

Health Care Transformation in Canada

E-PRESCRIBING

IMPROVE TIMELY ACCESS

LONG-TERM CARE

SUPPORT INFORMAL CAREGIVERS

ENHANCE COLLABORATIVE TEAM-BASED CARE

CREATE NATIONAL STANDARDS

HEALTH INFORMATION

PHYSICIAN ASSISTANTS

PATIENT-CENTRED CARE

INVEST IN RECRUITMENT

PAY-FOR-PERFORMANCE



CHANGE THAT WORKS. CARE THAT LASTS.

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MEDICAL
ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 72,000 members and the Canadian public, CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial associations and 51 national medical organizations.

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OPENING DECLARATION

Canada's prized Medicare system is facing serious challenges on two key fronts: in meeting the legitimate health care needs of Canadians and in being affordable for the public purse. The founding principles of Medicare are not being met today either in letter or in spirit. Canadians are not receiving the value they deserve from the health care system. In both 2008 and 2009, the Euro-Canada Health Consumer Index ranked Canada 30th of 30 countries (the U.S. was not included in the sample) in terms of value for money spent on health care. Canadians deserve better.

Canada cannot continue on this path. The system needs to be massively transformed, a task that demands political courage and leadership, flexibility from within the health care professions and far-sightedness on the part of the public. It is a lot to demand, but nothing less than one of Canada's most cherished national institutions is at stake. Unwillingness to confront the challenges is not an option.

With this report, "Health Care Transformation in Canada: Change that Works, Care That Lasts" the Canadian Medical Association (CMA) declares its readiness to take a leadership position in confronting the hard choices required to make health care work better for Canadians. The focus of reform must better serve the patient. The system must adjust to changing needs for care and do so without crowding out other societal needs; many of them determinants of health themselves, such as education and sanitation, and the challenges posed by Canada's geographic, cultural, economic and emerging demographic realities.

This report sets out an ambitious but realizable roadmap to ready the system for the future. Its triple aim is to improve the health of the population at large, to improve the health care experiences of patients, and to improve the value for money spent on health and health care. The CMA seeks to spark a spirited discussion among physicians, other health care providers, governments and the public at large so that an urgent effort can be undertaken to put an improved system on a path to sustainability by the time the federal-provincial/territorial Health Accord expires on March 31, 2014. By so doing, a renewed Health Accord will be enabled to maximize value for patients and sustain a strong health care system for future generations.

This report is divided into three parts: The Problem; Our Vision; and The Framework for Transformation. It is in this last section that the CMA puts forth a five-pillar transformational plan, including a Charter for Patient-Centred Care, for securing Canada's public health care future. These policy directions have been influenced by our consultations with patients, patient advocacy groups and the public. These initiatives are necessary to support the important work already underway in illness prevention and health promotion, in enhancing capabilities for diagnosis and treatment, and in monitoring system performance. They also represent directions we must take towards preparing for the needs of future generations of Canadians.

The CMA, our partner provincial/territorial medical associations and the physicians of Canada are committed to the changes that will allow us to fulfill our objective to provide patients with optimal care within an effective, accountable and sustainable system today and for generations to come.

EXECUTIVE SUMMARY

Medicare has enjoyed the resounding support of Canadians for nearly half a century. But new times bring new challenges to the health care system and so it has been forced from time to time to adapt and evolve. This document is predicated on the belief of the CMA that new demands for adaptation must be addressed starting now, and in a manner consistent with the spirit and principles that have guided Medicare from the beginning.

This report is divided into three Parts. The first lays out the underlying problem confronting the system; the second outlines a vision for Canada's health system by modernizing the guiding principles of Medicare, and the third provides the CMA's prescription for improving the system within and beyond the five original principles that are set out in the *Canada Health Act* (universality, accessibility, comprehensiveness, portability and public administration).

Following the main report, Appendix A addresses the issue of health care funding and sustainability. This is meant to inform readers regarding the complexities inherent in the challenge of sustaining health care provision and funding for current and future populations.

Part 1: The Problem

Canada's health care system is valued by its citizens. At the same time, it is increasingly recognized that the system is inadequate to meet 21st Century needs and is in urgent need of reform. Canadians wait too long for care. Care providers feel overworked and discouraged. There are insufficient mechanisms to monitor system performance. Technical support needs modernizing.

Closer examination of how the five Medicare principles are being met reveals a number of concerns. While there is universal coverage for a narrow range of medically-necessary services, access to other essential health care services is inconsistent, both within and across jurisdictions. Exceedingly long waits for necessary medical care is prevalent. Efficiencies in the management of our health care system must also be found as Canada has recently been ranked last out of 30 countries in terms of value for money spent.

Part 2: Our Vision

There are numerous steps required to transform Canada's health care system so that it becomes highly effective and meets the health needs of Canadians. A first step is to re-examine the five principles of the *Canada Health Act* and modernize them as they are no longer sufficient to meet current and evolving needs.

All Canadians must have timely access to an appropriate array of medically-necessary services across the full continuum of care, independent of their ability to pay. All health care must be patient-centred. Care must be delivered effectively and must be well-coordinated among all care providers. The health care system must be properly resourced to deliver care in a sustainable way that can accommodate our ever-changing health care needs.

Part 3: The Framework for Transformation

The CMA's Health Care Transformation Plan has three core goals: improving population health, improving the patient experience of health care, and improving the value for money spent on health care. The CMA has created a Framework for Transformation listing the actions needed for change – organized under five pillars:

1. Building a culture of patient-centred care
 - Creation of a Charter for Patient-centred Care
2. Incentives for enhancing access and improving quality of care
 - Changing incentives to enhance timely access
 - Changing incentives to support quality care
3. Enhancing patient access along the continuum of care
 - Universal access to prescription drugs
 - Continuing care outside acute care facilities
4. Helping providers help patients
 - Ensuring Canada has an adequate supply of health human resources
 - More effective adoption of health information technologies
5. Building accountability/responsibility at all levels
 - Need for system accountability
 - Need for system stewardship

The CMA recognizes that none of these directions, taken separately, will transform our health care system. Nor do they represent an exhaustive list of steps, as there are many other directions that can be taken to support our vision. This framework does, however, contain the necessary directions toward the more efficient, high-functioning, patient-focused system that Canadians deserve.

Summary of CMA Recommended Directions

Implementation of these recommendations will require the collaboration of all levels of government and medical and other health organizations.

1. Gain government and public support for the CMA's Charter for Patient-Centred Care.
2. Implement partial activity-based funding for hospitals, whereby facilities are funded based on the number of patients they treat and the types of illnesses they have, to improve timely access to facility-based care.
3. Implement appropriate pay-for-performance systems to encourage quality of care at both the clinician and facility level.
4. Establish an approach to comprehensive prescription drug coverage to ensure that all Canadians have access to medically necessary drug therapies.
5. Begin construction immediately on additional long-term care facilities.

6. Create national standards, with input from both federal and provincial/territorial governments, for continuing care provision in terms of eligibility criteria, care delivery and accommodation expenses.
7. Develop options to facilitate pre-funding long-term care needs.
8. Initiate a national dialogue on the *Canada Health Act* in relation to the continuum of care.
9. Explore ways to support informal caregivers and long-term care patients.
10. Develop a long-term health human resources plan through a national body using the best available evidence to support its deliberations. Within this plan:
 - a) Increase medical school and residency training positions.
 - b) Invest in recruitment and retention strategies for physicians, nurses and other health care workers.
 - c) Ease the process of integration into our health care workforce for international medical graduates and Canadian physicians returning from abroad.
 - d) Introduce new providers such as physician assistants to the health care workforce and enhance collaborative, team-based care where appropriate.
11. Adopt the CMA's five-year plan to set out clear targets for accelerating the adoption of Health Information Technology (HIT) in Canada.
12. Accelerate the introduction of e-prescribing in Canada to make it the main method of prescribing by 2012.
13. Require public reporting on the performance of the system, including outcomes.
14. Establish an arm's-length mechanism to monitor the financing of health care programs at the federal and provincial/territorial levels.

PART 1: THE PROBLEM

Summary: Canada's health care system is valued by its citizens. However, not only is our Medicare system failing to meet the five principles — universality, accessibility, portability, comprehensiveness and public administration — originally laid out in the 1984 Canada Health Act, but those five principles, while still relevant, need to be expanded in scope to serve the current and future health needs of Canadians.

Canadians believe that the relief of suffering and the promotion of health and human dignity are vitally important – for philosophical as well as pragmatic reasons. Simply stated, there is a broad recognition that health is a valued “good” allowing all Canadians to flourish as individuals and groups. Notwithstanding this fundamental belief, neither of the imperatives of our health care system – optimizing function and the compassionate relief of suffering and promotion of dignity – is being met for many people. Our population and our health providers encounter these failures on a daily basis.

Polls show that most Canadians unwaveringly support the five principles laid out in the 1984 *Canada Health Act* — universality, accessibility, portability, comprehensiveness and public administration.¹ In fact, since Medicare was first introduced – in Saskatchewan in 1962 and throughout the rest of Canada soon afterward – the idea of universal health care has become central to our national identity. Nearly half a century after Medicare was first introduced, however, Canada's health care system is falling short of the demands being placed on it from patients and providers.

Canadians well understand that universal health care requires significant public resources to maintain. While the escalating costs of health care are often perceived as the overriding problem, there are other factors contributing to the crisis.

Surveys have repeatedly shown that Canadians are highly satisfied with the care they receive once it is delivered. However, the general view among most Canadians is that their health care system is not as well managed as it must be. They are increasingly concerned about the lack of timely access to see their family physician, the long wait times for diagnostic testing, a widespread lack of access to specialists and specialized treatment, and the compromised quality of care in overburdened emergency rooms, or the unavailability of nearby ER facilities altogether. With our aging population, end of life issues are becoming increasingly important, yet many do not have access to expert palliative care.

The founding principles of Medicare are not being met today either in letter or in spirit. Canadians are not receiving the value they deserve from the health care system. Issues such as quality of care, accountability and sustainability are now recognized as key aspects of a high-performing health system. “Health” by today's standards is not just the assessment and treatment of illness, but also the prevention of illness, and the creation and support of social factors that contribute to health.

Also missing from our current system, but vitally important to proper care, is health information technology (HIT). In this area, Canada is woefully lacking in both resources and coordinated efforts toward a plan of HIT implementation.

Before addressing the missing elements in Canada's health care system, a proper diagnosis of the current system requires a closer look at how the health care system fails to deliver on all five founding principles of Medicare.

1. Universality

Studies have consistently shown that poorer, marginalized populations do not access necessary care. Wealthier populations use health care services more frequently than lower-income populations despite higher illness rates in low-income populations. Poorer communities have fewer services to support good health.

The most vulnerable populations are least able to access and navigate the health care system. At the same time, these are the people most likely to need health care because the essential determinants of health – housing, education and food security – are often not available to them.

