécanisme de financement fédéral distinct de l'actuel TCSPS (les principes de la *Loi canadienne sur la santé* visent uniquement le TCSPS).
- Le Comité croit fermement que le financement fédéral supplémentaire prévu pour l'expansion de la couverture publique doit être fondé sur des conditions particulières de transparence et de reddition de compte (principes complètement absents de la *Loi canadienne sur la santé*).

D'autres principes que ceux contenus dans la *Loi canadienne sur la santé* sont nécessaires pour les nouveaux programmes proposés dans le rapport, mais l'important doit rester la prestation de services de qualité en

fonction des besoins. Dans le même ordre d'idée, la loi couvrant les nouveaux programmes doit garantir l'accès à des services raisonnablement comparables pour tous les Canadiens partout au pays. Pour déterminer ce qui est comparable, il faudra élaborer des normes nationales applicables à tous les services financés par l'État, qu'ils soient dispensés par des fournisseurs privés à but lucratif ou non, ou par des fournisseurs ou des établissements de soins de santé publics. Par conséquent, le Comité recommande :

***Le Comité croit que des principes autres que ceux qui sont contenus dans la Loi canadienne sur la santé sont nécessaires, mais que l'important doit rester la prestation de services de qualité en fonction des besoins.***

**Que le gouvernement fédéral adopte de nouvelles mesures législatives pour mettre en oeuvre une couverture des coûts exorbitants de médicaments de prescription, des soins à domicile post-hospitaliers et de certains soins palliatifs à domicile. Ces nouvelles mesures doivent énoncer explicitement les conditions relatives à la transparence de la prise de décisions et à la reddition de comptes.**

## CONCLUSION

---

Au début de ses travaux il y a deux ans, le Comité a souscrit à deux grands objectifs de la politique publique en matière de santé au Canada, à savoir :

- tous les Canadiens doivent avoir accès en temps opportun aux services de santé médicalement nécessaires sans égard à leur capacité de payer;
- aucun Canadien ne doit subir de difficultés financières excessives du fait du coût des soins des santé.

Ces deux objectifs, et particulièrement le premier, sous-entendent que les services médicalement nécessaires fournis dans le cadre de l'assurance-santé sont de qualité élevée. En effet, à quoi servirait, aux fins du système de soins de santé du Canada, de fournir l'accès à des services de qualité inférieure?

Le Comité reconnaît de plus que l'importance accordée à l'équité est aussi un élément important de la perception qu'ont les Canadiens du système de soins de santé. Cette importance accordée à l'équité sous-tend les principes axés sur le patient que sont l'universalité, l'intégralité, la transférabilité et l'accessibilité du système, et auxquels le Comité — et les Canadiens — souscrivent sans réserve.

Mais, pour les Canadiens, l'équité s'entend également de l'égalité d'accès aux services — les Canadiens bien nantis ne devraient pas avoir la possibilité d'acheter leur place au haut des listes d'attente. Les données des sondages d'opinion ont à maintes reprises démontré que le fait de devoir attendre des mois pour obtenir un diagnostic ou un traitement médical est le plus grand sujet de préoccupation et de plainte, de la part des Canadiens, au sujet du système de soins de santé. Malgré ce qu'en disent certains, permettre aux Canadiens nantis de payer pour obtenir des services dans un établissement de soins de santé privé n'est pas une solution. En effet, une mesure de ce genre violerait le principe d'égalité d'accès. La solution consiste donc plutôt à adopter la garantie de soins que le Comité recommande dans le présent rapport.

À la lumière des témoignages recueillis au fil de ses audiences des deux dernières années ainsi que des données des sondages d'opinion, le Comité sait aussi que les Canadiens trouvent le système actuel inefficace. Par ailleurs, ils ne sont pas prêts à y investir davantage tant que ces lacunes n'auront pas été corrigées. Le Comité est conscient qu'il ne sera pas facile de modifier cette perception négative entretenue par le public. Il faudra mettre en œuvre des mécanismes pour inciter toutes les composantes du système à travailler plus efficacement. Il faudra aussi que le mode de fonctionnement du système, notamment la façon dont les fonds publics sont dépensés, soit plus transparent et permette une meilleure reddition de comptes.

***[...] quiconque propose un plan de réforme et de renouvellement du système de soins de santé a l'obligation de dire combien il en coûtera pour le mettre en œuvre. [...]Ceux-ci [les Canadiens] ne peuvent porter un jugement éclairé sur le bien-fondé d'un projet de plan de réforme que s'ils en comprennent parfaitement les avantages et s'il savent combien il leur en coûtera pour le mettre en œuvre.***

Au moment de formuler ses recommandations, le Comité a aussi tenu compte de deux autres facteurs. Premièrement, pour satisfaire au deuxième objectif de la politique publique énoncé ci-dessus — à savoir qu'aucun Canadien ne doit subir de difficultés financières excessives — il faut prendre *dès maintenant* des mesures pour combler les importantes lacunes du régime d'assurance-santé. Le Comité croit que les Canadiens qui ont vraiment besoin d'aide et qui n'ont pas les moyens de payer pour l'obtenir, devraient pouvoir compter sur le soutien de l'État. Cela ne veut pas dire pour autant qu'il faut mettre en place de nouveaux programmes avec couverture au premier dollar dans des secteurs comme l'assurance-médicaments ou les soins à domicile. De l'avis du Comité, la prudence exige que l'élargissement de la portée du système actuel afin d'en combler les lacunes se fasse de façon graduelle et dans un esprit pratique.

Le deuxième facteur dont il est tenu compte dans les recommandations du Comité est la croyance selon laquelle quiconque propose un plan de réforme et de renouvellement du système de soins de santé a l'obligation de dire combien il en coûtera pour le mettre en œuvre. La description du mode de financement doit de plus être compréhensible pour les Canadiens. Ceux-ci ne peuvent porter un jugement éclairé sur le bien-fondé d'un projet de plan de réforme que s'ils en comprennent parfaitement les avantages et s'ils savent combien il leur en coûtera pour le mettre en œuvre.

C'est pourquoi le Comité a décidé, même si cela est extrêmement inhabituel (et serait même, aux dires de certains, exceptionnel), d'établir le coût de ses recommandations *et* de proposer une option pour générer les nouvelles recettes fédérales nécessaires à leur mise en œuvre intégrale. À nos yeux, le fait d'omettre de le faire contribuerait à perpétuer le mythe selon lequel les soins de santé sont un bien « gratuit ». Nous servirions ainsi directement les fins de ceux qui s'opposent à la réforme. En ne proposant pas de plan pour générer des recettes, le Comité se trouverait à passer outre au critère de transparence et de responsabilisation qui, comme il le réitère lui-même dans toutes ses recommandations, doit s'appliquer à l'ensemble du système de soins de santé.

***En ne proposant pas de plan pour générer des recettes, le Comité se trouverait à passer outre au critère de transparence et de responsabilisation qui, comme il le réitère lui-même dans toutes ses recommandations, doit s'appliquer à l'ensemble du système de soins de santé.***

Le Comité est conscient que la mise en œuvre de sa liste de recommandations exigera *un changement d'attitude considérable de la part de l'ensemble des intervenants* du système de soins de santé. Par exemple :

- Le passage à une formule de financement fondée sur les services dispensés modifiera le mode de gestion des hôpitaux. La direction des hôpitaux et les professionnels de la santé oeuvrant en milieu hospitalier seront beaucoup plus conscients de ce qui dans leur façon de procéder est efficace et de ce qui ne l'est pas. Il faudra aussi que les hôpitaux des grandes régions urbaines soutiennent la concurrence d'autres hôpitaux et cliniques spécialisées.
- Les changements que suppose la réforme des soins de santé primaires obligeront les médecins de famille à accepter des changements à la façon dont ils sont rémunérés (c.-à-d. le remplacement de l'habituelle formule de

rémunération à l'acte par un modèle principalement axé sur la capitation mais comportant aussi une part de rémunération à l'acte). Il faudra aussi modifier la portée des règles de pratiques de tous les professionnels de la santé afin de s'assurer qu'elles ne font pas obstacle à leur capacité de mettre pleinement à profit leurs compétences.

- Les changements que suppose la réforme des soins de santé primaires exigeront aussi qu'un patient consente à demeurer avec le médecin de famille de son choix pendant un an, à moins qu'il ne déménage dans une autre collectivité. La recommandation relative aux dossiers de santé électroniques exigera qu'un patient accepte de donner l'approbation nécessaire à l'utilisation efficace des dossiers de santé. (Comme il l'a expliqué au chapitre dix, le Comité croit qu'il est possible de mettre en place un système de dossiers de santé électroniques et que le système d'information qui en découlera fonctionnera de façon entièrement conforme à l'esprit et à la lettre des lois visant à protéger les renseignements personnels).
- Les gouvernements provinciaux/territoriaux devront modifier un aspect important de leur approche à l'égard du système de soins de santé et souscrire à une garantie de soins de santé, c'est-à-dire assumer la responsabilité des conséquences de leurs décisions antérieures de sabrer dans les budgets et de restreindre l'offre de services de soins de santé.
- Les gouvernements provinciaux/territoriaux devront aussi renoncer à leur approche actuelle de commandement et contrôle à l'égard des soins de santé et permettre la mise en place d'un système de mesures incitatives, et les changements d'attitude qu'elle suppose, pour produire les résultats souhaités.
- Le gouvernement fédéral devra consentir à la création d'un fonds indépendant, dont la surveillance sera assurée par un commissaire aux soins de santé et un conseil national des soins de santé, qui le conseilleront sur la façon dont le fonds doit être dépensé. Ces conseils devront être rendus publics, et les autorités responsables devront rendre compte annuellement au public de la façon dont les fonds affectés aux soins de santé sont effectivement dépensés. C'est là une étape essentielle pour regagner la confiance du public dans le système.
- Le gouvernement fédéral devra aussi accepter qu'il a un important rôle de chef de file à jouer et qu'à cet égard, il lui incombe de soutenir financièrement l'infrastructure essentielle au succès du système national de soins de santé. Doivent faire partie de cette infrastructure, les 16 centres universitaires des sciences de la santé, les ressources humaines affectées au secteur des soins de santé dans l'ensemble du pays, les moyens technologiques, les systèmes d'information et le secteur de la recherche.
- Le gouvernement fédéral devra aussi accepter qu'il a un rôle important à jouer dans le financement et la mise en valeur des programmes de promotion de la santé et de prévention des maladies chroniques.

Enfin, il importe d'insister sur l'importance déterminante des objectifs de plus grande responsabilisation et de plus grande transparence dans la position du Comité sur les types

de réforme nécessaires dans le système de soins de santé, et sur le rôle crucial que doit jouer l'amélioration de l'information, à tous les niveaux du système, pour mettre en œuvre ces objectifs. Ce surcroît d'information est nécessaire pour les raisons suivantes :

- premièrement, pour accroître la transparence des mécanismes de prise de décisions concernant l'affectation des ressources – principalement en ce qui a trait à l'argent, mais aussi en ce qui a trait aux ressources humaines;
- deuxièmement, pour accroître la responsabilité des personnes, des établissements et des gouvernements qui décident des types de services qui sont couverts par le régime public d'assurance-santé et de la façon dont les différents services seront offerts;
- troisièmement, et peut-être ce qui est le plus important, pour modifier l'objet du débat public pour le faire porter sur les services et les niveaux de service plutôt que sur les questions d'argent.

Les Canadiens ont le droit de débattre de la question de savoir s'ils sont prêts à payer davantage pour obtenir de meilleurs niveaux de service. Ils ont le droit de comprendre les liens existants entre les niveaux de financement et les niveaux de service. L'évolution du débat public au sujet des soins de santé marquera une étape importante vers l'obtention de l'appui du public à l'égard de la restructuration et du renouvellement des services hospitaliers et des services médicaux financés par l'État.

Le Comité est pleinement conscient que sa liste de recommandations fera l'objet d'un examen attentif et critique. Cela est tout à fait compréhensible lorsqu'une question d'intérêt public aussi fondamentale que celle des soins de santé est en jeu. En fait, il se peut très bien que les lecteurs du présent rapport appuient chacun leur propre sous-ensemble de recommandations.

**Il n'existe pas de solution parfaite. Tous les intéressés doivent être prêts à faire des compromis pour que la réforme profite à tous les Canadiens. Toute réforme sera vouée à l'échec si l'on s'entête à rechercher la perfection ou à vouloir satisfaire toutes les demandes.**

Nous invitons toutefois les lecteurs à garder à l'esprit que toute réforme majeure d'un système d'importance, en particulier lorsqu'il s'agit d'un système aussi complexe que celui des soins de santé, n'est jamais parfaite. *Il n'existe pas de solution parfaite.* Tous les intéressés doivent être prêts à faire des compromis pour que la réforme profite à tous les Canadiens. Toute réforme sera vouée à l'échec si l'on s'entête à rechercher la perfection ou à vouloir satisfaire toutes les demandes.

