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Chair

Mr. Bill Casey

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): We'll call the meeting to order.

There are a couple of housekeeping issues that I want to go over before we go very far. We asked the minister if we could have the reports on e-cigarettes and safety code 6, and she replied that we have to bring those reports back to this committee, discuss them, and pass them, and then she will respond to them. However, as they are now, they are expired.

I think the committee is interested in having responses to those two studies. If we want to do that, we have to bring them back, refresh them, and table them in the House of Commons in order for them to respond. Does anybody want to make a motion to do that?

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Sure. I'll make a motion to bring those reports back so that we can have the minister give us a response.

The Chair: Could the analysts give each member a copy of those two reports, the one on e-cigarettes and the one on safety code 6, so that we will have them right away? We'll bring them back at a future date.

Also, the issue of marijuana came up in the last meeting. Dr. Leitch raised the marijuana issue in the last meeting, and we wrote to the Minister of Justice to ask if we could expect a reference for any legislation to come this way. We don't have an answer yet, but I just wanted to let you know that we're working on that.

In the meantime, we should move ahead with those two reports, and we'll get them under way.

We have two distinguished witnesses here today, and we're looking forward to hearing from them. Ms. Abby Hoffman is the assistant deputy minister, strategic policy, and Ms. Gigi Mandy is the director of the Canada Health Act division, strategic policy.

We'd welcome opening statements, if you have them. You have the floor.

Ms. Abby Hoffman (Assistant Deputy Minister, Strategic Policy, Department of Health): Good afternoon to all of you.

Thanks for the invitation to talk to the committee about the Canada Health Act generally, and the Canada Health Act annual report for 2014-15, which was tabled in Parliament just about a month ago, on February 25.

To start, I want put the Canada Health Act in context. I'll start by making a few comments about the role of the federal government in Canada's health care system.

As you likely all know, as a partner with many other players, most notably the provinces and territories, the federal government has a number of functions: we protect Canadians from environmental risks associated with unsafe food, health, or consumer products; we approve drugs for sale in the Canadian marketplace and monitor their safety; we respond to infectious disease outbreaks and various health emergencies; we support the delivery of health care to first nations and the Inuit, federal inmates, members of the Canadian Forces, and veterans; we promote and fund innovation and research in health care; and we inform Canadians about various health risks and beneficial practices that will help them make healthy choices.

With respect to health care specifically, while responsibility for the delivery of health care services rests primarily with provinces and territories, historically and currently, the federal government has exercised its spending power to support provinces and territories in the discharge of their responsibilities, and in so doing, to set the underlying principles and values for health care systems across the country.

As you know, the main vehicle through which the federal government transfers funds to provinces and territories is the Canada health transfer. By way of reference, in 2015-16, the current fiscal year, the federal government provided about $34 billion via the CHT, which represents a little over 23% of the total spending by provinces and territories. This transfer of funds to provinces and territories under the CHT is not automatic. In fact, in order to receive its full allocation, each province or territory must ensure that its publicly funded health insurance plan meets the requirements of the Canada Health Act.

The conditions and criteria of the act are, in effect, the national principles that guide the Canadian health care system: universality, comprehensiveness, accessibility of care, portability, and public administration. These principles indicate who shall be covered, for what, in general terms, and where within Canada and beyond our borders, as well as the basic character of provincial health insurance systems—that is, that those shall be publicly administered and operate on a non-profit basis.

Very importantly, the act also has provisions that discourage direct charges to patients for publicly insured health care services. These charges, defined variously as extra billing or user charges, are articulated in the act. These provisions are a critical element, giving meaning to the accessibility principle.

As the only federal legislation pertaining directly to the delivery of health care services, the Canada Health Act is a good example of the federal government using its spending power to set national standards and promote the primary objective of Canadian health care policy, which, as stated in section 3 of the act, 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”.

The CHA is an excellent example of how governments have worked together over time to solve complex social policy challenges. In the annual report, there is a description of the relevant history in some detail. I just want to touch here on a couple of key milestones.

Canada's commitment to a largely publicly funded health care system began in 1947 as an ambitious and visionary experiment in public hospital insurance in Saskatchewan. Ultimately, to support replication of the Saskatchewan arrangements, the federal government passed the Hospital Insurance and Diagnostic Services Act in 1957, which committed the federal government to share the cost of these services with provinces. By 1961, all other provinces and territories had adopted similar models.

A few years later, the same pattern was repeated when Saskatchewan expanded its public health insurance regime into coverage for physician services. The Parliament of Canada passed the Medical Care Act in 1966, and again, other provinces and territories followed suit by 1972. By that time, both hospital and physician services were available to Canadians through a universal, pooled risk health insurance scheme.

● (1535)

Although Saskatchewan's Tommy Douglas saw publicly insured hospital and physician services as simply the initial stages of a medicare system that would eventually include other elements of care such as dental or access to drugs, the focus of Canadian medicare has remained focused on hospital and physician services.

Moving ahead a little bit in historical terms, by 1979, it was apparent that the objective of federal support for physician and hospital services for Canadians was being undermined by additional charges levied directly on patients.

In response to this growing threat to universal access to care, in 1979, at the request of the federal government, Justice Emmett Hall undertook a review of the state of heath care services in Canada. His report affirmed that health care services in Canada ranked among the best in the world, but he warned that extra billing by doctors and user charges levied by hospitals were creating a two-tier system that threatened universal accessibility of care.

Justice Hall's report and the national debate it generated led to the enactment of the Canada Health Act in 1984. The act retained the basic principles contained in those two earlier pieces of legislation and reaffirmed the country's commitment to a universal health insurance program by adding specific prohibitions on extra billing and user charges. In effect then, the goal of the Canada Health Act is to ensure that medically necessary physician and hospital services, as well as certain surgical dental services are available to Canadians on uniform terms and conditions, and without financial or other barriers.

The federal government encourages provinces and territories to experiment and design health care systems that meet their own particular circumstances, so long as the principles of the CHA are respected.

Since the act was passed, adherence by provinces and territories to its principles has meant that the provincial and territorial health insurance systems are much more alike than they are different. The machinery of the administration of the act also contributes to the consistency of a nationally publicly funded health care system. For example, Health Canada chairs a federal-provincial-territorial committee on reciprocal billing, which helps resolve issues Canadians may face when moving to other provinces or when travelling.

Health Canada also hears from Canadians through correspondence and telephone calls. In some cases, departmental officials are able to assist Canadians as they navigate the health care system and we may even intervene on their behalf.

For example, and this is a recurring situation, Canadians who move from one area of the country to another do not always understand that they are required to register with their new province's health insurance scheme. This only comes to their attention when they try to secure care using an expired or out-of-province card from their old province of residence. Working with both implicated provinces, we have on many occasions been able to assist Canadians in maintaining their coverage.

