SENATE SÉNAT
CANADA

Time for Transformative Change

A Review of the 2004 Health Accord

Standing Senate Committee on Social Affairs, Science and Technology

The Honourable Kelvin K. Ogilvie
Chair

The Honourable Art Eggleton, P.C.
Deputy Chair

March 2012

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Extract from the *Journals of the Senate*, Thursday, June 23, 2011:

With leave of the Senate,

The Honourable Senator Ogilvie moved, seconded by the Honourable Senator Frum:

That, pursuant to Section 25.9 of the *Federal-Provincial Fiscal Arrangements Act*, the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on the progress in implementing the 2004 10-Year Plan to Strengthen Health Care;

That the papers and evidence received and taken and work accomplished by the committee on this subject during the Fortieth Parliament be referred to the committee; and

That the committee submit its final report no later than December 31, 2011, and that the committee retain all powers necessary to publicize its findings until 180 days after the tabling of the final report.

The question being put on the motion, it was adopted.

Extract from the *Journals of the Senate*, Wednesday, November 30, 2011:

The Honourable Senator Ogilvie moved, pursuant to notice of November 29, 2011, moved:

That notwithstanding the Order of the Senate adopted on June 23, 2011, the date for the presentation of the final report by the Standing Senate Committee on Social Affairs, Science and Technology on the progress in implementing the 2004, 10-Year Plan to Strengthen Health Care, be extended from December 31, 2011 to March 31, 2012.

The question being put on the motion, it was adopted.

Gary W. O'Brien

Clerk of the Senate

Members

The Honourable Kelvin Kenneth Ogilvie, Chair
The Honourable Art Eggleton, P.C., Deputy Chair

The Honourable Senators:
Catherine S. Callbeck
Andrée Champagne, P.C.
Jane Cordy
Jacques Demers
Lillian Eva Dyck
Yonah Martin
Pana Merchant
Judith Seidman
Asha Seth
Josée Verner

Ex Officio Members:
The Honourable Senators Marjory LeBreton, P.C. (or Claude Carignan) and James Cowan (or Claudette Tardif).

Other Senators who have participated from time to time in the study:
The Honourable Senators Braley, Campbell, Comeau, Day, Eaton, Housakos, Hubley, Lang, Meighen, Mercer, Neufeld, Patterson, Peterson, Raine, Rivard and Zimmer.

Parliamentary Information and Research Services, Library of Parliament:
Karin Phillips, Analyst.

Clerk of the committee:
Jessica Richardson

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Diane McMartin, administrative assistant

EXECUTIVE SUMMARY

A. Introduction

On January 31, 2011, the Minister of Health requested that the Standing Senate Committee on Social Affairs, Science and Technology initiate the second parliamentary review of the 10-Year Plan to Strengthen Health Care (10-Year Plan), an agreement reached by First Ministers on September 16, 2004 that focuses on federal/provincial/territorial (F/P/T) collaboration in the area of health care reform. The committee's study is undertaken pursuant to section 25.9(1) of the Federal-Provincial Fiscal Arrangements Act, which requires that a parliamentary committee review progress towards the implementation of the 10-Year Plan on or before March 31, 2008 and three years thereafter. The committee's review also includes an examination of the separate *Communiqué on Improving Aboriginal Health*, which was released by First Ministers and Leaders of National Aboriginal Organizations[1] on 14 September, 2004.[2]

This report presents the committee's findings regarding progress towards the implementation of the 10-Year Plan and the *Communiqué on Improving Aboriginal Health* and identifies further actions that could be taken in support of the objectives outlined in these documents. It reflects the testimony presented by witnesses over the course of 13 hearings and one roundtable discussion, as well as many written submissions received from interested organizations and individuals.

The key themes raised by these witnesses provide the basis and spirit of the recommendations outlined in this report. Witnesses emphasized to this committee the central importance of adopting a holistic understanding of health that sees physical and mental wellbeing as inextricably linked and equally important to the efficiency and quality of health care systems. This holistic concept of health has become a framing principle for this report.

Witnesses also stressed that many of the factors that influence the health outcomes of Canadians lie beyond health care systems and are located in the social determinants of health, a point that is reflected most clearly in the poorer health status of Aboriginal peoples and the challenges children and youth face with respect to mental health and obesity.

Throughout the course of this study, witnesses were emphatic that health care reform could only be achieved by breaking down the different silos within health care systems. They insisted that different health care sectors such as primary, acute, continuing care and mental health services be integrated through common governance structures and funding arrangements and supported by seamless information systems. The integration of different health care professionals into primary

[1] These included the Assembly of First Nations (AFN), the Inuit Tapiriit Kanatami (ITK), the Métis National Council (MNC), the Congress of Aboriginal Peoples (CAP) and the Native Women's Association of Canada (NWAC).

[2] Canadian Intergovernmental Conference Secretariat, "Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting," Special Meeting of First Ministers and Aboriginal Leaders, Ottawa ON, 13 September 2004, http://www.scics.gc.ca/english/conferences.asp?x=1&a=viewdocument&id=1167

health care teams requires the adoption of different methods of remuneration that allow for different health care professionals to work together. Furthermore, they underscored the vital importance of making patients' needs and perspectives central to these reform efforts.

Witnesses provided exciting examples of reforms occurring at the front lines of health care delivery in Canada. However, they indicated that systemic change had stalled. When compared internationally, they noted that Canada is no longer seen as a model of innovation in health care delivery and financing. They therefore identified the need for specific mechanisms to promote the implementation of new practices in health care systems across the country. Otherwise, they feared that health care reform in Canada would never evolve beyond a pilot project.

Finally, many witnesses said that resources currently committed to federal, provincial and territorial health care systems are sufficient to provide Canadians with a high standard of quality health care, but they also told the committee that innovation-based transformation is needed to achieve and sustain these systems. These witnesses were unequivocal in their insistence that any increases in health care funding be used to promote change rather than maintain the status quo. They therefore argued that governments need to focus on creating incentives to transform health care systems. The committee heard that there is a real appetite among health care professionals to truly transform the way that they do business and achieve lasting reform. The committee believes that the time for this transformative change is now. It therefore recommends:

RECOMMENDATION 1

That the committed annual increase in funding transferred from the federal government to the provinces and territories, through the Canada Health Transfer, be used by governments in great part to establish incentives for change that focus on transforming health-care systems in a manner that reflects the recommendations outlined in this report, and the overarching objectives of the 2004 10-Year Plan to Strengthen Health Care, including the need for measurable goals, timetables and annual public reporting through existing mechanisms.

B. Progress in Implementing the 10-Year Plan to Strengthen Health Care

An agreement between First Ministers, the 10-Year Plan to Strengthen Health Care identified ten main priorities for health care reform in Canada:[3]

- reducing wait times and improving access;
- strategic health human resource (HHR) action plans;
- home care;

[3] Further details regarding these ten components of the 10-Year Plan and its associated communiqués are outlined in subsequent sections of this report. Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

- primary health care reform, including electronic health records and telehealth;
- access to care in the North;
- National Pharmaceuticals Strategy;
- prevention, promotion and public health;
- health research and innovation;
- accountability and reporting to citizens; and
- dispute avoidance and resolution.

In support of these objectives, the federal government provided provinces and territories with additional long-term funding amounting to $41.3 billion from 2004 to 2014.[4] The bulk of the funding would be provided through the Canada Health Transfer (CHT)[5], as a conditional cash transfer that would escalate by 6 per cent per year, amounting to $35.3 billion in total by 2014. In addition to funding provided through the CHT, the federal government allocated $5.5 billion over a 10-Year period to reduce wait times. A further $500 million was earmarked for enhanced investments in medical equipment. Finally, $850 million was allocated to Aboriginal health programs and the Territorial Health System Sustainability Initiative (THSSI). The following sections examine how jurisdictions have used these funds to meet the specific commitments under each component of the 10-Year Plan.