De même, la réforme échouera si l'on s'entête à vouloir aborder de front tous les problèmes des soins de santé sans d'abord commencer par trouver des solutions à quelques-uns d'entre eux, en particulier en ce qui a trait aux services hospitaliers et aux services médicaux. Ces tendances, de même que l'importance accordée aux intérêts personnels de ceux qui oeuvrent dans le système, expliquent l'échec des tentatives de réforme antérieures.

Conscients de ces dangers, nous avons travaillé fort pour élaborer une série de recommandations qui, de notre point de vue, revêtent un caractère pratique, offrent une solution

médiane en termes idéologiques, sont réalisables et devraient mener à une amélioration sensible des services hospitaliers et des services médicaux dans le secteur des soins de santé. Nous croyons que la restructuration et le renouvellement du système de soins de santé au Canada sont possibles si nous procédons à une réforme graduelle.

Nous espérons que les intervenants de tous les secteurs du système national de soins de santé et, en fait, tous les Canadiens examineront les recommandations avec la même approche pratique que le Comité et que tous seront prêts à faire certains compromis afin d'atteindre notre objectif commun, à savoir se doter d'un système de soins de santé financièrement viable et dont les Canadiens peuvent vraiment être fiers.

***Nous espérons que les intervenants de tous les secteurs du système national de soins de santé et, en fait, tous les Canadiens examineront les recommandations avec la même approche pratique que le Comité et que tous seront prêts à faire certains compromis afin d'atteindre notre objectif commun, à savoir se doter d'un système de soins de santé financièrement viable et dont les Canadiens peuvent vraiment être fiers.***





## LISTE DES RECOMMANDATIONS PAR CHAPITRE

---

### CHAPITRE UN

#### LA NÉCESSITÉ D'UN RAPPORT ANNUEL SUR L'ÉTAT DU SYSTÈME DE SOINS DE SANTÉ ET SUR L'ÉTAT DE SANTÉ DES CANADIENS

##### **Un commissaire national aux soins de santé et un conseil national des soins de santé**

Qu'un nouveau comité fédéral-provincial-territorial composé de cinq représentants provinciaux-territoriaux et cinq représentants fédéraux soit mis sur pied. Il aura pour mandat de nommer un commissaire national aux soins de santé et les huit autres membres d'un conseil national des soins de santé, choisis parmi les candidats proposés par le commissaire.

Que le commissaire national aux soins de santé soit chargé des responsabilités suivantes :

- présenter au comité fédéral-provincial-territorial des candidatures pour le conseil national des soins de santé et présider le conseil une fois les nominations ratifiées;
- surveiller la production d'un rapport annuel sur l'état du système de soins de santé et sur l'état de santé des Canadiens qui comprendra des constatations et des recommandations pour améliorer la prestation et les résultats des soins de santé au Canada;
- travailler en collaboration avec le conseil national des soins de santé afin de conseiller le gouvernement fédéral sur l'affectation des recettes additionnelles perçues afin de réformer et de renouveler le système de soins de santé conformément aux recommandations formulées dans le présent rapport;
- embaucher le personnel nécessaire pour réaliser cet objectif et travailler en étroite collaboration avec les organismes indépendants existants afin de réduire au minimum le chevauchement des fonctions.

Que le gouvernement fédéral verse 10 millions de dollars par année afin de financer le travail de ce commissaire et de ce conseil en vue de produire un rapport annuel sur l'état du système de soins de santé et sur l'état de santé des Canadiens, ainsi que de conseiller le gouvernement fédéral sur l'affectation du surcroît de recettes perçu afin de réformer et de renouveler le système de soins de santé.

## **CHAPITRE DEUX**

### **RESTRUCTURATION ET FINANCEMENT DES HÔPITAUX AU CANADA**

#### **Financement fondé sur les services dispensés**

Que l'on adopte pour les hôpitaux un mode de financement fondé sur les services dispensés. Ce mode de financement convient particulièrement aux hôpitaux communautaires situés dans les grands centres urbains. Il faut pour cela :

- qu'un nombre suffisant d'hôpitaux soient tenus de soumettre à l'Institut canadien d'information sur la santé des données sur leurs tarifs par cas et leurs coûts;
- que l'Institut canadien d'information sur la santé établisse, en collaboration avec les provinces et les territoires, une tarification détaillée afin de réduire la tentation du surclassement;
- que le gouvernement fédéral octroie à l'Institut canadien d'information sur la santé des crédits permanents qui seront consacrés à la collecte et à l'estimation des données nécessaires à la mise en œuvre du financement fondé sur les services dispensés;
- que l'on passe assez rapidement au financement fondé sur les services dispensés. Le Comité estime raisonnable de prévoir une période de transition de cinq ans.

Que le financement fondé sur les services dispensés soit complété par une méthode de financement additionnelle qui tiendrait compte des services uniques qu'offrent les centres universitaires des sciences de la santé, y compris l'enseignement et la recherche.

Que, dans l'élaboration d'une formule de rémunération fondée sur les services dispensés pour le financement des hôpitaux communautaires, l'on tienne compte des facteurs suivants :

- Isolement : les hôpitaux ruraux ou éloignés doivent assumer des coûts plus élevés que ceux des grands centres urbains.
- Taille : les petits hôpitaux assument des coûts plus élevés par cas pondéré que les grands hôpitaux. Un rajustement devrait être apporté pour tenir compte de ces réalités.

#### **Investissements pour appuyer les hôpitaux**

Que le gouvernement fédéral participe aux dépenses en immobilisations associées à l'expansion des hôpitaux situés dans des endroits où la croissance démographique est exceptionnellement élevée, c'est-à-dire les régions où la croissance démographique dépasse la moyenne provinciale de 50% ou plus. Cet apport devrait représenter 50 % du total de l'investissement en immobilisations nécessaire. En tout, le gouvernement fédéral devrait consacrer 1,5 milliard de dollars à cette initiative sur une période de dix ans ou 150 millions de dollars annuellement.

Que le gouvernement fédéral devrait encourager les provinces et les territoires à explorer des partenariats entre le secteur public et l'entreprise privée en vue d'obtenir un investissement supplémentaire dans la capacité hospitalière.

Que le gouvernement fédéral verse 4 milliards de dollars au cours des dix prochaines années (soit 400 millions de dollars par année) aux centres universitaires des sciences de la santé pour leurs dépenses en immobilisations.

Que les centres universitaires des sciences de la santé soient tenus de faire rapport de leur utilisation de ces fonds fédéraux.

## **CHAPITRE TROIS**

### **DÉLÉGUER PLUS DE RESPONSABILITÉS AUX RÉGIES RÉGIONALES DE LA SANTÉ**

Que les régies régionales de la santé des grands centres urbains puissent exercer un contrôle sur le coût des services médicaux en plus d'assumer leur responsabilité à l'égard des services hospitaliers dans leur région. Le pouvoir de dépenser pour l'achat de médicaments de prescription devrait également leur être délégué.

Que les régies régionales de la santé puissent choisir entre différents fournisseurs (particulier ou établissement) en fonction de la qualité et des coûts et récompenser les meilleurs fournisseurs par un volume accru. Ainsi, les RRS seraient dans l'obligation d'établir des contrats clairs où le volume des services et les objectifs de rendement seraient précisés.

Que le gouvernement fédéral encourage le transfert des responsabilités des gouvernements provinciaux et territoriaux aux régies régionales de la santé et participe à l'évaluation de la portée des réformes de marché interne menées à l'échelle régionale.

## **CHAPITRE QUATRE**

### **RÉFORME DES SOINS DE SANTÉ PRIMAIRES**

Que le gouvernement fédéral continue de travailler avec les provinces et les territoires à la réforme de la prestation des soins primaires et qu'il assure un soutien financier permanent aux projets de réforme entraînant la création d'équipes de soins de santé primaires pluridisciplinaires qui :

- visent à offrir une large gamme de services 24 heures sur 24, sept jours sur sept;
- veillent à faire en sorte que les services soient dispensés par les professionnels de la santé compétents qui conviennent le mieux;
- utilisent à leur pleine mesure les capacités et les compétences d'un éventail de professionnels de la santé;
- adoptent d'autres modes de rémunération que les honoraires à l'acte, par exemple la capitation, soit exclusivement, soit dans le cadre d'une formule de financement mixte;

- cherchent à intégrer des stratégies de promotion de la santé et de prévention de la maladie dans leur travail quotidien;
- assument progressivement une plus grande part de responsabilité à l'égard des besoins en santé et en bien-être de la population desservie.

Que le gouvernement fédéral puise 50 millions de dollars par année dans les nouvelles recettes que le Comité lui a recommandé de générer, pour aider les provinces à mettre sur pied des groupes de soins primaires.

## **CHAPITRE CINQ**

### **DES SOINS DE SANTE EN TEMPS OPPORTUN**

Ce chapitre ne contient pas de recommandation.

## **CHAPITRE SIX**

### **LA GARANTIE DE SOINS DE SANTÉ**

Qu'un délai d'attente maximum tenant compte des besoins soit fixé et rendu public pour chaque type d'intervention ou de traitement majeur;

Qu'une fois ce délai expiré, l'assureur (le gouvernement) paie pour que le patient puisse immédiatement faire des démarches pour subir l'intervention ou le traitement en question ailleurs au Canada ou, au besoin, à l'étranger (par exemple, aux États-Unis). C'est ce qu'on appelle la garantie de soins de santé.

Que le processus d'établissement des normes régissant les périodes d'attente soit de portée nationale ;

Qu'un organisme indépendant, chargé d'examiner les données scientifiques et cliniques pertinentes, soit mis sur pied;

Que les normes régissant les périodes d'attente portent sur quatre principaux types d'intervention : consultation pour soins primaires, première consultation d'un spécialiste, test diagnostique et chirurgie.

## **CHAPITRE SEPT**

### **ÉTENDRE LA COUVERTURE POUR INCLURE LA PROTECTION CONTRE LES COÛTS EXORBITANTS DES MÉDICAMENTS DE PRESCRIPTION**

Que le gouvernement fédéral mette en place un programme visant à protéger les Canadiens contre les dépenses exorbitantes en médicaments de prescription.

Pour tous les régimes admissibles, le gouvernement fédéral accepterait de payer :

- 90 % des dépenses en médicaments de prescription dépassant 5 000 \$ dans le cas des personnes dont le total combiné des dépenses personnelles non remboursables et de la contribution de la province ou du territoire à leur égard est supérieur à 5 000 \$ au cours d'une année;
- 90 % des dépenses en médicaments de prescription dépassant 5 000 \$ dans le cas des participants à un régime privé d'assurance-médicaments complémentaire dont le total combiné des dépenses personnelles non remboursables et de la contribution du régime d'assurance privé à leur égard est supérieur à 5 000 \$ au cours d'une année.
- Les 10 % restants seraient assumés par un régime provincial/territorial ou par un régime privé complémentaire.

Pour être admissibles à ce programme fédéral :

- les provinces et les territoires devront mettre en place un programme garantissant qu'aucune famille n'aura à payer de sa poche plus de 3 % de son revenu familial pour acheter des médicaments de prescription;
- les promoteurs des régimes privés d'assurance-médicaments complémentaire existants devront garantir qu'aucun participant n'aura à payer de sa poche plus de 1 500 \$ par année; ainsi, les dépenses personnelles non remboursables de chaque participant seraient plafonnées à 3 % de son revenu familial ou à 1 500 \$, selon le moins élevé des deux montants.

Que le gouvernement fédéral travaille en étroite collaboration avec les provinces et les territoires afin d'établir une liste nationale unique des médicaments admissibles.

## **CHAPITRE HUIT**

### **ÉLARGIR LA COUVERTURE POUR INCLURE LES SOINS ACTIFS À DOMICILE**

#### **Début et fin des SAD**

Qu'une période de SAD désigne l'ensemble des services de soins à domicile reçus entre la première date de prestation de services suivant le congé d'hospitalisation, si cette date survient moins de trente jours après le congé, jusqu'à concurrence de trois mois après le congé de l'hôpital.

#### **Financement des SAD dirigé vers les hôpitaux**

Que le financement des soins actifs à domicile soit d'abord dirigé vers les hôpitaux.

Afin d'encourager l'innovation et l'intégration de services et d'améliorer l'efficacité et l'efficacités des services de soins de santé nécessaires, indépendamment du cadre dans lequel ces services sont reçus, que soit élaborée une méthode de remboursement pour les SAD, basée sur les services, conjointement avec les arrangements fondés sur les services pour chaque période de soins hospitaliers.

#### **Eventail des services couverts**

Que la gamme de services, de produits et de technologies pouvant être utilisée pour faciliter les soins à domicile après une hospitalisation ne fasse pas l'objet de restrictions.