Canada's system of universality resonates strongly with Canadians. However, while there is universal first-dollar coverage for insured hospital and medical services, there is uneven coverage of other services also essential to health and quality of life (e.g., prescription drugs and home care).

2. Accessibility

The principle of accessibility in the *Canada Health Act* does not define “timely access” to necessary care. For many patients, the months of waiting for necessary treatment amount to a complete lack of “accessibility.”

While wait times have been reduced for a limited number of surgical procedures, many Canadians are still waiting far too long to receive necessary medical care for a wide variety of conditions. For many types of treatments, Canadians wait longer than citizens in most other industrialized countries that have similar universal health systems. Approximately five million Canadians do not have a family doctor, severely restricting access to adequate primary medical care.

3. Comprehensiveness

Provincial/territorial health insurance plans must insure all “medically necessary” hospital and physician services.

Canadians are entitled to all medically necessary (evidence-informed) services to the greatest extent possible. However, since Medicare was established in the 1960s, care patterns have shifted dramatically – away from being primarily acute care in nature, to broader health needs including prevention, treatment and long-term management of chronic illnesses. In addition, new technologies, treatments and medications that were not foreseen by the original planners of Medicare have been developed to diagnose and treat illnesses.

At the time the *Canada Health Act* was passed, physician and hospital services represented 57% of total health spending; this has declined to 41% in 2008.² Notwithstanding these changes, there is significant public spending beyond services covered by the *Act* (in excess of 25% of total spending) for programs such as seniors' drug coverage and home care; however, these programs are not subject to the *Act*'s program criteria and are often subject to arbitrary cutbacks. While a majority of the working-age population and their families are covered by private health insurance, those with

lower incomes are less likely to enjoy such benefits. Furthermore, the proportion of Canadians working in non-standard employment conditions (e.g., part-time, temporary or contract work) is increasing and these workers are less likely to have supplementary benefits.³ In addition, while most jurisdictions provide some form of seniors' drug coverage, access to other supplementary benefits post-retirement is most likely highly variable.

Some of the more severe gaps in coverage include:

- the lack of access to prescription medications for those without private health insurance or who are ineligible for government drug benefit programs; this problem is particularly significant for many residents in Atlantic Canada
- the lack of continuing care, including both support for people to stay in their home (home care) or appropriate residential care (e.g., facility-based long-term care)
- a lack of adequate mental health services. Mental illness is one of the leading burdens of illness in Canada. Access to mental health services for both children and adults is poor. Psychiatric hospitals are not covered under the *Canada Health Act*. Many essential services, such as psychological services or out-of-hospital drug therapies, are not covered under provincial/territorial health insurance plans.

4. Portability

Canadians should receive coverage while travelling outside of their home province or territory.

Portability under the *Canada Health Act* does not cover citizens who seek non-urgent and non-emergency care outside their home province or territory. Canadians who obtain such care in another province or territory are not covered by their health insurance program unless they receive prior approval (usually for services not available in their home province or territory).

This principle is honoured by some jurisdictions but has never been fully implemented in Québec. Québec did not sign bilateral reciprocal billing agreements with the other provinces and territories stipulating that providers would be reimbursed at host-province rates. Consequently, Québec patients who receive medical care outside of their province must often pay cash for medical services received and then apply to recoup a portion of their costs from the Québec health insurance program.

5. Public administration

Health care insurance plans must be administered and operated on a non-profit basis. The principle of public administration is often misinterpreted to mean public financing of publicly delivered services. In fact, while Medicare services (medically necessary hospital and physician services) are overwhelmingly publicly financed, most services are privately delivered. Most physicians are independent contractors while most hospitals are private organizations governed by community boards. This misconception of what constitutes public administration has inhibited the development of innovative models for publicly funded, privately delivered services.

While Canada's system of Medicare is administered publicly, a case can certainly be made that Canada's health care system is not delivering value for the money spent: Canada is one of the highest spenders of health care when compared to other industrialized countries that offer universal care – Canada is the fifth-highest spender per capita on health care and sixth-highest in terms of spending

on health as a percentage of GDP. Canadians spent an estimated \$183 billion on health care in 2009, or \$5,452 per person.² Of this amount, \$3,829, or 70%, is spent through the publicly funded system. Health care spending in Canada has increased by 6.8% annually over the past five years and has been increasing faster than the growth in the economy and more importantly faster than revenues at the federal and provincial/territorial levels.

Canada's health care system is under-performing on several key measures, such as timely access, despite the large amounts we spend on health care. Experts agree that Canada's current health care system is not delivering the level of care that other industrialized countries now enjoy. The Conference Board of Canada⁴, the World Health Organization⁵, the Commonwealth Fund⁶ and the Frontier Centre for Public Policy⁷ have all rated Canada's health care system poorly in terms of "value for money" and efficiency. New governance models should be considered to improve both system effectiveness and accountability.

FISCAL SUSTAINABILITY

In addition to the need for improving the performance of our health system is the issue of fiscal sustainability. In 1998, the Auditor General of Canada, Denis Desautels, was among the first to sound an alarm about sustainability with a report on the implications of the aging population. His report projected that government spending on health as a share of GDP; if increases continued apace at an annual rate of 2% of real growth; could as much as double from its 1996 level of 6.4% to 12.5% by 2031.⁸ According to the most recent estimates from the Canadian Institute for Health Information (CIHI), government health spending as a percentage of GDP reached 8.4% in 2009ⁱ – a level which has already exceeded the 8.1% estimate for 2011 set out in the high-growth scenario of the 1998 report.²

Most recently, Parliamentary Budget Officer Kevin Page has again sounded the alarm in his February 2010 Fiscal Sustainability report.⁹ He projects that total provincial-territorial government health expenditure could rise to over 14% of GDP by 2040-41. This report presents estimates of the fiscal gap (which is defined as the increase in taxes and/or reduction in spending, measured relative to GDP) that is required to achieve sustainability over the long term. Under their baseline scenario, the government would need to increase revenue and/or reduce spending by \$15.5 billion annually, starting immediately. Given that most commentators expect the demand for health care services to increase, reduced spending seems unlikely; hence the need to increase revenue is the most likely option. If there is no political appetite or public support for increasing public revenues for health on the basis of universality and risk pooling then we will be faced with choosing among options for raising funds from private sources.

A more detailed analysis of health care funding and sustainability is contained in Appendix A.

i Derived as the .7023 public share of the estimate of 11.9% of GDP going to total health expenditure.

PART 2: OUR VISION

Summary: There are numerous steps required to transform Canada's health care system so that it becomes highly effective and meets the health needs of Canadians. A first step is to re-examine the five principles of the Canada Health Act — universality, accessibility, comprehensiveness, portability, and public administration — and modernize them to meet current and evolving needs.

MODERNIZING THE PRINCIPLES OF MEDICARE

Change must be undertaken with the patients' interests at the centre. To the CMA, this means meaningful implementation and modernization of the *Canada Health Act*. Transformational change will refocus our system so that serves the patient — not the other way around as is so often the case today. Canada must follow the lead of other developed countries with universal health care systems that have succeeded in this fundamental objective.

Below are the modernized principles for Canada's health system recommended by the CMA:

1. Universality

All Canadians must have access to the full range of necessary (evidence-informed) health care services using a variety of funding options as necessary to ensure universal coverage regardless of ability to pay. This includes meeting the needs of vulnerable populations who may not be able to access services due to a variety of barriers (e.g., geographical, socio-economic and demographic).

2. Accessibility

All Canadians must have timely access to the full array of health care services over their life span, from primary care (including health promotion and illness prevention) through institutionally based secondary and tertiary care, to community and home-based services that promote rehabilitation and health maintenance, and to palliation at the end of life. There should be clear, measurable wait-time targets/benchmarks for access to necessary care, with publicly funded alternatives available in situations where timely care is not locally available to patients in need.

3. Comprehensiveness

All Canadians must have access to the full complement of health services, with incentives in the system to encourage the prevention of illness and to promote optimum health while addressing the complex causative pathways affecting health and disease (i.e., social determinants of health). A defined set of nationally comparable, publicly funded core services should be available to all Canadians chosen through an evidence-informed and transparent manner. There should be an ongoing monitoring of the comparability of access to a full range of medically necessary health services across the country.

4. Portability

All Canadians must be eligible for coverage while travelling within Canada, outside of their home province/territory. This principle must be honored in all jurisdictions, and apply to all levels of necessary care.

5. Public administration

Services must be appropriately, efficiently and effectively delivered, with providers and patients working together to determine how that is done. The system must ensure that care is integrated and coordinated among providers and services to maintain continuity of care. From the patients' perspective, care must be well-coordinated among providers and between levels (i.e., physician to hospital, hospital back to home, etc.), supported by a functional and secure electronic health information system.

The system should be guided by properly structured incentives to reward efficient provision of timely, high-quality patient care. This would include incentives such as activity-based funding of hospitals (i.e., paying on the basis of services provided), and pay-for-performance measures for health care providers, with competition based on valid measures of quality and efficiency. The system would utilize both public and private service providers, and put uniform requirements and regulations in place for measuring quality.ⁱⁱ

The system must be able to demonstrate good value for money. There must be accountability mechanisms and performance measurements in place to ensure responsibility for monitoring and managing system performance (e.g., efficiency and effectiveness) at all levels. Regular public reporting on system performance will be required. Societal health goals and targets focused on outcomes will be set and monitored. Health care providers and the community will be actively involved in system decision-making.

6. Patient-centred

The system needs to be patient-centred. Patient-centred care is seamless access to the continuum of care in a timely manner, based on need and not the ability to pay, that takes into consideration the individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity.

7. Sustainability

The system must be properly resourced in a sustainable manner. Funding must be sufficient to meet ongoing health care needs. The system must be resilient; that is, capable of withstanding or accommodating demand surges and fiscal pressures. It must have the capacity to innovate and improve and be able to anticipate emerging health needs. Prospective monitoring and documentation of emerging health needs and the burden of illness must be undertaken on an ongoing basis. Strategies must be developed and implemented to meet those needs properly.

ⁱⁱ The CMA's 2007 policy statement '*It's still about access! Medicare Plus*' sets out comprehensive recommendations for the public-private interface in the delivery and funding of health care.

PART 3: THE FRAMEWORK FOR TRANSFORMATION

Summary: The CMA's Health Care Transformation Plan has three core goals: improving population health, improving the patient experience of health care, and improving the value of money spent on health care. There are numerous steps required to transform Canada's health care system so that it becomes highly effective and meets the health needs of Canadians. The next steps are contained in a Framework for Transformation, organized under five pillars, with specific recommendations for action.

1. *Building a culture of patient-centred care*
 - *Creation of a Charter for Patient-centred Care*
2. *Incentives for enhancing access and improving quality of care*
 - *Changing incentives to enhance timely access*
 - *Changing incentives to support quality care*
3. *Enhancing patient access along the continuum of care*
 - *Universal access to prescription drugs*
 - *Continuing care outside acute care facilities*
4. *Helping providers help patients*
 - *Ensuring Canada has an adequate supply of health human resources*
 - *More effective adoption of health information technologies*
5. *Building accountability/ responsibility at all levels*
 - *Need for system accountability*
 - *Need for system stewardship*

The CMA recognizes that none of these directions, taken separately, will transform our health care system. Nor do they represent an exhaustive list of steps, as there are many other directions that can be taken to support our vision. This framework does, however, contain the necessary directions toward the more efficient, high-functioning, patient-focused system that Canadians deserve.

