Project Research Paper

A Cross-Provincial Study of Health Care Reform in Canada

Grey Literature Review: Synthesis Paper

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Introduction

Standing apart from the general academic health policy literature are the multiple systemic studies of the health care system. These system-wide studies have become vastly more numerous in the last two decades both at the provincial/territorial level and at the national level (most recently). The most common of these are the commissions, task forces and advisory committee's struck by provincial governments seeking advice on major reforms to provincial health care delivery systems. Less common have been federally commissioned reports and an additional body of grey literature exists in the form of reports or studies produced through non-governmental organizations (IRPP) or through stakeholder groups in the health care field (CMA). Between the mid to late 1980s and the present virtually every province has commissioned a system wide study and sought recommendations for reform.

Clearly these reports serve a political purpose and their frequency can be explained in part as highly visible public policy exercises by governments. This may in part explain why two relatively distinct "waves" of provincial reports can be identified; the first set emerging in the mid to late 1980s and early 1990s amidst economic recession and fiscal restraint and a second emerging in the late 1990s and early part of the present decade as these fiscal pressures eased somewhat. In several provinces, most notably in Alberta, Saskatchewan and Québec, there have, in fact, been multiple system-wide analyses conducted within a span of a little more than a decade. The most recent of these provincial reports or inquiries are often distinct in their focus, objectives and recommendations for health care reform and thus can shed light on a decade of thinking among policy makers. They have, however, at times, also reiterated the work of previous commissions and inquiries conducted within the same jurisdiction leading to speculation as to whether earlier recommendations were either unfulfilled or misguided in terms of their focus or objectives. For example the Fyke Commission was obliged to make further recommendations to fine tune the governance structure and the organization of acute care services reminiscent of the recommendations of the Murray Commission report of the late 1980s. Parallels can be drawn in Alberta between the Mazankowski report and its calls for increasing consumer choice and an expanded role for the private sector, which echo recommendations contained in the earlier Rainbow report. And in Québec, between Clair and the Rochon Commission, both of which attempted to clarify the roles and responsibilities of CLSCs. Of note, with very few exceptions later reports do not generally acknowledge the work of their predecessors.

While there were noticeable shifts in emphasis between earlier and later reports within jurisdictions, there were significant parallels to be drawn between recommendations made by reports conducted across jurisdictions. Reports of the late 1980s and early 1990s, for example, emphasized decentralized decision making and regionalized service delivery. While decentralization and regionalization were hailed in various reports as the means to improved responsiveness, accountability and integration there was an overriding theme commonly shared within the reports that viewed regionalization as key to improving efficiencies within health care delivery and thereby reduce costs and containing expenditure growth. With relatively few exceptions the focus of these early reports is dominated by issues related to cost containment, cost-effectiveness and efficiency and subsequently with regionalization, deinstitutionalization (shifting care from expensive institutional settings) and hospital restructuring (combating over-institutionalization and excess capacity). While certainly not corollary objectives, in the hierarchy of overarching immediate objectives, comprehensiveness, accountability, improved quality, system integration and so on are viewed as long-term objectives to be realized as a

consequence of rationalization. Thus, while these reports advocate a more patient centred (needs-based funding), evidence-based (outcome and performance measurements), and comprehensive (pharmacare, home care, primary health care) health delivery system, organizational change is facilitated first and foremost by structural change.

By no means uniform in their stated goals and objectives, reports of the late 1990s and beyond have display similarities in their emphasis on advancing primary health care, revisions to the governance structure, the development of health and management information systems, financing arrangements, health human resources, wait-list management, coverage (both expanding and restricting) and the role of the private sector. Common themes emerging from these reports stress long-term sustainability (as opposed to immediate and short-term cost containment), an increasing focus on accountability and transparency, and issues related to access and quality. With relative consistency primary health care has increasingly been seen as viewed as a fundamental next step in health care delivery reforms and the "foundation" of the health care system. This is closely followed by clarifying lines of responsibility within the governance of the health system and to increasingly make interrelationships between providers, health authorities and governments more precise, and in many cases, more contractual in nature.

There are thus observable shifts in stated goals, objectives and recommendations between provincial reports emerging in the late 1980s and early 1990s and those of the last five or six years. Clearly, one explanation is that earlier reforms were largely implemented or successful in accomplishing stated goals. For example, by the late 1990s most jurisdictions had established regional structures, rationalized hospital services, took steps to reduce physician supply or otherwise restrained insurance plan expenditures. In fact, it is reasonable to suggest that by the mid-1990s many of the structural reforms in aid of cost reduction had been undertaken. Others have simply been abandoned, attempts to reduce physician supply for instance were common in a number of jurisdictions and moves were made to reduce medical school enrollments. However by the late 1990s, these policies had been reversed and recommendations related to health human resources were unanimous in their calls for incentives to combat shortages of both physicians, as well as, other health care professionals. But there are clearly indications to suggest that the anticipated results of structural reforms did not materialize. For example, while regional structures were adopted there is evidence to suggest that decentralization did not achieve stated objectives. Acute care capacity was reduced in most provinces but supportive services such as primary health care or home care had not developed in the vacuum created by shifting services away from institutional settings. Later reports are characterized by an emphasis on management and accountability structures both because of the political consequences of cuts and recognition that the system will not automatically respond in anticipated ways simply by cutting off the flow of resources.