1. Reducing Wait Times and Improving Access to Care

As part of the 2004 10-Year Plan, First Ministers agreed to achieve reductions in wait times for procedures in five priority areas: cancer, heart, diagnostic imaging, joint replacements and sight restoration by March 31, 2007. In order to demonstrate meaningful progress in reducing wait times in these areas, First Ministers agreed to:[6]

- Establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be produced by December 31, 2005;
- Establish evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration by December 31, 2005 through a process developed by Federal, Provincial and Territorial Ministers of Health;
- Establish multi-year targets to achieve priority benchmarks by December 31, 2007; and

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[4] Finance Canada, "The Canada Health Transfer," brief submitted to the Senate Standing Committee on Social Affairs, Science and Technology, March 2011.

[5] The Canada Health Transfer consists of cash levels that are set in *Federal-Provincial Fiscal Arrangements Act* and an equalized tax point transfer to the provinces and territories that grows in line with economy and is based upon a province or territory's resource revenue and its participation in Canada's equalization program. For further details, please see: James Gaulthier, "Background Paper: The Canada Health Transfer: Changes to Provincial Allocations," Publication No. 2011-02E, 25 February 2011, http://lpintrabp.parl.gc.ca/lopimages2/prbpubs/pdf/bp1000/2011-02-e.pdf

[6] *Ibid.*

- Report annually to their citizens on their progress in meeting their multi-year wait-time targets.

In their evaluation of progress towards achieving these objectives, the committee found that governments had, for the most part, met their obligations in relation to the establishment of benchmarks in four of the five priority areas (cancer, heart, sight restoration, and joint replacement) and reporting on progress. In addition, the committee heard that targeted funding had resulted in an increase in the number of surgeries in the priority areas, as well as the number of diagnostic imaging services performed. Moreover, the committee heard that eight out of ten Canadians were indeed receiving treatment within the established time frames. However, the committee also heard from witnesses that there were significant variations among provinces in meeting the benchmarks in some of the priority areas and considers this to be a concern.

The committee also heard that the wait time agenda had certain limitations, including that the benchmarks established were not based upon sufficient research, which in some cases, led to questioning of their appropriateness by health care providers and policy makers. Moreover, they were not patient-centred in that they did not reflect the complete wait times experienced by patients across the continuum of care, with witnesses emphasising the lack of timely access to primary care physicians as being of particular concern.

The committee also heard from witnesses that further meaningful reductions in wait times could best be achieved through reforms to health care systems and increasing efficiencies through management practices, rather than by increasing funding alone. With respect to moving the wait-times agenda forward, the committee recommends:

RECOMMENDATION 2

That provinces and territories continue to develop strategies to address wait times in all areas of specialty care, as well as access to emergency services and long-term care, and report to their citizens on progress.

RECOMMENDATION 3

That the federal government work with provinces, territories and relevant health-care and research organizations to develop evidence-based pan-Canadian wait-time benchmarks for all areas of specialty care that start when the patient first seeks medical help.

RECOMMENDATION 4

That the federal government provide the Canadian Health Services Research Foundation[7] or the Canadian Institutes of Health Research with funding to:

a) **commission research that would provide the evidence base for the development of pan-Canadian wait-time benchmarks for all areas of specialty care; and**
b) **commission research to evaluate the appropriateness of existing pan-Canadian wait-time benchmarks related to cancer, heart, sight restoration, and joint replacement.**

RECOMMENDATION 5

That the Health Council of Canada examine best practices in reducing wait times across jurisdictions, through improvements in efficiency, focusing in particular on management practices such as pooling waitlists, the adoption of queuing theory and the development of referral guidelines and clinical support tools.

RECOMMENDATION 6

That the federal government work with provincial and territorial governments to develop a pan-Canadian vision statement that would foster a culture of patient-centred care in Canada through the establishment of guiding principles that would promote the inclusion of patient needs and perspectives in an integrated health-care-delivery process.

RECOMMENDATION 7

That the federal, provincial and territorial governments ensure accountability measures be built into the Canada Health Transfer agreement, to address the needs of disabled persons.

2. Health Human Resources

In the 10-Year Plan, First Ministers agreed to increase the supply of health care professionals in Canada, as shortages were seen as particularly acute in some parts of the country.[8] They also agreed to ensure an appropriate mix of health care professionals and to make their health human resources

[7] The Canadian Health Services Research Foundation is an independent not-for-profit corporation established through endowed funds from the federal government and its agencies that is dedicated to accelerating health-care improvement and transformation, by converting innovative practices and research evidence into practice. It commissions research that focuses on the following areas: health-care financing and transformation, primary care, and Canada's aging population. http://www.chsrf.ca/AboutUs.aspx

[8] Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

(HHR) action plans public by December 31, 2005. In addition, the federal government committed to:[9]

- Accelerating and expanding the assessment and integration of internationally trained health care graduates for participating governments;

- Targeting efforts in support of increasing the supply of health care professionals for Aboriginal communities and Official Languages Minority Communities;

- Take measures to reduce the financial burden of students in specific health education programs; and

- Participate in health human resource planning with interested jurisdictions.

Overall, the committee heard from witnesses that there have been significant increases in the supply of health professionals in Canada since the 10-Year Plan was signed in 2004, including in areas of federal responsibility such as Official Language Minority Communities and First Nations and Inuit communities. However, the committee heard that shortages remained an ongoing concern, particularly in rural and remote areas and Aboriginal communities. The committee also heard that there is a need to make greater efforts to promote the inter-professional education and training of health professionals in order to promote ongoing efforts towards the development of multi-disciplinary health care teams across Canada. In addition, the committee heard that current efforts to support the integration of Internationally Educated Health Professionals (IEHPs) into health care systems need to be accelerated. The committee is also of the view that the federal government needs to play a greater leadership role in promoting pan-Canadian collaboration HHR planning with interested jurisdictions. As witnesses articulated, this is necessary in order to support jurisdictions in identifying which health professionals need to be trained to meet and reflect the differing needs of their populations. The committee therefore recommends:

RECOMMENDATION 8

That the federal government take the lead in working with the provinces and territories to:

a) evaluate the impact of health-human-resource observatories in other jurisdictions;
b) conduct a feasibility study, and determine the benefit of establishing a pan-Canadian health-human-resource observatory and report on the findings.

[9] *Ibid.*

RECOMMENDATION 9

That the Canadian Institutes of Health Information include linguistic variables in their collection of data related to health human resources and populations served by health-care systems across Canada.

RECOMMENDATION 10

That the federal government work with the provinces and territories and relevant health-care organizations to reduce inequities in health human resources, such as rural and remote health care, vulnerable populations, and Aboriginal communities.

RECOMMENDATION 11

That the federal government, through its Foreign Credential Recognition Program, take the lead in working with provincial and territorial jurisdictions and relevant stakeholders to accelerate their efforts to improve the assessment and recognition of the foreign qualifications of internationally educated health professionals and their full integration into Canadian health-care systems, in line with the principles, obligations and targets agreed upon in the Federal/Provincial/Territorial *Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications*.

RECOMMENDATION 12

That the federal, provincial and territorial governments work with universities and colleges to increase inter-professional training of health-care practitioners to continue the development of multi-disciplinary health-care teams in Canada.