#### **Fonds pour les SAD grâce au financement fondé sur les services dispensés**

Que les hôpitaux aient la possibilité d'établir des liens contractuels directement avec les fournisseurs de soins à domicile ou avec des agences intermédiaires pouvant prendre des dispositions en matière de prestation de services et de gestion de cas.

Que les contrats établis avec les fournisseurs de services de soins à domicile incluent, en plus des ententes de remboursement en fonction des services, des mécanismes pour surveiller la qualité et le rendement des services, ainsi que les résultats prévus.

#### **Partage des coûts du programme SAD**

Que le gouvernement fédéral établisse un nouveau programme national de soins actifs à domicile, qu'il financera à parts égales avec les provinces et territoires (50 / 50).

Que le programme des SAD soit considéré comme un prolongement de la couverture médicale nécessaire déjà prévue par la *Loi canadienne sur la santé* et que, par conséquent, le coût intégral du programme soit couvert par le gouvernement (à parts égales entre le gouvernement fédéral et les gouvernements provinciaux-territoriaux).

## **CHAPITRE NEUF**

### **ÉTENDRE LA COUVERTURE POUR INCLURE LES SOINS PALLIATIFS À DOMICILE**

Que le gouvernement fédéral s'engage à verser 250 millions de dollars par année au titre d'un programme national de soins palliatifs à domicile, élaboré de concert avec les provinces et les territoires et financé à 50 % par chacune des deux parties.

Que le gouvernement fédéral étudie la possibilité de permettre que des prestations d'assurance-emploi soient versées pendant une période de six semaines aux salariés canadiens qui choisissent de s'absenter du travail pour prodiguer des soins palliatifs à domicile à un parent mourant.

Que le gouvernement fédéral étudie la possibilité d'étendre l'application des mesures fiscales déjà existantes aux personnes qui s'occupent d'un membre d'un proche mourant ou à celles qui paient pour obtenir ces services au nom du mourant.

Que le gouvernement fédéral modifie le *Code canadien du travail* de façon à permettre aux employés de s'absenter dans les situations de crise familiale, par exemple pour s'occuper d'un proche mourant, et qu'il collabore avec les provinces afin de favoriser de telles modifications aux codes provinciaux du travail.

Que le gouvernement fédéral prenne l'initiative en tant qu'employeur en modifiant la législation du Conseil du Trésor afin de protéger les emplois de ses propres employés qui s'occupent d'un proche mourant.

## **CHAPITRE DIX**

### **LE RÔLE DU GOUVERNEMENT FÉDÉRAL DANS L'INFRASTRUCTURE DE SOINS DE SANTÉ**

#### **Technologies de la santé**

Que le gouvernement fédéral verse aux hôpitaux des fonds expressément destinés à l'achat et à l'évaluation de technologies de la santé. Le gouvernement fédéral devrait consacrer à cette fin 2,5 milliards de dollars au total sur cinq ans (ou 500 millions de dollars par année). De ce montant, 400 millions de dollars seraient alloués annuellement aux centres universitaires des sciences de la santé, et 100 millions de dollars aux hôpitaux communautaires. Le financement des hôpitaux communautaires serait partagé à parts égales avec les provinces, tandis que le financement des centres serait assuré intégralement par le gouvernement fédéral.

Que les établissements bénéficiant de ce programme fassent rapport de la façon dont ils utilisent les fonds reçus.

## **Dossiers de santé électroniques**

Que le gouvernement fédéral accorde un financement additionnel à Inforoute Santé du Canada Inc. pour permettre à cette entreprise de créer, de concert avec les provinces et les territoires, un système national de dossiers de santé électroniques.

Que le financement fédéral supplémentaire versé à *Inforoute* s'élève à 2 milliards de dollars sur cinq ans, soit une enveloppe annuelle de 400 millions de dollars.

## **Évaluation du rendement du système**

Que le gouvernement fédéral accorde un financement annuel supplémentaire de 50 millions de dollars à l'Institut canadien d'information sur la santé et verse en outre une somme annuelle de 10 millions de dollars au Conseil canadien d'agrément des services de santé. Ce nouvel investissement fédéral contribuera à l'établissement d'un système national d'évaluation de l'efficacité et des résultats du système de soins de santé et facilitera ainsi la tâche au commissaire national aux soins de santé.

## **Protection des renseignements personnels sur la santé**

Que les enjeux clés suivants fassent l'objet d'une plus grande harmonisation et coordination entre les instances fédérales, provinciales et territoriales :

- des règles d'accès sélectif restreignant l'accès aux utilisateurs autorisés en fonction des fins pour lesquelles ceux-ci ont besoin des renseignements;
- des règles de consentement régissant la forme et les critères à respecter pour qu'un consentement soit valide;
- des conditions autorisant l'accès sans consentement à des renseignements personnels sur la santé dans des circonstances exceptionnelles et pour des fins précises;
- des règles régissant la conservation et la destruction des renseignements personnels sur la santé;
- des mécanismes permettant d'assurer une surveillance suffisante des systèmes de DSE d'un organisme à l'autre.

Qu'Inforoute Santé du Canada Inc. et d'autres investisseurs clés structurent leurs critères d'investissement de façon à créer des conditions de nature à encourager les concepteurs de systèmes DSE à trouver des solutions utiles et pratiques en matière de protection des renseignements personnels pour permettre :

- l'adoption de mesures de sécurité d'avant-garde pour protéger les renseignements personnels sur la santé et soumettre les opérations à une vérification;
- un partage entre les différents dépositaires qui ont accès aux DSE et les utilisent de la responsabilité en matière de reddition de comptes;



- une coordination entre les dépositaires de façon que les patients puissent concrètement exercer leur droit d'accès à leur DSE pour y rectifier une inexactitude et contester en cas de non-conformité.

Que les principaux intervenants, notamment les ministères de la Santé fédéral, provinciaux et territoriaux, Inforoute Santé du Canada Inc., l'Institut canadien d'information sur la santé et les Instituts de recherche en santé du Canada, veillent à :

- entreprendre une étude rigoureuse des facteurs qui déterminent l'attitude des Canadiens à l'égard de ce qui leur paraît être une utilisation acceptable ou non acceptable des renseignements personnels concernant leur santé;
- amorcer un dialogue éclairé et valable avec les principaux intervenants, notamment les groupes de patients et les représentants des consommateurs;
- mettre en œuvre une stratégie de communication publique ouverte, transparente et itérative pour expliquer les avantages des DSE.

## **CHAPITRE ONZE**

### **LES RESSOURCES HUMAINES DE LA SANTÉ**

#### **La nécessité d'études sur la productivité**

Que l'on effectue des études pour trouver des moyens d'améliorer la productivité des professionnels de la santé. Ces études devraient être effectuées ou commandées par le comité national de coordination des ressources humaines en santé dont le Comité recommande la création.

#### **Un comité national de coordination des ressources humaines de la santé**

Que le gouvernement fédéral travaille avec d'autres parties intéressées afin de créer un comité national permanent de coordination des ressources humaines de la santé, composé de représentants des principaux intervenants et des différents ordres de gouvernement. Son mandat serait le suivant :

- diffuser des renseignements à jour sur les besoins en ressources humaines;
- coordonner des projets visant à assurer un nombre suffisant de diplômés pour réaliser l'objectif d'autosuffisance en matière de ressources humaines;
- partager et promouvoir les pratiques exemplaires quant aux stratégies servant à retenir des professionnels de la santé compétents, et coordonner les efforts de rapatriement des professionnels de la santé canadiens qui ont émigré;
- recommander des stratégies pour accroître le nombre de professionnels de la santé provenant de groupes sous-représentés, comme les peuples autochtones, ainsi que dans les régions mal desservies, particulièrement les régions rurales et éloignées;

- examiner les possibilités en vue d'une meilleure coordination, entre les divers ordres de gouvernement, des exigences en matière d'accréditation et d'immigration.

### **Augmenter le bassin des ressources humaines de la santé**

Que le gouvernement fédéral :

- Travaille avec les gouvernements provinciaux pour faire en sorte que toutes les écoles de médecine et de sciences infirmières reçoivent les augmentations de financement nécessaires pour leur permettre d'accroître le nombre d'inscriptions.
- Mette en place des mécanismes permettant un financement fédéral direct afin de soutenir un plus grand nombre d'inscriptions dans les écoles de médecine et de sciences infirmières, et assure la stabilité du financement en vue de la formation de professionnels paramédicaux.
- Examine les programmes fédéraux de prêts étudiants offerts aux professionnels de la santé et y apporte les modifications nécessaires afin que les augmentations inévitables de frais de scolarité ne nuisent pas aux étudiants défavorisés sur le plan socioéconomique.
- Travaille avec les gouvernements provinciaux pour faire en sorte que la rémunération des différentes catégories de professionnels de la santé tienne compte du niveau de formation réel exigé d'eux.

Que le gouvernement fédéral travaille avec les provinces et les facultés de médecine et de sciences infirmières afin de financer des places à l'intention des étudiants d'origine autochtone, en plus des places offertes à la population générale.

Que, pour faciliter le retour au Canada des professionnels de la santé canadiens travaillant à l'étranger, le gouvernement fédéral travaille avec les provinces et les associations professionnelles afin d'informer ces professionnels des nouvelles perspectives d'emploi au Canada, et qu'il étudie la possibilité d'adopter des incitatifs fiscaux à court terme pour ceux qui sont prêts à rentrer au Canada.

Que le gouvernement fédéral verse dès maintenant 160 millions de dollars par année afin que les écoles de médecine canadiennes puissent recruter 2 500 étudiants de première année d'ici 2005.

Que le comité national de coordination des ressources humaines en santé dont le Comité propose la création soit chargé de surveiller les niveaux d'inscription des écoles de médecine du Canada et qu'il conseille le gouvernement fédéral à cet égard.

Que le gouvernement fédéral contribue financièrement à accroître le nombre de postes de médecins résidents afin d'atteindre un ratio de 120 pour 100 diplômés des écoles de médecine canadiennes.

Que le gouvernement fédéral travaille avec les provinces afin d'établir des normes nationales pour l'évaluation des diplômés en médecine étrangers, et qu'il fournisse un financement continu

pour mettre en œuvre un programme accéléré visant à délivrer des licences aux diplômés étrangers qualifiés et à intégrer complètement ces derniers au système canadien de soins de santé.

Que le gouvernement fédéral introduise graduellement du financement au cours des cinq prochaines années de façon que le nombre de diplômés des programmes de sciences infirmières atteigne 12 000 en 2008 dans l'ensemble du Canada, et qu'il continue à fournir un financement supplémentaire complet aux provinces pour toutes les places dans les écoles de sciences infirmières au-delà de 10 000 inscriptions, et ce, aussi longtemps qu'il sera nécessaire pour enrayer la pénurie d'infirmières au pays.

Que le gouvernement fédéral verse 90 millions de dollars par année tirés des recettes supplémentaires dont le Comité recommande le prélèvement, afin de permettre aux écoles d'infirmières du Canada de produire 12 000 diplômés d'ici 2008.

Que le gouvernement fédéral verse 40 millions de dollars par année tirés des recettes supplémentaires dont le Comité recommande le prélèvement, afin d'aider les provinces à accroître le nombre de diplômés des professions paramédicales chaque année.

Que l'allocation exacte de ces fonds soit déterminée par le comité national de coordination des ressources humaines en santé.

Que le gouvernement fédéral consacre 75 millions de dollars par année des nouveaux fonds que recommande de recueillir le Comité afin d'aider les centres universitaires des sciences de la santé à payer les coûts liés à l'accroissement du nombre de places de formation pour l'ensemble des professions de la santé.

### **Examiner les règles relatives au champ de pratique**

Qu'un examen indépendant des règles relatives au champ de pratique et des autres règlements concernant ce que chaque professionnel de la santé peut ou ne peut pas faire soit effectué dans le but d'élaborer des propositions qui feraient en sorte qu'on utilise pleinement les compétences des divers professionnels de la santé et que les soins de santé soient fournis par le professionnel qualifié qui convient le mieux.

## **CHAPITRE DOUZE**

### **FAVORISER L'EXCELLENCE DANS LA RECHERCHE CANADIENNE EN SANTÉ**

#### **Jouer le rôle de chef de file dans la recherche en santé**

Que la recherche et sa concrétisation dans le système de soins de santé figurent régulièrement à l'ordre du jour des rencontres des ministres et sous-ministres fédéraux, provinciaux et territoriaux de la santé, et que l'Institut de recherche en santé du Canada soit représenté et participe à l'établissement des programmes de recherche en santé lors de ces réunions. Ces mesures aideront énormément à soutenir une culture d'appui à la création et à l'utilisation des connaissances générées par la recherche en santé partout au Canada.

Que le gouvernement fédéral établisse, sur une base régulière et en collaboration avec tous les intervenants, des objectifs et des priorités nationaux pour la recherche en santé.