For the transformation plan to succeed, the following key enablers must be in place:

- leadership at all levels including strong political leadership
- well-informed Canadians who understand the need for, and characteristics of, a high-performing health system
- patients, physicians and other providers actively involved in the reform and management of the system
- a commitment to sustainability with adequate levels of resources to ensure that services are in place
- health information technology in place to improve service delivery, manage care within and between services, and monitor and evaluate organization and system performance
- incentives properly aligned to support a variety of funding and delivery models that can meet system goals (e.g., to improve access, to improve quality)
- co-ordinated health human resources planning at the provincial/territorial and national levels
- a commitment to support continuous quality improvement and evidence-informed decision-making at both the policy and clinical levels.

These five pillars contain the directions which the CMA believes are necessary to successfully transform our health care system. Many other reforms have been proposed in Canada and elsewhere but based on international experience, these should receive priority attention.

1. BUILDING A CULTURE OF PATIENT-CENTRED CARE

The concept of “patient-centred care” is taking hold in other developed countries which are also in the process of reforming their health care systems. The essential principle is that health care services are provided in a manner that works best for patients. Health care providers partner with patients and their families to identify and satisfy the range of needs and preferences. Health providers, governments and patients each have their own specific roles in creating and moving toward a patient-centred system.

Patients have consistently emphasized the importance of being respected, having open communication and confidentiality of personal information, in addition to quality medical care. While building a patient-centred system is clearly better for patients, it is also better for physicians and all health care providers and administrators. In a patient-centred system, physicians are provided the optimal environment to give the best possible medical care. From the perspective of health administrators, recruitment and retention of providers who are satisfied with their work and their environment can have many tangible benefits. For instance, hospitals employing patient-centred care principles have found improvements in patient outcomes in areas ranging from decreased length of stay and fewer medication errors to enhanced staff recruitment.¹⁰

It is recognized that health care providers strive to practise patient-centred care. Often the issue is that the system – intended to serve as a network of services – is where patient-centred care breaks down.

CHARTER FOR PATIENT-CENTRED CARE

An important first step in building a culture of patient-centred care is to establish a *Charter for Patient-centred Care*. As a vision statement, the Charter is built on a foundation of reasonableness and fairness, while acknowledging resource constraints. Notwithstanding resource constraints, governments have the duty to ensure availability of the resources required to provide high quality care. This Charter is a mutually reciprocal covenant among patients, physicians, other health care providers, funders and organizers of care.

Dignity and respect

- All persons are treated with compassion, dignity and respect.
- Health care is provided in an environment that is free from discrimination and/or stigma of any kind.
- Health care services respond to individual needs and give consideration to personal preferences.

Access to care (timeliness, continuity, comprehensiveness)

- Access to and timeliness of appropriate medical and psychiatric services is determined by health need.
- Access to appropriate services is not limited by the patient’s ability to pay.
- Care is continuous between health care providers and across settings.

Safety and appropriateness

- Care is provided in accordance with the applicable professional standard of care, by appropriately qualified health care providers, regardless of the location of service.
- Care is based upon the best available evidence and is provided in the safest possible environment.
- The quality of all health care services is evaluated, monitored and improved proactively.
- Care is informed and influenced by lessons learned from any critical incident or adverse event and by patient experiences.

Privacy and security of information

- Personal health information is collected, stored, accessed, used, disclosed and accessible to patients in accordance with applicable law and professional codes of ethics.
- Providers and recipients of care share responsibility for the accuracy and completeness of information in personal health records.

Decision-making

- Patients participate actively with providers in decisions about their medical care and treatment.
- Personal support and assistance with communication is available when required.
- Patients may appoint another person (proxy decision-maker) to act on their behalf and to be aware of their personal health information.
- Decisions for care are made with full disclosure of all relevant information.
- Patients may consent to or refuse any examination, intervention or treatment, and may change or vary their decisions without prejudice.
- Individuals may decline to participate in research without prejudice.

Insurability and Planning of health services

- All parties use health care resources appropriately.
- Recipients and providers are informed and are able to be involved directly, or through representatives, in the planning, organization, delivery and evaluation of health care services.
- Decisions about the provision and insurability of drugs and all other treatments or services are made in accordance with evidence and best practices.
- Government decision-making with respect to the planning, regulation and delivery of health care products and services is transparent.

Concerns and complaints

- Patients may comment on any aspect of their personal health care and have concerns investigated and addressed without repercussions.
- Patients receive timely information and an expression of regret and sympathy if there is any adverse event during their care, regardless of the reason for such event.
- Providers speak publicly and advocate on behalf of Canadians for the provision of high quality care.

Direction

The creation of a *Charter for Patient-centred Care*, as presented above, is a solid foundation on which to build a culture of patient-centred care. In order for the Charter to work, it needs to have supporting mechanisms to ensure accountability. Metrics must be identified to track the elements of the Charter. The Charter needs to be accepted by governments, providers and patients to have an impact on the health system culture and care.

Other examples of activities to promote a culture of patient-centred care may include:

- increasing availability of programs to prevent illness
- increasing involvement of patients and their families in the delivery of care when desired (e.g., if preferred by the patient, family and friends may be trained to help provide care for patients while in the hospital or community)
- soliciting patients' feedback on health care services received, and readiness to make changes based on that feedback
- establishing patient and family advisory councils for hospitals or health regions
- establishing a process for patients or their family members to quickly and efficiently raise a concern about care
- providing patients with information about how to access medical records while in the hospital or in the community

Progress to date/Next steps

The final report of Saskatchewan's Patient First Review, *For Patients' Sake* (2009),¹¹ devoted considerable attention to the need to re-orient health care to a more patient-centred system. As Commissioner Tony Dagnone stated in his report, "patient-first must be embedded as a core value in health care and be ingrained in the 'DNA' of all health care organizations". The report recommended the adoption of a Charter of Patient Rights and Responsibilities for that province.

More recently, an advisory committee to the Alberta Minister of Health has also recommended the creation of a Patient Charter for that province.¹²

Lessons can be learned from the effects of patient charters in other developed countries. The National Health Service in England recently adopted a constitution which establishes its principles and values: sets out the rights to which patients, public and staff are entitled; includes pledges that the National Health Service is committed to achieve; delineates the responsibilities which the public, patients and staff owe to one another to ensure that the National Health Service operates fairly and effectively.¹³ The Australian Charter of Healthcare Rights describes seven charter rights to which patients, consumers, carers and families are entitled and the ways they can contribute to ensuring their rights are upheld.¹⁴ Those rights are: access, safety, respect, communication, participation, privacy and a right to comment on care and have concerns addressed.

2. PROVIDING INCENTIVES TO ENHANCE ACCESS AND IMPROVE QUALITY OF CARE

Canadians have consistently identified timely access as Canada's most pressing health issue. Many other health systems around the world have been successful in dealing with timely access and now

are examining the quality of care being delivered. This direction looks at changing incentives to accomplish two related objectives: improving timely access and supporting quality care.

A. Enhance timely access

Most provinces have taken steps to improve timely access to certain components of their health system. For instance, the Saskatchewan Surgical Initiative has set a target for specialty wait times to be no longer than three months within the next four years.¹⁵

At the physician level, several initiatives are underway across Canada. In late 2009, the Primary Care Wait Time Partnership involving the College of Family Physicians of Canada (CFPC) and the CMA released its final report entitled, *The Wait Starts Here*.¹⁶ The report identifies several strategies for improving timely access to primary care. Efforts are also underway in some jurisdictions, such as in Manitoba, to improve the referral process from family physician to specialist (i.e., the timeliness and the appropriateness of referrals).

Activity-based funding – an idea raised in the Kirby Commission’s final report¹⁷ – is another strategy to improve timely access at the facility level. Activity-based funding is a reimbursement mechanism that pays hospitals for each patient treated on the basis of the complexity of their case. A reimbursement level is set for each type of case then applies to all hospitals within the jurisdiction. It is also known as service-based funding, case-mix funding or patient-focused funding. As such, funding is viewed as “following the patient” since the hospital is paid only if the service is provided, resulting in increased productivity and in some instances, competition among hospitals to treat patients.

Financing of hospital services in most industrialized countries involves some portion of activity-based funding. Canada, although it has been a pioneer in the methodology that underlies activity-based funding, has had limited application for funding purposes. Most hospitals in Canada receive their funding in the form of a global budget that is usually based on historical funding levels. As a result, a well-performing hospital emergency room does not receive any additional funding for seeing more patients.

Direction

Canada should move toward partial activity-based funding for hospitals to improve hospital productivity. It is almost impossible to decrease wait times and reward productivity without this change in funding. While some countries have implemented 100% activity-based funding, other countries have shown that productivity can increase when even 25% of hospital funding is allocated in this manner.

Progress to date/Next steps

A number of provinces have taken steps to introduce activity-based funding for facility-based care. The government of British Columbia announced that it will provide “patient-focused funding” for the province’s 23 largest hospitals.¹⁸ Ontario already has some limited activity-based funding for its hospitals and the government has announced that it will introduce patient-based payment for hospitals on April 1, 2011 as part of a multi-year implementation plan.¹⁹ Alberta announced in 2009 that it would be adopting a form of activity-based funding for long-term care facilities that started

April 1, 2010 and for hospitals the year after.²⁰ While not yet in place in Québec, the adoption of activity-based funding was recommended in the 2008 Castonguay report.²¹

Much of the work involved in supporting the adoption of partial activity-based funding has already been undertaken by CIHI and its well-developed Case Mix Group program supported by case-costing data from BC, Alberta and Ontario.

B. Support quality care

Timely access is one dimension of quality. But there are many other dimensions of quality including safety, effectiveness, appropriateness and acceptability. More recently in Canada, attention is now focused on incentives to improve quality in the processes of care to achieve better outcomes.

Incentives for providers

Pay-for-performance involves the use of an incentive payment to reward a hospital or physician provider for achieving a target for the quality of patient care. This may be linked to processes or outcomes of care and could be related to the attainment of a specified threshold and/or percentage improvement. Performance incentives may also be linked to the structure of health care delivery as well as the process of that delivery.²² It is important to note that pay-for-performance, which refers to incentive payments for achieving quality targets, is not the same as activity-based funding, which is a reimbursement mechanism that pays hospitals for each patient treated on the basis of the complexity of their case.

Performance incentives can be targeted at both group output provided by a team of providers (nurses, physical therapists, physicians, etc.) as well as individual members of the team. The incentives may also be targeted at measuring the process involved in delivering the desired health care output.

