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Romanow and Beyond: A Primer on Health Reform Issues in Canada

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Discussion Paper No. H|05
Health Network

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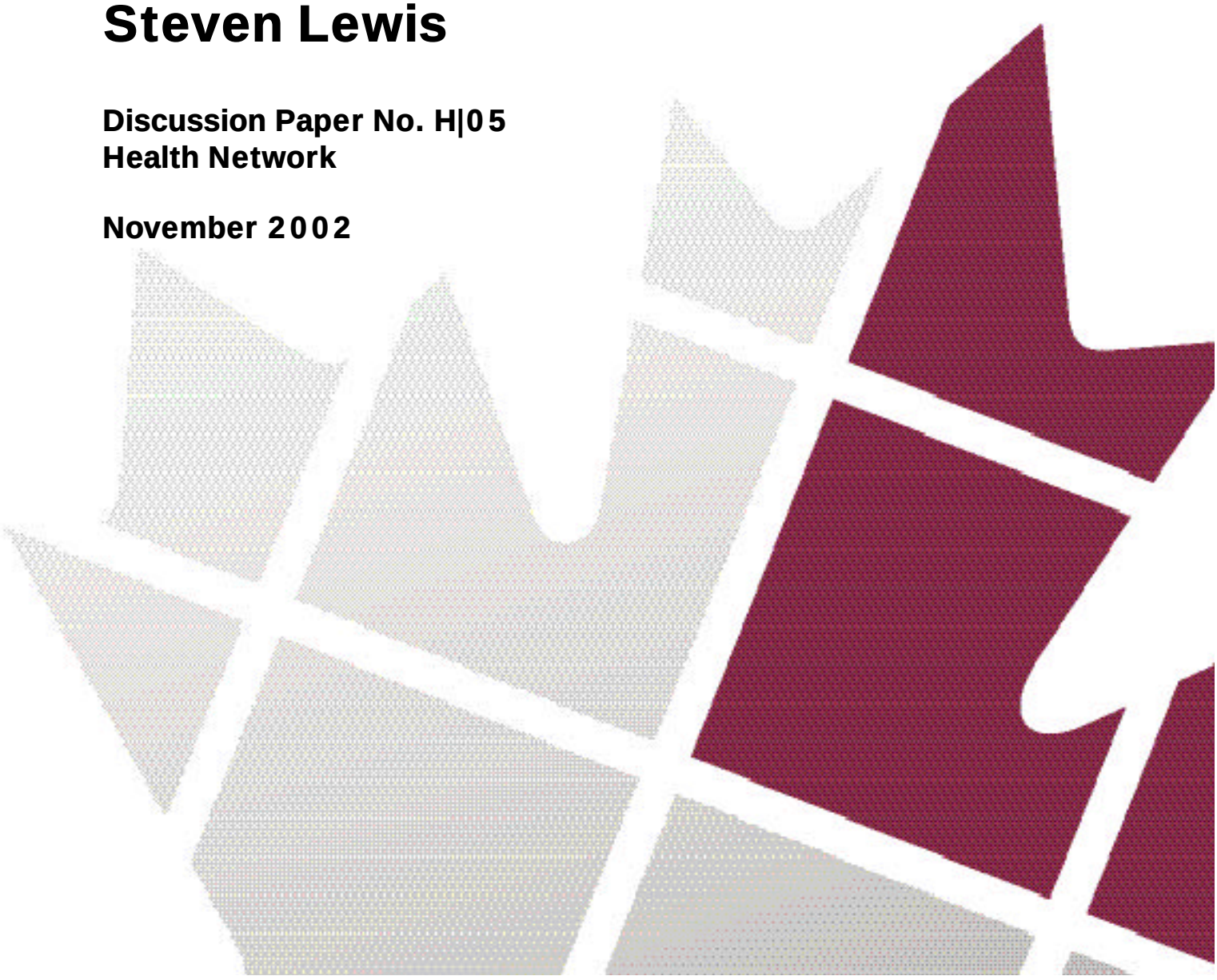

Romanow and Beyond:
A Primer on Health Reform Issues in Canada

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Table of Contents

Foreword

Over the past five years, Canadians have been presented with eight major reports on future directions for health policy – from five provincial and three federal commissions or advisory committees. Taken together, the reports would require days of continuous reading for the studious citizen. When the Romanow Commission publishes its final report at the end of November 2002, the stage will be set for Canada's First Ministers and Health Ministers to make decisions to reshape the health system for future decades.

To help Canadians digest this deluge of advice and to trace the roots of the decisions to be made in 2003, this brief paper summarizes the main themes in the eight reports and identifies the areas of agreement and disagreement. While there are obviously important differences in view across the country, the paper shows that there is a broad consensus on the priority areas for decision making.

I wish to thank Cathy Fooks, and Steven Lewis for their crisp summary of the reports. Cathy Fooks is Director, CPRN's Health Network, and Steven Lewis is President of Access Consulting. He was also a member of the National Forum on Health, and an advisor to the Fyke Commission in Saskatchewan and to the Romanow Commission in the first six months of its deliberations.