Que le gouvernement fédéral favorise la collaboration entre différents intervenants lorsqu'il exécute, finance et utilise des recherches en santé. On pourrait ainsi disposer des meilleures ressources possibles, tout en réduisant au minimum le chevauchement et le double emploi.

Que le gouvernement fédéral assume un rôle de leadership, par l'entremise des Instituts de recherche en santé du Canada et de Santé Canada, dans l'élaboration d'une stratégie visant à encourager l'échange de chercheurs entre le gouvernement, le milieu universitaire et le secteur privé, y compris les organisations bénévoles nationales.

#### **Financer la recherche en santé**

Que le gouvernement fédéral, par l'entremise aussi bien de Santé Canada que des Instituts de recherche en santé du Canada, assure la coordination et fournisse les ressources nécessaires pour que le Canada contribue à la révolution scientifique et en bénéficie, de façon à en maximiser les avantages économiques, sanitaires et sociaux pour les Canadiens.

Que les Instituts de recherche en santé du Canada et Génome Canada financent des projets de recherche qui assureront au Canada un rôle de chef de file mondial dans ce nouveau domaine de la génomique et de la génétique humaine afin que le système de soins de santé puisse profiter de cette nouvelle technologie pour améliorer la santé des Canadiens.

Que les Instituts de recherche en santé du Canada jouent un rôle de chef de file dans l'établissement de pratiques exemplaires pour ce qui est questions éthiques complexes que soulève l'utilisation de cette nouvelle technologie en recherche et en soins de la santé.

Que le gouvernement fédéral :

- augmente, dans un laps de temps raisonnable, sa contribution financière à la recherche extérieure en santé, de façon à atteindre un niveau de 1 % des dépenses totales consacrées aux soins de santé au Canada, ce qui signifie un investissement supplémentaire de 440 millions de dollars de la part du gouvernement fédéral;

- reconnaisse que la recherche en santé est un projet de longue haleine et, par conséquent, établisse des plans à long terme clairs pour le financement de la recherche en santé, et s’y conforme, particulièrement par l’entremise des Instituts de recherche en santé du Canada. Plus précisément, le gouvernement fédéral devrait adopter un horizon de planification de cinq ans pour le budget des IRSC;
- fasse un investissement prévisible et suffisant dans la recherche interne en santé.

Que Santé Canada :

- dispose des ressources financières et humaines de recherche en santé qu’il lui faut pour s’acquitter de son mandat et de ses obligations;
- entreprenne activement d’établir des liens et des partenariats avec d’autres intervenants du domaine de la recherche en santé.

Que le gouvernement fédéral, par l’entremise des Instituts de recherche en santé du Canada, de Santé Canada et de la Fondation canadienne de la recherche sur les services de santé, consacre des fonds supplémentaires à la recherche sur les services de santé et à la recherche clinique, et qu’il collabore avec les provinces et les territoires pour que les résultats de ces recherches soient largement diffusés parmi les fournisseurs, les gestionnaires et les décideurs du domaine des soins de santé.

### **Recherche sur la santé de segments de population vulnérables**

Que le gouvernement fédéral, par l’entremise des Instituts de recherche en santé du Canada et de Santé Canada, affecte davantage de fonds à la recherche portant sur la santé de segments particulièrement vulnérables de la société canadienne.

Que le gouvernement fédéral affecte des fonds supplémentaires à l’Institut de la santé des Autochtones des IRSC, afin d’intensifier la participation des chercheurs canadiens en santé, et notamment des Autochtones eux-mêmes, aux recherches visant à améliorer la santé des Autochtones canadiens.

Que Santé Canada reçoive des ressources supplémentaires pour étendre sa capacité de recherche et renforcer sa capacité d’intégration des résultats de la recherche dans le domaine de la santé des Autochtones.

Que le gouvernement fédéral affecte davantage de ressources à l’Initiative de recherche en santé mondiale.

### **Commercialization les résultats de recherche en santé**

Que le gouvernement fédéral exige de tous les bénéficiaires de subventions fédérales à la recherche en santé l’engagement explicite d’obtenir le maximum d’avantages pour le Canada quand les résultats de la recherche subventionnée sont utilisés à des fins lucratives.

Que les Instituts de recherche en santé du Canada, sans faire abstraction de la valeur sociale de la recherche en santé n’ayant pas de résultats commerciaux lucratifs, cherchent à favoriser les

retombées économiques au Canada découlant de leurs investissements dans la recherche canadienne en santé, quand les résultats de cette recherche sont utilisés à des fins lucratives. Ce faisant, les IRSC devraient élaborer une stratégie d'innovation visant à accélérer et à faciliter la commercialisation des résultats de la recherche en santé.

Que le gouvernement fédéral investisse des ressources supplémentaires, dans le cadre de la stratégie d'innovation des IRSC, pour valoriser la production des chercheurs canadiens en santé et renforcer la capacité de commercialisation des résultats de la recherche en santé financée par des fonds fédéraux. Le nouveau financement devrait s'ajouter aux investissements actuels dans la recherche en santé. Il faudrait en particulier rendre permanent le financement des coûts indirects de la recherche par les organismes subventionnaires du Canada. Les responsables de la recherche en santé devraient rendre compte de l'utilisation des fonds de commercialisation.

### **L'éthique en recherche en santé**

Que Santé Canada prenne l'initiative, en collaboration avec les intervenants, de l'élaboration d'un système commun de gouvernance de la recherche en santé effectuée sur des sujets humains s'appliquant à toute la recherche que le gouvernement fédéral exécute, finance et utilise dans ses activités de réglementation.

Que, dans l'élaboration de ce système de gouvernance de l'éthique, Santé Canada considère les éléments suivants comme essentiels au progrès :

- travailler en premier sur toute la recherche (en santé) que le gouvernement fédéral exécute, finance ou utilise dans ses activités de réglementation, afin d'élaborer un système efficace et efficient de gouvernance qui sera adopté comme norme partout au Canada;
- accorder une grande importance, dans le système de gouvernance, à des mécanismes efficaces d'éducation et de formation, destinés à tous ceux qui s'occupent de recherche et d'éthique de la recherche et dotés d'un processus d'agrément correspondant aux responsabilités des différents participants;
- élaborer des normes, fondées sur l'*Énoncé de politique des trois Conseils*, les lignes directrices de la Conférence internationale d'harmonisation relatives aux essais cliniques sur des sujets humains et d'autres normes pertinentes canadiennes et étrangères, pouvant servir de base à l'autorisation ou à l'agrément des fonctions ou des comités d'éthique de la recherche à un niveau correspondant aux attentes des Canadiens et aux normes d'autres pays;
- veiller à l'actualisation de l'*Énoncé de politique des trois Conseils* et à son maintien à l'avant-garde des politiques internationales régissant l'éthique ou la recherche sur des sujets humains;
- faire disparaître les incohérences entre les différentes politiques qui régissent actuellement la recherche sur des sujets humains et faire concorder les normes canadiennes avec celles d'autres pays qui influent sur la recherche canadienne;

- établir un processus d'autorisation ou d'agrément des fonctions d'éthique de la recherche, qui soit indépendant du gouvernement, mais qui soit clairement tenu de lui rendre compte de son activité;
- élaborer le système de gouvernance dans le cadre de consultations de fond ouvertes et transparentes avec les intervenants.

Que tous les ministères et organismes fédéraux imposent le respect des normes du Conseil canadien de protection des animaux dans :

- toute la recherche effectuée dans des installations fédérales;
- toute la recherche financée par des ministères et organismes fédéraux, mais effectuée en dehors des installations fédérales;
- toute la recherche effectuée sans financement fédéral en dehors des installations fédérales, mais dont les résultats sont présentés au gouvernement fédéral ou sont utilisés par lui dans l'exercice de fonctions prévues par voie législative.

### **La protection des renseignements personnels sur la santé**

Que des règlements comme celui que proposent les Instituts de recherche en santé du Canada fassent l'objet de l'étude la plus complète et la plus équitable possible dans le cadre des discussions qui se tiendront sur les moyens de clarifier et de préciser la loi, afin d'en atteindre les objectifs sans entraver d'importantes recherches destinées à améliorer la santé des Canadiens et à leur assurer de meilleurs services de santé.

Que des discussions se poursuivent entre les intervenants, le commissaire à la protection de la vie privée et les ministères fédéraux et provinciaux qui s'occupent de la prestation, de la gestion, de l'évaluation et de l'assurance de la qualité des services de santé.

Que le gouvernement fédéral, par l'entremise des Instituts de recherche en santé du Canada et de Santé Canada et de concert avec d'autres intervenants intéressés, élabore et mette en œuvre un programme de sensibilisation du public destiné à assurer une meilleure compréhension :

- de la nature et de la raison d'être des grandes bases de données contenant des renseignements médicaux personnels, qui doivent être tenues pour assurer le fonctionnement d'un système public de soins de santé;
- du besoin essentiel de faire une utilisation secondaire de telles bases de données aux fins de la recherche en santé et de la gestion des soins.

Que le gouvernement fédéral, par l'entremise des Instituts de recherche en santé du Canada et de Santé Canada et de concert avec d'autres intervenants intéressés, se charge de favoriser :

- une discussion et un examen réfléchis des questions éthiques, concernant notamment le consentement éclairé, que pose l'utilisation secondaire des renseignements médicaux personnels aux fins de la recherche en santé et de la gestion des soins;

- une étude approfondie des mécanismes de contrôle et d'examen nécessaires pour s'assurer que les bases de données contenant des renseignements médicaux personnels sont efficacement créées, tenues et protégées et que leur utilisation aux fins de la recherche en santé et de la gestion des soins est faite d'une manière ouverte, transparente et responsable.

Que les Instituts de recherche en santé du Canada, en partenariat avec le secteur privé et d'autres intervenants, continuent d'étudier les aspects éthiques des relations entre les secteurs afin de veiller à ce que la collaboration et les partenariats jouent dans l'intérêt de tous les Canadiens.

## **CHAPITRE TREIZE**

### **UNE POLITIQUE PUBLIQUE « PRO-SANTÉ » – LA SANTÉ AU-DELÀ DES SOINS DE SANTÉ**

#### **Stratégies nationales de prévention des maladies chroniques**

Que le gouvernement fédéral, de concert avec les gouvernements provinciaux et territoriaux et en consultation avec les principaux intervenants (dont l'Alliance pour la prévention des maladies chroniques au Canada), mette en œuvre une stratégie nationale de prévention des maladies chroniques;

Que cette stratégie s'inspire des initiatives en cours, mais qu'elle prévoie aussi une meilleure intégration et une meilleure coordination;

Que le gouvernement fédéral consacre 125 millions de dollars par année à la stratégie nationale de prévention des maladies chroniques;

Que des objectifs précis soient fixés dans le cadre de la stratégie et que les résultats soient évalués régulièrement en fonction de ces objectifs.

#### **Infrastructure de la santé publique**

Que le gouvernement fédéral assure un leadership fort en matière de soutien, de coordination et d'intégration de l'infrastructure de la santé publique et des efforts de promotion de la santé au Canada et qu'il y affecte davantage de fonds. Il devrait consacrer 200 millions de dollars de plus à cette entreprise très importante.



## **CHAPITRE QUATORZE**

### **COMMENT ADMINISTRER LES FONDS SUPPLÉMENTAIRES QUE LE GOUVERNEMENT FÉDÉRAL CONSACRERA À LA SANTÉ**

Que le gouvernement fédéral crée un fonds réservé aux soins de santé, distinct du Trésor. Ce fonds contiendra les recettes supplémentaires qu'il destine aux soins de santé.

Que les sommes réservées aux soins de santé ne soient consacrées qu'à la santé. De plus, qu'elles servent à opérer de véritables changements et une vraie réforme, c'est-à-dire exclusivement à étendre la couverture de l'assurance-santé et à restructurer et renouveler le système public de soins hospitaliers et de soins fournis par les médecins.

Que le conseil national des soins de santé soit chargé de conseiller le gouvernement fédéral sur la façon de dépenser les fonds réservés aux soins de santé, et que ses conseils soient rendus publics dans un rapport annuel.

Que le gouvernement fédéral soumette le fonds réservé aux soins de santé à des vérifications annuelles confiées au Bureau du vérificateur général du Canada. Que les résultats de ces vérifications soient rendus publics.

Que le gouvernement fédéral exige que les provinces et les territoires fassent rapport annuellement à la population canadienne quant à l'utilisation des sommes fédérales provenant du fonds réservé aux soins de santé.

## **CHAPITRE QUINZE**

### **COMMENT GÉNÉRER DES FONDS ADDITIONNELS POUR LES SOINS DE SANTÉ**

#### **Pour financer les recommandations de ce rapport**

Que le gouvernement fédéral institue une prime nationale variable au titre de la santé pour générer les recettes nécessaires au financement de la mise en œuvre des recommandations du Comité.