Canada will likely follow the lead of other countries in increasing the focus on the outputs and outcomes of the health care system. The promise of pay-for-performance programs is that they can improve access, quality and accountability. Pink et al.²³ have tried to synthesize the international experience with pay-for-performance and its implications for Canada. Based on this assessment they offer four key considerations:

1. Pay-for-performance could potentially be used to target individual providers, provider groups/organizations, or health regions.
2. The selection of quality measures should consider provincial/territorial health goals and objectives, measures included in existing report cards, evidence and the ability to risk-adjust and the extent of provider acceptance.
3. Development of pay for performance should consider factors that are within the scope of control of providers, use positive incentives over disincentives and consider size/timing and perceived fairness of awards.
4. Program evaluation should consider the impact on patients and providers, quality measurement and how payments are used to improve quality.

In addition, they cite the need to address enablers/barriers including information technology, consultation, implementation costs and resistance.

Direction

Implement appropriate pay-for-performance systems. Adopt principles that secure equity and efficiency in pay-for-performance programs in Canada that will ensure the best outcomes for patients, physicians and the health care system at large.

Progress to date/Next steps

Pay-for-performance has already started in a number of provinces as seen in the table below.

Examples of pay-for-performance programs already in effect in Canada

Province	Type of program
Nova Scotia	Family Physician Chronic Disease Management Incentive Program
Ontario	Cumulative Preventive Care Bonuses for achieving specified thresholds of preventive care for their patients in five areas: influenza vaccine, pap smear, mammography, childhood immunizations and colorectal cancer screening
Manitoba	Physician Integrated Network has a Quality Based Incentive component ²⁴
Alberta	Performance and Diligence Indicator (PDI) Fund for Family Physicians: The PDI Fund provides payments to family physicians who meet specific indicators in the care of their patients. The PDI program “will provide payments to individual family physicians, in and out of primary care networks, who meet specific performance and/or diligence indicators that deliver substantive clinical value” ²⁵
British Columbia	Full Service Family Practice Incentive Program: this includes an obstetrical care bonus payment and an expansion of the Full Service Family Practice Condition Payments that were introduced in 2003. The condition-based bonus payments are related to the monitoring patients’ course of care according to BC Clinical Guidelines for diabetes, congestive heart failure and hypertension ²⁶

Pay-for-performance programs will continue to expand in Canada. Governments and insurance companies are introducing pay-for-performance incentive programs throughout the industrialized world with the goal of improving health care delivery efficiencies and especially to improve patient care. These are lofty goals because measuring improvements in patient care is complicated. It is vital that physicians, patients and the health care system establish principles that can guide them to make the best decisions concerning pay-for-performance. The scope of the program and what is measured will surely evolve. Full-scale adoption requires an electronic medical record (EMR) to be in place.

Incentives for patients

At a macro level, public policies can be instituted to encourage healthy behaviours and environmental improvements (e.g., water quality standards). At the individual level, consideration should be given to empowering patients through the use of patient incentives.

A rapidly emerging dimension of pay-for-performance is the use of incentives directed at the patient for health maintenance and healthy behaviours. Hall has reported that a number of US employers are offering tangible rewards to employees such as cash, merchandise, vacation days, and reductions in health care premiums or deductibles.²⁷ These incentives are targeted variously at:

- activity (e.g., completing a health risk assessment)
- achievement (e.g., quitting smoking, lowering Body Mass Index)
- adherence (e.g., remaining tobacco-free for 12 months)

Positive incentives are used to promote healthy behaviours by transferring funds or alternate benefits to an individual. They work by providing immediate rewards for behaviours that usually provide only long-term health gains. Positive incentives have been shown to be effective in promoting singular, discrete behaviours, such as vaccinations, screening programs, and attending follow-up appointments. An example of an existing Canadian federal government incentive is the children's fitness tax credit. This credit is intended to promote physical activity among children by off-setting some of the cost incurred by families for sports and leisure programs.

In Germany, bonuses for healthy behaviours are integrated into the health system. They are offered for both primary and secondary prevention, including check-up programs, achieving healthy weights, smoking cessation, memberships in sports clubs, and other health-promoting activities. The bonuses take the form of points that can be redeemed for items, including sports equipment, health books or reduction in insurance premiums, or in some cases cash. There are also bonuses, in the form of a reduction in co-payments, for adhering to the treatment plan and participating in special care plans.²⁸

Negative incentives or disincentives by governments largely involve the use of regulation and taxation in order to change individual behaviour. This helps to create an environment in which healthy choices are easier to make. For example, the taxation of tobacco, alcohol or unhealthy foods (such as those high in fat, salt or sugar) are commonly cited interventions. Taxes on tobacco products have been highly effective in reducing use. Studies linking cost to consumption of high-sugar content beverages demonstrate a strong link between higher prices and reduced consumption.²⁹

3. ENHANCING PATIENT ACCESS ALONG THE CONTINUUM OF CARE

The continuum of care may be defined as the array of health services, regardless of the age of the recipient, ranging from primary care (including health promotion and illness prevention), through institutionally based secondary and tertiary care for acute medical situations, to community- and home-based services that promote health maintenance and rehabilitation for people with chronic problems, and finally to palliation at the end of life.

There is a strong realization that Canada's Medicare system covers a decreasing portion of this continuum. An example of where deficits exist is mental health. The CMA's 2008 annual meeting (General Council) tackled the issue of improving access to mental health services as part of a greater effort led by the Mental Health Commission of Canada. The CMA is currently working toward the several resolutions that were adopted, but there are two other areas that are in urgent need of attention.

Crucial to improved care is (A) universal access to comprehensive prescription drug coverage and; (B) improving access to continuing care (long-term care, home care and palliative care/hospice).

Physicians currently spend a significant amount of time assisting patients to obtain access to necessary prescription drugs. Physicians and families are also heavily engaged in time-consuming efforts to place patients in long-term care facilities or secure assistance in the home. Improving access for Canadians in these two areas would help create a more patient-centred health care system, and enhance efficiency for providers.

CMA approved a new policy on *Funding the Continuum of Care* in December 2009 that identifies a number of overall principles to enhance the continuum of care:

- optimal management of the continuum of care requires that patients take an active part in developing their care and treatment plan, and in monitoring their health status
- the issue of the continuum of care must go beyond the question of financing and address questions related to the organization of the delivery of care and to the shared and joint responsibilities of individuals, communities and governments in matters of health care and promotion, prevention and rehabilitation
- support systems should be established to allow elderly and disabled Canadians to optimize their ability to live in the community
- strategies should be implemented to reduce wait times for accessing publicly funded home and community care services
- integrated service delivery systems should be created for home and community care services
- any request for expanding the public plan coverage of health services, in particular for home care services and the cost of prescription drugs, must include a comprehensive analysis of the projected cost and potential sources of financing for this expansion

A. Universal access to prescription drugs

Prescription drugs represent the fastest-growing item in the health budget, and the second-largest category of health expenditure. It is estimated that less than one-half of prescription drug costs were publicly paid for in 2008.² Moreover, Canada does not have a nationally coordinated policy in the area of very costly drugs that are used to treat rare diseases.

The term “catastrophic” has been used by First Ministers and in the National Pharmaceutical Strategy to describe their vision of national pharmaceutical coverage. As defined by the World Health Organization, catastrophic expenditure reflects a level of out-of-pocket health expenditures so high that households have to cut down on necessities such as food and clothing and items related to children’s education. From the CMA’s perspective, the goal is comprehensive coverage for the whole population, pooling risk across individuals and public and private plans in various jurisdictions.

Direction

Governments, in consultation with the life and health insurance industry and the public, should establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial/territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies.

Such a program should include the following elements:

- a mandate for all Canadians to have either private or public coverage for prescription drugs
- uniform income-based ceiling (between public and private plans and across provinces/territories) on out-of-pocket expenditures on drug plan premiums and/or prescription drugs (e.g., 5% of after-tax income)
- federal/provincial/territorial cost-sharing of prescription drug expenditures above a household income ceiling, subject to capping the total federal and/or provincial/territorial contributions either by adjusting the federal/provincial/territorial sharing of reimbursement or by scaling the household income ceiling or both
- group insurance plans and administrators of employee benefit plans to pool risk above a threshold linked to group size
- a continued strong role for private supplementary insurance plans and public drug plans on a level playing field (i.e., premiums and co-payments to cover plan costs)

Furthermore the federal government should:

- establish a program for access to expensive drugs for rare diseases where those drugs have been demonstrated to be effective
- assess the options for risk pooling to cover the inclusion of expensive drugs in public and private drug plan formularies
- provide adequate financial compensation to the provincial and territorial governments that have developed, implemented and funded their own public prescription drug insurance plans
- provide comprehensive coverage of prescription drugs and immunization for all children in Canada
- mandate the CIHI and Statistics Canada to conduct a detailed study of the socio-economic profile of Canadians who have out-of-pocket prescription drug expenses, in order to assess barriers to access and to design strategies that could be built into a comprehensive prescription drug coverage program

Progress to date/Next steps

Provinces and territories have begun to establish public programs of income-based prescription drug coverage. Québec was the first, starting in 1997, and it remains the only province to mandate universal coverage — that is, citizens must have either public or private coverage. Alberta is the most recent to move in this direction, with a seven-point pharmaceutical strategy that was introduced in 2009.³⁰

Overall, however, there is significant variation between the coverage levels of the various plans across Canada. For example, the Manitoba Pharmacare Program is based on adjusted total income (line 150 of the Income Tax return). For families with incomes above \$75,000 the deductible is set at 6.08% of total family income.³¹ In Newfoundland and Labrador, the ceiling on drug costs is set at 10% of net family income (line 236 of the Income Tax return).³² There is wide variation in the burden of out-of-pocket expenditure on prescription drugs in Canada. In 2006 there was almost five-fold variation in the percentage of households spending more than 5% of net income on prescription drugs between PEI (10.1%) and Ontario (2.2%).³³

There is some concern about access to cancer drugs, particularly those that are administered outside of hospital. The Canadian Cancer Society has recently reported that of the 12 cancer drugs approved since 2000 that are administered outside a hospital or clinic, three-quarters cost \$20,000 or more annually.³⁴ In 2009, Ontario Ombudsman André Morin issued a report critical of the Ministry of Health's decision to limit public funding of the colorectal cancer drug Avastin to 16 cycles.³⁵ Subsequently the government announced that it would cover the cost beyond the 16 cycles if medical evidence from a physician indicates that there has been no disease progression.³⁶

Most, if not all, key national health stakeholders (hospitals,³⁷ pharmacists,³⁸ nurses,³⁹ brand name pharmaceuticals,⁴⁰ life and health insurance industry⁴¹ plus the health charities) have adopted policy statements on catastrophic coverage. There seems to be an unprecedented consensus among health stakeholders on this issue.

The most likely window of opportunity to urge the federal government to take action in this area will be the renegotiation of the Health Accord that is set to expire on March 31, 2014.