Of course, when Canadians reach out to us to comment on the delivery of specific services, we refer them to provincial and territorial ministries who have jurisdiction in this area.

I want to stress on the issue of compliance by provinces and territories that the health insurance plans of the provinces and territories generally respect the criteria and conditions of the Canada Health Act. In fact, the legislation in most provinces, governing their health insurance schemes, often goes well beyond the requirements of the Canada Health Act both in terms of the range of services covered and mechanisms to ensure compliance with the values and principles of universally accessible health care.

Many jurisdictions, as you likely know, cover to a certain degree vision care, pharmaceuticals used outside of hospitals, ambulance services, and so on. When provinces and territories provide care outside the scope of the act, they are not bound by the requirements of the act. They are free to arrange those services on their own terms and conditions, and according to their own priorities. This allows jurisdictions to target specific populations such as children, the elderly, or specific regions, and to require some sharing in costs by patients.

We recognize that while the CHA may establish important principles, provinces and territories are responsible for administering their multi-faceted systems that are usually governed by considerably more complex legislation detailing every aspect of how their health insurance scheme is administered, and how their health care system is organized, financed, and governed.

● (1540)

While the core principles of the Canada Health Act have enduring value, as health care evolves, the legislation has been subject to periodic clarification and interpretation to ensure its application to new circumstances.

Administration of the act, by way of example, has been informed by three very important key interpretation letters over the past 30 years.

In 1985, Minister Jake Epp's letter elaborated in great detail on the provisions of what was then still new legislation.

A decade later, in 1995, Minister Diane Marleau communicated the federal policy on private clinics, which expanded the definition of hospital to include facilities where patients, at that time, had to pay facility fees to receive services covered under medicare. Her letter was intended to put an end to those kinds of patient charges.

Finally, in 2002, Minister Anne McLellan wrote to the provinces and territories to outline a Canada Health Act dispute avoidance and resolution process. The objective of this initiative was to encourage ongoing communication, in the interest of avoiding disputes in the first place. In the event that such a dispute did occur and was not resolvable through our normal informal processes, a formal process to deal with these disputes was set out.

When instances of possible non-compliance with the Canada Health Act arise, our approach to the administration of the act emphasizes transparency, consultation, and dialogue with provincial and territorial health ministries. We rely on the goodwill of provinces and territories as we work through issues of concern, because under the act we do not have any direct investigative powers.

The application of financial penalties, through deductions under the Canada health transfer, is considered only as a last resort when all other options to resolve an issue collaboratively have been exhausted. These penalties are documented in the annual report, which you may have seen.

As you may have seen in the annual report that was tabled in February, from the time of the passage of the Canada Health Act until March 2015, over $10 million has been deducted from provincial or territorial transfer payments as a consequence of extra billing and user charges. That may seem like a small amount. I'll just note that the $10 million does not include close to $245 million that was deducted from 1984 to 1987 and subsequently refunded to the provinces and territories when they agreed to eliminate extra billing and user charges. That refund mechanism, which is no longer in effect, was intended at the time to act as an incentive for provinces and territories to come into compliance with the act. That's why the provision was time limited.

I want to be clear that our goal in administering the Canada Health Act is not simply to levy penalties. In fact, it's not really to levy penalties at all, but rather, to achieve compliance and therefore ensure access to insured services for Canadians, without barriers associated with ability or willingness to pay.

Let me quickly make a couple of comments about the annual report.

Tabling the report is a legislative requirement. It must be tabled in the first 15 sitting days of each calendar year. Although it is tabled in the federal Parliament, the content of it reflects the collaborative effort of provincial, territorial, and federal governments to inform Canadians about their publicly funded health insurance plans.

The federal section of the 2014-15 version of the report describes the Canada Health Act, our approach to administering it, and compliance issues that were on the table during the 2014-15 reporting period. As you may have seen, the bulk of the report is actually taken up by overviews of provincial and territorial health insurance plans. This information is provided to us at our request by provinces and territories. This data shows how each of those plans meets the conditions and criteria of the act, along with relevant statistics on publicly insured hospital, physician, and surgical-dental services in each jurisdiction.

However, it's important to note at the same time that while the report contains a lot of information about medically necessary physician and hospital services, which are subject to the criteria and conditions of the act, the report's scope does not extend to reporting on the status of the Canadian health care system as a whole. It is simply a report on the extent to which provincial and territorial health insurance plans comply with the conditions and the criteria of the act.

● (1545)

As I come close to the end of my remarks here, let me comment briefly on compliance issues. In terms of specific issues noted in this year's report, you will see a commentary on a deduction to British Columbia's CHT payment in the amount of a little over $241,000. This deduction was taken in respect of extra billing and user charges at private surgical clinics in B.C.

The report also notes a number of other recent and long-standing compliance issues. These issues vary from following up on stakeholder allegations of extra billing, to insisting that patients cannot be billed directly when they elect, for example, to have robotic-assisted surgery. Over the last year, we've approached provinces where hospitals were charging patients directly for preferred hospital accommodation when ward space was not available. We've also raised concerns in some parts of the country about membership fees at primary care clinics which, in our judgment, had the potential to pose a barrier to access to insured services.

I'm happy to say that our compliance work is generally conducted as a two-way street. From time to time provinces come forward and ask for advanced assessments of initiatives they are considering, to ensure that those conform to the requirements of the act, or at least they know in advance what might ensue if there's an issue or a proposal that might fall outside the act.

In the year in question we provided two such assessments. One concerned a proposal by a charitable foundation to pay for a nurse practitioner clinic dedicated to the clients of a community resource centre. The province was concerned that providing preferred access to clients would pose accessibility concerns under the act, but we advised the questioner that since the services were not provided by physicians nor in a hospital there were no concerns under the act.

The second assessment concerned a proposal by a group of ophthalmologists who wanted to charge patients for tests when they were performed in a physician's office instead of in a hospital. In that case there was a concern about the Canada Health Act, since the tests form part of a physician service, and no direct fees may be charged for such services when they are insured by a provincial or territorial health insurance plan. That proposal was abandoned.

Lastly, before turning to questions I'd like to touch on a recurring criticism that we certainly hear, and that is, that the Canada Health Act is an outdated piece of legislation that impedes innovation and modernization of health care systems. Not surprisingly, we have another view.

We'd like to remind members of the committee that the act allows provinces and territories the flexibility to experiment with various governance, organizational, delivery, and financing arrangements, provided those experiments meet the Canada Health Act test of no direct patient charges for insured services.

For example, many provinces are experimenting with family health teams, where physicians and other health care professionals work together to manage various aspects of patient care.

Other provinces have made care for those suffering from chronic conditions in remote areas less burdensome through tele-monitoring of patients' conditions.

