Commission on the Future of Health Care in Canada

Commission sur l'avenir des soins de santé au Canada

BUILDING *on* VALUES

THE FUTURE OF HEALTH CARE IN CANADA

ROY J. ROMANOW, Q.C.

COMMISSIONER

Final Report

NOVEMBER 2002

Building *on* Values

The Future of Health Care in Canada

National Library of Canada cataloguing in publication data

Commission on the Future of Health Care in Canada

Building on Values: The Future of Health Care in Canada – Final Report

Commissioner: Roy J. Romanow.
Issued also in French under title:
Guidé par nos valeurs : l'avenir des soins de santé au Canada
Includes bibliographical references.
Issued also in print format.
ISBN 0-662-33043-9
Cat. No. CP32-85/2002E-IN

1. Medical care – Canada.
2. Public health – Canada.
3. Medical policy – Canada.
4. Health services administration – Canada.
II. Romanow, Roy J.
II. Title.

RA412.5C2S52 2002 362.1'0971 C2002-980275-X

Commission on the
Future of Health Care
in Canada

Commission sur
l'avenir des soins de santé
au Canada

Commissioner
Roy J. Romanow Q.C.

Executive Director
Gregory Marchildon, PhD

P.O. Box 160, Station Main
Saskatoon, Canada S7K 3K4
306 975-6888 Fax *306* 975-6890
www.healthcarecommission.ca

Commissaire
Roy J. Romanow, c.r.

Directeur exécutif
Gregory Marchildon

C.P. 160, Succursale Main
Saskatoon, Canada S7K 3K4
306 975-6888 Télécopieur *306* 975-6890
www.commissionsoinsdesante.ca

November 2002

TO HER EXCELLENCY THE GOVERNOR IN COUNCIL

By Order in Council P.C. 2001-569, I was requested to inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment.

I am pleased to report that my Commission's multi-faceted consultations with Canadians demonstrated their commitment to the original ideals of medicare as well as their willingness to change basic practices and approaches in order to make the system as a whole more sustainable for the 21st century. I have relied upon their experience and wisdom as well as the best research and evidence available in coming to my conclusions and recommendations.

I have been honoured to have the responsibility of working to fulfill this mandate and I am pleased to submit for your consideration the Final Report of the Commission on the Future of Health Care in Canada.

Respectfully submitted,

Roy J. Romanow, Q.C.
Commissioner

Contents

Mandate xi

A Message to Canadians xv

Executive Summary xxiii

1 Sustaining Medicare 1
- What is Sustainability? 1
- Health and Health Care Services 2
  - Health Care and the Canadian Constitution 3
  - Medicare and Beyond 4
  - Private For-Profit Service Delivery: The Debate 6
- Needs and Outcomes 9
  - Performance of the Canadian System 9
  - Responsiveness to Specific Illnesses 14
  - Disparities within Canada 16
  - Anticipating an Aging Population 20
- Resources in the System: The Case of Funding 23
  - Canada's Reliance on Taxes 24
  - Use of Private Insurance and Out-of-pocket Payments 24
  - The Balance between Public and Private Funding of Health Care 26
  - Alternative Funding Sources 28
- Sustaining Canada's Health Care System – Looking Ahead 43

2 Health Care, Citizenship, and Federalism 45
- Directions for Change 45
- The Case for Change 45
- Establishing a Canadian Health Covenant 48
  - A Commitment to Canadians 48
- Achieving the Vision: National Leadership in Health 52
  - A New Approach to National Leadership 52

Role of the Health Council of Canada ... 54
Health Council Operation and Structure ... 57
Modernizing and Updating The *Canada Health Act* ... 59
The Principles of a Modernized *Canada Health Act* ... 60
Expanding Medicare Coverage: Short Term and Long Term ... 63
Clarifying Coverage under the *Canada Health Act* ... 64
Providing Stable and Predictable Federal Funding ... 65
Introducing a New Canada Health Transfer ... 65
Short-Term Funding Issues ... 71
What Does This Mean for Canadians? ... 72

3 INFORMATION, EVIDENCE AND IDEAS ... 75
Directions for Change ... 75
The Case for Change ... 75
Building Canada's Health Information Technology Infrastructure ... 76
Introducing Personal Electronic Health Records ... 77
A Leadership Role for Canada Health Infoway ... 79
Empowering Canadians and Protecting Their Privacy ... 80
Expanding Health Literacy ... 81
Streamlining and Improving Health Technology Assessment in Canada ... 83
The Growing Importance of Health Technology Assessment ... 83
Expanding Health Technology Assessment in Canada ... 85
Building Canada's Health Research Knowledge Base ... 86
Taking the Next Steps to Expand Our Knowledge Base ... 87
Forging Better Linkages ... 89
What Does This Mean for Canadians? ... 89

4 INVESTING IN HEALTH CARE PROVIDERS ... 91
Directions for Change ... 91
The Case for Change ... 91
The Current Situation for Canada's Health Workforce ... 92
The Nursing Situation ... 94
Access to Doctors ... 96
Paying for Nurses and Doctors ... 101
International Mobility of Health Care Providers ... 102
Allied Health Care Providers and Managers ... 103
A National Effort Is Needed ... 104
Immediate Investments in People and Change ... 105
Addressing Gaps in Supply and Distribution ... 106
Changing Roles and Responsibilities ... 106

Planning for Change Over the Longer Term ... 108
Improve Information about Canada's Health Workforce ... 108
Review and Renew Education and Training Programs for Health Care Providers ... 109
Develop a Comprehensive Plan for the Future of Canada's Health Workforce ... 110
What Does This Mean for Canadians? ... 113

5 PRIMARY HEALTH CARE AND PREVENTION ... 115
Directions for Change ... 115
The Case for Change ... 115
Primary Health Care in Canada – Opportunities and Obstacles ... 117
Primary Health Care Opportunities ... 117
Obstacles to Primary Health Care ... 118
Evolving Approaches to Primary Health Care ... 119
Fast-Tracking Primary Health Care Change ... 121
Using the Primary Health Care Transfer as a Catalyst for Action ... 121
Establishing Four Essential Building Blocks ... 121
Building National Momentum, Attacking Obstacles and Reporting Progress ... 125
Building and Maintaining Momentum ... 126
Strengthening the Role of Prevention ... 128
Promoting Good Health ... 128
Addressing Leading Causes of Major Health Problems ... 129
A National Immunization Strategy ... 134
What Does This Mean for Canadians? ... 135

6 IMPROVING ACCESS, ENSURING QUALITY ... 137
Directions for Change ... 137
The Case for Change ... 137
Reducing Waiting Times and Managing Wait Lists ... 138
Waiting for Health Care ... 138
Managing Wait Lists ... 141
Considering Care Guarantees ... 144
Improving Quality ... 150
Assessing Quality in Canada's Health Care System ... 150
Setting a Vision for Quality in Health Care ... 152
Measuring and Improving Quality ... 152
Linking Performance Measurement with Quality Improvements ... 153

Improving Access for Official Language Minorities ... 154
Improving Access and Quality for Official Language Minorities ... 154
Addressing the Diverse Health Needs of Canadians ... 155
What Does This Mean for Canadians? ... 157

7 Rural and Remote Communities ... 159
Directions for Change ... 159
The Case for Change ... 159
Identifying the Issues ... 160
Disparities in Health ... 161
Disparities in Access to Health Care ... 162
Disparities in Access to Health Care Providers ... 162
Differences in Approaches ... 163
Setting a Clear Vision and Principles ... 165
Improving Access to Health Care ... 166
Expanding the Supply of Health Care Providers in Smaller Communities ... 166
Expanding Telehealth Approaches ... 166
Improving Health ... 168
What Does This Mean for Canadians? ... 169

8 Home Care: The Next Essential Service ... 171
Directions for Change ... 171
The Case for Change ... 171
Home Care in Canada ... 173
Variations across the Country ... 173
Funding for Home Care ... 174
Looking Ahead ... 175
Making Home Care the Next Essential Service ... 176
Defining and Funding a National Platform of Home Care Services ... 177
Home Mental Health Case Management and Interventions ... 178
Post-Acute Home Care ... 180
Palliative Home Care ... 181
Improving Support for Informal Caregivers ... 183
Recognizing the Role of Informal Caregivers ... 183
Taking the Next Steps ... 185
Adequate and Appropriate Health Human Resources ... 185
Continuity and Co-ordination of Health Care ... 185
Integration with Primary Health Care ... 187
Expanding Home Care ... 187
What Does This Mean for Canadians? ... 187

9 Prescription Drugs ... 189
Directions for Change ... 189
The Case for Change ... 189
A Snapshot of Prescription Drugs in Canada ... 191
The Expanding Role of Prescription Drugs ... 191
Access to Drugs and Drug Coverage ... 194
The Cost of Prescription Drugs ... 196
Establishing a New Catastrophic Drug Transfer ... 197
Establishing a National Drug Agency ... 199
Identifying Problems with the Current Approach ... 199
Roles, Responsibilities and Funding of the National Drug Agency ... 201
Benefits of a National Drug Agency ... 203
Establishing a National Formulary ... 205
Integrating Prescription Drugs into the Health Care System ... 206
Medication Management and Primary Health Care ... 206
Collecting and Sharing Information ... 208
Reviewing Aspects of Patent Protection ... 208
What Does This Mean for Canadians? ... 210

10 A New Approach to Aboriginal Health ... 211
Directions for Change ... 211
The Case for Change ... 211
Addressing the Aboriginal "Disconnect" ... 212
Constitutional Assumptions ... 212
Funding for Health Services ... 214
Health Status ... 218
Access to Health Services ... 220
Cultural and Political Diversity ... 221
The Northern Territories Issue ... 222
An Innovative Solution ... 223
A Partnership Approach to Health ... 224
Frameworks and Funding ... 225
Creating Aboriginal Health Partnerships ... 226
How Partnerships Would Work ... 227
Leadership and Accountability Structures ... 228
Possible Scenarios for Aboriginal Health Partnerships ... 229
What Does This Mean for Canadians? ... 231

11 HEALTH CARE AND GLOBALIZATION ... 233
Directions for Change ... 233
The Case for Change ... 233
Globalization and Its Impact on Canada ... 234
Health Care and International Trade Agreements ... 235
Trade in Health Care ... 238
Health as a Canadian Foreign Policy Priority ... 240
Preserving Canada's Health System in Relation to International Agreements ... 241
Preventing Challenges under International Agreements ... 241
Building Alliances with Other Countries ... 242
Improving Health in Developing Countries ... 243
Playing an International Leadership Role ... 243
Building Health Care Systems in Developing Countries ... 243
Sharing Information with Other Countries ... 244
What Does This Mean for Canadians? ... 245

CONCLUSION ... 247
Recommendations ... 247
Proposed Timelines for the Implementation of the Recommendations ... 255

APPENDICES ... 257
A Submissions ... 259
B Consultations ... 271
C The External Research Program ... 301
D Commission Staff ... 309
E Statistical History of Health Expenditures and Transfers in Canada, 1968 to 2002 ... 311
F Primary Care Organizations in Canada, 2002 ... 321
G Consultants' Estimates on Costs of Targeted Home Care ... 325
H Acknowledgements ... 331

LIST OF FIGURES, TABLES AND MAPS ... 333

BIBLIOGRAPHY ... 339

P.C. 2001-569

CANADA
PRIVY COUNCIL

Certified to be a true copy of a Minute of a Meeting of the Committee of the Privy Council, approved by Her Excellency the Governor General on the 3rd of April 2001

Whereas achieving and maintaining good health and ensuring universal access to quality health services is a matter of concern to all Canadians;

Whereas in September, 2000, all First Ministers on behalf of Canadians affirmed their support for a common vision for health and for the five principles embodied in the *Canada Health Act*;

Whereas all First Ministers, in addition to agreeing on specific measures, committed themselves and their governments to a partnership to strengthen and renew health services for Canadians;

And whereas the strong attachment of Canadians to a health system that meets the needs of all Canadians and the commitment of governments to work together constitute the foundation for a public dialogue on the long-term sustainability of Canada's publicly funded health care system;

Therefore, the Committee of the Privy Council, on the recommendation of the Prime Minister,

(*a*) advise that a Commission do issue under Part I of the *Inquiries Act* and under the Great Seal of Canada appointing Mr. Roy J. Romanow, Q.C., as Commissioner to inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment;

(*b*) direct that the Commissioner be authorized to conduct the work of the inquiry in two stages, the first focusing on fact-finding resulting in an interim report and the second emphasizing dialogue with the Canadian public and interested stakeholders based on the interim report;

(*c*) direct that the Commissioner submit an interim report (based on the work conducted in stage one), in both official languages, to the Governor in Council in approximately nine months, and a final report (based on the interim report and the work conducted in stage two) with recommendations, in both official languages, to the Governor in Council on or about November, 2002; and

(*d*) advise that the Commissioner

(i) be authorized to appoint advisers and create advisory mechanisms as he deems appropriate for the purpose of the inquiry,

(ii) be authorized to consult with provinces and territories and groups and individuals having an interest in or responsibility for health care in Canada and to use the means and vehicles required to ensure that a dialogue with Canadians occurs during the course of the inquiry,

(iii) be authorized to adopt such procedures and methods as he may consider expedient for the proper conduct of the inquiry, and to sit at such times and in such places in Canada as he may decide,

(iv) be authorized to rent such space and facilities as may be required for the purposes of the inquiry, in accordance with Treasury Board policies,

(v) be authorized to engage the services of experts and other persons as are referred to in section 11 of the *Inquiries Act*, at such rates of remuneration and reimbursement as may be approved by the Treasury Board,

(vi) be directed, in making his interim and final reports, to consider and take all necessary steps to protect classified information, and

P.C. 2001-569

(vii) be directed to file the papers and records of the inquiry with the Clerk of the Privy Council as soon as is reasonably possible after the conclusion of the inquiry.

CERTIFIED TO BE A TRUE COPY–COPIE CERTIFIÉE CONFORME

CLERK OF THE PRIVY COUNCIL–LE GREFFIER DU CONSEIL PRIVÉ

A Message to Canadians

In April 2001, the Prime Minister established the Commission on the Future of Health Care in Canada and gave me the privilege of serving as its sole Commissioner. My mandate was to review medicare, engage Canadians in a national dialogue on its future, and make recommendations to enhance the system's quality and sustainability. At the time, I promised Canadians that any recommendations I might eventually propose to strengthen this cherished program would be evidence-based and values-driven. I have kept my word.

My team and I have worked hard to assemble the best available evidence. We began by analyzing existing reports on medicare and by inviting submissions from interested Canadians and organizations. To clarify our understanding of key issues, we organized expert roundtable sessions and conducted site visits, both in Canada and abroad. Where we identified knowledge gaps or needed a fresh perspective, we commissioned independent experts to conduct original research. Finally, I met directly with Canada's foremost health policy experts to hear their views, challenge them and have them challenge me.

We also worked hard to engage Canadians in our consultations, because medicare ultimately belongs to them. We partnered with broadcasters, universities, business and advocacy groups, and the health policy community to raise awareness of the challenges confronting medicare. The contribution of the health research community to this effort has been invaluable. We also established formal liaison contacts with provincial governments to share information, and I spoke with the Premiers and heard from many health ministers. I also had the privilege of leading one of the most comprehensive, inclusive and successful consultative exercises our country has ever witnessed. Tens of thousands of Canadians participated, speaking passionately, eloquently and thoughtfully about how to preserve and enhance the system. We also sought advice from health experts and from Canadians in interpreting the results of our processes. I am proud that respect, transparency, objectivity and breadth of perspective have been hallmarks of this process.

These past 18 months have been among the most challenging and rewarding of my more than three decades in public life. Having examined the research, and having met with Canadians from sea-to-sea-to-sea, I am more confident than ever in the system's potential to meet the needs of Canadians, now and in the future. Canadians remain deeply attached to the core values at the heart of medicare and to a system that has served them extremely well. My assessment is that, while medicare is as sustainable as Canadians want it to be, we now need to take the next bold step of transforming it into a truly national, more comprehensive, responsive and accountable health care system. Making Canadians the healthiest people in the world must become the system's overriding objective. Strong leadership and the involvement of Canadians is key to preserving a system that is true to our values and sustainable.

Canadians Remain Attached to the Values at the Heart of the System

In their discussions with me, Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity. These values are tied to their understanding of citizenship. Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth. Building from these values, Canadians have come to view their health care system as a national program, delivered locally but structured on intergovernmental collaboration and a mutual understanding of values. They want and expect their governments to work together to ensure that the policies and programs that define medicare remain true to these values.

Medicare Has Served Canadians Extremely Well

I am pleased to report to Canadians that the often overheated rhetoric about medicare's costs, effectiveness and viability does not stand up to scrutiny. Our health outcomes, with a few exceptions, are among the best in the world, and a strong majority of Canadians who use the system are highly satisfied with the quality and standard of care they receive. Medicare has consistently delivered affordable, timely, accessible and high quality care to the overwhelming majority of Canadians on the basis of need, not income. It has contributed to our international competitiveness, to the extraordinary standard of living we enjoy, and to the quality and productivity of our work force.

The System Is as Sustainable as We Want It to Be

For years now, Canadians have been exposed to an increasingly fractious debate about medicare's "sustainability." They have been told that costs are escalating and that quality of services is declining. They have heard that insatiable public expectations, an aging population and the costs of new medical technologies and prescription drugs will inevitably overwhelm the system. They have been warned that health spending is crowding out other areas of public investment. Thus one of the fundamental questions my report must address is whether medicare is sustainable? My answer is that it is if we are prepared to act decisively.

Governments talk about sustainability in terms of "costs" and financial impacts. This discussion often has more to do with "who pays" than "how much" we pay. In listening to these debates, it is sometimes hard to realize that health spending in Canada is on par with most countries in the Western world, that it is substantially lower than in the United States, and that we devote a smaller portion of our Gross Domestic Product (GDP) to health care today than we did a decade ago.

More troubling is the notion that somehow our health care system is on "auto-pilot" and immune to change. I believe this is fundamentally inconsistent with the ingenuity and innovation that has for so long defined the Canadian way. It is baseless and false. Governments can make informed choices about how and where to invest; they are not powerless to change current spending trajectories. Better management practices, more agile and collaborative institutions and a stronger focus on prevention can generate significant savings. Technological advances can also help to improve health outcomes and enable a more effective deployment of scarce financial and

human resources. Indeed, our health care system is replete with examples of excellence in innovation, many of them world-class. The bigger issue is whether we have the right information and the courage we need to make the choices that support sustainability.

To be sure, the system needs more money. In the early 1990s, the federal share of funding for the system declined sharply. While recent years have seen a substantial federal reinvestment into health care, the federal government contributes less than it previously did, and less than it should. I am therefore recommending the establishment of a minimum threshold for federal funding, as well as a new funding arrangement that provides for greater stability and predictability – contingent on this replenishment supporting the transformative changes outlined in this report. Money must buy change, not more of the same.

But individual Canadians view sustainability from a very different vantage point. The key "sustainability" question for the average Canadian is, "Will medicare be there for me when I need it?" While it is very clear that a majority of Canadians support medicare in its current form, it is not perfect. Some people, particularly Aboriginal peoples and those in rural and remote parts of the country, cannot always access medical services where and when they need them. There are also inefficiencies and mismatches between supply and demand that have resulted in unacceptable times for some medical procedures. These problems must be tackled on a priority basis or they will eventually erode public confidence in medicare and with it, the consensus that it is worth keeping. I am therefore recommending new initiatives to improve timely access to care, to enhance the quality of care the system provides, a more co-ordinated approach to health human resources planning, and a special focus on the health needs of Aboriginal peoples.

We also need to renovate our concept of medicare and adapt it to today's realities. In the early days, medicare could be summarized in two words: hospitals and doctors. That was fine for the time, but it is not sufficient for the 21st century. Despite the tremendous changes over the past 40 years, medicare still is largely organized around hospitals and doctors. Today, however, home care is an increasingly critical element of our health system, as day surgery has replaced the procedures that once took weeks of convalescence in hospital. Drugs, once a small portion of total health costs, are now escalating and among the highest costs in the system. The expense associated with some drug therapies or of providing extended home care for a seriously ill family member can be financially devastating. It can bankrupt a family. This is incompatible with the philosophy and values upon which medicare was built. It must be changed. I am therefore recommending that home care be recognized as a publicly insured service under medicare and that, as a priority, new funds be invested to establish a national platform for home care services. I am also recommending the creation of a national drug strategy, including a catastrophic drug insurance program to protect Canadian families.

I know these views will provoke a hot debate in Canada, particularly among those who advocate "less government" and less government money in health care. The problem with these arguments is that they are focused on the cost to governments, not Canadians. A more narrowly structured system of medicare might free up governments to spend tax dollars on other priorities, or simply on tax relief. But either way, individual Canadians would still be left to personally bear the costs of services that are not covered. To me, that is contrary to the spirit and intent of medicare. It is not the Canadian way.

Canadians Want and Need a Truly National Health Care System

As I noted earlier, Canadians' attachment to medicare is based on their understanding of it as a right of citizenship. They connect with the values that define medicare, not the particular features of the system in place in their province or territory. Canadians expect the system to guarantee them relatively similar access to a common basket of medicare services of equal quality, regardless of where they live. They expect governments, providers and caregivers to work collaboratively to maintain a system with these attributes.

The fact that Canadians perceive health care as a national endeavour should not be construed as an invitation for federal intrusion into an area of primary provincial jurisdiction. Nor should it be interpreted to mean a "one-size-fits-all" approach to health care delivery. In a country as geographically, economically, regionally and culturally diverse as ours, this is neither realistic nor desirable. Medicare must be constantly renewed and continually refined, if it is to remain relevant and viable. A new common approach is needed to encourage, not constrain, innovation. If we allow medicare to become static, it will become brittle and eventually break.

Canadians realize that illness and injury know few boundaries; they afflict all of us. They understand that organizing health care solely along constitutional lines or provincial boundaries makes little practical sense. They recognize that sometimes by design, sometimes by financial necessity, and more often by default, provinces are increasingly willing to go it alone insofar as their respective health care "systems" are concerned. Today, we sit on the cusp. Left unchecked, this situation will inevitably produce 13 clearly separate health care systems, each with differing methods of payment, delivery and outcomes, coupled by an ever increasing volatile and debilitating debate surrounding our nation, its values and principles.

This is no way to renew a program of such immense personal and national importance and, for sure, it is no way to strengthen those foundations that unify us as a nation. It is time for governments, caregivers and Canadian citizens to embark together on the road to renewal. The reality is that Canadians embrace medicare as a public good, a national symbol and a defining aspect of their citizenship. I am therefore recommending a series of measures to modernize the legislative and institutional foundations of medicare that will better equip governments to move forward together to provide Canadians with the health care system they want.

Canadians Want and Need a More Comprehensive Health Care System

We must transform our health care "system" from one in which a multitude of participants, working in silos, focus primarily on managing illness, to one in which they work collaboratively to deliver a seamless, integrated array of services to Canadians, from prevention and promotion to primary care, to hospital, community, mental health, home and end-of-life care.

Indeed, despite our common use of the term "our health care system," the relevance of this term is increasingly doubtful. A system where citizens in one part of the country pay out-of-pocket for "medically necessary" health services available "free" in others, or where the rules of the game as to who can provide care and under what circumstances vary by jurisdiction, can scarcely be called a "system."

There are many examples of the "disconnect." Elderly people who are discharged from hospital and cannot find or afford the home or community services they need. Women – one in

five – who are providing care to someone in the home an average of 28 hours per week, half of whom are working, many of whom have children, and almost all of whom are experiencing tremendous strain. Health professionals, who are increasingly stressed, while performing tasks ill suited to their abilities and training. Patients, who are forced to navigate a system that is a complex and unfriendly mystery, in order to find the right specialist, the nearest facility, and the best treatment. People who are forced to repeat lab tests, and to recount their medical histories time and time again. We need clear and decisive action to modernize the system and make it more durable and responsive. I am therefore recommending a series of measures to create a more comprehensive system whose component parts fit together more seamlessly.

Canadians Want and Need a More Accountable Health Care System

Accountability must also be improved. Health care in this country is now a $100 billion enterprise, one of our society's largest expenditures. Yet no level of government has done a very good job accounting for how effectively that money is spent. Canadians still do not know who to believe in the debate over which level of government is paying what share for health services.

Canadians are the shareholders of the public health care system. They own it and are the sole reason the health care system exists. Yet despite this, Canadians are often left out in the cold, expected to blindly accept assertion as fact and told to simply trust governments and providers to do the job. They deserve access to the facts. Canadians no longer accept being told things are or will get better; they want to see the proof. They have a right to know what is happening with wait lists; what is happening with health care budgets, hospital beds, doctors, and nurses, and whether the gaps in home and community care services are being closed; whether the number of diagnostic machines and tests is adequate; and whether treatment outcomes are improving.

Information is a key ingredient. We live in an age of laser surgery and are unlocking the mystery of the human gene, yet our approach to health information is mired in the past. We gather information on some health issues, but not on others. And much of the information we gather cannot be properly analyzed or shared. Indeed, we know far more about resources and the dollars being spent than we do about the return on those investments. Better information will facilitate evidence-based decision making. How can we hold health care managers accountable if what they are managing cannot be measured? If we are to build a better health system, we need a better information sharing system so that all governments and all providers can be held accountable to Canadians. I am therefore recommending a series of measures to improve transparency across the system, to make decision-making structures more inclusive, to accelerate the integration of health informatics, to provide for a secure electronic health record for Canadians that respects their right to privacy, and to give Canadians a greater say in shaping the system's future.

Making Canadians the Healthiest People in the World

During our public hearings, many presentations focused on the need to improve our understanding of the determinants of health. I heard that the quality of the air we breathe, of the water we drink, and of the food we eat directly affects our health and our health care system. I learned that educated, employed and physically active Canadians are far more likely to be healthy than those who are not, and that spiritual, emotional and physical well-being are often inextricably linked. I also heard that lifestyle changes can markedly reduce the incidence and

severity of many major and debilitating diseases. Keeping people well, rather than treating them when they are sick, is common sense. And so it is equally common sense for our health care system to place a greater emphasis on preventing disease and on promoting healthy lifestyles. This is the best way to sustain our health care system over the longer term.

The health care system must be on the front lines of this effort. However, we must also invest in related areas of public life to create community mobilization, a sense of social inclusion and provide the infrastructure that enables healthier lifestyle choices. Investing in public housing, a clean environment and education are all part of the solution leading to a healthier Canada.

But we need more than rhetoric; we need action. I am therefore recommending a greater emphasis on prevention and wellness as part of an overall strategy to improve the delivery of primary care in Canada, the allocation of new moneys for research into the determinants of health, and that governments take the next steps for making Canadians the world's healthiest people.

A System Based on Canadian Values

Early in my mandate, I challenged those advocating radical solutions for reforming health care – user fees, medical savings accounts, de-listing services, greater privatization, a parallel private system – to come forward with evidence that these approaches would improve and strengthen our health care system. *The evidence has not been forthcoming.* I have also carefully explored the experiences of other jurisdictions with co-payment models and with public-private partnerships, and have found these lacking. There is no evidence these solutions will deliver better or cheaper care, or improve access (except, perhaps, for those who can afford to pay for care out of their own pockets). More to the point, the principles on which these solutions rest cannot be reconciled with the values at the heart of medicare or with the tenets of the *Canada Health Act* that Canadians overwhelmingly support. It would be irresponsible of me to jeopardize what has been, and can remain, a world-class health care system and a proud national symbol by accepting anecdote as fact or on the dubious basis of making a "leap of faith."

Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care.

It has been suggested to me by some that if there is a growing tension between the principles of our health care system and what is happening on the ground, the answer is obvious. Dilute or ditch the principles. Scrap any notion of national standards and values. Forget about equal access. Let people buy their way openly to the front of the line. Make health care a business. Stop treating it as a public service, available equally to all. But the consensus view of Canadians on this is clear. No! Not now, not ever. Canadians view medicare as a moral enterprise, not a business venture.

Tossing overboard the principles and values that govern our health care system would be betraying a public trust. Canadians will not accept this, and without their consent, these "new" solutions are doomed to fail. Canadians want their health care system renovated; they do not want it demolished.

But we must also recognize that since the earliest days of medicare, public and private sector care providers (including fee-for-service doctors) have been part of our health care system. Our system was never organized according to a strict protocol; it evolved in accordance with the

existing capacity of public and private providers, changing notions of what constitute "core services," and the wishes of Canadians.

One of the most difficult issues with which I have had to struggle is how much private participation within our universal, single-payer, publicly administered system is warranted or defensible. On the one hand, I am confronted by the fact that the private sector is already an important part of our "public" system. The notion of rolling back its participation is fraught with difficulty. On the other hand, I am acutely aware of the potential risks to the integrity and viability of our health care system that might result from an expanded role for private providers.

At a minimum, I believe governments must draw a clear line between direct health services (such as hospital and medical care) and ancillary ones (such as food preparation or maintenance services). The former should be delivered primarily through our public, not-for-profit system, while the latter could be the domain of private providers. The rapid growth of private MRI (magnetic resonance imaging) clinics, which permit people to purchase faster service and then use test results to "jump the queue" back into the public system for treatment, is a troubling case-in-point. So too is the current practice of some worker's compensation agencies of contracting with private providers to deliver fast-track diagnostic services to potential claimants. I agree with those who view these situations as incompatible with the "equality of access" principle at the heart of medicare. Governments must invest sufficiently in the public system to make timely access to diagnostic services for all a reality and reduce the temptation to "game" the system. In order to clarify the situation in regard to diagnostic services, I am therefore recommending that diagnostic services be explicitly included under the definition of "insured health services" under a new *Canada Health Act*.

Conclusion

Canada's journey to nationhood has been a gradual, evolutionary process, a triumph of compassion, collaboration and accommodation, and the result of many steps, both simple and bold. This year we celebrate the 40th anniversary of medicare in Saskatchewan, a courageous initiative by visionary men and women that changed us as a nation and cemented our role as one of the world's compassionate societies. The next big step for Canada may be more focused, but it will be no less bold. That next step is to build on this proud legacy and transform medicare into a system that is more responsive, comprehensive and accountable to all Canadians.

Getting there requires leadership. It requires us to change our attitudes on how we govern ourselves as a nation. It requires an adequate, stable and predictable commitment to funding and co-operation from governments. It requires health practitioners to challenge the traditional way they have worked in the system. It requires all of us to realize that our health and wellness is not simply a responsibility of the state but something we must work toward as individuals, families and communities, and as a nation. The national system I speak about is clearly within our grasp.

Medicare is a worthy national achievement, a defining aspect of our citizenship and an expression of social cohesion. Let's unite to keep it so.

Roy J. Romanow, Q.C.
Commissioner

Executive Summary

Taken together, the 47 recommendations contained in this report serve as a roadmap for a collective journey by Canadians to reform and renew their health care system. They outline actions that must be taken in 10 critical areas, starting by renewing the foundations of medicare and moving beyond our borders to consider Canada's role in improving health around the world.

Chapter 1 – Sustaining Medicare

Chapter 1 argues that Canada's health care system has served Canadians well and is as sustainable as Canadians want it to be. In addition to the imperative for social consensus for a public health system, the issue of sustainability needs to be assessed from three dimensions – services, needs and resources. Effective governance is needed to bring equilibrium between these dimensions.

Services: The practice of medicine and the range and nature of treatment options has changed significantly since medicare was introduced 40 years ago. The biggest changes have been outside the traditional medicare "core" of hospital and physician services, in areas like pharmaceuticals and home care. Concerns also exist about timely access to existing services, particularly in rural and remote areas, limited progress in advancing primary health care reforms and growing wait lists, especially for diagnostic services.

Needs: Our health care system is adequately meeting our needs. Canada's health outcomes compare favourably with other countries and evidence suggests that we are doing a good job in addressing the various factors that impact on overall health. But there is room for improvement. However, there are serious disparities in both access to care and health outcomes in some parts of the country, particularly for Aboriginal peoples and in the north, which need to be addressed. Meeting the needs of an aging population will add costs to our system, but these can be managed if we begin to make the necessary adjustments now.

Resources: Canada's spending on health care is comparable with other OECD countries and we spend considerably less per capita than the United States. All OECD countries are facing increasing health care costs and experience suggests that the wealthier the country, the more it spends on health care. While some have suggested that Canada relies too heavily on taxation to support its health system, comparisons show we are not much different than other countries. Alternative funding approaches currently under discussion in some circles have a number of

problems and would shift the burden of funding from governments to individuals. Moreover, there is no evidence their adoption would produce a more efficient, affordable or effective system. There are, however, serious problems in the balance of funding between federal and provincial governments. The federal share of health funding has dropped and health care is now taking up an increasing portion of provincial budgets. Health care costs are likely to continue to increase and choices will have to be made about how to manage them. Provided the system is prepared to change to meet their needs and expectations, Canadians appear willing to pay more for health care.

Chapter 2 – Health Care, Citizenship and Federalism

Chapter 2 lays the foundation for all other aspects of the report and recommends a renewed commitment to medicare, new governance approaches, stable and predictable long-term funding, and targeted funding to facilitate change in critical areas.

Directions for Change

Establish a new Canadian Health Covenant as a tangible statement of Canadians' values and a guiding force for our publicly funded health care system

A proposed new Canadian Health Covenant would confirm our collective vision for the future of health care in Canada and clearly outline the responsibilities and entitlements of individual Canadians, health providers, and governments in regard to the system.

Create a Health Council of Canada to facilitate collaborative leadership in health

A new Health Council of Canada would help foster collaboration and co-operation among provinces, territories, and the federal government. The Council would play a key role in setting common indicators and benchmarks, in measuring and tracking the performance of the health system, and in reporting results regularly to Canadians. Because of the important role of the Council in measuring results, the Canadian Institute for Health Information (CIHI) should form the backbone for the proposed new Council.

Modernize the* Canada Health Act *by expanding coverage and renewing its principles

While the *Canada Health Act* (CHA) has served us well and has achieved iconic status, this does not mean it should be immune from change. The five principles of the CHA should be reaffirmed, the principle of comprehensiveness updated and the principle of portability limited to guaranteeing portability of coverage within Canada. A new principle of accountability should be added to the CHA to address Canadians' concern that they lack sufficient information to hold the appropriate people accountable for what happens in our health care system. The current scope of publicly insured services should also be expanded beyond hospital and physician care to include two new essential services – diagnostic services and priority home care services described in Chapter 8. Finally, the CHA should include an effective dispute resolution process.

Clarify coverage by distinguishing between direct and ancillary health services, and change practices contrary to the spirit of medicare

The growing reliance on private advanced diagnostic services is eroding the equal access principle at the heart of medicare. The CHA must include public coverage for medically necessary diagnostic services. Governments have a responsibility to invest sufficiently in the public system to make timely access to diagnostic services for all a reality. In a similar vein, they should also reconsider the current practice by which some workers' compensation agencies contract with private providers to deliver fast-track diagnostic services to potential claimants.

Provide stable, predictable and long-term funding through a new dedicated cash-only transfer for medicare

A new dedicated cash-only Canada Health Transfer should be established as part of the *Canada Health Act.* It will require an increased share of federal funding and will include an escalator provision that is set in advance for five years to ensure future funding is stable, predictable and increases at a realistic rate, commensurate with our economic growth and capacity to pay.

Address immediate issues through targeted funding

Five new targeted funds should be established:

- A Rural and Remote Access Fund: to improve timely access to care in rural and remote areas.
- A Diagnostic Services Fund: to improve wait times for diagnostic services.
- A Primary Health Care Transfer: to support efforts to remove obstacles to renewing primary health care delivery.
- A Home Care Transfer: to provide a foundation for an eventual national home care strategy.
- A Catastrophic Drug Transfer: to allow provincial drug programs to expand and improve coverage for their residents.

These targeted federal funds and transfers should be provided to the provinces and territories on the condition that they match or exceed federal support for these priorities. They would be short-term (two-year) arrangements until the new Canada Health Transfer is implemented. Thereafter, the Canada Health Transfer will fund these priorities directly.

Chapter 3 – Information, Evidence and Ideas

Chapter 3 sets the stage for electronic health records, a more comprehensive use of information management and technology, including health technology assessment, to provide essential information throughout the health care system, and a targeted focus on applied research.

Directions for Change

Enable the establishment of personal electronic health records for each Canadian building on the work currently underway in provinces and territories

Many provinces and territories have taken steps to develop electronic health records and all agree that this is essential to improve how the health care system functions. Building on the resources already available in the provinces and territories and through Canada Health Infoway, it is important to accelerate the process and to make the promise of electronic health records a reality.

***Take clear steps to protect the privacy of Canadians' personal health information, including an amendment to the* Criminal Code of Canada**

There are clear benefits to Canadians from electronic health records. They would have access not only to their own health information but also to a comprehensive base of trusted and reliable information about a variety of health-related issues. Canada Health Infoway should take the lead in promoting harmonized privacy rules across the country, and breaches of privacy should be treated as an offense under the *Criminal Code of Canada.*

Provide better health information to Canadians, health care providers, researchers and policymakers – information they can use to guide their decisions

Health care providers, researchers and policymakers need better information to guide their decisions. In addition to electronic health records, Canada Health Infoway should take the lead in establishing a comprehensive source of trusted health information that could be used by a variety of providers, decision makers and Canadians.

Expand the scope, effectiveness and co-ordination of health technology assessment across Canada

Promising advances in medical technology are occurring almost daily. While they have the potential to provide better treatments and cures, their costs are often substantial. Because of the growing importance of health technology assessment and the need to link it with broader assessments in the health care system, the current work of the Canadian Coordinating Office for Health Technology Assessment should become a vital part of the Health Council of Canada and provide a national focus for health technology assessment.

Create new research centres for health innovation

Canada has a solid base of research organizations but there are gaps in the applied research agenda. To address those gaps, four new Centres for Health Innovation should be established focusing on rural and remote health, health human resources, health promotion and pharmaceutical policy.

Forge stronger linkages with researchers in other parts of the world and with policymakers across the country

Canada's health care system has much in common with other countries around the world, especially European countries and members of the Organisation for Economic Co-operation and Development (OECD). It is important to develop deeper linkages among researchers around the world and to tap into available sources of information than can help support sound decision making in Canada.

Chapter 4 – Investing in Health Care Providers

Chapter 4 addresses the future for Canada's health workforce, tackling immediate issues of supply and distribution but also larger issues relating to their changing roles and responsibilities, and the need for comprehensive, long-term national strategies.

Directions for Change

Address the need to change the scopes and patterns of practice of health care providers to reflect changes in how health care services are delivered, particularly through new approaches to primary health care

Changes in the way health care services are delivered, especially with the growing emphasis on collaborative teams and networks of health providers, means that traditional scopes of practice also need to change. This suggests new roles for nurses, family physicians, pharmacists, case managers and a host of new and emerging health professions.

Take steps to ensure that rural and remote communities have an appropriate mix of skilled health care providers to meet their health care needs

A portion of the funds from the proposed new Rural and Remote Access Fund, as well as those from the Diagnostic Services Fund, the Primary Health Care Transfer and the Home Care Transfer, should be used to ensure that people in smaller communities across the country have access to an appropriate mix of skilled providers.

Substantially improve the base of information about Canada's health workforce

There are serious gaps in what we know about Canada's health workforce. Concerted actions should be taken through the Health Council of Canada to collect, analyze and provide regular reports on critical issues including the recruitment, distribution, and remuneration of health care providers.

Review current education and training programs for health care providers to focus more on integrated approaches for preparing health care teams

One of the best ways of ensuring that health care providers are able to work effectively in new, more integrated settings is to begin with their education and training. Education programs should be changed to focus more on integrated, team-based approaches to meeting health care needs and service delivery. The Health Council of Canada should help co-ordinate efforts to achieve these changes.

Establish strategies for addressing the supply, distribution, education, training, and changing skills and patterns of practice for Canada's health workforce

Health workforce issues affect all provinces and territories. Changes are necessary to facilitate concerted action at the national level, and long-term planning. The Health Council of Canada can serve as an important catalyst in this regard.

Chapter 5 – Primary Health Care and Prevention

Chapter 5 outlines the need to accelerate ongoing efforts to reform how primary care services are delivered in Canada and to improve their focus on wellness. It also identifies ways to remove traditional obstacles to these reforms.

Directions for Change

Finally make a major breakthrough in implementing primary health care and transforming Canada's health care system

The combined outcome of the actions proposed in this report must be to transform Canada's health care system and have it focus squarely on primary health care. Canadians should have access to an integrated continuum of care 24 hours a day, 7 days a week, no matter where they live.

Use the proposed new Primary Health Care Transfer as the impetus for fundamental change in how health care services are delivered across the country

The new Primary Health Care Transfer should provide the funding needed to accelerate primary care beyond the stage of pilot projects to achieve permanent and lasting change.

Build a common national platform for primary health care based on four essential building blocks

There is no single model for primary health care that captures the diversity of needs and situations in Canada. However, a scattered approach with no consistency across the country is not the solution. Instead, four essential building blocks should define primary health care across the country: continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives for health care providers to participate in primary health care approaches.

Mandate the proposed Health Council of Canada to hold a National Primary Health Care Summit to mobilize action across the country, then maintain the momentum by measuring progress and reporting regularly to Canadians

Overcoming the numerous obstacles to primary health care requires determined and decisive action across the country. A national summit organized by the Health Council of Canada should mobilize action and, more importantly, "shine the spotlight" on the obstacles to change and set the stage for regular reports to Canadians on the progress being made.

Integrate prevention and promotion initiatives as a central focus of primary health care targeted initially at reducing tobacco use and obesity, and increasing physical activity in Canada

For too long, Canada's health care system has been overly focused on treatment rather than prevention. A central focus of primary health care must be on preventing illness and injury and helping Canadians stay healthy. Targeted actions should be taken to reduce tobacco use, reduce the alarming rates of obesity in Canada, and encourage more Canadians to live active lifestyles.

Implement a new national immunization strategy

Most Canadians remember being immunized against diseases like polio, measles or, more recently, meningitis. Canada has a reasonable track record on immunizations compared to other countries, but there is evidence that current programs are dated. We also need to take steps to ensure that Canada is well prepared to face new and emerging problems resulting from globalization and the evolution of infectious diseases.

Chapter 6 – Improving Access, Ensuring Quality

Chapter 6 directly tackles Canadians' concerns about waiting times, access and quality in our health care system.

Directions for Change

Use the new Diagnostic Services Fund to shorten waiting times for diagnostic services

There is clear evidence that Canada has under-invested in diagnostic technologies in comparison with other OECD countries and the result is long waiting times for essential diagnostic tests. The new Diagnostic Services Fund should be used not only to purchase equipment but also to train the necessary staff and technicians. Targeting this area as a first priority, provinces and territories could free up additional resources to address wait times for other essential services.

Implement better ways of managing wait lists

Wait lists in Canada are often poorly managed and there are few standard approaches in place to assign people to a wait list or co-ordinate lists among different providers or facilities. Steps must be taken to put centralized approaches in place within health regions, on a province-wide basis or even, in some cases, on a national basis. Patients also have a right to good information about how long they can reasonably expect to wait for treatment and what other options are available to them.

Take deliberate steps to measure the quality and performance of Canada's health care system and report regularly to Canadians

We cannot expect to keep improving the health care system if we do not have the necessary information to measure and track results. The proposed Health Council of Canada could play a vitally important role, working with the provinces and territories to collect comparable information and report regularly to Canadians on their health care system. This would include information on waiting times and a variety of measures of the quality of the system.

Ensure that the health care system responds to the unique needs of official language minorities

Being able to access health care in either official language is an important dimension of Canada's health care system. It is important not only from the perspective of access but also to ensure that people can understand and respond to treatment. Steps should be taken to build on the many successful approaches in place across the country to improve access to health services in both official languages.

Address the diverse health care needs of Canadians

Canada is a diverse country, and that diversity should be reflected in our health care system. The care we deliver should match the needs of different groups of Canadians, from men and women, to new Canadians, to visible minorities, people with disabilities and others.

Chapter 7 – Rural and Remote Communities

Chapter 7 establishes a new Rural and Remote Access Fund to improve access to quality health care and services in smaller communities across the country.

Directions for Change

Establish a new Rural and Remote Access Fund to support new approaches for delivering health care services and improve the health of people in rural and remote communities

A new Rural and Remote Access Fund should provide a catalyst for a range of actions to improve access to, and the quality of, health in rural and remote communities. Provinces and territories would be expected to work directly with communities to identify needs and choose the best approaches for meeting those needs on a community-by-community basis.

Use a portion of the Fund to address the demand for health care providers in these communities

One of the biggest challenges smaller communities face is attracting and retaining health professionals. The issue is less about the sheer numbers of health care providers and more about the preferences of many professionals to live in major urban centres. A portion of the proposed new Fund could be used to develop a mix of strategies for attracting and retaining a mix of skilled health care providers in rural and remote communities.

Expand telehealth to improve access to care

Telehealth uses information technologies to link patients and health care providers to a wide variety of services outside their community. People in rural and remote locations can be linked to family physicians, specialists and other health services in other centres where health care providers can diagnose, treat and provide consultations at a distance. A portion of the Rural and Remote Access Fund should be used to build on the work already underway in many provinces and territories, and to expand the use of telehealth to improve access to health care services and information.

Chapter 8 – Home Care: The Next Essential Service

Chapter 8 outlines three critical areas where home care must become an essential service under the *Canada Health Act* umbrella.

Directions for Change

Use the proposed new Home Care Transfer to establish a national platform for home care services

The proposed new Home Care Transfer should be used to ensure that all Canadians have access to a common platform of essential home care services.

Revise the* Canada Health Act *to include coverage for home care services in priority areas

Home care is an increasingly essential part of our health care system. While it is not possible to include all home care services under the *Canada Health Act*, immediate steps should be taken to bring services in three priority areas under the umbrella of the *Canada Health Act* – home mental health case management and intervention services, post-acute home care, and palliative home care.

***Improve the quality of care and support available to people with mental illnesses by including home mental health case management and intervention services as part of the* Canada Health Act**

Mental health has been described as the "orphan child" of health care. Today, mental health care is largely a home and community-based service, but support for it has too frequently fallen short. It is time to take the long overdue step of ensuring that mental health home care services are included as medically necessary services under the *Canada Health Act*, and available across the country.

Expand the* Canada Health Act *to include coverage for post-acute home care including medication management and rehabilitation services

Advances in medical technologies and treatments mean that many procedures that previously required long hospital stays can be replaced by day surgeries or brief overnight stays. But many patients still need follow-up care and rehabilitation services in their own home. Providing coverage for post-acute home care services across the country on equal terms and conditions through the *Canada Health Act* is a necessary and logical next step. Coverage for post-acute home care should include case management, health professional services, and medication management.

Provide* Canada Health Act *coverage for palliative home care services to support people in their last six months of life

Given the option, information suggests that a growing number of Canadians with terminal illnesses would choose to spend their final days at home surrounded by family and friends rather than in an institution. Yet access to palliative care is uneven and depends very much on where people live and the resources of their community. The option of dying at home should be available to all Canadians in all communities. This step will make it easier for terminally ill Canadians to opt to spend the last six months of their lives receiving care at home.

Introduce a new program to provide ongoing support for informal caregivers

With more and more Canadians being treated at home rather than in other care centres, the burden on informal caregivers has grown significantly. Our health care system simply could not function without the thousands of parents, loved ones, family and friends that provide direct

support in the home. That support should be recognized by allowing informal caregivers to take time off work and to qualify for special benefits under Canada's Employment Insurance program. Human Resources Development Canada, in conjunction with Health Canada, should move forward with this initiative as a priority.

Chapter 9 – Prescription Drugs

Chapter 9 addresses the difficult issue of prescription drugs, takes the important first step to integrate prescription drugs into Canada's health care system, and proposes a new National Drug Agency.

Directions for Change

Take the first steps to better integrate prescription drugs into Canada's health care system

Prescription drugs are a large and rapidly growing component of the health care system. Some have argued that prescription drugs should be brought completely under medicare while others argue that would potentially bankrupt the system. The Commission's view is that we need to begin the process of integrating coverage for prescription drugs within medicare as part of a longer term strategy to ensure all Canadians benefit from comprehensive prescription drug coverage.

Use the new Catastrophic Drug Transfer to offset the cost of provincial and territorial drug plans and reduce disparities in coverage across the country

There are serious disparities across Canada in terms of catastrophic coverage for prescription drugs. Under this proposed new program, provinces and territories would receive additional funds to help cover the costs of prescription drug plans and protect Canadians against the potentially "catastrophic" impact of high cost drugs. This measure provides a clear incentive for provinces and territories to expand their coverage and will reduce inter-regional disparities.

Establish a new National Drug Agency to control costs, evaluate new and existing drugs, and ensure quality, safety, and cost-effectiveness of all prescription drugs

A new prescription drug comes onto the market in Canada every four to five days, and forecasts are that these numbers will increase rapidly. New research on genetic testing and biotechnology will undoubtedly bring with it a host of complex and difficult social, ethical and financial issues. Canada must have a comprehensive, streamlined and effective process in place for addressing these issues and ensuring the safety and quality of all new drugs before they are approved for use in Canada. But just as important, processes should be in place for reviewing drugs on an ongoing basis, monitoring their use and outcomes across the country, and for sharing timely and complete information and analyses. A new independent National Drug Agency would perform these functions on behalf of all governments and all Canadians.

Establish a national formulary of prescription drugs to provide consistency across the country, ensure objective assessments of drugs, and contain costs

Currently, each province and territory has its own list of prescription drugs that are covered under its drug insurance plan. A national formulary, developed by the National Drug Agency in conjunction with the provinces and territories, would support the goals of consistent coverage, objective assessments, and cost containment.

Develop a new medication management program for chronic and some life-threatening illnesses as an integral part of primary health care

Primary health care reform is an essential component of our vision for the future of Canada's health care system. Linking medication management with primary health care would ensure that the effectiveness of prescription drugs could be monitored on an ongoing basis by teams and networks of health care providers working with individual patients.

Review aspects of Canadian patent law

Like all other manufactured goods, patents protect new prescription drugs. The extensive 20-year guarantee of exclusive access to the Canadian market remains a matter of considerable debate in Canada. Canada's patent laws are consistent with international standards and our prices are lower on average than in other countries. However, certain aspects of Canada's patent laws should be reviewed to improve access to generic alternatives and to contain costs.

Chapter 10 – A New Approach to Aboriginal Health

In Chapter 10, we address the serious disparities in health for Canada's Aboriginal peoples and propose a new approach that cuts across traditional boundaries and focuses squarely on improving their health.

Directions for Change

Consolidate Aboriginal health funding from all sources and use the funds to support the creation of Aboriginal Health Partnerships to manage and organize health services for Aboriginal peoples and promote Aboriginal health

Aboriginal health programs are funded from a variety of sources including the federal government, provincial and territorial governments, local Bands and, in some cases, municipal governments and regional health authorities. Unfortunately, the resources are split among different organizations and objectives and, as such, their potential to benefit Aboriginal peoples cannot be effectively leveraged. Under this new approach, funding from all sources would be consolidated and allocated to new Aboriginal Health Partnerships (AHP), created solely and specifically to organize health services and improve the health of the communities and people they serve.

Establish a clear structure and mandate for Aboriginal Health Partnerships to use the funding to address the specific health needs of their populations, improve access to all levels of health care services, recruit new Aboriginal health care providers, and increase training for non-Aboriginal health care providers

This concept is a new one for Canada. It pools community-based expertise and resources into a single organization whose sole mandate and purpose is to organize services on behalf of Aboriginal peoples. These partnerships would be responsible for assessing needs, delivering services or purchasing them from other organizations, assessing outcomes on an ongoing basis, and providing public reports on the effectiveness and results of their efforts.

Ensure ongoing input from Aboriginal peoples into the direction and design of health care services in their communities

Through the proposed new AHP, Aboriginal peoples would have direct input and would be able to work with the AHP to ensure that programs are adapted to meet their needs and the needs of their community.

Chapter 11 – Health Care and Globalization

Chapter 11 moves beyond Canada's boundaries to examine Canada's role in the global context.

Directions for Change

Take clear and immediate steps to protect Canada's health care system from possible challenges under international law and trade agreements and to build alliances within the international community

There are no clear and definitive answers to the question of what international trade agreements mean for Canada's health care system. In the face of that uncertainty, the solution is not to sit back and wait for the outcomes of potential challenges under the various trade agreements. Rather, it is to take proactive steps to ensure that Canada can continue to make whatever policy decisions it deems necessary to maintain or expand the public health care system. Canada should build strategic alliances with other countries around the world that share this view.

Play a leadership role in international efforts to improve health and strengthen health care systems in developing countries

It is time for Canada to use both its positive relationships with developing countries and its considerable expertise in health care to contribute to health and health care around the world. This would involve strengthening Canada's role in foreign aid programs to assist in training much-needed health care providers for developing countries and in promoting public health initiatives designed to prevent the spread of illnesses such as polio, HIV/AIDS, and other communicable diseases.

Reduce our reliance on the recruitment of health care professionals from developing countries

Visit a small rural community and chances are good you will meet a doctor from a developing country who has come to Canada to practice. Canada has made extensive use of foreign-trained medical graduates, particularly in communities that have had trouble attracting Canadian doctors. While Canada has a long-standing policy of welcoming immigrants from around the world, we have an obligation to help protect health care systems in developing countries. We must learn to solve our problems domestically rather than rely on luring physicians away from developing countries where their services are desperately needed.

1 Sustaining Medicare

The heart of the Commission's mandate was to make recommendations "to ensure the long-term sustainability of a universally accessible, publicly funded health system." The rationale behind this mandate was quite simple. For a number of years now, Canadians have been told by some of their governments and a number of health policy experts that the system popularly known as medicare is no longer "sustainable."

At the same time, the Commission's extensive consultations with Canadians and its comprehensive research program clearly indicate that Canadians *want* the system to be sustainable, not only for themselves but for future generations of Canadians. They want it to change, and to change in some very fundamental and important ways. But they also want it to endure and, indeed, to thrive.

Is it possible to reconcile these two perspectives? The place to start is with a clear understanding of what makes a system sustainable and what needs to be done to ensure that Canada's health care system is sustainable in the future.

What Is Sustainability?

In some ways, the word "sustainability" both illuminates and obscures the debate. It is a word that is immediately understandable and yet open to multiple interpretations and misinterpretations. Moreover, much of the recent debate on health care has focused on one aspect only – namely costs. People conclude that the system is not sustainable because it costs too much money, it takes too large a proportion of governments' budgets, or it is an impediment to lowering taxes. There are others who argue that the problem with the system is the way it is organized and the inefficiencies that result. Reorganize the system, they argue, and there is more than enough money to meet our needs. Still other voices have argued that the only problem with the system is the lack of money provided in recent years. Restore and increase the financial resources, they argue, and all will be well.

In the Commission's view, this narrow focus on money is inadequate and does not help inform the debates or enable an overall assessment of whether or not Canada's health care system is sustainable.

Instead, the Commission takes the view that:

Sustainability means ensuring that sufficient resources are available over the long term to provide timely access to quality services that address Canadians' evolving health needs.

For many years, health policy experts have focused on three essential dimensions that are each key to sustaining the health care system:

- **Services** – A more comprehensive range of necessary health care services must be available to meet Canadians' health needs. The services must be of a high quality and accessible on a timely basis. This aspect of sustainability involves looking at the changing ways health care services are delivered, whether they are accessible for Canadians, and whether they are efficiently and effectively delivered.
- **Needs** – The health care system must meet Canadians' needs and produce positive outcomes not only for individual Canadians but also for the population as a whole. This dimension examines how Canada's health care outcomes measure up to other countries, identifying disparities in the health of different Canadians and looking at trends in health.
- **Resources** – This includes not only financial resources but also the required health care providers and the physical resources (facilities, equipment, technology, research and data) that are needed to provide the range of services offered.

There is no "invisible hand" that silently and unobtrusively keeps these elements in balance. Decisions about providing adequate resources imply that there is political support by governments and by Canadians to continue supporting the system through public funds and public oversight. Maintaining the balance is, in fact, a deliberate act of will on the part of society and, thus, it is the overall governance of the system at all levels that ultimately decides how these elements are balanced.

Governance involves the political, social and economic choices that Canadians, their governments, and those in the health care system make concerning how the system continues to balance the health services, health needs, and resources that make up the system.

The following sections of this chapter address the complex and thorny issue of sustainability from those three essential dimensions – services, needs and resources – and looks at the changing way the health care system has been governed. What this review shows is that the system continues to do many things well. At the same time, there are a number of things it can and must improve. The system is neither unsustainable nor unfixable, but action is required to maintain the right balance between the services that are provided, their effectiveness in meeting the needs of Canadians, and the resources that we, as Canadians, are prepared to dedicate to sustain the system in the future.

Ultimately, the question of whether and how the system is sustained comes down to choices by those who govern the health care system – by providers, by governments, by administrators and by Canadians themselves.

Health and Health Care Services

Canada's health care system provides a range of services, some of which are covered by the *Canada Health Act* and the well-known five principles, some that are covered by provinces and territories, and some that are provided through the private sector. In large part, provinces and territories are responsible for organizing and delivering health care services to people across the country. Since medicare was first established, there have been considerable changes in both the scope of health care services provided in Canada and the different ways they are organized and delivered from relatively large regional health authorities to small clinics or doctors' offices.

Services offered in our health care system can be differentiated by their complexity and intensity: the more or less specialized nature of interventions to maintain or restore health and the number of qualified health personnel needed to see the interventions through.

At one end of the spectrum are a wide variety of services that are covered by the public health care system: public health programs aimed at the prevention of illness such as the immunization of children; visits to family physicians, pediatricians or gynecologists; diagnostic tests; and day surgery. Moving across the spectrum, we find the complex and intense care that requires the increasing use of advanced technology as well as highly trained specialists and large support teams. In addition, long-term or continuing care is typically provided in nursing homes or other specialized residential settings for people who require ongoing medical attention and support but who do not need to be treated in hospitals. Palliative care is provided to people who are dying and is available in hospitals, hospices and, to a growing extent at home. Home care is an increasingly important component of health care that can allow people to avoid hospitalization or recover at home following a shorter hospital stay. At any point along the spectrum, people can and frequently do receive prescription drugs.

The key question in terms of sustainability is whether this vast continuum of services provided in Canada's health care system meets the needs of Canadians, is accessible, and can be adapted in the future to meet the changing needs of Canadians.

Health Care and the Canadian Constitution

The Canadian constitution does not address health and health care as a single subject nor does it explicitly allocate responsibility to one order of government or another. Both provincial and federal governments have varying degrees of jurisdiction over different aspects of the health care system (Braën 2002; Leeson 2002). However, through a number of court cases and legal interpretations, it is now well accepted that the provinces have primary jurisdiction over the organization and delivery of health care services in Canada. In contrast, Yukon, Nunavut and the Northwest Territories do not have formal constitutional powers over health care, although they have assumed these responsibilities in recent years.

As Justice Estey of the Supreme Court of Canada pointed out in *Schneider v. The Queen*: "Health is not a subject specifically dealt with in the *Constitution Act* either in 1867 or by way of subsequent amendment. It is by the Constitution not assigned either to the federal or provincial legislative authority" (quoted in Gibson 1996, 1). In Peter Hogg's (1997, 485) words, "health is an 'amorphous topic' which is distributed to the federal Parliament or the provincial Legislatures depending on the purpose and effect of the particular health measure in issue." The reason for this is that the concept of health care is a modern one with assumptions and meanings that could not have been predicted by the constitution. A simple analogy to "health and health care" would be "the environment," another contemporary concept foreign to 19th century thinking and, therefore, absent from the original constitutional division of powers.

While the provinces have primary responsibility for health care delivery, the federal government has constitutional authority and responsibility in a number of very specialized aspects of health care (e.g., the approval and regulation of prescription drugs) and in critical areas of publicly funded health care, including the protection and promotion of health. The federal government also is responsible for providing health services to specific groups of Canadians, including First Nations and Inuit peoples as well as members and veterans of the Armed Forces and members of the Royal Canadian Mounted Police.

Perhaps the most visible federal role in health care comes through its transfer of funds to the provinces through what is called the "federal spending power." This often-controversial power is not specifically identified in the constitution but rests on court decisions that have upheld the federal government's right to spend money in areas of provincial jurisdiction.

The spending power can be used to provide direct payments to individuals (such as Family Allowances in the past or the current Millennium Scholarships), to other third parties such as universities (e.g., the Canada Research Chairs), or to the provinces for such things as post-secondary education, social services or health care. Such transfers to the provinces often come with "conditions" on how the money is supposed to be spent.

The spending power has been contested by some provinces, which argue that health care is exclusively a provincial jurisdiction, that the "conditions" imposed by the federal government distort their own spending priorities, and that Ottawa's fiscal powers should be curtailed. In spite of these objections, various legal cases have consistently upheld the constitutionality of the federal spending power and, more specifically, the right to provide conditional funding to the provinces (Braën 2002).

Medicare and Beyond

Most Canadians give little thought to the constitutional division of powers over health care. When they think of medicare, they think, first and foremost, of the services that the system provides. However, there are many misconceptions about what medicare is and what it is not – and some of those misconceptions may stem from the complex relationship that has developed between the federal and provincial-territorial governments for funding and organizing the system.

In 1957, the federal government, under the *Hospital Insurance and Diagnostic Services Act* (HIDSA), agreed to reimburse provinces for a portion of the cost of providing hospital insurance to their residents. Some provinces had already created hospital insurance programs by this point and the others were encouraged to do so by the offer of partial federal funding. In the late 1960s and early 1970s, following the report of Justice Emmett Hall's Royal Commission on Health Services (1964) and building on the model introduced in Saskatchewan, the federal government again used its spending power to encourage provinces to expand hospitalization insurance to include basic physician services as well. They agreed to cover a portion of the cost of those expanded services under the *Medical Care Act* of 1966. This expanded the program that became known to the public as medicare. The result is complete coverage for all necessary hospital and physician services through a publicly funded "single-payer" insurance system. As a result, no Canadian has to pay for those services at the time he or she uses them.

In 1984, the *Medical Care Act* and HIDSA were replaced by the *Canada Health Act* (CHA), which enumerated the five principles that have, in recent years, come to define the Canadian health care system: public administration, universality, accessibility, portability, and comprehensiveness. These principles have also become the conditions that the federal government has placed on its transfer of funds to the provinces. The provinces must ensure that their health insurance programs meets the conditions set out in the *Canada Health Act* in order to receive their full share of federal funding, and they must report annually to the federal government on how they meet the conditions of the CHA. In 2001/02, CHA services amounted to almost $44 billion or 42.4% of total (public and private) health expenditures.

The federal government's role in relation to hospital and physician services covered under the *Canada Health Act* primarily involves transferring funds to the provinces and ensuring that the conditions of the Act are met. *Canada Health Act* services are insured and administered by the provinces and territories, and delivered through a variety of organizations such as regional health authorities, hospitals, physician practices, and health clinics. As discussed in more detail later in this chapter, the relative size of the federal transfer compared to the provincial cost of delivering health services has become a dominant and disruptive theme of contemporary intergovernmental relations in Canada.

In addition to hospital and physician services, provinces and territories provide a range of additional health care services including prescription drug plans, home care, continuing care and long-term care. The nature and scope of these services vary considerably depending on the individual provincial and territorial plan. In addition, some provinces provide coverage for services such as rehabilitation, physiotherapy or chiropractic care while others do not. Unlike the single-payer system for hospital and physician services, provincial coverage for prescription drugs and various other health services such as home care does not necessarily cover the full costs. Instead, provincial plans supplement, to varying degrees, private insurance and private payment. These services amounted to almost $26 billion, which was 25.2% of total health care expenditures in Canada in 2001/02. Moreover, public coverage for these other health care services is generally accompanied by co-payments, deductibles, and means testing and is, therefore, not the type of fully insured coverage we have come to expect for *Canada Health Act* services.

The private sector also plays a role in Canada's health care system. Private health care services are those that we either pay for directly ourselves or are covered through private insurance plans or employee benefit plans. For example, the vast majority of dental services in Canada are paid for through employer-provided insurance coverage or by individuals directly. Private services amounted to just over $33 billion in 2001/02, which was 32.4% of total health care expenditures.

There is also a small area of overlap between public and private health care services. This overlap includes two areas: services provided under workers' compensation programs for injuries sustained on the job, and tax subsidies to encourage the private sector to provide supplementary insurance (largely for prescription drugs and dental services not covered in provincial and territorial plans). Individuals also receive tax deductions if their medical expenses are more than 3% of their income. In 1994, these tax breaks were estimated to be worth about $2.5 billion (Smythe 2001). They have grown rapidly since that time and likely are worth closer to $4 billion today, including roughly $3 billion given up by governments for not taxing private health premiums paid by employers and a further $1 billion for the tax credits for individual health costs as well as various disability allowances. These tax subsidies are not typically included in estimates of public spending on health care.

The health care system has expanded considerably to respond to the changing nature of health care and medical science, the wishes of Canadians in different provinces and territories, and the availability of resources within any particular province. There are only minor differences between provinces in terms of the *Canada Health Act* services that are covered. For example, some provinces cover annual eye exams while some do not. Beyond these services, all provinces provide some level of home care services, some form of public prescription drug insurance for vulnerable populations, and some range of continuing or long-term care.

There are also similarities in the way provinces have chosen to organize the delivery of health care services. The most prominent trend in recent years has been regionalization. Provinces have created regional health authorities with responsibility for organizing, delivering and co-ordinating public health programs, hospital services, community care and long-term or continuing care services within a particular region of the province. The province of Quebec led this move in the 1970s, but today every province has created health regions, although in Ontario these regions have only a consultative role.

Private For-Profit Service Delivery: The Debate

One of the most contentious issues facing Canadians is the extent to which the private sector should be involved in delivering health care services. Currently, provincial and territorial governments provide coverage for a range of services and those services can be delivered in any number of ways. Almost all Canadian hospitals are not-for-profit institutions and, in most provinces, are operated by regional health authorities. Most physician services are delivered by what are effectively owner-operated small businesses ranging from single-physician practices to multi-provider clinics that may include a range of health care providers. Large for-profit corporations deliver a narrower range of services including laboratory services and continuing and long-term care.

In the face of continuing pressures on the health care system, some argue that more private for-profit service delivery ought to be introduced in order to bring more resources, choice and competition into the Canadian health care system and to improve its efficiency and effectiveness. Others argue as strongly that the private sector should be completely excluded from health care delivery, suggesting that private for-profit delivery runs counter to Canadians' values, is inequitable, and less cost-effective than public delivery in the long run.

To try to make sense of this debate, it is important to distinguish between two types of services: direct health care services such as medical, diagnostic and surgical care; and ancillary services such as food preparation, cleaning and maintenance. An increasing proportion of ancillary services provided in Canada's not-for-profit hospitals are now contracted out to for-profit corporations. Canadians seem to find this role for private sector companies acceptable and some studies suggest that these enterprises achieve economies of scale (McFarlane and Prado 2002). Ancillary services are relatively easy to judge in terms of quality – the laundry is either clean or it is not, the cafeteria food is either good or it is not. Consequently, it is relatively easy to judge whether the company is providing the service as promised. Also, there is a greater likelihood that there are competitors in the same business to whom hospitals can turn for laundry or food services if their current contractor is unsatisfactory.

In terms of direct health care services, the precise number of for-profit facilities delivering direct health care services is unknown. One estimate in 1998 (Deber et al.) suggested that there were 300 private for-profit clinics in Canada delivering many diagnostic and therapeutic services formerly provided in hospitals, including abortions, endoscopies, physiotherapy, new reproductive technologies and laser eye surgeries. In addition, there are a growing number of small private for-profit hospitals or stand-alone clinics in some provinces providing more complex surgeries, some requiring overnight stays. These facilities vary considerably in terms of the number of services they offer and their ownership structure. Furthermore, some provinces have expressed an interest in contracting out an increasing number of surgical services to private for-profit hospitals and clinics in the hope of realizing efficiencies.

Unlike ancillary services, direct health care services are very complex and it is difficult to assess their quality without considerable expertise. Indeed, the effects of poorly provided service may not be apparent until some time after the service has been delivered, as in the event of a post-operative complication. This is what most clearly distinguishes direct health care services from ancillary services – a poorly prepared cafeteria meal may be unpleasant, but poor quality surgery is another matter altogether. It is also unlikely that there would be a significant number of competitors able to offer health care services if a given for-profit provider is unsatisfactory. There simply is not a significant surplus of health care administrators or providers waiting in the wings to take over service delivery in a hospital. Thus, if services are of poor quality, it is going to be much harder to find a replacement once public facilities have stopped providing the services – the capacity that existed in the public system will have been lost.

Some suggest that private for-profit delivery is more efficient than not-for-profit delivery (Gratzer 1999 and 2002). Given that most of the private facilities currently operating and being planned focus only on providing a limited range of services, there are some important concerns that must be addressed in terms of how these facilities interact with the more comprehensive public system. In effect, these facilities "cream-off" those services that can be easily and more inexpensively provided on a volume basis, such as cataract surgery or hernia repair. This leaves the public system to provide the more complicated and expensive services from which it is more difficult to control cost per case. But if something goes wrong with a patient after discharge from a private facility – as a result, for example, of a post-operative infection or medical error – then the patient will likely have to be returned to a public hospital for treatment insofar as private facilities generally do not have the capacity to treat individuals on an intensive care basis. Thus, the public system becomes liable for the care triggered by a poor quality outcome within a private facility, yet under current arrangements there is no way for the public system to recover those costs from the private facility. In other words, the public system is required to provide a "back-up" to the private facilities to ensure quality care.

Proponents of for-profit care may insist that the quality of care is not an issue, but there is evidence from the United States to suggest that the non-profit sector tends to have better quality outcomes than the for-profit sector in such things as nursing home care (Harrington 2001; Marmor et al. 1987) and managed care organizations and hospitals (Kleinke 2001; Gray 1999). More recently, a comprehensive analysis of the various studies that compare not-for-profit and for-profit delivery of services concluded that for-profit hospitals had a significant increase in the risk of death and also tended to employ less highly skilled individuals than did non-profit facilities (Devereaux et al. 2002).

For those reasons, the Commission believes a line should be drawn between ancillary and direct health care services and that direct health care services should be delivered in public and not-for-profit health care facilities.

There are, however, several grey areas around the issue of private for-profit delivery. First, diagnostic services have expanded considerably in the past few years and, in many cases, these services are provided in private facilities under contracts with regional health authorities or provincial governments. Much of this involves relatively routine procedures such as laboratory tests and x-rays that can be done with little delay or wait on the part of the patient. But there appears to be a growing reliance on the private provision of more advanced and expensive

diagnostics such as MRIs (magnetic resonance imaging), for which the waiting times in the public system can be frustratingly long because of what appears to be an under-investment in such technology within the public system. The growth of private advanced diagnostic facilities has permitted individuals to purchase faster service by paying for these services out of their own pocket and using the test results to "jump the queue" back into the public system for treatment. While this is not currently a common occurrence, Canadians made it clear to the Commission that they are deeply concerned about the prospect of this becoming routine (Commission 2002a).

Medicare rests on the principle that an individual's financial resources should not determine access to services. In the Commission's view, governments have a responsibility to guarantee that the public system has sufficient resources to ensure appropriate access to advanced technology. Increased investment within the public system for new diagnostic technology can remove the temptation to "game" the system by individuals and health care providers through the private purchase of diagnostic tests that could allow them to jump the queue.

The second grey area is services provided to workers' compensation clients with job-related injuries and illnesses. Because of the belief that it is important to get these people back to work quickly, these clients get preferential treatment in accessing diagnostic and other health care services over those whose illness or injury is not work related or who may not be formally employed. As suggested in Chapter 2, this current exception under the *Canada Health Act* should be reconsidered.

The third grey area is contracting out of surgical services. In some cases, regional health authorities have contracted with private for-profit facilities that provide specific surgeries such as cataract and some day surgeries. Again, there is no clear evidence that this practice is more efficient or less costly than providing the services in an adequately resourced not-for-profit facility.

Services and Sustainability

Services are the first element in our definition of sustainability. The previous information suggests that there are complex, and sometimes confusing, relationships between the federal, provincial and territorial governments. Much has changed since medicare was first introduced. The range of services is growing and changing with new advances in medicine and, as a result, the biggest growth in services is outside of hospital and physician services. Subsequent chapters will show that there is tremendous growth in home care and that prescription drugs have become the fastest growing part of the health care system. Canadians also are only too well aware of the fact that services are not always available on a timely basis. In areas like diagnostic services and some surgeries, people sometimes wait too long for access to the services they need. People in rural and remote communities also have problems in accessing services. In spite of what appears to be almost overwhelming support for primary health care, only limited progress has been made in extending primary health care across the country. All of these issues apply in every province and territory. The conclusion, then, on services and sustainability is that more needs to be done to ensure timely access to quality services. The answer, however, is not to look to the private sector for solutions. Instead, governments should seek the best solutions within the public system and ensure that adequate resources are available and services are accessible to all.

The Commission is strongly of the view that a properly funded public system can continue to provide the high quality services to which Canadians have become accustomed. Rather than subsidize private facilities with public dollars, governments should choose to ensure that the public system has sufficient capacity and is universally accessible. In addition, as discussed in Chapter 11, any decisions about expanding private for-profit delivery could have implications under international trade agreements that need to be considered in advance.

Needs and Outcomes

There is a direct and dynamic relationship between the services that are provided and Canadians' changing health care needs. The ability of health services to meet health needs is affected by the following factors:

- Limited fiscal resources to address the range of health needs;
- Limited physical resources, equipment and new technologies;
- Imbalance in the supply, distribution and scopes of practice of health care providers;
- Demographic, societal, and technological changes that make some services (e.g., prescription drugs and home care) more important or essential than they were in the past; and
- Canadians' growing expectations that an increasing range of treatments will be provided within the public system.

Balancing these various factors requires a high level of responsiveness and flexibility in the health care system – something Canada's system appears to have done reasonably well in the past. The following sections describe the performance of the health system in meeting Canadians' needs as measured by the health status of Canadians, the responsiveness of the system, disparities in health outcomes, and anticipating changing needs.

Performance of the Canadian System

Determinants of Health

In 1974, Canadian Minister of Health Marc Lalonde published a seminal report on the determinants of health (Canada 1974). Determinants of health include a range of factors that explain why a person is or is not healthy – biological factors, lifestyle choices, environmental conditions, and the organization of the health care system itself. This broader approach to health looks at not just the health of individuals but also at the health of the population, factors that affect health overall, and trends in the health of different groups of people within our society.

The population health approach focuses on "upstream" determinants of health in order to prevent or reduce "downstream" problems that have to be addressed by the health care system. For example, individuals who live in a highly polluted environment tend to have greater health care needs than those who live in cleaner environments. Conversely, if the environment is healthy, then people are healthier and the burden on the health care system is reduced. People who live in wealthier societies across the world also have significantly better health outcomes – longer lives, lower infant mortality rates, fewer chronic illnesses – than those in poorer societies. Other factors such as large disparities in the distribution of income and wealth, the level of educational attainment, and the literacy rate also have an impact on the health of a population. The greater the economic and social inequality within a society the lower the health outcomes

(Wilkinson 1996). To address issues related to population health, governments, health care providers and policymakers look to injury and illness prevention programs, health protection and promotion programs and services, as well as the many diverse programs, policies and initiatives that support healthier social and physical environments. These initiatives can range from encouraging healthier lifestyles among individual Canadians to programs to reduce poverty and ensure a cleaner environment.

In the decades since the Lalonde report, Canadians have continued to be in the forefront of population health thinking, as demonstrated by reports such as *Achieving Health for All: A Framework for Health Promotion* (1986) by former federal Minister of Health Jake Epp, the Ontario government's Early Years Study (1999), and the pioneering work conducted by Fraser Mustard and the Canadian Institute for Advanced Research. Not surprisingly, this population health approach was endorsed in the recommendations of all recent Canadian reports on health care, including the National Forum on Health (1997), Quebec's Clair Commission (2000), Saskatchewan's Fyke Commission (2001), Alberta's Advisory Council under Mazankowski (2001), and recent work by the Senate Standing Committee on Social Affairs, Science and Technology (2001, 2002).

Overall Performance

Eight countries – the United Kingdom, Sweden, Germany, France, Japan, Australia, the Netherlands and the United States – have been selected for comparison with Canada based on their size, wealth and health policy characteristics. These comparisons are used throughout the report at various points in an effort to ensure that we compare relatively similar countries at all times. These countries also display a broad range of public and private mechanisms, financing and delivery of health services based on a classification developed for the Organisation for Economic Co-operation and Development (Propper 2001). In addition, two composite indices have been used. One measures the thirty countries that are members of the OECD that range from mid-income countries such as Turkey and Poland to the high-income countries noted above. The other index is the average for the G7 countries – the United States, Japan, Germany, France, the United Kingdom, Italy and Canada – seven of the largest and wealthiest economies in the world.

From a population health perspective, a number of indicators of the overall health of Canadians can be considered. These broad measures address some of the key determinants of health as well as track progress on international indicators of the health of Canada's population compared with others around the world.

Based on the United Nations Human Development Index of income per capita, literacy, and life expectancy, Canada scores very high. For a number of years, Canada was ranked number one in the world and, although it is currently in third position behind Norway and Sweden (UNDP 2002), the system is clearly doing well. Other international yardsticks, however, such as the United Nation's Human Poverty Index (HPI), show a quite different picture. The HPI measures relative deprivation in terms of standard of living, education and longevity. By this measure, Canada is in 11th place behind the Scandinavian countries, Germany, France, Japan and Spain, among others (UNDP 2001). On this index, Canada is not doing as well as it should.

In many cases, precise indicators are not available to allow us to measure the state of health and health needs in Canada, and compare our health outcomes with other countries. Because health has frequently been defined as the absence of illness in an individual, only the most serious problems – those that often lead to the death of patients – are generally tracked in health statistics (Hadley 1982). Nonetheless, there are some important indicators that are consistently tracked on a national and international basis.

Life expectancy at birth is one of the most established and widely available summary measures of health status. Life expectancy at age 60 provides a measure of the health status of the elderly population. Both measures (see Figures 1.1 and 1.2) reflect improvements in the standard and quality of life, as well as the extent of our collective wealth and the way it is shared. The quality of the health care system and its ability to provide people with the care they need also has an impact on life expectancy.

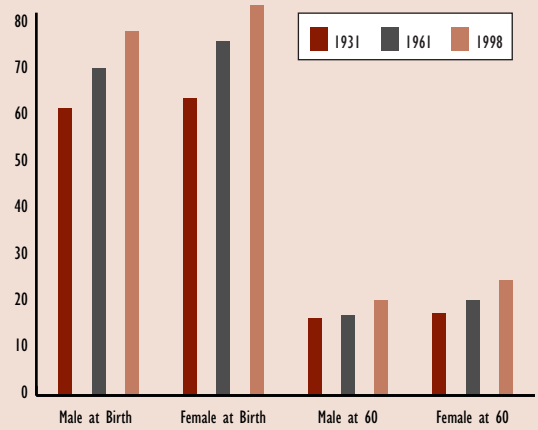
Since the 1930s, the life expectancy of Canadians has increased by 17.7 years to 75.4 years for men and 81.2 for women. Since the implementation of medicare at the beginning of the 1970s, Canadians' life expectancy has risen approximately one year for every five calendar years. In 1999, Canada's life expectancy at birth was 5th among all OECD countries.

Another measure is the number of potential years of life lost (see Figure 1.3), that is, preventable deaths that occur before people reach the age of 70. In large part, this measure reflects the quality and accessibility of the health care system. Since the creation of medicare, Canada's performance has improved considerably, moving from a rate of 9,395 years lost per 100,000 people in 1960 to a rate of 3,803 years in 1997. With these results, Canada ranked favourably in 8th position in comparison to all other OECD countries in 1998.

Since its 2000 report, the World Health Organization (WHO) has encouraged its members to collect data on the number of disability-free years of life as a measure of whether societies are adding not only to the length of people's lives but also the quality of their lives (see Figure 1.4). Both medical care and the effectiveness of prevention programs should have an impact on increasing the number of years people live without disabling conditions. With an estimated ranking of 9th among 30 OECD countries (Mathers et al. 2000), this is also an area in which Canada fares reasonably well, though it could do better.

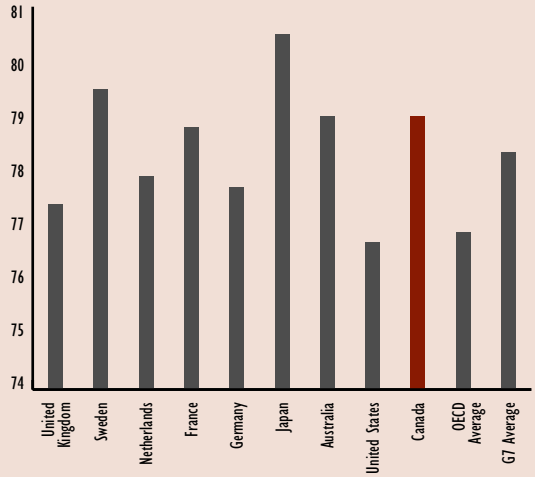
One area where Canada has made some progress is in reducing infant mortality rates, an almost direct reflection of improvements in education, health, housing and nutrition, and the overall standard of living. Low rates also demonstrate the impact of primary health care initiatives and, in particular, the quality of prenatal care. Canada's infant mortality rate decreased steadily from a rate of 27.3 deaths per 1,000 births in 1960 to 5.3 deaths per 1,000 in 2000 (see Figure 1.5). In spite of this progress, there is still considerable room for improvement. Canada is currently ranked 17th among all OECD countries with a rate that is considerably higher than Japan and most Western European countries (see Figure 1.6). Another measure of health status is perinatal mortality – the number of deaths that occur between the 28th week of pregnancy and the first month of a baby's life. As with infant mortality, decreases in the perinatal mortality rate reflect the living conditions of the mother and the quality of prenatal care. For example, a non-smoking mother in good health and whose pregnancy is monitored by competent health care professionals is far more likely to carry the pregnancy to term and to give birth to a healthy baby. Perinatal mortality also varies according to the level of care available to a baby born prematurely, with a low birth weight, or when complications arise during childbirth.

Figure 1.1
Life Expectancy in Years, by Sex, at Birth and at Age 60, Canada, Selected Years



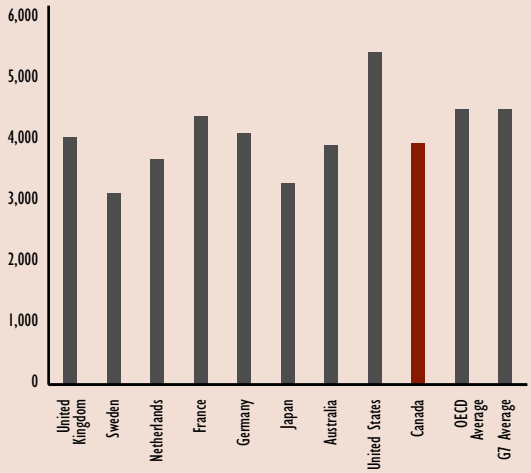
Source: Statistics Canada 1983; OECD 2002b.

Figure 1.2
Life Expectancy in Years at Birth among OECD Countries, 1999



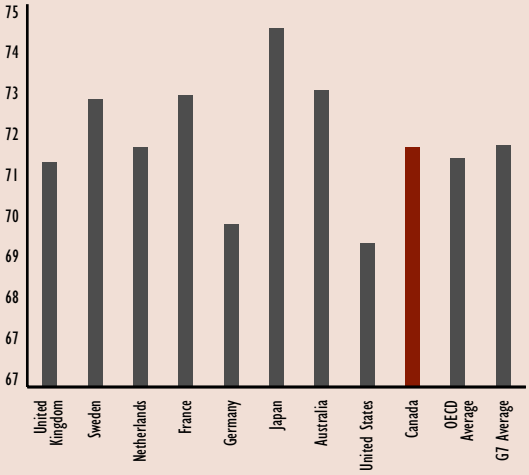
Note: 1999 is the most recent year for which comparable data are available.
Source: OECD 2002b.

Figure 1.3
Potential Years of Lost Life (Years Lost per 100,000 People) among OECD Countries, 1998



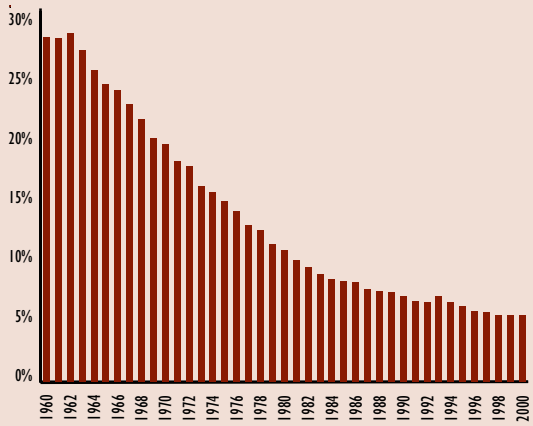
Note: 1998 is the most recent date for which comparable figures are available. Figure for Canada is 1997.
Source: OECD 2002b.

Figure 1.4
Disability Adjusted Life Expectancy in Years at Birth among OECD Countries, 1999



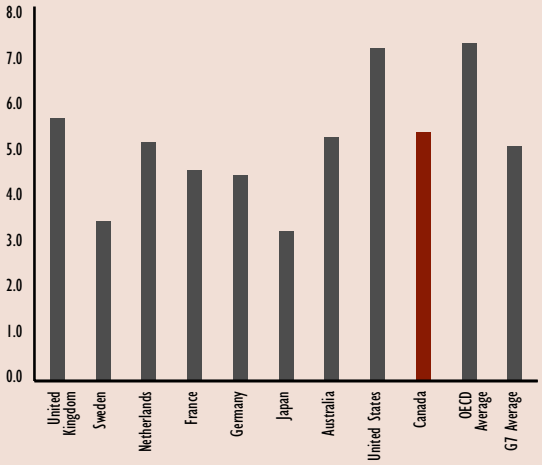
Source: Mathers et al. 2000.

Figure 1.5
Infant Mortality (Rate per 1,000 Live Births) Canada, 1960 to 2000



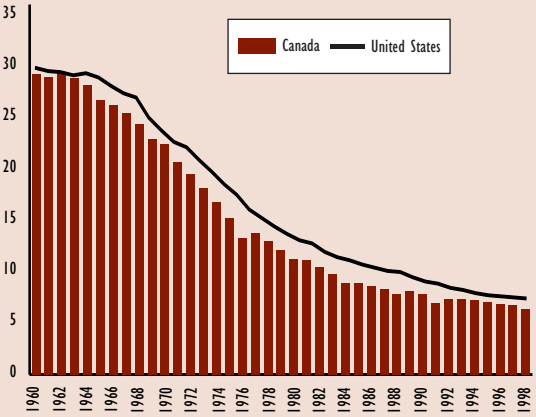
Source: OECD 2002b.

Figure 1.6
Infant Mortality (Rate per 1,000 Live Births) among OECD Countries, 2000



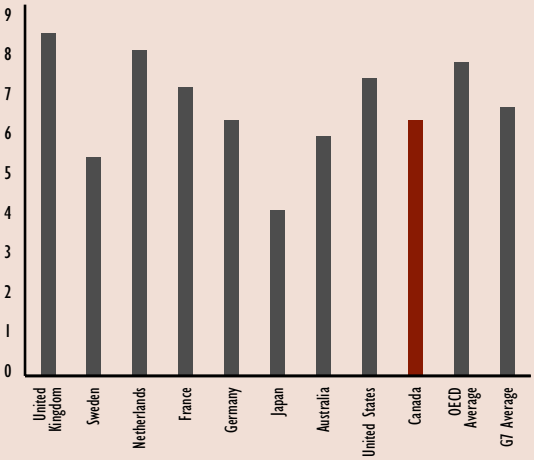
Note: Figures for Canada and the United States are for 1999.
Source: OECD 2002b.

Figure 1.7
Perinatal Mortality (Rate per 1,000 Live Births) Canada and the United States, 1960 to 1998



Note: 1998 is the most recent year for which comparable data are available.
Source: OECD 2002b.

Figure 1.8
Perinatal Mortality (Rate per 1,000 Live Births) among OECD Countries, 1998



Note: 1998 is the most recent year for which comparable data are available.
Source: OECD 2002b.

A decrease in the rate of perinatal mortality partially reflects the quality and, even more so, the accessibility of specialized medical care. Compared to all other OECD countries, Canada's relative position is not exceptional, with a rate of 6.2 deaths per 1,000 births in 1998 and a ranking of 10th. However, compared with the United States, Canada's perinatal mortality has consistently been lower, suggesting that general access to hospital and medical care within the Canadian system is a significant factor in our progress in reducing perinatal mortality (see Figures 1.7 and 1.8).

Equity

A key consideration in addressing the performance of any health care system, including ours, is equity. Equity means that citizens get the care they need, without consideration of their social status or other personal characteristics such as age, gender, ethnicity or place of residence. Equity addresses questions such as whether some groups in our society have better access to health care or better health outcomes than others (Goddard and Smith 2001).

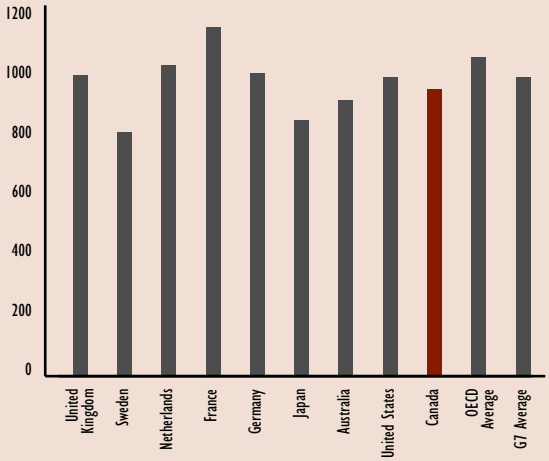
Spending on health care does appear to make a difference in health outcomes. Health indicators such as life expectancy and infant mortality clearly show that problems are ameliorated when spending increases (Crémieux et al. 1999). But the effect is neither immediate nor direct. An inefficient system, for example, may use additional health resources to provide higher salaries to health care providers without a corresponding improvement in services. A system with poor accessibility may not assist people who could benefit most from the services. These reasons are often used to explain why a system that spends a great deal of money, such as that in the United States, does not produce the results that would be expected.

A multi-country coalition of researchers has focused on assessing equity in various OECD countries for more than a decade. Their conclusions show that Canada compares favourably with other countries and also highlight a number of areas where the results are very positive. For example, there do not appear to be any equity problems in terms of accessing general practitioners based on socio-economic status. In fact, people with lower socio-economic status tend to have more visits to a family practitioner than the general population. In this respect the absence of co-payments is also noted as one of the strong points of the Canadian system (van Doorslaer et al. 2002). On the other hand, Canadians' access to specialists appears to be easier for people with higher incomes (Atler et al. 1999).

Responsiveness to Specific Illnesses

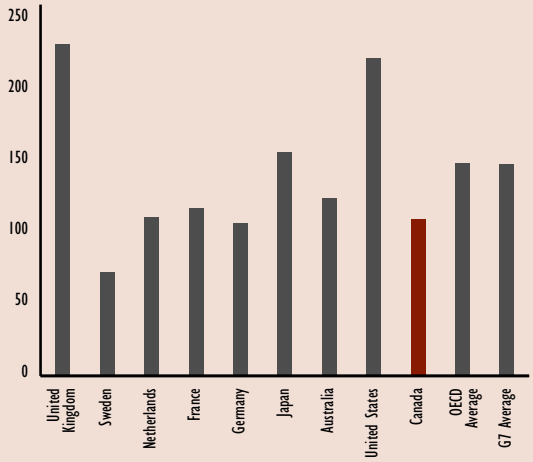
Another way of assessing the performance of the health care system in meeting Canadians' needs is to look at how well it responds to a host of specific health problems, such as cardiovascular disease, stroke and other cerebrovascular problems, serious respiratory ailments, and cancer. On the whole, the picture that emerges is a positive one. Canada is generally above or within the average range of OECD comparison countries (see Figures 1.9 to 1.12). In fact, as with other countries, Canadian indicators are at times excellent (e.g., cerebrovascular accidents) and at times poor (e.g., respiratory diseases). For example, in the case of cerebrovascular problems, Canada is ranked 3rd among all OECD countries while for cardiovascular disease, the situation is less favourable, with Canada ranking 13th.

Figure 1.9
Potential Years of Lost Life: Malignant Neoplasms (Years Lost per 100,000 People) among OECD Countries, 1998



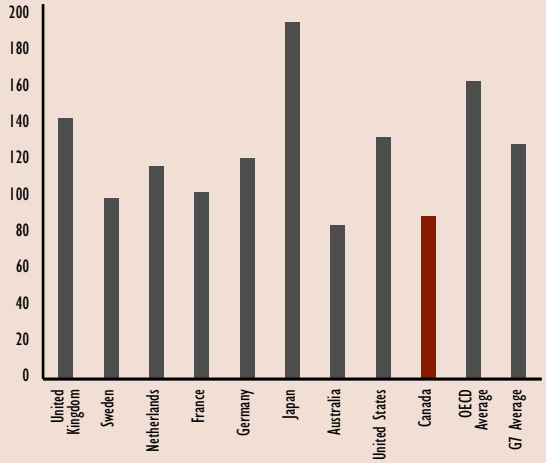
Note: 1998 is the most recent year for which comparable data are available.
Source: OECD 2002b.

Figure 1.10
Potential Years of Lost Life: Diseases of the Respiratory System (Years Lost per 100,000 People) among OECD Countries, 1998



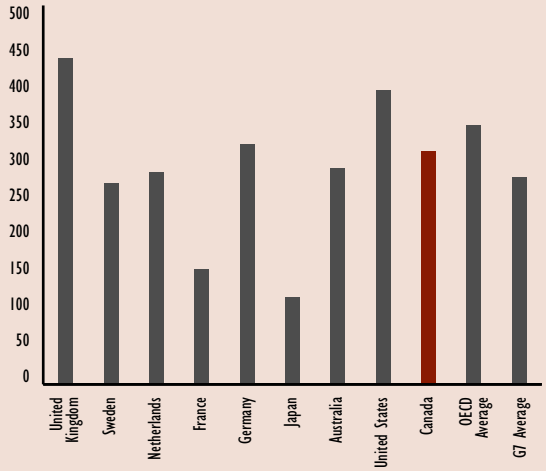
Note: 1998 is the most recent year for which comparable data are available.
Source: OECD 2002b.

Figure 1.11
Potential Years of Lost Life: Cerebrovascular Diseases (Years Lost per 100,000 People) among OECD Countries, 1998



Note: 1998 is the most recent year for which comparable data are available.
Source: OECD 2002b.

Figure 1.12
Potential Years of Lost Life: Ischaemic Heart Diseases (Years Lost per 100,000 People) among OECD Countries, 1998



Note: 1998 is the most recent year for which comparable data are available.
Source: OECD 2002b.

Disparities within Canada

Despite the fact that Canada's health system compares well with those of other wealthy industrialized nations, there are serious disparities in health outcomes within Canada. Depending on where a person lives, there are real inequities in the way Canadians benefit from the public health care system.

These disparities primarily reflect underlying economic, demographic and cultural realities such as: the relative poverty or affluence of different regions; the degree of urbanization; the population density; or the ethnic composition (Statistics Canada 2000). The disparities can also reflect the different political culture or social cohesion of a province or region, varying levels of public tolerance for certain risk behaviours such as smoking or alcohol abuse, the extent to which comprehensive health policies are in place, and the degree of co-operation with and among health professionals.

There are serious disparities between people who live in the northern part of Canada versus the south and between people who live in Atlantic Canada and the rest of the country. In other words, the lines of disparity not only run north and south but also east and west.

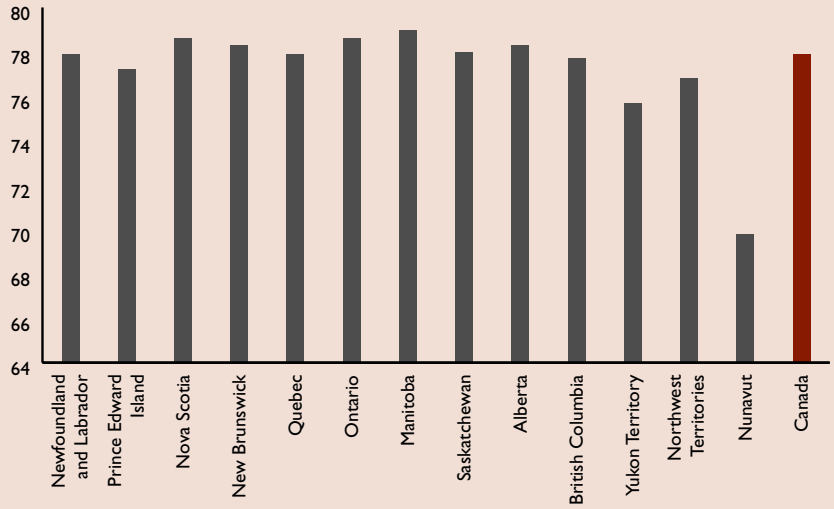
A recent study demonstrated that at one extreme, the inhabitants of the Nunavik region in Quebec live an average of 15.8 years less than people who live in Richmond, British Columbia (Statistics Canada 2002h). Given that it takes the passage of approximately five years to gain one year of life expectancy, this translates into a difference between the two communities of almost 79 years of history in terms of health status and social development. However, to put this in perspective, even the very small difference between the neighbouring communities of Vancouver (life expectancy of 78.6 years) and Richmond (life expectancy of 81.2 years) translates into a difference of 13 years in health and social development. Figure 1.13 compares life expectancy among all provinces and territories.

The availability of health care also varies greatly in Canada and there are obvious disparities in access on north-south lines. To a great extent, population density determines whether people have access to health care providers, medical resources, and advanced hospital care. The northern regions of Canada are less populated and, as a result, they are relatively less well served than the southern regions. At the same time, particular provinces such as Newfoundland and Labrador and Quebec have chosen to provide more medical resources in terms of physicians and facilities than the size or distribution of their populations would suggest (see Map 1.1).

There also are variations in the rates of different procedures that do not always reflect the relative wealth or size of the population in different provinces and territories. For example, a comparison of the number of hospitalizations following hip fractures in each of the provinces and territories shows that the rates are higher in Alberta and British Columbia, in spite of the fact that they have younger populations and wealthier economies than provinces like New Brunswick or Nova Scotia where the rates are lower (see Map 1.2).

Another way of assessing the availability of health care is to ask Canadians whether they think the health care system is meeting their needs. The answers to these questions are sometimes difficult to interpret because they do not necessarily correspond to differences in either the health status of the people surveyed or their needs. At the same time, these surveys can potentially identify health needs that are not being met. Current surveys suggest that there are

Figure 1.13
Life Expectancy in Years at Birth, by Province, Territory and Canada, 1996



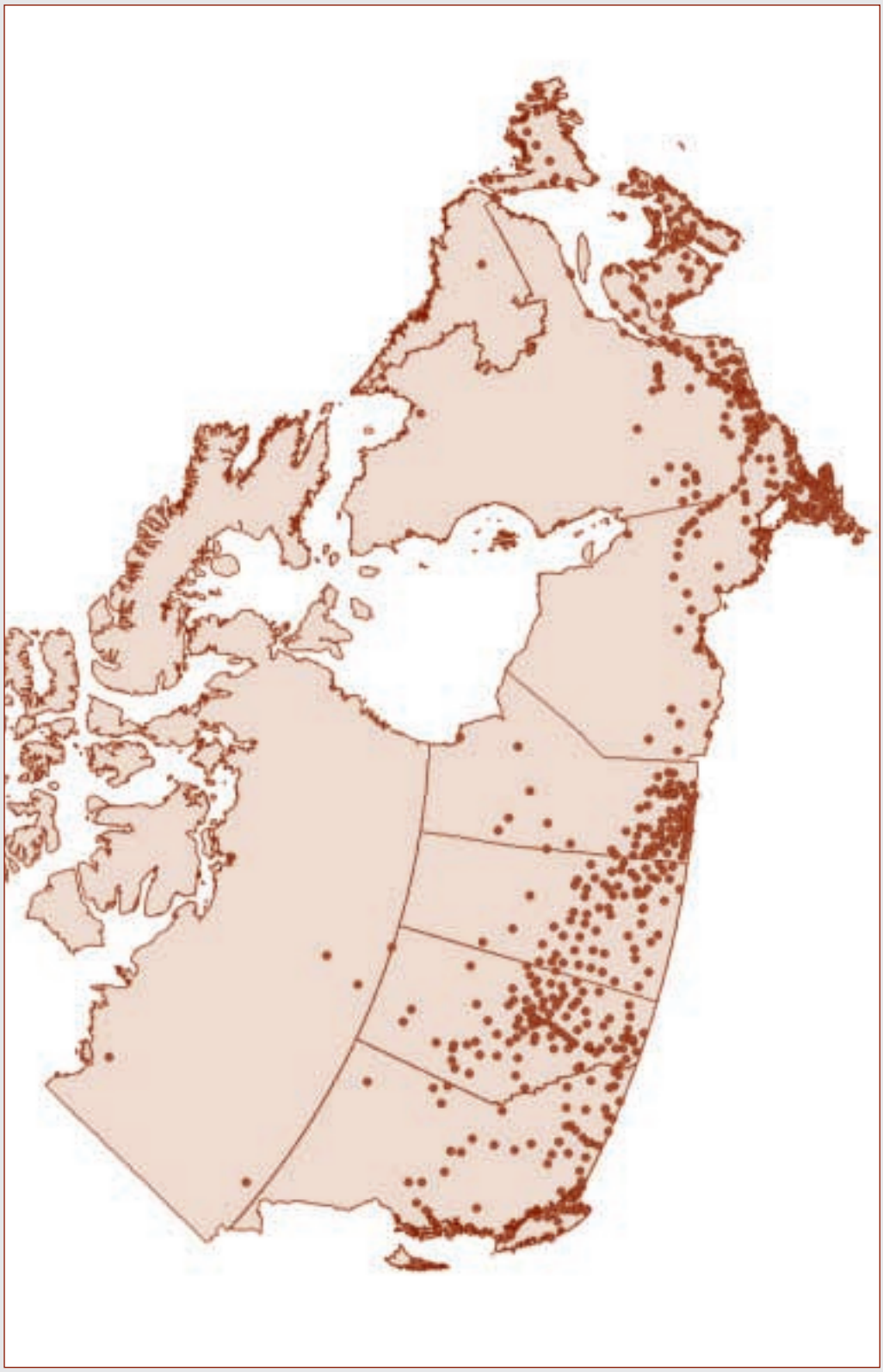
Note: Life expectancy figures at the provincial and territorial level only available for 1996.
Source: CIHI 2002f.

very minimal variations across the country and most Canadians remain satisfied with the quality of care they receive. Given the differences in availability of care across the country, the uniformity of satisfaction may indicate that Canadians adjust their expectations to the level of care that is available (see Figures 1.14 and 1.15).

Disparities in the quality of health care are more difficult to measure. One approach is to track the number of interventions done in a hospital that could have been dealt with earlier or in another way, before hospitalization was required. These types of interventions are measured in terms of ambulatory care sensitive conditions (see Map 1.3) which are often considered to be strong indications of the quality of the health care system (Brown et al. 2001; Billings et al. 1996). An adequate and well-functioning primary health care system is certainly one way of preventing unnecessary hospitalizations. One of the paradoxes of the Canadian health system is the fact that primary health care services are more fully developed in the richer and more populated provinces that also have the most hospitals. In contrast, the provinces with the fewest hospitals also have a limited capacity to prevent and resolve health problems before hospital care is needed.

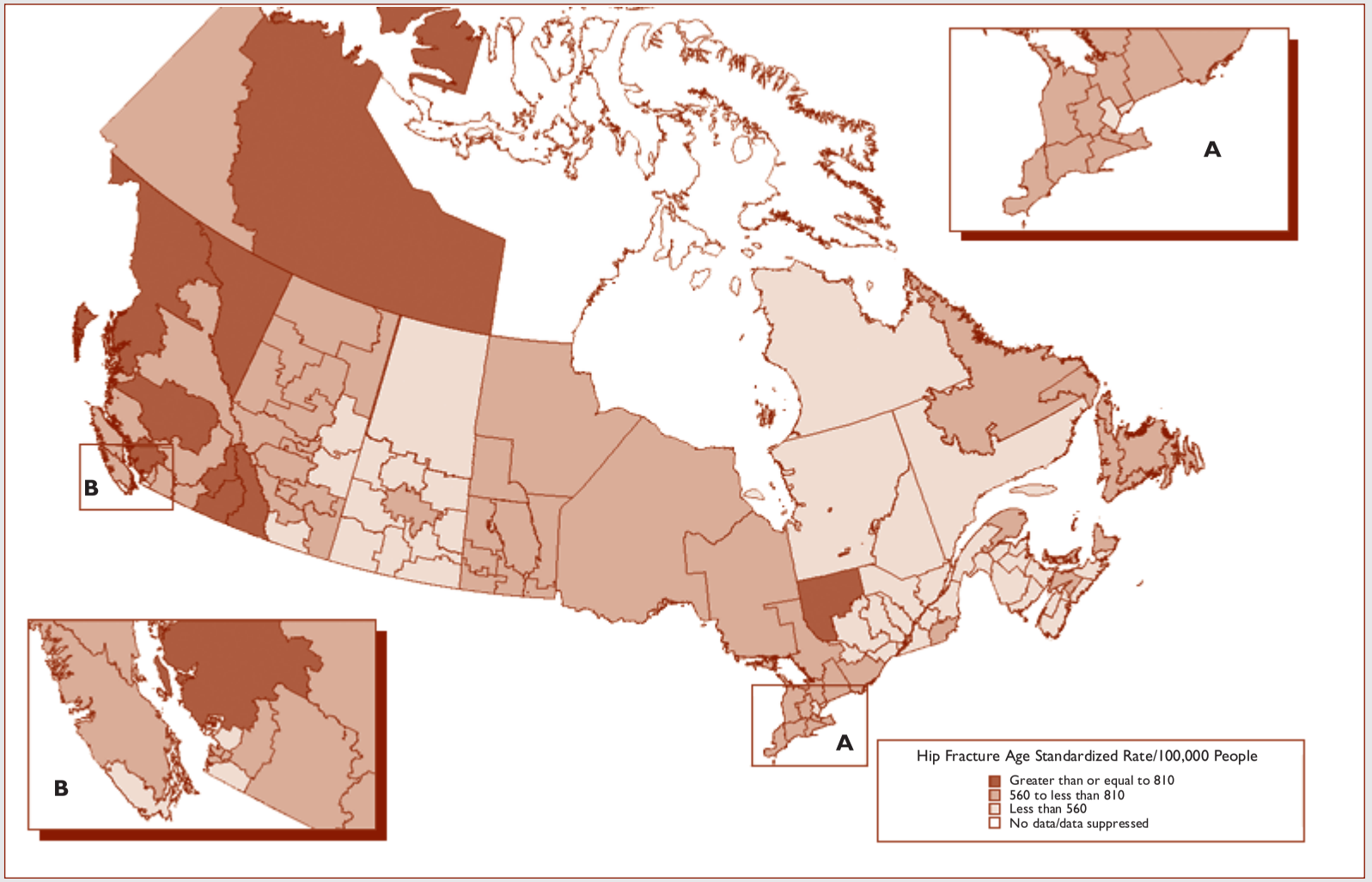
Disparities in the health of Canadians can also be measured by asking them what they think of their own health status. Canadians tend to rate their own health status better than would be expected based on objective measures. People in parts of the country with lower health status – people who may have lower life expectancies or who are chronic smokers – tend to rate their health status much the same as people in regions with higher life expectancies and more healthy lifestyles. Clearly, people's expectations and their assessments of health are affected by their community and the part of the country where they live.

Map 1.1 Acute Care Facilities in Canada, 1999/2000



Source: CIHI 2002.

Map 1.2 Hip Fracture Hospitalizations by Health Region, 1999/2000

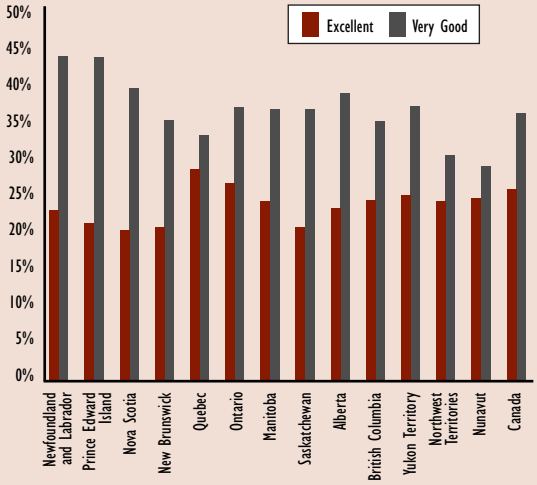


Source: CIHI 2002.

Figure 1.14
Percentage of the Population Reporting "Unmet Health Care Needs," by Province, Territory and Canada, 2000/01

Source: Statistics Canada 2002f.

Figure 1.15
Self-reported Health as "Excellent" and "Very Good," by Province, Territory and Canada, 2000/01



Source: CIHI 2002f.