Judith Maxwell
November 2002

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Introduction

Canadians are currently awaiting the release of the final report from the Commission on the Future of Health Care in Canada (the Romanow Commission) expected at the end of November 2002. Along with the already-released final report from the Standing Senate Committee on Social Affairs, Science and Technology and a series of provincial reports released over the last five years, there is a remarkable body of work available to decision makers as they contemplate changes to Canada's health care system. A First Ministers' meeting is expected early in 2003 to review recommendations and to decide on an implementation approach. What are the likely areas of agreement and disagreement?

This paper has two objectives:

- To summarize emerging themes in key Canadian health reform reports over the last 5 years at the provincial and national levels; and,

- To identify areas of agreement and disagreement within the key themes.

The paper is neither an extensive literature review nor a comprehensive summary of all the recommendations presented to the public. It is meant to be a primer for those interested in the future of the Canadian health care system but unfamiliar with the existing rules, arrangements and proposals for reform.

Reports Reviewed

We reviewed five provincial reports (Alberta, New Brunswick, Ontario, Quebec and Saskatchewan) and three national reports (National Forum, The Senate Committee and the Interim Report from the Romanow Commission). The mandates of each varied from general investigative and consultative processes to analysis of specific reforms such as the implementation of regional health authorities. Appendix A provides brief details about each review process.

Health Reform Themes

Nine themes are identified as priorities for health care reform. While the reform documents highlighted many other issues, these nine themes appeared consistently at the provincial level, the national level or across both jurisdictions. The nine major themes are:

- A focus on population health;
- Financing the health care system;
- Primary care reform;
- Regionalization of service delivery;
- Pharmaceutical policy;
- Health human resource planning;
- Quality improvements and infrastructure supports;

- Governance and accountability mechanisms;
- Home care services.

Table One provides a quick summary of the themes in each report. The X indicates the theme appeared specifically in the report as a section or recommendation. As the interim report of the Romanow Commission did not contain specific recommendations, we classified the themes on the basis of the areas the Commissioner identified for further discussion.

Table One
Themes for Health Reform in Canada

	Population Health	Finance	Primary Care	Regionalization	Drugs	Health Human Resource	Quality	Governance	Home Care
Alberta	X	X	X	X		X	X	X	
New Brunswick	X		X	X	X	X	X	X	
Ontario			X	X		X	X	X	
Quebec	X	X	X	X		X	X	X	
Saskatchewan	X	X	X	X	X	X	X	X	
National Forum	X	X	X	X	X	X	X	X	X
Kirby	X	X	X	X	X	X	X	X	X
Romanow	X	X	X	X		X	X	X	X

The following section provides a brief description of the themes and the proposals for reform in each area.

Population Health Focus

All the reports reviewed recognized the need to increase efforts to promote health and wellness, and emphasized the non-medical determinants of health. While the language varied slightly across jurisdictions, the policy goal was the same – to improve the health status of citizens through mechanisms other than the traditional health care system.

Beginning with the 1974 Lalonde Report, Canada has been an intellectual leader in identifying the non-medical determinants of health and advocating a broad strategy for improving the health of its people. More recently, this has become known as a population health approach,

incorporating themes such as developmental biology, the environment, material and social inequality, occupational health, social capital, etc. Provincial government planning documents and legislation frequently use the language of population health to define their goals and in some cases, their accountability frameworks. A population health approach often highlights inequalities and how to overcome them, and allocates resources on the basis of need. It suggests investing more heavily to alter the determinants of sub-optimal health and less heavily in areas that generate modest additional benefits at the margin. While these ideas and themes are widely accepted in theory, there has not been a major population health-oriented transformation of public sector activities. Some of the most promising developments have been intersectoral child action plans, supported by federal and provincial financial contributions.

Financing the Health Care System

Increasingly, the question of how to fund health care services in Canada has become a focal point. Is there enough money? Who pays for what? Do we need to increase taxes? Should the private sector play a larger role in delivering or financing services? These questions have been raised in the public debate and it is therefore not surprising that almost all the reform reports addressed the issue of public funding.

Health care in Canada is both publicly and privately financed. Public sector funds are usually raised through general taxation and are used to pay for all of the costs of a defined set of services (mainly hospital and physician care), and some of the costs of others (such as drugs). Private sector expenditures include out-of-pocket payments for items not financed through the public plan and the costs for services covered by private health insurance individually purchased or available through employment arrangements.

There is an important distinction between how the system is *financed* and how services are *delivered.* Historically, religious and other charitable organisations established hospitals and other services well before the government became a major funder. The non-profit sector remained a prominent player in the system as Medicare evolved. While 73% of the system is now publicly financed, the government directly provides only a small portion of services. The great majority of services continue to be delivered by private, non-profit corporations (hospitals, community agencies, long term care facilities) or independent contractors (mainly physicians). In some provinces, a significant amount of publicly financed services is delivered by for-profit corporations particularly nursing home chains and home care agencies.