#### **Pour financer les dépenses fédérales actuelles au titre des soins de santé**

Que le gouvernement fédéral procède au choix d'une source de recettes réservées qu'il affectera au financement de sa contribution annuelle au programme national canadien d'assurance-santé, laquelle est actuellement évaluée à environ 62 % du TCSPS.

Que, si l'on retient la TPS comme source de recettes réservées au financement de la contribution pécuniaire actuelle du gouvernement fédéral au régime national d'assurance des soins hospitaliers et des soins dispensés par les médecins, la moitié du produit de la TPS (3,5 des 7 points de la taxe) soit réservé au secteur de la santé, de manière à permettre au gouvernement fédéral de faire une contribution additionnelle au financement du système actuel de soins hospitaliers et de soins

dispensés par les médecins. (Cela viendrait s'ajouter aux crédits fédéraux nécessaires à la mise en œuvre des recommandations énoncées dans le présent rapport.)

Que la part de chaque province et territoire de la contribution annuelle du gouvernement fédéral au financement du régime courant de soins hospitaliers et de soins dispensés par les médecins soit calculée au prorata de la population, mais corrigée pour tenir compte, d'une manière ou d'une autre, du poids démographique de la population âgée de 70 ans et plus.

## **CHAPITRE SEIZE**

### **VIABILITÉ FINANCIÈRE DU SYSTÈME DE SOINS DE SANTÉ : LES CONSÉQUENCES DE L'INACTION**

Ce chapitre ne contient pas de recommandation.

## **CHAPITRE DIX-SEPT**

### **LA LOI CANADIENNE SUR LA SANTÉ**

Que le gouvernement fédéral, en collaboration avec les provinces et territoires, établisse un comité permanent – soit le comité sur la couverture de l'assurance-santé publique – constitué de citoyens, d'éthiciens, de fournisseurs de soins de santé et de scientifiques.

Que ce comité ait pour mandat d'examiner les services et de recommander ceux qui doivent être couverts par l'assurance-santé publique.

Que le comité sur la couverture de l'assurance-santé publique rende compte de ses constatations et recommandations au conseil national des soins de santé.

Que, en premier lieu, le comité sur la couverture de l'assurance-santé publique soit chargé d'élaborer des normes nationales pour orienter les décisions relatives à la couverture publique des soins de santé.

Que le comité sur la couverture de l'assurance-santé publique soit chargé de déterminer les paramètres nationaux applicables aux soins à domicile post-hospitaliers et aux soins palliatifs dispensés à domicile.

Que le gouvernement fédéral adopte une nouvelle loi portant création de la garantie nationale de soins de santé. La nouvelle loi comprendra une définition de la notion d'« accès en temps opportun » que prévoit une telle garantie.

Que le principe de gestion publique contenu dans la *Loi canadienne sur la santé* soit maintenu à l'égard des services hospitaliers et médicaux assurés par l'État, c'est-à-dire qu'un seul assureur – soit le gouvernement – paie les services publics hospitaliers et médicaux dispensés par des fournisseurs ou des établissements de soins de santé publics ou privés.

Que le gouvernement fédéral, par l'intermédiaire de Santé Canada, précise la notion de gestion publique en vertu de la *Loi canadienne sur la santé* de façon à reconnaître explicitement que ce

principe s'applique à la gestion de l'assurance-santé publique et non à la prestation des services de santé assurés par l'État.

Que le gouvernement fédéral adopte de nouvelles mesures législatives pour mettre en oeuvre une couverture des coûts exorbitants de médicaments de prescription, des soins à domicile post-hospitaliers et de certains soins palliatifs à domicile. Ces nouvelles mesures doivent énoncer explicitement les conditions relatives à la transparence de la prise de décisions et à la reddition de comptes.



### **LIST DES PRINCIPES DU VOLUME CINQ (AVRIL 2002)**

---

Les principes suivants, qui ont été énoncés dans le volume cinq, ont guidé le Comité à développer le plan d'action détaillé qui est présenté dans ce rapport.

#### **L'ASSUREUR :**

1. Les services hospitaliers et les services dispensés par un médecin couverts par la *Loi canadienne sur la santé* sont financés (assurés) exclusivement par le gouvernement, directement ou par l'intermédiaire d'un organisme indépendant.
2. Le montant des fonds publics consacrés à l'assurance des soins de santé publics est stable et prévisible.
3. Le gouvernement fédéral joue un rôle de premier plan dans le maintien d'un système national d'assurance-santé.
4. La détermination des services couverts par l'assurance-santé publique se fait d'une façon ouverte et transparente. Les services de santé couverts par la *Loi canadienne sur la santé* sont assurés par l'État. Les autres services de santé continuent d'être financés à partir de sources publiques et privées, comme c'est déjà le cas.
5. Le gouvernement fédéral contribue en permanence au financement des technologies de la santé.
6. Le gouvernement fédéral consacre davantage d'argent aux éléments du secteur de la santé et des soins de santé vis-à-vis desquels il assume d'importantes responsabilités.
7. Les conséquences des modifications du niveau ou du montant des fonds publics consacrés aux services hospitaliers et aux services dispensés par un médecin sont bien pesées par le gouvernement et expliquées en détail à la population au moment où ces changements sont effectués et annoncés.

#### **LE FOURNISSEUR DE SOINS :**

8. La méthode de rémunération des hôpitaux est modifiée durant la première phase de la réforme des soins de santé : le financement par budget annuel global est remplacé par un financement fondé sur les services dispensés.
9. Les régies régionales de la santé sont chargées de l'achat des services hospitaliers auprès des établissements de leur région.
10. La réforme des soins primaires aboutira à une médecine de groupe organisée en cliniques ouvertes 24 heures sur 24, sept jours sur sept.

11. Pour faciliter la réforme des soins primaires, les omnipraticiens ne sont plus rémunérés exclusivement à l'acte, mais au moyen d'une formule mixte qui combine la rémunération par capitation, la rémunération à l'acte et d'autres formes de rémunération.
12. De nouvelles règles concernant les champs d'activité et d'autres dispositions sont élaborées pour permettre à tous les professionnels de la santé du secteur des soins primaires d'offrir l'éventail complet des services pour lesquels ils sont formés.
13. Durant la seconde étape de la réforme des soins de santé, un « marché interne » sera probablement constitué où les équipes de soins primaires achètent, pour le compte de leurs clients, des services de santé auprès des hôpitaux et des autres établissements de santé.
14. Une stratégie nationale (et pas exclusivement fédérale) permet de garantir une offre suffisante de fournisseurs de soins de santé et une exploitation optimale de leurs services.

### **L'ÉVALUATEUR :**

15. Les impératifs de la responsabilisation et de la transparence à l'égard du financement et de la prestation des soins de santé exigent le déploiement d'un système de dossiers de santé électroniques (DES) capable de saisir de l'information sur le rendement du système de soins de santé et ses résultats.
16. La saisie des résultats des traitements et du rendement du système de soins de santé fait partie intégrante du système d'information sur la santé. Ces activités de contrôle et d'évaluation sont réalisées par un organisme national (et non fédéral) indépendant et sont financées par l'État.

### **LE PATIENT :**

17. Le système public de soins de santé du Canada est axé sur le patient.
18. Des mécanismes sont institués pour encourager les patients à faire un usage aussi efficace que possible des services hospitaliers et des services des médecins. Ces mécanismes excluent l'imposition de frais d'utilisation pour des services médicaux considérés comme nécessaires.
19. On accorde la priorité aux programmes qui ont pour but de responsabiliser les personnes à l'égard de leur santé. Le gouvernement fédéral peut jouer un rôle important à cet égard.
20. Un délai d'attente maximum devrait être fixé et rendu public pour chaque type d'intervention ou de traitement majeur. Une fois ce délai expiré, l'assureur (le gouvernement) engage les dépenses nécessaires pour que le patient bénéficie immédiatement de l'intervention ou du traitement en question ailleurs au Canada ou, au besoin, à l'étranger.

# ANNEXE C

## LISTE DES TÉMOINS

---

### 1<sup>RE</sup> SESSION DE LA 37<sup>E</sup> LÉGISLATURE

#### **Mercredi 24 avril 2002**

*Commission de restructuration des services de santé (Ontario) :*  
Dr Duncan Sinclair, ancien commissaire

#### **Jeudi 25 avril 2002**

*Santé Canada :*  
Marcel Nouvet, sous-ministre adjoint, Direction générale de l'information, de l'analyse et de la connectivité  
Michel Léger, directeur exécutif, Division des alliances stratégiques et des priorités, Direction générale de l'information, de l'analyse et de la connectivité

#### **Mercredi 1 mai 2002**

*Institut canadien d'information sur la santé :*  
Michael Decter, président, Conseil d'administration

#### **Lundi 6 mai 2002**

*Calgary Health Region :*  
Jack Davis, président-directeur général

*À titre personnel :*  
Claude Forget, ex-ministre de la Santé, province de Québec

*Université Dalhousie :*  
Dre Nuala Kenny, professeur de pédiatrie; présidente, Département de bioéthique

*Hôpital St. Michael's :*  
Jeffrey Lozon, président-directeur général

*À titre personnel :*  
Graham Scott, ex-sous-ministre de la Santé, province de l'Ontario

*Hôpital Royal Columbian :*  
Dr Les Vertesi, directeur médical

#### **Mercredi 8 mai 2002**

*À titre individuel :*  
L'honorable Monique Bégin, c.p.

#### **Jeudi 9 mai 2002**

*Université Dalhousie :*  
Lawrence Nestman, professeur, École d'administration des services de soins de santé

**Mercredi 22 mai 2002**

*Association médicale canadienne :*

Dr Peter Barrett, ancien président

Dre Susan Hutchison, présidente, Forum des omnipraticiens.

*Ontario Medical Association :*

Dr Elliot Halparin, président

Dr Kenneth Sky, ancien président

*Association des hôpitaux de l'Ontario :*

Mark Rochon, membre, Comité de défense

*Association canadienne des institutions de santé universitaires :*

Glenn G. Brimacombe, président-directeur général

*University Health Network :*

Kevin Empey, directeur financier

**Mercredi 29 mai 2002**

*Capital Health Authority (Edmonton) :*

Dr Ken Gardener, vice-président, Affaires médicales

*Réseau Santé familiale de l'Ontario :*

Dre Ruth Wilson, présidente

Donna Segal, chef de la direction

**Jeudi 30 mai 2002**

*Université McMaster — Centre for Health Economics and Policy Analysis (CHEPA) :*

Dr. Brian Hutchison, directeur

*Université de Guelph :*

Brian Ferguson, professeur, Département des sciences économiques

**Lundi 3 juin 2002**

*Département de la politique sanitaire, de la gestion et de l'évaluation des soins de l'Université de Toronto :*

Raisa Deber

*Université de la Colombie-Britannique :*

Robert G. Evans, Département des sciences économiques et Centre pour la recherche sur les services et les politiques sanitaires

*Fédération des contribuables canadiens :*

Walter Robinson, directeur fédéral

*Conference Board du Canada :*

Paul Darby, directeur, Prévisions économiques

*À titre personnel :*

David Kelly



### **Mercredi 5 juin 2002**

*Association canadienne des soins de santé :*  
Sharon Sholzberg-Gray, présidente et PDG  
Larry Odegard, PDG, Forum

*Association canadienne des chaînes de pharmacies :*  
Lori Turik, vice-présidente, Affaires publiques  
Deb Saltmarche, directrice de la pharmacie

### **Jeudi 6 juin 2002**

*Association des infirmières et infirmiers du Canada :*  
Ginette Lemire Rodger, présidente  
Robert Calnan, président élu

*Association des infirmières et infirmiers auxiliaires du Canada :*  
Kelly Kay, représentante

### **Mercredi 12 juin 2002**

*Institut C.D. Howe :*  
Jack Mintz, président-directeur général

### **Jeudi 13 juin 2002**

*Association canadienne des institutions de santé universitaires :*  
Glenn Brimacombe, PDG

*Hôpital St. Michael's :*  
Jeffrey Lozon, président et PDG

*Centre universitaire de santé McGill :*  
Dr Hugh Scott, directeur exécutif

*Applied Management :*  
Bryan Ferguson, associé

*Fraser Group :*  
Ken Fraser

*Tristat Resources :*  
Richard Shillington, directeur

### **Lundi 17 juin 2002 (séance du matin)**

*(Par vidéoconférence)*

*Gouvernement du Danemark :*  
John Erik Petersen, chef, ministère de la Santé et de l'Intérieur  
Dr Steen Friberg Nielsen, président-directeur général, Top Management Academy  
Morten Hjulsgaard, chef de ministère, Conseil national de la santé  
Dr Arne Kverneland, chef, Division de l'informatique médicale, Conseil national de la santé  
*À titre personnel :*  
Brian Herman, conseiller, Affaires politiques et culturelles, ambassade du Canada au Danemark

**Lundi 17 juin 2002 (séance de l'après-midi)**

*Ministère de la Santé et du Mieux-être du gouvernement du Nouveau-Brunswick :*  
Cheryl Hansen, directrice du Programme extra-mural