National studies have been more frequent in the later part of the decade. For instance, until the mid-1990s and the National Forum on Health, no independent, federally sanctioned system-wide analysis had been conducted, but since 1997 there have been reports composed by the National Forum on Health, the Standing Senate Committee on Social Affairs, Science and Technology and by the Romanow Commission. For much of the decade there had been an acknowledged reluctance exhibited by federal authorities to commission such inquiries but this had clearly changed by the later part of the decade. A number of factors may explain this sea change. For example, the same easing of fiscal pressures at the federal level created space on the political agenda for health care reform which had been crowded out previously by deficit

reduction. Another is that public perceptions of structural reforms and cost-cutting have reached a critical mass and have forced their way onto the policy agenda.

In part, this analysis was undertaken to determine whether or not the perception that the pace of health care reforms has been slow or only modestly successful is either explicitly or implicitly acknowledged by decision-makers. In short, do these successive attempts to reform the health care system address the slow rate of change and acknowledge either past failures or impediments to real systemic change not adequately addressed or accounted for during past attempts. In specific areas of health reform commentary has been quite explicit, for example, the Kirby Committee addresses perceived barriers that have prevented the full development of RHAs. The Romanow Commission hints that primary care reform has been slow to develop because of existing interests and a lack of political will to challenge the status quo.

Selection Criteria and Methodology

Generally, included as part of the examination are the final or summary reports, including executive summaries, progress reports, and some discussion papers and background studies for the various reports. Generally, all task forces have been considered for this list, both department- and minister-initiated, joint-jurisdictional, those of mixed origin, including hybrid governmental and non-governmental, and strictly non-governmental, such as those struck by associations.

The reports included for analysis were chosen because of their comprehensiveness. Reports focusing on particular sectors or aspects of health care delivery were excluded from consideration for the purposes of this analysis, although the report of the Ontario Hospital Restructuring Committee was included in order to have a sample of government commissioned reports for each of the project's provincial case studies. The analysis, however, is not complete but merely a sampling of grey literature as a basis of comparison between jurisdictions and within jurisdictions over time to gauge the evolution of policy development as captured or informed by such studies.

The approach taken was to assess the reports in terms of their diagnosis, defined policy objectives emanating from that diagnosis, elaborated policy objectives or underlying assumptions about where the system is inappropriately focused, how the reports seek to realign policy focus through major recommendations and, finally, identify the levers of change through which system reform is primarily directed. The reports were assessed in terms of the analysis of the health systems under observation and their identification of perceived inefficiencies or inadequacies to existing health care delivery or of their assessment of perceived barriers or impediments to reform or of previous attempts at reform. Following from the diagnosis, the reports were then analyzed in terms of where the reports focused recommendations. For comparison purposes these were narrowed down into specific categories: financial, jurisdiction and governance, delivery organization or programming. Recommendations from the reports were assessed in terms of priority. Typically, major recommendations were identified in the report as being "fundamental" or "key" to the foundation of subsequent reforms. Recommendations were ordered in terms of priority to match stated policy objectives with key recommendations. And finally, policy levers or policy choices reflect through what mechanisms policy change is to be realized. As with policy objectives, levers for change or policy choices reflected in the recommendations were categorized in terms for comparison purposes. These categories included: institutional changes required, resources, financial, organizational, ideational, interest groups or stakeholders. Institutional changes reflected recommendations for significant changes to existing legislation or governance structures. Resources incorporate recommendations that focus on

distribution of existing health human resources, institutional capacity and so on. Financing is distinguished from existing resources to highlight instances in which recommendations are driven primarily as a result of increases or restraint in terms of allocation mechanisms or funding mechanisms. Organizational change reflects a focus on changes to delivery mechanisms or through an emphasis on aspects of service delivery. Ideational choices are intended to reflect attempts to alter behaviour or consumer expectations or operational assumptions about public policy. And finally, interest groups and stakeholders reflect those recommendations through which change is largely driven by an accommodation with organized interests, for example, professional associations (see appendix).

Provincial Reports

(See Table 1: Provincial Reports 1988 to 1991)

Mandates

The allocation of resources within provincial health systems dominates the mandates of many of the reports commissioned. Invariably the various commissions, task forces and advisory councils were to examine the funding of health services and evaluate and make recommendations to improve resource allocation. Several provincial reports focused their inquiries on recommendations concerning the use and demand on the health care system. In a number of provinces this was specifically related to the issue of financing and was asked to study the factors influencing the supply and demand for services. Based on these evaluations they made assessments concerning current levels of financing and to 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. The mandate of both the Rochon Commission in Québec and the Gallant Report in Nova Scotia were both heavily focused on examining the costs of the health care delivery system and recommendations to reduce costs while maintaining effectiveness.