In the public sector, the majority of spending is financed at the provincial level because s. 92 of the *Constitution Act* assigns the organisation and regulation of health services mainly to the provinces. The federal government is responsible for services for aboriginals covered by treaties, members of the armed forces, and other limited responsibilities such as health promotion and disease surveillance. The federal government contributes through three mechanisms:

- an annual cash transfer for health care. The current agreement is known as the *Canada Health and Social Transfer (CHST)* and runs until 2002-03. A minimum of $12.5 billion annually is provided ($19.1 billion in 2002-03), although the size of the transfer has been the subject of some controversy between the two levels of government and a matter of constant negotiation. The transfer is to cover health care spending, post-secondary education and

social assistance costs. The original design of the CHST nominally calculated the proportion of transfers intended for each of the three areas. In practice, the money flows into provincial coffers to be spent as the provinces wish. There is no accounting required for actual expenditures. In terms of health care, provinces are free to spend the money as they wish as long as they honour the principles of the *Canada Health Act.* If a province breaches the principles of the CHA, the federal government can withhold its financial contribution.[1] Since provisions such as "comprehensiveness" and "accessibility" are very loosely defined by the *Canada Health Act*, and have yet to be the subject of compliance debates, the clear and enforceable notion of a national health care standard applies rather narrowly to policies surrounding financial transactions, not substantive service configurations or quality.

- the granting of tax points whereby the federal government decreases its tax rate so that the province can increase theirs;

- an equalisation program by which resources are transferred from the richer provinces to the less well resourced to ensure that reasonably comparable services are available across the country.

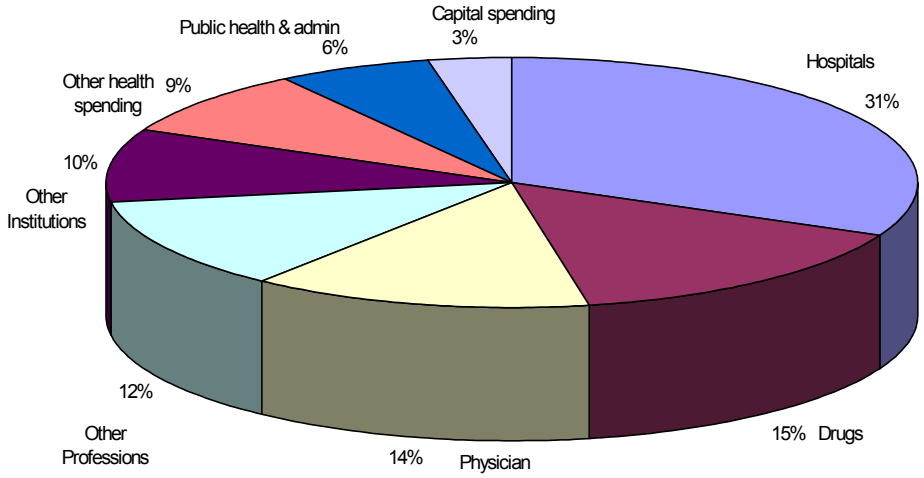
According to the Canadian Institute for Health Information, total health expenditures in Canada grew at an average annual rate of 11.2% between 1975 and 1991. As cost cutting exercises were in full swing, the average annual growth rate dropped to 2.4% between 1991-1996, however, public sector spending actually declined when adjusted for inflation. After 1996, growth resumed and even accelerated: 4.9% in 1997, 6.6% in 1998 and 7.2% in 1999. Estimates for growth in 2000 and 2001 are 7.1% and 6.9% respectively.[2] In dollar amounts, Canadians spent an estimated $102 billion for health care in 2001. In per capita terms, this is equivalent to $3298 per person.

The majority of the spending is in the public sector ($74 billion) with 91.6% coming from provincial governments. Of the $28 billion private sector total, about half is paid for by third-party insurance and half comes directly from citizens in out-of-pocket payments.

Major Spending Categories and Cost Drivers
There are 8 categories of spending within health care expenditures as listed below along with the dollar amounts and the percentage of total spending for 1999 (CIHI, 2001).

[1] In practice the only time the federal government has withheld funding is when provinces have allowed physicians to charge patients directly for services, violating the *Canada Health Act* provision that medically necessary physician (and hospital) services shall be provided without charge at point of service.
[2] All growth rates and figures are actual (i.e. unadjusted for inflation or population growth). In recent years, inflation has been low and health spending increases have been high. Thus, real per capita growth rates have been high by historical standards.

1999 Health Spending in Canada
by Category (% of total expenditures)



Two areas contribute primarily to the increase in costs: wages and salaries (largely physicians and nurses), negotiated with provincial governments; and, drug costs. Drug costs are the fastest growing portion of health care costs, increasing by an average of 8.7% a year since 1997.

Health Care as a Proportion of Provincial Government Spending
Provincial governments have expressed concern that the ever-increasing costs of health care are crowding out other areas of provincial spending. Is "health care eating everyone else's lunch?"