*Home and Community Care Evaluation and Research Centre de l'Université de Toronto :*  
Peter Coyte, codirecteur

*Hollander Analytical Services :*  
Marcus Hollander, président

*Du Conseil canadien des chefs d'entreprise :*  
David Stewart-Patterson, vice-président principal, Politiques

**VOLUME CINQ (15 octobre 2001- 7 mars 2002)**

**Lundi 15 octobre 2001**

*Université du Manitoba*  
Linda West, professeure, Asper School of Business

*Frontier Centre for Public Policy :*  
Peter Holle, président

*Western Canadian Task Force on Health Research and Economic Development :*  
Henry Friesen, chef d'équipe  
John Foerster  
Audrey Tingle  
Chuck Lafleche

*Offices régionaux de la santé du Manitoba :*  
Bill Bryant, président, Conseil des présidents  
Kevin Beresford, président, Conseil des administrateurs  
Randy Lock, directeur général

*Centre d'élaboration et d'évaluation de la politique des soins de santé du Manitoba :*  
Noralou Roos

*Women's Health Clinic :*  
Madeline Boscoe, coordonnatrice de parrainage

*Hospice and Palliative Care Manitoba :*  
Paul Henteleff, président, Comité de parrainage  
John Bond, membre, Comité de parrainage  
Margaret Clarke, directrice générale

*Canadian Union of Public Employees in Manitoba (CUPE) :*  
Paul Moist, président  
Lorraine Sigurdson, coordonnatrice des soins de santé

*Société franco-manitobaine :*  
Daniel Boucher, président-directeur général

## **Mardi 16 octobre 2001**

*Saskatchewan Registered Nurses' Association :*  
June Blau, présidente

*Infirmières de l'Ordre de Victoria :*  
Bob Layne, vice-président, Planification et relations gouvernementales (région de l'Ouest)  
Lois Clark, directrice générale, IOV du centre-nord de la Saskatchewan  
Brenda Smith, membre du conseil d'administration national (Saskatchewan)

*Association des services des soins de santé communautaires (Saskatoon) :*  
Kathleen Storrie, vice-présidente  
Ingrid Larson, directrice des relations avec les membres

*À titre personnel :*  
Dr John Bury

*Syndicat canadien de la fonction publique (SCFP) de la Saskatchewan :*  
Tom Graham, président, SCFP Saskatchewan  
Stephen Foley, président, Conseil de la santé  
John Welden, coordonnateur de la santé, Conseil de la santé

*Chambre de commerce de Saskatoon :*  
Dave Ductchak, président  
Kent Smith-Windsor, directeur général  
Jodi Blackwell, directrice de la recherche et des opérations

*Arthritis Society of Saskatchewan :*  
Sherry McKinnon, directrice exécutive  
Joy Tappin, membre du conseil d'administration

*Association canadienne des loisirs/parcs :*  
Randy Goulden, directeur exécutif, Tourisme Yorkton

*Ralliement national des Métis :*  
Gerald Morin, président  
Don Fidler, directeur, Soins de santé

## **Mercredi 17 octobre 2001**

*Premier's Advisory Council on Health (Alberta) :*  
Le très honorable Don Mazankowski, C.P., président  
Peggy Garritty

*Ministère de la Santé et des Services sociaux (Nunavut) :*  
L'honorable Edward Picco, ministre

*Calgary Health Region :*  
Jack Davis, président-directeur général

*Capital Health Authority :*  
Sheila Weatherhill, présidente-directrice générale

*Canadian Practical Nurses Association :*  
Pat Fredrickson, présidente

*Université de l'Alberta - Faculté des soins infirmiers :*  
Dre Donna Wilson

*Health Sciences Association of Alberta :*  
Elisabeth Ballerman, présidente

*Alberta Association of Registered Nurses :*  
Sharon Richardson, présidente

*United Nurses of Alberta :*  
Heather Smith, présidente

*Friends of Medicare :*  
Christine Burdett, présidente provinciale  
Tammy Horne, membre

*À titre personnel :*  
Kevin Taft, député, Assemblée législative de l'Alberta

*Western Canada Waiting List Project :*  
John McGurran, directeur de projets

*Primary Care Initiative :*  
Dre June Bergman

*Alberta Consumers Association :*  
Wendy Armstrong

*Fédération des communautés francophones et acadiennes du Canada :*  
George Arès, président

*Conseil consultatif national sur le troisième âge :*  
Pat Raymaker, présidente

*Alberta Council on Aging :*  
Neil Reimer, secrétaire-trésorier

*Nechi Institute :*  
Richard Jenkins, directeur de la commercialisation et de la promotion de la santé  
Ruth Morin, présidente-directrice générale

*Executive of the Alberta and Northwest Conference of the United Church of Canada - Health Advisory Committee :*  
Louise Rogers  
Kent Harold  
Don Junk

**Jeudi 18 octobre 2001**

*Saskatchewan Committee on Medicare :*  
Ken Fyke, président sortant

*Tommy Douglas Research Institute :*  
Dave Barrett, président  
Marc Eliesen, coprésident

*Market-Media International Corporation :*  
Joan Gadsby, présidente

*Université de la Colombie-Britannique – Médecine familiale, Programme de résidence :*  
Dr J. Galt Wilson, directeur des programmes - Site Prince George

*Université de la Colombie-Britannique :*  
Dr John A. Cairns, doyen de la médecine  
Dre Joanna Bates, doyenne associée, Admissions

*Conseil des professions de la santé :*  
Dianne Tingey, membre  
Gerry Fahey, directeur exécutif

*Cambie Surgery Centre :*  
Dr Brian Day, fondateur

*À titre personnel :*  
Cynthia Ramsay, économiste de la santé

*Health Association of British Columbia :*  
Lorraine Grant, présidente du conseil d'administration  
Lisa Kallstrom, directrice générale

*Université de la Colombie-Britannique :*  
Professeur John H.V. Gilbert, coordonnateur des sciences de la santé

*Université de la Colombie-Britannique - Vancouver Hospital and Health Sciences Centre :*  
Professeur Charles Wright, Centre for Clinical Epidemiology and Evaluation

*Université de la Colombie-Britannique - Centre for Health Services and Policy Research :*  
Professeure Barbara Mintzes

*Professional Association of Residents of British Columbia :*  
Dre Kristina Sharma

### **Vendredi 19 octobre 2001**

*Association médicale canadienne :*  
Dr Peter Barrett, président sortant  
Dr Arun Garg, président, Conseil de la politique et de l'économique de la santé

*Association médicale de la Colombie-Britannique :*  
Dre Heidi Oetter, présidente  
Darrell Thomson, directeur, Analyse de l'économique et de la politique

*Université de la Colombie-Britannique - Anxiety Disorders Unit, Department of Psychiatry :*  
Dr Peter D. McLean, professeur et directeur

*Maples Surgical Centre (Manitoba) :*  
Dr Mark Godley

### **Lundi 29 octobre 2001**

*Canadian Radiation Oncology Services :*  
Dr Thomas McGowan, président et directeur médical

*Fédération des contribuables canadiens :*  
Walter Robinson, directeur fédéral

*Conseil canadien des Églises :*

Stephen Allen, membre de la Commission justice et paix et coprésident de la Commission oecuménique sur les soins de la santé

*Buffett Taylor Associates Ltd., société d'experts-conseil en avantages sociaux et en mieux-être au travail :*

Edward Buffet, président-directeur général

*À titre personnel :*

Dr Michael M. Rachlis

*Medical Reform Group :*

Dr Joel Lexchin

*At Work Health Solutions Inc. :*

Dr Arif Bhimji, président

Gery Barry, président et directeur général de Liberté Santé

*Association des consommateurs du Canada :*

Jean Jones, présidente du Comité sur la santé

Mel Fruitman, président

*Ontario Association of Optometrists :*

Dr Joseph Chan, président

*Instruments Médicaux du Canada (MEDEC) :*

Peter Goodhand, président

*AstraZeneca :*

Gerry McDole, président-directeur général

*Comcare services de santé :*

Mary Jo Dunlop, président

*Hôpital St-Michael :*

Jeffrey Lozon, président-directeur général

*Association des centres de santé de l'Ontario :*

Gary O'Connor, directeur général

*Association médicale de l'Ontario :*

Dr. Kenneth Sky, président

*Société d'Arthrite :*

Denis Morrice, président et directeur général

*SAUVE-QUI-PENSE :*

Dr Robert Conn, président et directeur général

*Société canadienne du cancer :*

Dr Barbara Whyllie, directrice, Politique de contrôle

Mme Cheryl Mayer, directrice, Programmes de lutte contre le cancer

*Association ontarienne des services de rétablissement en toxicomanie et Association d'intervention auprès des toxicomanes :*

Jeff Wilbee, directeur général

**Mardi 30 octobre 2001**

*Institut canadien d'information sur la santé :*

Michael Decter, président, conseil d'administration

*Association des hôpitaux de l'Ontario :*

David MacKinnon, président directeur général

*Association des infirmières et infirmiers autorisés de l'Ontario :*

Doris Grinspun, directrice exécutive

*Université McMaster, Département d'économie :*

Jeremiah Hurley, professeur

*Université de Toronto, Département des sciences de la santé publique :*

Dr. Cameron Mustard, professeur

*Université de Toronto :*

Colleen Flood, professeur

*Drug Trading Company Limited :*

Larry Latowsky, président directeur général

Jane Farnham, vice-présidente, Pharmacie

*Association des pharmaciens du Canada :*

Ron Elliott, président

*GlaxoSmithKline :*

Geoffrey Mitchinson, vice-président, Relations publiques

*Medtronic :*

Donald A. Hurley, président

*Association canadienne des personnes retraitées :*

Lillian Morgenthau, présidente et co-fondatrice

Dr. Bill Gleberzon, directeur exécutif associé

*Association canadienne pour l'intégration communautaire :*

Cheryl Gulliver, présidente

Connie Laurin-Bowie

Margot Easton

*Institut Roeher :*

Cameron Crawford, président

*À titre individuel :*

Clement Edwin Babb

Robert S. W. Campbell

**Mercredi 31 octobre 2001**

*À titre personnel :*

L'honorable Claude Forget

L'honorable Claude Castonguay

André-Pierre Contandriopoulos, professeur, Faculté de médecine, Université de Montréal

*Hôpital Hôtel-Dieu de Québec :*  
Dr Serge Boucher

*Conseil du patronat du Québec :*  
M. Gilles Taillon, président

*Chambre de commerce du Canada :*  
Mme Nancy Hughes Anthony, présidente-directrice générale  
M. Michael N. Murphy, vice-président principal, Politiques

*À titre personnel :*  
M. Jean-Luc Migué  
M. Lee Soderstrom, professeur, Département d'économie, Université McGill

*Institut économique de Montréal :*  
M. Michel Kelly-Gagnon, directeur exécutif  
Dr Edwin Coffey, professeur adjoint retraité de la Faculté de médecine, Université McGill, et ex-président de  
l'Association médicale du Québec

*Fondation Frosst pour les soins de santé :*  
Dr Monique Camerlain, présidente du conseil d'administration  
Mme Janet Castonguay, directrice exécutive

#### **Jeudi 1 novembre 2001**

*Association des optométristes du Québec :*  
Langis Michaud, président  
Marie-Josée Crête, directrice générale adjointe  
Clairmont Girard, conseiller

*Collège des médecins du Québec :*  
Dr Yves Lamontagne, président  
Dr André Garon, secrétaire général délégué

*À titre individuel :*  
Robert Dorion

*Association canadienne des compagnies d'assurance de personnes :*  
Mark Daniels, président  
Greg Traversy, vice-président-directeur général  
Yves Millette, vice-président senior, Affaires (Québec)  
Frank Fotia, vice-président, Assurance collective

*À titre individuel :*  
Dr Margaret A. Somerville, directrice intérimaire, McGill Centre for Medicine, Ethics and Law, Université McGill  
Robyn Tamblyn, professeur agrégé, Département d'économie, Université McGill

*Merck Frosst Canada Ltée :*  
Kevin Skilton, directeur, Politique et planification  
Terrance Montague, directeur, Politique en matière de santé

*Association québécoise des droits des retraités (AQDR) :*  
Ann Gagnon, conseillère sur la santé  
Yolande Richer, vice-présidente, Communications  
Myroslaw Smereka, directeur général



## **Lundi 5 novembre 2001**

*Ministère de la Santé et des services communautaires, Terre-Neuve :*

Robert C. Thompson, sous-ministre  
Beverly Clarke, sous-ministre adjointe  
Catherine Donovan

*Infirmières de l'Ordre de Victoria du Canada :*

Mme Patricia Pilgrim, présidente, Région de St. John's  
Mme Bernice Blake Dibblee, directrice exécutive, Région de St. John's

*Association des infirmières et infirmiers diplômés de Terre-Neuve et du Labrador :*