3. Home Care

Under the 10-Year Plan, First Ministers recognized the importance of home care as an essential part of an integrated patient centred health care system and[10] they agreed to provide first dollar coverage[11] for certain home care services by 2006:[12]

- short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;

[10] Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

[11] First dollar coverage refers to an insurance policy that provides full dollar coverage of the service without the payment of a deductible by the client.

[12] Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

- short-term acute community mental health home care for two-week provision of case management and crisis response services; and

- end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life.

The 10-Year Plan further required that jurisdictions report on progress towards the implementation of these services with Health Ministers providing an additional report to First Ministers on the next steps in fulfilling home care commitments by December 31, 2006.

The committee's review found that jurisdictions had made progress in improving access to acute home care services; acute community mental health home care services; and end-of-life care. However, the review also found that governments did not meet their reporting requirements relating to home care due to a lack of agreement regarding developing indicators and targets for progress in this area. The committee also shares the concerns of witnesses related to the increased costs of drugs and supplies experienced by patients and families as a result of being treated out-of-hospital, as well as the reduction of chronic home care services currently being offered, given the increasing burden of chronic diseases in Canada. The committee also heard from witnesses that overall, the 10-Year Plan adopted a narrow approach to addressing home care that did not include ensuring access to a broad range of services that were considered by witnesses to be important parts of home care. In addition, the committee heard that home care needs to be better integrated with the acute and primary care sectors, mental health services, as well as the full range of continuing care services that includes palliative care and facility based-long term care. Finally, the committee agrees with witnesses that governments need to take further action to promote access to high quality palliative and end-of-life care in Canada, as well as raise awareness among Canadians regarding the importance of planning end-of-life care. The committee therefore recommends:

RECOMMENDATION 13

That the federal government work with provincial, territorial governments and other relevant stakeholders to develop indicators to measure the quality and consistency of home care, end-of-life care, and other continuing care services across the country.

RECOMMENDATION 14

That where necessary, jurisdictions expand their public pharmaceutical coverage to drugs and supplies used by home care recipients.

RECOMMENDATION 15

That the Mental Health Commission of Canada work with the home care sector to identify ways to promote the integration of mental health and home care services.

RECOMMENDATION 16

That Health Canada, taking the lead, work with provinces and territories to create and implement an awareness campaign for Canadians about the importance of planning end-of-life care.

RECOMMENDATION 17

That the federal government work with provincial and territorial governments to develop a pan-Canadian Homecare Strategy, which would include a focus on reducing the burdens faced by informal caregivers.

RECOMMENDATION 18

That the federal government work with the provinces and territories to increase access to palliative care as part of end of life health services in a broad range of settings including residential hospices.

RECOMMENDATION 19

That the federal, provincial, and territorial governments develop and implement a strategy for continuing care in Canada, which would integrate home, facility based long-term, respite and palliative care services fully within health care systems. The strategy would establish clear targets and indicators in relation to access, quality and integration of these services and would require governments to report regularly to Canadians on results.

4. Primary Care Reform

The 10-Year Plan highlighted timely access to family and community care through primary health care reform as an ongoing priority; and therefore, First Ministers committed to ensuring that 50% of Canadians have 24/7 access to multidisciplinary health care teams by 2011.[13] They further agreed to establish a best practices network to share information and find solutions to barriers to progress in primary health care reform. The committee's study revealed that though there were many innovations occurring in primary care to ensure that 50% of Canadians had 24/7 access to a multi-disciplinary health care team, jurisdictions have yet to meet this goal. The committee heard from witnesses that key challenges relating to achieving systematic primary care reform are: current remuneration models; the lack of governance mechanisms to manage and steer reform efforts; and the need for targeted conditional funding arrangements. The committee is of the view that jurisdictions need to find ways to address these key challenges and re-commit to meeting the goal established in the 10-Year Plan. The committee heard from witnesses that there was also an ongoing

[13] Health Canada, "First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care," 16 September, 2004," http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

need to share best practices in primary health care reform and jurisdictions should work together to address their common challenges. Witnesses felt that the federal government could play a leadership role by promoting the sharing of best practices in these areas. The committee therefore recommends:

RECOMMENDATION 20

That the federal, provincial and territorial governments share best practices in order to examine solutions to common challenges associated with primary-care reform, such as: the remuneration of health professionals; the establishment of management structures to guide primary-care reform; and the use of funding agreements linked to public health goals.

RECOMMENDATION 21

That the federal government work with the provinces and territories to re-establish the goal of ensuring that 50 per cent of Canadians have 24/7 access to multi-discliplinary health-care teams by 2014.

5. Electronic Health Records and Tele-health

In the 10-Year Plan, First Ministers recognized the development of Electronic Health Records (EHRs)[14] and tele-health as integral parts of health care renewal, particularly in rural and remote areas.[15] They therefore agreed to accelerate the development of EHRs across the country, as well as tele-health in rural and remote areas. Consequently, the federal government agreed to invest an additional $100 million in the development of electronic health records through Canada Health Infoway Inc.[16] During the course of the committee's study, the importance of the development of electronic health records to health care reform in Canada was stressed by almost all witnesses. The committee heard that EHRs would promote the integration of different sectors of the health care system by allowing patient information to be seamlessly transferred from primary care to acute, home and long-term care. EHRs would also promote patient safety through drug information systems and allow for increased accountability within the system, as information systems would enable better monitoring of patient outcomes.

However, the committee also heard the frustrations of health practitioners related to EHRs, in particular, how local systems between doctor's offices and nearby hospitals did not have the same standards and could therefore not communicate. For policy makers, low up take among physicians, a lack of harmonization in privacy laws across the country, and the overall cost of the system

[14] An electronic health record (EHR) refers to a secure and private record that provides, in a digital or computerized format, lifetime information on a person's history within the health care system.

[15] Health Canada, *Health care system: A 10-year plan to strengthen health care*, 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

[16] Canada Health Infoway Inc. is the private not-for-profit cooperation, which was established with the mandate of building the foundations of an interoperable EHR in Canada.

remained key concerns. Tele-health was also seen as a key resource promoting innovations and reducing costs in health care delivery in the North, though it remained unclear how many Canadians have access to these services. All witnesses agreed that both EHRs and tele-health were areas in health care reform that called for federal leadership and on-going investments. The committee therefore recommends:

RECOMMENDATION 22

That the Government of Canada continue to invest in Canada Health Infoway Inc. to ensure the realization of a national system of interoperable electronic health records.

RECOMMENDATION 23

That Canada Health Infoway Inc. target its investments to:

a) **projects aimed at upgrading existing components to meet national interoperability standards set by the organization; and**
b) **promoting the adoption of electronic medical records by health professionals in Canada, including working with stakeholders to identify effective incentives in this area.**

RECOMMENDATION 24

That Canada Health Infoway Inc. work with provinces and territories and relevant stakeholders to:

a) **establish a target that would outline when all existing components of the EHRs would be upgraded to meet national interoperability standards;**
b) **establish a target that would outline when at least 90 per cent of all physicians in Canada will have adopted electronic medical records;**
c) **ensure that electronic health record systems are currently being designed and implemented in a way that would allow for secondary uses, such as health system research and evaluation; and**
d) **develop a systematic reporting system in relation to access to tele-health services in Canada.**

RECOMMENDATION 25

That the federal government work with provinces and territories to examine approaches to addressing differences in privacy laws across jurisdictions in relation to the collection, storage and use of health information.