Focus and observed policy levers

As the table above indicates, the central focus of provincial reports by the governments of British Columbia, Alberta, Saskatchewan and Nova Scotia was on decentralization and the creation of regional authorities. The decentralization of decision-making authority becomes the organizing principle upon which health care reform is to be driven. In Québec regionalization had already been well under way but much of Rochon was devoted to clarifying the budget allocation process for regional boards including making regional authorities responsible for budgetary surpluses and deficits. In some jurisdictions decentralization and regionalization with their attendant focus on accountability and local decision-making is a necessary governance change for rationalizing acute care delivery.

Centralized control provided little incentive for providers to participate in the management of service delivery since all relevant decisions including budgeting are made elsewhere. The budgeting process was generally viewed as the primary instrument for rationalizing the existing health care system. This is accomplished first, by making the system accountable through 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. In all instances while the allocation of resources was

left to individual regions, funding levels were still controlled by the individual ministries and departments.

Hospital restructuring and an overall concern with moving the system away from institution-based care is most often rationalized on the basis of cost-containment, cost-effectiveness and efficiency grounds. In the case of Saskatchewan, Ontario and Nova Scotia there hospital restructuring is also part of efforts to move toward more cost-effective methods of treatment including primary care reform but in virtually all instances over utilization, demographic change and changes in clinical practice and technology are seen as primary factors in allowing for a reduction in the number of available beds and closures and consolidation of hospital services. The most significant cost-driver in all jurisdictions in acute care delivery and with a cost-containment emphasis to all the reports hospital restructuring is key to reduction of overall costs.

Predominating discussions regarding health human resources issues are physician remuneration and supply issues. As with hospital expenditures, provincial insurance plans are significant cost-drivers within provincial health systems. In most jurisdictions fee-for-service payment is seen is an inappropriate incentive in those provinces where regionalization and community-based or primary health care figure prominently. In those jurisdictions fee-for-service payment is an impediment to larger system reform. While restraining expenditures of medical insurance plans is at least part of the focus of the analysis of physician services in most of the reports, in BC and NS, these jurisdictions sought to explicitly limit physician supply and access to billing numbers. Only in Alberta was there a significant emphasis on physician recruitment and retention issues with a concern for the under supply of health providers in general. Saskatchewan, Québec and Nova Scotia raised concern to a lesser extent with respect to the under supply of physicians and other health care providers in rural and remote communities.

Physician remuneration issues are highly significant in the report of the Ontario Task Force on the Use and Provision of Medical Services which was a collaborative study between the Ministry and OMA. While the report expressed an ongoing interest in alternate payment schemes these were to be explored in greater detail in subsequent negotiations. The real emphasis on fee-for-service billings was over the issue of clinical practice guidelines and establishing standards. The Rochon Commission also placed significant emphasis on the development of practice guidelines as part of an overall emphasis on evidence-based decision-making throughout the system.

All jurisdictions express concern over the lack of relevant health information upon which decisions affecting the health system are to be made, particularly with respect to resource allocation decisions. However, while many jurisdictions openly speak of evidence-based decision making and improved data collection only in Ontario, Québec and Nova Scotia is the development of such systems treated as major component of provincial health system reform. In Ontario, the development of clinical practice guidelines dominates concern over relevant health information systems. In Nova Scotia, the emphasis is on “better management” and information systems better management by regional managers or hospital boards in the allocation of financial and human resources. Only in Québec is a fully comprehensive health information system seen as necessary for developing system-wide goals and clinical guidelines and technology assessment.

Primary health care in these earlier reports is often a corollary to either shifting resources away from institutional-based care or as a function of strategies for health human resources policies. Of note, very few practical models of primary health care emerge, although multi-

disciplinary team approaches are explored, particularly in Saskatchewan, Québec and Nova Scotia.

Deinstitutionalization and the shifting of care from more expensive institutional settings and hospital restructuring through closures, conversion and the amalgamation of institutional boards and in most respects to reduce capacity was designed to address the predominant cost-drivers in the system and force the system into alternate models of care. Regional authorities would as a consequence would, so the reports largely presume, expand community-based programs and become the source of innovation within the health system. In short, these earlier reports are far more detailed and implementation specific in their recommendations on decentralization and rationalizing acute care delivery at the institutional level and questions related to overall system efficiency and cost-control than for issues such as comprehensiveness, accountability, improved quality, system integration.

Provincial Reports: The Next Generation

(See Table 2: Provincial Reports 2000 to 2002)

Mandates

Of note, the mandates of the various reports issued in later reports were dominated by assessments of the sustainability of the public health care system. Earlier reports did not focus on the long-term sustainability of public systems but with more immediate and short term estimates of the adequacy of existing funding levels and with restraining expenditure growth. Specifically, 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.

Focus and observed policy levers

Where cost-containment, rationalization and deinstitutionalizing the system are overarching themes pervading earlier reports, this second generation of systemic reviews focus on long-term sustainability, access, quality and performance issues.

