

Project Research Paper

A Cross-Provincial Study of Health Care Reform in Canada

Academic Literature Review: Report Summaries

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British Columbia

Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs (1991).

Author: The British Columbia Royal Commission on Health Care and Costs (Chair Justice Peter D Seaton).

Year: 1991

Subject: Provincial health system

Sub-topics:

- Financing.
- Governance
- Acute Care
- Health Information
- Performance measurement
- Health Human Resources

Source: The British Columbia Royal Commission on Health Care and Costs

Background:

The Commission was formed in May of 1990 and was comprised of 6 commissioners with Justice Peter Seaton as chair. The Commission concluded its work in November of 1991 having produced a final report of three volumes and conducting widespread consultations with the general public.

Purpose:

The Commission's mandate was to first and foremost examine the structure, organization and management of the health care system with respect to its ability to provide quality, access and cost-effectiveness in the future. It was also charged with assessing current utilization and efficacy of hospital, continuing care, medical services and prescription drug programs in search of possible efficiencies. Major elements of the health care system and the methods of funding of these services were to be evaluated and options presented to improve resource allocation. The report was also to consider manpower requirements and initiatives that would promote healthy public policies.

Issues and Findings:

By its own admission, the Commission acknowledged that the breadth and scope of its terms of reference and the limited term made it impossible for it to completely fulfill its task. Instead, the Commission focused on an analysis of the existing structure and options for reorganization. The most far reaching and fundamental recommendations from the report are contained in the section entitled "organization" and includes major proposals

for population health goals and targets, management and governance of the health care system, the use and development of alternative delivery organizations, rural and remote health, principles of medicare and cost effectiveness with respect to financing and resource allocation. This is followed by detailed analysis and individual recommendations in a number of key areas including: children, aboriginal health, disabilities, mental health, diagnostic services, prescription drugs, hospitals, home care and others. The last section of the report deals specifically with health care personnel. The report begins with an overview of the evolution of the health care system and the initial focus of the health system on the curing of illness rather than with the prevention of injury and disease. That early system was largely under the control of family physicians including the hospital system. Under this environment neither taxpayers nor even governments, largely responsible only for paying for the system, had much input as to the direction of the health care system. The result has been an over emphasis on curative services to the detriment of other policies to improve public health and an expectation of unfettered access to high technology medical care on demand.

The “central economic fact of the last decade” is that the provincial economy has been in decline and this has resulted in limited scope for overall expansion of government expenditures. In such an environment, expanding programs in health care require shifting of resources from other programs. Increasing fiscal restraint has made even this difficult resulting in even significant attempts at change within the health sector tend to be cancelled out over time. Within the health sector there has been little or no change in the relative share of resources flowing either to hospitals, physicians or continuing care throughout the 1980s. Given this rigid pattern, if overall growth in expenditures continues with no changes to the delivery of health services, the money available for health will only increase with increasing provincial debt or increased taxes. In the Commission’s view, the money currently within the health system must be used more effectively and that meant the shifting of resources within the system.

The current system has developed as a result of decades of programs and policies arising both out of political as well as medical need. The system has lacked a comprehensive plan and therefore has evolved without coherence and with specific objectives in mind. The system also lacks the ability to assess itself and to objectively evaluate its own efficiency or effectiveness. Acting on its own analysis and consultation process, the report early on recommends the creation of an independent and permanent Provincial Health Council. Among its responsibilities, this council would oversee the operation of the entire health system and review the policies, plans and programs of the Ministry of Health or any other public or private body “whose actions affect the health of residents of the province. The council would also have the task of reporting to the public on the functioning of the public health system.

An initial step in redirecting the goals and objectives of the system is to change the emphasis on institutional and physician care. The least amount of money possible should be spent on providing high quality medical care if the object of the system is to improve health. This means a spending more money on preventative measures to reduce illness and improve quality of life and thus the report turns its attention to areas outside of the

health care field. This requires that the government focus on key determinants of health such as poverty, childhood development, labour market policies, public health issues such as immunization and so on. A significant recommendation emanating from this section of the report is the need to establish a comprehensive set of health status indicators and use these to plan and evaluate public policies. The Commission noted that while the health system collects data pertaining to the administration of the health care system it has limited data pertaining to health status on which to evaluate the health effects of proposed provincial programs or legislation or resulting from changes to existing programs or legislation.

Providing optimal care depends on a variety of factors including access to comprehensive health data. The Commission noted that while information is collected by the system, this data is not used to assess the health of patients upon entering and leaving the system or the result of treatments made either in the institutional setting or outside. The result is that the system has no means of evaluate, a particular medical or public health intervention, professional reviews or the relative performance of different institutions. The most significant barrier to the development of appropriate measurements of quality and performance is a lack of leadership which must be assumed by the Ministry of Health. Among its recommendations the report calls for the establishment of a consistent set of data to be collected to establish system requirements and the elimination of data collection that is currently collected and not used. It called upon the province to broaden the mandate of the BC Office of Health Technology Assessment to include quality assurance assessments and to examine utilization rates to establish protocols on a province-wide basis. It also recommended that facilities, programs and professionals providing care in the province must by statute conduct quality assurance and utilization management activities to continually evaluate their own performance.

Centralized management of the health care system has been insensitive to the needs of regional communities and inflexible both in terms of programming and resource allocation. Centralized control provides little incentive for providers to participate in the management of service delivery since all relevant decisions including budgeting are made by the Ministry. Tertiary care and surgical waiting lists in the province also suffer lack of coordination, planning, appropriate distribution or public accountability. The Commission's view was that decentralization of the system would improve the efficiency and effective use of health care resources by allowing greater decision-making to be done at the local level and in response to the needs of particular communities. Greater efficiencies could be realized through regional coordination and integration of institutions and providers. The system would also be more responsive by providing appropriate care as near as possible to individuals and would encourage greater public accountability in the management of health care resources. Under the decentralized system proposed by the Commission, the Ministry of Health would develop system-wide goals, objectives and standards but would establish budget envelopes in consultation with regions for the allocation of resources. The Ministry would also be responsible for the coordination of data collection and the monitoring and evaluation of the overall health system. The Commission proposed a "matrix organization" in which regional Ministry offices would coordinate community priorities and, in conjunction with hospital boards, long-term care

institutions, health professionals and community groups and organizations, develop plans for regional health services delivery. Regional budget envelopes would include funds for all health programs in the region, funds from the Medical Services Plan allocated for the region, as well as, capital and other operational monies. These funds would be transferred on a weighted per capita formula that included some assessment of regional variations in risk factors.

Additional recommendations addressed the need to undertake a thorough and comprehensive analysis to determine the nature, amount and cost of tertiary care being provided hospitals. While delivery and resource allocation for primary and secondary care would be devolved to the regional offices, tertiary care planning would remain with the Ministry. The Ministry in consultation would establish tertiary care objectives and plan, coordinate and evaluate the delivery of tertiary services. Hospitals boards would retain their autonomy subject to regional control for the provision of primary and secondary care services. Tertiary care programs would remain under the direction of the Ministry in order to rationalize services while service agreements would be negotiated with the regions.

Other recommendations related to the management of health services ranged from specific disease management (HIV and AIDS) to rural and remote health concerns to hospitals. The report includes an extensive analysis of what it describes as “alternative health service delivery organizations” such as CLSCs in the province of Québec, and acknowledges that such organizations have the capacity to reduce the number of hospitalizations and improve access. The thrust of the analysis focuses on shifting the system away from fee-for-service delivery and thereby develop incentives that would focus on prevention and health promotion activities. It noted that such organizations have had limited success within the province primarily because of the opposition of physicians and their professional organizations to a perceived loss of clinical autonomy. Its recommendations, however, were limited to calling on the Ministry of Health make a commitment to develop alternate health service delivery organizations and oversee the development, coordination and integration of policies, procedures and legislation necessary to support them.

Major recommendations included increasing incentives for retention and recruitment of health professionals to rural and remote communities and the creation of an inventory of services and sharing agreements among rural and remote communities. The hospital sector, the report observes, consumes half of the Ministry’s budget and serious evaluation of the appropriateness of hospital use and the long-term scale of the hospital sector is required. The Commission noted that an analysis indicated that the system was plagued by unnecessarily extended lengths of stay for short and long-term care patients and inappropriate admissions. A major component of inappropriate admissions and lengths of stay were attributed to occupants of acute care beds who would have been more appropriately transferred to long-term care. If the focus of the health system is to change from institutions to the community and a greater emphasis spent on alternate programs which provide care locally significant changes will be required in the acute care sector. This also represents a significant “pool of resources” that should be redirected into other

sectors including home care services and long-term care facilities. Its recommendation was that the province expand home support services to redirect funds from the institutional setting. Expansion of home support services would be principally funded by reductions in admission rates and lengths of stay in acute care facilities.

In its analysis of health human resources, the Commission observed that despite recommendations of a 1973 report entitled *Health Security of British Columbians* calling for a comprehensive review of health personnel requirements in the province, no such systematic review had ever been undertaken. The central theme of the Commission's review is the principle that health personnel planning should be based on identifiable needs. No such basis for health planning exists and instead the numbers of physicians is based solely on Medical Services Plan expenditures which it notes are inaccurate for a number of reasons including the assumption that all physician billings are appropriate, because they fail to take into account changes in the relative roles of health personnel over time and because they ignore the influence of special interests influencing the system. A health care personnel plan would be based on a number of factors to correctly estimate the province's long-term needs based on population demographics, inter-provincial migration, available resources and the number of available training positions. Additionally it would take into account changes in clinical practice and the effect of substituting other appropriately trained health care workers. The Commission's principle concern was with a relative oversupply of physicians in major centres and recommended limiting the number of physicians allowed to practice within the province and the distribution of those physicians to adequately address shortages in rural and remote communities. Among its recommendations, it suggested negotiating enrolment levels with medical schools based on demographic projections and limiting the number of immigrant physician's granted the right to practice in the province.

Major Recommendations:

- Recommends that the government of British Columbia confirm the five principles of medicare, as described in the Canada Health Act by enacting them in legislation.
- A Provincial Health Council should be established to establish goals for the health system, review the system's progress on achieving these goals, and report to the public on its performance.
- That the provincial government establish a comprehensive set of health status indicators and use these to plan and evaluate public policies.
- Recommends that the Ministry of Health determine and collect the health information necessary to province to evaluate the effectiveness of health services.
- Recommends expanding the mandate of the BC Office of Health Technology Assessment to include utilization management and quality assurance activities.
- Recommends requiring by statute that all facilities, programs and professions providing health care conduct quality assurance and utilization management activities.
- Recommends that the Ministry of Health assume responsibility for province-wide goals, priorities, strategic plans, standards and guidelines. The Ministry will also continue to be responsible for budgets, including regional resource allocations

across all programs. The Ministry will be responsible for information management systems, utilization management, quality assurance and program monitoring.

- Recommends the development of a regional health services system by decentralizing control for area-specific health services planning and resource allocation.
- Recommends that regional budgets be based on a weighted capitation formula which incorporates local service needs and a broad base of population health risk indicators.
- Regional budget processes are to be public, allowing consumer and provider input into decision-making.
- The province should undertake a thorough and comprehensive analysis to determine the nature, amount and cost of tertiary care being provided in BC Hospitals. The Ministry in consultation will establish tertiary care objectives and plan, coordinate and evaluate the delivery of tertiary services.
- The Ministry of Health make a commitment to develop alternate health service delivery organizations and oversee the development, coordination and integration of policies, procedures and legislation necessary to support them.
- Recommends that there be an annual global cap placed on gross payments to physicians. The cap should respond to population change and price level but not to increased utilization.
- Recommends that total funding for hospitals and continuing care be capped in the same way as physician costs.
- Recommends that funds be transferred over time from the acute care hospital sector to continuing care, including home care and other forms of less expensive institutional and residential care services.
- Recommends a major expansion in the capacity of long term care facilities to support the transfer of patients from acute care facilities.
- The Commission recommends that the Ministry of Health, in cooperation with hospitals and health professionals, develop standards for patterns of care for common hospital procedures. These standards shall be made public and used to identify regions and institutions where acute care hospital utilization is deemed excessive.
- Recommends that the increases in home care budgets to provide for patients transferred from acute care be no greater than those services would have cost in acute care.
- Recommends that the Ministry encourage the development of free-standing health facilities to provide some of the services now carried out in acute care facilities. These facilities are to be reimbursed on a contractual terms.
- Recommends that the Ministry of Health make a detailed assessment of health care personnel requirements in the province and publish a provincial health care personnel plan based on identifiable needs.
- Recommends that the Ministry of Health and the BCMA give priority to the joint development of a program to limit the number of physicians.

- Recommends the Ministry shift away from fee-for-service reimbursement toward salaried positions for hospital-based specialists and toward contractual relationships between specialists and community-based clinics.
- Recommends that the Ministry of Health in cooperation with the BCMA establish a permanent independent board to provide public scrutiny, monitor the structure and value of the items in the fee schedule and publish an annual report.

Alberta

The Rainbow Report: Our Vision for Health (1989).

Author: Premier's Commission on Future Health Care for Albertans (Chair)

Year: 1989

Subject: Provincial Health System

Sub-topics:

- Health promotion and disease prevention
- Demographic trends, lifestyle trends and consumer expectations on the need for, and delivery and costs of health care.
- Funding for health care services.
- Supply, education, qualifications and distribution of health care professionals.
- Performance measurement
- Governance
- Health Human Resources
- Health Information
- Environmental protection and health

Source: Premier's Commission on Future Health Care for Albertans

Background:

The Commission, comprised of a chairman and six Commission members plus a Deputy Commissioner who also acted as the Executive Director, was asked to conduct an inquiry on future health requirements for Albertans. The Commission released its interim report with 14 recommendations prior to the issuing of a final report in December of 1989.

Purpose:

The Commission was asked to conduct an inquiry on future health requirements for Alberta. Special emphasis was placed projections of provincial population and trends, on preventative health and healthy public policy issues, on advances in medical technology and practice and on types and patterns of illness. In addition, the Commission was asked to examine the roles, responsibilities and expectations of individual Albertans, of communities, providers, the government and private sector interests in the delivering of future health services and programs. Within this context, the Commission was charged with examining possible directions for change, specifically incentives and mechanisms to maintain system quality and accessibility while at the same time promoting the “most innovative, effective and economical use of health resources.

Issues and Findings:

The opening chapter deals with health promotion and reduction of preventable disease and injury. Begins with a demographic profile of Albertans and concludes the median age of the population will shift upward. General discussion about health status followed by a general description of the prevalence and forms of illness that affect the province. Two major themes emerge from the profiles which are stressed throughout the report. The first is the role of the individual in maintaining or increasing their own health. The second deals with reducing preventable disease and injury. The Commission acknowledges that health promotion and prevention activities have “struggled in the shadow of acute care for legitimate inclusion in the health care arena” (Vol. II, 44). The initial recommendations of the Commission stress the development of a community-based approach to promotion and prevention activities and facilitated by an increase to a full one per cent of the Alberta Health budget targeted toward community-based promotion, protection and prevention programs.

Chapter two follows with a description of the health system with its emphasis on institutional care. The problem is not with over-institutionalization but with dependence or over reliance on institutional care. A focus on institutional care predominated by the publicly funded system, acts as a barrier to the creation of a system likely to foster the “independence and interdependence” alluded to above. This shift from a dependent to a more independent, responsible status allows the development of broader, more encompassing approaches to health. “There must be a shift in the relationships between patients and providers, and among providers, and among hospitals and other health care facilities” (Vol. II, 46).

“There is a tendency to take for granted those programs and services which we consider to be free” (32). The costs of the services provided through government insurance programs are largely not visible to either “consumers” or providers. The Commission recommended that information on the appropriate and responsible use of the health system be provided to educate “consumers” and health care providers. Information on the health system would become part of both primary and secondary education in the province.

However, in the Commission's view the fundamental impediment to individual autonomy, responsibility and self reliance in the utilization of health services were existing funding mechanisms: "We need a funding structure that will be flexible, and will encourage and reward efficiency and effectiveness on the part of the consumers and providers (Vol. II, 79). An additional consequence of the existing system for funding health care is that it limits individual choice. Consumers, having paid for coverage through taxes and premiums, are "forced" to choose only those services provided under government insurance. The narrow range of services offered under the public system, largely defined by the Canada Health Act, was also viewed as a barrier to the development of a more comprehensive health care system. Emanating from this emphasis on individual choice and flexibility, the Commission recommended a system of incentives that would be provided to Albertans to maintain a healthy lifestyle, and some form of reward be provided to those who used the health care system "significantly less than the norm."

In the words of the Commission, "mature interdependence and acceptance of personal responsibility are fundamental goals of this report" (Vol. I, 35). The report speaks of the "political will" necessary to granting controlled private access to public funds for health care. The Commission called upon the provincial government to explore "the option of a system that provides individual Albertans with the responsibility for disbursing, managing and monitoring the funds required for their health care needs." Basic services required within the narrow scope of the CHA would remain fully insured and accessible through the public system, all other health services (provided by medical as well as non-medical practitioners), the Commission speculated, might then be funded through either a public supplemental insurance plan, a third party insurance plan, or left to individual consumers to opt out.

While it suggested "basic" services under the Alberta Health Care Insurance Plan remain publicly funded, the Commission also recommended that basic services eligible under the public plan be defined narrowly as those services covered under the CHA and those deemed essential based on criteria established in consultation with health care practitioners and consumers. Overall the system would be expanded by the inclusion of services outside of the CHA and outside the definition of "basic services" by direct payment through supplemental insurance.

In order to make the health care system more responsive to consumers, the Commission advocated a transfer of responsibility and accountability by recommending that the province be divided into nine autonomous administrative areas within defined boundary structures, accountable through regional health authorities. Each authority would be required to report annually to the department of health on activities, resource utilization, programs and services, fiscal arrangements and health status within its jurisdiction. These health authorities would be comprised of locally-elected trustees.

In its report, the Commission stated that a major and pressing problem within the health system was the lack of coordination and communication in the development of comprehensive health policy. There was a deficit in the system's ability to plan and a failure to articulating overall goals and objectives. The Commission's response

recommended the provincial government appoint an “Advocate for a Healthy Alberta” to review the “efficiency, effectiveness and suitability of our health system.” The advocate would oversee the long-range and strategic planning, and health policy analysis for Alberta. The Commission recommended the Advocate remain at arms length from government and provide a regular “report card” on the results of its review of the efficiency and effectiveness of the health system.

As part of the Commission’s concern for assessing the “efficiency, effectiveness and suitability” of the health system it recommended the mandate of the Alberta Heritage Foundation for Medical Research be reviewed and expanded to include research into health care systems, health status, intervention outcomes, and promotion and prevention. Additionally, the Foundation would provide the mechanism for more extensive surveillance and assessment of medical technology. To increase the Foundation’s capacity its funding would be increased annually by at least one per cent for 10 years.

Other significant themes covered by the Commission’s report included health human resources and environmental protection. On the issue of health human resources the Commission limited its commentary to ensuring that the system provide the requisite numbers of health professionals and that the system provide the proper “climate” which “attracts, retains, rewards and retrains competent, caring and committed providers in sufficient numbers to maintain the level and type of services required by consumers.” With this in mind, the report recommended that the health manpower needs of the health authorities be reviewed to ensure sufficient numbers of providers of the required mix are being attracted to and trained in the appropriate disciplines and that post secondary institutions be informed of emerging trends and needs so they can respond promptly with relevant training and retraining programs, and continuing education courses. Of note, the Commission commented on the need for the development of better working relationships within the health care system (Vol. I, 44) and recommended that the various institutions within the health system direct more effort and programs toward conflict management among health disciplines.

Finally, the Commission stressed that it was essential to include specifically the health component as part of environmental protection as part of an overall focus on determinants of health. It recommended that the province develop an Alberta Code of Health and Environmental Ethics and introduce legislation, regulations and procedures to ensure that the “health impact on Albertans is given full and equal consideration in matters of economic development and diversification, and job creation.”

Major Recommendations:

- Funding for health promotion and illness/injury prevention should increase to an additional 1% of its overall health care budget.
- Establishment of a committee to develop a strategy for the implementation of a system to collect, transfer, store and update individual health data.
- The Government of Alberta should explore the option of a system that provides all Albertans with the responsibility for disbursing, managing and monitoring the

- funds required for their health care needs. That it explore a system of personalized funding that determines individual/family annual health care expense budgets
- The Government of Alberta should, in consultation with health care practitioners and consumers, define what it considers to be basic insured services covered by the Alberta Health Care Insurance Plan.
 - The provincial government consider a supplemental health insurance plan for Albertans who want the option of additional services beyond the basic insured services.
 - That the Alberta Health Care Insurance Plan, through either the basic or supplementary plan, expand coverage to include alternate care providers.
 - An Advocate for a Healthy Alberta should be appointed to focus on the health status of Albertans; to review the efficiency, effectiveness and suitability of the health system; to set the long term planning and priorities of the health system; and to communicate on health matters with and to Albertans and the government.
 - The province be divided into nine autonomous administrative areas, accountable through appropriately named Health Authorities.
 - That Alberta health disburses health and health care funds directly to individual health authorities responsible for provision of services, including the appropriate methods of compensation.
 - That each Authority report annually to the department of health on activities, resource utilization, programs and services, fiscal arrangements and health status with in its jurisdiction.
 - That each health authority board be comprised of locally-elected trustees.
 - That the Government of Alberta declare health and health care as high priority services, including those which are defined as basic to the Alberta Health Care Insurance Plan, and thus ensure and protect budget allocations during periods of economic restraint.
 - The mandate of the Alberta Heritage Foundation for Medical Research be reviewed and expanded to include research into health care systems, health status, intervention outcomes, and promotion and prevention and that its funding be increased annually at a minimum of one per cent for 10 years.
 - The province of Alberta provide the resources to establish a mechanism to assess health technologies.
 - The Government of Alberta should develop an Alberta Code of Health and Environmental Ethics.

A Framework for Reform: Report of the Premier's Advisory Council on Health (2001).

Author: Premier's Advisory Council on Health for Alberta (Chair Don Mazankowski)

Year: 2001

Subject: Provincial Health System

Sub-topics:

- Funding for health care services.
- Governance
- Supply, education, qualifications and distribution of health care professionals.
- Health Information
- Performance measurement

Source: Premier's Advisory Council on Health for Alberta

Background:

Like other jurisdictions, Alberta had begun to restructure and rationalize its health care system in the mid-1990s. The most profound restructuring process occurred in 1995 with the creation of regional health authorities. During that time, significant restraint measures were put in place on overall government spending including health. The Government of Alberta came under increasing public criticism in the later part of the 1990s for what were viewed as unnecessary and extreme cuts to its health care budget.

Purpose:

The Council was established to provide the government with advice on the preservation and future enhancement of quality health services in the province and on the continuation of a sustainable publicly funded health system. To that end it was asked to assess the sustainability of the current publicly funded system, propose viable strategies and approaches, and recommend a framework for reform consistent with the principles of the Canada Health Act.

Issues and Findings:

In the preamble to the report, the Council identifies what it views as the major challenges facing the health care system. The most profound of these challenges is with the sustainability of the current system based on how the system is funded. It suggested that if the system continues to remain one wholly tax-based and publicly funded “we have little choice but to ration services.” The report indicates that despite funding increases access has increasingly become an issue, particularly in relation to waiting times and the availability of health professionals. Its conclusion is that the system is inappropriately organized and operates as an “unregulated monopoly where the province acts as insurer, provider and evaluator of health services” (4) devoid of either choice or competition.

The report begins with an overview of the health status of Albertans and an acknowledgement of the superior importance of the health determinants on health status. The “first reform” underscored by the Council is to stay healthy. In aid of advancing the goal of improved individual health there should be a strong commitment to providing education, setting clear health objectives and targets and providing better information. The report notes that while health promotion and disease prevention initiatives are critical

to overall population health, acute care is still given a higher priority by regional health authorities who consistently spend only 3% of their budgets on these activities.

“Alberta’s health system... operates as an unregulated monopoly,” the report states, the provincial government defines what are insured services, pays for all insured services, restricts by law the provision of private services, directly or indirectly administers health services, governs care, and defines, collects and reports information on its own performance (21). The health system as it is currently organized does not provide the right incentives for people to stay healthy and or economize in their use of health services. The absence of choice or competition, means the system fails to encourage the most effective or efficient services. The Council thus recommended that the government’s multiple roles as insurer, provider and evaluator of health services should be broken up. Instead, the role of government should be on strategic planning and direction and as the primary but not exclusive source of funding for health authorities. It recommended that private sector delivery options be expanded and noted that Alberta has legislation for regulating private sector organizations, with standards set by the college of physicians and surgeons.