Recent figures indicate there is indeed a crowding out effect with health care spending accounting for well over 40% of total provincial spending in Ontario and over 35% in Newfoundland, Nova Scotia, Manitoba, Saskatchewan, and British Columbia. However, observers note that health care consumes about the same percentage of the Gross Domestic Product (between 9% and 9.5%) as it did a decade ago. Hence the "crowding out" results partly from government decisions to reduce taxes and therefore revenues available to spend on programs.

Almost all the reform reports discussed the need for new mechanisms to fund the system although specific proposals varied widely.

Increase the Role of the Private Sector
A number of reports raised the issue of increasing the role of the private sector. There is considerable confusion over terms here, and it is essential to understand precisely what is entailed in various proposals. There is little controversy about the role of *non-profit* private sector delivery of services: it is the Canadian norm. The controversy is whether the private *for-profit* sector should be more centrally engaged in the direct provision of services through public financing.

The proposals for increasing private sector involvement normally take one of five forms:

- Discontinue insuring, partially or totally, some services (by definition these must be non-hospital, non-physician services as mandated by the *Canada Health Act*). For instance chiropractic services require a co-payment in Saskatchewan and have a capped number of visits annually in Ontario, after which the patient, or the insurance company, pays the full fee. This approach shifts financing from public to private sources but delivery would not necessarily change;

- Increase user fees for certain services such as charging close to the full cost of residential long-term care. This approach shifts financing from public to private sources – most likely out-of-pocket payments as the market for long term care insurance is unlikely to be large given the premiums required to make it sustainable;

- Encourage or mandate the public system to contract out specific services to the private sector. British Columbia is currently pursuing this strategy for laundry, housekeeping and food services and Alberta's Bill 11 allows regional health authorities to contract the provision of certain medical procedures to private, for-profit clinics that are also allowed to provide non-insured services to paying customers. The Ontario government has indicated in its 2002 provincial budget that it will follow the Alberta model. This approach retains public financing but shifts delivery from the non-profit to the for-profit sector;

- Permit or encourage employers and the public to purchase more private health insurance to diminish perceived pressure on publicly financed programs. This approach shifts financing from public to private and it may lead to increased for-profit delivery;

- Approach private capital markets to finance major construction projects, such as hospitals, with leaseback arrangements so that government does not have to incur the debt load. Examples include the University Hospital Network bond issue in Ontario or the proposed Abbotsford Hospital project in British Columbia. This approach retains public financing for services but provides a profit margin for the private financiers who supply the capital.

Canadian citizens do not appear enamoured of increased private financing as it runs counter to fundamental Canadian values of equity and fairness. In a recent citizens dialogue process commissioned by the Romanow Commission, citizens were clear they did not want the ability to pay to be a deciding factor for accessing the health care system. They favoured increased revenues raised through general taxation as the more equitable option as long as efficiency gains were achieved through restructuring efforts.

Primary Care Reform

Every report reviewed identified the need to restructure the way we deliver primary care. Without reforming primary care, we cannot do much about other important parts of the system. The terms differ. The Ontario Health Services Restructuring Commission called for comprehensive primary health care groups. The Mazankowski report called for "care groups" to provide a range of services. The Clair Commission called for primary care networks and family

medicine groups. The Premier's Health Quality Council in New Brunswick called for community health centres and the Fyke Commission in Saskatchewan called for the establishment of primary health service teams and primary health networks.

Regardless of the labels, the models all contain similar concepts to organise what Fyke calls "everyday services." Various provinces are attempting some form of reorganisation – some as full-fledged new models and others as pilot projects. Common elements are:

- Continuity of services 24 hours a day, seven days a week in person or by phone;
- The development of genuinely interdisciplinary teams of health professionals going beyond the family physician and a nurse;
- The ability for patients to choose their primary care provider(s) and, in some cases, the expectation they will sign up ("roster") with their choice for a minimum period of time;
- A focus on wellness and health promotion activities;
- Funding would be a mixture of capitation arrangements, fee-for-service for specialised services and program funding.

The key area of contention relates to the role of the family physician. This plays out in both the design of the new model and whether family physicians remain as the gatekeeper for the patient. Do physicians draw in other health professionals as they deem appropriate, or, does the patient access other health professionals directly? If the latter, then the patient may frequently see a nurse or a pharmacist or a social worker without seeing the family physician first. Physicians would see more complex cases on an as needed basis, or would consult on case reviews, without necessarily seeing the patient. How teams and centres are organised, their accountabilities, and how work is distributed have profound implications for how they should be paid. All models assume that funding should be based on the needs of the population served rather than how many services are provided by which people.

For decades, there have been numerous examples in Canada of non-traditional primary health care practice, from community clinics to non fee-for-service group practices. All have been voluntary and it is difficult to know whether these initiatives would be successful in circumstances where practitioners may be resistant to change.