Where decentralization and regionalization dominated the earlier reports, fundamental to the restructuring of health care systems in these later reports is the development of primary health care. With the exception of Alberta, the development of primary health care is seen as fundamental to or described as the "foundation" upon which provincial health systems depend. Only in Alberta where financing, wait list management and defining scope of insured services occupy much of the report's attention, is the significance of the primary health care delivery system not highlighted as the basis of reform. A predominant theme of primary health care reform is improved accessibility and quality. Primary health care development is also key to overall concerns with long-term sustainability, with primary care providers acting as the "gatekeepers" to more expensive and specialized secondary and tertiary services.

The health system is "under managed and under measured" was the comment of the Fyke Commission and this is consistent with recommendations from other jurisdictions in their analysis of the governance of the health system. In virtually all jurisdictions there was an imperative to redefine the accountability lines and decision-making structures. Generally this meant focusing on overall strategic planning for the system and an emphasis on performance measurement. In Saskatchewan, Ontario, Québec, and to a lesser extent in Newfoundland, there is a repeated emphasis on centralized strategic planning (the development of system wide goals and targets for the health system) and evaluation and performance measurement of the system.

At the same time, in most jurisdictions while there is a renewed commitment to regional authorities more precise lines of accountability and reporting mechanisms are highlighted between regions and central authorities.

This was not the case in Alberta where the emphasis on governance was to increase the autonomy of regional health authorities and diminish that of the central authority to merely that of "primary, but not exclusive source of funding." Even the evaluative role of the Ministry would be diminished relative to that recommended in other jurisdictions.

Among priorities for health system reform health information systems, performance measurement and evidenced-based decision making was a consistently high on the agenda of later health reports. Health information systems and health data management were seen as necessary infrastructure both to the advancement of primary health care (electronic health records) and for long-range strategic planning efforts and resource allocation. Needs-based or population-based funding mechanisms figure prominently in the analyses with an increased desire to fund regional authorities or institutions based on long-range strategic plans and well developed goals and standards based on defined population health needs.

Making the system more accountable for resource allocation decisions is evident in the extent to which all jurisdictions emphasize performance measurement and reporting mechanisms. Without exception, each jurisdiction recommended some form of public reporting mechanism either through annual performance reports by the relevant ministry or department or through the creation of independent councils or commissions charged with assessing overall system performance including outcomes, cost and population health status.

Recruitment and retention of health providers is a consistent theme among all of the reports. The recommendations do not focus so consistently on physician services but are expanded to include recruitment and retention incentives for nurses and other health professionals. Where some earlier reports recommended limits on medical school enrollments, reports from this period emphasis greater collaboration and coordination between post-secondary institutions to expand training programs.

Because of the relative emphasis the reports place on primary health care delivery, there is an increased sense of universal urgency in the development of alternate payment mechanisms for physicians.

Hospital restructuring continues to be high on the agenda of Saskatchewan, Ontario and Québec. Rationalizing specialized secondary and tertiary care rather than simple concern for an over supply of acute care beds becomes the focal point in Saskatchewan and Québec. The emphasis is on concentrating specialized services in order to improve quality of care. The reorganization of secondary and tertiary care also addresses shortages of specialists and limitations on available high technology diagnostic and treatment services.

While primary health care was the focal point of alternative health delivery modes, home care, palliative care, long-term care as well as the utilization of a mix of alternate health care providers.

In both Alberta and Québec there were calls for a re-evaluation of the scope of insured services. In both jurisdictions a process of continuous review was recommended for defining a list of core services for the publicly insured system.

National Reports

(see Tables 3-6)

Mandates

While federally driven studies of the national health care system have been relatively few and far between, there have been other studies undertaken by national stakeholder organizations and third party organizations that attempted to evaluate the health care system in terms of its national dimensions. These reports have generally focused on the federal-provincial-territorial relationship in funding publicly insured services and in evaluations of national standards for federal financing. One of the earliest of these studies was undertaken by the Canadian Medical Association in the mid-1980s. The task force established by the CMA was specifically mandated to assess the allocation of health care resources in the face of an increasing elderly population and the explosion of new technology. Population aging and technology were anticipated to be the predominant cost-drivers in a system already troubled by a growing debate about the adequacy of its funding.

The terms of reference for the National Forum on Health were not defined in precise terms. It was mandated to "inform and involve Canadians in seeking out innovative ways to improve the health care system and the health of the Canadian population" but was not asked specifically to assess any particular aspect of the national health system. This contrasts with the later mandates of both the Kirby and Romanow Commissions. 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. Specifically, the Committee was to examine the fundamental principles on which Canada's publicly funded health care system is based. 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 and examine the health care systems in foreign jurisdictions for alternate approaches to health care delivery and financing. The focus of the Romanow Commission was even narrower in its mandate by being tasked specifically with an evaluation of the publicly funded health care system, and to recommend policies to ensure over the long term the sustainability of a universally accessible, publicly funded health system.

This increasingly specific focus on the publicly funded system and sustainability was characteristic of other reports as well. The report of the provincial-territorial Ministers of Health was predictably focused on making recommendations for "ensuring the integrity and stability of the publicly funded health system" with special emphasis on the level of federal transfers and the role of the federal government in meeting provincial and territorial health needs. But this was also characteristic of other reports issued by non-governmental and stakeholder groups. As with recommendations contained in both Kirby and Romanow, the Institute for Research on Public Policy's task force had focused on sustainability of the national health care system and specifically with addressing the addressing the relationship between federal and provincial governments both in terms of "funding and leadership."