The effectiveness of regional health authorities as accountable and responsive institutions has been impeded because they lack sufficient control over their own resources which come almost exclusively from provincial government. The Council observed that much “time and energy” was spent by regional authorities lobbying for more funds from government and that as part of an annual budget cycle regional health authorities have had limited capacity for long range planning. Additionally, costs within the system are largely driven by physicians over which, since they must operate within budget parameters set by government, regional authorities have no capacity to control. The result has been poor access and the rationing of existing health services in the form of waiting lists and shortages of health care providers. Regional health authorities are unable to respond to health providers in making changes, particularly when funding is restrained. The report also suggested that the health authorities suffered from the appearance political influence in decision-making, in part a product of the complexities of the accountability lines between board members and the provincial government. It also suggested that there was little sharing of expertise among regional health authorities and that, in general, the regional health authorities suffered from “gaps in performance reporting.”

With the provincial government limited in its capacity as simply the source of funding for regional health authorities and with private delivery options available, health authorities would be responsible for providing services directly through service agreements with public and or private sector providers and, at times, through other regions. Physicians and groups of health providers should be encouraged to set up “health care businesses” and compete amongst themselves for contracts with the regional health authorities or to individuals. This would require the development of a comprehensive model of primary health care. The Council pointed out that these must go beyond simply “pilot projects” which in the past have been initiated but abandoned due to high administrative overhead and chronic under funding. However, the most significant barrier to primary health care

reform has been the fee-for-service mode of payment for physicians. There is no system in place for paying alternate providers within a multidisciplinary setting.

The report then moves on to describe the rising costs of health care in Alberta. Alberta's health care system is sustainable in its current form only if revenues increase faster than spending. The report comments on the volatile nature of the provincial economy and that despite the efforts of health authorities or the provincial government to restrain the costs of health care, population increases, aging, new technologies and drugs will continue to rise. Health spending is crowding out other spending by government on social services and education. The Council's conclusion is that the system with its current reliance on tax funding is unsustainable and the government should consider new sources of revenue. The report very briefly outlines options it recommends be considered including: medical savings accounts, increased health care premiums, user fees, co-payments, deductibles, taxable benefits or supplementary insurance. These options would be studied in greater detail by the provincial government. Also recommended for study, the Council suggested regional health authorities might also be allowed to raise additional revenues of their own through plebiscite or through charges for ancillary services.

The initial set of basic insured services covered by the Alberta Health Care Insurance Plan extended to medically necessary physician services, dental-surgical services, hospital services and insured surgical services. However, the system has evolved beyond those basic services to include home care, physical therapy, rehabilitation, drugs. Advances in medical technology, surgical procedures and therapies means that there is ongoing pressure on the public system to increase the list of services offered. The report asks whether it is reasonable to limit the list of services offered and questions whether some that currently are included in the list of insured services might possibly be dropped. The Council recommends that the government establish an expert panel to make decisions on what health services are publicly insured in addition to those required under the *Canada Health Act*.

As with other jurisdictions within Canada, Alberta has experienced increasing pressure on providing an adequate supply of health care providers. In part, the shortages reflect the loss of health professionals to the United States. But the report also suggests that shortages are a product of the "supply and demand" of the labour market resulting from boom and bust cycles for funding health care. Central planning approaches haven't worked well as reflected in past decisions to reduce enrolments in medical faculties and nursing programs that are now having a serious impact on the immediate shortage of doctors and nurses. Projections for the province's needs also often don't take into account the availability or scope of practice of other professionals. Compounding these problems, there are serious issues related to the morale and levels of dissatisfaction among health professionals. In particular, the report points to the condition of nurses in the province and the availability of full time positions and staff shortages. The report also acknowledges that recruitment of physicians to rural areas, despite incentive programs continues to be a significant problem.

Part of the solution recommended by the Council involved improving the utilization of health care providers. Some services provided by physicians could be provided by nurses, nurse practitioners or pharmacists. Some work done by nurses could be done by licensed practical nurses. The report noted, however, that a number of barriers prevent this including the rigid structures in place for the remuneration of physicians, nurses and other health providers. “Mechanisms for the remuneration of multidisciplinary teams does not exist” that would allow for the development of alternate delivery models such as primary health care and “disease management practices.” The Council also expressed concern over the reluctance of health providers to give up part of their professional “scope of practice.” Among the recommendations it urged professional organizations to be more willing to compromise on the issue of “scope of practice.” Dissatisfaction with the workplace should be improved by involving doctors and nurses in decision making processes, providing expanded continuing education opportunities and creating more full time nursing positions. There should be a continuation of incentive programs to recruit and retain health professionals in rural areas. It also recommended improved training in province rather than rely on attracting professionals from other provinces, although it did not suggest that this practice should be discouraged.

A fundamental problem with the system is that it is not evidence-based. Decision making is often based on “past experience, expediency, political influences or in the interests of health professionals or organizations” rather than outcomes assessment. While some work has been done to set standards and benchmarks and measure results, the Council noted that this work is not currently used as the basis of decision making in health and neither health authorities or providers are held accountable for results. Of particular note was the absence of standards and targets for appropriate wait times and clinical practice guidelines for physicians. Part of the gap in setting standards and target outcomes in the health sector can be attributed to an “under-investment” in information technology. Again, this is due in no small measure to the multiple roles as payer, insurer and service provider under the public system and a general lack of incentive to conduct self-assessment. A more public and transparent process of setting targets and reporting on performance may provide more incentive to improve quality and results. It therefore recommended the establishment of an independent arms length body responsible for evaluating outcomes. Related to the issue of wait-times, the Council also recommended the government consider a 90-day health guarantee to ensure the system is responsive within prescribed time frame. It recommended that the Alberta Heritage Foundation should expand its mandate to include quality of care assessments, particularly as they relate to the technology assessments and before decisions are made to purchase new equipment or treatments. And finally, the report recommended greater investment toward the development of integrated patient records and electronic health cards.

Major Recommendations:

- Establish clear health objectives and targets for population health. And provide better incentives for people to remain healthy.
- 90-day guarantee for certain health services.

- Implement effective ways of reducing waiting lists including the establishment of centralized booking and posting waiting times on a website.
- Expand alternate care models such as primary health care and disease management programs.
- Establish an expert panel to make decisions on what health services are publicly insured in addition to those required under the *Canada Health Act*.
- Implementing electronic health records, establishing electronic health cards and providing long-term funding for information technology.
- Setting distinct responsibilities for government and health authorities. Establish multi-year contracts between health authorities and government encourage service agreements with a wide variety of providers.
- Encourage a mix of public, private and not-for-profit organizations and facilities to deliver health care services.
- Ensure the provincial government continues to fund the majority of health care costs, while diversifying the “revenue stream.”
- Explore and implement a “made in Alberta” approach to funding health care services including: increased premiums, user fees, taxable health benefits, dedicated health tax, supplementary insurance, medical savings accounts, and private sector funded and delivered services.
- Develop a comprehensive workforce plan, improving workforce morale, implementing alternative ways of paying physicians, and encouraging health providers to implement new ways of delivering services.
- Establish a permanent, arms length Outcomes Commission to measure results, track outcomes and report to Albertans.

Saskatchewan

Future Directions for Health Care in Saskatchewan (1990).

Author: Saskatchewan Commission on Directions in Health Care (Chair Murray)

Year: 1990

Subject: Provincial Health System

Sub-topics:

- Institutional treatment and support services
- Insured services
- Community health services
- Demographic trends, lifestyle trends and consumer expectations on the need for, and delivery and costs of health care.
- Supply, education, qualifications and distribution of health care professionals.

- The nature and distribution of health care facilities and services.
- The efficacy and cost-effectiveness of new technologies
- The organization and delivery of health care services particularly as they relate to accessibility and cost-effectiveness.
- Communication of health information and illness prevention through public health.
- Quality assurance
- Health care service utilization
- Funding for health care services.

Source: Saskatchewan Department of Health, Public Affairs Branch

Background:

The stated purpose of the Commission's work was to modernize the delivery of health care services in Saskatchewan. The system, as it had historically been organized, did not reflect the demographic character and population distribution of the province. At the time of the report the province had the highest number of per capita acute care beds in the country and some of the highest admission rates per capita of any province.

While funding and cost-effectiveness issues are given consideration in the Commission's mandate, the province's very poor fiscal climate at the time of the report is never an explicitly stated rationale for the report's writing. By 1989/90 the province's health spending had doubled from its 1980/81 figure, however, health spending as a percentage of overall spending increased by only 1% over the same period.

Purpose:

In its mandate, the Commission was to "investigate issues affecting the quality, availability, accessibility and cost of health care services, with particular consideration of the differences between rural and urban communities." It was first to identify emerging long-term trends affecting delivery and provide recommendations specifically to improve the "efficiency of the system while maintaining quality and accessibility." Secondly, it was to provide recommendations for managing future health care delivery needs including funding, technology, human resources and education and training.

Issues and Findings:

The Commission's report is divided into three parts with a context for change, directions for change and commentary on health related matters. The context for change looks at demographic, population distribution, illness patterns and changes in the health delivery system (prescription drug utilization, physician numbers and visits). The report goes on to conclude that its mandate involves the redesign of a "health care system built in Saskatchewan in the 1940s for the province of the 1940s, and enlarged upon in the 1960s for the province of that time.

Saskatchewan had built a system that was dependent upon technology, institutions and highly trained professionals. The users of all these facilities and services have become

dependent upon them, and the system has encouraged them to do so. The report notes that such a system has driven “consumer expectations” of a comprehensive, universal and free medicare system that users have increasingly taken for granted. Evidence suggests that rural residents increasingly bypass smaller rural hospitals in favour of those located in larger centres. This is compounded by a fee-for-service system of physician remuneration that encourages over utilization and waste. The example given is the provincial prescription drug plan which is evidence of the constant expansion of the existing delivery system and of over-utilization.

Additionally, demographic changes in the province (aging, aboriginal population), changes in population distribution (increasing urbanization), and changes in patterns of illness (increasingly devoted to the treatment of chronic conditions) have resulted in a system that is both open-ended and lacking sufficient controls on the utilization of resources. The result is a system that is also increasingly becoming more expensive and an increasing burden on provincial finances and on individual taxpayers.

The existing structure of institutional care and pre-existing boards impede a sense of ownership of the system among “consumers” necessary for rationalizing and streamlining the existing system. Additionally, the commission concludes that if all these boards, agencies and institutions continue to line up separately for provincial funding, institutions will be financed first and best to the exclusion of community-based care and public health.

The reorganization of the governance structure within the health care system is seen as “the most important section of the Commission’s report.” Regionalization becomes the lynchpin and basis of the modernization and rationalizing of the existing health care system. This is accomplished first, by making the system accountable through the creation of regional health divisions that are managed by elected councils responsible for the allocation of resources including the funding of hospitals and payment of health care professionals. Of note, the report is very explicit about the financing of health care remaining a responsibility of the provincial government.

Regionalization and community control would allow for the development of and proper funding of less expensive and more targeted community health programs. These types of programs were insufficiently developed primarily because of the focus on institutional care noting that they have failed to receive sufficient resources because they haven’t been attached to “large and easily recognizable buildings like hospitals.” Community-based services “need to be given the same high profile and funding priority as the institutional sector if the health system is to move forward.” This particular section emphasizes the “primary care role” of interdisciplinary teams. Not explicitly referred to in terms of “primary health care models.”

While it focuses on interdisciplinary teams, the report’s major consideration is with the existing remuneration system and its tendency to promote “over-medication, excessive recall of patients, inadequate communication and consultation.” The Commission concluded that a major restructuring of the payment system was needed and that options to the fee-for-service model should be developed.

The last major thrust of the Commission's report is an emphasis on "outcomes measurement" and program evaluation. This is primarily related to program evaluation and clinical practice (reducing admission rates, length of stay) as it relates to the institutional sector and to utilization. The report notes that it becomes critical that decisions and directions affecting the system should be based on objective research and proven and the pre-existing system pays of institutional care and physician autonomy has resulted in "insufficient attention is being given to measuring the results of the activities and programs which are undertaken."

Major Recommendations:

- Establishment of 15 "health service divisions."
- Establishment of division councils comprised of 10 to 12 elected members.
- Assignment of fiscal management and staffing responsibility to division councils
- Development of funding policies which provide more flexibility in the allocation of funds.
- Categorization of all hospitals in the province to reflect the services they are required to provide.
- Redesignation and redefinition of the hospitals in the smallest communities into new multi-purpose facilities known as family health care centres.
- Redefinition of the role and relationship of base hospitals in major centres to increase the rationalization of clinical programs and coordination of hospital services.

- Restructuring of legislation and the payment system to encourage the development and introduction of different medical practice models, including group practice.
- Establishment of medical services centres with teams of health professionals providing basic medical services.
- Adoption of stricter provincial regulations concerning the establishment, operation and ownership of auxiliary and supplementary clinics, and limits on the kinds of involvements physicians may have with such clinics.
- Creation of an autonomous Health Analysis and Development Commission which reports directly to the legislative assembly, and which has provincial responsibilities to monitor and analyse health programs and practices, determine their effectiveness and efficiency, and recommend policies to government and division councils.

Caring for Medicare: Sustaining a Quality System (2001).

Author: Commission on Medicare (Commissioner Kenneth J. Fyke)

Year: 2001

Subject: Provincial Health System

Sub-topics:

- Primary Health Care
- Tertiary Care Services
- Public Health and Health Promotion
- Performance measurement
- Governance
- Health Human Resources
- Health Information
- Financing.

Source: Government of Saskatchewan

Background:

Formed in June of 2000 by then Premier Roy Romanow, the Commission on Medicare released its report to then Premier Lorne Calvert in April of the following year. The Commission followed an election year in which the government was returned only through the formation of a coalition with the opposition liberals and in which the health care reforms of previous years and health care in general had been a significant campaign issue.

Additionally, Premier Romanow's creation of the Fyke Commission was intended to spark a dialogue in the absence of discussions surrounding the establishment of a national inquiry into public health care and followed on the heels of SUFA.

Purpose:

The Commission was mandated to provide recommendations on the "continuation of publicly funded, publicly administered Medicare." The mandate was specifically concerned with the sustainability of the publicly funded system and its continued ability to both respond to the province's unique health care needs and to improve the general health and well being of the province's population. The public system's ability to respond to provincial health care needs was to be measured in terms of its long term capacity to ensure accessibility, equity and quality.

Issues and Findings:

Two primary reasons are offered as to why the system requires study. One is that the system has been in a state of constant reform since the early 1990s and these reforms need to be assessed and evaluated. Fyke describes itself as a "reaffirmation" of past reform insights on primary health services, population health, health financing, equity and access. However, while acknowledging substantial gains in structural reform and the integration of health services many of the "ambitious goals set in the early 1990s have not yet been realized." The second is that there is a constant evolution in health care driven by technology, drugs and clinical practice. This innovation requires constant

reorganization, almost as though the reform process commenced in the 1990s instilled a new culture of revolution in health care. Reorganization and refinement of integration are the ongoing dynamics of the new system.

The “biggest challenges of modern health care” identified in the report are accountability and sustainability. The Commission suggests that the current system has focused on maximizing accessibility while leaving the issue of system accountability to be “defined in terms of volume.” This emphasis on volume of services is at the source of concern over the financial sustainability of the system if the response to every perceived problem is to add more beds, doctors and nurses. This is identified as the pervasive culture of health care and a culture that must change because it ignores the most fundamental crisis in the system which is waste and error. What the system needs to focus on is quality and declares that “we are entering a new era of performance measurement and accountability.” The health care system is under measured and under managed. As public reporting on system performance improves, “the focus will shift to the quality and efficiency problems that are the true enemies of sustainability.”

The report points to the development of “primary health services” as the foundation of a system that promotes and maintains health as well as providing everyday health care. Investment in primary health services, integrated with a well functioning specialized service delivery system, will ensure the organizational structure is in place to support a quality health system. Fyke also argues that investments in primary care services are more efficient and produces better overall health status and improved quality of “life years” relative to similar investments in sophisticated medical technologies and treatments.

The Commission declares that primary health services should be at the “top of the health care agenda.” The report recommends the establishment of “interdisciplinary health service teams” comprised of physicians, nurses, pharmacists, therapists and other health professionals to provide a comprehensive range of first contact services. In its recommendation of a team approach to primary care reform it noted that solo physician practice is unsustainable given the province’s difficulty in recruiting and retaining physicians. Solo physician practice models also limit the integration between physicians and other health care providers. The creation of interdisciplinary teams of health professionals in health services centres provides for improved accessibility to primary health services particularly for rural and northern residents. Drawing on its extensive public consultations the report notes that “participants in the public and health care provider dialogue suggested that the fee-for-service system for physicians is a barrier that prevents innovative approaches to health services” (14). While making no specific recommendation to end fee-for-service billing, health districts would be responsible for the organization and management of interdisciplinary teams, primary health services delivered by those teams and including the contracting or otherwise paying for the services of physicians, nurses and other professionals.

To compliment primary health care teams a core of community based services would also be required that includes: home care and special home care services; public and mental

health services linked in a network of several primary health teams; a provincially coordinated emergency response system; a system of primary health centres and community care centres and the development of a “telephone advice system” as a supplement to primary health services.

While primary health care is the foundation of the evolving system the report also acknowledged a further refinement of acute care reorganization. In keeping with the Commission’s conclusion that the health system was woefully “under managed” and “under measured” it made recommendations in two key areas: management of specialized services and performance and quality assessment.

As noted in the report, the province continued to have more acute care beds and higher admission rates than other jurisdictions. The report suggested this was an indication that less invasive and less expensive alternatives were not being made use of. Decisions related to what services were provided and their location had been left to individual districts and the provincial government simply approved these plans and provided necessary funding. This planning approach was seen as ineffective and further noted that “the Government’s annual budget cycle is a weak instrument for planning and may not be consistent with longer-term trends and the need for stability” (24). The Commission recommended that the Department of Health should be responsible for the planning and location of specialized treatment centres in an effort to both reflect the “demographic reality of the province” while at the same time ensuring a balance between “access and quality.”

The report recommended that clearly defined and measurable population health goals should be developed and adopted across the province so that health districts are clear on “good health” targets and objectives. The annual reporting of districts and of the government of Saskatchewan would require not only an accounting of “outputs” in terms of services delivered and resources utilized but would also be required to assess outcomes in terms of meeting specified health targets.

The responsibility of determining long range targets and acceptable standards would fall to a newly created Quality Council. The Quality Council would be an evidence-based organization, at arm’s length from government and reporting to the legislature. Its responsibilities would include: the development of a general quality assessment and performance framework for the province; assess population, volume and infrastructure required to deliver quality care; develop benchmarks for the system including utilization targets; review and make recommendations on scope of practice and division of responsibilities among health care providers; report on clinical error; report on overall system quality performance; identify and report on significant variations in practice within the system and recommend benchmarks; participate in the development of performance indicators for specific services and programs; evaluate and assess new technologies, drugs and other clinical developments.

The report singled out drug programs as an example of improving quality. The Commission points out that drugs are clearly “medically necessary” and despite their integral and growing importance have not been included under the CHA. This absurdity

is understood in policy terms because of severe deficiencies in quality control related to prescription drugs. “There was limited analytic capacity and virtually no policy to reveal and control excess utilization. There were few tools to reduce ineffective prescribing, poor compliance or polypharmacy.” These conditions “created an atmosphere of greatly increased utilization” that is here is directly linked to decisions by governments to severely curtail eligibility under the provinces drug plan. The result has been “policy gridlock” since governments are afraid to incorporate drugs into their public health care programs in any substantive way.

Major Recommendations:

- Establishing Primary Health Service Teams bringing together a range of health care providers including family physicians;
- Integrating individual teams into a Primary Health Network, managed and funded by health districts, which includes enhanced community and emergency services.
- Further reduction of the number of health districts and concentration of tertiary care to major centres
- Utilization of beds and resources based on standards established by a Quality Council
- Public health, health promotion, and disease and injury prevention strategies
- Regular reports on defined and measurable health goals
- Strategies to address the broader determinants of health
- A northern health strategy
- Continuing development of health indicators
- Establishment of a Quality Council
- Annual reports on the health system
- Incentives and funding to develop accountability and quality
- Co-ordinated human resources planning and management on a provincial basis
- The renewal of health science education programs, including increased funding for health research equalling 1% of public health spending
- Investments in information systems including the development of electronic health records

Ontario

Final Report of the Task Force on the Use and Provision of Medical Services (1990).

Author: Task Force on the Use and Provision of Medical Services (Chair Graham W.S. Scott).

Year: 1990

Subject: Provincial health system

Sub-topics:

- Health information
- Practice guidelines
- Health human resources

Source: Government of Ontario

Background:

The Task Force on the Use and Provision of Medical Services was launched on February 12, 1988, by the Ministry of Health and the Ontario Medical Association (OMA). The task force was not the first joint attempt by the two parties to examine the use and demand on health services in the province. Previously the Health Services Patterns Project had collapsed three years earlier when the OMA demanded greater involvement in the direction of policy. The result was that relationships between the Ontario Government and the OMA remained strained throughout much of the late 1980s and early 1990s.

Purpose:

The Task Force was charged with reviewing existing data, to commission new data and studies and make necessary recommendations concerning the use and demand on the health care system in the delivery of medical care.

Issues and Findings:

The Task Force initially set out to identify the factors driving the health care system, particularly focused on medical care delivery, and to establish both a short-term and long-term set of priorities for action and implementation recommendations. Short-term initiatives were to focus on specific narrow issues related to practice patterns and guidelines and long-term initiatives were to focus on major complex issues requiring intensive research and analysis. Over the course of the two years in which the Task Force met however, it acknowledged that the approach was “less precise” than it had anticipated. For example, it conducted a large scale cholesterol study to assess specific practice patterns and produce guidelines on a specific medical care issue. However, the issue raised considerations about role and impact of practice guidelines in general. The result is that the report of the Task Force is largely a set of recommendations for cooperation between the OMA and the Ministry of Health on further development of policy in key areas of medical services delivery through the creation of the Joint Management Committee.

In its final report the Task Force summarized its broad conclusions regarding the reform of medical service delivery. Its initial conclusion was that comprehensive reforms cannot be undertaken without reasonable consensus for change among the principle

stakeholders. The health care system is both large and complex and consists of many constituent parts each with its own resistance to certain types of change. The system is not predisposed to change or reform in any rapid fashion but can with consultation, respond to focused and planned reform provided that they are capable of demonstrating quantifiable improvements in both quality and efficiency. Meaningful and lasting reform therefore necessitates that there be an emphasis on an “upfront” investment in research, planning and education. A profound barrier to system planning is an absence of quality health information. The report notes that while there is an abundance of information contained in written records much of that information is of little value in terms of planning. Simply put, the report says that “we simply do not know enough about what is happening in doctors’ offices, hospitals, laboratories and community health centres to assess accurately these trends, motivations, incentives, practice patterns and health outcomes” (11). Without the development of adequate management information there is no way to assess the “downstream” consequences of policy decisions. This, the report states, has contributed to the system becoming increasingly costly. The typical response to cost pressures has been to contain them through supply management which inevitably leads to poorer quality. The report recommended therefore that the Ministry of Health commence consultations with professional health groups to consider what effective steps can be taken to improve, design and implement health information systems. It noted that proposals to initiate a “universal individual health identifier” would improve the quality of health data, there would need to be a particular emphasis placed on management information systems.

Another factor in the increasing cost of medical services has been the application of new technologies whether equipment, clinical procedures or pharmaceuticals. Generally these new technologies have been adopted without regard to their cost-effectiveness. Among the consequences noted by the report, new technologies have distorted the spending priorities of institutions, led to the over-use and misuse of technology and resulted in the “misdirection” of available human resources. As a result their introduction has been less than cost-effective and without regard to necessary reforms in other areas that should have “accompanied” their introduction. For example, existing and older technologies are left in place with little or no justification for their continued use. The introduction of new technologies and the continued application of old technologies require proper management which necessitates effective assessment both in terms of cost and quality of care. Earlier in its mandate the Task Force had explored the establishment of the Ontario Council on Health Technology, an agency with the mandate to conduct technology assessment. In the final report it recommended that the JMC proceed with implementation plans for such an agency.