Since no direct charges are made to patients in either of these cases there is no concern under these alternative delivery models. We think they are examples of the way in which the act is sufficiently flexible to accommodate delivery models that, frankly, were not envisaged in 1984 when the act was passed.

Let's just make this our concluding comment in these initial remarks. Our general view is that we think the values that underpin the act—those of equality, fairness, and solidarity—are just as relevant today as they were in 1984, and they will remain relevant as we continue to improve our health care system to meet the evolving needs of Canadians.

Mr. Chairman, I'll stop there, and both Gigi Mandy and I will be happy to take the members' questions.

Thank you.

● (1550)

The Chair: Thank you very much.

It sounds to me like you must make a lot of judgment calls in the run of a day.

We'll start our questioning with Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you for that very interesting and informative presentation.

One of the things you spoke of was how the Canada Health Act does exclude some services, in particular out-of-hospital pharmaceuticals and ambulance services. Would you see the exclusion of these services as a problem for the long-term viability of the Canada Health Act?

● (1555)

Ms. Abby Hoffman: I'll start, and Gigi may want to comment.

They don't impact the viability of the act in that it's still the case that a very large portion of health care spending in Canada goes to hospital and physician services. They are, obviously, governed by the conditions and criteria of the act.

I think it is the case that the result of the Canada Health Act's focus on physician and hospital services does mean that across the country other services, such as the ones you've mentioned and many others, are either not covered at all, or if covered, are covered in different ways in different parts of the country. The good news is that in many provinces they've evolved to pretty much the same level of development, so a lot of these services are covered in some manner or another. Drug coverage is clearly an issue, as well as access to other services in the community, for example, home care.

The fact that there are differences across the country is an issue of concern, even if provincial and territorial funding in these areas is quite robust. At this point, that is simply the state of play across the country.

Mr. Doug Eyolfson: Could Health Canada measure the potential benefit of universal coverage for pharmacare in cost savings to the health care system, versus the outlay of cash initially to establish such a system?

Ms. Abby Hoffman: Are you speaking specifically about drugs, or are you talking more—

Mr. Doug Eyolfson: I'm talking more about drugs. Is there any analysis that might look at the cost of funding out-of-hospital pharmaceuticals versus the costs saved to the health care system by improving outcomes in those who can't afford them? Has any analysis like that been done?

Ms. Abby Hoffman: There's no algorithm that makes a precise calculation of the consequences of forgone access to drugs among those Canadians who cannot afford to fill prescriptions. We do know from various surveys that it's not a huge portion, but there is a critical mass of Canadians who actually say they do not fill or renew prescriptions because they simply cannot afford to. We do know that there are downstream costs to the health care system, incremental costs associated with that. We would note from any of these studies that have been done that they are likely larger than the costs associated with providing drug coverage for those individuals.

Yes, there are downstream costs in terms of deteriorating health, possible admission to hospital, and utilization of other health care services. I think it's actually the reason that now, as you know, under the discussions about a shared health agenda and the potential of a new health accord, access to pharmaceuticals is one of the key components of that effort. There is a lot of concern about both the cost implications and the toll that it's taken on the health of those individuals who simply cannot afford drugs.

The people we're talking about are individuals who do not qualify for provincial/territorial public drug plans, which are mainly focused on older Canadians or people on social assistance. We are talking about people whose employment status is such that they don't have access to private insurance. There's that still quite sizable portion of the population who pay out of pocket for their own drugs. And a portion of those people—about a quarter of the total, some smaller portion, but nonetheless a significant portion—simply cut back on drugs that they should otherwise be using.

Mr. Doug Eyolfson: Based on your experience, if there were to be some level of expanded coverage for out-of-hospital pharmaceuticals, can you see what kinds of high-level administration challenges there would be, other than the initial outlay of funds?

● (1600)

Ms. Abby Hoffman: The design of any kind of program that would try to bring in some sort of coherent coverage regime would have to deal first of all with who's eligible, under what conditions, how are they being reimbursed for drugs, on what kind of formulary, and with what kind of copays or patient contributions.

One thing initially one would want to guard against is people finding a new initiative so attractive they remove themselves from either their existing employment-based supplementary benefits coverage, or they remove themselves from some other public plan.

The complexities around the design of drug plans are quite significant. The provincial programs, the federal government's program for first nations and Inuit, and the non-insured health benefits programs are complex things to design. I think ultimately most people would argue whether somebody has access to an employment-based program, or they have access to a publicly financed plan, the parameters should be the same.

A lot of people talk about having for example a common formulary for access to drugs for all Canadians regardless of how they have their coverage financed.

The Chair: Mr. Carrie.

Mr. Colin Carrie: I want to thank Dr. Hoffman for being here. Whenever we have such a famous and inspirational Canadian in front of us, I think we're honoured by that.

My first question to you is basically an update. I think you're aware of Quebec's Bill 20. I was wondering where that legislation is at, and what the department's viewpoint is on it.

Ms. Abby Hoffman: You're talking about the intent to develop a schedule of fees that patients would be charged, or I would say the owners of clinics would be allowed to impose on patients for certain services delivered in clinics.

At the moment our understanding is the legislation has been passed. A schedule of permissible fees is being developed. Up to this point, that fee schedule has not been published. An effective date, in our understanding, is possibly in late spring. In the May to June period, that schedule would be published, and the regulations would be in effect that would allow providers to levy these fees for services in a particular facility; that is, in clinics.

Of course it hasn't happened yet, so nobody has been charged anything. We certainly would say that is a fairly direct challenge to the Canada Health Act.. Interestingly, as we understand the arrangements, some of those same services if provided in a hospital would be provided to patients without any fee being imposed. This would be a fee that would be charged in particular settings where these services would be delivered.

Mr. Colin Carrie: Thank you for that.

For my second question, you mentioned in your presentation that the Canada health transfers are up to $34 billion, or somewhere around there.

Out of curiosity, in about the last 10 years has the federal government ever lowered or cut these transfers, or have they always gone up every year?

Ms. Abby Hoffman: The transfers are subject to arrangements between the federal government and the provinces. Currently the year-over-year increase of the total pot of the Canada health transfer is 6%. There is a complex formula. It's less complex than it used to be because it's now on an equal per capita basis for determining how much each province gets. The only reason I'm suggesting that it's complicated is because when there was a move from an old formula to equal per capita then adjustments had to be made to move forward into that new regime.

No jurisdiction has received less in any year through the CHT than they received in a prior year. In cases where there had been deductions associated with issues of compliance under the Canada Health Act, the amounts are as much symbolic as they are material. In recent years none of the deductions to CHT for non-compliance have significantly eroded what any jurisdiction has received as CHT.

● (1605)

Mr. Colin Carrie: Thanks for clarifying that, because I've heard that some people out there are stating that the federal government has cut transfers.