Focus and observed policy levers

National studies (See Table 7: National Reports) have been more frequent in the later part of the decade. For instance, until the mid-1990s and the National Forum on Health, no independent, federally sanctioned system-wide analysis had been conducted, but since 1997

there have been reports composed by the National Forum on Health, the Standing Senate Committee on Social Affairs, Science and Technology and by the Romanow Commission. For much of the decade there had been an acknowledged reluctance exhibited by federal authorities to commission such inquiries but this had clearly changed by the later part of the decade. A number of factors may explain this sea change. For example, the same easing of fiscal pressures at the federal level created space on the political agenda for health care reform which had been crowded out previously by deficit reduction. Another is that public perceptions of structural reforms and cost-cutting have reached a critical mass and have forced their way onto the policy agenda.

Issues of governance and health financing are inextricably linked in most of the reports, funding of the system is key to addressing both recommendations for system reform, including expansion of coverage into areas like primary care, home care and pharmacare programs and bringing these within the scope of publicly funded services but also to sustaining existing services within the public system. Most of the reports however emphasize changes to governance structures as prerequisite to additional investments or as an accountability mechanism.

Conclusions

- Rationing resources was the instrument for change in earlier reports. It was largely assumed that taking away hospital beds would lead to a leaner and meaner system that would inevitably lead to better utilization of resources and compel regional authorities, health providers and patients to make better choices.
- With immediate and short-term goals achieved (namely cost-containment) and governments largely focused on exogenous factors of deficit reduction, long-term goals identified in health care reform agendas may have been left to languish.
- That accessibility becomes a predominant objective of the system suggests that the short term consequences had a real impact on health care quality. Wait lists and shortages of health professionals. As fiscal pressures at the provincial and federal level eased and governments were no longer given carte blanche in terms of cost containment increasingly the squeezing of health care budgets and constraints on health services grew as a
- The reports reflect this cosmic view of health services reform. That's why the focus on improving access and the need to clarify responsibilities through accountability mechanisms. Things like health councils and performance reporting, health charters and the like.
- What is the instrument for change in later reports? Accountability mechanisms. Public scrutiny I would guess is designed to motivate and provide incentive. It seems evident that governments over-estimated the "spontaneous generation" of organizational changes. Primary health care, home care and so did not automatically spring up in the vacuum left behind by structural reform. This extends right from the level of health providers and an emphasis on primary health care… making physicians and other health providers directly responsible for the overall health of the population. The assumption no doubt being that physicians will want to provide the most effective and efficient means at their disposal for maintaining health. But health providers need access to a variety of things that will allow them to be judicious in terms of managing patients. This is also why the emphasis on comprehensiveness. Home care and pharmacare are necessary ingredients as are long-

term care and mental health services and so on. Contractual relationships with providers and regional health authorities are important instruments of accountability.

- What remains left in the vacuum is probably such things as health promotion and disease prevention as well as non-health specific determinants. That will likely be left to a third phase of health care reforms as governments potentially move toward inter-sectoral coordination of environmental and social determinants. Again, Québec may be a precursor by having long since moved toward integrated health and social services policies.

Bibliography

Alberta, Premier's Commission on Future Health Care for Albertans (1989). *Rainbow Report: Our Vision for Health*. 2 Vols. Premier's Commission on Future Health Care for Albertans

Alberta. Ministry of Health and Wellness (2001). *A Framework for* reform: *Report of the Premier's Advisory Council on Health.* Premier's Advisory Council on Health, D. Mazankowski, chair.

British Columbia. Royal Commission on Health Care and Costs (1991). *Closer to* Home: *Report of the British Columbia Royal Commission on Health Care and Costs*. Mr. Justice Peter D. Seaton, chairman ... [et al.].

Canada, Commission on the Future of Health Care in Canada (2002). *Building on Values: The Future of Health Care in Canada.* Commission on the Future of Health Care in Canada (Commissioner: Roy J. Romanow, QC).

Canada. Standing Senate Committee on Social Affairs, Science and Technology (2002). *The Health of Canadians – the Federal Role: Recommendations for Reform.* Standing Senate Committee on Social Affairs, Science and Technology, Senator M. Kirby, chair.

Canadian Medical Association (2002). *A Prescription for Sustainability.* Canadian Medical Association, Submission to The Commission on the Future of Health Care in Canada.

Canadian Medical Association. A Task Force on the Allocation of Health Care Resources (1984). *Health: a Need for Redirection.* A Task Force on the Allocation of Health Care Resources, Joan Watson, chair.

Health Canada. The National Forum on Health (1997). *Canada Health Action: Building on the Legacy.* The National Forum on Health.

Institute for Research on Public Policy (2000). *The IRPP Task Force on Health Policy: Recommendations to First Ministers.* The IRPP Task Force on Health Policy, M. Decter, chair.

Newfoundland and Labrador. Department of Health and Community Services (2002). *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador.* Department of Health and Community Services.