A major theme of the Task Force centred on the development of practice guidelines. In the report the Task Force devotes a great deal of emphasis on the challenges associated with establishing and disseminating such guidelines. It commented on the complexity and volume of medical information on clinical practice and the difficulty of physicians to keep pace with changes. This is primarily responsible for the variations that exist in practice approaches to the same conditions. Definitive practice guidelines require considerable investment in research, education and communications. The development of

practice guidelines draws on a variety of skills and resources and must be conducted in a highly independent fashion. The advice of specialists, practical experience in service delivery, quality of research, experience in other jurisdictions, epidemiological data and analysis and economic considerations are needed to develop guidelines that will meet the requirements of the public interest and the medical profession.

During the mandate of the Task Force it attempted to apply different methodologies to a number of different clinical studies in the attempt to establish practice guidelines. As a result of these exercises it concluded that “there is no one simple formula that can be applied to team building” that will result in making assessments about different areas of medical practice. The intricacies of different procedures, availability of data and so on will all tend to influence the weighting of the methodology in such a way that general balance is difficult to achieve. Additionally, what the report calls “marketing and monitoring” requirements are key to the success and failure of guidelines even when they are established. The translation of practice guidelines into clear and usable forms for physicians in daily practice requires considerable work and resources. By the end of the Task Force mandate the best it could recommend, despite the emphasis placed on this work, was that the JMC take steps to establish a guideline development and dissemination body to begin the process of developing and disseminating guidelines.

The Task Force during the course of its mandate made modest progress on examining variations in practice patterns. Among the areas of study most remained incomplete by the end of the mandate. This included a general investigation of hospital utilization trends which failed to produce any useful recommendations other than to contribute to the need for better health information. Similarly, a study on differentials in the practice patterns of female physicians was commenced, the influence of demographic shifts on practice patterns, general factors influencing demand for medical services and studies into fee-for-service reimbursement and alternate payment mechanisms were all incomplete referred to the JMC for further investigation.

The final report suggested that the barriers the Task Force encountered in addressing specific issues such as guidelines and technology assessment rested not only in the issues themselves but in the process employed in its work. It noted that the potential originally envisioned in melding Ministry of Health “policy leadership” with the medical expertise of the OMA was never fully realized. The report laments the fact that as its work became increasingly complex and it had insufficient resources allocated to shore up project planning and development. Also of note, the report states that while dedicated resources were vital to carry out the process, so too was access to the internal resources of the two organizations partnered in the Task Force and subsequently in the JMC. It cautioned that both the Ministry of Health and OMA needed to be committed to the work of the Task Force and that both need to feel a “sense of ownership” in the success and failure of the JMC. Thus a majority of the reports recommendations concern ensuring that the JMC have the resources sufficient to carry out the tasks commenced by the Task Force and that the JMC have both the independence and capacity to function in an independent fashion.

Major Recommendations:

Recommendations listed below are referred to the Joint Management Committee which was itself a product of and succeeded the Task Force on the Use and Provision of Medical Services as the vehicle for collaboration between the Ministry of Health and the Ontario Medical Association. Thus an important outcome of the work of the Task Force was the establishment of the Joint Management Committee (JMC)

- Recommends the Ministry of Health initiate consultations with professional health groups to consider what effective steps can be taken to improve, design and implement health information systems.
- That the Ministry of Health and the Ontario Medical Association, through the JMC, establish a technology assessment agency.
- Recommends the JMC take steps to establish a guideline development and dissemination body to begin the process of developing and disseminating guidelines.
- Recommends that a substantial budget be established to ensure the JMC has the capability to establish independent major initiatives reporting to it.
- That the JMC review all the earlier recommendations of the Task Force in light of current developments.
- Recommends the JMC review the data and analysis concerning the measurement of the demand for medical services and the issue of patient classification systems generally and pursue further research into this area.
- Recommends the JMC consider further studies into the impact of the increasing number of women entering the medical profession and its effect on the use and provision of medical services.
- That the JMC pursue the Task Force proposal for an examination of cardiac diagnostic procedures and their relation to self-referral for diagnostic testing generally.

The Ontario Health Services Restructuring Commission. (2000).

Author: The Ontario Health Services Restructuring Commission (Chair Duncan Sinclair).

Year: 2000

Subject: Provincial health system

Sub-topics:

- *Hospital restructuring*
- *Governance*
- *Primary Health care*
- *Performance measurement*

Source:**Background:**

The *Health Services Restructuring Commission* (HSRC) was established in March 1996 by the Ontario Government as an arms-length body to “facilitate and expedite” hospital restructuring and to advise the government on other changes required to improve the accessibility, quality and cost-effectiveness of the health care system. Between 1989 and 1995, 11,000 hospital beds were closed while hospital funding increased by over 20 per cent. Yet none of Ontario's 250 hospital sites was consolidated (HSRC).

Purpose:

The Health Services Restructuring Commission was an independent body established by the Ontario Government in March 1996. Its role was to expedite hospital restructuring in the province, and to advise the Minister of Health on revamping other aspects of Ontario’s health services system. In addition to directing hospitals to amalgamate, transfer or accept programs, change their volumes, cease to operate or make any other changes considered to be in the public interest. This advisory role included giving advice about reinvestment needed in other sectors/services to implement hospital restructuring. Finally, the HSRC was given authority to recommend ways and means to create a truly integrated, coordinated health services system in Ontario.

Issues and Findings:

While the Commission was delegated the power of the Minister of Health to close and merge hospitals and to move clinical activity between hospitals, authority over the funding of hospitals remained with the Minister of Health. The decisions of the HSRC related to hospital restructuring were predicated on performance benchmarks for acute and mental health care, estimates of population growth and aging, increased investments in other sectors of the health care system (particularly home care and long-term care and investments in health system infrastructure which would be associated with the restructuring process and a revised governance model to support the changes. Implementation of its decisions related to hospitals, the Commission cautioned, were contingent upon timely reinvestments in other services. The report advises that the various elements of the health care system (hospitals, home care, long-term care, primary care, etc.) required increased integration and coordination. Additionally, it recommended the government assume a stronger role in governing the system and devolve the management of its elements to integrated health systems, organizations able to manage their resources to meet the particular needs for health services in the communities, districts or regions. Of note, the Commission stated that “progress toward greater integration” would require a level of leadership and political will “that exceed current capacity given the many competing agendas.” It warned that without system wide goals and targets “our many health care ‘silos’ will be perpetuated.”

HSRC’s mandate focused primarily on “rationalizing” the hospital sector. The main objective was to create a coordinated hospital sector capable of providing accessible services of high quality within the limits of a reasonable share of provincial spending on

health. Among its observations, the Commission cited advances in technology and clinical practices, resultant shortened lengths of stay, a shift to day surgery, out-patient and ambulatory care, advances in drug therapy, the availability of home treatments and other factors also considered in the process of restructuring the hospital sector. Hospitals were also performing significantly different services than in the past, including sub-acute care, rehabilitation, as well as more specialized services including MRIs, hip and knee replacements and cardiac surgery. While there was an increased need for services such as home care, community mental health and long-term care that would also greatly reduce the demand on in-patient services, resources were being used to maintain hospital surplus capacity. The Commission's recommendations were twofold. Urban hospitals were consolidated and networks of rural and northern hospitals created to improve accessibility, quality and cost-effectiveness of hospital services through clinical and administrative efficiencies. HSRC also created networks to coordinate specific hospital services at the local, regional and provincial levels. For example, networks for both rehabilitation and children's health services were established in Ottawa and Toronto.

“The biggest issue requiring immediate attention is that of creating *governance and leadership* of the system.” The Commission suggested that the Ministry of Health and Long-Term Care (MOHLTC) functioned solely as principle source of financing for the system but was not sufficiently articulating “system-wide” goals for the health system. It argued that the current focus of the Ministry overly concerned with “operational matters” and “micro-management” The Ministry was thus tasked with clarifying the role of government as the senior “governor of the system” while shifting more responsibility and accountability for managing health services to communities. The MOHLTC would be responsible for establishing overall direction through legislation, regulations, policy guidelines, and standards. It would continue to fund and determine the ‘appropriate’ budgetary levels within which the health system operates, but should leave spending decisions within regions, districts or institutions to local control. Another primary responsibility would be ensuring development and maintenance of a shared, comprehensive health information system to link all elements of the system together. The Ministry would also be responsible for what the Commission referred to as “system redesign tools” such as incentives/disincentives, performance targets and evaluation to make the system more responsive and accountable. The Ministry would be subsequently responsible for following up on assessments and evaluation to improve the performance of the system to ensure efficiency, quality and accessibility standards continued to be met over the long term.

The report points out that while a number of organizations and providers are investing in information technology, this is being done without any comprehensive framework to coordinate those investments or facilitate the sharing of information. In the absence of data and information there is neither knowledge nor effective accountability for either governance or operation of any health care services. This lack of information poses a serious impediment to system coordination and integration. Another significant problem is the absence of a comprehensive legislative framework to protect the privacy of health information. Earlier in the Commission's mandate it presented the MOHLTC with the Ontario Health Information Management Action Plan. Among the proposals put forward

and recommended in its final report, it called upon the government to develop personal health information legislation and regulations. Furthermore, it recommended the creation of an independent Health Information Management Agency, reporting to the Minister of Health, to advise on developing health information technology. An interim Advisory Council would be established to develop implementation plans for an integrated health information system including design details, responsibilities, and performance measures. The Health Information Management Agency would be subsequently responsible for developing and ensuring standards are met, privacy issues, funding, strategy, advice, and audit mechanisms.

Despite widespread agreement on the need for change and the components necessary to support it, there has been little progress made on improving primary health care services in Ontario. The Commission's report, *Primary Health Care Strategy*, identified five components of its vision of primary health care services and the conditions necessary for successful implementation. The five essential features of its primary health care strategy included:

- access to a defined range of comprehensive primary health care services;
- access 24-hours-a-day, 7-days-a-week;
- Health care professionals working in group practices, and providing comprehensive primary health care to a defined population.
- Consumers choice with respect to primary care physician or primary care nurse practitioner;
- Primary health care groups organized into “inter-professional” teams. Groups will include physicians and nurse practitioners together with other health care professionals directly involved in the delivery of care in the group practice.

Successful implementation of such a primary health care system would first require a population-based funding approach, with resources managed directly by the primary health care team, including the mechanism and level of remuneration for all providers. The system would also require “information management” to support the primary health care teams by making available relevant and accurate consumer health information and mechanisms to coordinate care between primary health care groups and other organizations and health care providers offering different levels of care. Among its recommendations the report advocated “Implementation and Monitoring Committee” made up of consumers, health care professionals and managers to implement the strategy. Support the committee with a secretariat and have it report directly to the Minister of Health and Long-Term Care.

As the HSRC considered ways and means of improving co-ordination and integration in the health system, evidence from other jurisdictions suggests that community-based system development is also needed to achieve greater continuity of care, and to yield improved quality, access and consumer satisfaction. It also explored the role for Academic Health Science Centres (AHSCs) particularly, how these centres could form “new organizational relationships” within their regions to create the conditions for greater co-ordination and integration. AHSCs would form working partnerships with regional and district institutions, providers and organizations. The highly centralized and hierarchical

relationships would be replaced with a “shared sense of leadership” to allow the institutions to work together and make the most effective use of available skills, knowledge and resources for patient care, research and education. The Commission suggested but made no specific recommendations to state that expanding the role of AHSCs would be facilitated greatly were AHSCs to be given formal responsibility and the resources necessary to convert themselves from centres into networks.

Problems within the health care system, particularly in the face of restructuring, have “traditionally” been dealt with on “crisis by crisis” basis. Given the complexity of health care and the government’s need balance multiple competing interests, decision-making within the system has reflected the bureaucratic structures within which they are made and not on an objective process and mechanisms to determine how well the system is working and to identify where improvements need to be made. The system’s focus, the Commission states, “should be on benefiting the consumer.” The restructured health services system must have the capacity to continually improve its performance through assessment and monitoring of indicators of health status and health system performance. To this end, the report recommended the Ministry a systems-wide view, supported by a comprehensive approach to improving health system performance. In the absence of an agency or organization responsible for system’s wide performance measurement, the Commission proposed an independent, third-party “Health System Improvement Council” responsible for monitoring and evaluating the performance of the health system in Ontario. This independent organization would be comprised of consumers and providers and health experts and arms-length from the both the MOHLT and professional health associations and organizations. There are a broad range of activities that the Council should be responsible for on an ongoing basis. These activities include communicating and disseminating the results of performance assessments to the public and providers through an annual public accountability report, and providing regular advice to the Minister of Health on establishing system priorities and improving health system performance.

Major Recommendations:

- Identify a body to act on the recommendations for reinvestments in non-acute care and implementation of advice on restructuring of and reinvestment in mental health, long-term care and home care services.
- Articulate and communicate goals for the health system to guide future reforms and service improvements.
- Redefine and clarify the role of the MOHLTC as the agent of the governors and *leader* of the health system and providing overall direction through legislation, regulations, policy guidelines, and standards.
- Move to implement the HSRC’s strategy *to* develop a comprehensive health information management system in Ontario.
- Enact personal health information legislation and regulations.
- Establish a Health Information Management Agency as an arms-length entity, accountable to the government, and reporting to the Minister of Health.

- Move to implement the HSRC's Primary Health Care Strategy in a planned and comprehensive manner, over six years.
- Establish an Implementation and Monitoring Committee made up of external representatives of consumers, health care professionals and managers to implement the primary health care strategy.
- That the MOHLTC establish the mechanisms necessary to work with Academic Health Science Centres toward the creation of a more integrated health services system.
- Adopt a system's view, supported by a comprehensive approach to improving health system performance.
- Establish an arms-length, third-party Health System Improvement Council with the purpose of ensuring, monitoring, assessing and improving the performance of the health system in Ontario.

Québec

Rapport de la Commission d'enquête sur les services de santé et les services sociaux (1988).

Author: Commission d'enquête sur les services de santé et les services sociaux (Chair Jean Rochon).

Year: 1988

Subject: Provincial Health and Social Services System

Sub-topics:

- Governance
- Financing.
- Performance measurement
- Health Human Resources
- Health Information

Source: Québec: Commission d'enquête sur les services de santé et les services sociaux

Background:

Originally created in June of 1985, the Commission was formed to report on health and "related social services" within the province. In January of 1986, this original mandate was revised to both shorten the term of the Commission and yet expand its mandate to include "all social services."

Purpose:

The Commission of Inquiry was struck with the express purpose of examining the operation and financing of both health and social services in the province. It was specifically asked to evaluate the coordination of decision making within the context of the joint responsibilities of the Department of Health and Social Services, and between regional councils and institutions. Similarly it was asked to evaluate the mechanisms for cooperation between the Department and stakeholders, particularly the role of health and social services professionals. In terms of financing, the Commission was asked to study the factors influencing the supply and demand for services and, in particular, the impact of new technologies in the health sector. Based on this evaluation, it was to assess the current levels of financing for the Department and consider and recommend funding options. And finally, to evaluate the decision making processes for allocating resources within the system and financial reporting and accountability mechanisms.

Issues and Findings:

The report is divided into four parts. The first deals with the evolution of Québec society and relevant health and social problems attendant with that evolution. The second deals with the development and evolution of health and social services programs including the evolution of the financing arrangements. This is followed by an analysis of the health and social status of Quebecers at the time of the report and identifies gaps within the existing health and social services system. Part four discusses what it calls the “new relationships” that should become the basis of policy and programs in the province.

The Commission concludes from its assessment that the health and social services system in Québec works reasonably well and compares favourably in terms of health and social systems elsewhere in the industrial world. The system has succeeded in removing the principal financial barriers which prevented access to health and other social services and has largely succeeded in controlling costs in the system. However, an analysis of the evolution of the last two decades leads the Commission to conclude that the system is now “a hostage of vested interest and pressure groups.” According to the report, the situation exists presently because there are no results-oriented targets in place for the system and no “inter-sectoral” accountability. The main recommendations for reform were concentrated around making the system outcomes oriented, enhancing transparency and accountability in decision-making through increased public participation, increased decentralization and better adaptation to regional and community needs, improved inter-sectoral (local, regional and provincial) coordination and integration, a population health approach that targets determinants of health and social status, a renewed commitment to public financing and public administration of health and social services.

Planning for both health and social services has become almost completely separated from the allocation of resources in the system. Rather than allocating resources based on their impact on the health and welfare of the population, decisions appear to have been the result of conflict between various interests groups and their strategic policies, including the interests of institutions, health providers, community organizations, regional councils and government. This has happened due primarily to an absence of clearly stated objectives and long-term planning but has been exacerbated by efforts at

cost-control and fiscal restraint during periods of recession. A revamped system of health and welfare should reflect a popular consensus on objectives, priorities and methods for implementation. To achieve this, the Commission first recommends a process of mobilization of all actors within the health and social services system around shared set of values, principles or priorities whether this is at the community, regional or central level. Once in place, these priorities should be evidence-based with clear mechanisms for evaluation and coordination in place.

The report recommends a clarification of roles and responsibilities toward the goal of long-range and evidenced-based targets and objectives for the system. At the central level the Ministry of Health and Social Services, its role would shift toward a macro planning, developing system-wide goals and objectives, and an evaluation role. The Ministry would also be responsible for inter-regional coordination, the dissemination of best practices and information. The Commission also recommended the creation of a Council on Health and Welfare responsible for advising the Ministry on long term trends. At the regional level elected boards would replace the existing regional councils. Each regional board would strike a committee to identify and list priorities developed in consultation with the individuals, representatives of different socio-economic groups, institutions chosen by the board. Each board would be responsible for ensuring the participation of the community in planning, program evaluation and the allocation of resources. Budget allocations to institutions and organizations would be based on the needs of the programs developed and not relative to the institutions or organizations themselves.

Much of the Castonguay-Nepveu Commission's earlier efforts to decentralize the administration and delivery of health and social services to the regional level have not taken place in a meaningful way. CLSCs, CSS, DSC established to make services more regionally or community responsive in their programming have not provided the kind of community input and decision-making that was intended at their creation. A major shortcoming, the Commission argued, was that these boards are dominated by health and social services professionals and other personnel closely associated with individual institutions. Its recommendation was that institutional boards should be composed in a manner that more closely representative of the population being served.

Services are currently fragmented with little integration among institutions. This has resulted in accessibility problems a lack of continuity of care. The Commission recommended a system that is patient-centred with resources organized toward improving first contact, evaluation and orientation to the appropriate services to guarantee greater accessibility. It made special mention of the need for greater cooperation and coordination among institutions and professionals. It observed that such coordination is impaired by professional and institutional competition among the components of the system. The Commission also recommended dispensing with a funding formula based on the needs of institutions in favour of one that funds specific programs and objectives and distributes funds to institutions accordingly. These programs should aim for the following general objectives: accessibility with a minimum of delay, needs-based provision of services, continuity of care and the coordination of providers and professionals to ensure individuals receive all the appropriate services necessary. This approach will improve the

comprehensiveness of the system in terms of professionals, community organizations and institutions.

Additional recommendations focused on the need for the system to pay greater attention to the quality of service rendered to cultural communities and to native peoples. For Cree and Inuit communities, regional boards of health and social services would be placed under the jurisdiction of their respective governments.

The Commission's analysis concludes that centralized financing continues to serve Québec well despite the marked decrease in public health expenditures in the face of the recession of mid 1980s. The history of budget allocation mechanisms (e.g. global budgets) in the health and social services sector is indicative of attempts by the government of Québec to ensure balance and equity while seeking cost control. However, the process of budget allocations, the reports states, is "essentially political" given the predominance of institutional, professional and other interest groups. Neither has the system ever provided incentives or penalties for good or poor budgeting performance at the institutional level.

Again, the system needs to be focused on agreed upon goals and targets which in turn must include not just institutional or professional interests. The population must therefore have necessary information and power to decide. Every organizational facet of the system must be involved: the services covered, the mechanisms of allocating budgets, the impact of regulations, management of human resources, the development of information systems, the development of performance measurements must all be integrated into the budgetary process.

The report recommends that the allocation of resources should be based on a three year planning of expenditures, developed as a function of priorities and objectives, and resulting from performance and results obtained. The ministry would allocate its budget between province-wide programs and regional programs. Both budgets would require the approval of the National Assembly. The Ministry would be responsible for the development of an allocation formula for regional envelopes. Regional boards would agree on three-year plans for financing. This financing would be in the form of a global budget based on a per-capita basis. The envelopes then will reflect the demographics of the region. Distribution would be based on three-year plans but budgets would continue to be dispersed annually. Regional budgets would be used to cover programs which are the responsibility of the Regional Board. It would also include capital and equipment costs. The budget would also include funds for the remuneration of health professionals who work with the programs covered. Regional boards would be responsible for their own deficits and by the same token would be allowed to retain any surpluses. Within the region, financing would take place on the basis of programs. The regional board would not only decide what priorities make up the objectives of the region but also what programs must be put in place in order to achieve those objectives and what resources should be allocated.

In order to ensure accountability by regional boards and the various providers, the Commission proposed a number of mechanisms. Regional boards would be solely responsible for their deficits and surpluses. Additional funds could be provided for innovative programs or best practices to encourage better performance. In addition, since the boards would be elected, the Commission believed that accountability should involve the ability to levy taxation, albeit at a marginal rate and only destined to finance deficits.

The Commission is of the opinion that the financial resources currently administered by the Régie de l'assurance-maladie du Québec should be regionalized, except for those amounts paid to professionals working the province-wide programs. Current budgets aimed at providing incentives to improve the geographic distribution of physicians should also be regionalized. Regional boards would be able to use these funds to remunerate professionals working in the region based on payment mechanisms developed through central negotiations; pay for services rendered to individuals in the region by professionals in other regions; use these funds as incentives to attract professionals based on regional needs.

Among the concerns expressed by the Commission was the lack of collaboration among professionals. It suggested that greater collaboration between physicians and other front line resources in the community could be achieved by associating physicians as part of particular programs or population groups. Physician remuneration would be factored into program budgets with the physician paid on a lump-sum basis for their participation in specific programs. Physicians working in institutions would receive a fixed-type (salary) for the whole of their medical and administrative functions. They could top up their salaries through fee-for-service payments up to a predetermined ceiling. Additionally, regulations governing scope of practice would be revised to allow for increased flexibility in the use of different providers. Professional organizations should also not be the only recourse for the public. The report recommended the creation of an ombudsman in the province to investigate public complaints in addition to the ruling of a professional body.

Other recommendations address the Commission's observation that the system lacks sufficient evaluation and performance measurement. It recommended the establishment of a Task Force with a mandate to make a thorough assessment of existing health information systems with an emphasis on electronic information systems. Better utilization of information and evaluation of practices, the expanded dissemination of information and reporting between individuals, organizations, institutions and regional and central authorities should bring about improvements in quality services. The health technologies and their wide-spread utilization for the past two decades made it imperative that mechanisms be developed in order to evaluate both the technologies and the conditions under which they are utilized. In order to accomplish this, an advisory council for the evaluation of such technologies independent of the Ministry of Health and Social Services would be created.

The report also pointed out that the province at the time experienced a shortage of clinical researchers, epidemiological research, evaluation research and organizational and operational research. The most critical problem was in a shortage of new researchers

researches emerging from within Québec and cautioned that the Development of health research will depend upon the support given to the training of researchers, opportunities for career development and financing of priority research projects. Applied Social research was also badly underdeveloped in the province and new money needed to be directed toward applied social research. The Commission believes that funds for supporting bio-medical research and training and recruitment of researchers must be consolidated.

Major Recommendations:

- Recommends a process of mobilization of all actors within the health and social services system around shared set of values, principles or priorities to make the system more evidenced-based.
- The report recommends a clarification of roles and responsibilities between the Ministry of Health and Social Services, Regional councils and institutions.
- The commission recommended the creation of a Council on Health and Welfare responsible for advising the Ministry on long term trends and in terms of inter-sectoral coordination.
- Regional Councils would be replaced by elected Regional Boards with 3 year mandates.
- Institutional boards should be composed in a manner that more closely representative of the population being served.
- The Commission recommended a system that is patient-centred with resources organized toward improving accessibility.
- A funding formula based on specific programs and objectives.
- To improve long-term planning, the allocation of resources to health and social services should be based three year plans developed by the Ministry and regional boards.
- The report recommended the creation of an ombudsman in the province to investigate public complaints in addition to the ruling of a professional body.
- Creating a Task Force with a mandate to make a thorough assessment of existing information technologies. Create an independent advisory council to assess health technologies.