6. Access to Care in the North

The 10-Year Plan also recognized the importance of improving access to health care services in northern communities. As a result, the federal government provided $150 million over five years to the Territorial Health System Sustainability Initiative (THSSI) in order to: facilitate long-term health reforms; establish a federal/territorial working group to support the management of the fund; and enhance direct funding for medical transportation costs.[17] The federal government also agreed to develop a joint vision for the North in collaboration with the territories.[18]

The committee's study found that funding provided through the THSSI had enabled the territories to introduce numerous initiatives that addressed their unique challenges related to health care delivery, including: the high costs of medical travel, addressing the burden of chronic diseases and mental health issues; collaborating across jurisdictions; improving the recruitment and retention of health human resources; and addressing the broader social determinants of health. However, the committee heard that these challenges still remained and some, such as the cost of medical travel, were increasing due to demographic changes in the region and the nature of health care service delivery. The committee therefore heard that future funding arrangements needed to reflect these ongoing unique needs and be provided in a predictable manner. The committee also heard that territorial jurisdictions needed to focus their efforts on continuing to develop accountability measures and enhancing collaboration in addressing jurisdictional barriers related to health care delivery and dealing with the broader social determinants of health. The committee therefore recommends:

RECOMMENDATION 26

Recognizing the ongoing unique challenges associated with health and health care delivery in the North, that the federal government extend its funding of the Territorial Health System Sustainability Initiative beyond 2014 in a manner that is both sustainable and predictable.

RECOMMENDATION 27

That the Federal/Territorial (F/T) Assistant Deputy Ministers' Working Group work with relevant stakeholders and communities to:

- **a) improve accountability measures to evaluate the performance of health care systems in the North; and**
- **b) address jurisdictional barriers as they relate to health care delivery and addressing the broader social determinants of health, including potable water and decent housing.**

[17] Health Canada, *A 10-year Plan To Strengthen Health Care*, 16 September 2004.
[18] *Ibid*.

7. The National Pharmaceuticals Strategy

As part of the 10-Year Plan, First Ministers agreed to establish a National Pharmaceutical Strategy (NPS), which would address common challenges associated with pharmaceutical management in Canada. First Ministers agreed that the NPS would include nine elements[19] and agreed to establish a Ministerial Task Force, which would be responsible for the development and implementation of these nine elements and report on their progress by 30 June 2006. The committee heard that after the signing of the 10-Year Plan in 2004, jurisdictions began advocating for a more focused agenda for the NPS, which would include five priority areas: costing models for catastrophic drug coverage; expensive drugs for rare diseases; the establishment of a common national formulary; real world drug safety and effectiveness; and pricing and purchasing strategies.[20] The committee heard that the Ministerial Task Force released its progress report in 2006 which identified recommendations for future action in these areas. Though no further collaborative work was currently being undertaken by the Ministerial Task Force, the committee heard from witnesses that its recommendations formed the basis of further work undertaken by individual jurisdictions.[21]

Overall, the committee's review of the implementation of the NPS found that progress towards its five main priorities was mixed and that F/P/T collaboration had slowed substantially after 2006. Though some jurisdictions had moved forward in the provision of catastrophic drug coverage, the committee heard that disparities and inequities in the provision of pharmacare continue to persist and there was a need for governments to work together to develop a national pharmacare program. Meanwhile, the committee heard that the Common Drug Review (CDR) had helped jurisdictions contain costs and achieve harmonized drug formularies through its formulary recommendations, but other witnesses suggested that a national formulary was still necessary. The committee heard that the efforts of the CDR were being supplemented by the federal government`s establishment of the Drug Safety and Effectiveness Network (DSEN), which conducts research evaluating the safety and effectiveness of drugs in real world settings. Witnesses articulated that there was a need to engage private drug insurance companies in these cost saving efforts to ensure the sustainability and affordability of the drug coverage programs that the majority of Canadians currently rely on. Witnesses highlighted the rising costs of newer specialized drugs as a key threat to the sustainability of both private and public drug coverage programs in Canada. Meanwhile, the committee did not

[19] The nine elements included the following: develop, assess and cost options for catastrophic pharmaceutical coverage; Establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness; Accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process; Strengthen evaluation of real-world drug safety and effectiveness; Pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines; Enhance action to influence the prescribing behaviour of health care professionals so that drugs are used only when needed and the right drug is used for the right problem; Broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record; Accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs; and Enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies. Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

[20] Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05cv-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[21] *Ibid.*

receive testimony as to whether Health Canada intended to develop a regulatory framework for expensive drugs for rare diseases. The committee therefore recommends:

RECOMMENDATION 28

That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability; including a national catastrophic drug coverage program and a national formulary.

RECOMMENDATION 29

That governments, acting together, work with private health insurance companies to encourage their adoption of best practices in cost containment strategies.

RECOMMENDATION 30

That Health Canada report on progress towards the development of a regulatory framework for expensive drugs for rare diseases as part of its annual performance report to Parliament.

8. Prevention, Promotion and Public Health

In the 10-Year Plan, First Ministers recognized the importance of public health efforts, including health promotion, disease and injury prevention, in improving health outcomes for Canadians and ensuring the sustainability of the health care system. First Ministers therefore committed to accelerate their ongoing work towards the establishment of a pan-Canadian Public Health Strategy that would set goals and targets for improving the health status of Canadians and focus on common risk factors for diseases. They further agreed to collaborate on developing coordinated responses to infectious disease outbreaks and other public health emergencies through the F/P/T Pan-Canadian Public Health Network. In addition, the federal government committed to increasing its investments in the National Immunization Strategy (NIS), which was to provide new immunization coverage for Canadian children.

The committee found that the objectives outlined in the 10-Year Plan relating to the development of a Pan-Canadian Public Health Network and increasing investments in the National Immunization Strategy had been met, though there is also an on-going need to fund and elaborate on the NIS to address the risks posed by communicable diseases. The committee's study also found that efforts towards the development of a pan-Canadian Public Health Strategy had been unsatisfactory. Though witnesses recognized the importance of addressing current priorities such as chronic diseases, promoting healthy lifestyles, and preventing childhood obesity, they explained that the public health

agenda needed to be broader, including focusing on widening health disparities by addressing the social determinants of health and recognizing that addressing mental health issues represent a key component of overall health and well-being. They also identified the need to reduce the number of injuries in Canada and their associated burden on the acute care system as another priority. The committee recognizes the importance of these issues, as well as the fact that important work has already been undertaken in these areas by the Mental Health Commission of Canada and this committee's own Subcommittee on Population Health. The committee therefore recommends:

RECOMMENDATION 31

That the Public Health Agency of Canada continue its efforts to renew the National Immunization Strategy, including the establishment of goals, objectives and targets.

RECOMMENDATION 32

That the federal government work with provincial and territorial, and municipal governments to develop a Pan-Canadian Public Health Strategy that prioritizes healthy living, obesity, injury prevention, mental health, and the reduction of health inequities among Canadians, with a particular focus on children, through the adoption of a population-health approach that centres on addressing the underlying social determinants of health.

RECOMMENDATION 33

That Health Canada, upon receipt of the Mental Health Commission report, use data developed on pan-Canadian child and youth mental-health issues to inform policy and program decisions relating to child and youth mental health.

9. Health Innovation

In the 10-Year Plan, the federal government committed to continuing its investments in science, technology and research to promote the adoption of new, more cost-effective approaches to health care, as well as facilitate the adoption and evaluation of new models of health protection and chronic disease management.[22] The committee's study revealed that the federal government was making significant investments in health research that was allowing for discoveries, which were reducing adverse reactions and mortality rates, and were cutting costs across health care systems. However, the committee heard that there were concerns among witnesses that insufficient resources were being dedicated to health services research. The committee also heard that the Canadian Institutes of Health Research (CIHR) had developed a new Strategy for Patient Oriented Research that would provide funding for health innovations in different areas of health care service delivery over ten

[22] Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

years. The committee heard that the federal government, in collaboration with provincial and territorial governments, could enhance these efforts through the creation of a specific mechanism dedicated to promoting health innovation in Canada, which would be established to promote collaboration among governments in identifying, disseminating, and implementing leading practices in health care service delivery across health care systems. The committee therefore recommends:

RECOMMENDATION 34

That the federal government, taking the lead, work with provincial and territorial governments to establish a Canadian Health Innovation Fund to identify and implement innovative and best practice models in health care delivery and the dissemination of these examples across the health system.