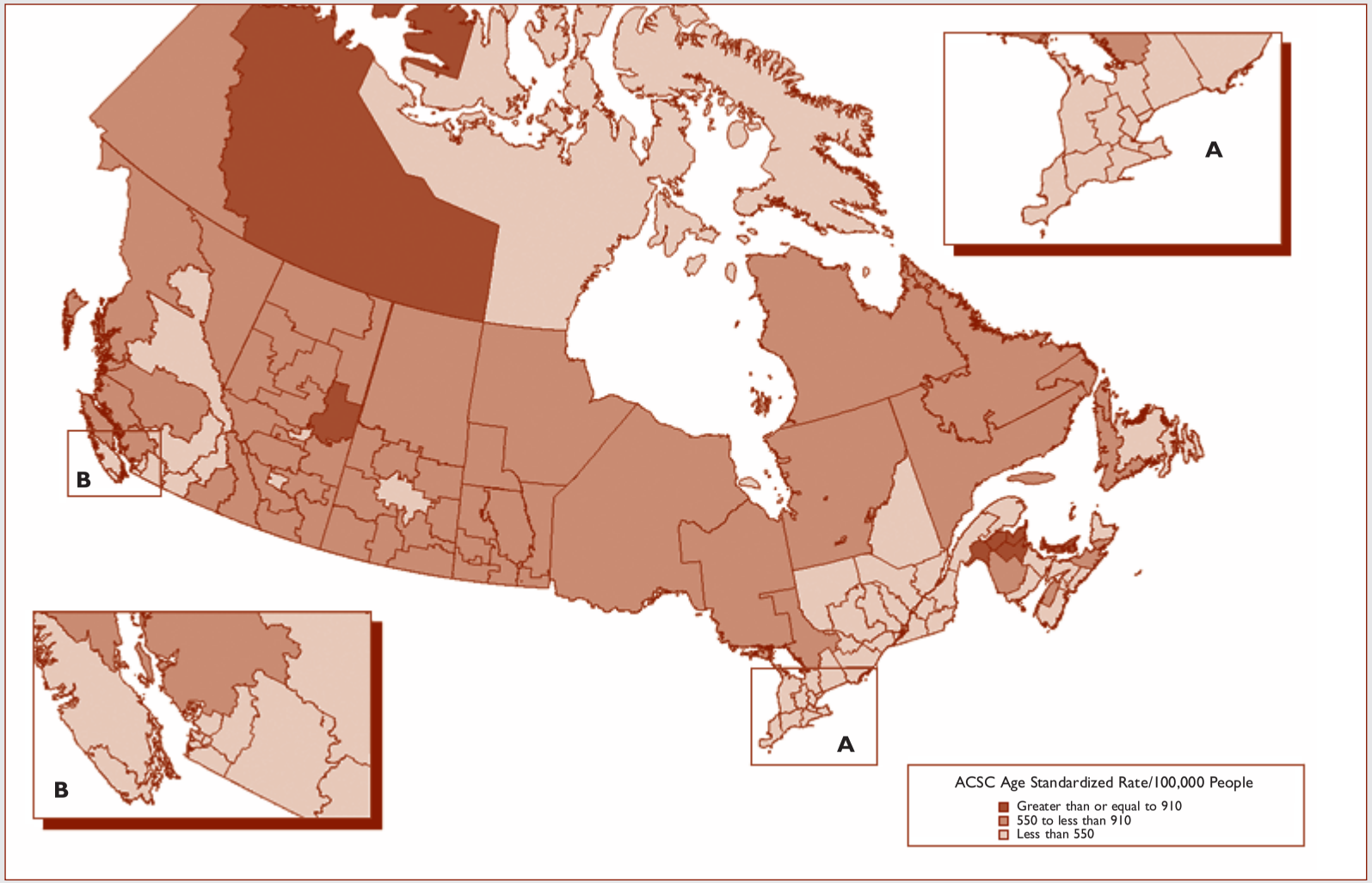
Anticipating an Aging Population

Much has been made of the fact that Canada's population is aging and, for some, this is yet another reason to worry that Canada's health care system may not be sustainable. Demographic trends show that the proportion of Canadians 60 years and older is expected to grow from 17% today to 28.5% by 2031 (see Figure 1.16). Some think that this increase in the proportion of older people means that health care spending will spiral out of control and the health care system will be hard pressed to meet the increased demands for services. They point to the fact that more money is spent on health care as people age. Table 1.1 shows that the average annual per capita spending on health care for people 65 and over is roughly three times the amount spent on all age groups. Health expenditures typically increase with age, although most analysts agree that aging alone will only drive up costs by about 1% a year (Conference Board of Canada 2001).

The impact of aging on the health care system is not something that is unique to Canada. If we look beyond our borders, other comparable countries have already experienced the aging of their populations and have been able to manage their costs as well. As one study points out:

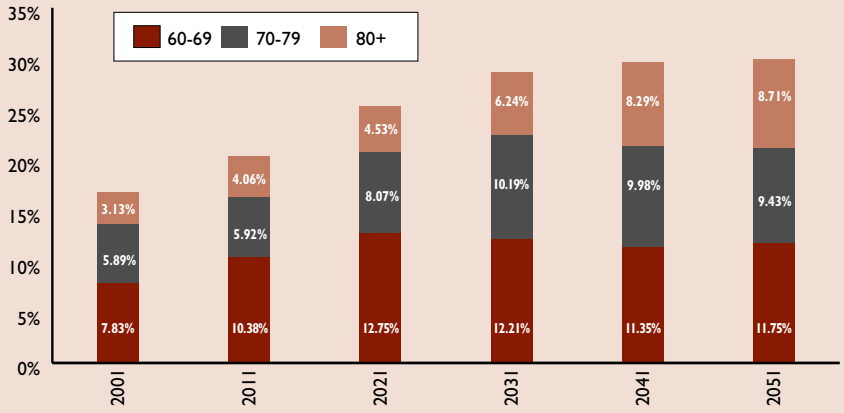
> Much of the international evidence reviewed indicated that modest growth in economies should insure that most countries are able to manage the growth in their elderly populations and increased health care spending in the future. It is also worth remembering that there are countries which already have significantly larger elderly populations than Canada, spend significantly less and achieve similar health outcomes in comparison to Canada (Rosenberg 2000, 20).

Map 1.3 Ambulatory Care Sensitive Conditions by Health Region, 1999/2000



Source: CIHI 2002.

Figure 1.16
Population Projections for Canada, Percentage of the Population Aged 60 and Over, 2001 to 2051



Source: Statistics Canada 2000.

Table 1.1
Average Annual per Capita Expenditure, by Age and Sector, 2000/01

	Public	Private	Total
All age groups	$2,243.56	$930.69	$3,174.24
65+	$8,524.72	$2,309.30	$10,834.02
65-74	$4,975.16	$1,648.37	$6,623.53
75-84	$10,083.36	$2,451.91	$12,535.27
85+	$21,878.36	$5,256.59	$27,134.95

Source: Health Canada, 2001d.

There is another difficult but important question to address, namely, will future generations of aging Canadians be in better health than preceding ones? Aside from problems related to poor nutrition, notably obesity, Canada ranks within or above the average among leading industrialized nations in terms of lifestyles and programs that are likely to have an effect on health. This suggests a positive future, provided Canadians continue to take steps to improve their lifestyle and stay healthy.

However we look at the evidence, it leads to the same conclusion. It is indisputable that Canada will be "greyer" in the future than it is now but that reality is neither a catastrophe waiting to happen nor an issue that simply can be ignored. The baby boomers of today will be healthier in old age than their parents were, with fewer chronic health conditions, and fewer health problems caused by smoking and other lifestyle factors. Even with this, however, the demand for particular kinds of services will increase. For example, with an aging population there will likely be an increase in the number of people who require joint replacement or suffer

from Alzheimer's disease and other types of dementia. Provincial and territorial health care systems have to be ready to respond. The process of adjusting health programs and financing should begin to address the impact of aging, and in particular, the increase in demand for services linked to a decrease in independence as people age (Hogan and Hogan 2002). Because it may be impossible to accurately forecast the health needs of the population too far in advance, however, flexible approaches need to be taken to avoid the trap of investing in facilities and programs that may or may not be needed as Canada's population ages. With foresight and appropriate planning, the health care system can adapt in a timely manner to the new reality of an older population.

Needs and Sustainability

The second key dimension of assessing sustainability is needs, namely, does the health care system adequately meet Canadians' needs. The answer is a qualified yes. Canada's health outcomes compare favourably with other countries and evidence suggests that we are doing a good job of addressing factors that affect the overall health of Canadians. There are, however, areas where there is room for improvement. And there are serious disparities in both access to health care and health outcomes in some parts of Canada. Clearly, more needs to be done to reduce these disparities and also to address a number of factors that affect Canadians' health such as tobacco use, obesity and inactivity. These factors are addressed specifically in Chapter 5 of this report. The other conclusion is that aging is not the ominous threat to future sustainability of our system that some would suggest. Aging will challenge and add costs to our health care system, but those costs can be managed, particularly if we begin to prepare and make adjustments to anticipate the impact of an aging population.

Resources in the System: The Case of Funding

As was noted at the outset of this chapter, the third major component of the definition of sustainability relates to the availability of necessary resources. The health care system needs a variety of resources in order to deliver services and meet the health care needs of the population. That includes not only financial resources but also human and physical resources such as equipment, facilities and technology. Chapter 3 deals with the information resources that are needed to allow providers, governments and citizens to make informed decisions about the system generally and about their own personal care. Chapter 4 deals with the supply, distribution and changing role of health care providers. Chapter 6 deals with the availability and accessibility of equipment and facilities. All of these are essential for an efficient and effective health care system.

However, the primary focus of much of the debate about sustainability has been about money. Questions about the increasing costs of health care, who pays for what aspects of the health care system, and whether we will be able to afford the health care system in the future have played a significant part in the debates about medicare's sustainability. The debate has centered on whether there is too little public money in the system, whether there should be different ways of raising those public funds and whether the system as we know it is "affordable"

any longer. Because other chapters do not deal with these issues in detail, the remainder of this chapter addresses the fiscal questions directly, beginning with how Canada's funding for health care compares with other countries, whether other options for funding should be considered, and the relative shares paid by different governments.

Canada's Reliance on Taxes

Canadians pay, directly or indirectly, for every aspect of our health care system through a combination of taxes, payments to government, private insurance premiums, and direct out-of-pocket fees of varying types and amounts. Some have suggested that Canada relies too heavily on taxation to support its health care system.

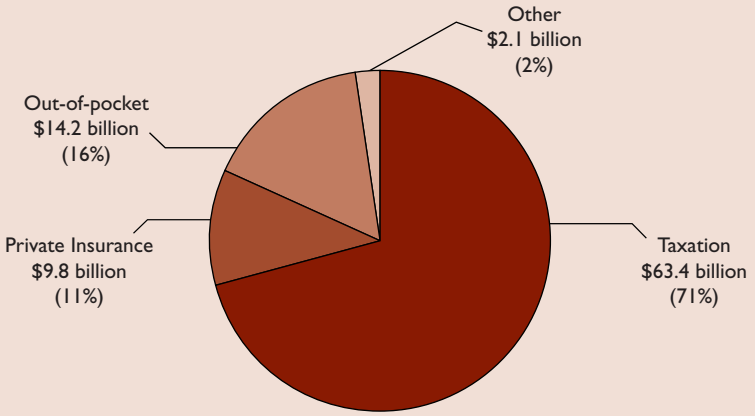
As Figure 1.17 illustrates, 71% of the total funding for Canada's health care comes from taxation. In countries such as Germany, Japan, France and the Netherlands, the majority of funding for health care comes from social insurance premiums in the form of employment payroll taxes. In most developed countries (other than those that rely heavily on social insurance), between 70 and 80% of total health care is funded through the taxation system (Mossialos et al. 2002). Based on the comparisons in Figure 1.18, it is hard to conclude that Canada depends too heavily on taxes to support health care.

Use of Private Insurance and Out-of-pocket Payments

One area where Canada differs from most OECD countries is in co-payments and user fees. While Canada relies almost entirely on taxes to fund hospital and physician services, co-payments and user fees for these services are common in most OECD countries. At the same time, Canada relies more heavily on private insurance and out-of-pocket payments for health care services that are not covered by the *Canada Health Act*.

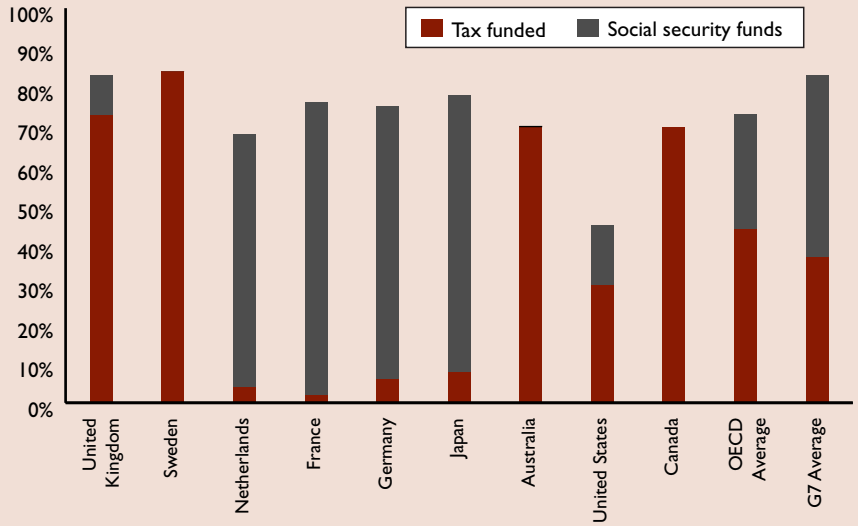
Table 1.2 shows the percentage of costs for non-CHA health services that are paid for privately, either through private insurance or direct payments by individuals. Dental services, for

Figure 1.17 Total Health Expenditures by Source of Finance, 1999



Note: 1999 is used here rather than forecasted data for 2000 or 2001. The "other" component of private sector financing includes such items as non-patient revenue to hospitals including ancillary operations, donations, and investment income.
Source: CIHI 2001e.

Figure 1.18 Public Share of Total Health Expenditures: as Tax Funded and Social Security Funds, 1998



Note: 1998 is the most recent date for which comparable figures are available.
Source: WHO 2001.

Table 1.2
Private Sector Health Expenditures, by Source of Finance and Use of Funds, Canada, 1999

	Private Sector			Public Sector	Private Sector as Percent of Total Goods and Services
	Households (Out-of-pocket)	Private Insurance	Total		
	($000,000)			($000,000)	
Professional Services:					
Dental care	$2,870	$3,508	$6,378	$397	94
Vision care	$1,701	$428	$2,129	$218	91
Other services	$717	$482	$1,199	$546	69
Health Care Goods:					
Prescribed drugs	$2,302	$3,387	$5,689	$4,418	56
Over-the-counter drugs	$1,641	..	$1,641	..	100
Personal health supplies	$1,575	..	$1,575	..	100
Other health care goods	$178	$50	$228	$435	34
Total	$10,984	$7,855	$18,839	$6,014	76

Note: "Other services" include expenditures for chiropractors, massage therapists, orthoptists, osteopaths, physiotherapists, podiatrists, psychologists, private duty nurses and naturopaths. "Personal health supplies" include items used primarily to promote or maintain health (e.g., oral hygiene products, diagnostic items such as diabetic test strips, and medical items such as incontinence products). "Other health care goods" include hearing aids and other medical appliances.
Source: CIHI 2001e.

example, are almost entirely funded (94%) through private insurance and direct fees in Canada but are often part of public coverage in many Western European countries.

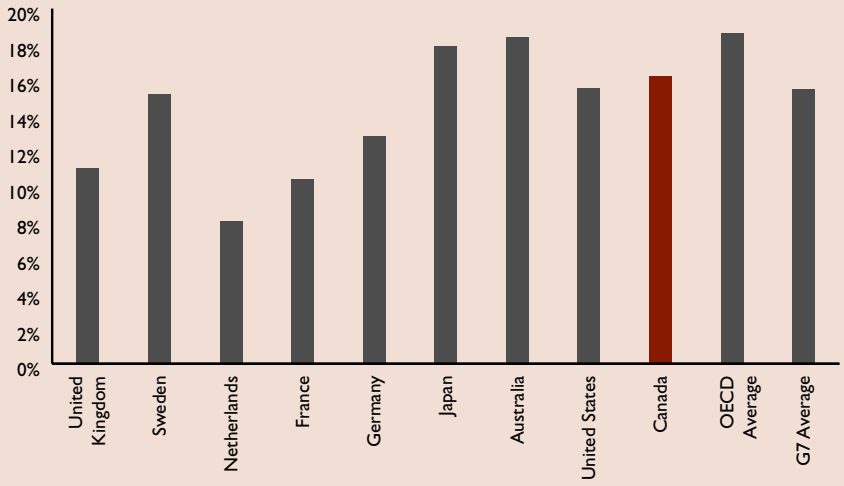
In comparison with selected countries, only Japan and Australia have higher levels of out-of-pocket expenditures than Canada while in the United Kingdom, Sweden, the Netherlands, Germany, and France all have substantially lower levels of out-of-pocket payments (see Figure 1.19). This is because the fees charged in those countries are low and represent a relatively small proportion of the real cost of the services provided. Canadians, however, pay relatively high co-payments and deductibles for prescription drugs and health services outside the CHA and this results in Canada having a higher percentage of out-of-pocket payments than other countries.

Even though the co-payments and deductibles are high, the percentage of out-of-pocket payments in Canada accounts for a relatively small percentage of the total costs of health care services and is lower than the OECD average. Canada, like most of the wealthier OECD countries including the United States, relies primarily on funding provided through governments or through insurers. In high-income countries, what we call "third-party" payments (i.e., payments made by governments or insurers) make up between 80 and 90% of health expenditures (OECD 2002b). In less wealthy OECD countries, however, there tends to be a much higher reliance on out-of-pocket payments.

The Balance between Public and Private Funding of Health Care

There is some debate in Canada about the appropriate balance between public and private funding for health care. Recently, a number of Canadian providers, scholars and journalists argued in favour of a greater private role in funding Canadian health care on the assumption that Canadian health care spending is overly weighted to the public side (Gratzer 2002). However,

Figure 1.19 Share of Total Health Expenditures Paid "Out-of-pocket," among OECD Countries, 1998



Note: All data obtained from OECD except Sweden. Sweden's out-of-pocket expenditure is based on data obtained from the European Observatory's Health Systems in Transition profile for Sweden (2001). The Observatory remarks that private insurance expenditures in Sweden comprise roughly 1% of total health expenditures. Using OECD figures for total and private health expenditures for Sweden, the out-of-pocket figure represents the residual amount devoted to private health expenditures after the private insurance component has been subtracted. This figure was then divided by the total health expenditure. The figure is approximately 15.2%. 1998 is the most recent year for which comparable data are available. Figures for the United Kingdom are from 1996.

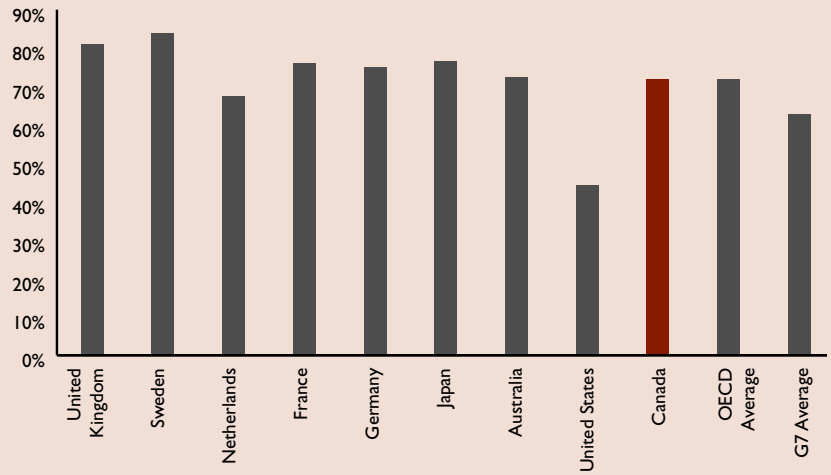
Source: OECD 2002b; Hjortsberg and Ghatneker 2001.

a comparison with other industrialized countries shows that Canada is hardly an exception in terms of the public share of total health expenditures. The United Kingdom, Sweden, Germany, France, Japan and Australia all have larger public health care sectors than Canada, while the Netherlands' public share is slightly lower than Canada's (see Figure 1.20). What is truly noteworthy is the extent to which these countries' public health care expenditures resemble each other.

While most wealthy countries rely heavily on public funding for health care, private insurance plays a significant role in funding health care in the United States. Private insurance in the United States is supported by tax breaks known as "tax expenditure subsidies." These subsidies exist, but to a much lesser extent, in all the comparison countries. Since these subsidies are not generally included when public health care expenditures are tallied, they are difficult to trace and are therefore referred to as "covert" expenditures (Mossialos and Dixon 2002). In fact, tax subsidies play an enormous role in providing health care coverage in the United States. When these tax breaks are taken into account, the public share of health care spending in the United States increases to nearly 60% of its total health care spending (Woolhandler and Himmelstein 2002). This changes the common perception that the United States has a predominantly private system of health care.

Even without including tax subsidies, the extraordinarily high level of total health care spending in the United States translates into far more spending per capita than in Canada and the other OECD countries. This has been described as tantamount to paying for national health insurance and, in return, getting a fragmented system with significant gaps in coverage – the worst of both worlds. While the United States' "health care system is usually portrayed as largely private," a more apt description is "[p]ublic money, private control" (Woolhandler and Himmelstein 2002, 22). Indeed, the larger the public share of health care financing beyond tax expenditure subsidies, the more total health expenditures are capable of being controlled. In contrast, the larger the private share of health care financing, the more difficult it is to control health care expenditures (Majnoni d'Intignano 2001).

Figure 1.20 Share of Total Health Expenditures Paid by Public Sector, 2000



Note: Figures for Australia, Germany and Sweden are for 1998.
Source: OECD 2002b.

Alternative Funding Sources

In recent years, a number of suggestions have been made that Canada should consider alternative ways of paying for health care services. These proposals may be a reaction to the fact that people see costs increasing, are worried about sustainability, and question whether we should change the current funding system to look for additional sources of revenue. Undeniably, each of these proposals has some potential to raise additional money to fund the health care system. But some pose problems in terms of the impact they would have on access and equity. A number of the most common proposals are critically examined below.

User Fees and Out-of-pocket Co-payments

User fees are definitely a "hot button" issue for many Canadians. While many are opposed to user fees because they discourage poorer people from accessing health care services, others see user fees as a necessary way of either raising additional funds for health care or curbing abuse of the health care system. Interestingly, during the Citizens' Dialogue sessions held by the Commission, the interest in user fees was not aimed at raising more revenue for the system but at curbing what some participants felt was abuse and unnecessary use of the system (Commission 2002a).

There is overwhelming evidence that direct charges such as user fees put the heaviest burden on the poor and impede their access to necessary health care. This is the case even when low-income exemptions are in place. The result may be higher costs in the long run because people delay treatment until their condition gets worse. In addition, user fees and co-payments also involve significant administrative costs that directly reduce the modest amount of revenue generated from the fees (Evans 2002a; Evans et al. 1993; Barer et al. 1993, 1979; CES 2001).

One of the key features of the *Canada Health Act* was its effective ban on user fees for hospital and physician services. Given what we know about the impact of even relatively low user fees, the Commission feels that this was the right decision then and remains the right decision today.

Medical Savings Accounts

Perhaps no recent suggestion for raising additional revenue has attracted as much attention as medical savings accounts, in part because they seem to address some of the criticisms of user fees. Medical savings accounts (MSAs) can be designed in a number of different ways but the fundamental concept is that individuals are allotted a yearly health care allowance and they can use it to "purchase" health care services (Gratzer 2002, 1999; Migué 2002; Ramsay 2002). If they have funds left in their MSA allowance at the end of the year, depending on how the plan is designed, they may be able to keep the funds or save them for future years when their health care costs may be higher.

MSAs are intended to provide patients with more control and to inject market forces into the organization and delivery of health care services. They provide patients with an incentive to "shop" for the best services and best prices, and to avoid unnecessary treatments, particularly if they get to keep any surplus in their account at the end of the year. If the costs of health care services people use in a year are higher than their yearly allowance, they would be required to pay all or a portion of the additional costs, depending on how the plan was designed. Most MSA

proposals discussed in Canada involve a so-called "corridor" where people pay some of the cost of health care expenses above their annual allowance up to a certain point before catastrophic coverage funded entirely by government would cover any remaining costs (Mazankowski 2001).

Because medical savings account approaches are relatively new, we know very little about their effects and the literature to date is contradictory. MSAs have been implemented on a small scale in the United States, on an experimental basis in several cities in China, in South Africa where they constitute half of the private for-profit health insurance market, and on a nationwide basis in Singapore. It is difficult, however, to compare these experiences to the Canadian situation. With the exception of China, these countries have predominantly private financing and private delivery of health care services. This means people in those countries may have a much greater opportunity to "shop around" for health care services. Singapore's experience shows that hospitals tend not to compete on the basis of price for necessary services, but aggressively market expensive add-ons, some of which are of questionable value.

The limited evidence available suggests that medical savings accounts have a number of shortcomings that have been understated or ignored by their proponents (Maynard and Dixon 2002; Shortt 2002; Hurley 2000, 2002; Barr 2001). Overall, MSAs are based on the assumption that the use of necessary health care services is highly discretionary, when this is almost invariably not the case.

MSAs are unlikely to effectively control overall spending on health care (Forget et al. 2002). Most health care costs are incurred by a small proportion of people who have very high health care needs and they will continue to spend a lot regardless of whether or not they have an MSA. Under some designs, costs could actually increase because governments would not only provide the initial allowance but also continue to pay for catastrophic insurance to protect people against very high costs. If people were allowed to keep the money left in their MSA at the end of the year, this money would be lost to the health care system and would have to be made up through other means.

MSAs may compromise equity in access to health care services. If individuals are required to pay once they have used all of their MSA allowance, it could cause hardships for people with lower incomes or higher health care needs due to chronic or life-threatening conditions. This is precisely the reason why Canada's medicare system was introduced – to avoid a situation where wealthy people could get access to all the health care services they needed and poor people could not.

Tax-based Co-payments, Tax Credits and Deductibles

A number of recent articles have focused on the use of the tax system as a way of increasing private payment in the health care system (Aba et al. 2002; Aba and Mintz 2002; Reuber and Poschmann 2002). The simplest way of doing this would be to include publicly provided health care services as a taxable benefit on individuals' annual income tax returns (Kent 2000). People would get something like a T4-H showing the cost of the health services they received in a year. This amount would be added to their taxable income and they would pay additional taxes to cover a portion of the cost of the health services they received.

On the positive side, this approach would raise additional revenues. People would know the costs of the services they received, and any additional taxes would be based on their ability to pay. On the other hand, the approach could potentially bankrupt people who had chronic health

conditions or who suffered a catastrophic illness or injury. To address this concern, the amount of the co-payment or additional taxes a person paid could be capped at a certain percentage of his or her income and very low-income people could be exempt (Aba and Mintz 2002).

Even with these conditions, there are concerns with this approach. Fundamentally, it means that if people are sick or injured, they will be taxed more and pay more for health care. This is counter to the basic premise in Canada's health care system that access should be determined only by need and not by ability to pay. As in the case of MSAs or user fees, it may result in people not using needed health care services, a phenomenon that has been seen in a number of European systems (CES 2001). It also raises the question of whether middle and higher income earners, who currently pay the bulk of the costs of a universal health care system, will eventually become dissatisfied when they also have to pay even more at tax time based on their use of the health care system.

Public-Private Partnerships

While different options like user fees, taxable benefits or medical savings accounts are designed to provide more private payments for health services, other approaches such as public-private partnerships (P3s) are being considered as a way of supporting capital projects. P3s involve a number of different options including long-term outsourcing contracts, joint ventures, strategic partnerships, or private financing models. In the United Kingdom, under private financing initiatives (PFI), private sector firms are awarded long-term contracts to design, build, finance and operate hospitals.

While P3s may be a useful means of bringing the innovation of the private sector to bear, they are not without their critics. In many cases, governments find P3s attractive because the private sector company assumes the heavy capital costs of a project and governments are only required to pay "rental fees" over the longer term. Unfortunately, while P3s may cost governments and taxpayers less in the short term, these arrangements often cost more in the longer term (Sussex 2001). The rental costs charged to governments must be high enough to allow the private sector partner to recoup its costs and make a profit for its shareholders. The cost of borrowing is often higher for the private sector than for governments. And P3s often have higher administration costs. Critics also suggest that the quality of private for-profit run facilities can be lower than publicly run facilities and that, in some cases, these arrangements have resulted in beds being closed and staff being reduced (Pollack et al. 2001). This is not to say that P3s are without a place (for example in the case of health information systems), but they are no panacea and their use and value need to be carefully considered.

Should Canada Consider Alternative Funding Schemes?

Each of the alternative options outlined above would raise more money for the health care system or free up money for governments to spend on other priorities such as lowering taxes or paying down debt. However, many of the options also compromise the principles and values on which Canadians built the health care system. Some of the options would simply shift the burden of health expenditures from the public purse to individuals and would ultimately undermine the equity that currently exists in both funding and access to needed health care services.

Through the Commission's consultations, Canadians indicated that they were willing to pay more in taxes to sustain the health care system, but only if changes are made to improve the current system. Consistent with this view, some have suggested a dedicated tax for health care. This could take a number of different forms. At one end of the spectrum is what public finance experts call a hypothecated tax – a single-purpose tax that is formally separated from all other revenue streams in a special fund similar to the Canada or the Quebec Pension Plans. At the other end of the spectrum, a health tax or premium could be established, but the money flows into the general revenue funds of governments. Both may satisfy the public's desire to ensure some degree of transparency and accountability but they provide less than perfect solutions in other respects.

In the case of the hypothecated tax, the amount collected could only be used for health care purposes, irrespective of shifting needs. This might be fine in normal years, but if any government needed to suddenly shift resources from health care to another priority in the face of an unexpected crisis, it would be prevented from doing so. In contrast to health care, pensions are a relatively small part of government expenditures so the impact of having dedicated taxes for pensions is not as great.

In the case of a notionally earmarked tax, given the sheer size of the health care system, it would be almost impossible to raise the necessary funding for health care through a single, dedicated tax. In fact, a number of provinces that once had sales taxes that were, in principle, earmarked for health and education have since dropped this type of labeling. At the same time, that is not to say that earmarked taxes could not be used to fund a portion of the health care bill (Senate 2002c). During the Commission's Citizens' Dialogue, the idea of a dedicated tax was strongly supported by many Canadians because it would provide assurance that additional taxes paid by Canadians would, in fact, go to health care rather than other programs and services. It also is a way of improving transparency and accountability for the additional funds raised from taxpayers. Given this, it would be useful for governments to consider notionally earmarked taxes for health in the future.

Based on evidence both in Canada and internationally, progressive taxation continues to be the most effective way to fund health care in Canada. From what the Commission heard from Canadians through the Citizens' Dialogue and other consultations, the large majority of Canadians do not want to see any change in the single-payer insurance principle for core hospital and physician services. There also continues to be a strong consensus among Canadians that "ability to pay" should not be the predominant factor in how we fund key aspects of our health care system. Canadians want necessary hospital and physician services to be fully funded through our taxes. This may be because our tax-funded, universal health care system provides a kind of "double solidarity." It provides equity of funding between the "haves" and the "have-nots" in our society and it also provides equity between the healthy and the sick.

Future Sustainability

In many respects, the critical issue is not so much whether Canada's health care system is financially sustainable today but whether it will be sustainable in the future, given current trends and increasing costs. Making projections about future costs and financial sustainability may sound easy, but it is more than a simple accounting calculation. Forecasts of public revenues

have to take into account the potential growth of the economy combined with interest payments on debt or long-term financial commitments as a result of past decisions. Forecasts depend on how various cost factors are assessed including the evolving needs and expectations of people served by particular programs. The projections also need to consider competing demands for spending on other programs or on tax reductions. In many cases, political assessments and value judgements of the relative merits of spending more in one area and less in another are very difficult to factor into projections for future spending.

That being said, it is important to look at the issue of future financial sustainability by examining Canada's spending on health care compared to other countries as well as the trends within Canada, both in terms of provincial-territorial funding and federal funding. It also is important to consider the role of the health care sector in Canada's economy, not just as a driver of costs but also as a significant contributor to economic growth.

Comparisons with Other Countries

If we look back to 1970, total and public health care costs have increased in Canada as a percentage of Gross Domestic Product (GDP). At the time medicare was introduced, Canada spent about 7% of GDP on total health care costs. Thirty years later, Canadian health care costs take up about 9.1% of our GDP. On the public side, Canada was spending approximately 5% of GDP on health in 1970 and by 2000 this had grown to 6.5% (see Appendix E).

In terms of current comparisons with specific OECD and G7 countries, Canada's spending on health care on both a per capita basis and as a percentage of GDP is slightly higher than the OECD average but very comparable to the G7 average (see Figures 1.21 to 1.24).

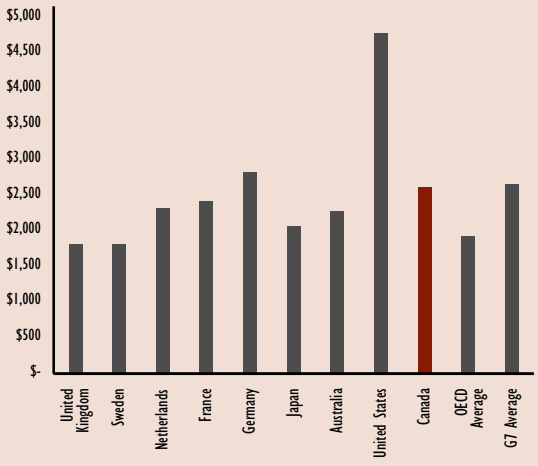
Looking at comparisons with the United States (see Figures 1.25 and 1.26), Canadian spending closely tracked American spending until the early 1970s when the addition of physicians' services to single-payer insurance plans broke the pattern. Since that time, the long-term trend in health care costs in Canada has been more in line with trends in European countries while the United States has moved further away from the OECD average.

Canada's proximity to the United States is both an opportunity and a challenge. The exposure of Canadian scientists, researchers, patients and health care providers to American medical and scientific innovations, American research organizations and high-end health care facilities (such as the Mayo Clinic) raises expectations of what can be done in Canada. While all OECD countries face increasing health care costs, Canada's pressures will always be more intense because of our relationship with, and proximity to, the United States.

Health Care Spending Trends in Canada

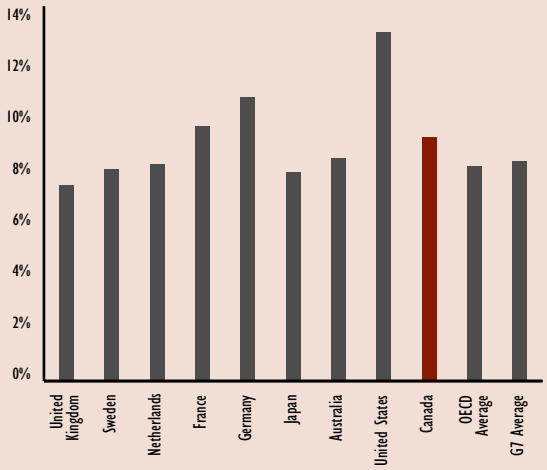
Like all other OECD countries, Canada's spending on health care is increasing. But to address the question of sustainability, it is important to break down the various components of the health care system to see where the costs are increasing the most. The cost of hospital and physician services has grown at a much slower rate than other health care services and programs covered by the provinces and territories (see Figures 1.27 and 1.28). Both private and provincial government per capita spending on non-CHA services has grown considerably in recent years while per capita spending on hospital and physician services is currently no higher than it was in 1991 when it reached a peak of $1,265 per person. On a national basis, hospital and physician

Figure 1.21
Per Capita Total Health Expenditures (US$ PPP), 2000



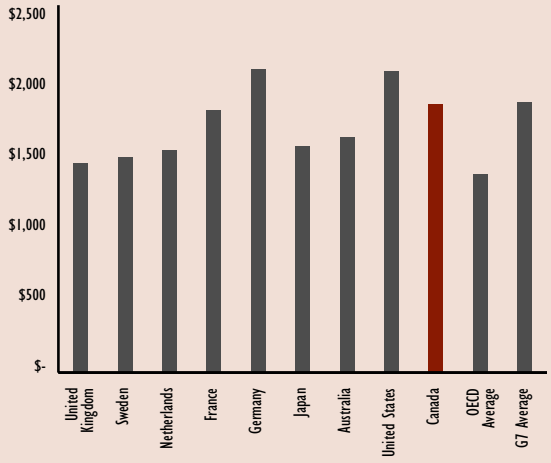
Source: OECD 2002b.

Figure 1.22
Total Health Expenditures as a Percentage of GDP, 2000



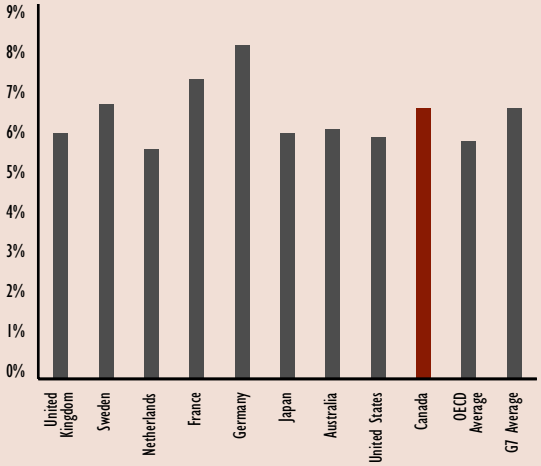
Source: OECD 2002b.

Figure 1.23
Per Capita Public Health Expenditures (US$ PPP), 2000



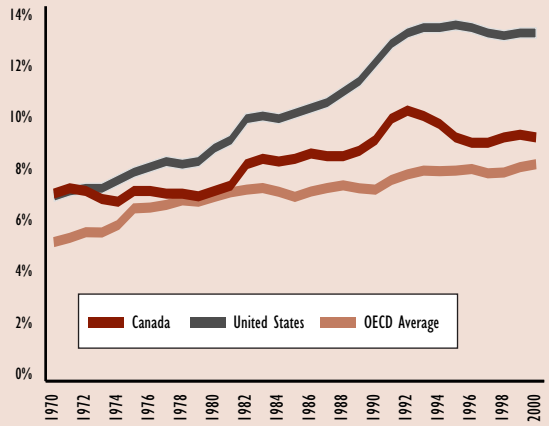
Source: OECD 2002b.

Figure 1.24
Public Health Expenditures as a Percentage of GDP, 2000



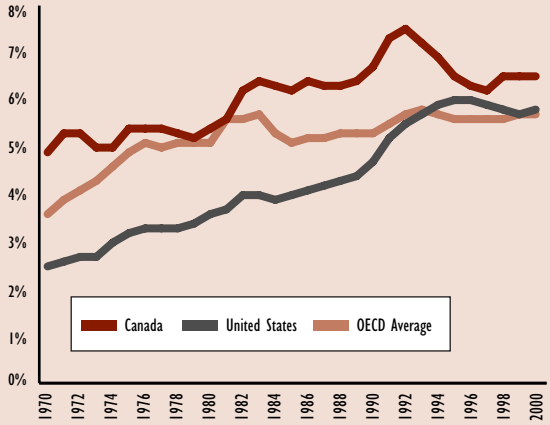
Source: OECD 2002b.

Figure 1.25
Total Health Expenditures as a Percentage of GDP, Canada, United States and OECD, 1970 to 2000



Source: OECD 2002b.

Figure 1.26
Public Expenditures as a Percentage of GDP, Canada, United States and OECD, 1970 to 2000



Source: OECD 2002b.

services now constitute about 63% of total provincial-territorial health care spending compared to 77% in 1975 (see figures 1.29 and 1.30). Thus the overall increase in provincial per capita health care spending – which rose 15.6% between 1991 and 2001 – reflects the fact that the cost of non-CHA services is rising faster than CHA services (CIHI 2002f) and is illustrative of the way in which the use of health care services is changing.

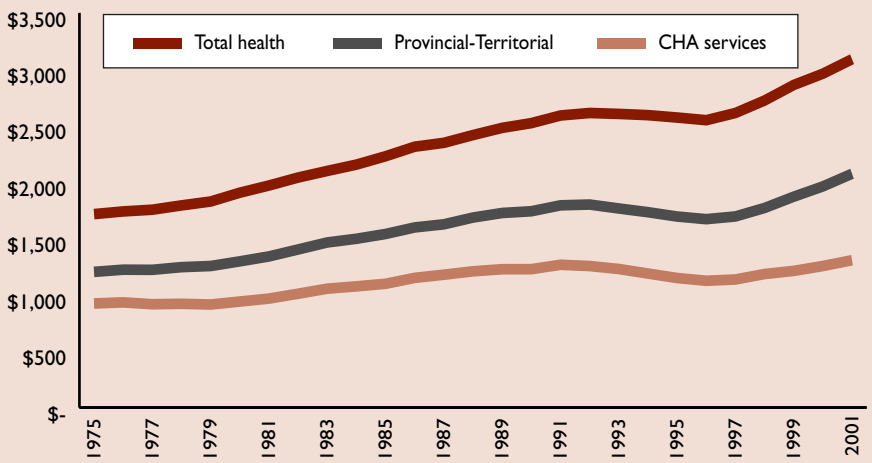
Prescription drugs provide the most graphic example of the shift in the various components of spending within the health care budget. In 1975, prescription drug costs made up a relatively stable share of about 6% of health care spending. But by the mid-1980s, that share had begun a steady climb and, by 2001, the share had doubled to 12% (CIHI 2002f). The rapid escalation of drug costs has added over half a percentage point to the share of Canada's national income (GDP) that is spent on health care.

There also have been significant increases in other components of provincial and territorial spending on health care since 1975, including public spending on:

- Home care services, which has increased from $26 million in 1975 to approximately $2.7 billion in 2001 (CIHI 2001d; HC 2002d);
- Other institutions such as nursing homes, which has grown from $800 million in 1975 to $6.8 billion in 2001 (CIHI 2002f); and
- Non-physician professional health care services, which has increased from $120 million in 1975 to $800 million by 2001.

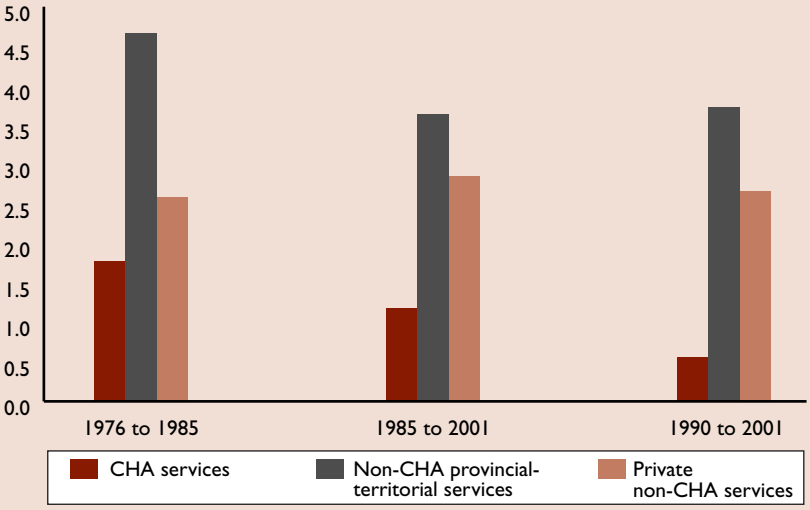
This does not mean, therefore, that we can simply target growing costs in key areas – such as prescription drugs and home care, as the culprits in increasing health care costs. Expanding use of prescription drugs and home care has reduced the reliance on more expensive hospital care and are part of changing trends in how health care services are delivered. These changing trends

Figure 1.27
Per Capita Total, Provincial-Territorial and CHA Health Expenditures (Constant 1997 Dollars), 1975 to 2001



Note: Figures for 2000 and 2001 are CIHI forecasts.
Source: CIHI 2001e.

Figure 1.28
Average Annual Rate of Change in per Capita Expenditures on CHA and Non-CHA Services (Constant 1997 Dollars), 1976 to 2001



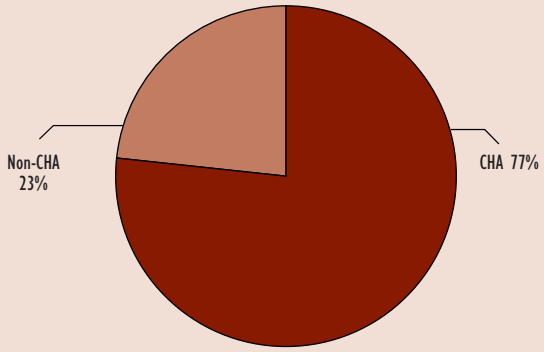
Note: Figures for 2000 and 2001 are CIHI forecasts.
Source: CIHI 2001e.

and the connections between various components of the health care system need to be considered as part of any analysis of the future costs of the system.

Federal and Provincial-Territorial Shares of Health Care Spending

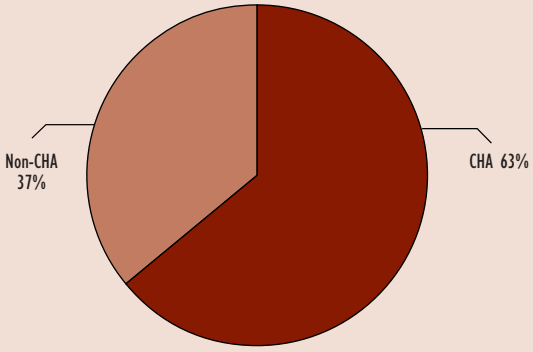
As noted earlier in this chapter, federal, provincial and territorial governments share responsibility for funding health care. This partnership has changed over time as has the benchmark for determining the appropriate contribution of each order of government. In the last

Figure 1.29
Distribution of Provincial-Territorial Expenditures between CHA and Non-CHA Services, 1975



Source: CIHI 2001e.

Figure 1.30
Distribution of Provincial-Territorial Expenditures between CHA and Non-CHA Services, 2001 (Forecast)



Source: CIHI 2001e.

decade or more, defining that balance in terms of funding has been the subject of considerable acrimony and debate. Provinces accuse the federal government of no longer shouldering its traditional share of the rising costs of health care while the federal government counters by saying provinces have chosen to finance tax cuts over health care.

Since medicare began, there have been three major regimes through which the federal government has provided funds to the provinces for health care. The first federal transfer regime for health began in 1957 with the *Hospital Insurance and Diagnostic Services Act*. The formula for federal funding involved matching the costs of providing hospital insurance in the provinces on a per capita basis (half of which was based on their individual costs and the other half on the national average). A similar cost-sharing arrangement was introduced (but calculated solely on the basis of the per capita share of the national average) in 1966 with the passage of the *Medical Care Act* that extended federal contributions to physician services in the provinces. These funding arrangements were based on 50/50 cost sharing for eligible provincial hospital and physician services, not all provincial health expenditures. The federal share in the final year of this cost-sharing regime for total physician and hospital services was close to 47%, which can easily be assumed to be close to 50% of eligible services.

These early pieces of legislation provided the dedicated funding for hospital and physician services that were necessary to put medicare in place. Under the original design, however, the financial cost of medical and hospital insurance posed significant problems for the federal, provincial and territorial governments. For the federal government, a primary concern was that relevant spending decisions were being made in the provinces and the federal government could not control the level of transfers to the provinces under shared-cost arrangements.

Provincial and territorial governments also sought an increased degree of autonomy with regard to the disbursement of federal funds. Funding was confined to hospital and physician services at a time when provincial health systems were expanding beyond this narrow set of

services, and health services that were not eligible for federal funding under the original cost-sharing arrangements were taking up an increasing share of provincial and territorial health care spending.

To address these concerns, a new block transfer mechanism for funding both health and post-secondary education was negotiated and introduced in 1977. This second transfer regime, known as Established Programs Financing (EPF), effectively broke the link between actual expenditures for hospital and physician services made by provinces and territories and the level of federal transfers for health. From this point on, increases in federal funding were based on a formula in which transfers increased in relation to growth in the economy (measured as per capita Gross National Product) rather than based on actual provincial and territorial expenditures for hospital and physician services. The importance of this change was that after EPF, provincial expenditures on health that exceeded the rate of economic growth and population change were borne exclusively by provincial governments, thus providing the federal government with the predictability it sought in terms of its own expenditures. At the same time, EPF provided provinces with increased flexibility because federal funds were no longer exclusively designed to support hospital and physician services. In addition, under the new arrangements, the way in which transfers were delivered was changed. In the first year of the agreement, provinces would receive a cash transfer equal to one-half of the total value and the remainder would come in the form of tax points: the federal government reduced its percentage of personal and corporate income taxes to give room to the provinces to increase their own taxes. After 1977, the cash portion would increase according to the escalator formula, while the tax points would increase in accordance with growth in the provincial economy as reflected in increased tax revenues collected. Since a tax point yields less revenue in low-income than in high-income provinces, the value of the tax points were to be equalized to the national average.

These arrangements served the short-term needs of both orders of government, but there were significant and unforeseen consequences to the new formula. Some provinces used this new flexibility to allow physicians and hospitals to extra-bill or charge user fees to patients as a means of offsetting increased health care costs and demands for increases in professional fees paid to doctors. But what this did was shift a larger portion of those increasing costs to those who most needed health care services – the poor and the sick. In response, Justice Emmett Hall (1980) conducted a review of health services in Canada and reported to then federal Minister of Health, Monique Bégin. The result was the creation of the *Canada Health Act* introduced by Bégin in 1984. It enumerated the five principles we know today and also allowed the federal government to withhold a portion of cash transfers to provinces that allowed extra-billing or user fees.

As Table 1.3 indicates, the CHA was, in the years immediately following its passage, an effective means for the federal government to discourage the use of extra-billing or user fees. By initially reducing transfers to those provinces that allowed extra-billing but then restoring the funding once provinces eliminated such charges, the federal government succeeded in rolling back such practices. However, the federal government has proven to be reluctant to impose penalties related to other provincial practices that could be seen to be in violation of the five principles of the Act, but which did not involve user fees or extra-billing. Thus, while the CHA was very successful in changing provincial behaviour in the narrow sense of eliminating user fees and extra-billing, it was less successful as a general guarantor of medicare as a whole.

Table 1.3
Reductions in Federal Transfers Under the *Canada Health Act* ($Thousands)

	1984/85 to 1989/90	1990/91 to 1994/95	1995/96 to 2000/01
Extra-billing	$135,589	$1,982	$43
User fees	$111,143	$0	$6,283
Total	$246,732	$1,982	$6,326

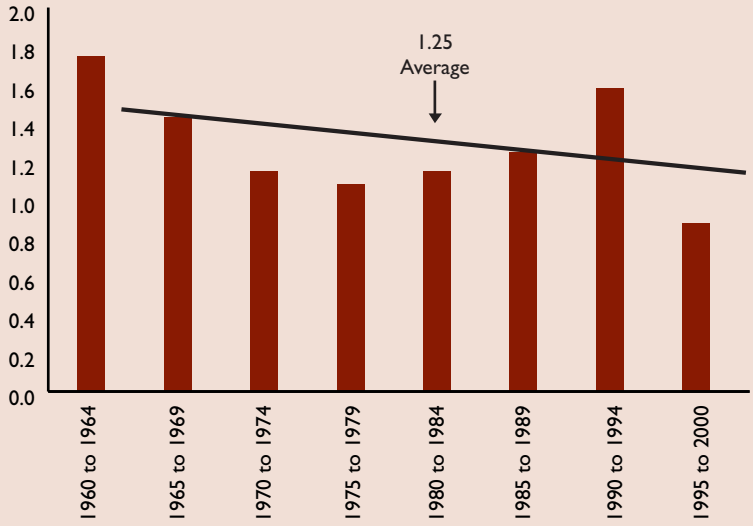
Note: The above table shows only deductions under the *Canada Health Act*. Since 1984/85 to the present of the approximately $255 million deducted $247 million have been refunded to those provinces which subsequently complied with the conditions of the *Canada Health Act* for which the deductions had originally been made.
Source: Health Canada 2001a.

Another consequence of EPF became apparent in 1982 when the federal government unilaterally changed the formula for its contribution. The total EPF transfer was now calculated for each province on the basis of the per capita entitlement in the base year, escalated by nominal GNP and population growth. The cash portion of the transfer was calculated as the difference between the value of the tax points and the total provincial entitlement. In addition, the federal government unilaterally reduced the value of the escalator formula, first in 1986 and again in 1989. In 1991, EPF entitlements were frozen at their 1989/90 levels. At the same time, the notional value of the tax points continued to grow as a proportion of the total entitlement relative to the cash portion. In one estimate, federal cash transfers for health were anticipated to completely disappear for all provinces by 2010 (Smith 1995). By their very nature, tax point transfers are essentially unconditional since there is no mechanism whereby the federal government could withhold transfers in the event a province or territory failed to comply with the conditions attached to federal dollars.

In 1995, the third federal transfer regime was introduced in the form of the Canada Health and Social Transfer (CHST). The CHST has been a contentious program since it was introduced. In addition to health care and post-secondary education that were part of EPF, social assistance and social services were added to the new omnibus CHST transfer. Like EPF before it, only a portion of the CHST is intended for health care and involves a mix of cash and the tax points. The combination of funding three major social programs through a single block transfer, in addition to the complexities of the cash and tax portions of the arrangements, make estimating the value of the federal contribution to health care extremely obscure to even the most informed.

Historically, there has been a powerful and direct relationship between increasing health care spending and the overall growth in the economy, with costs for health care services increasing slightly more than increases in the nation's wealth. This was captured under both the original cost-sharing arrangements. As health expenditures at the provincial and territorial level increased so too did the federal contribution. What the original cost-sharing arrangements lacked, however, was an incentive for cost-containment as the relationship between federal transfers and provincial and territorial expenditures was open-ended. EPF made the correlation between economic growth and health services spending more direct by linking federal transfers to growth in GNP. The escalator under EPF had the effect of restraining the growth of health care expenditures to a level comparable to growth in the economy.

Figure 1.31
Ratio of Annual Rate of Growth in Total per Capita Health Expenditures to Annual Rate of Growth in GDP for Canada, 1960 to 1964, to 1995 to 2000



Note: The average value for elasticity appearing in the figure is based solely on calculations from 1960 through 2000 and projections for 2001 to 2005 are not included. In addition, two anomalous years have been excluded from the calculations. These are 1982 and 1991. In 1982, the elasticity figure is 7.47 and the figures in the preceding and following years are 1.25 and 1.34; in 1991, the figure was 31.53 and in the preceding and following year the rates were 2.55 and 2.73.
Source: CIHI 2002e; Statistics Canada 2002c.

Figure 1.31 shows the historic relationship between rates of growth in per capita health expenditures and that of GDP. Since the 1960s, health expenditures have consistently grown at a higher rate than growth in the economy. The very high ratio of health spending to economic growth in the 1960s reflects the early stages of medicare as the system was being constructed. However, the ratio moderated over time as the system matured. The relationship over the entire period averages out to roughly 1.25, meaning that for every 10% increase in GDP our health services expenditures have increased by 12.5%. This suggests that even the escalator formula for EPF with its direct link to growth in the economy was not sufficient to keep pace with health care costs. This became exacerbated by unilateral federal reductions in the escalator and finally with the freeze on EPF increases.

Under the CHST, there is no mechanism for providing for natural increases in health care spending in the calculation of federal transfers. Increases in CHST transfers are at the discretion of the federal government. Since its inception there have been two increases, one in 1999 and another in September 2000. The absence of an escalator formula for increases in federal contributions to provincial and territorial health expenditures means that there is no link between the growth in either health expenditures or the growth in the economy. This results in provinces making regular demands for increases in the transfer and has contributed to the highly politicized and acrimonious nature of the debate over health care funding in recent years.

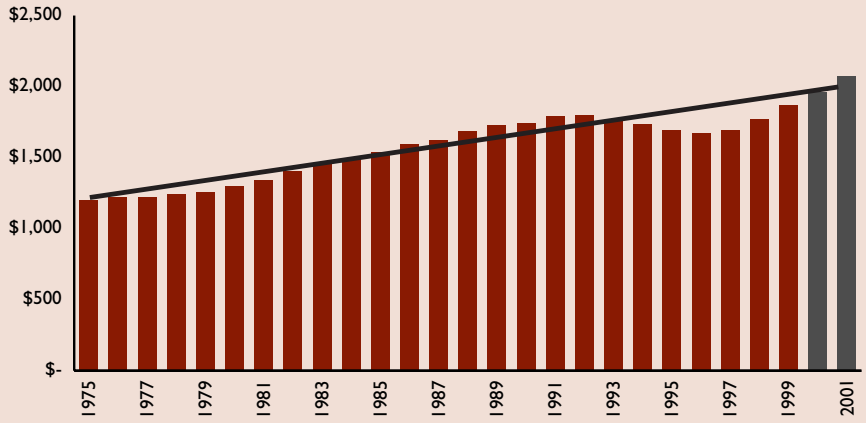
This is the historical context in which the current debate over appropriate levels of funding has taken place. Looking at the impact of these various shifts in funding arrangements over time,

the relative share between the federal and provincial governments has become increasingly obscure. In part, the complexities of the arrangements themselves have largely contributed to this confusion.

Health Care Spending as a Share of Provincial Budgets

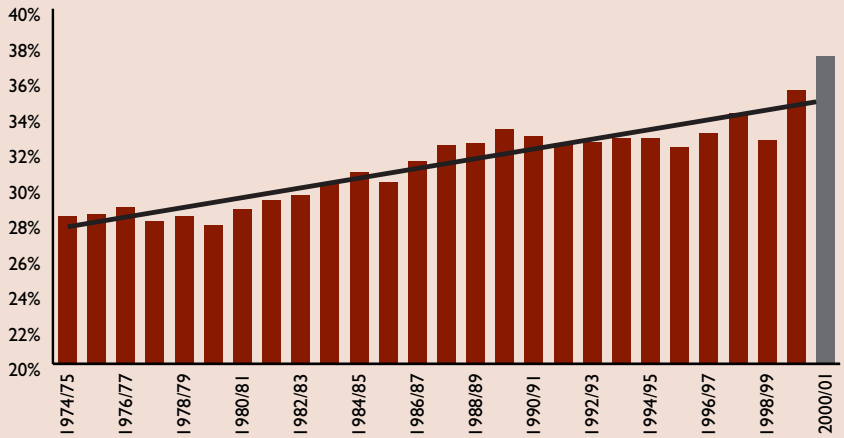
As a result of growing costs, provincial governments have, in recent years, warned both their residents and the federal government that health care spending is "crowding out" other spending and policy priorities such as education, infrastructure, debt reduction and tax cuts. Except for a short period in the early to mid-1990s, real provincial and territorial spending on

Figure 1.32 Provincial-Territorial Government Sector per Capita Health Expenditures (Constant 1997 Dollars), 1975 to 2001



Note: Figures for 2000 and 2001 are forecasts only.
Source: CIHI 2001e.

Figure 1.33 Provincial-Territorial Health Expenditures as a Percentage of Program Spending, 1975 to 2001



Note: Figures for 2000/01 are CIHI forecasts only.
Source: CIHI 2001g.

health care has been climbing (see Figure 1.32). Adjusting for inflation, per capita provincial and territorial spending on health care rose from an average of $1,200 per person in 1975 to almost $2,100 per person in 2001 (CIHI 2001e).

Figure 1.33 illustrates that health care spending is taking up an increasing share of total provincial and territorial spending on programs. In 1999/2000, health spending accounted for 35.4% of provincial and territorial program spending compared to 28% in 1974 to 1978. There are a number of reasons why health care spending is taking up an increasing share of governments' budgets and the reasons vary among provinces and territories. However, three reasons are common to all provinces:

- The impact of cost-cutting in the early 1990s compromised public confidence in the system and created the need to reinvest in recent years (Tuohy 2002);
- The growing cost of prescription drugs, home care and other health care expenses is constantly driving up provincial spending on health care even though hospital and physician care may be growing at a more acceptable rate (Evans 2002b); and
- The cost of recent large increases in health care provider remuneration following years of restraint in the 1990s.

However, not all commentators accept the provinces' arguments that their current expenditure patterns are unsustainable. Boychuk (2002) argues that provincial health expenditures relative to GDP are the same now as a decade ago and that recent increases are a result of unleashing the "pent-up demand" created by the expenditure cuts of the mid-1990s. The system is only unsustainable, he argues, if we accept that:

- Spending will increase even faster than is necessary to deal with an aging population and the increase in the cost of current services; or
- There is a consensus that the tax burden on Canadians is itself unsustainable and must be lowered.

The perception that there is a fiscal crisis in health care is as important as the reality, however, since the perception undermines the public's confidence in the system regardless of whether steps are taken to contain costs.

These issues are important ones for the provinces and territories. Shouldering the lion's share of risk for growing health care costs, they face far greater anxiety about their ability to fund health care in the future. Furthermore, both federal and provincial governments now are politically committed to a policy of phased-in tax reductions. These tax cuts are estimated to be worth $40 billion in total in 2001/02 (Yalnizyan 2002) – one half from the federal government and one half from the provinces. In comparison to these tax cuts, federal health funding increased by $2.8 billion while provincial spending on health care increased by $4.8 billion in the same year (see Appendix E).

Health as a Major Contributor to the Economy

Discussions about health care are most often focused on costs while, in fact, health care is also a major contributor to Canada's economy and economies around the world.

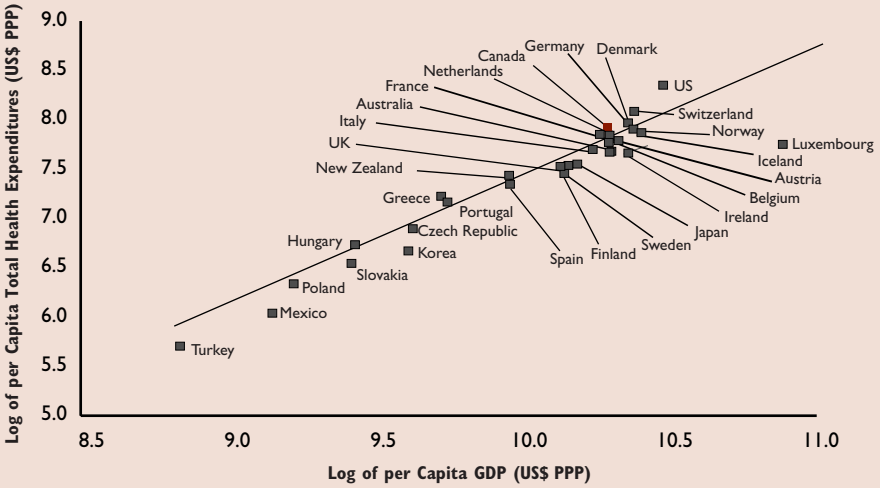
According to American economist William Nordhaus, the "medical revolution over the last century appears to qualify, at least from an economic point of view, for Samuel Johnson's accolade as 'the greatest benefit to mankind'" (2002, 38). This increase in economic value comes from numerous directions including improvements in:

- Basic knowledge from the germ theory of disease at the beginning of the 20th century to the more recent DNA revolution;
- Public health capital and infrastructure;
- Diagnostic tools and processes;
- Logistics in terms of obtaining critical care (e.g., emergency response);
- Treatment technologies and protocols including pharmaceuticals.

In the early 1990s, rising health care costs were seen in many countries as an obstacle to balancing budgets and cutting taxes. This created the view that health care costs were a threat to future national competitiveness. But based on Nordhaus' calculations, it appears that health care spending contributed at least as much to the American economy as spending on all other consumption expenditures combined. Canadian economist Tom Courchene (2001) has made a similar argument about viewing health care expenditures as a dynamic investment in the economy rather than simply as consumption.

Health care investments not only lead to longer and more productive working lives on an individual basis; properly targeted public health care investments can also provide countries with a competitive advantage. According to the Canadian Council of Chief Executives' submission to the Commission (2002, 2), "Canada's business leaders have been strong supporters of Canada's universally accessible public health care system" because it provides a "significant advantage in attracting the people and investment that companies need to stay competitive." Indeed, the "big three" automakers (Ford, General Motors and Daimler-Chrysler) recently signed joint letters with their largest union, the Canadian Autoworkers, expressing support for Canada's publicly funded health care system and noting that it provides an important competitive advantage to the Canadian auto and auto-parts industries relative to their American counterparts. In short, it is

Figure 1.34 Ratio of Total Health Expenditures to Economic Growth among OECD Countries (US$ PPP), 2000



Note: Purchasing Power Parity (US PPP) is a currency conversion that equalizes the purchasing power of different currencies and expresses these in terms of their US dollar value. This means that a given sum of money, when converted into different currencies, will buy the same basket of goods and services in all countries. Thus PPPs are the rates of currency conversion that eliminate differences in price levels between countries.

Source: OECD 2002b.

more economical for the employers to pay taxes in support of medicare than to be forced to buy private health insurance for their workers.

It is also true that health care is what economists call a superior good in that, as individuals, we tend to spend progressively more on health care than other goods and services as our incomes go up. Based on a series of international studies summarized by Gerdtham and Jönsson (2000), higher income is the single most important factor determining higher levels of health spending in all countries (see Figure 1.34). Indeed, the more economically developed the country, the more pronounced the effect (Scheiber and Maeda 1997). According to Reinhardt et al. (2002, 171), per capita GDP is without doubt "the most powerful explanatory variable for international differences in health spending."

Resources and Sustainability

What conclusions can we draw about resources and sustainability? Canada's spending on health care is comparable with other OECD countries although we spend considerably less per capita than the United States. All OECD countries are facing increasing health care costs and experience suggests that the wealthier the country, the more it spends on health care. Some suggest that Canada relies too heavily on taxation, and yet, comparisons show that we are not much different from other countries. A look at various alternative ways of funding health care shows that each option raises a number of problems and many would simply shift the burden of funding from governments to individual Canadians. At the same time, there are serious problems in the balance between federal and provincial-territorial funding for health care, and health care is taking up an increasing proportion of provincial budgets. Later chapters of this report address specific ways in which steps can be taken to control rising costs, especially for prescription drugs. But the reality is that health care costs are likely to continue to increase and choices have to be made about how those costs will be managed. Overwhelmingly, Canadians told the Commission that they are prepared to pay more for health care to ensure the system's sustainability, provided the system is prepared to change to meet their needs and expectations.

Sustaining Canada's Health Care System – Looking Ahead

This first chapter has provided a wealth of information that helps address three perspectives on the sustainability of Canada's health care system: the services it provides, its performance in meeting Canadians' health needs, and the availability of sufficient financial resources to fund the system.

Taken together, these three dimensions allow us to draw an overall conclusion about whether or not Canada's health care system is sustainable. The Commission's conclusion is that the system is sustainable, but only if the system changes in some very important and crucial ways. Services need to be reorganized, access needs to be improved, health needs must be met and disparities reduced.

Sustainability relies on achieving the right balance among the services that are provided, the health needs of Canadians, and the resources we are prepared to commit to the system. Finding that balance is up to those who govern the health care system – individual Canadians, communities, health care providers, health authorities and hospital administrators, and governments. The decisions they make together will determine whether or not the system is sustainable in the future. Their decisions should be guided by the values of Canadians who, as noted at the outset of this chapter, want medicare to endure and thrive.

The ultimate purpose of the following chapters of this report is to remodel medicare for the 21st century – to make it sustainable for years to come. It begins in Chapter 2 with a call to Canadians to renew our collective commitment to health care and put new governance mechanisms in place to provide clear leadership on issues of national concern. It also calls on the federal government to increase its share of funding for health care, put stable, sustainable funding in place, and target specific funds to address pressing problems in the system. But the message clearly is that more funding must not go simply to shore up the status quo – it must buy change. The report then moves to some of the essential underpinnings of the health care system – ensuring that we have better information and evidence to guide decisions and that we have both an adequate supply and the right distribution of health care providers. It also includes a clear message that the roles and responsibilities of health care providers need to evolve with changing approaches to health care. The report then turns to some of the most crucial aspects of how the system currently delivers health care services and provides concrete recommendations on improving access, moving ahead with primary health care reform, and beginning the important steps of integrating home care and prescription drugs under the *Canada Health Act*. Finally, the report returns to the issue of governance in making recommendations, first, for a new approach to the delivery of services for Aboriginal peoples in Canada (whose health status continues to be perhaps the system's greatest failure to date) and, second, for a positive and proactive approach to the international governance of health care in a globalized world.

Taken together, these recommendations will allow the system to not only satisfy the health needs of Canadians but, perhaps more importantly, to meet their expectations and restore their confidence in medicare.

Sustaining the Canadian health care system has always been about the choices we make and our understanding of what our responsibilities and entitlements are within the system. So it is there that we must begin – by laying a new foundation for the governance of the system. With that foundation in place, the challenge then is in the hands of governments, and all Canadians, to seize on the opportunities for change, make the right choices, and ensure that Canadians get what they truly want – an excellent health care system that is sustainable not only today but for generations of Canadians to come.

2 Health Care, Citizenship and Federalism

Directions for Change

- ***Establish a new Canadian Health Covenant as a tangible statement of Canadians' values and a guiding force for our publicly funded health care system.***
- ***Create a Health Council of Canada to facilitate collaborative leadership in health.***
- ***Modernize the* Canada Health Act *by expanding coverage and renewing its principles.***
- ***Provide stable, predictable and long-term funding through a new dedicated cash-only transfer for medicare.***
- ***Address immediate issues through targeted funding.***

The Case for Change

All aspects of the Commission's review have pointed to an overriding conclusion that there is no need to abandon the principles or values underpinning Canada's health care system. Medicare has served this country very well. But there have been many changes since the early days and medicare needs to change to meet the new dynamics of Canada's health care system. Canadians understand and support the need for change. They are prepared to change their *ideas* about how the health care system can and should work, but they are not prepared to abandon or compromise their *ideals*, and rightly so.

Sustaining Canada's health care system and ensuring that it remains true to its ideals depends very much on the choices we make. The preceding chapter concluded that medicare is sustainable if the health care system is prepared to change – if services are reorganized to meet changing needs and if financing is adequate, stable and predictable.

As was noted in Chapter 1, achieving the right balance among services, needs and resources in the health care system depends, in large part, on decisions that are made by those who oversee the system, including providers, hospitals, health authorities and, of course, federal, provincial and territorial governments. Throughout the course of the Commission's public consultation process and its dialogue with Canadians, significant frustration was expressed at the inability of those charged with governing the system to handle and resolve their differences in a productive

manner. Different approaches, different priorities and different visions of what the health care system should look like are part and parcel of living in a country as large and as diverse as Canada. In some ways, a certain level of disagreement is always going to be present.

But disagreements can be handled in either a productive or unproductive manner. They can lead to finger pointing and distrust where the goal is to lay blame for a problem rather than resolve it. Alternatively, disagreements can lead to a tradition of compromise and negotiation that results, in the end, in decisions that are in the best interests of Canadians and the health care system itself. In the Commission's view, those charged with the governance of the health care system need to restore a level of mutual respect and trust that has been missing in recent years, especially in the relationship between the federal government and the provincial and territorial governments, and among the various actors in the health care system.

The corrosive and divisive debates must end. If the status quo continues, the result will be the eventual unravelling of Canada's health care system into a disparate set of systems with differing services, differing benefits and differing ways of paying for health care across the country. This is not what Canadians want or expect for their health care system or for their country.

Canadians expect both orders of government to respond to important social needs and priorities, including health care. The role of each order of government in any particular social policy area reflects different understandings of how best to separate or share responsibility for meeting particular social needs. How governments do this reflects not only their formal constitutional roles, but also considerations of efficiency, equity and how best to redistribute resources. An effective federal role in health care can result in efficiency and equity gains as the risks and costs of ill-health are redistributed nationally rather than borne individually or shared only provincially (Banting and Boadway 2002). Notwithstanding, the primary responsibility of provinces for delivering and organizing health services, effective federal government involvement in health care can ensure the existence of relatively similar levels and quality of service across the country.

Historically, the federal government encouraged the adoption of publicly administered single-payer insurance systems in the provinces through the use of the federal spending power. The success and longevity of medicare is in part due to the federal government's ongoing social program transfers, equalization payments, and its willingness to use its political capital to promote and defend the system. It was federal legislation – first the *Hospital Insurance and Diagnostic Services Act* (1957) and then the *Medical Care Act* (1966) – that, along with federal money, established a national approach to health care in Canada. And when extra-billing and user fees threatened the accessibility of medicare, the federal government responded with the *Canada Health Act*. These actions reflect Canadians' belief that access to health care services was not only a personal, community or provincial issue, but also a national issue that demanded active participation by the federal government.

But, in recent years, as discussed in more detail later in this chapter, the federal government has attempted to maintain its role as the defender of medicare's national dimensions while simultaneously reducing its responsibility and risk for managing the increasing costs and changing expectations within the system. This has put the federal government at odds with the provinces. The Canadian public nevertheless remains committed to a national approach to health care, and expects that a broad range of necessary and high-quality health services will be available to all citizens of this country on an equal basis.

A fundamentally new approach is needed, not only to foster trust but also to resolve disputes and conflicts in a productive and transparent manner. More importantly, Canadians want and expect to see their governments and those in the health care system working together to address many of the pressing issues outlined in subsequent chapters of this report. What is needed is a truly national approach to medicare in the 21st century – an approach that sets aside the differences of provinces, territories and the federal government, and puts new and more effective governance approaches in place.

> *"Medicare has as much iconic force here as the Constitution does in the USA."*
>
> University of McGill, Faculty of Medicine. Presentation at Montreal Public Hearing.

Only by taking co-operative, deliberate, and decisive action on those issues, and setting aside differences of the past can we hope to restore Canadians' confidence in the future of their health care system. To achieve these objectives, the following actions are required:

- **A renewed commitment to a universally accessible, publicly funded health care system** – Canadians value the health care system, but there is some confusion over what our collective vision is for the future. The obligations and responsibilities of Canadians, health care providers, and governments also need to be clarified. This should be done through a new Canadian Health Covenant, endorsed by governments and based on the values Canadians share. The Covenant must be a clear statement – in essence, a new "social contract" – that reflects our commitment to health care as a vital part of society. It should serve as a guiding force in reforming and modernizing our health care system and restoring Canadians' confidence.
- **Strengthening collaboration and leadership** – Health care is a partnership of individuals, health care providers and governments. While provinces and territories have primary responsibility for the delivery of health care, the federal government also has important responsibilities in terms of addressing issues that are national in scope and in providing a stable base of funding. The current intergovernmental mechanisms for addressing health issues have become increasingly dysfunctional and characterized by fractious debate between federal and provincial and territorial governments over who is responsible for what and whether each party is paying its fair share. A new Health Council of Canada – a creation of the federal, provincial and territorial governments – should de-politicize this debate and provide a foundation for a more constructive and innovative partnership.

> *"Cooperative federalism is the strategy that has always made Canada work most effectively. All Canadians benefit when the Federal and Provincial governments join together in agreement on policies and programs."*
>
> Canadian Pensioners Concerned 2001. Written submission.

- **A *Canada Health Act* for the 21st century** – The *Canada Health Act* has served Canadians well. However, the definition of what is considered medically necessary and covered under the Act needs to be updated to reflect the realities of our contemporary health care system. Canadians also expect more accountability in how their health care system is managed and this should be reflected in the Act. By updating the *Canada Health Act*, we can ensure that it provides a solid foundation for managing our health care system in the 21st century.

> *"'Revisiting' and 'updating' do not mean "abandoning" the* Canada Health Act. *They mean ensuring that the Act and its principles are relevant and meaningful to the world we face today and the one we are heading into tomorrow."*
>
> College of Family Physicians of Canada 2001. Written submission.

- **Adequate, stable and predictable funding arrangements** – Canadians are concerned about increasing costs and confused by continuing debates between the federal government and the provinces and territories about their relative shares of funding and "how much is enough." The objective should be to establish new funding arrangements that are adequate, stable and predictable over the longer term and de-politicize day-to-day health care issues. The federal government should reinforce its funding for the health care system by expanding its financial commitment to health care, replacing the current transfer system with a cash-only transfer, and building in mechanisms for adjusting the transfer on an ongoing basis.
- **Targeted efforts to address immediate priorities** – Access to care is the number one concern for Canadians. Later chapters identify the need to take decisive action to improve Canadians' access to diagnostic services, primary health care, home care and prescription drugs. People in rural and remote parts of Canada face particular challenges in accessing a range of health care services. Immediate, targeted funding from the federal government is essential to address these priorities. As these areas are critical to effective reform of the health care system, they should also be considered as priority areas for funding under new long-term funding arrangements for health.

These five steps are essential and lay the groundwork for the actions and recommendations set out in the remainder of this report.

Establishing a Canadian Health Covenant

RECOMMENDATION 1:

A new Canadian Health Covenant should be established as a common declaration of Canadians' and their governments' commitment to a universally accessible, publicly funded health care system. To this end, First Ministers should meet at the earliest opportunity to agree on this Covenant.

A Commitment to Canadians

Canadians' confidence in the health care system must be restored. They need to know what they can expect from the system and what the system expects from them. A critical step in restoring their confidence lies in making a clear statement of values and expectations that underlie the system and guide its future, as stated by Canadians during the Commission's consultations, and include the following:

- **Universality** – Everyone should be included and have access to the benefits of Canada's health care system on the same terms and conditions.
- **Equity** – Access to health services should be based on need and need alone, not on other factors such as wealth, origin, the region where people live, their gender or age.

- **Solidarity** – As Canadians, we have a collective responsibility to provide essential health care services to all Canadians, not for only this generation of Canadians but for those who worked to build the system in the past and for generations of Canadians to come.
- **Responsiveness** – Canadians want and expect both quality of care and timely access to care to be essential hallmarks of the health system.
- **Wellness and responsibility** – Canadians understand that they have a personal responsibility for staying healthy and they want their health care system to put more emphasis on preventing illness and injury.
- **Efficiency and value for money** – People see increasing costs and, as taxpayers and owners of the health system, they expect efficiency and the best value for every dollar spent on health care.
- **Accountability and transparency** – People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funders, and essential participants in the health care system.

"For my husband, the war against cancer ended on February 11, 2000. When he and I were married, we had made vows that each of us would stand by the other in sickness and in health, until death did us part. We also held the belief that the health care system in this country had a similar obligation to the people who paid taxes and spent their lives making this a better place."

VIBEKE HLADY. PRESENTATION AT VANCOUVER PUBLIC HEARING.

Governments must now affirm those values and reasonable expectations in a clear and tangible way. To that end, a First Ministers' meeting should be called at the earliest opportunity to establish a new Canadian Health Covenant. The Covenant should have the following objectives:

- To clearly state the objectives of the health care system for the public, for patients, and for health care providers;
- To inform, educate and support better decision making in our health care system;
- To serve as a common foundation for collaboration among governments, the public, and health care providers and managers.

During its hearings, the Commission heard suggestions that some sort of "Covenant" or "Patient Bill of Rights" was necessary and should set out clear legal rights and obligations, similar to those set out in the *Canadian Charter of Rights and Freedoms.* The value of a Covenant lies, however, in the fact that it reflects the consensus of Canadians as affirmed by their governments, not in the establishment of new rights that would be subject to legal interpretation and ultimately decided by the courts rather than by Canadians themselves.

Ultimately, the Covenant should stand as a clear statement by and to Canadians – in essence, a new "mission statement" for our health care system. It should be supported by First Ministers, formally endorsed by a resolution of the federal government and each of the provincial and territorial governments, and widely circulated to the public and health care providers. The following proposed Covenant has been developed based on a wide range of inputs and advice the Commission received from Canadians.

A Proposed Health Covenant for Canadians

Canada was founded on the basis of co-operation, perseverance and mutual respect. Canadians continue to be recognized throughout the world for these qualities. Building from this solid foundation, as Canadians, we agree to apply and be bound by the following in shaping our health care system:

Mutual Responsibility: The success of our health care system requires a balance between our personal responsibility for our own health and our mutual responsibility for our health care system. All Canadians share the responsibility for maintaining this system through their actions and tax dollars, and all should contribute to it within their means.

A Public Resource: Our health care system is a public resource and a precious national asset.

Patient-centred Care: The direction of our health care system must be shaped around health needs of individual patients, their families and communities.

Equity: All Canadians are equally entitled to access our health system based on health needs, not ability to pay.

A Universal, Accessible, and Portable System: Public health insurance must be accessible to all Canadians on uniform terms and conditions, regardless of where they live in the country. But the provision of care should be sensitive to the race, colour, gender, sexual orientation, ability, disability, ethnic origin, language, place of residence, social or economic status, and religion of those using the system.

A Respectful, Ethical System: Our health care system must be based on the highest ethical standards, and must recognize the worth and dignity of the whole person including biological, emotional, physical, psychological, social and spiritual needs.

Transparency and Accountability: The decisions governments and providers make in operating our health care system should be clear and transparent. Canadians are entitled to regular reports on the status, quality and performance of our health care system.

Public Input: Public participation is important to ensuring a viable, responsive and effective health care system.

Quality, Efficiency and Effectiveness: The resources needed to support our health care system are limited, and the system must be run as efficiently as possible. Care should be integrated, multidisciplinary, timely and convenient, and services should be designed around the health of the population, with emphasis on the physical, social, economic and environmental determinants of health. Wellness, public health and prevention must be a major focus of the system. Decisions at all levels of the system must be based on the best available information, and we must foster innovation and sharing of best practices.

Responsibilities and Entitlements of Individual Canadians

Canadians:

- have a responsibility to observe good health practices, and to promote and support the well-being of their families and communities.
- have a responsibility to use the system prudently, and to support the system through their actions and tax dollars.

- are entitled to health services based on health needs, not ability to pay.
- are entitled to timely, high quality care.
- are entitled to make informed decisions regarding their personal care, and to receive all information and medical documentation related to them, while respecting the judgement and expertise of health providers.
- are entitled to have appropriate input into, as well as to be informed of relevant policies and laws, including procedures for complaints, and all Canadians are entitled to utilize appeals/complaints mechanisms relating to the system.
- are entitled to be treated in a courteous, respectful and dignified manner, and consistent with relevant legislation, should have their right to privacy respected.

Responsibilities and Entitlements of Health Care Providers

Health care providers:

- have a responsibility to ensure that the health care system places the highest priority on the concerns and health needs of patients.
- have a responsibility to work with governments, the public and each other to continuously improve the quality of services and maximize patient safety.
- have a responsibility to respect the confidentiality and privacy of individual patients.
- have a responsibility to provide information to patients on treatments, related services, and available alternatives, while taking into account the preferences of their patients.
- have a responsibility to exercise prudent management and careful stewardship of resources in support of our health care system, as these resources are finite.
- have a responsibility to uphold all professional standards.
- are entitled to professional recognition, the ability to exercise clinical judgement, and reasonable compensation.
- are entitled to be treated with dignity and respect in the performance of their duties.
- are entitled to a meaningful role in making decisions related to the operation of the system.

Responsibilities and Entitlements of Governments

Governments:

- have a responsibility to develop and administer the health care system for the common good of all and in a manner that provides equitable access and treatment for all Canadians.
- have a responsibility to dedicate adequate, stable and predictable funding for our health care system in a manner transparent to Canadians.
- have a responsibility to work collaboratively with each other and with the public and health care providers, as appropriate, to foster innovation and ensure the system remains responsive and sustainable.
- have a responsibility to regularly review the performance and operation of the health care system and report to the public so that Canadians can make informed decisions and contribute to the system in an informed way.

- have a responsibility to ensure that decisions regarding the future direction of our health care system are made with transparency and accountability to all; this means establishing goals, targets, and benchmarks for the system, tracking performance and reporting to the public.
- have a responsibility to ensure that health services are delivered in a way that ensures the flexibility necessary to reflect local needs and circumstances.
- have a responsibility to establish appropriate mechanisms that allow the public and health care providers meaningful input into decisions on the future of our health care system.
- have a responsibility to develop healthy public policies that are designed and implemented in a manner consistent with promoting the health of the population.
- are entitled to have their jurisdictional roles and responsibilities recognized and respected in charting new directions for the health care system of the future.

Canadians and their elected representatives may choose to endorse or amend this proposed Covenant. However the final statement is crafted, a Covenant is an essential step in restoring Canadians' confidence, reaffirming our collective commitment to medicare, and reflecting Canadians' values in a clear and compelling statement of our vision and expectations for Canada's health care system.

Achieving the Vision: National Leadership in Health

RECOMMENDATION 2:

A Health Council of Canada should be established by the provincial, territorial and federal governments to facilitate co-operation and provide national leadership in achieving the best health outcomes in the world. The Health Council should be built on the existing infrastructure of the Canadian Institute for Health Information (CIHI) and the Canadian Coordinating Office for Health Technology Assessment (CCOHTA).

RECOMMENDATION 3:

On an initial basis, the Health Council of Canada should:

- **Establish common indicators and measure the performance of the health care system;**
- **Establish benchmarks, collect information and report publicly on efforts to improve quality, access and outcomes in the health care system;**
- **Coordinate existing activities in health technology assessment and conduct independent evaluations of technologies, including their impact on rural and remote delivery and the patterns of practice for various health care providers.**

RECOMMENDATION 4:

In the longer term, the Health Council of Canada should provide ongoing advice and co-ordination in transforming primary health care, developing national strategies for Canada's health workforce, and resolving disputes under a modernized *Canada Health Act.*

A New Approach to National Leadership

As noted in Chapter 1, federal, provincial and territorial governments share responsibility for various aspects of our health care system. Unfortunately, in recent years, the ability of governments to work together within this framework has been challenged by a number of high profile disputes. The proposed Canadian Health Covenant can be a first step in addressing these challenges and establishing a common vision.

The time has come for governments to focus on a collective vision for the future, rather than the jurisdictional or funding issues that have been the focus of intergovernmental debate for much of the past decade. This collective vision must focus on achieving effective reform and modernizing the system. It must reflect the priorities of Canadians. Ultimately, the collective objective of current and future Canadian governments should be to establish and maintain Canada as the country with the healthiest population in the world. Achieving this objective will take time as well as focused, collective action. But the goal is within our means if governments, health providers and the public make a joint commitment and follow through with decisive action.

At the same time, it would be unfair to assume that the problems facing the governance of our health system are simply the result of a lack of clear vision. There are functional problems in how our governments interact with one another that must be addressed. These problems are as follows:

- **Dysfunctional intergovernmental relations** – No single government has clear constitutional authority for our health care system. As a result, it is not always obvious to Canadians which order of government is accountable for addressing specific issues and ensuring good performance. In recent years, governments have addressed this challenge by committing to "clarifying roles and responsibilities" and "reducing duplication and overlap." While these are useful efforts to streamline the governance of our health care system, the reality is that the nature of our constitution – and the nature of our health care system itself – make it impossible to divide the management of all aspects of health care into neat federal or provincial "boxes." Intergovernmental debate can be a healthy way of defining and achieving national goals, but in recent years these debates have become complex and perhaps dysfunctional (Boychuk 2002). Consistently, the Commission heard that intergovernmental conflict and mistrust are serious barriers to the smooth functioning and sustainability of medicare.

> *"The pointing of fingers at one another must come to an end; governments must find a way of working together or they risk losing what Canadians value most."*
>
> ASSOCIATION OF CANADIAN ACADEMIC HEALTHCARE ORGANIZATIONS 2002. WRITTEN SUBMISSION.

- **Intergovernmental mechanisms that lack public input** – The "machinery" of intergovernmental relations is cumbersome. In addition to regular meetings of health ministers and deputy ministers, there currently is a dizzying array of dozens of working

groups and a number of arm's length institutions that shape national health policies and approaches. Few Canadians understand this system, and even fewer understand how their needs, views or expectations are taken into account (O'Reilly 2001). Clearly, there is value in streamlining the intergovernmental process, and more importantly, in establishing new mechanisms to improve transparency and allow public input (Abelson and Eyles 2002).

- **Need for stable, long-term leadership** – Establishing and implementing the national vision for health care requires strong and consistent leadership. It means health care must continue to be a priority not only for individual governments but also for all governments working together (Adams 2001). Fortunately, we are halfway there. Given the importance of health care, it is already a major focus of discussion among the cabinets of federal, provincial and territorial governments. At the intergovernmental level, health is commonly discussed by both health and finance ministers, and in recent years, by Canada's first ministers. Unfortunately, despite the high priority of health care on the agendas of our governments, we lack a consistent approach that provides long-term leadership and direction. All too often, straightforward tasks in managing the system get mired in politics because of differing views on objectives and competing interests. Federal, provincial and territorial ministers of health are in a unique position to establish strategic directions, but ministers and their deputy ministers often change with such frequency that few stay in their positions for more than a year or two. This underscores the need for a stable mechanism like the proposed Health Council of Canada to provide an ongoing base of advice and information.

"We haven't reached a stage where we should neglect a collaboration among the two levels of government under the heading of health. We believe that we must develop a collegiate health care system to permit both governments to assume the action that is necessary to reform the system."

CONSEIL DU PATRONAT DU QUÉBEC. PRESENTATION AT QUEBEC CITY PUBLIC HEARING.

These concerns suggest that:

- achieving an effective national health care system will require better collaboration between federal, provincial and territorial governments on national priorities and key challenges, in order to meet the needs of all Canadians;
- a key objective in shaping any new intergovernmental process should be restoring trust and implementing a national vision;
- the intergovernmental process in health needs to be streamlined and its accountability, transparency and ability to take account of and reflect the views of Canadians need to be improved; and
- strong, consistent and longer term leadership is needed from health ministers and deputy ministers in order to manage the system in the interest of all Canadians.

Role of the Health Council of Canada

To provide national leadership, the mandate of the Health Council of Canada should be to:

- act as an effective and impartial mechanism for the collection and analysis of data on the performance of the health care system;
- provide strategic advice and analysis to federal, provincial and territorial health ministers and deputy ministers on important and emerging policy issues; and
- seek ongoing input and advice from the public and stakeholders on strategic policy issues.

Ultimately, the Council should be a collaborative mechanism that can drive reform and speed up the modernization of the health care system by "de-politicizing" and streamlining some aspects of the existing intergovernmental process. The Council should also be a broadly based mechanism that provides analysis and advice on key national health issues.

Immediate Priorities

The Council should immediately focus on three priority areas that are urgent in stabilizing and improving the health system:

- **Accelerating the establishment of common indicators and measuring the performance of the health care system** – Governments and health organizations need better information to guide policy decisions, make choices and make the best use of resources in our health care system. The public are demanding better accountability from the system and regular information that allows them to judge the results that are being achieved. As a priority, the Health Council of Canada must establish a national performance review framework that builds on the existing work of the federal-provincial Performance Indicators Review Committee (PIRC) in conjunction with the Canadian Institute for Health Information and Statistics Canada. This framework should start with common definitions and comparable performance indicators on health status, outcomes, quality of services, and reporting requirements.

  The work of the Council should culminate in annual reports to the public and governments that are widely distributed, discussed and debated across the country. The Council's annual reports to Canadians should include the core components set out in the following box.

Annual Performance Reports from the Health Council of Canada

Each year, the Health Council of Canada should report to Canadians on

- the health of Canadians, providing information on international comparisons, variations across the country, and improvements over time;
- the performance of the health care system, again with international comparisons, noting significant regional or other variations, and highlighting improvements over time;
- progress in developing common indicators and performance measures, including waiting times for certain services and treatments as well as challenges in rural and remote areas;
- results achieved by intergovernmental structures, agencies and organizations as well as make recommendations for improvement;
- trends in the supply and distribution of health care providers, including a progress report on activities by the Council to address health human resources issues, outcomes, and best practices;
- best practices in Canada and initiatives to improve access, quality and efficiency;
- outcomes of technology assessments that are of broader interest;
- progress on primary health care initiatives;
- issues in dispute among governments and how they are resolved.

There is a significant overlap between the proposed work of the Health Council of Canada in measuring and assessing performance and the work of the Canadian Institute for Health Information (CIHI), which is itself a partnership between the federal and provincial governments. In many ways, the existing, important work of CIHI must form the statistical and analytical backbone for the work of the Health Council of Canada. For this reason, CIHI should be formally integrated into the Council.

- **Reporting on issues related to access and quality, and providers** – Canadians are worried about the accessibility and quality of their health care system as well as its ability to provide safe and reliable care. The challenge of access to the system is particularly significant in rural and remote parts of Canada, where resources are quite limited. Dealing with this challenge also requires comprehensive and reliable data on the supply and distribution of health care providers. Working with non-governmental organizations such as the multi-stakeholder National Steering Committee on Patient Safety and the voluntary Canadian Council on Health Services Accreditation, the Health Council of Canada can play a critical role in data collection and analysis on all these important issues, including national benchmarks for quality and patient safety and in-depth analysis of how access in rural and remote areas can be improved.

  Currently CIHI maintains databases on physicians, registered nurses and other health care providers, including licensed practical nurses, midwives, physiotherapists, pharmacists, occupational therapists, health administrators and executives, among many others. This work would provide the foundation for the analytical expertise that the Health Council of Canada should develop over time.
- **Assessing new technologies** – The use of technology in our health care system has critical implications for the efficiency and effectiveness of the system. The existing federal-provincial Canadian Coordinating Office for Health Technology Assessment plays an important role in the collection, analysis and dissemination of information on the cost and effectiveness of health technologies, as well as their impact on health outcomes. CCOHTA's role as a clearinghouse and disseminator of information on technology assessment is critical in reducing overlap among provinces that have their own technology assessment agencies, and in providing support to other provinces and territories that lack this capability. With new advances in medical technology, technology assessment will become increasingly important across the country. At the same time, technology assessments should not be done in isolation of their impact on all aspects of health and the health care system. Because of the importance of linking technology assessments to the quality and effectiveness of the health care system, the Commission believes that the mandate and resources of CCOHTA should be integrated with the Health Council of Canada's role in assessing the overall performance of the system. In this way, Canadians, governments, and health care providers would have more comprehensive assessments of all aspects of the health care system, including technology assessment. The Council could also ensure that the outcomes of technology assessments are widely shared with governments, providers and the public.

Medium- and Longer-term Priorities to Transform the Health Care System

The proposed Health Council of Canada is a new approach and care should be taken to ensure that its work meets the needs of Canadians and their governments. Once the Council is established and working effectively on the initial priority areas, the federal, provincial and territorial governments may wish to expand its mandate to include the following key areas:

- **Facilitating primary health care** – New primary care approaches are being initiated in every part of the country, and Canada's First Ministers identified primary health care as a priority in their September 2000 Accord. A subsequent chapter of this report outlines actions that should be taken to build on that work and expand primary health care across the country. The Health Council can play a key role in advising governments on accelerating the ongoing development of a national framework for primary health care, monitoring and measuring the success of new primary health care initiatives, and identifying obstacles to progress.
- **Providing advice and co-ordination related to the supply, distribution and changing roles of health care providers** – Many parts of Canada are facing both supply and distribution problems with health care providers. This problem is of particular concern in rural and remote parts of the country. On top of these challenges, the face of health care is changing and the traditional roles of different health providers are becoming blurred. Temporary and ad hoc approaches to these problems are not the solution. Building from the recommendations set out in Chapter 4 of this report, the Health Council of Canada can play a key role in providing advice on pressing national health human resources issues. It can provide advice – developed independently from both governments and provider organizations – on how these issues might be managed consistently and, perhaps, collectively across the country. Over time, it could assist health ministers in developing a national framework to deal with issues like compensation.
- **Assisting in the resolution of disputes** – Earlier this year, the federal Minister of Health made a proposal for a new approach for avoiding and resolving disputes under the *Canada Health Act*. Building from this proposal, and from proposed modifications to the *Canada Health Act* set out later in this chapter, the Council could play an important role in fact-finding and mediating disputes between governments. Ultimately, the Council could play an important advisory role in helping governments decide how they can resolve disputes between one another.

Health Council Operation and Structure

The Health Council of Canada is not intended to simply be another advisory body in the already complex web of committees and expert panels that now exist in health. It should be a new way of doing business. It should function as a broadly based mechanism for analysis and assessment that looks at our national health care system as a whole. It also should provide an effective mechanism for facilitating public input on critical health issues. Over time, it is expected that the Health Council will play an important role in providing advice to governments on health human resources issues, co-ordinating technology assessment, facilitating primary health care reform, and in developing of effective means to measure the performance of the system.

In this context, the Council's operating principles should be as follows:

- The Council should report to federal, provincial, and territorial health ministers.
- The Council should respect the constitution and the responsibilities of provincial, territorial and federal governments.
- Reports and analyses prepared by the Council should be made public unless there are exceptional circumstances as directed by ministers of health.
- The Council should place a high priority on public input into its work. It should explore ways of regularly consulting with Canadians including the possibility of town hall meetings and extensive use of the Internet. It should also consider an approach similar to the Commission's Citizens' Dialogue to conduct an annual check-up with a representative sample of Canadians from across the country. More importantly, it could use this type of deliberative consultation to allow Canadians to propose policy options and shape the policy dialogue (Dickinson 2002).
- The Council should establish mechanisms to regularly consult with stakeholders. Specifically, it should establish a permanent advisory committee that includes a cross-section of representatives from the major health professions, the scientific and academic community, the business community, the volunteer sector, public and community health groups, regional health authorities and hospital groups. Through this committee, the Council should seek regular advice and feedback on its business plan, priorities and special projects.
- It is critical that the proposed work of the Council remain relevant both to governments and to Canadians. To this end, health ministers should review the work of the Council periodically, perhaps every five years, to determine whether its role should be expanded or adjusted.

The structure of the new Council will also be critical in determining its relevance and effectiveness. In the Commission's view, the Council's Board should be appointed through consensus of federal, provincial and territorial governments, and it should include:

- Representation from the public;
- Representation from the academic, scientific and professional community;
- Individuals with working knowledge in the area of governance and management of the health system; and,
- Appropriate regional representation from across our country.

The following sets out one possible option for the structure of the Council's Board. In addition to a board, the Council would require a professional staff and support from a full-time executive director. To avoid extra expenses and duplication, the existing staff and resources of CIHI and CCOHTA should be integrated into the Council. The Council should be run as efficiently as possible and its annual operating costs initially should not exceed the combined budgets of CIHI and CCOHTA.

A Possible Model for the Health Council of Canada

Membership

- The Health Council of Canada should have a 14-member board appointed by consensus of federal, provincial and territorial health ministers and comprised of the following:
  - 3 representatives of the public
  - 4 representatives of the provider and expert community recognized for their competence in health policy and practice
  - 7 government appointees selected as follows:
    - 1 appointed by consensus of the governments of the Yukon, Northwest Territories and Nunavut
    - 1 appointed by the consensus of the governments of British Columbia, Alberta, Saskatchewan and Manitoba
    - 1 appointed by Ontario
    - 1 appointed by Quebec
    - 1 appointed by consensus of the governments of New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador
    - 2 appointed by the Government of Canada.

Selection

- Board members would be appointed for a three-year term, with the possibility of one reappointment for an additional three years.
- Board members would hold a formal fiduciary responsibility to the Health Council Board; Board membership should be "personal" to the individual and should not depend on or change with a change in the board member's current employment.
- Regional appointees would require the consensus approval of the jurisdictions in that region, and all participating jurisdictions should have an opportunity to have their representative sit on the Board over time.
- To ensure that the Chair of the Board is clearly accountable to the Health Council and to signal the independence of the Council, the Chair of the Board should be selected from among board members by the Board itself. The nominee selected by the Board should be presented to federal, provincial and territorial ministers for consensus confirmation.

Modernizing and Updating the *Canada Health Act*

RECOMMENDATION 5:

The *Canada Health Act* should be modernized and strengthened by:

- **Confirming the principles of public administration, universality and accessibility, updating the principles of portability and comprehensiveness, and establishing a new principle of accountability;**
- **Expanding insured health services beyond hospital and physician services to immediately include targeted home care services followed by prescription drugs in the longer term;**

- **Clarifying coverage in terms of diagnostic services;**
- **Including an effective dispute resolution process;**
- **Establishing a dedicated health transfer directly connected to the principles and conditions of the *Canada Health Act*.**

The *Canada Health Act* has served Canadians well. In many respects, it has become an icon to Canadians. They view it as a hallmark of Canadian society and the five principles closely match their values. All of this has made the *Canada Health Act* virtually immune to change. In fact, most Canadians would not stand idly by and accept changes that would destroy this symbol of Canadian identity.

At the same time, Canadians understand that much has changed since the early days of medicare when the health care system could largely be defined by two words – hospitals and doctors. They see new technologies, new treatments and cures, new diagnostic tests, more people being treated and cared for at home, and the burgeoning role of prescription drugs, and they understand the need for the health care system to change and adapt with changing times and changing care. Canadians understand that much can be done to prevent illness and injury, and they expect to see a better balance in their health care system. In fact, the last thing Canadians want is for their health care system to remain as a static entity, fixed in time and unable and unwilling to change. The critical task, then, is to modernize the *Canada Health Act* while remaining true to Canadians' expectations and their values.

The Principles of a Modernized *Canada Health Act*

The principles of the *Canada Health Act* began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians. In particular, the public administration, universality and accessibility principles are as relevant and necessary today as they were when first introduced. The principles of portability and comprehensiveness need some fine tuning to fit the realities of health care in the 21st century, while a sixth principle of accountability should be added to a new *Canada Health Act* to reflect Canadians' desire for more accountability in the health care system.

Principle 1: Public Administration

The principle of "public administration" must be maintained. This establishes a single-payer system for health care services covered under the *Canada Health Act*. It requires provincial health care insurance plans to be administered and operated on a non-profit basis by a public authority appointed or designated by the provincial or territorial government.

The principle of public administration ensures that a single-payer system will continue to be the cornerstone of the Canadian system. A single-payer system has two great advantages over a multi-payer, private insurance system. It does a better job of controlling costs and it facilitates equitable access (Maynard and Dixon 2002).

On the cost-efficiency side, private insurance has very high administrative costs related to billing, contracting, reviewing utilization, and marketing because of the large infrastructure required to assess risk, set premiums, design complex benefit packages, review claims, and pay (or deny) individual claims. Moreover, the tax subsidies used to encourage coverage through private insurance and the use of tax revenue to cover the poorest (and generally sickest) people in society are both inefficient and highly regressive (Mossialos and Dixon 2002).

A single-payer system is more efficient because it is administered by a single agent that is either the government or a body delegated by the government. This means that substantial resources are not wasted in processing insurance claim forms from multiple companies. It also means that providers – particularly physicians and their employees – avoid the overhead required to collect bills from their patients.

Over a decade ago, Woolhandler and Himmelstein (1991) estimated that Canadians spent two-thirds less than Americans on health care administration. Their analysis was largely confirmed by the U.S. General Accounting Office (1991) and the Congressional Budget Office (1991). Their most recent work (Woolhandler et al. 2002) concludes that each Canadian pays $325 per year (out of a total health administration bill of almost $10 billion) compared to $1,151 paid by each American per year (out of a total health administration bill of $320 billion).

Principle 2: Universality

This principle is widely valued by Canadians and should be retained as a hallmark of a renewed *Canada Health Act*. This principle ensures that provincial and territorial health insurance schemes cover everyone in the same manner and under the same terms and, together with the principle of accessibility, marks the system's commitment to preserving and promoting equity for all Canadians.

Principle 3: Accessibility

Similarly, the Commission recommends keeping the principle of accessibility in a new *Canada Health Act*. This principle is the "other half" of the system's commitment to equity. Accessibility was added to the guiding principles of the *Canada Health Act* in the 1980s as part of the move to ban user fees and extra-billing. The principle ensures that there are no barriers, particularly no financial barriers, to accessing the system. To reinforce this principle, both user fees and extra billing should continue to be prohibited under a new *Canada Health Act*. Taken together, the principle of accessibility and the principle of universality confirm the conviction of Canadians that essential health care services must be available to all Canadians on the basis of need and need alone.

> *"The role of the federal government for me would be to ensure that from sea to sea … the basic things would be the same."*
>
> ASSOCIATION DES RÉGIONS DU QUÉBEC. PRESENTATION AT QUÉBEC CITY PUBLIC HEARING.

Principle 4: Portability

This principle currently is included in the *Canada Health Act*. It addresses three situations:

- **Health coverage if people get ill or injured in another province** – If Canadians are travelling within Canada and need medically necessary hospital and physician services while they are in another province, those services must be covered by their province's health insurance plan at the rates approved in the province where the services were provided.

- **Health coverage when people move within Canada** – Canadians who move from one province to another must be covered by their originating province until they meet the minimum residency requirements for coverage in their new home province. The waiting periods for coverage in their new province cannot be longer than three months.
- **Health coverage outside Canada** – If Canadians are travelling outside of Canada and require services covered under the *Canada Health Act*, they must be reimbursed by their respective province to the level that those services would have been covered by their province's provincial plan.

In reality, not all of these conditions are met by the provinces. All provinces respect the limit on residency requirements and meet their obligations to people who move from their province to another. And all provinces participate in reciprocal billing arrangements for hospital services provided to visitors from other provinces. But not all provinces participate in similar arrangements for physician services, meaning that individuals who see doctors while visiting other parts of the country could find themselves having to pay for the service directly and then seek reimbursement from their own province (HC 2001a). And for financial reasons, five provinces refuse to provide out-of-country coverage as required under the *Canada Health Act* (Flood and Choudhry 2002). In spite of these inconsistencies, the federal government has never reduced cash transfers to provinces that do not meet the current portability requirements.

Portability is a key aspect of the mobility rights of Canadians. These rights are protected under the *Canadian Charter of Rights and Freedoms*. A good argument can be made that failure to provide continuing health care coverage when people move from one province to another would seriously compromise Canadians' mobility rights. The mobility of Canadians is also important from an economic perspective, ensuring that people can move from province to province for employment opportunities.

The same argument, however, does not apply to out-of-country coverage. In other social programs, such as education, there is no expectation or guarantee that people can access these services outside Canada at taxpayers' expense. Out-of-country coverage for health care should be considered a benefit if provinces choose to provide it but not entitlement under the *Canada Health Act*. To make the best use of limited resources, the principle of portability should be limited to supporting mobility within Canada and it should, in the future, be strictly enforced. At the same time, the Canadian government should be encouraged to negotiate agreements to guarantee emergency care for Canadians travelling abroad. Many OECD countries such as Australia, New Zealand and the United Kingdom rely on this approach (Flood and Choudhry 2002).

Principle 5: Comprehensiveness

The current *Canada Health Act* includes the principle of comprehensiveness. However, for the last 35 years, comprehensiveness has been limited to "insured health services" defined as medically necessary hospital and physicians services (including dental surgery services performed in hospitals). This is not how the average person would define comprehensive.

Despite this, comprehensiveness should be retained as a principle, not so much as a description of existing coverage under the *Canada Health Act* but as a continuing goal. It should be redefined to mean that, as financial resources permit and as the health care system changes, the definition of comprehensiveness (and of services insured under provincial plans) should

continue to evolve to improve the continuum of care. Immediate changes should be made to expand insured services to include medically necessary diagnostic and home care services. In the longer term, the principle of comprehensiveness should be revisited and updated periodically.

> *"Our system lacks communication, lacks clear accountability…"*
>
> WILLIAM SILVER. PRESENTATION AT REGINA PUBLIC HEARING.

Principle 6: Accountability

Currently, there is no principle in the *Canada Health Act* that addresses accountability. During the consultation process, Canadians expressed their deep suspicions about the way governments have managed their health care system and where the money goes.

As the owners, funders, and users of the health care system, Canadians have a right to know how their system is being administered, financed and delivered, and which order of government is responsible for which aspects of the health care system. A new principle in the *Canada Health Act* should confirm the importance of accountability in the health care system. In particular, provincial, territorial and federal governments have a collective responsibility to:

- clarify the roles and responsibilities of governments as well as intergovernmental processes and expected outcomes;
- ensure adequate, stable and predictable funding;
- explain in an open and understandable way where the money goes in terms of the national dimensions of health care funding; and
- inform Canadians on the performance of the health care system.

This accountability can be reinforced through annual reports to the public provided by the proposed Health Council of Canada.

> *"I hope you would understand our desire to have a more responsible, accountable system and that we are, as Canadians, willing to participate and be responsible for our health as well. Hopefully, this will, in the long-term, make effective use of our resources."*
>
> INDIVIDUAL, CITIZENS' DIALOGUE, HALIFAX.

Expanding Medicare Coverage: Short Term and Long Term

The principle of comprehensiveness highlights the gap between what should theoretically be included as part of medicare and the services that are actually included as "insured health services" under the current *Canada Health Act*. This gap exists in the first place because of the impossibility of the public purse covering all health services immediately. Financial probity requires that services be added as fiscal resources permit. Public coverage in Canada began with hospitals in the 1950s and physician services in the 1960s. Each new step has been preceded by much discussion concerning the public resources required to fund such services.

At the same time, advances in medical technology and changes in health care delivery since medicare was introduced have meant that many services can now be provided outside hospitals and by professionals other than physicians. Since the 1990s, there has been much discussion about expanding medicare coverage, particularly for home care and prescription drug therapies.

The Commission believes that the time has come for another major step forward. As outlined in Chapter 8, a group of home care services has been identified for immediate inclusion in a modernized *Canada Health Act*. These services include home mental health case management and intervention services, post-acute home care and rehabilitative care, as well as palliative home care. Other home care services can be added as public finances permit in the future.

Prescription drugs have been the subject of much debate in Canada both because of their growing cost to governments and individuals and the lack of uniform national coverage. The Commission believes that the recommendations provided in Chapter 9 set the stage for eventual inclusion of prescription drug therapies under the *Canada Health Act*.