Commission d'étude sur les services de santé et les services sociaux. (2000).

Author: Commission d'étude sur les services de santé et les services sociaux (Chair Michel Clair).

Year: 2000

Subject: Provincial Health and Social Services System

Sub-topics:

- Governance
- Financing.
- Management
- Performance measurement
- Health Human Resources
- Health Information

Source: Government of Québec

Background:

The Commission was created in June of 2000 with a mandate to carry on public consultation on emerging issues facing health and social service delivery in the province.

Purpose:

The focus of the Commission's mandate was with the organization and financing of existing public health and social services. More precisely it examined the long-term sustainability of the health and social services system while at the same time, ensuring that the system is organized in such a way as to meet Québec's evolving health and social service needs.

Issues and Findings:

Problems facing the health and social services system according to the Commission's conclusions are primarily organizational and involve the governance arrangements, management and administration and human resources. However, the Commission also cautioned that to ensure the sustainability of the system, it must first of all be accepted that the resources that Québec society can devote to health and social services are limited. What resources are committed must be done so effectively, efficiently and produce measurable results. The unavoidable conclusion the report draws is that even with optimal performance, choices will still have to be made about what services are to be provided under the public system and how they will be paid for in the future.

The report begins by describing the population health status, demographics and trends in chronic disease within the province. The reports first recommendations relate to maintaining good health and the need to direct the system and individuals toward health promotion and disease prevention. Concrete proposals would see targeted programs of early child development, a focus on major chronic diseases that effect the adult population and for seniors a program that improves quality of life and protection programs. The Commission's major proposals concern the organization of services and whether the system is capable of providing equitable access, continuity and comprehensive care. The report goes on to state that it seeks to go beyond clichés about "patient-centred" care and propose actual models for the reorganization of services. The report begins with an examination of primary health care in the province.

Primary health care must be made the foundation of the health and social service system. The CLSCs become responsible for basic community based social and mental health services. These include basic health care services such as vaccination, dental care, etc.,

perinatal services, childhood development services like speech therapy, family assistance and support consultation services. However, existing CLSCs don't provide the same basic services both health and social services are provided unevenly with some CLSCs offering physician services and while others do not. These same issues of access and continuity affect health professionals who have difficulty accessing specialists and necessary diagnostic equipment. The hospital ER becomes the simplest way to obtain these services which results in overcrowding of ERs. Much of the structural reorganization of services had been begun by earlier reforms with centralizing primary health care services within CLSCs. However, while the province was successful in reducing the number of institutions and performing more services at the community and family level, CLSCs failed to develop over time in the way envisioned originally. A major barrier had been attempts to centralize family physician practice within the CLSC.

The report recommends abandoning the notion of a seamless integration of all primary care services under the CLSC. Rather than a forced union of physician practices and CLSCs, the report proposes a "negotiated formal partnership." The Commission encouraged groups of physicians and other health providers to form multidisciplinary groups called Family Medicine Groups. These groups would be responsible for a range of "defined" services for a population of citizens voluntarily registered with a particular Family medicine group. Groups of 6 to 10 family physicians and 2 to 3 nurse clinicians or practical nurses would be responsible for providing 24/7 primary health care services. These Family Medicine Groups, along with CLSCs, CHLDSs, local and regional hospitals would establish "service corridors" and contractual relationships with regional boards. Regional boards would be responsible for organizing primary care medical networks that include CLSCs, regional hospitals and Family Medicine Groups.

To ensure the optimal use of specialized medical services in a coordinated fashion, secondary and tertiary care and other hospital services would be consolidated and reorganized in a hierarchical configuration. Local hospitals would be confined to general surgery and other basic hospital services, regional hospitals would offer basic specialist services and finally highly specialized acute care and treatment requiring the greatest expertise and technologies would be concentrated in supraregional or university hospitals. Hospitals within a region would negotiate "service corridors" for specialized treatment and diagnostic care. Hospitals could even negotiate multiple service agreements and thereby introduce a quasi-competitive environment.

The report states that there is a real shortage of physicians in certain regions, in certain types of institutions and in particular specialties and programs. A major barrier to physician retention and recruitment is physician dissatisfaction with access to secondary and tertiary care consultation and diagnostic and treatment resources. Accordingly, reorganizing primary health care networks and hospitals services should improve access to specialists and related diagnostic resources. Additionally, the report recommended that physicians and nurses need to become more directly active in the organization and management of the system, particularly in the institutional setting. The intention is to draw health professionals more into a case management role while formalizing roles and responsibilities within the health care network. To that end, the report recommends a

system of formalized contracts between physicians and hospitals that would specify not only responsibilities but payment and mechanisms for evaluation. It proposed that family physicians within the Family Medicine Groups be placed on a mixed or blended payment system that would include capitation, lump sum payments for participation in specific programs and fee-for-service. Regional boards would also have funds available outside the payment agreement for physicians, to provide incentives to recruitment and retention of medical staff.

Among other recommendations on human resources, the Commission observed that the system lacked a continuous and integrated long-range health human resources policy and that the Ministry, regional boards and institutions should formalize human resources policy at all levels. It also recommended that both the Ministry and Regional boards report annually on the distribution of health human resources. A severe limitation to the optimal use of health and social services professionals within the primary care network envisioned in the report was that while professional groups sought a widening of their own scopes of practice they were unwilling to share or relinquish their own existing scope of practice with other professionals. The Commission proposed that the existing Ministerial Task Force on Health Professionals and Human Resources work to seek amendments to professional regulations that would facilitate interdisciplinary work.

The report includes a detailed description of public expenditures on health and social services in Québec. Among the observations made in the report, health and social services expenditures have, over time, steadily crowded out other public expenditures on education and infrastructure. Additionally, trends indicate that health and social services expenditures continue to increase which lead the Commission to conclude that the system is becoming unsustainable as a purely tax funded system. A major theme of the discussion related to the financing of health and social services in the province is that tax funded health systems are vulnerable to tax revenues which are prone to fluctuation. In its commentary the report warns that “this is liable in the future to force the state to “non-selectively and without warning” de-insure services.

The report states the prerequisites for maintaining the solidarity and equity upon which the public system is based is the need to make choices, ration and to perform. Currently there is no clearly defined basket of services and no systems for measuring performance. A major shortfall of the existing system according to the report is that it is under-managed: “We believe that management is an essential function which has for too long been devalued in the operation of health and social services” (101). Insufficient financial, medical and administrative data are impediments to efficient management. It is impossible to assess the real cost of services or the cost benefits associated with CLSCs. Resources have in the past been allocated according to historic “silos” to both regions and institutions rather than on specified targets and performance standards or on episodes of care, based on best practice and actual volumes. Resources allocations to institutions would be made on the basis of their performance “rather than on their capacity to consume” (155). The system would in this way be moved to a “weighted per capita” system for which regions would be accountable for the consumption of services and resources. With this in mind, the report recommends that the Ministry and Conseil du

tresor review budgeting mechanisms to make them conform to long term organizational goals and performance targets and proposed “triennial budget” forecasts for the base health and social services budget so that the regional boards, institutions and professionals within the network could manage accordingly. The Ministry and the Conseil du tresor would also develop a mechanism for monitoring the growth of health and social service expenditures and report annually. Develop a program aimed at achieving effectiveness and efficiency in the management of the network.

The Commission also called for the creation of some mechanism to evaluate and continuously review the scope of insured services, utilization, technology and pharmaceuticals. The report also urges that effective and secure clinical and management information systems be developed. To widen coverage and make the system more comprehensive the government should examine various forms of collective insurance. It proposes moving more of the health system to a compulsory insurance plan similar to the Québec drug plan. While more costly administratively it would be preferable to wholesale de-insurance. The Commission also suggested that the participation of the private should be re-examined as a potential compliment to the public service. The management of services by private enterprises, the report argues, could easily be regulated by the government without putting public funding at risk or of eventual privatization or to the detriment of public sector jobs. The government of Québec develop partnerships with the private sector and other third party insurers. Its reasoning was that these would accelerate the penetration of information technologies and decrease the necessary capital investment required by the Ministry and institutions.

The Commission concludes with a recommendation that the government define precisely the governance in a way that conforms to the organizational, management and performance principles outlined in the report. The role of the Ministry of Health and Social Services would emphasize the role of strategic planning and assume the predominant role in the evaluation and performance measurement of the system. To this end, the report proposes the creation of a task force comprised of public administrators, private sector managers, health professionals and the general public with the mandate to advise the government on the renewal of the Ministry’s mandate. There would be a renewed commitment to regional boards and lines of accountability and responsibility. The government would renew the mandate of regional boards, ensuring they have the autonomy necessary to implement programs, organize services and allocate resources. The management and organization of primary care institutions (CLSCs, CHSLDs, hospitals), however, would be brought under one single authority. Within each region, the boards of various institutions would be consolidated. Three year performance contracts would be negotiated between institutions and regional boards on the basis of shared responsibility and clear accountability for results for which they would report annually.

Major Recommendations:

- Prevention is the central element of a Québec health and welfare policy.
- Primary health care be made the foundation of the health and social service system.
- Clarify CLSC mandate to define a common set of basic services.

- Medical services within the primary care network to be delivered by interdisciplinary Family Medicine Groups.
- Secondary and tertiary care and hospital services be consolidated and reorganized in a hierarchical configuration.
- Physicians and nurses become more directly active in the organization and management of the system, particularly in the institutional setting.
- An emphasis on creating the conditions conducive to recruitment and retention of physicians.
- Develop a continuous and integrated long-range health human resources policy.
- Professional regulations strengthened to make physicians more accountable to individual citizens.
- Regional boards should be able to enter into service agreements with the Ministry and medical associations. That they have funds available outside the payment agreement for physicians, to provide incentives to recruitment and retention of medical staff.
- The Ministry and Regional boards report annually on the distribution of health human resources.
- Effective and secure clinical and management information systems be developed.
- Conseil du trésor, the Ministry and Regional boards recognize the role of executive directors in the management of institutions as well as achieving national and regional objectives with respect to organizing services, human resources and financial performance.
- The Ministry, Regional boards and institutions develop a permanent workforce planning process.
- Develop a monitoring system to ensure future needs for professional staff.
- Professional regulations be revised to allow interdisciplinary work.
- Recognize the vulnerability of funding based on taxation.
- Government examine appropriate levels of public expenditure.
- Introduce a 3 year budget cycle for the network.
- To widen coverage the government should examine various forms of collective insurance.
- The Ministry and Conseil du trésor review resource allocation methods to greater conform to long term organizational goals and performance targets.
- Establish a mechanism to evaluate and continuously review the scope of insured services, utilization, technology and pharmaceuticals
- The Ministry and the Conseil du trésor develop a mechanism for monitoring the growth of health and social service expenditures and report annually.
- The government of Québec develop partnerships with the private sector and other third party insurers.
- The government adopt a strategy aimed at ensuring priority services while at the same time making the transition to a more effective organization of services.
- Change the role of the Ministry to emphasize the role of strategic planning, health and social policy evaluation and performance measurement.
- Renewed commitment to Regional boards and lines of accountability and responsibility

- Primary care institutions (CLSCs, CHSLDs, hospitals) should be brought under one single authority in a given region. This should include a unified board of directors...
- Some members of the board of directors of local institutions be elected while others appointed.
- Three year performance contracts should be negotiated between institutions and regional boards on the basis of shared responsibility and clear accountability for results. Reports annually.

Nova Scotia

The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy (1989).

Author: The Nova Scotia Royal Commission on Health Care (Chair: J. Camille Gallant)

Year: 1989

Subject: Provincial Health System

Sub-topics:

- Governance
- Financing.
- Management
- Performance measurement
- Health Human Resources
- Health Information

Source: The Nova Scotia Royal Commission on Health Care

Background:

The unemployment rate in the province in 1988 was 10.2 percent with growth in the labour force anticipated to continue to exceed growth in employment. Nova Scotia's accumulated provincial debt had climbed to \$4 billion or approximately 17 percent of the provinces expenditures being devoted to debt servicing. Slow growth in the provincial economy, projected to continue into the next decade, was well below trends in health care expenditures.

Purpose:

The mandate was heavily focused on examining the costs of the health care delivery system and recommendations to reduce costs while maintaining effectiveness. It directed the Commission explicitly to avoid recommendations that would lead to hospital user

fees or direct charges by physicians. More specifically, it was to examine increases in the costs of hospital care and physician costs incurred by the Medical Services Insurance Plan. Additional directives included an analysis of service duplication and methods to improve efficiency, an assessment of physician manpower requirements and an assessment of the administrative efficiencies of hospitals and recommendations of “alternate practice” which would optimize the hospital system.

Issues and Findings:

Since the inception of medicare the evolution of the system has been oriented towards only one component of health care “the acute care institutional model.” The reliance upon medical and institutional care is seriously constricting resources available for other, equally important aspects of health care, such as health promotion, disease prevention and community-based programs. This reliance has also hindered the development of other forms of care such as “rehabilitative care, pastoral care, home care and palliative care.” Furthermore the health care system with its orientation fixed on institutional care has evolved without reference to changing population demographics and patterns of illness. Together with constraints upon provincial finances, these factors threaten the continued provision of quality, accessible care. The Commission’s analysis suggests that the level of funding allocated to health is sufficient to meet the needs of the population, however, the allocation of resources must be reassessed and redirected towards a more balanced and responsive system. The conclusion of the Commission was that the only way the government of Nova Scotia can continue to provide the appropriate and quality health services required in a fiscally responsible manner is by adopting fundamental structural and administrative reform. The strategy establishes a new definition of health incorporating a comprehensive approach to health policy; structural and organizational changes involving broader levels of public input and extensive decentralization of the system puts. Policy and planning, human resources management, information systems, and the funding and budgetary process form part of an integrated process and the basis of a results-oriented system whose main objective is the provision of quality and cost-effective health services.

The report begins in Chapters one and two with setting the context and guiding principles for the recommendations that follow. The report begins first by introducing the concept of an outcomes oriented health system, one which cannot continue to grow at the expense of the province’s other social programs which also contribute to overall population health. Second, responsible use of limited resources requires that citizens feel a sense of stewardship over the health care system and influence in decision-making. The “key guiding principle” is the dual concepts of decentralization, the delegation of responsibility to regional authorities; and regionalization, the development of a network of services to meet the needs of a region. Fourth, accountability is a product of an emphasis on decentralization and community control. And lastly, the principle of matching resources to local health requirements means health services, health professionals, the appropriate use of technology and capital financial resources are all targeted toward a continuum of care.

Chapter two explores the fiscal context including provincial health expenditures, the fiscal climate, and budgetary processes. The province's ability to sustain expenditure levels on the major components of its health system, physician services, hospital services and pharmacare, must be weighed in the light of the current and anticipated economic environment. The Commission noted that projections of a slower pace of economic growth for the next decade suggested a reduced ability for the province to maintain health expenditures that exceeded expected growth rates. Additionally, federal contributions to Nova Scotia's health care costs had fallen, according to the Commission, by 10 percentage points in less than a decade with transfers to the provinces scheduled to be reduced by 2 percentage points annually.

Central to the reform of the health system is a change in government policy on health. Currently the system is focused on the treatment of illness and a comprehensive health policy should be supportive of the attainment of health. Key principles guiding the development of a comprehensive health policy are: equity, individuals should have equal opportunity of achieving and maintaining good health; participation, in the planning of the new system and its priorities; an inter-sectoral approach, planning must involve include other determinants of health; an ecological perspective, that considers the environment and social conditions. In recommending the development of a comprehensive health policy, the government, in conjunction with the Ministry of Health and the proposed health council would develop specific health goals and standards for overall population health status. In an effort to increase public participation in health planning, the Commission proposed the formation of a Provincial Health Council to advise the government on policy and priorities and provide a vehicle for public dialogue. The Health Council would monitor, assess and report on the performance of the health system. To ensure visibility and further the goal of an inter-sectoral approach the Council would report directly to the provincial cabinet.

The report notes that responsibility for health programs within the province was split between the Department of Health and Fitness, the Health Services and Insurance Commission and the Commission on Drug Dependency. It observed that fragmentation and segregation of responsibilities made coordination of operations complex. The Commission recommended therefore that these separate functions be consolidated under a new Ministry of Health. The reorganized Ministry's principle role in the health system would lie in the developing a provincial health strategy which in turn would be advised by the provincial health policy and goals articulated by the Provincial Health Council. In addition to being responsible for medium and long-range planning, the Ministry would set standards and guidelines, quality assurance assessment, and program evaluation and monitoring of health outcomes. In consolidating the operations of the Ministry of Health and Fitness and the Health Services and Insurance Commission, the new Ministry would develop increased capacity for managing the budgetary process.

Information systems are a prerequisite for accountable management. A fundamental revamping and consolidation and general improvement of all means of obtaining accurate health information will be essential in order to focus on outcomes. While the new Ministry can take steps to improve its own research and information capacity, the

Commission recommended that the government fund a separate, multi-disciplinary Health Policy and Management Research Centre in conjunction with Dalhousie University.

Regional administration of services would overcome a fundamental weakness of health care delivery in the province. In the estimation of the Commission, responsiveness and flexibility to “consumers” was not a hallmark of centralized management and regionalization would not only improve the quality of services but distribution and the duplication of services. Program and service delivery in the province was fragmented by having community services, drug dependency programs, community health units and hospital administrative units not sharing the same set of boundaries. In addition, the nine hospital administrative regions lacked sufficient populations to support a wide variety of specialized services. Regionalization, by combining administration, policy and decision-making at the level of consumers, would rationalize, coordinate and integrate the full range of health services. The report proposed four regional health authorities would be appropriate but deferred the drawing of boundaries to the proposed Provincial Health Council. Regional health authorities would themselves be autonomous bodies, external to government comprised of “consumers and providers” of health care at the community level appointed by the government based on a public nomination process. Regional health authorities would be funded on a capitation formula that took into account population, demographics and regional health status. Based on “regional service plans” which take into account local and regional priorities and meeting the guidelines of the provinces long-range plan, regional authorities would enter into and manage contracts with hospitals, physicians and community health organizations. Regional health authorities would therefore not directly provide services but would be accountable to the Minister of Health for the management of service delivery.

A key focus of the report’s governance strategy was to emphasize greater inter-sectoral coordination. The Commission suggested that coordination of government departments with health-related policy interests were needed at the central level. The operational links between administrative units of government departments must be reinforced with key departments with relevant policy interests, such as Education, Environment, Labour, Housing and Health, should be brought together to coordinate policy and administration. Joint strategies would be developed to deal with target populations with poor health status such as low income earners, the disabled and the elderly. The Commission thus advocated the formation of a committee under the direction of the Cabinet Secretariat consisting of the relevant senior government officials for each department. At the same time it broadened its focus to include greater inter-provincial coordination since the province was a centre for tertiary care among the Atlantic Provinces. It thus advocated joint coordination of policy and health at the level of the Maritime Provinces’ Health Secretariat to, among other issues; develop joint strategies on human resources, technology and pharmaceutical assessments.

Health human resources policy must be based on a planning process that takes into account present and future health needs, and is capable of adaptation to changing needs and alternate modes of service delivery. Ultimately it must be flexible, to allow the mix

of health professionals to be managed in a way which best and most efficiently meets the health requirements of the population. It observed that in the past, decisions have not always been adequately related to population-based needs but by the “aspirations of national professional organizations.” The mix of health providers is oriented towards the medical profession and hospital-based care. With health care delivery becoming more home and community-based, the personnel mix must reflect this trend and provide for alternate means of offering service. Certainly based on the recommendations contained in the report, a restructured health system would require a new balance of health care providers. Not only would a new mix of health providers be necessary, but a re-examination of the scope of services delivered by professional groups. A major impediment identified in the report to the efficient utilization of health human resources, is the perceived rights of established professions to preserve traditional scope of practice and restricting the delegation of functions to others. In particular, primary care services that traditionally were performed only by physicians could optimally be performed competently and more cost-effectively by others. Thus as part of its recommendations toward a comprehensive health human resources strategy the Commission called upon the Ministry to base this strategy first and foremost on population-needs assessments but also upon changing roles of all health professionals in order to determine precise numbers, mix, training requirements, scope of practice and distribution.

A priority should be placed on the development of a health human resources plan for nurses who will play an enhanced and increasingly independent role in a decentralized health care system. Important impediments to the development of an effective nursing strategy include poor levels of job satisfaction, a lack of recognition by other health professionals and organizational structures which do not provide input from nursing staff in decision-making that directly affects them. Management of workload, a central issue to nurses, is extremely difficult due to a lack of flexibility with respect to staffing levels which are based on patient utilization rates and ignore vacation leave, sick time and other factors included in collective bargaining processes. Low salaries are also cited by the report as a key issue in contributing to job dissatisfaction among the nursing profession. The Commission noted that studies indicate that between 40 and 90 per cent of visits to family physicians could potentially be delegated to nurse practitioners. As providers of primary health care, nurse practitioners could become the first point of contact in the health system, replacing physicians in certain setting, routing patients through the system and guiding and assisting in local health promotion and prevention initiatives. It recommended therefore, that a policy and administrative framework for expanding the role of nurses in the delivery of primary health care be established. Additionally, it called upon the Provincial Health Council to develop an interdisciplinary demonstration project which would include an enhanced role for nurses in providing primary care in a community setting.

A strategy to manage the administration of physician services must clearly involve a multi-faceted approach, consisting of policies of physician supply, distribution and utilization. A major contributor to Medical Services Insurance expenditures in the province are due to an increase in physician supply resulting in a corresponding increase in utilization. Limiting the rate of growth in physician supply must become a high

priority for the new Ministry. Additional complexities to the issue of physician supply arise from the introduction of new medical technologies, increasing sub-specialties, demographic and morbidity patterns which make it increasingly necessary to make the availability of physician services responsive to actual needs. While issuing stark warnings of over-supply in general, pockets of under-supply in certain areas requires that planning for physician services needs should be linked to regional requirements. It recommended therefore, that the Ministry establish targets for physician numbers in the province in number and specialty consistent with the needs of the Provincial Health Strategy. While physician resources planning was to be based on assessed needs, the Commission called for an immediate reduction in the number of medical school enrolments by 25% and limits on the number of immigrant physicians. To address supply and distribution problems, the Commission recommended the immediate restriction of new billing numbers to the Medical Services Insurance Plan. Decentralization and regionalization also require improved geographic distribution of physicians to ensure accessibility and the principle of bring resources to assessed needs. Methods of payment for physician services should provide incentives that will encourage a focus on health outcomes, quality of care and patient satisfaction. Fee-for-service remuneration, the Commission argues, is open-ended and leads to cost-escalation, leads to over-servicing, and encourages practice methods which do nothing to contribute to prevention and promotion activities. The Commission therefore recommended a mixed system which included fee-for-service, capitation and salary. Capitation would be introduced in certain practice settings, particularly to encourage the development of Health Services Organizations.

Other recommendations in the report focused on the “revitalization” of some existing services including the recommendation that the Ministry reallocate resources to foster the development of health promotion and community-based programs. It proposed that community health programs should receive an increased budget allocation of one per cent of the budget of the Ministry of Health in each of the next five years. The Commission recommended an assessment of the Coordinated Home Care to measure program effectiveness but did not specifically advocate expansion of the program. Palliative care programs should be further integrated components of health services at the tertiary, regional and community levels. Mental health services, the Commission argued, should be significantly broadened beyond the institutional services which currently dominate the mental health budget. With respect to pharmaceuticals the Commission expressed concern over inappropriate prescribing and over medication and proposed the drug utilization reviews be expanded and better information and drug education be provided to physicians. The report did recommend that the Ministry of Health expand the Pharmacare Programme to individuals on social assistance and that criteria be developed for further expansion to include “catastrophic drug” coverage. It also recommended that the province mandate a lowest-available price product method of payment for prescription drugs covered under the Pharmacare program.

Major Recommendations:

- The Government formally adopt a broad definition of health based on principles of a Comprehensive Health Policy.