RECOMMENDATION 35

That the Canadian Institutes of Health Research provide an interim report in five years evaluating the implementation and impact of its Strategy for Patient Oriented Research, including its findings related to new primary care models.

RECOMMENDATION 36

That Health Canada create a network between federally funded pan-Canadian health research organizations, and other interested stakeholders that would focus on identifying leading practices in health care delivery and work together to promote their dissemination in health care systems across Canada.

RECOMMENDATION 37

That the federal government ensure that there is ongoing funding dedicated towards health services and systems research either through the Canadian Institutes of Health Research or the Canadian Health Services Research Foundation

10. Accountability and Reporting to Citizens

In the 10-Year Plan, all governments committed to report to their residents on the performance of their health care systems, as well as on its key components such as wait times, health human resources, and home care through the development of common indicators and benchmarks.[23] The committee heard from witnesses that accountability and reporting requirements of the 10-Year Plan had led to enhanced collection of data and the development of health indicators measuring health system quality and performance. However, they explained that there was a need to develop a pan-Canadian health indicator framework to allow for common measurements of health care system

[23] *Ibid.*

quality and performance, inter-jurisdictional comparisons and pan-Canadian reporting. The committee heard that ongoing efforts in these areas were necessary to promote health care reform and quality improvement. The committee also heard that these efforts were being reinforced by the establishment of health quality councils in different jurisdictions across Canada. The committee heard that health quality councils should be established across Canada and be given a mandate focusing on dimensions of quality beyond those outlined in the 10-Year Plan, including patient safety, effectiveness, patient-centeredness, efficiency, timeliness, equity and appropriateness. The committee therefore recommends:

RECOMMENDATION 38

That the federal government through Health Canada work with organizations such as the Canadian Patient Safety Institute to promote the development of health-quality council concepts.

RECOMMENDATION 39

That the Canadian Institute for Health Information work with provincial and territorial governments and relevant stakeholders to develop a pan-Canadian patient-centred comparable-health-indicator framework to measure the quality and performance of health-care systems in Canada.

11. Dispute Avoidance and Resolution

The 10-Year Plan also included a provision that formalized a dispute avoidance and resolution process related to the interpretation and enforcement of the principles of the Canada Health Act, which was agreed to through a series of letters between the Premier of Alberta and then Prime Minister Jean Chrétien in April 2002.[24] During the course of its review, the committee heard from witnesses that the dispute avoidance activities undertaken by Health Canada had been successful in preventing the need for using the formal dispute resolution process agreed to by governments. The committee also heard that the process had allowed for transparency in the enforcement of the Canada Health Act through its reporting requirements. However, the committee also received written submissions outlining instances of violations of the Canada Health Act by private for-profit health delivery clinics in Canada. They therefore called for the federal, provincial and territorial governments to take a more proactive role investigating these violations and enforcing the principles of the Act. The committee therefore recommends:

[24] Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

RECOMMENDATION 40

That all governments put measures in place to ensure compliance with the Canada Health Act and more accountability to Canadians with respect to implementation of the Act.

C. Implementing the Communiqué on Improving Aboriginal Health

On 13 September, 2004 First Ministers and the Leaders of the National Aboriginal Organizations agreed to the *Communiqué on Improving Aboriginal Health*, in which they committed to developing a blueprint to improve the health status of Aboriginal peoples through initiatives that would focus on:[25]

- Improving delivery and access to health services to meet the needs of all Aboriginal peoples through better integration and adaptation of all health systems;
- Measures that will ensure that Aboriginal peoples benefit fully from improvements to Canadian Health systems; and
- A forward looking agenda of prevention, health promotion and other upstream investments.

The *Communiqué* also announced $700 million in federal funding for initiatives developed in support of these objectives.[26]

During the course of its review, the committee heard from witnesses that the *Communiqué* had led to the development of the *Blueprint on Aboriginal Health: A 10-Year Transformative Plan*, which outlined a plan to close the gap in health outcomes between the general Canadian population and Aboriginal peoples, including First Nations, Inuit and Métis, within 10 years.[27] The committee also heard that the federal funding under the *Communiqué* had created many programs that were seen by witnesses as important. However, they outlined several ways in which they could be improved, including: ensuring that all Aboriginal organizations had equitable access to funding; providing stable multi-year funding arrangements; and ensuring that these initiatives reflected the unique needs and cultures of different Aboriginal peoples. Furthermore, they explained that the gap in health outcomes between Aboriginal and non-Aboriginal Canadians remained despite these initiatives. Consequently, they saw that there was a need to address ongoing challenges such as jurisdictional issues related to health care financing and delivery and the social determinants of health. The committee heard that the way forward in this area was the establishment of new health governance models, such as the historic tripartite health agreement in British Columbia, as well as

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[25] Canadian Intergovernmental Conference Secretariat, "Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting," Special Meeting of First Ministers and Aboriginal Leaders, Ottawa ON, 13 September 2004, http://www.scics.gc.ca/english/conferences.asp?x=1&a=viewdocument&id=1167

[26] Health Canada, "Commitments to Aboriginal Health," *Health Care System: Information*, September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/fs-if_abor-auto-eng.php.

[27] Health Canada, "Blueprint on Aboriginal Health: A 10-Year Transformative Plan," Prepared for the Meeting of First Ministers and Leaders of National Aboriginal Organizations, 24-25 November, 2005, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-blueprint-plan-abor-auto/plan-eng.pdf.

ensuring that Aboriginal organizations had a voice in the design and delivery of the programs affecting them. The committee therefore recommends:

RECOMMENDATION 41

That Health Canada work with provincial and territorial partners to ensure equitable access to programs and initiatives related to improving Aboriginal health.

RECOMMENDATION 42

That Health Canada work with provinces and territories to ensure that the design and delivery of its programs and initiatives meet the unique needs and culture of Inuit people.

RECOMMENDATION 43

That Health Canada work closely with provincial and territorial governments to ensure improvements in Aboriginal health through the federal, provincial and territorial multi-year funding agreements.

RECOMMENDATION 44

That the federal government work with Aboriginal communities to improve the delivery of health-care services in Canada, and deal specifically with removing jurisdictional barriers.

RECOMMENDATION 45

That Health Canada establish a working group with provincial and territorial partners and all national Aboriginal organizations to identify ways in which the role of Aboriginal organizations could be strengthened in the policy-making and development process.

RECOMMENDATION 46

That the federal government work with the provinces and territories to address the social determinants of health, with a priority focus on potable water, decent housing and educational needs.

D. Conclusion

The committee believes that it is important for governments to keep in mind that two years remain before the expiry of the 10-Year Plan in 2014. The committee's review found that more progress needs to be made towards its objectives, in particular in the areas of primary care reform, establishing electronic health records, health human resources planning, and catastrophic drug coverage. However, the committee's review revealed that real systematic transformation of health

care systems across the country had not yet occurred, despite more than a decade of government commitments and increasing investments. For witnesses appearing before the committee, the way forward was clear: long lasting transformative change could only occur through the breaking down silos between sectors within health care systems; facilitating collaboration among different health care professionals; adopting compatible health information systems; and establishing health governance and funding arrangements to support these developments. In addition, health care systems need to be reoriented towards the prevention of disease and injury; the needs of patients; and a holistic view of health which sees physical and mental wellbeing as inextricably linked, while not forgetting that many of the factors that affect the health and wellbeing of Canadians remain outside of health care systems. Our witnesses spoke with conviction and experience. It is now time for us to act.