How effective have previous increases in the federal health care funding been in promoting health care system reform efforts? Also, what kind of accountability is there with the transfers? I know the federal government has been giving 6% per year. For example, in Ontario I think for a few years their increases in spending have only been 2%, so they're getting 6% and spending 2%. Just out of curiosity, do you think the accountability measures that are there are good enough, or is it something that needs to be looked at?

Ms. Abby Hoffman: There's one accountability measure, as I mentioned, related to the CHT, and that's the requirement to comply with the Canada Health Act. I think it's fair to say that the transfers for health are, obviously, in respect of health, but they're also part of the fiscal arrangements of the country. Ultimately, as far as the CHT is concerned, it's up to each province or territory to decide how they spend that money.

I should just note one thing from a pure mathematical standpoint. You may be right that the Canada health transfer has gone up in percentage rates that exceed the growth in health care spending in particular recipient provinces. But it's worth remembering that the federal government's contribution is somewhere in that 20% to 24% range. I'm not belittling the value of 6% on 23%, but obviously the bulk of the burden of spending on health care is still borne by provincial treasuries.

Also, I'll just say that under the 2004 accord there were reporting obligations, which provinces and territories accomplished. They do not, however, constitute iron-clad guarantees about either reporting or what the recipient province or territory will do with the money. I think this is simply a matter of respecting the jurisdictional responsibilities the provinces, territories, and federal government respectively have.

Mr. Colin Carrie: I know we've made major investments in stuff like the Canadian partnership organizations, such as the Canadian Partnership Against Cancer, the Mental Health Commission of Canada, and other national associations working to address Canadians' biggest health challenges. I was wondering if you could let us know the biggest successes achieved in these areas and how you think the organizations should be adapting to new challenges as we go forward.

Ms. Abby Hoffman: Mr. Carrie, are you talking specifically about organizations like the Canadian Partnership Against Cancer?

● (1610)

Mr. Colin Carrie: Yes.

Ms. Abby Hoffman: I'll just say—and this may or may not be known to members of the committee—that there are eight organizations that Health Canada funds, which play various roles in the health system. There's the cancer partnership, the Canadian Institute for Health Information, the Mental Health Commission, the Canadian Centre on Substance Abuse, the Patient Safety Institute, the Canada Health Infoway, and so on.

These organizations, which we describe as "shared governance organizations", are managed.... In fact, most of them were created by the federal government, but they have federal, provincial, and territorial representation on them. They are intended to be highly responsive to needs identified across the country.

Unlike the CHT, which, as I mentioned, is a lot of money with an important accountability but really only in the area of the Canada Health Act, these other organizations have a specific responsibility in their particular area of interest. The Canada Health Infoway is specifically in the business of advancing electronic health records, and that sort of thing. The cancer partnership is dedicated to getting everybody in the cancer community working to the same objectives with the most important advances in cancer control and prevention.

I don't know if I would characterize it as saying that we have more control over those organizations. That's not really the main point I want to make. What I simply want to say is that they are clearly focused on their main business. There are not issues around whether or not, for example, the Canadian Partnership Against Cancer is spending money on something other than cancer. They can't, they don't, and they won't. They are really focused on their task.

The total cost to the federal government of these organizations I've just mentioned, in terms of budgetary allocation, is less than $400 million a year, which is not a large amount in the grand scheme of health care spending in Canada, which is in the hundreds of billions of dollars. They really do very important work with, as I say, relatively small resources, because of the very focused mandates they have and the governance that helps direct the work they do.

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Ms. Hoffman and Ms. Mandy, for being with us today.

Ms. Hoffman, you've already covered the general scheme of the act. You mentioned in this report that over the last 20 years the federal government reductions in health transfers to provinces and territories based on Health Act violations totalled $10 million. I think your words were that it was fairly small. That's the first reaction I had. I was surprised that in 20 years it's only been $10 million when the act calls for dollar-for-dollar reduction for violations of the Canada Health Act. My first question is: does that figure accurately reflect dollar for dollar the exact amount charged for health services delivered to Canadians across this country in the 20-year period?

Ms. Abby Hoffman: There's one example, and it's actually one of the examples that's cited in the report this year. I'll just connect my comment here to something that I touched on in my remarks which is that the objective here is not to impose penalties. The objective is to try to bring the respective provincial health insurance programs into alignment with the Canada Health Act.

We know in British Columbia, because it's the subject of an ongoing dialogue with that province, that one could make an estimate of charges that are being levied on patients that exceed the amount of our deduction, which I think I identified is something in the range of a quarter of a million dollars. The deduction we made is based on the actual documented extra billing and user charges that we know have been levied in British Columbia. Could we, via process of extrapolation based on other evidence, audit reports, and so on, come to the conclusion that in fact the amount is higher than that? Yes, we probably could, and we may in fact come to that decision at some point. Right now we are working with the province and officials in the medical services plan in B.C. to see if we can't find some other solution.

I'll just say that this gets complicated because a number of the people in British Columbia, as patients who accept patient charges, willingly do so because they think it's a benefit to them to jump the queue and get what they believe will be faster access to care.

Mr. Don Davies: There are two options, and I hear stories of user fees as the health critic for the New Democrats. There's a proliferation of extra charges for diagnostic services across the country. I mean, there's a new MRI clinic that's opening in Saskatchewan. I hear stories of constant up-selling for people, let's say in cataract surgery, where for a little extra money you can get a superior lens. Quantum-wise, would you agree with me that this figure has to represent... I mean, the amount of extra billing or user fees in this country clearly exceeds the amount that the federal government is actually recovering. I don't quarrel with the general approach of trying to be collaborative, but I just want to get an idea of the quantum.

Ms. Abby Hoffman: I think what you've asserted is fair. I will just note, though, when you're talking about up-charge, whether it's for a lighter weight cast, or some kind of—I don't want to call them bells and whistles because there may be some therapeutic benefits—norm in that jurisdiction, the standard of care up to here is publicly insured. If somebody wants to pay for an embellishment then they're free do to that, but I think where we want to draw the line is that what would be defined as medically necessary care is covered.

The issue of private clinics is a long-standing issue, and we're very concerned about it. I'll just say, just so members of the committee are aware, that there is a charter challenge in British Columbia. An owner of one of the more lucrative private clinics is basically asserting that his charter of rights as a provider and the charter of rights of patients are being infringed by virtue of his not being able to sell care and the patients not being able to buy it. I think frankly the result of that case will have a very important impact.

● (1615)

Mr. Don Davies: The other thing that came to me when I looked at the chart in your report is that British Columbia has been penalized—if I can use that word—13 years in row. That doesn't speak to me to the effectiveness of trying to discipline provinces to respect the Canada Health Act. Now, I know a part of that must be the Day clinic over and over again.