- Recommends the appointment of a Provincial Health Council, reporting to cabinet, and advising the Ministry of Health on provincial health policy and goals. The Council will additionally take responsibility for the monitoring and evaluation of the performance of the health system.
- Recommends that the government merge the Department of Health and Fitness, the Health Services and Insurance Commission and the Commission on Drug Dependency into an integrated Ministry of Health.
- That the government and Dalhousie University jointly establish a Health Policy and Management Research Centre to undertake health surveys, evaluations, research projects and planning studies.
- The Government of Nova Scotia should establish a Regional Health Authority in each region, based on boundaries defined by the Health Council, and appoint the boards of these Regional Authorities based on a public nomination process. The Ministry of Health will immediately begin transferring to the Regional Health Authorities financial resources for the management of all health care services.
- The Government immediately establish, under the aegis of the Cabinet Secretariat, a committee to strengthen interdepartmental coordination on health related issues at the senior government level.
- Recommends that the Ministry of Health and Provincial Health Council develop a comprehensive health human resources plan based on health needs of the population and a review of present and future roles of all health professionals to determine numbers, mix, training, scope of practice and distribution of health professionals.
- That the Ministry of Health place the utmost priority on the planning of nurses human resources.
- Recommends that the policy and administrative framework for an expanded role for nursing in the delivery of primary health care be established.
- Recommends that the Ministry of Health place the utmost priority on physician human resources planning strategies, working in consultation with key groups
- Recommends that the Ministry establish targets for physician numbers, in total and specialty, commensurate with the Provincial Health Strategy and that necessary measures required to achieve these targets, including reductions in enrolment and immigration, be immediately implemented.
- That to regulate the supply and geographic distribution of physicians, the government of Nova Scotia immediately take steps to restrict new Medical Services Insurance billing numbers issued to physicians performing insured services in the province.
- Recommends the Government of Nova Scotia introduce a mixed system of remuneration for physicians, including fee-for-service, salary and capitation methods of payment
- That the government develop the administrative framework and establish alternate settings for the practice of medicine, such as Health Service Organizations and Community Health Centres.
- Recommends the Ministry reallocate resources to foster the development of health promotion and community-based programs. Community health programs should

- receive an increased budget allocation of one per cent of the budget of the Ministry of Health in each of the next five years.
- That steps be taken with respect to the Coordinated Home Care Programme including the development of a process which measures program effectiveness.
 - That palliative care programs be recognized as integral components of health services at the tertiary, regional and community levels.
 - Recommends that the range of services for mental health provided by the Ministry of Health be significantly broadened beyond the institutional services which currently dominate the mental health budget
 - That drug utilization reviews be expanded in order to reduce over-medication and that better information and drug education be provided to physicians.
 - Recommends the Ministry of Health eliminate the actual acquisition cost method of payment and mandate a lowest-available price product method of payment.
 - That the Pharmacare Programme should be uniformly extended to individuals on social assistance and that criteria should be developed for further expansion to include “catastrophic drug” coverage.

Newfoundland and Labrador

Healthier Together: A Strategic Health Plan for Newfoundland and Labrador (2002).

Author: The Government of Newfoundland and Labrador, Department of Health and Community Services

Year: 2002

Subject: Provincial Health System

Sub-topics:

- *Primary Health Care*
- *Acute Care*
- *Sustainability*
- *Health Human Resources*

Source: The Government of Newfoundland and Labrador

Background:

The strategic plan came in the aftermath of regional health forums held across the province in the fall of 2001. The process brought together submissions from both stakeholders and the general public and recommendations concerning both health and community services issues proposed during these hearings were to be the basis of the development of the strategic plan along with a variety of reports from committees and task forces set up by the provincial government to work parallel to the health forums. The

document *Healthier Together* unlike other volumes contained within the summaries was an internal document produced by the Department of Health and Community Services.

Purpose:

Healthier Together represents the Government of Newfoundland and Labrador's five year strategic plan for the provincial health system. The report sets the long-term goals upon which regional boards, institutions and health organizations would be called upon to base their own strategic plans.

Issues and Findings:

The strategic planning document is divided into two parts. Part one identifies strategic challenges facing the health and community services system. Among the challenges noted in the document is concern with the province's poor health status relative to other Canadian provinces. Another is demographic change, including both population aging and distribution. Concerns related to service quality and accessibility focus on primary health care delivery, the location of services, organization and governance, long-term care and support services and the availability of mental health services. Lastly, the section addresses the long term sustainability of the existing system. Part two sets out the strategic plan for addressing these challenges. It begins with a statement of goals and objectives of the health and community services system. Goals and objectives focus on improving overall health status, refocusing the system toward health promotion and disease prevention and maintaining overall system quality and ensuring accessibility.

As noted in the report, Newfoundland and Labrador have particularly high rates of circulatory disease, cancer and diabetes relative to other provinces. At the same time, the province was equally high relative to other parts of the country in terms of risk factors associated with these diseases: smoking, obesity, alcohol consumption and inactivity. The population is undergoing change in size and composition. Newfoundland's population is declining over time while the population is shifting and concentrated in the St. John's metropolitan area while rural populations have decreased. Aging is also a key feature of demographic change, meaning that greater emphasis needs to be placed on services and supports for seniors. The report sets out priorities for its "wellness strategy" which focus on increasing healthy behaviours, improving health outcomes and through targeting specific diseases, and ensuring healthy growth and development for children and youth. The report identifies a number of specific targets for improvement in rates of smoking, physical activity and obesity to be achieved within five years. Similar targets are set to reduce incidences of major chronic illness such as diabetes, heart disease and stroke. Key to this wellness strategy is making health promotion and protection an integral feature of the primary health care system by ensuring that the new model for primary health care delivery includes health promotion as part of a defined set of core services.

Citing a provincial advisory committee on primary care, a significant problem with the delivery of health services was what it described as "system disconnect." System disconnection means that health care providers, whether physicians, nurses, or other health care professionals, are providing uncoordinated, fragmented services to individual

patients dealing with only one aspect of a patient's care without reference to services being provided by other professionals. A further associated problem is that the absence of integrated care has led to gaps in the range of services available to clients, most notably health promotion and disease prevention activities. A major impediment to community care is linked to physician compensation and morale, particularly in rural and remote locations where there have been notable retention and recruitment problems. The report notes that primary care models are being tested across the country and that Newfoundland currently has pilot projects which should be capable of providing valuable information on the development of a primary health care delivery model. Primary health care is viewed as a solution to the multiple problem of system disconnect, provider turnover, a lack of integrated care that addresses promotion and prevention activities while at the same time being more cost-effective and addresses sustainability issues.

In advancing primary care it acknowledged that the existing infrastructure to support primary health care is poor and that, in addition to insufficient networking of providers, there were inadequate numbers of required staff in several key areas, and linkages between primary health care and secondary care are often weak and fragmented. The province's new primary care strategy would promote a "team-based, interdisciplinary approach to service provision where physicians, nurses and other health professionals cooperate in providing services" (19). The provincial government would develop standards of access and identify the appropriate funding levels to support a core set of services which would be available at a primary health care site. Physicians within the primary care network would enter into agreements with regional boards for a defined set of medical services to be delivered to a defined population. Ideally, although part of the province's long-range plan, primary health care services would be delivered in "one-stop" primary care sites for each geographically defined region. Regions would establish mechanisms through which community participation would be sought in identifying regional needs and developing strategic plans. Setting immediate targets within the first five years of the strategic plan, the government would begin the development of a detailed implementation plan for primary health care reform. A Provincial Primary Health Care Advisory Committee consisting of stakeholders would be called upon to oversee implementation to ensure it fulfilled the "vision and goals" of the strategic plan.

Currently there are no standards to ensure timely and reasonable access to primary health care, particularly for rural residents. It notes, however, that one of the challenges faced is that health services are difficult to sustain in areas of low population density because of provider turnover. While the report did not elaborate standards or guidelines for "reasonable access" or "timeliness," it did provide principles upon which the location of services should adhere. Emergency and primary health services should be provided "close to home" 24 hour, seven-days-a-week basis. Chronic care should be accessible through cost-effective community-based programs. Access to overnight convalescence, respite and palliative care should be provided in the community. Some regions capable of supporting few specialties experience increased retention and recruitment difficulties that result in instability and create long-delays in service. At present there are several areas with relatively low volumes of specialized secondary care. These factors contribute to low quality. Research indicates that better clinical outcomes occur in centres of high

volumes of clinical care. The report concludes therefore, that secondary and tertiary services should be concentrated where they are capable of sustaining high volumes of clinical activity. Specialists services, because they are required less frequently and by a relatively small proportion of the population should be situated based on quality and efficiency rather than proximity. And province-wide protocols for waiting times and diagnostic testing should be developed based on consistently applied assessments of need. Secondary care facilities would be grouped according to the ability to support specialized services. Level one hospitals (small regional hospitals) would have a minimum of specialized services, level two hospitals would have populations capable of supporting a core set of specialty services such as general surgery, paediatrics, obstetrics, while level three hospitals would have sufficient population to support a full complement of specialists. Tertiary care in the province would be concentrated in the St. John's region.

Most of the province's capacity in long-term care and supportive services were designed and built over 20 years ago. Since then there have been significant changes in models and standards for long-term care. The current array of residential, day, home and community-based services are inadequate in a number of ways. Even with regionalization, problems occur with coordinating client services within some regions. This is particularly acute for patients requiring services from multiple providers or organizations. While the province has developed a single entry and placement process there are sometimes differing processes regarding how priorities are set for clients requiring long-term placement. There are repeated occurrences of people who would be eligible for long-term care who are obliged to remain in acute care because of the limited availability of long-term beds. At the same time, patients occupy long-term care institutional beds that could be better served in less regulated non-institutional environments. Alternate care models in the community or home are not readily available on a consistent basis across the province. Mental health services remain woefully under-developed with significant gaps in home support, family support, day programs, case management and other types of care are also provided in a limited and inconsistent fashion. Even where these services are available there is often a "disconnect" between institutional and community-based services.

There is an ongoing concern with sustainability. Significant cost-drivers in the system include: new technology (particularly diagnostic equipment), new pharmaceuticals, wage and compensation pressures, community pressures to sustain services, population aging. It notes that Newfoundland and Labrador continue to sustain the highest per capita costs in the country. It notes that while the population has declined, infrastructure costs and service levels have not decreased. Newfoundland and Labrador also continue, despite urbanization, to have widely dispersed populations. Newfoundland continues to have some of the highest length of stay rates in the country. The solutions to efficiency concerns will require more than managerial responses and will require structural solutions and changes in the traditional practice patterns of health professionals.

Responses for the regional forums indicate that the least acceptable solutions to funding problems are tax increases, user fees or transferring funds from other public services. Rather reallocation of funds within the health and community services, from areas of

lowest need or priority to high priority areas is required. It also suggested that there is room for alternative approaches which see the delivery of services through non-profit organizations and the private sector provided standards and accessibility are preserved.

Currently the Health and community services system suffers from a lack of accountability. This is only partially being addressed by the requirement of the Department of Health and Community Services providing an annual report on the health system. It is also being improved with the development of a “social audit” which includes a performance measurement framework and provincial health indicators. At the regional level there needs to be more information flowing to the provincial level to monitor the outcomes of health services at the regional level and more information flowing from regional boards to their constituents and make annual reports of their activities available to the public. Health stakeholder groups such as professional associations and unions must also be more accountable for their own demands on the system in the same way that individuals must be more accountable for personal health choices.

Major Recommendations:

- To codify these guiding principles the government will develop a health charter. The charter will outline the commitments which citizens can rely on related to service delivery.
- To improve the health status of the population a wellness strategy will be developed. A wellness strategy will help balance the health agenda by increasing investment in health promotion, health protection and disease and injury prevention. A wide set of health status indicators will be used to measure and monitor the success of the strategic health plan
- A provincial coordinating community of stakeholder groups will be established to further refine the wellness priorities, coordinate initiatives inside and outside the public sector, and provide continuing leadership and guidance.
- Foster sound research and evaluation practices that will provide information for evidenced-based decision-making at the community level.
- Development of a detailed provincial plan primary health care as the focus of delivery for the health and community services system. The new direction promotes a team-based, interdisciplinary approach to service provision where physicians, nurses and other health professionals cooperate in providing services.
- Creation of a Provincial Primary Health Care Advisory Committee consisting of key stakeholders to ensure that implementation is consistent with the vision and goals of the Strategic Health Plan.
- Development of a physician network within each primary health care team that will have a defined relationship with a regional health board. This relationship will involve an agreement for a defined set of medical services to be delivered to a defined population.
- Development of primary health care centres for each geographic area with linkages or networks to other “off-site” services throughout the region.

- Levels of remuneration for physician services and standards of payment will be made at the provincial level. The method of remuneration for the physician network will be determined through agreements with regional boards.
- Agreements between physician networks and regional boards will include the method and details for monitoring evidence-based decision making and ongoing evaluation.
- Each primary health care region will develop a mechanism for identifying the health needs of the population so that services can be planned accordingly.
- Information and communications technology will be developed over time to support the new primary health care model. This will include an electronic patient record and a unique personal identifier number.
- Reorganization of secondary care into three distinct levels of care with increasing specialization and increasing in volume of services performed. Tertiary care to be concentrated within St. John's.
- Development of a comprehensive mental health strategy based on recent provincial reports, reviews and stakeholder committee reports¹.
- Development of a strategy for long-term care and supportive services to be developed in consultation with all stakeholder groups by 2002-2003.
- The provincial government will establish standards for necessary qualifications for appointees of regional boards to enhance the transparency of the appointment process.
- To improve the health status of the population, the NLCHI (Newfoundland and Labrador Centre for Health Information) will continue to develop the health information network over the next five years, with the ultimate goal of developing an electronic health record for each resident of the province.
- The Department of Health and Community Services will continue to enhance systems to support communicable disease management and health surveillance.

National

Health: a Need for Redirection (1984).

Author: A Task Force on the Allocation of Health Care Resources (Chair: Joan Watson)

Year: 1984

Subject: National Health System

Sub-topics:

¹ Cited in the report are: *Valuing Mental Health (2001)*, results from an internal review of provincial mental health system and the report of the stakeholder committee organized to review the *Mental Health Act*.

- Aging
- Medical technology
- Governance
- Financing

Source: Canadian Medical Association

Background:

The Task Force was formed and funded by the Canadian Medical Association although it acted as an independent body. The Task Force was criticized for its direct links to the Canadian Medical Association.

Purpose:

The Canadian Medical Association requested a Task Force, composed mainly of lay people, to examine the allocation of health care resources in the face of an increasing elderly population and the proliferation of new medical technologies. In an effort to measure the extent to which these forces will affect the traditional provision of health care services, the Task Force was mandated to commission external research studies, hold discussions with experts, meet with government representatives and conduct open hearings.

Issues and Findings:

An area of predominant concern to the Task Force was the increasing need for more attention to the elderly population. The report notes that while seniors expressed programs that emphasize independence and remaining in the community and in the home over institutionalization, there is strong evidence to suggest that necessary supportive services in many instances were grossly inadequate. The growing number of elderly will impose an increasing strain on existing physical, human and financial resources and projections indicated that the health care system could not continue to afford to institutionalize the elderly at its current rate. Projections commissioned for the Task Force estimated that demographic change and population aging would require an increase in overall health expenditures of 75% or an annual increase of approximately 1.4% annually through to 2021. A major problem would be the required additional construction and additional institutional beds required. Its conclusion was the redirection of health care resources in the development of community services to keep the elderly out of institutions both to reduce long-term costs and improve quality of life. Such services as respite care, home care, day surgery, palliative care services it argued had the potential, if implemented, to reduce the rate of utilization increases due to the aging of the population.

An additional problem noted by the report is that standards and appropriateness of care appears to suffer from a limitation on the number of available spaces and a general lack of coordination. It noted that a key factor in the effective provision of care is to provide a continuum of care. Although most provinces provide different levels of care there are indications that problems exist with coordination between institutions and between health and social services departments. Additionally, availability of spaces makes shifting of patients between institutions and between levels of care is difficult. The Task Force

recommended that there should be enough flexibility within the system to enable and individual to move freely from one level of care to another and an assessment service so that the needs of each individual can be periodically evaluated and met. Coordinated care should be provided, preferably through multi-level care facilities. Also recommended were the introduction and the enforcement of strict regulations defining meaningful new standards in nursing homes. The Task Force also recommended that all jurisdictions move as quickly as possible towards the elimination of “care for profit” institutions and establish non-profit facilities (nursing homes).

The development of medical technology has posed significant problems for the health care system. When a new technology becomes available there is pressure to disseminate it widely and quickly. Public expectations of access to the latest technology are high, there has been an increase in medical specialization related to technological disciplines. A more pressing problem identified by the Task Force is that in addition to the many effective and valuable diagnostic and therapeutic procedures, there are also a significant number of technologies whose benefits are not established. In fact, it was the conclusion of the Task Force that not only were there unsubstantiated benefits or value to some medical technologies but that in some instances a real risk associated to untested technologies.

Economic considerations will play a limiting role in the provision of health care and there is therefore a pressing need to organize, rationalize and channel available resources with respect to technology. Despite this the associated costs of new technologies will continue to increase. What the Task Force concluded was that the primary culprit with respect to increasing costs was not high technology but the increase in lower priced tests and procedures. It noted that there has been little information or research available on the real impact of health technology on overall costs.

The Task Force observed that many areas of the country do not have available to them the medical technologies which have been developed and adopted elsewhere. Apart from the limitations dictated by economic considerations, accessibility is limited by practical problems of distance and population distribution. Ensuring adequate accessibility represents a major challenge to governments. The Task Force speculated that a policy of planned and coordinated regionalization in the provision of medical technology might be the basis of easing the access problems associated with technological services. Among its recommendations for change the Task Force called for the establishment of a uniform set of guidelines for evaluating, acquiring, operating, and funding high technology. These guidelines would be developed in consultation with the relevant parties such as the Canadian Hospital Association, the Canadian Medical Association and governments. Potentially the development of a National Health Technology Assessment Council was foreseen reporting to the Federal-Provincial Council of Ministers of Health. There is a need to rationalize and coordinate the provision of all technologies, particularly those that are expensive and complex. The Task Force endorsed the concept of regionalization, the sharing of facilities to provide better health care services. It also recommends that the increased profusion of “low ticket, high volume” procedures be re-examined.

A “central and obvious problem” the Task Force writes, “is the complexity of the health care system in Canada which embraces two orders of government, federal and provincial, and a rich multiplicity of health care providers” (81). This complexity is compounded by the fragmentation of the health system into silos that are largely independent and uncoordinated in terms of their activities, demands and objectives. Conflict among the constituent parts of the system, between federal and provincial governments, between provincial governments and the health care profession and among health care providers themselves, prevents meaningful discussion and hinders the implementation of needed reforms. There are also no systemic goals for the system as a whole and no mechanism for Canadians to express dissatisfaction with the systems ability to meet needs or to articulate opinions. The political process is insensitive to the needs or desires of the Canadian public. At the same time, the system is under increasing pressure to maintain services with increasingly scarce resources. Most provinces have sought to contain these pressures through limits on global levels of expenditures rather than by making needed changes to achieve maximum efficiency or effectiveness. As resources have continued to diminish or were restricted, relationships between providers and provincial governments have become more strained. The Task Force begins to address these problems first by recommending an expanded role for the Federal-Provincial Council of Health Ministers. A permanent forum for the identification and resolution of problems, it suggested, would depoliticize debates arising among governments.

A federal-provincial body would likely be insufficient to meet the concerns of consumers and providers of health care services however. According to the report, wide-spread scepticism over the political process would not make the Council of Health Ministers a relevant body for addressing the gap between governments, providers and consumers. The Task Force’s concept of a health council is designed to provide direct access for providers and consumers to the political process. The council would be mandated to identify key issues related to health, propose solutions, resolve jurisdictional disputes between providers and serve as a watchdog and advisory body to the Federal-Provincial Council of Health Ministers. Its recommendation for a Canadian Health Council composed of consumers, ombudsmen and health professionals, which would serve as an advisory group to the Federal-Provincial Council of Health Ministers. The Federal-Provincial Council of Health Ministers and a Canadian health council would principally address policy options, professional jurisdictional disputes, and the problems of health care delivery occurring at the political level.

The history of conflict and confrontation between the two orders of government continues to dominate the debate surrounding the funding issue. Controversy has arisen over two issues, provinces arguing that transfer levels are inadequate to maintain services and the medical profession claiming that funding levels are inadequate and pose a threat to medicare. The federal response has been that the real threat to medicare lies in extra billing and user fees. The Task Force concluded that it was unable to assess the extent of existing inefficiencies, and because there is no guarantee that putting more money into the system is necessarily the best way of improving health, the Task Force cannot no clear recommendation with respect to the funding issues. It limited its commentary to the effect that if Canadians wish to enjoy a national health care system which incorporates

some degree of equity, additional assistance must be given to those provinces which are unable to allocate any more of their own funds towards health care.

Major Recommendations:

- Recommends there should be enough flexibility within the system to enable and individual to move freely from one level of care to another, and an assessment service so that the needs of each individual can be periodically evaluated and met. Coordinated care should be provided, preferably through multi-level care facilities.
- Recommends the introduction and the enforcement of strict regulations defining meaningful new standards in nursing homes.
- Recommends that all jurisdictions move as quickly as possible towards the elimination of “care for profit” institutions and establish non-profit facilities (nursing homes).
- Recommends establishing a uniform set of guidelines for evaluating, acquiring, operating, and funding high technology. These guidelines should be developed in consultation with the relevant parties such as the Canadian Hospital Association, the Canadian Medical Association and governments. Potentially the development of a National Health Technology Assessment Council was foreseen reporting to the Federal-Provincial Council of Ministers of Health.
- Recommends rationalization and coordination in the provision of all technologies, particularly those that are expensive and complex. The concept of regionalization, the sharing of facilities to provide better health care services.
- Recommends that the increased profusion of “low ticket, high volume” procedures be re-examined.
- Recommends an expanded role for the Federal-Provincial Council of Health Ministers.
- Recommends the establishment of a Canadian Health Council composed of consumers, ombudsmen and health professionals, which would serve as an advisory group to the Federal-Provincial Council of Health Ministers.

Canada Health Action: Building on the Legacy (1997).

Author: The National Forum on Health.

Year: 2000

Subject: National Health System

Sub-topics:

- Governance
- Financing
- Primary Health Care
- Pharmacare
- Home Care
- Health information and technology
- Health Human Resources
- Population health

Source: National Forum on Health

Background:

The National Forum on Health was launched in 1994 by then Prime Minister Jean Chrétien. Established as a purely advisory body, it was composed of 24 volunteer members, many of which were recognized health policy experts, and with the Prime Minister acting as Chair and then Minister of Health David Dingwall as Vice Chair. The Forum published a final report in two volumes as well as a five volume series of 42 studies on determinants of health, comparative health systems and resource allocation and evidence-based decision making in the health sector.

Originally the Forum was sought the full participation of provincial governments. However, in the face of the federal government's ongoing deficit reduction strategy and a freeze on transfer payments for health and social services, the Forum remained a federally driven process. In the midst of the Forum's mandate, the Federal government instituted the Canada Health and Social Transfer.

Purpose:

The Forum's mandate was to inform and involve Canadians in seeking out innovative ways to improve the health care system and the health of the Canadian population. Its principle function having entered into a dialogue with the Canadian public was to advise the government on its findings and make recommendations. The task was understood to relate specifically to the development of national policies.

Issues and Findings:

The Forum identified four key areas on which its work would focus. Working groups were established to prepare synthesis reports in each of these key areas. Volume two of the final report of the Forum presents the synthesis papers and recommendations which formed the basis of the set of priority areas upon which the Forum saw the need for especially urgent and immediate action. The Values Working Group examined the values and principles identified by Canadians as central to the health care system. Its

conclusions were based on focus group responses, quantitative research and public opinion pole data. The “Striking a Balance” Working Group focused on the allocation of limited health resources within the system, specifically with respect to preserving the health system but also with improvement in the overall health and health status of Canadians. It paid special attention to the balance of resources within the health sector but additionally to the balance of resources between the health sector and other sectors of the economy. The Determinants of Health Working Group examined the non-medical determinants of health and sought to recommend appropriate actions to improve overall population health status. Particular emphasis was placed on the “macro-economic environment” to assess the impact on health. Finally, a working group considered how health information could be used to support and encourage a culture of evidence-based decision making. The recommendations emerging from these synthesis groups become the basis of the Forum’s final recommendations for immediate action. Thus the Forum’s blueprint for system reform and renewal begins with action to stabilize and preserve the health care system through organizational changes to address immediate concerns over limited resources, quality and access. This is followed by recommendations to act on existing knowledge on the determinants of health, particularly to act on addressing the non-medical determinants of health. And finally, the report urges the creation of a culture of evidence-based decision making with respect to health and health care and the information infrastructure necessary to sustain it.