Nevertheless, provinces such as Ontario have set ambitious targets of 80% of all family physicians in new models by 2004, albeit under a somewhat conservative model of modified fee-for-service payment.[3] Saskatchewan's Action Plan for Health Care calls for 80% of all family physicians to participate in significantly different primary health care models by 2011. Quebec has announced the establishment of the first 20 family medicine groups with a plan to implement 300 over a four-year time frame to serve 75% of the population. New Brunswick has recently established its first two community health centres.

[3] There has been some confusion recently in the press as to whether or not the government is maintaining the target. The Minister of Health has said they are on track but the chair of the implementation agency has said they are not.

Regionalization

All the reports reviewed, other than the National Forum[4], discussed the need for either creating new regional structures or improving the existing ones.

All Canadian provinces have embraced some form of regional health authority or regional health board with the exception of Ontario. (Although recently, regional health boards for mental health services have been proposed in Ontario by Ministerial-appointed task forces.)

According to the Canadian Centre for the Analysis of Regionalization and Health, regionalization is defined as a process through which a board is responsible for the delivery of health care services and programs to a defined population in a specific geographic area.

Regional health authorities across Canada differ in size, structure, scope of responsibility, and number per province but have common features:

- autonomy and responsibility for the majority of health services in a region;
- appointed, or combined appointed and elected boards;
- responsibility for funding and delivery of community health services;
- responsibility for funding and delivery of institutional health services;
- an increased focus on prevention;
- an aim to integrate services;
- an aim to reduce duplication and overlap.

The issue of autonomy is a major bone of contention. Boards, managers and government officials all attest to confusion as to precisely where autonomy begins and ends with regional health authorities. The boards and managers believe they are responsible for matters over which they have no control. Government officials, on the other hand, believe the boards do not exercise their authority optimally.

Regional health authorities are a relatively new structure in the Canadian system and the jury is still out as to whether they have achieved goals of better integration and improved population health. Recent initiatives in the West have decreased the number of authorities[5] and increased the size of the community for which they are responsible. As well, the initial design of regional health authorities excluded important parts of the health care system from their jurisdiction such

[4] This may be related to timing as the Forum reported in 1997 when Regional Health Authorities had only just been or were in the process of being established.

[5] From a total of 52 regional health authorities and community councils in British Columbia to 5 large regions, including one that encompasses 64% of the geographic land mass of the province; and from 32 health districts to 12 health regions in Saskatchewan. Recent newspaper articles from Alberta report contemplation of reducing the 17 RHAs – whose boards were elected in the Fall of 2001 – to somewhere between 5 to 7 but this is not official policy at the time of writing.

as physician primary care and most specialty care services, drugs and mental health budgets.[6] It is often asserted that excluding these important components from the jurisdiction of regional health authorities compromises planning, integration, the realisation of cost efficiencies, and the development of a unified culture of quality improvement. The Senate Committee final report did recommend an expansion of authority for regional health structures to include services like physician services and drugs in the funding envelope.

Pharmaceuticals

The issue of pharmaceutical policy appears to be more a national concern than it is a provincial one, although provincial governments worry constantly about escalating costs. Both the National Forum and the Senate Committee reports called for a version of a national pharmacare program and although the Romanow Commission did not highlight it in its interim report, it is expected the final report will deal with the issue.

Provincially, only New Brunswick had specific recommendations for pharmaceutical policies. The Fyke report in Saskatchewan cautiously recommended a national pharmacare program if certain important conditions could be met.

Drug costs, policies, and programs have been volatile and controversial over the past 30 years. In 1975, total spending on drugs was $1.1 billion, accounting for 8.8% of total health care spending. By 2001, drugs cost an estimated $15.5 billion, or 15.2% of all health care expenditures, a proportion second only to hospitals. In 2001, an estimated 49.2% of prescription drug costs were financed by government – the highest proportion ever, up from 25% in 1976, and 41.5% as recently as 1998. Despite these increases, the publicly financed proportion in Canada is considerably lower than in most advanced OECD countries.

The *Canada Health Act* requires only that drugs provided during an inpatient hospital stay be provided free of charge to the patient. Perhaps predictably, there has been great variety, both between jurisdictions and over time, in provincial drug policies and financing patterns. In the mid-1970s, Saskatchewan introduced a universal drug plan that provided all drugs listed on the provincial formulary free of charge except for a modest dispensing fee (about $2). Other provinces implemented more selective programs, focusing on three groups: the indigent (typically defined as those on social assistance); the elderly (residents 65 and over); and those with certain conditions requiring prolonged and expensive pharmacotherapy. Each province established a drug formulary overseen by a committee that assesses drugs for inclusion. Drugs covered in one province may be excluded in another, and there is little consistency among provinces in decisions to include or exclude newly-approved drugs.

[6] The provinces have not configured their regions identically. Prince Edward Island had the most expansive vision, including health, education, social services, and even corrections. It has since scaled back and taken provincial specialty services out of the mix under its own authority. Quebec's regions span health and social services. New Brunswick and Newfoundland divided institutional and community services among different authorities. The remainder devolved what are normally considered health services to their RHAs, although Alberta only recently announced the inclusion of mental health under regional responsibility and it continues to maintain a separate process for financing province-wide tertiary care services.