I want to move to another issue of the five principles. We've had in the news in the last 30 days a handful of first nations communities in this country declaring public health emergencies, and that is not a new story, unfortunately, in this country. In terms of the principles of universality and accessibility to make sure that Canadians have reasonable access to reasonably comparable levels of service, how we square that with the fact that we have first nations across this country who clearly do not have universal or equivalent access to health services. I'm wondering if the department has a view on that.

Ms. Abby Hoffman: I think it's our understanding the committee may be doing some work specifically on the issue of health care and the health status of first nations and Inuit. If I may, I think I would rather defer to my colleagues in the first nations and Inuit health branch, who can better speak to these issues.

However, I would say just as a general point at this stage that the circumstances in those environments—and maybe as you've expressed it—are not issues related to the Canada Health Act. These are issues related to the fairness and the appropriateness with which first nations individuals, particularly those on reserve, who are living in very, very difficult conditions—

Mr. Don Davies: May I interrupt you to ask a quick question? I'm sorry, I don't mean to, but I want to clarify this. Don't first nations fall under the direct responsibility of the federal government?

Ms. Abby Hoffman: First nations and Inuit would be regarded as insured persons for the purpose of the Canada Health Act. They receive services from the federal government. They are also entitled to services from provincial and territorial governments.

A lot of the issues, as I think you know, have to do with the kind of interface of what the federal government provides, what first nations health authorities provide, and what the provinces and territories may provide.

The Chair: Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

Ms. Hoffman, we're very fortunate to have the opportunity to ask you questions today.

I was looking at the principles of the Canada Health Act: universality, comprehensiveness, accessibility of care, portability, and public administration. Quebec has what is known as a two-tier system, with private clinics and such offering services. It's an issue that's come up before. In Canada, some $34 billion in funding is allocated across the health care sector.

What are the standards of care, in terms of the service quality the public can expect? Statistically, where do things stand, and what is the level of care provided? We talk a lot about public funding in the health care sector, but what we don't hear much about are important measures like response or wait times. I'm talking about how long members of the public and patients have to wait to receive services. As a result, those who can afford it have the option of accessing services through private clinics and the private sector, thus perpetuating the two-tier system.

I'd like to hear your thoughts on that.

[*English*]

Ms. Abby Hoffman: Well, first of all, I can say that with respect to the Canada Health Act specifically it does not impose on provinces and territories any particular standard of care. The Canada Health Act is all about the conditions under which the public health insurance scheme in a particular jurisdiction operates.

I think we would share with you the concern both about variability in access to services and, whether it's variable or not, about waiting times that are of such a duration for critical services that they actually imperil the health status of members of the population.

With respect to the *système à deux vitesses*, obviously we are very concerned about that. We have been discussing this issue with officials in Quebec specifically for some time.

Similarly, elsewhere in the country where we know there are charges for services at clinics, we have conversations with those jurisdictions. This is particularly the case in diagnostic clinics. If an individual is able to pay and get more rapid access, let's say, for an MRI or some other diagnostic test, not only do they get that initial diagnostic test more quickly, but they get access, then, to the care they might need based on the result of that test as well. This remains a concern for us. We've tried many different ways over the years to.... We have a private clinics policy that's aimed at addressing some of these concerns, but I can tell you that it's not an easy thing to do.

Gigi, do you want to make any further comment on clinics?

● (1620)

Ms. Gigi Mandy (Director, Canada Health Act Division, Strategic Policy, Department of Health): I think you pretty well covered it. We do have a lot of concerns. There are provinces that have strong regulatory frameworks, and the services in their private clinics are well integrated into the public system. They're provided under contract and patients have a way to pay. Other provinces don't have strong regulatory frameworks, and that's where you see the patients being charged directly at the clinic and issues of concern to us arising.

[*Translation*]

Mr. Ramez Ayoub: I'd like to make sure I understand the situation.

The Canada Health Act ensures the provision of services but does not address service quality or delivery. That dimension is the responsibility of the province, is that correct?

[*English*]

Ms. Abby Hoffman: That's correct. The act does not prescribe with any degree of specificity what services shall be provided and what specific quality standards shall prevail. That is up to the jurisdiction in question to determine.

[*Translation*]

Mr. Ramez Ayoub: There were other issues I wanted to ask you about, but I can't seem to get past this one.

Handing the responsibility over to the provinces is one thing, but ensuring universal access to care is another. The money is paid out, but no follow-up or information is available when it comes to the quality of care. And no such statistics are available, either. What's gone on over the past 10 or 20 years in terms of the level of health care provided nationwide? I don't mean in each province, but from coast to coast to coast. The goal is to make sure that Canadians all over the country have access to the same level of service and health care. How can we possibly achieve that without any statistics or data on service quality?

[*English*]

Ms. Abby Hoffman: I'll make a distinction between whether or not there are data available and whether or not there's a requirement based on the results of those data to make adjustments where necessary, that is, where the performance of a particular health care system is not comparable with what it might be elsewhere in the country.

There's a lot of information available. The Canadian Institute for Health Information is a national health data organization, financed mainly by the federal government, but with contributions from the provinces and territories. It collects and produces a lot of health information. You can go on that site and look under “health system performance”, put in your postal code, put in the name of a local hospital or health authority, and get a huge amount of information about the performance of that particular institution or health region. Then you can compare these data with those of other health authorities or institutions across the country. The information is there.

There's also a lot of information comparing Canada's performance with that of other countries in the OECD and elsewhere. But to your specific point, nobody is calling for immediate measures to be taken here. This is the reality of the country. The information is there, but the decisions on where to make adjustments fall principally on individual provinces and territories and their governance structures to determine where remediation occurs.

● (1625)

The Chair: Dr. Leitch.

Hon. K. Kellie Leitch (Simcoe—Grey, CPC): Thank you for your time today. We really appreciate it.

I know all of us want to end up on the same page as we try to contemplate some of these things over the next year or two. Since I live in this system, I would hope I understand somewhat how it works.

Could you tell us what you view as the current challenges for access to care? Those of us who are standing on the front lines can sometimes see things a bit differently. It can sometimes become frustrating because of the situation you're standing in at that specific moment. It's also important to look at the broader issues of access to care and how we should be addressing them. It would be useful to understand these issues and how you identify them, because they may be different from the ones we're identifying here. Dr. Eyolfson and I may experience other things first-hand.

What are your criteria for addressing access to care? How do we get the right outcomes, and what are the criteria that Health Canada is looking at to try to get us to that right place?

Ms. Abby Hoffman: Well, maybe I'll identify a few areas in response to your question, which gets at the imponderables of health care policy in the country.

First is the whole issue of those services that are, at this point, provided in the health care systems across the country on a discretionary basis. Whether we're talking about home care or access to drugs or mental health services or palliative care or whatever, I think many people would say these are elements one would expect to be generally available in contemporary health care systems. They are provided to a degree in most provinces and territories, but to a highly variable extent and certainly not at the level one would expect to serve the whole population well. That's one huge area of challenge.