The Forum noted that repeated provincial commissions and task forces during the 1980s focused on the health system being fundamentally sound and adequately funded. These same reports generally pointed to organizational and structural changes to improve the quality and efficiency of the system. It noted that only fiscal restraint in the 1980s and early 1990s has raised concerns over sustainability and made change no longer simply desirable but necessary. It was the opinion of the Forum that existing levels of expenditure for health care, both public and private, were sufficient to maintain accessibility and quality care. However, the present structure cannot accommodate speedy and drastic reductions or shifting of resources without compromising access and quality. Fundamental to medicare is the principle of universal access and without ensuring this principle will compromise the entire system. Change, the report argues, must by necessity be accomplished at a cautious pace otherwise confidence in the system will be put at risk.

The report’s first recommendations reaffirm the commitment to the publicly funded system. It recommended maintaining public funding for medically necessary services through general taxation and retaining a “single payer” model for insured health services to ensure preserving the values of equity and accessibility. It notes that, “twelve interlocking, single-payer health insurance plans” reduces administrative costs, promotes cost reduction rather than the shifting of costs onto individuals, and provides more consistency and bargaining power in dealing with health care providers and the health care industry. Addressing the issue of increased privatization as a means of cost-control, it writes, “The profit motive in financing health care is inconsistent with the view of health as a public good and moreover leads to high administration costs and inequities in access and quality.”

Key to recommendations to preserving and protecting the system is a continued and strengthened federal/provincial/territorial partnership. This included retaining the federal role in preserving and protecting through the Canada Health Act and renewed commitment to the five principles. It recommended stronger collaboration between federal/provincial/territorial governments but stopped short of any notion of joint enforcement or oversight of the Canada Health Act. However, this requires a significant and ongoing financial contribution through federal transfers. These transfers must be stable and predictable over time so that the pace of reforms at the provincial/territorial level does not become destabilized. Provincial and territorial governments are largely responsible and accountable for service delivery and therefore best positioned to manage change in the system. However, reductions in federal transfers have imposed change at a pace that “cannot be absorbed” by provincial and territorial health systems. The Forum recommended that a cash floor be imposed upon federal transfers under the CHST suggested an appropriate level would amount to approximately \$12.5 billion annually. The federal government should also refrain from unilateral action in other areas of federal policy that would offload costs onto provincial/territorial budgets.

The most significant challenge for the system is to maintain universally accessible and quality health services under a public system with fewer resources. When public funding is reduced, the system typically responds by offloading costs by doing less. This offloading generally shifts public costs onto individuals either by de-insuring or introducing user fees. Such approaches serve only to undermine support for the public system and while they may reduce public costs they inflate total health care costs. In the Forum’s view, “if we focus on total costs and value for money, the evidence suggests that increasing the scope of public expenditure may be the key to reducing costs. The second major thrust in preserving the system is to move toward a more integrated and comprehensive system that “funds the care, not the provider or the site.” Currently the focus of public funding of medicare is focused on funding hospital and physician services. This severely limits the potential of more cost-effective methods of care through home care or the use of alternate health care providers and so on. A major barrier that makes the offloading of costs more attractive than substantive organizational change is the rigid and compartmentalized manner in which services are currently funded, organized and delivered. The criteria it proposed for public funding was “medically necessary care” and integrating under the auspices of the Canada Health Act along with hospital and physician services primary health care, home care and pharmaceuticals.

Under an integrated publicly funded system would require provinces and territories to offer a combination of insured home care services to post acute, chronic and palliative care patients. Incentives should be in place to ensure that people are treated in the most appropriate, cost effective setting, taking into account total public and private costs. A public, single point of entry should be used to conduct comprehensive, multidisciplinary assessments to determine which services are needed on a case by case basis and to match these services with public and/or private providers. Home care services would not require additional long-term investments to sustain since cost-savings on the institutional side would offset the cost of expanded home care.

Public financing of pharmaceuticals is the only way to ensure universal access and cost-effectiveness. Inclusion of medically necessary pharmaceuticals would represent a substantial increase in public expenditures but the benefits of inclusion would likely see a reduction in total health costs. However, to include pharmaceuticals, systems and policies need to be in place to manage utilization, ensure appropriate prescribing and control costs (e.g., comprehensive information systems, competitive bulk purchasing and reference based pricing). There would also be transitional costs as private plans for pharmaceuticals are absorbed into the public system. Finally it called on collaboration between federal/provincial/territorial governments, private payers (employers and unions) as well as consumers to develop a comprehensive plan for inclusion.

Without exception, primary care reform is high on the agenda of all provinces and territories. The report stops short of proposing any single model that would be wholly appropriate for all jurisdictions but did suggest that key elements of primary health care reform should include realignment of funding to patients and a remuneration system for health care providers that is not based on volume of services “but promotes a continuum of preventative and treatment services and the use of multidisciplinary teams.” To facilitate primary care reform a health transition fund would be provided to support evidenced based decision making to support primary health care. The fund would support pilot projects, disseminate results and promote implementation of the best models. It recommended that the Federal/Provincial/Territorial Conference of Deputy Ministers of Health would be the mechanism for collaboration and administration of the fund.

Since the Lalonde report, there has been a broader understanding of the factors that contribute to good health that has resulted in efforts by government to address some of the determinants of health. Primarily the focus of this activity has been concentrated in individuals and lifestyle choices. Continuing research on the non-medical determinants of health however have focused increasingly of factors beyond “the immediate control of individuals, professionals and communities.” While the report devotes a considerable amount of space related to overall determinants of health, it devoted particular attention to socioeconomic determinants as of particular concern. Specifically, the Forum wrote: “we are particularly concerned about the impact of poverty, unemployment, and cuts in social supports on the health of individuals, groups and communities. Among its recommendations, the Forum called for significant investment in children and families. It recommended that in conjunction with other levels of government a broad integrated child and family strategy consisting of both programs and income support. Specifically, it recommended an income-tested benefit program to address child poverty replacing existing federal child tax benefit and provincial welfare programs into a single benefit. It recommended the strengthening of community-based programs to enhance parental skills and early childhood development. Also, it recommended review of policies and programs to ensure that they provide access to affordable child care services with special attention to be placed on the needs of Aboriginal children. It further recommended modifications to existing tax policies in favour of families with children.

The role of governments in improving the overall health status of the population extended beyond activities to address specific groups. The Forum argued that there needed to be an explicit acknowledgement of the health and social impacts of economic policies particularly action to help individuals who are trying to enter the workforce. It said a priority must be placed on improving the entrance of young Canadians into the workforce. It recommended that all government economic policies be analyzed explicitly from the perspective of their impact on health. To support a wider understanding of socio-economic impact on health a National Population Health Institute would be established to advise and to report on the impact of economic policies including the economic and social costs of unemployment.

There is an increasing imperative, given the limits of available resources and the need to maintain public confidence in the system through necessary change, to make transparent decision-making within the health system. The Forum observed that while some decisions are based on sound evidence many decisions related to the health care sector are a product of the values and interests of decision-makers themselves as well as the situation or context in which the decisions are made. The system collects considerable administrative data on individuals contact with the health sector but collects insufficient data on the results. The Forum noted that administrative data is rarely linked to information about factors such as socioeconomic status, educational status, employment status and so on. Nor is it linked to the outcome of the specific intervention. There is little information resulting from analysis of such data at either the individual or population level. In the absence of high quality data, the system has failed to develop the proper mechanisms or protocols, clinical guidelines or care management strategies to assist in daily decision-making.

An important aspect of the development of appropriate health information management is the accountability function. As currently constituted no organization has been developed with the capacity to collect and analyze information, report to the public on health status and system performance, promote the need for population health research and evidenced-based decision-making and respond to health policy decisions already taken. The need for appropriate information is particularly acute in the midst of restructuring, particularly as provincial governments move to decentralize services at the regional level. The report calls on the federal Minister of Health to assume leadership in the development of an evidence-based system. Key to assuming this role is the foundation of a national population health data network that would link provincial and territorial agencies into a single national agency. A national agency would require the cooperation of federal, provincial and territorial governments to coordinate information collection to ensure a standardized set of “longitudinal data” on health status and system performance. The proposed National Population Health Institute should be called upon to aggregate and analyze data; develop data standards and common definitions; report to the public on national health status and health system performance; and act as a resource for the development and evaluation of public policy. The institute would collaborate with provincial and territorial agencies and would report publicly on trends both nationally and inter-provincially.

The Forum also noted there were significant gaps in the knowledge about women's health, ethnic and cultural influences, non-medical determinants of health and alternative or complementary practices and therapies. Public interest in alternative or complementary treatments has increased with little or no systematic information to determine which alternative or complementary interventions are beneficial and which are potentially harmful. Furthermore, basic and clinical research continues to receive far more emphasis and funding than research on the non-medical determinants of health. This would appear to be a serious imbalance given the relative impact of non-medical factors on the overall health status of the population. It proposed therefore, the development of a comprehensive research agenda be developed to address these gaps, and to identify mechanisms to promote analysis, translation, dissemination and implementation to improve available health information. Areas identified for immediate increased research on non-medical determinants of health, women's health (also noting the need to increase and promote female researchers) and Aboriginal health. The Forum noted that there was ample evidence that the health status of Aboriginals is poor relative to other Canadians but information is lacking on effective, culturally appropriate interventions to improve the health status of Aboriginal peoples. A major recommendation called for an Aboriginal Health Institute to help aboriginal communities find solutions to their health problems and take action.

The Forum was also concerned about the asymmetry between the information available to health care providers and that available to patients. Demands by patients for greater involvement in decision-making has made it essential that the public be able to access user friendly information. It recommended therefore that a nationwide population health information system be established to support clinical, policy and health services decision-making, as well as decision making by patients and the public at large.

Major Recommendations:

- Recommended that federal/provincial/territorial Ministers of Health articulate a national health policy framework and a renewed commitment to the principles of the Canada Health Act
- Maintenance of public funding for medically necessary services
- Retaining a "single payer" model for insured health services
- Establish a cash floor on federal transfers to the provinces and territories.
- Maintaining a strong federal/provincial/territorial partnership
- Expanded publicly funded medically necessary services to include home care and prescription drugs
- Reform of primary health care funding, organization and delivery
- Establishing a multi-year transition fund to support evidence-based innovations.
- A broad integrated child and family strategy consisting of both programs and income support.
- Collaboration among the federal government, the private sector, and existing foundations to strengthen community action
- An Aboriginal Health Institute to help aboriginal communities find solutions to their health problems and take action

- Explicit acknowledgement of the health and social impacts of economic policies, and action to help individuals who are trying to enter the workforce.
- That the federal Minister of Health take leadership in the development of an evidence-based system
- That a nationwide population health information system be established to support clinical, policy and health services decision-making, as well as decision making by patients and the public at large.
- That a comprehensive research agenda be developed to address gaps in our current knowledge, and to identify mechanisms to promote analysis, translation, dissemination and uptake so that high quality content is available for the health information system.

Understanding Canada's Health Care Costs: Final Report (2000).

Author: Provincial and Territorial Ministers of Health.

Year: 2000

Subject: National Health System

Sub-topics:

- Financing

Source: Provincial and Territorial Ministers of Health

Background:

The final report on the sustainability of the health care system was released at the Annual Premier's conference in Winnipeg in August of 2000. The report provided provincial and territorial leaders with ammunition heading into the First Ministers Meeting in Ottawa in September of 2000 which resulted in a health accord between the provincial, territorial and federal governments.

Purpose:

The document was designed to provide background for informing their ongoing discussions on sustaining and renewing health care in Canada. Prepared by provincial/territorial Health Ministers, the report was designed to show that while Canadians continue to be well-served by their health systems the provinces and territories face growing demands for health care services fuelled by changing demographics, new services and technologies, and the cost of renewal. The document was designed to show that the provinces were united in calling on the federal government to sharing the costs of

health care and other social programs by restoring CHST transfers and by implementing an appropriate escalator.

Issues and Findings:

The report examines how the health care system is financed, provides an analysis of innovations that are already underway in provinces/territories and looks at the current and future cost drivers and accelerators in Canada's health system. The report argues that provinces/territories are already significantly involved in activities that are improving the quality of health care services provided to Canadians. It also illustrates the source and size of health care cost drivers, as well as the significant additional costs associated with health system reforms. As key in the process of stabilizing and sustaining the health care system, Provincial and Territorial Premiers are unanimous in calling on the federal government to immediately and fully restore funding cut from the Canada Health and Social Transfer (CHST), and implement an appropriate escalator to ensure that funding for health through the CHST keeps pace with the economic trends, social factors, and changing health technology, which impact on the sustainability of the system

Between 1996 and 1999, health care spending increased on average 4.2 per cent annually, the same as growth in the economy. The report notes that an examination of long-term spending on health care reveals that the federal government has consistently reduced its contribution to health care funding. This has resulted in a significant funding gap. This funding gap represents the difference over time, between what the federal government has contributed to the health care system by way of its transfers to provinces and territories and what the provinces/territories have spent in meeting cost pressures. Since the beginning of block funding, the growth of health care spending has consistently been higher than the growth of the economy. Yet the highest escalator attained for block funding was one matching the growth in Gross Domestic Product (GDP) and this existed only for the first few years after the introduction of block funding in 1977. The period from the mid-1980s to the mid-1990s was one of reduced escalators and frozen transfer amounts. Further, the federal government made substantial cuts between 1994/95 and 1998/99 in the major transfer helping to fund health care and other social programs. The report called for the CHST to be restored by \$4.2 billion, with an appropriate escalator to ensure that funding for health through CHST keeps pace with the economic trends and social factors, which impact on the sustainability of the system. This figure is presented as a compromise by provincial and territorial leaders who point out in the report that the gap between what the federal government is now contributing and what it had been scheduled to contribute is significantly larger. For example, if the base CHST amount had been increased since 1994/95 relative to increases in health care spending by provinces, the figure would have been \$8.8 billion higher in 2000/01.

In addition to back-filling the funding gap, provinces and territories have also invested heavily in health system renewal and innovations, since the mid-1980s. Every province and territory has responded to changes in medical technology, emerging diseases and chronic conditions, changing medical practice patterns, new pharmaceuticals, and changes in the health needs of their citizens. All provinces and territories have responded to these changes by implementing system renewal initiatives and innovations aimed at

making their health systems more accessible, more appropriate and sustainable, while, at the same time, assuring that high-quality services continue to be provided. In addition, all provinces and territories have worked in partnership with health providers to identify efficiencies and productivity improvements. These reforms have also been undertaken to modernize the health system to better serve Canadians. All provinces and territories are implementing health reform in all sectors of the system. These include improvements in the delivery and management of hospital care, improving the access to physician services and primary care, rapid expansion of home care and other community services, investments in long-term care, and improving access to new technologies, including acute care and drug therapies. While these are being implemented at different paces, the direction of reform and investment is consistent. The purpose of health reform is not to reduce spending levels. It is to improve access, quality and cost effectiveness. It may also help moderate future growth curves. The report notes, however, that further reforms will require significant investments. While provinces and territories will continue to identify and seek to find cost efficiencies it will be extremely difficult to replicate the efficiencies gained in the 1990s in the near term. Cost pressures will continue at a rapid rate and it is therefore vital that any application of reforms be flexible, allowing for unique needs and program mixes of individual provinces and territories.

Every province and territory faces a growing demand for health care services fuelled by demographics, new technologies, pharmaceuticals, and other growing costs of providing service. As the report illustrates, the rising need for additional health services is not sustainable without significant new federal funding. Recent provincial/territorial health care budgets have risen well in excess of inflation, population growth, or the economy. Provincial and territorial health expenditures for Canada are currently close to \$56 billion. Even with modest changes in the pattern of service delivery, basic factors (population growth, aging, inflation, rising costs for current programs) are projected to increase health expenditures by approximately five per cent per year. Examples of accelerators include: emerging and new technologies (such as major joint surgery, neonatal and fetal technologies, dialysis, organ transplantation, genetic testing and therapy), and increased incidence of chronic and new diseases such as heart disease, diabetes, tuberculosis, Hepatitis C, HIV, and AIDS. In addition, new pharmaceuticals, declining productivity gains, and changing expectations will also impact on costs. It is clear that provinces and territories will have to continue to actively manage the system and seek further productivity measures to help address the magnitude of expenditure pressures and to meet future demand.

Major Recommendations:

- Recommends that the federal government immediately and fully restore funding cut from the Canada Health and Social Transfer (CHST), and implement an appropriate escalator.

The IRPP Task Force on Health Policy: Recommendations to First Ministers (2000).

Author: Institute for Research on Public Policy (Chair: Michael Decter).

Year: 2000

Subject: National Health System

Sub-topics:

- Governance
- Financing
- Pharmacare
- Home Care
- Primary Health Care
- Health information and technology

Source: Institute for Research on Public Policy

Background:

The Task Force was convened to study, beyond the narrow issue of funding, specific reforms to enable the public health care system to perform better. In eight short policy papers, the IRPP Task Force on Health Policy tackled issues such as excellence and accountability in health care, a disentanglement of the roles and responsibilities of each level of governance, a return to local initiative, and a renewed focus on serving the needs of individual patients. These papers formed the basis of the Task Force's final recommendations and an open letter to First Ministers.

Purpose:

In presenting their report to First Ministers, members of the IRPP Task Force on Health Policy aim was to outline issues that required the attention of decision-makers, consider potential challenges and benefits of certain proposals for reform, and encourage an informed public debate on the future of Medicare.

Issues and Findings:

The Task Force recommendations begin with identifying the concerns of the Canadian public with regard to the health care system. It notes among these the blurring entitlements and shifting costs from government to individuals, particularly the concern that as services move from the hospital to the community and the home, which services are to be fully covered by medicare. Similarly, the question of variability in coverage from province to province, specifically as they pertain to prescription drugs and home care services. Canadians are experiencing both a growing personal burden of assuming the responsibility of caregiver for family members with acute and chronic care needs as well as a growing financial burden for drugs, home care and long-term care. The loss of public confidence in the system it suggests can be traced to a number of factors. A theoretical definition of medicare that no longer relates to the actual health care that Canadians are receiving and have come to expect. Conflicting visions of what constitutes the optimal approach to meeting the health care needs of Canadians among federal and

provincial governments as well as between these governments and the public. There are also public perceptions of a lack of leadership and direction in the planning of the health system. This includes a lack of clear lines of accountability between the public and the providers and managers of health care.

The Task Force groups these concerns into four areas in which the system is underperforming. First, it suggests there is an absence of “excellence” as the standard sought for the system. Second, there needs to be clearly defined goals and modes of accountability for both federal and provincial governments in the overall planning and organization of the health care system. Third, the management of health care services delivery in communities across Canada should be decentralized. And finally, there needs to be increased stability of health care services with regard to both funding and leadership.

The lack of definition of the principles of the *Canada Health Act* has been the root cause of much of the ambiguity regarding how provinces can alter their modes of delivering services while remaining within the parameters of federal funding. The report begins with redefining the rules of what it envisions as “medicare plus” and reform of the *Canada Health Act*. It notes that a broader set of principles will not eliminate conflict, but it could lead to a more reasoned debate. In addition, broader principles may enable the system to better meet the concerns of citizens in areas such as timeliness and quality. The principles of universality and accessibility remain intact but comprehensiveness it recommends should be redefined to encompass drug treatment and alternate modes of delivery such as home care. While making no specific recommendations, the Task Force did note that the system requires public governance and public policy direction and standards for health care, but not necessarily public management. Added to the “new rules” governing the health system is the notion of quality, specifically to include not only how a service is delivered but also its appropriateness to the needs of the patient and the outcome for that patient. Quality needs to be benchmarked to leading international standards. The health care system must be transparent and accountable to the public as well as to governments, for resources used and results achieved.

In the longer term, the Task Force recommends that the CHA should be monitored by a national health council, jointly appointed by Ottawa and the provinces and operating at arm’s length from the governments. The council would be mandated to present detailed report cards on the performance of the system in terms of the health status of Canadians, adherence to the principles of medicare and the provincial Patients’ Charters. The council’s role could be undertaken by existing bodies such as the Canadian Institute for Health Information and the Canadian Institutes of Health Research.

Recognizing that the financial and operational responsibilities related to the CHA are overwhelmingly provincial, the role of the federal government in this component of health care must be one of facilitator and honest broker between the provinces. Armed with the reinterpretation of the five principles of medicare and aided by the national health council, the federal government would also be in a much stronger position to monitor adherence to the CHA.

The Task Force concludes, however, that the *Canada Health Act* cannot serve as the basis of service quality standards. More precision is required at the level of the individual patient. It recommended the development of a Patients' Charters would refer to individuals' entitlements under those programs. It is also important that Patients' Charters be adopted at the provincial level to allow for an adaptation of the entitlements of patients to the particular circumstances of each province. The introduction of a Patients' Charter would refocus the delivery of health care services on the patient and on the quality of these services in each and every community. Thus, with a new emphasis on outcomes for patients rather than processes, the current tendency to centralize decision-making and standardize practices across a province would shift to a regionally-managed system flexible enough to be customized to the needs of particular regions and individual patients.

In health care as in other public services, "one size fits all" approach has placed limitations on the system. The Task Force notes that principles of "equity and solidarity" can all be met by allocating responsibility and authority according to the principle of subsidiarity: the principle that the level of governance that is both closest to the people and best able to deliver a given service should be responsible for that service. The *Canada Health Act* requires that health insurance plans be administered by the provinces and territories and carried out on a not-for-profit basis by a public authority. The report notes that while partial responsibility for the management of services has been devolved to local or regional authorities in some provinces, too many key decisions continue to be made in the provincial departments of health. The result has undermined local, volunteer decision-makers from finding innovative ways of meeting the needs of their community. The Task Force sets out the following model for clarifying the roles and responsibilities of the various governments.

The Task Force argues that decentralization to regional health bodies has not yet produced optimal results in terms of health outcomes, efficiency of resource utilization, or in terms of recruitment and retention of providers. In part, this is due to the fact that in no province has responsibility and authority for a full spectrum of health care services been assumed by these regional bodies. Incomplete devolution of responsibility for common services perpetuates their duplication, sustains the incidence of patients falling through the cracks, and allows continued fragmentation of the continuum of care. In large part, the assessment to date of the results of regionalization has been frustrated by the absence throughout of common standards on such fundamental data as the nature of patient/provider identifiers and encounters, diagnoses, and outcomes.

Regional Health Organizations made up of elected and/or appointed representatives of populations of not less than 100,000 people should be responsible for the coordination of all health care service providers in a given region. These authorities would purchase the services required to with funds derived from provincial/territorial governments and assume clinical and fiscal accountability for health outcomes and the status of the population.

Provincial and territorial governments should be responsible for the articulation and communication of broad systemic goals. This would include establishing qualitative and performance standards and expectations for health care services. Provincial and territorial ministries would develop policies to ensure adherence to the overarching national principles, establish and maintain data standards and health information management systems, ensure accountability for the operation of the health care system, oversee health professional education and, provide funding to health organizations commensurate with their responsibilities. The federal government together with provincial and territorial governments would develop consensus on and interpret the values of the Canadian people regarding health care and ensure that these values are reflected in the overarching principles that guide legislation and frame the delivery of service, and make certain that they are applied equitably everywhere.

Understanding that health care remains a provincial jurisdiction and that the natural role for the federal government is the supportive one of facilitator, realignment of roles and responsibilities as well as of modes of interaction is in order. The federal government would also provide sufficient funding to the provincial/territorial governments to enable adherence to those principles applicable to health care services throughout the country. Either directly or through an independent advisory body, the federal government would ensure that all agents in the delivery of health services strive for excellence. On funding, Ottawa can and should commit itself to stability of funding in health care. To improve accountability to taxpayers, the federal government should introduce a new finance bill that would separate all funds (tax points and cash) transferred to the provinces for health care purposes from the funds allocated to other social services. It would make for a healthier relationship if the tax points “lost” by Ottawa to the benefit of the provinces were once and for all withdrawn from the equation and the debate. Future contributions should be made through cash transfers only. Accept responsibility for and fund such health care programs as the federal, provincial and territorial governments may jointly agree are best offered on a country-wide basis.

The first areas in which enhanced services should be considered are home care and pharmacare. This entitlement should be an intrinsic part of their health care insurance. Home care will require new funding from governments, a formal policy framework and the associated accountability mechanisms. While the Task Force felt that a national pharmacare program should be universal in the coverage, it concluded that such a program would be “too radical” given the state of federal and provincial relations. A second option would be the development of national standards to be accepted by each provincial drug plan. Chief among these standards would be universality. The current level of cost-sharing between patients and governments would be made the same across Canada. Considerations would be given to a premium-based approach supplemented by cost sharing. Employers would continue to contribute to pharmaceutical expenses.