The incomplete coverage of drugs by government has created a niche for private insurance, and the highly individualized approaches of provinces have precluded development of a comprehensive and standardized national approach to drug policy. There are huge interprovincial variations: for instance, a low-income Saskatchewan senior with average drug use would have paid $497 out-of-pocket in 1998 while her Ontario counterpart would have paid only $42.

In 1997, the National Forum on Health recommended a national, universal pharmacare program on the grounds that drug therapy is clearly a "medically necessary" service, and the existing patchwork of programs served neither to control costs, nor distribute benefits in accordance with need. While many interest groups and policy analysts continue to support the recommendation, neither level of government has shown much interest. The provinces, already saddled with rapid cost increases, are reluctant even to discuss a national program unless Ottawa firmly commits major, stable funding. This may, in part, help explain why the issue was not more dominant in the provincial health reform reviews. The Senate Committee also recommended a largely federally-funded program to cover mainly catastrophic medication costs for Canadians combined with limited insurance coverage related to income.

The federal government did contribute $21.5 billion in additional health care funding over 5 years under the terms of the September 2000 First Ministers Memorandum but almost none came with strings attached. However, the communiqué did signal an intention to cooperate more effectively to develop strategies for assessing the cost-effectiveness of prescription drugs and to develop common assessment processes.

Health Human Resources

All reports reviewed identified the need for a different approach to dealing with health human resource planning in Canada.

During the mid 1990s, health human resource issues were not front and center, as provincial governments struggled with economic slow down and the need to constrain health care budgets and projected growth expectations. However, beginning in the late 1990s, claims about shortages, under-supply, lack of access and terms like "crisis" began to dominate public and political debate. These statements, often originating with providers and their associations, generated studies, working groups, fact finders etc. As report upon report piled up, most provinces found themselves forced to respond. Focusing at first on nursing issues, and more recently, on physician issues, Canada has reverted to a view that we require more health care providers educated, trained and working in Canada.

Recently, provinces have taken modest steps to increase the number of professionals trained in Canada and have attempted organised recruitment efforts. Most provinces have also put in place retention programs and location incentives to attract personnel to designated underserviced areas. These initiatives at the provincial level are often in direct competition with each other.

The processes of education, training and deployment of health personnel in Canada suffers from a number of barriers to achieving co-ordinated policy implementation. These include:

- too many players making policy change slow and cumbersome;
- fragmented and profession-specific planning initiatives;
- a lack of control over location of practice and types of services delivered;
- education and training programs misaligned with population health needs;
- poor planning methodologies;
- a lack of co-ordination across jurisdictions;
- a lack of data (particularly for groups other than physicians and nurses).

A number of short term solutions have been proposed such as reducing regulatory barriers to make better use of internationally trained graduates; reducing regulatory and professional barriers to expand scopes of practice allowing non-physician personnel to play a greater role in the provision of care; consolidation of the more high risk procedures in teaching centres with greater investment in telehealth technology. However, the reform reports identify a requirement for longer term solutions such as the creation of a national planning focus to break the implementation logjam.

Quality, Performance Measurement and Information Systems

All of the reform reports identified the need for improved patient outcomes, clear performance targets and publicly reported measurement of those targets, and better information systems to underpin policy, planning and research activities.

Amid the funding turbulence of the 1990s there was a growing awareness of quality problems and utilization anomalies quite unrelated to absolute levels of funding. The growing capacity to undertake health services research (including the establishment of provincial centres in British Columbia, Saskatchewan, Manitoba, and Ontario in the 1990s) began to generate findings that could not be attributed to resources alone. Studies revealed systemic quality problems and an absence of benchmarks for determining appropriate utilization rates. At the same time, a number of provincial organizations and professional societies produced literally thousands of clinical practice guidelines for physicians. The main goal of this activity is often described by the terms "evidence-based medicine" and "evidence-based decision-making."

The quality improvement movement that began in industrial settings has attracted devotees in health care. These efforts gradually attracted a following, but it took the publication of a landmark report in 1999 to quantify the toll of substandard quality on a national (US) basis: an estimated 50,000 to 100,000 deaths in hospitals caused by medical error. The report was front-page news and galvanized enormous public and professional interest in addressing quality problems. A similar report is in preparation in Canada, with results expected by mid-2003.

Most provinces have set up processes to develop performance indicators, and there is a national effort underway under the auspices of the Canadian Institute for Health Information. The Federal/Provincial/Territorial Health Ministers agreed to a set of 14 performance indicators and the first reports were published this Fall. Reform reports propose a variety of structures to deal with this information – a Quality Council in Saskatchewan; a Health Services Utilization and Outcomes Commission in Alberta; a Health Research Institute in New Brunswick and a National Health Care Commission at the national level.