B. Continuing care

Continuing care includes services to the aging and to the disabled of all ages provided by long-term care, home care and home support.⁴² Because continuing care services are excluded from the *Canada Health Act*, they are, for the most part, not provided on a first-dollar coverage basis. As this kind of care moves away from hospitals and into the home, the community or into long-term care facilities, the financial burden has shifted from governments to the general public. Furthermore, there is tremendous variation across the country in the accessibility criteria for both placement in long-term care facilities and for home care services.

According to Statistics Canada's most recent population projections, the proportion of seniors in the population (65+) is expected to almost double from its present level of 13% to between 23% and 25% by 2031.⁴³ While the impact of an aging population on our health care system must not be overlooked, the continuing care needs of the disabled population at all ages must also be appropriately addressed.

In the 2004 Health Accord, the provinces and territories agreed to publicly fund two weeks of acute home care after hospital discharge, two weeks of acute community mental health care and end-of-life care.⁴⁴ Outside of these areas, the types of services offered and funding models vary widely. Continuing care in Canada faces three key challenges:

1. **Lack of capacity and access:** There is tremendous variation among regions in the levels of public funding for facility-based long-term care. Part of the reason is the lack of national standards for home care services, which results in a wide range of the types of services available, their accessibility, wait times and eligibility for funding. The widespread scarcity of long-term care facilities and home care services has had deleterious consequences: emergency departments are being used as holding stations while admitted patients wait for a bed to become available, surgeries are being postponed, and the care for Alternate Levels of Care patientsⁱⁱⁱ is compromised in areas that may not suit each patient's specific needs. Major investment is required in community and institutionally based care.

ⁱⁱⁱ Patients who remain in hospital while waiting for placement in long-term care facilities or for home care arrangements to be made.

2. Lack of support for informal caregivers: Much of the burden of continuing care falls on informal (unpaid) caregivers. More than one million employed people aged 45-64 provide informal care to seniors with long-term conditions or disabilities⁴⁵ and 80% of home care to seniors is provided by unpaid informal caregivers.⁴⁶
3. Lack of funding for long-term care: It is impractical to expect future requirements for long-term care to be funded on the same “pay-as-you-go” basis as other health expenditures. While there is general agreement that, wherever possible, residents should contribute at least a partial payment toward the cost of accommodation at a long-term care facility, the calculation for these charges is inconsistent across the country.

Direction

Ensure that all Canadians have affordable and timely access to all elements of any continuing care they require.

The CMA recommends the following actions:

- Construction should begin immediately on additional long-term care facilities. With the senior population projected to increase to around 24% of the population by 2031, and with 3.5% of seniors currently living in these facilities, in order to simply maintain the same occupancy rates, we will need roughly 2,500 additional homes by then. The Building Canada Fund is an ideal source of initial infrastructure funding.
- The federal government should work with the provinces and territories to create national standards for continuing care provision in terms of eligibility criteria, care delivery and accommodation expenses, using the Veterans Independence Plan as a starting point.
- The federal government should make long-term care insurance premiums tax deductible, introduce a Registered Long-term Care Plan and/or consider adding a third special provision for the Registered Retirement Savings Plan (RRSP) that is similar to the Lifelong Learning Plan and the Home Buyers' Plan, which will allow working adults to draw from their RRSP, without penalty, to pay for their long-term care or home care needs; and consider adding a third payroll tax for continuing care purposes.
- Governments initiate a national dialogue on the *Canada Health Act* in relation to the continuum of care.
- Governments should adopt a policy framework and design principles for access to publicly funded medically necessary services in the home and community setting that can become the basis of a “Canada Extended Health Services Act”.
- Governments and provincial/territorial medical associations review physician remuneration for home- and community-based services.
- Governments undertake pilot studies to support informal caregivers and long-term care patients, including those that
 - a) explore tax credits and/or direct compensation to compensate informal caregivers for their work
 - b) expand relief programs for informal caregivers that provide guaranteed access to respite services in emergency situations
 - c) expand income and asset testing for residents requiring assisted living and long-term care
 - d) promote information on advance directives and representation agreements for patients

Progress to date/Next steps

Many other groups have released reports on this issue, including the Canadian Healthcare Association's 2009 reports on home care and long-term care. Among many other recommendations, both of these reports call for the introduction of national minimum standards for care and additional support for caregivers.^{47, 48}

New Brunswick announced an ambitious long-term care strategy in early 2008 and the province has invested \$167 million in long-term care facilities since 2007. There are plans to open 318 nursing home beds over the next three years, with plans to open a total of 700 in the next 10 years.⁴⁹ The federal government should use New Brunswick as an example to encourage all other provinces and territories to follow suit.

In its final report released in April 2009, the Special Senate Committee on Aging made 32 recommendations; eight of them specifically address health care for seniors in terms of care provision, accommodation and affordability.⁵⁰

As with improving access to prescription drugs, the most likely window of opportunity to press the federal government to take action in the area of continuing care will be the renegotiation of the 2004 Health Accord that is set to expire on March 31, 2014.

4. HELPING PROVIDERS HELP PATIENTS

The fourth pillar of health care transformation speaks to creating necessary resources to support patient-centred care. Two areas that are absolutely essential are: (A) an adequate supply of health human resources; and (B) health information technology at the level in which care is provided or point of care.

A. Health human resources

Every high-performing health system begins with a strong primary care system in place. Yet roughly 5 million Canadians do not have a regular family physician, and once Canadians do access primary care, they often face long waits to see consulting specialists, and further waits for advanced diagnostics and ultimately treatment. Part of the reason for these delays is the shortage of health care professionals in Canada.

An Organization for Economic Co-operation and Development (OECD) study of countries with wait times shows that the availability of physicians has the strongest association with lower wait times than any other factor.⁵¹ Notably, Canada's physician supply relative to the population is far below the OECD average. Statistics indicate that in 2006 Canada had only 2.15 practising physicians per 1,000 population compared to the OECD average of 3.07.⁵² With the number of medical graduates similarly low in comparison to the OECD average, Canada cannot expect to make up the difference without some new sources for physicians.

Nurses and other health professionals are also in short supply, in Canada and across the globe. The Canadian Nurses Association is projecting a shortage of 60,000 full-time equivalent nurses in Canada by 2022 if no new policies are adopted,⁵³ and Western Europe is also experiencing a significant nursing shortage. The global shortage of health professionals compounds the problem — while Canadian training programs still lack sufficient seats to produce enough new providers to meet

current and future demands, Canadian-educated physicians, nurses, technicians, etc, are being lured away by ample opportunities to train and work outside of Canada.

Initiatives such as the Nursing Sector Study,⁵⁴ Task Force Two,⁵⁵ the 2004 *Federal/Provincial/Territorial 10-year Plan to Strengthen Health Care*⁴⁴ and the 2005 *Framework for Collaborative Pan-Canadian Health Human Resources Planning*⁵⁶ have all yielded abundant information and recommendations, yet Canada still seems unable to maintain a stable supply of physicians, nurses, technicians or other health care professionals to provide the care and treatment patients need.

In its 2008 election platform, the federal government announced that it would contribute funds to the provinces and territories to create 50 new residency positions (\$10 million/year for four years), ease repatriation of Canadian physicians living abroad (\$5 million/year for four years) and help fund the development of nursing recruitment and retention pilot projects (\$5 million over three years). On May 10, 2010, Health Minister Leona Aglukkaq announced funding of \$6.9 million for 15 additional family medicine residents in the University of Manitoba's Northern and Remote Family Medicine Program. This is a promising start.⁵⁷

Collaborative care models – whereby health professionals work together with, and in the best interests of, the patient – can help address some of the gaps in health human resources. Over the past decade there have been three key trends pertinent to collaboration in health care:

- the contention/recognition that collaboration is an important element of quality patient-centred care
- the growing interest in inter-professional education among health professions
- the sustained efforts by governments to foster multidisciplinary teams by creating competitive conditions in primary care through expanding the scope of other non-physician providers

Physicians recognize the value of collaboration. The Royal College of Physicians and Surgeons of Canada (RCPSC), the CFPC and the CMA have all released policy documents that identified collaboration with other health professionals as a key role of the physician.^{58,59,60} The RCPSC has since been working to incorporate these roles and competencies in postgraduate medical training programs across Canada. In 2006, the national boards of ten health professional organizations including CMA and CFPC each ratified the principles and framework for interdisciplinary collaboration in primary health care that were developed by a consortium of staff of these organizations, sponsored by the federal Primary Health Care Transition Fund.⁶¹

In an effort to find ways to better distribute the workload and improve access to care, much attention has been turned to the role of physician extenders such as physician assistants. Physician assistants can be trained to work autonomously to evaluate, diagnose and treat patients in a partnership and with the supervision of a licensed physician.

In Canada, four programs exist to train physician assistants. The Canadian Forces Medical Services School at the Canadian Forces Base Borden in Ontario trains Canadian Forces members while civilian physician assistants can train at McMaster University, the University of Toronto and the University of Manitoba. After the CMA Board approved the inclusion of the physician assistant profession as a designated health science profession within the accreditation process in 2003, its Conjoint Accreditation Services accredited the Canadian Forces' Physician Assistant Program in

2004. Although this program is currently the only one accredited, the other three schools are undergoing the process.

Working smarter, Canada needs to be more systematic about innovations and adoption of health sector resources. There is no national body in Canada equivalent to the Institute for Healthcare Improvement in the US, or the National Health Service's Institute for Innovation and Improvement in England, that is charged with promoting innovation in the delivery of health services. In Canada, the \$800-million 2000 Primary Health Care Transition Fund and its fore-runner the \$150-million 1997 Health Transition Fund were intended to buy transformation in areas linked to primary care. For the most part, this resulted in short-term pilot demonstration projects that ended when the money ran out. Arguably only Ontario and Alberta have achieved lasting results through the development and proliferation of new models of primary care delivery.

Direction

Ensure Canada's health care system has an adequate supply of human resources. Addressing health human resource shortages is critical to ensuring a sustainable, accessible and patient-centred health care system. The evaluation of and long-term planning for health human resources needs to be performed by a national body using the best available evidence to support its deliberations. Based on the defined need, there are four main mechanisms to address the shortage of health human resources in the Canadian health care system. These are:

1. increase medical school and residency positions to replenish and increase our physician supply for the future
2. invest in recruitment and retention strategies for physicians, nurses and other health care workers
3. ease the process of integration into our health care workforce for international medical graduates and Canadian physicians returning from abroad
4. introduce new providers such as physician assistants to the health care workforce

Progress to date/Next steps

Immediate specific steps for increasing Canada's supply of health human resources are as follows:

1. Urge the federal government to honour the remainder of its 2008 commitment to fund residency positions, repatriation of Canadian physicians abroad and pilot projects to recruit and retain nurses.
2. Secure comprehensive funding plans for physician assistant compensation.
3. Continue to work with the Federation of Medical Regulatory Authorities of Canada and provincial/territorial medical associations to monitor the impact of the new labour mobility provision of the Agreement on Internal Trade on the distribution and mobility of physicians.
4. Work with provincial/territorial medical associations to carry out an inventory and assessment of the payment arrangements across Canada that foster the emergence of new practice models based on an interdisciplinary approach and the use of new information technologies.
5. Work with other stakeholders to promote the idea of a national locus for innovation in the delivery of health care.