Clarifying Coverage under the *Canada Health Act*

If medicare is to thrive, it must adapt to the changing nature of health care. Diagnostic services are a case in point. Many, perhaps most, diagnostic tests can now be performed safely and efficiently outside hospitals. Blood tests and X-rays have been performed in this manner for many years. More recently, a growing number of MRIs and CT scanning tests have been performed in specialized, free-standing clinics. Diagnostic services are the essential "front end" of medical care that precedes critical interventions, including, for example, surgery and chemotherapy in cancer treatment.

Currently, there are serious backlogs in wait lists for access to advanced diagnostic services across the country and evidence suggests that, compared with other countries, Canada may have under-invested in some of the newer and more expensive diagnostic services. This has created a 'private market' for more timely diagnostic services. Patients who do not wish to wait in the public sector queues may buy access (if they can afford to do so) to a diagnostic test such as an MRI. But, if the test results reveal a serious condition requiring immediate treatment, the patient who has privately purchased an MRI can queue-jump ahead of others waiting for diagnosis and potential treatment. This raises a problem. Access to cancer treatment, for example, is on the basis of urgency of need. But this cannot be determined without proper diagnosis through one or more tests. If these can be purchased privately, then initial access is being determined by ability to pay rather than need.

It is true that all medically necessary diagnostic services are within the principles and conditions of the *Canada Health Act* in two ways. First, if they are provided within a hospital, they are automatically considered to be "insured health services." Second, if they are provided or ordered by a physician as a "medically required service," then they are also insured under the terms of the Act. But the difficulty lies with the phrase "medically necessary."

To clarify the situation, diagnostic services should be explicitly included under the definition of "insured health services" under a new *Canada Health Act*. These front-end services are an essential part of medicare and should not be the vehicle for queue-jumping in the public system. As a result, all diagnostic services except those that are being performed for a clearly non-medically necessary purpose, such as cosmetic surgery, should be subject to the conditions and principles of the *Canada Health Act*, including the prohibitions on user fees (including facility fees) and extra-billing. In other words, the *Canada Health Act* should be amended to clarify that it covers all diagnostic services reasonably required to assess a patient's need for medically necessary hospital and physician services. In the event of any further violations, the federal government would be obliged to withhold its medicare contributions by an amount equal to that paid out-of-pocket by individuals for MRI and other diagnostic tests.

This recommendation, however, does not address the anomaly of access to diagnostic services by workers' compensation clients as discussed in Chapter 1. While workers' compensation rules for health care performed an important function in the past, many would

agree with one physician's assessment that today this preferential access amounts to "officially sanctioned queue-jumping in the public system" (quoted in LeBourdais 1999, 859). Indeed, the vast majority believe that all Canadians are equally entitled to timely service, regardless of their employment status. The elderly and children, for example, are just as deserving of prompt diagnosis as injured workers. For the same reasons that private payment for diagnostic services is contrary to the basic principle of medicare, this "public" form of queue-jumping should be redressed in a modernized *Canada Health Act*.

Providing Stable and Predictable Federal Funding

RECOMMENDATION 6:

To provide adequate funding, a new dedicated cash-only Canada Health Transfer should be established by the federal government. To provide long-term stability and predictability, the Transfer should include an escalator that is set in advance for five year periods.

RECOMMENDATION 7:

On a short-term basis, the federal government should provide targeted funding for the next two years to establish:

- **a new Rural and Remote Access Fund**
- **a new Diagnostic Services Fund**
- **a Primary Health Care Transfer**
- **a Home Care Transfer**
- **a Catastrophic Drug Transfer**

As outlined in the first chapter of this report, the heart of the Commission's mandate is to make recommendations to ensure the long-term sustainability of the health care system. Sustaining the health care system is fundamentally about making choices – getting the governance approach right, and finding the right balance between services, needs and resources.

The primary objective must be stable, long-term, predictable and adequate funding for Canada's health care system. At the same time, there are immediate challenges that must be addressed to improve Canadians' access to health care services. The combination of a new funding mechanism and short-term targeted actions should serve to meet both of these objectives.

Introducing a New Canada Health Transfer

The question of the respective federal and provincial shares of the health care "bill" has been hotly contested over the past few years. The debate has not been helped by the complexity of the Canada Health and Social Transfer (CHST) funding mechanism as discussed in Chapter 1 (also see IIGR 2002). The Commission believes a dedicated health transfer must be created based upon the existing "health" component of the CHST. While this would be a new federal transfer to the provinces, it is essential that both orders of government agree to its structure and cash base.

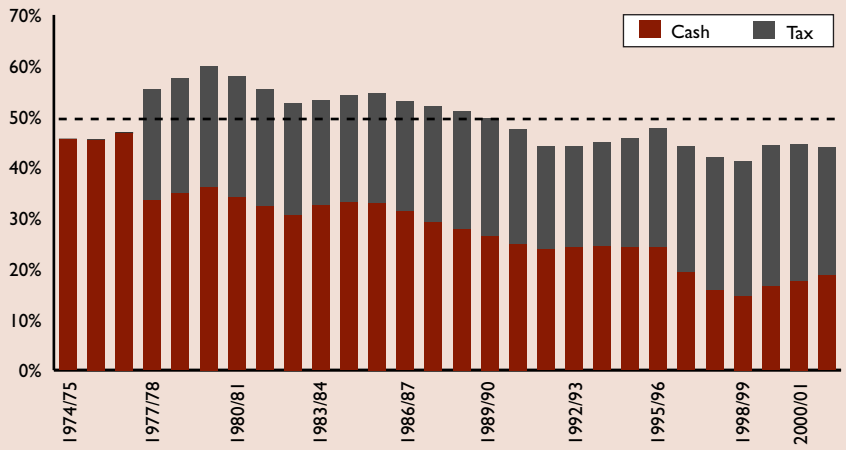
Understanding the importance of creating a dedicated transfer requires a brief overview of health transfers that have been at the heart of the debate. The original "medicare bargain" involved the federal government sharing with the provinces all eligible hospital and physician expenditures on a 50:50 basis. Historically the principle of cost sharing only covered what would become known as *Canada Health Act* services. Over time, however, the public along with governments increasingly debated cost sharing in the context of total provincial health expenditures. Both are compared below.

Figure 2.1 illustrates the federal contribution for eligible services for the past three decades (see Appendix E). The federal government argues that total federal expenditures (cash plus tax points) must be considered in determining its share. Doing this, the federal share of provincial hospital and physician expenditures has ranged from a high of almost 60% at the end of the 1970s to a low of slightly more than 41% at the end of the 1990s. The provinces generally view federal funding commitments in terms of federal cash payments alone. Federal "cash only" transfers for hospital and physician expenditures have ranged from a high of close to 47% in 1976/77 to a low of 14.6% in 1998/99.

Figure 2.2 demonstrates the extent to which the federal share of total provincial health expenditures has always been well below the 50% line, even with tax points included. Reaching a crest of a 43% contribution to total provincial and territorial health expenditures in 1979/80, federal cash and tax point transfers allocated to health had sunk to a low of 27.5% by 2001/02. As for cash, the highest point reached was an almost 38% contribution in 1971/72 which had dropped to slightly less than 10% by 1998/99.

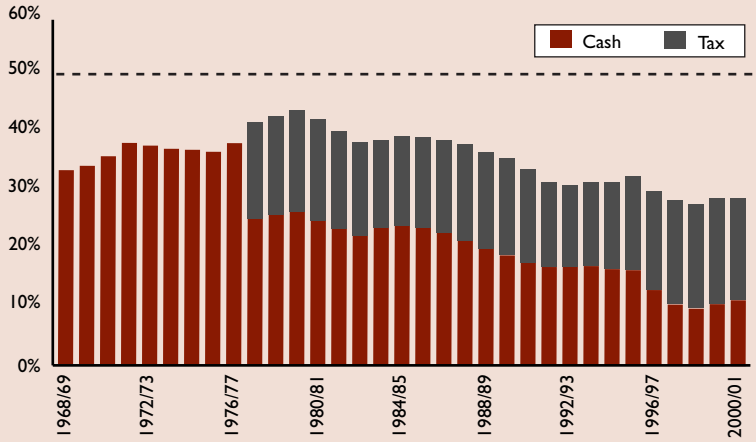
In their recent sparring over health transfers, Ottawa and the provinces have tried to put the best possible spins on their respective versions of this history. For its part, Ottawa has downplayed the fact that its contribution to provincial health expenditures has been declining as a share of those costs for the past two decades. Just as importantly, the federal government has successfully moved the risk of growing health expenditures to the provinces through its occasional reductions in the cash portion of the transfer and the elimination of an escalator when the CHST was introduced as described in Chapter 1.

Figure 2.1 Federal Contribution to Provincial-Territorial Expenditures on Hospital and Physician Services, 1974/75 to 2001/02



Source: Appendix E.

Figure 2.2 Federal Contribution to Total Provincial-Territorial Health Expenditures, 1968/69 to 2000/01



Source: Appendix E.

For their part, the provinces have conveniently eliminated the tax transfer from their calculations of the federal contribution despite the fact that they welcomed the original tax points transfer in 1977, assuming as they did at the time that its value would eventually grow faster than the cash contribution. In addition, they have continued the rhetoric that the original 50:50 cost-share bargain was for all provincial health expenditures even though it was only intended to cover the narrower band of medicare services.

All of these arguments divert us from focusing on the most elemental aspects of the Canadian system. They obscure the critical role that the federal government has played in the past through health transfers in getting medicare off the ground on a national basis and in protecting it when the system was threatened by user fees and extra-billing. They prevent us from seeing the central and innovative role the provinces have always played in the administration and delivery of health services, including establishing the first workable medicare model.

Whatever the actual value of the federal contribution, several points are clear. First, the medicare bargain involved something closer to a 25% cash contribution to provincial *Canada Health Act* expenditures after the provinces obtained the other half in the form of a permanent tax transfer. Second, the tax transfer made the federal government's contribution to medicare extremely difficult to calculate by both governments and the general public. Third, the mixing of policy purposes – health being mixed with post-secondary education (EPF) and later with social assistance and social services (CHST) – only added to the lack of clarity. And fourth, the freezing and subsequent elimination of a funding escalator in the 1990s, further reduced predictability by leaving transfer increases to federal discretion.

The time has come for Ottawa to once again take on more of an equity position in the medicare enterprise. For these reasons, a new Canada Health Transfer should be exclusively a cash transfer, effectively dividing the CHST into a health transfer and a social transfer. This would provide Canadians with greater assurance that a given amount of their federal tax money is being used for health care rather than other programs or tax cuts. It would require that a certain percentage of the revenue used to fund provincial and territorial health plans is collected on a

national tax base, thereby distributing the burden of financing Canada's most expensive social program. And it would automatically improve accountability and transparency by allowing Canadians to clearly see "where the money goes." The time has come for the provinces to agree on a reasonable cash contribution by the federal government given the history of the transfers, including the real and substantial contribution of tax transfers. This reasonable cash contribution should also be stable and predictable.

In concluding that the new federal transfer should be "all-cash," the Commission carefully considered and rejected the idea of maintaining, or even expanding, tax point transfers. While a tax transfer theoretically should provide stability and predictability (Rode and Rushton 2002), the actual history of tax transfers for health indicates they are quickly ignored and discounted by the jurisdictions that receive them. In addition, there is no guarantee that the revenue generated from tax points will be used for health care. Finally, and most importantly however, tax point transfers eliminate any possibility of the federal government facilitating future expansions of medicare or helping to safeguard the fundamental principles underpinning the system. Ottawa's ability to act as a catalyst in protecting and extending the national dimensions of medicare is directly proportional to the size of its cash contribution to provincial expenditures (Maslove 1998).

"I don't think many people I talk to … know that CHST includes health care, post-secondary education and social services.… Separating out health care from the CHST … would be helpful for accountability in health care [financing should not be combined] in a federal funding omelet."

PREMIER GARY DOER. PRESENTATION AT WINNIPEG PUBLIC HEARING.

The dedicated cash transfer should be directly written into a new *Canada Health Act*. This would directly link the policy purposes of the Act with a stable funding mechanism in the same way that transfer funding was part of the *Medical Care Act*. The new arrangement would replace CHST contributions for health with an all-cash transfer.

What might be the agreed-upon cash floor of the proposed Canada Health Transfer? One perspective is to accept the original 43% of the CHST notionally allocated to health when the CHST was first introduced. As shown in Table 2.1, $8.14 billion would be extracted from the current CHST, leaving approximately $10.16 billion cash in a future Canada Social Transfer. The $8.14 billion includes the health cash increases agreed to by the provincial and territorial governments as part of the First Ministers' September 2000 accord (see Appendix E which sets out the manner in which the allocation was derived).

"An increase in the CHST is urgent to consolidate public health services; opening up negotiations on a new fiscal sharing arrangement would lend a new dynamism to the federation."

CONFÉDÉRATION DES SYNDICATS NATIONAUX. PRESENTATION AT MONTREAL PUBLIC HEARING.

The Senate Standing Committee on Social Affairs, Science and Technology in their final report (2002c), recently put forward a 62% allocation based upon the federal Department of Finance's most recent position that the CHST cash allocation for health should approximate the relative share of current provincial spending for health care as a percentage of all provincial spending for health care, post-secondary education, social assistance and social services (including early childhood development). This would amount to an $11.35 billion cash floor using 2001/02 fiscal year calculations.

Table 2.1
Allocation Formulas for The Cash Base of Health and Social Transfers

Allocation Formula	Allocation Per Cent	Hypothetical Canada Health Transfer Cash Value, 2001/02 ($Billions)	Hypothetical Canada Social Transfer Cash Value, 2001/02 ($Billions)
Historic basis	43%	$ 8.14	$10.16
Senate Committee	62%	$11.35	$ 6.95

Source: Appendix E; Canada, Senate 2002c.

As Table 2.1 illustrates, however, the larger the cash floor for the proposed Canada Health Transfer, the smaller the cash floor for the Canada Social Transfer, and if too small a cash amount is left for post-secondary education, social assistance and social services, the result might actually be detrimental to the health system in the long run. As noted in Chapter 1, investments that improve the level of education and reduce income disparities can often have a significant long-term impact on the health of the population, thereby ultimately reducing health care costs. The clear danger in using the higher allocation is that it directly limits the cash available to maintain these other programs. In addressing the apparent deficit in health funding, that deficit should not be passed on to post-secondary education and social assistance. As a result, the Commission has adopted a base health allocation for the cash value of federal transfers of 43% of the current CHST cash contribution.

Using this allocation the cash value of the CHST contribution was $8.14 billion in 2001/02 and amounts to approximately 18.7% of current provincial-territorial expenditures on *Canada Health Act* services. This is not enough. The Commission's view is that, at a minimum, future federal expenditures should be based on its past cash commitment of 25% of provincial-territorial costs for services covered under the *Canada Health Act*.

Using the past fiscal year (2001/02) as the base line, achieving a 25% federal share would have required a $10.87 billion federal contribution toward the estimated $43.48 billion worth of provincial-territorial spending on current CHA services. Increasing federal funding commitments to reach 25% would thus have required an additional $2.73 billion. By 2005/06 the value of CHST cash transfers for health are projected to be worth $8.82 billion or 16.7% of provincial-territorial spending on *Canada Health Act* services. If provincial-territorial expenditures climb to $53 billion (see Appendix E), a 25% federal share would mean a required federal cash contribution of $13.19 billion by 2005/06.

As table 2.2 below indicates, moving to a 25% federal share by 2005/06 would require a further investment of approximately $4.4 billion. This does not include, however, additional investments by the provinces levered through new federal investments. Beyond these increases, if the scope of eligible CHA services is expanded to include targeted home care services as well as funding for a catastrophic drug transfer (as a type of extended health care service not yet subject to all of the principles of the CHA, but as a candidate for full inclusion in the not-too-distant future), the cash base will increase accordingly. Taking this into consideration, the Commission believes that a minimum $6.5 billion federal contribution must be added into the base by 2005/06 for a total cash base of $15.3 billion.

Table 2.2
Estimates of CHST Transfers and Required Additional Funding under a Canada Health Transfer

Fiscal Year	Estimated Provincial-Territorial Hospital and Physician Expenditures	Projected CHST Cash Transfers	Federal Share of Provincial-Territorial Hospital and Physician Expenditures	Canada Health Transfer – 25% Federal Share of Hospital and Physician Services Only	Additional Revenues Required
	($Billions)	($Billions)		($Billions)	($Billions)
2001/02	$43.48	$8.14	18.7%	$10.87	$2.73
2002/03	$45.52	$8.16	17.9%	$11.38	$3.23
2003/04	$47.80	$8.41	17.6%	$11.95	$3.54
2004/05	$50.24	$8.67	17.3%	$12.56	$3.89
2005/06	$52.75	$8.82	16.7%	$13.19	$4.37

Source: Appendix E.

This increased investment by the federal government is not only consistent with the original medicare commitment, it is essential to protect, promote, and enhance the national dimensions of public health care in Canada. The final recommendation is also consistent with a recent proposal by Tom Kent (2002), one of the architects of medicare in the 1960s, who argued that such a reinvestment would be a prerequisite to the federal government resuming a leadership role with the provinces in shaping the future of medicare.

A core objective of any new transfer or any reinvestment of funds should be to create a stable and predictable funding commitment for medicare in the future. In the Commission's view, increases to the transfer should be based on expenditure projections that are agreed upon by both orders of government and forecast by a body that has the confidence of both. This cash escalator should be expressed as absolute increases to the total transfer, and set out over a five-year time horizon to provide predictability.

A preferable alternative to this approach may be a fixed escalator formula. Such a formula could take into consideration not only the rate of growth in expenditures under the *Canada Health Act* but growth in the economy. The escalator could be set at the rate of growth in Canada's economy (measured by a rolling five-year historic average of GDP) multiplied initially by 1.25. The figure of 1.25 is based on the long-term trend (1960 to 2000) between growth in total health expenditures relative to the growth of the Canadian economy as described in Chapter 1. The multiplier of 1.25 could be revised every five years to reflect more current data.

Some might argue that it would be preferable for any escalator to be set strictly at or below the rate of economic growth. But as noted in Chapter 1, it has been the case for decades that the more our income grows, the more of that income we choose to devote to health care, both as individuals and collectively through our governments. This type of escalator would ensure that the growth of the proposed Canada Health Transfer is tied to the rate of growth in the economy in a realistic way.

The Covenant described earlier ensures that both orders of government agree on fundamental principles and objectives. At the same time, however, governments will need to agree on the changes that they are buying with their new investments both in terms of short-term fixes to the system and, more importantly, long-term changes in direction. At this time, they should also agree on the new cash basis of the proposed Canada Health Transfer and the approach to its escalation over time. Failure to reach a formal agreement on these issues will mean that the intergovernmental wrangling over who is paying what share for health will continue into the future and this will mean that necessary health care reforms will continue to be overshadowed by these debates. First Ministers in particular should be prepared to exercise the requisite leadership that will establish the fundamental basis for medicare for the next 20 years.

Short-Term Funding Issues

A new *Canada Health Act* incorporating the proposed Canada Health Transfer may take a year or two to prepare and pass. In the meantime, action must be taken. As a consequence, both orders of government must commit to a common set of priorities. To facilitate this, the Commission calls on the federal government to provide targeted, short-term funding for these priorities. In turn, the provinces and territories must understand that this short-term federal funding cannot be a "blank cheque" and must shape their health budgets in the immediate future to reflect the agreed-upon priorities, matching or exceeding federal support for these priorities. This will ensure that both orders of government are moving in the same direction as we chart a course of reform and modernization of our health care system.

On a priority basis, targeted funding programs should be put in place to fix pressing problems and gaps in the existing system (see Table 2.3). That includes a Rural and Remote Access Fund as well as a Diagnostic Services Fund. The federal government should establish these two funds as soon as possible, with $1.5 billion allocated to each fund. Funding should be provided to the provinces and territories on a population health basis that takes into account the size, demographics (including age and gender), and health of the population served.

Table 2.3
One Time Bridge Funding to the Canada Health Transfer ($Billions)

	2003/04	2004/05	Cumulative Targeted 2003/04 to 2004/05	Additional Cash Investment 2005/06
Diagnostic Services	1.5		1.5	
Rural and Remote Access	1.5		1.5	
Primary Health Care Transfer	1.0	1.5	2.5	**6.5**
Home Care Transfer	1.0	1.0	2.0	
Catastrophic Drug Transfer	–	1.0	1.0	
Total cash base for Canada Health Transfer				**15.32**

The Diagnostic Services Fund would allow provinces and territories to increase their investment in advanced diagnostic services in order to improve access for their residents. Funds could be used for purchasing this equipment as well as employing and training the necessary personnel to operate and maintain this equipment.

The purpose of the Rural and Remote Access Fund would be to improve access in rural and remote communities (see Chapter 7) by:

- addressing problems in the supply and distribution of health care providers;
- supporting expansion of innovative approaches to telehealth; and
- initiating broader, population-based demonstration projects.

In addition to these two targeted funds, an additional three transfers should be established to jump-start major change in the system in the next two years. These transfers should be made conditional on the provinces and territories using the funds for the three purposes described below. Funds should be distributed to the provinces and territories on a per capita basis.

- **Primary Health Care Transfer** – This transfer should reflect the objectives and framework presented in Chapter 5 and be used to spearhead primary health care change on a large scale across Canada. The federal transfer should be set at $1 billion beginning in 2003/04 with a further $0.5 billion invested in the following year. Provinces and territories would be required to invest identical amounts in those years.
- **Home Care Transfer** – This transfer would support expansion of the *Canada Health Act* to include targeted home care services and implementation of the recommendations set out in Chapter 8. The federal investment in this transfer should be $1.0 billion annually, beginning in 2003/04.
- **Catastrophic Drug Transfer** – This $1.0 billion transfer would cover 50% of the provincial and territorial costs of their drug insurance plans above a pre-set threshold. The transfer should begin in 2004/05 to allow sufficient time for planning and negotiation. This new initiative is described in detail in Chapter 9, but its main purposes are to offset the high cost of provincial and territorial drug plans and to provide the provinces and territories with an incentive to expand their plans' coverage.

The message from these targeted funds and transfers is clear. Additional funding cannot be used simply to support or stabilize the status quo. New funding from the federal government must, in effect, buy change – real and substantial change that reflects Canadians' priorities, addresses the most pressing needs, and sets the stage for ongoing and fundamental transformation of Canada's health care system.

What Does this Mean for Canadians?

Canadians have said they want their health care system remodelled. They want it to meet their needs today but more importantly, they want assurances that the system will be sustained so that future generations of Canadians can share in the benefits of an efficient, high quality and accessible health care system. To meet those expectations, we need to shore up the foundation and make sure it reflects the changing nature of health and the health care system.

The recommendations in this chapter are the foundation for all other recommendations in this report. First and foremost, they reaffirm and strengthen medicare with a shared vision for the

future. They mean all Canadians can look to a new Canadian Health Covenant as the embodiment of their values and expectations for Canada's health care system.

With a new Health Council of Canada in place, Canadians can expect to see strong leadership across the country and collective efforts by governments and health providers to improve health and health care.

Canadians will have better information about their health care system and the results that it achieves. With this information, they will be able to hold their governments and those in the health care system accountable for the results that are achieved and the progress that is made.

A renewed *Canada Health Act* with six solid principles will provide a strong foundation and ensure that the health care system not only reflects Canadians' values but also continues to change and evolve to meet Canadians' needs.

Consistent with recommendations in later sections of this report, targeted funding means Canadians should begin to see almost immediate steps to improve access to diagnostic services, home care, primary health care, and address access problems in rural and remote communities. And it means all Canadians will be covered for the high cost of prescription drugs.

With co-operative actions by both federal and provincial-territorial governments, it means the squabbles over who pays for what should be replaced by adequate, stable and predictable funding over the longer term.

These are not vague promises that governments and health care providers can debate and discuss in the years to come. Canadians have spoken. Now they expect to be heard. They expect tangible proof that governments can and will work together to establish a new direction for health care reflecting Canadians' values and Canadians' priorities. It is now up to the federal, provincial and territorial governments to seize the opportunity, take action to put the necessary agreements and funding in place, and show Canadians that they have every reason to be confident about the future of their public health care system.

3 Information, Evidence and Ideas

Directions for Change

- ***Enable the establishment of personal electronic health records for each Canadian, building on the work currently underway in provinces and territories.***
- ***Take clear steps to protect the privacy of Canadians' personal health information, including an amendment to the* Criminal Code of Canada.**
- ***Provide better health information to Canadians, health care providers, researchers and policymakers – information they can use to guide their decisions.***
- ***Expand the scope, effectiveness and co-ordination of health technology assessment across Canada.***
- ***Create four research Centres for Health Innovation to address the gaps in applied research in important areas of Canada's health care system, including rural and remote health, health human resources, health promotion and pharmaceutical policy.***
- ***Forge stronger linkages with researchers in other parts of the world and with policymakers across the country.***

The Case for Change

We repeatedly hear that the 21st century is the age of information and evidence – a time when the keys to progress and success lie in our ability to innovate, to tap into new information and evidence and transform ideas into exciting new developments, new services, and new solutions. In health, information, evidence and ideas have the potential to unlock the cures to many of today's illnesses, identify the genetic source of chronic illnesses, give health care providers access to the latest and best information on new treatments or drugs, improve the quality and safety of care within the health care system, and most importantly, empower patients to manage and maintain their own health.

Some might wonder why a chapter on information would figure so prominently and be placed at the beginning of a report on the future of Canada's health care system. The answer is

that leading-edge information, technology assessment and research are essential foundations for all of the reforms outlined in subsequent chapters of this report. Furthermore, health research – especially biomedical and scientific research – is an increasingly important component of Canada's knowledge economy and a source of high-skilled, well-paid employment for thousands of Canadians.

To take full advantage of the potential of information, evidence and ideas in the health care system, the necessary information infrastructure must be in place. This requires action on three important fronts: putting essential information management and technology systems in place, improving our ability to assess and manage the potential benefits of health care technologies, and expanding our applied research capacity across the country.

These three aspects are clearly linked. Putting the information management and technology infrastructure in place means that essential information can be collected, compiled and used to make better decisions and improve quality and care within the system. Improving our ability to assess new technology means that only the most effective new treatments, prescription drugs or equipment would be purchased and used in Canada's health care system. With better information management and technology in place, researchers can assess the impact and value of different treatments and approaches to delivering health care services in addition to developing and testing new discoveries and cures. Together, these three "pieces of the puzzle" can create a 21st century information and evidence infrastructure that will guide and inform the future of Canada's health care system, improve its efficiency, and most importantly, improve the health of Canadians.

Building Canada's Health Information Technology Infrastructure

RECOMMENDATION 8:

A personal electronic health record for each Canadian that builds upon the work currently underway in provinces and territories.

RECOMMENDATION 9:

Canada Health Infoway should continue to take the lead on this initiative and be responsible for developing a pan-Canadian electronic health record framework built upon provincial systems, including ensuring the interoperability of current electronic health information systems and addressing issues such as security standards and harmonizing privacy policies.

RECOMMENDATION 10:

Individual Canadians should have ownership over their personal health information, ready access to their personal health records, clear protection of the privacy of their health records, and better access to comprehensive and credible information about health, health care and the health system.

RECOMMENDATION 11:

Amendments should be made to the *Criminal Code of Canada* to protect Canadians' privacy and to explicitly prevent the abuse or misuse of personal health information, with violations in this area considered a criminal offense.

RECOMMENDATION 12:

Canada Health Infoway should support health literacy by developing and maintaining an electronic health information base to link Canadians to health information that is properly researched, trustworthy and credible as well as support more widespread efforts to promote good health.

Introducing Personal Electronic Health Records

Information technology has literally revolutionized the way information is collected, stored, shared and used. It is one of the "four strong winds" forcing change in health care today (Decter 2000). Good information systems are essential to a high quality health care system. They allow health care providers, managers and policymakers to share information and use the best available evidence to guide their decisions. They can also forge a strong link between quality on the one hand and accountability on the other.

Increased use of information technology in health care can also have important benefits for patients. It can provide them with better access to their own health information as well as to relevant health knowledge, which in turn allows them to play a more active role in maintaining their health and making decisions about their medical care.

Provinces and territories, health regions, and health care providers understand and support the need to make better, more effective use of information technology in addressing a number of challenges in today's health care system. Yet, despite this consensus, progress has been slow and provincial and federal initiatives are being developed in isolation, despite the fact that the costs of each government going it alone are very high. Initiatives in provinces are motivated by different interests and objectives and it is not always clear if the projects are driven by administrative priorities, commercial interests, or the interests of citizens. In addition, as outlined in Chapter 7, there is much that remains to be done to provide rural and remote parts of the country with the basic electronic infrastructure to facilitate developments such as telehealth.

Much of the focus in information technology applications in health care has been on electronic health records. Why are electronic health records so important?

Electronic health records are one of the keys to modernizing Canada's health system and improving access and outcomes for Canadians. An electronic health record provides a "collection of personal health information of a single individual, entered or accepted by health care providers and stored electronically. The record may be made available at any time to providers, who have been authorized by the individual, as a tool in the provision of health care services" (HC 2001f). Data are entered on individuals' personal health records every time they visit their physician, have a prescription filled, have a lab test, or go to the hospital. The electronic record provides a systematic, historic record of every interaction a person has with the health care system.

Currently, much of the clinical and administrative information in the health system is contained in files of paper records. In most cases, health care providers and their organizations decide what information is relevant for their purposes and what form the information should take. As a result, the current health record system can be described as an assortment of non-standardized patient information stored in isolated patient records.

Paper records are increasingly becoming obsolete and inadequate. They limit the flow of information, insufficiently document patient care, impede the integration of health care delivery,

create barriers to research, and limit the information available for administration and decision making. They also limit Canadians' ability to access their personal health records and use their personal health information for making decisions about their own health and health care.

In contrast, electronic health records provide important advantages.

- Diagnoses, treatments and results can be improved when health care providers have access to complete personal health information and can link that information to clinical support tools. In a recent survey from the Canadian Medical Association, over 76% of physicians agreed that improving how patient information is shared is an important or very important potential benefit of electronic health records. Further, 68% agreed that the use of electronic health records would result in improvements in clinical processes, efficiency of workflow, and continuity of care. Almost 60% said that electronic health records would improve the quality of care (Martin 2002).
- Accuracy of personal health records can be improved. With an electronic health record, information from a variety of health care providers is collected and stored on a single record, providing a more complete and more accurate record of an individual's personal health history.
- Efficiency can be improved. As one health region described it, roughly 30% of nursing time is spent managing paper records. Just a 5% reduction in the time nurses spend doing charts could free up the equivalent of 90 nursing positions and generate $5 million a year in savings. They also point to potential efficiencies in managing chronic diseases by targeting efforts to expand electronic health records at the primary health care level (Calgary Health Region 2002a and 2002b).
- Electronic health records provide aggregate data that can be used in health research and in health surveillance, tracking disease trends and monitoring the health status of Canadians.
- Security can be improved. From the point of guaranteeing necessary access to health records, precautions need to be put in place to ensure that electronic health records do not become an obstacle when accessing health services. Necessary safeguards must be in place to ensure that a network crash never serves as an obstacle to obtaining necessary care. Furthermore, electronic health records bring together a host of health records that were previously physically dispersed into a new comprehensive format. This change will have important implications in terms of the physical security of personal health information.

"A jewel in our crown is our electronic medical record system … We believe the M-R [Medical Record] is the key tool in improving health outcomes for our patients … and it saves time and money."

GROUP HEALTH CENTRE SAULT STE. MARIE. PRESENTATION AT SUDBURY PUBLIC HEARING.

With a complete system of electronic health records in place, there are some important benefits for individual Canadians, for health care providers, researchers and the system as a whole.

Individual Canadians would have secure on-line access to their personal electronic health records. One potential scenario could involve the development of a Web site to access personal electronic health records similar to on-line banking, where individuals could log onto the system using a personal identification number. At the click of a mouse, they would have access not only to their personal health information but also to a broader base of general information on health issues. With this information, individuals can play a more direct role in managing their own health.

Health care providers would have access to clinical decision support tools to assist them in making decisions based on the best available evidence. Health care providers would be able to access patient records at the point of a clinical encounter. It would help manage the massive amounts of complex health information and ensure that health care providers have complete and accurate information about patients' health and health care histories. It also would improve physicians' ability to access the latest information, select the best course of action, and use evidence to guide their decisions.

Researchers and policymakers would have access to aggregate data compiled through the electronic health record system. These data could be extracted generically for health research purposes, without being linked to any individual electronic health record. The Commission understands that researchers would, in many cases, prefer to have access to "person-oriented" health information to allow them to track certain illnesses or health-related factors over time. Only when there are sufficient safeguards in place and the system has demonstrated its ability to protect the privacy of individuals, should researchers have access to "person-oriented" data. This information could be used to monitor and measure outcomes and allow increased health surveillance in the management and treatment of particular diseases, especially for patients with chronic illnesses.

> *"There is no national, interprovincial or cross-jurisdictional coordinating body to ensure health practitioners have cost effective and universal access to the best patient care and health research information."*
>
> CANADIAN HEALTH LIBRARIES ASSOCIATION 2001. WRITTEN SUBMISSION.

Finally, the overall quality of the health care system can be improved. The electronic health record system would enhance the ability of health care managers and researchers to identify and respond to medical errors or problems that occur in the health care system, and improve patient safety and quality of care. Currently, problems in the health care system related to patient safety are not well monitored or identified for a host of reasons including the lack of information technology to monitor and track errors and also the fear of blame and litigation.

A Leadership Role for Canada Health Infoway

Clearly, the benefits of electronic health records are substantial for Canadians, for health care providers and managers, and for governments. While a number of electronic health record initiatives are underway across the country, progress on the major provincial initiatives has been slow and costs have been high. Greater collaboration among governments could both speed up development and save costs for all Canadians.

Some intergovernmental co-ordination has occurred under the intergovernmental Advisory Committee on Health Infostructure (ACHI). In December 2000, ACHI released a *Blueprint and Tactical Plan for a pan-Canadian Health Infostructure* identifying the following three priorities (HC 2000):

- developing an electronic health record system;
- developing integrated provider solutions, including clinical decision support tools and ultimately an electronic provider portal; and
- providing relevant, credible and timely health information to the public to empower individuals to manage their own health through a Canadian Health Network and self-care and telecare services.

Following from the First Ministers' Agreement in September 2000, the federal government invested $500 million into Canada Health Infoway. Infoway is an independent, non-profit

corporation with responsibility for accelerating the development and adoption of modern systems of information technology with the aim of providing better health care. Infoway is currently attempting to build on existing initiatives and pursue collaborative relationships with the provinces and with the Advisory Committee on Health Infostructure. The Commission believes that, with continuing diligence, Infoway's funding can go a long way in supporting the necessary ongoing efforts to create a national electronic record system. Further funding, if necessary, should come only after discussion by the federal, provincial and territorial health ministers.

Given its mandate, Infoway is uniquely poised to provide overall leadership and to act as a catalyst in moving forward on essential information management and technology initiatives. This work will require ongoing support from provincial, territorial and federal governments to ensure that decisive and timely action can be taken to put the necessary systems and networks in place. There is wide consensus in the health care system that electronic health care records are essential to future improvements in the system and in the quality of care. Deliberate action is needed on an urgent basis to put the necessary systems in place and begin to see some tangible and concrete progress. The proposed Health Council of Canada should conduct an assessment of Infoway's progress in this area in two years' time and provide its findings and future recommendations in a public report to Canadians and health ministers.

Empowering Canadians and Protecting Their Privacy

Moving to an electronic health records system provides important benefits to Canadians, particularly in terms of giving them ready access not only to their own personal health care information but also to a wealth of trusted, credible information on a variety of health topics.

At the same time, many Canadians worry that their personal health information could be abused or misused. Issues surrounding protection of privacy are serious and complex. On the one hand, Canadians need a strong assurance that their personal health information is used only by those who need it and only under certain circumstances. The Privacy Commissioner of Canada notes that there are privacy risks whenever personally identifiable information is stored electronically. Therefore, rules need to be in place to ensure that personal health information is carefully safeguarded. Most often, those rules focus on requiring individuals' consent before their personal information is accessed and shared. On the other hand, health care providers need access to personal health information in order to provide the best possible care to patients, to guide their decisions, and ensure that they have a complete picture of an individual's health needs. Privacy rules have to strike the right balance between strict privacy protection procedures and the legitimate and important need for health care providers to access personal health information, often on an urgent or emergency basis.

"We are still very concerned, obviously, about privacy of information and personal health information; but in order for the system to function as efficiently as possible … there needs to be access and a flow through of the information."

Consumers' Association of Canada. Presentation at Toronto Public Hearing.

Consistent and clear privacy rules should be in place across the country. With the aim of protecting individual health information to the greatest extent possible, amendments should be made to the *Criminal Code* to make abuse or misuse of personal health information a criminal offense. Specifically, it should be a criminal offense for anyone to acquire, use or share another person's personal health information for purposes

that do not explicitly relate to the management of the health of the person to which the records relate. These amendments should also prohibit authorized users of the information from utilizing it for purposes other than this intent without the consent of the patient.

Expanding Health Literacy

Another important benefit to Canadians lies in the potential for the electronic health record system to go beyond just a record system to provide comprehensive health information. Increasingly, Canadians are turning to the Internet as a source of health information. Roughly half of the people who use the Internet use it to search for health-related information (Statistics Canada 2001d). Despite concerns that specific health information is difficult to access and may not be credible, the majority agreed that the Internet, as a health resource tool, has made them more knowledgeable about their health and health-related issues.

> *"We need to do more than disseminate reliable nutritional information, we must also motivate Canadians to use that information."*
>
> DIETICIANS OF NEWFOUNDLAND AND LABRADOR. PRESENTATION AT ST. JOHN'S PUBLIC HEARING.

To provide Canadians with the necessary tools and information about health and health issues, a multi-layered approach is needed – one that addresses not only how health information is packaged but also how it is accessed, interpreted and used (Jadad 1999). Specifically, Canadians need:

- comprehensive and integrated pools of credible information that are presented in intellectually appealing and user-friendly formats;
- timely access to relevant and credible health information;
- optimal skills to process and understand the relevance of health information; and
- receptive environments where they are able to use information as part of decisions they make about their health and health care.

Looking at the various Web sites of health information available today, it is obvious that the public sector has played a limited role in providing health information to the public (HC 2001f). In contrast, the private sector, in the United States in particular, has flooded the Internet with electronic health information. Unfortunately, the credibility of this information is uncertain since much of it is posted and sponsored by particular commercial enterprises.

To date, a primary source of electronic health information for Canadians has been the Canadian Health Network. The network currently provides 12,000 e-based English and French language health resources on 26 health topics ranging from health promotion and ways of staying healthy to specific illnesses such as cancer. These resources reach beyond Canadian sites and material to include relevant international material. In addition, the network provides links to discussion groups on various topics and offers users a guide for evaluating the quality and reliability of other health information available on the Internet.

> *"Canadians strongly value and endorse individual responsibility and accountability and want information that will help them to make educated life choices. They also believe that governments are responsible for providing them with the information they need."*
>
> FPT MINISTERS RESPONSIBLE FOR PHYSICAL ACTIVITY 2001. WRITTEN SUBMISSION.

Infoway should play a key role in promoting health literacy as it relates to the development of an electronic health record system by opening the door to a vast amount of trusted, credible health information for Canadians. It should build on work already done by the Canadian Health Network and establish linkages to other reliable sources of electronic health information. The Network could serve as the foundation for the development of a comprehensive health information Web site with

links to a number of credible national and international Web sites. Infoway should also work with the Canadian Institutes of Health Research to build up an electronic health information evidence base and link it into current electronic health record developments. Linkages should be made with existing health information sources at the provincial, territorial and regional levels, particularly in the area of prevention and promotion.

The following vignettes provide examples of how access to personal health records, combined with trusted sources of health information, can benefit individual Canadians.

A young woman learns from her doctor that she is pregnant for the first time. Her physician gives her some good information about the things she needs to do to make sure she has a healthy pregnancy, including taking vitamins, watching her diet, exercising regularly, and avoiding alcohol. She has heard about several risk factors and wants to do as much as she can to avoid them. So she goes on the Internet, enters her personal identification number, and has access to important facts from her personal health history. She knows, for example, that a family history of diabetes might have an impact. She connects to the health information side of the system and finds a wealth of reliable information about pregnancy and diabetes, including the signs to watch for. She makes a list of some questions she wants to ask her doctor at her next visit. She also finds links to other information and resources available in her community.

An elderly couple has led an active and independent life, but recently, the husband has been showing persistent signs of forgetfulness and disorientation. The doctor confirms it is the early signs of Alzheimer's disease. Faced with this devastating news, they decide to learn as much as they can so they can be well prepared for what is to come. They contact a local branch of the Alzheimer's Society and learn the latest and most accurate information is available through the electronic health records system. They go to the local library and are able to access the information using the husband's personal identification number. Although the computer is in the library, they can use it in confidence because the system protects their privacy. They find a lot of helpful information. They also get information on personal directives and living wills that allows them to discuss the options and make decisions along with their children.

A 12-year-old boy has been diagnosed with juvenile diabetes. He needs to track his insulin levels and other information about how he is feeling through the day and provide that information to the health management team that is monitoring his care. With that information, they can regulate his dosage of insulin, his diet, his activity levels, and help manage his care. The boy uses a mobile device like a Palm pilot. He feeds information into the Palm pilot during the day, and at night, he hooks it up to his home computer, types in his personal identification number, and sends it to the health management team. During regular meetings, he and his parents go over the information with the health management team. He and his parents can also use his personal identification number to access information about juvenile diabetes, especially research that is underway to find a cure.

Streamlining and Improving Health Technology Assessment in Canada

RECOMMENDATION 13:

The Health Council of Canada should take action to streamline technology assessment in Canada, increase the effectiveness, efficiency and scope of technology assessment, and enhance the use of this assessment in guiding decisions.

The Growing Importance of Health Technology Assessment

Advances in health technology have tremendous potential for changing the organization and delivery of health care services and improving health outcomes for Canadians, but they come at a price. More varied and sophisticated equipment and products come onto the market on an almost daily basis. In making decisions about whether to purchase and use these new technologies, health care managers and decision makers must rely on the best available assessment of the impact, benefits and effectiveness of new technologies on health care and health outcomes.

Health technology assessment is a comprehensive and systematic assessment of the conditions for and the consequences of using health care technology. It provides relevant information to managers, decision makers, and health care providers on the safety, economic efficiency, clinical effectiveness, as well as the social, legal and ethical implications of using new and existing technologies. Indeed, health technology assessment should be about what is best for the patient – medically and economically – and not about technology for technology's sake. The assessment is intended to help health policymakers, providers, and especially, health organization managers make decisions about whether to purchase and use new technologies, whether to replace old technologies with new ones, and what benefits they can expect to see.

With continuing innovations in technology and mounting cost pressures, the need for careful technology assessment will become even more acute. Suggestions have been made that, with rapidly expanding and changing knowledge and new technologies and treatments, health care providers have trouble keeping up with the knowledge being generated (Davenport and Glaser 2002). The best way to enhance their use of information is to "make the knowledge so readily accessible that it can't be avoided" (Davenport and Glaser 2002, 108).

In a similar vein, Morgan and Hurley (2002a) suggest that the inflationary pressures associated with health care technologies could be better controlled through policies that influence decisions made by health care providers in their clinical encounters with patients. In other words, for health care providers to use technology effectively, they need accurate and relevant information and the right incentives for its use when they are dealing directly with patients.

New health care technologies also have the potential to raise serious social and ethical considerations, particularly in areas such as biotechnology where issues such as cloning, eugenics or new genetic and reproductive technologies pose troubling and complex questions that go well beyond science or medicine. Accordingly, suggestions have been made that processes for technology assessment need to be transparent, accountable and allow for meaningful input from Canadian citizens (Lehoux 2002).

Provinces, territories and the federal government understand the importance of carefully assessing health care technology before it is implemented or used in the health care system. This assessment is critical to ensure the safety and effectiveness of the technology and also to get the best value and clear improvements in health outcomes for a substantial investment in new technology.

At the provincial level, several provinces have established health technology assessment agencies to provide policy advice and to guide decisions on health technology. These provincial bodies have built a strong reputation for effective work, but they face two challenges: first, they have limited assessment capacity (in both financial and human resources) and second, their efforts to disseminate their assessments along with clinical practice guidelines and care protocols are insufficient (Lehoux 2002). Consequently, there is a significant gap between the work of these assessment agencies and the decision makers and planners making decisions on the uptake of new and existing technology.

The provinces, territories and the federal government have also worked together to establish and fund the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). CCOHTA's role is to co-ordinate health technology assessment across the country, to facilitate information exchange, pool resources, co-ordinate priorities for health technology assessments, minimize duplication as well as conduct its own technology assessments in areas where gaps exist. Despite its extensive mandate, several reports and studies have pointed to the need to strengthen CCOHTA's co-ordinating role (McDaid 2000; HC 1999a; Battista et al. 1995). As set out in Chapter 2, this can be achieved by having the Health Council of Canada assume the current responsibilities of CCOHTA.

Overall, there are a number of obstacles that prevent maximum utilization of health technologies and their assessments in Canada.

- Not enough attention is paid to identifying and setting priorities for assessing emerging health technologies. In particular, there is a need for a cross-country early warning system to support future development and diffusion of new health technologies.
- The overall level and scope of health technology assessment has been limited compared with other OECD countries. For example, there currently is no formal process for evaluating all telehealth applications and there has been only minimal technology assessment of PET (positron emission tomography) scanners, in spite of the fact the equipment has been in use in Canada for over 20 years.
- Health technology assessments are often not sufficiently comprehensive, either because they fail to fully consider the social, legal and ethical implications of the use of health technologies, or because they fail to provide sufficiently detailed economic evaluations. This may explain, in part, why health technology assessments have, so far, had a marginal impact on resource allocation decisions. Assessment agencies have also had limited contact with decision makers, planners and health care providers, and decision makers and planners have not made effective use of the assessment materials provided to them.
- There is a lack of relevant research on the relationship between health technologies and overall improvements in health outcomes. Decisions about purchasing new technology are too frequently made without knowing the impact of that technology on addressing population health needs.

- Decisions regarding the uptake and diffusion of technologies are primarily taken at the provincial, territorial, regional health authority or individual hospital or health program level with only limited co-ordination across or within jurisdictions.

Expanding Health Technology Assessment in Canada

The proposed Health Council of Canada should have a two-fold mandate in the area of health technology assessment. First, it should increase the overall technology assessment capacity in Canada. Second, with CCOHTA being folded into the Council, it will be able to continue to share assessment information among jurisdictions. Clear linkages should be developed between the Health Council of Canada and the current work being conducted at the intergovernmental level in setting up shared sites of excellence for low volume surgeries such as pediatric cardiac surgery and gamma knife neurosurgery (FMM 2002).

Given finite resources in the health care system, the Council should facilitate intergovernmental collaboration in the development, co-ordination and implementation of a health technology strategy to guide more efficient financing, management and utilization of technologies within the Canadian health system, with a long-term goal of assessing all health technologies in use across the country. This strategy would:

- Establish a framework for the overall management of technologies within the health system, with priority on assessing health technologies that impact rural and remote health delivery (e.g., telehealth applications) and primary health care change;
- Explore the possibility of harmonizing financing for the acquisition, upgrading and maintenance of high-cost technologies such as diagnostic imaging technology, including MRI (magnetic resonance imaging) and CT (computed tomography) scanners;
- Develop a targeted plan for the adoption of specialized technologies that takes into account specific population needs, the availability of health human resources and the necessary infrastructure to support these given technologies;
- Address current gaps in our knowledge about the clinical benefits and cost-effectiveness of health technologies as well as the added value of improving health outcomes for Canadians in general and for people with certain diseases;
- Support the development of clinical practice guidelines based on evidence derived from health technology assessments either at the national or interprovincial level; and
- Strengthen training programs and ensure a stable health human resources supply to manage and appropriately use health technology. (This links with the Council's overall work on health human resources as set out in the following chapter.)

Increased health technology assessment should serve as a driving force to encourage the adoption and implementation of appropriate health technologies. It should ensure that provinces and territories are keeping pace in adopting new technologies and that health professionals and decision makers use technology assessments to guide their decisions. In future, the Health Council may want to consider ways of seeking input from Canadians on issues where new health technologies have significant ethical, moral or social implications.

Building Canada's Health Research Knowledge Base

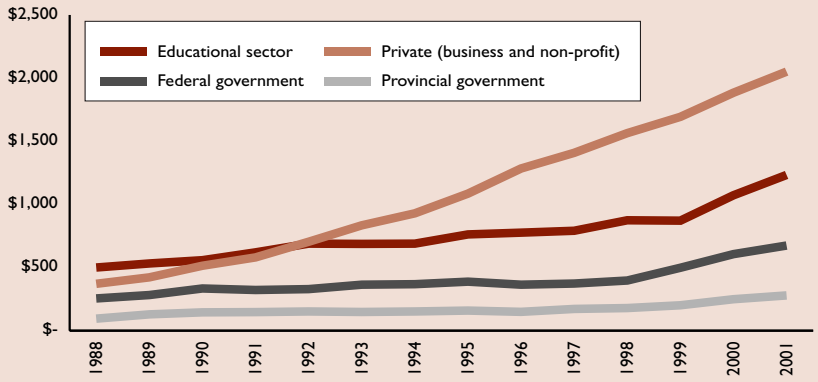
RECOMMENDATION 14:

Steps should be taken to bridge current knowledge gaps in applied policy areas, including rural and remote health, health human resources, health promotion, and pharmaceutical policy.

Canada's health research infrastructure consists of a rich and diverse network of individual scientists, academics and organizations. This research is conducted by individual university-based scientists and researchers whether working alone, in groups or networks, in research and scientific institutes, and perhaps most importantly, in teaching hospitals across the country. Funding for this research comes from federal and provincial arm's length granting bodies, from private sector companies such as the pharmaceutical industry, and from non-governmental agencies such as the Canadian Cancer Foundation and the Heart and Stroke Foundation that fund research on specific diseases. The vast majority of this research, and the funding for it, are dedicated to biomedical and scientific research aimed at disease prevention, treatment and analysis. Canada has a long tradition in excellence in clinical research. From the historical achievements of Banting and Best in discovering insulin to modern research on genetics, Canada has an impressive community of dedicated clinical researchers. In 1997, the $36 billion life sciences industry in Canada accounted for 86,000 jobs and is expected to grow to 130,000 jobs by 2003.

On the whole, Canada has seen an increase in health-related research and development expenditures since the early 1990s (see Figure 3.1). Federal funding for health research and development has risen from $255 million in 1988 to $674 million in 2001 (Statistics Canada 2001a).

Figure 3.1 Distribution of Health-related R & D Expenditures in Canada ($Millions), by Source of Funds, 1988 to 2001



Source: Statistics Canada 2001a.

In 2000, the federal government established the Canadian Institutes of Health Research (CIHR) with the primary objective of strengthening and integrating the health research infrastructure in Canada. CIHR is comprised of 13 organizations that support and link over 6,000 researchers across disciplines, sectors and regions. These organizations and researchers address issues ranging from biomedical and scientific research into cancer, genetics and diabetes to Aboriginal health, gender and health policy.

Taking the Next Steps to Expand Our Knowledge Base

Health research has played an essential role in the history of the public health system and will continue to do so in the future. With the variety of different funding agencies and bodies in place across the country, there are sufficient resources for institutes and their partners to conduct necessary research and evaluations, and disseminate results. In spite of this, there are a number of important problems and challenges within the health care system that currently receive insufficient attention within the scientific community, among governments and health researchers. On several occasions, the Commission was struck by the minimal amount of information available on issues as vital as rural and remote health and health care delivery, or interprofessional collaboration in primary health care settings. Health research challenges in these and other applied research areas require immediate attention and an associated investment of resources, both human and financial.

To this end, the Commission recommends that four Centres for Health Innovation for applied policy research should be created as soon as possible by the Canadian Institutes of Health Research. The federal government has increased CIHR funding substantially in recent years and appears sympathetic to CIHR's desire to see that funding rise to $1 billion per year in the next few years. The Commission supports this direction. If this occurs, the CIHR should consider setting aside $20 million to fund the proposed Centres for Health Innovation, at a modest cost of $5 million for each centre per year. This cost is based upon the existing costs of the current policy-related institutes of the CIHR. The following four centres should be established:

> *"The biggest risk to public medicare in Canada is, in fact, the risk of failing to innovate."*
>
> David McKinnon, Ontario Hospital Association. Sustainability Policy Dialogue.

- **Rural and remote health issues** – The CIHR has already committed $5.2 million and the federal government has committed $1 million to research related to challenges faced by rural and remote communities. However, research to date has been conducted on a piecemeal basis. Rural health researchers have tended to work in relative isolation, just like the people and communities they study. A rural health agenda should be developed to address issues like health conditions and determinants, healthy behaviours, delivery and organization of services, and health status of people living in rural, remote and northern communities.
- **Interprofessional collaboration and learning** – Despite increasing calls for interprofessional collaboration, particularly in relation to primary health care, there is limited research on effective ways of implementing new mixes of skills and providers in health care delivery settings. New work environments and new divisions of labour call for new approaches to collaboration among health care providers in order to maximize the use of the health workforce. There also is limited information about the health care workplace in terms of its organization, planning, the nature of group practice, payment

mechanisms and incentives, and professional responsibility. A Centre for Health Innovation on interprofessional collaboration could go a long way in developing and disseminating best practices in the area of interprofessional collaboration to support primary health care.

- **Health promotion** – Despite numerous studies highlighting the merits of wellness and prevention in improving the health of individuals, organizations have yet to devote sufficient resources to make health promotion a priority. A centre for health innovation focusing on health promotion would support the development of programs aimed at improving individuals' physical and mental health as well as targeting prevention efforts and services in the Canadian population.
- **Pharmaceutical policy** – Greater emphasis needs to be placed on pharmaceutical policy research in order to support integration of prescription drugs into the health care system. Independent pharmaceutical policy research would help ensure that Canadians are getting the best value for their investment in drugs. A new Centre for Innovation on Pharmaceutical Policy would serve as a vehicle for evaluating pharmaceutical policy, disseminating best practices, and providing objective and reliable knowledge to the Canadian public. While pharmaceutical companies would continue to do their own research and development activities, the Centre for Health Innovation on pharmaceutical policy would ensure that policy-oriented research is as free from commercial influence as possible. The Centre could also play an important role in issues related to ethics, particularly in the relationship between the pharmaceutical industry and ongoing pharmaceutical research.

"Research is essential to a cost-effective, innovative and sustainable health care system."

CANADIAN INSTITUTES OF HEALTH RESEARCH 2002. WRITTEN SUBMISSION.

As suggested by the CIHR, these Centres for Health Innovation should be established with a mandate to "engage government, industry, community groups, health charities and others to foster and disseminate a culture of innovation and evidence-based decision-making across the health care system" (CIHR 2002, 20). CIHR would be responsible for the establishment, oversight and evaluation of the performance of these new centres. The Centres for Health Innovation should also be closely linked to the ongoing work of the Health Council of Canada, particularly in relation to its role in providing regular reports to Canadians on the performance of the public health care system.

Once these initial Centres for Health Innovation have been established and have demonstrated their effectiveness in encouraging and supporting both research and innovation in key areas, consideration should be given to establishing future centres in the following areas:

- patient safety
- mental health
- telehealth
- genomics and proteomics
- chronic disease management

Forging Better Linkages

The primary value of these centres would be to inform and guide policy decisions. Unfortunately, current structures and mechanisms within the health care system do not promote this kind of linkage (Lomas 2000). The proposed Centres for Health Innovation will help to bridge that gap in certain areas. In addition, there is a need for a more global approach to establishing and maintaining linkages between researchers and policymakers. One way of doing this is to encourage secondments of individuals to "work in each other's world." In this way, researchers would gain experience in the policy environment and policymakers would gain a better understanding of the research domain. Over the longer term, these secondments will help to ensure more effective dissemination of research and analysis and its use in guiding health policy decisions. The Canadian Health Services Research Foundation should be tasked with this initiative.

Another important linkage is with research initiatives around the world. While much of our focus is and should be on health and health care issues here in Canada, many of the issues we face today are also faced by countries around the world. Much of what we hear on the research front comes from studies in the United States. But the fact is, Canada's health care system has more in common with health care systems in European Union countries, Australia or New Zealand. This sets us apart from other countries in North and South America and highlights the need for us to look more carefully at work being done abroad. CIHR should be responsible for establishing deeper linkages between Canadian research efforts and research efforts and results in other countries around the world. In particular, linkages should be formed with the World Health Organization, the European Observatory, and research organizations in the European Union, Australia and New Zealand.

What Does This Mean for Canadians?

Canadians understand the importance of knowledge and ideas in developing new solutions. They understand the need to harness the combined potential of knowledge, information and technology to improve health and health care for patients, permit better evidence-based decision making to support citizens, health care providers, policymakers and managers, and find new treatments and cures.

With the recommendations in this report, Canadians can expect:

- A 21st century information and evidence infrastructure that is responsive, adaptable, and sustainable over the long term and meets the changing needs and objectives of Canada's health care system;
- More accessible access to information and analysis on the performance of the health care system and the health of Canadians;
- Better access to personal health information as well as access to a wealth of trusted and reliable health information to make informed choices about their own health;
- Clear rules for protecting the privacy and security of their health information;
- Assurance that their health care providers have access to complete information about their health as well as the latest information on health treatments, protocols and guidelines; and

- Access to the best and most appropriate health care technology combined with assurance that new technology has been carefully assessed.

With the necessary investment and infrastructure, Canada can tap the full potential of research, knowledge and technology. This comprehensive strategy will put Canada at the forefront and ensure that we continue to develop, explore, and implement new ideas and new technology to improve Canadians' health and the health care system.

4 Investing in Health Care Providers

Directions for Change

- ***Address the need to change the scopes and patterns of practice of health care providers to reflect changes in how health care services are delivered, particularly through new approaches to primary health care.***
- ***Take steps to ensure that rural and remote communities have an appropriate mix of skilled health care providers to meet their health care needs.***
- ***Substantially improve the base of information about Canada's health workforce through concerted actions by the Health Council of Canada to collect, analyze and provide regular reports on critical issues including the recruitment, distribution, and remuneration of health care providers.***
- ***Review current education and training programs for health care providers to focus more on integrated approaches for preparing health care teams.***
- ***Establish strategies for addressing the supply, distribution, education, training, and changing skills and patterns of practice for Canada's health workforce.***

The Case for Change

The health care system is fundamentally about people. Its focus is on people. Every aspect of the health care system is driven by, and dependent on, people, from an anxious mother talking with a nurse to the heroic efforts of emergency staff. Health care is a cutting edge industry with highly trained and skilled people – people with years of training and experience, and people who care deeply about the future of the health care system.

For the past two decades, continuing changes in how health care services are delivered combined with efforts to contain costs in every province and territory have taken their toll on Canada's health workforce. Although the problems differ for different health care providers, the malaise is widespread and, in some cases, it has moved from mere discontent to outright anger and frustration. Canadians are confronted with these problems on a regular basis both in their interactions with the health care system and through regular media reports of the latest "crisis" in health care.

Across Canada, every province and territory is looking for the most effective ways to address the challenge of training, recruiting and retaining health care providers, and encouraging them to practice in rural and remote communities. Competition between provinces and territories is intense and, in many ways, counterproductive. While much of the focus is on immediate and looming shortages of some health care providers, especially nurses, the deeper and more complex issues relate to their changing roles, the need to re-examine traditional scopes of practice, and the challenge of getting the right mix of skills from an integrated team of health care providers to deliver the comprehensive approaches to health care that Canadians expect.

The solutions to these issues are not easy nor can they be achieved overnight. Targeted funds in the proposed Rural and Remote Access Fund and the Diagnostic Services Fund should be used to fast-track action in addressing pressing problems in rural and remote communities and, ultimately, increase the supply of technicians and specialists to provide diagnostic services and improve Canadians' access to these important tests. The Primary Health Care Transfer and the Home Care Transfer must be an investment in change – using the stimulus of these targeted funds to address important issues related to changing scopes of practice and the emerging role of new members of the health care team. The proposed Health Council of Canada should play a leading role in substantially improving our base of information and understanding about Canada's health workforce. It should also review the way health care providers are educated and trained. In the longer term, the Health Council should play an important role in helping to plan for the future of Canada's health workforce by examining trends in their roles, scopes and patterns of practice, education, training, and remuneration.

Addressing these issues will take willingness on the part of all parties to set aside old grievances and entrenched positions, and begin to trust one another again. Health care providers and their organizations must be called upon to embrace far-reaching changes in the health workplace, some of which may change the nature of their work and especially their relationships with other health care providers. Provinces and territories must be willing to set aside their competition for health care workers and instead be prepared to work together on comprehensive strategies across the country. Sensitive issues such as wage settlements, scopes of practice, and working conditions must be addressed in an open and direct way.

It is only through concerted, collaborative and decisive action across the country that we will be able to address the pressing problems of today and ensure an adequate, productive, and positive workforce for the future.

The Current Situation for Canada's Health Workforce

Across Canada, there were over 1.5 million people working in health care and social services in 2000. Nurses (including registered nurses, licensed practical nurses, and registered psychiatric nurses) made up 35% of the health workforce while physicians made up 8%. The remaining 57% included a range of health care providers such as chiropractors, medical radiation technologists, social workers, and home care workers (CIHI 2001b). The supply, mix and distribution, and how these various health care providers work together are different in different workplaces, communities, provinces, and territories.

For Canadians, much of the concern relates to real and perceived shortages for certain health care providers. This is a particular concern for nurses because their numbers have dropped in recent years. Between 1991 and 2000, in effect, there was an 8% drop in the number of registered nurses per 100,000 people and a 21% drop in the number of licensed practical nurses. The decrease in licensed practical nurses is substantial in comparison with other health professions whose supply has increased (Table 4.1).

For nurses and doctors, there are four related issues of concern in the current system:

- **Supply and distribution** – Whether the problems experienced by communities in attracting and retaining health care providers are one of supply or distribution is really a matter of perspective. For people in a rural community that cannot attract a general practitioner, the problem is one of supply (i.e., they see a shortage of doctors as the problem). From a province-wide or national basis, however, the problem is more one of distribution of physicians (i.e., there may be enough doctors overall but not in certain rural and remote and inner city communities). Canada has fewer nurses today than it did a decade ago and this is also negatively affecting some communities.
- **Skills and roles** – There has been considerable discussion of the changing skills and roles of nurses and doctors (and other health providers as well) in terms of what they are trained to do as part of their professional roles. Nurse practitioners, for example, are trained to provide some health services that used to be the exclusive responsibility of physicians. Despite much rhetoric about interprofessional co-operation, in reality, the professions tend to protect their scopes of practice. Each profession appears willing to take on more responsibilities, but is unwilling to relinquish some duties to other professions.

Table 4.1
Percentage Change in the Number of Selected Health Professionals (Number per 100,000 People), 1991 to 2000

	1991	2000	Percent Change
Registered nurses	820	753	-8
Licensed practical nurses	298	236	-21
Physicians	187	187	0
Pharmacists	70	79	13
Dentists	51	56	9
Physiotherapists	38	46	21
Psychologists	34	43	25
Dental hygienists	34	48	42
Chiropractors	13	18	36
Optometrists	10	11	14

Note: Registered nurses (RNs) include the number of RNs employed in nursing, full-time and part-time, and all nurses who are involved in direct patient care as well as administration, teaching and research. Licensed practical nurses include all registrants regardless of activity or employment status. Physicians include those involved in clinical and non-clinical practice but exclude interns and residents. Chiropractors include regular members, new graduates and special members.
Source: CIHI 2002d, 2001c.

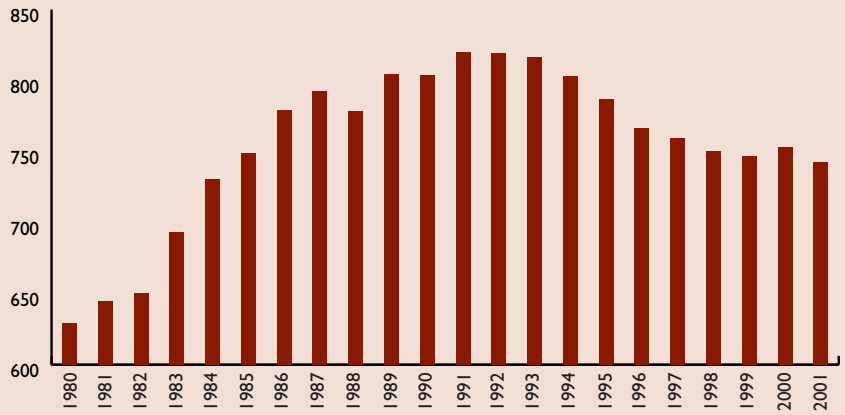
- **Patterns of practice and professional autonomy** – Patterns of practice refer to how health care providers deliver services within their workplace. For nurses, their pattern of practice has changed, but they have had little control over those changes. Fewer nursing administrators and less administrative support have resulted in an increased burden for nurses, leaving less time for direct care. Nurses have also been shifted in and out of their areas of expertise, from emergency rooms and intensive care to pediatrics and geriatrics, and from practice in teams in hospitals to individual practice in home care. For physicians, the situation is different. For the most part, physicians have considerable control over their patterns of practice both as individuals and through their respective professional organizations. Some physicians, for example, do limited work in hospitals. Some choose to work in multidisciplinary primary health care settings while others prefer a more traditional solo or group practice. Traditionally, decision makers have re-organized the pattern of practice of nurses pretty much at will, but attempts to change the pattern of practice of physicians are met with the stiff opposition of the medical profession who see this as a threat to their professional autonomy.
- **Quality of working life** – For nurses especially, quality of work life is a serious concern. Morale has declined substantially and nursing organizations point to this as one of the reasons for a significant number of nurses choosing to leave their profession. They also suggest that the persistent low morale has an impact on the quality of patient care. Employers, unions and professional organizations are addressing these issues, but, in recent years, the relationships between these organizations have been less than positive and strikes have been regular occurrences in almost every part of the country. Physicians also have concerns about quality of work life, but they tend to have more direct control over their working conditions than do nurses.

The Nursing Situation

In the last 20 years, the supply of nurses has fluctuated significantly. From 1980 to 1991, there was a steady increase in the number of nurses from a low of 629.1 per 100,000 people, or one nurse for every 159 people, to a peak of 819.9 per 100,000, or one nurse for every 122 people. Since 1991, the ratio has steadily declined (CIHI 2002f) (see Figure 4.1). In OECD countries, variations in the number of nurses per capita tend to reflect the way the health care system is organized, which means there is no "natural" level of demand for nurses. Canada's rate of nurses per capita is low in comparison to the Scandinavian countries but higher than in Spain, Greece or the United Kingdom (Saltman and Figueras 1997).

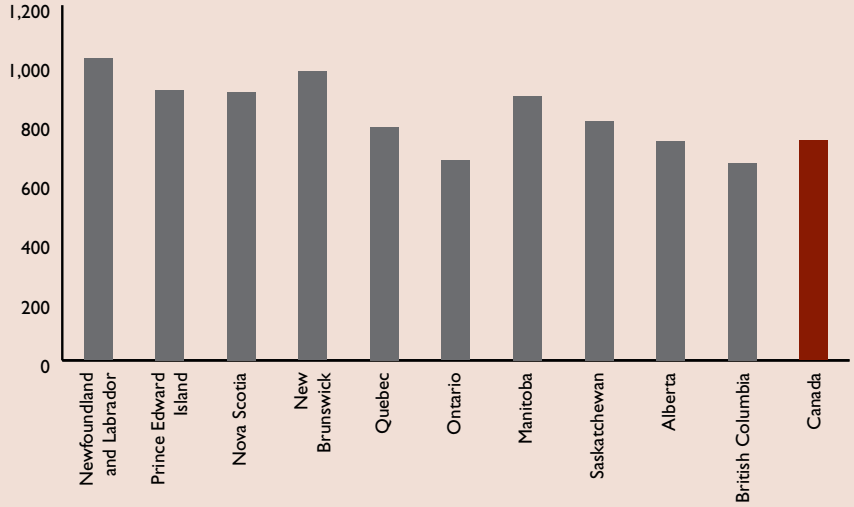
The overall numbers, however, are only part of the story. The supply of nurses varies considerably across Canada. As shown in Figure 4.2, in 2001 the ratio of nurses to 100,000 people among provinces ranged from a low of 666.4 (one nurse for every 150 people) in British Columbia to a high of 1,019.8 (one nurse for every 98 people) in Newfoundland and Labrador. The Canadian average was 742.4 nurses per 100,000 Canadians (one nurse for every 135 people) (CIHI 2002f). While these numbers may tell part of the supply story, they do not tell us how many of these nurses are working, or are available to work, full time.

Figure 4.1
Total Number of Registered Nurses in Canada (per 100,000 People), 1980 to 2001



Source: CIHI 2002f.

Figure 4.2
Number of Registered Nurses (per 100,000 People), by Province, 2001



Source: CIHI 2002f.

It also looks like the demand for nurses will increase even more in the future. The following are some of the key problems that have been identified:

- **Too few graduating nurses** – There has been a reduction of over 50% in the number of graduates from nursing schools in the past 10 years. On top of that, of those who graduate, 3 in 10 either leave the country or leave the nursing profession within five years of graduating (CNA 2001).
- **Too many nurses leave the profession due to stress, poor working conditions and poor morale** – A number of submissions from nurses paint a picture of nurses who barely have time to stop and think about what they are doing and why. Koehoorn et al. (2002, 6)

> *"We are now in the winter of nurses' discontent. Without dramatic action on the part of all levels of government and employer organizations, there'll be no thaw soon."*
>
> CANADIAN FEDERATION OF NURSES UNIONS 2001. WRITTEN SUBMISSION.

> *"For nurses on the job right now, work means mandatory overtime. Mandatory overtime means that you can be disciplined if you refuse. It places an undue burden on nurses and our families, and it puts patient care in jeopardy …"*
>
> CANADIAN FEDERATION OF NURSES UNIONS 2001. WRITTEN SUBMISSION.

noted that "an increasing number of nurses in Canada have faced mandatory overtime, mandatory on-call, refusal of holidays and time off for education and training, and placements in areas outside of their specialty." The strain of these working conditions leads to increased illness and injury, and an overall decline in morale among nurses. Absenteeism among nurses rose steadily from 6.8% in 1986 to 8.5% in 1999 and has become a major expense for institutions and the health care system (CHSRF 2001).

- **The nursing profession is aging** – The average age of a Canadian registered nurse increased by 1.3 years from 42.4 years in 1997 to 43.7 years in 2001 (CIHI 2002d). Since most nurses retire in their mid-fifties, a large group of nurses is expected to leave the profession in the next decade (CHSRF 2001).
- **Interprovincial rivalries for scarce resources** – All provinces are in a highly competitive race for every available nurse and nursing graduate. The quick fix has been to increase remuneration in an attempt to attract and retain nurses. Not surprisingly, provinces that can afford to pay more are luring nurses away from provinces that simply cannot compete. The current gap between the highest and lowest maximum annual salaries for registered nurses is $17,803, with salaries ranging from a high of $63,784 in Ontario to a low of $45,981 in Prince Edward Island (CFNU 2002).
- **Changes in health care delivery** – Changes in how health care services are organized and delivered in hospitals and other settings have had a direct impact on the workload of nurses and the competencies they are expected to have. In some cases, positions of head nurses and clinical nurse specialists were eliminated or severely reduced as part of cost-cutting measures. Combined with that, there have been extensive reductions in other administrative and support services and, as a result, many non-nursing functions have been transferred to nurses (Koehoorn et al. 2002). As a result, nurses are spending less time nursing and are not able to use their full range of skills.

Access to Doctors

While there is no consensus on whether or not we are facing an impending national "crisis" in the supply of physicians, access to physicians is undeniably an issue in many communities across the country.

Between 1980 and 1993, the number of general practitioners for every 100,000 people increased from 76.4 general practitioners to a peak of 101.5. By 1999, the number had dropped to 94.0 (one doctor for every 1,063 people) but it has been steadily increasing ever since. The picture for specialists is somewhat different. Between 1980 and 1994, the number of specialists per 100,000 Canadians increased steadily from 74.7 to 90.0. After a slight drop in 1995-96, the number of specialists has been steadily increasing and, in 2001, the number of specialists per 100,000 people reached 92.7 (1 for every 1,077 people), the highest point in over 20 years (CIHI 2002f) (see Figure 4.3 and Map 4.1).

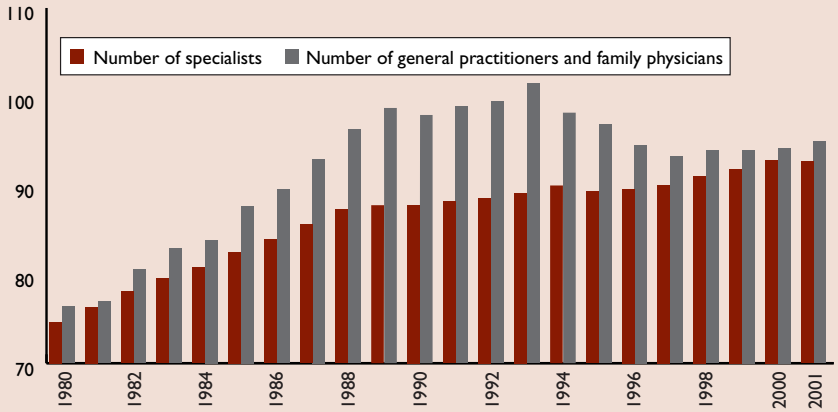
As in the case of nurses, looking at Canadian averages tells only part of the story. There are significant differences among the provinces and territories in the supply of family physicians and general practitioners, with Newfoundland and Labrador having the highest number per 100,000 people in 2001 and Prince Edward Island having the lowest (CIHI 2002f) (see Figure 4.4 and Map 4.2).

A number of factors have a direct impact on the supply of physicians including age, speciality, clinical demands, community needs and size, place of graduation, and workloads. The gender of the physician also has an effect. In 2000, women accounted for close to half (49.6%) of all students graduating with medical degrees, an increase over 1980, when only 32% of graduates were women (ACMC 2001). This shift in the mix of male and female physicians has had an impact on changing trends in physician practice, with more female physicians choosing general and family practice compared to medical specialities (Chan 2002).

While physician organizations (CMA 2002) and many communities point to serious problems in meeting the need for physicians, other studies suggest that there is far less consensus about whether or not we have a crisis in the supply of physicians. A recent report prepared for the Canadian Institute for Health Information (Chan 2002) suggests that the apparent shortage is more perceived than real. At the same time, access to physicians and specialists varies significantly across the country, and some communities lack the supply of health professionals necessary to ensure access to even basic health services.

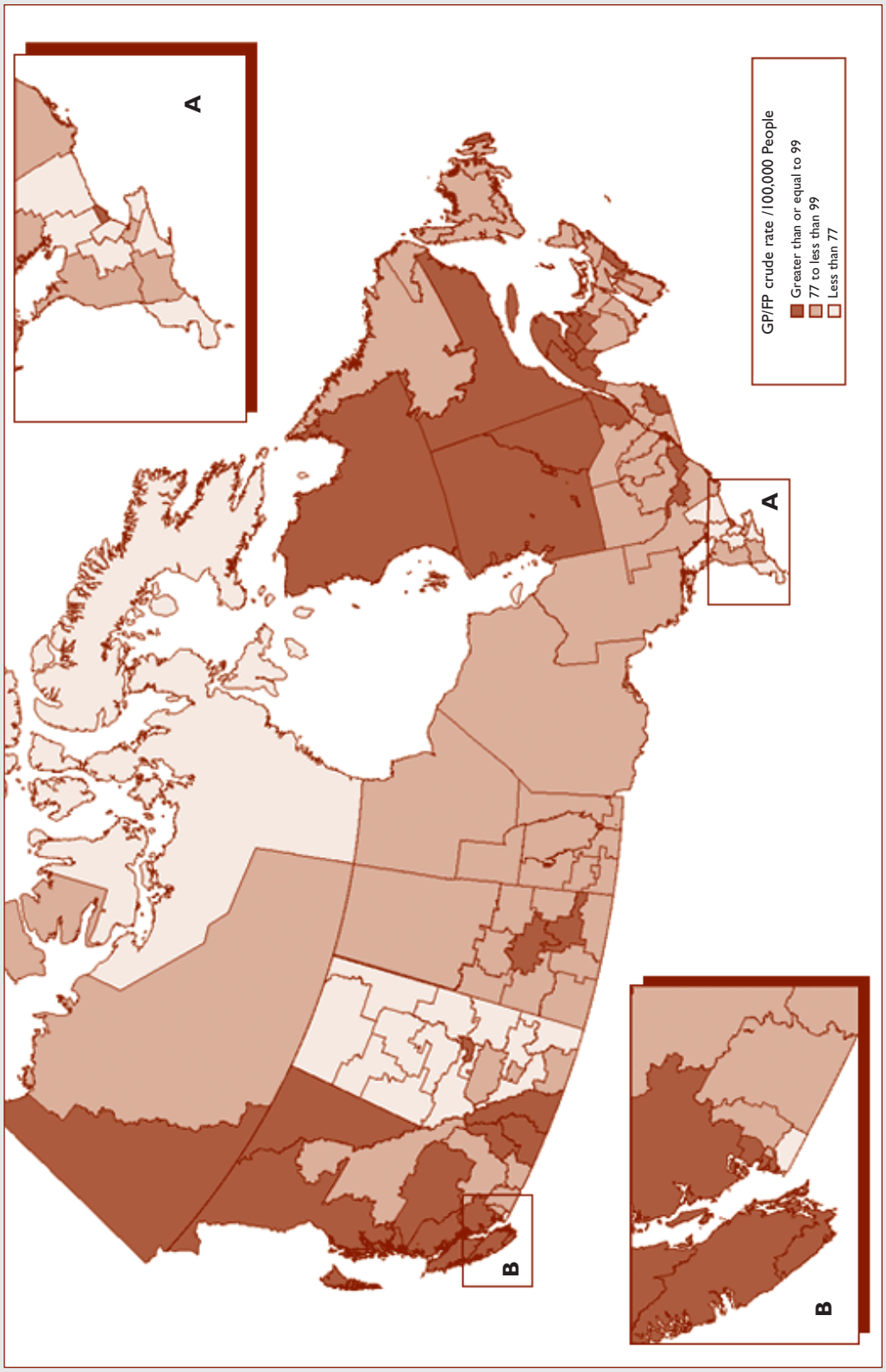
Experience in many provinces and the territories, as well as in OECD countries, suggests that short-term solutions aimed at increasing the supply of physicians do not translate into improvements in the supply of physicians in communities in need, from rural and remote areas to inner cities. In the past, the Canadian Medical Association (CMA 2001) has resisted government action requiring physicians to practice in smaller communities, characterizing it as both punitive and coercive. But the answer also does not lie in simply paying physicians more to entice them to smaller communities. Research shows that: “Heavy workloads and high patient

Figure 4.3 Total Number of General Practitioners/ Family Physicians and Specialists (per 100,000 People), 1980 to 2001



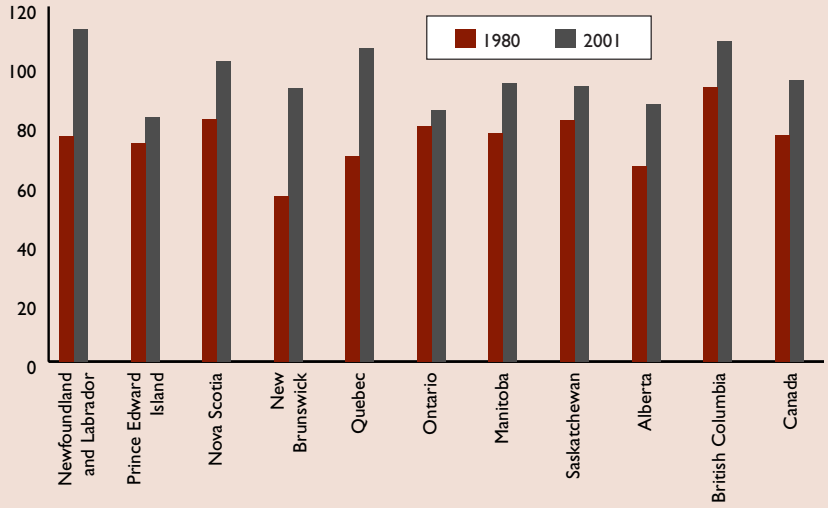
Source: CIHI 2002f.

Map 4.1 General/Family Physicians by Health Region, 1999



Source: CIHI 2002.

Figure 4.4 Number of General Practitioners/ Family Physicians (per 100,000 People), by Province, 1980 and 2001



Source: CIHI 2002f.

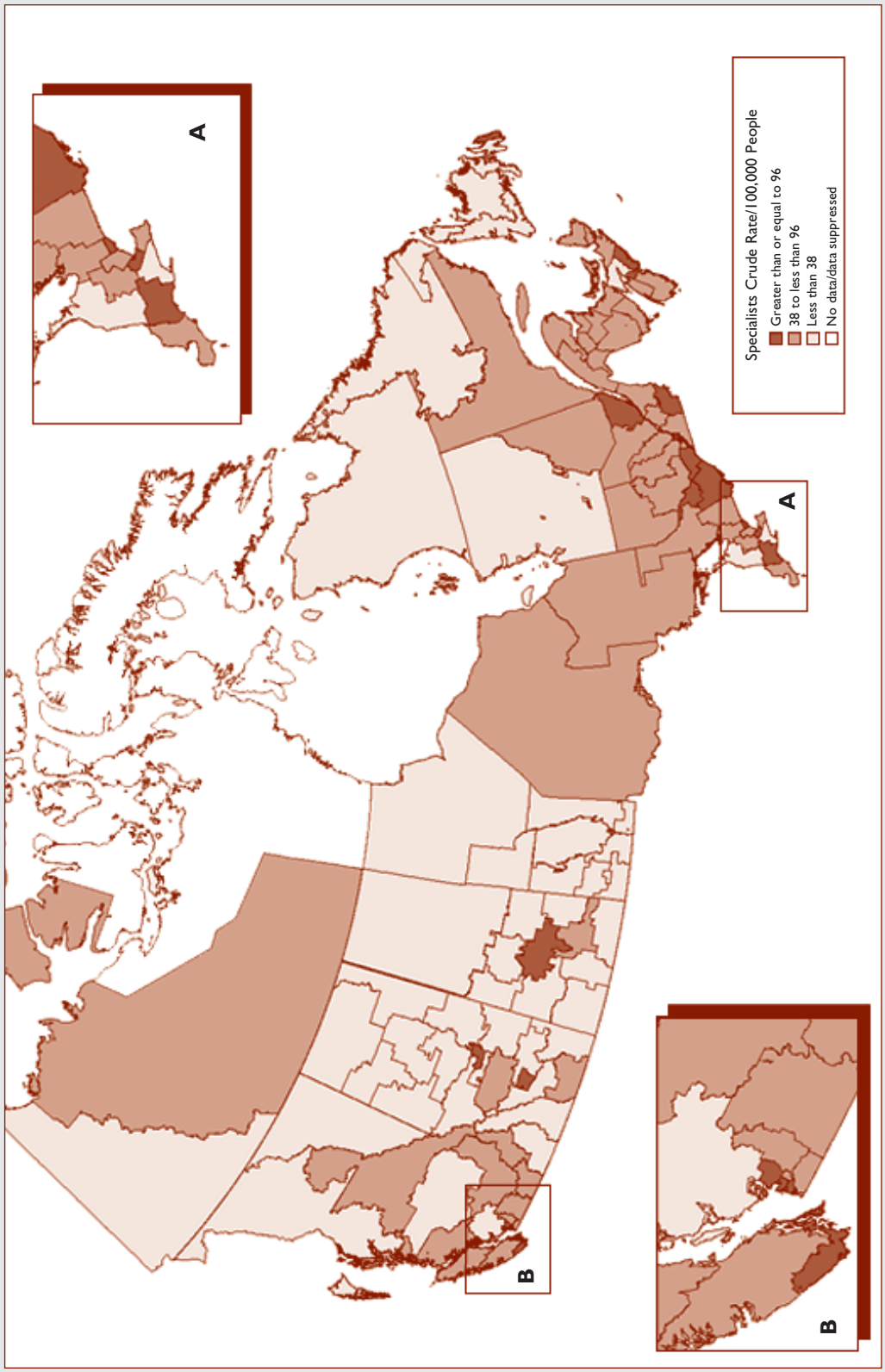
demands and expectations, lack of flexibility in working arrangements and [health services] reorganization, as well as training and career development issues all appear to impact upon recruitment and retention to a much greater degree than does remuneration" (Gavin and Esmail 2002, 77).

The education and training of physicians can have an impact on where they choose to practice. With more exposure to and experience in rural settings as part of their education programs, the likelihood of graduating doctors wanting to practice in rural settings increases (BCMA 2002). Recent efforts by the Society of Rural Physicians of Canada and the College of Family Physicians of Canada to develop national curricula and guidelines are a step in the right direction. But there is much more to be done.

In their presentation to the Commission, the Professional Association of Internes and Residents of Ontario noted that governments "… have tried to dictate through legislative and bureaucratic fiat where new doctors can practice, regardless of the real community need for our services. We successfully resisted these discriminatory and punitive measures, by working with the communities themselves to identify real, effective, comprehensive, sustainable and non-coercive solutions" (PAIRO 2002, 3). In their words, they represent the new "face of medicine" – a new generation of physicians that is more open to working in a diversity of locations and models of health care delivery.

While the Commission is encouraged by such sentiment, it remains to be seen just how open the medical profession is to change. If the openness means only that "nature should take its course" or that the scope of practice of physicians is sacrosanct, then this is clearly insufficient. If it means a willingness to shift responsibility for some activities now performed solely by doctors to other health care providers and to seriously consider how the mix of skills can be adjusted and reformed, then the Commission sees some cause for optimism. The openness of the

Map 4.2 Specialist Physicians by Health Region, 1999



Source: CIHI 2002.

medical profession to change must begin to yield real results in the short term if the medical profession is to forestall the kinds of government action they see as coercive.

Furthermore, as the following sections suggest, salaries for both physicians and nurses have the potential to become significant cost drivers in the health care system. The current fee-for-service approach to paying physicians is seen by many as an obstacle to primary health care. Suggestions for addressing this issue are included in Chapter 5. Physician organizations across the country play a powerful role in negotiating physician payments with governments. These negotiations take place behind closed doors and, in recent years, have resulted in public acrimony, threats and actual withdrawal of services by physicians. The focus has primarily been on money and less on identifying the deliverables physicians are expected to provide in exchange for increasing payments. Some suggest that future negotiations with physicians should clearly outline the deliverables physicians are expected to provide such as ensuring adequate access to health care services, changing their patterns of practice to facilitate primary health care or to meet changing needs in the health care system, or achieving certain outcomes for their patients (e.g., screening for certain tests).

> *"Turning to the commitment of new doctors to medicare … new doctors are passionately committed to working in, and preserving and enhancing, a universal one-tier accessible comprehensive public medicare system, one in which all Canadians have equal access to physician, hospital and other essential health care services."*
>
> Canadian Association of Internes and Residents. Presentation at Charlottetown Public Hearing.

Paying for Nurses and Doctors

In recent years, there has been considerable focus on the salaries of nurses and the incomes of physicians, largely as a result of negotiations between governments and provider organizations.

From 1960 to 1992, the average rate of increase in the annual income of physicians was slightly above 6%. Between 1993/94 and 1998/99, the rate of growth in the annual average payment to fee-for-service physicians (which includes about 73% of physicians in Canada) slowed to an average of about 1.5% a year (CIHI 2001a, 1999). However, recent negotiations with provincial governments have resulted in substantially higher increases. In February 2001, the Alberta government provided a 35% increase in its Medical Services Budget to pay for physician services as a result of the latest agreement with the Alberta Medical Association (AMA 2001). More recently, fee schedules negotiated in 2002 for physicians in New Brunswick and British Columbia include increases of 15.0 and 20.6%, respectively (Morris 2002; British Columbia Ministry of Health Services 2002).

Between 1966 and 1995, nursing incomes in Canada grew by an annual average of 6.3% compared with a range of 6.1% in Germany and Sweden to 7.3% in Japan. Increases in nursing incomes also slowed in the mid-1990s to 2% in 1995. But settlements in the past few years have showed marked increases. In Alberta, the three-year collective agreement signed with the United Nurses of Alberta in 2001 provided wage increases of between 17.0 and 20.5% in the first year (UNA 2001). Similarly, in Saskatchewan and Manitoba, wage increases of 20% over three years and 20% over two years have been granted since 2001 (MNU 2002; SUN 2002).

Recent trends in these negotiations and settlements threaten to become a major cost driver. Even before the substantial increases in the past few years, the incomes of Canadian doctors and

nurses were at the very upper end of the OECD-country scale. In 1992, for example, physician incomes in Canada were considerably higher than France, Australia, Japan, Sweden and the United Kingdom. Only Germany and the United States had comparable or higher rates of remuneration. The situation for nurses was similar. This leads the Commission to urge provider associations and governments to consider the impact of future negotiations on the sustainability of medicare.

International Mobility of Health Care Providers

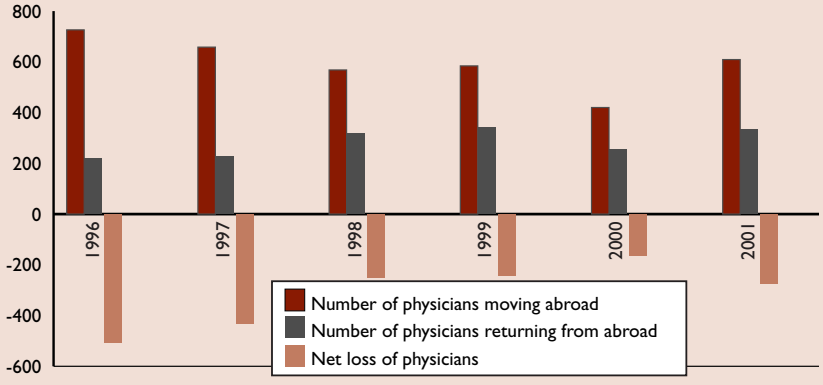
Canadians are well aware of continuing stories of nurses, doctors and other health care providers leaving Canada to work in other countries, particularly the United States. Health care providers are part of an increasingly mobile workforce that is in high demand around the world.

In terms of physicians, in 1996, Canada lost a net 508 physicians to other countries, but by 2000, that number dropped to 164 (CIHI 2001f). The most recent information indicates that the downward trend may have reversed and the net loss of physicians to other countries climbed to 275 in 2001 (CIHI 2002e) (see Figure 4.5).

Aside from physicians, there are large numbers of Canadian-trained health care professionals – most of them registered nurses – that have moved to the United States to find employment. Recent efforts by Canadian health care institutions to "repatriate" Canadian health care providers working abroad have met with limited success since the system is not always able to guarantee the kinds of opportunities that are being offered south of the border.

There also are significant numbers of international medical graduates who come to Canada as immigrants. International graduates have to undergo an extensive assessment process before they are allowed to practice in Canada. The approval and integration process spans several years and is quite complex, causing significant delays. As a result, many health care professionals from other parts of the world find it difficult to get meaningful work in the health care system. Governments and professional organizations need to streamline the process for recognizing foreign training and provide additional training for immigrant health care professionals where necessary.

Figure 4.5
Canadian Physicians Moving Abroad and Returning from Abroad, 1996 to 2001



Source: CIHI 2002e, 2001f.

In some cases, provinces and territories have actively recruited medical graduates from developing countries in order to meet the needs for physicians in Canada, especially in rural and remote areas. Until the late 1970s, Canada openly sought and recruited international graduates from medical schools, giving them "preferred status" in our immigration policy. At that time, international graduates made up 30% of our physician workforce, but that number has since dropped to just under 23% (CIHI 2001e) (see Table 4.2). Despite this decline, some provinces like Saskatchewan continue to rely heavily on international graduates to meet demands in their communities while other provinces like Quebec depend far less on international graduates.

As noted in Chapter 11 on globalization, there are serious concerns about Canada's practice of recruiting physicians from developing countries. While international medical graduates who want to immigrate to Canada should not be prevented from doing so, provinces and territories should reduce their reliance on physicians from developing countries and take steps, instead, to recruit and retain more physicians within Canada.

Allied Health Care Providers and Managers

While much of the focus is on nurses and doctors, there are numerous issues that affect other health care providers as well, including workplace issues, scopes of practice, and the impact of changing ways of delivering services. The multiplicity of health care providers is both a tremendous resource and a challenge in terms of sorting out new models of primary health care, new roles and responsibilities, and more collaborative ways of working together. Furthermore,

Table 4.2
Distribution of International Medical Graduates, by Province, 2001

Province/Territory	Total Physicians	Canadian MD Graduates	International MD Graduates	Percent Distribution of International MD Graduates
Newfoundland and Labrador	945	531	395	41.8
Prince Edward Island	190	156	28	14.7
Nova Scotia	1,885	1,389	494	26.2
New Brunswick	1,179	923	251	21.3
Quebec	15,866	14,024	1,800	11.3
Ontario	21,482	16,206	5,268	24.5
Manitoba	2,093	1,366	613	29.3
Saskatchewan	1,549	743	796	51.4
Alberta	5,154	3,755	1,385	26.9
British Columbia	8,105	5,854	2,250	27.8
Yukon	54	35	9	16.7
Northwest Territories	37	28	6	16.2
Nunavut	7	4	3	42.8
Canada	58,546	45,014	13,298	22.7

Note: Excludes "unknown place of graduation."
Source: CIHI 2002e.

with advances in medical technology, the health care system will need an increasing supply of highly specialized and skilled technicians.

In addition to allied health providers and professionals, health care managers are frequently overlooked in the health care system, yet their work is vitally important to the overall organization, planning, and funding of health care systems across the country. Often working behind the scenes, health care managers are responsible for threading the pieces together, organizing services, and trying to get the best value for the health resources available – in terms of both people and dollars. Health managers are responsible for implementing difficult decisions and managing complex and evolving organizations, but their jobs were made doubly difficult during the fiscal restraints of the 1990s. As the Canadian College of Health Service Executives notes, "excessively rapid and often unplanned change has undermined executives' ability to [manage] in a logical and rational manner." They also point to a lack of consistency in leadership and vision, and the negative impact this has on managers' ability to understand their roles and carry out a cohesive plan (CCHSE 2001, 4).

A National Effort Is Needed

No matter how you look at the information on the current situation for health care providers in the country – whether you are a health professional, a health care manager, a provincial, territorial or federal government official or leader, a patient waiting to see a doctor, or a community desperately looking for a nurse – it is impossible to escape the following conclusions:

- The current situation is serious and demands national solutions;
- Recruiting, training, and retaining more nurses and doctors over the next decade are crucial, especially for remote, rural, and northern communities;
- The problem is only partly about supply. It also is about distribution, scope of practice, patterns of practice, and the right mix of skills among various health care providers;
- Health care managers are under increasing strain and suffer from the lack of a clear vision for moving forward;
- Primary health care will provide important benefits to Canadians and should give them access to teams and networks of qualified health providers. But transformations in the way health care providers work together will not happen overnight; and
- New approaches to education and training are needed in addition to a careful look at how the roles and responsibilities of various providers are changing along with changing patterns of care.

These challenges are significant and apply to every province and territory. This also is clearly an area where actions in one province or territory have spillover effects in other provinces and territories. Given this reality, the best approach is for provinces and territories to work together on solutions that will address not only their own specific challenges but also ensure that Canada continues to have an adequate, well-educated, and effective health workforce for the future.

Immediate Investments in People and Change

RECOMMENDATION 15:

A portion of the proposed Rural and Remote Access Fund, the Diagnostic Services Fund, the Primary Health Care Transfer, and the Home Care Transfer should be used to improve the supply and distribution of health care providers, encourage changes to their scopes and patterns of practice, and ensure that the best use is made of the mix of skills of different health care providers.

The health care system depends on people, and the ability of the system to move ahead with the reforms envisioned in this report will depend not only on having an adequate supply and the right distribution of health care providers, but also on their willingness to look at new approaches to how they deliver care.

There is little doubt that the fluctuations in funding for health care in the late 1980s and throughout the 1990s had some negative effects on Canada's health workforce. As provincial, territorial and federal governments struggled to balance their books, "stop and go" funding negatively affected the supply of health care providers and seriously hampered attempts at long-term planning. This lack of continuity and predictability in funding has had a lasting impact on the delivery of health care services and the quality of work life for health care providers and professionals.

Immediate action needs to be taken on two fronts:

- Improving the supply and distribution of health care providers in two priority areas – ensuring that rural and remote communities have the right mix of skilled health care providers to meet their needs, and improving the supply of specialized technicians to keep pace with increasing demands for diagnostic testing; and
- Transforming the skills and roles of health care providers consistent with the overall directions for change outlined in this report.

Recommendations outlined in Chapter 2 propose a series of targeted funds and transfers to address priority areas and provide the transition to a new dedicated health transfer. Several of these funds, particularly the Rural and Remote Access Fund, the Diagnostic Services Fund, the Primary Health Care Transfer and the Home Care Transfer, should be used to address challenges in the supply, distribution and mix of skills of health care providers.

These additional funds should be specifically targeted to the most effective ways of addressing the most pressing problems. However, the Commission strongly feels that the additional funds should not become a target for increasing salary pressures from health care providers. There is a serious political risk to all parties – governments, health care providers and their organizations, and regional health authorities – if the bulk of the additional funds simply goes to pay more for the same level of service, the same access, and the same quality. This simply will not be acceptable to Canadians.

To address and resolve issues with today's health workforce, it is important to go beyond what health care providers are paid and address the more complex but important issues of what they do, and how their roles must change to reflect new ways of delivering health care services.

Addressing Gaps in Supply and Distribution

Problems of rural communities in attracting and retaining an adequate supply of health care providers are well known and are discussed in Chapter 7. One of the major obstacles to improving access to essential health care services in rural and remote communities is the serious challenge these communities face in attracting and retaining health care providers. Over the next two years, expanding the supply of health care providers in these communities should be a major objective of the proposed Rural and Remote Access Fund. That may mean that a portion of that fund goes to creating incentives, financial and otherwise, to attract and retain the right mix of professional skills in those communities.

"It is partially a myth to say that we are lacking doctors in the province of Quebec. Why? Because we don't have the courage to ask them to serve where and when we need them."

Conseil provincial pour la protection des malades. Presentation at Montreal Public Hearing.

In the case of diagnostic services, information provided in Chapter 6 shows that Canada has fallen behind in its investment in diagnostic technology and, as a result, waiting times for access to MRI (magnetic resonance imaging) and CT (computed tomography) scans are increasing. However, purchasing the equipment is only one part of the solution. A portion of the proposed new Diagnostic Services Fund should be used to recruit and train the necessary supply of technologists and specialists needed to meet the demands and improve Canadians' access to these essential services.

Changing Roles and Responsibilities

Issues related to health care providers are more complex than simply whether we have enough nurses, doctors, pharmacists, or dentists. The roles of various health care providers are changing as new models of delivering care are explored and implemented. The appearance of new professionals and new modes of health care delivery, not to mention the appearance of new needs within the health care system, involve major changes in the scope of practice of each health profession. The attempt to create a health care system that is more "patient-centered" leads inevitably to the desire to change the way health professionals are trained, the way they are paid, and the way in which they work together (Lissauer 2002).

If Canada is to move ahead on major reform to its health care system, the mix and skills of health care providers and how they work together must be addressed. As Jane Salvage (2002, 16) has written:

> Tinkering with the boundaries while failing to examine the core of what health workers do and how they do it is like rearranging the deckchairs on the Titanic. Allocating the tasks differently is the easy bit, and that is hard enough. The division of labour may have changed dramatically over the years, but the core assumptions about how professionals work have remained very largely intact.

The nursing situation is a case in point. Across Canada, there has been an increasing emphasis on the role of nurse practitioners who can take on roles that traditionally have been performed only by physicians. This could even include providing nurse practitioners with admitting privileges to hospitals so that they could refer patients and begin initial treatment in hospitals. But, while nurses have eagerly embraced an expanded role at one end of the spectrum of their responsibilities, they have been less inclined to give up some responsibilities to licensed practical nurses, for example, and others with a similar mix of skills to provide direct care for patients.

The same can be said of physicians. There is little doubt that the doctor-patient relationship is central to the care physicians provide. Yet it also means they have often been unwilling to share responsibility for the care of their patients with others who are in a good position to co-ordinate care across the different aspects of the health care system, from diagnostic tests, to acute care and home care. An increasing emphasis on primary health care – where physicians are expected to participate in and share responsibilities with a team of different health care professionals – will also have an impact on patterns of practice for physicians as well as the way they are paid for their services.

As outlined in both subsequent chapters on primary health care and home care, new roles are also likely to emerge as the health care system continues to change. Case managers, for example, will play an increasingly important role in co-ordinating and managing primary health and home care services for their patients. The case manager would provide a critical point of contact for patients and for other health care providers. In the past, physicians have traditionally played this "gatekeeper" role, deciding what types of services a patient needs and where those services should be provided. Not surprisingly, nurses have suggested that this is a role they could play. However, case managers do not have to be either doctors or nurses, provided that they are in a position to co-ordinate care and ensure timely access to the care people need. As primary health care and home care expand in the future, it is likely that the role of case managers will have a direct impact on the working relationships of different health care providers.

> *"You have to use your workforce adequately.... You shouldn't hire nurses as receptionists."*
>
> Union Québecoise des infirmiers et infirmières auxiliaires du Québec. Presentation at Québec City Public Hearing.

Primary health care also places a clear emphasis on flexible responsibilities and the importance of multidisciplinary teams and networks of providers working together to address their patients' health needs. This will affect not only nurses and doctors but other health care providers as well. Both Chapter 9 on integrating prescription drugs and Chapter 8 on home care reflect a growing emphasis on medication management programs. This is likely to have a direct impact on the role of pharmacists and make it possible for them to play an increasingly important role as members of the health care team. With the emphasis on prevention and promotion, various health care providers and others in the community can be expected to play a more active role.

There also are a number of new and emerging health professions such as children's nurse practitioners, physician's assistants, and clinical children's nurses. The emergence of these and other new, highly trained professions requires an ongoing reassessment of the scopes of practice of existing health care providers and a re-balancing of the mix of skills among the various providers. In fact, the more the health care system changes, the more likely it is that traditional scopes and patterns of practice will be challenged.

Two of the proposed new Transfers – the Primary Health Care Transfer and the Home Care Transfer – are intended to significantly change how health care is delivered in Canada. Both will require changes in how health care providers work together, share responsibilities, and combine a mix of different skills in order to provide the best outcomes for patients.

In terms of primary health care, the new transfer is intended to kick-start widespread change and expansion of primary health care approaches across Canada. In the case of the Home Care

Transfer, there will be an increasing emphasis on post-acute care, palliative care, and mental health case management and interventions. A portion of both of these transfers should be used to address the necessary changes in scopes of practice and to facilitate teams of health care providers.

Planning for Change over the Longer Term

RECOMMENDATION 16:

The Health Council of Canada should systematically collect, analyze and regularly report on relevant and necessary information about the Canadian health workforce, including critical issues related to the recruitment, distribution, and remuneration of health care providers.

RECOMMENDATION 17:

The Health Council of Canada should review existing education and training programs and provide recommendations to the provinces and territories on more integrated education programs for preparing health care providers, particularly for primary health care settings.

RECOMMENDATION 18:

The Health Council of Canada should develop a comprehensive plan for addressing issues related to the supply, distribution, education and training, remuneration, skills and patterns of practice for Canada's health workforce.

Improve Information about Canada's Health Workforce

Comprehensive and national data on the state of the health workforce are critical. At the outset, the Council should take steps to address the serious gaps in information about Canada's health workforce. Beyond basic data on the supply and distribution of nurses and doctors, little is known about other health professionals and providers. Only limited information is available on effective strategies for encouraging different members of the health workforce to work together. Furthermore, standardized information is not available across the country so it is difficult to track trends, gather comparable information on the supply of health care providers, or assess whether the current mix of health care providers will meet the current and future health needs of Canadians (CIHI 2002b).

These major gaps in information need to be addressed. Standards must be set for collecting data across the country so that the situation in different provinces and territories can be compared, and trends in supply, distribution, mobility, and composition can be monitored and analyzed on an ongoing basis. This information base is essential for long-term effective planning for the future of Canada's health workforce.

The Canadian Institute for Health Information (CIHI) has begun important work in this area, but much more needs to be done. The new Health Council of Canada, with CIHI as its information backbone, could become a world leader in data collection and analysis in health human resources planning and development. As part of this work, the Health Council should

collect and assess national and international data on remuneration, conditions of work, the quality of work life for health professionals, workload, and other issues that affect Canada's workforce. This information should assist governments, health providers and their organizations in addressing these issues on a longer-term basis.

Review and Renew Education and Training Programs for Health Care Providers

Current initiatives in primary health care highlight the need for providers to work together in integrated teams and networks focused on meeting patients' needs. In recent years, some have suggested that the education and training of providers is falling short of meeting Canadians' health care needs. A host of reasons have been offered for the need to change how health care providers are educated today, including the following:

- Health care is a dynamic environment that calls for constant learning and change;
- A shift to evidence-based health care requires new skills;
- Changes are needed in the relationship between providers and patients as patients take a more proactive role in their health and health care;
- Changes in how health care services are delivered have a direct impact on the mix of skills expected of health care providers;
- New role models are needed to reflect the different ways of delivering health care services; and
- Canadians expect more emphasis on health promotion, wellness and disease prevention as an essential part of their health care system.

In view of these changing trends, corresponding changes must be made in the way health care providers are educated and trained. As one presenter described it, we have largely been training our health care professionals in silos. Then when they graduate, we call on them to work together (Bowmer 2002). If health care providers are expected to work together and share expertise in a team environment, it makes sense that their education and training should prepare them for this type of working arrangement.

Some work on interprofessional education is already underway in Canada, including the recent collaboration between the Canadian Nurses Association, the Association of Canadian Medical Colleges, and the Canadian Association of University Schools of Nursing in partnership with Health Canada. The College of Health Disciplines at the University of British Columbia is also doing important work in this area. In a submission to the Commission, they indicated that "The basic notion that underpins the College is that interprofessional education and collaboration is essential to achieving effective delivery of health care" (University of British Columbia College of Health Disciplines 2001). They describe interprofessional education as "a learning process in which different professionals learn from, learn about and team with each other in order to develop collaborative practice." While these developments are a step in the right direction, a presenter from the School of Nursing in Victoria acknowledged that there is considerable room for improvement. She urged governments to help the professions evolve, while at the same time cautioning them to avoid destructive top-down approaches that work against the very relationships they are trying to promote (University of Victoria School of Nursing 2002).

The Health Council of Canada, with representation from health care providers, could play an important role in examining current programs for educating and training the mix of health

care providers in Canada and recommending an integrated educational curriculum for future health care providers. It could also explore a range of issues including barriers to entry to education programs, especially medical schools, ways of recruiting more Aboriginal health care providers (as discussed in Chapter 10), and ways of expanding experiences in rural and remote communities (as discussed in Chapter 7).

Develop a Comprehensive Plan for the Future of Canada's Health Workforce

As one report described it, health human resources planning is like a "classic soap opera – tune out for years, and there is a reasonable chance that not much will have changed when one returns" (Barer et al. 1999, 3). It is time to bring this soap opera to a satisfying conclusion. Throughout its consultations, the Commission repeatedly heard calls for leadership and a more concerted effort across the country to address not only the immediate issues but also to initiate a national discussion about future needs, and the best ways of optimizing Canada's health workforce.

In the work done for the Commission by the Canadian Policy Research Networks, the researchers quickly came to the conclusion that there is "… one key thing that must take place if we are to get anywhere with improving health human resource planning capacity. Over and over again in this project, we were told that there is currently no viable mechanism for health human resource planning in Canada and therefore, human resource issues go round in circles, never really getting to the heart of the matter" (CPRN 2002, 36).

Experience with health human resources (HHR) planning in Canada has been plagued by the following problems:

- **Planning is intermittent at best** – There is little evidence that planning adequately considers population demographics and trends, the broader determinants of health, the specific needs of patients, or the unique and shared knowledge and skills of health care providers. Further, planning approaches are frequently based on one-time estimates focusing on a single discipline.
- **Too often, the emphasis is on quick fixes** – According to a roundtable on health human resources sponsored by the Commission, Canada has a relatively poor track record in health human resources planning because its policies have tended to focus on quick-fix solutions. As British Columbia's Minister of Health Planning pointed out, we are currently paying the price for decades of patchwork vision (British Columbia 2002).
- **The lack of adequate planning has contributed to the declining quality of work life for health professionals** – Our over-reliance on part-time, casual and overtime work has created a health care workforce that is extremely dissatisfied with its work environment. The Clair Commission in Quebec observed that "Recent years have been difficult for the people who work in the health and social services network. To this day, overwork, the instability of work teams and shortages in some professional categories, in particular nurses, along with all sorts of inflexibilities, continue to create the general feeling of dissatisfaction, exhaustion and gloominess that too often prevail in the network's institutions" (Clair 2001, 106). The declining quality of the health care workplace, especially in nursing, has also created further pressure on salary rates across the country.