Mme Sharon Smith, présidente

*Syndicat canadien de la fonction publique, Terre-Neuve :*

M. Wayne Lucas, président

*À titre personnel :*

Mme Maud Peach

*Institut national du cancer du Canada :*

M. Roy West, président

*Weight Watchers :*

Mme Marlene Bayers, directrice régionale

*Fondation de Terre-Neuve pour le traitement et la recherche sur le cancer :*

Mme Bertha H. Paulse, présidente-directrice générale

*À titre personnel :*

Mme Karen McGrath, directrice générale, ministère de la Santé et des services communautaires, Région de St. John's (Terre-Neuve)

## **Mardi 6 novembre 2001**

*Travailleurs canadiens de l'automobile :*

Cecil Snow, président, Nova Scotia Health Care Council

*Nova Scotia Association of Health Organizations :*

Robert Cook, président-directeur général

*Bureau d'assurance du Canada :*

George Anderson, président-directeur général  
Paul Kovacs, premier vice-président des politiques et économiste en chef

*Coalition canadienne contre la fraude à l'assurance :*

Mary Lou O'Reilly, directrice générale

*Atlantic Institute for Market Studies :*

Le Dr David Zitner, professeur associé en matière de politique de santé

*Université Dalhousie :*

Dre Nuala Kenny, professeure de pédiatrie et présidente, Département de bioéthique  
Dr Vivek Kusumakar, responsable du groupe de recherche sur les troubles de l'humeur, Département de psychiatrie  
Lawrence Nestman, professeur, École d'administration des soins de santé, Faculté des professions de la santé  
Dr Thomas Rathwell, professeur et directeur, Faculté des professions de la santé  
Dr Desmond Leddin, chef, Division de la gastro-entérologie

Dr George Kephart, directeur, Unité de recherche en santé de la population, Département de la santé communautaire et de l'épidémiologie  
Dr Kenneth Rockwood, Faculté de médecine, Division de la médecine gériatrique

*Nova Scotia Valley Caregivers Support Group :*  
Maxine Barrett

*Elizabeth May Chair in Women's Health and the Environment, Université Dalhousie :*  
Sharon Batt, présidente

*Feminists for Just and Equitable Public Policy :*  
Georgia MacNeil, présidente

*Cape Breton Regional Health Care Complex :*  
John Malcolm, chef de la direction  
Dr Mahmood Naqvi, directeur médical, Installation régionale du Cap-Breton

*Capital District Health Authority :*  
Le Dr John Ruedy, vice-président, Affaires académiques

*Association médicale canadienne :*  
Le Dr Henry Haddad, médecin, président  
Bill Tholl, secrétaire général  
Le Dr Bruce Wright, président, Medical Society of Nova Scotia  
La Dre. Dana W. Hanson, président élu

*Conseil santé communautaire de Cobequid :*  
Ryan Sommers

*Santé Canada :*  
Anne-Marie Léger, analyste des politiques

### **Mercredi 7 novembre 2001**

*Ministère des Sciences et des Services sociaux de l'Île-du-Prince-Édouard :*  
L'honorable Jamie Ballem, M.A.L., ministre

*P.E.I. Seniors Advisory Council :*  
Heather Henry-MacDonald, présidente

*Syndicat canadien de la fonction publique, Division de l'Î.-P.-É. :*  
Bill A. McKinnon, représentant national  
Donalda MacDonald, présidente  
Raymond Léger, responsable de la recherche

*Ministère de la Santé et des services sociaux de l'Île-du-Prince-Édouard :*  
Mary Hughes-Power, directrice, Soins intensifs et de longue durée  
Deborah Bradley, gestionnaire, Politique de santé publique  
Dr Don Ling, directeur, Services médicaux  
Rory Francis, sous-ministre  
Bill Harper, sous-ministre adjoint  
Jean Doherty, coordinatrice, Communications  
Susan Maynard, planificatrice principale, Services de santé  
Kathleen Flanagan-Rochon, coordonnatrice, Services communautaires

*Collège des médecins de famille du Canada :*  
Dr Peter MacKean, président du conseil d'administration

*Queen Elizabeth Hospital :*  
Iain Smith, coordonnateur, Utilisation des médicaments

*Prince Edward Island Pharmacy Board :*  
Mme Neila Auld, directrice exécutive

*Queen's Regional Health Authority :*  
Sylvia Poirier, présidente

*West Prince Regional Health Authority :*  
Ken Ezeard, directeur général

*Southern King's Health Authority :*  
Betty Fraser, directrice générale

*Centre de santé communautaire Évangéline :*  
Elise Arsenault, coordinatrice

*East Prince Regional Health Authority :*  
David Riley, directeur général

*Université Dalhousie :*  
Dr Stan Kutcher, chef, Département de la santé communautaire et de l'épidémiologie/psychiatrie

#### **Jeudi 8 novembre 2001**

*Faculté des sciences infirmières de l'Université du Nouveau-Brunswick :*  
Dre Margaret Dykeman

*Association des soins de santé du Nouveau-Brunswick :*  
M. Robert Simpson, président-directeur général

*Association canadienne des chaînes de pharmacies :*  
Sherry Porter, représentante pour les Maritimes  
Sandra Aylward, vice-présidente, Services pharmaceutiques

*À titre personnel :*  
Dr Russell King, ancien ministre de la Santé du Nouveau-Brunswick  
William Morrissey, ancien sous-ministre de la Santé du Nouveau-Brunswick

*Applied Management :*  
Bryan Ferguson, associé

*Société des Acadiens et Acadiennes du Nouveau-Brunswick :*  
Daniel Thériault, directeur général

*Association canadienne des Snowbirds :*  
Bob Jackson, président

*Fédération des citoyens âgés du Nouveau-Brunswick Inc. :*  
Helen Ladouceur, membre  
Eileen Malone, membre

*Association catholique canadienne de la santé :*  
Mme Sandra Keon, secrétaire-trésorière et vice-présidente des programmes cliniques de l'hôpital de Pembroke

*Forces policières de Miramichi :*

Caporal M. Michael Gallagher, Division des drogues  
*Syndicat canadien de la fonction publique, Nouveau-Brunswick :*  
Raymond Léger, représentant de la recherche

*Association nationale des retraités fédéraux :*

Rex G. Guy, président national  
Roger Heath, agent de recherche et des communications

*Union des Indiens du Nouveau-Brunswick :*

Nelson Solomon, directeur de la santé  
Wanda Paul Rose, coordonnatrice  
Norville Getty, expert-conseil

*Association des infirmières et infirmiers du Nouveau-Brunswick :*

Roxanne Tarjan, directrice générale

### **Jeudi 21 février 2002**

*La Fédération canadienne des syndicats des infirmières et infirmiers :*

Kathleen Connors, présidente

*Coalition canadienne de la santé :*

Dr. Arnold Relman, ancien rédacteur en chef, *New England Journal of Medicine*  
Michael McBane, coordonnateur national

*Association nationale des retraités fédéraux :*

Rex G. Guy, président national  
Roger Heath, agent de recherche et de communications

### **Jeudi 7 mars 2002**

*Association canadienne des soins de santé :*

Sharon Sholzberg-Gray présidente directrice générale  
Kathryn Tregunna, directrice, Élaboration des politiques

*Congrès du travail du Canada :*

Kenneth V. Georgetti, président  
Cindy Wiggins, recherchiste principale, Direction des politiques sociales et économiques

## **VOLUME TROIS (28 mai 2001-14 juin 2001)**

### **Lundi 28 mai 2001**

*(par vidéoconférence)*

*Ministère de la santé, du bien-être et des sports des Pays-Bas :*

Dr. Hugo Hurts, directeur adjoint, Division de l'assurance-santé

*Institut international d'études sociales des Pays-Bas :*

Dr. James Bjorkman

### **Jeudi 7 juin 2001 (9 heures)**

*(par vidéoconférence)*

*Parlement suédois (Riksdag) :*

Lars Elinderson, Membre suppléant, Comité de la santé et du bien-être

**Lundi 11 juin 2001**

(par vidéoconférence)

*Ministère de la santé de l'Allemagne :*

Georg Baum, directeur général, chef du conseil d'administration soins de santé

Dr. Margot Faelker, directrice adjointe, section des questions financières relatives à l'assurance-santé réglementaire

Dr. Rudolf Vollmer, directeur général, chef du conseil d'administration, Assurance des soins infirmiers à long terme

*Royaume-Uni – Ministère de la santé – Division de la recherche opérationnelle et économique :*

Clive Smee, conseiller économique en chef

*Université de Birmingham :*

Chris Ham, professeur et directeur, Centre de gestion des services de santé

*London School of Economics :*

Julien LeGrand, professeur de politique sociale, soins de santé et sociaux LSE Richard Titmuss

**Mardi 12 juin 2001**

(par vidéoconférence)

*Institut australien de la santé et du bien-être :*

Dr. Richard Madden, directeur

*Australian Health Insurance Association :*

Russel Schneider, PDG

*National Centre for Epidemiology and Population Health – Australian National University*

Dr. Tony Adams, professeur en santé publique

*Health Insurance Commission :*

Dr. Brian Richards

*Association médicale de l'Australie :*

Dr. Carmel Martin, directeur

Dr. Roger Kilham

**Mercredi 13 juin 2001**

*Santé Canada :*

Ake Blomqvist, professeur invité, Direction de la recherche appliquée et de l'analyse, Direction générale de l'information, de l'analyse et de la connectivité et professeur, Université of Western Ontario

*Université de Calgary :*

Professeur Cam Donaldson, Département d'économie

*Université de Toronto (par vidéoconférence) :*

Professeur Colleen Flood, Faculté de droit

*À titre individuel :*

Claude Forget

*Université de Toronto :*

Professeur Mark Stabile, Département d'économie

Professeur Carolyn Tuohy, Département de sciences politiques

**Jeudi 14 juin 2001**

(par vidéoconférence)

*U.S. Department of Health and Human Services :*

Christine Schmidt, adjointe du secrétaire adjoint délégué à la politique en matière de santé, Bureau du secrétaire adjoint, Planification et évaluation

Ariel Winter, analyste

Tanya Alteras, analyste

**VOLUME DEUX (21 mars 2001-7 juin 2001)****Mercredi 21 mars 2001**

*Statistique Canada :*

Réjean Lachapelle, directeur, Direction de la démographie

Jean-Marie Berthlot, chef, Groupe d'analyse et de modélisation de la santé, Division des études sociales et économiques

Brian Murphy, analyste principal de recherche, Groupe de la modélisation socio-économique

*Institut canadien des actuaires :*

David Oakden, président

Rob Brown, membre de la Commission d'étude sur le financement des soins de santé

Daryl Leech, président, Comité des soins de santé

*Conseil consultatif national sur le troisième âge :*

Dr. Michael Gorodn, membre

*Conference Board of Canada :*

James G. Frank, Ph.D., économiste en chef et vice-président

Glenn Brimacombe, directeur du programme sur la santé

**Jeudi 22 mars 2001**

*Institut C.D. Howe :*

William B.P. Robson, vice-président et directeur de la recherche

*Université McMaster :*

Byron G. Spencer, professeur

*Université d'Ottawa :*

Dr. William Dalziel

**Mercredi 28 mars 2001**

*IMS Health Canada :*

Dr. Roger A. Korman, président

*Association des pharmaciens du Canada :*

Dr. Jeff Poston, directeur exécutif

*Health Promotion Research :*

Dr. Robert Coombs, président et PDG

*Santé Canada :*

Barbara Ouellet, directrice, Soins à domicile et produits pharmaceutiques, Direction générale des politiques et de la consultation

#### **Jeudi 29 mars 2001**

*Association canadienne des radiologistes :*  
Dr. John Radomsky

*Office canadien de coordination de l'évaluation des technologies de la santé :*  
Dr. Jill Sanders, présidente et PDG

*L'institut Fraser :*  
Martin Zelder, directeur de la recherche sur les politiques de santé

*À titre individuel :*  
Professeur David Feeny

#### **Mercredi 4 avril 2001**

*Santé Canada :*  
Dr. Christina Mills, directrice générale, Centre de prévention et de contrôle des maladies chroniques – Direction de la santé de la population et de la santé publique  
Dr. Paul Gully, directeur général par intérim, Centre de prévention et de contrôle des maladies infectieuses  
Dr. Clarence Clotney, directrice par intérim, Division du diabète, Bureau des maladies cardio-respiratoires et du diabète, Centre de prévention et de contrôle des maladies chroniques  
Nancy Garrard, directrice, Division du vieillissement et des aînés

*Université Dalhousie :*  
Dr. David MacLean, chef de département, Santé communautaire et épidémiologie

#### **Jeudi 5 avril 2001**

*Santé Canada :*  
Abby Hoffman, directeur général, Direction des soins de santé – Direction générale de la politique de la santé et des communications  
Cliff Halliwell, directeur général, Direction de la recherche appliquée et de l'analyse, Direction générale de l'information, de l'analyse et de la connectivité  
Nancy Garrard, directrice, Division du vieillissement des aînés