Since it can take ten years or longer to train a new physician depending on specialty, the results of increasing medical school placements and residency positions will not be immediate. However, this plan would ultimately increase the future supply of physicians, and serve as a step toward becoming more self-sufficient in the future.

As medical education and postgraduate training extend beyond academic health science centres to the community, and as inter-professional education takes on greater emphasis, educational programs need to ensure quality training experiences. Physicians-in-training require adequate human, clinical and physical resources to train appropriately. Programs must ensure that all new teaching sites are properly equipped to take learners.

Training new providers, such as physician assistants, is a medium-term option since it takes fewer years (as few as two depending on the program) to train them. Increasing their numbers within the health workforce and permitting them to share some tasks will allow physicians to devote more one-on-one time with patients. Similarly, integrating international medical graduates and repatriating Canadian physicians currently practising outside the country could be a quicker method of increasing physician numbers than training new physicians, provided that appropriate immigration policies and licensure processes are in place.

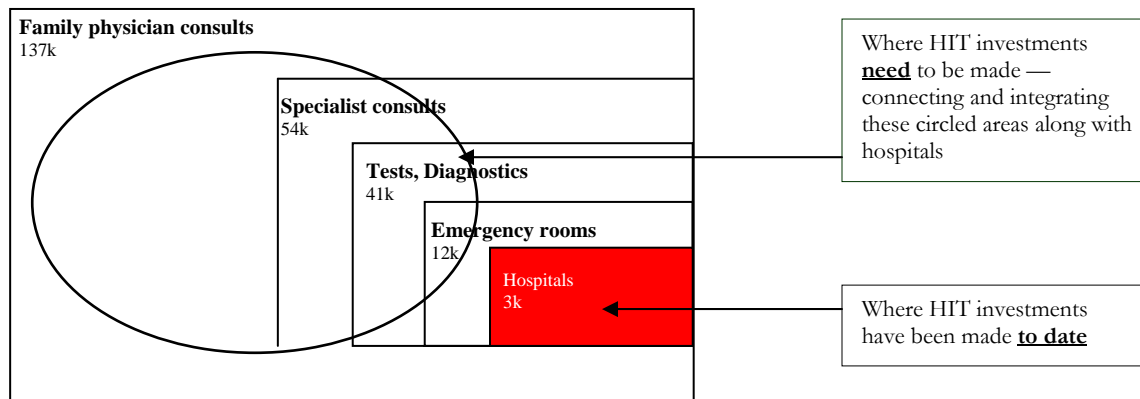
Removing certain constraints, such as limited operating room times, and providing support for collaborative models of care would allow the health human resources currently available to optimize their ability to practise. These options could see results in the shorter term.

B. More effective adoption of health information technologies (HIT)

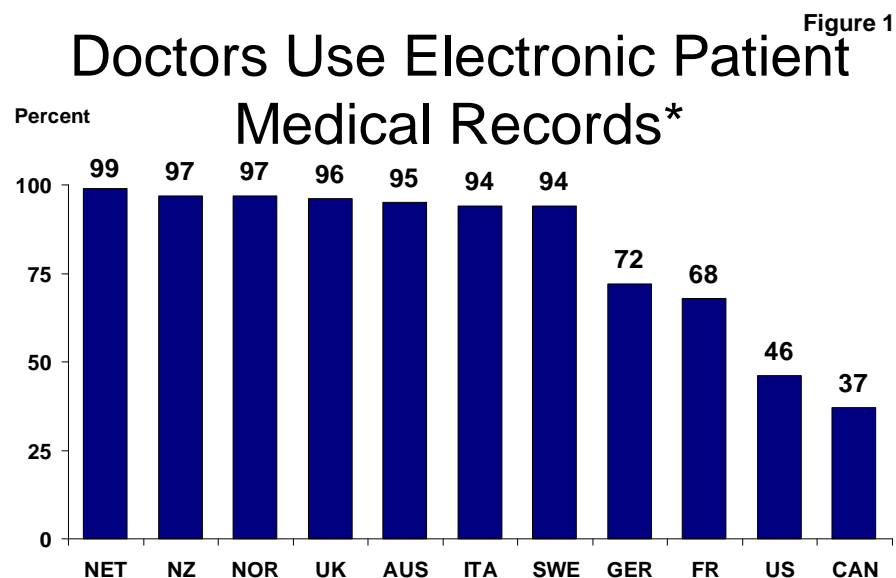
Over the past decade, Canada's ministers and deputy ministers of health have been developing strategies to relieve mounting pressures within the health care sector. In all of these strategies, HIT has been viewed as a foundational component. Five main reasons for implementing HIT have been identified: improved health outcomes (patient safety, wait time reduction), increased accessibility, better integration of health care "silos," cost efficiencies and improved patient-provider satisfaction.

Multi-billion dollar investments made in Canada on HIT, however, have not yet resulted in significant benefits to providers or patients. In large measure this is due to the fact that all jurisdictions have taken a top-down approach to their HIT strategies and focused their investment on large-scale HIT systems and architecture, with very little investment being made at the points of care where the actual benefits of HIT will be realized.

The majority of health care occurs at the local level. Some 400 million patient encounters take place in Canada each year with most occurring in primary care settings with physicians, clinical teams, in home care and long-term care facilities.⁶² Patient-physician office interactions outnumber patient-hospital interactions by a ratio of 18 to 1. In Ontario (Diagram 1), just 3,000 out of an average of 247,000 patient visits per day – or 1.2% – are made in hospitals.

Diagram 1. Patient visits per day in Ontario (Canada Health Infoway)

Compared to a select group of other industrialized countries, Canada ranks *last* in terms of “health information practice capacity” (i.e., the use of EMRs in primary care practice). According to the most recent Commonwealth Fund study (Figure 1) conducted in 2009, only 37% of Canadian primary care physicians use some form of EMR. That compares to 99% in the Netherlands, 97% in New Zealand, 96% in the UK and 95% in Australia.⁶³



* Not including billing systems.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Direction

We need to move from a top-down approach to one that gives all providers, and in particular physicians, the lead role in determining how best to use HIT to improve care, improve safety, improve access and help alleviate our growing health human resource issue. HIT adoption needs to be accelerated, but in a way that focuses on the individual patient and where he or she interacts with the health care delivery system, with the intent of improving quality of care and patient safety. An important priority must be a clear, target-driven plan that meets the needs of Canadian physicians and their patients.

The CMA and provincial/territorial medical associations will develop a five-year plan with clear targets for accelerating the adoption of HIT in Canada. This includes working with governments to accelerate the introduction of e-prescribing in Canada to make it the main method of prescribing by 2012.

Progress to date/Next steps

In February 2009, the federal government announced a \$500 million investment in HIT, with specific focus on EMRs and point of care integration, as part of their Economic Stimulus package. Transfer of these funds to Canada Health Infoway was delayed due to concerns over accountability and lack of progress on the electronic health record (EHR) agenda on the part of Infoway and most jurisdictions. The Office of the Auditor General's report on Infoway, and six provincial audits on jurisdictional EHR progress addressed these concerns and the funds were finally transferred in spring 2010.

CMA is working to ensure that the bulk of this investment is allocated to physician EMRs, as well as local interoperability solutions and applied research on EMR use and patient tools. How to achieve this goal will be described in detail in the CMA's upcoming five-year strategy for HIT investment in Canada, a plan to connect the delivery points at the front lines of care.

Provincially, BC, Alberta, Saskatchewan, Ontario and Nova Scotia have established EMR funding programs and are the most likely to meet targets and realize the value of HIT. The addition of \$500 million federal stimulus funding to this environment will allow the remaining provinces and territories to implement similar programs.

The key will be to focus HIT efforts and investment directly at the point of care. The CMA five-year HIT plan takes a grassroots, bottom-up approach and identifies ways to quickly implement local and regional solutions that will deliver short-term, tangible benefits without building un-scalable, expensive point-to-point solutions.

The five-year HIT plan in and of itself is not the goal of this undertaking. The key to effectiveness lies in ensuring any HIT plan sets clear benchmarks and targets for reporting progress and demonstrating value of accelerated HIT adoption in terms of patient care – access, quality and safety.

The CMA five-year HIT strategy will set out clear targets and metrics for benchmarking progress and demonstrating value. Tracking and reporting on progress against these targets would occur over the following three to five years, with a final report card to be released at the end of this period.

5. BUILDING ACCOUNTABILITY/RESPONSIBILITY AT ALL LEVELS

Two key issues confronting the Canadian health care system are (A) the lack of accountability for system quality of care and performance, and (B) the lack of stewardship for the integrity of the public health insurance program and its long-term financial sustainability.

A. Need for system accountability

The past decade has seen growing demand for accountability for performance and outcomes at all levels of the health care system, which has been impossible to deliver due to a lack of direction,

resources or accountability. As a result, Canada's ability to report publicly on the performance of the Canadian health care system has been piecemeal at best. A main stumbling block is the federal/provincial/territorial dynamic, with provinces and territories being primarily responsible for health care.

In 2000, First Ministers made a commitment to develop common indicators to report to their citizens and in 2003 they set out some 40 indicators in the areas of timely access, quality, sustainability and health status and wellness. Subsequently, the Health Council of Canada was set up to monitor the 2003 Health Accord, but since 2004 only the federal government has honoured its commitment to produce indicators, and Québec and Alberta do not participate on the Health Council. The December 2008 report of the federal Auditor General criticized Health Canada for a lack of interpretation in its report and on the limited number of indicators specific to the First Nations and Inuit Health, for which Health Canada is responsible.⁶⁴

Some national organizations and private organizations are reporting on health system performance at the macro level. CIHI has been producing annual wait time reports in the past years. Think tanks that have also reported on health system performance include: the Commonwealth Fund, the Conference Board of Canada (which has ranked Canada as a middle-of-the-pack performer) and the Euro-Canada Health Consumer Index, which has ranked Canada 30th out of 30 countries in terms of value for money spent on health care in both 2008 and 2009 (the US was not included).⁷ The Wait Time Alliance⁶⁵ has produced five report cards on wait times, assessing national and provincial/territorial performance on access to elective care. The CMA has been releasing an annual report card as part of the General Council meetings for the past nine years.

At the provincial/territorial level, reporting on health system performance varies widely. All provinces and territories have been reporting wait times, albeit in varying degrees and quality, for some elective surgical care. Several provinces have quality health councils which are producing reports on the quality of care being received. The Ontario Health Quality Council has released several reports on the performance of Ontario's health system, reporting on nine attributes of a high-performing health system.⁶⁶ Many of these reports call for the need to accelerate the adoption of electronic health records to acquire better data and properly assess health system performance.