- **Planning has been limited to individual provincial and territorial initiatives** – In isolation, provinces, territories and individual communities are developing their own solutions to many of the challenges facing their health workforce, from specific initiatives to recruit and retain professionals in rural and remote communities to targeted education and training programs. The result is considerable duplication in efforts across the country. Barer et al. (1999, 39) suggested that our lack of a national approach to health human resources planning, coupled with limiting and narrow perspectives from individual provinces concerned with their own supply issues, has resulted in "a history of destructive competition rather than cooperation." Some also have suggested that the decisions of some provinces result in effectively "poaching" scarce health professionals from other provinces. As was observed at the Commission's expert roundtable in Halifax, "Across the board, we have a national pool of trainees – yet provinces are working in isolation without a national presence. There is an irony in Nova Scotia increasing enrollment in medical schools when what we are training is more doctors for Alberta."
- **Planning is complicated by the interdependency of issues and the significant number of actors involved** – Workforce planning is affected by a number of interrelated issues including education and training, scopes of practice, different regulations in the various provinces and territories, and continuing workforce tensions in the health care system. Combined with that, there is a multiplicity of actors involved from provincial and territorial governments to universities, regulatory bodies, unions, and individual employers (see Table 4.3). As CPRN (2002, 40) notes, "Historically, Canada has had a situation in which governments do one thing, educational institutions do another, and regulatory authorities do a third."

Provinces, territories and the federal government understand the seriousness of the issues and are prepared to work together on solutions. In September 2000, First Ministers agreed to work together to "coordinate efforts on the supply of doctors, nurses and other health care personnel so that Canadians, wherever they live, enjoy reasonably timely access to appropriate health care services" (FMM 2000). The need for collaborative action was echoed by provincial Premiers at their annual meeting in the Fall of 2001. They agreed that "Provinces and territories should utilize a common approach … in the determination of the scope of practice amongst health professionals." They also agreed that "There must be better planning and inter-provincial cooperation in training and recruiting health professionals to ensure that there is an adequate level of health care professionals available" (APC 2001).

The proposed Health Council of Canada, with expertise drawn from providers, is the best vehicle for addressing health human resources issues and driving the process forward over the longer term. It can serve as a focal point for facilitating co-operation among governments, health providers and the public. It can address sensitive issues such as demands from various health provider organizations and changing scopes of practice through an arm's length, independent body. The Health Council should also be able to independently examine the relationships between health professions and encourage better communication.

To fulfil this role, the Health Council of Canada should expand on the work of the current intergovernmental Advisory Committee on Health Human Resources. It should draw on the expertise of people outside of government and undertake the necessary research and analysis to

Table 4.3
Policy and Planning Responsibilities across Canada

Policy Levers Employed for HHR Planning	Provincial/Local	National
Data collection and monitoring	Ministries of Health Research organizations Local communities	CIHI Stakeholder organizations
Setting number of undergraduate positions	Ministries of Health Ministries of Colleges/ Universities Faculties of medicine/nursing/ other health sciences	
Setting number and mix of post-graduate positions	Ministries of Health Faculties of medicine/nursing/ other health sciences	
Setting tuition costs	Universities Ministries of Colleges/Universities	
Determining education curriculum	Faculties of medicine/nursing/ other health sciences	Medical Council of Canada
Determining training curriculum	Faculties of medicine/nursing/ other health sciences Academic health science centres	Royal College of Physicians and Surgeons of Canada College of Family Physicians of Canada
Registration and licensing standards	Regulatory bodies	
Ongoing competency assessment	Regulatory bodies Employers	Royal College of Physicians and Surgeons of Canada College of Family Physicians of Canada
Practice standards	Regulatory bodies Professional associations Employers	Royal College of Physicians and Surgeons of Canada College of Family Physicians of Canada Professional associations
Scopes of practice	Regulatory bodies	
Immigration policy	Provincial governments	Government of Canada
System financial incentives	Ministries of Health Bargaining agents	
Recruitment and retention programs	Ministries of Health Local communities Employers	
Job design	Unions Employers	
Collective agreements	Provincial governments Bargaining agents	

Source: CPRN 2002.

fill the gaps in what we know today. To support this important work, the Health Council of Canada will be able to build on the current expertise of CIHI, draw upon existing sources of information, and work closely with the Canadian Health Services Research Foundation and other relevant research and policy organizations in Canada.

Overall, what is needed is "a fundamentally new approach to the people side of the health care system – treating employees as assets that need to be nurtured rather than costs that need to be controlled" (Koehoorn et al. 2002, 2). Experience has shown that there is little chance of success if the key actors are not directly involved in the process of change in health care. Too often, health human resources have been treated as a cost that needs to be contained as opposed to a means by which the system can realize its objectives (Dallaire and Normand 2002). Through its leadership role, the Health Council of Canada can bring together health care providers, provinces and territories, and other key players in the health care system to address long-term issues and make a lasting and profound change in the future of Canada's health workforce.

> *"People on the front lines of providing care don't feel they're being listened to."*
>
> DR. DENISE BOWES. PRESENTATION AT OTTAWA PUBLIC HEARING.

What Does This Mean for Canadians?

Canadians are concerned about the supply and distribution of nurses, doctors and other health care providers. They have listened to fears of an impending crisis and expect something to be done. They have heard about the need for better planning, but too frequently, they have not seen this translated into action. Too many Canadians still do not have a doctor in their community, have to wait to see a specialist, or find too few nurses in the emergency department when they need urgent care.

Beyond those immediate concerns, health care providers have serious concerns about the quality of their work life and have repeatedly called for action to improve morale and day-to-day working conditions. Furthermore, continuing changes in how health care services are provided – particularly the move to primary health care – mean that many of the traditional barriers between health care providers need to be broken down. While overnight solutions are simply not possible, Canadians deserve nothing less than a full-scale national effort to address these pressing issues on an urgent basis.

With the actions outlined in this chapter, Canadians can expect to see:

- Immediate, targeted actions to expand the supply and distribution of health providers and professionals, especially in rural and remote communities;
- A stable and sustainable supply of health care providers and professionals in the future;
- Better use of the mix of skills of various health care providers, going beyond the boundaries of traditional scopes of practice;
- Health care providers who are educated, willing and able to work together as teams and networks to meet their patients' needs;
- Regular reports on the progress being made on today's pressing issues and the plans for the future.

There is also a direct message for health care providers in these recommendations. Action must be taken to address their concerns about growing stress and tension in the workplace. But, in return, health care providers must be prepared to set aside old practices, old ways of thinking and old complaints about past problems.

All players in the health care system – from governments to front-line health care providers – need to focus firmly on the future, embrace the need for change, and begin the process immediately.

5 Primary Health Care and Prevention

Directions for Change

- ***Finally make a major breakthrough in implementing primary health care and transforming Canada's health care system.***
- ***Use the proposed new Primary Health Care Transfer as the impetus for fundamental change in how health care services are delivered across the country.***
- ***Build a common national platform for primary health care based on four essential building blocks.***
- ***Mandate the proposed Health Council of Canada to hold a National Primary Health Care Summit to mobilize action across the country, then maintain the momentum by measuring progress and reporting regularly to Canadians.***
- ***Integrate prevention and promotion initiatives as a central focus of primary health care targeted initially at reducing tobacco use and obesity and increasing physical activity in Canada.***
- ***Implement a new national immunization strategy.***

The Case for Change

There is almost universal agreement that primary health care offers tremendous potential benefits to Canadians and to the health care system. The majority of policy experts and health care professionals consider primary health care to be an absolute priority. In September 2000, federal, provincial and territorial First Ministers agreed to work together on a primary health care agenda. In the words of the First Ministers' agreement: "Improvements to primary care are crucial to the renewal of health services. Governments are committed to ensuring that Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings" (FMM 2000).

Canadians, too, appear to support primary health care change. While they may not understand all the details of what primary health care means, recurrent themes in the consultations and opinion polls conducted by the Commission underscore the importance they place on health promotion and prevention, their hope for strong and accessible primary health care services, and their desire to have a long-lasting and trusting relationship with a health care professional (EKOS 2002). At the public consultations and expert roundtables, a remarkable number of people told the Commission that they would like to see the development of a complete and effective primary health care system. Most of the presentations to the Commission captured, in one way or another, either of these two important themes: continuity and co-ordination of health care and health services; and action on individual and population health.

For health care, it is remarkable to see such a high degree of agreement. The issue, then, is not whether primary health care is the right approach to take but, rather, removing the obstacles and actually making it happen.

Unlike other initiatives described in this report, primary health care is not a single program that can be designed, developed, and implemented. Primary health care is about fundamental change across the entire health care system. It is about transforming the way the health care system works today – taking away the almost overwhelming focus on hospitals and medical treatments, breaking down the barriers that too frequently exist between health care providers, and putting the focus on consistent efforts to prevent illness and injury, and improve health. In fact, no other initiative holds as much potential for improving health and sustaining our health care system. By making primary health care the central point of our health care system, we can:

- Take immediate action to prevent illness and injury, and improve the health of all Canadians;
- Reduce costly and inefficient repetition of tests and overlaps in care provided by different sectors and different providers;
- Replace unnecessary use of hospital, emergency, and costly medical treatments with comprehensive primary health care available to Canadians 24 hours a day, 7 days a week;
- Break down the barriers between health care providers, facilities, and different sectors of the health care system and concentrate on the common goal of improving health and health care for Canadians.

"The system becomes bogged down when people go for secondary treatment when they could use primary care. If we corrected this, we could achieve savings."

Association des optométristes du Québec. Presentation at Québec City Public Hearing.

It is impossible to put a dollar figure on these benefits, but there is every reason to believe that primary health care would not only save Canadians money in terms of their future investment in the health care system but also improve health and save lives. In short, primary health care is essential to transforming Canada's health care system.

The Commission shares the frustration of many that progress to date has been fragmented and far too slow. The proposed new Primary Health Care Transfer is critical to kick-start the process and move beyond a series of isolated, short-term experiments in primary health care to true and lasting reform. The transfer to the provinces and territories should be tied to the clear condition that provinces and territories will move ahead with primary health care based on four essential building blocks – continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives. A National Primary Health Care Summit

would then mobilize action across the country and focus concerted efforts on identifying and removing obstacles to implementation of primary health care. The proposed Health Council of Canada should be called upon to track and measure progress, and provide independent reports to Canadians on the progress of primary health care reform. These actions, combined with deliberate steps to integrate prevention with primary health care, should result in the kind of breakthrough that is needed to transform Canada's health care system and improve the health of Canadians for generations to come.

Primary Health Care in Canada – Opportunities and Obstacles

Primary Health Care Opportunities

In recent years, there has been a great deal of focus on primary health care in Canada and some confusion about what it means. Primary health care is actually made up of the following diverse and complex components:

- It combines high quality comprehensive medical, nursing and other health care services with disease prevention and health education programs;
- Services are provided not only to individuals but also to communities as a whole, including public health programs that deal with epidemics, improve water or air quality, or health promotion programs designed to reduce risks related to tobacco, alcohol and substance abuse;
- Services are organized so that they address the needs and characteristics of the population that is served – either a group of people living in a defined location (territorial approach) or a group of people who belong to a particular social or cultural group (population approach);
- Teamwork and interdisciplinary collaboration are expected from health care providers either working in primary health care organizations or participating in networks of providers;
- Services are available 24 hours a day, 7 days a week;
- Decision making is decentralized to community-based organizations to ensure that services are adapted to the needs and characteristics of the population served and that communities can be mobilized around health objectives that directly affect their community.

The overall aim of primary health care is to significantly increase the importance of the first line of care and those who deliver these "first contact" services. In effect, primary health care is "the central function and main focus" of the health care system (WHO 1978).

There are a number of benefits to primary health care.

- **More co-ordinated care** – For individual Canadians, primary health care means they have access to a team or network of health care providers working together on their behalf to co-ordinate their care across different aspects of the health care system from counselling them on how to stay healthy or quit smoking to treating illnesses, providing hospital care, following up with home care services, or monitoring people's use of prescription drugs.

- **Better quality of care** – More effective care can be provided at the front lines where people first come in contact with the health care system. Teams and networks of health care providers and other agencies can work together and share responsibility for an individual's care. With comprehensive information provided through electronic health records as outlined in Chapter 3, health providers can continuously monitor people's health, track their progress if they have certain illnesses, and take a broader approach to helping them stay healthy.
- **Better use of resources** – Emergency and hospital care are among the most expensive aspects of the health care system. With effective primary health care in place, people would be less likely to rely on emergency departments to get advice or assistance with relatively minor ailments or persistent health conditions that cannot be properly dealt with in busy emergency departments. By emphasizing prevention of illness and wellness, the long-term result should be less need for expensive hospital treatments especially for treating heart disease, some cancers, or a host of other illnesses that are directly related to lifestyle factors. Even when hospital treatments may be required, effective primary health care will ensure that people's care after they leave hospital is well co-ordinated with home care, prescription drug use, and rehabilitation to minimize the chances people will need to be re-admitted to hospital.

Obstacles to Primary Health Care

In the face of widespread agreement about the potential benefits of primary health care, some would ask why we are still at the pilot project stage 30 years after primary health care reform was actively promoted in Canada (Hastings 1972).

In part, some of the obstacles and delays in implementation are inherent in any process of change. Transforming the health care system to focus on primary health care is not a simple task. Refocusing a system as large and complex as health care means revisiting decisions that were made many years ago about how the system should be organized and what types of services should be provided.

The desire for perfection is also an obstacle to change. Primary health care advocates have pushed their own ideal models and solutions. But for a number of reasons, these ideal approaches are not always practical in the real world, primarily because they require too many changes at the same time – changes in training and the scope of practice of health care providers, in health care organizations, in patient attitudes, in the level of preparation of decision makers, in funding requirements, and in lifestyles. Experiments in Canada and abroad in the 1990s have shown that it is impossible to act on such a wide front without jeopardizing the quality of life of health professionals, the support of the population, or even the quality of care (Rochefort 2001).

In addition to these issues, primary health care faces six concrete obstacles:

- **The central and predominant focus on hospital and medical care** – Canada's health care system is focused primarily on hospitals and medical treatments. These areas are often identified with the greatest successes of modern medicine. But they also involve the most invasive and most costly solutions. Primary health care means striking a better balance between efforts to prevent illness and injury and those that cure people when they are sick.

- **Increasing professional specialization and protection** – Health care providers are becoming increasingly specialized and there is a long-standing tradition of carefully guarding their professional scope of practice. The development of primary health care runs against this trend and demands flexible working arrangements and shared responsibilities among health care providers.
- **Fragmented health care delivery** – Health care services are typically organized around fragmented "silos" based on who delivers the service and where it is delivered. Primary health care emphasizes the continuity of care across the various sectors. Providers and organizations are encouraged to integrate services from the first contact with a physician or nurse practitioner to services for people who are convalescing, have chronic illnesses, or who need acute or specialized services.

> *"Health care should be perceived as a continuum, not a series of vignettes."*
>
> Faculty of Medicine, McGill University. Presentation at Montreal Public Hearing.

- **Lack of health information** – Comprehensive, timely and accurate information is lacking and is not used effectively to guide decisions in our health care system. Using the new technologies and approaches to electronic health records outlined in Chapter 3, primary health care can improve the quality of care and ensure that information is available to health care providers and decision makers and, in particular, individual Canadians using the system.
- **Limited control by patients over their own care** – Currently, most patients have only a passive role in decisions about their own health care and are able to exercise only limited control. The development of primary health care focuses on patients and gives them a dominant role in decision making.
- **Marginal prevention and promotion** – In the current system, prevention and promotion activities are a small fraction of the work of governments, regional health authorities and health care providers, and investment in disease prevention remains a low priority for government spending (Majnoni d'Intignano 2001). Primary health care puts a major emphasis on prevention and promotion activities ranging from national programs to a battery of local and regional initiatives.

> *"I think that if we could have a heath care system that would listen more to the people that it's providing care to, that we would probably be doing a whole lot better."*
>
> Joanne Neubauer. Presentation at Victoria Public Hearing.

To make progress in overcoming any one of these obstacles is a major challenge, let alone all six areas at once. In many respects, primary health care goes against the grain. It goes against entrenched practices in the prevailing culture of our health care system and it sometimes runs into powerful interests and long-standing privileges. The various obstacles cannot be overcome through a single, rigid approach. Given the diversity of communities and circumstances across the country, it makes good sense to take a flexible approach that can be adapted to different communities and different groups of people.

Evolving Approaches to Primary Health Care

A number of different approaches to primary health care have been developed in Canada and in other jurisdictions around the world. It is a case where many paths can lead to the same destination.

Following the First Ministers' agreement in September 2000, an $800 million Primary Health Care Transition Fund was established to support primary health care projects across Canada. To date, the Fund has supported a number of pilot projects and the evaluation of their effectiveness. The Fund established a model for primary health care that included the following conditions:

- An increase in community-based primary health care organizations that provide comprehensive services to a certain population;
- More interdisciplinary teams with enhanced roles for nurses, pharmacists and other providers;
- Better linkages to hospitals, specialists, and other community services;
- An increased emphasis on health promotion, disease and injury prevention, and management of chronic illnesses;
- Expanded access to essential services 24 hours a day, 7 days a week (HC 2002a).

This model reflects the general consensus around primary health care and leaves considerable flexibility for provinces and territories to design and implement various approaches consistent with the overall model. It also has resulted in a number of different pilot projects across Canada.

While the approaches to primary health care continue to evolve, a number of concerns have been identified. Some aspects of primary health approaches are not necessarily grounded in research and evidence but, rather, appear to be based on good ideas or preferences. In fact, there are "enough examples of well meaning interventions with adverse effects" to suggest that "good intentions [are not] a sufficient basis for policy making" (MacIntyre and Petticrew 2002, 802). Additionally, merely adding more primary health care organizations without an overriding plan may not result in the kind of comprehensive change that many would like to see. The Quebec example is a case in point. The comprehensive network of clinics (CLSCs) in Quebec – some of which combine both health and social services – was established without ever fundamentally altering the structure of the health care system or affecting the priorities of decision makers and users of the system. Finally, there is a tendency with some models to consider each condition of the model as an end in itself. As a result, the entire project can be compromised if any one condition is not met.

As indicated in Appendix F, there are hundreds of primary health care organizations in place across the country and numerous initiatives underway to create more. Unfortunately, for the most part, efforts made across Canada to implement primary health care have concentrated on isolated pilot projects with short-term funding. The approaches are fragmented and piecemeal and have not been able to capitalize on the potential for transforming the health care system. Delays in moving ahead with primary health care have had a ripple effect across the health care system. The case of emergency departments in Canada offers a startling illustration. In the absence of primary health care alternatives, patients and health care providers have few options other than using emergency departments (Canadian Association of Emergency Physicians 2001). This problem is made even worse if hospitals are unable to make the best use of their available beds due to a lack of community-based programs to provide home care support for people who are recuperating.

All of these experiences with primary health care to date have provided a good beginning, but together, they have not created the major breakthrough in primary health care that is needed to transform the health care system. The best approach, in the Commission's view, is to:

- Provide targeted funding tied to a common national platform of essential building blocks for primary health care;
- Create an impetus and the right incentives for widespread change;
- Clearly identify and remove obstacles; and
- Openly report to Canadians so they can hold their governments and health care providers accountable if progress is not made.

Fast-Tracking Primary Health Care Change

RECOMMENDATION 19:

The proposed Primary Health Care Transfer should be used to "fast-track" primary health care implementation. Funding should be conditional on provinces and territories moving ahead with primary health care reflecting four essential building blocks – continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to achieve transformation.

Using the Primary Health Care Transfer as a Catalyst for Action

Several important points are clear from the experience in Canada and around the world. Primary health care has the potential to fundamentally transform the way health care is delivered in Canada. The benefits to individual Canadians and to the health system would be enormous both in terms of improving health and in sustaining the health care system. There is almost unanimous agreement that this is the direction we should be headed. The difficulty lies not in choosing the destination but in overcoming the obstacles that stand in the way of making primary health care the fundamental pivot of Canada's health care system.

Establishing Four Essential Building Blocks

In the Commission's view, the following four building blocks, set out in order of priority, are essential to primary health care in Canada and cut across all potential models of care:

1. ***Continuity and co-ordination of care***
2. ***Early detection and action***
3. ***Better information on needs and outcomes***
4. ***New and stronger incentives***

Within the scope of these four building blocks, there is considerable room for action and flexibility. The Commission does not believe that there is a single model for primary health care. However, given the importance of these four building blocks and the need to move ahead in the concerted way across the country, funding from the Primary Health Care Transfer should ensure that these conditions are met through a variety of approaches that are developed and implemented in provinces and territories.

Continuity and Co-ordination of Care

Too often, Canadians are left to fend for themselves and find their way through a maze of services and providers to get the best information and the full range of services they might need. This fragmentation is also a source of needless cost. It leads to a multiplicity of repeated tests and consultations. It is often accompanied by "horizontal" rigidity between medical specialities (e.g., endocrinology and cardiology independently providing care for a person with diabetes) or by "vertical" rigidities between levels of care (e.g., institutional care and home care for an elderly person). Other costs are generated by poor patient care or by care that is not at an adequate level (Kohn et al. 2000).

Some important steps must be taken through primary health care to address this problem and provide continuity of care.

- **Case managers** – A case manager is someone who guides individual patients through the various aspects of the health care system and co-ordinates all aspects of their care. The objective is to personalize care for patients and to provide appropriate linkages between different levels and types of care. In many models, family physicians play the role of case manager. Proponents of "advocacy nursing" see nurses as the patient's key contact point and guide through the health care system. However, a very successful Health Transition Fund project demonstrated that the case manager does not necessarily have to be a doctor or a nurse as long as access to required medical and nursing services is assured without untimely delays and unnecessary restrictions (Durand et al. 2001). The important role of case managers is also highlighted in Chapter 8 on home care.
- **Service integration** – Primary health care organizations can take on different aspects of diagnosis, treatment, and rehabilitation for patients in addition to new responsibilities in prevention and health promotion (Shortell et al. 1994). This concept of service integration is at the heart of initiatives in many provinces to regionalize services.
- **Care networks or health management programs** – These networks typically focus on providing ongoing care for people with chronic health conditions. In this approach, teams of health care professionals participate in developing and implementing plans for a patient's care, making sure he or she receives all the appropriate services including medications, prevention or education activities, and medical treatments.

Early Detection and Action

Along with the development of primary health care, there is a growing recognition of the need to integrate public health perspectives with front line medical care. In the United States, for example, experience has shown that the separation of prevention from medical treatment at the clinical level leads to poorer treatment and lower quality preventive care in terms of screening. As one expert suggests, "Too many things can go wrong when a woman's physician is not held responsible for making sure she gets regular mammograms and Pap smears and following up to ensure that abnormal findings are dealt with promptly" (Davis 2002, 125). General practitioners or nurse practitioners should systematically assess their patients' risk factors including smoking, nutrition and physical activity. In certain European models, primary health care organizations are also given the responsibility for immunization campaigns that have led to impressive success rates (Saltman and Figueras 1997).

Primary health care can play an important role in preventing illness and injury, and improving health over the long term. Two types of actions are critical – those that are designed to encourage people to adopt healthier lifestyles such as programs to improve cardiovascular health or reduce smoking, and those that are targeted at specific risks and preventing certain illnesses through screening, immunization, and infant care.

Better Information on Needs and Outcomes

Information is critical for primary health care, particularly given the flexible options, different types of care, and different health care providers involved. As Hutchison and Abelson (1996) suggest, information is essential to primary health care because:

- It helps patients make informed choices on available services as well as on diagnostic, therapeutic and preventive options;
- It gives health care providers the information they need about their patients and their care so that they can provide continuity of care, monitor their health and provide appropriate prevention programs when necessary;
- It allows health care professionals to keep up with the immense amount of knowledge necessary for good practice and to apply this knowledge to their patients' specific circumstances;
- It gives health care administrators the information they need to ensure that communities' needs are addressed and that resources are allocated to priority needs;
- It provides in-depth knowledge of the health needs and expectations of the population and, at the same time, allows policymakers to assess the impact of different approaches on improving the quality of primary health care services.

For these reasons, primary health care should be a major focus for actions designed to implement electronic health records and link patients and health care providers not only to patient records but also to comprehensive sources of reliable information about illnesses, prevention, and prescription drugs. Recommendations in this area are highlighted in greater detail in Chapter 3.

New and Stronger Incentives

The best way of implementing primary health care and making it the central focus of the health care system is to have appropriate incentives in place. These include:

- **Financial incentives** – Under the current system, the way in which physicians are paid and the lack of appropriate mechanisms for paying other health care providers in primary health care settings are significant obstacles. Incentives need to be put in place for health care providers to work in primary health care settings and be paid appropriately for the comprehensive care they provide.
- **Certainty and stability** – Primary health care initiatives to date have been uncertain and limited in time and scope. Some assurance that primary health care is "here to stay" and that new models will not quickly be replaced once temporary funding runs out would encourage more health care providers and health regions to pursue these approaches. It also would provide more time for primary health care organizations to build strong relationships with patients, their families and their communities, and allow professionals to develop their skills and competencies in a primary health care environment.

- **Recognition of front line staff** – In primary health care, health care providers who are the front line of service are critical. Their role should be valued as an essential part of the health care team.
- **Work-life conditions** – Primary health care organizations should provide more flexibility for health care providers in terms of how services are organized and delivered, less rigid scopes of practice, more variety in the type of work, and shared responsibilities for patients and their health.
- **Quality of care** – Many health care providers understand that primary health care can provide better quality of care because they are able to spend more time with patients and give them more attention, develop personal and stable relationships, reduce the risk of errors, and achieve better health outcomes. This is a strong incentive for both health care providers and patients.

"There should be a shift from fee-for-service to salary and many young doctors would actually prefer this to being concerned with overhead."

ROBERT YOUNG. PRESENTATION AT HALIFAX PUBLIC HEARING.

The issue of how physicians are paid has been the subject of much debate. Many suggest that one of the key obstacles to further development of primary health care is the persistence of fee-for-service payments for physicians. Paying physicians for each separate service they provide can create a perverse incentive to focus on the quantity of services provided rather than on the quality of services in order to maximize a physician's income. The other problem is that current fee schedules often do not provide a mechanism for paying physicians for providing more comprehensive care focused on prevention. There are some situations where fee-for-service payment may be the most appropriate approach, such as payments for specialist services. However, for general practitioners and family physicians, fee-for-service payment plans can be a major obstacle to primary health care.

Most primary health care models focus on alternative payment schemes for physicians, such as salaries or rostering in which physicians are paid a set annual amount for each individual who signs up as their patient. These alternatives would allow physicians to spend more time with their patients, learn more about their health and their lifestyle, and develop a more holistic approach to their treatment that no longer focuses on the number of billable services provided. No single payment scheme is without its downside. Salaried doctors may choose to provide only the minimum service required knowing it will not affect their income, and capitation can provide an incentive for doctors to only accept healthy patients on a roster because they will require less time for care. Indeed, there is some evidence to suggest that mixed payment schemes may offer the best compromise for securing doctors' incomes and allowing them more time to care for individual patients (Mathies 2000).

Some would go even further in terms of changing how physicians are paid. Currently, regional health authorities in most provinces are responsible for the organization and delivery of health care services, including primary health care. Physicians directly affect much of the services regional health authorities are expected to provide from diagnostic tests to surgical time. Yet, fee-for-service physicians bill directly to the provincial government insurance plan for payment. Arguments have been made that this separation between the people in charge of "organizing services" and the people in charge of "paying doctors" further inhibits the development of primary health care and must be resolved.

Two recent provincial health care reviews suggested that provincial governments give serious consideration to making regional health authorities responsible for paying some fee-for-service doctors in order to allow them greater flexibility in developing primary health care initiatives and alternative payment schemes (Fyke 2001; Mazankowski 2001). The Commission agrees that this option deserves further investigation by provincial governments.

> *"Primary health care does not simply mean changing the way we pay physicians – rather, it includes determinants [of health]…."*
>
> Victoria Coalition for Healthcare Reform. Presentation at Victoria Public Hearing.

The intent of the Primary Health Care Transfer is to provide a major catalyst for primary health care reform across the country. The goal is not hundreds more small-scale experiments with primary health care but fundamental, lasting transformation of the health care system.

With these building blocks in mind, funds from the Primary Health Care Transfer should be allocated to provinces and territories to address the following:

- Providing training and retraining for health care providers to work in primary health care environments. This would also include training for case managers whose role will be vitally important to the success of primary health care approaches;
- Implementing new approaches for paying physicians and other health care providers so that the best use can be made of the mix of skills of various health care providers;
- Substantially expanding health promotion and prevention programs. (Further information about targeted areas for these investments is provided in subsequent recommendations in this chapter); and
- Collecting information, evaluating results, assessing outcomes and sharing best practices in primary health care.

The proposed Primary Health Care Transfer would provide $1 billion to the provinces and territories on a per capita basis for the next two years. Provinces and territories would be expected to match the federal Transfer using new and existing resources already allocated to primary health care initiatives. Funds should be provided on the condition that provinces and territories would allocate funding to the priorities noted above and implement primary health care approaches.

Building National Momentum, Attacking Obstacles and Reporting Progress

RECOMMENDATION 20:

The Health Council of Canada should sponsor a National Summit on Primary Health Care within two years to mobilize concerted action across the country, assess early results, and identify actions that must be taken to remove obstacles to primary health care implementation.

RECOMMENDATION 21:

The Health Council of Canada should play a leadership role in following up on the outcomes of the Summit, measuring and tracking progress, sharing information and comparing Canada's results to leading countries around the world, and reporting to Canadians on the progress of implementing primary health care in Canada.

Building and Maintaining Momentum

Provinces and territories have primary responsibility for deciding how health care services are organized and delivered in their health care system, including primary health care. It is up to them to decide which of the different approaches to primary health care is most appropriate and most viable for their residents.

Nonetheless there is considerable room for collaboration and co-operation. For many years, the provinces and territories have worked together on common issues of concern, sharing ideas and learning from each other's experiences. Furthermore, the potential for primary health care and the important role it can play in transforming the health care system demands national leadership and national action.

For these reasons, the Commission calls on the provinces and territories to join forces to galvanize the energy and ideas of health care providers and others through a National Summit on Primary Health Care to be organized by the proposed Health Council of Canada. The Health Council would then be responsible for following up on the outcomes of the Summit, measuring progress and providing regular reports to Canadians.

The proposed Summit should bring together representatives of the federal, provincial and territorial health ministries, as well as representatives of the key health professions, regional health authorities across the country and people with front line experience in primary health care. Other organizations from the public and private sector, including regulatory bodies, voluntary organizations and unions, should also be involved. And ample opportunity should be provided for a cross-section of Canadians to participate in this important event.

The purpose of the Summit should be to:

- Critically examine achievements to date in terms of implementing primary health care consistent with the four building blocks identified by the Commission;
- Identify the barriers and the actions that need to be taken to overcome them;
- Mobilize concerted action on best practices on primary health care;
- "Shine the spotlight" on those responsible for primary health care, identify where progress is or is not being made, and lay the groundwork for measuring future results.

The Summit must be more than just a gathering of advocates for primary health care. Its focus must be on action and implementation. The participants need to confront the difficult challenges, including scope of practice issues, and should clearly highlight the remaining obstacles to change. The Summit should bring experts from other countries to assess the current situation in Canada and provide their insights. The recommendations from the Summit must set the stage for concerted action across the country. Much like the World Health Organization and UNICEF conference on primary health care in 1978 spurred action around the world, the national Summit in Canada should help build momentum for change.

To follow through on the outcomes of the Summit, the Health Council of Canada should play a crucial leadership role, working with provinces and territories to measure and report on progress. Specifically, the Health Council should:

- Develop indicators and measure progress in key areas including integration of prevention into medical care, retention of health professionals, adoption of alternative modes of remuneration for health care providers, and effectiveness of primary health care approaches in improving health outcomes;

- Report regularly and clearly to Canadians on the progress of their governments and health care providers in removing obstacles to widespread implementation of primary health care;
- Expand primary health care research on controversial issues such as the remuneration of health care professionals, work organization, funding of primary health care organizations, and registration (rostering) of patients;
- Compare outcomes in Canada with best practices in other countries around the world; and
- Assist in the development of health promotion and prevention initiatives to ensure that information is shared with the general public through a variety of media.

The Health Council should also be in a good position to support the provinces and territories as they move ahead with strategies for implementing primary health care. Those strategies should focus on four conditions that are necessary for successful change (Nestle 2002).

- **Proposals based on evidence** – As noted earlier, there is insufficient and even contradictory evidence on important characteristics of primary health care including work organization, professional remuneration, the quality of care or patient satisfaction (Hutchison et al. 2001; Abelson and Hutchison 1994). This leaves a number of issues open for endless debate and discussion. The Health Council of Canada can play an important role, working with major research organizations to expand targeted research in these areas.
- **A clear message** – One of the difficulties with primary health care is that the message is not always clear in terms of what primary health care is intended to do and why it is a preferred approach for our health care system. Based on the outcomes of the Summit, the Health Council should work with the provinces and territories to develop and communicate a consistent message to Canadians about the objectives and benefits of primary health care.
- **Well-identified targets** – The Health Council of Canada should take the lead in developing appropriate targets, tracking results and measuring progress in achieving the targets. This should build on the development of electronic health records and the overall work of the Council in developing and reporting on key health indicators.
- **Targeted approaches to individuals and communities** – Primary health care initiatives should be focused on individuals and their communities. This means being clear on objectives and expectations and the benefits primary health care can provide. This is true for health care providers as well. At the end of the change process, primary health care providers need to understand that they will have a broader role in the health care system, better working conditions, and a greater ability to respond to their patients' needs and improve their health. The public needs to see that primary health care is living up to its promise of providing better access, better integration and better care. The Health Council, provinces, and territories need to reinforce these messages with Canadians as we move ahead with transforming Canada's health care system.

Strengthening the Role of Prevention

RECOMMENDATION 22:

Prevention of illness and injury, and promotion of good health should be strengthened with the initial objective of making Canada a world leader in reducing tobacco use and obesity.

RECOMMENDATION 23:

All governments should adopt and implement the strategy developed by the Federal, Provincial and Territorial Ministers Responsible for Sport, Recreation and Fitness to improve physical activity in Canada.

RECOMMENDATION 24:

A national immunization strategy should be developed to ensure that all children are immunized against serious illnesses and Canada is well prepared to address potential problems from new and emerging infectious diseases.

Promoting Good Health

One of the key objectives of primary health care is to prevent illness and injury, and improve the overall health of Canadians. There is a growing awareness that many illnesses can be prevented if people take better care of their health. For example, over 90% of type II (or adult-onset) diabetes and 80% of coronary heart disease could be avoided with good nutrition, regular exercise, the elimination of smoking, and effective stress management (WHO 2002). Over 90% of lung cancer deaths and 30% of all other cancer deaths could be prevented in a tobacco-free society (Statistics Canada 2002d).

There also is a growing understanding that broader determinants of health such as lifestyle factors, adequate housing, a clean environment and good nutrition have an important impact on the health of individuals and communities, and also hold tremendous potential for improving health and preventing illnesses. Primary health care organizations and providers need to pay more attention to the impact these broader determinants of health can have both on individuals and communities. A focus on the determinants of health at the community level can result in actions to strengthen social support mechanisms (Mechanic 2000). Many types of health organizations, including medical clinics and hospitals, have been engaged in all sorts of partnerships with social agencies in their communities (Gamm 1998). In fact, health organizations have the same responsibility to the communities they serve as physicians have toward their patients – they must prevent illness as well as heal and provide support and advice as well as treatment.

"Healthy populations need treatment less often, and respond more effectively when treatment is required."

Canadian Public Health Association 2001. Written submission.

The impact of determinants of health and lifestyle choices is well known to governments and to health care organizations. Unfortunately, the key problem lies in turning this understanding into concrete actions that have an impact on individual Canadians and communities. In many

areas in public health, the gap between knowledge and practice is still too great. Too often, to paraphrase the World Health Organization's definition of public health, "a comprehensive understanding of the ways in which lifestyles and living conditions determine health status," is not followed by a corresponding urge "to mobilize resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health" (WHO 1998, 3).

A portion of the proposed new Primary Health Care Transfer should be targeted to expanding efforts by provinces and territories to prevent illnesses and injuries, promote good health, and integrate those activities with primary health care. The Health Council of Canada can also play a major role in identifying and promoting healthy living conditions and the adoption of healthy lifestyles. By integrating the Canadian Institute for Health Information with the Health Council, the Council would assume responsibility for CIHI's work on the Canadian Population Health Initiative, a special program intended to provide information on the determinants of health, contribute to the development of population health information infrastructure, support policy analysis, and share new knowledge with decision makers and the public.

> *"According to the World Health Organization, much of the world's future health burden will be a result of lifestyle practices."*
>
> FPT Ministers Responsible for Physical Activity 2001. Written submission.

Another important initiative is the proposed creation of a new Centre for Health Innovation focusing on health promotion outlined in Chapter 3. This Centre would provide reliable and objective information on best practices across the country, trends in health risks and behaviours that threaten or compromise health, and work with provinces, territories and the Health Council of Canada to develop effective health promotion strategies.

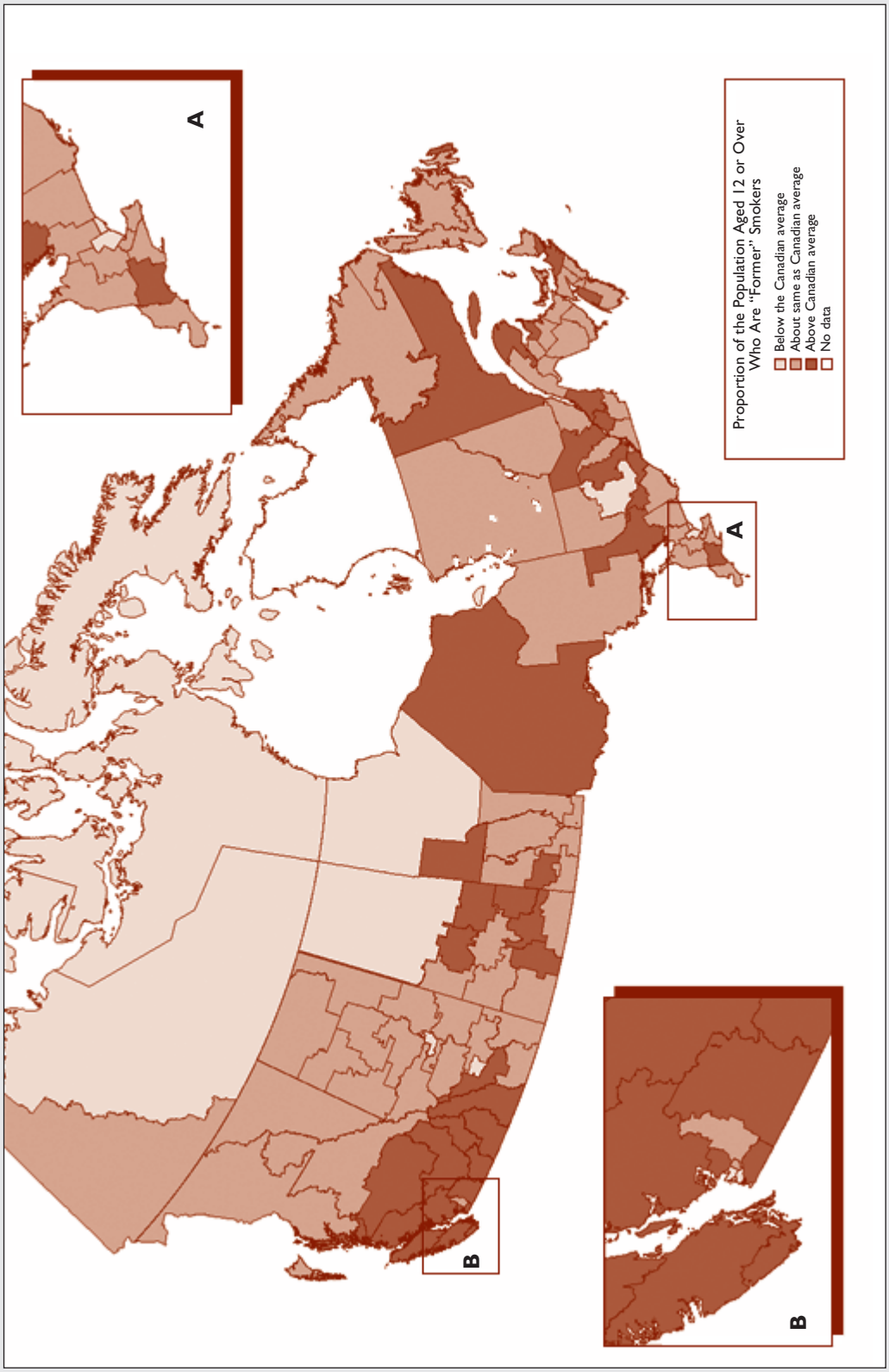
Addressing Leading Causes of Major Health Problems

Behaviours such as smoking, lack of physical activity, poor diet, and alcohol use have profound effects on health, largely because they are related to the leading causes of death, illness and disability such as heart disease, cancer, stroke, respiratory disease, diabetes and injuries. Recent increases in certain forms of cancer and diabetes can largely be attributed to individual health practices such as smoking, diet, and physical activity. Provinces, territories and the federal government have taken action to put health promotion strategies in place to address these concerns and some good progress has been made. Yet Canada continues to have high rates of heart disease, some cancers and other diseases that could be largely prevented.

Consider these facts about smoking (see Maps 5.1 and 5.2):

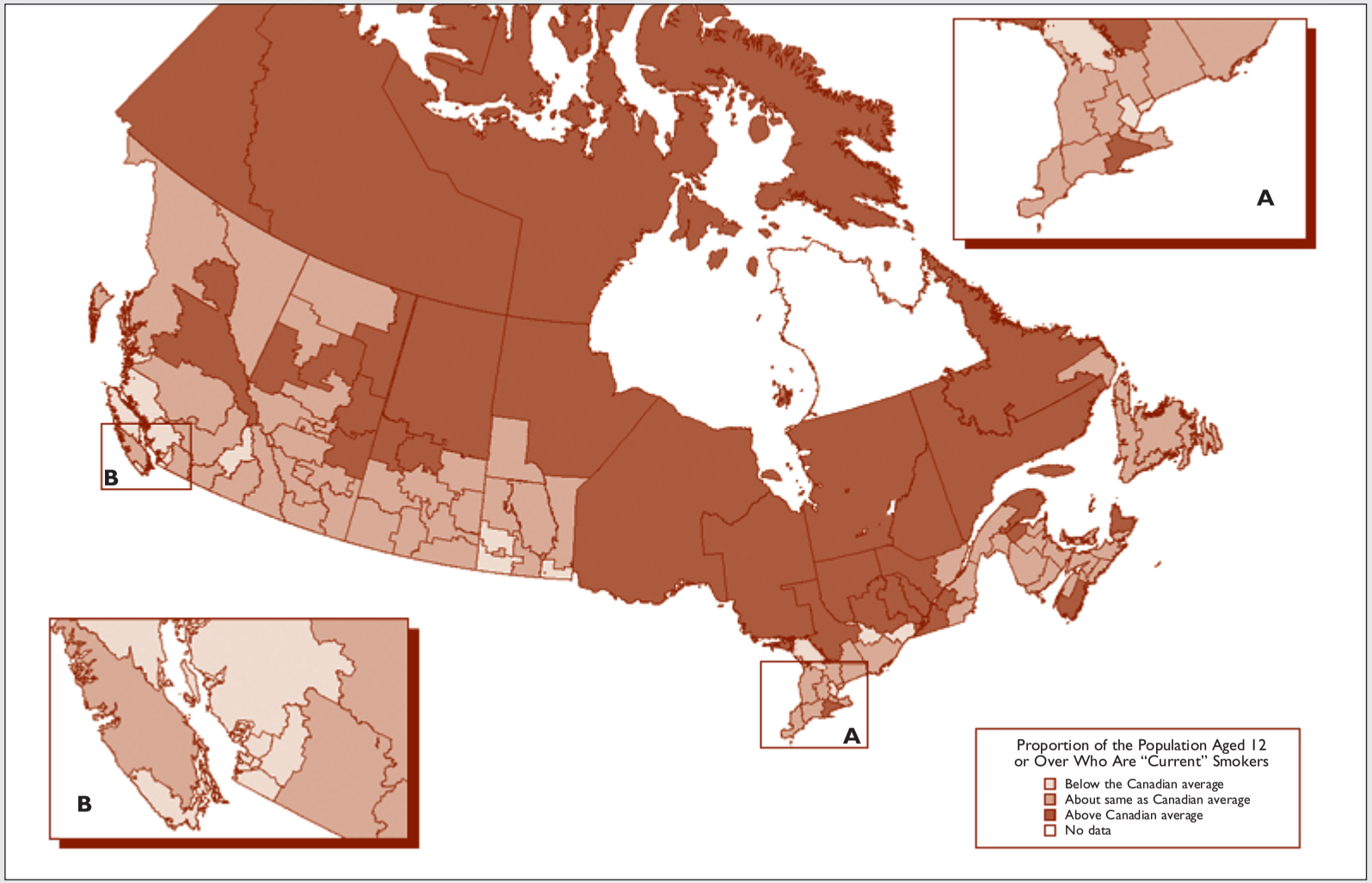
- Estimates are that smoking costs our economy more than $16 billion each year, including $2.4 billion in health care costs and $13.6 billion due to lost productivity through sick days and early death (Stephens et al. 2000);
- One study suggests that an effective school-based smoking prevention program could potentially result in an initial 6% reduction of smoking and 4% over the long term. It estimates the cost-benefit of such a program could mean net savings of up to $619 million annually (Stephens et al. 2000);
- Smoking also takes a horrible toll on Canadians; up to 45,000 Canadians die each year from smoking (Makomaski-Illing and Kaiserman 1999);

Map 5.1 "Former" Smokers, by Health Region, 2000/01



Source: Statistics Canada 2002.

Map 5.2 "Current" Smokers, by Health Region, 2000/01



Source: Statistics Canada 2002.

- In the late 1990s, 19.2% of Canadian women were daily smokers. This number compares favourably with rates in other OECD countries but it is significantly higher than rates in Japan where only 14.5% of Japanese women smoke. Twenty-two percent of Canadian men smoked daily in the late 1990s compared to 19.2% in Sweden (OECD 2001a).

Obesity is also becoming a major threat to the health of many Canadians.

- In 1997, obesity resulted in $1.8 billion in medical costs (Birmingham et al. 1999).
- Since 1994/95, the percentage of the population aged 20 to 64 (excluding pregnant women) reported as obese has increased from 13.4 to 15.2% in 2000/01 (Statistics Canada 2002g).
- Canadians are now more likely to be obese than adults in most other OECD countries. Countries such as the Netherlands, Norway, Sweden and Switzerland have adult obesity rates more than one-third lower than Canada (OECD 2001a). On the other hand, the United States and the United Kingdom have higher obesity rates.
- While obesity can be influenced by genetic factors, physical inactivity and poor diet are clearly significant factors (McDonald 1995).
- Nine percent of Canadians age 12 and over are concerned about the amount of fat in their diet but are not taking any action to reduce it (FPT Advisory Committee on Population Health 2000).

"Physical inactivity costs the Canadian health care system at least $2.1 billion annually in direct health care costs."

FPT Ministers Responsible for Physical Activity 2001. Written submission.

Evidence also suggests that Canadians are not as physically active as they should be in order to maintain good health (see Map 5.3). Fifty-seven percent of Canadians 18 and over do not meet minimum recommended guidelines for physical activity, down from 79% in 1981. In 2000, over one-half of children aged 5 to 17 did not meet recommended levels of physical activity (Canadian Fitness and Lifestyle Research Institute 2002). Physical inactivity cost the health care system an estimated $2.1 billion in 1999. Reducing the prevalence of physical inactivity by 10% would save $150 million in health care costs per year. Approximately 21,000 lives were lost prematurely in 1995 because of physical inactivity (Katzmarzyk et al. 2000).

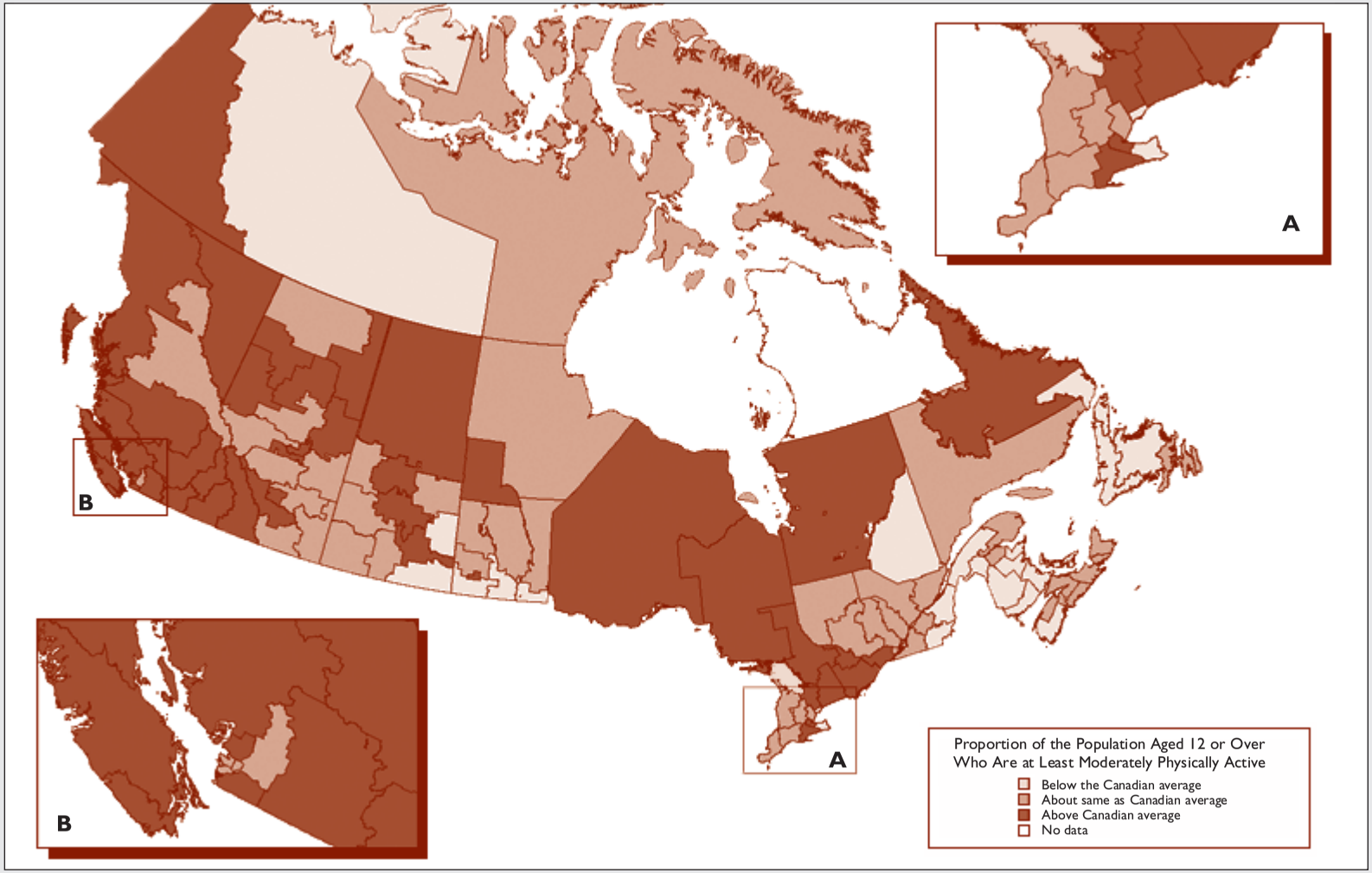
The Federal/Provincial/Territorial Ministers Responsible for Sport, Recreation and Fitness presented a strategic blueprint to the Commission on April 7, 2002, in Iqaluit, to increase the level of physical activity in Canada by:

- Increasing the time devoted to physical education and sport in schools;
- More systematically educating all Canadians on the value of physical exercise;
- Encouraging more active forms of recreation through community-based programs; and
- Supporting healthier workplaces that encourage less sedentary lifestyles.

The Commission wholeheartedly supports the thrust and objectives of this strategy.

Clearly, these three areas – tobacco use, obesity, and physical inactivity – are priority areas that must be addressed in order to improve the health of Canadians and prevent illness in the years to come. Tackling these issues will take a concentrated effort and investment on the part of all governments. The Health Council of Canada can play a leading role in sharing information about best practices and working with provinces and territories on effective, targeted promotion strategies. Dedicated promotion strategies supported by the new Primary Health Care Transfer can

Map 5.3 Leisure Time Physical Activity, by Health Region, 2000/01



Source: Statistics Canada 2002.

make Canada a leader in reducing smoking and obesity, increasing physical activity, and reducing the incidence of serious illnesses such as heart disease, cancer, and respiratory disease. A recent survey report by the Canadian Cancer Society indicated that efforts to raise awareness of the health risks of smoking can have positive results. In a Fall 2000 survey, 43% of smokers said the graphic health warnings on cigarette packages raised their concerns about the health risks of smoking and 44% said they were motivated to quit (Martens 2002). These and other efforts to reduce smoking and address the growing problem of obesity should be expanded across Canada.

As noted in Chapter 2, the proposed Health Council of Canada would include the important work underway by the CIHI. One of its current initiatives is the Canadian Population Health Initiative. This intergovernmental work should continue under the Health Council of Canada and should assist in assessing health promotion initiatives and measuring the benefits of integrating prevention with primary health care. Important links should also be established with the proposed Centre for Health Innovation focusing on health promotion outlined in Chapter 3.

A National Immunization Strategy

Immunization is one of the most effective illness prevention strategies. Canada has a solid record in this area and immunization rates for most infectious diseases compare favourably with other OECD countries.

In the past few years, however, the cost of new vaccines and the lack of accurate information on their effectiveness and safety have worried public health specialists. The fact that Canadian immunization programs are dated and have been in place for many years adds to the concern that Canada is not well prepared to face new and emerging problems due to globalization and the evolution of infectious diseases. In addition, in some regions of the country, immunization rates have deteriorated as a result of public fear of vaccines as well as lack of attention by health care professionals.

"Vaccination is one of the most cost effective health interventions available."

TORONTO PUBLIC HEALTH 2002. WRITTEN SUBMISSION.

The National Advisory Committee on Immunization has facilitated discussion about these issues with the provinces, territories and federal government. But even the specialists who participate in this committee admit that the time has come to move to another stage in which some form of joint planning is done in addition to sharing information. Some specific measures have been suggested (Canadian Public Health Association 2002; Embree 2001) including:

- Establishment of an immunization registry
- Harmonization of immunization schedules
- Identification of national standards in terms of coverage
- Vaccine safety monitoring
- National procurement and evaluation policies
- National information and awareness campaigns.

The proposed National Drug Agency outlined in Chapter 9 should be responsible for developing guidelines and purchasing vaccines as part of a new national immunization strategy.

What Does This Mean for Canadians?

The objective of moving ahead with primary health care is nothing short of transforming Canada's health care system. It means that the promise and potential benefits of primary health care can be achieved – not overnight, and not in some hasty, haphazard way, but in a practical, deliberate, and consistent way across the country.

The Commission calls on provinces and territories to take the next essential step to move forward with a national platform for primary health care in place – a platform that is built on four essential building blocks. The proposed Primary Health Care Transfer should provide the financial incentive and support for provinces and territories to move, and move quickly, with major steps to implement primary health care approaches and begin work on the important goal of preventing major illnesses over the longer term.

For Canadians, the benefits are clear:

- All Canadians will have better access to primary health care approaches focused specifically on maintaining and improving their health.
- Their experiences with the health care system will no longer be isolated events but will be linked by a common thread – primary health care – bringing together all aspects of the care they need from dealing with minor illnesses to managing prescription drug use, screening for cancer, ensuring that home care is available, or providing support in people's last months of life.
- The health care system will have a better balance between preventing illness and injury and taking action when people are sick.
- With deliberate actions to prevent illness and injuries, promote good health, and give people access to appropriate care, better use can be made of available resources, and costs can be contained.
- Teams and networks of health care providers can work together to address health problems, reduce and prevent the incidence of leading diseases, co-ordinate care for their patients, and share responsibility for providing comprehensive care for Canadians.
- People who are chronically ill or who have ongoing mental health problems will get the care and support they need through a variety of primary health care approaches.
- Rates for certain preventable illnesses and injuries should go down as a result of dedicated efforts to promote good health. These deliberate and concerted efforts to improve overall health will pay dividends for generations to come.

6 Improving Access, Ensuring Quality

Directions for Change

- ***Use the new Diagnostic Services Fund to shorten waiting times for diagnostic services.***
- ***Implement better ways of managing wait lists.***
- ***Take deliberate steps to measure the quality and performance of Canada's health care system and report regularly to Canadians.***
- ***Ensure that the health care system responds to the unique needs of official language minorities.***
- ***Address the diverse health care needs of men and women, visible minorities, people with disabilities, and new Canadians.***

The Case for Change

Canadians want and expect to have access to health care services when and where they need them. They expect high standards of quality to be met. They expect the treatments and services they receive to be based on the best available scientific evidence and the latest knowledge. And they expect the health care system to diagnose health problems, cure illnesses and treat injuries, and help improve not only their overall health but their quality of life as well. Too often, however, those expectations are not being met and, as a result, Canadians' faith in the health care system is undermined.

Providing timely access to quality health care services is a serious challenge in every province and territory. Consistently, the Commission heard concerns from Canadians about waiting for diagnostic tests, waiting for surgeries or waiting to see specialists. In the minds of many Canadians, the quality of our health care system should be judged, first and foremost, by its ability to provide timely access to the care people need. In fact, quality is about a lot more than access. It includes a number of important factors related to the safety of the treatments and the outcomes that are achieved. Understandably, Canadians' first concern is with access, and that

> *"It was Einstein who said 'insanity is doing things the way we have always done them and expecting different results.' To address the problem of accessibility, we must explore new ways of delivering care, rather than assuming the solution lies only in continuing expansion of hospital based programs."*
>
> Hamilton HSO Mental Health and Nutrition Program 2001. Written submission.

issue must be dealt with on a priority basis. At the same time, quality will be an increasingly important issue and one that needs to be addressed on an ongoing basis.

The sections of this chapter outline specific and deliberate actions that should be taken to reduce waiting times, put objective and transparent processes in place for managing wait lists, measure the performance of Canada's health care system and use that information to improve quality, as well as improve access and quality for minority language communities and meet the differing health care needs of men and women, visible minorities, people with disabilities and new Canadians.

By taking action on these issues on an urgent basis, we can restore Canadians' confidence in their health care system and, most importantly, we can make sure they get timely access to high quality health care services.

Reducing Waiting Times and Managing Wait Lists

RECOMMENDATION 25:

Provincial and territorial governments should use the new Diagnostic Services Fund to improve access to medically necessary diagnostic services.

RECOMMENDATION 26:

Provincial and territorial governments should take immediate action to manage wait lists more effectively by implementing centralized approaches, setting standardized criteria, and providing clear information to patients on how long they can expect to wait.

Waiting for Health Care

Identifying the Problem

Waiting for health care is a serious concern for Canadians and it has become a preoccupation for health care professionals, managers, and governments. Studies and public opinion polls have consistently shown that one of the top concerns of rural and urban Canadians is health care access (Mendelsohn 2002; Sanmartin et al. 2002; CPRN 2001; Rural Secretariat Research and Analysis Group 2001). At their August 2002 meeting, Canada's Premiers acknowledged that access to health services was the highest priority for all Canadian citizens.

> *"I go to Emergency when I am sick; there are no other choices. Waiting to see a specialist is a long-term wait, usually about 6-12 months."*
>
> Ross Howard 2001. Written submission.

Time and time again, the Commission heard that, when it comes to access to specific diagnostic procedures and some surgical procedures, wait lists (i.e., the number of people waiting for a particular service) and waiting times (i.e., the average time people are on the wait list before they receive a service) are too long. Long waiting times are the main, and in many cases, the only reason some Canadians say they would be willing to pay for treatments outside of the public health care system. Health care providers, regional health authorities and hospitals are trying to keep pace with growing demands. More surgeries, treatments and tests are being performed, but demands often outstrip their ability to deliver the necessary services on a timely basis. As a participant in

the Commission's Policy Dialogue on Access at Dalhousie University put it, long waiting times are not caused by the system performing fewer diagnostic and surgical procedures but because medical advances now allow us to deliver more of these services and to a wider range of people.

While the concerns of Canadians are clear, the debate over waiting times and wait lists is anything but. The debate has become clouded by contradictory evidence and conflicting claims by health care professionals, managers, health policy experts, and governments at all levels across the country (Lewis et al. 2000; Barer and Lewis 2000; Shortt 1999). The current debate appears to be polarized between two extreme and incompatible positions:

- Those who look at the way wait lists are managed across the country and conclude either that it is impossible to say whether there is a problem or that the problem is more perception than reality; and
- Those who use incomplete information to conclude that the problems are so severe that the only solution is to allow parallel private facilities in which individuals can use their own funds to purchase some services and, in their view, "take some pressure off the public system."

The Commission rejects both of these positions.

"I am one of that great cadre called 'elective' patients. We are not seen as emergencies … I have recently had a hip replacement; I was waiting for that replacement for almost two years … the word 'elective' is offensive; it isn't as though we're going to the store to buy some shrimp versus some liver: we have no choice about using the health care system."

CAROLYN ATTRIDGE. PRESENTATION AT VICTORIA PUBLIC HEARING.

In response to the first view, the problem is not just one of perception. There is evidence to suggest that there are problems in waiting times for some services but not in others. A comprehensive examination of the situation in Manitoba, for example, showed that the provincial system was dealing well with life-saving surgeries such as bypass operations, but not as well with non-life-threatening elective surgeries (DeCoster et al. 2000).

In response to the second view, those who argue that the public system is no longer able to manage the situation fail to take into account the progress that is being made in some jurisdictions. In addition, private facilities may improve waiting times for the select few who can afford to jump the queue, but may actually make the situation worse for other patients because much-needed resources are diverted from the public health care system to private facilities.

As individual provinces and territories have struggled to deal with waiting times and wait lists within their own systems, progress is being made in some areas but more effort needs to be put into generalizing those efforts across the country (Glynn et al. 2002; Lewis et al. 2000). Clearly, the progress is not fast enough for Canadians. More can and must be done across the country to give Canadians what they want and deserve – timely access to the health care services they need.

Addressing Immediate Priorities – Access to Diagnostic Services

There are three key areas where the health care system needs to solve waiting times and wait list problems:

- Access to advanced diagnostic technologies such as MRIs (magnetic resonance imaging) and CT (computed tomography) scanners;

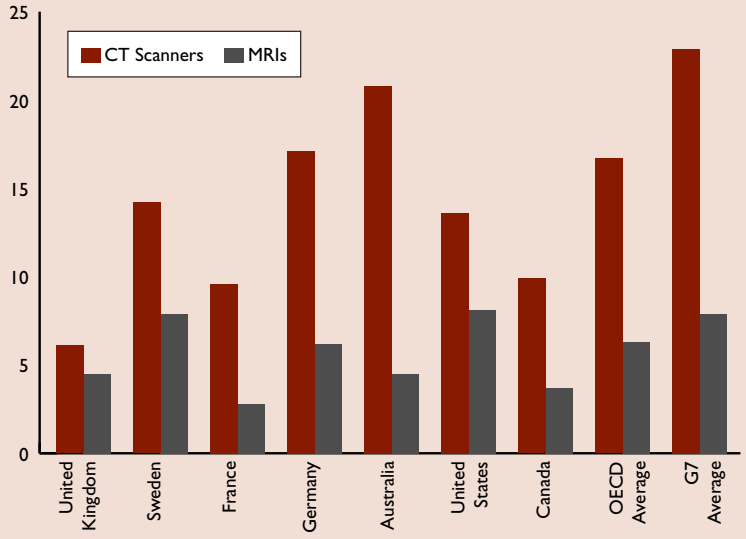
- Access to specialists (though this varies greatly between specialities, between provinces and even within provinces); and
- Access to some surgical procedures (e.g., hip and knee replacements) that may not be life-saving but would improve the patient's quality of life.

While each of these three areas is important, the Commission believes that immediate and tangible improvements can be made by addressing access to diagnostic services on a priority basis. Problems in access to necessary diagnostic services can create bottlenecks in the rest of the health care system. They also extend waiting times for patients who often must have a diagnostic test to confirm a diagnosis before surgery or further treatment. By focusing on diagnostic services as a first priority, provinces and territories can increase their investment in necessary equipment and staff, and free up resources to be used to address pressing access problems in other areas. Recommendations on better ways of managing wait lists should also address a number of issues related to access to surgeries and specialists.

In terms of access to diagnostic technologies, there is no agreed upon definition of the "right" number of MRIs or other new diagnostic technologies for a particular population. Nonetheless, as Figure 6.1 shows, Canada has fallen behind other OECD countries in the integration of this technology into the health care system. There also is a significant variation among the provinces when it comes to the availability of advanced diagnostic technologies (see Figure 6.2 and Map 6.1). While there may be many reasons for this under-investment, the most obvious is that these technologies are incredibly expensive to purchase and require significant funds to operate on an ongoing basis.

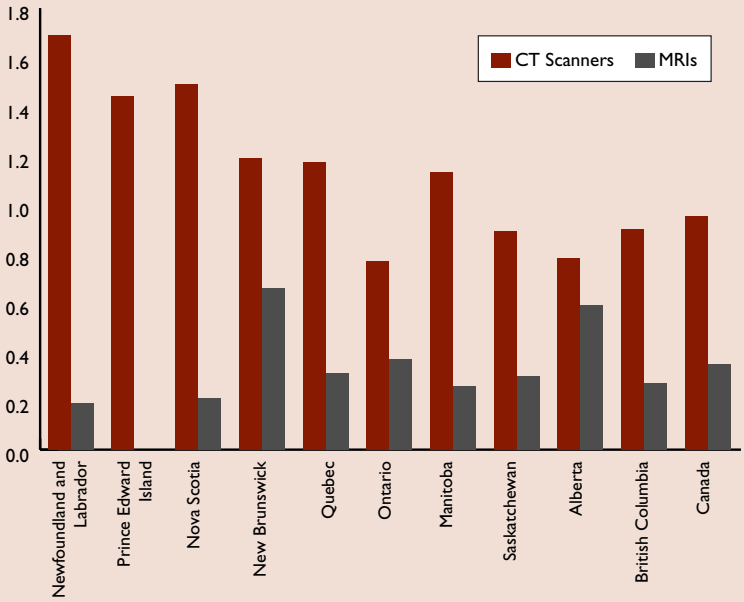
The proposed new Diagnostic Services Fund would provide direct support to provinces and territories to increase their investment in advanced diagnostic technologies. Funds should be used not only for purchasing technology but also for training and hiring the necessary staff and

Figure 6.1 Selected Imaging Technologies (Number per Million People) among OECD Countries, 1999



Note: Due to limitations on the data only those countries for which reasonably current inventories exist have been used. Japan has been excluded from the countries selected due to the disproportionate numbers of imaging technologies in use relative to other OECD countries but is included in the calculation of OECD and G7 averages. Figures for Canada are 2001 and for Australia 1995.
Source: CCOHTA 2002a,b.

Figure 6.2
Selected Imaging Technologies (Number per 100,000 People), by Province and Canada, 2001



Source: CCOHTA 2002a,b.

technicians to operate and maintain the equipment, and interpret the results. The provinces and territories should work closely with the expanded technology assessment capability of the Health Council of Canada to ensure that new diagnostic technologies are assessed and integrated appropriately into the health care system. Steps should also be taken to ensure that diagnostic technologies are used appropriately (i.e., the tests are warranted given the medical conditions of patients) and efficiently (i.e., making the maximum use of the equipment). Investments in diagnostic technology will create some much-needed "breathing space" and give provinces and territories the opportunity to invest existing resources in reducing waiting times in other important areas.

Managing Wait Lists

Current Problems with Wait Lists

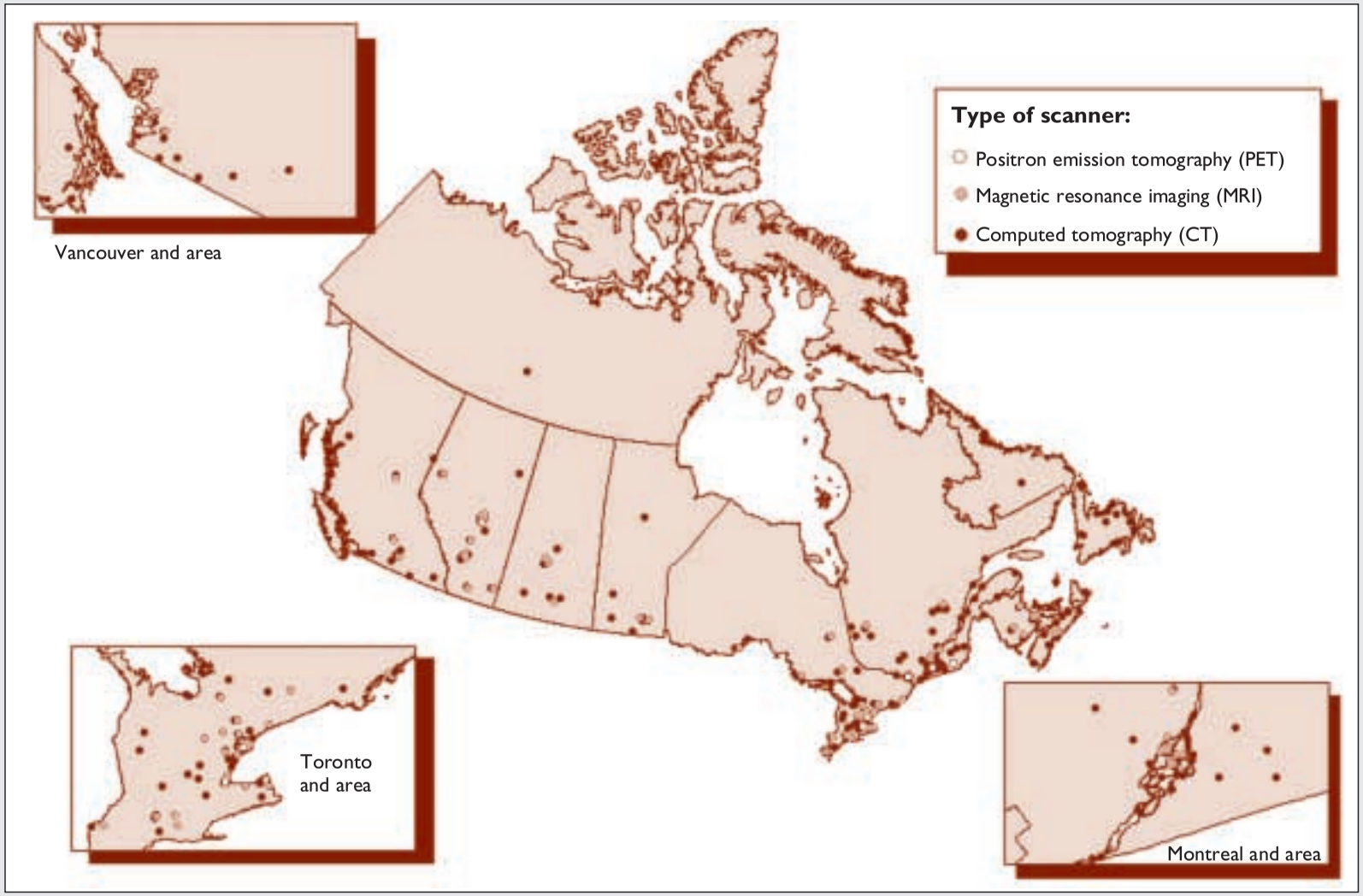
One of the most serious concerns is not only the length of time some people wait but the way in which wait lists are managed. In fact, to say wait lists are "managed" is almost a misnomer. There is no consistent way of dealing with wait lists in particular regions let alone on a provincial or national basis. This affects the health of people who wait and it seriously undermines Canadians' confidence in their health care system.

When individual Canadians are told that they are on a wait list for a particular service, they probably assume that there is a master list that is managed and co-ordinated based on the urgency of their need. In reality, that is not what happens.

This is how wait lists are managed in Canada today.

- Most wait lists are managed by individual physicians or individual hospitals (with the exception of some cardiac surgery lists and cancer care lists).
- There is little co-ordination of those lists between physicians or between hospitals. That means an individual may be on a particular specialist's list for an appointment but there

Map 6.1 Scanners in Canadian Hospitals, 2001



Note: Reported by Hospitals or Health Authorities as of July 15, 2001.
Source: CCOHTA 2001.

may be other specialists who have shorter lists and could provide the service more quickly. Some people may prefer to consult with particular specialists or to wait for particular surgeons to perform their surgery. This certainly is their right, but it is a choice they make and it may mean they have to wait longer.

- There are few rules that govern when and whether a person should be put on a wait list for a particular service. Individual physicians have almost total discretion as to when a person is placed on a list. Furthermore, there is no consistency in terms of "when the clock starts ticking" – whether it is after the first visit to a family physician, the first visit to a specialist, when the diagnosis is made or when a patient's name is added to a particular physician's or hospital's wait list (Fyke 2001).
- There is no serious auditing of wait lists to see if individuals are on the list appropriately, if their condition or circumstances have changed so that they can be removed from the list, or whether some individuals are on more than one list for the same procedure or service (Sullivan and Baranek 2002).

In addition to the lack of clear procedures for defining and managing wait lists, there are a number of factors that influence the length of wait lists and average waiting times. There may not be a sufficient supply of specialists, surgeons, operating room nurses and technology. Specialized technology such as MRIs may be in short supply. And people themselves make choices that affect how long they wait, including decisions to delay or defer treatment for a variety of reasons.

With all of these factors combined, it perhaps is not a surprise that wait lists are handled in a somewhat haphazard manner. But the result is that the public is both confused and frustrated. They do not understand why they wait so long, whether the time they wait is appropriate or too long, and why something cannot be done to address their concerns. Furthermore, they are not always told how severe their condition is, whether their health will deteriorate further if they have to wait, and what options they might have in terms of seeing other specialists or going to other hospitals.

Actions Underway

Provinces and territories are well aware of these problems and a number of different initiatives are underway to try to address them. In addition to the Manitoba example cited earlier, some jurisdictions have good processes in place for managing waiting times for some of the more serious life-threatening conditions. Centralized registries for life-saving treatments such as cancer and cardiac care allow the system to prioritize patients according to their need and their risk (CardiacCareNetwork of Ontario 2001). However, these success stories have been difficult to transfer to other jurisdictions or to other kinds of services. And there still are instances in some provinces when individuals have to be transferred outside the country to receive care for life-threatening conditions. This cannot and should not be allowed to continue.

Some encouraging work has been done by the Western Canada Waiting List Project (Noseworthy et al. 2002). Established as a partnership among the western provinces, medical associations, regional health authorities and health research centres, the WCWLP has made important progress not just in understanding the reality of wait lists in western Canada, but also in developing tools for physicians to rank urgency and to ensure that wait lists are managed in a comprehensive, objective and transparent manner. The tools were tested by both physicians and

reviewed by focus groups of patients and were found to be effective particularly for assigning people to wait lists for general surgery, knee and hip replacements, cataract surgery, and children's mental health. One limitation of the WCWLP is the fact that it did not address such life-threatening illnesses as cancer or cardiac care. Work from Manitoba and Ontario suggests that the greatest effort will be needed in addressing problems related to life-threatening illnesses, not only because they are the hardest problems to tackle but also because they are the ones that are most important to Canadians. Nonetheless, the work of the WCWLP is an important example of how provinces and territories, health authorities and health care providers can work together to manage waiting times and wait lists in a much more effective manner.

Considering Care Guarantees

One approach for addressing the problem of wait lists is establishing "care guarantees." This option was recommended in the Senate Committee's (2002) recent examination of the Canadian health care system and the Premier's Advisory Council on Health in Alberta (Mazankowski 2001). Care guarantees provide patients with a guarantee that they will have access to the treatment they need within a certain period of time. They have been implemented in several European countries including the United Kingdom, Sweden and Denmark.

The advantage of care guarantees is the certainty and reassurance they provide to patients. They also require health care authorities, providers and hospitals to take steps to ensure that the guarantees can be met. On the other hand, care guarantees should be approached with some degree of caution.

Currently, reliable methods are not available to determine what the appropriate guarantee should be and what the likelihood is that the health care system would be able to meet the time limits set in a guarantee. Care guarantees should rely on an objective assessment of both the capacity of the system to provide the necessary service or treatment within a certain timeframe and the urgency of the condition being treated. They cannot simply be pulled out of thin air and trumpeted to Canadians as a magic bullet solution.

The other major concern is with the difference between life-saving and elective procedures. Long waiting times for the diagnosis and treatment of life-threatening medical conditions such as cancer and cardiac care are unacceptable. But the issue is different for elective surgeries or services that are not life-saving. To begin with, it is difficult to rank elective surgeries by the level of urgency. For example, is Mr. Smith's knee replacement more pressing than Ms. Jones' hip replacement? This is not to say that elective surgeries should be viewed as unimportant or unnecessary just because the condition they treat is not life threatening. Over time, people's health can deteriorate as they wait for elective surgeries. There are important quality of life issues that can be associated with hip replacements or cataract surgery. Providing these surgeries can prevent other medical conditions such as depression in patients whose lives are negatively affected by their decline in mobility or independence. But provincial and territorial health care systems need flexibility in managing these surgeries effectively. That flexibility could be lost if care guarantees were rigidly applied. It also would be unfortunate to see the provincial and territorial health care systems handcuffed into care guarantees for elective or non-life-saving services that could, in practice, mean they would have to reallocate resources away from life-saving surgery or treatment in order to meet the care guarantees for other services.

"Inuit people are put at higher risk due to waiting times."

NUNAVUT MINISTER OF HEALTH AND SOCIAL SERVICES. PRESENTATION AT IQALUIT PUBLIC HEARING.

Putting Co-ordinated Processes in Place

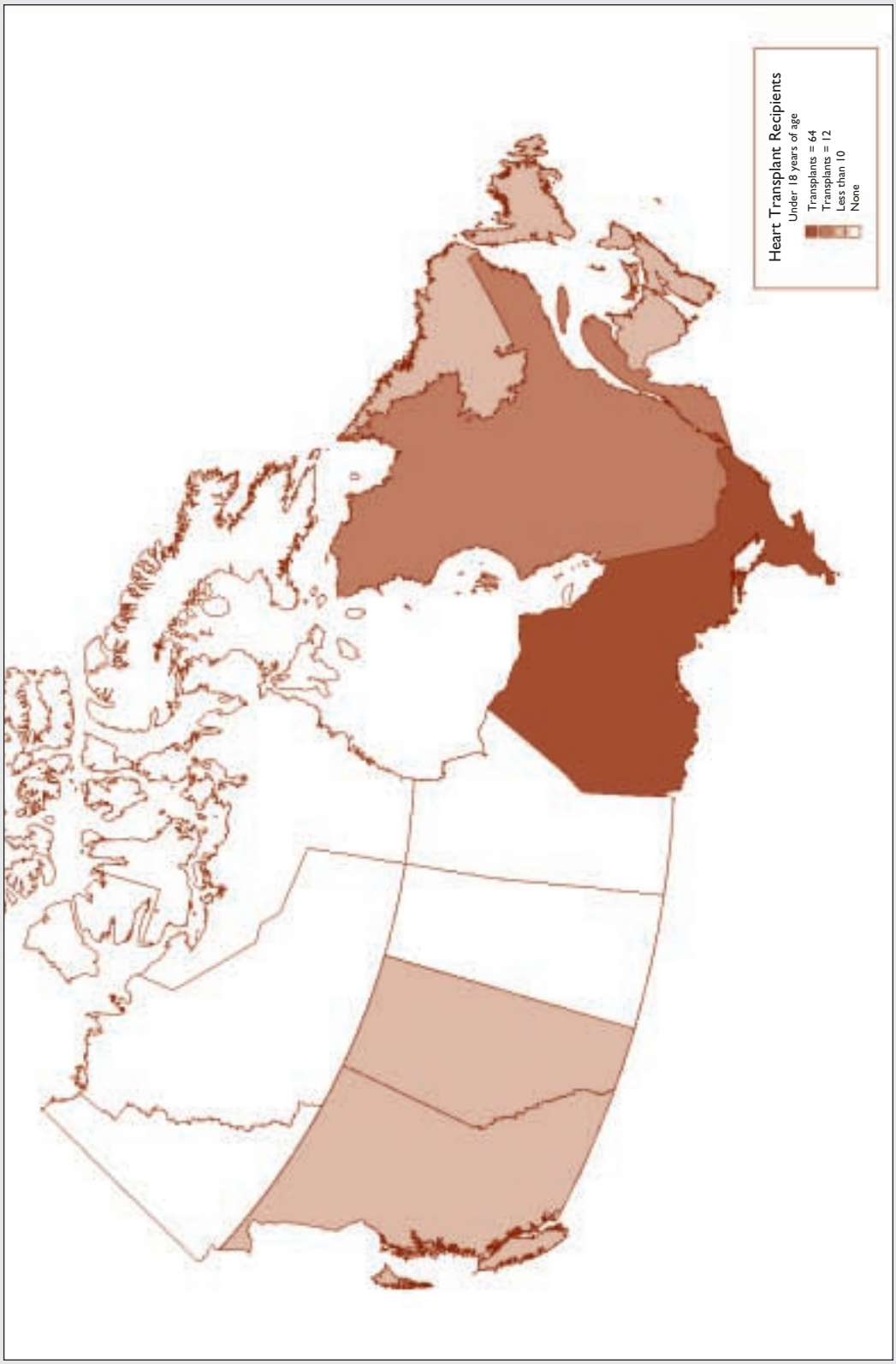
While care guarantees may not be the answer, the issue of waiting times cannot be left on the back burner. The work of the WCWLP, CardiacCareNetwork, and other projects underway across the country are important first steps, but it is time to "walk more quickly" with deliberate steps to manage wait lists and provide objective and clear information for patients waiting for care.

Specifically, steps should be taken by the provinces and territories, working with regional health authorities, hospitals, physicians and other health organizations to:

- Implement procedures for managing wait lists in a centralized manner either within specific regions of a province, in the province or territory as a whole, or between provinces depending on the particular service involved;
- Implement standardized and objective criteria for assessing patients to ensure that the time they wait between when they are diagnosed and when they are treated depends only on the seriousness of their health needs. This work should be done with the full participation of health care professionals involved in providing the services;
- Provide health professionals with the necessary training to ensure that patients' needs are objectively assessed according to the standardized criteria; and
- Provide patients with a clear and understandable assessment of:
  - Why a particular service or procedure is being suggested and the options and alternatives that are available on an interim and longer term basis, including the option of seeing another physician;
  - The relative seriousness of their needs for the particular services based on an objective assessment by health professionals and reflecting the standardized criteria;
  - The approximate time they should expect to be on the wait list for a particular service given the severity of their medical need; and
  - Any changes to a patient's condition or developments in the health care system that could either lengthen or shorten the wait time.

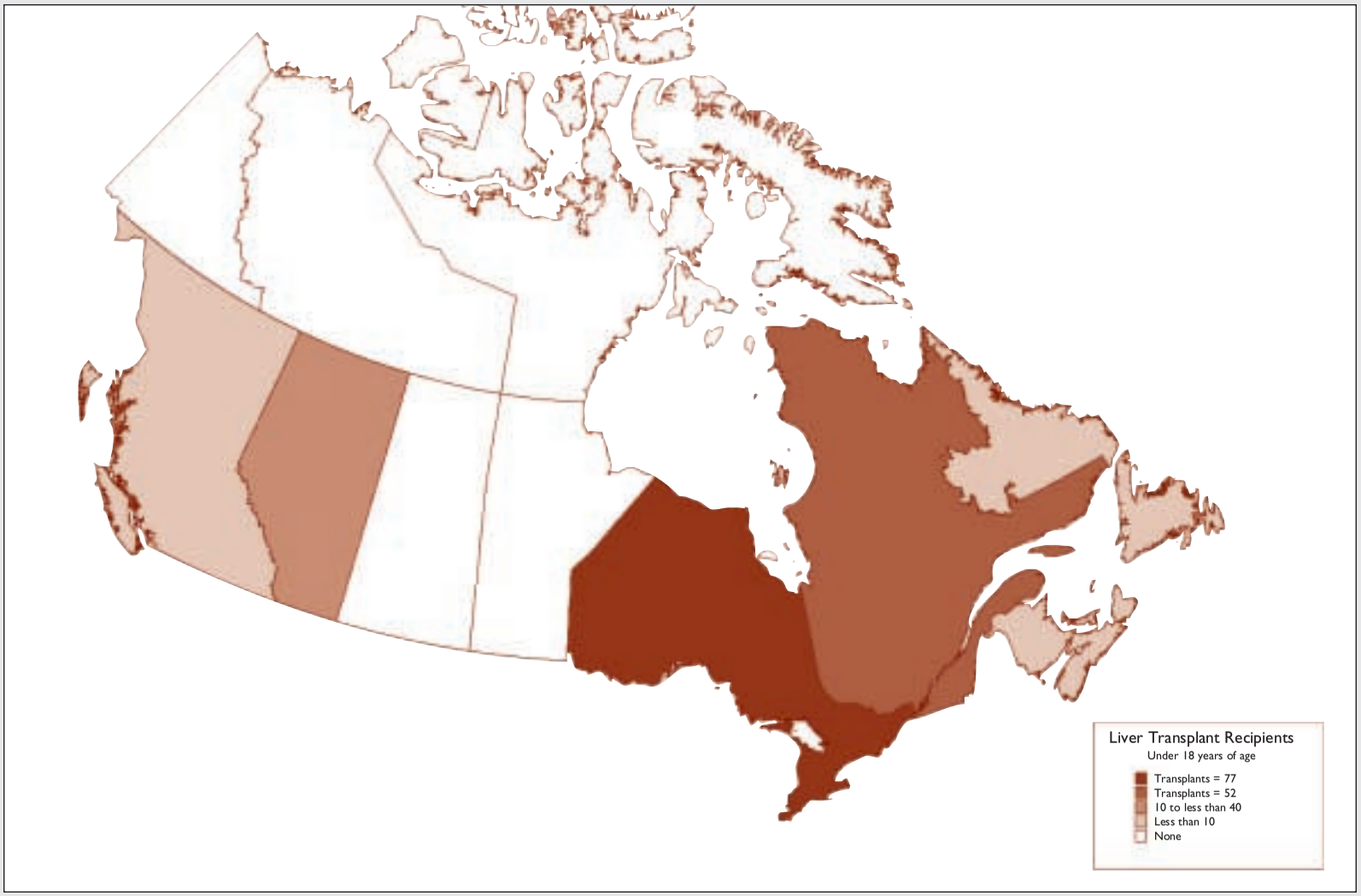
Wait lists can be managed at different levels, either within a particular region, across a province or territory, or even on a national basis. The evidence clearly suggests that wait lists for elective surgeries and a great deal of diagnostic tests are probably best managed by individual regional health authorities or within a province or territory as a whole. For advanced life-saving surgeries such as cardiac and cancer treatment – areas where services tend to be concentrated in major urban centres – wait lists may best be managed on a province-wide basis with some interprovincial co-operation for provinces that may not offer these advanced services themselves. There are a small number of life-saving procedures such as pediatric liver transplants, heart transplants and single and double lung transplants, for example, that are performed so infrequently and require such a specialized range of personnel and training, that the lists are best managed on a national basis through provincial and territorial collaboration. Maps 6.2, 6.3 and 6.4 show the concentration of these highly specialized surgeries across the country.

Map 6.2 Heart Transplant Recipients, under 18 Years of Age, by Province of Treatment, 1996 to 1999



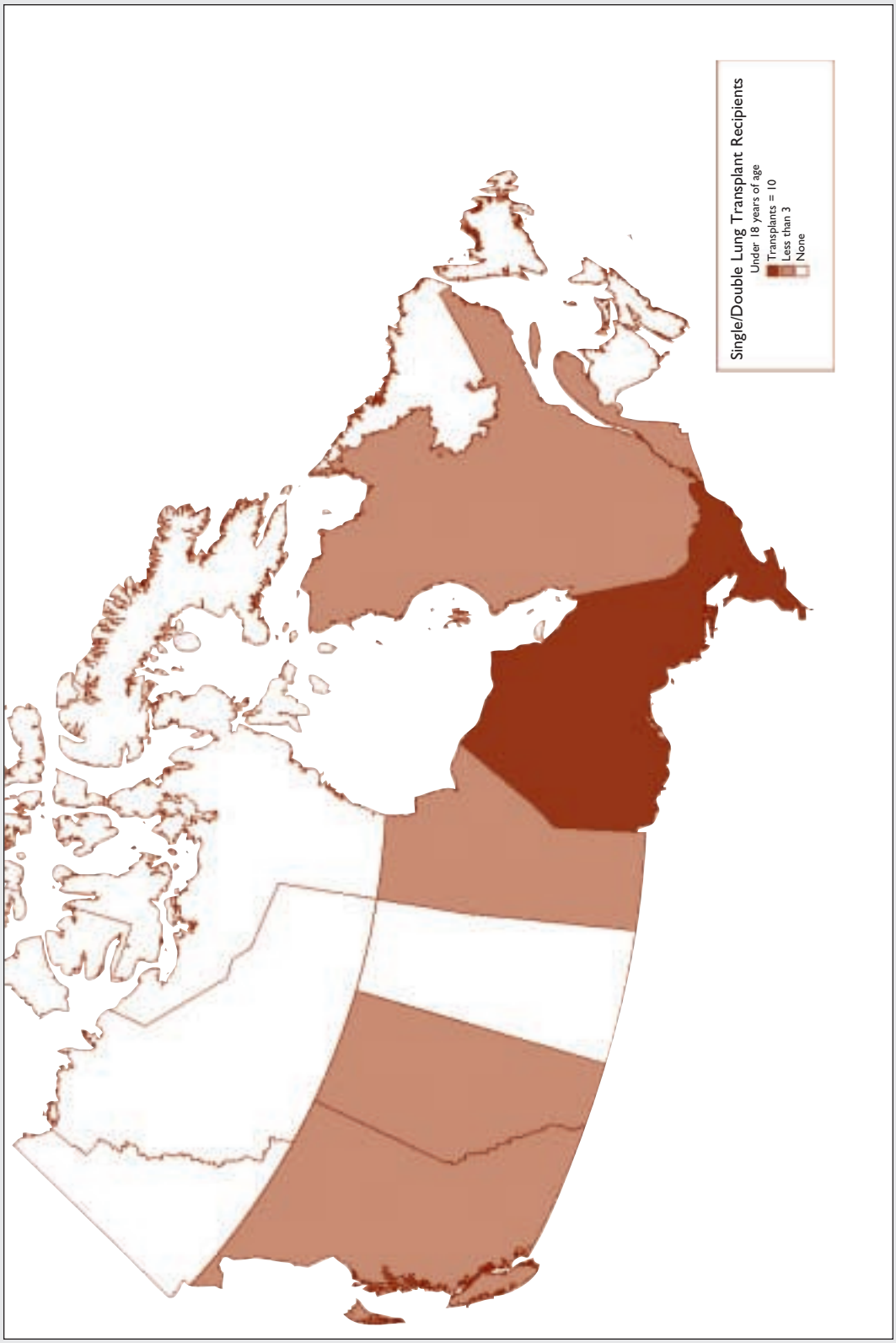
Source: Canadian Organ Replacement Registry, CIHI 2002.

Map 6.3 Liver Transplant Recipients, under 18 Years of Age, by Province of Treatment, 1996 to 1999



Source: Canadian Organ Replacement Registry, CIHI 2002.

Map 6.4 Single/Double Lung Transplant Recipients, under 18 Years of Age, by Province of Treatment, 1996 to 1999



Source: Canadian Organ Replacement Registry, CIHI 2002.

Perhaps the most important result from co-ordinated management of wait lists is better information for patients. With a standardized and objective assessment of a patient's need for a particular service (whether it is elective surgery, life-saving surgery or access to advanced diagnostics), physicians and other health care professionals can provide patients with a reasonable assessment of how long they can expect to wait for a particular service. This information and assurance will be a tremendous improvement over the current situation.

As better information, more consistent processes and objective criteria are in place, the health care system should be able to provide appropriate and realistic targets for patients. When it comes to life-threatening or potentially life-threatening conditions, Canadians should be confident that the health care system can tell them:

- How long they will wait for a diagnosis;
- How long they will wait to see a specialist to confirm the diagnosis and plan a course of treatment;
- How long they will wait before the treatment of their condition begins; and
- How long they will wait for appropriate rehabilitation therapy after treatment.

Canadians also need to understand that immediate service is not always possible. As consumers, we have come to expect that products and services should be available when and where we want them. With health care, that simply is not always possible. There are times when people have to wait because the system is busy addressing the needs of people with more serious health problems. There are times when people have to travel to other centres to get the health care services they need. The important thing is for Canadians to know that waiting times are being reduced, that people with the most urgent needs do not have to wait, and that wait lists are being managed in a co-ordinated and objective way based on the urgency of people's needs.

"In addition to the safety and quality of care provided, attention must be paid to the appropriateness of care. It is time for us to stop the dangerous, challenge the futile, and question the unknown."

CANADIAN HEALTHCARE ASSOCIATION 2001. WRITTEN SUBMISSION.

Taken together, the recommended actions to manage wait lists should achieve three broad goals – fairness, appropriateness, and certainty. Fairness means that wait times are set on objective criteria based on patients' needs rather than by individual providers or hospitals. Appropriateness means that the time people wait is appropriate for their condition. And certainty means that people will have a clear understanding of how long they can expect to wait and why. In future, it should be possible to set benchmarks and track progress in meeting those benchmarks on an ongoing basis.

To make real progress in meeting those goals, it will require:

- The willingness of individual physicians to relinquish their personal management of individual wait lists and participate instead in the development of objective and transparent assessment criteria to be applied to all patients;
- The willingness of regional health authorities, hospitals, and provincial and territorial health departments to provide the infrastructure for central management and co-ordination of wait lists with the full participation of health professionals and the public;
- The willingness of provincial and territorial governments to work collaboratively in the management and co-ordination of wait lists for some procedures and services that are best managed interprovincially;

- The willingness of the public to participate actively in their own care and to hold the system accountable for providing services within a reasonable time period; and
- Adequate resources to provide timely access to care.

The Commission urges health care providers, regional health authorities, hospitals and provincial/territorial governments to get on with the job, and soon. As part of its annual reports, the Health Council of Canada should track and report on progress in reducing waiting times so the Canadian public is in a position to judge the performance of their region, their province and Canada as a whole in comparison with results in other countries.

Improving Quality

RECOMMENDATION 27:

Working with the provinces and territories, the Health Council of Canada should establish a national framework for measuring and assessing the quality and safety of Canada's health care system, comparing the outcomes with other OECD countries, and reporting regularly to Canadians.

Assessing Quality in Canada's Health Care System

What do we mean by quality in the health care system? Simply put, quality health care is about delivering the best possible care and achieving the best possible outcomes for people every time they deal with the health care system or use its services. As Saskatchewan's Commission on Medicare put it,

> Essentially it boils down to doing the best job possible with the resources available. It means achieving stated goals and targets. It is measurable against accepted and valid standards. It is incompatible with waste, duplication, and fragmentation. It is about minimizing underuse, overuse and misuse. It is not about heroic effort or the futile pursuit of the impossible. It is unlikely to be achieved by a demoralized workforce or inadequately trained personnel. It does not thrive where there is conflict or lack of consensus on goals and mission. It is about leadership, goal setting, teamwork, process, measurement, commitment, incentives and accountability. (Fyke 2001, 44-45)

Improving quality, then, can mean a number of different things. For patients, high quality health care means that their needs and expectations are being met. For health care providers, quality health care means their diagnoses are accurate, they are part of a well-functioning system, and the care they provide is appropriate and effective. For our society as a whole, it means that the overall health of Canadians improves.

The most important work in providing quality health care for Canadians happens "at the coal face" – in every interaction people have with health care providers and people working on the front lines of Canada's health care system. It is only through the dedicated efforts of these people that the quality of health care can actually be improved. At the same time, their actions can be supported by comprehensive actions across the country to measure and assess quality, identify problem areas and success stories, and give health care providers and administrators the tools they need to improve health care.

In every province and territory and in every health region, hospital, clinic, health program or facility, efforts have been underway to continually improve Canada's health care system and

the outcomes it achieves. As outlined in the first chapter of this report, the outcomes achieved in our health care system are comparable with those in many other industrialized countries around the world. Yet there also are signs that the quality is not as good as Canadians or health care providers expect.

Canada lags behind many other countries such as the United Kingdom, the United States and Australia where national strategies are in place to improve quality and patient safety. Again, to quote Saskatchewan's Commission on Medicare (Fyke 2001, 45): "The health care system is data-rich, and information poor: there is little that tells managers, the public or providers about the quality of their labours in relation to agreed-upon goals and standards. There are no benchmarks for either utilization (how many procedures should be done in a population) or outcomes (what difference should we expect from a service, what is an acceptable failure rate)".

Similarly, another article notes that "The health care system itself is now being identified as a major cause of illness, death and added costs because of errors, infections, the adverse effects of medications, the underuse of effective interventions and the provision of unnecessary or inappropriate care. For the health care system to aspire to a safety level of other modern industries (e.g., airlines) there will be a need for: leadership and vision; better data systems and information on performance; commitment and skills development among providers; and better accountability" (Millar 2001, 79).

A recent report released by the United States Institute of Medicine (CQHA 2001) reported that, in the United States, there is a "quality chasm" between average care (the care we have) and the best quality care (the care we could have). It found that the need to improve quality stems from a combination of overuse, underuse, and misuse of the health care system. Overuse involves the unnecessary use of particular interventions or treatments such as major surgeries (i.e., coronary bypass or hysterectomies) or the unnecessary prescription of antibiotics in particular circumstances. Underuse is characterized by insufficient use of particular interventions or preventive measures such as low rates of immunization or screening for particular diseases such as breast or cervical cancer. Misuse is characterized by "failures to execute clinical care procedures properly" (Berwick 2002, 82).

"The collection and use of relevant performance indicators will require an organizational culture that recognizes and rewards continuous quality improvement."

CANADIAN HEALTHCARE ASSOCIATION 2001. WRITTEN SUBMISSION.

The Institute acknowledged that challenges of quality in the health care system are "not because of a failure of goodwill, knowledge, effort or resources devoted to healthcare but because of fundamental shortcomings in the way healthcare is organized." One of the architects of the report, Donald Berwick, suggested that "… we should judge the quality of professional work, delivery systems, organizations, and policies first and only by the cascade of effects back to the individual patient and to the relief of suffering, the reduction of disability, and the maintenance of health" (Berwick 2002, 89).

The study also noted that the United States struggles with insufficient information on the performance of its health care system, indicating that there is more information on the quality of the airline or automobile industries than on the quality of health care. These conclusions apply to Canada as well. Unfortunately, we lack the basic and critical information needed to measure the results, assess performance, and judge the quality of the health care system. Moreover, current responsibilities for ensuring quality and safety are widely distributed among different

players and organizations in the health care system, including professional and regulatory bodies. These various players in the system do not share a common understanding of the challenges in improving quality and safety. Nor do they share a common vision for the future.

Setting a Vision for Quality in Health Care

The Commission's vision for a high quality health care system is one where:

- Patients and their safety are at the heart of health care delivery in Canada;
- Disparities are addressed and there are minimal variations in health outcomes and access across the country;
- Individuals and organizations involved in the delivery of health care work to continuously improve the quality of health care services;
- Support is provided to foster a culture of learning rather than a culture of blame and finger pointing;
- Health care providers and professionals work collaboratively and safely to meet a consistent, high standard of care;
- Risks to patient safety are reduced as much as possible; and
- Information and data are collected and used to support quality management and improvements to the health care system over the long term, with particular emphasis on monitoring and reducing the number of serious adverse events that affect patients' safety.

Achieving this vision is primarily the responsibility of the provinces and territories. However, the Health Council of Canada can and should play an important role in working with provinces, territories, health care providers, health regions, and Canadians to ensure that this vision is achieved. The work of the Council should focus on two important areas:

- Establishing consistent approaches for measuring and reporting on quality in Canada's health care system; and
- Building on the work underway in provinces, territories, and various organizations to provide a clear link between information on the performance of the system and actions being taken to improve quality and safety.

Measuring and Improving Quality

Several major reports on health care across Canada have highlighted the need for better information about quality in the health care system and recommended the establishment of a new body to track system performance and outcomes. In Alberta, the Premier's Advisory Council on Health recommended the establishment of a permanent, arm's length Outcomes Commission. In its words, "Tracking and monitoring outcomes and providing regular reports to Albertans is an essential way of improving quality in health care" (Mazankowski 2001, 68). Similarly, Saskatchewan's Commission on Medicare recommended the creation of a Quality Council with a mandate to improve the quality of health services in the province (Fyke 2001). In Quebec, Clair notes that "All countries that have publicly funded systems (Europe and elsewhere) are moving resolutely towards new strategies designed to provide the incentive to improve performance and to measure results. We must do the same" (Clair 2001, 130).

Work is underway in provinces and territories to consistently measure performance and to use that information to improve quality and outcomes. As noted in Chapter 2, the Health Council

of Canada can play an important role in supporting the work underway in the provinces, particularly the work of various quality councils or commissions currently being considered or established by some provinces.

Specifically, the Health Council of Canada should be responsible for developing a national quality performance assessment framework. This framework should build on the intergovernmental work of the Performance Indicators Reporting Committee (currently reporting to the Deputy Ministers of Health), which has developed comparable indicators pursuant to the First Ministers' Agreement on Health of September 2000. It also should incorporate the work currently underway by the Canadian Institute for Health Information (CIHI) to develop common indicators and report regularly to Canadians on the performance of Canada's health care system. Steps should be taken to:

- Work with provinces and territories to identify a comprehensive core set of indicators to provide better information about the state of the health care system and the health of Canadians;
- Ensure a consistent approach to data collection and analysis across jurisdictions based on agreed upon performance indicators;
- Assess and monitor health data and evaluate the health status, health outcomes, quality of service, patient safety, and reporting protocols;
- Widely disseminate information about best practices in achieving high quality and safe health care in various health care settings;
- Report regularly to the public on progress in improving the performance of the health care system in the longer term (Chapter 2 provides a summary of the key areas for annual reports to Canadians); and
- Monitor the relative performance of the Canadian health care system in comparison with other countries, particularly the OECD.

> *"… the task of improving the quality of health care in Canada demands attention from all health care leaders and agents – governmental and non-governmental alike."*
>
> ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA 2001. WRITTEN SUBMISSION.

Linking Performance Measurement with Quality Improvements

Developing sound and consistent measures of the quality of Canada's health care system is important work, but to have an impact, it must be linked to effective mechanisms and policy changes aimed at improving quality and outcomes. To make this link, the Health Council of Canada should work with provinces, territories and various organizations currently in place to accredit and monitor quality and safety in Canada's health care system.

The Canadian Council on Health Services Accreditation (CCHSA) is a national non-governmental organization. It accredits hospitals, long-term care institutions, rehabilitation institutes and primary health care organizations. Its mandate ties into virtually all care-related activities of health care professionals. On a voluntary basis, the CCHSA conducts regular reviews and assessments in Canada and makes recommendations on areas for improvement.

Because of the importance of linking performance information to the continuing accreditation of hospitals and other health care facilities, the Health Council of Canada should work closely with the CCHSA. Performance measures established through the work of the Council as well as regular information on outcomes would provide an important base of information for linking outcomes to ongoing accreditation of health care facilities, particularly in the area of patient safety.

The Health Council of Canada should also develop linkages with the National Steering Committee on Patient Safety and work underway by CIHI and the Canadian Institutes of Health Research (CIHR) to assess adverse events that affect patient safety. In effect, the Council would serve as a co-ordinating body, bringing together a network of organizations and initiatives underway across the country to address issues related to quality and patient safety. As noted earlier, the Council would provide important comparative information to support the work of various quality committees and outcomes commissions currently being established in some provinces.

In summary, the work of the Health Council of Canada is essential to replace today's patchy picture of Canada's health care system with a clear, comprehensive and consistent analysis of the outcomes the system achieves and the progress that is being made in improving quality. This information will guide decision makers, identify areas where action is needed, compare Canada's outcomes with other countries around the world, and perhaps most importantly, provide Canadians with solid information about the performance of their health care system.

Improving Access for Official Language Minorities

RECOMMENDATION 28:

Governments, regional health authorities, health care providers, hospitals and community organizations should work together to identify and respond to the needs of official language minority communities.

Improving Access and Quality for Official Language Minorities

Although access is traditionally looked at in terms of waiting times or distance, it can also be affected by social and cultural factors such as language, gender, education and wealth. When people are receiving care in a hospital or another health care program, both their access and the quality of care they receive may be inhibited by problems in communication, understanding or acceptance.

The Commission heard from many francophone groups about the impact language has on access to quality care. For example, in Ottawa, the Commission was asked how an abused child would be able to communicate his or her situation to a health care professional in a language other than his or her own (Réseau des services de santé en français de l'Est de l'Ontario 2002). Similarly, for general health care and especially in emergency situations, inaccurate or partial communication can result in a failure to access appropriate care (Association canadienne-française de l'Alberta 2002).

Both the Consultative Committee for French-Speaking Minority Communities (CCFSMC) and the Fédération des communautés francophones et acadienne du Canada (FCFA) indicate that quality is closely tied to the ability of health care providers to assist, advise, guide, and educate patients. A number of studies confirm the importance of language in the effective delivery of health care services. They conclude that the language barrier:

- Reduces the use of preventive services;
- Increases the amount of time spent in consultations, the number of diagnostic tests ordered, and the probability of confusion in the diagnostic and treatment processes;

- Influences the quality of services where good communication is essential such as mental health services, social services, physiotherapy, and occupational therapy;
- Reduces the probability of compliance with treatment; and
- Reduces the patient's satisfaction with the care and services received (Consultative Committee for French-Speaking Minority Communities 2001).

Access to health care services for official language minorities in Canada varies across the country and continues to be a problem in spite of the fact that communities, regional health authorities, institutions and provincial governments are taking steps to ensure that official language minorities have access to at least a minimum level of service in the language of their choice.

In response to the formidable challenges they face, some of Canada's francophone communities, with the assistance of both provincial and federal governments and regional health authorities, have developed innovative, and often inexpensive, initiatives to obtain and improve access to quality French language health services. A number of these initiatives clearly demonstrate that it is possible to deliver quality services even in very small francophone communities and to develop effective approaches that respond to the needs of communities (FCFA 2001).

As part of the consultation process, many francophone groups suggested that access to health care in Canada's two official languages should be written into the *Canada Health Act* as a condition of federal funding. The Commission recognizes the importance of receiving health care services in a person's first language, however, making this a national legislated guarantee is not necessarily the best approach for achieving that objective.

In the Commission's view, the most effective approach is to concretely support and extend successful initiatives to improve access to health care services in both official languages. Health Canada should continue to play an important role in sharing information about the various initiatives underway across Canada and in providing financial support to organizations, regional health authorities, institutions, provincial and territorial governments in overcoming language barriers to access. Regional health authorities – as the primary deliverers of service – should also take steps to overcome language barriers through staff training, building ties with minority language organizations and communities, and using technology such as telehealth to provide services to small minority language communities.

Addressing the Diverse Health Needs of Canadians

RECOMMENDATION 29:

Governments, regional health authorities, and health care providers should continue their efforts to develop programs and services that recognize the different health care needs of men and women, visible minorities, people with disabilities, and new Canadians.

Canada has a diverse population and that diversity should be reflected in Canada's health care system. Issues related to gender, language, and cultural background have a profound impact on people's roles, how they view and use health care services, and how they respond to different programs and approaches to care (CIHR Institute of Gender and Health 2002).

Gender can influence how individuals are treated in the health care system and can influence their health outcomes. It is well documented that women carry the larger burden for informal caregiving in our society. This is something that must be taken into account as provincial and territorial health care systems put a greater emphasis on home care. (Chapter 8 addresses home care and informal caregiving in more detail.) We also know there is a marked tendency for men to make less use of preventative health care information and they seek help less frequently for health problems such as mental illnesses. These differences in how men and women access and use health services need to be addressed in the health care system.

Canadians with physical and mental disabilities have their own unique challenges in accessing health services. While there has been a great deal of progress in recent years, it appears to the Commission that this progress is limited by two important factors. First, the responsiveness of the system to the unique needs of disabled Canadians is often directly related to the strength of the lobbying efforts of advocacy organizations which can vary from jurisdiction to jurisdiction. Second, efforts to improve access appear concentrated in urban areas which can leave disabled Canadians in rural areas doubly isolated. At the same time, the needs of disabled Canadians can vary significantly from community to community which requires provincial governments and regional health authorities with an important responsibility to enhance their efforts to ensure that their residents' access to health services is not impaired by virtue of their disability.

New Canadians who may have limited fluency in either official language also face challenges in accessing services in the health care system. They have a tendency to make less use of primary health care services. This can delay early diagnosis and treatment of illness and result in a greater use of more expensive diagnostic and specialist services. Nonetheless, the first contact most new immigrants have with Canada's social services is through the health care system. This contact can serve as an important element in their socialization to Canadian society and in their understanding of the entitlements to health care that come with being a Canadian citizen.