Nova Scotia. The Nova Scotia Royal Commission on Health Care (1989). *The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy.* The Nova Scotia Royal Commission on Health Care, J. Camille Gallant, chair.

Ontario. Task Force on the Use and Provision of Medical Services (1990). *Final report of the Task Force on the Use and Provision of Medical Services.* Task Force on the Use and Provision of Medical Services.

Ontario. The Ontario Health Services Restructuring Commission (2000). *Looking Back, Looking Forward: Seven Points for Action.* The Ontario Health Services Restructuring Commission.

Ontario. The Ontario Health Services Restructuring Commission (2002). *Looking Back, Looking Forward: The Legacy Report.* The Ontario Health Services Restructuring Commission.

Provincial and Territorial Ministers of Health (2000). *Understanding Canada's Health Care Costs: Final Report.* Provincial and Territorial Ministers of Health.

Québec. Commission d'enquête sur les services de santé et les services sociaux (1988). *Rapport de la Commission d'enquête sur les services de santé et les services sociaux.* Commission d'enquête sur les services de santé et les services sociaux, J. Rochon, chair.

Québec. Commission d'etude sur les services de santé et les services sociaux (2000). *Rapport de la Commission d'etude sur les services de santé et les services sociaux: les solutions émergente*. Commission d'etude sur les services de santé et les services sociaux. M. Clair, chair.

Saskatchewan. Commission on Directions in Health Care (1990). *Future Directions for Health Care in Saskatchewan.* Commission on Directions in Health Care D. Murray, chair

Saskatchewan. Commission on Medicare (2001). *Caring for Medicare* : *Sustaining a Quality System.* Commission on Medicare, Commissioner K. Fyke.

Appendix

Provincial Reports

Table 1: Provincial Reports 1988 to 1991

	Diagnosis (barriers and impediments)	Policy Objectives	Policy Focus (of Major Recommendations)	Policy Levers and Choices
BC ('91)	• System controlled by family physicians. • Over emphasis on curative services over other policies to improve public health. • Consumer expectations of access to high technology medical care. • Programs and policies arising out of political decisions. • A lack of leadership • Centralized management	• Delivery organization • Financial • Programming	• Governance • Hospital Restructuring • Health human Resources Health Information • Performance measurement	• Resources (limits on (institutional and physician care). • Institutional change (regionalization). • Organizational change
AB ('89)	• Over reliance on institutional care. • Existing funding mechanisms (public financing) is an impediment to individual autonomy, responsibility and self reliance in the utilization of health services. • The limited services offered under the *Canada Health Act* impede the development of a more comprehensive health care system. • System lacks overall goals and objectives.	• Financial • Jurisdiction/governance • Programming • Delivery organization	• Governance • Coverage • Health human resources	• Idea and values (choice/competition) • Financing (private financing of services) • Institutional change (regionalization).
SK ('90)	• Over reliance on costly institutional care, technology and physician services. • A comprehensive, universal and free medicare system that users have increasingly taken for granted. • Fee-for-service system of physician remuneration encourages over utilization and waste. • The system is increasingly becoming a burden on provincial finances and on individual taxpayers.	• Delivery organization • Financial • Programming • Jurisdiction/governance	• Governance • Primary health care • Health human resources • Hospital restructuring.	• Institutional change (regionalization as the instrument of rationalization) • Resources (limits on (institutional and physician care). • Organizational change

	• The existing structure of institutions and pre-existing boards impedes a sense of ownership of the system among "consumers" necessary for rationalizing and stream-lining the existing system. • Existing governance structure and funding mechanisms fund institutions to the exclusion of community-based care and public health.			
ON ('90)	• A lack of consensus for change among the principle stakeholders. • A profound barrier to system planning is an absence of quality health information. • Improper assessment of new technologies, clinical procedures or pharmaceuticals. • Inability of physicians to keep pace medical information on clinical practice.	• Delivery organization • Financial	• Hospital Restructuring • Health human resources • Health and management information • Health technology	• Interest groups/stakeholders • Organizational change
QC ('88)	• The system is the hostage of vested interest and pressure groups. • The system lacks results-oriented targets. • No "inter-sectoral" accountability. • Planning has become separated from resource allocation. • Regional boards dominated by health and social services closely associated with individual institutions. • The process of budget allocations is "essentially political". • The system lacks incentives or penalties for good or poor budgeting performance at the institutional level. • A lack of collaboration among professionals.	• Jurisdiction/governance • Delivery organization	• Evidence-based decision-making • Governance • Needs-based funding • Health human resources • Health information. • Primary care (health and social services)	• Institutional change (further decentralization). • Organizational change • Interest groups/stakeholders • Ideas and values
NS	• Over reliance on costly institutional and	• Financial	• Governance	• Resources (limits on

(‘89)	physician services. • Provincial finances threaten the continued provision of quality, accessible care. • Fragmentation and segregation of responsibilities made coordination of operations complex. • Centralized management unresponsive and inflexible. • Decision-making not adequately related to population-based needs. • Inflexibility of traditional scopes of practice by established professional groups.	• Delivery organization • Jurisdiction/governance	(regionalization) • Performance measurement • Health and management information systems • Health human resources • Needs-based funding • Primary health care.	institutional and physician care) • Organizational change