The Task Force also suggested that the health care system will not achieve excellence as an integrated system without the pervasive use of information technologies and appropriate state-of-the-art medical technologies on the other. The Report consequently recommend consideration of the creation of a joint federal-provincial Health Technology

Resources Fund, as a source of capital investments, to be re-assessed after its first 10 years of operation.

Among other areas touched on by the report, it suggested experimentation in primary care by way of further devolution of budgetary responsibility to groups of family doctors and community nurses, similar to the GP Fundholding initiatives and Primary Care Trusts in the UK. Health organizations could finance groups of family doctors and nurses by way of an annual risk adjusted payment per patient enrolled with them. The success of the British Fundholding experiment has important implications for primary care reform in Canada. The attractiveness, for both patients and physicians, of empowering general practitioners to make a broad range of purchasing decisions on behalf of their patients, was demonstrated by the way in which this initially voluntary option gained acceptance and was then universalized and made compulsory. Although the process of universalization will bear careful watching, the British experience suggests that Canada could considerably accelerate experimentation with primary care reform pilot projects.

Major Recommendations:

- Recommended a framework commitment and a process for arriving at a fully reformed health care system. Health Ministers and senior officials could work on the details and report regularly to First Ministers. In 12 to 18 months, our governments could achieve a long-term national plan for health care reform.
- Recommended a renewed commitment to local initiative and autonomy. Provincial and territorial governments should reallocate to local or regional bodies the responsibility and the corresponding authority for managing and operating the health care services needed by the people in their communities.
- Recommends establishing clear mechanisms through which decision-makers are made accountable to each other and to the Canadian public.
- Recommends that Health organizations should be accountable to the provinces for achieving measurable health goals and health care service standards, set by the provinces in negotiation with them.
- Recommends rewarding initiative and good performance should prevail throughout the integrated regional health community. Funding should follow the patient, wherever possible, as he or she chooses his or her own health care provider or institution.
- Recommends that Health organizations should be required to publish and disseminate a statement of patient rights, expectations and responsibilities with regard to the appropriateness, quality and timeliness of care.
- Recommends the introduction of a Patients' Charter to refocus the delivery of health care services on the patient and on the quality of these services.

- Recommends that the federal government commit itself to stability of funding in health care. To improve accountability to taxpayers, the federal government should introduce a new finance bill that would separate all funds (tax points and cash) transferred to the provinces for health care purposes from the funds allocated to other social services.
- Recommends that tax points be withdrawn from the equation of health care transfers. Future contributions should be made through cash transfers only.
- Recommends redefining the principles of medicare. The federal government and the provinces, possibly with citizens' participation, should reinterpret each of the five principles of medicare.
- Recommends that the *Canada Health Act* should be monitored by a national health council, jointly appointed by Ottawa and the provinces and operating at arm's length from the governments.
- Recommends that home care and pharmacare be new programs jointly expanded into by the Federal government and the provinces and territories and included under "insured services" under the *Canada Health Act*.
- Recommends a national pharmacare program should be developed through greater standardization and harmonization of provincial drug plans with national standards negotiated among governments.
- Recommends that consideration be to a premium-based approach supplemented by cost sharing. Employers would continue to contribute to pharmaceutical expenses.
- Recommends the creation of a joint federal-provincial Health Technology Resources Fund, as a source of capital investments, to be re-assessed after its first 10 years of operation.

The Health of Canadians – the Federal Role: Recommendations for Reform (2002).

Author: Standing Senate Committee on Social Affairs, Science and Technology (Chair: Senator Michael J. L. Kirby).

Year: 2002

Subject: National Health System

Sub-topics:

- Acute Care
- Primary Health Care
- Governance
- Pharmacare
- Health Human Resources
- Financing

Source: Government of Canada

Background:

The two-year study of the Canadian health system by the Standing Senate Committee on Social Affairs, Science and Technology commenced in the fall of 1999 and during the course of its term produced six volumes culminating in a set of final recommendations. Over the two year life of the study the Committee heard testimony from some 400 individuals including current and former politicians, senior bureaucrats, health policy experts, stakeholder organizations and various other interested groups. The Senate Standing Committee on Social Affairs, Science and Technology has an ongoing mandate to examine legislation and matters relating to social affairs, science and technology generally, including health and welfare.

Purpose:

The terms of reference for the Standing Senate Committee on Social Affairs, Science and Technology were that it would be authorized to examine and report upon the state of the health care system in Canada by no later than June of 2002. The Committee was to examine the fundamental principles on which Canada's publicly funded health care system is based. Pursuant to this, it would examine the historical development of Canada's health care system. It would examine the health care systems in foreign jurisdictions for approaches to health care delivery and financing. The Committee would look at the pressures on and constraints of Canada's health care system both financial and systemic. And finally, the Committee would examine the role of the federal government in Canada's health care system.

Issues and Findings:

The Committee's final report characterizes its own recommendation as roughly grouped into six categories. Recommendations for restructuring the acute care sector; the development of a "health care guarantee"; expanding public insurance to include coverage for catastrophic prescription drug costs, immediate post-hospital home care costs and costs of providing palliative care; strengthening both the federal contribution and the federal role in health care infrastructure and; a series of recommendations for raising additional federal revenues, and how those revenues could be administered in a transparent and accountable manner in order to implement the recommendations in the

report. The report concludes with observations about the consequences that would arise if additional federal revenues are not invested in the health care system.

Part one of the report begins with an overview of the Committee's previous work in volumes one through five in which the Committee sets the context within which the current national health care system operates. Of the federal role it is evident to the Committee that Canadians wish to see national principles maintained and look to the federal government as critical to maintaining these principles. Health care reform will require injections of additional revenues and the federal government must be the primary source for these new funds. Only the federal government is capable of the redistributive function necessary to ensure all provinces have the resources necessary to provide comparable levels of services. Only the federal government is in a position to harmonize standards among provinces through financial incentives. The substantial transfers made by the federal government, according to the principle of accountability, give the federal government a "seat at the table" in the direction of health care reform.

In the Committee's view rising costs indicate that the publicly funded health care system as it is currently organized and operated is not fiscally sustainable given current funding levels. There is increasing evidence to suggest that the system is unable to meet demand in a manner that ensures timely access to quality services. In view of this, the Committee states that Canadians and their governments have three choices: increased rationing of public services (waiting lists); increase revenues; allow for a parallel private system. The reports conclusion is that additional revenues, some \$5 billion annually are required to reorganize and restructure the current system but some mechanisms must be in place to ensure the additional revenues purchase the reforms advocated in the rest of the report.

This overview provides the basis of the Committee's conclusion that the system needs be more accountable and better governed. Flowing from this is the recommendation that there be access to a reliable and non-partisan assessment of the health care system. The health care system lacks "leadership" or governance. Currently the system relies on intergovernmental relations between the provinces and the federal government which are highly dysfunctional and characterized by blame-shifting for the deterioration of the publicly funded system. "Fundamentally," the Committee states, "the issue is one of accountability" and what the system lacks is an independent body responsible for reporting annually on the state of the national health system and on the health status of Canadians. Its proposal for "depoliticizing" the system is with the appointment of a National Health Care Commissioner and Council whose primary function would be to oversee the production of an annual report which would include recommendations on improving health care delivery and health outcomes, as well as, advise the federal government on how it should allocate new revenues to renew and reform the system. The selection of the Commissioner and Council would be made by a federal-provincial-territorial Committee comprised of equal numbers of federal representative and provincial/territorial representatives.

Part two of the report examines efficiency measures necessary to improve the system. It focuses first on current methods employed for funding hospital based services. The

Committee believes that current funding mechanisms, where these are based on funding inputs and not on final outcomes, must be revised to focus on performance in delivering hospital services. Case-mix funding, says the Committee, is more equitable and has the added advantage of encouraging both efficiency and performance. “Service-based funding” would contribute to measuring the cost of specific hospital services; improving overall hospital efficiency; enable the public to compare hospitals based on their respective performance; enhance hospital accountability; foster competition among hospitals; reduce waiting lists; encourage the development of centres of specialization. The Committee recognizes that hospital funding is a provincial matter; however, the federal government could promote service-based funding by supporting the health care infrastructure and “infostructure” necessary to enable provinces to implement service-based funding. The Committee recommends that hospitals should be funded under a service-based remuneration scheme. It recommended however that Academic Health Sciences Centres be augmented by an additional funding mechanism that takes into account the teaching and research functions performed by them.

The Committee believes that RHAs have done a commendable job of integrating and organizing health services for people in their regions during the last decade, and that they should be given more responsibility and authority for delivering and/or contracting for the full range of publicly insured services. The Committee also believed that regionalization would foster competition among health care providers and encourage cost-effectiveness and efficiency in service delivery. It recommended further devolution to overcome some barriers to the full realization of RHAs. Budgets for RHAs are determined at the provincial level as are performance targets. RHAs, it argued, are obliged to devote considerable energies to lobbying provincial governments for necessary funding which might be better spent setting local priorities. RHAs are obliged to establish business plans or budget estimates but these are generally not linked to specific target outcomes. Physicians expenditures are not included in RHA budgets, although decisions made by physicians directly impact on costs incurred by RHAs. The Committee believes that increased responsibility for decision-making, enhanced responsibility for planning and better control over the allocation of resources would lead to greater integration of health services. The role of government should be that of overall system governance, setting policies with respect to population health goals, negotiating strategic plans and budgets.

Primary care is centred on family physicians and general practitioners but a number of weaknesses are identified with the way primary care is delivered. There are barriers to access in that care is generally not available after hours or on weekends. There is poor information sharing, collection and management. And there is a misalignment of incentives, particularly fee-for-service remuneration which rewards episodic rather than continuing care and health promotion. Advantages to the formation of Primary Care Groups (PCGs), groups of physicians and or physicians and other health providers, include guaranteed access to primary care services on a 24 hour basis, better utilization of health personnel, cost-effectiveness (over expensive emergency room treatment), increased emphasis on health promotion and disease prevention. While the report acknowledges the diversity of primary health care models being utilized currently and the

absence of a “one-size-fits-all” approach, it did highlight what it deemed the necessary components of a functioning primary health care approach. This includes: 24 hour delivery of a comprehensive range of services; delivery of services by the most appropriately trained care provider; adoption of alternate methods of funding to fee-for-service; integration of health promotion and illness prevention; integration of electronic patient records. Among acknowledged impediments to primary care reform noted in testimony to the Committee, it suggested vested interests among professional organizations (it noted the Ontario model was a bilateral negotiation between the province of Ontario and the OMA). This was recognized as perhaps the most profound barrier to implementation. Among other barriers was fee-for-service remuneration, shortages in qualified personnel, initial start-up costs and the absence of electronic information infrastructure. The Committee recommended that the federal government work with the provinces to reform primary health care and that it provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care teams.

The issue of timely access to health care, particularly waiting times for diagnostic services, hospital care and access to specialists was identified by the Committee as a primary threat to the single payer insurance model. Failing to address access issues will increase pressure for private options; including constitutional challenges on the existing prohibition against private delivery. The Canada Health Act stipulates “reasonable access” but in no way defines what constitutes reasonable access. The Committee identifies two predominant reasons for perceived waiting list problems. One is the apparent shortage of diagnostic equipment and personnel. This can be traced back to decisions by governments made as a result of attempts to reduce costs. The second is the absence of a disciplined, prioritized waiting lists based on standards, criteria and clinical guidelines. It notes that there is a problem distinguishing between waiting lists that are the result of real shortages of personnel and equipment and physician/patient generated demand. The Committee’s opinion is that a major factor in growing waiting lists is the slowness of “players” in the system – hospitals and their specialist physicians and surgeons in particular – to apply systematic management to waiting lists for all major procedures and diagnostic tests and consultations. The responsibility for waiting list problems should be placed on the shoulders of governments for not funding the system adequately and jointly on governments and health providers for not developing clinical, needs-based waiting list management systems. It recommended that for each major procedure or treatment, a maximum, needs-based waiting time be established and made public. This is the health care guarantee. Beyond this maximum the insurer would be required to pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including another country if necessary. The process of establishing standard definitions for waiting times would be national in scope. An independent body would be established to consider the relevant data and clinical standards and times. The definitions would focus on waiting times for primary health care consultation, waiting times for initial specialist consultation, waiting times for diagnostic tests and waiting times for surgery.

In developing its proposal to expand public insurance of catastrophic prescription drugs the Committee sought to achieve two objectives. One was to prevent financial hardship as a result of expensive or prolonged drug treatments. The second was to ensure the sustainability of current prescription drug coverage programs both provincial public and private supplementary drug insurance plans. Specifically the Committee's proposal calls for the federal government to assume 90% of the cost of prescription drugs beyond a specific threshold. Provincial public and private insurance plans would then be responsible for the remaining 10% of expenses beyond the threshold. These plans would have to meet specific criteria for eligibility and a national formulary would have to be created to allow for uniformity and define eligibility under the plan. Federal money would enable provinces to pay for whatever improvements to provincial prescription drug plans are required to be put in place to meet the proposed threshold.

Currently each province and territory offer some form of home care program, but not as a "medically necessary" service under the Canada Health Act. Therefore publicly funded home care varies considerably in terms of eligibility, scope of coverage and applicable user charges. Recent hospital transformations through closures, mergers, reductions in length of stay, and changes to the size and function of hospitals have shifted the traditional home care caseload, putting a heavier emphasis on post-acute home care recipients. Control and responsibility for the organization and delivery of post-acute home care varies but is usually the responsibility of organizations that are distinct from hospitals. This has created a parallel set of entrenched interests, pitting organizations responsible of hospital care against those responsible for home care, and creating conflict that has foreclosed on or restricted opportunities for service integration, prevented innovation and put unnecessary limits on service cost-effectiveness. Directing the funding for the provision of post-acute home care to hospitals will allow them to benefit from the potential cost-savings associated with shorter lengths of stay, thereby encouraging the uptake of home care and greater use of post-acute home care. The Committee believes that efficiency gains in the provision of both hospital care and post-acute home care are better advanced through vertical integration and recommends a service-based method of reimbursement for post acute home care should be developed in conjunction with service-based arrangements for each episode of hospital care. The Committee recommends the federal government establish a new National Post-Acute Home Care program, to be jointly financed with the provinces and territories on a 50:50 basis. Additionally, it recommended that the program be treated as an extension of medically necessary coverage already provided under the Canada Health Act and that therefore the full cost of the program should be borne by the provincial, territorial and federal governments.

The report declares that health care technology, health records and the evaluation of quality, performance and outcomes are three areas of Canadian health care infrastructure that must be given priority by the federal government. In terms of health care technology it noted that the shortage and the use of outdated equipment impede high-quality treatment. Moreover, the deficit in health care technology has translated into limited access to necessary care and lengthened waiting times. The Committee therefore recommended additional funding for the purchase of health care technology from the

federal government to support the provinces and territories to purchase new medical equipment. Federal funding would be provided within a multi-year fiscal framework, responding to requests initiated by health care institutions themselves with review by a group of independent experts. The report recommends federal funding of \$2.5 billion over 5 years to hospitals for the purchase and assessment of health technologies. It also recommended an additional \$2 billion over five years to support Canada Health Infoway in collaboration with provincial governments in developing a national system of electronic health records.

Health human resources in the report include not only addressing the shortage of professionals in all health care disciplines but also finding ways to increase the productivity of health professionals. The Committee suggested that independent research organizations not affiliated to the medical profession undertake detailed studies of physician productivity. In order to address shortages, the report advocates that Canada develop a strategy to enable the country to become self-sufficient in health human resources. The federal government must play a much stronger role in coordinating efforts to deal with health human resources shortages and recommended the creation of a permanent National Coordinating Committee for Health Human Resources to disseminate data on human resource needs and best practices among different levels of government and representatives of key stakeholder groups. It also recommended that the federal government facilitate expansion of enrollments for physicians and other health care professionals. This included federal funds directed toward medical colleges.

The report also states that Canada must actively engage in health research to capture its share of benefits: including economic benefits. The federal government has critical role to play as a facilitator, catalyst, performer, consensus builder and coordinator in the overall effort to nurture excellence in health research. Its primary recommendation was for the federal government to increase its financial contribution to extramural health research to 1% of the value of total health care spending. It estimated that such a commitment would require an additional \$440 million annually.

When considering the system's fiscal sustainability, two interrelated constraints must be taken into account. The first is the willingness of taxpayers to pay for the system. The second is the need for continued economic growth and the corresponding need for governments to keep tax rates at levels that do not damage Canada's ability to invest, create jobs and remain competitive with other OECD countries. Continuing upward cost pressures are related to drugs, new technology, aging, and health human resources. In the Committee's view, given all the competing demands on the federal budget (agriculture, the armed forces, urban infrastructure), additional health care funding from the federal government will have to come from new money, not from revenue transferred out of existing sources. Additional funding, it concluded can either be raised through the public purse or privately. On the latter the Committee rejects large scale private financing which would lead to a parallel private delivery system, although it believes that a limited and regulated role for private funding is desirable. The Committee strongly believed that funding for medically required hospital and physician care remain the responsibility of a publicly funded and administered health care insurance program.

The Committee believes strongly that the money the federal government transfers to the provinces for health care should give the federal government some role in decisions regarding the reform and restructuring of the health care system and new revenues should not be used to fund the status quo. New revenues generated for the funding of health care should be captured in an earmarked fund distinct from general revenues. The Committee's estimates for reforming and restructuring the health care system require an additional \$5 billion annually and considered two options for raising these additional revenues: a National Health Care Sales Tax and a National Variable Health Care Insurance Premium, choosing the latter for its final recommendation. It also was opposed to increasing federal funding through the existing CHST mechanism. Rather it recommended that the federal government determine an "earmarked" revenue source equal to the value of the existing health care component of CHST transfers and speculated on allocating a portion of GST revenues as a possible source.

Major Recommendations:

- Recommends establishment of a National Health Care Commissioner and National Health Care Council.
- Recommends that hospitals be funded on a service-based financing mechanism.
- Recommends the devolution of further responsibility to regional health authorities
- Recommends that the federal government enact new legislation instituting health care coverage for catastrophic prescription drugs, post-hospital home care and some palliative care in the home.
- Recommends that the federal government work with the provinces to reform primary health care and that it provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care teams.
- Recommends the federal government provide \$2.5 billion in funding for the purposes of purchasing and assessment of health care technology.
- Recommends the federal government provide additional financial support to Canada Health Infoway Inc. to develop, in collaboration with provincial and territorial governments, a national system of electronic health records.
- Recommends the federal government additional annual funding to the Canadian Institute for Health Information and Canadian Council on Health Services Accreditation to establish a national system of evaluation of health care system performance.
- Recommends the federal government work with other concerned parties to create a permanent National Coordinating Committee for Health Human Resources.
- Recommends the federal government in conjunction with provincial governments to increase funding to post-secondary institutions for expanded enrolments and establish mechanisms for the direct federal funding of expanded medical school enrolments.
- Recommends the federal government increase its financial contribution to extramural health research to achieve a level of 1% of total Canadian health care spending.

- Recommends that the federal government establish an Earmarked Fund for Health Care that is distinct and separate from the Consolidated Revenue Fund. The Earmarked Fund will contain the additional revenue raised by the federal government for investment in health care. And furthermore, that the money from the Earmarked Fund be used solely for the purpose of health care, specifically to fund expansion public health care coverage and for restructuring and renewal of the publicly funded hospital and doctor system
- Recommends that the federal government establish a National Variable Health Care Premium in order to raise the necessary federal revenue to finance the implementation of the Committee's recommendations.
- Recommends that the federal government determine an earmarked revenue source which would fund the federal share of CHST for health care.
- Recommends that the federal government in collaboration with the provinces and territories establish on a permanent basis The Committee on Public Health Care Insurance Coverage with a mandate to review and make recommendations on the set of services that should be provided under the public health care system.
- Recommends that federal legislation enact the National Health Care Guarantee.
- Recommends that the principle of public administration of the Canada Health Act be maintained for publicly insured hospital and doctor services
- Recommends that the principle of public administration under the Canada Health Act be clarified to make explicit that the principle applies to the administration of public health care insurance and not the delivery of publicly administered health care services.

A Prescription for Sustainability (2002).

Author: Canadian Medical Association

Year: 2002

Subject: National Health System

Sub-topics:

Source: Canadian Medical Association

Background:

The report *A Prescription for Sustainability* was the CMA's the last of three submissions made to the Commission on the Future of Health Care in Canada. The first report, entitled *Getting the Diagnosis Right*, provided background on the state of the Canadian health care system. This was followed by an interim submission, entitled *Getting It Right*, outlining some of the broad choices that, in the CMA's opinion would have to be made to help stabilize medicare and make it sustainable in the long term.

Purpose:

The CMA proposes 5 recommendations involving the implementation of three integrated “pillars of sustainability” that together will improve accountability and transparency in the system. These pillars would also serve as the basis for addressing the many short- to medium-term issues facing medicare today and into the future. To this end, the CMA put forward 25 recommendations suggesting specific “hows” for solving critical problems affecting the health care system.

Issues and Findings:

The primary thrust of the CMA submission is that the current health policy decision-making system is fundamentally flawed. It advocates three steps which must be taken to refocus the system on the health of Canadians. The three inextricably linked “pillars of sustainability” are long-term structural and procedural reforms needed to improve accountability and transparency and, which it views as key to the overall sustainability of the system. These “pillars” are: a Canadian Health Charter, a Canadian Health Commission, and a renewal of the federal legislative framework. Beyond these structural and governance questions the report identifies several other changes required to meet specific needs within the system in the short to medium term. The CMA report thus provides specific recommendations in the areas of stakeholder input and accountability, defining the public health system (e.g. core services, a “safety valve”, Public Health, aboriginal health), strategic investments in the health care system (e.g. human resources, capital infrastructure, surge capacity, information technology, and research and innovation), health system financing and the organization and delivery of services (e.g. consideration of the full continuum of care, physician compensation, rural health, the private sector, the voluntary sector and informal caregivers).

The report commences with an overview of the problems afflicting the system for which organizational and structural changes are necessary. Shortages of providers, poor access, resource constraints and passive privatization that occurred through most of the 1990s have combined to create uncertainties around the scope of coverage and the standard of care Canadians can expect from their health care system. The CMA argues that these uncertainties that accompany unplanned changes have also had a deleterious effect on the Canadian economy and a demoralizing effect on the health care community. A clarification of the social contract for health is required at the highest level. Having examined the relevant legal, political and health policy considerations, the CMA proposes the development and formal approval of a Canadian Health Charter. The Canadian Health Charter would reaffirm the social contract that is medicare and acknowledges the ongoing roles of governments in terms of overall coordination and health planning. The Charter would set out the accessibility and portability rights and responsibilities of residents of Canada and the rights and responsibilities of the governments, providers and patients in Canada. The Canadian Health Charter would set out the requirement for national planning and coordination based on such principles as collaboration, evidence-based decision-making, stable and predictable funding, regional and local flexibility, and accountability. It could also specify areas where national planning and coordination are required, particularly with respect to the determination and

regular review of core health care services; the development of national benchmarks for timeliness, accessibility and quality of health care; health system resources including health human resources and information technology; and the development of national goals and targets to improve the health of Canadians. Additionally, the Charter would also provide for the creation of a Canadian Health Commission to monitor compliance with and measure progress towards charter provisions, report to Canadians on the performance of the health care system, and provide ongoing advice and guidance to the Conference of Federal–Provincial–Territorial Ministers on key national issues.

The CMA report notes that what is evident after a decade of attempts at reform and the release of numerous federal and provincial commissions, task forces and advisory bodies is that strategic health planning in health is an ongoing process. The report concludes that a permanent, depoliticized forum at the national level is required to both provide national oversight and to open the decision-making process up to providers and consumers. The national body that the report envisions would be permanent, at arm's length from governments and have the freedom to conduct research and advise governments on a broad range of health and health care issues. However, it should also maintain close links with government agencies such as the Canadian Institute for Health Information and the Canadian Institutes for Health Research to facilitate its work. The Commission should be open and transparent to remove decision-making from what it terms the “black box of executive federalism.” The composition of the Commission should reflect a broad range of perspectives and expertise necessary to fulfill its mandate including representation from the public and stakeholders. Although the Commission would be established by the federal government, its structure, composition and mandate will have to be legitimate in the eyes of provincial and territorial governments. The Commission should be chaired by a Canadian Health Commissioner, who would be an officer of Parliament (similar to the Auditor General) appointed for a five-year term by consensus among the federal, provincial and territorial governments. The Commissioner would be afforded the powers necessary to conduct the affairs of the Commission, such as the power to call witnesses before hearings of the Commission. The Commission's mandate would include monitoring of the Canadian Health Charter, report annually on the performance of the health system and the health status of the population, advise the Federal-Provincial-Territorial Ministers of Health on critical questions such as defining the basket of core services eligible for public financing, establish national benchmarks for timeliness, access and quality, the planning and coordination of resources at the national level including human resources, technology and infrastructure, develop national targets and goals for population health.