In St. John's, Newfoundland, the Commission heard from members of the National Organization of Immigrant and Visible Minority Women of Canada (2002), the Multicultural Women's Organization of Newfoundland and Labrador (2002), and a representative of Newfoundland and Labrador Health in Pluralistic Societies (2002). They suggested that health services should be more culturally sensitive, that health promotion materials should be written in more than the two official languages, and that health care professionals should reflect the diversity of Canadian society and understand the ethnic and cultural backgrounds of the populations they serve.

Provincial health systems across the country are increasingly sensitive to these issues and are working in a number of ways to reduce barriers to access that may exist as a result of disability, gender, ethnicity, language or culture. At the national level, the creation of an Institute of Gender and Health as part of the Canadian Institutes of Health Research is an encouraging development. At the community level – with the support of regional health authorities, health organizations, provincial and territorial governments – there is a growing emphasis on building primary health care networks that focus on the needs of immigrant populations and established ethnic communities.

Looking ahead, provincial and territorial health care systems, regional health authorities and health care institutions should actively involve different ethnic communities and new Canadians in identifying needs and designing programs to meet those needs. Research on various illnesses, conditions, treatments, and prevention programs should ensure that gender differences are included. Multidisciplinary research should address issues specific to gender and ethnicity, and the impact of these differences on health. Finally, health promotion and prevention programs should be specifically targeted to the unique needs of men and women, and people with different language and ethnic backgrounds.

What Does This Mean for Canadians?

It is time to restore Canadians' confidence in their health care system. And the best way to do that is by showing real progress on the issues that concern them most – waiting for care and improving quality. Canadians may be willing to take more time to address some of the other important issues and recommendations in this report. But they are running short of patience when it comes to essential steps to improve access and quality in today's health care system.

The recommendations in this chapter are designed to meet a number of critically important objectives, including:

- Reinforcing our commitment to provide accessible, safe and high quality health care to all Canadians;
- Reducing waiting times and taking concrete steps to improve access to diagnostic services;
- Improving the management and co-ordination of wait lists and ensuring that consistent and objective criteria are put in place;
- Providing Canadians with better information about how long they can expect to wait for certain services and treatments;
- Measuring performance in a consistent and comprehensive way, and using that information to improve the quality of Canada's health care system;
- Providing Canadians with regular reports on the quality and outcomes of Canada's health care system, and how our results compare with other leading countries around the world;
- Improving access to health care for official language minorities in Canada;
- Ensuring that the health care system responds to the different health care needs of Canadians, including men and women, visible minorities, people with disabilities and new Canadians.

Transforming these objectives into concrete results depends on the willingness of health care providers, health authorities, provinces, territories and the federal government to take action. Canadians have heard the promises before, then been disappointed by the lack of results. It is time to move beyond mere promises to clear deliverables. Canadians want action to improve quality and access in their health care system. They deserve nothing less.

7 Rural and Remote Communities

Directions for Change

- ***Establish a new Rural and Remote Access Fund to support new approaches for delivering health care services and improve the health of people in rural and remote communities.***
- ***Use a portion of the Fund to address the demand for health care providers in these communities.***
- ***Expand telehealth to improve access to care.***

The Case for Change

Given its geographic makeup, Canada faces unique challenges in the delivery of health care. The vastness of the Canadian landscape, combined with the fact that many Canadians live in isolated and remote communities, makes it difficult to ensure that all our citizens have access to health care services regardless of where they live.

Canada may, in fact, have a very good health care system with health outcomes that are generally among the best in the world. But there are growing signs that this is not the reality for Canadians living in smaller or more isolated communities across the country.

During the Commission's consultations, Canadians living in rural and remote communities spoke directly about their serious concerns. They spoke of the need for good health and good access to health care not only because it is essential to sustain their own quality of life, but also the quality of life in their communities (CPRN 2001).

People's choice of whether or not to live in smaller communities is affected by whether or not they can get reasonable access to health care (Association des régions du Québec 2002). That view was echoed by rural physicians who said, "geography is a determinant of health" (Society of Rural Physicians of Canada 2002).

Information on disparities in health confirms that view – geography is, in fact, a determinant of health. People in rural and remote communities have poorer health status than Canadians who live in larger centres. Access to health care also is a problem, not only because of distances, but because these communities struggle to attract and keep nurses, doctors and other health care providers.

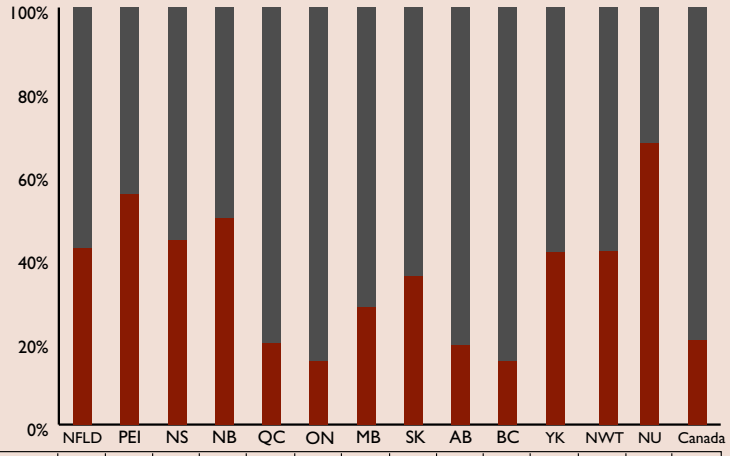
Recommendations in other chapters of this report – to expand primary health care, expand coverage for home care and prescription drugs, or shorten waiting times – will have an impact on people in smaller communities. But the focus of this chapter is squarely on two pressing issues: improving health and improving access to health care for people in rural and remote communities.

Identifying the Issues

Using the Statistics Canada definition of "rural," Figure 7.1 shows that there are wide variations in the proportion of rural to urban populations in each of the provinces and territories. The proportions range from just over 15% in British Columbia and Ontario to 68% in Nunavut. However, these proportions tell only part of the story. While the percentages in provinces like Ontario may be small, because of the size of the population, the numbers are actually quite large.

Rural Canada is not a single, homogeneous population. Diversity is a characteristic of Canada and it applies to smaller communities just as it does to the largest cities. Some rural communities are relatively close to major urban centres while others are not. Some are located in large agricultural regions, while others are coastal communities or located in the remotest regions of Canada's north. Both the health needs and the way in which they should be addressed vary for different communities. As with many other issues in health care, there is no "one size fits all" solution.

Figure 7.1 Population Counts (Thousands) for Canada, Provinces and Territories, and Census Division by Urban and Rural, 2001 Census – 100% Data



	NFLD	PEI	NS	NB	QC	ON	MB	SK	AB	BC	YK	NWT	NU	Canada
Urban	296	61	507	368	5,817	9,663	805	629	2,405	3,310	17	22	9	23,908
Rural	217	75	401	362	1,420	1,747	314	350	570	598	12	16	18	6,099

Note: Statistics Canada defines rural population in terms of the rural fringes of census metropolitan areas (CMAs) and census agglomerations (CAs), as well as populations living in rural areas outside CMAs and CAs. A CMA or CA is an area consisting of one or more adjacent municipalities situated around a major urban core. To form a CMA, the urban core must have a population of at least 100,000. To form a CA, the urban core must have a population of at least 10,000. Yukon and the Northwest Territories have high urban percentages because of the concentration of population in Whitehorse (CA = 21, 405 in 2001) and Yellowknife (CA = 16,541 in 2001).

Source: Statistics Canada 2002b, 2001b.

While there are clear distinctions between "rural" and "remote" communities, to simplify the language in this chapter, the terms "rural" or "smaller communities" are occasionally used to refer to all types of rural and remote communities. Issues specific to these communities also overlap with Aboriginal health issues (addressed in more detail in Chapter 10) since many Aboriginal peoples live in smaller communities.

Rural communities may be diverse, but they share some common problems in health status, in access to health care, and in approaches that have typically been taken in the past to address those issues.

Disparities in Health

Health indicators have consistently shown that the health status of people living in rural communities, especially people in northern communities, is not as good as the rest of the Canadian population.

Statistics Canada and the Canadian Institute for Health Information (CIHI) developed health indicators for 139 health regions in Canada. They grouped health regions into three categories: predominantly urban, intermediate and predominantly rural (see Table 7.1). This information shows that:

- Life expectancy for people in predominantly rural regions is less than the Canadian average;
- Disability rates are higher in smaller communities;
- Rates for accidents, poisoning and violence are also higher in smaller communities; and
- People living in remote northern communities are the least healthy and have the lowest life and disability-free life expectancies.

Table 7.1
Health Status for Populations in Predominately Urban, Intermediate and Predominately Rural Health Regions in Canada, 1996[1]

Indicator of Health Status	Predominantly Urban	Intermediate	Predominately Rural
Life expectancy at birth: years	78.8	77.7	77.0
Infant mortality rate per 1,000 live births	5.1	6.3	7.1
Total mortality: age-standardized rate per 100,000 people	657.0	704.8	748.3
All circulatory disease-related deaths: age-standardized rate per 100,000 people	243.4	260.5	269.6
All cancer-related deaths: age-standardized rate per 100,000 people	181.1	193.0	194.6
Unintentional injury-related deaths: age-standardized rate per 100,000 people	25.9	34.7	45.4

1 The health regions are grouped according to proportion of total population located in rural and small town (RST) areas in a manner similar to the OECD classification of rural and urban. Predominately urban health regions contained less than 15% RST population; intermediate health regions contained 15-50% RST population and predominately rural health regions contained over 50% RST population. The rates are the average values for the health-region groups. Data are as of 2001.The data also have not been adjusted to take into account the gender distribution of people in the different regions.

Source: Statistics Canada 2001c.

The health of a community also appears to be inversely related to the remoteness of its location. In Quebec, for example, there is "a trend toward a progressive deterioration in health as one moves from [the] area bordering urban centres into the very remote hinterland" (Pampalon 1991, 359). The situation is similar in most other provinces and territories. In fact, these challenges are not unique to Canada. Other countries such as the United States, Australia, and even relatively small and compact countries like the United Kingdom, have similar challenges (Gamm et al. 2002; Humphreys et al. 1996; Braden and Beauregard 1994; Fearn 1987).

Disparities in Access to Health Care

Canadians in rural communities often have difficulty accessing primary health care and keeping health care providers in their communities, let alone accessing diagnostic services and other more advanced treatments. In some northern communities, the facilities are limited and in serious need of upgrading.

People in rural communities also have the added burden of paying for the high costs of travel in order to access the care they need. This often means days or weeks away from family and social support as well as the added cost of accommodation and meals.

In the 1990s, many provinces took steps to rationalize the delivery and administration of health care as part of health care reforms. As a result, some services were centralized into larger centres. Partly because of these changes, provincial and territorial ministries of health and regional health authorities have used a number of different approaches to improve access through outreach programs, financial assistance for people who need to travel to access care, and new delivery approaches like telehealth. These efforts, to greater or lesser degrees, have helped improve access. But the problem is far from solved. In fact, some would say that there is an "inverse care law" in operation. People in rural communities have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres.

Disparities in Access to Health Care Providers

Problems in access to health services quite often stem from serious shortages in health care providers in rural communities.

Access to physicians and specialists varies significantly across the country and some communities do not have access to even the most basic health care services because they lack the necessary health care providers. In 1993, there was less than one physician per 1,000 people in rural and small town areas, compared to two or more physicians per 1,000 people in larger urban centres. The average resident in rural communities and small towns was 10 km from a physician, compared to less than 2 km for a resident in larger urban centres (Ng et al. 1999).

In northern communities, the problems are stark. About 16,000 people live in the most northern part of Canada, at 65-69 degrees north latitude (northern parts of Yukon, Northwest Territories and Nunavut). About two-thirds of them live more than 100 km from a physician. And no physicians normally live above 70 degrees north latitude to serve the 3,300 people living there (Ng et al. 1999).

Given the shortages of nurses across the country, it is safe to assume the problems of recruiting and retaining nurses in smaller communities are serious indeed. According to the Canadian Health Services Research Foundation, "It's not just a question of having a lot of people to work in the healthcare system; it's also about making sure healthcare workers are well distributed through the provinces and among urban, rural and remote areas" (CHSRF 2002b, 3).

> *"… What community wants an uncommitted doctor who practices there for a few years before decamping to a more desirable locale?…"*
>
> CANADIAN FEDERATION OF MEDICAL STUDENTS 2001. WRITTEN SUBMISSION.

The problem of attracting health care providers to rural communities is exacerbated by competition among individual provinces and territories. Keeping health care providers in rural areas is an ongoing problem, and territories compete to attract and retain the supply of health care providers they need.

The problems with the supply of physicians in rural and remote communities demand solutions. But the experiences of many provinces and territories as well as OECD countries suggest that short-term solutions aimed at increasing the overall supply of physicians do not necessarily translate into improvements in their supply in these communities. Provincial and territorial governments have tried providing incentives to encourage physicians to move to rural areas through higher pay or other financial incentives. In other cases, governments have tried to limit where new physicians can practice in order to encourage more of them to work in rural communities.

> *"The more exposure you have in training and post-graduate training programs to rural settings … the more likely we are to have people who want to work in rural communities."*
>
> BRITISH COLUMBIA MEDICAL ASSOCIATION. PRESENTATION AT VANCOUVER PUBLIC HEARING.

Physicians typically object to measures that limit their ability to choose where they practice. Part of the answer certainly lies in increasing physicians' exposure to rural settings as part of their education and training. With increased exposure to, and experience in, rural settings, the likelihood of graduating doctors wanting to practice in rural settings increases (BCMA 2002). Recent efforts by the Society of Rural Physicians of Canada and the College of Family Physicians of Canada to develop national curricula and guidelines are a step in the right direction. But there is much more to be done.

Differences in Approaches

Currently, there is no coherent national approach for addressing issues specific to rural communities. Provinces and territories are developing different ways to address the issues, but they are doing so in isolation, without enough attention to co-ordination or the overall picture.

A review of current approaches points to the following issues:

- **The lack of consensus on what "adequate" access should include** – There is no consensus today on what constitutes adequate access and what services are most important for people to be able to access. One approach is to identify a basic core of services for different types of rural communities. This approach would clearly distinguish between the core services that would be available to people in their own communities and the services they would have to access from other centres. Key stakeholders, including health care providers and community members, should be involved in identifying and agreeing on the core services to be available in each community or region.

- **The need for effective linkages with larger centres** – While some health care services can be delivered in smaller communities, some form of networked system that links those communities with urban centres is inevitable. Smaller communities simply cannot sustain a full range of services. Ontario's "Rural and Northern Health Care Framework" (Ontario. Ministry of Health 1997) is an example of linkages between rural facilities, hospitals in regional centres and tertiary-care institutions in metropolitan areas, but it is by no means the only model. Similar linkages were proposed by Saskatchewan's Commission on Medicare (Fyke 2001). Specialized services will continue to be concentrated in larger centres, but their linkages to rural communities should be improved.
- **The challenges of serving the smallest and most remote communities** – These communities are the most difficult to serve because they have too few people to sustain anything but the most basic services, and even that can be difficult. Other countries face similar challenges and the models they have developed may be worth examining in Canada. For example, Australia developed a "Healthy Horizons" framework for improving access and health in small and remote communities (Australia 1999). This and similar models in other countries should be explored to see if they could be adapted to suit the unique Canadian context.
- **A focus on symptoms rather than causes** – With few exceptions, strategies and programs have focused on how to deliver services and how to recruit and retain more health care providers. Although lack of access to health services as well as physicians and nurses are undoubtedly very serious problems, resolving these issues may not be enough to improve the health status of people in rural communities in a significant way. Instead, more emphasis needs to be placed on addressing the fundamental causes of the "rural health deficit."
- **The predominance of "urban" approaches applied to rural communities** – Many health care administrators, planners and providers rely on urban-focused approaches instead of developing alternative models to suit the unique circumstances of those communities. These primarily urban models make it difficult, if not impossible, for smaller communities to catch up to their urban counterparts. There is an increasing understanding that rural health problems are unlikely to be adequately addressed by mainstream programs alone (Humphreys et al. 2002). Unique rural health problems require urgent attention and unique rural conditions need to be taken into account in addressing those problems. The situation for health care providers is a case in point. Trends point to increasing specialization in skills and training. This might meet the needs of "high-tech" and research-intensive medicine in large hospitals in major urban centres, but the needs are almost the opposite for rural communities. They need a different kind of "specialist" – namely, well-trained and experienced generalist practitioners who "specialize" in delivering high quality primary health care in rural communities.
- **The lack of research** – Policies and strategies for improving health and health care in smaller communities have not been based on solid evidence or research. Until recently, Canadian research on rural health issues has been piecemeal in nature and limited to small-scale projects. To make matters worse, despite the wealth of health-related data at

the federal, provincial and territorial levels, most data collected or released are frequently not presented in a manner that supports meaningful rural health research and analysis (Pitblado et al. 1999). Furthermore, as with health research in general, there is little connection between decision makers and researchers. As a result, rural health policies, strategies, programs and practice have not been as effective as they could have been.

Setting a Clear Vision and Principles

Clearly, there are important challenges to address. The place to start is with a vision where Canadians residing in rural and remote regions and communities are as healthy as people living in metropolitan and other urban centres. This vision was echoed by Jose Amaujaq Kusugak at the Montreal public hearing who said, "I believe that … the success of our Health Care System as a whole will be judged not by the quality or service available in the best of urban facilities, but by the equality of service Canada can provide to its remote and northern communities" (Inuit Tapiriit Kanatami 2002).

This vision should guide all rural health initiatives including policy development, program planning, clinical practice, research, and health human resources development. It should be supported by the following principles:

- Rural health initiatives should be designed to provide equity in both access to health care and in health outcomes.
- No single strategy is appropriate for all communities. Unique approaches are needed to address the diverse health needs and different circumstances of different communities.
- Both short-term, immediate issues (such as access to nurses and doctors) and long-term, more fundamental issues (such as economic and living conditions) must be addressed.
- Health strategies should be focused on outcomes. Different approaches can be used as long as the objective is to improve health and access to health care.
- Policies, strategies and programs should be based on evidence and informed by research. The outcomes of various approaches also need to be objectively assessed.
- Strategies developed for urban centres may or may not be appropriate for rural communities. Rural communities may need to adapt urban-based approaches or may have to design their own strategies to meet their unique needs.
- Community members, federal, provincial and territorial governments, regional health authorities, health care providers and other stakeholders need to be involved in finding solutions and taking necessary actions.

> *"The future is grounded in the present. A keen appreciation of how rural health care is unique is important in determining possible models that will work and can be sustained."*
>
> Society of Rural Physicians of Canada 2001. Written submission.

A truly national approach is needed to address the serious health challenges in rural health and to complement local or regional initiatives. Although many of these health issues have regional or local characteristics, they share common features and common problems – problems that require a national response. The provinces have constitutional responsibility for

administering provincial health care systems and delivering health services to their citizens. However, the federal government could play a co-ordinating and facilitating role by working closely with the provinces and territories, as well as other stakeholders. Taken together, the following cluster of actions recommended in this and other chapters of this report will ensure that people in rural communities have better access to health care and better health.

Improving Access to Health Care

Expanding the Supply of Health Care Providers in Smaller Communities

RECOMMENDATION 30:

The Rural and Remote Access Fund should be used to attract and retain health care providers.

RECOMMENDATION 31:

A portion of the Rural and Remote Access Fund should be used to support innovative ways of expanding rural experiences for physicians, nurses and other health care providers as part of their education and training.

Improving access in smaller communities is tied directly to their ability to attract and retain health care providers. The immediate injection of additional funds from the Rural and Remote Access Fund should be directed to addressing this serious problem. Provinces and territories should decide which approaches are most appropriate for their communities, including the short-term option of using financial incentives to attract doctors and nurses to rural and remote communities.

A more promising solution over the longer term lies in the education and training of health care providers. As noted by the Association of Canadian Medical Colleges, a number of rural initiatives are taking place in Canadian medical schools (ACMC 2002). However, more work needs to be done to expand training opportunities for a range of health care professionals in rural and remote settings. Collaborative approaches to rural health practice are needed to get the maximum benefits from the skills of multidisciplinary teams and networks. More flexible use of health care providers should be encouraged, and training and support should be given to informal caregivers to support the role they play in rural settings.

Expanding Telehealth Approaches

RECOMMENDATION 32:

The Rural and Remote Access Fund should be used to support the expansion of telehealth approaches.

A number of innovative approaches can be used to improve access in smaller communities. Telehealth is a prime example. It uses information technologies to link patients and health care providers to a spectrum of services that can be brought together to provide higher quality care.

It offers tremendous possibilities for overcoming the obstacles of distance and improving access to health care in rural communities (Pong 2002). People in rural and remote locations can be linked to family physicians, specialists and other health services in major centres. Health care providers can diagnose, treat and provide consultations at a distance. Patients and health care providers can have access to information about illnesses and the approach can also be used both for educating patients and providing professional development for health care providers in more remote locations. A variety of approaches can be used ranging from tele-triage to tele-education, and more recently, to tele-homecare. Several provinces have done extensive work on telehealth initiatives, particularly Newfoundland and Labrador.

Telehealth is particularly promising for northern Canada. The Honourable Edward Picco, Minister of Health and Social Services in Nunavut, noted that telehealth has the potential to be a lifesaver in Nunavut (Nunavut 2002). Ensuring access to health care is a daunting challenge when some people live in communities more than 2,000 km apart. Recognizing the potential benefits, the Government of Nunavut has signed agreements with the governments of Australia and Newfoundland and Labrador to share information and new developments in telehealth. In their view, increased use of telehealth technology will result both in cost savings and in improved health for territorial residents (Nunavut 2002).

Similarly, conditions in the north have required Yukoners to find innovative ways of providing effective and accessible health care. Telehealth applications have been used to facilitate increased mental health services, professional and continuing education, and family doctor visits. Most communities in the Yukon are a five- to six-hour drive away from Whitehorse and many are in locations that often are inaccessible by road or plane, especially in bad weather. There are instances where Yukon residents must rely on out-of-territory hospitals for specialized services. The cost of a single flight can be more than $10,000. Consequently, the costs of the Yukon medical travel plan have increased by 26% over the last five years (Yukon 2002).

The situation in the Northwest Territories is similar. People in the Northwest Territories face serious health issues including high rates of certain illnesses combined with a number of social factors that affect health. These challenges are exacerbated by the fact that health care services are stretched thin and access is seriously limited by the interplay of geographical expanse and limited health human resources and health care facilities. As a result, the government spends 6.5% of its budget for health and social services on transportation (NWT 2002).

With better evidence and evaluation, more effective choices can be made about the best use of telehealth technologies in specific settings. Actual evidence of the benefits of telehealth is minimal (Roine et al. 2001) and one study (Whitten et al. 2002, 1437) concluded that “there is presently no persuasive evidence about whether telemedicine represents a cost-effective means of delivering health care.” This is not to suggest that telehealth initiatives should not proceed. Rather, it points to a need for increased attention and effort in the evaluation of telehealth applications.

Because of the potential for telehealth to improve access to health care, the Rural and Remote Access Fund should be used to expand telehealth applications. Funds should be used to support both the necessary equipment within smaller communities as well as the necessary education, training and support to allow these technologies to be used and managed effectively.

Early experience in the provinces is pointing to the immense value of telelearning and continuing education using information and communication technologies. Individual investments in telehealth should reflect the needs in individual communities and ensure that:

- The necessary policies are in place for licensing health care providers to deliver health services at a distance (in particular, cross-jurisdictionally);
- Privacy and security issues for patients have been adequately addressed;
- Training and support is available to facilitate effective and efficient use of telehealth applications; and
- The impact of telehealth applications on health outcomes in rural and remote communities is assessed.

Implementation of telehealth is hampered by the fact that many smaller communities do not have high-speed connections to the Internet. These connections depend on having access to technology known as basic broadband infrastructure. According to a recent report by the OECD (2001c), Canada ranks second in terms of overall broadband access, behind Korea, but ahead of Sweden and the United States. Despite this relatively high ranking, the National Broadband Task Force estimates that there are approximately 5,000 communities (79% of all Canadian communities) that fall into the "harder-to-serve" category. In their view, "the most revolutionary aspect of broadband is its potential to reduce … distance and time as cost factors – in economic activity and in providing public services" (Canada. Industry Canada 2001, 3). The Task Force recommended that broadband facilities and services be extended to all Canadian communities by 2004, with priority given to First Nations, Inuit, rural, and remote communities.

Priorities for future expansion of Canada's broadband infrastructure should take central account of how telehealth care can improve access to health care in rural and remote communities across the country.

Improving Health

RECOMMENDATION 33:

The Rural and Remote Access Fund should be used to support innovative ways of delivering health care services to smaller communities and to improve the health of people in those communities.

In the past, innovative approaches have been funded primarily through pilot projects. The problem with this approach is that projects tend to be limited in both size and scope. Full-scale demonstration projects, supported by the Rural and Remote Access Fund, would allow provinces and territories to test not only innovative approaches to delivery of health care services and initiatives but also to explore the underlying causes of health problems in smaller communities.

Our experience in addressing a full range of factors and conditions that affect people's health at the community or regional level has been limited. As a result, the relationship between health determinants, health behaviours and health status is largely unknown (Roussos and Fawcett 2000). Lower educational attainment, higher unemployment and poorer access to health care undoubtedly have an impact on the health status of people in smaller communities, but the specific impact of these factors has not been studied in a comprehensive way. Similarly, the

impact of living in smaller communities on health behaviours and health status needs much more study. It is even less clear how adverse conditions in rural and remote communities can be ameliorated or reversed.

Multi-faceted approaches to strengthen social capital, enhance community resilience, build a viable economic base, and foster positive health behaviours are also limited. But there are some good models to follow such as the Canadian Heart Health Initiative, the Healthy Community Movement, and Better Beginnings Better Futures. These approaches take a broader approach, not just focusing on a particular illness but also including a number of factors that affect people's health.

The population health demonstration projects envisioned in this report should be much larger in scale than previous pilot projects and involve different partners in different sectors of the economy and society in those communities. The objective is to find the best approaches to strengthen community resiliency, social capital and local capacity, improve healthy behaviours and lifestyles, and improve the overall health status of people in rural and remote communities.

The Rural and Remote Access Fund should support provinces, territories, communities and health authorities in developing and implementing a variety of models and approaches. For the Fund to be successful, a process must be in place to monitor, evaluate and disseminate the results of these demonstration projects, and, in particular, to highlight best practices and enable Canadian communities to learn from each other's experiences. Funding should be based on demonstrated needs in communities, the use of innovative approaches to address those needs, and the potential of demonstration projects to result in overall improvements in the health of people in smaller communities across the country.

What Does This Mean for Canadians?

For people living in rural and remote communities, it means that some of their most pressing health needs will be addressed. It means that deliberate, decisive and immediate action can be taken to address severe shortages in health care providers in many smaller communities. It means the potential of new approaches like telehealth to literally bring health care to the doorstep of people in rural and remote communities can be realized. And over the longer term, it means the disparities between the health status of people in smaller communities and the rest of the Canadian population can be appreciably reduced.

8 Home Care: The Next Essential Service

Directions for Change

- ***Use the proposed new Home Care Transfer to establish a national platform for home care services.***
- ***Revise the* Canada Health Act *to include coverage for home care services in priority areas.***
- ***Improve the quality of care and support available to people with mental illnesses by including home mental health case management and intervention services as part of the* Canada Health Act.**
- ***Expand the* Canada Health Act *to include coverage for post-acute home care including medication management and rehabilitation services.***
- ***Provide* Canada Health Act *coverage for palliative home care services to support people in their last six months of life.***
- ***Introduce a new program to provide ongoing support for informal caregivers.***

The Case for Change

Home care is one of the fastest growing components of the health care system. Services that used to be provided exclusively in hospitals, doctors' offices, clinics, or long-term care facilities now can be provided in people's homes. Home care services now include a wide range of treatments from follow-up visits to check on how well a person is recovering after surgery, to regular visits to seniors to monitor their health or, in some cases, even complex treatments such as dialysis or intravenous therapies. The advantages are obvious. People get to stay in their own homes with the assurance that someone will be there to monitor their health. For some people, especially seniors or people with disabilities, it means they can maintain their independence. The costs are generally lower than keeping people in hospital. Based on a major Canadian project known as the National Evaluation of the Cost-Effectiveness of Home Care (Hollander and Chappell 2002), there is growing evidence that investing in home care can save money while improving care and the quality of life for people who would otherwise be hospitalized or institutionalized in long-term care facilities.

Although home care is not currently considered a medically necessary service under the *Canada Health Act,* provinces and territories recognize its value and have taken steps to expand home care under provincial and territorial health care plans. But there are wide variations across the country in terms of what types of home care services are covered and how much individuals pay to cover a portion of the costs.

Because home care has become a partial substitute for care that was previously provided primarily in hospitals or by physicians, and because of the value of effective home care services both to individuals and the health care system, a strong case can be made for taking the first step in 35 years to expand coverage under the *Canada Health Act*. As outlined in Chapter 2, the Commission recommends that the definition of what is covered under the *Canada Health Act* should immediately be expanded to include medically necessary home care as well as diagnostic services (discussed in greater detail in Chapter 6).

This important step reflects the views expressed by many Canadians as part of the Commission's consultations. The Commission repeatedly heard that our definition of "medically necessary" should not be confined to hospital and physician services. The definition should be based on need, not where the service is provided or who provides the service.

Because of the significant costs that would be involved in including all home care services under the *Canada Health Act*, priorities should be placed on the most pressing needs. There is little doubt that effective home care support is vitally important to people with mental illnesses, to people who have just been released from hospital, and to those who are in their last months of life. These three areas – mental health, post-acute care, and palliative care – should be the first three home care services to be included under a revised *Canada Health Act*.

The Commission also heard consistently about the important role family, friends and other informal caregivers play in looking after people who have chronic illnesses or disabilities, ongoing mental health problems, or who face months of rehabilitation time at home. The pressures on these caregivers are significant and should be recognized. A new national program should be established through Employment Insurance to provide direct support to informal caregivers and allow them to spend the necessary time caring for their family members.

Taken together, these recommendations would have a tremendous impact on Canadians from coast to coast to coast. For thousands of people with mental illnesses, it gives assurance that they will be able to live full and productive lives in their community with the ongoing support they need when they need it. For people recuperating from surgeries at home, for example, it means adequate home care services will be available. For those who are facing the end of their lives, it means home care support will be there to help them and their families. And for family members in each of these situations, it means they will have direct support and the time they need to help provide care. It also means that current provincial and territorial resources dedicated to home care services in these three priority areas would be freed up to provide additional home care services for people with physical disabilities and chronic illnesses.

Home Care in Canada

Variations across the Country

Everyone seems to know intuitively what home care is; yet there is no single definition of what home care means. At a minimum, it is a term used for an array of services that allow individuals who suffer some mental or physical incapacity to live at home and receive the care they need. Quite often, the effect of this is to prevent, delay or substitute home care for hospital or long-term residential care. Home care support generally includes:

- Professional services such as nursing, physiotherapy, occupational therapy, and speech therapy;
- Personal care including assistance with the activities of daily living, such as bathing, toileting, transferring and grooming;
- Home making and home support to assist with the activities of daily living, such as cleaning, doing laundry and meal preparation.

Hollander and Walker (1998) note that differences in home care relate primarily to three different functions:

- Maintenance or prevention – helping people with health problems remain at home and preventing institutionalization;
- Long-term care substitution – meeting the needs of people at home who would otherwise be institutionalized; and
- Acute care substitution – allowing people to be treated at home rather than having to remain in, or enter, acute care facilities.

Since the 1970s, provinces and territories have established and funded home care programs. For a variety of reasons, including different regional needs and priorities, variations in provincial and territorial budgets, and the evolution of local health care programs, it is not surprising that there are significant variations across the country, not only between provinces and territories, but also within them. Despite these challenges, some general comparisons can be made in terms of the range of home care services, difference in eligibility requirements, and funding for home care.

Home Care Services

All provinces and territories offer some assessment and case management as part of home care services. However, the similarity ends there. For home nursing care, some provinces provide extensive coverage while others limit home nursing care to a monthly dollar amount, hourly limits or the equivalent cost of institutional care. For home medical supplies, some provinces and territories provide supplies for a limited time or for acute home care only, and some base their decisions on means testing. For home rehabilitation services, some provinces and territories offer full programs while others offer none at all.

Eligibility for Home Care Services

There also are differences in eligibility requirements. As a result, people living in one province may be eligible for certain services while people in other provinces with similar circumstances are not.

With the exception of British Columbia, where eligibility can require 12 months of residency, general eligibility requirements for home care across the country include:

- three months residency
- a health insurance card
- a health or medical need for care
- a suitable home for care (safe, with adequate family, social, or community support)
- a physician referral (in some provinces and territories).

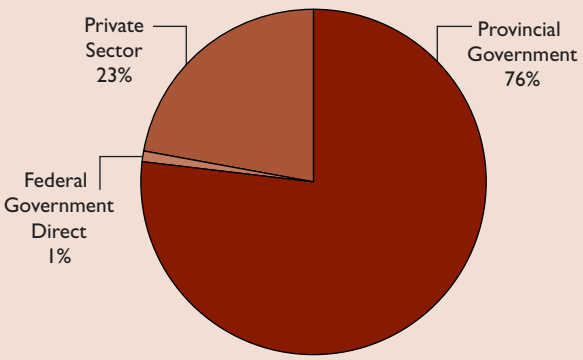
Within these general eligibility requirements, some provinces and territories provide complete coverage for certain services while others provide more limited home care services according to acuity of illness, financial means, dollar limits or other criteria.

Funding for Home Care

Currently, home care services are funded through a combination of provincial and territorial funds, federal funds, private insurance, and payments by individual Canadians (see Figure 8.1). In some provinces, means testing is used to determine access to home care services.

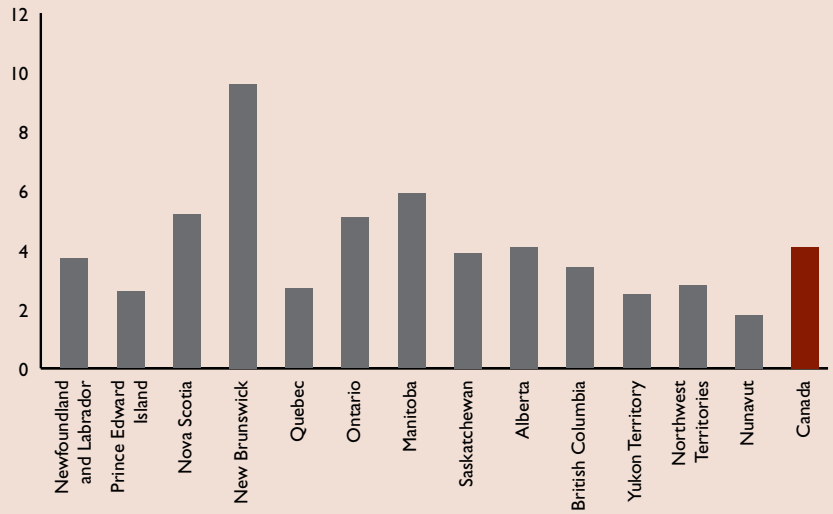
In terms of the percentage of provincial and territorial budgets spent on health care, there also are wide variations across the country. New Brunswick, for example, spends close to 10% of its total health care budget on home care compared with less than 2% in Nunavut (see Figure 8.2). On average, provinces and territories spend between 4 and 5% of their health

Figure 8.1 Percentage Distribution of Home Care Expenditures, by Source of Finance, 2000/01



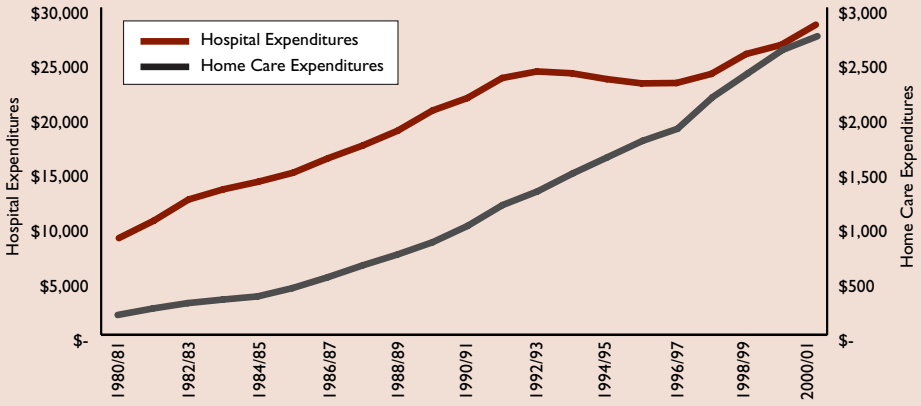
Note: Private sector home care expenditures were estimated by Health Canada based on results of Statistics Canada surveys as well as the input from private providers of home care services. Estimates of home care paid by private insurers was not available and is therefore not included.
Source: Health Canada 2001d; CIHI 2001d.

Figure 8.2 Provincial-Territorial Home Care Expenditures as a Percentage of Total Provincial-Territorial Health Expenditures, 2000/01



Source: Health Canada 2001d.

Figure 8.3 Provincial-Territorial Hospital and Home Care Expenditures ($Millions), 1980/81 to 2000/01



Source: Health Canada 2001d.

budgets on home care. Between 1980/81 and 2000/01, the average annual rate of growth for home care expenditures by provincial and territorial governments was 14% compared to 6.2% for hospitals and 7.1% for all provincial-territorial health expenditures (see Figure 8.3).

Looking Ahead

Looking ahead, there is every reason to assume that the demand for home care services will increase. That demand will be driven by a number of factors including:

- New advances in treatments, medications and technology that make it increasingly possible for people to be treated at home rather than in hospital or in other institutions;

- New primary health care models that enable teams and networks of health care providers to manage and monitor people's health at home and in their communities;
- A growing elderly population that wants access to home care;
- Increasing pressures on informal caregivers;
- Continuing trends for early discharge from hospital;
- The overall cost-effectiveness of home care;
- Improvement in the quality of life resulting from home care;
- Accelerated healing times; and
- Ethical considerations around providing specific care in certain settings.

> *"We need to make decisions even beyond the cost – that is, [on] the value added of being able to remain at home, for instance."*
>
> Association québecoise des pharmaciens propriétaires du Québec. Presentation at Québec City Public Hearing.

Given these trends, it is important to address current disparities in home care services across the country. The extent of regional variations in home care has some Canadians wondering if they should move to areas with better programs in their later years of life so they will have access to the services they need. When differences in health care coverage and services across the country have this effect on Canadians, it suggests something must be done. Disparities across the country also mean that many people have significant home care needs that currently go unmet. Finally, provincial and territorial spending on home care will continue to grow as this becomes an increasingly important component of the continuum of care provided for Canadians. For these reasons, the first critical steps should be taken to integrate home care into the publicly funded health care system and include priority home care services under a revised *Canada Health Act.*

Making Home Care the Next Essential Service

RECOMMENDATION 34:

The proposed new Home Care Transfer should be used to support expansion of the *Canada Health Act* to include medically necessary home care services in the following areas:

- **Home mental health case management and intervention services should immediately be included in the scope of medically necessary services covered under the *Canada Health Act.***
- **Home care services for post-acute patients, including coverage for medication management and rehabilitation services, should be included under the *Canada Health Act.***
- **Palliative home care services to support people in their last six months of life should also be included under the *Canada Health Act*.**

Defining and Funding a National Platform of Home Care Services

Canadians have said that home care services are too important to be excluded from the definition of insured health services under the *Canada Health Act*. While it is not financially feasible to include all home care services under the *Canada Health Act* at this time, the first step is to establish a national platform of services that would be available to Canadians in all parts of the country under the same terms and conditions.

A national platform for home care services would, in effect, set a "floor" of services that must be available across the country. Establishing a national platform for home care services does not preclude provinces, territories or regions from adding to the basic services to meet the needs and priorities of their communities. In fact, the additional support for home care provided through the proposed new Home Care Transfer should free up resources that should be used to improve and expand existing home care benefits for people with chronic and long-term health problems and disabilities. Over time, as fiscal resources permit, more home care services could be brought under the *Canada Health Act* umbrella.

In terms of the costs of expanding coverage for home care services, the Commission relied on the work of several consultants (Hirdes et al. 2002) to estimate the costs involved in including the three priority areas under the *Canada Health Act* – home mental health services, post-acute home care, and palliative home care. The consultants' findings and the approach they took in preparing an estimate are included in Appendix G.

Based on their analysis, the estimated costs (excluding perscription drugs) would be as follows:

Home mental health case management and intervention	$568.1 million
Post-acute medical care	$117.7 million
Post-acute rehabilitation	$204.6 million
Palliative home care	$ 89.3 million
Total	$979.7 million

As noted in Chapter 2, the proposed Home Care Transfer would provide $1 billion to kick-start expanded coverage for home care services in the three priority areas on the condition that provinces and territories provide home care services consistent with the national platform. After an initial two-year period, the Home Care Transfer should be rolled into the long-term Canada Health Transfer. This would ensure that ongoing, stable funding is available to support continuing integration of home care services as an essential component of the health care system.

> *"We need a national home care plan that entrenches home support within the foundations of our system in Canada so that [we] can move freely about Canada without having to worry about whether any one region might exclude our presence simply by not having a home support program."*
>
> HOME SUPPORT ACTION GROUP OF VICTORIA. PRESENTATION AT VICTORIA PUBLIC HEARING.

Home Mental Health Case Management and Interventions

Mental health has often been described as one of the "orphan children" of medicare. The Commission consistently heard that it is time to deal with this issue and bring mental health into the mainstream of public health care. The reality is that mental health care has changed and it is now largely a home- and community-based service with only a small number of people needing hospital or institutional care and even then, only for shorter periods of time. The Commission's recommendation reflects this reality and takes the long overdue step of ensuring that mental health home care services are included as medically necessary services under the *Canada Health Act* and available to Canadians across the country.

Significant changes in how mental health services are provided date back to the early 1960s. Emmett Hall's Royal Commission on Health Services (1964, Vol. 1, 21) reported that "[o]f all the problems presented before the Commission, that which reflects the greatest public concern, apart from the financing of health services generally, is mental illness…" The Hall Commission recommended that mental health care should be integrated into the hospital system by adding psychiatric wards and wings to hospitals, replacing larger, segregated mental asylums. Mental illness was to be given the same status as physical illness in terms of the organization and provision of services.

"You sir, and the Commission, are my last hope for reform in the mental health system."

CLAUDETTE GRIEB. PRESENTATION AT TORONTO PUBLIC HEARING.

At the time that Hall reported, a trend to move mental health patients from asylums to hospitals and from hospitals to the community was underway. Hall's recommendations reflected this trend. In reference to children with mental illnesses, Hall (1964, Vol. 1, 24) wrote that "the majority [of them should] not be segregated in institutions but remain at home, in the community."

Over the next few decades, de-institutionalization became more widespread. According to the Canadian Mental Health Association (2001, 8), in the 1960s and 1970s, "budgetary considerations and new medications combined with a new vision of 'community psychiatry' … led to the deinstitutionalization of large numbers of patients with serious mental illness." The goal at the time was short-term outpatient treatment or a brief stay in a general hospital in order to "normalize" mental illness and make it an "illness like any other."

Despite these early recommendations and changes in society, mental health care remains one of the least integrated aspects of health care. By the mid-1970s, it became clear that the process of de-institutionalization was flawed. As the Canadian Mental Health Association (2001, 8) described it, "For many former hospital residents the new system meant either abandonment, demonstrated by the increasing numbers of homeless mentally ill people; 'trans-institutionalization': living in grim institution-like conditions such as those found in the large psychiatric boarding homes; or a return to family who suddenly had to cope with an enormous burden of care with very little support. In addition, fears and prejudices about mental illness, in part responsible for the long history of segregation in institutions, compounded the problems in the community. These attitudes increase the barriers to access to community life in areas such as employment, education and housing."

Recent history has shown that the trend to treating people with mental illnesses in their own communities rather than in institutions has not been accompanied by sufficient resources. Many mental health patients were discharged with insufficient resources and networks to support their ability to live at home. Often, to be eligible for home care, a person had to have a physical disability or difficulties with activities of daily living. These requirements preclude many people with mental illnesses from accessing necessary home care interventions and support. According to the Canadian Mental Health Association (2001), one of the main lessons to be learned from this failed experiment is that clinical services must be in place in the community before hospital beds are closed.

In the case of mental illnesses, home care is not simply an alternative to institutionalization. Treating people effectively in the community rather than in institutions or hospitals *requires* home care, particularly in order to ensure that people with mental illnesses continue to take their medications appropriately and do not need repeated re-admissions.

> *"People with mental illness are excluded from home care and home support services – unlike people with physical illnesses or disabilities – and these would make an enormous difference to their health."*
>
> CANADIAN MENTAL HEALTH ASSOCIATION, NEWFOUNDLAND AND LABRADOR DIVISION. PRESENTATION AT ST. JOHN'S PUBLIC HEARING.

In addition to improving care and support for people with mental illnesses, providing case management and interventions when needed is also a cost-effective approach. It not only precludes the need for people to stay in institutions but it also prevents the high costs of continuous re-admission to hospitals or other facilities. In many cases, a home care client may have a brief episode of unmanageable behaviour in the home and institutionalization will occur immediately. By focusing home mental health care on people who generally live well in the community, but who may have occasional problems, recurrent institutionalization can be prevented or minimized, and very large savings to the system can be realized (Hollander and Chappell 2002).

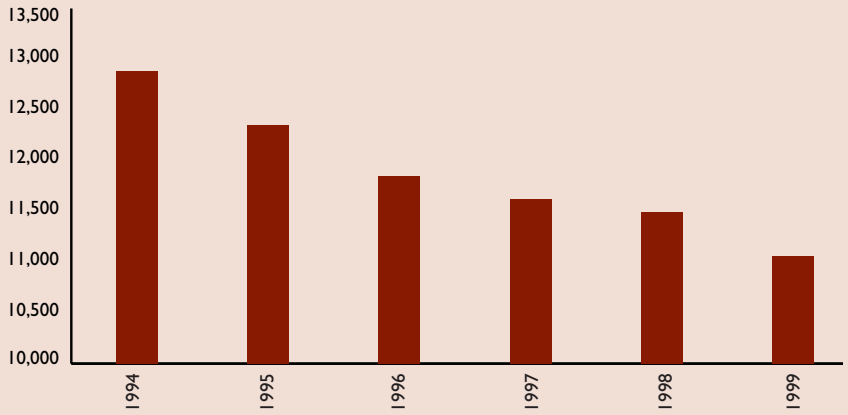
Two types of home care services should be available for people with mental health problems. The first is case management, in which a case manager would work directly with the individual and with other health care providers and community agencies to monitor the individual's health and make sure the appropriate supports are in place. This would ensure both continuity and co-ordination of care. The second is home intervention to assist and support clients when they have an occasional acute period of disruptive behaviour that poses a threat to themselves or to others and could trigger unnecessary hospitalization.

As the average age of Canada's population increases, the number of people with dementia and Alzheimer's disease is expected to increase. Currently, people with these illnesses remain in their own homes as long as possible, but the burden of care on their family is enormous. With case management support, family members and the individuals involved would have the support they need in terms of assessing changing needs, providing the necessary care, and planning for a time when these individuals may no longer be able to remain in their own homes.

Post-acute Home Care

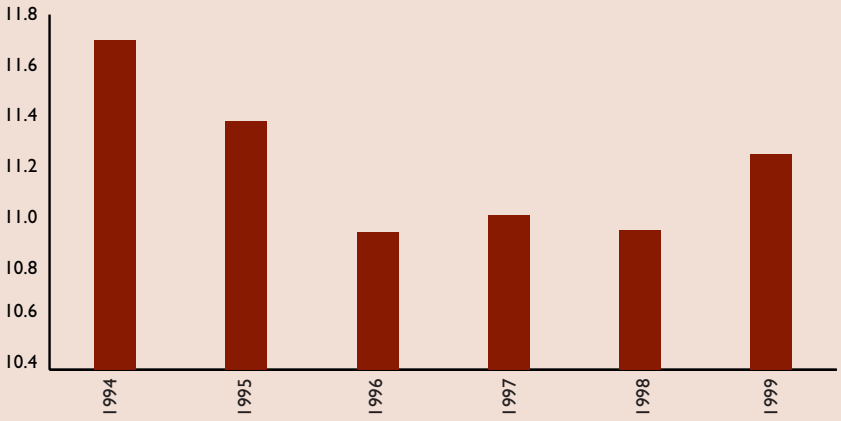
Changes in health care delivery have resulted in shorter hospital stays and more services being delivered at home rather than in hospital. Advances in technology and new prescription drugs (Cregan 1999) and hospital policy (RNAO 1997) often mean people need to spend less time in hospital. New surgical techniques mean that people face shorter recuperation times and are more able to return to their own homes to convalesce. "In addition, research on aging suggests that improved health status of seniors has had an impact on decreasing the number of hospitalization days by two-thirds since 1970" (CIHR Institute of Aging 2002) (see Figures 8.4 and 8.5).

Figure 8.4 Inpatient/Acute Care Admissions, Age Standardized (Number per 100,000 People), Canada, 1994 to 1999



Note: Figures are comprised of the average of provincial standardized rates of admission.
Source: CIHI 2002c.

Figure 8.5 Inpatient/ Acute Care Hospitalizations: Average Length of Stay, Aged 65+, Canada, 1994 to 1999



Note: Figures are comprised of provincial average length of stay data.
Source: CIHI 2002c.

While there are some clear advantages to early discharge for many patients, early discharge from hospital is not always beneficial. Some patients who are discharged early are unable to perform the normal activities of daily living, have complex medical needs that require ongoing professional attention, or have considerable medication requirements. In these cases, discharging people early from hospital without adequate resources simply shifts the burden for care from hospitals to patients and their families. Furthermore, discharging patients – especially when they are elderly – without adequate assessment of their post-acute care needs can considerably increase the risk of re-admission (Afilalo 2001).

There is good reason to believe that home care has picked up where hospitals left off. It is commonly held that hospitals have decreased inpatient days because of the "belief that significant public sector cost savings may be realized by redirecting care away from institutions and towards the community" (Coyte 2000, 7). This is not unique to Canada. A British study reports that "Pressure on hospital beds, the increasing age of the population, and high costs associated with acute hospital care have fuelled the search for alternatives to inpatient hospital care" (Richards et al. 1998, 1797). Home care services have become a less costly substitute for many services that were previously provided in hospitals.

> *"We want a national system for home care. We have examples throughout the country that show that some of our older people have to be hospitalized when they could be cared for at home for much less money. And for this we recommend a national system well financed by the federal government, the provinces and the territories."*
>
> Assemblée des ainées et ainés francophones du Canada. Presentation at Winnipeg Public Hearing.

The current trends for early release from hospital are expected to continue and new advances in technology and prescription drugs are likely to make it possible to provide more services safely in the home. Because these home care services substitute for services that previously would have been covered in hospital, it makes sense that they should be covered under the *Canada Health Act*, even though they are provided at home. Post-acute home care services are generally a cost-effective alternative to delivering these same services in hospital. Providing coverage under the *Canada Health Act* would support the current trend to increasing care at home and ensure that post-acute home care is available on the same terms and conditions across the country.

Coverage for post-acute home care should include case management, health professional services, and medication management. Post-acute home care should be provided for a maximum of 14 days following discharge from acute care or for a maximum of 28 days if rehabilitation is needed for the specific condition (Appendix G).

Palliative Home Care

Palliative care is currently provided in hospitals, long-term care facilities and hospices, as well as through home care. When it is provided in a hospital, palliative care is fully publicly covered as a medically necessary service under the current *Canada Health Act.* When it is provided at home, only some health care services and prescription drugs are covered depending on each provincial, territorial, or regional program.

According to the Canadian Hospice Palliative Care Association (2001), few provinces have designated palliative care as a core home care service with a specific budget. The Association

> *"My personal experience with end-of-life care took place in 1997 when my 7-year-old son Matthew was dying of cancer.… During the final stages of his disease, Matthew received excellent multi-disciplinary care.… I had assumed that this same level of care was available to all people of all ages who need end-of-life care in Newfoundland and Labrador. I now know this is far from accurate … make certain that the delivery of end-of-life care becomes a truly universal service available to all individuals with a need."*
>
> Honna James-Hodder. Presentation at St. John's Public Hearing.

> *"My three year old son was diagnosed with cancer. When I faced decisions about his treatment, palliative care was not available at that time in home and it is not available today."*
>
> Hospice Palliative Care Association of PEI. Presentation at Charlottetown Public Hearing.

notes that "Resources required to provide good care in the community, either in a person's home or in a specialized residential hospice, have not been made available, even when access to hospital beds has been reduced."

There are considerable disparities in access to palliative care across the country. These services have been developed on an ad hoc basis and are limited by the financial capability of communities and charitable organizations. Consequently, many Canadians do not have access to palliative care. Some estimates suggest that only 5% of Canadians have access to hospice palliative care. These services are primarily provided for people with cancer. Canadians who live in remote and rural communities, and individuals with disabilities also have limited access to hospice palliative care (Canadian Hospice Palliative Care Association 2001).

Disparities in access to palliative care were highlighted by a Senate Subcommittee chaired by Senator Sharon Carstairs, Minister with Special Responsibility for Palliative Care, its report entitled *Quality End-of-Life Care: The Right of Every Canadian* (Senate 2000). The report suggests that access to palliative care is often based on "the luck of the draw" rather than a basic entitlement of Canadians. As one provincial presenter suggested, "[Palliative] home care is variable, fragmented, and financed through different mechanisms. There are few consultation teams available for home or long-term care situations and minimal community hospice services to provide visiting volunteers, day programs, and respite for families. The delivery system … is too rigid for the 24-hours a day care required by terminally ill people at home." Senator Carstairs and her Subcommittee have highlighted a number of important concerns related to palliative care. The work currently underway on developing a national strategy for end-of-life care will undoubtedly provide valuable assistance to governments as they seek to go beyond the national platform recommended in this report.

Problems with lack of access to palliative home care are likely to increase in future as Canada's population ages. A 1997 Angus Reid poll found that approximately 80% of Canadians prefer to die at home (CACC 2001). The percentage of hospital deaths peaked in 1994 at 80.5% and, by 1997, it had dropped to 75.3% in a steady trend-line (Wilson et al. 2001). Notwithstanding this trend, the Canadian Association for Community Care reports that home-based palliative care is "often not possible because of the lack of home-based palliative care services" and that "only about 10% of Canadians have access to palliative care services."

More compelling than this growth in demand, however, is the suggestion that there is a right to die with dignity, and that this includes the right to die at home (Hospice Palliative Care Association of Prince Edward Island 2002). As the Seniors Resource Centre of Newfoundland and Labrador (2002) told the Commission, "Seniors do not wish to end their days in institutions." Instead, they would prefer to be in the comfort of

their homes, surrounded by familiar faces and a comforting environment. One of the objectives of helping people die with dignity is to reduce pain as much as possible and to maintain the highest possible level of functioning (CACC 2001). While these objectives can be met both at home and in institutions, the home is often the best place to maintain the highest level of functioning.

Including palliative home care as an essential service for Canadians can be justified on many different grounds, not the least of which is our social obligation to people during their dying days. It is a highly emotional time and a compassionate society must ensure that people have the care and support they need to spend their remaining time at home, if that is their choice. And, as pointed out in the final report of the National Evaluation of the Cost-Effectiveness of Home Care (Hollander and Chappell 2002, xi) palliative care at home "should result in fewer trips to the hospital and save money."

Some limits around the time frame for palliative care are necessary. Depending on patients' particular condition, they may live for long periods of time in spite of the fact that they have a terminal illness and are receiving no other treatments to attempt to cure the illness. People can have living wills and "do not resuscitate" orders precluding heroic measures for many years prior to their death. Therefore, eligibility to receive palliative home care should be limited to individuals who have a prognosis of death within six months. People would be eligible for palliative home care based on a referral from their physician. The types of palliative home care services should include pain and symptom relief, case management, professional services, medication management, and counselling when needed. Respite care should also be provided when appropriate.

"… the federal government [should] immediately assess the need for home care and pharmacare for the dying … [and] … implement income and job protection for family members who are caring for the dying."

CANADIAN PALLIATIVE CARE ASSOCIATION. PRESENTATION AT OTTAWA PUBLIC HEARING.

"The focus should be on allowing people to die with dignity and to recognize that death is normal and has a special place."

ASSOCIATION QUÉBECOISE DES SOINS PALLIATIFS. PRESENTATION AT QUÉBEC CITY PUBLIC HEARING.

IMPROVING SUPPORT FOR INFORMAL CAREGIVERS

RECOMMENDATION 35:

Human Resources Development Canada, in conjunction with Health Canada should be directed to develop proposals to provide direct support to informal caregivers to allow them to spend time away from work to provide necessary home care assistance at critical times.

Recognizing the Role of Informal Caregivers

Quite simply, home care could not exist in Canada without the support of social networks and informal caregivers. By informal caregivers, we mean the family members and friends who provide support on an unpaid basis (Hollander and Chappell 2002).

While there are varying estimates of how much home care support is provided by informal caregivers, all estimates are high. The Ontario Coalition of Senior Citizens' Organizations (2002), for example, estimates that 85 to 90% of home care is provided by family and friends.

Similarly, the Family Caregivers Association of Nova Scotia (2002) estimates that 80% of care needs of Canada's elderly are addressed by informal caregivers. Informal caregivers play a critically important role in providing ongoing care, support, and advocacy for people with physical disabilities. In terms of the numbers of informal caregivers, the Canadian Association for Community Care reports that currently there are three million informal caregivers in Canada ranging from teenagers to seniors (CACC 2001).

In addition to informal caregivers, there also is an abundance of volunteers who devote hours of service caring for people who are ill. The Health Charities Council of Canada (2002) estimated that, in 1997, 93 million hours of formal volunteering were provided in Canada, on top of over 2 billion hours of informal caregiving. The combined value of these services was estimated at between $20 and $30 billion.

Informal caregivers play an essential role in the delivery of home care services and in the health and care of their families and friends. Many informal caregivers are more than happy to provide care and support to their loved ones, but the reality is that caregiving is becoming an increasing burden on many in our society, especially women. A recent study suggests that caregivers experiencing the strain of caregiving have 63% higher mortality rates (Schultz and Beach 1999).

The Commission heard repeated concerns about the burden of informal caregiving and the impact it has on the lives of many Canadians. A representative of the Assemblée des aînées et aînés francophones du Canada (2002) at the public hearing in Winnipeg told the Commission that his mother took care of his grandmother for 24 years and that his sister left a religious order to take care of their mother – all with no compensation. Many presenters expressed the view that family members should not be forced to care for the ill (Fédération des infirmières et infirmiers du Québec 2002; Laurentian University, School of Nursing 2002) and expressed concern about the particular burden that home care places on women (Pauktuutit-Inuit Women's Association 2002; Prince Edward Island Nurses Union 2002). The Association québecoise de défense des droits des personnes retraitées et préretraitées (2002) suggested that social policies should be established to give relatives incentives to keep their loved ones at home, and to make it easier for them to do so. In St. John's, the Commission was reminded that an aging population will require more publicly funded health care due to the fact that there will be fewer and fewer younger family members to take care of those who are aging (Seniors Resource Centre of Newfoundland and Labrador 2002).

To acknowledge the important role of informal caregivers, various forms of support are possible from direct remuneration to tax breaks, job protection, caregiver leave, and respite. In the Commission's view, informal caregivers should be able to take time from their jobs to provide the necessary care at home. The most direct way of providing this support would be through Employment Insurance benefits. People should be granted time off for informal caregiving at home for family members and loved ones at critical times. While the specific eligibility criteria should be developed by the federal government, it should be possible to introduce this new benefit within the resources that are currently available in the Employment Insurance program.

Taking the Next Steps

Extending the revised *Canada Health Act* to include coverage for home care services as defined earlier in the chapter is a critical first step. But to gain the most benefits from home care services, they need to be fully integrated with the continuum of care provided in the health care system. In effect, home care should not be seen as a distinct category of care but as a key part of the health care system.

A number of issues need to be addressed by provinces and territories on an ongoing basis in order to integrate home care more fully into the continuum of care.

Adequate and Appropriate Health Human Resources

As home care services continue to expand, there will be growing demands for trained home care providers. Case managers will become increasingly important in co-ordinating care with a team of health care providers and other sectors of the health care system including hospitals, long-term care facilities, and hospices. For post-acute home care, for example, the case manager should be someone involved in patient discharge who assesses the needs of the patient, determines if post-acute home care is appropriate, and determines the length of time and the services to be provided. For palliative home care, the case manager should be someone who co-ordinates services for patients in conjunction with physicians, family members, and other agencies. In home mental health intervention, the case manager should be a professional with training in the mental health field who can quickly assess the emergency needs of a client or family in crisis and dispatch the necessary home intervention team to handle the situation.

Continuity and Co-ordination of Health Care

Studies suggest that efficiency can be improved if there are effective linkages between home care and other aspects of the health care system. A 2001 Health Transition Fund report demonstrated that, by bridging the gap between hospital and community care with a nurse discharge co-ordinator, readmission to hospital can be reduced considerably (Afilalo 2001).

Several reports and studies point to the importance of good discharge planning and effective home care programs. A study on home-based intervention for people with congestive heart failure showed a reduction in hospital re-admissions and improvements in survival (Stewart and Horowitz 2002). Similarly, a study on elderly patients found that if there is appropriate screening of elderly patients in emergency departments and appropriate referrals are made before the patients are discharged, a seamless delivery system of health care can be provided. In addition, the study showed that "[a] home care visit resulting from a referral may be all that is needed for the maintenance of a patient's condition. To improve the quality and continuity of patient care, home care screening should be integrated into the routine discharge Emergency Department activities" (Castro et al. 1998, 127). Another study recommended that all emergency departments adapt the use of a high risk assessment tool for the clinical nurse to use to screen for patients that will benefit from the work of the discharge co-ordinator (Afilalo 2001). Hollander and Chappell (2002) also reported that, with stable home care arrangements (i.e., clients who remain at the same level for six months or more), the costs of care are about 50% less than facility care. However, when home care clients change their type of care, the cost is only 10 to 30% less than the costs of facility and extended care.

Continuity of care is also critically important for patients. For home care to be as effective as possible, ongoing communication is necessary to prevent the revolving door effect of patients transferring back and forth between levels and types of care. This kind of revolving process can offset the savings gained through home care. It also has costly effects, especially in the case of the elderly who often suffer from relatively minor ailments that could easily be treated at home at a lesser cost than in hospital.

The need to integrate home care with the overall continuum of care is well recognized by provincial and territorial Premiers. At their January 2002 meeting, the Premiers agreed to a series of initiatives to foster the integration of home care into a seamless continuum of care and to establish common practices across the country. Among their objectives, the Premiers agreed to:

- Explore options to provide support and assistance to families and other caregivers who care for people in the home;
- Identify approaches to facilitate broader adoption of technology including telehealth technologies for use in home and community settings;
- Support collaboration between home and community care and housing providers to develop innovative and affordable supportive living and other facility arrangements;
- Examine approaches that will improve the continuity of care for home care clients by enhancing co-ordination and linkages between home care providers and other health care providers (in acute care, primary care and long-term care sectors); and
- Collaborate on identifying common data elements across provinces and territories that would promote consistent classification of home care clients, allow for comparisons of home and community care services and outcomes, lead to better research and evidence-based decision making, and provide better linkages to other settings and levels of care.

In terms of moving ahead with concrete actions to improve integration and continuity of care, several suggestions have been made to improve the infrastructure in home care, by the Canadian Home Care Association (2001), the Canadian Association for Community Care and the Canadian Home Care Association (2001), Hollander and Walker (1998), as well as in background work done for the Annual Premiers' Conference in the Fall of 2002. The suggestions include establishing:

- A single point of access to home care and residential services;
- Co-ordinated assessment and placement at the system level to ensure that there is an appropriate determination of a client's needs, and development of a care plan to address those needs;
- Formal linkages among primary care physicians, acute care hospitals, housing options, long-term care facilities and the case management function in the home care sector;
- Co-ordinated information systems to support these linkages;
- A consistent client classification system that allows for the comparison of clients across service delivery components, by level of care;
- Policies that foster the most cost-effective delivery of services through co-ordinated, ongoing, system-level case management – whatever the site of service – and that provide stability for clients, families and service providers; and
- Planning processes that include home and community care organizations and representatives as participants at both the health care system level and in local or regional health authority networks.

Integration with Primary Health Care

Because of the central importance of primary health care in providing comprehensive care, linkages between primary health care teams and networks and home care are essential. In several provinces, telephone information lines are available 24 hours a day, 7 days a week to provide immediate access to health information and advice. These services should have clear links to home care services. Primary health care teams and networks can also serve an important role in identifying people who need expanded home care services in order to maintain their health. New developments in electronic health care records outlined in Chapter 3 would also provide an essential link between home care and primary health care, and allow providers to share important information and track the health of their patients on an ongoing basis.

Expanding Home Care

The Commission's recommendations would expand home care in three priority areas – home mental health case management and intervention, post-acute home care and home palliative care – and also provide a significant benefit to informal caregivers. The largest component of current provincial and territorial home care budgets goes to support home care for people with chronic health problems or physical disabilities. As noted earlier, while the Home Care Transfer is not specifically targeted at these needs, the introduction of caregiver support should provide a significant benefit for family members caring for people with chronic illnesses and physical disabilities. The new Transfer should also free up a substantial amount of funds in current home care budgets. Provinces and territories should immediately be able to use those freed up resources to expand services and address the pressing home care needs of people with chronic conditions and physical disabilities. In the future, as resources permit, expanded home care services focused on meeting the needs of people with chronic illnesses and physical disabilities could be included under the *Canada Health Act*. It is the Commission's hope that these further steps will be pursued by all governments as soon as resources permit.

What Does This Mean for Canadians?

Making certain aspects of home care an insured service under the revised *Canada Health Act* is a clear sign that Canada's health care system is evolving to meet the changing reality of health care delivery in Canada.

More specifically, as a result of these recommendations:

- All Canadians from coast to coast to coast will have access to essential home mental health case management and interventions, post-acute home care services, and palliative home care services;
- Particularly in the case of mental health, trained professionals will be available to intervene with temporary behaviour or other problems and help people with mental health problems cope with their illnesses on an ongoing basis;
- Essential home care support will be available for people with dementia and Alzheimer's disease to help them and their families cope with the situation and make decisions about the best options for care;
- People who are dying and who prefer to die in their own homes will get the care they need to be able to die with dignity;

- People who are released early from hospital will receive the necessary treatments and support at home, including support for rehabilitation; and
- For the first time, the invaluable role of informal caregivers will be recognized and supported, and people will be able to take the time they need from work to provide care for their loved ones at home.

This is a vitally important step for Canadians. It means home care will be increasingly integrated with the rest of Canada's health care system. And it means Canadians will be able to maintain their health, recuperate and recover, or spend their dying days in their own homes with the care and support they need.

9 Prescription Drugs

Directions for Change

- ***Take the first steps to better integrate prescription drugs into Canada's health care system.***
- ***Use the new Catastrophic Drug Transfer to offset the cost of provincial and territorial drug plans and reduce disparities in coverage across the country.***
- ***Establish a new National Drug Agency to control costs, evaluate new and existing drugs, and ensure quality, safety, and cost-effectiveness of all prescription drugs.***
- ***Establish a national formulary of prescription drugs to provide consistency across the country, ensure objective assessments of drugs, and contain costs.***
- ***Develop a new medication management program for chronic and some life-threatening illnesses as an integral part of primary health care.***
- ***Review aspects of Canadian patent law.***

The Case for Change

When medicare was first introduced, prescription drugs played a limited role in the health care system and in the day-to-day lives of the vast majority of Canadians. Today, they are a fact of life for many Canadians. Prescription drugs provide relief from many of our regular aches and pains. They also protect children from illnesses, cure diseases that once were a death sentence, and help manage the chronic health conditions of thousands of Canadians. Prescription drugs have also replaced the need for some intensive surgeries and have helped to reduce recovery times, often allowing people to recover at home rather than in hospitals. In fact, they have fundamentally changed the face of health care in Canada.

Looking ahead, there is every reason to believe that we have only seen the tip of the iceberg when it comes to the potential for new prescription drugs. In the future, we can expect continued increases in both the supply of, and demand for, drugs, driven by the advent of new genetic

technologies and the ability to detect and prevent many genetic diseases (Miller et al. 2002). As we learn more about our genetic make-up and genetic factors that cause certain diseases, we may be able to develop and prescribe medications that will prevent many congenital diseases.

The current and potential benefits of prescription drugs are undeniable. But the benefits will only be fully realized if prescription drugs are integrated into the system in a way that ensures they are appropriately prescribed and utilized and that the costs can be managed.

As the following sections of this chapter indicate, rising costs are an increasing worry, both for provinces and territories and for individual Canadians. There are also disparities in coverage across the country. The process for evaluating and approving new prescription drugs is time-consuming and each province and territory has its own approach for deciding which prescription drugs are covered under its insurance plan. In spite of considerable efforts by provinces and territories, costs are increasing and taking up an increasing share of health care budgets across the country. Furthermore, prescription drugs continue to be on the sidelines of Canada's health care system rather than integrated, as they should be, with primary health care and with other aspects of the health care system.

Given the expanding role of prescription drugs in Canada's health care system, a strong case can be made that prescription drugs are just as medically necessary as hospital or physician services (National Forum on Health 1997). However, the immediate integration of all prescription drugs into a revised *Canada Health Act* has significant implications, not the least of which would be substantial costs. Therefore, the goal should be to move in a gradual but deliberate and dedicated way to integrate prescription drugs more fully into the continuum of care. Over time, these proposals will raise the floor for prescription drug coverage across Canada and lay the groundwork for the ultimate objective of bringing prescription drugs under the *Canada Health Act*.

Two critical issues must be addressed. The first is improving access and ensuring that financial barriers do not prevent Canadians from accessing the prescription drugs they need. Currently, there are disparities in coverage across the country and these disparities could worsen as costs for prescription drugs increase. The second issue is continuing to improve the quality, safety and cost-effectiveness of prescription drugs.

To address those issues, five essential steps must be taken:

- **A new Catastrophic Drug Transfer** – As mentioned in Chapter 2, provinces and territories would receive additional funds through this new federal transfer to help cover the high costs of prescription drug plans and protect their residents against the potentially "catastrophic" impact of high cost drugs. This provides a clear incentive for provinces and territories to expand their coverage and reduce disparities across the country.
- **A new National Drug Agency** – One new prescription drug comes onto the market in Canada every four to five days. In the future, that pace will accelerate. New research on genetic testing and biotechnology will undoubtedly bring a host of complex and difficult issues. Canada must have a comprehensive, streamlined, and effective process in place for addressing these issues and ensuring the safety, quality and cost-effectiveness of all new drugs before they are approved for use in Canada. But just as important, processes should be in place for reviewing drugs on an ongoing basis, monitoring their use and outcomes across the country, and sharing high quality, timely information, and analysis

with provinces and territories, health care providers, researchers, and Canadians. A new independent National Drug Agency would perform these functions on behalf of all governments and all Canadians.

- **A national formulary for prescription drugs** – Currently, each province and territory has its own list of prescription drugs that are covered under its drug insurance plan. A national formulary, developed by the National Drug Agency in conjunction with the provinces and territories, would provide consistent coverage, objective assessments, and help contain costs.
- **A new medication management program linked to primary health care** – Primary health care reform is an essential component of our vision for the future of Canada's health care system. Linking medication management with primary health care would ensure that the effectiveness of prescription drugs can be monitored by teams and networks of health care providers working with individual patients on an ongoing basis.
- **Patent review** – Aspects of Canada's patent laws should be reviewed in order to improve access to generic drugs and contain costs.

Provinces and territories are well aware of both the enormous potential and the growing costs of prescription drugs. Individually and collectively, they have taken steps to try to manage costs within their own jurisdictions and to explore the most effective solutions. However, given the national scope of the issues and the substantial costs involved, this is a clear case where there is more to be gained by working together rather than proceeding on many separate tracks. The five key steps proposed in this chapter provide an opportunity for provinces and territories to work with the federal government to improve access to essential prescription drugs, contain costs, protect safety and quality, link pharmaceutical information networks and ensure that, as Canadians, we get the best health outcomes for our rapidly growing investment in prescription drugs.

A Snapshot of Prescription Drugs in Canada

Prescription drugs play an increasingly important role in Canada's health care system. The following sections highlight the expanding role of prescription drugs, disparities in access and coverage across Canada, and the increasing cost of prescription drugs in provincial and territorial health care budgets.

The Expanding Role of Prescription Drugs

To put the role that prescription drugs play in our health care system in context, consider these facts:

- 300 million prescriptions are filled in Canada each year, amounting to about 10 prescriptions for each man, woman or child;
- As shown in Table 9.1, Canadian family spends an average of close to $1,210 a year on prescription drugs. This is a lot of money but a small proportion of Canadians, especially people with chronic illnesses and some elderly people, spend considerably more.

"Evidence strongly suggests that drugs are money well spent. Yet considerable evidence also points to significant waste, and inappropriate prescribing and use."

Canadian Pharmacists Association 2001. Written submission.

Table 9.1
Utilization of Prescriptions, 2001

Average family size	3.0
Prescriptions per person	10.1
Prescriptions per family	30.3
Average prescription price	$39.92
Consumption per family/year	$1,209.58

Source: IMS HEALTH Canada et al. 2002.

Prescription drugs play an important role in two key areas:

- **Treatment of life-threatening, chronic and common illnesses** – Scientists and drug companies continue to develop new prescription drugs that either cure or delay the progress of deadly illnesses. These so-called "miracle drugs" save lives and provide substantial benefits to individual Canadians, but the costs can be very high. While the price of the drugs may come down over time, the fact that they are widely used means that the overall costs continue to be substantial and drive up overall drug budgets.

  Some drugs help treat chronic conditions such as asthma, high blood pressure, coronary heart problems, diabetes, and mental illnesses. People with these chronic illnesses are required to take prescription drugs regularly over extended periods of time, sometimes for their entire lives. The cost of these medications is generally less than the cost of new miracle drugs. However, because they are taken over a longer period of time and by a large number of people, they make up a significant proportion of heath spending. The role of prescription drugs in managing chronic illnesses will increase as our society ages (Morgan and Hurley 2002b). Furthermore, we are now starting to see new, high-cost (and controversial) preventative medications that may delay the onset of debilitating diseases. An example is Interferon Beta 1b for people with multiple sclerosis. The regular use of this drug was estimated to cost $16,685 per person per year (Brown et al. 2000), but its effectiveness remains a matter of some debate.

  Not surprisingly, the most common prescription drugs mirror the most common illnesses in the population. Information from Quebec shows that more than half of all the prescription medications consumed in that province in 2000 were from only six classes of medicines (see Table 9.2), corresponding to some of the most common illnesses in the population – heart disease, gastric and duodenal ulcers, mental illness, and arthritis (Montmarquette 2001).

"When I was diagnosed at the age of two, life-expectancy [for Cystic Fibrosis] was six years. When I graduated from the college of law at the age of thirty-one, life expectancy was thirty-two years. During those intervening years the disease did not change; what did change was the discovery of new treatments for Canadians … Unfortunately universal access is no longer the case … new drugs may or may not be covered in different provinces … We need a uniform drug coverage with universal access for all Canadians."

CHRIS MACLEOD. PRESENTATION AT TORONTO PUBLIC HEARING.

Table 9.2
Increase in Spending for Six Categories of Pharmaceuticals in the Quebec Drug Insurance Program, 1997 to 2000

Categories	Cost ($Millions) 1997	1998	1999	2000	Growth 1997 to 2000 (%)
Lipid reducing agents	105.7	131.0	158.4	189.6	79.3
Anti-hypertensives	111.9	135.2	161.7	193.5	73.0
Anti-inflammatories (analgesics)	60.0	61.3	71.4	119.0	98.3
Psychotropic	69.6	93.7	123.0	150.0	115.4
Gastrointestinal	89.6	108.1	129.7	150.6	68.0
Anti-infectives	82.1	97.9	111.0	120.8	47.2
Subtotal	518.9	627.2	755.2	923.5	78.0
Total drug costs	1,119.4	1,292.8	1,498.4	1,772.2	58.3
Proportion spent on six categories (%)	46.4	48.5	50.4	52.1	

Source: Quebec, MSSS 2001.

- **Substitution for other medical interventions** – Prescription drugs are increasingly used as a substitution for other treatments and medical interventions, including surgery. For example, new medications for treating peptic ulcers mean that surgeries for ulcers have virtually disappeared in the past 15 years (HC 2001g). Certain drugs allow people to be released more quickly from hospital so they can return to their own homes and families rather than staying in hospital. This saves on the cost of hospital stays but results in increased costs for drugs and home care services. Unfortunately, the data are simply not available to allow us to put a dollar figure on these "substitution" costs and to accurately assess how much we are saving in hospital costs by spending more on prescription drugs.

  One of the most dramatic changes has occurred in the field of mental health. Prior to the advent of psychotropic drugs in the 1960s, many individuals with untreatable mental illnesses were hospitalized repeatedly or even indefinitely. Today, these same mental illnesses can often be controlled with prescription drugs, allowing many people to lead full and satisfying lives without recurring hospitalization, particularly if they have adequate support available in their homes and communities.

As the role of prescription drugs in the health care system expands, a number of concerns have been identified.

- The cost of prescription drugs is increasing. Recent data from the United States indicate that the average price of a new speciality drug is two and a half times higher than the price of similar, older medications (NIHCM Foundation 2002).

- While new drugs can make a profound difference, some new prescription drugs are not significantly more effective than older, less expensive drugs in terms of improving survival rates, quality of life of users or patient safety (Garattini and Bertele 2002).
- Existing medications often are put to new use and this increases both the price and the consumption of those drugs. A study in the United States demonstrated that finding new uses for existing medications, with only slight modifications in their ingredients, resulted in a 75% increase in the price of the medications (NIHCM Foundation 2002).
- Prescription drugs are not always used appropriately. In a submission to the Commission, the Canadian Pharmacists Association suggested that "One significant cost driver rarely discussed is the unquantifiable cost to the system of inappropriate drug use. … We know how much we spend … [b]ut we do not know how much we are wasting" (Canadian Pharmacists Association 2002,1). They estimate that the cost of underuse, misuse and overuse could range from $2 to $9 billion a year.
- As more people are treated with drug therapies either in hospital or at home, errors in the prescription and administration of drugs have increased and, in the United States, they are the sixth leading cause of death (Lazarou et al. 1998). Errors that could have been prevented with better information systems and better integration of prescription drug care with the rest of the health care system have been estimated to cost about $10.9 billion a year (Kidney and MacKinnon 2001).

Access to Drugs and Drug Coverage

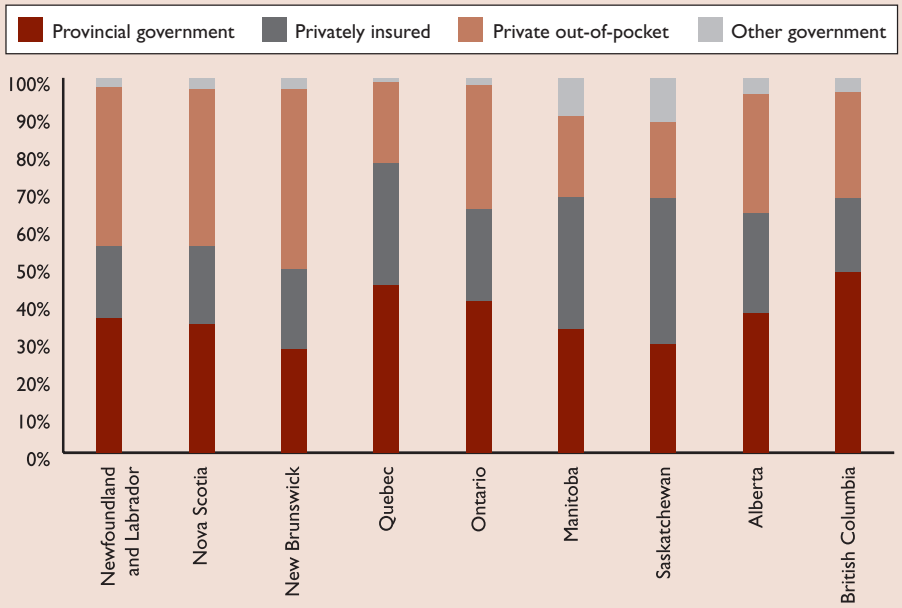
Disparities among the Provinces and Territories

Canada has a fragmented system of drug coverage across the country (Grégoire et al. 2001). To a very large extent, people's income, the kind of job they have, and where they live determine what type of access they have to prescription drugs.

There is considerable variation among provincial plans in terms of who is covered, for what drugs, and what kinds of co-payments or deductibles are required (see Figure 9.1). Provincial plans vary between those that cover a wider range of prescription drugs for a targeted group of people (e.g., seniors and social assistance recipients) and those that provide benefits for a broader range of people but cover a narrower range of drugs and have high co-payments and deductibles in order to limit utilization. There is significantly less coverage for prescription drugs in Atlantic Canada compared to the rest of the country. And provinces with a larger industrialized base tend to have more generous employer-sponsored drug insurance programs while smaller, less industrialized provinces are less likely to have private insurance that covers expenses that are not picked up by the public plan.

Not surprisingly, given the variability in provincial plans, there is extremely limited interprovincial portability of provincial drug plan benefits. When people move from one province to another, they generally lose their drug coverage and have to wait for three months to be eligible in their new province (Applied Management et al. 2000b). In effect, the lack of portability in prescription drug plans can be a barrier to mobility across the country.

Figure 9.1 Coverage of Prescription Drug Expenditures, by Source of Finance, 1999



Note: Data not available for Prince Edward Island, Yukon, Northwest Territories or Nunavut.
Source: CIHI 2002a; Canada, Senate 2002a.

Private and Public Coverage

Canada has a mix of private and public coverage for prescription drugs. The majority of drug costs are covered through employer-sponsored private group insurance plans. Provincial and territorial plans subsidize the cost of prescription drugs for their residents, particularly social assistance recipients and seniors. The federal government provides drug coverage for registered First Nations and eligible Inuit through the Non-Insured Health Benefits Program (NIHB) for drug needs that are not covered by provincial and territorial plans. It also provides prescription drug coverage for members of the Armed Forces and eligible veterans (Applied Management et al. 2000a). This combination of private and public plans determines who has access to prescription drugs, under what conditions, and how much they pay.

Data from the Canadian Institute for Health Information (CIHI 2002a) indicates that in 1999:

- Private insurance plans covered approximately 34% ($3.4 billion) of prescription drug costs;
- Individual Canadians paid 22% ($2.3 billion) of prescription drug costs out of their own pockets;
- Public insurance plans covered approximately 44% ($4.4 billion) of prescription drug costs; and
- The relative share of private spending (56%) versus public spending (44%) has changed little since 1985.

The mix of public and private coverage results in all but a small minority of Canadians having some form of coverage for prescription drugs. However, there are significant disparities in coverage across the country and these disparities could well become worse as provinces and territories face rising costs for prescription drugs.

The Cost of Prescription Drugs

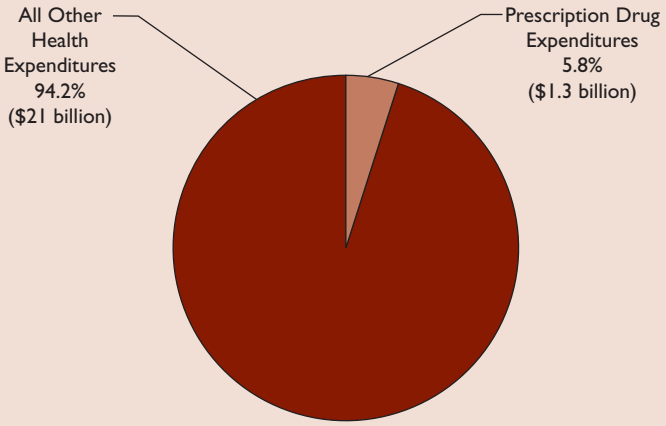
In 1980, $1.3 billion was spent on prescription drugs in Canada, about 5.8% of total spending on health care in the country (see Figure 9.2). By 2001, the percentage had doubled to 12% and the total amount of money spent on prescription drugs had climbed dramatically to $12.3 billion (see Figure 9.3).

There is every reason to believe that the use of prescription drugs will become even more widespread in the future and that costs will continue to increase. Given this reality, provinces and territories will face serious challenges in trying to manage costs on the one hand and ensure reasonable access to medically necessary drugs on the other. Their choices are limited. They can: restrict coverage to a narrower range of drugs; increase deductibles and co-payments; reduce spending in other areas of the health care budget; or find other ways to raise the necessary revenues to pay for increasing drug costs. The first two options – limiting coverage or increasing deductibles – would have a negative impact on a sizeable minority of Canadians that rely on public insurance plans (Applied Management et al. 2000b).

A better option is for provinces and territories to work together to address these issues from a common perspective. By working together, they can:

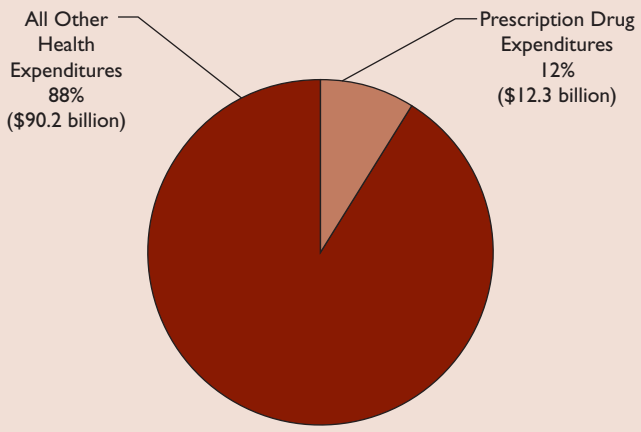
- Ensure that all Canadians have equitable access to medically necessary prescription drugs regardless of where they live or their personal circumstances;
- Ensure the quality and safety of new and existing drugs;
- Manage and contain costs.

Figure 9.2
Prescription Drug Expenditures as a Proportion of Total Health Expenditures, 1980



Source: CIHI 2002a; CIHI 2001e.

Figure 9.3
Prescription Drug Expenditures as a Proportion of Total Health Expenditures, 2001



Source: CIHI 2002a; CIHI 2001e.

Establishing a New Catastrophic Drug Transfer

RECOMMENDATION 36:

The proposed new Catastrophic Drug Transfer should be used to reduce disparities in coverage across the country by covering a portion of the rapidly growing costs of provincial and territorial drug plans.

Canadians with very high prescription drug needs are expected to shoulder a considerable financial burden simply because they were born with a serious illness or are struck by an illness at some point during their lives. In some provinces, programs are in place to provide assistance to cover an individual's or a family's drug costs if they exceed a high deductible. In other provinces, this assistance is not available. Based on what we know about Canadians' values, people's access to necessary prescription drugs should not be determined by where they live.

Through the Catastrophic Drug Transfer, the federal government would provide targeted funding to cover a portion of provincial and territorial drug insurance costs. This is how the new transfer would work.

- The federal government would reimburse 50% of the costs of provincial and territorial drug insurance plans above a threshold of $1,500 per person per year (i.e., the point at which drug expenses for an individual would be considered "catastrophic"). This threshold is roughly equivalent to the deductibles in many of the provinces' drug plans and would cause the least amount of disruption to existing drug insurance plans.

"… drug therapy has to produce definite improvements in patients' quality of life, be accessible, be used cost effectively and do no harm."

Canadian Pharmacists Association 2001. Written submission.

- With the additional funds provided through the Transfer, provinces and territories would be expected to expand access to prescription drugs within their own drug insurance plans by reducing their deductibles or co-payments, or by extending coverage to people who are not now included under their plans.
- The federal Catastrophic Drug Transfer would be based on conditions and reporting requirements jointly agreed to by the federal government and individual provincial and territorial governments.

In order to estimate the potential costs of the Catastrophic Drug Transfer, the Commission asked the Manitoba Centre for Health Policy (MCHP 2002) to provide a detailed analysis of drug costs for the province of Manitoba in recent years. The Manitoba database, which is widely considered to be the most comprehensive database of its kind in Canada, was then used by the Commission to estimate the potential cost of the Catastrophic Drug Transfer on a national basis.

An essential first step was selecting an appropriate threshold for catastrophic coverage. The threshold should be low enough to ensure that real changes are made in the way prescription drugs are covered and integrated into the health care system. On the other hand, if the threshold were too low, the costs would be prohibitively high for the federal government. Taking these considerations into account, a threshold of $1,500 was selected, as noted above.

Based on a threshold of $1,500, the Manitoba data showed that for 2000/01:

- There were 39,878 Manitobans with drug costs in excess of $1,500 a year;
- These people had 2,049,855 prescriptions at an average cost of $54.53 each;
- The average cost of prescriptions for Manitobans that year was $35.08, indicating that people with high drug needs also needed drugs that are more expensive than the average;
- The total cost to the Manitoba Pharmacare plan for these individuals was approximately $112 million or 44% of the total cost ($256 million) of the public plan (MCHP 2002).

A number of factors and assumptions were considered in order to extrapolate the Manitoba data to the rest of the country. Manitoba's formulary is reasonably generous relative to other provinces and territories. The size of the prescription drug market in Manitoba relative to the rest of the country was included in the calculations. An assumption was made that people in other parts of the country with high total drug costs would also pay, on average, more per prescription than people with lower drug costs. And finally, a 15% margin of error was included to account for different patterns of drug use, access and demographics.

Based on these assumptions, the cost of the Transfer could range from $749.1 million to $1.01 billion. To be fiscally prudent, the Commission has chosen to use the higher figure for the Catastrophic Drug Transfer. Using the Manitoba example, of the total costs noted above, the province spent approximately $52 million to provide coverage for people, minus the $1,500 threshold. The Catastrophic Drug Transfer would have covered 50% of these costs, giving Manitoba an additional $26 million to put toward increasing access to prescription drugs.

In addition to providing incentives for provincial and territorial governments to expand access to prescription drugs, the new Catastrophic Drug Transfer would have a number of additional benefits. It would be an important first step in integrating prescription drugs into Canada's health care system because it would allow important information to be collected on how drugs are utilized on a national scale. Perhaps most important to Canadians, the new Catastrophic Drug Transfer would reduce disparities across the country and ensure that, regardless of where people live, they would be protected from the high cost of prescription drugs.

Establishing a National Drug Agency

RECOMMENDATION 37:

A new National Drug Agency should be established to evaluate and approve new prescription drugs, provide ongoing evaluation of existing drugs, negotiate and contain drug prices, and provide comprehensive, objective and accurate information to health care providers and to the public.

Identifying Problems with the Current Approach

The current system for approving new drugs for use in Canada and deciding which prescription drugs are covered in each of the provinces and territories is cumbersome, complex, and time-consuming. Health ministers across the country have acknowledged this problem and, at their September 2002 meeting, agreed to establish a single, common drug review process to streamline drug assessment and decisions about listing drugs on provincial insurance plans. Furthermore, provinces and territories share a common concern about their inability to contain increasing costs or to influence the price of prescription drugs.

The following sections highlight problems with the current processes for addressing the costs of prescription drugs and ensuring their quality and safety.

Addressing the Cost of Drugs

The price of prescription drugs is addressed primarily through the Patented Medicine Prices Review Board (PMPRB), created by the federal government in 1987. At the time the Board was established, Canadian prices for patent drugs were second only to the United States and there was a fear that prices would go even higher as a result of new patent protection laws that extended protection for brand name drugs to 20 years. Since 1987, Canadian prices for patented drugs have dropped in comparison to median prices in other countries and now are less than in the United States (which has the highest prices among OECD countries), Switzerland, the United Kingdom and Germany, but higher than in France, Italy and Sweden (PMPRB 2002). In the case of generic drugs, the federal government does not regulate their prices and the price of generic drugs in Canada is "well above the median foreign prices today" (Critchley 2002, 5).

> *"There should be a national strategy to deal with public expectations and about what is and is not covered – and there should be a ban on advertising.… There should be further study of the apparent over-prescription of pharmaceuticals."*
>
> Standing Committee on Social Programs. Presentation at Yellowknife Public Hearing.

Provinces and territories are concerned with the rising costs of prescription drugs and have taken steps individually and collectively to try to contain costs. The specific approaches range from careful approval of all new drugs to be covered in each province (establishing a "formulary of approved drugs") to the Reference Drug Program in British Columbia. Some provinces have generic drug substitution policies that either permit or require pharmacists to substitute a therapeutically equivalent generic drug for a higher cost brand name product when filling prescriptions. Some have experimented with risk-sharing arrangements with drug companies to limit total expenditures on a new drug and one province used price freezes in order to contain costs.

Individual actions by provinces and territories have had limited success. What is clear is that no single province or territory or the federal government acting alone can hope to control drug costs within its respective part of the health care system. The issues are national in scope and the problems are similar in every part of the country. This is a clear case where the best solution lies in a national approach where provinces, territories and the federal government can share their expertise, streamline processes, and pool their collective influence in addressing drug prices. A National Drug Agency would provide the most effective vehicle for provinces and territories to work together on national strategies for containing drug costs.

Evaluating the Effectiveness of New Drugs

Decisions on whether or not new drugs are safe for use in Canada currently are made by Health Canada. The approval process was developed 40 years ago in the aftermath of the thalidomide tragedy. During the 1990s, several studies highlighted weaknesses in the approval of pharmaceutical products before they are allowed on the market (Krever 1997; Gagnon 1992; Hlynka 1991). Those studies recommended steps to improve the methods and rules for prescription drug approvals. The Gagnon Report, for example, recommended the creation of an independent drug evaluation agency linked to a network of centres of excellence in universities across the country. In 1992, a group appointed by the federal and provincial deputy ministers of Health also recommended the creation of a national agency, independent of Health Canada and other governmental agencies, to undertake the evaluation of new technologies, evaluate prescription drugs that were already on the market, and bring together similar data from other countries (Federal-Provincial Task Force 1992). Provincial and territorial ministers came to a similar conclusion at their meeting in January 2002. And various experts have continued to call for Health Canada to create an independent agency to evaluate and approve prescription drugs (Rawson 2002).

> *"It is important that the system of drug approval be expedited. There should also be post drug approval – because there may be long-term side effects."*
>
> Société canadienne de la sclérose en plaques. Presentation at Montreal Public Hearing.

Why does the Canadian system of pharmaceutical evaluation need to be reformed?

- **The current process has been in place for many years and has resisted frequent attempts to modernize it** – Since the Canadian system was introduced, the key objective was to ensure the safety of drugs before they are approved for use in Canada. The focus is on assessing the risks and benefits of a new prescription drug before it reaches the market based on clinical trials and manufacturing guidelines. This approach is fine in and of itself, but it does not address the fact that problems with new drugs may not be evident until after thousands or even millions of prescriptions have been filled. Furthermore, the process does not compare the efficiency of new prescription drugs to existing drugs on the market or to other therapeutic approaches that could be used. Yet this is critically important information for policymakers and health care providers to guide their decisions on including prescription drugs in insurance plans or in choosing the most effective medication or treatment.

- **Despite much effort by Health Canada, there are significant delays in the drug approval process** – Canada's drug approval process is one of the longest among OECD countries. The median time for drug approvals in Canada in 1995 was 650 days compared to Australia at 562 days, the United States at 464 days, Sweden at 444 days, and the United Kingdom at 439 days. The approval time in Canada fell to 490 days in 1997 but, by 2000, it was back up to 650 days (Rawson 2000). Longer approval times are often attributed to the lack of resources dedicated to delicate and technical work by Health Canada to ensure that the risk of error is virtually non-existent.

  It is important to note that, in spite of the lengthy review process, Canadians are not deprived of access to potentially life-saving medications. Health Canada has introduced a process for "fast-tracking" the approval of drugs intended for treating serious, life-threatening or severely debilitating illnesses or conditions. As of November 1, 2002, the target for screening and review of these drugs is 215 days (HC 2002b). Additionally, Health Canada has a process in place for granting special access to non-approved or experimental drug products and therapies in cases of life-threatening illness where other conventional therapies have failed or where no comparable drug is approved for use in Canada (HC 2002c).

  With a growing number of new prescription drug discoveries, the pressures on the existing process will only increase. Furthermore, genomics and biotechnology are bringing more and more advances to the forefront. Each of these new developments will not only have to be evaluated from a clinical perspective but also will be subject to intense ethical and political debate over the appropriate and inappropriate use of reproductive technologies, genetic testing and cloning.
- **The role of pharmaceutical companies in the evaluation process needs to be addressed** – Pharmaceutical companies complain about bottlenecks in the federal government's regulatory process. They argue that the current process curbs innovation and delays not only the introduction of new patent medicines but also the eventual introduction of generic drugs. Their frustration is heightened by the fact that pharmaceutical companies currently cover 82% of the costs of the evaluation process for drugs aimed at the Canadian market. Not surprisingly, if they are paying the majority of the costs, they want a quicker process in place. Some have suggested that a more direct link should be established between their payment for evaluations and the performance of the evaluation system. The problem is that this would create an inevitable "conflict of interest" for the agency doing the evaluation in that their budgets would be determined by their ability to meet the expectations of pharmaceutical companies for timely drug approvals. Recent controversies in the United States over the relationship between the Food and Drug Administration and the pharmaceutical industry indicate that even a system with strong safeguards can sometimes be seen to be too close to the drug industry (Moynihan 2002).

Roles, Responsibilities and Funding of the National Drug Agency

All of these issues can and should be addressed through the proposed new National Drug Agency. The Agency would be established as a federal agency with federal regulatory powers, operate independently from Health Canada, and report directly to Parliament. It should build on

the expertise currently in place in the federal government and the provinces as well as university-based centres of excellence such as the proposed *Centre for Innovation on Pharmaceutical Policy* outlined in Chapter 3.

The National Drug Agency should be responsible for:

- Negotiating, analyzing and monitoring drug pricing by both brand name and generic drug manufacturers and providing information about drug pricing in Canada and abroad;
- Efficiently reviewing clinical research and approving new drugs and vaccines for use in Canada and collaborating with similar agencies in other industrialized countries;
- Engaging in pharmaco-surveillance and assessing outcomes;
- Providing pharmaco-economic evaluations of drugs already on the market;
- Developing an early warning system to deal with expensive new drugs, including the products of advanced genetic technologies;
- Establishing and managing a common national drug formulary to ensure that decisions on including or excluding particular drugs are based on the best available clinical, pharmacological and economic evidence;
- Collecting and disseminating information related to prescribing practices and the utilization of prescription drugs in Canada as part of an effort to improve the overall process of clinical and economic evaluation;
- Ongoing monitoring and review of industry practice related to patent protection legislation;
- Disseminating objective and reliable knowledge and information to health professionals and the public;
- Developing the guidelines and purchasing vaccines for a new national immunization strategy (outlined in Chapter 5).

One of the critical roles of the National Drug Agency involves negotiating and monitoring drug prices. The Agency would be responsible for leading negotiations with pharmaceutical companies and handling bulk purchase agreements in an effort to ensure that the price of prescription drugs can be contained. Its role in scrutinizing drug prices would apply to both brand name and generic drugs as well as vaccines and some over-the-counter medications. With changes in the international marketplace for drugs, the National Drug Agency will need to develop new methods for evaluating drug prices and reporting to governments and to Canadians. Information on the price of drugs and the possible relationship of those prices to patent protection will inform and help guide Canada's international efforts to ensure that pharmaceutical prices are not allowed to grow unchecked.

"We are concerned that some pharmaceutical companies spend more of their budgets on marketing than on research and development. This makes us wonder if the drugs we are getting are really the best for us, or simply the ones with the best ad campaign."

EDMONTON HIGHLANDS HEALTH CARE ACTION GROUP 2002. WRITTEN SUBMISSION.

Another important role of the National Drug Agency is to communicate evidence-based information and guidance to both health professionals and to patients, using various media including the Internet. This relates directly to recommendations earlier in this report on introducing electronic health records and establishing a comprehensive source of electronic health information. There is no doubt that the public wants more information about drugs and their effectiveness. Rather than leave this to pharmaceutical companies, the National Drug Agency could

meet this need by providing balanced, objective information in an accessible manner. This is a much better approach than direct-to-consumer advertising in place in the United States. This type of advertising is a major business in the United States and it has been shown to affect patients' requests for drugs. Studies suggest that since restrictions on direct-to-consumer advertising in the United States were relaxed in 1997, nearly $3 billion have been spent each year on advertising drugs to American consumers (Morgan and Hurley 2002a). The federal government should continue to prohibit direct-to-consumer advertising of prescription drugs in Canada. The role of informing Canadians is better served by the National Drug Agency acting in the public interest.

The new agency should include the price control functions of the Patented Medicine Prices Review Board, but be expanded beyond patented drugs to include generic prescription drugs as well in order to ensure that the price of *all* prescription drugs is fair to consumers. It also should include all the perscription drug analysis, surveillance, approval and pharmaco-surveillance functions currently undertaken by Health Canada. Rather than creating a huge new bureaucracy, the Agency should work with a network of experts and centres of excellence across the country. This approach has achieved impressive results in Australia where expert committees oversaw the approval process, the registration of new drugs on the national formulary, and post-market clinical and economic evaluations (Birkett et al. 2001).

In terms of funding for the National Drug Agency, the current budgets of the federal bodies to be integrated into the Agency should be sufficient to ensure its viability, considering the economies of scale that can be achieved. The Agency would continue to receive funding from the pharmaceutical industry for drug approvals, but the Commission strongly believes that the industry's contribution should not be directly tied to paying for any particular service. In effect, a "firewall" must be established between the industry's financial contribution and the Agency's work. Very stringent guidelines for pharmaceutical industry contributions should be in place to ensure the Agency's independence from the industry it regulates.

Benefits of a National Drug Agency

A National Drug Agency would provide a number of important benefits.

- Decisions about adding prescription drugs to public insurance plans would be guided by consistent principles. These include: ensuring that prescription drugs provide real benefits; they are safe; they are used efficiently; and that there are measurable clinical and economic advantages in choosing one drug over another. It also would ensure that health professionals and patients have objective and understandable information to guide their choices about treatments and drugs.
- The drug evaluation and approval process would be streamlined. This is particularly important as the demand for evaluations grows as a result of new discoveries and developments. A National Drug Agency would also be able to collaborate with other similar agencies in industrialized countries to streamline the evaluation process and share information on the evaluation of new and existing drugs.
- Assessments of new drugs would address a number of factors in addition to clinical safety. Clinical concerns – such as the physiological effect of the medicine, the comfort it provides to patients, its side effects, potential interactions with other medicines and so on – need to be addressed. But economic concerns also are important, especially the relative cost of the medicine compared to other medicines and even with other therapeutic approaches.

- The cost and use of prescription drugs could be contained by systematically evaluating new and existing prescription drugs and sharing that information broadly within the health care system. Lessons learned about the use of particular drugs in real situations could also be fed back into the process of approval, evaluation and dissemination and assist in the development of guidelines for use of prescription drugs. In the final analysis, drugs should be approved for use and coverage in the health care system solely on the basis of their effectiveness or efficiency, not simply because they are new or because pharmaceutical companies have invested a lot in their development.
- Combining the approval, evaluation and dissemination functions into a single National Drug Agency would provide for significantly better use of both people and dollars. It also means that resources could be used not only to review and approve new drugs, but also to evaluate drugs that are already on the market and to disseminate information more widely than has been possible in the past.
- The process would not only speed up the review and approval of new prescription drugs but also streamline the introduction of generic drugs.
- A National Drug Agency would provide governments more leverage with pharmaceutical companies in order to try to constrain the ever-increasing cost of drugs. In relation to other countries, Canada has never been a major player in the international pharmaceutical trade and our ability to influence or contain prices for prescription drugs is severely limited. This situation is made even worse by the fact that there currently is no national mechanism in place for dealing with the approval of drugs or their use across Canada. A National Drug Agency would combine the forces of the provinces, territories and the federal government and increase our ability to influence the policies of major pharmaceutical companies. As noted in Chapter 11, Canada should work with other countries to contain costs on an international basis.

"Surely there must be a way … for us to be able to purchase drugs in a collective way rather than in thirteen different ways."

CONGRESS OF UNION RETIREES OF CANADA. PRESENTATION AT OTTAWA PUBLIC HEARING.

Traditionally, assessments of the efficiency of a particular drug have been left in the hands of individual physicians. For example, many Canadian parents have received prescriptions for antibiotics for the treatment of common ear infections for their children. To make a decision on the best course of action, their doctor had to consider the age of the child, the number of recurrences of the infection, the advantage of certain dosages or drugs over others and also, in more extreme cases, the advantages of surgery. The doctor may choose to prescribe painkillers or antibiotics depending on the child's condition. But he or she might also have had to consider whether the parents could afford the prescription and whether they had coverage under provincial or employer plans.

Relying on physicians to make these complex assessments may have been an effective strategy in the past, but given the scope of new medications on the market today and anticipated in the future, relying on physicians alone to make these decisions is no longer appropriate or realistic. Consider these facts.

- According to Health Canada's drug product database there were almost 22,000 drug products available on the market in Canada in 1999 for human use. Of these drug products, approximately 5,200 are prescription drugs, excluding biologic drug products

and those drugs considered controlled substances (PMPRB 2000). In 2001, 82 new patented drug products were introduced, an average of 1 new product every 4.5 days (PMPRB 2002). This is a dramatic increase over 1996 when only 21 new products were introduced, an average of 1 every 17 days (PMPRB 1997).

- Certain side effects associated with new medications are so rare or only occur in combination with other medications that they are not discovered in the clinical trials and do not become apparent until the medications have been widely prescribed in the general population.
- The increasing number and use of prescription drugs multiplies the risk of potentially dangerous drug interactions.

On top of these concerns, patients increasingly want to play an active role in decisions about their own treatments. It is difficult for physicians to be the only or the primary source of information on prescription drugs. Physicians also deal with individual patients on a case-by-case basis and may not necessarily consider the option of providing a less expensive but equally effective medication unless they have reliable guidelines in place.

It is important, then, to ensure that physicians, patients, insurers and governments have access to understandable and sophisticated information on the economic effects of particular drugs and prescribing practices. This information, provided by the National Drug Agency, would allow:

- Clinicians to make decisions in the best interest of their patients (to prescribe the most appropriate medicine, taking into account the available knowledge, on the one hand, and the medical history of the patient, on the other);
- Patients to participate in decisions in an informed way or at least to understand the benefits and risks associated with the medicine that is prescribed;
- Pharmacists to be able to understand the rationale for the prescription and to advise patients accordingly;
- Administrators of insurance plans or managers of public drug plans to be assured that the best possible choices are made among a range of equivalent medicines.

Establishing a National Formulary

RECOMMENDATION 38:

Working collaboratively with the provinces and territories, the National Drug Agency should create a national prescription drug formulary based on a transparent and accountable evaluation and priority-setting process.

Currently, each province and territory maintains a "formulary" of approved drugs – a list of drugs it covers as part of its drug insurance plan. Private insurers in each province or territory often base their coverage on the formulary of approved drugs in each jurisdiction. Because of the impact of decisions to list drugs on the formulary, pharmaceutical companies and various interest groups often lobby provincial and territorial governments to ensure that certain drugs are included on their respective drug formularies.

Aside from the resulting patchwork of coverage across the country (with different provinces covering different prescription drugs) there are two other significant problems with this

approach. First, it means that individual provinces and territories are faced with powerful lobbying activities from the pharmaceutical industry and other interest groups to have "their drug" placed on the formulary. This can result in some drugs being included on formularies for reasons other than their effectiveness. Decisions made in one province can also have a ripple effect and increase pressure on other provinces to make similar decisions. Second, it limits the ability of each government to negotiate price and volume discounts with manufacturers because no single province has a large enough market share to influence the price.

A national formulary of approved drugs would:

- Be based on a transparent and accountable evaluation and priority-setting process including rigorous pharmaco-economic evaluations;
- Give the National Drug Agency more power to negotiate prices with pharmaceutical companies on behalf of the provinces and territories; and,
- Establish a national list of prescription drugs to be covered in Canada in order to reduce both the disparities across the country and the pressures faced by individual provinces and territories to cover new prescription drugs.

Developing and maintaining a national drug formulary should be a key responsibility of the proposed new National Drug Agency. The Agency would be responsible for evaluating drugs and negotiating a national formulary with the provinces and territories on an ongoing basis.

Integrating Prescription Drugs into the Health Care System

RECOMMENDATION 39:

A new program on medication management should be established to assist Canadians with chronic and some life-threatening illnesses. The program should be integrated with primary health care approaches across the country.

RECOMMENDATION 40:

The National Drug Agency should develop standards for the collection and dissemination of prescription drug data on drug utilization and outcomes.

Medication Management and Primary Health Care

With a national formulary in place, the next important step is to link medication management to primary health care. Guidelines should be established to move in stages to a more comprehensive medication management program within five years.

The objective of a medication management program is to make a clear link between individuals' use of prescription drugs and primary health care. As noted earlier in this report, primary health care is a vital component of our vision for Canada's health care system. Integration of prescription drugs with primary health care can best be accomplished as part of a "health management approach" in which individuals' health is monitored by a team or network of health care providers working with the individuals themselves. For people with chronic health care conditions such as diabetes, for example, it means that they would have access to a range of

health care providers such as physicians, nurses, dieticians, pharmacists, and counsellors working together to monitor and help them manage their health. Part of that management would be the effective use of prescription drugs and other medications.