Provincial Reports: The Next Generation

Table 2: Provincial Reports 2000 to 2002

	Diagnosis (barriers and impediments)	Policy Objectives	Policy Focus (of Major Recommendations)	Policy Levers and Choices
AB ('02)	• System with its current reliance on tax funding is unsustainable. • Service rationing due to a reliance on a wholly tax-based and publicly funded system. • The health system as currently organized does not provide the right incentives. • The absence of choice or competition. • Regional health authorities lack sufficient control over their own resources. • Shortages of health professionals. • A fundamental problem with the system is that it is not evidence-based.	• Financial • Delivery organization • Jurisdiction/governance	• Financing • Waiting-list management • Coverage • Electronic health information systems • Governance • Privatization • Health human resources (recruitment and retention, physician remuneration) • Primary health care • Outcomes and performance measurement	• Financing (private financing of services) • Idea and values (choice/competition) • Institutional change (further decentralization) • Interests/stakeholders
SK ('01)	• System lacks accountability. • The most fundamental crisis in the system which is waste and error. • The health care system is under measured and under managed. • Solo physician practice models limit the integration between physicians and other health care providers. • The fee-for-service system for physicians is a barrier that prevents innovative approaches to health services. • The budget cycle is a weak instrument for planning. • Limited analytic capacity and no policy to assess performance.	• Delivery organization • Jurisdiction/governance • Programming • Financial	• Primary health care • Governance • Hospital restructuring • Outcomes and performance measurement • Health and management information • Rural and remote health.	• Organizational change • Institutional change (refined governance structure) • Financing/resources (allocation mechanisms)
ON ('00)	• Service integration impeded by a lack of leadership and political will and competing agendas.	• Delivery organization • Jurisdiction/governance • Financial	• Hospital restructuring • Home care • Long-term care	• Institutional change (decentralization) • Resources (limits on

	• Absence of system wide goals and targets. • Resources were being used to maintain hospital surplus capacity. • The absence of data and information impedes accountability. • Primary health care system would require a population-based funding approach.	• Programming	• Primary health care • Governance • Health and management information • Outcomes and performance measurement	institutional care) • Organizational change
QC (‘00)	• A major barrier had been attempts to centralize family physician practice within the CLSC. • A major barrier to physician retention and recruitment is physician access to specialized services. • Professional scope of practice is a barrier to the optimal use of services. • Tax funded health systems are vulnerable to revenue fluctuation.	• Jurisdiction/governance • Delivery organization • Financial	• Primary health care • Hospital restructuring • Health human resources (recruitment and retention) • Health and management information systems • Financing • Coverage	• Organizational change • Institutional change (refined governance structure) • Financing (private financing options) • Resources (limits on scope of coverage) • Interests/stakeholders
NFLD (‘02)	• A lack of integration and coordination among health professionals. • A major impediment to community care is physician compensation and morale. • Existing infrastructure to support primary health care is poor. • Significant cost-drivers: new technology), pharmaceuticals, wage and compensation pressures, community pressures to sustain services. • The Health and community services system suffers from a lack of accountability. • Lack of information to monitor the outcomes of health services. • Health stakeholder groups insufficiently accountable for the own	• Delivery organization • Jurisdiction/governance • Financial	• Primary health care • Long-term care • Health human resources (retention and recruitment) • Governance • Rural and remote health • Hospital restructuring • Waiting list management • Financing.	• Organizational change • Financing/resources (allocation mechanisms) • Idea/values (private delivery options) • Institutional change (refined governance structure)

	demands placed on the system.			

Comparisons of "Policy Objectives" between generation 1 and 2 reports within jurisdictions

Table 3: Alberta

	1989	2002
AB	• Financial • Jurisdiction/governance • Programming • Delivery organization	• Financial • Delivery organization • Jurisdiction/governance

Table 4: Saskatchewan

	1990	2001
SK	• Delivery organization • Financial • Programming • Jurisdiction/governance	• Delivery organization • Jurisdiction/governance • Programming • Financial

Table 5: Ontario

	1990	2000
ON	• Delivery organization • Financial	• Delivery organization • Jurisdiction/governance • Financial • Programming

Table 6: Québec

	1988	2000
QC	• Jurisdiction/governance • Delivery organization	• Jurisdiction/governance • Delivery organization • Financial