Ontario has been a leader in health care reporting within Canada. Since the early 1990s, the Ontario Cardiac Care Network has been the gold standard for the comparison of cardiac centres on the basis of wait time and crude and risk adjusted mortality and length of stay data.⁶⁷ In 1997, a research team at the University of Toronto, funded by the Ontario Hospital Association, began developing a hospital report that focused on key areas of hospital activity including patient perceptions of hospitals.⁶⁸

In 2007, CIHI released Canada-wide Hospital Standardized Mortality Ratios (HSMR) for the first time. The HSMR is the ratio of actual (observed) deaths to expected deaths, and is adjusted for several factors that affect in-hospital mortality.⁶⁹

Most recently, the Saskatchewan Health Quality Council issued its first *Quality Insight* report which reports at the health region (and, in some cases, hospital) level on 121 indicators in the areas of chronic diseases (asthma, diabetes, post heart attack), drug management and patient experience.⁷⁰

The quest to improve quality of care is a dominant issue in European health systems. The UK, Denmark and the Netherlands have all implemented mechanisms to monitor the performance of their health system. Accountability and monitoring instruments in place in these three countries include: ratings of hospitals, ratings of doctors and system performance reports. In addition, the UK has organizations devoted to monitoring and improving the quality of its health care system.

Public reporting on health system performance enjoys high public acceptability. This was the finding of CMA's consultation process for its health care transformation project. Seventy percent of the public surveyed by Ipsos Reid supported independent reviews of hospitals on quality and performance.

National Health Goals were developed by the Government of Canada and approved in a broad consensus by all of the provinces and territories in 2005.⁷¹ While there was universal acceptance of these goals at the time, there has been limited action on developing a framework and indicators for monitoring achievements. Comprehensive approaches to population health require coordinated action across governments, supported by a common vision, such as national health goals. The CMA strongly supports the advancement of the National Health Goals agenda and believes that public reporting of supporting indicators reflecting the determinants of health as well as health services and outcomes are an important component of improving the health status of Canadians.⁷²

Direction

Improve the accountability of the Canadian health care system by reporting publicly on the performance of the system including outcomes. What is needed is a systemic approach to public reporting that shifts the focus from “blame and shame” to quality improvement.

Progress to date/Next steps

Based on the foregoing, the most likely opportunity for advancing the idea of increased public reporting in the short term will be to work with existing national and provincial/territorial organizations involved in acquiring and analyzing data related to health system performance. At the federal level, the renegotiation of the Health Accord in the lead-up to March 31, 2014 is the best opportunity to see a heightened commitment to improve public reporting at a coordinated federal-provincial-territorial level.

Provincially, Québec's recent budget devoted considerable attention to the issue of system accountability. That government announced the annual publication of health accounts to improve transparency and public awareness on health care spending. The accounts, released with the budget, list health and social services spending and revenues. It also includes a breakdown of health sector resources including the number of physicians and nurses and hospitalization days.

B. Need for system stewardship

To ensure accountability and responsibility, it will be necessary to establish an arm's-length, independent body to monitor, in a transparent manner, the medium to longer-term prospects of the comparability and financing of health care programs for Canada and the provinces and territories.

Since its establishment, Canada's national Medicare program has been a funding partnership between the federal and provincial/territorial governments. Since the mid-1990s, this partnership

has been beset by problems, due in part to the exclusive jurisdiction of the provinces/territories to administer health programs and to the federal government's unilateral cut to cash transfers of some \$6 billion with the implementation of the Canada Health and Social Transfer in 1996.

Three broad concerns have been expressed:

1. Lack of accountability of the provincial/territorial governments for use of health transfer funds: at the provincial level, the reports of both the Ménard (2005)⁷³ and Castonguay (2008)²¹ commissions in Québec called for the establishment of a health account which would provide accountability for how revenues collected for health are used and to inform the public about issues such as financial sustainability of health programs.
2. Canada is a “patchwork quilt” in terms of the continuum of care: there is increasing concern about the wide variation in the level of services provided across the country. The *Canada Health Act* program criteria only apply to hospital and medical services, and those represent just 41% of total health spending. There is roughly a further 25% of health spending that is public but there is wide variability across jurisdictions with respect to coverage of broader continuum care, such as home care and prescription drugs. For example, Statistics Canada estimates that there was almost five-fold variation in the proportion of households spending more than 5% of net income on prescription drugs in 2006, ranging from 2.2% in Ontario to 10.1% in PEI.³³
3. Canada may not be able to sustain Medicare on a “pay-as-you-go” basis: in 1998 the Auditor General of Canada published a report on the implications of the aging population which projected that government spending on health as a share of GDP could as much as double from its 1996 level of 6.4% to 12.5% by 2031 if it increased at an annual rate of 2% real growth.⁸

In 1998 the Auditor General recommended that the government produce long range financial projections on the basis of status quo policies and alternatives that would be presented to Parliament. In its response, the government indicated that it would continue its fiscal planning on the basis of setting and meeting short-run targets.

Clearly we need to be able to look beyond year-over-year budgeting and reporting.

The Parliamentary Budget Officer has recently published a report on Canada's emerging “structural deficit” that estimated this shortfall will reach a level of \$19 billion in 2013-14.⁷⁴ The Parliamentary Budget Officer's mandate does not extend to the provincial/territorial governments.

While a number of agencies and organizations are doing work related to long-term system sustainability, each is constrained in some manner from carrying out the forward looking cross-jurisdictional analyses that are required.

Direction

Establish an arm's-length mechanism to monitor the financing of health care programs for the federal and provincial/territorial levels, to assess the comparability of coverage across jurisdictions, to assess value for money and to make recommendations to governments on the sustainability of the current Medicare program and mechanisms to fund additional programs that cover the continuum of care.

Progress to date/Next steps

At the federal level, the renegotiation of the Health Accord in the lead-up to March 31, 2014 is the best opportunity to see if such a concept could be acceptable at the federal/provincial/territorial level.

The CMA met with federal and provincial auditors general on March 16, 2010 to discuss system accountability and sustainability. The auditors general were very interested in this issue and some anticipate examining the matter in the coming months.

PART 4: AN ACTION PLAN FOR 2010-2014

With the CMA's ambitious triple aim of improving the health of the population at large, patients' health care experience and value for money spent, the transformation of health care will inevitably be a multi-year and multi-pronged initiative.

The first priority has been the release of this document, with its emphasis on adopting a *Charter for Patient-centred Care*. The final goal is to ensure that the First Ministers' Agreement in 2014 addresses longer-term fundamental issues, such as providing appropriate access to comprehensive pharmaceuticals and continuing care for all Canadians, and implementing a proper accountability framework.

As a multi-year initiative, the CMA will pursue the actions described under the health care transformation directions between now and 2013, in time for the negotiation of the next potential Health Accord expected to take effect after the current 2004 agreement expires.

As previously mentioned, the directions listed do not represent an exhaustive list. Rather, they are intended to serve as a foundation for change that will build momentum for health care transformation leading to better care.

It will be important to demonstrate tangible results – early wins – so that the public, health care providers and system funders can sense the move toward a more patient-focused system and become energized to implement subsequent actions.

Summary timeline of key health care transformation deliverables

Release of Framework and <i>Charter for Patient-centred Care</i>	Summer 2010
IT: Federal support for EMRs	2010
Partial Activity-Based Funding	Beginning 2010
Interoperability/e-prescribing	2011-2012
Health human resources – new funding models (physician assistants)	2011
Comprehensive pharmacare/long-term care	2014 Accord
Accountability Framework	2014 Accord

PART 5: CONCLUSION

The policy directions contained in this document, while fundamental, do not represent the entire array of possible choices. This document focuses on the “what” of health care transformation. The “how to” of implementation will require considerable further work, tailored to the needs and circumstances of the various jurisdictions and their populations.

Some of the directions in this document are meant to be carried out by government, some by providers, and some by patients. Many, but not all, of the ideas set out in this document will require additional investment by governments. It will not be possible to implement all of these policy directions at the same time. Much of what is outlined here will be put in place at the provincial/territorial level and will be phased in as each jurisdiction deems fit. Provinces and territories must be encouraged to share the lessons they learn as changes are made so that other jurisdictions can build on their successes. Provision must be made for evaluation and mid-course correction to ensure that the proposed directions achieve their intended objectives.

The CMA, our partner provincial/territorial medical associations and the physicians of Canada are committed to inspiring change, for the benefit of the patients we serve and in the interests of our members. The aspirations embodied in this document will foster transformation that allows us to accomplish our goals as physicians – to serve the public, provide for our patients’ health needs optimally, and to make our health care system more effective, accountable and sustainable now and for the generations to come.

APPENDIX A – HEALTH CARE FUNDING AND THE SUSTAINABILITY CHALLENGE

Highlights:

The ability to pay for health care, which is in competition with all the other legitimate uses for public funds, and the ability to maintain a health workforce are both central to the concept of sustainability. While there is ample evidence that health spending continues to outpace other areas of public expenditure and the growth of government revenue, there is no consensus that we need to act on it. The section notes the necessity of raising funds from private sources if there is no political appetite or public support for increasing public revenues for health.

Other key points in this section:

- *Appropriate investments in health care result in improved health, which reduces health care demand in the future by decreasing the burden of illness in the population. Better health and the resultant improved productivity of the population pays economic dividends for the country.*
- *Given our changing population demographics, governments in Canada will face challenges finding new revenue streams to fund appropriate initiatives such as long-term care, home care or enhanced pharmaceutical coverage over the next two decades.*
- *A large unfunded liability will be created as a consequence of the need to address our growing, aging population that is increasingly burdened with multiple chronic illnesses. Only recently have a few jurisdictions recognized the unfairness of saddling this economic burden on future generations.*
- *Overall health spending is consuming a rising proportion of total government program spending. It also is rising faster than the growth in our GDP, so our ability to pay for health care is increasingly in question. Other important societal programs will be increasingly jeopardized in order to pay for health care programs.*
- *Methods to manage the gap between current levels of expenditure and what will be required to maintain and respond to future health care demands include, a) reducing services and therefore reducing expenditures, b) raising taxes and c) developing new sources of revenue (such as patient co-payments, population health premiums and private insurance).*
- *Our system and culture relies on the principle of collective risk-pooling so as to lessen individual burden. To sustain health care for current and future Canadians and to expand the basket of required coverage, given our changing demographic reality, creative approaches to managing and funding our health system are necessary.*

The ability to pay for health care is increasingly in question. The challenge of sustaining our health care system is what makes it imperative to move forward now with health care transformation. Sustainability in health care may be defined as the ability to deliver universal publicly funded health care services without compromising other government programs or the ability of future generations to pay. In 2001 the Honourable Roy Romanow was tasked by the federal government to study and make recommendations in order to “ensure over the long-term the sustainability of a universally accessible, publicly funded health system.” The Romanow Commission put forward 47 recommendations in 2002 with a view to “buying change”.⁷⁵ Similarly, the Kirby Commission in its review of the Canadian health care system recommended an additional \$5 billion of federal funding per year to restructure and renew Medicare.¹⁷ These reports were followed by additional federal funding in the amounts of \$34.8 billion and \$41.3 billion in the 2003⁷⁶ and 2004⁴⁴ First Ministers’ Accords respectively. Eight years later it is evident that, for the most part, these Accords bought time, not change.