It also means that pharmacists can play an increasingly important role as part of the primary health care team, working with patients to ensure they are using medications appropriately and providing information to both physicians and patients about the effectiveness and appropriateness of certain drugs for certain conditions. This expanded role would allow pharmacists to consult with physicians and patients, monitor patients' use of drugs and provide better information and communication on prescription drugs. In the future, there may also be a role for pharmacists who are not engaged in the retail sale of prescription drugs to prescribe certain drugs under specific, limited conditions.

> *"This [costs/benefits of alternatives, in a medication strategy] would permit health professionals, and particularly pharmacists, to promote the proper use of medication more effectively."*
>
> Association québecoise des pharmaciens propriétaires du Québec. Presentation at Québec City Public Hearing.

Under current drug insurance plans, evidence suggests that costs have a direct impact on whether or not people comply with their prescriptions. For example, people may stop taking both essential and non-essential medications when they are faced with onerous co-payments, deductibles or co-insurance (Adams et al. 2001; Tamblyn et al. 2001; Soumerai et al. 1993). People with lower incomes are most affected by these out-of-pocket charges (Kozyrskyj et al. 2001). If people refuse to take necessary drugs because of the costs, it affects not only the individuals involved but also their families, their communities, and the overall health of the population. It also can increase costs in the longer term. For certain conditions, such as the treatment of mental illness or the management of chronic health conditions, a failure to take or to keep taking medications can have serious negative consequences, including repeated hospitalization. Through a medication management program, people would be linked to a primary health care team and the likelihood of inappropriate or incomplete use of prescription drugs would be reduced.

The proposed medication management program should be based on rigorous standards and protocols. In the first instance, it should cover chronic conditions such as arthritis, diabetes and mental illness, and life-threatening conditions such as cardiovascular disease and cancer. Consideration should also be given to providing coverage for elderly people because of the serious consequences to their health if they do not take their medications because of the costs. Over time, the medication management program could be expanded to include pre- and post-surgical drug therapies as part of a more global approach to primary health care.

How would this type of medication management drug program work?

- The federal government would expand the Catastrophic Drug Transfer to include the medication management program.
- The expanded transfer would reimburse provinces and territories for the cost of drugs used in a prescription management program provided that the drugs are on a national formulary and proven to be effective in treating a particular illness, disease or condition.
- Disease management protocols would be in place and would guide decisions about the prescriptions a patient receives.
- Incentives would be introduced to ensure access to essential prescription drugs and the selection of cost-effective products while, at the same time, providing some flexibility for both prescribers and patients.

Collecting and Sharing Information

Another important step is to link information on prescription drugs with primary health care and ongoing health research. National standards should be set for collecting data on drug utilization and outcomes while preserving personal privacy. The data should be "linkable" to existing health research databases and made available for use in policy-related research, particularly focusing on drugs that are available in the marketplace. Steps should also be taken to ensure that the information can be integrated with electronic patient records and electronic prescribing tools. As outlined in Chapter 3, electronic health records are an important way of tracking health information and ensuring that complete and accurate information is available to health care providers and individual Canadians. This is particularly important in prescription management programs where electronic health records would allow members of a primary health care team to monitor and assess the effectiveness and outcomes of prescription drugs for individual patients.

Developing comparable and comprehensive information is essential for a number of purposes. It would provide a base of information to use in national evaluations of the safety of new and existing prescription drugs. It would provide information to health authorities, provinces and territories to guide their decisions on the best "basket" of drugs to be covered. It also would give health care providers and individual patients access to the best available evidence on certain drugs and guide their choices of the right medication for the patient's particular health needs.

Reviewing Aspects of Patent Protection

RECOMMENDATION 41:

The federal government should immediately review the pharmaceutical industry practices related to patent protection, specifically, the practices of *evergreening* and the notice of compliance regulations. This review should ensure that there is an appropriate balance between the protection of intellectual property and the need to contain costs and provide Canadians with improved access to non-patented prescription drugs.

Like other manufactured goods, new prescription drugs are protected by patents. In the case of prescription drugs, current patent laws guarantee exclusive access to the Canadian market for 20 years. This extensive protection for new prescription drugs remains a matter of considerable debate despite the fact that it has become the international norm. On the one hand, it protects the intellectual property of pharmaceutical companies and helps offset the considerable investment they make in researching and developing new drugs. On the other hand, it delays the introduction of lower cost generic drugs.

During the Commission's public hearings, many people pointed to extensive patent protection as one of the reasons why drug costs are high. In fact, as noted earlier, patented medicines are cheaper on average in Canada than in other jurisdictions, particularly the United States, although recent reports suggest that this cost advantage is shrinking (PMPRB 2002).

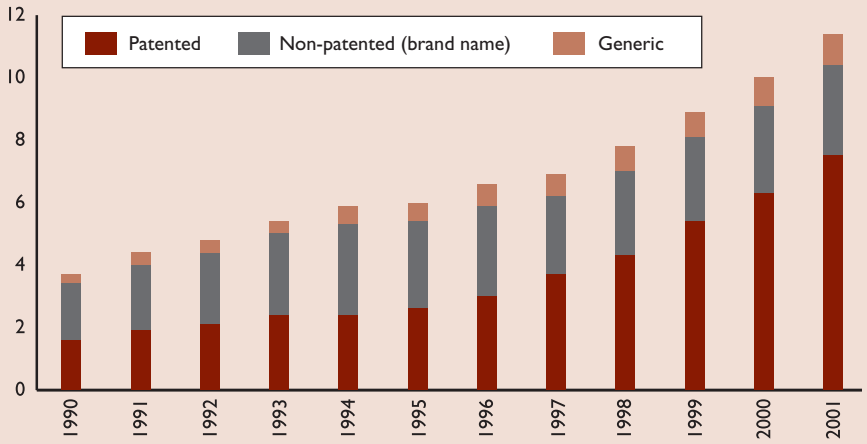
While some may suggest that Canadian drug patent legislation is a key obstacle to controlling drug prices, in fact, Canadian legislation is in line with international standards. Furthermore, there is no empirical evidence to suggest that Canada's patent protection laws are responsible for increasing drug prices.

A particular concern with current pharmaceutical industry practice is the process of "evergreening," where manufacturers of brand name drugs make variations to existing drugs in order to extend their patent coverage. This delays the ability of generic manufacturers to develop cheaper products for the marketplace and it is a questionable outcome of Canada's patent law.

Furthermore, regulations under the patent law require generic drug manufacturers to demonstrate that their product is not infringing on a patent held by another drug manufacturer rather than putting the onus on the patent drug manufacturer to show that their patent has been infringed – what is referred to as the notice of compliance regulations. Suggestions have been made that this leads to "pre-emptory" lawsuits from patented drug manufacturers as a way of delaying the approval of generic drugs. Clearly, if this is the case, the practice is not in the public interest. The federal government should review this issue, determine what constitutes a legitimate extension of patent protection, and also consider ways of streamlining the approval of generic drugs (see Figure 9.4).

Looking ahead, there will be a number of important challenges for Canada's patent laws to address. One of the most controversial issues relates to gene patenting. Canada's current patent law does not specifically prevent patenting of human genes, DNA sequences and cell lines. This issue has sparked considerable debate not only in Canada but also around the world (Ontario 2002). Canada's Premiers addressed this issue in January 2002. They expressed concerns about the need for the right protections and safeguards to be in place and agreed to work together on a co-ordinated framework. The Premiers called for federal action to review these issues as well as the implications for the *Patent Act*. The Commission supports the Premiers' view that the federal government should review the current provisions of the patent law in relation to the issue of patenting of genes and DNA.

Figure 9.4 Manufacturers' Sales ($Billions) of Patented and Non-Patented Drugs, 1990 to 2001



Source: PMPRB 2002.

What Does This Mean for Canadians?

Prescription drugs play a growing and essential role in Canada's health care system and the health of Canadians. They are a vital component of the health care system and that reality should be reflected in how we fund, cover and ensure access to quality, safe and cost-effective prescription drugs.

With the recommendations in this chapter, disparities across the country in coverage for the high cost of prescription drugs will be reduced and eventually eliminated. That means Canadians can move from one part of the country to the next and know that they will receive similar coverage. It also means that coverage against the catastrophic costs of prescription drugs will not depend on where people live or their incomes. With this essential step in place, further action can be taken to integrate prescription drugs with the care people get through primary health care approaches across the country. For an increasing number of Canadians with chronic illnesses and health conditions, this will be a welcome addition and an important step in ensuring they get the best outcomes from their prescription drugs.

Finally, Canadians can be assured that the safety and quality of the drugs they use will be safeguarded by a new National Drug Agency. And through the combined efforts of the Agency and provinces and territories, important steps can be taken to ensure that we get the best outcomes for our substantial and growing investment in prescription drugs.

10 A New Approach to Aboriginal Health

Directions for Change

- ***Consolidate Aboriginal health funding from all sources and use the funds to support the creation of Aboriginal Health Partnerships to manage and organize health services for Aboriginal peoples and promote Aboriginal health.***
- ***Establish a clear structure and mandate for Aboriginal Health Partnerships to use the funding to address the specific health needs of their populations, improve access to all levels of health care services, recruit new Aboriginal health care providers, and increase training for non-Aboriginal health care providers.***
- ***Ensure ongoing input from Aboriginal peoples into the direction and design of health care services in their communities.***

The Case for Change

The future of Canada's health care system must reflect the values, needs and expectations of all Canadians, including Canada's Aboriginal peoples. The poor health status of Canada's Aboriginal peoples is a well-known fact and a serious concern not only to Aboriginal peoples but also to all Canadians. The situation is simply unacceptable and must be addressed.

Aboriginal health issues have been studied in greater detail by other commissions and committees, including the Royal Commission on Aboriginal Peoples (RCAP). In spite of these various studies and a number of initiatives underway in every province and territory, the fact remains that there are deep and continuing disparities between Aboriginal and non-Aboriginal Canadians both in their overall health and in their ability to access health care services. The reasons for this are complex and relate to a number of different factors, many of which have less to do with health and more to do with social conditions.

To understand the various issues and to hear directly from Aboriginal peoples, the Commission worked with the National Aboriginal Health Organization (NAHO 2002) to host a national forum on Aboriginal health issues. People from First Nations, Metis, Inuit and urban Aboriginal communities came together to share their success stories, their challenges, and their views on the future of health care.

From these discussions and consultations, it is clear that a new approach is needed – one that tackles the root causes of health problems for Aboriginal peoples, cuts across administrative and jurisdictional barriers, and focuses squarely on improving the health of Aboriginal peoples. Specifically, actions must be taken to:

- Consolidate fragmented funding for Aboriginal health to take the best advantage of the total potential funds available in order to improve health and health care for Aboriginal peoples;
- Create new models to co-ordinate and deliver health care services and ensure that Aboriginal health care needs are addressed;
- Adapt health programs and services to the cultural, social, economic and political circumstances unique to different Aboriginal groups; and
- Give Aboriginal peoples a direct voice in how health care services are designed and delivered.

Addressing the Aboriginal "Disconnect"

In fundamental terms, there is a "disconnect" between Aboriginal peoples and the rest of Canadian society, particularly when it comes to sharing many of the benefits of Canada's health care system. There are at least five underlying reasons for this disconnect:

- Competing constitutional assumptions
- Fragmented funding for health services
- Inadequate access to health care services
- Poorer health outcomes
- Different cultural and political influences

Constitutional Assumptions

There are conflicting views about constitutional responsibilities for Aboriginal health care and the result is a confusing mix of federal, provincial and territorial programs and services as well as services provided directly by some Aboriginal communities.

The Canadian government is responsible for funding and organizing services for some groups of Aboriginal peoples, primarily those First Nations and Inuit people living on reserves. According to the federal government, however, there is no constitutional obligation or treaty that requires the Canadian government to offer health programs or services to Aboriginal peoples. As a result, the federal government limits its responsibility to being the "payer of last resort." A 1974 ministerial policy statement describes federal responsibility for Aboriginal health issues as voluntary, aimed at ensuring "the availability of services by providing it directly where normal services [were] not available and giving financial assistance to indigent Indians to pay for necessary services when the assistance [was] not otherwise provided" (Canada. Health and Welfare 1974). This continues to be the position of the federal government.

Aboriginal peoples do not share the federal government's view. They link federal health programs to statutory or treaty obligations or, more broadly, to the trustee role of the federal government (AFN 2002; Ahenakew and Sanderson 2001; APNQL 1999). This understanding was most clearly and comprehensively put forward in the final report of the RCAP in the mid-1990s.

For many years now, a process has been underway for transferring certain responsibilities for managing and delivering health services, especially community health and primary health care services, from Health Canada to Aboriginal communities (see Table 10.1). As of 2001, 82% of eligible First Nations and Inuit communities have, or are in the process of, transferring responsibility, with 46% having signed transfer agreements (FNIHB 2001). The communities that have assumed responsibility for health services have had the opportunity "to test their own capacity to manage programs and eliminate cultural and linguistic barriers in the delivery of health care services" (Favel-King 1993). This transfer of control is sometimes seen as an intermediate step toward self-government (Read 1995).

> *"… there are federal and provincial jurisdictional issues and we are the shuttle in the badminton game back and forth."*
>
> NAHO 2002. Dialogue on Aboriginal Health: Sharing Our Challenges and Our Successes.

Table 10.1
First Nations and Inuit Health – Transfer Payment – 2001/02

	2001/02 Main Estimates
Contributions for integrated Indian and Inuit community-based health care services	$ 291,493,000
Payment to Indian bands, associations or groups for the control and provision of health services	$ 161,349,000
Contribution to support pilot projects to assess options for transferring the Non-Insured Health Benefits Program to First Nations and Inuit control	$ 24,000,000
Contributions to Indian bands, Indian and Inuit associations or groups or local governments and the territorial governments for non-insured health services	$ 83,761,000
Payments to the Aboriginal Health Institute/Centre for the Advancement of Aboriginal Peoples' Health	$ 7,500,000
Contributions for First Nations and Inuit health promotion and prevention projects and for developmental projects to support First Nations and Inuit control of health services	$ 29,037,000
Contributions to universities, colleges and other organizations to increase the participation of Indian and Inuit students in academic programs leading to professional health careers	$ 2,992,000
Contributions to the Government of Newfoundland toward the cost of health care delivery to Indian and Inuit communities	$ 583,000
Contributions to Indian and Inuit associations or groups for consultations on Indian and Inuit health	$ 979,000
Contributions on behalf of, or to, Indians or Inuit toward the cost of construction, extension or renovation of hospitals and other health care delivery facilities and institutions as well as of hospital and health care equipment	$ 1,413,000
Contributions toward the Aboriginal Head Start On-Reserve Program	$ 22,500,000
Total contributions	$ 625,607,000

Source: Canada. Treasury Board Secretariat 2002.

The transfer of health and health care responsibilities to Aboriginal communities is an important objective. However, it also is a cause for concern. Some fear that the end result will be federal government withdrawal from its historical commitment to protect the health of Aboriginal peoples (Waldram et al. 1995; Weaver 1986). Others criticize the policy for failing to consider emerging needs (O'Neil 1995).

The Auditor General of Canada (2000) has repeatedly questioned the appropriateness of transferring responsibilities to Aboriginal communities because they are not directly accountable to Parliament for how the funds are used and there are no requirements in place to assess whether the organizations receiving the funds are able to manage them appropriately. Other concerns relate to the fact that funding can be transferred, but it is difficult to transfer knowledge and experience in addressing a variety of health care issues "on the ground." It will take time for communities to develop experience and networks of contacts to solve specific health problems. Because of this, the success of the transfer of responsibility will depend, in part, on whether communities can be supported long enough so that they can build the necessary experience and networks of contacts and supports.

Health Canada indicated to the Auditor General of Canada (2000) that while the transfer initiative allows First Nations and Inuit to take charge of community-based services, its aim is not to modify the general approach to health problems. And because the transfer policy is directed primarily at residents of reserve-based communities, it does not provide solutions for problems faced by urban Aboriginals, even though their numbers are growing and their health problems are more evident. In fact, in 1996, at least 5 out of 10 Aboriginals lived in urban communities.

Not surprisingly, Aboriginal representatives in Canada do not speak with a single voice on the issue of the transfer of responsibility for health care. The diversity of interests, needs and capacities among Aboriginal communities and organizations leads to different views of how the delivery of Aboriginal health services should be organized. The Commission heard calls for greater federal, provincial and territorial collaboration with Aboriginal communities. Conversely, there also were calls for the provinces to stay out of delivery of services since it was the federal government's responsibility to deal with these issues on a one-to-one basis with Aboriginal peoples. The one common thread was a consistent call for more active participation of Aboriginal peoples, communities and organizations in deciding what services are delivered and how.

Funding for Health Services

Given the complexities of constitutional and governance issues, it comes as no surprise that funding for health services for Aboriginal peoples is equally complex.

Federal funding supports three types of health programs and initiatives (see Table 10.2):

- Public or community health programs;
- National initiatives that are directed at health and health-related issues such as the Aboriginal Diabetes Initiative and the National Native Alcohol and Drug Abuse Program. These initiatives vary according to where they are delivered and the characteristics of the population they are intended to serve; and,
- Individual funding that provides support for prescription drugs, dental and vision care, and transporting patients to and from specific health care services.

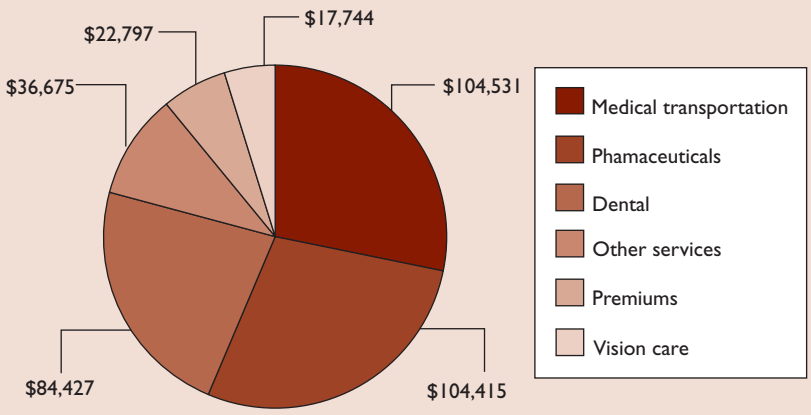
Table 10.2
Program Coverage for Different Aboriginal Populations in Canada, 1999/2000

	First Nations on Reserve	Inuit in Inuit Settlement/Community	First Nations (On/Off Reserve)	Inuit (On/Off Settlement)	Metis	All Aboriginal Peoples (On/Off Reserve + Status, Non-status)
Addiction						
National Native Alcohol and Drug Abuse Program – Residential Treatment Program	X	X	X	X		
National Native Alcohol and Drug Abuse Program – Community-based Program			X			
Solvent Abuse Program	X	X	X	X		
Tobacco Control Strategy	X	X				
Children						
Aboriginal "Head Start"	X					
Canada Prenatal Nutrition Program	X	X				
FAS/FAE Initiative (Foetal Alcohol Syndrome)	X	X				
Chronic Disease						
Aboriginal Diabetes Initiatives – Care, Treatment, Lifestyle Support	X (+ Community north of 60)	X				
Aboriginal Diabetes Initiatives – Primary Prevention and Promotion	X	X	X	X	X	X
Communicable Disease						
Communicable Disease Control	X (+ Individuals living on reserve)					
HIV/AIDS Strategy	X			X (Inuit in Labrador)		
Tuberculosis Elimination Strategy	X			X (Northern Quebec & Labrador)		
Community Health Services						
Brighter Futures (Mental Health, Child Development, Healthy Babies, Injury Prevention, Parenting Skills)	X	X				
Building Healthy Community (Mental Crisis Intervention)	X	X				
Community Health Prevention and Promotion (Maternal, Child Health, School Health, Adolescent Health, Adult Health, Elder Health)	X	X				
Community Health Primary Care (Emergency Care, Non-urgent Care)	X (Services may be provided to non-First Nations clients where these services are not otherwise readily available)	X (Services may be provided to non-First Nations clients where these services are not otherwise readily available)				
Community Nutrition						
Dental/Oral Health Strategy (National School of Dental Therapy, Oral Health Promotion and Prevention)	X (+ Innu people)	X				
First Nations and Inuit Home and Community Care Program	X (+ First Nations community north of 60)	X				
Capacity Development						
Health Careers (Bursaries and Scholarship, Community-based Activities)	X	X	X	X	X	X
Non-insured Health Benefits						
(Dental Health, Medical Transportation, Drugs, Medical Supplies and Equipment, Vision Care, Mental Health)	X	X (+ Recognized Innu)	X	X (Recognized Inuit)		

Source: Health Canada 2001c.

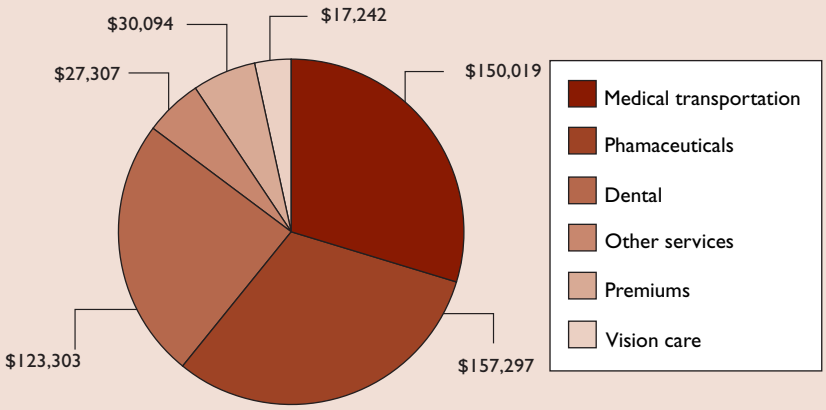
As of March 2001, the total amount of federal funding for health under direct First Nations and Inuit control amounted to $588.6 million, with 31% of that ($182.5 million) covered by transfer agreements (FNIHB 2001) (see Figures 10.1, 10.2 and 10.3). A large proportion of that funding goes to individuals through the Non-Insured Health Benefits (NIHB) program. This program functions like an insurance plan rather than as part of an integrated health care system for Aboriginal peoples. The Auditor General of Canada (1997) has commented that the current scheme encourages both patients and providers to "over-consume" care. Mechanisms are in place to control administration and assess compliance, but there are no mechanisms to encourage more effective care or to change the behaviour of either patients or providers. Prevention programs or health education, for example, are not a part of this program.

Figure 10.1
NIHB Annual Expenditures by Benefit ($Millions), 1991/92



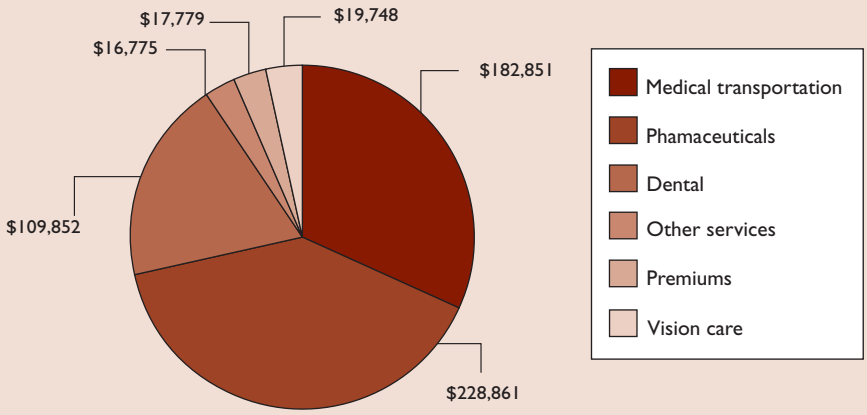
Source: Health Canada 2001h.

Figure 10.2
NIHB Annual Expenditures by Benefit ($Millions), 1995/96



Source: Health Canada 2001h.

Figure 10.3
NIHB Annual Expenditures by Benefit ($Millions), 2000/01



Source: Health Canada 2001h.

In addition to federal programs, Aboriginal peoples most often rely on hospital and medical care available in their home province and benefit from these services in the same way as other residents. However, the federal government does not compensate provinces for providing health services to Aboriginal peoples except under some specific local agreements. The costs of these services are not specifically accounted for, but recent estimates suggest they could be as high as 80% of the average health care costs of the population of a province. Information from Saskatchewan suggests that combined federal and provincial per capita health expenditures for First Nations people in that province are almost double the provincial average. This is consistent with findings from the Manitoba Centre for Health Policy's in-depth inquiry done in partnership with the Manitoba First Nations (Martens et al. 2002).

For a number of reasons, the current funding situation is confusing and unsatisfactory.

- Not all Aboriginal peoples have equal access to programs and services offered by the federal government. Benefits vary according to where people live (i.e., on or off reserve), how they are identified (e.g., First Nations, Inuit or Metis) and their legal status as treaty or non-treaty. This leads to growing dissatisfaction among Aboriginal peoples who are not eligible for federal programs.
- The fact that certain federal programs appear to be more generous than similar provincial programs is often an irritant to neighbouring non-Aboriginal communities. They view the differences in access to federal and provincial programs as a breach of equity.
- Funding for Aboriginal health services is scattered among federal, provincial and territorial governments, and Aboriginal organizations. This makes it difficult to co-ordinate and get the maximum benefit for the amount of funding available. Studies suggest that the problem is not the level of funding for health care services but rather the fragmentation of funding, which in turn leads to poorly co-ordinated programs and services. As the Manitoba Centre for Health Policy suggests:

> R[egistered] F[irst] N[ations] people make high use of health care services. They average one more visit per year to a physician than other Manitobans. They also average twice the hospitalization rate and 1.7 times the total days in hospital. So the system appears to be responding to the needs of those in poorer health, which is good news. The bad news is that poorer health is not likely due to a lack of health care services; more health care doesn't appear to be the answer (Martens et al. 2002).

Health Status

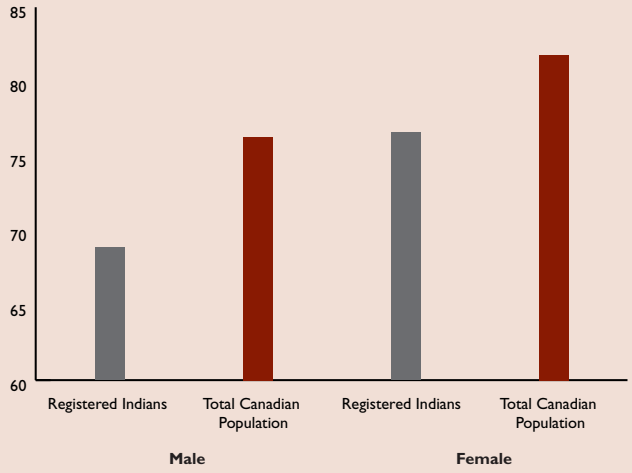
The general health status of Aboriginal peoples is better today than it was 50 or even 10 years ago primarily because of noticeable improvements in living conditions and continued investments in disease prevention and public health. Access to running water and housing conditions on reserves also have improved considerably over the past 10 years (INAC 2002).

Yet the disparities with other Canadians remain. In 2000, the gap between life expectancy of registered First Nations people and other Canadians was estimated at 7.4 years for men and 5.2 years for women (INAC 2002) (see Figure 10.4). Life expectancy for other Aboriginal groups has not been rigorously measured on a national basis but suggestions are that the situation is likely comparable, if not worse, for other Aboriginal populations, especially those living in the three territories (see Figure 10.5).

The Aboriginal population is younger, on average, than the rest of the Canadian population. In 1996, the difference was about 10 years. Compared to the general population, the proportion of Aboriginal children under five years of age (for every 1,000 women of childbearing age) was 70% greater for Aboriginal peoples (Statistics Canada 1998). Canada's Aboriginal population is also growing at a rate of 3% per year, more than double the Canadian rate.

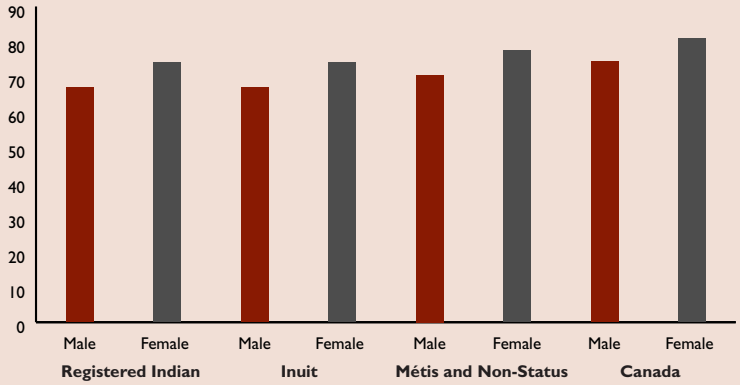
Studies show that young Aboriginals are more often exposed to problems such as alcohol abuse and drug addiction than other Canadians of the same age. Combined with pervasive poverty, persistent racism, and a legacy of colonialism, Aboriginal peoples have been caught in a cycle that has been perpetuated across generations.

Figure 10.4
Life Expectancy at Birth, Registered Indian Population, 2000



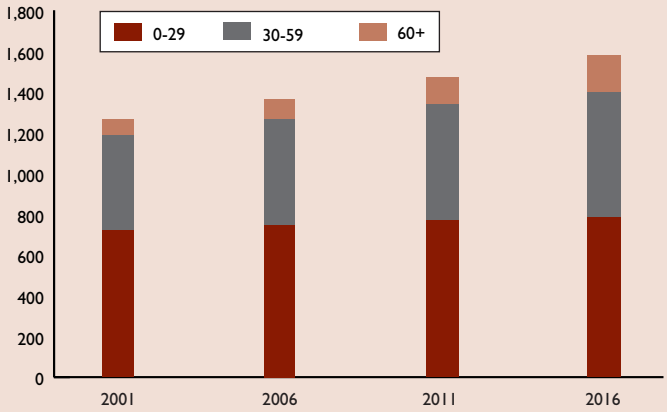
Source: Canada, INAC 2000.

Figure 10.5
Life Expectancy at Birth, Aboriginal Peoples and Canadian Population, 1991



Source: Statistics Canada 1995.

Figure 10.6
Population Projections for the Aboriginal Population in Canada, by Age Group, (Thousands), 2001 to 2016

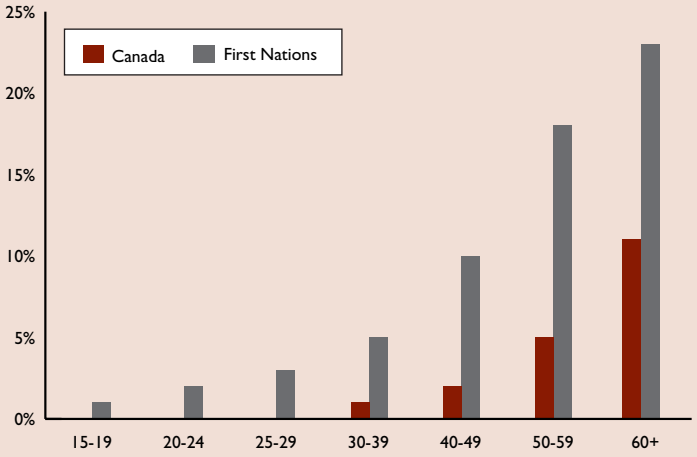


Source: Statistics Canada 1995.

There also is a sizeable group of young Aboriginal people who now are entering adult life (see Figure 10.6). These young people not only need an acceptable standard of living, employment, a good education and adequate housing, but also support in addressing health problems they may have experienced as children or adolescents.

Throughout the Commission's public hearings, numerous Aboriginal representatives expressed serious concerns about the persistent disparities in health status experienced by Canada's Aboriginal peoples. They emphasized indicators such as the high diabetes rate (see Figure 10.7), growing rates of HIV infection, cardiac problems (Southern Chiefs Organization and Assembly of Manitoba Chiefs 2002), and high disability rates – especially mental disabilities (BC Aboriginal Network on Disability Society 2002). They also highlighted the lack of a holistic strategy that recognized traditional approaches, as well as the lack of sufficient resources to deal with these problems (AFN 2002).

Figure 10.7
Incidence of Diabetes among First Nations and Canada, by Age Group, 1991



Source: Canada, INAC 2002.

Access to Health Services

In the past 10 years, Aboriginal peoples' access to health services has improved markedly, especially access to hospital care and prescription drugs. But more needs to be done to close the gap between access for Aboriginal peoples and the general population.

One of the important issues affecting access for Aboriginal peoples, and for all Canadians, is the supply and distribution of health care providers. During the Aboriginal health forum co-hosted by NAHO, the Commission heard consistently from participants about the challenges in recruiting and retaining Aboriginal health care providers in their communities. This is true for First Nations, Inuit, Metis, and urban Aboriginal groups. In 1997/98, there were almost 2,000 qualified Aboriginal health care workers in Canada, including 800 nurses and 67 doctors. This makes up less than 1% of the health care providers in Canada, far lower than the proportion of Aboriginal peoples to the general population (FNIHB 1999).

Efforts to expand the number of Aboriginal health care providers through training and partnerships are essential. In addition, more needs to be done to provide appropriate training for non-Aboriginal health care providers so they are in a better position to meet the health needs of Aboriginal communities. This requires a concerted effort to recruit health care providers from Aboriginal communities and to expand training initiatives for non-Aboriginal health care providers. The Eskasoni Health Centre in Cape Breton, where physicians from Dalhousie University Medical School are brought into Mi'kmaq communities to deliver services, has shown that positive results can be achieved when non-Aboriginal health care providers have opportunities to work in Aboriginal communities and learn their particular needs and culture. Examples like this and other programs across the country need to be significantly expanded.

In recent years, a number of positive initiatives have been taken to address some of the determinants of health for Aboriginal peoples rather than simply treating illnesses. These initiatives have been based on a partnership between Aboriginal communities and various levels of government. These partnerships are necessary in order to break down the barriers between different policy sectors (APNQL 2000; AHABC 1999), whether they are as a result of federal,

provincial or local jurisdiction. The key is to break down the "silos" that currently exist between health policy and other social policy areas such as education, housing or social services. In the Eskasoni case, the development of a remarkable primary health care model was hampered time and again by legal and administrative obstacles associated with jurisdiction, in particular, the designation of some funding as "health" funding and some as "social services" funding (Hampton 2001).

This theme of breaking down silos and integrating services was repeated by governments, by Aboriginal leaders, and by health policy experts at the Commission's public hearings, in meetings with various organizations, and during the expert roundtables held across the country. In many respects, providing integrated services means setting aside a priori assumptions about who should be responsible for organizing and delivering services for Aboriginal peoples. Some remain convinced that the effective resolution of Aboriginal health problems will be achieved through a combination of more individual control over their own health and more effective self-government at the collective level (NAHO 2001; First Nations Chiefs' Health Committee 2000). However, given the overlapping responsibilities and the complexity of the health issues involved, better results could be achieved by sharing responsibilities rather than jealously guarding jurisdiction.

"A population health approach most closely reflects an Aboriginal view of health and may best serve to support policy changes, legislative and policy reform between all levels of government in collaboration with Aboriginal governments provided an Aboriginal view of health is maintained."

Métis National Council 2002. Written submission.

At the NAHO forum (2002) and during public hearings, the Commission also heard that delivering health care services in a culturally sensitive way was very important, particularly for non-Aboriginal health care providers. The Canadian Public Health Association (2001, 6) emphasized the same point. In their view, "Only by designing programs that respect the cultures of the nation's people and communities and by celebrating Canada's diversity, can health professionals help improve the health of vulnerable populations and reduce the demands on the health system as a whole."

Cultural and Political Diversity

Aboriginal peoples have strong and diverse cultures. In the case of First Nations, for example, there are more than 600 different communities that fall under approximately 50 culturally and linguistically distinct groups dispersed across Canada. The values and customs of these diverse groups must be respected and reflected in both the design and the delivery of health care services. There also are a large number of political entities that represent different Aboriginal populations at different levels, including local Band Councils, regional Tribal Councils, provincial organizations, national organizations, as well as organizations representing Aboriginal women and urban Aboriginals.

Both the cultural diversity and the diversity of political organizations must be reflected in whatever approaches are used to improve access and health for Aboriginal peoples. Given this diversity, it may be best to emphasize regional or local solutions that can be more focused on specific communities or community needs rather than searching for broad

"Inuit have their own ideas on how to improve their health. Innuqatigittarniq – the health interconnection of mind, body, spirit and environment – is one of the lamps or qulliqs lighting the way for Inuit health reform. Qaujamajatuqangit – Inuit traditional knowledge – is another such qulliq."

Qikiqtani Inuit Association 2002. Written submission.

solutions that are unlikely to address the unique needs of different communities across the country. Local and regional approaches may also be more effective in attracting more Aboriginal peoples to various health care professions and in recruiting non-Aboriginal providers to work in Aboriginal communities.

The Northern Territories Issue

The existence of three vast territories in Canada's north – Yukon, Northwest Territories and Nunavut – deserves special attention in developing health policy for Aboriginal peoples. Twenty percent of the population in the Yukon, half of the population in the Northwest Territories and 85% of the population of Nunavut are Aboriginal, each with different proportions of First Nations, Inuit and Metis (see Table 10.3).

The territories also have unique constitutional arrangements that are different from the 10 provinces. The Parliament of Canada determines their governance structure and the nature and extent of the jurisdiction that can be exercised locally by the territories. Parliament also provides for the essential financial needs of the territorial governments. In general, the territorial governments have responsibilities for delivering health care services that are comparable to the provinces. Federal funding is provided under the *Canada Health Act* under the same conditions and principles (Brown 2000). The notable exception is the Yukon self-government agreement that was concluded in 1994. The agreement states that the Yukon is responsible for "… provision of health care and services to citizens of the First Nation, excluding regulation and licensing of facility-based services outside the settlement land of the First Nation" (Canada. Department of Justice 1994).

During a large part of the territories' history, federal authorities directly managed and delivered services in hospitals, clinics and other health centres. At the beginning of the 1980s, the federal government began to transfer responsibility for health care services to the territorial governments. Responsibility for health care services was transferred to the Northwest Territories

Table 10.3
Federal Transfers to Territorial Governments

	Demography		Fiscal Arrangement (Revenue Sources) 2001/02		
	Total Population	Aboriginal Population	Territorial Formula Financing	Canada Health and Social Transfer	% of Estimated Territorial Revenues Coming from Transfer Payments
Northwest Territories	40,900	47.7%	$510,000,000	$55,000,000	57%
Nunavut	28,200	85.0%	$611,000,000	$31,000,000	84%
Yukon	29,900	20.1%	$346,000,000	$33,000,000	70%

Note: Aboriginal Population figures are based on Statistics Canada 1996 Census Data.
Source: Canada. Department of Finance Canada 2002b.

in 1988. But as the transfer of responsibility only targeted services that were usually insured by the provinces, the NIHB program and some other national health programs were excluded. A comparable agreement was reached with the Yukon in 1997.

In 1988, the federal government entered into an agreement with the government of the Northwest Territories for the administration of health services including the NIHB program. When Nunavut was created in April 1999, the agreement was transferred to the Government of Nunavut as well. Both governments receive annual funding for the ongoing administration of NIHB. Program criteria, eligibility, and rates are set by the federal government and the government must have written approval from the Minister of Health for contracts in excess of $50,000. The situation is a bit different for the Yukon because the management of NIHB has been transferred to Aboriginal communities rather than to the Yukon government.

Sparse populations and chronic shortages of resources have required each territorial government to concentrate on providing as wide a range of primary health care services as possible, although even this is often a significant challenge. A large proportion of hospital and advanced diagnostic needs are met through service arrangements with various provinces.

In Nunavut and the Northwest Territories, access to health services is available to all residents regardless of their membership in one or another ethnic community. Paradoxically, the only rules that exclude people from access to services are those established by the federal government for the NIHB program for First Nations and Inuit.

Without idealizing the situation, the northern territories have been able to strike a balance between preserving the traditional way of life for different groups and communities and moving ahead with social policies that reflect common values for all residents. In effect, they have established a collective citizenship that emphasizes social solidarity for all groups and cultures but, at the same time, respects the cultural and ethnic differences of their populations. This model should serve as an example for the rest of Canada.

Against this backdrop of issues and "disconnects" affecting Aboriginal peoples across Canada and the unique challenges of people in the north, the following recommendations propose fundamentally new funding and institutional arrangements for addressing those issues and – perhaps most importantly – improving the health of Aboriginal peoples.

An Innovative Solution

RECOMMENDATION 42:

Current funding for Aboriginal health services provided by the federal, provincial and territorial governments and Aboriginal organizations should be pooled into single consolidated budgets in each province and territory to be used to integrate Aboriginal health care services, improve access, and provide adequate, stable and predictable funding.

RECOMMENDATION 43:

The consolidated budgets should be used to fund new Aboriginal Health Partnerships that would be responsible for developing policies, providing services and improving the health of Aboriginal peoples. These partnerships could take many forms and should reflect the needs, characteristics and circumstances of the population served.

A Partnership Approach to Health

Currently, there are three main options for financing, organizing and delivering health care services to Aboriginal peoples:

- The status quo in which Health Canada would continue to negotiate individual arrangements with communities for the transfer of funds and responsibility for delivering health care services;
- The approach recommended by the Royal Commission on Aboriginal Peoples that would tie the delivery of health services to larger objectives of expanding Aboriginal self-government models across the country (RCAP 1996); and
- A more recent approach suggesting that Aboriginal health services should be integrated into provincial health care systems and become the responsibility of provincial governments (Richards 2002).

Needless to say, there are supporters and critics for each of these approaches. Transferring responsibility from Health Canada to Aboriginal communities has been successful in some respects, but it fails to deal adequately with problems of accountability, transparency and capacity building within Aboriginal communities. The self-government approach requires a number of immensely complex and divisive constitutional issues to be resolved by governments and Aboriginal peoples or the courts. Transferring responsibility to the provinces ignores the constitutional responsibility of the federal government and would require funds already transferred to Aboriginal communities to be shifted to the provinces. It also provides no guarantee that Aboriginal peoples would have a voice in how services are organized and delivered.

Because of the difficulties with each of these approaches, a new and innovative solution is proposed. It takes the existing resources provided by governments and Aboriginal organizations and pools them into consolidated funds that can be used to improve health and health care for Aboriginal peoples. And it proposes new Aboriginal Health Partnerships to take responsibility for organizing, co-ordinating and ensuring that the health needs of Aboriginal peoples are met.

"… one of the essential ingredients in creating effective Aboriginal health systems is a multi-jurisdictional approach to health service reform."

National Aboriginal Health Organization 2001. Written Submission.

The approach cuts across all existing administrative and political lines and puts the focus squarely on health care. It is both a practical and a principled approach that reflects the values expressed so often to the Commission by both Aboriginal and non-Aboriginal individuals and organizations. It relies on an understanding of specific Aboriginal environments and communities in all their varied dimensions. It also may produce results that can be applied in other communities and other settings across the country. Various approaches for delivering primary health care in different settings could use the approach suggested here as a model. And the option certainly would be open for partnerships to involve both Aboriginal and non-Aboriginal peoples.

In short, this approach:

- Encompasses the positive elements of the transfer initiatives already underway in terms of ensuring that services are designed and delivered in a way that reflects the needs of different Aboriginal communities;
- Ensures that the various agreements and arrangements that have been negotiated over the years are taken into account;

- Reflects the fact that the political and constitutional status of Canada's Aboriginal peoples is constantly evolving. Rather than trying to pre-judge the direction of those changes, the approach is flexible enough to accommodate this evolution and the development of different models of self-government in the future;
- Involves both orders of government and Aboriginal organizations in real and meaningful partnerships with proper accountability arrangements;
- Is equitable in that it would work for a variety of Aboriginal communities regardless of their location, community, status or health needs;
- Recognizes the essential role Aboriginal peoples must play in defining and implementing programs to meet the needs of their populations.

Frameworks and Funding

The first step is to establish a framework agreement among the federal, provincial and territorial governments and Aboriginal organizations on how funds would be consolidated in particular provinces and territories. These framework agreements would set out the basic conditions for consolidating and allocating funds for Aboriginal health services.

While it might be tempting to think in terms of a single national framework, given the diversity of cultures, languages, needs and circumstances across the country, a national model likely is unworkable. Instead, framework agreements should be negotiated on a provincial or territorial basis. This would provide the flexibility necessary to accommodate innovative approaches in various provinces and territories. It would not preclude framework agreements that involve more than one province or territory, particularly in cases where reserves cross provincial boundaries, members of particular communities move back and forth across provincial borders, or where there are enough similarities among Aboriginal groups in different provinces to make a common framework appropriate.

The negotiation of these framework agreements should involve both orders of government that contribute to the consolidated budget as well as those Aboriginal organizations (mostly at the Band or local level) within a province or territory that currently (or in the future) control some portion of funds designated for health services. Again, given the diverse ways in which transfer agreements have been negotiated across the country, in all likelihood the representation around the negotiating table would differ dramatically across the country.

While there undoubtedly will be variations, all framework agreements should:

- Describe the terms by which each of the funding partners agrees to contribute to the consolidation of funds;
- Ensure that each order of government remains accountable to its own legislative body;
- Ensure that each participating Aboriginal organization remains accountable to its own membership;
- Describe the terms and conditions under which any funding partner may withdraw from the agreement and from a particular Aboriginal Health Partnership;
- Reflect an understanding that the consolidated funds remain, in effect, "latent" until such time as individual Aboriginal Health Partnerships are formed in specific communities and with specific mandates that would allow them to draw from the consolidated funds. The current arrangements for the funding and delivery of services would remain in place until Aboriginal Health Partnerships have been established.

In terms of funding, the combination of federal, provincial and territorial funding, along with funding transferred to Aboriginal organizations, provides a stable and substantial base of funding to support Aboriginal health care programs and services. As noted earlier, a substantial amount of funding has been transferred to certain First Nations and Inuit communities. The current fragmented approach does not allow either Aboriginal peoples or governments to get the maximum benefit from the amount of money that is being spent. Nor does it allow policymakers to use the available resources in a co-ordinated way as a lever for change in either health behaviours or health services. A consolidated fund would address these concerns and also allow all Aboriginal peoples to benefit regardless of their status, location or health needs.

The provincial and territorial framework agreements would provide a consolidated budget on an annual basis. The consolidated funds would be drawn on a per capita basis to fund specific Aboriginal Health Partnerships that serve particular populations, communities or regions within a province or territory. The funds would only be transferred to Partnerships once they had detailed plans in place and could demonstrate their ability to co-ordinate and deliver services according to their plans. Until Partnerships are in place, the funds would remain under the control of the government or Aboriginal organization that currently holds them.

Creating Aboriginal Health Partnerships

Aboriginal Health Partnerships could be organized in many different ways. The key is that they must reflect the needs and circumstances of the communities and people they serve. In the words of a participant in the Aboriginal forum, "what works is a community-centred approach, not a cookie-cutter approach, not a policy created in distant lands and applied to us" (NAHO 2002). In some cases, communities where self-government structures are in place could play an important role in the control and management of health programs. This is especially true in self-governing communities that serve a specific population and area and where it is possible to mobilize resources in a systematic and stable way. On the other hand, urban Aboriginal peoples might be better served by teams or networks of health care providers. One example of this approach is the Indian Health Service in the United States that now operates integrated health centres in urban areas (Indian Health Service 2001; Kunitz 1996).

Aboriginal Health Partnerships should reflect the positive features of some of the most successful initiatives underway in different parts of the country including the Eskasoni program in Nova Scotia, the Northern Health Strategy in Saskatchewan, the Pangnirtung Health Centre in Nunavut, and the Anishnawbe project in Toronto. These features include:

- Restructuring health care services around prevention and primary health care in order to use the nearest available resources to meet the needs of Aboriginal peoples;
- Integrating programs and resources to address both the social policy and the health policy dimensions of illness and overall health;
- Using a networking approach to provide a continuum of services, especially for services and care that are not available in the community;
- Providing stable funding that is consistent with both health and social objectives; and
- Developing health and social management capacities in communities.

A number of common principles should underlie how Aboriginal Health Partnerships would operate.

- **Partnerships should take a holistic approach to health** – Partnerships should look beyond more narrow health issues and consider broader conditions that help build capacity and good health in individuals and communities, such as nutrition, housing, education, employment and so on. The Partnerships should be used to break down the barriers between social policies and health policies in order to address the underlying causes of Aboriginal health problems. They should address not only local needs and conditions but also common issues that affect Aboriginal peoples across the country. Provinces and territories that manage basic activities, programs and health resources should be actively involved.
- **Services must be adapted to the realities of the Aboriginal communities** – Approaches that adapt health services to the social and cultural realities of different Aboriginal communities are providing the best results. Obviously, social and cultural barriers can impede the delivery of health care services and lead to incomplete and impersonal care. If programs and services are adapted to local circumstances, it is not only easier to identify individuals' health care needs but also to achieve objectives that go beyond the immediate health problem to the social conditions that can promote better health. This adaptation can be achieved by involving Aboriginal peoples directly in defining the services that are needed and how they are to be organized and delivered. The process should reflect the values rooted in the political and cultural traditions of different Aboriginal peoples.
- **Partnerships should reflect the specific needs of the communities they serve** – There is no single model that is appropriate, given the diverse needs of Aboriginal communities. Partnerships should be organized and managed in a way that meets the specific needs and diverse circumstances of Aboriginal peoples and the various communities involved. This could mean Partnerships could be arranged on a regional, community or local basis, depending on the needs and preferences of Aboriginal peoples.

How Partnerships Would Work

The following key elements describe how Aboriginal Health Partnerships would operate:

- Per capita funding would be provided from the consolidated budgets in each province, territory or region based on the number of Aboriginal peoples who sign up to be served by the Partnership as well as interested non-Aboriginal peoples who may choose to be served by the Partnership;
- The Partnerships would operate on a "fundholder" model where the Partnership would be responsible for organizing, purchasing and delivering health care services that could range from establishing primary health care networks to more integrated organizations responsible for managing a larger range of services;
- Aboriginal Health Partnerships would be responsible for adapting health care services to the cultural and social circumstances of Aboriginal peoples by:
  - Designing and organizing health care services taking into account the special social, cultural, linguistic and economic circumstances of the population being served;

  - Improving access to primary, acute and advanced diagnostic care for Aboriginal peoples; and
  - Recruiting and expanding opportunities for health care providers from Aboriginal communities and increasing training initiatives for non-Aboriginal health care providers to prepare them to deliver services to Aboriginal patients within and outside their communities.
- The Partnership should be responsible and accountable for the funds it receives and how those funds are used for Aboriginal health and health-related services. The Partnership should be established as a not-for-profit community corporation with a Board of Directors comprised of representatives of the funders (primarily Aboriginal organizations with direct control over funds designated for the provision of health services along with federal, provincial and territorial governments), and other individuals involved in establishing the Partnership (e.g., key organizers, users and health care providers).

Leadership and Accountability Structures

The proposed leadership and accountability structures for Aboriginal Health Partnerships are a new approach for Canada. The responsibilities envisioned for members of the Board of Directors for the Partnerships go beyond any current models in place in Canada's health care system today. Establishing the Partnership as a fundholding organization able to purchase or contract for services from regional health authorities, hospitals or other health organizations also is new for Canada, although it has some parallels with the responsibilities of regional health authorities in some provinces.

Clear conditions must be in place to address and to clarify the responsibility and accountability for the Aboriginal Health Partnership. They should include:

- An explicit mandate for the Partnership;
- Up-to-date information on performance indicators; and
- The capacity to make decisions based on the best available evidence.

Structures would have to be in place to allow the Partnership to discuss options, exchange ideas, and also to produce financial accounts that are public and open to all those involved.

Given the fact that this is a new concept both for governments and for Aboriginal peoples, it likely will take some time before a significant number of these Partnerships are in place across the country. This is a reasonable approach and it allows time to experiment with different approaches and to assess their impact. In the meantime, provinces, territories, the federal government and Aboriginal leaders and communities should work together to explore this approach and to continue to expand and improve health programs and services for Aboriginal peoples.

Possible Scenarios for Aboriginal Health Partnerships

The above discussion points out some of the essential features that would need to be in place for Aboriginal Health Partnerships to operate. But what would these Partnerships look like and what kinds of things would they do? The following scenarios describe how an Aboriginal Health Partnership could work in both an urban setting and in an Aboriginal community.

Three different models could act as starting points for consideration:

- A regional partnership model targeting all individuals who want to benefit from integrated and culturally appropriate health services in a given area;
- A community initiative model for individual or a small number of communities that share historical, linguistic and cultural characteristics; and
- A local partnership model based on teams of health care providers and other concerned advocates with services targeted primarily to urban Aboriginal peoples.

The three examples in the following boxes are meant to serve as illustrations only. The way a Partnership would actually work may well vary from all three examples. If there are a number of Partnerships in a province, for example, the province may want to set up a provincial framework for specialized hospital and diagnostic services, at the same time allowing for considerable variations in the way primary health care services are delivered. Partnerships with an initial mandate for a particular range of services could expand over time as their capacity for co-ordinating and integrating services grows. This would provide a smoother transition where the role and responsibilities of the Partnerships could evolve or be phased in on a pre-determined but flexible schedule rather than having them take over responsibility for a broad range of services all at once.

A Regional Aboriginal Health Partnership

A regional Aboriginal Health Partnership could mirror regional health authorities that currently exist in many provinces. A number of different Aboriginal communities in one region of a province could work together to decide what health care services were needed and how they should be accessed or delivered. The communities would establish a Board of Directors for the Partnership including representatives of the communities being served, the federal, provincial and territorial governments, and the Aboriginal organizations involved. The Aboriginal Health Partnership might choose to maintain responsibility for public and population health initiatives and the delivery of primary health care services within some or all the communities involved. The particular mix of services in any community would depend on the size of the community and the ability of the Partnership to provide the necessary resources in terms of both health care providers and financial support. The Partnership may choose to work with existing regional health authorities to draw up service agreements for the delivery of diagnostic and acute care or other health care services. These service agreements would ensure that services delivered by the health authorities are appropriate and adapted to the cultures of the communities. In effect, the Partnership would "buy" health care services on behalf of its members and would be able to negotiate the conditions for the delivery of those services.

A Community-based Aboriginal Health Partnership

A community-based Aboriginal Health Partnership could be implemented by either a single Aboriginal community or by a small number of communities working together. The population of these communities would have to be large enough to sustain the services being delivered. The members of the Board of Directors would include representatives of the Band Council(s), the federal government, the provincial or territorial government, and several people from the Aboriginal community. The Partnership would receive a pool of funds from the Band Council, the federal and provincial or territorial governments based on the number of people in the community and would be responsible for making decisions about how those funds were used. It would operate independently of the political structures in place in the community and be responsible specifically for health and health-related issues. The Partnership could design and deliver a range of public health, primary health care and social services that are specifically aimed at the needs of its community members. The services would be delivered in a manner consistent with the cultural traditions of the community. The Partnership could also contract with a nearby regional health authority to provide hospital and advanced diagnostic services.

An Urban Aboriginal Health Partnership

An urban Aboriginal Health Partnership could be organized by a group of health care providers and Aboriginal peoples who are frustrated with the fragmented array of services in a particular city and see the value in bringing these services together in a more co-ordinated and culturally sensitive way. The Partnership would be led by a Board of Directors including representatives of the provincial, territorial and federal governments, Aboriginal and non-Aboriginal organizations, and some health providers associated with the new approach. Once the Partnership is in place, Aboriginal peoples in the city would be able to "sign up" to receive their primary health care services from the Health Partnership. The Partnership would receive funding for every person who signs up for the Partnership's services. It would use these funds to provide or purchase primary health care and other health care services. It could enter into contractual arrangements with its local health authority or hospital board to provide acute and advanced diagnostic services. And it could develop a network of linkages with social service agencies and schools so it is able to address issues related to poverty, housing and education.

What Does This Mean for Canadians?

The recommendations in this chapter are focused primarily on the needs of Aboriginal peoples and on ensuring that concerted efforts are made to address the serious and continuing disparities between their health and the health of non-Aboriginal peoples. New ideas and innovative solutions are proposed – ones that will challenge Aboriginal community members, their leaders, and provincial, territorial and federal governments to set aside funding issues, set aside past practices and political disagreements, and focus instead on a single overriding goal – improving the health of Aboriginal peoples.

For non-Aboriginal Canadians, this means that deliberate action will be taken to improve the health of Aboriginal peoples. They, too, want to see progress. They want their Aboriginal neighbours and friends to enjoy the same health status and the same benefits of the public health care system as the vast majority of Canadians.

The challenge of moving forward will be in the hands of Aboriginal leaders and the federal, provincial and territorial governments. It will take the trust and willingness of all parties to seize the ideas and recommendations in this chapter, take action, and improve the health of Aboriginal peoples, especially the health of their children and their hope for the future.

11 Health Care and Globalization

Directions for Change

- ***Take clear and immediate steps to protect Canada's health care system from possible challenges under international law and trade agreements and to build alliances within the international community.***
- ***Play a leadership role in international efforts to improve health and strengthen health care systems in developing countries.***
- ***Reduce our reliance on the recruitment of health care professionals from developing countries.***

The Case for Change

Mention the word "globalization" and most people think immediately of the growing interconnectedness of economies, increased mobility of people and capital, the rise of huge multinational companies, international trade agreements, and the use of information technology to establish immediate market links around the world. But in fact, globalization is about much more than economics. Globalization has political, social and cultural consequences that affect almost every aspect of our society.

Though there is no standard definition of globalization, most commentators agree that it results in the increased flow and exchange of:

- Goods and services through direct trade between nations;
- Capital, including investment by foreign-based companies or individuals;
- Labour, including the ability of people to seek employment across international borders; and
- Information, using the Internet and other communications technology to transmit and share information.

It is important to understand how health care fits within this international global context. Concerns have been expressed that international trade agreements could have an impact on our health care system and future reforms that could be made. Others take the opposite view and say that Canada's health care system is protected from the impact of trade agreements. There are no definitive answers to this debate, but it is clear that Canada can and must take whatever steps are

necessary to preserve the future of Canada's health care system and protect it from the potential impact of international trade agreements and laws. Canada also has an opportunity to take an international leadership role in sharing its expertise and helping developing countries improve their health care systems and the health of their people.

Globalization and Its Impact on Canada

The key characteristic of globalization is the speed of economic and political changes rather than the direction of those changes (Helliwell 2000). In fact, trade liberalization, deregulation and consolidation of multinational corporations have been underway for most of the 20th century. While some argue that the world is not any more globalized now than it was in the era when colonial powers used their vast empires to create unprecedented international flows of goods and people, the difference now is the pace of change. Global communications networks have made capital increasingly mobile and, with the relatively low cost of transportation, goods and services can be produced and shipped around the globe faster, cheaper and in greater quantities.

As the speed of these changes has increased, so have the intensity of the debates by those who see globalization as a positive trend or a serious threat. On the one hand, globalization blurs the borders between countries, people, and ideas. Communications technology reduces the significance of location and distance. People can communicate instantaneously, buy goods and services, or get the latest ideas and information from almost anywhere in the world. International trading rules are becoming more uniform. And people are more aware of what is happening in other parts of the world and the impact our actions and policies have on other people around the globe.

Globalization has also been a divisive force. While it has broken down many of the barriers between countries, there also are signs of increased nationalism, ethnic strife, protectionism, and resistance to trade liberalization. On the other hand, countries that once were able to restrict their citizens' access to information or to influences outside their borders find themselves increasingly unable to control the flow of information across borders via the Internet. As a result, globalization may provoke some countries to "build walls" in order to protect economic, political, and social space that is perceived to be under threat (Turenne-Sjolander 1996). In addition, those who see the negative aspects of globalization express concerns about the potential loss of sovereignty and point to studies that show increasing disparities between people in highly developed and industrialized countries, and those in the very poorest developing countries (UNDP 2002).

With these growing tensions, it is not surprising that international institutions charged with creating and extending international trade increasingly find themselves at the centre of heated debates over international and domestic politics. The World Bank, the World Trade Organization, and the International Monetary Fund have become the focus of intense political debate and conflict as people search for ways to ensure their ultimate accountability to the governments that created them.

Paradoxically, both the proponents and the critics of globalization see the same end point – a borderless world where capital, labour, goods and services, ideas and information flow unimpeded by national boundaries or domestic policy preferences. Depending on the perspective people take, this can be viewed either as a positive sign of the world coming together or as a serious threat to the independence and autonomy of individual nations.

The fact that we are moving to a more globalized world is not to suggest that national borders are irrelevant. National borders still shape our political communities, our political preferences, and our economic behaviour in very important ways (McCallum 1995). Whatever impact globalization has had, it should not be assumed that borders no longer matter and that the formal and informal networks that traditionally operated within individual nations no longer serve to hold those states together. For example, even though there is a great deal of trade between provinces and the United States (e.g., between Ontario and the American Midwest or between British Columbia and the Pacific Northwest), the political, economic and cultural linkages that bind the country together on an east-west basis remain strong and continue to define us as a nation. Further, smaller national and regional economies do not appear to be less viable than before globalization and continue to rank well in terms of general economic measures (e.g., GDP per capita), as well as measures of welfare and citizen satisfaction. This suggests that globalization is not necessarily a threat to the independence of smaller economies (Helliwell 2000).

The issue, then, is not necessarily whether globalization is good or bad for Canada. Canada is, and will continue to be, a trading nation with strong international connections. Instead, the focus should be on the steps that can and should be taken to ensure that the increasing economic interdependence of countries like ours does not compromise our ability to make our own decisions about political, economic and social policies, including health care. In the past, our relative size, especially in relation to the United States, has meant that Canada has been a "rule-taker" (i.e., a country that accepts the rules set down by more powerful countries) rather than a "rule-maker" (i.e., a country that acts with other like-minded countries to set the rules). But as the number of countries that are parties to international agreements grows and international trade organizations struggle to balance social policy interests of their members with the commitment to open up markets to trade, Canada is well placed to work with other like-minded countries to ensure that international agreements protect our social policies while not depriving us of the benefits of increased trade.

Health Care and International Trade Agreements

Concerns about the potential impact of globalization on Canada's health care system have focused, for the most part, on the perceived potential of international trade agreements to limit the policy choices federal, provincial and territorial governments can make in relation to the health care system. In almost every one of the Commission's public hearings as well as the regional roundtables, concerns were expressed by experts and citizens alike that Canada's health care system should be protected from the impact of international trade agreements. The focus is

primarily on the North American Free Trade Agreement and agreements negotiated under the auspices of the World Trade Organization.

Since the 1980s in particular, significant efforts have been made to liberalize international trade through a variety of bilateral and multilateral trade agreements. These agreements began as an effort to reduce tariffs and other barriers to trade but have expanded to include trade in services and the international protection of intellectual property.

Canada is involved in a number of international trade agreements, including the following:

- The North American Free Trade Agreement (NAFTA) grew out of a bilateral agreement with the United States in the late 1980s that was subsequently expanded to a continental trade agreement that includes Mexico.
- The World Trade Organization (WTO) Agreement on Tariffs and Trade is the successor to the General Agreement on Tariffs and Trade (GATT) and is the general agreement concerning trade in goods administered by the WTO. The WTO was created in 1995 and provides an institutional framework for a number of international trade agreements.
- The General Agreement on Trade in Services (GATS) came into effect with the creation of the WTO.
- The Agreement Respecting Trade-Related Aspects of Intellectual Property Rights (TRIPS) was negotiated under the auspices of the WTO and will be one of the key focal points of the current round of WTO negotiations.

The intent of these international trade agreements is to reduce barriers in trade of both goods and services across international boundaries. They are explicitly designed to limit the ability of governments to adopt policies that would make access to international markets inappropriately difficult. Each agreement requires the countries involved to submit their policies to binding trade dispute mechanisms. If one country that is a party to an agreement feels that another member country is unfairly restricting access to their own markets or engaging in practices that give their own goods and services an unfair advantage in international markets, they can refer their concerns to a trade dispute panel whose decision is binding.

The various international agreements have several important common features. They all typically include a commitment to national treatment. This means the governments involved agree to treat foreign goods, services or investments on the same terms as they treat their own national providers of the same goods, services or investments. Under NAFTA, for example, Canada must provide the same treatment to foreign investors "in like circumstances" as it does to domestic investors. Similar provisions are also included in GATS (Lexchin et al. 2002).

Each of the agreements has particular exceptions and "reservations." Under NAFTA, "social services established or maintained for a public purpose" are exempted from the terms of the agreement. Successive Canadian governments have argued that this reservation protects the public health care system from the full force of NAFTA's provisions and means that services that existed prior to the agreement are protected. However, there is no clear definition of what constitutes a "social service" or what determines whether a service is established for a "public purpose" (CCPA 2002, 8; Johnson 2002). Similarly, many of Canada's obligations under the GATS apply only to those services or sectors that are explicitly made subject to the agreement. To date, Canada has chosen not to make hospital services and a whole array of health services subject to the GATS or to open them to foreign private investment or delivery by foreign-based companies.

The complexity of the various agreements is staggering. It is no surprise, then, that there are sometimes heated debates and disagreements among experts and even governments about what the agreements mean and what their potential impact could be.

People who support increased trade liberalization and economic interdependence insist that Canada's social policy is protected from any potential negative impact through safeguards in international trade agreements. With health care, they argue that the agreements not only protect the existing public health care system but also allow provinces and territories to expand it as they see fit. On the other hand, those who are skeptical about economic integration fear that the agreements may not have successfully carved off Canada's social policies and that public services may eventually be subject to the rules of international trade. Some fear that the agreements will require governments to open up the delivery of health care services to private for-profit delivery by foreign health care companies.

The evidence on both sides of the debate is contestable and often based on interpretations about what the agreements "might," "could," or were "intended to" mean. What is most frustrating is that the agreements can easily be read in a number of ways. There are only a limited number of legal decisions on the agreements and those decisions are often contradictory and open to many different interpretations. In terms of NAFTA, the situation is even more complicated because the decisions of its dispute resolution panels are not binding on each other. A decision by one panel at one point in time on one particular issue does not bind another panel to accept that interpretation of the agreement (Epps and Flood 2002).

Another concern with NAFTA is that, unlike other trade agreements under the World Trade Organization, there is no ongoing process for amending NAFTA. It is, to some degree, a "locked" agreement that would require all three governments to agree simultaneously to "unlock" it (Johnson 2002). The result is that Canada is left in a position where it can only assert its particular interpretation of the agreement (especially related to how comprehensively the social services reservation should be interpreted) and trust that its interpretation will prevail in dispute settlement processes. Ouellet (2002) has also argued that there is a risk that subsequent WTO agreements may contain provisions that run counter to some provisions of NAFTA.

In spite of the fact that there has been no formal declaration on what is or what is not protected by the reservation under NAFTA, there is strong consensus that the existing single-payer monopoly of Canada's health care system is not subject to a challenge under NAFTA (CCPA 2002; Epps and Flood 2002; Johnson 2002). It is less clear what would happen if one or more provinces or territories or the federal government decided to make significant changes in the insurance or delivery of health care services. While NAFTA appears to protect the current health care system, there is some uncertainty around the question of whether it protects future changes that could be made in the health care system (Epps and Flood 2002). It would depend on what kind of reforms a particular government introduced and whether those reforms meant that the health care system would still meet the requirements of "social services provided for a public purpose." Research done for the Commission argues that if, for example, governments were to include some expanded level of pharmaceutical insurance, incorporate some range of home care services under the *Canada Health Act*, or allow private for-profit organizations to deliver health care services, then international trade agreements could come into play.

A related issue is the obligation of signatories to international agreements to provide compensation to foreign investors if they put policies in place that are deemed to "expropriate" the investment of foreign companies. If, for example, a government were to decide that all home care services should be publicly delivered, it could be subject to claims for compensation from foreign-based companies that delivered home care services or from insurers who sell private insurance for home care services. Similarly, if a government decided to expand public coverage for prescription drugs in such a way that excluded private insurers from the market, there may also be claims for compensation.

In health care, claims for compensation are theoretically possible. It is not necessarily clear that compensation would have to be paid to foreign investors; it depends on how health reforms are framed and implemented (Johnson 2002). In reality, there are very few foreign-based companies directly involved in delivering health care services in Canada. Services like home care are delivered mostly by relatively small, private companies owned and based in Canada. And most private insurers in Canada are domestic firms. Rather than conclude, then, that Canada is hemmed in to the current system and cannot change, the more reasonable conclusion is that if we want to expand the range of services in the public system, it is better to do it now while there still is very little foreign presence in health care in Canada and the potential costs of compensation are low.

One significant caution involves opening up delivery of medical services to for-profit entities, hospitals or specialized clinics. Some have described this as a "one-way valve" that, once opened, may not be able to be closed (CCPA 2002). It is possible that, once foreign-based for-profit hospitals are allowed to operate, it would be very difficult to reverse course and subsequently preclude those hospitals from operating even if their services were of poorer quality, their costs were high, or their presence no longer reflected the policy goals of Canadians. Another concern relates to large corporate entities, especially those in the United States, choosing to expand into the Canadian market. NAFTA would make it virtually impossible to exclude these foreign companies on the basis of their nationality alone. Once there is a significant foreign presence engaged in for-profit delivery of health care services, any attempt to restrict its access to the market in the future may result in relatively high compensation claims. It also is possible, but not certain, that opening the door to foreign for-profit health care delivery in one province could force other provinces and territories to make similar provisions.

All of these issues and potential "what if" situations continue to be the subject of considerable debate in Canada. But the reality is that there are no clear and definitive answers to the question of what international trade agreements mean for Canada's health care system.

Trade in Health Care

Most Canadians probably do not think of health care as something that is traded internationally. The vast majority of health care services are provided by local health care professionals and delivered primarily in local communities. When patients in a city like Kamloops or a town like Baie Comeau are referred to a specialist, they may need to travel to Vancouver or Québec City, but they rarely are referred to specialists in other countries.

In a few cases, health care services are purchased from other countries, most frequently the United States. In these cases, the services are very specialized and are not available in Canada. If Canadians become ill or are injured while travelling in other countries, they may receive

treatments that are partially reimbursed by their health care system. In these cases, neither the service nor the service provider crosses a border; instead, the patient goes to where the service is available. Consequently, this is not typically considered trade in the way it is generally understood, although some suggest that it should still be considered as trade in health care services (Vellinga 2001).

As technology and advances in specialized kinds of medical treatment become more widespread, trade in health care services will become more common. The use of advanced diagnostic testing technologies, satellite communication, telehealth, and the Internet may make it possible, and perhaps even desirable, for a patient in Kamloops or Baie Comeau to get the advice and expertise of highly regarded specialists in San Diego or Helsinki. Similarly, patients in Tennessee or Alaska might receive consultations from leading pediatric care specialists at Toronto's Hospital for Sick Children. In fact, there already are examples of physicians being able to assist in surgeries through satellite transmissions linking a doctor in one country with a surgery being performed in another country. In these cases, neither the patient nor the health care provider crosses a border but the service does. This kind of trade in health care services may be minuscule today, but it will become increasingly common in the future. Governments need to come to grips with how this technology gets integrated into their respective health care systems, how it is paid for, and how the services are provided (Vellinga 2001).

Aside from trading expertise in health care, health care is a product-intensive service. Everything from bandages, intravenous bags and hospital beds to computer software and advanced diagnostic equipment are goods that are manufactured in one location and shipped to another, often across borders. In these cases, the goods are treated like any other commodity that is traded and is subject to a growing array of international trade agreements.

Prescription drugs are the single most important set of health care "goods" that is traded across international borders. As noted earlier in this report, prescription drugs are a growing component of the health care system. The pharmaceutical industry is also increasingly dominated by a relatively small number of large trans-national corporations with research and development facilities around the world. Their investment in research and development can be shifted relatively quickly from one place to another.

While drug research, development and manufacturing are important components of the economies in several provinces, primarily Quebec and Ontario, in fact, Canada has never been a major player in the international prescription drug trade. Canada has traditionally been a net importer of prescription drugs; however, Canada's balance of trade in pharmaceuticals is getting worse. Canada is becoming less self-sufficient when it comes to pharmaceutical production and estimates are that the trade deficit could grow to $7.7 billion by 2005 and $11.4 billion by 2010 compared with a deficit of $4.7 billion in 2001 and $1.8 billion in 1997 (Reichert and Windover 2002). As Canada becomes more reliant on drugs developed and manufactured abroad, the benefits of research and development are increasingly occurring outside of Canada. This also means that federal, provincial and territorial governments have less leverage with pharmaceutical companies when it comes to constraining the ever-increasing costs of prescription drugs.

In the future, the National Drug Agency recommended in this report will work with similar agencies in other countries to streamline the process for approving new drugs and sharing information on the pharmaco-economic impact of new and existing drugs. The approval time for

new drugs and the process for introducing generic drugs could be shortened by a deliberate effort to take advantage of the wealth of international information on pharmaceutical testing and evaluation. Canada also has an opportunity to work with other countries and use their collective leverage with trans-national pharmaceutical companies to control the costs of prescription drugs and ensure that the approved drugs are both effective and economical.

Health as a Canadian Foreign Policy Priority

Numerous individuals and organizations made submissions to the Commission addressing the issue of globalization and health care. Despite this concern and the fact that Canada is a signatory to an array of international agreements to promote access to health care as a fundamental right (Blouin et al. 2002), health policy has been focused on what happens in our own country. Moreover, the broader area of international health promotion is very much an afterthought in Canada's foreign policy.

This may be changing. In November 2001, the Canadian International Development Agency (CIDA) launched an Action Plan on Health and Nutrition. The plan recognizes that promoting better health in developing countries is as important for Canada as improving health at home. As noted on CIDA's Web site, "In a world where communicable diseases know no borders, where tensions and strife in one region can send tremors of unease around the globe, investing in global health helps to ensure Canadians' own health and security."

In an increasingly interconnected world, Canada cannot isolate itself from health issues in other countries. The increased mobility of people across the globe means that health problems that at one time would have remained relatively isolated in one part of the world now can spread faster and more widely (WHO 1997). The spread of drug-resistant strains of tuberculosis, HIV, and the West Nile Virus all point to the reality that health care challenges in one region of the world can quickly become a global problem. Indeed, these issues go beyond being health problems and can become matters of international and domestic security. For example, the social and economic devastation caused by the HIV/AIDS crisis in southern Africa can threaten the stability of developing democracies in the region and provide a breeding ground for political extremism, civil wars, ethnic conflicts, and even genocide. To believe that such events would not affect Canada and other nations is to fail to recognize how much the world has changed in the past few decades.

Despite the concerns Canadians might have about our own health care system, international experts suggest that Canada's approach to publicly provided health care is a model for other countries. As we move ahead with new directions for governing, funding and organizing Canada's health care system, we have an opportunity to ensure that access to health care is not only part of our own domestic policy but also a prime objective of our foreign policy as well.

Canada's membership in the United Nations, the World Health Organization and the Pan-American Health Organization, combined with our reputation on the international stage, give us the opportunity to take a more prominent role in making health and health care an international priority. This will require us to move from merely talking about health as a human right to taking more concrete action to assist in improving the health of people beyond Canada's borders (Blouin et al. 2002). Working with the World Health Organization to strengthen and renew the International Health Regulations on monitoring and containing communicable diseases would, for example, be an important first step in reinforcing Canada's commitment to international health.

Within this global context, Canada has an opportunity not only to protect and preserve its health care system from any potential impact of international trade agreements but also to play a more prominent role in improving health and health care around the world.

Preserving Canada's Health System in Relation to International Agreements

RECOMMENDATION 44:

Federal and provincial governments should prevent potential challenges to Canada's health care system by:

- **Ensuring that any future reforms they implement are protected under the definition of "public services" included in international law or trade agreements to which Canada is party;**
- **Reinforcing Canada's position that the right to regulate health care policy should not be subject to claims for compensation from foreign-based companies.**

RECOMMENDATION 45:

The federal government should build alliances with other countries, especially with members of the World Trade Organization, to ensure that future international trade agreements, agreements on intellectual property, and labour standards make explicit allowance for both maintaining and expanding publicly insured, financed and delivered health care.

Preventing Challenges under International Agreements

There is an increasingly complex set of rules and agreements regarding international trade of goods and services. As a trading nation, Canada has a stake in ensuring that those rules not only promote international trade but also protect the right of all countries to make independent policy choices.

As noted earlier, there are ongoing debates about whether and to what extent international trade agreements have an impact on Canada's health care system. Some feel the potential threats of international agreements are serious while others think there is no need to be concerned about the potential constraints international trade agreements could impose on Canada's freedom to make its own policy decisions in health care. In the face of that uncertainty, the solution does not lie in sitting back and waiting for the outcomes of potential challenges under the various trade agreements but in taking a proactive approach to ensure that Canada can continue to make whatever policy decisions it sees fit to maintain and enhance our health care system, independent of any international trade agreements.

Governments should ensure that any proposed health care reforms continue to be consistent with the reservations under NAFTA (CCPA 2002; Johnson 2002; Ouellet 2002). This means provinces, territories and the federal government need to make it clear to our trading partners that Canada's health care system will continue to be designed, financed, and organized in a way that reflects Canadians' values. It does not mean that Canada is unwilling to participate in international trading regimes but that social policy such as health care is, in effect, "off limits" and remains the prerogative of federal, provincial, and territorial governments.

If there are disagreements about the potential meaning or impact of particular clauses or provisions in international trade agreements, governments in Canada, especially the federal government, have an obligation to state clearly and often their view on how those clauses should be interpreted by any adjudicating body. They also should reinforce Canada's position that reform of the Canadian health care system is not subject to claims for compensation from foreign-based companies under either NAFTA or the GATS. One important way of ensuring that reforms such as integrating prescription drugs or home care services continue to fall within the reservations set out in NAFTA is to ensure that they conform to the criteria for "public services" as defined in international law. To meet the requirements of this definition, public services should:

- Be universally accessible on the basis of need rather than the ability to pay;
- Have a clear public purpose and objective;
- Be financed out of public revenues; and
- Adopt standard procurement procedures that are intended to protect the public interest where private services are contracted.

Building Alliances with Other Countries

Canada is certainly not alone in wanting to preserve and protect its ability to set its own public policies independent of international trade agreements. Many countries have similar concerns. Organizations responsible for overseeing the process of trade liberalization, including the WTO, are coming under increasing internal and external pressure to ensure that the ability of individual governments to set their own health and social policies are not unduly constrained by international trade agreements.

In the most recent round of WTO negotiations, the most important result was the "heightened concern expressed … with social issues and … the ability of countries to address social problems" (Johnson 2002, 32). The so-called "Doha Declaration" that opened this round of negotiations made it quite clear that the TRIPS agreement "can and should be interpreted in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all" (WTO 2001, 1). Canada was a strong supporter of the Doha Declaration.

Many countries share Canada's concern about the potential for trade agreements to unduly constrain future policy options and want to ensure that efforts to liberalize trade do not override social policy objectives. It is clear from the latest round of negotiations that, at least for now, there is international agreement that countries must have significant room to adopt social policies, including health care policies that build the "social capital" of their societies in meaningful and productive ways.

Looking ahead, the best way for Canada to address the impact of globalization and international trade agreements, and achieve real and meaningful change is to build alliances with other countries and work within the current system of negotiations. Within the WTO, Canada should take a clear and unambiguous position that access to affordable, quality health care should not be compromised for short-term economic gain. Every country should retain the right to design and organize its health care system in the interests of its own citizens. International trade agreements should not penalize countries, especially those in the developing world, for protecting and promoting their own domestic approaches to delivering health care services.

Canadians believe that access to health care is a fundamental human right. The extension of that belief is that all countries should have the freedom to provide access on terms that are acceptable to their citizens.

By building alliances with the member countries of the WTO or other international organizations that highlight significant international health issues (e.g., the World Health Organization), Canada can not only preserve its right to make its own health policy decisions but also pursue international health policy directions that result in improved health for people around the world.

Improving Health in Developing Countries

RECOMMENDATION 46:

The federal government should play a more active leadership role in international efforts to assist developing nations in strengthening their health care systems through foreign aid and development programs. Particular emphasis should be placed on training health care providers and on public health initiatives.

RECOMMENDATION 47:

Provincial, territorial and federal governments and health organizations should reduce their reliance on recruiting health care professionals from developing countries.

Playing an International Leadership Role

As noted earlier, Canada's health care system is not immune to international developments. Outbreaks of diseases can quickly spread around the globe. The health workforce is becoming an international resource as all countries seek the best ways of attracting and keeping an adequate supply of nurses, doctors and other health care providers. Advances in technology, new discoveries in cures and treatments, and new ways in organizing and delivering health care services are no longer isolated to any one country. News travels fast in health care, as in most other areas of our society and economy.

In addition, Canada has a number of international obligations as a result of its participation in international health covenants and agreements such as the United Nations' Universal Declaration of Human Rights. Furthermore, Canada is well regarded on the international stage. It is time for Canada to use both its positive relationship with developing countries and its considerable expertise in health care to help improve health and health care around the world. That will involve strengthening Canada's role in foreign aid programs to assist in training much-needed health care providers for developing countries and in promoting public health initiatives designed to prevent the spread of illnesses such as polio, HIV/AIDS, and other communicable diseases.

Building Health Care Systems in Developing Countries

As noted in the chapter on Canada's health care providers, every province in Canada has a history of recruiting health care professionals from other countries, especially from developing countries. Some provinces depend quite heavily on international health care graduates to fill the gap in their own health workforce.

Individuals from developing countries have the right to emigrate and to choose Canada as their destination. For centuries, people have sought refuge from political turmoil, religious or ethnic persecution and poverty by immigrating to more prosperous countries that offer greater personal security and opportunity. In no way would we want to curtail the right of any individuals to seek a better life for themselves or their families. And the effective integration of these international medical graduates and other health professionals needs to be part of Canada's overall health human resource strategies.

But recruiting health care providers from developing countries raises important ethical concerns. Canada's problems in recruiting and retaining health care providers pale in comparison to shortages and distribution problems in developing countries (Mehmet 2002; Zurn et al. 2002). Given the limited resources of these countries, their investment in training health care professionals is proportionately far greater than the investment Canadians make in training their own health care professionals. Educated, professional people in developing nations also support political stability, economic development and the protection of human rights. When middle-class professionals are lured away by promises of greater economic opportunities abroad, they take with them their potential to contribute to the stability and progress of the nation they leave behind.

"Reliance on medical school graduates from other countries is, in the long-term, not an acceptable solution. As a relative rich country, Canada should take responsibility for training an adequate number of doctors to meet domestic needs."

CANADIAN FEDERATION OF MEDICAL STUDENTS 2001. WRITTEN SUBMISSION.

As a member of the international community, Canada has an ethical responsibility to ensure that it does not attempt to solve its shortages of health care professionals on the backs of less powerful, less wealthy and less developed nations. Provinces, territories and health regions should review their policies on recruiting health care professionals from developing countries and reduce their dependence on international graduates. Canada should also work with other countries to assist developing countries in strengthening their own health care systems – especially in the areas of public health and health information – so that expensively trained health care providers will want to stay in their own countries' health care systems.

Sharing Information with Other Countries

Part and parcel of globalization is the growing interconnectedness of a world in which information flows across borders at an ever-increasing pace. This provides tremendous potential to learn from the experiences of other countries not only in important areas of health policy but also in relation to the latest medical advances. The challenge is to work collaboratively with other countries to ensure that health information is reliable, accessible and accurate, and also can be shared among countries to support citizens, health care providers, managers, researchers and policymakers. The federal government can play a leadership role in working with other countries to develop clear guidelines for sharing information across international borders.

Many countries are facing the same challenges as our health care system in terms of providing timely access to comprehensive and accurate health information. The investments in, and co-ordination of, Canada's health infostructure recommended earlier in this report can put Canada in a strong position to take the lead in developing an international global network of

health information. This type of network would contribute significantly to our global health knowledge base, help facilitate international co-operation and information sharing, support developing countries with limited health information capacity, and help support improved health and health care outcomes over the longer term. By working with other members of the World Health Organization and the Pan-American Health Organization, Canada has a unique opportunity to shape not only how reliable and accessible information gets disseminated but also how this information is connected across jurisdictions.

The same technology can be used to share specific medical expertise among health care professionals around the world. Canadian physicians, for example, would be able to consult with colleagues anywhere in the world. They also would be able to provide information, advice and diagnoses to physicians in other parts of the world, especially in developing countries. By establishing a global health information network, Canadian health care professionals could work closely with colleagues in developing nations, allowing them to provide better care to their own citizens and encouraging them to stay in their own countries.

At the same time, the Commission understands that sharing information across international boundaries must respect and protect the privacy of individual patients. For that reason, appropriate international safeguards will need to be developed and implemented.

Establishing a global information network will be not be an easy task or something that can be accomplished in the near future. The challenges involved in extending health technology and information to the developing world are immense. Currently, less than 1% of global research and development is spent on technological innovations aimed specifically at poorer nations. New technology and health care innovations are, to put it bluntly, simply beyond the financial reach of much of the world's population (Donald 1999). It is naïve to believe that our own technological advances will simply "trickle down" to developing nations over time. Unless strategies are developed to ensure that developing nations can gain better access to information and health technology, there is a risk that this technology could exacerbate the divide between the developed and the developing world. Therefore, strategies to expand technology and health information need to be backed up with the same degree of global support that developed nations currently give to the range of international trade agreements that govern international trade relations.

What Does This Mean for Canadians?

There is no doubt that globalization will continue to have an impact on all aspects of our economy, society and culture, not only in Canada but in all countries around the world. Most often, the focus for Canadians is on our own problems – how do we sustain Canada's health system, improve access or attract enough health care providers to meet our needs. But Canada's health care system is not immune from changes around the world. As a country, we have a tremendous opportunity to lead the world in sharing health care expertise and helping to improve the health and health care of people in developing countries.

It is not possible to say with any certainty what impact international trade agreements could have on future changes in our health care system. The best approach in the face of this uncertainty is, in some ways, to hope for the best, prepare for the worst, and work with other countries to ensure that trade agreements clearly respect the diversity and relative sovereignty of

every country to make choices about its own social policies, including health care. In terms of future changes to Canada's health care system, the objective must be to ensure that international agreements do not constrain our ability to introduce new options and new approaches to health care in Canada.

With these recommendations, Canadians can be assured that:

- Steps will be taken here in Canada and on the world stage to preserve and protect Canada's publicly funded health care system against any potential challenges under international trade agreements.
- Canada will work with other countries, especially those in the World Trade Organization, to ensure that when it comes to important social policy areas such as health care, all countries have the right to chart their own course independent of international trade agreements.
- Health care will become an important part of Canada's foreign policy and reflect our collective responsibilities for improving health and health care in developing countries.

Conclusion

In completing this report, I am acutely aware that the support of Canadians for their public health care system is conditional. It is given in exchange for a commitment that their governments will ensure that high quality care is there for them when they need it. If Canadians come to believe that their governments will not honour their part of the bargain, they will look elsewhere for answers. And the grave risk we will face is pressure for access to private, parallel services – one set of services for the well off, another for those who are not. Canadians do not want this type of system.

The changes I am proposing are intended to strengthen and modernize medicare, and place it on a more sustainable footing for the future. They are based on a vision of medicare as a national endeavour, where governments work together to ensure timely access to quality health care services as a right of citizenship, not a privilege. And they are designed to achieve a more effectively integrated and a more accountable world-class system that helps to make Canadians the healthiest people in the world.

The reform agenda is an ambitious one, but at a time when one of our most cherished national programs is at a crossroads, Canadians expect no less. The future of this report and of our health care system is now in the hands of Canadians. In the coming months, the choices we make, or the consequences of those we fail to make, will decide medicare's future. I believe Canadians are prepared to embark on the journey together and build on the proud legacy they have inherited. The next step – taking action to implement the recommendations – is where the most important, and perhaps the toughest, work begins. I have no doubt that Canadians and their governments are up to the challenge.

The 47 recommendations I have made in this report, and the timetable for their implementation, are outlined below.

Recommendations

RECOMMENDATION 1:

A new Canadian Health Covenant should be established as a common declaration of Canadians' and their governments' commitment to a universally accessible, publicly funded health care system. To this end, First Ministers should meet at the earliest opportunity to agree on this Covenant.

RECOMMENDATION 2:

A Health Council of Canada should be established by the provincial, territorial and federal governments to facilitate co-operation and provide national leadership in achieving the best health outcomes in the world. The Health Council should be built on the existing infrastructure of the Canadian Institute for Health Information (CIHI) and the Canadian Coordinating Office for Health Technology Assessment (CCOHTA).

RECOMMENDATION 3:

On an initial basis, the Health Council of Canada should:

- Establish common indicators and measure the performance of the health care system;
- Establish benchmarks, collect information and report publicly on efforts to improve quality, access and outcomes in the health care system;
- Coordinate existing activities in health technology assessment and conduct independent evaluations of technologies, including their impact on rural and remote delivery and the patterns of practice for various health care providers.

RECOMMENDATION 4:

In the longer term, the Health Council of Canada should provide ongoing advice and co-ordination in transforming primary health care, developing national strategies for Canada's health workforce, and resolving disputes under a modernized *Canada Health Act*.

RECOMMENDATION 5:

The *Canada Health Act* should be modernized and strengthened by:

- Confirming the principles of public administration, universality and accessibility, updating the principles of portability and comprehensiveness, and establishing a new principle of accountability;
- Expanding insured health services beyond hospital and physician services to immediately include targeted home care services followed by prescription drugs in the longer term;
- Clarifying coverage in terms of diagnostic services;
- Including an effective dispute resolution process;
- Establishing a dedicated health transfer directly connected to the principles and conditions of the *Canada Health Act*.

RECOMMENDATION 6:

To provide adequate funding, a new dedicated cash-only Canada Health Transfer should be established by the federal government. To provide long-term stability and predictability, the Transfer should include an escalator that is set in advance for five year periods.

RECOMMENDATION 7:

On a short-term basis, the federal government should provide targeted funding for the next two years to establish:

- a new Rural and Remote Access Fund
- a new Diagnostic Services Fund
- a Primary Health Care Transfer
- a Home Care Transfer
- a Catastrophic Drug Transfer

RECOMMENDATION 8:

A personal electronic health record for each Canadian that builds upon the work currently underway in provinces and territories.

RECOMMENDATION 9:

Canada Health Infoway should continue to take the lead on this initiative and be responsible for developing a pan-Canadian electronic health record framework built upon provincial systems, including ensuring the interoperability of current electronic health information systems and addressing issues such as security standards and harmonizing privacy policies.

RECOMMENDATION 10:

Individual Canadians should have ownership over their personal health information, ready access to their personal health records, clear protection of the privacy of their health records, and better access to comprehensive and credible information about health, health care and the health system.

RECOMMENDATION 11:

Amendments should be made to the *Criminal Code of Canada* to protect Canadians' privacy and to explicitly prevent the abuse or misuse of personal health information, with violations in this area considered a criminal offense.

RECOMMENDATION 12:

Canada Health Infoway should support health literacy by developing and maintaining an electronic health information base to link Canadians to health information that is properly researched, trustworthy and credible as well as support more widespread efforts to promote good health.

RECOMMENDATION 13:

The Health Council of Canada should take action to streamline technology assessment in Canada, increase the effectiveness, efficiency and scope of technology assessment, and enhance the use of this assessment in guiding decisions.

RECOMMENDATION 14:

Steps should be taken to bridge current knowledge gaps in applied policy areas, including rural and remote health, health human resources, health promotion, and pharmaceutical policy.

RECOMMENDATION 15:

A portion of the proposed Rural and Remote Access Fund, the Diagnostic Services Fund, the Primary Health Care Transfer, and the Home Care Transfer should be used to improve the supply and distribution of health care providers, encourage changes to their scopes and patterns of practice, and ensure that the best use is made of the mix of skills of different health care providers.

RECOMMENDATION 16:

The Health Council of Canada should systematically collect, analyze and regularly report on relevant and necessary information about the Canadian health workforce, including critical issues related to the recruitment, distribution, and remuneration of health care providers.

RECOMMENDATION 17:

The Health Council of Canada should review existing education and training programs and provide recommendations to the provinces and territories on more integrated education programs for preparing health care providers, particularly for primary health care settings.

RECOMMENDATION 18:

The Health Council of Canada should develop a comprehensive plan for addressing issues related to the supply, distribution, education and training, remuneration, skills and patterns of practice for Canada's health workforce.

RECOMMENDATION 19:

The proposed Primary Health Care Transfer should be used to "fast-track" primary health care implementation. Funding should be conditional on provinces and territories moving ahead with primary health care reflecting four essential building blocks – continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to achieve transformation.

RECOMMENDATION 20:

The Health Council of Canada should sponsor a National Summit on Primary Health Care within two years to mobilize concerted action across the country, assess early results, and identify actions that must be taken to remove obstacles to primary health care implementation.

RECOMMENDATION 21:

The Health Council of Canada should play a leadership role in following up on the outcomes of the Summit, measuring and tracking progress, sharing information and comparing Canada's results to leading countries around the world, and reporting to Canadians on the progress of implementing primary health care in Canada.

RECOMMENDATION 22:

Prevention of illness and injury, and promotion of good health should be strengthened with the initial objective of making Canada a world leader in reducing tobacco use and obesity.

RECOMMENDATION 23:

All governments should adopt and implement the strategy developed by the Federal, Provincial and Territorial Ministers Responsible for Sport, Recreation and Fitness to improve physical activity in Canada.

RECOMMENDATION 24:

A national immunization strategy should be developed to ensure that all children are immunized against serious illnesses and Canada is well prepared to address potential problems from new and emerging infectious diseases.

RECOMMENDATION 25:

Provincial and territorial governments should use the new Diagnostic Services Fund to improve access to medically necessary diagnostic services.

RECOMMENDATION 26:

Provincial and territorial governments should take immediate action to manage wait lists more effectively by implementing centralized approaches, setting standardized criteria, and providing clear information to patients on how long they can expect to wait.

RECOMMENDATION 27:

Working with the provinces and territories, the Health Council of Canada should establish a national framework for measuring and assessing the quality and safety of Canada's health care system, comparing the outcomes with other OECD countries, and reporting regularly to Canadians.

RECOMMENDATION 28:

Governments, regional health authorities, health care providers, hospitals and community organizations should work together to identify and respond to the needs of official language minority communities.

RECOMMENDATION 29:

Governments, regional health authorities, and health care providers should continue their efforts to develop programs and services that recognize the different health care needs of men and women, visible minorities, people with disabilities, and new Canadians.

RECOMMENDATION 30:

The Rural and Remote Access Fund should be used to attract and retain health care providers.

RECOMMENDATION 31:

A portion of the Rural and Remote Access Fund should be used to support innovative ways of expanding rural experiences for physicians, nurses and other health care providers as part of their education and training.

RECOMMENDATION 32:

The Rural and Remote Access Fund should be used to support the expansion of telehealth approaches.

RECOMMENDATION 33:

The Rural and Remote Access Fund should be used to support innovative ways of delivering health care services to smaller communities and to improve the health of people in those communities.

RECOMMENDATION 34:

The proposed new Home Care Transfer should be used to support expansion of the *Canada Health Act* to include medically necessary home care services in the following areas:

- Home mental health case management and intervention services should immediately be included in the scope of medically necessary services covered under the *Canada Health Act*.
- Home care services for post-acute patients, including coverage for medication management and rehabilitation services, should be included under the *Canada Health Act*.
- Palliative home care services to support people in their last six months of life should also be included under the *Canada Health Act*.

RECOMMENDATION 35:

Human Resources Development Canada, in conjunction with Health Canada should be directed to develop proposals to provide direct support to informal caregivers to allow them to spend time away from work to provide necessary home care assistance at critical times.

RECOMMENDATION 36:

The proposed new Catastrophic Drug Transfer should be used to reduce disparities in coverage across the country by covering a portion of the rapidly growing costs of provincial and territorial drug plans.

RECOMMENDATION 37:

A new National Drug Agency should be established to evaluate and approve new prescription drugs, provide ongoing evaluation of existing drugs, negotiate and contain drug prices, and provide comprehensive, objective and accurate information to health care providers and to the public.

RECOMMENDATION 38:

Working collaboratively with the provinces and territories, the National Drug Agency should create a national prescription drug formulary based on a transparent and accountable evaluation and priority-setting process.

RECOMMENDATION 39:

A new program on medication management should be established to assist Canadians with chronic and some life-threatening illnesses. The program should be integrated with primary health care approaches across the country.

RECOMMENDATION 40:

The National Drug Agency should develop standards for the collection and dissemination of prescription drug data on drug utilization and outcomes.

RECOMMENDATION 41:

The federal government should immediately review the pharmaceutical industry practices related to patent protection, specifically, the practices of evergreening and the notice of compliance regulations. This review should ensure that there is an appropriate balance between the protection of intellectual property and the need to contain costs and provide Canadians with improved access to non-patented prescription drugs.

RECOMMENDATION 42:

Current funding for Aboriginal health services provided by the federal, provincial and territorial governments and Aboriginal organizations should be pooled into single consolidated budgets in each province and territory to be used to integrate Aboriginal health care services, improve access, and provide adequate, stable and predictable funding.

RECOMMENDATION 43:

The consolidated budgets should be used to fund new Aboriginal Health Partnerships that would be responsible for developing policies, providing services and improving the health of Aboriginal peoples. These partnerships could take many forms and should reflect the needs, characteristics and circumstances of the population served.

RECOMMENDATION 44:

Federal and provincial governments should prevent potential challenges to Canada's health care system by:

- Ensuring that any future reforms they implement are protected under the definition of "public services" included in international law or trade agreements to which Canada is party;
- Reinforcing Canada's position that the right to regulate health care policy should not be subject to claims for compensation from foreign-based companies.

RECOMMENDATION 45:

The federal government should build alliances with other countries, especially with members of the World Trade Organization, to ensure that future international trade agreements, agreements on intellectual property, and labour standards make explicit allowance for both maintaining and expanding publicly insured, financed and delivered health care.

RECOMMENDATION 46:

The federal government should play a more active leadership role in international efforts to assist developing nations in strengthening their health care systems through foreign aid and development programs. Particular emphasis should be placed on training health care providers and on public health initiatives.

RECOMMENDATION 47:

Provincial, territorial and federal governments and health organizations should reduce their reliance on recruiting health care professionals from developing countries.

Proposed Timelines for the Implementation of the Recommendations

The vision implicit in this report will not be achieved overnight. However, the immediate priorities must be to strengthen medicare's legislative and institutional foundations, to stabilize funding, and to address the critical concerns that are eroding Canadians' confidence in the system.

At the conclusion of this section, I propose timelines to help guide sequencing and implementation of the Commission's 47 recommendations.

Policy Area	Early 2003	2003/04	2004/05	2005/06	2010	2011 to 2020
Governance	First Ministers Meeting and the adoption of the Canadian Health Covenant	Modernized *Canada Health Act* (CHA) passed by Parliament; Health Council of Canada established		Canada Health Transfer with escalator takes effect	Federal-provincial-territorial re-negotiation of Canada Health Transfer escalator every five years	
Information and Research	Development of electronic health records continues	Privacy guarantees placed in *Criminal Code*; Health Council begins work on performance indicators, data collection and technology assessment	Health Council's reports on Infoway's progress; Canadian Institutes of Health Research establishes first Centres for Innovation	Health Council develops user-friendly health information for Canadians; first fully functional electronic health records established	All provincial and territorial health records moved to electronic form with full interoperability	
Health Care Providers		Streamline process for recognition of international medical graduates; new personnel and new incentives to meet distribution problems under Rural and Remote Access Fund and Diagnostic Services Fund	Health Council of Canada develops long-term plan for health human resources planning	Health Council makes recommendations on reforms to training of health professionals and to the reform of scopes of practice		
Primary Health Care		$1 billion in new federal funding for primary health initiatives	$500 million in new federal funding for primary health care initiatives; National Summit on Primary Health Care	National Drug Agency launches national immunization strategy; Health Council reports to Canadians on progress on primary health care initiatives	Ongoing work by Health Council to facilitate development of primary health care	Full realization of integrated primary health care

Policy Area	Early 2003	2003/04	2004/05	2005/06	2010	2011 to 2020
Access and Quality	$1.5 billion Diagnostic Services Fund created	Federal funding for new diagnostic equipment and personnel; centralized management of wait lists undertaken by provincial governments		Health Council of Canada releases comprehensive set of performance and quality indicators for health system	Health Council regularly reports to governments and Canadians on access, quality and safety, and provides recommendations for improvements to be undertaken by governments	
Rural and Remote	$1.5 billion Rural and Remote Access Fund created	Federal funding for new initiatives on improving rural and remote access including supply, distribution and mix of health professionals and the expansion of telehealth		Expansion of telehealth and related initiatives through new Canada Health Transfer	Health Council of Canada regularly reports on the health of Canadians in rural and remote areas and makes recommendations for improvements to be undertaken by governments	
Home Care	New program to support informal caregivers	Priority home care services included in new CHA; $1 billion in new federal funding for home care initiatives	Expansion of provincial home care programs through new federal funds		Further expansion of home care services to be included in the CHA	Full integration of home and continuing care services into the CHA
Prescription Drugs		Federal government review of drug patent legislation	Establishment of National Drug Agency; $1 billion per year Catastrophic Drug Transfer takes effect	Development of National Drug Formulary	Establishment of Medication Management Drug Insurance Program linked to primary health care	Full integration of prescription drugs at all levels of care and coverage under the CHA
Aboriginal Health		Intergovernmental negotiations with Aboriginal organizations on the creation of consolidated funds	Establishment of consolidated funds available to fund new Aboriginal Health Partnerships	First Aboriginal Health Partnerships operating	Expansion of Aboriginal Health Partnerships across the country	Majority of Aboriginal health services delivered through Health Partnerships
Globalization	Clear steps to protect health care system from challenge under trade agreements; review practice of recruitment of health professionals from developing countries		Establishment of "health" as a foreign policy goal; alliance building with other nations to ensure that international trade agreements protect the sovereignty of nations to protect social policy priorities; expanded efforts to assist the development of health care systems in the developing world, including expanding public health initiatives and ensuring access to health care technology			

APPENDICES

SUBMISSIONS

During its Fact Finding phase from June to December 2001, the Commission issued a call for submissions, and in its ongoing efforts to remain transparent, posted the responses it received electronically on its Web site. The Commission received further submissions during the consultation phase of its mandate.

The following is a list of formal submissions received by the Commission up to September 13, 2002. Attributed to the original author, these submissions were prepared expressly for the Commission.

Beyond official submissions to the Commission, individuals and organizations also brought to the Commission's attention hundreds of briefs and policy documents. A statistical overview of the volume of calls to the Commission's toll-free information line, e-mails and correspondence is provided at the end of this appendix.

SUBMISSIONS FROM ORGANIZATIONS

Aboriginal Nurses Association of Canada

Aîné.e.s en Marche/Go Ahead Seniors Inc.

Alberta Association of Registered Nurses

Alberta Catholic Health Corporation

Alberta College of Social Workers

Alberta Consortium for Health Promotion Research and Education

Alberta Federation of Labour

Alberta Medical Association

Alberta Mental Health Board

Alberta New Democratic Party

Alberta Society of Friends of Medicare

Alberta Union of Provincial Employees

Alliance for Access to Medical Information

Alliance of Seniors to Protect Canada's Social Programs

Alternatives North

Amgen Canada Inc.

Assemblée des aînées et aînés francophones du Canada

Assemblée des premières nations du Québec et du Labrador et la Commission de la santé et des services sociaux

Association canadienne-française de l'Alberta

Association canadienne-française de l'Ontario

Association coopérative d'économie familiale de Québec

Association des arthritiques de Québec

Association des médecins de CLSC du Québec

Association des spécialistes en médecine interne du Québec

Association médicale du Québec

Association of Canadian Academic Healthcare Organizations

Association of Canadian Medical Colleges (November 2001)
Association of Canadian Medical Colleges (May 2002)
Association of Chinese Canadian Professionals (BC)
Association of Integrative Medicine of Prince Edward Island
Association of International Physicians & Surgeons of Ontario
Association of Local Public Health Agencies
Association of Massage Therapists and Wholistic Practitioners
Association of Midwives of Newfoundland and Labrador
Association of Newfoundland Psychologists
Association of Nurses of Prince Edward Island
Association of Ontario Health Centres
Association of Public Service Alliance Retirees
Association of Workers' Compensation Boards of Canada
Association québécoise des soins palliatifs
Atlantic Institute for Marketing Studies
Atlantic Seniors Health Promotion Network
Au Cœur de l'Être
Aventis Pasteur Limited

Bay of Quinte Conference/United Church of Canada
Baycrest Centre for Geriatric Care
BC Coalition of People with Disabilities
BC Freedom of Information and Privacy Association
B.C. Government and Service Employees' Union
B.C. Retired Teachers' Association
Bernard Betel Centre for Creative Living
BIOTECanada
Birches Family Advisory Council
Breastfeeding Committee for Canada
British Columbia Medical Association
British Columbia Old Age Pensioners Organization
British Columbia Psychological Association
Bromley Road Baptist Church Social Impact and Community Awareness Group

Calgary Meals on Wheels
Canada's Research-Based Pharmaceutical Companies (Rx&D)
Canadian Alliance of Community Health Centre Associations
Canadian Anesthesiologists' Society and the Association of Canadian University Departments of Anesthesiology
Canadian Association for Community Care and Canadian Home Care Association
Canadian Association for Parish Nursing Ministry
Canadian Association for Proximal Stabilization of Cerebral Palsy Children
Canadian Association of Advanced Practice Nurses
Canadian Association of Allied Health Programs
Canadian Association of Chain Drug Stores
Canadian Association of Emergency Physicians
Canadian Association of General Surgeons (CAGS)
Canadian Association of Healthcare Auxiliaries
Canadian Association of Internes and Residents
Canadian Association of Midwives
Canadian Association of Occupational Therapists
Canadian Association of Optometrists
Canadian Association of Pathologists
Canadian Association of Provincial Cancer Agencies
Canadian Association of Psychosocial Oncology
Canadian Association of Public Health Dentistry
Canadian Association of Radiologists
Canadian Association of Radiopharmaceutical Scientists
Canadian Association of Retired Teachers

Canadian Association of the Deaf
Canadian Association of University Teachers
Canadian Association on Gerontology/ Association canadienne de gérontologie
Canadian Auto Workers (CAW-Canada)
Canadian Auto Workers Local 222 Oshawa and Retired Workers Chapter
Canadian Blood Services
Canadian Cancer Advocacy Network
Canadian Cancer Society
Canadian Cardiovascular Society
Canadian Chamber of Commerce/ Chambre de Commerce du Canada
Canadian Chiropractic Association and the Canadian Memorial Chiropractic College
Canadian Coalition Against Insurance Fraud
Canadian Cochrane Network and Centre/ The Cochrane Collaboration
Canadian College of Health Service Executives
Canadian College of Health Service Executives – Bluenose Chapter
Canadian Congress of Neurological Sciences
Canadian Co-operative Association and Le Conseil Canadien de la Coopération
Canadian Council for Public-Private Partnerships
Canadian Council of Chief Executives
Canadian Council of Churches' Ecumenical Health Care Network and Kairos: Canadian Ecumenical Justice Initiatives, Kitchener consultation
Canadian Council on Health Services Accreditation
Canadian Council on Integrated Healthcare
Canadian Council on Social Development
Canadian Dental Association
Canadian Dental Hygienists Association
Canadian Drug Manufacturers Association
Canadian Federation of Medical Students
Canadian Federation of Nurses Unions
Canadian Federation of University Women
Canadian Geriatrics Society
Canadian Health Coalition
Canadian Health Libraries Association
Canadian Health Record Association, Canadian College of Health Record Administrators
Canadian Healthcare Association
Canadian Home Care Association
Canadian Hospice Palliative Care Association
Canadian Institute of Actuaries
Canadian Institute of Child Health
Canadian Institutes of Health Research
Canadian Institutes of Health Research, Institute of Aging
Canadian Institutes of Health Research, Institute of Gender and Health
Canadian Labour Congress
Canadian Life and Health Insurance Association Inc.
Canadian Medical Association/Association médicale canadienne (October 2001)
Canadian Medical Association/Association médicale canadienne (June 2002)
Canadian Medical Protective Association
Canadian Mental Health Association
Canadian Mental Health Association – Newfoundland and Labrador Division
Canadian Midwifery Regulators Consortium
Canadian National Institute for the Blind
Canadian Naturopathic Association
Canadian Nurses Association
Canadian Ophthalmological Society (December 2001)
Canadian Ophthalmological Society (June 2002)
Canadian Orthopaedic Association
Canadian Orthoptic Society
Canadian Paediatric Society
Canadian Pensioners Concerned (Ontario Division)
Canadian Pharmacists Association
Canadian Physiotherapy Association
Canadian Population Health Initiative, Canadian Institute for Health Information
Canadian Psychoanalytic Society
Canadian Psychological Association
Canadian Public Health Association/ Association canadienne de santé publique

Canadian Public Health Laboratory Forum
Canadian Rheumatology Association
Canadian Society of Addiction Medicine
Canadian Society of Nuclear Medicine
Canadian Society of Telehealth
Canadian Task Force on Preventative Health Care
Canadian Teachers' Federation/Fédération canadienne des enseignantes et des enseignants
Canadian Union of Public Employees
Canadian Union of Public Employees Ontario Division
Canadian Union of Public Employees Prince Edward Island
Canadian University Departments of Anaesthesia
Canadian Women's Health Network
Cancer Advocacy Coalition of Canada
CardiacCareNetwork of Ontario
Care Watch Toronto
CARP-Canada's Association for the Fifty-Plus
Catholic Health Association of Canada
Catholic Health Association of Manitoba
Catholic Health Association of Ontario
Catholic Women's League of Canada
Catholic Women's League of Canada, Ontario Provincial Council
Centrale des syndicats démocratiques
Centrale des syndicats du Québec
Centretown, Carlington, Somerset West and Sandy Hill Community Health Centres, Ottawa
Children and Youth Home Care Network
Chinese Canadian National Council
Chinese Medicine and Acupuncture Association of Canada
Chronic Disease Prevention Alliance of Canada
Church in Society Committee
Citizens for Choice in Health Care
Coalition for Active Living
Coalition for Primary Health Care
Coalition of National Voluntary Organizations
Coalition of Physicians for Social Justice
Coalition to Save Social Programs
College of Family Physicians of Canada/ Collège des médecins de famille du Canada
College of Health Disciplines, University of British Columbia
College of Medical Laboratory Technologists of Ontario
College of Physicians and Surgeons of Ontario
College of Registered Nurses of Manitoba
College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia
Collège québécois des médecins de famille
Communications, Energy and Paperworkers Union of Canada
Community Social Planning Council of Toronto
Concerned Friends of Ontario Citizens in Long Term Care Facilities
Confederation of Canadian Unions
Conférence religieuse canadienne – région du Québec
Congress of Union Retirees of Canada/ Association des syndicalistes retraités du Canada
Conseil du patronat du Québec
Conseil du travail d'Edmundston et région
Consumers' Association of Canada
Council of Canadians, Coquitlam Chapter
Council of Canadians Nelson Chapter, Health Committee
Council of Canadians with Disabilities
Council of Senior Citizens' Organizations of British Columbia
Cummings Jewish Centre for Seniors
CUPE Saskatchewan and the CUPE Health Care Council

Dakota Ojibway Tribal Council des premières nations du Québec et du Labrador
Deep River and District Hospital
Diagnostic Imaging and Therapy Systems Council

Drug Trading Company Limited
Durham Haliburton Kawartha and Pine Ridge District Health Council
Durham Paramedic Association
Durham Region Health Coalition

East Thompson/North Shuswap Community Health Advisory Committee
Ecumenical Health Care Network
Edmonton Highlands Health Care Action Group
Edmonton McClung and Edmonton Meadowlark NDP Provincial Constituency Associations
Eli Lilly Canada Inc.
Emergency Medical Services Chiefs of Canada
Emergency Nurses Association of Ontario
English Speaking Catholic Council
Extendicare (Canada) Inc.

