Project Research Paper

A Cross-Provincial Study of Health Care Reform in Canada

Academic Literature Review: Report Summaries

University of Regina

2002

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

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

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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:

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

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.

decline and this has resulted in limited scope for overall expansion of government expenditures. In such and 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
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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

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

institutions, health professionals and community groups and organizations, develop plans for regional health services delivery. Regional budget envelops 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.

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.
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
-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

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

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

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

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: (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:

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

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.

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 cos
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 Counc
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. BuETBT1 0 0c171024 40uero[(those9Ali)-3loID 6(ona)-5(l

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

such as primary

ons to be more

workplace should be improved by involving doctors and nurses in decision making processes, providing expanded continuing education opportunities and creating more full

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

Exanio m

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

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Background:

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 gi

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

Major Recommendations:

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

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 4(oBTpl)-6viousBTar. Thes aBTd 3ETBTe

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.

and sustainability. The Commission suggests that the current system has focused on

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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

s public

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

treatments.

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

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

provider dialogue suggested that the fee-for-service system for physicians is a barrier that

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 communit
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

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

consistent with longer-
recommended that the Department of Health should be responsible for the planning and location of s

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

ms
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

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
e 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
o policy to reveal
and control excess utilization. There were few tools to reduce ineffective prescribing,

ons by governments to

programs in any substantive way.

Major Recommendation

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

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

enough about what is

assess accurately these trends, motivations, incentives, practice patterns and health

information there is

states, has contributed to the system becoming increasingly costly. The typical response 5f man [illegible]

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

Source:

Background:
The *Health Services Restructuring Commission* (HSRC) was established in March 1996 by the Ontario Government as an arms-
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 (HRSC).

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
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

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

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.

governance and leadership
Long-Term Care (MOHLTC) functioned solely as principle source of financing for the
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- Ministry was thus tasked with clarifying the role of

accountability for managing health services to communities. The MOHLTC would be responsible for establishing overall direction through legislation, regulations, policy

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

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

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 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:

relationships 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 Given the complexity of health -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

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

Commission proposed an independent, third- Health System Improvement Council th 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.
- *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.

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.

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: (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:

Background:
Originally created in June of 1985, the Commission was formed to report on health and

was revised to both shorten the term of the Commission and yet expand its mandate to

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

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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, it 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- 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

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.

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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,

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 -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 is 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.

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 bet-4(prof)ishT1 0 i4.2(I the p)and the c24 364.15a

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researches emerging from within Québec and cautioned that the Development of health

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:

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
t
service needs.

Issues and Findings:

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

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
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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.,

tresor review budgeting mechanisms to make them conform to long term organizational

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

Primary care institutions (CLSCs, CHSLDs, hospitals) should be brought under one single authority in a given region. This should include a unified board of

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).

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

Issues and Findings:
Since the inception of medicare the evolution of the system has been ostsmntdito wr

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

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-
natio
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 horses 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

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

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 Newfoun
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
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 go(h c)43DTBT1 0 0 1b77nity cc D7700590

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

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

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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. Joh
Development of a comprehensive mental health strategy based on recent provincial reports, reviews and stakeholder committee reports

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

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 techno

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.

conclusions were based on focus group responses, quantitative research and public

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 -economic 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
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.

system. It recommended maintaining public funding for medically necessary services

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

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

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 in 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:

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

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

The Task Force concludes, however, that the *Canada Health Act*

Provincial and territorial governments should be responsible for the

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.

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

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.

-size-fits-
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

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
factor in growing waiting lists is the
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.

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.

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

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

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

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

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

Purpose:
The CMA proposes 5 recommendations involving the implementation of three integrated

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

affecting the health care system.

Issues and Findings:

hegs:

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,
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 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.

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.1 253.61 5desb-2(z)-t0f4(ve)4(l t)mo 19n

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 basC1/Langt(c)ETBT1 0 0 1 226.3794.5358 Tm[(f theJETBT1 0 0 1 138.7

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

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 sd e0es 5ers and

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 t
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 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
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:

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

principles of portability and comprehensiveness, and establish a new principle of

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

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 f

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.

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 Serv[illegible]