The directions set out in Part 3 of this report rest on two critical assumptions with respect to sustainability. The first is that there is a business case for quality. That is to say, investments in quality today will pay off in improved health that, in turn, will reduce health care demand and expenditures down the road. The resultant improved productivity from the reduction of illness in the population will generate economic dividends for the country.

A second assumption is that timely and appropriate interventions will relieve access bottlenecks currently generating unproductive costs. A study conducted for the CMA in 2008 makes the case: it estimated the cost of excess waiting for four procedures at almost \$15 billion.⁷⁷ Hence, the introduction of activity-based funding for hospitals might not reduce hospital costs in total, but if it increases throughput and timely access there will be offsets in improved quality of life and productivity of the population. Clearly, the gains resulting from these assumptions will not be realized in the short term.

All the numbers on sustainability, including the projections by Desautels and Page (highlighted in Part 1), assume the status quo in terms of publicly funded programs. But the current system is hardly sustainable on a quality of care basis, particularly given the demographic changes that will see fewer working-age Canadians supporting more and more elderly citizens weighed down by drug costs and the need, over time, for nursing home care. Given our changing population demographics, governments in Canada cannot avoid the challenge of finding new revenue streams to fund appropriate initiatives, such as long-term care, home care or enhanced pharmaceutical coverage over the next two decades.

Since the 1990s, there have been repeated recommendations for expanded public coverage of prescription drugs and home care. Health ministers have estimated it would cost \$5 billion for governments to provide “catastrophic” pharmaceutical coverage, meaning no household has to spend more than 5% of net income on prescription drugs.⁷⁸ In contrast, there has been no national policy discussion about the funding of long-term care. Alberta made an exploratory move in this direction in 2005 when it commissioned Aon Consulting to develop health insurance models for continuing care.⁷⁹ Aon estimated that in order to pre-fund projected costs to 2050, a flat dollar charge of \$779 per capita, indexed at 4% per year, would be required for all Albertans aged 16 or over.⁸⁰ Similarly, the Organization for Economic Co-operation and Development (OECD) has estimated that long-term care accounted for 1.2% GDP in Canada in 2005 and that, at a minimum, the burden will double to 2.4% by 2050.⁸¹ A significant amount of this share will almost certainly be publicly funded.

Canada will soon have to grapple with how to finance a more comprehensive – and expensive – system of health and continuing care. This, in turn, raises issues about intergenerational equity, that is to say the fairness with which the costs of the system are distributed between generations. If these escalating costs are not addressed now, future generations will be unfairly, and possibly untenably, saddled with the burden flowing from today’s growing elderly population.

Academics have developed a technique called generational accounting to measure this effect.⁸² Hagist has applied generational accounting to estimate the revenue gap for health expenditures in six countries. The revenue gap is the percentage increase in taxes that would have to be applied immediately for both living and future generations to bring current fiscal policy on a sustainable track. The same study also estimated a delayed revenue gap, which is the percentage increase that will be required if increases are postponed until 2050. The results for the six countries are shown in Table 1.

Table 1
Estimates of current and delayed revenue gap for health expenditures
Selected countries (% increase)

Country	Switzerland	Austria	France	Germany	UK	US
Revenue Gap	27.1	13.2	9.0	25.9	23.6	27.0
Delayed Revenue Gap	63.1	28.0	17.4	60.7	47.7	46.9

Source: Hagist, C. Demography and Social Health Insurance. Baden-Baden:Nomos, 2008.

As one can see, significant immediate increases in revenues are required in all six countries and much more drastic increases will be required if action is delayed. Klumpes and Tang have also applied generational accounting to the funding of the UK National Health Service. They found that under the base assumption of a 2% real interest rate, future tax payers will need to contribute about ten-fold what 2005 new tax payers did.⁸³ In Canada, Robson has applied similar methods to estimate the “unfunded liability” that will result from an aging population. He estimates that between 2007 and 2050, provincial and territorial health budgets will experience an aggregate liability of almost \$1.9 trillion if things continue along as they are.⁸⁴

Total health spending in Canada reached an historic high of 11.9% of GDP in 2009. While this reflects, in part, the effect of the recession in lowering GDP, health spending grew by 5.5% in nominal terms and 3.3% in real terms over 2008. Table 2 shows the average percentage increases in health and total program spending from 1999 to 2008 and the most recent experience of the provinces and territories as presented in their 2010-11 budgets.

Table 2▲
Health and Program Spending 1999-2008 and
Selected Indicators 2010 Provincial Territorial Budgets

Province / Territory	1999-2008 Average Annual % Increase in Health Spending ^a	1999-2008 Average Annual % Increase in Program Spending ^a	Health as % Program Spending 2010-11	% Increase in Health Spending 2010-11 over 2009-10	% Increase in Program Spending 2010-11 over 2009-10	% Increase in Revenue 2010-11 over 2009-10
NL	6.2	6.9	37.8	12.4	8.4	3.8
PE	8.4	5.9	37.3	3.9	0.3	2.9
NS	7.2	5.9	46.4	6.8	-0.3	3.5
NB	7.0	4.5	36.7	3.5	1.2	1.8
QC	6.4	5.4	44.7	3.7	2.9	2.9
ON ^b	7.7	6.0	39.8	6.0	6.5	10.8
MB	6.7	5.4	45.1	5.0	0.8	1.8
SK	7.2	6.6	43.4	6.4	0.6	-0.8
AB	10.2	10.2	44.7	16.6	5.6	1.3
BC ^c	6.4	3.6	45.6	5.1	4.8	5.8
NT	5.2	4.9	25.2	0.3	5.7	5.0
YT	8.1	7.4	21.9	-7.6	-0.8	8.0
NU	9.3	9.1	24.3	-3.7	1.9	5.9
Average	7.4	6.3	37.9	4.5	2.9	4.1

▲ Data sources available upon request

^a Source: Canadian Institute for Health Information

^b Note the budget also contains an estimate that health is 45% of program spending in 2010-11

^c Total health spending by function is estimated at 42.1% of all government spending

The evidence is incontrovertible that health spending has continuously outpaced other areas of public expenditure. All provinces are expecting further health spending increases in 2010-11 – ranging from 3.7% in Québec to 16.6% in Alberta. In eight out of ten provinces, increases in health spending exceed increases in both total program spending and provincial/territorial revenue. As a percentage of program spending, health stands near or just over 45% in six provinces.

Aside from Québec (which is discussed below), few measures have been taken to address the problem. It may well require a province or territory to exceed the psychological barrier of 50% to incite a concerted response. This is suggested by a February 2010 poll done for CMA by Ipsos Reid in which respondents were also asked to estimate the actual, appropriate and maximum proportions of their provincial/territorial budget that are or should be devoted to health. The averages estimated by the public are as follows:

- actual current percentage – 38%
- appropriate percentage – 47%
- maximum percentage – 52%.

The prospect of going beyond the 50% threshold of the share of government program spending on health might be likened to the proverbial “crossing the Rubicon,” which means following a course of action on which there is no turning back. To follow the 50%+ trajectory under the current parameters of Medicare, taxes will surely have to increase, either through general taxation or a dedicated health premium or some variant thereof. Another option that would still pool risk would be the establishment of a contributory social insurance fund.

If, however, there is no political appetite or public support for increasing public revenues for health on the basis of universality and risk pooling then we will be faced with options for raising funds from private sources. These could include co-payments for publicly insured services, private insurance or out-of-pocket payment for uninsured/deinsured services, and deductibles linked to utilization.

Québec has been the first among the provinces and territories to acknowledge that the current approach to funding health care is neither sustainable in the long term nor fair to future generations – and to announce measures to address the problem. It has taken three major task forces over the past decade to get to this point. In 2001 the Clair Commission recommended a capitalized (pre-funded) insurance plan to cover loss of autonomy.⁸⁵ Clair also put forward the idea of the creation of a provincial health insurance corporation apart from the Health Ministry. In 2005 the Ménard Committee again recommended the establishment of an insurance scheme for persons experiencing loss of autonomy, as well as the creation of a health and social services account that would provide transparency and accountability for the sources and uses of funds.⁷³ In 2008 the Castonguay Task Force recommended a dedicated “health stabilization fund” that would be funded in part by a deductible linked to medical visits that would be collected at year-end through the income tax system. Castonguay also recommended a health account.²¹

In response to these studies, the 2010-11 Québec budget contained the following measures:

- starting July 1, 2010 a health contribution (premium) will be introduced, to be collected through the tax system; starting at \$25 per adult, this will increase to \$200 by 2012 at which time it is expected to raise \$945 million

- further study of the introduction of a health deductible as proposed by Castonguay
- the introduction of an annual health account⁸⁶

Other jurisdictions will also need to give consideration to options for at least partially pre-funding future health care expenditures.

The findings of the February 2010 survey conducted for CMA by Ipsos Reid suggest that Canadians would prefer an option that would assure that funds raised would be dedicated to health care over an option that would simply add additional funds to the consolidated revenue account (Figure 2).

Figure 2 Funding Future Health Expenditures: Selected Options

A patient pay approach to funding is more popular than a tax-based solution by a 2 to 1 margin

Over the next two decades there will be fewer working Canadians relative to the total population. Which of the following do you think would be the best way of ensuring that there will be enough government tax revenue to pay for future health care expenditures without compromising other government programs?



Base: All respondents (n=2,017)

Source: Ipsos Reid, CMA, 2010

In considering such options, however, one must be mindful of the current experience with existing mechanisms that are available to Canadians to accumulate savings. According to Canada Revenue Agency Statistics for the 2007 tax year, one in four (26.4%) Canadians with a taxable return reported making a RRSP contribution.⁸⁷ The likelihood of making RRSP contributions was strongly correlated with income – 15% or fewer with those with incomes less than \$25,000 reported one, rising to greater than 60% among those with incomes of \$80,000 or greater. There may be greater uptake with the Tax-free Savings Account (TFSA) that was introduced in 2009. A poll done by Ipsos Reid in June 2009 found that 21% of households had opened a TFSA.⁸⁸ No research has been done on the salience of saving for future health needs as compared to RRSPs and TFSAs.

The CMA's 2006 discussion paper *It's About Access: Informing the Debate on Public and Private Health Care* provides a comprehensive overview and discussion of the international application and pros and cons of a range of public and private funding options.

It also sets out ten policy principles to guide policy decision-making related to the public-private interface. In brief, these are:

- | | |
|----------------------|--------------------------------|
| 1. Timely Access | 6. Quality |
| 2. Equity | 7. Professional Responsibility |
| 3. Choice | 8. Transparency |
| 4. Comprehensiveness | 9. Accountability |
| 5. Clinical Autonomy | 10. Efficiency ⁸⁹ |

We believe that these principles will serve to guide a national debate.

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