#### **Jeudi 26 avril 2001**

*Instituts de recherche en santé du Canada :*  
Dr. Alan Bernstein, président

*Santé Canada :*  
Kimberly Elmslie, directrice exécutive par intérim, Secrétariat de recherche en santé

*Statistique Canada :*  
T. Scott Murray, directeur général, Direction de statistique sociale et des institutions

#### **Mercredi 9 mai 2001**

*Les compagnies de recherche pharmaceutique du Canada :*  
Murray Elston, président

*Coalition pour la recherche biomédicale et en santé :*  
Dr. Barry McLennan, président  
Charles Pitts, directeur exécutif

*Centre d'excellence pour la santé des femmes :*  
Dr. Pat Armstrong

*Réseau canadien sur les maladies génétiques :*  
Dr. Ronald Worton, PDG et directeur scientifique

### **Jeudi 10 mai 2001**

*Santé Canada :*  
William J. Pascal, directeur général, Bureau de la santé et de l'inforoute, Direction générale de l'inforoute, de l'information, de l'analyse et de la connectivité

*Institut canadien d'information sur la santé :*  
Dr. John S. Millar, vice-président, Recherche et analyse

*Société canadienne de télésanté :*  
Dr. Robert Filler, président

*Ministère de la Santé et du Mieux-être du Nouveau Brunswick :*  
David Cowperthwaite, directeur du système d'information

### **Mercredi 16 mai 2001**

*Association médicale canadienne :*  
Dr. Peter Barrett, président

*Forum médical canadien, Groupe de travail 1 :*  
Dr. Hugh Scully, président

*Comité consultatif fédéral, provincial et territorial sur les Ressources humaines en santé :*  
Dr. Thomas Ward, président

*Association des infirmières et infirmiers du Canada :*  
Sandra MacDonald-Remecz, directrice de la politique, de la réglementation et de la recherche

*La Fédération canadienne des syndicats des infirmières et infirmiers :*  
Kathleen Connors, présidente

*Ordre des infirmières et infirmiers auxiliaires du Québec :*  
Régis Paradis, président

*Nurse Practitioners Association of Ontario :*  
Linda Jones

*Sociétés canadiennes en radiation et imagerie médicale :*  
Dr. Paul C. Johns, ancien président

*Association chiropratiques canadienne :*  
Tim St. Dennis, président

*Société canadienne de science de laboratoire médical :*  
Kurt Davis, directeur exécutif



## **Jeudi 17 mai 2001**

*Association canadienne de soins et services à domicile :*  
Nadine Henningsen, directrice exécutive

*Association canadienne de soins et services communautaires (ACSSC) :*  
Dr. Taylor Alexander, président

*Infirmières de l'Ordre de Victoria du Canada (VON Canada) :*  
Diane McLeod, vice-présidente, Planification des politiques et Relations gouvernementales, Région centrale

## **Mercredi 30 mai 2001**

*Santé Canada :*  
Ian Potter, sous-ministre adjoint, Direction générale des Premières nations et des Inuits  
Jerome Berthelette, conseiller spécial, Bureau du conseiller spécial en matière de santé des Autochtones, Direction générale des Premières nations et Inuits  
Dr. Peter Cooney, Directeur général intérimaire, Services de santé non assurés

*Affaires indiennes et du Nord Canada :*  
Chantal Bernier, sous-ministre adjointe, Programmes et politiques socio-économiques  
Terry Harrison, directrice, Services sociaux et justice

*Assemblée des Premières Nations :*  
Elaine Johnston, directrice, Soins de santé

*Ralliement national des Métis :*  
Gerald Morin, président

*Association des femmes autochtones du Canada :*  
Michelle Audette, présidente intérimaire et présidente des Femmes autochtones du Québec

*Congrès des Peuples Autochtones :*  
Scott Clark, président, United Native Nations

*Inuit Tapirisat du Canada :*  
Larry Gordon, membre ITC, Comité de la santé

*Pauktuutit Inuit Women's Association :*  
Veronica N. Dewar, présidente

*Organisation nationale sur la santé des Autochtones*  
Dr. Judith Bartlett, présidente  
Richard Jock, directeur exécutif

*Instituts de recherche en santé du Canada :*  
Dr. Jeff Reading, directeur scientifique, Institut de la santé des Autochtones

*Wikwemikong Health Centre :*  
Ron Wakegijig, guérisseur

*Organisation nationale des représentants indiens et inuit en santé communautaire*  
Margaret Horn, directrice exécutive

### **Jeudi 31 mai 2001**

*Santé Canada :*

Dr. John Wooton, conseiller spécial en santé rurale, Direction générale de la population et de la santé publique

*Association médicale canadienne :*

William Tholl, secrétaire général et président-directeur général

*Société de la médecine rurale du Canada :*

Dr. Peter-Hutten-Czapski, président

*Consortium for Rural Health Research :*

Dr. Judith Kulig

### **Mercredi 6 juin 2001**

*Université d'Ottawa :*

Professeur Martha Jackman, Faculté de droit

*Université de Calgary : (par vidéoconférence)*

Professeur Sheilah Martin, Faculté de droit

### **Jeudi 7 juin 2001 (11 h 00)**

*Santé Canada :*

Nancy Garrard, directrice générale intérimaire, Centre pour le développement de la santé humaine, Direction générale de la population et de la santé publique

Tom Lips, conseiller principal en matière de politique pour la santé mentale, Direction générale de la santé de la population et de la santé publique

Carl Lakaski, analyste principal, Santé mentale, Division des stratégies en matière de ressources humaines en santé, Direction générale de la politique de la santé et des communications

*Société canadienne de psychologie :*

Dr. John Service, directeur exécutif

*Alliance pour la maladie mentale et la santé mentale canadienne :*

Phil Upshall, coordinateur

*Association canadienne pour la santé mentale :*

Bonnie Pape

*Ministère de la Santé et du Bien-être du Nouveau-Brunswick :*

Ken Ross, sous-ministre adjoint, Service de santé mentale

## **VOLUME UN (2 mars 2000-21 septembre 2000) (2<sup>e</sup> session, 36<sup>e</sup> parlement)**

### **Jeudi 2 mars 2000**

Université de Toronto, Faculté de l'administration de la santé :

Raisa Deber, professeure

Santé Canada :

Dr. Robert McMurtry, *Chaire G.D.W. Cameron*

*Groupe d'intervention action santé (HEAL) :*  
Sharon Sholzberg-Gray, coprésidente  
Dr. Mary Ellen Jeans, coprésidente

*Réseaux canadiens de recherche en politiques publiques :*  
Sholom Glouberman, directeur, Réseau de la santé

**Mercredi 22 mars 2000**

Founder's Network :  
Dr. Fraser Mustard

Goldfarb Consultants :  
Dr. Scott Evans, consultant principal en statistique

Environics Research Group :  
Chris Baker, vice-president

*Santé Canada :*  
Wendy Watson-Wright, directrice générale, Direction des politiques et des projets majeurs – Direction générale de la promotion et des programmes de la santé

**Jeudi 23 mars 2000**

Santé Canada :  
Sylvain Paradis, gestionnaire intérimaire, groupe des politiques, Direction des politiques et des projets majeurs, Section de l'analyse quantitative et de la recherche – Direction générale de la promotion et des programmes de la santé  
Liz Kusey, analyste des politiques, Direction des politiques et des projets majeurs – Direction générale de la promotion et des programmes de la santé  
Monique Charon, directrice intérimaire, Politiques des programmes et planification, Division des politiques des programmes du Secrétariat du transfert et de la planification, Direction générale des services médicaux  
Mary Johnston, consultante en éducation, Section de la politique stratégique et de la coordination des systèmes, Division de l'enfance et de la jeunesse, Direction générale de la promotion et des programmes de la santé  
Julie MacKenzie, analyste principale en recherche, Section de la politique stratégique et de la coordination des systèmes, Division de l'enfance et de la jeunesse, Direction générale de la promotion et des programmes de la santé

Université Queen's– School of Policy Studies :  
Keith Banting, directeur

**Jeudi 6 avril 2000**

*Université de la Colombie-Britannique :*  
Robert G. Evans, directeur, Programme sur la santé de la population

Centre canadien de politiques alternatives :  
Colleen Fuller

The Fraser Institute :  
Martin Zelder, directeur de la recherche sur les politiques de santé

**Mercredi 3 mai 2000***Santé Canada :*

Cliff Halliwell, directeur général, Direction de la recherche appliquée et de l'analyse, Direction générale de l'information, de l'analyse et de la connectivité

Abby Hoffman, conseillère principale en politique

Frank Fedyk, directeur par intérim, Division de la Loi canadienne sur la santé, Direction des affaires intergouvernementales, Direction générale des politiques et de la consultation

**Jeudi 4 mai 2000***À titre individuel :*

Tom Kent

*Université de Toronto :*

Michael Bliss, professeur

**Mercredi 10 mai 2000***Université Western Ontario:*

Ake Blomqvist, professeur

*Université de Toronto :*

Colleen Flood, professeure

Mark Stabile, professeur

**Jeudi 11 mai 2000***Institut canadien d'information sur la santé :*

John S. Millar, vice-président, Recherche et analyse

*Université McGill :*

Margaret Somerville, professeure

*Université de l'Alberta :*

Laura Shanner, professeure

**Mercredi 17 mai 2000***À titre individuel :*

L'honorable Marc Lalonde, P.C.

**Mercredi 31 mai 2000***À titre individuel :*

L'honorable Monique Bégin, P.C.

**Mercredi 7 juin 2000***Ministère des Finances :*

Guillaume Bissonnette directeur principal, Direction des relations fédérales-provinciales et de la politique sociale

Barbara Anderson, directrice, Division des relations fédérales-provinciales et de la politique sociale

**Jeudi 21 septembre 2000***À titre individuel :*

Graham Scott, ancien sous-ministre de la Santé, province de l'Ontario



**AUTRES MÉMOIRES REÇUS :**

Abell Medical Clinic  
Action cancer Ontario - Division de l'oncologie préventive  
Alberta Centre for Injury Control and Research  
Amgen Canada Inc.  
Association canadienne des Fabricants de Produits Pharmaceutiques  
Association des facultés de médecine du Canada  
Association canadienne des hygiénistes dentaires  
Association canadienne des médecins d'urgence (ACMU)  
Association canadienne des médecins résidents  
B.C. Better Care Pharmacare Coalition  
Patricia Baird  
Bruce Bigham  
Brain Injury Association of Nova Scotia  
Robert D. Brown et Michanne Haynes  
Canada West Foundation  
Chemical Sensitivities Information Exchange Network Manitoba (CSIENM)  
Coalition canadienne des aidants et aidants naturels  
Comité exécutif de l'Association de compté du Nouveau parti démocratique de Ancaster-Dundas-Flamborough-  
Aldershot  
Compagnies de recherche pharmaceutique du Canada  
Conestoga College (Pat Bower, moniteur de cours)  
Conseil canadien sur les soins de santé intégrés  
Laurent Desjardins  
Faith Partners (Ottawa)  
Federation of Medical Women in Canada  
Sandra Finley  
Fondation canadienne du rein  
Fondation des maladies du cœur du Nouveau-Brunswick  
Dr. Michael Gordon, Baycrest Centre for Geriatric Care  
Serena Grant  
Health Care Corporation of St.John's  
Home-based Spiritual Care  
Inforoute Santé du Canada  
Institut de la santé de la population (Université d'Ottawa) (Dr. Joseph Losos, directeur)  
Institut de cardiologie de l'Université d'Ottawa  
Kids First Parent Association of Canada  
Dr. Lee Kurisko  
Caterine Lindman  
Jim Ludwig  
Dr. Keith Martin  
Dr. Ross McElroy  
Dr. Malcom S. McPhee  
Meals on Wheels of Calgary  
Medbuy Corporation  
Verna Milligan  
Moose Jaw-Thunder Creek District Health Board  
Dr. Earl B. Morris  
Fran Morrison  
John Neilson  
Ontario Chamber of Commerce  
Ontario Psychological Association  
Roy L. Piepenburg (Liberation Consulting)

Red Deer Network in Support of Medicare  
Réseau et centre Cochrane canadien  
Dr. Robert S. Russell  
Société canadienne de la sclérose en plaques  
Société canadienne du sang  
Société des obstétriciens et gynécologues du Canada  
Stratégie nationale de lutte contre le cancer  
Christa Streicher  
Thames Valley District Health Council  
Elaine Tostevin





*If undelivered, return COVER ONLY to:*  
Communication Canada – Publishing  
Ottawa, Ontario K1A 0S9

*En cas de non-livraison,  
retourner cette COUVERTURE SEULEMENT à:*  
Communication Canada – Édition  
Ottawa (Ontario) K1A 0S9