Second, even though we all like to think our health care systems are evolving and adapting, either to demographic change or to technology or whatever, the fact of the matter is that systems don't adapt as readily and as efficiently as they should. Very often there are very good ideas, but it takes a long time for those ideas to roll out across the country. I'll give you an example. In mainstream media in the last few days, you may have seen something about the astonishing overuse of prescription drugs, particularly psychoactive drugs, among elderly Canadians, particularly, but not only, by those individuals who are in nursing homes or other institutional settings. A lot of work has been done to try to make sure that only patients who have been properly diagnosed are actually being administered these drugs.

This is a great initiative and it's going on in some parts of the country. New Brunswick has just announced, for example, that it's going to roll this process out across its entire nursing home system. One could easily ask, if this is a problem everywhere in Canada, which we're led to believe it is, how long will it take to roll out the same protocol across the country. I'm simply saying there are a lot of things we know how to fix, but it takes a long time to roll those fixes out across the country.

Third, partly because of the Canada Health Act, but just for reasons of historical legacy, there's a real focus on hospitals, even though hospitals are consuming a slightly smaller portion of the total health care spending across the country than was the case maybe 20 to 40 years ago. I think we still do not have as much of a focus as we should on delivering care, particularly for people with chronic conditions, to people living in their own homes or in community settings. I think some people would argue that we're still not making investments in the optimal locations.

Fourth is with respect to digital and electronic health records and so on. We've made a lot of progress in the country in terms of digitizing test results and making sure that physicians' offices have access to electronic medical records, but these records often are not interoperable. Somebody can go to a hospital, and certain test results are recorded, and anyone with privileges at that hospital can get access to that information. The same patient goes to their family doctor who has a different system, and someone in that family doctor's office actually receives by mail or fax the results of a test done in a hospital, scans it, and puts it into a record in the physician's office. I think one could say this is a really suboptimal way of operating in 2016.

I could go on with a longer list, but those are four things I would say many people would say we need to tackle.

● (1630)

Hon. K. Kellie Leitch: I would agree with you, whether it be with regard to adaptability, consistency, or issues around shared services or challenges within the system.

In your opinion, with respect to how we move the bar on those key criteria in the plan going forward, what two or three mechanisms would you recommend to create that accountability in our relationship federally with our provincial partners?

To your point about rollout, it's fine that every time there's a new opportunity for better access to care for patients that we see it at the Hospital for Sick Children in Toronto, but, obviously, we want to see that in every children's hospital in the country and quickly, not two to five years hence. What are your thoughts from a public policy or program perspective with regard to addressing that accountability issue so that we close the gap in rollout consistency or otherwise?

Ms. Abby Hoffman: I would start by saying that I'm not too sure the federal government can really hold provinces and territories or health care institutions or regional health authorities to account for what they do or do not do. What we can do is try to provide support.

I'll go back to the example of the use of psychoactive drugs among seniors in institutions. We support an organization called the Canadian Foundation for Healthcare Improvement. It has done a lot of the preliminary work looking at this issue of the overuse of medications among seniors in institutions. I think the best thing we can do, and it doesn't cost a whole lot of money, is to support that organization so that, with the model they may develop in a couple of jurisdictions, they get support to be able to roll that out and talk to people elsewhere in the country, and the spread effect takes place as quickly as possible. That's more what we can do.

On a larger scale, just to go back to the issue of drugs and access, for example, and universal access or not, one of the most important things we can do in our own backyard, and with provinces and territories, is to focus on the issue of drug prices and drug costs. Drug coverage, and expanding that coverage, will be limited if Canadian drug prices and total costs remain as high as they are today. That's a different approach. It's not an accountability approach, it's working with provinces, building on some of the things they're already doing, and using some of the levers we have to try to get drug prices to the point where there's actually money freed up to expand coverage, while still operating within the same total drug bill.

The best way for us to operate depends on what it is.

Hon. K. Kellie Leitch: To disagree just slightly, I think having determined outcomes is actually valuable. Working toward those as goals is important.

Ms. Abby Hoffman: Yes.

Hon. K. Kellie Leitch: I don't think anyone who has been involved intimately with patient care or with research for patient care doesn't have a mindset of what their outcome will be or how many patients they want to involve in their study, etc. I think we do have to have a bit of granularity, which I associate with accountability in order to get to the right spot.

I have a different question—

The Chair: You're over your time. Sorry. That was very interesting, though.

Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you to Ms. Hoffman and Ms. Mandy for their valuable presentation.

Mental health has been highlighted as a priority under the Canada Health Act. Are there major differences between the provinces regarding the delivery of mental health services across the country, and does there need to be improvement across the board?

● (1635)

Ms. Abby Hoffman: There are only general references to mental health in the Canada Health Act. Regardless of that, I think everyone acknowledges that mental health services are very important, particularly for young people. If we think about children, teenagers, and young adults, mental health issues certainly are.... I don't want to say they're pervasive, but they are significant. I think we recognize that across the country.

Again, it's not just an issue of variability in services. I think almost everybody would say that the service offerings in mental health are not what they should be. It's partly an issue of money. It's partly an issue of trying to figure out how to provide mental health services in a way that is affordable. It doesn't necessarily mean that psychiatrists and psychologists are the only health professionals who actually can do something in the mental health area.

The government has made it clear as part of the discussions with provincial and territorial governments under a new health accord that mental health services is a focus of that activity. We're not at the place yet where I can say that we're doing this or we're doing that. That's an ongoing discussion with the provinces. I'll just say that it's a really important focus that will be pursued over the next several years.

Ms. Sonia Sidhu: Would you agree that access to mental health care is more difficult outside major urban centres? As well, how does our approach need to be different in rural areas?

Ms. Abby Hoffman: I think your point is well taken. There are challenges for individuals and families accessing mental health services in big cities, but the situation is compounded in less populous areas. We know, for example, there has been some good work done on delivering mental health services and counselling through telehealth applications. I think there are some things that can be looked at that will certainly help deal with mental health concerns of people living in smaller communities. Clearly, if you have a town of 5,000, 10,000, or even fewer people, it's unlikely there will be a full battery of mental health services available in the community on an ongoing basis. Other ways of delivering services to people in those kinds of settings will be required.

Ms. Sonia Sidhu: We live in an era in which technology plays a primary role in every sector, whether it's by increasing effectiveness, facilitating tasks, or offering better services.

In the health sector, the technologies that we currently use are in constant evolution. Those advancements are absolutely necessary in order to save lives.

What is Health Canada's commitment to facilitating innovation for health care services?

Ms. Abby Hoffman: There are a couple of things I could mention.