1. INTRODUCTION

On January 31, 2011, the Minister of Health requested that the Standing Senate Committee on Social Affairs, Science and Technology initiate the second parliamentary review of the *10-Year Plan to Strengthen Health Care* (10-Year Plan), an agreement reached by First Ministers on September 16, 2004 that focuses on federal/provincial/territorial collaboration in the area of health-care reform.[28] The committee's study is undertaken pursuant to section 25.9(1) of the *Federal-Provincial Fiscal Arrangements Act*, which requires that a parliamentary-committee review progress towards the implementation of the 10-Year Plan on or before March 31, 2008 and three years thereafter. Section 25.91 of the Act further clarifies that the *10-Year Plan to Strengthen Health Care* also includes the communiqués[29] released in respect of the First Ministers' Meeting on the Future of Health Care that was held from September 13 to 15, 2004. Section 25.9(2) of the Act requires that a report on the statutory review be tabled in Parliament within a three-month period following the beginning of the review, although an extension is possible.

The committee's review began on March 10, 2011, prior to the dissolution of the 40th Parliament on March 26, 2011. After the 2011 General Election, the committee received a letter from the Minister of Health on June 16, 2011 requesting that it resume its work on the statutory review. On June 23, 2011, an Order of Reference was adopted in the Senate, authorizing the committee to proceed with its study. Hearings resumed on September 29, 2011.

Over the course of its study, the committee held a total of 12 hearings and one roundtable discussion. Eleven hearings and the roundtable discussion focused on progress towards the implementation of the 10-Year Plan, where the committee heard from a broad range of witnesses, including: national organizations responsible for monitoring progress in the implementation of the 10-Year Plan, the Health Council of Canada and the Canadian Institutes of Health Information (CIHI); federal and provincial government officials; health-professional organizations and service providers; and academics and research organizations. In addition, the committee accepted written submissions from all organizations and individuals wanting to participate in the study.

An additional hearing was devoted to the examination of the implementation of the separate *Communiqué on Improving Aboriginal Health*, which was released by First Ministers and Leaders of the Assembly of First Nations (AFN), the Inuit Tapiriit Kanatami (ITK), the Métis National Council (MNC), the Congress of Aboriginal Peoples (CAP) and the Native Women's Association of Canada

[28] Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

[29] Two separate communiqués are associated with the 10-Year Plan to Strengthen Health Care, including the communiqué on "Asymetrical Federalism that respects Quebec's jurisdiction" and the *Communiqué on Improving Aboriginal Health*.

(NWAC) on 14 September, 2004.[30] During this hearing, the committee heard from these Aboriginal organizations, as well as federal government officials.

The committee's review did not examine the implementation of the September 15, 2004 communiqué between the Government of Canada and the Government of Québec on *Asymmetrical Federalism that respects Quebec's Jurisdiction*, which recognizes the Government of Québec's desire to exercise its responsibilities with respect to health-care delivery and report to its own citizens on progress in the area of health-care reform.[31] ***As a result, the recommendations of the committee are not intended to infringe on Quebec's jurisdictions in those areas.***

This report presents the committee's findings regarding progress towards the implementation of the 10-Year Plan and the *Communiqué on Improving Aboriginal Health,* and identifies further actions that could be taken in support of the objectives outlined in these documents. In addition, this report aims to highlight key themes in relation to health-care reform that were raised by witnesses throughout the course of its review. These key themes form the basis and spirit of the recommendations outlined in this report. They include the importance of a holistic understanding of health that sees physical and mental well-being as inextricably linked, with both being equally important to the efficiency and quality of the health-care system. As this concept of health is central to the committee's findings, it also acts as a framing principle for this report. In addition to the importance of a holistic view of health, the committee's review also identifies the need to break down silos within health-care systems, through integrating different sectors such as primary, acute, continuing care and mental-health services, and the need to focus on the patient's experience of the health-care system, as key components of health-care reform. The review also highlights that while change is occurring at the frontlines, leadership and the sharing of best practices are necessary to promulgate these new practices throughout health-care systems, which in turn will allow for real innovation to occur across the country. Finally, witnesses stressed that health-care reform could be achieved through improved efficiencies in the management and delivery of health care, and any increases in health-care spending should be used to create incentives to buy change. The committee therefore recommends:

[30] Intergovernmental Conference Secretariat, "Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting," Special Meeting of First Ministers and Aboriginal Leaders, Ottawa ON, 13 September 2004, http://www.scics.gc.ca/english/conferences.asp?x=1&a=viewdocument&id=1167.

[31] Health Canada, "Asymmetrical Federalism that respects Quebec's Jurisdiction," *Health Care System*, September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/bg-fi_quebec-eng.php

RECOMMENDATION 1

That the committed annual increase in funding transferred from the federal government to the provinces and territories, through the Canada Health Transfer, be used by governments in great part to establish incentives for change that focus on transforming health-care systems in a manner that reflects the recommendations outlined in this report, and the overarching objectives of the 2004 10-Year Plan to Strengthen Health Care, including the need for measurable goals, timetables and annual public reporting through existing mechanisms.

2. BACKGROUND: AN OVERVIEW OF COLLABORATION IN HEALTH-CARE REFORM IN CANADA

A. The Federal Role in Health and Health Care

Under the *Constitution Act, 1867*, health is not assigned exclusively to one level of government, but rather includes matters that could fall within both federal and provincial jurisdictions.[32] The Constitution grants the provinces primary jurisdiction in health-care delivery. Section 92(13), the power over "property and civil rights in the province," which covers contract, tort and property, is the main provincial power over health care.[33] It authorizes provinces to regulate businesses in the province, including the public and private provision of health-care insurance, which determines the payment schemes for services offered by health-care providers. Moreover, it also provides for the provincial regulation of health-care providers, including their training and licensing. In addition, section 92(7) grants the provinces authority to establish and regulate hospitals, as well as hospital-based health services, with the exclusion of marine hospitals.[34]

However, section 91 of the *Constitution Act, 1867*, also grants the federal government authority over some classes of people including: military, militia, and naval services; First Nations and Inuit; and federal inmates. Under section 95, the federal government also has jurisdiction over immigrants concurrently with the provinces. Consequently, the federal government provides some health services and benefits to approximately 1.3 million Canadians belonging to these groups.[35]

In addition, under the *Canada Health Act*[36], the federal government has used its spending power to establish national standards for the provinces' health-care insurance plans as a condition of federal cash contributions to these programs.[37] The federal spending power is not specifically identified in the Constitution, but rather is inferred from Parliament's jurisdiction over public debt and property (section 91(1A)) and its general taxing power (section 91(3)), and has been upheld through court decisions. In using its spending power, the federal government may establish conditions for federal grants to the provinces, including conditions that come within provincial jurisdiction and therefore cannot be directly legislated by Parliament.