Faith Partners
Family Caregivers Association of Nova Scotia
Family Council of Northwoodcare Incorporated
Federal/Provincial/Territorial Dental Directors Working Group
Federal Superannuates National Association
Fédération de l'Âge d'Or du Québec
Fédération des associations étudiantes du campus de l'Université de Montréal
Fédération des Associations Étudiantes en Médecine du Québec
Fédération des communautés francophones et acadienne du Canada
Fédération des infirmières et infirmiers du Québec
Fédération des parents francophones de Terre-Neuve et du Labrador
Fédération Franco-TéNOise
Federation of Saskatchewan Indian Nations

Gerontological Nurses Association (Ontario)
GlaxoSmithKline Inc.
Government of Newfoundland and Labrador, Department of Health and Community Services
Greater Ottawa Chamber of Commerce
Green Shield Canada
Grey Bruce Huron Perth District Health Council
Group of IX Seniors Organizations in Nova Scotia

Halifax Faith Groups
Hamilton HSO Mental Health & Nutrition Program
Health Action Lobby (HEAL)
Health and Community Services, St. John's Region
Health Association of BC
Health Care Coordination Initiative (Canadian Forces, Correctional Service Canada, Royal Canadian Mounted Police, and Veterans Affairs Canada)
Health Care Leaders Association of BC
Health Charities Council of Canada
Health Sciences Council at the University of Alberta
Heart and Stroke Foundation of Canada
Home Support Action Group and Dr. Kari Krogh
Hospital Employees' Union

Injured Workers Consultants Community Legal Clinic (Toronto)
Institute for Aboriginal Health, Division of First Nations Health Careers
Institute of Public Service of Canada and Yukon Employees Union of the Public Service Alliance of Canada
Insurance Bureau of Canada/Le Bureau d'assurance du Canada
International Association of Fire Fighters
International Society for Augmentative and Alternative Communication-Canada IWK Health Centre

Joint Provincial Nursing Committee of Ontario

KAIROS, Canadian Ecumenical Justice Initiatives
Kids First Parent Association of Canada
Kingston and the Islands Federal Liberal Association (Policy Committee)
Kingston Health Coalition

Learning Disabilities Association of New Brunswick
Lethbridge Raging Grannies
Liberal Party of Alberta

Medical Reform Group
Medtronic of Canada, Ltd.
Métis National Council
Montfort Hospital
Moose Jaw-Thunder Creek District Health Board
Mount Zion Lutheran Church, Edmonton
Mountain View Women's Institute
Movement for Canadian Literacy
Multicultural Women's Organizations of Newfoundland and Labrador, National Organization of Immigrant and Visible Minority Women of Canada and Newfoundland and Labrador Health in Pluralistic Societies
Multiple Sclerosis Society of Canada

National Aboriginal Health Organization
National Citizenship and Immigration Law Section, Canadian Bar Association
National Coalition for Vision Health
National Council of Women of Canada
National Defence Headquarters
National ME/FM Action Network of Canada
National Pensioners and Senior Citizens Federation (August 2001)
National Pensioners and Senior Citizens Federation (March 2002)
National Union of Public and General Employees
Native Women's Association of Canada
Nelson and Area Health Council
New Brunswick Catholic Health Association
New Brunswick Common Front for Social Justice
New Brunswick Council of Hospital Unions
New Brunswick Council of Nursing Home Unions
New Brunswick Federation of Union Retirees
New Brunswick Healthcare Association (NBHA)
New Brunswick Nurses Union
New Democratic Party of Canada
New Green Alliance
Newfoundland & Labrador Centre for Health Information and EDS Canada
Newfoundland and Labrador Federation of Labour
Newfoundland and Labrador Health Boards Association
Newfoundland and Labrador Nurses' Union
Newfoundland and Labrador Palliative Care Association
Norfolk General Hospital
Norms and Narratives Research Group, Social Sciences and Humanities Research Council
Northwest Territories Registered Nurses Association
Nova Scotia Advisory Council on the Status of Women
Nova Scotia Citizens' Health Care Network
Nova Scotia College of Chiropractors
Nova Scotia Government & General Employees Union
Nova Scotia League for Equal Opportunities
Nova Scotia Provincial Health Council
Nurses Association of New Brunswick

Occupational and Environmental Medical Association of Canada
Older Adult Centres' Association of Ontario
Older Women's Network (Hamilton and District Chapter)
Older Women's Network (Ontario) Inc.
Ontario Association of Medical Laboratories
Ontario Association of Non-Profit Homes and Services for Seniors

Ontario Association of Optometrists
Ontario Association of Social Workers and the Social Work Doctors' Colloquium
Ontario Brain Injury Association
Ontario College of Family Physicians
Ontario Consultants on Religious Tolerance
Ontario Federation of Labour
Ontario Health Coalition
Ontario Hospital Association
Ontario Long Term Care Association
Ontario Medical Association, Section on Emergency Medicine
Ontario Metis Aboriginal Association
Ontario Nurses' Association
Ontario Provincial Forum of Mental Health Implementation Task Force Chairs
Ontario Psychological Association
Ontario Psychological Association – Section on Independent Practice
Ontario Society (Coalition) of Senior Citizens' Organizations
Ontario Teachers Insurance Plan
Ontario Women's Health Council
Ordre des pharmaciens du Québec
Ottawa Health Coalition
Ottawa Hospital, Spiritual Care Advisory Committee

Paramedic Association of Canada
Parkinson Society Canada
Pensioners and Senior Citizens/ 50+ Federation
Prairie Hope Ministries Inc.
Prairie Women's Health Centre of Excellence
Premier's Council on the Status of Disabled Persons, New Brunswick
Prince Albert Citizen's Agenda Committee
Prince Edward Island Teachers Federation
ProBed Medical Technologies Inc.
Project Genesis
Province of Nova Scotia
Provincial and Territorial Ministers Responsible for Physical Activity, Recreation and Sport
Public Health Nursing Leaders Council of British Columbia
Public Service Alliance of Canada

Qikiqtani Inuit Association
Quality End-of-Life Care Coalition

Redberry Lake NDP Association
Region of Peel, Health Department
Regional Health Authorities of Manitoba
Registered Nurses Association of Ontario
Registered Psychiatric Nurses Association of Saskatchewan
Registry of Marriage and Family Therapists in Canada
Regroupement des intervenantes et intervenants francophones en santé et en services sociaux de l'Ontario
Réseau québécois pour la santé du sein
Retired Teachers of Ontario
Riverdale Seniors' Council
Roman Catholic Archdiocese of Halifax
Royal College of Physicians and Surgeons of Canada (October 2001)
Royal College of Physicians and Surgeons of Canada (June 2002)
Running to Daylight Foundation – The Ben Globerman Memorial
Rural Health Connection Committee

Safe Kids Canada and the Centre for Health Information and Promotion
Sal'i'shan Institute
Salvation Army
Saskatchewan Academic Health Sciences Network
Saskatchewan Action Committee, Status of Women
Saskatchewan Government and General Employees' Union-Health Sector
Saskatchewan Population Health and Evaluation Research Unit, Inc.
Saskatchewan Psychological Association
Saskatchewan Union of Nurses
Saskatchewan Voice of People With Disabilities

Saskatoon & District Chamber of Commerce Health Opportunities Committee
Saskatoon Council on Aging, Informal Caregiver Centre
Saskatoon Health Oasis
Schizophrenia Society of Canada
Seniors' Action and Liaison Team (Edmonton)
Senior Link
Senior Peoples' Resources in North Toronto Inc. (SPRINT)
Seniors Network BC
Seniors' University Group, Inc., University of Regina
Service Alliance of Canada
Service Employees International Union Canada
Services de Counselling de Hearst, Kapuskasing et Smooth Rock Falls
SMARTRISK
Social Policy Research Unit, University of Regina
Society of Obstetricians and Gynaecologists of Canada
Society of Rural Physicians of Canada
Squamish and District Labour Committee
St. Boniface General Hospital
St. Christopher House
St. John's Nursing Home Board
St. Joseph's Care Group, Marycrest Home for the Aged
St. Michael's Hospital
Steelworkers Organization of Active Retirees
Strait Richmond Community Health Board

Table de concertation en santé de l'Ontario
T-Fact Canada Corp. Ltd.
Thames Valley District Health Council
Toronto Dental Coalition
Toronto Health Coalition & Friends of Medicare Toronto
Toronto Public Health
Toronto Rehabilitation Institute
Toronto School of Traditional Chinese Medicine
Toronto & York Region Labour Council
Townshippers' Association
Transitional Council of the College of Osteopathic Manual Practitioners of Ontario

Ukrainian Women's Association of Canada
Union of Nova Scotia Municipalities
United Church of Canada
United Church of Canada, Hamilton Conference
United Steelworkers of America
United Steelworkers of America Local 1005
United Way of Greater Toronto
University College of the Cariboo
University Health Network (September 2001)
University Health Network (June 2002)
University of British Columbia School of Nursing

Valley Caregivers Support Group, Rural Nova Scotia
Vancouver-Quadra Constituency
Victoria Coalition for Health Care Reform
Victorian Order of Nurses

Watson Wyatt Canada
We Care for Tantramar Health Services Committee
Western Arctic Aboriginal Head Start Council
Western Cities Medical Health Officers
Whitehorse General Hospital
William M. Mercer Limited
Winnipeg Presbytery, The United Church of Canada
WoodGreen Community Centre of Toronto

Yee Hong Centre for Geriatric Care
YMCA Canada
York Support Services Network
YouthCO AIDS Society
Yukon Federation of Labour, Whitehorse General Hospital Local of the Professional Institute of the Public Service of Canada
Yukon Medical Association
YWCA of Canada

Submissions from Individual Canadians

Abell, Dr. Margaret E.; Abell, Dr. Nicholas A.; Abell, Dr. W. Robert
Alter, Dr. Robin
Andermann, Anne
Anderson, Richard
Arnott, Roy; Arnott, Barbara; Arnott, Joanne; Arnott, Mac; Arnott, David; Arnott, Jenna

Baltzan, Dr. M.A
Barnes, Keith E.
Basnyat, Dr. S.
Bass, Peter
Bazett, Michael
Becker, Dr. Henry A.
Bennett, Carolyn, MP
Bennett, Meagan
Bertoia, Frank
Bigham, Bruce
Bizon, Norman J.
Blair, Stephen G.
Boddy, Victoria
Boissonnault, Bruce A.
Bonham, Gerald
Braun, Jolene
Brett, Todd
Bryde, John
Byrne, Dr. Joseph M.

Calderhead, Vincent
Campbell, Elaine; Doran, Cheryl; Enman, Anna
Campigotto, Mary Jane
Caro, Dr. Denis H. J.
Castonguay, Claude (Ex-ministre de la santé du Québec)
Champagne, Philippe
Chance, Graham W.
Chatee, Selwyn
Church-Labrick, Conrad
Clarke, Stephen
Clarkson, Darrell
Cleveland, Dr. Eric
Conrick, Rev. Gail
Corley, Judy
Corney, Brenda D.
Crispo, Dr. John

Daniel, Alice J.
Dascavich, William
Davie, Brenda
Davitt, W. Shawn
Day, Dr. Brian
Denman, Harold
Desjardins, L.L.
Desjardins, Louis
Dickson, Jim
Disher, Sandi
Dobson, Joy
Dolesch, Steve

Eaton, R. Mike
Emerson, Dr. Brian P.
Erban, Joseph; Dworkind, Dr. Michael
Evans, Robert G.

Fahey, Marilyn
Fewster, Jean
Finley, Sandra
Finn, Jean-Guy
Fitzgerald, Dr. G. William N.
Flood, John M.
Ford, Dr. Denys K.
Frank, Dr. John
Fulton, Lorna

Gagliardi, Jack
Galbraith, Denise
Garic, Bojan

Gibson, Maggie
Godbout, Jean
Griew, Dr. Stephen
Gurin, David
Gventer, Matthew
Hack, Arshad
Hajaly, Robert
Haliburton, Mary-Sue
Halkett, Murray
Hann, Crystal
Hardy-Joel, Rhonda
Harris Burgess, Dr. Joanne
Heath, Olga
Hempel, Lina
Henry, Régis
Henshaw, Daniel
Heshka, Jean; Heshka, William
Hill, Percy
Hlady, Vibeke
Hoare, Christopher
Holmberg, Dale
Holzman, Linda
Howard, Ross
Hubbert, Anne
Hudson, Dr. John Edward

Johnson, Bonny
Johnson, Peter
Jones, Ernest
Jordan, Joe, MP
Jordon, Jim
Jost, Phil A.
Joyal-Painchaud, Monique

Kastelic, Kathryn
Kelly, Dr. Francis B.
Kelly, Wayne
Knowles, Caroline
Kochalyk, Kim I.
Kochan, Maria H.
Kreasul, Robert G.
Kristensen-Rawluk, Joan
Kumanan, Mekalai
Kurisko, Dr. Lee
Kwan, Klotz
Labaty, Christine
Lack, J.
LaMarre, Joshua
Lamarsh, John D. and Snider, Earle
Leadston, Thomas
Lee, Ed
Leonard, Shaina
Leung, Rebecca K.
Lichtman, J.
Lipka, Miguel Angel
Loiselle, Aurora
Lynch, Tim
Lytton, Hugh

MacDonald, Dr. M. H.
Mackey, Dr. Paul
MacLean, Michael; Jasper, Grace and the students of Social Work and Aging Course, Faculty of Social Work, University of Regina
Maher, E.J.
Malloy, M. L.
Mandzyk, Kim
Mark, Inky, MP
Mason, S.
Mayer, Teresa
Mccorquodale, Ross
McDaniels, Eugene
McGregor, Maurice
McGurrin, Helen
McInnes, Dawn
Milligan, Verna
Mitchell, Andrew
Moisse, Jim
Monahan, Kevin
Morgan, Gerry
Morrison, Bob; Morrison, Denise
Mosher, Cindy
Moulton, Carlyn

Neilson, John
Nelson, Vernon E.

Oancia, Tammy
O'Connor, Denise
O'Hagan, Mary
Olsen, John

Palmer, Patrick
Palmer, Selwyn
Papish, Dr. Roy O.
Parrish, Carolyn, MP
Patrick, Donald R.
Peters, Melissa
Pittman, Michael
Pniauskas, Sandi
Pond, Morgan
Popple, Jeff
Pratt, Camellia C.
Pratt, David, MP
Prytulak, Dr. Walter

Randall, Patricia L. (Caputo)
Rawluk, Tanya
Renwick, Jeff
Richardson, C. H.
Ritcey, Gerald C.
Roddick, Paul M.
Ross, Bob
Ross, Margaret M.; MacLean, Michael J.; Fisher, Rory
Rourke, Dorothy
Roy, Carole
Russell, Dr. Robert

Sarmiento, Linda
Scriver, Dr. Charles R.
Shaw, Mavis
Shaw, Otalene
Shewan, Mary Doris
Simpson, Eva; Simpson, John
Sloan, Gillian
Smith, David E. and St. Denis, Daniel
Sneddon, Bill
Souch, Arlene
Speck, Brandi
Speer, David
Spilchen, Marg
Staples, Brian
Stogre, Fr. Michael
Stolte, Juanita

Telegdi, Andrew, MP
Thériault, Gérard
Thompson, Brian
Throness, Laurie
Trudel, Paul
Tuck, Dennis G.
Tucker, Robert
Turner, Carolyn

Verburg, Geb
Vynckier, Cynthia

Waldner, Dianna
Warrick, Dr. Paddy
Watson, Ellen; Watson, Brad
Westfall, Andrea
White, Norma
Whitfield, Kyle
Williams, Lloyd R.
Wilson, E. Donald
Wirsig, Claus
Wiseman, Herb
Wolf, Shelly
Wong, Alfred

Zur, Andrew

Other Inputs to the Commission

In addition to formal submissions, the Commission also received informal submissions from individual Canadians, health care stakeholders and advocacy groups in the form of abstracts, e-mails, correspondence and calls to its toll-free public information line:

Type of Correspondence*	**Total**
Mail correspondence	6,736
E-mail correspondence	4,421
1-800 calls	2,927
Total Correspondence	**14,084**

*** As of September 13, 2002**

B CONSULTATIONS

CITIZENS' DIALOGUE SESSIONS

The Commission partnered with the Canadian Policy Research Networks, a not-for-profit policy think-tank, to organize 12 regional one-day "deliberative dialogue" sessions across the country. Each session brought together some 40 randomly selected Canadians. At the outset of the process, participants completed a questionnaire probing their perceptions of the challenges confronting Canada's health care system and their preferred solutions for addressing them. They were subsequently provided with a workbook outlining four scenarios for revitalizing the health care system that included arguments for and against each scenario. (An analysis of historical public opinion research data indicated that each of the scenarios enjoyed a relatively high level of public support – despite the seemingly irreconcilable values-base implicit among them. The purpose of the "deliberative dialogue" sessions was to oblige Canadians to make difficult choices between the competing scenarios.)

Working with professional facilitators, participants spent the balance of the day discussing the four scenarios and their likely consequences. At the end of the day, participants were asked to complete a second questionnaire to assess whether their initial perceptions had changed and if so, why. The results of the 12 sessions were analyzed and common themes and directions noted. A national public opinion survey was then undertaken to assess whether the results of the "deliberative dialogue" process would be validated. The four scenarios were:

- **More public investment** – The first scenario was to add more resources (such as doctors, nurses, and equipment) to deal with medicare's current problems by increasing public spending, either through a tax increase or by re-allocating funds from other government programs.
- **Share the costs and responsibilities** – The second scenario was to add more resources to deal with current problems not by increasing public spending but through a system of user co-payments for health care services that would provide an incentive for people not to over-use the system as well as needed funds.
- **Increase private choice** – The third scenario was to give Canadians increased choice in accessing private providers for health care services. Side-by-side with the public system, Canadians also could access health care services from a private sector provider (either for-profit or not-for profit) and pay for it from their own resources or private insurance.

- **Reorganize service delivery** – The fourth scenario was to reorganize service delivery in order to provide more integrated care, realize efficiencies and expand coverage. Under this scenario, each Canadian would sign up with a health care provider network that would work as a team to provide more co-ordinated, cost-effective services and improved access to care.

Date	Location
January 19, 2002	Montreal
January 20, 2002	Montreal (French)
February 2, 2002	Vancouver
February 9, 2002	Halifax
February 9, 2002	Thunder Bay
February 10, 2002	Halifax
February 16, 2002	Calgary
February 16, 2002	Bathurst (French)
February 23, 2002	Regina
February 23, 2002	Québec City (French)
March 2, 2002	Toronto
March 2, 2002	Ottawa

CPAC Televised Forums

In order to raise awareness of the challenges confronting the health care system and to encourage informed discussion during the public consultations, the Commission initiated a number of public education activities, including a series of nationally televised Policy Forums delivered in partnership with Canada's Public Affairs Channel (CPAC). This nationally televised six-part series featured health policy experts representing different points of view engaging in a moderated discussion of key health care issues. Each program was followed by an open-line call-in that allowed interested Canadians to question the participants.

Topics included:

- Values: What do Canadians want from their health care system?
- Sustainability: Can we afford Medicare?
- Leadership: Who should call the shots in Canada's health care system?
- Access: What health care rights should Canadians have?
- Principles: The *Canada Health Act*: Lightning rod or beacon?
- Innovation: Can innovation save Canadian health care?

January 24, 2002

Values: What do Canadians want from their health care system?

Crête, Jean
Professeur titulaire, Département de science politique, Université Laval

Graves, Frank
President, EKOS Research Associates

Mendelsohn, Matthew
Professor, Department of Political Studies, Queen's University

January 31, 2002
Sustainability: Can we afford Medicare?

Evans, Robert G.
Professor, Department of Economics, University of British Columbia

Haddad, Henry (Dr.)
Former President, Canadian Medical Association

Lee-Crowley, Brian
President, Atlantic Institute for Market Studies

February 7, 2002
Leadership: Who should call the shots in Canada's health care system?

Lomas, Jonathon
Executive Director, Canadian Health Services Research Foundation

Maslove, Allan
Professor, School of Public Administration, Carleton University

Paquet, Gilles
Senior Fellow at the Centre of Governance, University of Ottawa

February 14, 2002
Access: What health care rights should Canadians have?

Sinclair, Douglas (Dr.)
President, Canadian Association of Emergency Physicians

Wong-Rieger, Durhane
President, Anemia Institute

Wootton, John (Dr.)
Editor, Canadian Journal of Rural Medicine

February 21, 2002
Principles: The *Canada Health Act*: Lightning rod or beacon?

Flood, Colleen
Associate Professor, Faculty of Law, University of Toronto

Orovan, William (Dr.)
Chair of the Provincial Working Group on Financing of Academic Health Science Centres

Prémont, Marie-Claude
Associate Professor, Faculty of Law, McGill University

February 28, 2002
Innovation: Can innovation save Canadian health care?

Armstrong, Pat
Professor, Department of Sociology, York University

Poston, Jeff
Executive Director, Canadian Pharmacists Association

Rachlis, Michael (Dr.)
Health Policy Analyst

Open Public Hearings

In order to benefit from the input and counsel of individual Canadians and health care stakeholder and advocacy groups, the Commission organized 21 days of public hearings across the country. To facilitate access by those in remote communities, participants had the option of presenting their submissions by telephone. To ensure breadth of perspective and balanced participation, notices were placed in newspapers across the country inviting interested individuals and groups to come forward and to submit a one-page abstract of their proposed submission. At the end of each session, the Commission opened the floor to individuals who wished to comment on the proceedings or provide additional input. Participants had the option of addressing the Commission in either official language, and in Nunavut, special arrangements were made to allow presentations in Inuktitut. The Canadian Public Affairs Channel (CPAC) broadcast all sessions in both official languages.

Regina – March 4, 2002

Organization Presentations

Canadian Association of Retired Teachers
Canadian Taxpayers Federation
Citizens Concerned About Free Trade
Congress of Union Retirees of Canada
Council of Canadians
Divisions scolaires francophones
Fédération des communautés francophones et acadienne du Canada
Federation of Saskatchewan Indian Nations
Government of Saskatchewan – Hon. Lorne Calvert, Premier
Government of Saskatchewan – Hon. John Nilson, Minister of Health
Prince Albert Health District
Saskatchewan Action Committee, Status of Women
Saskatchewan Community Health Cooperative Federation
Saskatchewan Federation of Labour
Saskatchewan Medical Association
Saskatchewan Palliative Care Association
Saskatchewan Voice of People with Disabilities
Saskatoon and District Chamber of Commerce
Survivors of Suicide, Regina Chapter

Citizen Presentations

Adair, Carol
Bryden, John
Bury, John
Finley, Sandra
Gill, Carmen
Holmberg, Dale
Kerr, Mildred
Lavergne, Jocelyne
Silver, William
Storrie, Kathleen
Taylor, Allan
Thériault, Luc
Zerr, Deborah

Winnipeg – March 6, 2002

Organization Presentations

Assemblée des aînées et aînés francophones du Canada
Assembly of Manitoba Chiefs
Canadian Centre for Policy Alternatives

Citizen Presentations

Cooper, Austin
Currie Waldie, Mark
de Jardin, Alan

Canadian Union of Public Employees – Manitoba Regional Office
Catholic Health Association of Manitoba
Frontier Centre
Government of Manitoba – Hon. Gary Doer, Premier
Government of Manitoba – Hon. Dave Chomiak, Minister of Health
Government of Manitoba – Hon. Greg Selinger, Minister of Finance
Manitoba Association of Optometrists
Manitoba Centre for Health Policy
Manitoba Chiropractors Association
Manitoba Psychological Society
Manitoba Retirees
Redvers Chamber of Commerce Health Task Force
Société franco-manitobaine
Southern Chiefs Organization
University of Manitoba – College of Nursing
Winnipeg Regional Health Authority

DeWiele, Lorraine (Dr.)
Ducharme, Theresa
Hiebert, Eduard
Hryciw, Nancy
Hutchings, Douglas
Johnson, Paul
Peterson, Gary
Shapiro, Evelyn
Shtatleman, Barry
Somerville, Irvine
Somerville, Sandra
Vieno, Marlene
Yuin, Joseph

Vancouver – March 12, 2002

Organization Presentations

BC Coalition of People with Disabilities
BC Nurses Union
British Columbia Medical Association
Cambie Surgery Centre
Canadian Association of Provincial Cancer Agencies
Canadian Coalition Against Insurance Fraud
College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia
Fédération des francophones de la Colombie-Britannique
First National Chiefs' Health Committee
Fraser Institute
Government of British Columbia – Ministry of Health Services – Provincial Health Services Authority
Health Association of British Columbia
Info-Lynk Consulting
New Democratic Party of Canada – Alexa McDonough
University of British Columbia – Centre for Health Services and Policy Research

Citizen Presentations

Balabanov, Olive
Baxter, David
Blais, Lois M.
Cocks Hayward, Jane
Eagle, Ron
Hlady, Vibeke
William M. Mercer Ltd
Jordan, Jim
Koch, Thomas (Dr.)
Prouten, Bill
Rattew, Keith
Sobol, Isaac (Dr.)
Winters, Ronald
Wong, Alfred
Zeller, Allan L.

Victoria – March 14, 2002

Organization Presentations

BC Aboriginal Network on Disability Society

BC Government and Service Employees' Union

Canadian Cooperative Association – BC Region

Canadian Naturopathic Association

Government of British Columbia – Hon. Sindi Hawkins, Minister of Health Planning

Home Support Action Group of Victoria

Multiple Sclerosis Society

New Democratic Party of British Columbia – Joy McPhail

Pender Island Health Clinic

Seniors on Guard for Medicare

University of Victoria – School of Nursing

Victoria Coalition for Health Reform

Victoria Hospice Society

Citizen Presentations

Aikman, Chris

Attridge, Carolyn

Bevis, Fred

Brandt, Katherine

Buna, Michael (Dr.)

Cooper, Glenn

Dowman, Greg

Duncan, Peter (Dr.)

Galasso, Pascuale (Dr.)

Hayashi, Allen (Dr.)

Mackey, Paul (Dr.)

Martin, Victoria

Mattson, Debra

Neubauer, Joanne

Newbigging, Barbara

Scott, Donald

Starcher, Dana

Thompson, Patrick

Vantreight, Ian

Québec City – March 25, 2002

Organization Presentations

Association coopérative d'économie familiale du Québec

Association des arthritiques du Québec

Association des médecins de CLSC du Québec

Association des optométristes du Québec

Association des régions du Québec

Association des résidences pour retraités du Québec

Association médicale du Québec (AMQ)

Association québecoise de défense des droits des personnes retraitées et préretraitées

Association québecoise de soins palliatifs

Association québecoise des pharmaciens propriétaires

Centrale des syndicats démocratiques

Conférence religieuse canadienne région du Québec

Conseil du patronat du Québec

English Speaking Catholic Council

Fédération des infirmières et infirmiers du Québec

Federation of Québec Medical Student Societies (FQMSS)

Citizen Presentation

Price, Shelley

First Nations of Quebec and Labrador Health and Social Services Commission
Fraser Institute
Frosst Health Care Foundation
Liberal Party of Quebec – Hon. Jean Charest
Merck Frosst Canada Ltd.
Montreal Economic Institute (MEI)
Réseau québecois pour la santé du sein
Townshippers Association
VisualMed Clinical Systems Inc.

Montreal – March 26, 2002

Organization Presentations

Association des spécialistes en médecine interne du Québec
Association québecoise de gérontologie
Canadian Association for Retired People
Centrale des syndicats du Québec
Chambre de commerce du Québec
Coalition des médecins pour la justice sociale
Coalition pour le maintien dans la communauté
Coalition solidarité santé
Collège des médecins du Québec
Collège québecois des médecins de famille
Confédération des organismes de personnes handicapées du Québec
Confédération des syndicats nationaux
Conseil provincial pour la protection des malades
Cummings Jewish Centre for Seniors
Fédération des médecins omnipraticiens du Québec
Fédération des médecins spécialistes du Québec
Fédération des travailleurs et travailleuses du Québec
Fédération québecoise des sociétés Alzheimer
Force jeunesse
Inuit Tapiriit Kanatami
McGill University – Faculty of Law
McGill University – Faculty of Medicine
McGill University – Faculty of Medicine, Centre for Medical Education
Patients' Committee of the McGill University Health Care
Project Genesis
Société canadienne de la sclérose en plaques du Québec
Société canadienne de l'hémophilie – section Québec
Société canadienne de médecine nucléaire

Citizen Presentations

Alexan, Nadia
Banik, Upen
Donnelly, Brenda
Forget, Claude E.
Hushley, Del
Hussain, Jalaluddin

Toronto – April 2, 2002

Organization Presentations

Association canadienne-française de l'Ontario
Canada 25
Canadian Council on Integrated Health Care
Canadian Institutes of Health Research
Canadian Snowbird Association
Chiefs of Ontario
Consumers' Association of Canada
Government of Ontario – Hon. Tony Clement, Minister of Health and Long Term Care
Liberal Party of Ontario – Dalton McGuinty
New Democratic Party of Ontario – Howard Hampton
Ontario Dialogue on Health Care
Ontario Health Coalition
Ontario Hospital Association
Ontario Medical Association
Registered Nurses Association of Ontario
Rotary Club of Toronto – Don Valley
Toronto Health Coalition

Citizen Presentations

Babb, Clement
Chovaz McKinnon, Cathy
Crispo, John
Greenlea, Carol
Grieb, Claudette
Horsfall, Clive
Horsfall, Susan
Krehm, William
MacLeod, Chris
Marsden, Anne
Meade, Ethel
Oh, John
Rae, John
Reinsborough, Arleen
Reinsborough, John
Taylor, Marcia
Young, Gilbert

Ottawa – April 4, 2002

Organization Presentations

Assembly of First Nations
Canada's Research-Based Pharmaceutical Companies
Canadian Drug Manufacturers Association
Canadian Health Care Association
Canadian Health Coalition
Canadian Hospice Palliative Care Association
Canadian Labour Congress
Canadian Medical Association
Canadian Nurses Association
Canadian Public Health Association
Congress of Union Retirees
Health Charities Council of Canada
Insurance Bureau of Canada
National Council of Women
Ottawa Health Coalition
Réseau des services de santé en français de l'Est de l'Ontario
Royal College of Physicians and Surgeons of Canada

Citizen Presentations

Bond, Daryn
Bowes, Denise
Diegel, Martin
Diegel, Wendy
Duffey, Romney B.
Evans, Allayne
Hubbert, Anne
King, Phillip
Miller, Allison
O'Kelly, Fionuala
Priestman, Kathleen
Roy, Carole
Smith, Ralph
Sniderman, Allan
Snipper, Jon
Steeves, Valerie
Walker, John
Yeo, Michael

Iqaluit – April 8, 2002

Organization Presentations

Government of Nunavut – Hon. Edward Picco, Minister of Health and Social Services
Nunavut Tunngavik Incorporated
Pauktuutit – Inuit Women's Association of Canada
Qikiqtani Inuit Association

Citizen Presentations

Cooper, Rosemary
Ell, Monica
Galia, Rosario Ann
Idlout, Lori
Okalik, Eegesiak
Wilman, Mary

Sudbury – April 11, 2002

Organization Presentations

Cambrian College Pre-Health Group 24
Canadian Association of Chain Drug Stores
Canadian Psychological Association
Group Health Centre Sault Ste-Marie
Laurentian University – School of Nursing
Ontario Association of Speech Language Pathologists and Audiologists
Ontario Coalition (Society) of Senior Citizens' Organizations
Ontario College of Family Physicians
Ontario District Health Councils
Ontario Metis Aboriginal Association
Service de Counselling de Hearst-Kapuskasing-Smooth Rock
Society of Rural Physicians of Canada
Sudbury and District Board of Health
Sudbury and District Labour Council
United Steelworkers of America

Citizen Presentations

Blanco, Jose
Bond, Fred
Bucholtz, Elaine
Butcher, Marilyn
Fritz, Elaine
Glass, Karen
Hoop, Annette
Lounsbury, Hubert
Murray, J. Scott
Nash, Chris
Rebellaton, Nancy
Roellchen-Pfohl, Paul
Salamon, Steven A. J.
Skierszkan, Karl
Soule, Clarence

St. John's – April 15, 2002

Organization Presentations

Association of Registered Nurses of Newfoundland and Labrador
Canadian Mental Health Association, Newfoundland and Labrador Division
Canadian Treatment Action Council (CTAC)
Council of Canadians
Dieticians of Newfoundland and Labrador
Fédération des parents francophones
Government of Newfoundland and Labrador – Hon. Gerald Smith, Minister of Health and Community Services
Labrador Inuit Health Commission (LIHC)
Labrador West District Labour Council
Memorial University of Newfoundland – Faculty of Medicine

Citizen Presentations

Burke, Cynthia
Day, Judith (R.N.)
Eaton, Geoff
Heath, Olga
Hicks, Philip
Janes-Hodder, Honna
Mayo, Tom
Patey, Paul
Piller, Janine
Pittman, Michael
Walsh, Dale
Warrick, Paddy (Dr.)

Multicultural Women's Organization of Newfoundland and Labrador

New Democratic Party of Newfoundland and Labrador – Jack Harris

Newfoundland and Labrador Association of Public and Private Employees

Newfoundland and Labrador Health Boards Association

Newfoundland and Labrador Health in Pluralistic Societies

Newfoundland and Labrador Medical Association

Newfoundland and Labrador Nurses Union

Newfoundland and Labrador Public Health Association

Seniors Resource Centre of Newfoundland and Labrador

Social Sciences and Humanities Research Council of Canada (SSHRC) – Norms and Narratives Research Group

Halifax – April 17, 2002

Organization Presentations

Atlantic Institute for Market Studies

Canadian Auto Workers

Canadian Cardiovascular Society and the Canadian Council of Cardiovascular Nurses

Canadian Federation of Independent Business

Canadian Pediatric Society

Eskasoni Health Centre

Family Care Givers Association of Nova Scotia

Fédération acadienne de la Nouvelle-Écosse

Government of Nova Scotia – Hon. Jamie Muir, Minister of Health

Group of IX Seniors Organization in Nova Scotia

National Coalition for Vision Health

New Democratic Party of Nova Scotia – Darrell Dexter

Nova Scotia Association of Health Organizations

Nova Scotia Government and General Employees Union

Nova Scotia Nurses Union

Paramedic Association of Canada

Citizen Presentations

Antoft, Kell

Cameron, Alex

Coyle, Stephen

Hack, Arshad

Hann, Crystal

Jost, Phil A.

Kelly, Debbie

Klassen, Gerald (Dr.)

MacLellan, Mary Ruth

MacMaster, Edward

Matheson, Brian

O'Brien, Pearl

Smith, Cheryl

Taylor, Anna

Thorn, Ian

Walker, Mary-Ann

White, Cliff

Young, Robert

Charlottetown – April 18, 2002

Organization Presentations

Abegwit First Nations
Association of Nurses of Prince Edward Island
Canadian Association of Internes and Residents (CAIR)
Canadian Association of Public Dentistry
Canadian Union of Public Employees of PEI
Federal Superannuates National Association
Government of Prince Edward Island – Hon. Pat Binns, Premier
Government of Prince Edward Island – Hon. Jamie Ballem, Minister of Health and Social Services
Hospice Palliative Care Association of PEI
Medical Society of Prince Edward Island
New Democratic Party of Prince Edward Island – Herb Dickieson
PEI Advisory Council on the Status of Women
PEI Health Coalition
PEI Licensed Nursing Assistants Association
PEI Nurses' Union
PEI Regional Health Boards
PEI Union of Public Sector Employees
Société Saint-Thomas-d'Aquin
University of Prince Edward Island – School of Nursing

Citizen Presentations

Bingham, Ken
Broderick, Leo
Deacon, Donald
Foley, Michael
Kumanan, Mekalai
Lewis, Donna
McInnis, Charlene
Perry, Edith
Salonius, Peter
Toombs, Wilna

Fredericton – April 19, 2002

Organization Presentations

Canadian Association of Blue Cross Plans – Atlantic Region
Canadian Association of General Surgeons
Community & Hospital Infection Control Association of Canada (CHICA Canada)
Corporation Hospitalière Beauséjour
Government of New Brunswick – Hon. Bernard Lord, Premier
Government of New Brunswick – Hon. Elvy Robichaud, Minister of Health and Wellness
Mouvement acadien des Communautés en santé du Nouveau-Brunswick
New Brunswick Association of Nursing Homes Inc.
New Brunswick Council of Nursing Home Unions
New Brunswick Health Coalition
New Brunswick Healthcare Association
New Brunswick Physiotherapy Association
New Democratic Party of New Brunswick – Elizabeth Weir
Nurses Association of New Brunswick

Citizen Presentations

Adams, Cynthia
Anderson, Richard
Anderson, Vivienne
Corbett, Bradley
Dickinson, Randy
Grasse, Daniel J.
LeBlanc, Gilles
Linkletter, Dorothy
Low, Jacqueline
Mantz, Eileen
Neilson, John
Paynter, Martha
Renner, Serena
Schofield, Aurel
Smallwood, Shirley

Premier's Health Quality Council
Régie régionale Beauséjour
Wilmot United Church
Wilhelm, Linda

Calgary – April 30, 2002

Organization Presentations

Alberta Federation of Labour
Alberta Medical Association
Association canadienne-française de l'Alberta
Calgary Chamber of Commerce
Calgary Health Region
Canadian Association of Emergency Physicians
Canadian Association of Radiologists
Canadian Geriatrics Society
Canadian Mental Health Association
Government of Alberta – Hon. Gary Mar, Minister of Health and Wellness
Métis National Council
Premier's Advisory Council on Health – Rt. Hon. Don Mazankowski
United Nurses of Alberta
YMCA

Citizen Presentations

Aizenman, Rebecca
Ames, Davena
Bang, Karen Marybelle
Bankes, Hugh J.
Chambers, Steven
Corney, Brenda
Daniel, Alice
Dean, Kiri
Hasham, Salim
Hatcher, Mary
Hunt, Lee
MacDonald, M. H.
Maher, E. J.
McCaig, Bud
Morrison, Bob
Murray, Christopher
Parker, John
Ramjeeawon, Jack
Smith, Beverly
Swanson, Harold
Temple, Walley J.
Wilson, E. Donald

Whitehorse – May 2, 2002

Organization Presentations

Acquired Brain Injury for Community Living
Association Franco-Yukonnaise
Calgary Health Region – Division of Gynecology
Council of Yukon First Nations and Yukon First Nations Health and Social Commission
First Nations Health Program Committee
Government of the Yukon – Hon. Pat Duncan, Premier
Government of the Yukon – Hon. Sue Edelman, Minister of Health and Social Services
Government of the Yukon – Hon. Cynthia Tucker, Minister of Education, Policy Liaison

Citizen Presentations

Brookless, Carole
Larke, Bryce (Dr.)
Millard, Ron

New Democratic Party of the Yukon – Ken Boulton
Whitehorse General Hospital
Yukon Anti-Poverty Coalition
Yukon Association for Community Living
Yukon Coronary Health Improvement Project (CHIP)
Yukon Federation of Labour
Yukon Medical Association
Yukon Registered Nurses Association
Yukon Wholistic Health Network

Edmonton – May 14, 2002

Organization Presentations

Alberta Association of Registered Nurses
Alliance jeunesse-famille de l'Alberta
Association of Canadian Academic Healthcare Organizations
Canadian Public Health Laboratory Forum
Capital Health Authority
Chronic Disease Prevention Alliance of Canada
Citizens for Choice on Health Care
College of Physicians and Surgeons of Alberta
Communication, Energy, and Paperworkers Union
Edmonton Health Care Study Circle
First Nations Treaties 6, 7, and 8
Friends of Medicare
Liberal Party of Alberta – Kevin Taft
New Democratic Party of Alberta – Raj Pannu
Senior Action and Liaison Team (SALT)
Seniors Community Health Council
Society of Obstetricians and Gynecologists of Canada
University of Alberta – Parkland Institute

Citizen Presentations

Beliveau, Christine
Cameron, Brenda
Daly, Bill
Janz, Heidi
Langridge, Lise
Laughton, David
Lutes, Lynette
McPherson, Gary
Melnychuk, Stella
Milligan, Verna
Mills, Bob
Newman, Trudy
Rahn, James
Rogers, Robert Dale
Wilson, Donna (Dr.)
Wilson, Margaret
Wright, Robert

Yellowknife – May 16, 2002

Organization Presentations

Alternatives North
Canadian College of Health Services Executives
Canadian Public Health Association
Dene Nation
Fédération Franco-TéNoise
Government of First Nations
Government of the Northwest Territories –
Hon. Stephen Kakfwi, Premier

Citizen Presentations

Bourne, Joyce
Wasicuna, Bob

Government of the Northwest Territories – Hon. J. Michael Miltenberger, Minister of Health and Social Services
Legislative Assembly of the Northwest Territories – Standing Committee on Social Programs
Midwives Association of Northwest Territories and Nunavut
Northern Territories Federation of Labour
Northern Territories Medical Association
Northwest Territories Council of Persons with Disabilities
Northwest Territories Registered Nurses Association
Status of Women Council
Tree of Peace Friendship Centre
Western Arctic Aboriginal Head Start Council
Yellowknife Association of Concerned Citizens for Seniors

Ottawa – May 28, 2002

Organization Presentations

Aboriginal Nurses Association
Association of Ontario Health Centres
Canadian Chamber of Commerce
Canadian Chiropractors Association and Canadian Memorial Chiropractic College
Canadian College of Health Service Executives
Canadian Council on Social Development
Canadian Federation of Nurses Unions
Canadian Institute for Health Information
Canadian Institutes of Health Research – Institute of Aging
Canadian Life and Health Insurance Association
Canadian Medical Forum
Canadian Mental Health Association
Canadian Pharmacists Association
Canadian Union of Public Employees
Commission of Official Languages
Conference Board of Canada
Ecumenical Health Care Network
Health Action Lobby
Heart and Stroke Foundation of Canada
Montfort Hospital
National Aboriginal Health Organization
Native Women's Association of Canada
Ottawa Health Coalition
Sickle Cell Parents' Support Group
United Steelworkers of America

Citizen Presentations

Blair, Stephen
Cazabon, Benoit
Hughes, Joan
Pearson, Wendy
Skinner, Christopher
Weinman, Kyla
Williams, Colin J.
Wilson, Laura

Toronto – May 30, 2002

Organization Presentations

Arthritis Society of Canada
Association for Health Care Philanthropy of Canada
Association of Municipalities of Ontario
BIOTECanada
Canadian Union of Public Employees – Ontario Division
College of Physicians and Surgeons of Ontario
Committee on Monetary and Economic Reform
Ontario Joint Provincial Nursing Committee
Ontario Long Term Care Association
Ontario Nurses' Association
Ontario Women's Health Council
Professional Association of Internes and Residents of Ontario
Six Nations of the Grand River
Tommy Douglas Research Institute
York University

Citizen Presentations

Arnott, Barbara
Arnott, Roy
Barnard, Peter
Brideaux, Philip
Buchanan, Lembi
Conchelos, Mary
Corrigan, Joan
Dubois-Taylor, Lynette
Hassard, Murray
Hawkins, Miranda
Knox, Sarah
Noble, Martha
Pniauskas, Sandi
Rantucci, Melanie
Vandenbroucke, Margaret
West, Pamela

Toronto – May 31, 2002

Organization Presentations

Association of Canadian Medical Colleges
Canadian Association of Midwives
Canadian Association of Retired Persons (CARP)
Canadian Auto Workers Union
Canadian Cancer Society
Canadian Council of Chief Executives
Canadian Diabetes Association
Centre for Addiction and Mental Health
Coalition for Primary Health Care
Employer Committee on Health Care in Ontario
Medical Reform Group
National Union of Public and General Employees
St. Michael's Hospital
Toronto Public Health
University of Toronto – Faculty of Nursing

Citizen Presentations

Ania, Fernando
Bulley, Chris
Clark, Paul
Hunt, Margo
Joseph, Leela
Mak, Adriaan
Rae, Bob
Riley, Helen
Rubin, Murray
Smitherman, George
Thompson, Brian
van Oostveen, Jon
van Oostveen, Judy
Wirsig, Claus A.
Wu, Mary
Young, Terrence

Expert Workshops

In 9 of the 21 communities in which the Commission held public hearings, expert workshops were organized the day following the hearings. At these sessions, participants were asked to assist the Commission in interpreting the results of both the local Citizens' Dialogue session as well as the previous day's public hearings. Participants were also asked to provide advice on the issues of sustainability, access, governance, accountability and quality.

March 5, 2002, Regina, Saskatchewan

Participants:

Blau, June, Saskatchewan Registered Nurses Association

Burka-Charles, Marcy, Saskatchewan Population Health and Evaluation Research Centre University of Regina

Butler-Jones, David (Dr.), Chief Medical Officer of Health

Dosman, James, Community Action Group for Economic Development and Health Research

Gelhorn, Donald (Dr.), College of Family Physicians of Canada

Greyeyes, Doris, Federation of Saskatchewan Indian Nations

Kendel, Dennis (Dr.), College of Physicians and Surgeons of Saskatchewan

Labonte, Ron, Saskatchewan Population Health and Evaluation Research Centre University of Saskatchewan

Leis, Anne, Fédération des communautés francophones et acadienne du Canada

Longmoore, Rosalee, Saskatchewan Union of Nurses

Nelson, Dave, Canadian Mental Health Organization (Saskatchewan Division)

Norheim, Wes, Congress of Union Retirees of Saskatchewan

Sanderson, Sol, Federation of Saskatchewan Indian Nations

Simard, Louise, Saskatchewan Association of Health Organizations

Smillie, Christine, Canadian Diabetes Association Saskatchewan

Thompson, Laurie, Health Services Utilization and Research Commission

Whetstone, Arthur, Saskatchewan Chamber of Commerce

Yeates, Glenda, Saskatchewan Health

March 7, 2002, Winnipeg, Manitoba

Participants:

Chernomas, Robert, Department of Economics, University of Manitoba

Colon, Bailey, Assembly of Manitoba Chiefs

Corby, Linda, Dieticians of Canada

Donner, Lissa, Consultant

Frankel, Sid, Social Planning Council of Winnipeg

Grant, Karen, Women's Health Clinic Winnipeg

Hildahl, Wayne, Pan-Am Clinic

Howard, Jennifer, Policy Management Secretariat, Government of Manitoba

Hudson, Peter, Canadian Centre for Policy Alternatives, Manitoba Office
Johannson, Joan, Kairos, Canadian Ecumenical Justice Initiative
Johnston, Shirley, Manitoba Society of Seniors
Metge, Colleen J., Faculty of Pharmacy, University of Manitoba
Postl, Brian, Winnipeg Regional Health Authority
Roos, Noralou, Manitoba Centre for Health Policy, University of Manitoba

March 13, 2002, Vancouver, British Columbia

Participants:

Bruce, Ted, Vancouver Coastal Health Authority
Cohen, Marcy, BC Hospital Employees Union
Day, Brian, Cambie Surgery Centre
Gee, Linda, BC Ministry of Health and Long-Term Planning
Gilbert, John, College of Health Disciplines, University of British Columbia
Gutray, Bev, Canadian Mental Health Association, BC Region
Horvat, Dan, BC Ministry of Health Planning
Jones, Joyce, Seniors Network of BC
Lantz, Bonnie, Registered Nurses Association of BC
Nakagawa, Bob, Simon Fraser Health Region
Odegard, Larry, Health Association of BC
Thompson, Patrick, Council of Senior Citizens Organizations
Van Ginkel, Anita, Council of Canadians (Coquitlam Chapter)
Wang, Caroline (Dr.), Vancouver Medical Association

March 27, 2002, Montreal, Quebec

Participants:

Adam, Daniel, Association des hôpitaux du Québec
Aucoin, Leonard
Boucher, Denise, Confédération des syndicats nationaux
Brunet, Paul, Conseil provincial pour la protection des malades
Contandriopoulos, André-Pierre, Faculté de médecine, Université de Montréal
Desmeules, Marc, Faculté de médecine, Université Laval
Forget, Claude
Lamarche, Paul, Faculté de médecine, Université de Montréal
Maioni, Antonia, Institute for Canadian Studies, McGill University
Marchand, Louise, Chambre de Commerce du Québec
McGregor, Maurice, Royal Victoria Hospital
Millette, Yves, Association canadienne des compagnies d'assurances de personnes
Nadeau, Emilien, Association des Régions du Québec
Péladeau, Pierrot, Institut de recherches cliniques de Montréal
Valois, Marie, Ordre des infirmières et infirmiers du Québec
Veilleux Gerard, Power Communications
Vinay, Patrick, Université de Montréal

April 3, 2002, Toronto, Ontario

Participants:

Anderson, Geoff, Health and Policy Management and Evaluation, University of Toronto
Bonnett, Chris, Canadian Council on Integrated Health Care
Closson, Tom, University Health Network, Toronto General Hospital
Edelson, Miriam, Ontario Public Service Employees Union
Grinspun, Doris, Registered Nurses Association of Ontario
Gutkin, Cal (Dr.), College of Family Physicians of Canada
Heber, Alexandra, Medical Reform Group
Kaegi, Gerda
Kerbel, Carole, Toronto District Health Council
Lankin, Frances, United Way of Greater Toronto
Mallon, Ruth, Ontario Pharmacists Association
Moulton, Carlyn, THiiNC
Orovan, William, Ontario Hospital Association
Orsini, Steve, Ontario Hospital Association
Scott, Fran, Toronto Public Health
Yalnyzan, Armine, Canadian Centre for Policy Alternatives

April 5, 2002, Ottawa, Ontario

Participants:

Auffrey, Lucille, Canadian Nurses Association
Brimacombe, Glenn, Association of Canadian Academic Healthcare Organizations
Brown, Robert, Canadian Institute of Actuaries
Hackney, Christy, Intergovernmental Policy Unit, Ontario Ministry of Health and Long-Term Care
Heidemann, Elma, Canadian Council on Health Services Accreditation
Jamieson, Shelley, Extendicare
Lomas, Jonathan, Canadian Health Services Research Foundation
Marrett, Penny, Health Charities Council of Canada
McBane, Michael, Canadian Health Coalition
Millar, John, Canadian Institutes of Health Research
Savoie, Gerald, Montfort Hospital
Service, John, Canadian Psychological Association
Sholzberg-Gray, Sharon, Canadian Healthcare Association
Tholl, William (Dr.), Canadian Medical Association
Wiggins, Cindy, Canadian Labour Congress

April 16, 2002, St. John's, Newfoundland

Participants:

Anderson, Theresa, Labrador West District Labour Council
Butler, Roger, Family Practice Unit, Memorial University of Newfoundland
Dawe, Joan, Newfoundland and Labrador Department of Health and Community Services

Elliott, Pamela, St. John's Health CARE Corporation

Fitzgerald, Brenda, Health and Community Services St. John's Region

Kay, Michael, Newfoundland and Labrador Physiotherapy Association

Legge, Wanda, Newfoundland and Labrador Department of Health and Community Services

Murray, Michael, SSHRC Norms and Narratives Research Group, Memorial University of Newfoundland

Orchard, Carole, School of Nursing, Memorial University of Newfoundland

O'Reilly, Steve, Newfoundland and Labrador Centre for Health Information

Peters, Sharon, Faculty of Medicine, Memorial University of Newfoundland

Priddle, Margo, Canadian Pharmacists Association

Robbins, Carl, Telehealth and Education Technology Resource Agency Health Sciences Centre, Memorial University of Newfoundland

Rowe, Penny, Community Services of Newfoundland and Labrador

Woodward, Peter, Woodward Group of Companies

April 18, 2002, Halifax, Nova Scotia

Participants:

Arseneau, Catherine, Health Care Human Resource Sector Council

Batt, Sharon, Centre for Excellence in Women's Health

Chisholm, Robert, Canadian Union of Public Employees

Clarke, James (Dr.), Physician

Deacon, Colin

Elliot, Janice, Public Policy Forum

Keefe, Janice, Graduate Course in Policy, Family Studies and Gerontology, Mount Saint Vincent University

MacDonald, Noni, Faculty of Medicine, Dalhousie University

Malcom, John, Cape Breton District Health Authority

Tomblin Murphy, Gail, School of Nursing, Dalhousie University

Ward, Tom, Nova Scotia Department of Health

May 15, 2002, Edmonton, Alberta

Participants:

Ballermann, Elisabeth, Health Sciences Association of Alberta

Collette, Denis, University of Alberta

Fast, Yvonne, Canadian Union of Public Employees

Fredrickson, Pat, Canadian Practical Nurses Association

Gardiner, George, Council of Canadians

McPherson, Alec, Biomira

Meggison, Doug, Health Sciences Association of Alberta

Noseworthy, Tom, Faculty of Medicine, University of Calgary

Raina, Kim, Centre for Health Promotion Studies, University of Alberta

Shaskin, Igor, Pharmacists Association of Alberta

Shiell, Alan, Department of Community Health Services, University of Calgary

Spence, Matthew, Alberta Heritage Foundation for Medical Research
Temple, Walley, Tom Baker Cancer Centre
Tyrrell, Lorne, Faculty of Medicine and Dentistry, University of Alberta
Weatherill, Sheila, Capital Health Authority
Zussman, David, Public Policy Forum

Regional Forums

In order to facilitate the process of synthesizing the various inputs obtained through the 12 Citizens' Dialogue sessions, the 21 days of public hearings and the 9 Expert Workshops, the Commission organized 3 Regional Forums. These Forums were designed to enable the Commission to further engage the expert community in its deliberations and also to gauge the extent to which consensus existed across regions on the broad directions for renewing the health care system.

June 4, 2002, Halifax, Nova Scotia

Participants:

Brideau, Nicole, Nurses Association of New Brunswick
Clarke, Rick, Nova Scotia Federation of Labour
Dickinson, Randy, Premier's Council on the Status of Disabled Persons
Fitzgerald, Brenda, Health and Community Services, St. John's Region
Hughes, Mary, Hospice Palliative Care Association of PEI
Lee-Crowley, Brian, Atlantic Institute for Market Studies
Losier, Barbara, Mouvement acadien des Communautés en santé du Nouveau-Brunswick
Lucas Jeffries, Marian, New Brunswick Health Coalition
MacDonald, Noni, Faculty of Medicine, Dalhousie University
Murray, Michael, Community Health, Memorial University of Newfoundland
Simpson, Bob, New Brunswick Healthcare Association

June 11, 2002, Saskatoon, Saskatchewan

Participants:

Bruce, Ted, Vancouver Coastal Health Authority
Carrière, Alain, Nunatta Environmental Services Inc.
Chernomas, Robert, Department of Economics, University of Manitoba
Clarke, Rick, Nova Scotia Federation of Labour
Cohen, Marcy, British Columbia Employees Union
Corriveau, André, Health and Social Services, Government of the Northwest Territories
Donner, Lissa, Consultant
Horvat, Dan, Primary Care and Rural Programs, Ministry of Health Planning, Government of British Columbia
Leis, Anne, Fédération des communautés francophones et acadienne du Canada
Mirwald, Rita, Cameco
Nakagawa, Bob, Simon Fraser Health Authority

Pasquali, Paula, Health and Social Services, Government of Saskatchewan
Postl, Brian, Winnipeg Regional Health Authority
Simard, Louise, Saskatchewan Association of Health Organizations
Smith, Heather, United Nurses of Alberta
Thompson Laurence, Health Services Utilization and Research Commission
Weatherill, Sheila, Capital Health (Edmonton)

June 20, 2002, Toronto, Ontario

Participants:

Basrur, Sheela, Toronto Public Health
Connors, Kathleen, Canadian Federation of Nurses Unions
Herbert, Carol, University of Western Ontario
Jamieson, Shelly, Extendicare Canada Inc
Lozon, Jeff, St. Michael's Hospital
Martin, Murray, Hamilton Health Science Corp
Moulton, Carlyn, THiiNC
Murray, David, Group Health Centres
Orsini, Steve, Ontario Health Association
Sholzberg-Gray, Sharon, Canadian Healthcare Association
Tholl, William (Dr.), Canadian Medical Association
Wiggins, Cindy, Canadian Labour Congress

Partnered Dialogue Sessions

To broaden public awareness of key issues in the health care system and to engage the expert and academic communities in its deliberations, the Commission partnered with universities across the country to organize a series of televised, on-campus policy dialogue sessions. Each session featured a panel of health care experts who discussed possible solutions to key health care challenges. The topics discussed and policy options considered were based on nine issue/survey papers developed for the Commission by the Canadian Health Services Research Foundation. The topics included:

1. Home Care in Canada*
2. Pharmacare in Canada*
3. Access to Health Care in Canada
4. Sustainability of Canada's Health Care System
5. Consumer Choice Within a Publicly Funded System
6. The *Canada Health Act*
7. Globalization and Canada's Health Care System
8. Medically Necessary Care: What Is It, and Who Decides?*
9. Human Resources in Canada's Health Care System

* Held in both English and French.

Home Care in Canada, May 16, 2002

University of Windsor, Windsor, Ontario

Moderator:

Wong-Rieger, Durhane, Anemia Institute

Participants:

Derbyshire, Carol, Hospice of Windsor

Hearn, Ambrose, Victorian Order of Nurses

Henningsen, Nadine, Canadian Homecare Association

Hernandez, Cheri Ann, University of Windsor

Parent, Karen, Queen's University

Wittenberg, Jean-Victor (Dr.), Hospital for Sick Children

The *Canada Health Act*, June 10, 2002

University of Saskatchewan, Saskatoon, Saskatchewan

Moderator:

Wallin, Pamela, Pamela Wallin Productions Inc

Participants:

Barrett, Peter (Dr.), Canadian Medical Association

Bégin, Monique, Hon., Former Federal Minister of Health, University of Ottawa

Harrison, Liz, University of Saskatchewan

MacKinnon, Janice, Former Finance Minister of Saskatchewan

Orovan, Bill (Dr.), Ontario Medical Association

Smadu, Marlene, University of Saskatchewan

Access to Health Care in Canada, June 3, 2002

Dalhousie University, Halifax, Nova Scotia

Moderator:

Goldbloom, Richard, Dalhousie University

Participants:

Jurgens, Tannis (Dr.), Dalhousie University

Kam Tat Cheung, Cedric, Chinese Medicine and Acupuncture Association of Canada

Kenny, Nuala (Dr.), Dalhousie University

King, Russell (Dr.), Former New Brunswick Minister of Health

Sinclair, Douglas (Dr.), Queen Elizabeth II Health Sciences Centre

Consumer Choice Within a Publicly Funded System, June 17, 2002

University of Alberta, Edmonton, Alberta

Moderator:

Caulfield, Timothy, University of Alberta

Participants:

Deber, Raisa, University of Toronto

Graham, Wendy (Dr.), Primary Care Reform

Jacobs, Philip (Dr.), University of Alberta

Olhauser, Larry (Dr.), College of Physicians and Surgeons

Shiell, Robert, Canadian Prostate Cancer Network

Smith, Donna Lynn, University of Alberta

Pharmacare in Canada, September 5, 2002

Queen's University, Kingston, Ontario

Moderator:

Banting, Keith, Queen's University

Participants:

Blackburn, Jim, Association of Faculties of Pharmacy of Canada

Daniels, Mark, Canadian Life and Health Insurance Association

Ferguson, Bryan, Applied Management

Morrice, Denis, The Arthritis Society

Sinclair, Duncan, Queen's University

Willison, Don, McMaster University

Pharmacare in Canada, September 9, 2002

McGill University, Montreal, Quebec

Moderator:

Maioni, Antonia, McGill Institute for the Study of Canada

Participants:

Boucher, Laurier, Canadian Association of Social Workers

Chauvette, Lucie, Réseau québécois d'action pour la santé des femmes

Lamothe, Lise, Université de Montréal

Lelorier, Jacques (Dr.), Université de Montréal

Millette, Yves, Canadian Life and Health Insurance Association (Quebec Affairs)

Tamblyn, Robyn, McGill University

Medically Necessary Care: What Is It, and Who Decides? September 10, 2002

Université de Montréal, Montreal, Quebec

Moderator:

Molinari, Patrick, Université de Montréal

Participants:

Audet-Lapointe, Pierre (Dr.), Fondation québecoise du cancer

Barre, Paul (Dr.), Royal Victoria Hospital

Caty, Anne, Patient

Page, David, Canadian Hemophilia Society

Tessier, Dominique (Dr.), College of Family Physicians of Canada

Weinstock, Daniel, Université de Montréal

Sustainability of Canada's Health Care System, September 11, 2002

Toronto General Hospital, Toronto, Ontario

Moderator:

Graham, Wendy (Dr.), Primary Care Reform

Participants:

Aberman, Arnie (Dr.), University of Toronto

Barrett, Brendon (Dr.), Memorial University of Newfoundland

Goodhand, Peter, President, Medec

MacKinnon, David, President, Ontario Hospital Association

Sher, Graham (Dr.), President, Canadian Blood Services

Sutcliffe, Simon (Dr.), Executive Director, BC Cancer Agency

Human Resources in Canada's Health Care System, September 12, 2002

Memorial University,
St. John's, Newfoundland

Moderator:

Davis, Elizabeth

Participants:

Busing, Nick (Dr.), University of Ottawa

Clarke, James (Dr.), Canadian Association of Internes and Residents

Moore-Orr, Robin, Memorial University of Newfoundland

O'Brien-Pallas, Linda-Lee, University of Toronto

Webb, Maggie, Labrador Inuit Association

Globalization and Canada's Health Care System, September 19, 2002

University of British Columbia,
Vancouver, British Columbia

Moderator:

Gilbert, John

Participants:

Evans, Robert G., University of British Columbia

Harris, Susan, University of British Columbia

Labonte, Ronald, University of Saskatchewan

Morrow, Marina, BC Centre of Excellence for Women's Health

Sinclair, Scott, Canadian Centre for Policy Alternatives

Spiegel, Jerry, University of British Columbia

Medically Necessary Care: What Is It, and Who Decides? September 17, 2002

University of Manatoba,
Winnipeg, Manitoba

Moderator:

Finlay, Mary Lou

Participants:

Chernomas, Robert, University of Manitoba

Davidson, Janet, Toronto East General Hospital

Harvey, Dexter, University of Manitoba

Patel, Sunil (Dr.), Rural General Physician

Roos, Noralou, Director, Manitoba Centre for Health Policy

Sirna, Josie, Thalassemia Foundation

Home Care in Canada, September 23, 2002

Pavillion Jeanne de Valois,
Moncton, New Brunswick

Moderator:

McKee-Allain, Isabelle, Université de Moncton

Participants:

Baker, Cynthia, Université de Moncton

Guérette Daigle, Lise, New Brunswick Health (soins infirmiers et services aux patients à la Régie régionale Beauséjour)

Kaufman, Terry, CLSC Notre-Dame-de-Grâce

LeBlanc, Jeannette, Université de Moncton

Lirette, Willie, l'Association des aînées et aînés francophones du N.-B.

Schofield, Aurel (Dr.), College of Family Physicians

Issue Survey Papers

To enable Canadians to express their views on specific issues affecting the health care system, the Commission partnered with the Canadian Health Services Research Foundation to develop a series of nine issue/survey papers. Each of the 10-page papers followed an identical format:

- a brief overview of the issue;
- the enumeration of three policy alternatives and their respective strengths and weaknesses; and
- a series of survey questions that allowed interested individuals or groups to express their views and preferences on the alternatives.

The issue/survey papers were available through the Commission's toll-free information line and were posted on the Commission's Web site where they could be completed on-line.

Release Date	Title	Participation*
May 15, 2002	Homecare in Canada	2,545 Completed
May 15, 2002	Pharmacare in Canada	1,524 Completed
May 15, 2002	Access to Healthcare in Canada	1,594 Completed
June 10,2002	Sustainability of Canada's Healthcare System	1,730 Completed
June 10, 2002	Consumer Choice in Canada's Healthcare System	1,197 Completed
June 10, 2002	The *Canada Health Act*	1,012 Completed
July 10, 2002	Medically Necessary: What Is It, and Who Decides?	1,201 Completed
July 10, 2002	Health Human Resources in Canada's Healthcare System	1,143 Completed
July 10, 2002	Globalization and Canada's Healthcare System	1,487 Completed

* Participation numbers as of September 13, 2002.

Consultation Workbook

The *Shape the Future of Health Care Workbook* presented four perspectives for addressing the issue of medicare's sustainability, and outlined the pros and cons of each. The workbook was an important component of the consultation program because it gave the Commission insight into the "values" that Canadians want to see expressed in medicare's policies and programs. The four perspectives included:

- More public investment;
- More co-payments and cost sharing;
- Increased private choice; and
- Reorganized service delivery.

Release Date	Title	Participation	
March 7, 2002	On-line version	Initiated Completed	20,439 13,109
March 7, 2002	Paper base	Completed	1,083

Site Visits and Meetings with National Organizations and National Caucuses

To facilitate input by interested individuals and organizations, and to broaden the reach of its public awareness efforts, the Commission provided health care stakeholder and advocacy groups with information packages to share with their membership, and Parliamentarians with materials to share with their constituents. Over the course of its mandate, the Commission met directly with many of these groups and with the national caucuses of all federal political parties, with the exception of the Bloc Québecois. The Commissioner also conducted a series of site visits. These meetings included:

Site Visits

Visits were made to the following sites:

Aboriginal Head Start Program, Ndilo, Northwest Territories

Cambie Surgical Centre, Vancouver, British Columbia

CardiacCareNetwork of Ontario, Toronto, Ontario

CLSC Suzor Côté, Victoriaville, Quebec

Evangeline Community Health Centre, Wellington, Prince Edward Island

First Nations Health Program, Whitehorse, Yukon

GENOME Atlantic, Halifax, Nova Scotia

Group Health Centre, Sault Ste. Marie, Ontario

Hôpital Européen Georges Pompidou, Paris, France

Iqaluit Hospital, Iqaluit, Nunavut

Liljeholmens Community Clinic, Stockholm, Sweden

London Health Sciences Centre, London, Ontario

Manitoba Centre for Health Policy and Evaluation, Winnipeg, Manitoba

Mid-Main Community Health Centre, Vancouver, British Columbia

Pangnirtung Community Health Centre, Pangnirtung, Nunavut

South Riverdale Community Health Centre, Toronto, Ontario

St. Göran's Hospital, Stockholm, Sweden

St. Michael's Hospital, Toronto, Ontario

Telemedicine Centre, Health Science Complex, Memorial University, St. John's, Newfoundland

Toronto Rehab Cardiac Rehabilitation Program, Toronto, Ontario

University Health Network, Toronto Western Hospital, Toronto, Ontario

Whitehorse General Hospital, Whitehorse, Yukon

Meetings

Assembly of First Nations

Association of Canadian Academic Healthcare Organizations

Association of Canadian Medical Colleges

C. D. Howe Institute Health Seminar

Canadian Alliance Party Caucus

Canadian Association of Retired Persons

Canadian Blood Services

Canadian College of Health Service Executives

Canadian Council for Public-Private Partnerships

Canadian Drug Manufacturers Association

Canadian Federation of Independent Business

Canadian Health Coalition
Canadian Health Services Research Foundation
Canadian Healthcare Association
Canadian Home Care Association
Canadian Institute for Health Information
Canadian Institutes of Health Research
Canadian Labour Congress
Canadian Medical Association
Canadian Medical Forum
Canadian Mental Health Association
Canadian Nurses Association
Canadian Palliative Care Association
Canadian Pharmacists Association
Canadian Policy Research Networks
Canadian Population Health Initiative
Canadian Public Health Association
Canadian Union of Public Employees
Capital Health Authority, Edmonton
Coalition of National Voluntary Organizations
College of Family Physicians of Canada
Congress of Aboriginal Peoples
Council of Canadians
Dalhousie Medical Research Foundation
Department of Health (London, UK)
Extendicare (Canada) Inc.
Federal/Provincial/Territorial Ministers Responsible for Sport, Recreation and Fitness
Federation of Saskatchewan Indian Nations
Foundation for Integrated Medicine (London, UK)
Frosst Health Care Foundation
Health Services Restructuring Commission of Ontario
Inuit Tapiriit Kanatai (Inuit Tapirisat of Canada)
Liberal Party Caucus
Medical Reform Group
Métis National Council
Ministère délégué à la santé (Paris, France)
Ministry of Health and Social Affairs (Sweden)
National Forum on Health
Native Women's Association of Canada
New Democratic Party Caucus
Northern Health Strategy Working Group, Saskatchewan
Ontario Home Health Care Providers
Ontario Long Term Care Association
Ontario Medical Association
Organisation for Economic Co-operation and Development
Pan-American Health Organization, Dr. George O. A. Alleyne (Washington, DC)
Pollara Research
Premier's Advisory Council on Health, Alberta
Privacy Commissioner, George Radwanski
Progressive Conservative Party Caucus
Public Policy Forum
Public Service Alliance of Canada
Registered Nurses Association of Ontario
Royal College of Physicians and Surgeons of Canada
Saskatchewan Academic Health Sciences Network
Saskatoon District Health
Senator Hillary Rodham Clinton (NY), (Washington, DC)
Special Assistant to the President for Health Policy, Anne Phelps (Washington, DC)
Standing Senate Committee on Social Affairs, Science and Technology
Task Force on Health Research and Economic Development, Saskatchewan
THiiNC Health Inc.
United Way of Greater Toronto
University Health Network (Toronto)
University Hospital Network (Toronto)
World Bank, Chris Lovelace (Washington, DC)

Speeches and Presentations

In addition, the Commissioner has formally addressed a number of stakeholder and other groups across the country and elsewhere, including:

Canadian Federation of Nurses Unions (June 1, 2001, Edmonton, Alberta)

Institute for Research on Public Policy (June 11, 2001, Montreal, Quebec)

Canadian Medical Association (August 14, 2001, Québec, Quebec)

Canadian Chamber of Commerce (September 17, 2001, Winnipeg, Manitoba)

London Health Sciences Centre (September 28, 2001, London, Ontario)

Ditchley Foundation (September 28, 2001, Cambridge, Ontario)

National Association of Canadian Clubs (September 29, 2001, Saskatoon, Saskatchewan)

Queen's University (October 12, 2001, Kingston, Ontario)

Conference Board of Canada (October 18, 2001, Ottawa, Ontario)

Carleton University (October 18, 2001, Ottawa, Ontario)

Business Council on National Issues (October 19, 2001, Toronto, Ontario)

Canadian Public Health Association (October 23, 2001, Saskatoon, Saskatchewan)

College of Family Physicians of Canada (October 25, 2001, Vancouver, British Colombia)

National Health Policy and Research Conference (November 5, 2001, Saskatoon, Saskatchewan)

Conference of the Organisation for Economic Co-operation and Development (OECD) (November 6, 2001, Ottawa, Ontario)

Faculty of Applied Health Sciences, University of Waterloo (November 20, 2001, Waterloo, Ontario)

Frosst Health Care Foundation (November 21, 2001, Toronto, Ontario)

Corpus Christi College, Oxford University (November 26, 2001, Oxford, UK)

Ontario Hospital Association (February 13, 2002, Toronto, Ontario)

Canadian College of Health Service Executives (February 14, 2002, Toronto, Ontario)

McGill University Health Care Conference (February 15, 2002, Montreal, Quebec)

School of Advanced International Studies (SAIS), Johns Hopkins University – roundtable discussion (February 25, 2002, Washington, DC)

School of Advanced International Studies (SAIS), Johns Hopkins University (February 26, 2002, Washington, DC)

Standing Committee on Health (House of Commons) (February 28, 2002, Ottawa, Ontario)

University of British Columbia Research Awareness (March 11, 2002, Vancouver, British Columbia)

University of British Columbia – Public Forum on Health Care (March 13, 2002, Vancouver, British Columbia)

Simon Fraser University (March 13, 2002, Vancouver, British Columbia)

McGill University – Faculty of Management (March 27, 2002, Montreal, Quebec)

Truro Chamber of Commerce (April 16, 2002, Truro, Nova Scotia)

Association of Universities and Canadian Colleges (April 17, 2002, Halifax, Nova Scotia)

Association of Medical Colleges of Canada (April 28, 2002, Calgary, Alberta)

Healthcare Philanthropy Canada (April 29, 2002, Banff, Alberta)

Townhall Meeting (May 1, 2002, Whitehorse, Yukon)

Canadian Pharmacists Association (May 13, 2002, Winnipeg, Manitoba)

Canadian Health Economics Research Association Conference (May 23, 2002, Halifax, Nova Scotia)

Canadian Health and Life Insurance Association (May 29, 2002, Montreal, Quebec)

Canadian Labour Congress (June 11, 2002, Vancouver, British Columbia)

Canadian Nurses Association (June 25, 2002, Toronto, Ontario)

National Aboriginal Achievement Awards (July 10, 2002, Ottawa, Ontario

Canadian Medical Association Annual Meeting (August 20, 2002, Saint John, New Brunswick)

Canada Seminar – Harvard University (October 16, 2002, Boston, MA)

Health Care Panel – Yale University (October 17, 2002, New Haven, CT)

Health Care Panel – New School University (October 18, 2002, New York City, NY)

Memorial University of Newfoundland (October 23, 2002, St. John's, Newfoundland)

Commonwealth Fund (October 24, 2002, Washington, DC)

C THE EXTERNAL RESEARCH PROGRAM

The Commission's external research program consists of a number of different but interrelated components, which are outlined more fully below. The program was designed to solicit not only critical analysis of the existing body of knowledge around health care in Canada and elsewhere, but also to fill in gaps in that knowledge and to provide the Commission with new insights into how best to confront the challenges facing Canada's health care system.

DISCUSSION PAPERS

A total of 40 discussion papers were commissioned from scholars, policy analysts, and experts from across the country and internationally. These papers were focused on specific questions relating to the following four key research themes articulated by the Commission in the Spring of 2001 and outlined in the Interim Report in early 2002:

a) Canadian values and democratic institutions
b) The sustainability of the health care system
c) Identifying and overcoming barriers to change
d) Strengthening collaboration within the health system

All the discussion papers were subject to a peer review process undertaken on behalf of the Commission by the Institute of Health Services and Policy Research (IHSPR) of the Canadian Institutes of Health Research (CIHR). The Commission would like to thank Morris Barer, Donna Shields-Poe, Diane Watson and Rob Courchaine of the IHSPR for their assistance in administering the peer-review process. The final versions of the papers were issued, in both official languages, on the Commission's Web site.

The list of papers is as follows:

- Julia Abelson and John Eyles (McMaster University) *Public Participation and Citizen Governance in the Canadian Health System;*
- Pat Armstrong (York University) and Hugh Armstrong (Carleton University) *Planning for Care: Approaches to Health Human Resources Policy and Planning;*
- Gerard W. Boychuk (University of Waterloo) *The Changing Political and Economic Environment of Health Care in Canada;*
- André Braën (University of Ottawa) *Health and the Distribution of Powers in Canada;*
- Timothy Caulfield (University of Alberta) *How Do Current Common Law Principles Impede or Facilitate Change?;*

- François Champagne (University of Montreal) *The Ability to Manage Change in Health Care Organizations;*
- Clémence Dallaire and Sonia Normand (Laval University) *Changes and a Few Paradoxes: Some Thoughts on Health System Personnel;*
- Raisa Deber (University of Toronto) *Delivering Health Care Services: Public, Not-for-Profit, or Private?;*
- Jean-Louis Denis (University of Montreal) *Governance and Management of Change in Canada's Health System;*
- Harley D. Dickinson (University of Saskatchewan) *How Can the Public Be Meaningfully Involved in Developing and Maintaining an Overall Vision for the Health Care System Consistent with Its Values and Principles?;*
- Robert G. Evans (University of British Columbia) *Raising the Money: Options, Consequences, and Objectives for Financing Health Care in Canada;*
- Katherine Fierlbeck (Dalhousie University) *Paying to Play? Government Financing and Health Care Agenda Setting;*
- Colleen M. Flood and Sujit Choudhry (University of Toronto) *Strengthening the Foundation: Modernizing the Canada Health Act;*
- Anita J. Gagnon (McGill University) *Responsiveness of the Canadian Health Care System Towards Newcomers;*
- Sholom Glouberman and Brenda Zimmerman (Baycrest Centre for Geriatric Care, Toronto) *Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like?;*
- Donna Greschner (University of Saskatchewan) *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?;*
- Michel Grignon, Valérie Paris, Dominique Polton, in collaboration with Agnès Couffinhal and Bertrand Pierrard (CREDES, Paris, France) *Influence of Physician Payment Methods on the Efficiency of the Health Care System;*
- Seamus Hogan and Sarah Hogan (University of Canterbury, New Zealand) *How Will the Ageing of the Population Affect Health Care Needs and Costs in the Foreseeable Future?;*
- Louis M. Imbeau, Kina Chenard and Adriana Dudas (Laval University) *The Conditions for a Sustainable Public Health System in Canada;*
- Martha Jackman (University of Ottawa) *The Implications of Section 7 of the Charter for Health Care Spending in Canada;*
- Jon R. Johnson (Goodmans, Toronto) *How Will International Trade Agreements Affect Canadian Health Care?;*
- John N. Lavis (McMaster University) *Political Elites and Their Influence on Health-Care Reform in Canada;*
- Howard Leeson (University of Regina) *Constitutional Jurisdiction Over Health and Health Care Services in Canada;*
- Pascale Lehoux (University of Montreal) *Could New Regulatory Mechanisms Be Designed after a Critical Assessment of the Value of Health Innovations?;*
- Antonia Maioni (McGill University) *Roles and Responsibilities in Health Care Policy;*

- Theodore R. Marmor (Yale University), Kieke G. H. Okma (Queen's University and Ministry of Health, Welfare and Sport, the Netherlands) and Stephen R. Latham (Yale University) *National Values, Institutions and Health Policies: What Do They Imply for Medicare Reform?;*
- Ian McKillop (Wilfrid Laurier University) *Financial Rules as a Catalyst for Change in the Canadian Health Care System;*
- Steve Morgan (University of British Columbia) and Jeremiah Hurley (McMaster University) *Influences on the "Health Care Technology Cost-Driver";*
- Richard Ouellet (Laval University) *The Effects of International Trade Agreements on Canadian Health Measures: Options for Canada with a View to the Upcoming Trade Negotiations;*
- Réjean Pelletier (Laval University) *Intergovernmental Cooperation Mechanisms;*
- Jayne Renee Pivik (University of Ottawa) *Practical Strategies for Facilitating Meaningful Citizen Involvement in Health Planning;*
- Marie-Claude Prémont (McGill University) *The Canada Health Act and the Future of Health Care Systems in Canada;*
- Cynthia Ramsay (Elm Consulting, Vancouver) *A Framework for Determining the Extent of Public Financing of Programs and Services;*
- Candace Johnson Redden (Brock University) *Health Care Politics and the Intergovernmental Framework in Canada;*
- Jean-Luc Migué (Fraser Institute) *Funding and Production of Health Services: Outlook and Potential Solutions;*
- François Rocher and Miriam Smith (Carleton University) *Federalism and Health Care: The Impact of Political-Institutional Dynamics on the Canadian Health Care System;*
- Melissa Rode (independent scholar) and Michael Rushton (University of Regina) *Options for Raising Revenue for Health Care;*
- Alan Shiell (University of Calgary) and Gavin Mooney (Curtin University of Technology, Perth, Australia) *A Framework for Determining the Extent of Public Financing of Programs and Services;*
- Stephen Tomblin (Memorial University) *Creating a More Democratic Health System: A Critical Review of Constraints and a New Approach to Health Restructuring;*
- Gail Tomblin-Murphy (Dalhousie University) and Linda O'Brien-Pallas (University of Toronto) *How Do Health Human Resources Policies and Practices Inhibit Change? A Plan for the Future.*

RESEARCH PROJECTS

In those areas where it was felt that the Commission's deliberations would benefit from more in-depth analysis of key issues and challenges facing the system, the Commission designed three major research initiatives. The terms of reference for each of these projects were designed with the assistance of outside experts who provided input on the key research questions that would be the focus of these projects (these roundtables are noted in the Interim Report).

In the Fall of 2001, the Commission posted three "Request for Proposals" calling on research teams from across the country to design projects that would answer the questions posed in the RFPs. A panel consisting of senior Commission staff, academics and a representative of the Federal Department of Public Works and Government Services evaluated the proposals submitted. The applications were judged on the basis of the suitability of the research team, the credentials of the individual team members and, most importantly, the scholarly merit of the proposed research plan.

The work for these projects was begun in late 2001 and completed in the summer of 2002. Each of these projects consisted of a different set of research products (e.g., background research papers, comprehensive literature reviews, annotated bibliographies, expert interviews and roundtables), but each team was required to summarize its work in a detailed Final Report that was posted, in both languages, on the Commission's Web site. Copies of the other research products will form part of the official archive of the Commission. However in the interim those other research products are available on request from the principal investigators listed below (subject to any conditions they may specify).

The three research project teams are:

a) Fiscal Federalism and Health
   - Principal Investigator: Harvey Lazar, Director, Institute of Intergovernmental Relations, Queen's University, Kingston, Ontario K7L 3N6
   - Investigators: Keith Banting (Queen's University); Robin Boadway (Queen's University); David Cameron (University of Toronto); Jennifer McCrea-Logie (University of Toronto); France St. Hillaire (Institute for Research on Public Policy, Montreal); Jean-François Tremblay (Queen's University)

b) Globalization and Health
   - Principal Investigator: Bruce Campbell, Executive Director, Canadian Centre for Policy Alternatives, 410-75 Albert St., Ottawa, Ontario K1P 5E7
   - Investigators: Chantal Blouin (North-South Institute, Ottawa); John Foster (North-South Institute, Ottawa); Ronald Labonte (Universities of Saskatchewan and Regina); Joel Lexchin (York University); Matthew Sanger (Canadian Centre for Policy Alternatives, Ottawa); Steven Shrybman (Sack, Goldblatt and Mitchell, Ottawa); Scott Sinclair (Canadian Centre for Policy Alternatives, Ottawa)

c) Health Human Resources
   - Principal Investigator: Cathy Fooks, Director, Health Network, Canadian Policy Research Networks, Suite 600, 250 Albert Street, Ottawa, Ontario, K1P 6M1
   - Investigators: Katya Duvalko (University of Toronto); Patricia Barenak (University of Toronto); Lise Lamothe (University of Montreal); Kent Rondeau (University of Alberta)

CITIZENS' DIALOGUE PROJECT

In conjunction with the Canadian Policy Research Networks (CPRN) and Viewpoint Learning, the Commission undertook a unique process of engaging citizens across the country in a structured dialogue concerning both options for health care reform and the trade-offs involved in making particular choices for future health policy initiatives. Using a methodology originally

developed by Viewpoint and scenarios developed in conjunction with the Commission that reflected the different types of reform proposals most often put forward for public debate, CPRN held 12 day-long dialogue sessions across the country involving cross-sections of the Canadian public.

The objective of these dialogues was to gain insight into the values of Canadians with regard to the health care system and to understand what trade-offs Canadians would find most acceptable in any set of reforms to the system. The results of these dialogues were then compared with a national public opinion survey (conducted by EKOS Research Associates) in order to test whether the views expressed in the dialogues were consistent with those held more generally in the population.

In preparation for the dialogue sessions and the analysis of those results, the Commission also asked a leading public opinion scholar to conduct a comprehensive analysis of past public opinion surveys concerning Canadians' attitudes toward the health care system.

Both the historical public opinion analysis and the results of the Citizens' Dialogue process were made available, in both official languages, on the Commission Web site. These two documents are:

a) Matthew Mendelsohn (Queen's University). *Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation.*

b) Judith Maxwell, Karen Jackson, Barbara Legowski (CPRN), Steven Rosell and Daniel Yankelovich (Viewpoint Learning), in association with Pierre-Gerlier Forest and Larissa Lozowchuk (Commission on the Future of Health Care in Canada). *Report on Citizens' Dialogue on the Future of Health Care in Canada.*

Expert and Research Roundtables

During the course of its fact-finding and research phases, the Commission asked four institutions to host roundtables on key issues on which the Commission felt that a sustained dialogue with noted experts would be particularly informative for its own deliberations.

In all these instances the material prepared for the roundtable by participants remains the property of the host institution. At least two of those institutions, the Collège des Économistes de la Santé in Paris and the C. D. Howe Institute in Toronto, have indicated their intention to publish at least some of the material presented. Those wishing to learn more about the presenters or the presentations are encouraged to contact the host institutions for each of the roundtables indicated below.

Expert Roundtable on Public-Private Partnerships

Held on November 27, 2001, by the London School of Hygiene and Tropical Medicine in London, UK

Participants:

- Roy J. Romanow, Commissioner, Commission on the Future of Health Care in Canada
- Nick Black, Professor of Health Services Research, London School of Hygiene and Tropical Medicine (Organizer)
- Greg Marchildon, Executive Director, Commission on the Future of Health Care in Canada

- Pierre-Gerlier Forest, Director of Research, Commission on the Future of Health Care in Canada
- Steve Dewar, Acting Director of Health Policy, King's Fund
- Carol Popper, Professor of Economics, University of Bristol
- Simon Stevens, Managing Director of Healthcare Services Division, Nestor plc
- Steve Davies, Senior Research Fellow, University of Wales (Cardiff)
- Declan Gaffney, Greater London Authority
- Jon Susses, Associate Director, Office of Health Economics, London

Research Roundtable on Co-Payments and Related Policy Options

Held on November 29, 2001, by the Collège des Économistes de la Santé in Paris, France

Participants:

- Roy J. Romanow, Commissioner, Commission on the Future of Health Care in Canada
- Gérard de Pouvourville, Président, Collège des Économistes de la Santé (Organizer)
- Greg Marchildon, Executive Director, Commission on the Future of Health Care in Canada
- Pierre-Gerlier Forest, Director of Research, Commission on the Future of Health Care in Canada
- Ian McLean, Plenipotentiary Minister, Canadian Embassy
- Stefan Felder, University of Magdebourg, Germany
- Marc Jegers, Free University of Brussels, Belgium
- Livio Grattini, Institute Mario Negri, Milan, Italy
- Jakob Kjellberg Christensen, Danish Institute for Health Services Research, Denmark
- Ulf Persson, University of Lund, Sweden
- Guillem Lopez I Casanovas, University Pompeu Fabra, Barcelona, Spain
- Agnès Couffinhal, CREDES, Paris, France
- Valérie Paris, CREDES, Paris, France

Expert Roundtable on Health System Cost-Drivers

Held on February 25, 2002, by the School of Advanced International Studies at Johns Hopkins University in Washington, DC.

Participants:

- Roy J. Romanow, Commissioner, Commission on the Future of Health Care in Canada
- Charles Doran, Director of the Center for Canadian Studies, School of Advanced International Studies, Johns Hopkins University (Organizer)
- Greg Marchildon, Executive Director, Commission on the Future of Health Care in Canada
- Pierre-Gerlier Forest, Director of Research, Commission on the Future of Health Care in Canada
- Tom McIntosh, Research Coordinator, Commission on the Future of Health Care in Canada
- Henry J. Aaron, Senior Fellow, Brookings Institution, Washington, DC
- Howard Palley, Chair, Health Specialization, School of Social Work, University of Maryland

- Donald M. Steinwachs, Chair, Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University
- Pauline Vaillancourt-Rosenau, School of Public Health, University of Texas
- Colleen M. Grogan, School of Social Service Administration, University of Chicago
- Tamara Woroby, Center for Canadian Studies, School of Advanced International Studies, Johns Hopkins University
- Chris Gray, graduate student, Center for Canadian Studies, School of Advanced International Studies, Johns Hopkins University

Research Roundtable on Financing Options for Health Care

Held on May 24, 2002, by the C. D. Howe Institute in Toronto, Ontario

Participants:

- Roy J. Romanow, Commissioner, Commission on the Future of Health Care in Canada
- Jack M. Mintz, President and CEO, C.D. Howe Institute, Toronto, Ontario (Organizer)
- Greg Marchildon, Executive Director, Commission on the Future of Health Care in Canada
- Pierre-Gerlier Forest, Director of Research, Commission on the Future of Health Care in Canada
- Tom McIntosh, Research Coordinator, Commission on the Future of Health Care in Canada
- William B. P. Robson, Vice-President and Director of Research, C. D. Howe Institute, Toronto, Ontario
- Jean-Luc Migué, Senior Fellow, Fraser Institute
- Shay Aba, Policy Analyst, C. D. Howe Institute, Toronto, Ontario
- Åke Blomqvist, University of Western Ontario
- Michanne Haynes, Institute for International Business, University of Toronto
- David Laidler, University of Western Ontario
- John Richards, Simon Fraser University
- Mark Mullins, Economic Consultant
- Allison O'Brien, Institute of Public Economics, University of Alberta
- Paul Boothe, Institute of Public Economics, University of Alberta
- Mark Stabile, Department of Economics, University of Toronto
- Grant Reuber, G. L. Reuber and Associates, Inc., Toronto, Ontario
- Finn Poschmann, Senior Policy Analyst, C. D. Howe Institute, Toronto, Ontario
- Robert D. Brown, FCA

Mapping Canada's Health Care System

The Commission contracted the Canadian Institute for Health Information (CIHI) to produce a number of maps detailing different aspects of Canada's health care system. These maps included such things as the distribution of health providers across the country and the location of sophisticated diagnostic technology. The majority of the maps, however, focused on "performance indicators" such as years of disability-free life expectancy, the prevalence of ambulatory care sensitive conditions, the prevalence of particular health conditions such as asthma, and other health determinants such as income, unemployment, physical activity and smoking rates.

These maps played an important role in the deliberations of the Commission as it worked to understand the regional differences in both the health status of Canadians and the performance of the provincial and territorial health systems. Some of these maps have been reproduced throughout this report.

The Commission would like to thank the staff of CIHI for their hard work in producing these maps, particularly Jennifer Zelmer and Indra Pulcins, who were responsible for overseeing the mapping project (and acted as a liaison with Statistics Canada, which produced some of the data for the maps).

D Commission Staff

This report would not have been possible without the hard work and dedication of all those who worked for the Commission. I would like to specifically thank **Greg Marchildon**, Executive Director and Lead Drafter, as well as:

Cécile Allard, Director, Corporate Support Services
Michel Amar, Director, Communications and Consultation
Jennifer Bayne, Director, Knowledge Management
Lillian Bayne, Associate Executive Director to February 2002, and Special Advisor, Stakeholder and Expert Relations from February 2002
Laurie Best, Manager, Communications to October 2001
Nicole Bilodeau, Correspondence and Records Management Clerk
Carlo Binda, Manager, Intergovernmental Relations
Audrey Bufton, Manager, Correspondence to June 2002
Chantelle Calder, Executive Assistant to Research Director
Carolynne Chateigner, Administrative Support to October 2001
Pauline Duperreault, Manager, Records Management and Correspondence
Louise Durocher, Office Manager, Ottawa
Pierre-Gerlier Forest, Co-Director, Research to February 2002 and Director, Research from February 2002
Peggy Garritty, Writer, December 2001, July 2002
Nadia Gilbert, Research and Policy Analyst
Phil Gordon, Liaison/Outreach Officer
Lynn Gray, Financial Manager
Claude-Jean Harel, Web Site Communications Editor
Bob Harvey, Manager, Information Services to May 2002
Nancy Johnson, Administrative Support to May 2002
Meghan Jones, Travel Logistics and Claims Clerk
Céline Kidder, Client Services and Reception
Louise Lang-Levesque, Executive Assistant to Executive Director to June 2002
Gordon Lawson, Research and Policy Analyst
Steven Lewis, Co-Director, Research to February 2002

Larissa Lozowchuk, Research and Policy Analyst
Marie-Josée Maisonneuve, Client Services and Reception
Geneviève Martin, Research and Policy Analyst
Sinead McGartland, Assistant, Communications
Tom McIntosh, Research Coordinator
Robert McMurtry, Special Advisor
Larissa McWhinney, Research and Policy Analyst
Mindy Meckelborg, Correspondence Clerk
Andrew Noseworthy, Director, Intergovernmental Relations to February 2002
and Acting Executive Director from February 2002
Kevin O'Fee, Research and Policy Analyst
Angela Pedley, Executive Assistant to the Commissioner
Beryl Radcliffe, Contracts and Records Management
Nathalie Roy, Research and Policy Analyst
Nathan Schalm, Research Support
Julie Schneiderman, Events Planning and Communications
Louise Séguin-Guénette, Coordinator, Publications
Cheryl Seneschen, Administrative Support to November 2001
Jayne Simms-Dalmotas, Associate Director, Communications and Consultation
Cristina Ugolini, Research and Policy Analyst
Nicole Viau-Cheney, Director, Administration to July 2001
Fulai Wang, Information Services Support
Chad Watson, Administrative Support

Statistical History of Health Expenditures and Transfers in Canada, 1968 to 2002

The tables on the following pages commence with the fiscal year 1968/69 because of the lack of consistent and reliable data respecting public expenditures for health in years prior to this date. Blank spaces within columns represent where data were unavailable for that year or judged to be unreliable. The data selected are those determined to be the most consistent and reliable based upon official sources.

All data pertaining to federal transfer payments have either been provided directly by the Department of Finance Canada or are derived from departmental source material (see technical notes). Figures related to the allocation of cash transfers for the period 1968/69 to 1976/77 (the combined value of transfers made under the *Hospital Insurance and Diagnostic Services Act* and under the *Medical Care Act* and including the cash value of tax abatements made to the Province of Quebec in lieu of Hospital Insurance) appear as provided by the Department of Finance Canada. Similarly, federal transfers made during the period 1977/78 to 1995/96 through Established Programs Financing (EPF) and their distribution either in cash or tax points, and in terms of the notional allocation for health, also appear in the form in which the figures were supplied to the Commission on the Future of Health Care in Canada by the Department of Finance Canada. For the period 1996/97 to 2005/06 (CHST), only the total transfer value and the total cash and tax point calculations for the CHST were provided by the Department of Finance. For the purposes of Appendix E, the calculation of notional allocations for "health" from the CHST are made by the Commission on the Future of Health Care in Canada (see technical notes for details).

Appendix E.1: Public Health Expenditures and Federal Transfers for Major Social Programs Including Notional Allocations for Health (Current Dollars Unless Otherwise Specified): 1968/69 to 2001/02 and Projections Beyond

Health Transfer Regime	Fiscal Year	A	B	C	D	E	F	G	H	I	J	K	L	M	N
		Total Public and Private Health Expenditures	Total Public and Private Health Expenditures (Constant 1997 Dollars)	Total Public Sector Health Expenditures	Total Public Sector Health Expenditures (Constant 1997 Dollars)	Total Provincial-Territorial Health Expenditures	Provincial-Territorial Expenditures for Hospital and Physician Services	Total Federal Direct Health Expenditures	Combined Federal and Provincial-Territorial Health Expenditures	Total Major Social Transfers	Cash Component of Major Social Transfers	Tax Point Component of Major Social Transfers	Health Component Total Federal Transfers for HIDSA and Medicare (1968/69 to 1976/77), EPF (1977/78 to 1995/96) and CHST	Health Component Federal Cash Transfers for HIDSA and Medicare(1968/69 to 1976/77), EPF (1977/78 to 1995/96) and CHST	Health Component Federal Tax Point Transfers for EPF (1977/78 to 1995/96) and CHST
		($Millions)													
Hospital Insurance and Diagnostic Services Act (1957) and The *Medical Care Act* (1966)	1968/69	4,911.9	..	..	..	2,515.2	..	..	..	..	831.1	..	831.1	831.1	..
	1969/70	5,505.3	..	..	..	3,255.8	..	..	..	..	1,100.0	..	1,100.0	1,100.0	..
	1970/71	6,253.8	..	..	..	4,144.6	..	..	..	..	1,468.3	..	1,468.3	1,468.3	..
	1971/72	7,118.7	..	..	..	4,752.6	..	..	..	..	1,792.0	..	1,792.0	1,792.0	..
	1972/73	7,787.7	..	..	..	5,326.1	..	..	..	..	1,984.7	..	1,984.7	1,984.7	..
	1973/74	8,699.4	..	..	..	5,902.7	..	..	..	..	2,168.3	..	2,168.3	2,168.3	..
	1974/75	10,223.9	..	..	..	7,177.6	5,770.7	363.0	7,540.5	..	2,624.7	..	2,624.7	2,624.7	..
	1975/76	12,200.6	39,695.6	9,301.4	29,730.5	8,742.2	6,985.0	410.0	9,152.2	..	3,168.2	..	3,168.2	3,168.2	..
	1976/77	14,051.0	40,778.2	10,818.5	30,619.6	9,883.7	7,974.9	449.6	10,333.3	..	3,728.0	..	3,728.0	3,728.0	..
Established Programs Financing (EPF) (1977)	1977/78	15,451.2	41,621.0	11,845.8	30,924.8	11,317.0	8,431.1	483.8	11,800.8	8,201.1	5,462.4	2,738.7	4,673.0	2,814.0	1,858.9
	1978/79	17,108.4	42,953.6	13,042.1	31,718.6	12,589.1	9,285.5	486.2	13,075.3	9,304.4	6,202.4	3,102.0	5,345.0	3,239.0	2,105.5
	1979/80	19,170.1	44,216.2	14,552.7	32,281.8	14,066.4	10,183.8	521.7	14,588.1	10,591.5	7,027.9	3,563.6	6,094.0	3,675.0	2,418.8
	1980/81	22,308.7	46,703.1	16,852.1	33,922.0	16,372.0	11,863.9	602.2	16,974.2	12,022.5	7,853.8	4,168.7	6,863.0	4,033.0	2,829.5
	1981/82	26,289.1	48,863.8	19,955.0	35,583.2	19,419.6	13,965.6	722.9	20,142.4	13,620.4	8,880.1	4,740.2	7,726.0	4,508.0	3,217.5
	1982/83	30,771.7	51,224.7	23,459.4	37,548.5	22,866.0	16,489.1	898.8	23,764.8	15,632.6	10,270.9	5,361.6	8,682.0	5,043.0	3,639.3
	1983/84	34,053.9	53,220.1	26,095.3	39,539.8	25,061.3	18,032.4	1,027.0	26,088.2	17,251.6	11,771.7	5,479.8	9,590.0	5,861.0	3,719.5
	1984/85	36,759.2	55,162.3	27,973.0	40,845.2	26,642.8	19,125.6	1,132.5	27,775.3	18,540.8	12,569.6	5,971.3	10,379.0	6,326.0	4,053.1
	1985/86	39,858.5	57,583.8	30,111.7	42,460.9	28,727.5	20,456.5	1,166.1	29,893.6	19,971.1	13,434.7	6,536.3	11,171.0	6,735.0	4,436.6
	1986/87	43,350.0	60,372.6	32,541.3	44,467.1	31,097.5	22,446.2	1,292.4	32,389.8	21,231.0	14,018.3	7,212.6	11,905.0	7,010.0	4,895.7
	1987/88	46,821.3	62,085.0	35,087.8	45,932.7	33,401.6	24,261.8	1,368.9	34,770.5	22,548.1	14,436.8	8,111.3	12,590.0	7,085.0	5,505.6
	1988/89	50,982.6	64,754.1	38,187.2	48,164.4	36,595.0	26,160.8	1,574.2	38,169.1	24,010.8	15,111.7	8,899.1	13,315.0	7,274.0	6,040.3
	1989/90	56,115.6	67,668.6	41,931.3	50,197.5	40,225.9	28,543.2	1,724.6	41,950.5	25,669.3	15,891.9	9,777.4	14,179.0	7,542.0	6,636.5
	1990/91	61,047.0	69,863.6	45,469.9	51,639.3	43,194.7	30,438.9	2,053.6	45,248.3	26,462.5	16,384.5	10,078.0	14,411.0	7,571.0	6,840.5
	1991/92	66,246.2	72,591.6	49,351.4	53,796.2	47,085.6	33,268.8	2,130.2	49,215.8	27,423.6	17,409.4	10,014.2	14,701.0	7,904.0	6,797.2
	1992/93	69,764.8	74,119.0	51,666.3	54,686.3	48,659.2	33,811.8	2,224.2	50,883.4	28,300.4	18,396.4	9,904.0	14,919.0	8,197.0	6,722.5
	1993/94	71,514.1	74,736.7	51,952.7	54,297.8	48,430.4	33,713.5	2,300.6	50,731.0	28,991.4	18,810.3	10,181.1	15,131.0	8,221.0	6,910.5
	1994/95	73,138.4	75,284.2	52,668.7	54,189.8	49,042.5	33,463.7	2,593.7	51,636.1	29,369.9	18,719.0	10,650.9	15,302.0	8,073.0	7,229.4
	1995/96	74,063.2	75,488.8	52,783.4	53,694.3	48,827.3	32,875.8	2,692.4	51,519.7	29,882.4	18,476.4	11,406.0	15,697.0	7,955.0	7,741.9
Canada Health and Social Transfer (CHST) (1996)	1996/97	74,689.3	75,604.5	52,807.1	53,409.3	49,070.3	33,028.8	2,578.5	51,648.8	26,900.0	14,741.8	12,158.2	14,592.0	6,339.1	8,253.0
	1997/98	78,326.1	78,326.1	55,004.8	55,004.8	51,394.7	34,399.8	2,942.8	54,337.5	25,838.8	12,500.0	13,338.8	14,429.4	5,375.0	9,054.4
	1998/99	83,516.8	82,355.1	59,065.7	58,438.2	55,004.5	36,754.0	3,090.5	58,095.0	26,841.3	12,500.0	14,341.3	15,109.9	5,375.0	9,734.9
	1999/00	89,546.6	87,240.2	63,372.2	62,221.2	59,104.5	37,911.4	3,451.8	62,556.3	30,068.2	14,500.0	15,568.2	16,802.7	6,235.0	10,567.7
	2000/01	95,881.3	91,098.2	69,037.7	65,980.4	64,466.8	41,246.2	3,732.9	68,199.7	31,912.5	15,500.0	16,412.5	18,375.8	7,235.0	11,140.8
	2001/02	102,511.9	96,013.6	74,465.0	70,468.5	69,301.6	43,482.1	3,737.1	73,038.7	34,400.5	18,300.0	16,100.5	19,068.0	8,139.0	10,929.0
Projections	2002/03	106,714.9	..	..	..	72,558.8	45,525.8	..	..	35,663.6	19,100.0	16,564.0	19,398.6	8,155.0	11,243.6
	2003/04	110,983.5	..	..	..	76,186.7	47,802.0	..	..	37,000.0	19,800.0	17,200.0	20,088.4	8,413.0	11,675.4
	2004/05	116,754.6	..	..	..	80,072.2	50,239.9	..	..	38,300.0	20,400.0	17,900.0	20,821.5	8,671.0	12,150.5
	2005/06	122,709.1	..	..	..	84,075.8	52,751.9	..	..	39,800.0	21,000.0	18,800.0	21,576.4	8,815.0	12,761.4

Appendix E.2: Percentage Share and Rate of Change in Public Health Expenditures and Major Social Transfers Including Notional Allocation for Health: 1968/69 to 2001/02 and Projections Beyond

Health Transfer Regime	Fiscal Year	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
		Total Public and Private Health Expenditures	Total Public and Private Health Expenditures (Constant 1997 Dollars)	Total Public Sector Health Expenditures	Total Public Sector Health Expenditures (Constant 1997 Dollars)	Total Provincial-Territorial Health Expenditures	Provincial-Territorial Expenditures for Hospital and Physician Services	Total Federal Direct Health Expenditures	Combined Federal and Provincial-Territorial Health Expenditures	Total Major Social Transfers	Cash Component of Major Social Transfers	Tax Point Component of Major Social Transfers	Total Federal Health Transfers as a Proportion of Total Provincial-Territorial Health Expenditures	Federal Health Cash Transfers as a Proportion of Total Provincial-Territorial Health Expenditures	Federal Tax Point Transfers as a Proportion of Total Provincial-Territorial Health Expenditures	Total Federal Health Transfers as a Proportion of Provincial-Territorial Expenditures for Hospital and Physician Services	Federal Health Cash Transfers as a Proportion of Provincial-Territorial Expenditures for Hospital and Physician Services	Federal Tax Point Transfers as a Proportion of Total Provincial-Territorial Health Expenditures for Hospital and Physician Services	Provincial-Territorial Health Expenditures as a Proportion of Provincial-Territorial Program Spending	Total Health Expenditures as a Proportion of GDP	Total Public Health Expenditures as a Proportion of GDP
		(%)																			
Hospital Insurance and Diagnostic Services Act (1957) and The *Medical Care Act* (1966)	1968/69	13.6%	..	..	..	14.3%	..	..	..	..	..	..	33.0%	33.0%	..	..	..	..	..	6.5%	..
	1969/7	12.1%	..	..	..	29.4%	..	..	..	..	32.4%	..	33.8%	33.8%	..	..	..	..	..	6.6%	..
	1970/71	13.6%	..	..	..	27.3%	..	..	..	..	33.5%	..	35.4%	35.4%	..	..	..	..	..	7.0%	4.9%
	1971/72	13.8%	..	..	..	14.7%	..	..	..	..	22.0%	..	37.7%	37.7%	..	..	..	..	..	7.2%	5.3%
	1972/73	9.4%	..	..	..	12.1%	..	..	..	..	10.8%	..	37.3%	37.3%	..	..	..	..	..	7.1%	5.3%
	1973/74	11.7%	..	..	..	10.8%	..	..	..	..	9.2%	..	36.7%	36.7%	..	..	..	..	..	6.8%	5.0%
	1974/75	17.5%	..	..	..	21.6%	..	..	..	..	21.0%	..	36.6%	36.6%	..	45.5%	45.5%	..	28.3%	6.7%	5.0%
	1975/76	19.3%	..	..	..	21.8%	21.0%	13.0%	21.4%	..	20.7%	..	36.2%	36.2%	..	45.4%	45.4%	..	28.4%	7.1%	5.4%
	1976/77	15.2%	2.7%	16.3%	3.0%	13.1%	14.2%	9.6%	12.9%	..	17.7%	..	37.7%	37.7%	..	46.7%	46.7%	..	28.8%	7.1%	5.4%
Established Programs Financing (EPF 1977)	1977/78	10.0%	2.1%	9.5%	1.0%	14.5%	5.7%	7.6%	14.2%	..	46.5%	..	41.3%	24.9%	16.4%	55.4%	33.4%	22.0%	28.0%	7.0%	5.4%
	1978/79	10.7%	3.2%	10.1%	2.6%	11.2%	10.1%	0.5%	10.8%	13.5%	13.5%	13.3%	42.5%	25.7%	16.7%	57.6%	34.9%	22.7%	28.3%	7.0%	5.3%
	1979/80	12.1%	2.9%	11.6%	1.8%	11.7%	9.7%	7.3%	11.6%	13.8%	13.3%	14.9%	43.3%	26.1%	17.2%	59.8%	36.1%	23.8%	27.8%	6.9%	5.2%
	1980/81	16.4%	5.6%	15.8%	5.1%	16.4%	16.5%	15.4%	16.4%	13.5%	11.8%	17.0%	41.9%	24.6%	17.3%	57.8%	34.0%	23.8%	28.7%	7.1%	5.4%
	1981/82	17.8%	4.6%	18.4%	4.9%	18.6%	17.7%	20.0%	18.7%	13.3%	13.1%	13.7%	39.8%	23.2%	16.6%	55.3%	32.3%	23.0%	29.2%	7.3%	5.5%
	1982/83	17.1%	4.8%	17.6%	5.5%	17.7%	18.1%	24.3%	18.0%	14.8%	15.7%	13.1%	38.0%	22.1%	15.9%	52.7%	30.6%	22.1%	29.5%	8.1%	6.2%
	1983/84	10.7%	3.9%	11.2%	5.3%	9.6%	9.4%	14.3%	9.8%	10.4%	14.6%	2.2%	38.3%	23.4%	14.8%	53.2%	32.5%	20.6%	30.1%	8.3%	6.4%
	1984/85	7.9%	3.6%	7.2%	3.3%	6.3%	6.1%	10.3%	6.5%	7.5%	6.8%	9.0%	39.0%	23.7%	15.2%	54.3%	33.1%	21.2%	30.8%	8.2%	6.2%
	1985/86	8.4%	4.4%	7.6%	4.0%	7.8%	7.0%	3.0%	7.6%	7.7%	6.9%	9.5%	38.9%	23.4%	15.4%	54.6%	32.9%	21.7%	30.2%	8.2%	6.2%
	1986/87	8.8%	4.8%	8.1%	4.7%	8.2%	9.7%	10.8%	8.4%	6.3%	4.3%	10.3%	38.3%	22.5%	15.7%	53.0%	31.2%	21.8%	31.4%	8.5%	6.4%
	1987/88	8.0%	2.8%	7.8%	3.3%	7.4%	8.1%	5.9%	7.3%	6.2%	3.0%	12.5%	37.7%	21.2%	16.5%	51.9%	29.2%	22.7%	32.3%	8.4%	6.3%
	1988/89	8.9%	4.3%	8.8%	4.9%	9.6%	7.8%	15.0%	9.8%	6.5%	4.7%	9.7%	36.4%	19.9%	16.5%	50.9%	27.8%	23.1%	32.4%	8.3%	6.2%
	1989/90	10.1%	4.5%	9.8%	4.2%	9.9%	9.1%	9.6%	9.9%	6.9%	5.2%	9.9%	35.2%	18.7%	16.5%	49.7%	26.4%	23.3%	33.2%	8.5%	6.4%
	1990/91	8.8%	3.2%	8.4%	2.9%	7.4%	6.6%	19.1%	7.9%	3.1%	3.1%	3.1%	33.4%	17.5%	15.8%	47.3%	24.9%	22.5%	32.8%	9.0%	6.7%
	1991/92	8.5%	3.9%	8.5%	4.2%	9.0%	9.3%	3.7%	8.8%	3.6%	6.3%	-0.6%	31.2%	16.8%	14.4%	44.2%	23.8%	20.4%	32.4%	9.7%	7.2%
	1992/93	5.3%	2.1%	4.7%	1.7%	3.3%	1.6%	4.4%	3.4%	3.2%	5.7%	-1.1%	30.7%	16.8%	13.8%	44.1%	24.2%	19.9%	32.5%	10.0%	7.4%
	1993/94	2.5%	0.8%	0.6%	-0.7%	-0.5%	-0.3%	3.4%	-0.3%	2.4%	2.2%	2.8%	31.2%	17.0%	14.3%	44.9%	24.4%	20.5%	32.7%	9.8%	7.2%
	1994/95	2.3%	0.7%	1.4%	-0.2%	1.3%	-0.7%	12.7%	1.8%	1.3%	-0.5%	4.6%	31.2%	16.5%	14.7%	45.7%	24.1%	21.6%	32.7%	9.5%	6.8%
	1995/96	1.3%	0.3%	0.2%	-0.9%	-0.4%	-1.8%	3.8%	-0.2%	1.7%	-1.3%	7.1%	32.1%	16.3%	15.9%	47.7%	24.2%	23.5%	32.2%	9.1%	6.5%
Canada Health and Social Transfer (CHST 1996)	1996/97	0.8%	0.2%	0.0%	-0.5%	0.5%	0.5%	-4.2%	0.3%	-10.0%	-20.2%	6.6%	29.7%	12.9%	16.8%	44.2%	19.2%	25.0%	33.0%	8.9%	6.3%
	1997/98	4.9%	3.6%	4.2%	3.0%	4.7%	4.2%	14.1%	5.2%	-3.9%	-15.2%	9.7%	28.1%	10.5%	17.6%	41.9%	15.6%	26.3%	34.1%	8.9%	6.2%
	1998/99	6.6%	5.1%	7.4%	6.2%	7.0%	6.8%	5.0%	6.9%	3.9%	0.0%	7.5%	27.5%	9.8%	17.7%	41.1%	14.6%	26.5%	32.6%	9.1%	6.5%
	1999/00	7.2%	5.9%	7.3%	6.5%	7.5%	3.1%	11.7%	7.7%	12.0%	16.0%	8.6%	28.4%	10.5%	17.9%	44.3%	16.4%	27.9%	35.4%	9.2%	6.5%
	2000/01	7.1%	4.4%	8.9%	6.0%	9.1%	8.8%	8.1%	9.0%	6.1%	6.9%	5.4%	28.5%	11.2%	17.3%	44.6%	17.5%	27.0%	37.3%	9.1%	6.5%
	2001/02	6.9%	5.4%	7.9%	6.8%	7.5%	5.4%	0.1%	7.1%	7.8%	18.1%	-1.9%	27.5%	11.7%	15.8%	43.9%	18.7%	25.1%	..	9.3%	6.8%
Projections	2002/03	4.1%	..	..	..	4.7%	4.7%	..	..	3.7%	4.4%	2.9%	26.7%	11.2%	15.5%	42.6%	17.9%	24.7%	..	..	..
	2003/04	4.0%	..	..	..	5.0%	5.0%	..	..	3.7%	3.7%	3.8%	26.4%	11.0%	15.3%	42.0%	17.6%	24.4%	..	..	..
	2004/05	5.2%	..	..	..	5.1%	5.1%	..	..	3.5%	3.0%	4.1%	26.0%	10.8%	15.2%	41.4%	17.3%	24.2%	..	..	..
	2005/06	5.1%	..	..	..	5.0%	5.0%	..	..	3.9%	2.9%	5.0%	25.7%	10.5%	15.2%	40.9%	16.7%	24.2%	..	..	..