First of all, we support an organization called the Canadian Agency for Drugs and Technologies in Health. One of the things that it does is assesses the potential benefits of new technologies as they come on stream and provides advice to provinces and territories and health care institutions and providers, and so on, so that good decisions can be made about when to adopt a new technology, for what kinds of patients, when to decommission or take out of circulation technologies that are no longer optimal.

In the area of e-health we certainly have provided a lot of support historically to the Canada Health Infoway to pursue all kinds of health information technology advances, including in telehealth, electronic health records, that sort of thing.

The Chair: Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Dr. Hoffman, for your information.

I have a question. I'm hearing more and more about Canadians seeking surgical procedures or dental procedures outside the country, whether because they want to fast-track treatment or because it's less expensive for things like dentures and teeth implants and such. Then they come back to Canada and they develop complications and so they seek treatment within Canada, often costing taxpayers more with the treatment and the healing than it would be to actually do the procedure to begin with.

I just want to know what your thoughts are with respect to what is occurring. Are these incidents increasing? Are you hearing more and more of these types of stories? I certainly am, with some of my constituents.

What policies are in place with respect to people like this who come back and seek these treatments?

● (1640)

Ms. Abby Hoffman: Well, we're hearing about this as well, maybe through the same sources, which are significantly through the media.

I think I can tell you that most provincial and territorial jurisdictions do have systems for advance approval of procedures that are done out of the country. However, clearly a lot of the cases you're referring to are instances where someone just simply chooses...either the procedure is not available in Canada and they think it will be better for them, or as you say, they may not wish to wait, or who knows precisely the circumstances.

Of course, one of the benefits of our system is that regardless of how somebody becomes ill, if individuals go to another country and have botched procedures or the procedures they've undergone don't produce the result that they expected, and they actually are more ill than they were, those individuals are entitled to receive care in Canada. It's partly an issue of public information. We know over time people have gone to the United States, Mexico, or other countries seeking care, thinking that it's a silver bullet for whatever condition they're suffering from, and the consequences unfortunately have been dire.

I think a lot of this is about public education and people needing to be cautioned to be very careful about a decision to get care in another country without consulting anyone, either their own doctor or their own insurance scheme, whether it's public or private insurance. It's a risky business, and we are hearing about more of these cases.

Ms. Gigi Mandy: I was just going to add that we've heard recently about people who have gone out of country seeking bariatric surgery, people who are overweight but may not meet the criteria for the surgery here. There was one case in the news about a woman who was only 35 pounds overweight. That's what she wanted to lose. She went out of the country and had surgery, and had disastrous effects.

One of the problems is when people come back, they often may have incomplete medical records. It really poses challenges for the doctors here who are trying to correct the problems because they don't know exactly what has been done or what the complications were.

Mr. Len Webber: That's very interesting. Again, thank you for that. I hear more and more of it daily and it is a concern. Of course, public awareness is key to that.

The Chair: Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much.

Some of my earlier questions have been asked already. I'm going to go into a different area. The Minister of Health has a requirement to develop a new health accord by the end of 2017 or 2018.

What do you view as the main challenges at that table? Where will the resistance by the provinces and territories be to a health accord?

Ms. Abby Hoffman: I don't know that I would necessarily say resistance. There is always a delicate balance in a discussion about what priorities should be and within those priorities what actions should be taken.

The government was quite clear in its platform commitments that it wanted to pursue an accord. It wanted to have an accord that would be focused on mental health, home care, innovation, and pharmaceuticals.

When Minister Philpott met with her provincial and territorial colleagues in January in Vancouver, there was an agreement among that collection of ministers that aspiring to an accord with those priority areas was something that they were prepared to pursue. That's step one. We've got a general agreement that those are areas that require attention.

When it comes to the specifics of what will be done in each area, this will be the subject of discussion. At the end of the day, the communiqué that ministers released in January talked about bilateral agreements. These are bilateral agreements between the federal government and each individual province or territory. The discussion that's going on now is in regard to the kinds of initiatives in these areas that will be on the table for discussion and potentially for support.

The art of achieving an accord is to get to an array of proposals and ideas which would allow every jurisdiction to say, “Here are things that really are important for our particular jurisdiction,” which means it could be quite a different arrangement within a broad umbrella approach across the country.

In some cases it will be easier to arrive at a conclusion. For example, to take the area of drugs, everybody agrees that drug prices are too high and, generally, it's agreed that there are two ways of trying to deal with drug prices. You can regulate or you can use market power; that is, collective purchasing power to negotiate better with manufacturers, or some combination of the two.

That's an example where at this point, and not getting into all the detail, it's reasonable to presuppose that governments generally will be on the same page.

In other areas, take home care, for example, everybody recognizes that we don't have sufficient home care in the country, but the specific aspects of home care that maybe need improvement—

● (1645)

Mr. John Oliver: I want to ask about home care because I am curious about it. It doesn't follow as clearly as hospital and physician care under the CHA. Would you view home care as part of the CHA mandate?

Ms. Abby Hoffman: I would not view it technically as part of the Canada Health Act. The general feeling about home care is that, particularly but not only for older Canadians who may have one or maybe multiple chronic conditions, those individuals may from time to time have acute episodes and need to be hospitalized. For the most part their care should be provided through the sort of primary care system and through care that's mainly delivered in home and community settings.

Everybody kind of agrees with that sort of general philosophy. Exactly how that's achieved depends. Ontario, for example, is basically pulling back from a system of delivering home care that it had in place for quite a long time. Other provinces are taking different approaches.

Mr. John Oliver: I am also curious about compliance. The penalty model or the clawback model doesn't appear to have a lot of compliance problems, other than what we saw in British Columbia and Newfoundland. The last five or six years have been very quiet on the compliance front.

Is that because you're not able to detect it or don't hear about it? When you do hear about it, are the tools you have sufficient or do you think there should be stronger tools built in?

Ms. Abby Hoffman: We're not going to say that we know about every single issue that may crop up across the country. We think we've got a pretty good idea of what's going on. We don't, however, have any authority to investigate. We cannot go out to a clinic and conduct an audit or demand to see the books of a health care institution. The federal government does not have that authority.

Having said that, I'm not too sure that we necessarily want it or need it. I think, generally speaking, we feel that we are aware of issues out there and we then enter into the dialogue with the province or territory in question. As I indicated in my remarks, it's a bit variable across the country. The largest province right now, Ontario, has the fewest compliance issues. Ontario is, to our knowledge—I can always be proven wrong—absolutely assiduous about following up on any allegation that a patient has been charged. They have very effective legislation, which has many more powers than the Canada Health Act, to actually go out, investigate, and penalize a physician or a clinic owner. They reimburse any patient who it's believed has been charged unfairly under their legislation, and ours.