Comprehensive and accurate measurement and reporting requires good data. Major initiatives are underway in several provinces, and the federal government has established the National Health Infoway as a crown corporation to pursue Canada-wide initiatives. The electronic health record is the core of the overall vision. Despite expenditures from tens to hundreds of millions of dollars, implementation of the electronic health record has proceeded slowly, hampering clinical care, real-time evaluation, quality improvement, and systemic analysis. Information technology expenditures in Canada are typically 2% of total health care budgets, well behind the 5%-8% reported in the United States.

Canadian public opinion, and therefore government preoccupation, has focused on access more than quality per se. Waiting times are routinely "hot button" issues; there is widespread perception that waits are getting longer, and the media have given prominent play to delays in cancer care in Ontario and Quebec, and controversial remedial strategies such as sending patients to US border cities and contracting with a private clinic in Toronto. The few systematic studies of wait lists in Canada suggest that concerns are driven by anomalous rather than typical experiences: both Nova Scotia and Manitoba found that wait times did not lengthen appreciably in the 1990s, and a Health Canada study showed that particularly for elective procedures, wait list management was haphazard and fragmented. Fortunately, solutions appear to be on the horizon. The Western Canada Wait List Project developed pilot tools for needs-based prioritization of patients on wait lists for cataract surgery; general surgery; hip and knee replacements; access to MRI; and children's mental health.

A key issue under-pinning the technological advances is that of patient privacy. Electronic health records may improve patient care and provide better data for research. However, governments are currently struggling with policy frameworks that would enable these advances while protecting patient health information and privacy. Legislation at the federal and provincial levels protects information about individuals – some jurisdictions have separate legislation for the protection of personal health information. Issues of consent, access, use and disclosure, storage and disposal are all outlined in the statutes and relate to the provision of health care and secondary uses for the information such as research or fundraising.

Governance and Accountability

Almost all the reform reports identified governance and accountability issues as important for future reforms. This was reflected in three ways:

- *Improved federal-provincial relations:* The provinces contend that Ottawa now contributes only 14% to provincial health care spending and are currently running television and print ads on the subject. Ottawa claims it is closer to 30% if one includes the value of tax points transferred to provincial jurisdiction in the 1980s. Some argue that increased federal contributions will solve the problem and enable cost-shared programs in new areas like pharmacare or home care.

- *New accountability measures:* Almost all the reports propose some form of public reporting of funding, performance measures, health status information or some combination of all three

as a way to improve accountability to tax payers. As well, greater clarity around roles and responsibilities is proposed for the regional health authorities, the local service providers, the provincial Ministries or Departments of Health and the federal government.

- *New governance structures:* new organizations are proposed in a number of the reports to be responsible for implementing the new accountability measures. Although funded by government, they are to sit outside government structures and are to report directly to the public.

Home Care

Home care was not a major provincial theme for health reform but was identified in all three national reports. The Clair Commission did propose a "loss of autonomy insurance fund" that could be applied to home care patients.

Home care services include medically-oriented services, homemaking services and attendant care as well as preventive care that allows individuals to stay in their own home. Currently home care is not defined as a medically necessary service under *The Canada Health Act* and therefore public funding is neither mandatory nor uniform across the country.

Various options for funding home care have been proposed ranging from cost-sharing to targeted program funding to new tax incentives. This will depend largely on the way in which the federal/provincial/territorial governments agree at a general level about transfer mechanisms in the future.

Agreements and Disagreements

There are clearly six areas of agreement in direction arising from the work to date but simultaneously disagreements about the specific ways to implement proposals.

- *Re-investments are Required*

There is agreement that money is needed to achieve many of the agreed-to goals of health reform. Perhaps notably, Fyke argued most strongly that new money may not be required in the long run in that better quality care is often cheaper, and Kirby declared that new money should buy change, not uphold the status quo. Population-based wellness programs, new primary care delivery mechanisms, new medications, electronic health records and telehealth systems, new technology, upgrading existing physical plant, creating new governance structures and public reporting exercises – the list goes on and all of it requires investment. There is not agreement about how to finance the investment. Some argue for increased taxes (through general income tax or a dedicated levy), some argue for increased out of pocket payments either directly or through insurance, some argue for redirecting money already in the system.

- *Primary Care Reform is a Precursor to Other Health Reforms*

There is agreement that primary care needs to be delivered differently using a variety of health personnel in a team environment with 24-hour access for patients. There is not agreement about

the design of payment mechanisms, whether the changes should be voluntary or brought about by policy, or the speed with which these reforms should be implemented.

- *Scale of Regional Health Authorities*

There is agreement that some form of regional structure to deliver local services is a sensible way to organize health care services. There is not agreement about the most effective size of the geographic area under an authority's jurisdiction nor about what type of services should be included in the funding envelope. The provincial reports that expressed views on the subject tended to suggest larger and fewer regions than originally established in the first wave of reforms.

- *A Focus on Quality of Care*

There is agreement that information and research should be organized to analyse continually the quality of care being provided to citizens. There is not agreement about what to do with the results of these quality reviews, how to implement an electronic health record as the backbone of the enterprise or how to deal with privacy and confidentiality concerns over personal health information.