Under the *Canada Health Act*, the federal government has established the following national standards for provincial and territorial health-care insurance plans: (1) public administration; (2) comprehensiveness; (3) universality; (4) portability: and (5) accessibility. It is important to note that section 9 of the *Canada Health Act* dealing with comprehensiveness states that "the health-care insurance plan of a province must insure all insured health services provided by hospitals, medical

[32] Peter W. Hogg, *Constitutional Law of Canada* (5th Edition Supplemented 2007), Vol. 1, Thomson Carswell, Toronto, p. 32-1.
[33] *Ibid*, p.32-2
[34] *Ibid*.
[35] Federal Health Care Partnership, "FHP Office of Health Human Resources," http://www.fhp-pfss.gc.ca/fhp-pfss/ohhr-brhs/home-accueil.asp?lang=eng
[36] *Canada Health Act*, 1984, c.6, s.7
[37] Marlisa Tiedemann, "The Federal Role in Health and Health Care," PRB 08-58E, October 20, 2008, http://lpintrabp.parl.gc.ca/lopimages2/prbpubs/pdf/bp1000/prb0858-e.pdf.

practitioners[38] or dentists, and where the law of the province so permits, similar or additional services rendered by other health-care practitioners."[39] The *Canada Health Act* defines hospital services as services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.[40] It includes drugs, when administered in hospital, but not those administered outside of a hospital setting. Moreover, it does not include services excluded by the Act's regulations, namely nursing-home, intermediate-care services, adult residential-care service, home-care service, and ambulatory-health-care service. Finally, the Act does not require provincial and territorial health-care insurance plans to cover a broad range of health-care practitioners, such as psychologists, physiotherapists and pharmacists outside of a hospital setting, unless the province or territory so chooses.

The federal government also uses its criminal-law power under section 91 (27) to regulate areas relating to health.[41] The Supreme Court of Canada has interpreted the federal criminal-law power broadly to include protecting the physical health and safety of the public through the control of possible hazards, such as: food and drugs; medical devices; tobacco; pest-control products; and industrial and consumer products. As such, under the *Food and Drugs Act*, *1985*, the federal government is responsible for the regulation of the health and safety of pharmaceuticals in Canada.[42]

Finally, the Constitution also provides a basis for federal jurisdiction over public health, which has been defined as "the science and art of promoting health, preventing disease, prolonging life and improving the quality of life through the organized efforts of society."[43] Public health differs from health care through its focus on the health of the population as a whole, rather than the health of the individual patient, and its emphasis on the prevention of disease rather than clinical care.[44] The federal government derives its authority over public health, in part, from its power over quarantine under section 91(11) of the Constitution. However, the federal power over quarantine is limited to imposing quarantine on individuals or conveyances entering and leaving the country.[45]

In addition, the federal government has authority to act in the context of a public-health emergency, such as a pandemic, under section 91 of the Constitution, which grants power over "peace, order and good government" (POGG).[46] The POGG power allows Parliament to pass

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[38] The *Canada Health Act* defines a medical practitioner as a person lawfully entitled to practise medicine in the place in which the practice is carried out by that person. *Canada Health Act, 1984,* c.6, s.2.
[39] *Canada Health Act*, c.6, s.9
[40] *Canada Health Act, 1984,* c.6, s.2.
[41] Marlisa Tiedemann, "The Federal Role in Health and Health Care," PRB 08-58E, October 20, 2008, http://lpintrabp.parl.gc.ca/lopimages2/prbpubs/pdf/bp1000/prb0858-e.pdf
[42] *Food and Drugs Act*, *R.*S., c. F-27, s. 1.
[43] The National Advisory Committee on SARS and Public Health (Health Canada), *Learning from SARS: Renewal of Public Health in Canada*, 2003, p. 46, http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf.
[44] *Ibid*.
[45] Nola M. Ries, "Legal Foundations of Public Health in Canada," in *Public Health Law & Policy in Canada,* 2nd ed., ed. Bailey et al., Lexis Nexis Canada Inc., Markham, 2008, p. 13.
[46] Kumanan Wilson, "The Complexities of Multi-level Governance in Public Health," *Canadian Journal of Public Health*, Vol. 95, No. 6, December 2004, p. 410.

legislation that regulates matters related to national health and welfare.[47] It consists of two branches: an emergency branch which, in times of emergency, allows Parliament to enact laws that would normally lie within the jurisdiction of provincial legislatures; and a national dimensions branch, which allows Parliament to make laws in areas that concern Canada as a whole.[48]

However, the POGG power may only be used to regulate matters in which provinces are either unable to regulate effectively on their own, or the failure of one province to regulate would affect the health and welfare of residents in another province.[49] Moreover, the extent to which the federal government may apply this power without the consent of the provinces remains uncertain and subject to the interpretation of the courts.[50]

Meanwhile, the Constitution also grants the provinces jurisdiction over public health, pursuant to section 92(13) of the *Constitution Act, 1867*, relating to property and civil rights, which has been interpreted broadly to include public health.[51] In addition, further provincial authority over public health is derived from section 92(16), which grants the provinces power over "matters of a local or private nature" of which health and public health are considered part.[52] Moreover, section 92(8) of the Constitution grants provinces jurisdiction over municipalities, which had been responsible for public-health interventions prior to Confederation.[53]

B. F/P/T Collaboration in Health-Care Reform

Despite this separation of powers, federal, provincial and territorial governments have a history of collaborating in both health and health care. In recent years, this collaboration has focused on health-care reform. Beginning in 2000, Canadians became increasingly concerned with the quality of health care they were receiving, including the long wait times they were experiencing for hospital and medical services, resulting from fiscal constraint associated with the recession of the 1990s.[54] In addition, hospital closures meant that Canadians were relying increasingly on home- and community-care services outside the purview of the *Canada Health Act*.[55] In response to these concerns, F/P/T governments began a dialogue examining ways in which they could collaborate to improve the quality of health-care systems across the country, and the overall sustainability of Canada's medicare system. This resulted in a series of agreements and financial commitments, and culminated in the 2004 *10-Year Plan to Strengthen Health Care*.

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[47] *Ibid*.
[48] Marlisa Tiedemann, *Bill C-5: Public Health Agency of Canada Act*, LS-523E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 26 April 2006, p. 2, http://www2.parl.gc.ca/Content/LOP/LegislativeSummaries/39/1/c5-e.pdf.
[49] Wilson (2004), p. 410.
[50] *Ibid*.
[51] Wilson (2004) p. 409.
[52] *Ibid*.
[53] Elaine Gibson, "Public Health Information, Federalism and Politics," *Health Law Review*, Vol. 16, No. 1, 2007, p. 5.
[54] Health Council of Canada, "Rekindling Reform: Health Care Renewal in Canada, 2003-2008," June 2008, http://www.healthcouncilcanada.ca/tree/2.46-HCC_5YRPLAN_WEB_FA.pdf
[55] *Ibid*.

1) The 2000 Communiqué on Health

On September 11, 2000, First Ministers released a *Communiqué on Health* that outlined an Action Plan for Health-System Renewal that identified eight areas in which F/P/T governments would collaborate to promote health-care reform.[56] While respecting each level of government's full jurisdiction, First Ministers agreed to: improve access to quality care; engage in health education and strategies to prevent illness and support early-childhood development; promote the establishment of innovative interdisciplinary primary health-care models and their integration into the health-care system; coordinate efforts to increase the supply of health professionals, as well as identifying ways to improve their work-life conditions; strengthening investments in home- and continuing-care services as critical components of a more fully integrated health-care system; work together to develop a common intergovernmental advisory process to assess drugs for their potential inclusion in government drug plans, while the federal government agreed to strengthen its post-market surveillance of pharmaceuticals; develop electronic health records, including collaboration on the development of common data standards and enhancing the use of tele-health; and investing in health equipment and infrastructure that allow for timely access to appropriate preventative, diagnostic and treatment services. In support of these objectives, the federal government increased federal cash transfers by $23 billion over five years[57] and established an $800-million Primary Health-Care Transition Fund (PHCTF) to support provinces and territories in their efforts to reform the primary health-care system over a six-year period (2000-2006).[58]

2) 2003 First Ministers Accord on Health-Care Renewal

After the 2000 *Communiqué on Health*, federal, provincial and territorial governments commissioned a series of task forces and studies to solicit the views of Canadians on the publicly funded health-care system, and identify ways in which to promote its reform. In April 2001, the federal government established the Royal Commission on the Future of Health Care, chaired by Roy Romanow, former premier of Saskatchewan, to "undertake dialogue with Canadians on the future of Canada's public health-care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure long-term sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians, and strikes an appropriate balance between investments in prevention and health maintenance, and those directed to care and treatment."[59] Meanwhile, the Senate Standing Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby, also began a study in the spring of 2000 on the federal role in the public health-care system and the pressures and constraints facing that system. Both the Royal Commission and the Senate Committee produced their reports in the fall of 2002,

[56] Intergovernmental Conference Secretariat, "News Release-First Ministers Meeting Communiqué on Health," 11 September, 2000. http://www.scics.gc.ca/english/conferences.asp?x=1&a=viewdocument&id=1144

[57] Government of Canada, "The 2004 Health Accord," Technical Briefing to Senate Standing Committee on Social Affairs, Science and Technology," 8 March, 2011.