Two of the biggest challenges that are out there right at the moment—they've come up earlier in this conversation today—are in Saskatchewan and Quebec where there are legislative initiatives proposing to basically codify and allow patient charges. These are not a secret. It's not a question of us not knowing about them, it's a question of how best to enter into a conversation with the jurisdictions concerned to turn those situations around.

● (1650)

Mr. John Oliver: Has the dispute avoidance and resolution process that's been recently added in been helping a lot where you do hear and where you're working through them?

Ms. Abby Hoffman: Maybe the fact that it exists is helping.

The reality is, that formal process has actually never been used. It was put in place at a time when the debate between the federal government and provinces about the status of private clinics was very heated. It was a very charged environment. There have been offers on a couple of occasions by the federal minister to proceed with the dispute avoidance and resolution process. I think in one, if not both cases, a change in government ensued and the new government was not predisposed to pursue the cases so aggressively, so they were abandoned. I'm not making this as a prediction, but it is there and it's possible that if there are situations that are important and they're not able to be resolved, that proposal and process could be put back on the table.

The Chair: Mr. Davies, welcome back.

Mr. Don Davies: Thank you.

Just to pick up on that, I noticed Ontario hasn't paid a dollar in 20 years in violation of the Canada Health Act. I'm looking at a report done two years ago by the Ontario Health Coalition. They say six researchers, working with the Ontario Health Coalition, phoned 135 private clinics and hospitals to find out whether they charged patients user fees and extra billing for services. The researchers found that the majority of the private clinics they talked to charged patients user fees ranging from $50 to $3500 or more. We found that a significant number of the clinics are violating the Canada Health Act and Ontario legislation prohibition on user fees, extra billing, and the sale of queue-jumping. There's example after example, particularly in the eye field. There are $50 administration fees, snack fees for colonoscopies. I'm having a hard time squaring this, that by your report Ontario has a pristine record, and yet other people are finding that half the private clinics in Ontario are charging obviously hundreds of thousands, if not millions, of dollars in user fees a year.

I'm wondering if you could square that for me.

Ms. Gigi Mandy: There are two things. We did take the report to the Province of Ontario and asked them to investigate and get back to us. We were also aware of most of the instances that were documented in the report and had already approached Ontario about them.

As Abby mentioned, Ontario has a very strong framework. There are things that go on, and often they are mistakes, like an administrator at a clinic doesn't know that they can't charge a patient for that, or something happens that shouldn't happen. But Ontario is very good about investigating complaints, and unlike other provinces, it doesn't have to be the patient who brings a complaint to them directly. It can be a stakeholder group, it can be the media; they will investigate anything.

If they investigate a clinic and they find a charge for a colonoscopy or cataract surgery, they not only ensure that patient is reimbursed, they look at the records of all the patients who received the same service at that clinic and ensure they're reimbursed as well. In fact, Ontario very openly—

Mr. Don Davies: Sorry for interrupting. Do they actually get the money back from the clinic that charged them?

Ms. Gigi Mandy: They do. They reimburse the patient first, and then they recover the money from the physician.

Mr. Don Davies: So in your view it's working. Okay.

Ms. Gigi Mandy: That's right.

Mr. Don Davies: I have only a brief time. I want to get one more question, if I could, on a different subject. It's on the issue of access. I'm going to take the example of abortion services. We know that in Prince Edward Island—an entire province—and in vast rural areas in Canada, women do not have access to abortion services, and that's a medically necessary procedure as defined by the Supreme Court of Canada.

Why has P.E.I. not been penalized or addressed in some manner for failing to provide access to such an essential reproductive health service? Maybe give us the department's view on that.

● (1655)

Ms. Abby Hoffman: I'll start, and Gigi may want to add.

First of all I'll say that the issue of access to abortion services has been a long-standing concern. Over the last decade New Brunswick and P.E.I. have drawn the most attention and concern from us. There has been considerable evolution in New Brunswick, and some in P.E.I. It used to be, and is still the case today, that a woman in P.E.I. needed to go off the island. I think we would say it's hard to square that standard of care with real accessibility as we understand it under the Canada Health Act. There has been some flexibility in the criteria and conditions that apply to women who have to go off the island. We know that there are some discussions going on about dealing with the current situation of no access on the actual territory of Prince Edward Island. It continues to be a topic of discussion with respect to that part of the country.

In general we are concerned and we are having some discussions about it, about the fact that it is still the case not just in rural areas but elsewhere that often abortion services are available only in hospitals; they're insured only in hospitals. There may be a private clinic, but in some parts of the country, historically, if a woman went to a private clinic instead of a hospital she was charged and not necessarily reimbursed by the province, which is a clear Canada Health Act violation, because you cannot be charged for what is otherwise an insured service performed in a different institutional setting. It's an issue we continue to pay a lot of attention to.

It is a bit tricky under the Canada Health Act to say to a province, for example, that may have several hospitals that are performing abortions that they have to meet a threshold of availability—which might often mean either more hospitals or clinics—where abortion services could be provided. I think we would not be disinterested in this issue, but.... Finding a province in breach of the Canada Health Act on extra billing and user charges is, relatively speaking, straightforward: either an individual was charged or he or she wasn't. When it comes to determining whether the extent to which a service is available in a jurisdiction violates the accessibility principle is a lot different. We're having a conversation amongst ourselves right at the moment about New Brunswick, which has made considerable improvement over the last several years in this regard. But some people might look at the New Brunswick situation and say, “Well, that's great, but there are not enough locations”. We haven't made that determination yet.

I'll just simply say it's something we're concerned about, we pay a lot of attention to it, but it is very tricky to actually have us sitting here in Ottawa saying that this service is not available in a sufficiently geographically dispersed manner to meet an accessibility test. That's a tough one for us.

The Chair: You're done. You can come back, though.

Mr. Don Davies: Thank you.

The Chair: Well, thank you very much. That completes our round of questions. I had one myself.

You mentioned that the transfer payments are now determined on a per capita basis. What were they before, and what do you think they might be in the future, or what should they be?

Ms. Abby Hoffman: I think you might have to invite my colleagues from the Department of Finance to talk about that. It was a very complicated formula that has evolved over the years, but it took into consideration various issues related to taxation and fiscal capacity. People often said there was only a handful of people in Canada who could actually even understand what the basis was for the federal health transfer. There was a decision taken some time ago now, but brought into effect more recently, that the formula should be on an equal per capita basis.

I'll just simply say that the prior formula, which you really would have to talk to Department of Finance officials about, was much more complicated and had much more to do with the overall arrangements for fiscal federalism than it did for financing health care per se.

● (1700)

The Chair: Thank you for taking the time to do this. You certainly enlightened us on a lot of aspects of the Health Act.

I'm going to propose that we suspend the meeting for a few minutes and we go in camera. I know you don't like that. We're going to talk about people and people's names.

We'll suspend for a couple of minutes. Everybody will have to leave, except the members.

[*Proceedings continue in camera*]