Appendix E.1

Column A

CIHI defines total health expenditures as the combined value of both public and private sector health expenditures. Private health spending includes out-of-pocket expenditures made by individuals for health care goods and services; the health insurance claims paid by commercial and not-for-profit insurance firms, as well as the direct cost of administering those claims; private spending on health-related capital construction and equipment; and health research funded by private sources. For a detailed definition of public sector health expenditures see notes for column C.

The figures for total health expenditures are in calendar years. Figures for 2000 and 2001 are forecasts made by CIHI.

1968/69 to 1974/75: Statistics Canada 1983; Canada, Health and Welfare Canada 1979.

1975/76 to 2001/02: CIHI 2001e.

2002/03 to 2005/06: Figures are projections (appearing in red) based on Conference Board of Canada (2001) annual rates of increase for the health sector applied to CIHI data.

Column B

Constant dollars are used to show real (inflation adjusted) health expenditures. *Real* health expenditures are presented in constant 1997 dollars. Constant dollar expenditures were calculated by CIHI using price indices for public and private expenditures in each province and territory. The indices are the implicit price indices (IPI) for government current expenditures used to deflate public sector health care spending, and the health component of the Consumer Price Index (CPI) used to deflate private sector health spending. Statistics Canada developed both sets of indices.

Figures for 2000 and 2001 are forecasts made by CIHI.

1975/76 to 2001/02: CIHI 2001e.

Column C

Public sector health expenditures include health care spending by governments and government agencies and are comprised of four groups of public expenditures: 1) provincial-territorial governments; 2) federal direct; 3) municipal governments; and 4) social security funds including workers' compensation.

For a detailed description of the provincial-territorial government and federal direct sectors see accompanying notes for columns E and G.

The municipal government sector includes health care spending by municipal governments for institutional services, including public health, capital construction and equipment, and dental services provided by municipalities in the provinces of Nova Scotia, Manitoba and British Columbia. Designated funds transferred by provincial governments for health purposes are not included in the municipal sector but are included with provincial government expenditure.

Social security funds are social insurance programs that are imposed and controlled by a government authority. They generally involve compulsory contributions by employees and employers, and the government authority determines the terms on which benefits are paid to recipients. In Canada, social security funds include the health care spending by workers' compensation boards and agencies, and the drug insurance fund component of the Quebec drug

subsidy program. Health spending for workers' compensation includes what is commonly referred to by provincial workers' compensation agencies as medical aid.

Figures for 2000 and 2001 are forecasts made by CIHI.

1975/76 to 2001/02: CIHI 2001e.

Column D

For an explanation of constant dollar calculation see note for Column B.

Figures for 2000 and 2001 are forecasts made by CIHI.

1975/76 to 2001/02: CIHI 2001e.

Column E

The provincial-territorial government sector includes direct health spending by provinces and territories, federal health transfers to the provinces and territories, and provincial government health transfers to municipal governments.

Figures for 2000/01 and 2001/02 are forecasts made by CIHI.

1968/69 to 2001/02: CIHI 2002f.

2002/03 to 2005/06: Figures are projections (appearing in red) based on Conference Board of Canada (2002) annual rates of increase for the provincial-territorial government health sector applied to CIHI data.

Column F

Hospital expenditures are defined as expenditures made by hospitals licensed or approved by provincial-territorial governments and include those providing acute care, rehabilitation and convalescent care, as well as nursing stations and hospitals in rural and remote areas. Excluded from the definition of hospitals are mental institutions and special care facilities. This definition closely approximates those hospital services previously eligible for federal funding under the *Hospital Insurance and Diagnostic Services Act* and those services eligible according to the definition of insured services under the *Canada Health Act*.

The majority of physician expenditures are professional fees paid by provincial and territorial medical care insurance plans to physicians in private practice. Fees for services rendered in hospitals are included when paid directly to physicians by the plan. Also included are other forms of professional incomes including salaries, sessional (contract) and capitation.

Figures for 2000/01 and 2001/02 are forecasts made by CIHI.

1974/75 to 2001/02: CIHI 2002f.

2002/03 to 2005/06: Figures are Commission projections (appearing in red) based on the current share of total provincial-territorial expenditures devoted to hospital and physician services in fiscal year 2001/02. In 2001/02, hospital and physician services accounted for 62.7% of total provincial-territorial health expenditures. This percentage has been applied to estimates of total provincial-territorial health expenditures appearing in column E.

Column G

The federal direct sector refers to direct health care spending by the federal government in relation to health care services for special groups such as Aboriginal peoples, the Armed Forces and veterans, the RCMP and inmates of federal penitentiaries, as well as expenditures for health

research, health promotion and protection. Federal direct health expenditures do not include federal health transfers to the provinces.

Figures for 2000/01 and 2001/02 are forecasts made by CIHI.

1968/69 to 2001/02: CIHI 2002f.

Column H

Combined federal and provincial-territorial health expenditures in column H are the sum of columns E and G.

Column I

Major social transfers by the federal government are those made to provincial and territorial governments for health, social services and post-secondary education. These transfers include at various times the Canada Health and Social Transfer (CHST), the Canada Assistance Plan (CAP), Established Programs Financing (EPF) and dedicated cash transfers for health under the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*. The total value of major social transfers includes both cash payments and tax point transfers (the combined values of Columns J and K) for the post-1976/77 period.

1977/78 to 2005/06: Canada, Department of Finance Canada 2002c.

Column J

1968/69 to 2005/06: Canada, Department of Finance Canada 2002c.

Column K

1968/69 to 2005/06: Canada, Department of Finance Canada 2002c.

Column L

Federal transfers for health from 1968/69 to 1974/75 include only cash payments made under the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*.

Notional allocations for health under EPF (1977/78 to 1995/96) are based on the combined value of cash and tax transfer data for health provided by Department of Finance Canada. The tax and cash components notionally allocated for health under EPF were originally both set at 67.9% in 1977, but due to "6 and 5" price controls (begun in 1975) on the post-secondary education (PSE) cash component, the health cash share increased relative to the PSE component. As a result, based on Department of Finance Canada data the notional cash allocation for health ranges from 71.7% of total EPF cash in 1977/78 to 74.8% in 1995/96. The notional health allocation under the tax point transfer remains constant throughout at 67.9% of EPF tax transfers.

In addition, because of associated equalization of the tax point transfers, a portion of the tax transfer was actually made in cash but is included as part of the tax point transfer component by the Department of Finance Canada.

The notional allocation for health under the CHST (1996/97 to 2005/06) is based on the federal Department of Finance document *Backgrounder on Federal Support for Health in Canada* (March 2000). This document assumes a notional health allocation for the cash component of all CHST cash transfers of 43%, which in turn is based on the relative share of the combined value of EPF and Canada Assistance Plan cash transfers prior to their consolidation

under the CHST. The figure is derived by dividing the health cash component under EPF by the combined value of all EPF and Canada Assistance Plan cash transfers for the final year of these programs in fiscal year 1995/96. According to the Department of Finance Canada, in fiscal year 1995/96 the combined value of all EPF cash and CAP transfers was approximately $18.47 billion. Of that cash amount, roughly $7.96 billion was notionally allocated toward health under EPF. The notional allocation of tax point transfers under the CHST remains the same as under EPF since the tax points originally transferred in 1977/78 were transferred specifically for health and post-secondary education and did not include social services.

In September 2000, the federal government committed additional targeted transfers under the CHST for the Medical Equipment Fund, the Health Information Technology Fund, the Health Transition Fund for Primary Care, and Early Childhood Development. These targeted funds were intended as separate contributions for health and social services to be disbursed to provinces and territories between 2000/01 and 2005/06. Data provided by the federal Department of Finance includes these targeted transfers as part of the total CHST cash contribution. As a result, the Commission has calculated a basic CHST contribution by subtracting the value of these supplemental cash transfers from the total CHST cash contribution. In order to allocate those cash transfers specifically designed for health purposes, the cash made available to provincial and territorial governments through the Medical Equipment Fund, the Health Information Technology fund and the Health Transition Fund for Primary Care have been added to the health cash portion in the year and in the amounts for which the entitlements were set. Early childhood Development funds have been excluded from the calculation of the health component.

1968/69 to 2005/06: Canada, Department of Finance Canada 2002c.

Column M

Figures for the EPF cash component appear as provided by Department of Finance Canada. Based on these data the notional health allocation under the cash transfer ranges from a low of 71.7% (1977/78) to a high of 74.8% (1995/96).

The CHST cash transfer data provided by Department of Finance Canada do not include a notional allocation for health. The notional allocation for the health cash component of the CHST has been calculated by the Commission based on the 43% allocation described in the notes for column L and applied to the cash transfer data provided by the Department of Finance.

1968/69 to 2005/06: Canada, Department of Finance Canada 2002c.

Column N

Figures for the EPF tax point component appear as provided by Department of Finance Canada. The notional health allocation under the tax point transfer remains constant throughout at 67.9% of EPF tax transfers.

The CHST tax transfer data provided by Department of Finance Canada do not include a notional allocation for health. The notional allocation for the health tax point transfer component of the CHST has been calculated by the Commission based on the 67.9% allocation described above in the notes for column L and applied to the tax point transfer data provided by the Department of Finance.

1968/69 to 2005/06: Canada, Department of Finance Canada 2002c.

Appendix E.2

The annual rate of growth is calculated by subtracting the total value in the base year (e.g. 1968/69) from the total value for the following year (e.g. 1969/70) and dividing that sum by the value of the base year. The resulting value is expressed as a percentage.

Column A

Calculations based on column A from Appendix E.1.

Column B

Calculations based on column B from Appendix E.1.

Column C

Calculations based on column C from Appendix E.1.

Column D

Calculations based on column D from Appendix E.1.

Column E

Calculations based on column E from Appendix E.1.

Column F

Calculations based on column F from Appendix E.1.

Column G

Calculations based on column G from Appendix E.1.

Column H

Calculations based on column H from Appendix E.1.

Column I

Calculations based on column I from Appendix E.1.

Column J

Calculations based on column J from Appendix E.1.

Column K

Calculations based on column K from Appendix E.1.

Column L

Figures are calculated by dividing column L (total federal health transfers) by column E (total provincial-territorial health expenditures) in Appendix E.1.

Column M

Figures are calculated by dividing column M (health component of federal cash transfers) by column E (total provincial-territorial health expenditures) in Appendix E.1.

Column N

Figures are calculated by dividing column N (health component of federal tax point transfers) by column E (total provincial-territorial health expenditures) in Appendix E.1.

Column O

Figures are calculated by dividing column L (total federal health transfers) by column F (provincial-territorial health expenditures for hospital and physician services) in Appendix E.1.

Column P

Figures are calculated by dividing column M (health component of federal cash transfers) by column F (provincial-territorial health expenditures for hospital and physician services) in Appendix E.1.

Column Q

Figures are calculated by dividing column N (health component of federal tax point transfers) by column F (provincial-territorial health expenditures for hospital and physician services) in Appendix E.1.

Column R

Total program spending includes all provincial-territorial budgetary expenditures except debt servicing costs.

Figure for 2000/01 is a forecast made by CIHI.

1974/75 to 2000/01: CIHI 2001g.

Column S

All figures are for calendar years.

1968/69 to 2001/02: OECD 2002b.

Column T

All figures are for calendar years.

1970/71 to 2001/02: OECD 2002b.

Primary Care Organizations in Canada, 2002

The table that follows outlines the range of primary health care initiatives that have been undertaken or are being planned in each of the provinces and territories. The information for each jurisdiction was compiled by Commission staff from federal, provincial and territorial government publications and Web sites, but the information was verified by officials in each provincial or territorial department of health. What is immediately apparent is the variation in structure, governance and funding of primary health care initiatives across the country. In addition, some initiatives are relatively recent in origin while others have existed for a couple of decades.

	Primary Care Sites	Established	Governance	Funding	Other Initiatives
Newfoundland and Labrador	3 community health centres	1984, 1995, 1997	Health boards	Provincial government	The province has created an Office of Primary Health Care to develop a provincial Primary Health Care Framework and Implementation Plan. The province aims to establish, over the next five years, a network of Primary Health Care Teams.
	3 primary health enhancement sites	1997	Health boards	Provincial government	
Prince Edward Island	4 community health centres	1995 to 2000	Regional health board	Provincial government or health board	Development of family health centres.
Nova Scotia	9 community health centres (listed by the Federation of Community Health Centres of Nova Scotia)	1972 to 2002	Volunteer or elected board of directors	District health authority, Department of Health, fundraising	"Strengthening Primary Care in Nova Scotia" will continue with provincial funding until 2003.
New Brunswick	2 existing community health centres not presently accessible 24/7	1994 to1995	Regional health authorities	Provincial government	2 community health center pilot projects that meet the primary care criteria to be established in the province by late Fall 2002. Interdisciplinary Team Shared Practice Model. Collaborative practice demonstration project in family physician offices: implemented in 1999 and evaluated in 2000 – discontinued.
Québec	147 Centres locaux de santé communautaires	1972	Elected board of directors	Provincial government	Family medicine groups. Stated objective is for 300 primary care sites.
Ontario	55 community health centres	1970s	Elected community board	Provincial government. Also regional bodies, federal government and non-governmental organizations such as United Way	Expansion underway through creation of special purpose agency, the Ontario Family Health Network Agency, including recently announced expansion of 4 additional Family Health Networks. Recently announced additional investment in primary care in conjunction with the federal government through the Primary Health Care Transition Fund.
	2 family health networks	2002	Governance agreement required as part of the funding contract	Provincial government	
	14 primary care networks	1999	Governance agreement required as part of the funding contract	Provincial government	
	52 health services organizations	1970s	No specified governance structure	Provincial government	
	23 community sponsored contracts	1999	Governance requirements in funding contract	Provincial government	
	Group health centre	1970s	Community board	Provincial government	
	13 Northern Group Funding Programs	1999	Governance agreement required as part of the funding contract	Provincial government	

	Primary Care Sites	Established	Governance	Funding	Other Initiatives
Manitoba	27 sites including health centres, community nurse resource centres, primary health centres and community health centres	1994 to present	Regional health authority (all rural centres) board, service purchase agreement with regional health authority (urban centres, except one which is governed by Manitoba Health)	Mainly regional health authorities, a few by Manitoba Health	A Primary Health Care Network, made up of representatives of the regional health authorities and providing support to a provincial strategy, was formed in 2001. 12 planned community health and social service access centres in Winnipeg, one under construction and 2 currently in planning. A provincial Primary Health Care Policy Framework, which was approved in principle in March 2002, has been distributed broadly among regional health authorities.
Saskatchewan	3 community clinics	1962	Board of directors accountable to Saskatchewan Health	Provincial government	Establishment of primary health care teams and networks.
	21 primary health service sites (2 of the 21 are also community clinics for a total of 5)	1998 to 2002	Regional health authorities	Provincial government	
Alberta	More than 8 community health centres	1980 to present	Regional health authorities/community boards	Regional health authorities/ community board	Alberta Health and Wellness is conducting stakeholder consultations to identify primary health care strategies and develop a proposal for federal funding through the Primary Health Care Transition Fund.
British Columbia	At least 25 community health centres	Since 1970	Ranges from board of directors, local health authority or advisory committees	Local health authority through the Ministry of Health or Medical Services Branch of Health Canada if for First Nations.	Development of a proposal for the federal Primary Health Care Transition Fund led by the Division of Primary Health Services, Ministry of Health Services.
	8 primary health care organizations	Since 1992			
Yukon	Health centres		Yukon government	Yukon government	Currently no primary care renewal initiative underway in the Yukon.
Northwest Territories	23 community health centres	1992 to 1998	Health and social services authorities as described under the *Health Insurance* and *Health and Social Services Act.*	Department of Health and Social Services	As of 2002, the Department of Health and Social Services has been developing an integrated services delivery model. This model will describe core services and the applicable distribution, placement and delivery of primary health services.
Nunavut	26 health centres	April 1, 1999	Territorial and federal governments	Territorial and federal governments	Expansion of telehealth and health promotion activities.

Consultants' Estimates on Costs of Targeted Home Care

John P. Hirdes, Ph.D., University of Waterloo and Homewood Research Institute
Jeff Poss, P.Eng., MBA., University of Waterloo
John N. Morris, Ph.D., Hebrew Rehabilitation Center for the Aged, Boston
Brant E. Fries, Ph.D., University of Michigan, Ann Arbor and VA Medical Center

Several Canadian provinces have recently taken steps toward implementation of a common assessment approach as the basis for a home care information system. However, Canada does not yet have a comprehensive national database combining clinical, service utilization, cost, and outcome information for home care. As a consequence, it is not possible to simply summarize existing administrative data in order to calculate the expected costs of the core home care services recommended by the Commission. "Synthetic estimation" provides an alternative approach by combining available demographic data with research findings in order to simulate the expected rates of needs in the population and the costs of services to be allocated in response to those needs.

Data Sources

The primary sources of data for this analysis include: a) vital statistics (e.g., mortality) reported by Health Canada and Statistics Canada; b) health service utilization data reported by the Canadian Institute for Health Information; c) scientific publications; d) utilization data from individual health care agencies; and e) Resident Assessment Instrument – Home Care (RAI-HC) data from the RAI-Health Informatics Project (RAI-HIP) funded by the Health Transition Fund (Grant # ON421) and from the Government of Manitoba's pilot implementation of the RAI-HC.

The RAI-HC is a comprehensive assessment of the needs and services received by the community-based elderly and adults with disabilities. The assessments were completed by trained clinicians, and previous research has demonstrated the reliability and validity of RAI-HC data (Morris et al. 1997). The clinical and service use elements were used to construct groups corresponding to the expected clients for the four core recommended home care services (post-acute rehabilitation, post-acute medical care, palliative care and behaviour management). In addition, data on the receipt of formal services over the previous seven days were combined with discipline-specific billing rates provided by the Waterloo (Ontario) Community Care Access Centre (CCAC) to estimate weighted billing costs on a per diem basis by type of client. This cost

information could then be linked to population estimates and predicted days of service to estimate overall costs for the recommended services.

The RAI-HIP and Manitoba data are somewhat over-represented by longer stay, elderly home care clients. For example, Health Canada (2001) reports that about 73% of home care expenditures are made on persons aged 65 years or more, but 83% of the sample from which the RAI-HC data were obtained is 65 or older. The expected result of this modest bias is to over-estimate home care costs, since these individuals will tend to have more complex health care needs and potentially fewer informal supports available. The Manitoba and Ontario data are combined, but it should be noted that prevalence estimates for these groups tend to be lower in Manitoba than Ontario. Also, clients receiving no services over the past week and those who had been on service for less than one day were excluded from the analysis. Per diem rates of costs were calculated using weekly service utilization patterns or service since entry to home care if the length of stay was less than seven days. Cases with outlier values for certain services were assigned missing values for that variable. These data do not include out-of-pocket expenditures by home care clients, but they may include some private pay services.

Synthetic Estimation of Costs by Type of Service

The number of cases for each service was estimated in one of three ways. First, the number of elderly Canadians was multiplied by the expected proportion of individuals with an acute hospitalization in order to estimate the denominator for the two post-acute services (medical care and rehabilitation). CIHI (2001) reported the rates of hospitalization by age between 1994/95 and 1998/99 for 45- to 64-year-olds and 65- to 74-year-olds. The mid-point of the latter rates (29%) was used to estimate the overall number of post-acute cases. This will tend to over-estimate hospitalizations for younger individuals and under-estimate hospitalizations for older individuals. However, it is also important to note that hospitalization rates are falling, meaning that this approach is likely to over-estimate the number of post-acute cases over time. The second approach was to use the number of cancer deaths reported by the National Cancer Institute of Canada (NCIC 1999) as a base for estimating the number of palliative clients. The third approach was to combine Health Canada's estimate (MacAdam 1999) of the number of home care clients (840,000) with prevalence and incidence rates for aggressive behaviour from the RAI-HIP data. The specific estimates are described below. Table G.1 provides the estimates for all groups and Table G.2 provides a more detailed methodology for the behaviour management group.

Case Management and Behaviour Intervention: Home Mental Health

Home care clients requiring special interventions to manage behaviour that can be dangerous or distressing to others differ from the previous three groups, because they are expected to have much longer lengths of stay in home care (RAI-HC data suggest an average two-year length of stay). Therefore, this group will be more costly than others because of their prolonged lengths of service use. On the other hand, recent research by the RAI-HIP team has suggested that this group is at a particularly high risk of nursing home or psychiatric hospital admission, which would result in markedly higher costs to the health care system.

RAI-HC data were used to identify home care clients with the presence of any of the following aggressive behaviours: a) verbal abuse; b) physical abuse; or c) resisting care. The point prevalence of aggressive behaviours of this type was estimated to be 4.9% in home care, yielding 41,160 cases. However, 18.7% of these individuals die or are discharged from home care (typically to long-term care) within 90 days. Also, about one-fifth of the remaining 81.3% of those clients improve over time, such that they no longer demonstrate aggressive behaviours. On the other hand, about 2% of the clients not showing aggression at baseline, behave aggressively after 90 days. Therefore, within one fiscal quarter, one can expect to see 57,137 cases of aggressive home care clients. Since not all of these individuals require behaviour management services over the entire quarter, groups that had a change in status were assigned the mid-point of 45 days of service. Using RAI-HC data, the mean per diem cost of home care for this group was estimated to be $35.15 (Standard Deviation (SD – $69.22). The distribution of costs is highly skewed as demonstrated by a median cost of $18.16. However, the approach used here, and for subsequent services, is to err on the side of over-estimation of costs using the mean.

The quarterly costs were multiplied by four to yield an annual estimated cost of $527,917,167. However, an additional 10 days per year of more resource intensive service delivery (double the estimated per diem cost) is allocated to each case in order to support specialized behaviour management teams working with these clients. The total annual costs of behaviour management in home care is therefore estimated to be $568,084,478.

Post-acute Rehabilitation

Experts contacted by the research team suggested that about 15% of elderly acute care clients in the United States receive rehabilitation through home care (Knight Steel, personal communication). Data on acute care patients from the RAI-HIP study showed that 8% of patients aged 75 and older were expected to receive occupational therapy on discharge and about 14% were expected to receive physical therapy on discharge. The recommended estimate of 15% of acute patients receiving rehabilitation was used in this estimate resulting in 167,471 cases. On the other hand, it might be reasonably argued that there is substantial untapped potential for rehabilitation that could be addressed by better access to therapies. The Commission recommended 28 days of service for this group. Using RAI-HC data for all home care clients who had been hospitalized in the previous 14 days that were also receiving physical, occupational or speech therapy, the mean per diem cost of home care was estimated to be $43.63 (SD – $70.94). The median cost for this group was $27.63. The total annual costs of post-acute rehabilitation in home care is therefore estimated to be $204,588,685.

Post-acute Medical Care

The Health Services Utilization Research Commission (1998) reported that about 24% of acute hospital patients in the Hospital and Home Care Study received post-acute home care. This rate was multiplied by the 29% of the elderly population (3,849,897) to yield 267,953 cases. The Commission recommended 14 days of service for this group. Using RAI-HC data for all home care clients who had been hospitalized in the previous 14 days, the mean per diem cost of home care was estimated to be $31.39 (SD – $58.76) and the median cost was $15.35. The total annual costs of post-acute medical care in home care are therefore estimated to be $117,754,551.

Palliative Care

NCIC (1999) reported that there were 63,400 cancer deaths in Canada in 1999. These individuals could all be presumed to have been eligible for palliative care. However, it is important for palliative service to also be extended to other persons at the end of life (e.g., persons with renal failure, congestive heart failure, chronic obstructive pulmonary disease, ALS, AIDS). Therefore, the number of cases was increased by an additional 20% to allow inclusion of these other groups. It will also be true that not everyone will want palliative care at the end of life, and some deaths will happen faster than expected prior to initiation of palliative services. Therefore, an estimated two-thirds rate of uptake was used to identify 50,974 cases. The average length of stay in palliative care programs varies considerably, in part due to differences in eligibility criteria. The Edmonton palliative care program has an average length of stay of 21 days for an inpatient unit (Edmonton Palliative Care Program 2002). In contrast, the District of Columbia estimates an average length of stay of 35 to 40 days for palliative home care in the United States (DC 2002). The Commission recommended an average of 30 days of service for this population. RAI-HC data were used to identify all home care clients who died *and* who had any of these characteristics: a) the goal of care was palliative care; b) the client was reported to be receiving hospice/palliative services; or c) the client was described as having end-stage disease with an expectation of 6 months or less to live. The mean per diem cost of home care for this group was $58.40 (SD – $101.82) and the median cost was $25.21. The total annual cost of palliative home care is therefore estimated to be $89,305,747.

CONCLUSIONS

The estimates provided here are based on current Canadian practice patterns for the identified core services. That being said, the total cost of the four services recommended by the Commission to be core home care services is $979,733,461.

Table G.1
Estimates of Costs of Home Care Services Recommended by the Commission

Canadian population (all ages)	30,750,087	
Canadian population (65+)	3,849,897	
Number of home care clients	840,000	
Hospitalization rate (65+)	29%	
Case Management and Behaviour Intervention		
Point prevalence of home care clients with aggression	4.9%	
Incidence rate of aggression in home care clients	2%	
Number of cases	57,137	
Days of regular care	Up to 365	
Mean cost per day (regular care)	$35.15	
Annual cost (regular care)	$527,917,167	
Days of intensive behaviour care	10	
Mean cost per day (intensive behaviour care)	$70.30	
Annual cost (intensive behaviour care)	$40,167,311	
Annual cost (regular and behaviour care)		$568,084,478
Post-acute Rehabilitation		
Acute patients receiving home care rehabilitation	15%	
Number of cases	167,471	
Days of rehabilitation	28	
Mean cost per day	$43.63	
Annual cost		$204,588,685
Post-acute Medical Care		
Acute patients receiving post-acute home care	24%	
Number of cases	267,953	
Days of medical care	14	
Mean cost per day	$31.39	
Annual cost		$117,754,551
Palliative Care		
Cancer deaths	63,400	
Other palliative cases	12,680	
Expected uptake of palliative care	67%	
Number of cases	50,974	
Days of palliative care	30	
Mean cost per day	$58.40	
Annual cost		$89,305,747
TOTAL COSTS		**$979,733,461**

Table G.2
Estimates of Costs[1] of Regular Care for Clients Requiring Behaviour Management

			Cost While Aggressive Behaviour Present			Cost While Aggressive Behaviour *Not* Present		
	%	N	Days	Quarterly Cost	Cost for All Cases with Behaviour Present	Days	Quarterly Cost	Cost for All Cases with Behaviour *Not* Present
Number of home care clients		840,000						
Prevalence of aggressive behaviour	4.90	41,160						
Behaviour clients leaving home care (e.g., death, discharge all reasons)	18.70	7,697	45	$1,581.75	$12,174,603			
Behaviour clients still on service after 90 days	81.30	33,463						
– Behaviour clients still on service after 90 days whose behaviour has improved	21.40	7,161	45	$1,581.75	$11,327,069	45	$1,180.80	$8,455,826
– Behaviour clients still on service after 90 days whose behaviour has not improved	78.60	26,302	90	$3,163.50	$83,206,317			
Clients with no aggressive behaviour at baseline	95.10	798,840						
– Clients with no aggressive behaviour at baseline who develop aggressive behaviour after 90 days	2.00	15,977	45	$1,581.75	$25,271,303	45	$1,180.80	$18,865,405
Total for one quarter		57,137			**$131,979,292**			**$27,321,231**
Total for one year					**$527,917,167**			**$109,284,925**

[1] Assumes per diem cost of $35.15 for those with aggressive behaviour present and $26.24 for those with aggressive behaviour not present.

ACKNOWLEDGEMENTS

A large number of people offered me their advice and support throughout the production of this report. I would like to specifically thank the following people for their assistance:

Julia Abelson, Keith Banting, Monique Bégin, Robin Boadway, Nick Black, Allan E. Blakeney, Patrick Cummings, Jack Davis, Michael Decter, Gérard de Pouvourville, Charles Doran, Robert G. Evans, Colleen Flood, Ken Fyke, Christopher Ham, John Hobbs, Brian Hutchison, John Hirdes, Alejandro R. Jadad, A.W. Johnson, David Kelly, Harvey Lazar, Pascale Lehoux, Jonathan Lomas, Paul McDonald, Ian McKillop, Dale McMurchy, Jack Mintz, Steven Morgan, Tom Noseworthy, Raymond Pong, Michael Rachlis, John G. Richards, Samuel E.D. Shortt, Duncan Sinclair, Ingrid Sketris, Jim Stanford, France St. Hilaire, Terry Sullivan, Susan Tett, Brian Topp, Charles Webster, Durhane Wong-Rieger and David Zussman.

I would also like to thank the provincial-territorial liaison contacts who were nominated by Premiers to assist in information flow between the Commission and provincial-territorial governments, and I would like to acknowledge the support provided by the Manitoba Centre for Health Policy, and the federal, Saskatchewan and Manitoba Departments of Health.

List of Figures, Tables, and Maps

FIGURES

1.1 Life Expectancy in Years, by Sex, at Birth and at Age 60, Canada, Selected Years 12

1.2 Life Expectancy in Years at Birth among OECD Countries, 1999 12

1.3 Potential Years of Lost Life (Years Lost per 100,000 People) among OECD Countries, 1998 12

1.4 Disability Adjusted Life Expectancy in Years at Birth among OECD Countries, 1999 12

1.5 Infant Mortality (Rate per 1,000 Live Births) Canada, 1960 to 2000 13

1.6 Infant Mortality (Rate per 1,000 Live Births) among OECD Countries, 2000 13

1.7 Perinatal Mortality (Rate per 1,000 Live Births) Canada and the United States, 1960 and 1998 13

1.8 Perinatal Mortality (Rate per 1,000 Live Births) among OECD Countries, 1998 13

1.9 Potential Years of Lost Life: Malignant Neoplasms (Years Lost per 100,000 People) among OECD Countries, 1998 15

1.10 Potential Years of Lost Life: Diseases of the Respiratory System (Years Lost per 100,000 People) among OECD Countries, 1998 15

1.11 Potential Years of Lost Life: Cerebrovascular Diseases (Years Lost per 100,000 People) among OECD Countries, 1998 15

1.12 Potential Years of Lost Life: Ischaemic Heart Diseases (Years Lost per 100,000 People) among OECD Countries, 1998 15

1.13 Life Expectancy in Years at Birth, by Province, Territory and Canada, 1996 17

1.14 Percentage of the Population Reporting “Unmet Health Care Needs,” by Province, Territory and Canada, 2000/01 20

1.15 Self-reported Health as “Excellent” and “Very Good,” by Province, Territory and Canada, 2000/01 20

1.16 Population Projections for Canada, Percentage of the Population Aged 60 and Over, 2001 to 2051 22

1.17 Total Health Expenditures by Source of Finance, 1999 24
1.18 Public Share of Total Health Expenditures as Tax Funded and Social Security Funds, 1998 25
1.19 Share of Total Health Expenditures Paid "Out-of-pocket," among OECD Countries, 1998 26
1.20 Share of Total Health Expenditures Paid by Public Sector, 2000 27
1.21 Per Capita Total Health Expenditures (US$ PPP), 2000 33
1.22 Total Health Expenditures as a Percentage of GDP, 2000 33
1.23 Per Capita Public Health Expenditures (US$ PPP), 2000 33
1.24 Public Health Expenditures as a Percentage of GDP, 2000 33
1.25 Total Health Expenditures as a Percentage of GDP, Canada, United States and OECD, 1970 to 2000 34
1.26 Public Expenditures as a Percentage of GDP, Canada, United States and OECD,1970 to 2000 34
1.27 Per Capita Total, Provincial-Territorial and CHA Health Expenditures (Constant 1997 Dollars) 1975 to 2001 35
1.28 Average Annual Rate of Change in per Capita Expenditures on CHA and Non-CHA Services (Constant 1997 Dollars), 1976 to 2001 35
1.29 Distribution of Provincial-Territorial Expenditures between CHA and Non-CHA Services, 1975 36
1.30 Distribution of Provincial-Territorial Expenditures between CHA and Non-CHA Services, 2001 (Forecast) 36
1.31 Ratio of Annual Rate of Growth in Total per Capita Health Expenditures to Annual Rate of Growth in GDP for Canada, 1960 to 1964, to 1995 to 2000 39
1.32 Provincial-Territorial Government Sector per Capita Health Expenditures (Constant 1997 Dollars), 1975 to 2001 40
1.33 Provincial-Territorial Health Expenditures as a Percentage of Program Spending, 1975 to 2001 40
1.34 Ratio of Total Health Expenditures to Economic Growth among OECD Countries (US$ PPP), 2000 42

2.1 Federal Contribution to Provincial-Territorial Expenditures on Hospital and Physician Services, 1974/75 to 2001/02 66
2.2 Federal Contribution to Total Provincial-Territorial Health Expenditures, 1968/69 to 2001/02 67

3.1 Distribution of Health-related R & D Expenditures in Canada ($Millions), by Source of Funds, 1998 to 2001 86

4.1 Total Number of Registered Nurses in Canada (per 100,000 People), 1980 to 2001 95
4.2 Number of Registered Nurses (per 100,000 People), by Province, 2001 95
4.3 Total Number of General Practitioners/Family Physicians and Specialists (per 100,000 People), 1980 to 2001 97
4.4 Number of General Practitioners/Family Physicians (per 100,000 People), by Province, 1980 and 2001 99
4.5 Canadians Physicians Moving Abroad and Returning from Abroad, 1996 to 2001 . . . 102

6.1 Selected Imaging Technologies (Number per Million People) among OECD Countries, 1999 140
6.2 Selected Imaging Technologies (Number per 100,000 People), by Province and Canada, 2001 141

7.1 Population Counts (Thousands) for Canada, Provinces and Territories, and Census Division by Urban and Rural, 2001 Census – 100% Data 160

8.1 Estimates Percentage Distribution of Home Care Expenditures, by Source of Finance, 2000/01 174
8.2 Provincial-Territorial Home Care Expenditures as a Percentage of Total Provincial-Territorial Health Expenditures, 2000/01 175
8.3 Provincial-Territorial Hospital and Home Care Expenditures ($Millions), 1980/81 to 2000/01 175
8.4 Inpatient/Acute Care Admissions, Age Standardized (Number per 100,000 People), Canada, 1994 to 1999. 180
8.5 Inpatient/Acute Care Hospitalizations: Average Length of Stay, Aged 65+, Canada, 1994 to 1999. 180

9.1 Coverage of Prescription Drug Expenditures, by Source of Finance, 1999 195
9.2 Prescription Drug Expenditures as a Proportion of Total Health Expenditures, 1980 196
9.3 Prescription Drug Expenditures as a Proportion of Total Health Expenditures, 2001 197
9.4 Manufacturers' Sales ($Billions) of Patented and Non-Patented Drugs, 1990 to 2001 209

10.1 NIHB Annual Expenditures by Benefit ($Millions), 1991/92 216
10.2 NIHB Annual Expenditures by Benefit ($Millions), 1995/96 216

10.3 NIHB Annual Expenditures by Benefit ($Millions), 2000/01 217
10.4 Life Expectancy at Birth, Registered Indian Population, 2000 218
10.5 Life Expectancy at Birth, Aboriginal Peoples and Canadian Population, 1991 219
10.6 Population Projections for the Aboriginal Population in Canada, by Age Group, (Thousands), 2001 to 2016 219
10.7 Incidence of Diabetes among First Nations and Canada, by Age Group, 1991 220

TABLES

1.1 Average Annual per Capita Expenditure, by Age and Sector, 2000/01 22
1.2 Private Sector Health Expenditures, by Source of Finance and Use of Funds, Canada, 1999 25
1.3 Reductions in Federal Transfers Under the Canada Health Act ($Thousands). 38

2.1 Allocation Formulas for the Cash Base of Health and Social Transfers 69
2.2 Estimates of CHST Transfers and Required Additional Funding under a Canada Health Transfer 70
2.3 One Time Bridge Funding to the Canada Health Transfer ($Billions). 71

4.1 Percentage Change in the Number of Selected Health Professionals (Number per 100,000 People), 1991 to 2000 93
4.2 Distribution of International Medical Graduates, by Province, 2001 103
4.3 Policy and Planning Responsibilities across Canada 112

7.1 Health Status for Populations in Predominately Urban, Intermediate and Predominately Rural Health Regions in Canada, 1996 161

9.1 Utilization of Prescriptions, 2001 192
9.2 Increase in Spending for Six Categories of Pharmaceuticals in the Quebec Drug Insurance Program, 1997 to 2000 193

10.1 First Nations and Inuit Health – Transfer Payment – 2001/02. 213
10.2 Program Coverage for Different Aboriginal Populations in Canada, 1999/2000 215
10.3 Federal Transfers to Territorial Governments 222

MAPS

1.1 Acute Care Facilities in Canada, 1999/2000 18
1.2 Hip Fracture Hospitalizations by Health Region, 1999/2000. 19
1.3 Ambulatory Care Sensitive Conditions by Health Region, 1999/2000 21

4.1 General/Family Physicians by Health Region, 1999 98
4.2 Specialist Physicians by Health Region, 1999 100

5.1 "Former" Smokers, by Health Region, 2000/01 130
5.2 "Current" Smokers, by Health Region, 2000/01 131
5.3 Leisure Time Physical Activity, by Health Region, 2000/01. 133

6.1 Scanners in Canadian Hospitals, 2001 162
6.2 Heart Transplant Recipients, under 18 Years of Age, by Province of Treatment, 1996 to 1999. 146
6.3 Liver Transplant Recipients, under 18 Years of Age, by Province of Treatment, 1996 to 1999. 147
6.4 Single/Double Lung Transplant Recipients, under 18 Years of Age, by Province of Treatment, 1996 to 1999. 148

BIBLIOGRAPHY

Aba, S., W.D. Goodman, and J.M. Mintz. 2002. *Funding Public Provision of Private Health: The Case for a Copayment Contribution through the Tax System. C.D. Howe Institute Commentary 163*. Toronto, C.D. Howe Institute.

Aba, S., and J. Mintz. 2002. Should Public Health Care Benefits Be Included as Part of Taxable Income? Paper presented at the Roundtable on Financing Options for the Commission on the Future of Health Care in Canada. May 24, C.D. Howe Institute, Toronto.

Abelson, J., and J. Eyles. 2002. Public Participation and Citizen Governance in the Canadian Health System. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Abelson, J., and B. Hutchison. 1994. Primary Health Care Models: A Review of the International Literature. Hamilton, Centre for Health Economics and Policy Analysis, Working Paper 94-15.

ACMC (Association of Canadian Medical Colleges). 2002. Canadian Faculties of Medicine. Some Examples of Rural Educational Initiatives. Unpublished material.

———. 2001. *Canadian Medical Education Statistics*. Ottawa, Association of Canadian Medical Colleges.

Adams, A.S., S.B. Soumerai, and D. Ross-Degnan. 2001. The Case for a Medicare Drug Coverage Benefit: A Critical Review of the Empirical Evidence. *Annual Review of Public Health* 22, 49-61.

Adams. D., ed. 2001. *Federalism, Democracy and Health Policy in Canada*. Montreal, McGill-Queen's University Press.

Afilalo, M. 2001. *Impact of a Nurse Discharge Coordinator on the Successful Discharge of Elderly Patients from the Emergency Department*. Ottawa, Health Canada.

AFN (Assembly of First Nations). 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Ottawa Public Hearing, April 4, Ottawa, Ontario.

AHABC (Aboriginal Health Association of B.C.) 1999. *The Aboriginal Health Association of BC Aboriginal Health Handbook. Common-Unity: A Value, a Method and End*. Vancouver, Aboriginal Health Association of B.C.

Ahenakew, D., and S. Sanderson. 2001. Sovereignty and Treaty Relations Between First Nations and Canada. Paper presented at First Nations Health: Our Voice, Our Decisions, Our Responsibility. February 25-27, Assembly of First Nations, Ottawa, Ontario.

Alberta. 2001. *A Framework for Reform. Report of the Premier's Advisory Council on Health*. [D. Mazankowski, Chair]. Edmonton, Premier's Advisory Council on Health.

Alter, D.A., C.D. Naylor, P. Austin and J.V. Tu. 1999. Effects of Socio-Economic Status on Access to Invasive Cardiac Procedures and on Mortality After Acute Myocardial Infarction. *New England Journal of Medicine* 341(18), 1359-1367.

AMA (Alberta Medical Association). 2001. *Alberta Doctors Overwhelmingly Approve Agreement with Alberta Health*. News Release, February 27.

APNQL (l'Assemblée des Premières Nations du Québec et du Labrador). 2000. Mémoire intitulé « Organisation et financement des services de santé et des services sociaux. Commentaires et recommandations des Premières Nations du Québec » à la Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador. Wendake, Québec.

———. 1999. *Proposition de politique de santé. Un mandat pour les services sociaux et de santé des Premières Nations.* Wendake, Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador.

Applied Management in association with Fraser Group, Tristat Resources. 2000a. Canadians' Access to Insurance for Prescription Medicines: Executive Summary. Unpublished study submitted to Health Canada.

———. 2000b. Canadians' Access to Insurance for Prescription Medicines. Volume 1. Range and Extent of Coverage. Unpublished study submitted to Health Canada.

Assemblée des aînées et aînés francophones du Canada. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Winnipeg Public Hearing, March 6, Winnipeg, Manitoba.

Association canadienne-française de l'Alberta. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Calgary Public Hearing, April 30, Calgary, Alberta.

Association des régions du Québec. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Québec City Public Hearing, March 25, Québec City, Quebec.

Association québécoise de défense des droits des personnes retraitées et préretraitées. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Québec City Public Hearing, March 25, Québec City, Quebec.

Australia. 1999. *Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians*, 1999-2003. A Joint Development of the National Rural Health Policy Forum and the National Rural Health Alliance for the Australian Health Ministers' Conference.

Barer, M., V. Bhatia, G.L. Stoddart, and R.G. Evans. 1993. *The Remarkable Tenacity of User Charges: A Concise History of the Participation, Positions, and Rationales of Canadian Interest Groups in the Debate over "Direct Patient Participation" in Health Care Financing*. Vancouver, Centre for Health Services and Policy Research, University of British Columbia.

Barer, M., R.G. Evans, C. Hertzman, and J. Lomas. 1979. Controlling Health Care Costs by Direct Charges to Patients: Snare or Delusion? Toronto, Ontario Economic Council, Occasional Paper No. 10.

Barer, M.L., and S. Lewis. 2000. Waiting for Health Care in Canada: Problems and Prospects. Paper prepared for the Atkinson Foundation.

Barer, M.L., and G.L Stoddart. 1999. *Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited*. Discussion paper prepared for Federal/Provincial/Territorial Advisory Committee on Health Human Resources. Vancouver, Centre for Health Services and Policy Research, University of British Columbia.

Barer, M.L., L. Wood, and D.G. Schneider. 1999. *Toward Improved Access to Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited*. Vancouver, Centre for Health Services and Policy Research, University of British Columbia.

Barr, M.D. 2001. Medical Savings Accounts in Singapore: A Critical Inquiry. *Journal of Health Politics, Policy and Law* 26(4), 709-726.

Battista, R.N., D.H. Feeney, and M.J. Hodge. 1995. Evaluation of the Canadian Coordinating Office for Health Technology Assessment. *International Journal of Technology Assessment in Health Care* 11(1), 102-116.

BC Aboriginal Network on Disability Society. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Victoria Public Hearing, March 14, Victoria, British Columbia.

BCMA (British Columbia Medical Association). 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Vancouver Public Hearing, March 12, Vancouver, British Columbia.

Berwick, D.M. 2002. A User's Manual for the IOM's "Quality Chasm" Report. *Health Affairs* 21(3), 80-90.

Billings, J., G.M. Anderson, and L.S. Newman. 1996. Recent Findings on Preventable Hospitalizations. *Health Affairs* 15(3), 239-249.

Birkett, D.J., A.S. Mitchell, and P. McManus. 2001. A Cost-Effectiveness Approach to Drug Subsidy and Pricing in Australia. *Health Affairs* 20(3), 104-114.

Birmingham, C.L., J.L. Muller, A. Palepu, J.J. Spinelli, and A.H. Anis. 1999. The Cost of Obesity in Canada. *CMAJ* 160(4), 483-488.

Blendon, R.J., C. Shoen, C.M. DesRoches, R. Osborn, K.L. Scoles, and K. Zapert. 2002. Inequities in Health Care: A Five-Country Survey. *Health Affairs* 21(3), 182-191.

Blouin, C., J. Foster, and R. Labonté. 2002. Canada's Foreign Policy and Health: Towards Policy Coherence. Background Paper. Ottawa, Canadian Centre for Policy Alternatives.

Bowmer, I. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada. St. John's Public Hearing, April 15, St. John's, Newfoundland.

Boychuk, G.W. 2002. The Changing Political and Economic Environment of Health Care in Canada. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Braden, J.J., and K. Beauregard. 1994. *Health Status and Access to Care of Rural and Urban Populations*. U.S. Department of Health and Human Services (AHCPR Pub. No. 94-0031).

Braën, A. 2002. Health and the Distribution of Powers in Canada. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

British Columbia Aboriginal Network on Disability Society. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Victoria Public Hearing, March 14, Victoria, British Columbia.

British Columbia. Minister of Health Planning. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Victoria Public Hearing, March 14, Victoria, British Columbia.

British Columbia. Ministry of Health Services. 2002. *Doctors to Receive 20.6% Increase, Arbitration Ended*. News Release, 5 March.

Brown, A.D., M.J. Goldacre, N. Hicks, J.T. Rourke, R.Y. McMurtry, J.D. Brown, and G.M. Anderson. 2001. Hospitalization for Ambulatory Care-Sensitive Conditions: A Method for Comparative Access and Quality Studies Using Routinely Collected Statistics. *Canadian Journal of Public Health* 92(2), 155-159.

Brown, D.E. 2000. *An Overview of Evolution of the Health Service Delivery Arrangements in the North*. Ottawa, NelliganPower LLP.

Brown, M.G., T. J. Murray, I.S. Sketris, J.D. Fisk, J.C. LeBlanc, C.E. Schwartz, and C. Skedgel. 2000. Cost-Effectiveness of Interferon Beta-1b in Slowing Multiple Sclerosis Disability Progression. First Estimates. *International Journal of Technology Assessment in Health Care* 16(3), 751-767.

CACC (Canadian Association for Community Care). 2001. Witness at the Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology, May 17 (Issue No. 14), Ottawa, Ontario.

Calgary Health Region. 2002a. *Backgrounder: Electronic Health Record*. Calgary, Calgary Health Region.

———. 2002b. Verbal presentation to the Commission on the Future of Health Care in Canada, Calgary Public Hearing, April 30, Calgary, Alberta.

Canada. 2000. *Backgrounder on Federal Support for Health in Canada*. Ottawa, Government of Canada.

———. 1997. *Commission of Inquiry on the Blood System in Canada: Final Report*. [Justice H. Krever, Commissioner]. Ottawa, Commission of Inquiry on the Blood System in Canada.

———. 1996. *Report of the Royal Commission on Aboriginal Peoples. Volumes 1-5*. [R. Dussault, and G. Erasmus, Co-Chairs]. Ottawa, Royal Commission on Aboriginal Peoples.

———. 1964. *Royal Commission on Health Services, Volumes 1 and 2*. [Emmett M. Hall, Chair]. Ottawa, Royal Commission on Health Services.

Canada. Department of Finance. 2002a. *The Fiscal Balance in Canada – The Facts*. Ottawa, Department of Finance.

———. 2002b. *Major Federal Transfers to Provinces and Territories*. Ottawa, Department of Finance.

———. 2002c. Unpublished statistical data compiled for the Commission on the Future of Health Care in Canada. Ottawa, Federal-Provincial Relations and Social Policy Branch.

Canada. Department of Justice. 1994. *Yukon First Nations Self-Government Act*. Chapter 35. Ottawa, Department of Justice Canada.

Canada. Health and Welfare Canada. 1992. *Working in Partnerships: Drug Review for the Future*. [D. Gagnon, Chair]. Ottawa, Review of the Canadian Drug Approval System.

———. 1991. *A Blueprint for Developing a National Post Marketing Pharmaceutical Surveillance Program*. [J.N. Hlynka, Chair]. Ottawa, Bureau of Pharmaceutical Surveillance.

———. 1986. *Achieving Health for All: A Framework for Health Promotion*. Ottawa, Health and Welfare Canada.

———. 1979. *National Health Expenditures in Canada, 1960 to 1975*. Ottawa, Health and Welfare Canada.

———. 1974. *Policy of the Federal Government Concerning Indian Health Services*. Ottawa, Health and Welfare Canada.

———. 1972. *The Community Health Centre in Canada: Report of the Community Health Centre Project to the Conference of Health Ministers*. [J.E.F. Hastings, Chair]. Ottawa, Health and Welfare Canada.

Canada. Indian and Northern Affairs. 2002. *Basic Departmental Data – 2001*. Ottawa, Indian and Northern Affairs Canada.

Canada. Industry Canada. 2001. *The New National Dream: Networking the Nation for Broadband Access. Report of the National Broadband Task Force*. Ottawa, National Broadband Task Force.

Canada. Office of the Auditor General. 2000. Health Canada – First Nations Health: Follow-up. In *Report of the Auditor General of Canada*. Ottawa, Office of the Auditor General, Chapter 15.

———. 1997. Health Canada – First Nations Health. In *Report of the Auditor General of Canada*. Ottawa, Office of the Auditor General, Chapter 13.

Canada. Senate. 2002a. *The Health of Canadians – The Federal Role. Interim Report. Volume Two: Current Trends and Future Challenges*. [M.J.L. Kirby, Chair]. Ottawa, Standing Senate Committee on Social Affairs, Science and Technology.

———. 2002b. *The Health of Canadians – The Federal Role. Interim Report. Volume Five: Principles and Recommendations for Reform – Part 1*. [M.J.L. Kirby, Chair]. Ottawa, Standing Senate Committee on Social Affairs, Science and Technology.

———. 2002c. *The Health of Canadians – The Federal Role. Final Report on the State of the Health Care System in Canada. Volume Six: Recommendations for Reform*. [M.J.L. Kirby, Chair]. Ottawa, Standing Senate Committee on Social Affairs, Science and Technology.

———. 2001. *The Health of Canadians – The Federal Role. Interim Report. Volume Four: Issues and Options*. [M.J.L. Kirby, Chair]. Ottawa, Standing Senate Committee on Social Affairs, Science and Technology.

———. 2000. *Quality End-of-Life Care: The Right of Every Canadian. Final Report*. [S. Carstairs, Chair]. Ottawa, Standing Senate Committee on Social Affairs, Science and Technology, Subcommittee to update "Of Life and Death."

Canada. Treasury Board Secretariat. 2002. *2001-2002 Estimates. Parts I and II. The Government Expenditure Plan and the Main Estimates*. Ottawa, Treasury Board Secretariat.

Canadian Association for Community Care and the Canadian Home Care Association. 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "Sustaining Canada's Health Care System: The Role of Home and Community Care."

Canadian Association of Emergency Physicians. 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "Emergency Medicine: Change & Challenge."

Canadian Council of Chief Executives. 2002. Written submission to the Commission on the Future of Health Care in Canada, entitled "Shared Enterprise: Sustaining and Improving Health Care for Canadians."

Canadian Fitness and Lifestyle Research Institute. 2002. *2001 Physical Activity Monitor*. Ottawa, Canadian Fitness and Lifestyle Research Institute.

Canadian Home Care Association. 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "Formal Submission from the Canadian Home Care Association."

Canadian Hospice Palliative Care Association. 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "Submission to the Commission on the Future of Health Care in Canada."

Canadian Mental Health Association. 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "Submission by the Canadian Mental Health Association."

Canadian Pharmacists Association. 2002. Written submission to the Commission on the Future of Health Care in Canada, entitled "Presentation to the Commission on the Future of Health Care in Canada."

Canadian Public Health Association. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Ottawa Public Hearing, April 4, Ottawa, Ontario.

———. 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "Creating Conditions for Health."

CardiacCareNetwork of Ontario. 2001. *Driven by Data, Consensus and Concern*. Toronto, CardiacCareNetwork of Ontario.

Carstairs 2000. See Canada. Senate. 2000.

Castro, J.M., M.A. Anderson, K.S. Hanson, and L.B. Helms. 1998. Home Care Referral After Emergency Department Discharge. *Journal of Emergency Nursing* 24(2), 127-132.

CCHSE (Canadian College of Health Service Executives). 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "The Leadership Imperative – Clarity, Consistency and Collaboration Required."

CCOHTA (Canadian Coordinating Office for Health Technology Assessment). 2002a. *2001, National Inventory: CT Scanners (Computed Tomography)*. Ottawa, Canadian Coordinating Office for Health Technology Assessment.

———. 2002b. 2001, *National Inventory: MRI Scanners (Magnetic Resonance Imaging)*. Ottawa, Canadian Coordinating Office for Health Technology Assessment.

CCPA (Canadian Centre for Policy Alternatives). 2002. Globalization and Health: Implications and Options for Health Care Reform. Summary Report by the research consortium from Research Project on Globalization and Health prepared for the Commission on the Future of Health Care in Canada.

CES (Collége des Économistes de la Santé). 2001. Utilisation Fees Imposed to Public Health Care System Users in Europe. Proceedings of the Workshop on November 29 organised for the Commission on the Future of Health Care in Canada. Paris, Collége des Économistes de la Santé.

CFNU (Canadian Federation of Nurses Union). 2002. *CFNU National Nurses' Salaries Data Base*. Ottawa, Canadian Federation of Nurses Union.

Chan, B. 2002. *From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s?* Ottawa, Canadian Institute for Health Information.

CHSRF (Canadian Health Services Research Foundation). 2002a. Depoliticizing Healthcare: Achievable or Even Desirable? Third Annual Invited Exchange, May 31-June 1, organized by Canadian Health Services Research Foundation, Mississauga, Ontario.

———. 2002b. *Human Resources in Canada's Healthcare System*. Issue/Survey Paper prepared for the Commission on the Future of Health Care in Canada.

———. 2001. *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, Their Patients and the System. A Policy Synthesis*. Ottawa, Canadian Health Services Research Foundation.

CIHI (Canadian Institute for Health Information). 2002a. *Drug Expenditure in Canada, 1985-2001*. Ottawa, Canadian Institute for Health Information.

———. 2002b. *Health Care in Canada 2002*. Ottawa, Canadian Institute for Health Information.

———. 2002c. *Hospital Morbidity Database (HMDB)*. Ottawa, Canadian Institute for Health Information.

———. 2002d. *Supply and Distribution of Registered Nurses in Canada, 2001*. Ottawa, Canadian Institute for Health Information.

———. 2002e. *Supply, Distribution and Migration of Physicians in Canada, 2001*. Ottawa, Canadian Institute for Health Information.

———. 2002f. Unpublished statistical data compiled by the Canadian Institute for Health Information for the Commission on the Future of Health Care in Canada.

———. 2001a. *Average Payments Per Physician Report: Canada 1996/97 to 1998/99*. Ottawa, Canadian Institute for Health Information.

———. 2001b. *Health Care in Canada 2001*. Ottawa, Canadian Institute for Health Information.

———. 2001c. *Health Personnel in Canada, 1991 to 2000*. Ottawa, Canadian Institute for Health Information.

———. 2001d. *Home Care Estimates in National Health Expenditures. Feasibility Study*. Ottawa, Canadian Institute for Health Information.

———. 2001e. *National Health Expenditures Trends, 1975-2001*. Ottawa, Canadian Institute for Health Information.

———. 2001f. *Supply, Distribution and Migration of Physicians in Canada, 2000*. Ottawa, Canadian Institute for Health Information.

———. 2001g. *Preliminary Provincial and Territorial Government Health Expenditure Estimates, 1974/5-2001/02*. Ottawa, Canadian Institute for Health Information.

———. 1999. *Average Payments Per Physician Report: Canada 1993/94 to 1995/96*. Ottawa, Canadian Institute for Health Information.

CIHR (Canadian Institutes of Health Research). 2002. Written submission to the Commission on the Future of Health Care in Canada, entitled "Health Research: The Foundation of a Sustainable Canadian Health Care System."

CIHR (Canadian Institutes of Health Research). Institute of Aging. 2002. Written submission to the Commission on the Future of Health Care in Canada, entitled "Research on Aging: Providing Evidence for Rescuing the Canadian Health Care System."

CIHR (Canadian Institutes of Health Research). Institute of Gender and Health. 2002. Written submission to the Commission on the Future of Health Care in Canada, entitled "Gender, Sex, Health and Health Care."

Clair 2001. See Québec. Commission d'étude sur les services de santé et les services sociaux. 2001.

CMA (Canadian Medical Association). 2002. Written submission to the Commission on the Future of Health Care in Canada, entitled "A Prescription for Sustainability."

———. 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "Getting the Diagnosis Right: Toward a Sustainable Future for Canadian Health Care Policy."

CNA (Canadian Nurses Association). 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "Optimizing the Health of the Health System."

Commission. 2002a. *Report on Citizens' Dialogue on the Future of Health Care in Canada*. Prepared for the Commission on the Future of Health Care in Canada by J. Maxwell, K. Jackson, and B. Legowski (Canadian Policy Research Networks), S. Rosell and D. Yankelovich (Viewpoint Learning), in collaboration with P.-G. Forest and L. Lozowchuk (Commission on the Future of Health Care in Canada). Saskatoon, Commission on the Future of Health Care in Canada.

Conference Board of Canada. 2002. *Fiscal Prospects for the Federal and Provincial/Territorial Governments: Economic Performance and Trends*. Ottawa, Conference Board of Canada.

Conference Board of Canada. 20 01. *The Future Cost of Health Care in Canada, 2000-2020: Balancing Affordability and Sustainability*. Ottawa, Conference Board of Canada.

Courchene, T. 2001. *A State of Minds: Toward a Human Capital Future for Canadians*. Montreal, Institute for Research on Public Policy.

Coyte, P. 2000. Home Care in Canada: Passing the Buck. *Canadian Journal of Nursing Research* 33(2), 11-25.

CPRN (Canadian Policy Research Networks). 2002. Health Human Resource Planning in Canada. Summary Report by C. Fooks, K. Duvalko, P. Baranek, L. Lamothe, and K. Rondeau from Research Project on Health Human Resources prepared for the Commission on the Future of Health Care in Canada.

———. 2001. *Asking Citizens What Matters for Quality of Life in Canada. A Rural Lens*. Ottawa, Canadian Policy Research Networks.

CQHA (Committee on Quality of Healthcare in America). 2001. *Crossing the Quality Chasm: A New Health Care System for the 21st Century*. Washington, DC, National Academy Press.

Cregan, P. 1999. Early Discharge After Major Breast Cancer Surgery. *Breast NEWS: Newsletter of the NHMRC National Breast Cancer Centre* 5(1).

Crémieux, P.-Y., P. Ouellette and C. Pilon. 1999. Health-Care Spending as Determinants of Health Outcomes. *Health Economics* 8, 627-639.

Critchley, W.D. 2002. Drug Patents and Drug Prices: The Role of the PMPRB. Notes for an Address to the Drug Patents Conference, March 4, Toronto, Ontario. Ottawa, Patented Medicine Prices Review Board.

Dallaire, C., and S. Normand. 2002. Changes and a Few Paradoxes: Some Thoughts on the Health System Personnel. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Davenport, T.H., and J. Glaser. 2002. Just-in-Time Delivery Comes to Knowledge Management. *Harvard Business Review* 80(7), 107-111.

Davis, K. 2002. The Danish Health System Through an American Lens. Health Policy 59(2), 119-132.

DC (District of Columbia). 2002. Community-State Partnerships to Improve End-of-Life Care program. Kansas City, Midwest Bioethics Center.

Deber, R. 2002. Delivering Health Care Services: Public, Not-for-Profit, or Private? Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Deber, R., L. Narine, P. Baranek, N. Sharpe, K.M. Duvalko, R. Zlotnik-Shaul, P. Coyte, G. Pink, and A.P. Williams. 1998. The Public-Private Mix in Health Care. In *Striking a Balance: Health Care Systems in Canada and Elsewhere. Volume 4*. Ottawa, National Forum on Health.

DeCoster, C., L. MacWilliam, and R. Walld. 2000. *Waiting Times for Surgery: 1997/98 and 1998/99 Update*. Winnipeg, Manitoba Centre for Health Policy and Evaluation.

Decter, M.B. 2000. *Four Strong Winds: Understanding the Growing Challenges to Health Care*. Toronto, Stoddart Publishing.

Devereaux, P.J., P.T.L. Choi, C. Lacchetti, B. Weaver, H.J. Schünemann, T. Haines, J.N. Lavis, B.J.B. Grant, D.R.S. Haslam, M. Bhandari, T. Sullivan, D.J. Cook, S.D. Walter, M. Meade, H. Khan, N. Bhatnagar, and G.H. Guyatt. 2002. A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit Hospitals and Private Not-For-Profit Hospitals. *CMAJ* 166(11), 1399-1406.

Dickinson, H. 2002. How Can the Public Be Meaningfully Involved in Developing and Maintaining an Overall Vision for the Health Care System Consistent with Its Values and Principles? Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Donald, A. 1999. Political Economy of Technology Transfer. *BMJ* 319, 1-3.

Donaldson, C., G. Currie, and C. Mitton. 2001. *Integrating Canada's Dis-Integrated Health Care System: Lessons from Abroad. C.D. Howe Institute Commentary 151*. Toronto, C.D. Howe Institute.

Donaldson, C., C. Mitton, and G. Currie. 2002. *Managing Medicare: The Prerequisite to Spending or Reform. C.D. Howe Institute Commentary 157*. Toronto, C.D. Howe Institute.

Durand, P.J., A. Tourigny, L. Bonin, M. Paradis, A. Lemay, and P. Bergeron. 2001. Mécanisme de coordination des services géronto-gériatriques des Bois-Francs. Ottawa, Health Transition Fund, Health Canada.

Edmonton Palliative Care Program. 2002. Regional Care Services. Acute Palliative Care Unit. Edmonton, Community Care Services, Capital Health.

EKOS Research Associates. 2002. Report on the Future of Health Care in Canada: General Public Survey. Ottawa, EKOS.

Embree, J. 2001. It's Time for a National Immunization Strategy. *Paediatrics and Child Health* 6(6), 316-318.

Epps, T., and C. Flood. 2002. *The Implications of the NAFTA for Canada's Health Care System: Have We Traded the Opportunity for Innovative Health Care Reform*. Toronto, Faculty of Law, University of Toronto.

Evans, R.G. 2002a. Financing Health Care: Taxation and the Alternatives. In *Funding Health Care: Options for Europe*. Edited by E. Mossialos, A. Dixon, and J. Figueras. Buckingham, Open University Press, 31-58.

———. 2002b. Raising the Money: Options, Consequences, and Objectives for Financing Health Care in Canada. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Evans, R.G., M.L. Barer, G.L. Stoddart, and V. Bhatia. 1993. *It's Not the Money, It's the Principle: Why User Charges for Some Services and Not Others?* Vancouver, Centre for Health Services and Policy Research, University of British Columbia.

Family Caregivers Association of Nova Scotia. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Halifax Public Hearing, April 17, Halifax, Nova Scotia.

Favel-King, A. 1993. The Treaty Right to Health. In *The Path to Healing: Report of the National Round Table on Aboriginal Health and Social Issues*. Ottawa, Royal Commission on Aboriginal Peoples.

FCFA (Fédération des communautés francophones et acadienne du Canada). 2001. *French-Language Health Care: Improving Access to French-Language Health Services. Study co-ordinated by the FCFA du Canada for the Consultative Committee for French-Speaking Minority Communities*. Ottawa, Fédération des communautés francophones et acadienne du Canada.

Feachem, R.G.A., N.K. Sekhri, and K.L. White. 2002. Getting More for Their Dollar: A Comparison of the NHS with California's Kaiser Permanente. *BMJ* 324(7330), 135-141.

Fearn, R. 1987. Rural Health Care: A British Success or a Tale of Unmet Need? *Social Science and Medicine* 24(3), 263-274.

Federal-Provincial Task Force. 1992. Report to the Conference of Deputy Ministers of Health on a Canadian Agency for Information Assessment (National Formulary Service).

Fédération des infirmières et infirmiers du Québec. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Québec City Public Hearing, March 25, Québec City, Québec.

First Nations Chiefs' Health Committee. 2000. Transition Management Strategy. A New Way to First Nations Health. A Discussion Paper About the Future of First Nations Health Services. Vancouver, First Nations Chiefs' Health Committee.

Flood, C., and S. Choudhry. 2002. Strengthening the Foundation: Modernizing the Canada Health Act. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

FMM (First Ministers' Meeting). 2002. *Provinces Pave the Way for the Future of Health Care*. Provincial-Territorial Premiers' Meeting, January 24-25, Vancouver. Ottawa, Canadian Intergovernmental Conference Secretariat.

———. 2000. *First Ministers' Meeting Communiqué on Health*. September 11. Ottawa, Canadian Intergovernmental Conference Secretariat.

FNIHB 2001. See HC (Health Canada). 2001.

———. See HC (Health Canada). 1999b.

Forget, E.L., R. Deber, and L.L.Roos. 2002. Medical Savings Accounts: Will They Reduce Costs? *CMAJ* 167(2), 143-147.

FPT (Federal-Provincial-Territorial) Advisory Committee on Population Health. 2000. *Toward a Healthy Future: Second Report on the Health of Canadians*. Ottawa, Health Canada.

Fyke 2001. See Saskatchewan. Commission on Medicare. 2001.

Gagnon 1992. See Canada. Health and Welfare Canada. 1992.

Gamm, L. 1998. Advancing Community Health Through Community Health Partnerships. *Journal of Healthcare Management* 43(1), 51-67.

Gamm, L., L. Hutchison, G. Bellamy, and B.J. Dabney. 2002. Rural Healthy People 2010: Identifying Rural Health Priorities and Models for Practice. *Journal of Rural Health* 18(1), 9-14.

Garattini, S., and V. Bertele. 2002. Efficacy, Safety, and Cost of New Anticancer Drugs. *BMJ* 325(7358), 269-271.

Gavin, M., and A. Esmail. 2002. Solving the Recruitment Crisis in UK General Practice: Time to Consider Physician Assistants? *Social Policy and Administration* 36(1), 76-89.

Gerdtham, U.G. and B. Jönsson. 2000. International Comparisons of Health Expenditure: Theory, Data and Econometric Analysis. In *Handbook of Health Economics*, Volume 1A. Edited by A.J. Culyer, and J.P. Newhouse. New York, Elsevier, 11-53.

Gibson, D. 1996. The Canada Health Act and the Constitution. *Health Law Journal* 4, 1-33.

Glynn, P., M. Taylor, and A. Hudson. 2002. *Surgical Wait List Management: A Strategy for Saskatchewan. A Report to Saskatchewan Health*. Regina, Saskatchewan Health.

Goddard, M. and P. Smith. 2001. Equity of Access to Health Care Services: Theory and Evidence from the UK. *Social Science & Medicine* 53, 1149-1162.

Gratzer, D., ed. 2002. *Better Medicine: Reforming Canadian Health Care*. Toronto, ECW Press.

Gratzer, D. 1999. Code Blue: Reviving Canada's Health Care System. Toronto, ECW Press.

Gray, B.H. 1999. *The Empirical Literature Comparing For-Profit and Nonprofit Hospitals, Managed Care Organizations and Nursing Homes: Updating the Institute of Medicine Study*. Washington, DC, Coalition for Nonprofit Healthcare.

Grégoire, J.P., P. MacNeil, and K. Skilton. 2001. Inter-Provincial Variation in Government Drug Formularies. *Canadian Journal of Public Health* 92(4), 307-312.

Hadley, J. 1982. *More Medical Care, Better Health?: An Economic Analysis of Mortality Rates*. Washington, DC, Urban Institute Press.

Hall 1964. See Canada. 1964.

Hampton, M.-J. 2001. *The Eskasoni Story: Eskasoni Primary Care Project Evaluation. Final Report*. Ottawa, Health Canada.

Harrington, C. 2001. Residential Nursing Facilities in the United States. *BMJ* 323, 507-510.

Hastings 1972. See Canada. Health and Welfare. 1972.

HC (Health Canada). 2002a. *Primary Health Care Transition Fund*. Ottawa, Health Canada.

———. 2002b. *Guidance for Industry: Priority Review of Drug Submissions*. Ottawa, Health Canada.

———. 2002c. *Special Access Programme (SAP) Instructions for Making a Special Access Request*. Ottawa, Health Canada.

———. 2001a. *Canada Health Act Annual Report 2000-2001*. Ottawa, Health Canada.

———. 2001b. *First Nations and Inuit Control, Annual Report, 2000-2001*. Ottawa, First Nations and Inuit Health Branch.

———. 2001c. *First Nations and Inuit Health Program Compendium*. Ottawa, Health Canada.

———. 2001d. *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01. Statistical Annex*. Ottawa, Health Canada.

———. 2001e. *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01*. Methodology Guide. Ottawa, Health Canada.

———. 2001f. *Tactical Plan for a Pan-Canadian Health Infostructure. 2001 Update*. Federal-Provincial-Territorial Advisory Committee on Health Infostructure. Ottawa, Office of Health and the Information Highway.

———. 2001g. *Pharmacare in Canada: Issues and Options*. Ottawa, Health Canada, Working Paper 01-01.

———. 2001h. *Non-Insured Health Benefits Program: Annual Report 2000/2001*. Ottawa, First Nations and Inuit Health Branch.

———. 2000. *Blueprint and Tactical Plan for a Pan-Canadian Health Infostructure*. Federal-Provincial-Territorial Advisory Committee on Health Infostructure. Ottawa, Office of Health and the Information Highway.

———. 1999a. *Internal Review of the Canadian Coordinating Office for Health Technology Assessment*. Ottawa, Health Canada.

———. 1999b. *Second Diagnostic on the Health of First Nations and Inuit People in Canada*. Ottawa, First Nations and Inuit Health Branch.

Health Charities Council of Canada. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Ottawa Public Hearing, April 4, Ottawa, Ontario.

Helliwell, J. 2000. *Globalization: Myths, Facts, and Consequences*. Benefactors Lecture. Toronto, C.D. Howe Institute.

Hirdes, J., J. Poss, J.N. Morris, and B.E. Fries. 2002. Unpublished data prepared for the Commission on the Future of Health Care in Canada.

Hjortsberg, C., and O. Ghatnekar. 2001. *Health Care Systems in Transition: Sweden 2001*. Copenhagen, European Observatory on Health Care Systems.

Hlynka 1991. See Canada. Health and Welfare Canada. 1991.

Hogan, S., and S. Hogan. 2002. How Will the Ageing of the Population Affect Health Care Needs and Costs in the Foreseeable Future? Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Hogg, P. 1997. *Constitutional Law of Canada: Fourth Edition*. Scarborough, ON: Carswell.

Hollander, M., and N. Chappell. 2002. *Final Report of the National Evaluation of the Cost-Effectiveness of Home Care. A Report prepared for the Health Transition Fund, Health Canada*. Victoria, Centre on Aging, University of Victoria.

Hollander, M., and E. Walker. 1998. *Report of Continuing Care Organization and Terminology. Prepared on behalf of the Federal-Provincial-Territorial Committee of Officials for the Ministers Responsible for Seniors*. Ottawa, Health Canada.

Hospice Palliative Care Association of Prince Edward Island. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Charlottetown Public Hearing, April 18, Charlottetown, Prince Edward Island.

HSURC (Health Services Utilization Research Commission). 1998. *Hospital and Home Care Study*. Saskatoon, Health Services Utilization Research Commission.

Humphreys, J., D. Hegney, J. Lipscombe, G. Gregory, and B. Chater. 2002. Whither Rural Health?: Reviewing a Decade of Progress in Rural Health. *Australian Journal of Rural Health* 10, 2-14.

Humphreys, J., S. Mathews-Cowey, and F. Rolley. 1996. *Health Service Frameworks for Small Rural and Remote Communities – Issues and Options*. Armidale, University of New England.

Hurley, J. 2002. Medical Savings Accounts Will Not Advance Canadian Health Care Objectives. *CMAJ* 167(2), 152-153.

———. 2000. Medical Savings Accounts: Approach With Caution. *Journal of Health Services Research and Policy* 5(3), 130-132.

Hutchison, B., and J. Abelson. 1996. Models of Primary Health Care Delivery: Building Excellence through Planned Diversity and Continuous Evaluation. Hamilton, Centre for Health Economics and Policy Analysis.

Hutchison, B., J. Abelson, and J. Lavis. 2001. Primary Care in Canada: So Much Innovation, So Little Change. *Health Affairs* 20(3), 116-131.

IMS HEALTH Canada, Compuscript, and Statistics Canada. 2002. *Utilization of Prescriptions 2001*. Pointe-Claire, IMS HEALTH Canada.

INAC 2002. See Canada. Indian and Northern Affairs. 2002.

Indian Health Service. 2001. *Indian Health Service – An Agency Profile*. Rockville, Maryland, Indian Health Service.

Inuit Tapiriit Kanatami. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Montreal Public Hearing, March 26, Montreal, Québec.

Jadad, A.R. 1999. Promoting Partnerships: Challenges for the Internet Age. *BMJ* 319(7212), 761-764.

Johnson, J.R. 2002. How Will International Trade Agreements Affect Canadian Health Care? Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Katzmarzyk, P.T., N. Gledhill, and R.J. Shephard. 2000. The Economic Burden of Physical Inactivity in Canada. *CMAJ* 163(11),1435-1440.

Kent, T. 2002. *Medicare: It's Decision Time*. Ottawa, Caledon Institute of Social Policy.

———. 2000. *What Should Be Done about Medicare?* Ottawa, Caledon Institute of Social Policy.

Kidney, T., and N.J. MacKinnon. 2001. Preventable Drug-Related Morbidity and Mortality in Older Adults: A Canadian Cost-of-Illness Model. *Geriatrics Today* 4(3), 120.

Kleinke, J.D. 2001. Oxymorons: *The Myth of a U.S. Health Care System*. San Francisco: Jossey-Bass.

Koehoorn, M., G.S. Lowe, K.V. Rondeau, G. Schellenberg, and T.H. Wagar. 2002. Creating High-Quality Health Care Workplaces. Ottawa, Canadian Policy Research Networks, Discussion Paper No. W/14.

Kohn, L., J. Corrigan, and M. Donaldson, eds. 2000. *To Err Is Human: Building a Safer Health System*. Washington, DC, National Academy Press.

Kozyrskyj, A.L., C.A. Mustard, M.S. Cheang, and F.E. Simons. 2001. Income-Based Drug Benefit Policy: Impact on Receipt of Inhaled Corticosteroid Prescriptions by Manitoba Children with Asthma. *CMAJ* 165(7), 897-902.

Krever 1997. See Canada. 1997.

Kunitz, S.J. 1996. Public Health Then and Now. The History and Politics of U.S. Health Care Policy for American and Alaskan Natives. *American Journal of Public Health* 86(10), 1464-1473.

Langlois, K. 1997. A Saskatchewan Vision for Health: Who Really Makes the Decisions? In *Alternative Service Delivery: Sharing Governance in Canada*. Edited by R. Ford, and D. Zussman. Toronto, Institute of Public Administration of Canada and KPMG Centre for Government Foundation, 173-184.

Laurentian University, School of Nursing. 2002. Verbal presentation to the Commission on the Future of Health Care, Sudbury Public Hearing, April 11, Sudbury, Ontario.

Lazarou, J., B.H. Pomeranz, and P.N. Corey. 1998. Incidence of Adverse Drug Reactions in Hospitalized Patients. *JAMA* 279(15), 1200-1205.

LeBourdais, E. 1999. Preferential Treatment for WCB Patients Angers Some MDs. *CMAJ* 161(7), 859.

Leeson, H. 2002. Constitutional Jurisdiction Over Health and Health Care Services in Canada. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Lehoux, P. 2002. Could New Regulatory Mechanisms Be Designed after a Critical Assessment of the Value of Health Innovations? Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Lewis, S., M.L. Barer, C. Sanmartin, S. Sheps, S.E.D. Shortt, and P.W. McDonald. 2000. Ending Waiting-List Mismanagement: Principles and Practice. *CMAJ* 162(9), 1297-1300.

Lexchin, J., M. Sanger, and S. Shrybman. 2002. Assessing the Impact of Trade and Investment Agreements on Canadian Health Services and Health Policy. Background Paper. Ottawa, Canadian Centre for Policy Alternatives.

Lissauer, M. 2002. The Future Workforce. *BMJ* 325(7363):S73.

Lomas, J. 2000. Connecting Research and Policy. *Isuma: Canadian Journal of Policy Research* 1(1), 140-144.

MacAdam, M. 1999. Home Care: It's Time for a Canadian model. *Healthcare Papers* 1(4), 9-36.

MacIntyre, S., and M. Petticrew. 2000. Good Intentions and Received Wisdom Are Not Enough. *Journal of Epidemiology & Community Health* 54(11), 802-803.

Maioni, A. 2002. Roles and Responsibilities in Health Care Policy. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Majnoni d'Intignano, B. 2001. *Santé et économie en Europe*. Paris, Presses Universitaires de France.

Makomaski-Illing, E.M., and M.J. Kaiserman. 1999. Mortality Attributable to Tobacco Use in Canada and Its Regions, 1994 and 1996. *Chronic Diseases in Canada* 20(3), 111-117.

Marmor, T.R., M. Schlesinger, and R.W. Smithey. 1987. Nonprofit Organizations and Healthcare. In *The Nonprofit Sector: A Research Handbook*. Edited by W.W. Powell. New Haven, Yale University Press, 1-35.

Martens, D. 2002. Graphic Tobacco Warnings Having Desired Effect. *CMAJ* 166(11), 1453.

Martens, P., R. Bond, L. Jebamani, C. Burchill, N. Roos, S. Derksen, M. Beaulieu, C. Steinbach, L. MacWilliam, R. Walld, and N. Dik. 2002. *The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study*. Winnipeg, Manitoba Centre for Health Policy.

Martin, S. 2002. *What Paperless Office? CMAJ* 167(2), 182.

Maslove, A.M. 1998. National Goals and the Federal Role in Health Care. In *Striking a Balance: Health Care Systems in Canada and Elsewhere. Volume 4*. Ottawa, National Forum on Health, 367-399.

Mathers, C.D., R. Sadana, J.A. Salomon, C.J.L. Murray, and A.D. Lopez. 2000. Estimates of DALE for 191 Countries: Methods and Results. Geneva, World Health Organization, Global Programme on Health Policy, Working Paper No. 16.

Mathies, D.J. 2000. Better Funding Model Means Better Patient Care. *Family Practice Magazine*. March 1.

Maynard, A., and A. Dixon. 2002. Private Health Insurance and Medical Savings Accounts: Theory and Experience. In *Funding Health Care: Options for Europe*. Edited by E. Mossialos, A. Dixon, J. Figueras, and J. Kutzin. Buckingham, Open University Press, 109-127.

Mazankowski 2001. See Alberta. 2001.

McCallum, J. 1995. National Borders Matter: Canada-U.S. Regional Trade Patterns. *American Economic Review* 85, 615-623.

McDaid, D. 2000. ASTEC Report on Canada. London, Analysis of Scientific and Technical Evaluation of Health Interventions in the European Union.

McDonald, P.W. 1995. A Case for the Treatment of Obesity. *Journal of the Canadian Dietetic Association* 56, 131-136.

McFarlane, L., and C. Prado. 2002. *The Best-Laid Plans: Health Care's Problems and Prospects*. Montreal, McGill-Queen's University Press.

McMahon, F., and M. Zelder. 2002. Making Health Spending Work. *Healthcare Papers* 2(4), 43-47.

MCHP (Manitoba Centre for Health Policy). 2002. Unpublished data prepared for the Commission on the Future of Health Care in Canada.

Mechanic, D. 2000. Rediscovering the Social Determinants of Health. *Health Affairs* 19(3), 269-276.

Mehmet, O. 2002. The Emerging Global Labour Market: Some Implications for International Health. Paper presented at the World Health Organization consultation on Imbalances in the Health Workforce, March 10-12, Ottawa, Ontario.

Mendelsohn, M. 2002. *Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation*. Saskatoon, Commission on the Future of Health Care in Canada.

Migué, Jean-Luc. 2002. Funding and Production of Health Services: Outlook and Potential Solutions. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Millar, J. 2001. System Performance Is the Real Problem. *Healthcare Papers* 2(1), 79-84.

Miller, F., J. Hurley, S. Morgan, R. Goeree, P. Collins, G. Blackhouse, M. Giacomini, and B. O'Brien. 2002. *Predictive Genetic Tests and Health Care Costs: Final Report Prepared for the Ontario Ministry of Health and Long Term Care*. Hamilton, Centre for Health Economics and Policy Analysis.

MNU (Manitoba Nurses Union). 2002. *Nurses Ratify Agreement*. News Release, 18 April.

Montmarquette 2001. See Québec. Le Comité sur la pertinence et la faisabilité d'un régime universel public d'assurance médicaments au Québec. 2001.

Morgan, S., and J. Hurley. 2002a. Influences on the "Health Care Technology Cost Driver". Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

———. 2002b. The Health Economic Consequences of an Aging Population. *Expert Review of Pharmacoeconomics & Outcomes Research* 2(2), 89-91.

Morris, J.N., B.E. Fries, K. Steel, N. Ikegami, R. Bernabei, G.I. Carpenter, R. Gilgen, J.P. Hirdes, and E. Topinkova. 1997. Comprehensive Clinical Assessment in Community Setting: Applicability of the MDS-HC. *Journal of the American Geriatrics Society* 45(8), 1017-1024.

Mossialos, E., and A. Dixon. 2002. Funding Health Care: An Introduction. In *Funding Health Care: Options for Europe*. Edited by E. Mossialos, A. Dixon, J. Figueras, and J. Kutzin. Buckingham, Open University Press, 1-30.

Mossialos, E., A. Dixon, J. Figueras, and J. Kutzin, eds. 2002. *Funding Health Care: Options for Europe*. Buckingham, Open University Press.

Moynihan, R. 2002. Alosetron: A Case Study in Regulatory Capture, or a Victory for Patients' Rights? *BMJ* 325(7364), 592-595.

Multicultural Women's Organization of Newfoundland and Labrador. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, St. John's Public Hearing, April 15, St. John's, Newfoundland.

NAHO (National Aboriginal Health Organization). 2002. *Dialogue on Aboriginal Health: Sharing Our Challenges and Our Successes. Draft Proceedings*. Aboriginal Forum held in partnership with the Commission on the Future of Health Care in Canada, June 26, Aylmer, Québec. Ottawa, National Aboriginal Health Organization.

———. 2001.Written submission to the Commission on the Future of Health Care in Canada, entitled "Making a Difference."

National Forum on Health. 1997a. *Canada Health Action: Building on the Legacy. Volume I. The Final Report of the National Forum on Health*. Ottawa, National Forum on Health.

_____. 1997b. *Canada Health Action: Building on the Legacy. Volume II. Synthesis Reports and Issues Papers*. Ottawa, National Forum on Health.

National Organization of Immigrant and Visible Minority Women of Canada. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, St. John's Public Hearing, April 15, St. John's, Newfoundland.

NCIC (National Cancer Institute of Canada). 1999. *Canadian Cancer Statistics 1999*. Toronto, National Cancer Institute of Canada.

Nestle, M. 2002. *Food Politics: How the Food Industry Influences Nutrition and Health*. Berkeley, University of California Press.

New Brunswick. 2002. *New Contract for N.B. Doctors Offers Financial Incentives and Fatter Fees*. Canadian Press, 24 June.

Newfoundland and Labrador Health in Pluralistic Societies. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, St. John's Public Hearing, April 15, St. John's, Newfoundland.

Ng, E., R. Wilkins, J. Pole, and O.B. Adams. 1999. How Far to the Nearest Physician? *Rural and Small Town Canada Analysis Bulletin* 1(5), 1-7.

NIHCM Foundation (National Institute for Health Care Management Research and Educational Foundation). 2002. *Changing Patterns of Pharmaceutical Innovation*. Washington, DC, National Institute for Health Care Management.

Nordhaus, W. 2002. The Health of Nations: The Contribution of Improved Health to Living Standards. Cambridge, National Bureau of Economic Research, Working Paper 8818.

Noseworthy, T., J. McGurran, D. Hadom and the Steering Committee of the Western Canada Waiting List Project. 2002. Waiting for Scheduled Services in Canada: Development of Priority-Setting Scoring Systems. *Journal of Evaluation in Clinical Practise* 8. In Press.

Nunavut. Minister of Health and Social Services. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Iqaluit Public Hearing, April 8, Iqaluit, Nunavut.

NWT (Northwest Territories). Premier and Minister of Health and Social Services. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Yellowknife Public Hearing, May 16, Yellowknife, Northwest Territories.

OECD (Organisation for Economic Co-operation and Development). 2002a. *Measuring Up: Improving Health System Performance in OECD Countries*. Paris, Organisation for Economic Co-operation and Development.

———. 2002b. *OECD Health Data 2002b. A Comparative Analysis of 30 Countries*. Paris, Organisation for Economic Co-operation and Development.

———. 2001a. *Health at a Glance*. Paris, Organisation for Economic Co-operation and Development.

———. 2001b. *OECD Health Data 2001*. A Comparative Analysis of 30 Countries. Paris, Organisation for Economic Co-operation and Development.

———. 2001c. *The Development of Broadband Access in OECD Countries*. Working Party on Telecommunication and Information Services Policies. Committee for Information, Computer and Communications Policy. Paris, Organisation for Economic Co-operation and Development.

———. 2000. OECD Statistical and Analytical Information on Ageing. Prepared for the NBER-Kiel Institute Conference on Coping with the Pension Crisis – Where Does Europe Stand?, Berlin, March. Paris, Organisation for Economic Co-operation and Development.

O'Neil, J. 1995. Issues in Health Policy for Indigenous Peoples in Canada. *Australian Journal of Public Health* 19(6), 559-566.

Ontario. 2002. *Ontario Report to Premiers: Genetics, Testing & Gene Patenting: Charting New Territory in Healthcare. Executive Summary*. Toronto, Government of Ontario.

Ontario Coalition of Senior Citizens' Organizations. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Sudbury Public Hearing, April 11, Sudbury, Ontario.

Ontario. Ministry of Health. 1997. *Access to Quality Health Care in Rural and Northern Ontario: The Rural and Northern Health Care Framework*. Toronto, Ministry of Health.

O'Reilly, P. 2001. The Federal/Provincial/Territorial Health Conference System. In *Federalism, Democracy and Health Policy in Canada*. Edited by D. Adams. Montreal, McGill-Queen's University Press, 107-129.

Ouellet, R. 2002. The Effects of International Trade Agreements on Canadian Health Measures: Options for Canada with a View to the Upcoming Trade Negotiations. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

PAIRO (Professional Association of Internes and Residents of Ontario). 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Toronto Public Hearing, May 30, Toronto, Ontario.

Pampalon, R. 1991. Health Discrepancies in Rural Areas in Quebec. *Social Science and Medicine* 33(4), 355-360.

Pauktuutit – Inuit Women's Association. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Iqaluit Public Hearing, April 8, Iqaluit, Nunavut.

Pitblado, J. R., R.W. Pong, A. Irvine, K.V. Nagarajan, V. Sahai, J. Zelmer, L. Dunidowski, and D.A. Pearson. 1999. *Assessing Rural Health: Toward Developing Health Indicators for Rural Canada*. Sudbury, Centre for Rural and Northern Health Research.

PMPRB (Patented Medicine Prices Review Board). 2002. *Annual Report 2001*. Ottawa, Patented Medicine Prices Review Board.

———. 2001. *Annual Report 2000*. Ottawa, Patented Medicine Prices Review Board.

———. 1998. *Year-over-Year Changes in the Patented Medicine Prices Index 1988-1997. Tenth Annual Report*. Ottawa, Patented Medicine Prices Review Board.

Pollack, A., J. Shaoul, D. Rowland, and S. Player. 2001. Public Services and the Private Sector: A Response to the IPPR. London, Catalyst, Working Paper.

Pong, R. 2002. *Sharing the Learning. The Health Transition Fund. Synthesis Series. Rural Health/Telehealth*. Ottawa, Health Canada.

Prince Edward Island Nurses Union. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Charlottetown Public Hearing, April 18, Charlottetown, Prince Edward Island.

Propper, Carol. 2001. Expenditure on Health Care in the UK: A Review. *Fiscal Studies* 22, 151-184.

Québec. Commission d'étude sur les services de santé et les services sociaux. 2001. *Emerging Solutions: Report and Recommendations*. [M. Clair, Chairman]. Québec, Ministry of Health and Social Services.

Québec. Le Comité sur la pertinence et la faisabilité d'un régime universel public d'assurance médicaments au Québec. 2001. *Pour un régime d'assurance médicaments équitable et viable. Rapport préparé par le Comité sur la pertinence et la faisabilité d'un régime universel public d'assurance médicaments au Québec*. [C. Montmarquette, Président]. Québec, Ministère de la Santé et des Services Sociaux.

Ramsay, C. 2002. A Framework for Determining the Extent of Public Financing of Programs and Services. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

———. 2001. Beyond the Public-Private Debate: An Examination of Quality, Access, and Cost in the Health-Care Systems of Eight Countries. Vancouver, Western Sky Communications.

Rawson, N.S.B. 2002. Issues in the Approval of, Access to, and Post-Marketing Follow-Up of New Drugs in Canada: A Personal Viewpoint. *Pharmacoepidemiology and Drug Safety* 11(4), 335-340.

———. Time Required for Approval of New Drugs in Canada, Australia, Sweden, the United Kingdom and the United States in 1996-1998. *CMAJ* 162(4), 501-504.

RCAP (Royal Commission on Aboriginal Peoples). See Canada. 1996.

Read, S. 1995. Issues in Health Management – Promoting First Nations Wellness in Times of Change. In *A Persistent Spirit: Toward Understanding Aboriginal Health Care in British Columbia*. Edited by P.H. Stephenson, S.J. Elliott, L.T. Foster, and J. Harris. Victoria, Western Canadian Geographical, 297-325.

Reichert, B., and M. Windover. 2002. Canadian Pharma…Falling Behind? *Biotechnology Focus* 5(3), 16-18.

Reinhardt, U.E., P.S. Hussey, and G.F. Anderson. 2002. Cross-National Comparisons of Health Systems Using OECD Data, 1999. *Health Affairs* 21(3), 169-181.

Réseau des services de santé en français de l'Est de l'Ontario. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Ottawa Public Hearing, April 4, Ottawa, Ontario.

Reuber, G.L., and F. Poschmann. 2002. Increasing Patient Incentives to Improve the Financial Stability of the Health Care System. Paper presented May 24 at the Roundtable on Financing Options for the Commission on the Future of Health Care in Canada. Toronto, C.D. Howe Institute.

Richards, J. 2002. Indian/non-Indian Life Expectancy: Why the Gap? *Inroads* 12, 48-59.

Richards, S.H., J. Coast, D.J. Gunnell, T.J. Peters, J. Pounsford, and M.A. Darlow. 1998. Randomised Controlled Trial Comparing Effectiveness and Acceptability of an Early Discharge, Hospital at Home Scheme With Acute Hospital Care. *BMJ* 316(7147), 1796-1801.

RNAO (Registered Nurses Association of Ontario). 1997. *Policy Statement: Shortened Length of Obstetrical Stay*. Registered Nurses Association of Ontario.

Rochefort, D.A. 2001. The Backlash Against Managed Care. In *The New Politics of State Health Policy*. Edited by R.B. Hackey, and D.A. Rochefort. Lawrence, University Press of Kansas, 113-141.

Rode, M., and M. Rushton. 2002. Options for Raising Revenue for Health Care. Discussion Paper prepared for the Commission on the Future of Health Care in Canada.

Roine, R., A. Ohinmaa, and D. Hayley. 2001. Assessing Telemedicine: A Systematic Review of the Literature. *CMAJ* 165(6), 765-71.

Rosenberg, M.W. 2000. The Effects of Population Ageing on the Canadian Health Care System. Hamilton, Program for Research on Social and Economic Dimensions of an Aging Population (SEDAP), McMaster University, SEDAP Research Paper No. 14.

Roussos, S.T., and S.B. Fawcett. 2000. A Review of Collaborative Partnerships as a Strategy for Improving Community Health. *Annual Review of Public Health* 21, 369-402.

Rural Secretariat Research and Analysis Group. 2001. *Rural Canadians Survey 2001*. Ottawa, Rural Secretariat.

Saltman, R.B., and J. Figueras, eds. 1997. *European Health Care Reform: Analysis of Current Strategies*. Copenhagen, European Observatory on Health Care Systems.

Salvage, Jane. 2002. *Rethinking Professionalism: The First Step For Patient-Focused Care?* Future Health Worker Project. London, UK, IPPR.

Sanmartin, C., C. Houle, J.-M. Berthelot, and K. White. 2002. *Access to Health Care Services in Canada, 2001*. Ottawa, Statistics Canada.

Saskatchewan. Commission on Medicare. 2001. *Caring for Medicare: Sustaining a Quality System*. [K.J. Fyke, Commissioner]. Regina, Saskatchewan Health.

Scheiber, G., and A. Maeda. 1997. A Curmudgeon's Guide to Financing Health Care in Developing Countries. In Innovation in Health Care Financing. Edited by G.J. Scheiber. Washington, DC, World Bank, World Bank Discussion Paper No. 365, 1-38.

Schulz, R., and S.R. Beach. 1999. Caregiving as a Risk Factor for Mortality: The Caregiver Health Effects Study. *JAMA* 282(23), 2215-2219.

Senate 2001. See Canada. Senate. 2001.

Seniors Resource Centre of Newfoundland and Labrador. 2002. Verbal presentation to the Commission on the Future of Health Care, St. John's Public Hearing, April 15, St. John's, Newfoundland.

Shortell, S.M., R.R. Gillies, and D.A. Anderson. 1994. The New World of Managed Care: Creating Organized Delivery Systems. *Health Affairs* 13(5), 46-64.

Shortt, S.E.D. 2002. Medical Savings Accounts in Publicly Funded Health Care Systems: Enthusiasm Versus Evidence. *CMAJ* 167(2), 159-162.

———. 1999. Waiting for Medical Care: Is It Who You Know That Counts? *CMAJ* 161(7), 823-824.

Smith, Miriam. 1995 "Retrenching the Sacred Trust: Medicare and Canadian Federalism." In *New Trends in Canadian Federalism*. Edited by F. Rocher and M Smith. Peterborough: Broadview Press.

Smythe, J.G. 2001. Tax Subsidization of Employer-Provided Health Care Insurance in Canada: Incidence Analysis. Edmonton, Department of Economics, University of Alberta, Working Paper.

Society of Rural Physicians of Canada. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Sudbury Public Hearing, April 11, Sudbury, Ontario.

Soumerai, S.B., D. Ross-Degnan, E.E. Fortess, and J. Abelson. 1993. A Critical Analysis of Studies of State Drug Reimbursement Policies: Research in Need of Discipline. *Milbank Quarterly* 71(2), 217-252.

Southern Chiefs Organization and Assembly of Manitoba Chiefs. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Winnipeg Public Hearing, March 6, Winnipeg, Manitoba.

Statistics Canada. 2002a. *Annual Demographic Statistics 2001*. Ottawa, Statistics Canada.

———. 2002b. *Canadian Statistics. Population*. Ottawa, Statistics Canada.

———. 2002c. *CANSIM II, Table 380-0030 – Gross Domestic Product (GDP) and Gross National Product (GNP) at Market Prices*. Ottawa, Statistics Canada.

———. 2002d. *Changes in Cancer Incidence and Mortality*. Prepared by Jo-Anne Belliveau and Leslie Gaudette. Ottawa, Statistics Canada.

———. 2002e. *Health Indicators*. May 2002, Volume 2002(1). Ottawa, Statistics Canada.

———. 2002f. *Health Reports*. March 2002, Volume 13(3). Ottawa, Statistics Canada.

———. 2002g. *The Daily*. May 8. Ottawa, Statistics Canada.

———. 2002h. The Health of Canada's Communities. In *How Healthy Are Canadians: Annual Report 2002*. Ottawa, Statistics Canada.

———. 2001a. *Estimates of Total Expenditures on Research and Development in the Health Fields in Canada, 1988 to 2001*. Ottawa, Statistics Canada.

———. 2001b. *2001 Census. Population and Dwelling Counts. Census Metropolitan Areas (CMAs), Census Agglomerations (CAs)*. Ottawa, Statistics Canada.

———. 2001c. *Health Indicators*. December 2001, Volume 2001(3). Ottawa, Statistics Canada.

———. 2001d. *Overview: Access to and Use of Information and Communication Technology*. Ottawa, Statistics Canada.

———. 2000. *Population Projections for Canada, Provinces and Territories 2000-2026*. Ottawa, Statistics Canada.

———. 1998. *The Daily*. January 13. Ottawa, Statistics Canada.

———. 1995. Projections of Population with Aboriginal Ancestry, Canada, Provinces/Regions and Territories, 1991-2016. Ottawa, Statistics Canada.

Statistics Canada and the Social Science Federation of Canada. 1983. *Historical Statistics of Canada: Electronic Edition* (release date, 1999). 2nd ed. Ottawa, Statistics Canada.

Stephens, T., M.J. Kaiserman, D.J. McCall, and C. Sutherland-Brown. 2000. School-Based Smoking Cessation: Economic Costs Versus Benefits. *Chronic Diseases in Canada* 21(2), 62-67.

Stewart, S., and J.D. Horowitz. 2002. Home-Based Intervention in Congestive Heart Failure: Long-Term Implications on Readmission and Survival. *Circulation* 105(24), 2810-2812.

Sullivan, T., and P. Baranek. 2002. *First Do No Harm: Making Sense of Canadian Health Reform*. Toronto, Malcolm Lester.

SUN (Saskatchewan Union of Nurses). 2002. *Nurses Ratify Collective Agreement*. News Release, April.

Sussex, J. 2001. *The Economics of the Private Finance Initiative in the NHS*. London, The Office of Health Economics.

Tamblyn R., R. Laprise, J.A. Hanley, M. Abrahamowicz, S. Scott, N. Mayo, J. Hurley, R. Grad, E. Latimer, R. Perreault, P. McLeod, A. Huang, P. Larochelle, and L. Mallet. 2001. Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons. *JAMA* 285(4), 421-429.

Tuohy, C.H. 2002. The Costs of Constraint and Prospects for Health Care Reform in Canada. *Health Affairs* 21(3), 32-46.

Turenne-Sjolander, C. 1996. The Rhetoric of Globalization: What's in a Wor(l)d? *International Journal* 51(4), 603-616.

UNA (United Nurses of Alberta). 2001. *Multi-Employer (Facility) Collective Agreement Between The Provincial Health Authorities of Alberta and the United Nurses of Alberta for the Period April 1, 2001 to March 31, 2003*. Edmonton, United Nurses of Alberta.

UNDP (United Nations Development Programme). 2002. *Human Development Report 2002. Deepening Democracy in a Fragmented World*. Oxford, Oxford University Press.

———. 2001. *Human Development Report 2001. Making New Technologies Work for Human Development*. Oxford, Oxford University Press.

University of British Columbia, College of Health Disciplines. 2001. Written submission to the Commission on the Future of Health Care in Canada, entitled "The Importance of Interprofessional Education and Collaboration to the Future of Health Care in Canada."

University of Victoria, School of Nursing. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Victoria Public Hearing, March 14, Victoria, British Columbia.

U.S. Congressional Budget Office. 1991. *Universal Health Insurance Coverage Using Medicare's Payment Rates*. Washington, DC, U.S. Government Printing Office.

U.S. General Accounting Office. 1991. Canadian Health Insurance: Lessons for the United States. Pub. No. GAO/HRD-91-90. Washington, DC, U.S. Government Printing Office.

Van Doorslaer, E., X. Koolman, and F. Puffer. 2002. Equity in the Use of Physician Visits in OECD Countries: Has Equal Treatment for Equal Need Been Achieved? In *Measuring Up: Improving the Performance of Health Systems in OECD Countries*. Edited by P. Smith. Paris, Organisation for Economic Co-operation and Development, 225-248.

Vellinga, J. 2001. *International Trade, Health Systems and Services: A Health Policy Perspective*. Ottawa, Department of Foreign Affairs and International Trade.

Waldram, J.B.D., A. Herring, and T. Kue Young. 1995. *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspective*. Toronto, University of Toronto Press.

Weaver, S. 1986. Indian Policy in the New Conservative Government. *Native Studies Review* 2(1), 1-43.

Whitten, P.S., F.S. Mair, A. Haycox, C.R. May, T.L. Willians, and S. Hellmich. 2002. Systematic Review of Cost Effectiveness Studies of Telemedicine Interventions. *BMJ* 324(7351), 1434-1437.

WHO (World Health Organization). 2002. 30 Minutes for a Healthy Life Span. Press Release EURO/07/02. Geneva, World Health Organization.

———. 2001. *The World Health Report 2001. Mental Health: New Understanding, New Hope: Statistical Annex*. Geneva, World Health Organization.

———. 1998. *Health Promotion Glossary*. Geneva, World Health Organization.

———. 1997. *Anti-Tuberculosis Drug Resistance in the World*. The WHO/IUATDLD Global Project on Anti-Tuberculosis Drug Resistance Surveillance 1994-1997. Geneva, World Health Organization.

———. 1978. Declaration of Alma-Ata. International Conference on Primary Health Care, 6-12 September, Alma-Ata, USSR. Geneva, World Health Organization.

Wilkinson, R.G. 1996. *Unhealthy Societies: The Afflictions of Inequality*. London, Routledge.

Wilson, D., H. Northcott, C. Truman, S. Smith, M. Anderson, R. Fainsinger, and M. Stingl. 2001. Location of Death in Canada. A Comparison of 20th-Century Hospital and Nonhospital Locations of Death and Corresponding Population Trends. *Evaluation and the Health Professions* 24(4), 385-403.

Woolhandler, S., and D.U. Himmelstein. 2002. Paying for National Health Insurance – And Not Getting It. *Health Affairs* 21(4), 88-98.

———.1991. The Deteriorating Administrative Efficiency of the U.S. Health Care System. *New England Journal of Medicine* 324(18), 1253-1258.

Woolhandler, S., T. Campbell, and D. U. Himmelstein. 2002. Health Care Administration in the U.S. and Canada: Micro-Management, Macro-Costs. Unpublished manuscript.

WTO (World Trade Organization). 2001. *Declaration on the TRIPS Agreement and Public Health*. Adopted on November 14. Doha WTO Ministerial Conference, Fourth Session. Geneva, World Trade Organization.

Yalnizyan. A. 2002. Paying for Keeps: How the Feds Can Save Medicare. Canadian Centre for Policy Alternatives Monograph.

Yukon. Premier, Minister of Education, and Minister of Health and Social Services. 2002. Verbal presentation to the Commission on the Future of Health Care in Canada, Whitehorse Public Hearing, May 2, Whitehorse, Yukon.

Zurn, P., M. Dal Poz, B. Stilwell, and O. Adams. 2002. Imbalances in the Health Workforce. Briefing Paper from World Health Organization Consultation on Imbalances in the Health Workforce, March 10-12, Ottawa. Geneva, World Health Organization.