Flowing from the creation of the Canadian Health Charter will be a number of moral and political obligations directed at the federal, provincial, and territorial governments, providers and patients. One of the main purposes of the Charter is to reinforce the national character of Canada's health system. The CMA recommends that the federal government undertake a review of the *Canada Health Act* with the view to amending it to reflect the Canadian Health Charter. Although the CHA has been a lightning rod for several federal–provincial–territorial disputes over the years, the reasons for these disagreements have had more to do with politics than with the substance of the act. In

fact, if there is one public policy issue in Canada over which there is near unanimity across provinces and territories and across political parties, it is that the principles of the CHA are sound. Recently, federal, provincial and territorial governments agreed to establish a formal dispute avoidance and resolution mechanism to deal more openly and transparently with issues arising from the interpretation of the *Canada Health Act*. The CMA calls for the establishment of a process at the national level to determine and review regularly the basket of core services in an open, transparent and evidence-based manner. The CHA should be amended to provide for such a process. This would include changing the preamble to ensure that it reflects a modern vision and values of Medicare, provides for a Canadian Health Commission, recognizes the federal role and reflects the accessibility and portability rights of Canadians.

The report argues that cash transfers must be increased if the federal government is to be considered a credible partner in medicare. A larger and continuing federal role in health care financing is required, and the allocation of funds must be done more transparently and in support of a long-range planning. A first necessary step is increased transparency in federal funding for health care. As a result, the CMA suggests that federal government transfers for health must be disentangled from the CHST. Canadians have a right to know how much of their federal tax dollars is being transferred to provinces and territories to support medicare. It also recommended that the federal government's contribution to the publicly funded health care system be harmonized with the five-year review of the federal equalization program and be locked-in for a period of five years, with an escalator tied to a three-year moving average of per capita GDP. Federal contributions would rise to a target of 50% of provincial/territorial per capita health spending for core services and provide for notional earmarking of funds for health. That the federal government create special purpose, one-time funds totaling \$2.5 billion over five years (or build on existing funds) to address pressing issues in the following areas: health human resources planning, capital infrastructure, information technology, accessibility fund. Other recommendations included the creation of a blue ribbon panel of Parliament to work with the Canadian Health Commission to review the current provisions of federal tax legislation with a view to identifying ways of enhancing support for health policy objectives through tax policy. For example, the report suggests that tax incentives could be used to improve access to private supplemental insurance, or be used to address health human resource issues (e.g., attracting physicians and nurses to rural and remote areas, off-setting high costs of medical education, promoting continuing education). The level of support provided by the tax system for people facing high out-of-pocket expenses is a particularly pressing question.

No country in the world has been able to provide first-dollar coverage for timely access to all services. In light of the rapidly transforming delivery system with its shift from institutional to community-based care, a re-examination of the Medicare "basket" is overdue. Since the inception of medicare, core services have generally been understood to be those subject to the five program criteria set out in the *Canada Health Act*. However, as health care delivery has evolved, more and more services have migrated out of the hospital setting, effectively reducing the relative size of the basket of core services. For example, while hospital and physician expenditures accounted for 56% of total health

spending in 1984, by 2000 this had declined to 45%. If medicare is to remain relevant and sustainable then the notion of core services must be changed to cover an array of services consistent with the realities of health care in the 21st century. The process used to determine core services should be inclusive and transparent. Decisions should be evidence-based and not biased in favour of any single provider or setting in which care is provided.

The CMA report notes that if the basket of core services is to be expanded beyond its current conceptualization, then given limited fiscal resources and political priorities, governments will likely not be able to afford first-dollar coverage for an expanded set of core services. Without additional funding, resources will have to be reallocated from hospital and physician services to finance other services added to the basket. Rather the report suggests a different approach to funding core services. Under this approach, health services would be divided into three categories: those that are exclusively publicly funded, those that are partly publicly funded, and those that are exclusively privately funded. The services in the first two categories would be defined as core services. As discussed earlier, the basket of core services would be determined and regularly updated by a legitimate, multistakeholder group using an evidence-based process; it should no longer be defined on the basis of whether the services are 100% publicly financed. If core services are redefined to include services that are currently financed through a mix of private and public funding, then Canadians must be prepared to review the use of first-dollar coverage to ensure that it is applied where it is most needed to maintain access to core services. Uniform terms and conditions for core services with mixed private–public funding must also be developed, i.e., by defining the minimum level of public funding from all provinces and territories. In addition, patient cost-sharing arrangements for core services must be consistent across provinces and territories. And so the CMA report recommends that universal coverage for a basket of core services under uniform terms and conditions is maintained but that the scope of those core services be determined and be updated regularly to reflect and accommodate the realities of health care. It recommended that the scope of core services be determined and regularly updated by a federal provincial-territorial process that has legitimacy in the eyes of patients, taxpayers and health care professionals. Additionally, it recommends that governments develop a new framework to govern the funding of a basket of core services with a view to ensuring that Canadians have reasonable access to core services on uniform terms and conditions in all provinces and territories governments, providers and patients are accountable for the use of health care resources no Canadian is denied essential care because of her or his personal financial situation.

A common frustration in recent years among many physicians and patients has been the lack of any recourse or alternative care in Canada when the publicly funded health system fails to provide timely access to health care. The first step in addressing these issues is to define core services. The second step is to establish guidelines and standards around quality and waiting times that are evidence-based and that patients, providers and governments consider reasonable. The CMA report recommends the development and application of agreed upon standards for timely access to care, as well as provide for alternative care choices in Canada or elsewhere, if the publicly funded system fails to

meet these standards. That the following approach be implemented to ensure that governments are held accountable for providing timely access to quality care.

Other recommendations advanced in the report involved establishing a \$1 billion, five-year Health Resources Education and Training Fund to increase enrolment in undergraduate and postgraduate medical education and expand the infrastructure of Canada's 16 medical schools in order to accommodate the increased. And the creation of a national body comprised of stakeholders and government representatives to develop integrated health human resource strategies, provide planning tools for use at the local level and monitor supply, mix and distribution on an ongoing basis. The federal government would also be called upon to provide a one-time catch-up fund to restore capital infrastructure and engage in public-private partnerships as a source of funding for ongoing capital infrastructure investment needs. Included would be an additional ongoing investment in information technology and information systems, with the objective of improving the health of Canadians as well as improving the efficiency and effectiveness of the health care system.

Major Recommendations:

- Recommends the adoption a Canadian Health Charter setting out the accessibility and portability rights and responsibilities of residents of Canada and the rights and responsibilities of the governments, providers and patients in Canada.
- Recommends that a permanent Canadian Health Commission be established and operate at arm's length from governments.
- Recommends that the federal government undertake a review of the *Canada Health Act* with the view to amending it.
- Recommends that the federal government's contribution to the publicly funded health care system be harmonized with the five-year review of the federal equalization program and with an escalator tied to a three-year moving average of per capita GDP.
- Recommends federal contributions rise to a target of 50% of provincial/territorial per capita health spending for core services and provide for notional earmarking of funds for health.
- Recommends the federal government create special purpose, one-time funds totaling \$2.5 billion over five years to address pressing issues in health human resources planning, capital infrastructure, information technology, accessibility fund.
- Recommends that the scope of the basket of core services be determined and be updated regularly by a federal provincial-territorial process to reflect and accommodate the realities of health care delivery and the needs of Canadians.

That the scope of core services should not be limited by its current application to hospital and physician services.

- Recommends that legislation be amended to permit at least some core services to be cost-shared under uniform terms and conditions in all provinces and territories.
- Recommends that once the basket of core services is defined, minimum levels of public funding for these services be uniformly applied across provinces and territories.
- Recommends that Canada's health system develop and apply agreed upon standards for timely access to care, as well as provide for alternative care choices in Canada or elsewhere, if the publicly funded system fails to meet these standards.
- Recommends that governments must establish clear guidelines and standards around quality and waiting times that are evidence-based and that patients, providers and governments consider reasonable. And further, that An independent third-party mechanism must be put in place to measure and report on waiting times and other dimensions of health care quality.
- Recommends that the federal government establish a \$1 billion, five-year Health Resources Education and Training Fund to increase enrolment in undergraduate and postgraduate medical education and expand the infrastructure of Canada's 16 medical schools.
- Recommends that governments and communities make every effort to retain Canadian physicians in Canada through non-coercive measures and optimize the use of existing health human resources to meet the health needs of Canadian communities.
- Recommends the federal government establish a one-time catch-up fund to restore capital infrastructure to an acceptable level.
- Recommends that public-private partnerships (P3s) be explored as a viable alternative source of funding for capital infrastructure investment.
- Recommends the federal government make additional national investments in information technology and information systems.
- Recommends governments adopt national standards that facilitate the collection, use and exchange of electronic health information in a manner which ensures that the protection of patient privacy and confidentiality are paramount.
- Recommends the federal government's investment in health research be increased to at least 1% of national health expenditures.

- Recommends governments work with the provincial and territorial medical associations and other stakeholders to draw on the successes of evaluated primary care projects to develop a variety of templates of primary care models that would suit the full range of geographical contexts and incorporate criteria for moving from pilot projects to wider implementation, such as cost effectiveness, quality of care and patient and provider satisfaction.
- Recommends that family physicians remain as the central provider and coordinator of timely access to publicly funded medical services, to ensure comprehensive and integrated care, and that there are sufficient resources available to permit this.
- Recommends governments develop a national plan to coordinate the most efficient access to highly specialized treatment and diagnostic services.

Building on Values: The Future of Health Care in Canada (2002).

Author: Commission on the Future of Health Care in Canada (Commissioner: Roy J. Romanow, QC).

Year: 2002

Subject: National Health System

Sub-topics:

- Governance
- Financing
- Primary Health Care
- Pharmacare
- Home Care
- Health information and technology
- Health Human Resources
- Rural and remote health
- Aboriginal health care

Source: Commission on the Future of Health Care in Canada

Background:

Announced in April of 2001, the Commission on the Future of Health Care in Canada was formed and commenced an 18 month inquiry into the national health care system. Its formation was the culmination of several years of calls for the establishment of such an independent body of inquiry.

Purpose:

In the preamble to the Commission's terms of reference it is stated that "universal access to quality health services" are to be ensured as are of deep concern to Canadians, as well as, an overriding commitment to the principles of the *Canada Health Act* as confirmed by the provinces in their agreement of September 2000. Within this context, the Commission was asked to "inquire and undertake dialogue" on the future of the "public health care system." Its primary consideration as stated in the terms of reference was the "long-term sustainability of a universally accessible publicly funded health system."

Issues and Findings:

The report begins with an overview of the evolution of medicare and an evaluation of its effectiveness since its inception. Its conclusion is that the "health care system has served Canadians well" in terms of outcomes and as a point of social cohesion. The most pressing issue facing the public health system is sustainability and whether the system is in fact becoming unsustainable and or failing to provide quality and cost-effective health care. In answering this question the report argues sustainability needs to be assessed from the perspective of services, needs and resources. Health care has changed fundamentally since the inception of a publicly funded system, but the availability of services under the public system has not kept pace. At the same time, despite the fact that the public system does not reflect an appropriate mix of services, evidence suggests that in terms of outcomes the system has until now provided Canadians with good value. And finally, in terms of resources, the report argues that from an international perspective Canada's health care expenditures are not out of line with those of other countries and that the Canadian system's reliance on taxation has neither increased costs nor diminished efficiency. The perceived crisis in terms of the sustainability of the public system is largely a product of a decade of under funding, particularly as a result of reductions in transfers from the federal government.

The foundation of the report is predicated upon a renewed commitment to medicare, new approaches to the governance of the health care system, a return to stable and predictable long-term funding and short-term targeted funds to facilitate change in aspects of health delivery and infrastructure that have been undermined by restraint and under funding. In its report, the Commission speaks of the "inability of those charged with the governing the system to handle and resolve their differences. Continued disagreements among those charged with the governance of the system threaten to create a disparate set of systems with differing services, coverage and financing arrangements. In particular, the federal government has attempted to maintain its role as the defender of medicare's national principles while reducing its share of the risk in managing increasing costs within the system. This leads to a series of recommendations related to the governance of the health

care system. The report begins by recommending a new Health Care Covenant. The value of the Covenant is that it would reflect the consensus of Canadians to set of identified values and expectations formally endorsed by First Ministers. Included among these values and expectations are the principles of universality, equity, solidarity, responsiveness, personal responsibility for maintaining individual health, efficiency and accountability.

As noted in the report, federal, provincial and territorial governments share responsibility for various aspects of the health care system. However, the ability of governments to work within a cooperative framework has been impeded by a number of high profile disputes between governments which have underscored the inadequacies of existing intergovernmental coordination. Since no government has clear constitutional responsibility for health care there is a lack of visibility with respect to which order of government is accountable for addressing specific problems. The report notes that while intergovernmental debate has the potential to further national goals, in health care this has broken down into intergovernmental conflict and dysfunctional relationships. The Commission also suggested that the existing machinery of intergovernmental coordination is ineffective and cumbersome. Additionally, the system has lacked clear and consistent leadership as both elected officials and senior bureaucrats frequently change. To provide continuity in leadership, impartial assessment of system performance and depoliticize and streamline the intergovernmental process, the Commission recommended the establishment of the Health Council of Canada. The Council's board, the report suggests, should be comprised of both provincial and territorial representatives, representatives of the federal government, as well as, representatives from the public and provider and the expert community. The Health Council would establish common indicators of system performance, establish performance benchmarks for system performance, collect and disseminate information and coordinate existing activities in health technology assessment. It would also provide long-term advice and coordination in transforming primary health care; developing strategies for Canada's health workforce, and resolving disputes under the *Canada Health Act*.

The Commission notes that while the five principles of medicare were initially simple conditions attached to federal funding, they have come to represent the fundamental values Canadians attach to publicly funding health care. In particular, the principles of public administration, universality and accessibility under the *Canada Health Act*, it notes, "are as relevant and necessary today as they were when first introduced" (60). Other principles such as comprehensiveness and portability need to be revisited because they no longer reflect the evolution of the health system. Defining comprehensiveness as necessary hospital and physician services has limited the system from keeping pace with other modes of health care delivery and technological change. The report also recommended updating the *Canada Health Act* as part of its redefining of the governance structure of the health system. It notes that Canadians should have the right to know how the system is being administered, financed and delivered and which order of government is responsible for different aspects of the health care system. To this end the Commission recommended the *Canada Health Act* be "modernized and strengthened" by confirming the principles of public administration, universality and accessibility, update the

principles of portability and comprehensiveness, and establish a new principle of accountability. It also recommended that the definition of “insured services” be expanded to include targeted home care services and consider inclusion of prescription drugs. Additional recommendations included clarifying diagnostic services under the *Canada Health Act*, provision of a formalized dispute resolution mechanism and reasserting the link between health transfers to provincial and territorial governments and the principles and conditions of the Act.

Arguments over the relative share of health care costs borne by either the federal government or the provinces has diverted attention from the fact that the health systems evolution and continued sustainability is predicated on a significant federal presence. Decades of reductions in transfers for health have undermined the original basis of what the report describes as the “medicare bargain.” The Commission focused on the cash component of federal transfers and concluded that despite the debates of the past several years it was clear that the original bargain required a federal cash contribution of at least 25% of those services covered under the *Canada Health Act*. The Commission therefore recommended the creation of a new dedicated transfer for health separated from the existing CSHT. The cash transfer would immediately improve the visibility of fiscal arrangements between the federal government and the provinces. The report suggested an injection of federal dollars to bring the federal share of provincial expenditures on *Canada Health Act* services to the 25% level. Furthermore, the report suggested that the new Canada Health Transfer be written into a revised *Canada Health Act*, in order to once again link federal transfers to conditions. Additionally, the Commission recommended that the new transfer include some escalator formula linked to actual health care costs and gross domestic product.

In the short term, however, the Commission recommended a series of immediate targeted transfers to address what it considered areas of immediate concern. These included funds to establish a Rural and Remote Access Fund, Diagnostic Services Fund, Primary Health Care Transfer, Home Care Transfer and Catastrophic Drug Transfer. These funds it indicates are designed to promote change. As such, these transfers would be contingent upon provincial and territorial governments agreeing to meet federal conditions related to establishing programs or delivering services under the terms of the funds. These transfers would extend over a five year term before being rolled into the proposed Canada Health Transfer.

Primary health care, the report notes, has been universally seen as an absolute priority in reform of the system. “There is reason to believe,” the Commission writes, “that primary 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” (116). The report acknowledges that primary health care reform is essential in transforming the health care system. Despite widespread agreement about the benefits of primary care reform the Commission notes that after 30 years of discussion it remains in the pilot project stage. Obstacles to the reform of primary care include the system’s predominant focus on traditional hospital and physician-based care practices. Primary care development with its emphasis on flexible working arrangements runs counter to trends within health of

increasingly specialized health care providers and a tradition of protecting scope of practice. The integration of services and continuity of care sought by primary care runs counter to a health care delivery culture based on “silos” in which service delivery is fragmented. Other obstacles identified in the report include a lack of health information, a provider and institutional focus to the system and a lack of emphasis on disease prevention and health promotion. These obstacles have not been overcome by the rigid primary care models that have been developed. To overcome these obstacles, the report recommends the proposed Primary Health Care Transfer be used to “fast-track” primary health care implementation with funding conditional upon provinces and territories moving ahead with primary health care along a set of proposed “building blocks”. These building blocks include: continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to achieve change. The building blocks are designed to allow maximum flexibility for provinces to design and implement primary care initiatives that fit individual circumstances.

Despite not being defined a “medically necessary service” home care has expanded rapidly in the last two decades at the provincial and territorial level because of the cost effectiveness of providing appropriate care in non-institutional settings. The report indicates that a number of factors will likely increase the demand for home care services. Advances in medical treatments, prescription drugs and technology will allow for treatment outside of institutional settings. Primary health care reform and networks of health providers will allow for case management and monitoring within the community. A growing elderly population is likely to increase demands for access to home care services. Existing trends toward early discharge from hospital settings, also brought about as a result of treatments, therapies and technological advances will continue. Because home care services are not funded under the definition of “insured services” by the *Canada Health Act*, there is considerable variation in the range and coverage of home care programs at the provincial and territorial level. This includes variation in scope of coverage and methods of financing home care delivery. These disparities coupled with increased demand suggest that significant home care needs may go unmet even while provincial home care costs continue to rise and become increasingly significant components of provincial spending. The Commission report acknowledges however that significant costs would be involved in simply expanding the definition under the *Canada Health Act* to include all home care services. As a result, the report recommended inclusion of targeted home care services under the definition of “insured services.” These targeted programs would include post acute home care services, palliative home care and home mental health care management programs. The Home Care Transfer would be used to develop these programs where they are not already accessible and to offset the costs of these programs in provinces that already meet the conditions for the transfer.

The report notes that Canada has a fragmented system of prescription drug coverage and that access is largely determined by income, employment and variations in provincial drug plans. As with home care services, the Commission notes that prescription drugs should be defined as medically necessary and therefore integral to a comprehensive health system. Two critical issues emerged in the report: first was the need to improve access to prescription drugs and remove financial barriers, and the second, was to

improve quality and cost-effectiveness. The potential benefits of prescription drugs can be realized only if they are integrated into the system in a manner that ensures appropriate prescribing and costs can be managed. The Commission's primary recommendation call for establishing a Catastrophic Drug Transfer to be used to reduce disparities in drug coverage across the country by assuming a portion of the growing cost of provincial and territorial drug plans. The recommendations are designed to take the first step toward integration of prescription drugs into the health care system. The new Catastrophic Drug Transfer would offset provincial and territorial drug plans and reduce disparities in coverage across the country. Other recommendations related to expanded coverage of prescription drugs included the establishment of a new National Drug Agency to control costs, evaluate new and existing drugs and ensure the quality, safety and cost effectiveness of all prescription drugs. It also recommended the establishment of a national formulary to provide consistency across the country and conduct objective assessments of new prescription drugs.

Identified as improving access and quality, Chapter Six of the report acknowledges and addresses the issue of public concern with respect to wait times for both diagnostic and treatment services. Despite the preoccupation with the issue of waiting times the report acknowledges that precise information concerning access to services is incomplete. What the Commission did conclude was that there were priorities for action with respect to waiting times for diagnostic services and the need to expand availability of these services. However, it also acknowledged that technology assessment would be required to ensure that adopting new and emerging technologies was done in a cost-effective manner. The Diagnostic Services Fund should be used to shorten waiting times for diagnostic services. Additionally, the report recommends coordination of efforts to develop and implement wait list management programs. This would also include increased efforts to measure and assess performance in terms of waiting times for all services and report these on a regular basis to Canadians. Related issues addressed by the Commission included the need for improved health information and research. It recommended the establishment of personal electronic health records for each Canadian in conjunction with efforts already undertaken by provincial governments. This would provide health care providers, researchers and policy makers with information to guide decision-making. Expand the scope, effectiveness and co-ordination of health technology assessment. Increase health research spending by creating four research Centres for Health Innovation to address gaps in applied research in important areas of the health care system including priority areas defined by the Commission in rural and remote health, health human resources, health promotion and pharmaceutical policy.

Major Recommendations:

- Recommended the creation of a “Canadian Health Care Covenant” to be agreed upon by all First Ministers.
- Recommended the establishment of the “Health Council of Canada” by collaboration between provincial, territorial and federal governments. The Health Council would establish common indicators of system performance, establish performance benchmarks for system performance, collect and disseminate information and coordinate existing activities in health technology assessment.

The Health Council would provide long-term advice and coordination in transforming primary health care; developing strategies for Canada's health workforce, and resolving disputes under the *Canada Health Act*.

- Recommends the *Canada Health Act* be modernized and strengthened by confirming the principles of public administration, universality and accessibility and updating the principles of portability and comprehensiveness, and establishing a new principle of accountability.
- Recommends expansion of the definition of insured services under the Canada Health Act to include targeted home care and eventually pharmacare.
- Recommends that funding for health care be more explicitly linked to the principles and conditions of the Canada Health Act and that an effective dispute resolution mechanism be created.
- Recommends the creation of a “cash only” Canada Health Transfer with a built-in escalator formula set in advance for five-year intervals.
- Recommends the development of personal electronic health records in collaboration with provincial and territorial initiatives already underway. Canada Health Infoway should continue to develop a pan-Canadian framework for harmonizing provincial systems.
- Recommends the proposed Primary Health Care Transfer be used to “fast-track” primary health care implementation with funding conditional upon provinces and territories moving ahead with primary health care along a set of proposed “building blocks”.
- Recommends the establishment of a new Diagnostic Services Fund to be used by provincial and territorial governments to improve access to medically necessary diagnostic services.
- Recommends the establishment of a new Rural and Remote Access Fund to be used to attract and retain health care providers, promote telehealth initiatives and support innovative ways of delivering health care services to smaller communities.
- Recommends establishing a new Home Care Transfer to be used to support the expansion of the *Canada Health Act* to include medically necessary home care services in mental health, post-acute care and palliative care.
- Recommends establishing a Catastrophic Drug Transfer to be used to reduce disparities in drug coverage across the country by assuming a portion of the growing cost of provincial and territorial drug plans.
- Recommends the creation of a National Drug Agency to evaluate and approve prescription drugs, develop a national formulary, provide ongoing evaluation of existing drugs, negotiate and contain drug prices and provide comprehensive drug information.
- Recommends that current funding for Aboriginal health services provided by federal, provincial and territorial governments and Aboriginal organizations should be pooled into single, consolidated budgets in each province and territory and used to integrate Aboriginal health care services, improve access, and provide adequate and predictable funding.

- Recommends that the consolidated budgets for Aboriginal health services should be used to fund new Aboriginal Health Partnerships responsible for developing policies, providing services and improving the health of Aboriginal Peoples.

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