- *Health Human Resource Planning*

There is agreement that better planning mechanisms are required. There is not agreement about how to integrate mechanisms at the national level nor about how to make more use of non-medical personnel. In many ways, solving this dilemma is strongly related to sorting out current federal-provincial tensions.

- *Governance Mechanisms*

There is agreement governance mechanisms in the health care system need to be strengthened and that roles and responsibilities need to be clearly delineated. There is not agreement about the design or location of new organizations or about future funding transfer mechanisms.

Despite the plethora of analyses, reports and recommendations, there remains a great deal of territory for the Romanow Commission to explore with a view to achieving a national consensus on solutions. There seems little doubt that federalism in health care will be a major preoccupation of the report, and it is the area of greatest contention over the past decade. Many of the previous reports have addressed both the financial and quality issues to some extent, but there has yet to develop a guiding national vision that ties these strands together. Mr. Romanow has a solid foundation to build on: the real challenge will be to create both a vision and a strategy that enables the system to move beyond exhortation to action.

Appendix A: Health Reform Reports Reviewed

Provincial Reports

Caring for Medicare. Sustaining a Quality System by the Commission on Medicare, Province of Saskatchewan, 2000-2001.

A one-member Commission was appointed by the Premier in June 2000 to identify key challenges facing the people of Saskatchewan in reforming and improving Medicare; to recommend an action plan for delivery of health services; and to make recommendations to ensure the long-term stewardship of a publicly funded, publicly administered Medicare system. Commissioner Ken Fyke completed his final report in April 2001. The full report can be found at www.health.gov.sk.ca/info_centre_pub_commissiononmedicare-bw.pdf.

A Framework for Reform by the Premier's Advisory Council on Health, Province of Alberta, 2000-2001

A twelve-member Council was established by the Premier in January 2000 to analyze the challenges facing Alberta's health system. Chaired by the Honourable Don Mazankowski, the Council completed its report in December 2001. The full report can be found at www.gove.ab.ca/home/health_first/dcouments_maz_report.cfm.

Emerging Solutions by the Commission d'étude sur les services de santé et les services sociaux, Province of Quebec, 2000

A nine-member Commission was established in June 2000 by the Minister for Health and Social Services to hold a public discussion on the issues facing the health and social services system and to propose solutions for the future. Chaired by Michel Clair, the Commission completed its report in December 2000. Health and social services are under the jurisdiction of one government department in Quebec; thus, the scope of this report includes child and family services as well as health care. The full report can be found at www.msss.gouv.qc.ca

Health Renewal by the Premier's Health Quality Council, Province of New Brunswick, 2000-2002

A 14-member Council was established in January 2000 by the Premier to develop an action plan to move to a system of regional health authorities, oversee the implementation of a health care report card and other quality reporting measures, and assist in developing a Patient Charter of Rights and Responsibilities. Chaired by Michel Leger, the Council completed its report in January 2002. The full report can be found at www.gnb.ca/0089/documents/e-phqc.pdf.

Looking Back, Looking Forward. A Legacy Report from the Ontario Health Services Restructuring Commission, Province of Ontario, 1996-2000.

A twelve-member Commission was established in 1996 to make decisions about hospital restructuring; to provide advice to the Minister of Health about which health services would need

reinvestment; and to make recommendations to the Minister on restructuring other components of the health care system to improve quality of care, outcomes and efficiency and help create a genuine, integrated health services system. The Commission issued numerous directives and reports throughout its four year mandate with a final legacy report summarizing its work completed in March 2000. Although its work was primarily focused on restructuring Ontario's hospital sector, the Commission did deal with other health care sectors as important components of population-based health care systems. The Commission's reports can be found at http://192.75.156.24/.

National Reports

Canada Health Action: Building on the Legacy. Final Report of the National Forum on Health. Government of Canada, 1994-1997.

A twenty-four member forum was established by the Prime Minister in 1994 to involve and inform Canadians and to advise the federal government on innovative ways to improve the health system and the health of Canada's people. The final report was completed in 1997 and can be found at http://wwwnnfh.hc-sc.gc.ca.

Shape the Future of Health Care from the Commission on the Future of Health in Canada, Government of Canada, 2001-2002.

A one-member Royal Commission was established by the Prime Minister in April 2001 to inquire into and undertake dialogue with Canadians on the future of Canada's public health care system. An interim report was issued in February 2002 and can be found at http://www.healthcarecommission.ca. A final report is expected to be released at the end of November 2002.

The Health of Canadians – the Federal Role. Volume Six: Recommendations for Reform by the Standing Senate Committee on Social Affairs, Science and Technology, Government of Canada, 2001-2002.

An eleven-member Committee of the Senate of Canada was authorized in March 2001 to examine the principles on which Canada's publicly funded health care system is based; the historical development of the health care system; health care systems in foreign jurisdictions; the pressures and constraints of Canada's health care system; and, the role of the federal government in Canada's health care system. The Committee issued five volumes as interim reports and completed a final report in October 2002. The report can be found at http://www.parl.gc.ca

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