National Reports

Table 7: National Reports

	Diagnosis (barriers and impediments)	Policy Objectives	Policy Focus (Major Recommendations)	Policy Choices (levers for change)
Task Force on the Allocation of Health Care Resources (1984)	• Necessary supportive services (non-institutional or physician-based) grossly inadequate. • Institutionalization rates threaten to render the health care system unsustainable. • Standards and appropriateness of care suffer from lack of coordination. • Public expectations of access to new technology are high without proper assessment. • Economic considerations will play a limiting role in the available resources with respect to technology. • Coordination of two orders of government and multiplicity of health care providers is a central and obvious problem. • 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, 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.	• Delivery organization • Financial • Programming • Jurisdiction/governance	• Community-based services • Long-term care • Health technology • Governance	• Resources (de-emphasis on institutional care in favour of supportive services) • Organizational change • Institutional change (federalism)
National Forum on Health (1997)	• The present structure cannot accommodate speedy and drastic reductions or shifting of resources without compromising access and quality. • Reductions in federal transfers have	• Financial • Delivery organization • Jurisdiction/governance • Programming	• Governance (federalism) • Financing (maintenance of transfers) • Home Care	• Institutional change (federalism) • Ideas/values • Resources (allocation mechanisms)

	imposed change at a pace that "cannot be absorbed" by provincial and territorial health systems. • The most significant challenge for the system is to maintain universally accessible and quality health services under a public system with fewer resources. • Offloading has shifted public costs onto individuals either by de-insuring or introducing user fees. • The focus of public funding of medicare is focused excessively on funding hospital and physician services. • 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. • Decisions related to the health care sector are often not a product of evidence but of the values and interests of decision-makers. • The system lacks high quality data to develop the proper mechanisms or protocols, clinical guidelines or care management strategies.		• Pharmacare • Primary health care • Needs-based funding • Non-medical determinants of health (income support, childhood development, etc.) • Evidence-based decision-making • Health information	• Financing (sustain transfer levels) • Organizational changes
Provincial and Territorial Ministers of Health (2000)	• Reductions in federal government transfers resulted in a significant funding gap. • 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. • Opportunities for further cost efficiencies will be extremely difficult to replicate.	• Financial	• Financing • Governance • Health human resources • Primary health care • Evidence based decision making • Health technology • Home care • Pharmacare	• Financing (increases in transfer levels)
IRPP (2000)	• The lack of definition of the principles of the *Canada Health Act*.	• Jurisdiction/governance • Financial	• Governance • Financing	• Institutional change (systemic governance

	• The *Canada Health Act* is inadequate as the basis of service quality standards. • Centralized decision-making has community-level decision-making. • System integration is unfulfilled due to limited use of information technologies and medical technologies.	• Programming • Delivery organization	• Outcome and performance measurement • Pharmacare • Homecare • Health human resources • Health technology	structure/federalism) • Ideas/values • Resources (allocation mechanisms) • Organizational changes
Canadian Medical Association (2002)	• Shortages of providers, poor access, resource constraints and passive privatization have resulted in variations in the scope of coverage. • The system lacks a permanent, depoliticized forum at the national level to open the decision-making process. • The federal government's role has been undermined by reductions in cash transfers. • The allocation of federal funds must be done more transparently in support of long-range planning. • Services covered under the Canada Health Act are too narrowly focused on institutional and physician services. • Insufficient resources to finance other modes of delivery and services necessary for comprehensive system. • The lack of any recourse or alternative care when the publicly funded health system fails to provide timely access to health care.	• Jurisdiction/governance • Financial • Programming • Delivery organization	• Governance • Financing • Coverage • Waiting list management • Evidence-based decision making • Outcomes and performance measurement • Health human resources • Health technology and infrastructure • Health and management information • Home care • Pharmacare • Primary care	• Institutional change (governance) • Financing (increases in federal transfers/private financing options) • Resources (limits on scope of coverage) • Interest groups/stakeholders
Standing Senate Committee on Social Affairs, Science and Technology (2002)	• Publicly funded health care system as it is currently organized and operated is not fiscally sustainable given current funding levels. • The health care system lacks "leadership" or governance. • Current funding mechanisms are based on funding inputs and not on final outcomes or performance. • Regional Health Authorities are impeded from realization of full potential without	• Financial • Jurisdiction/governance • Delivery organization • Programming	• Financing • Hospital restructuring • Needs/service-based funding • Governance (regionalization) • Primary health care • Waiting list management • Pharmacare • Home care	• Financing (increases in federal transfers) • Institutional change (governance) • Organizational change • Resources (allocation mechanisms) • Interest groups/stakeholders

	further devolution. • A primary threat to the single payer insurance model is the issue of timely access to health care. • The shortage of medical technologies and the use of outdated equipment impede high-quality treatment, impede access and lengthen waiting times.		• Health technology and infrastructure • Health and management information • Outcomes and performance measurement • Health Human Resources • Health research	
Commission on the Future of Health Care in Canada (2002)	• Continued disagreements among those charged with the governance of the system. • The ability of governments to work within a cooperative framework has underscored the inadequacies of existing intergovernmental coordination. • There is a lack of visibility with respect to which order of government is accountable for addressing specific problems. • The existing machinery of intergovernmental coordination is ineffective and cumbersome. • The Canada Health Act principles no longer adequately reflect the evolution of the health system. • Decades of reductions in transfers for health have undermined the original basis of what the report describes as the "medicare bargain."	• Jurisdiction/governance • Financial • Programming • Delivery organization	• Governance (federalism) • Financing • Primary health care • Pharmacare • Home care • Health technology • Health information • Outcomes and performance measurement • Rural and remote health • Aboriginal health	• Institutional change (governance) • Financing (increases in federal transfers) • Organizational change