[58] Health Canada, "Primary Health Care Transition Fund," http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index-eng.php

[59] Royal Commission on the Future of Health Care in Canada, "Building on Values: The Future of Health Care in Canada," Ottawa, November 2002, http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

calling for increased federal funding, greater accountability by all governments, and strategic reforms to health-care services.[60] Recommendations from these two reports then formed the basis of the next F/P/T agreement on health-care reform: the 2003 First Ministers' Accord on Health-Care Renewal.[61]

The 2003 First Ministers Accord on Health Care Renewal identified numerous areas for reform initiatives, but prioritized the following. With respect to primary health care, First Ministers established the goal of ensuring that 50 per cent of their residents had access to an appropriate health-care provider 24 hours a day, seven days a week. First Ministers also agreed to provide first-dollar coverage for certain home-care services, while the federal government agreed to establish measures to support caregivers, including a compassionate-care benefit program through Employment Insurance, and job-protection measures through the Canadian Labour Code. Finally, First Ministers agreed that they would take measures by the end of 2005/2006 to ensure that Canadians had reasonable access to catastrophic drug coverage wherever they live. They also agreed to collaborate in pharmaceuticals management. In support of these three priority areas, the federal government established a $16-billion Health Reform Fund.[62]

The 2003 Accord also prioritized increasing the availability of publicly funded diagnostic care and treatment services, as a means of improving quality of care and reducing wait times. In support of this aim, the federal government established a three-year, $1.5-billion Diagnostic/Medical Equipment Fund.[63] First Ministers also prioritized the adoption of information technology and Electronic Health Records through Canada Health Infoway Inc., a non-profit organization established by First Ministers in 2001 to foster and accelerate the development and adoption of compatible electronic-health-record systems across Canada.[64] The federal government invested an additional $500 million for electronic-health-record systems.

As part of its accountability mechanisms, the 2003 Accord also established the Health Council of Canada to monitor and make annual public reports on the implementation of the Accord.[65] In accordance with the Accord, the Health Council of Canada was to report publicly through the F/P/T Ministers of health and include representatives of both orders of government, experts and the public.

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[60] Health Council of Canada, "Rekindling Reform: Health Care Renewal in Canada, 2003-2008," June 2008, http://www.healthcouncilcanada.ca/tree/2.46-HCC_5YRPLAN_WEB_FA.pdf

[61] Health Canada, "2003 First Ministers' Accord on Health Care Renewal," http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php

[62] Health Canada, "Federal Health Investments," 5 February 2003, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/fs-if_2-eng.php

[63] *Ibid.*

[64] Canada Health Infoway Inc., "About Canada Health Infoway Inc." https://www.infoway-inforoute.ca/lang-en/about-infoway

[65] Health Canada, "2003 First Ministers' Accord on Health Care Renewal," http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php

3) 2004 10-Year Plan to Strengthen Health Care

The 10-Year Plan to Strengthen Health Care expanded upon many of the commitments outlined in the 2003 Accord, identifying 10 main components for health-care reform:[66]

- reducing wait times and improving access;
- strategic health-human-resource (HHR) action plans;
- home care;
- primary health-care reform, including electronic health records and tele-health;
- access to care in the North;
- National Pharmaceuticals Strategy;
- prevention, promotion and public health;
- health research and innovation;
- accountability and reporting to citizens; and
- dispute avoidance and resolution.

In addition to these 10 components, the 10-Year Plan also makes reference to two separate communiqués related to health-care renewal. One communiqué from 15 September 2004 is an arrangement between the Government of Canada and the Government of Quebec, based upon the principle of asymmetric federalism that respects Quebec's jurisdiction in this area, which focuses on the funding of Quebec's separate plan that aims to improve access to quality care and reducing wait times.[67] The second communiqué dated 13 September 2004 is an agreement by all governments to work together to improve Aboriginal health.[68]

In support of the objectives outlined in the 10-Year Plan, the federal government provided provinces and territories with additional long-term funding amounting to $41.3 billion from 2004 to 2014.[69] The bulk of the funding would be provided through the Canada Health Transfer (CHT)[70], as a conditional cash transfer that would escalate by six per cent per year, amounting to $35.3 billion in

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[66] Further details regarding these ten components of the 10-Year Plan and its associated communiqués are outlined in subsequent sections of this report. Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

[67] Health Canada, "Asymetrical Federalism that respects Quebec's Jurisdiction," *Health Care System*, September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/bg-fi_quebec-eng.php.

[68] Health Canada, "Commitments to Aboriginal Health," *Health Care System: Information*, September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/fs-if_abor-auto-eng.php and Canadian Intergovernmental Conference Secretariat, "Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting," Special Meeting of First Ministers and Aboriginal Leaders, Ottawa ON, 13 September 2004, http://www.scics.gc.ca/english/conferences.asp?x=1&a=viewdocument&id=1167.

[69] Finance Canada, "The Canada Health Transfer," brief submitted to the Senate Standing Committee on Social Affairs, Science and Technology, March 2011.

[70] The Canada Health Transfer consists of cash levels that are set in the *Federal-Provincial Fiscal Arrangements Act*, and an equalized tax point transfer to the provinces and territories that grows in line with the economy, and is based on a province or territory's resource revenue, and its participation in Canada's equalization program. For further details, please see: James Gaulthier, "Background Paper: The Canada Health Transfer: Changes to Provincial Allocations," Publication No. 2011-02E, 25 February 2011, http://lpintrabp.parl.gc.ca/lopimages2/prbpubs/pdf/bp1000/2011-02-e.pdf

total by 2014. The cash transfer is conditional upon provinces and territories upholding the principles of the Canada Health Act. In addition to funding provided through the CHT, the federal government allocated $5.5 billion over a 10-year period to reduce wait times, through a $4.24 billion Wait-times Reduction Trust and an annual Wait-times Reduction Transfer of $250 million, beginning in 2009-10. A further $500 million was earmarked for enhanced investments in medical equipment. Finally, $850 million was allocated to Aboriginal health programs and the Territorial Health System Sustainability Initiative.

With respect to accountability, First Ministers agreed to report to their citizens on progress towards the implementation of the different components of the 10-Year Plan. In addition, they agreed that the Health Council of Canada would prepare an annual report to all Canadians on the health status of Canadians and health outcomes, as well as report on progress of elements set out in the plan. Finally, the Canadian Institute for Health Information was responsible for reporting upon reductions in wait times.

3. REDUCING WAIT TIMES AND IMPROVING ACCESS

A. Overview of Wait-time Commitments in the 10-Year Plan

As part of the 2004 10-Year Plan, First Ministers agreed to achieve reductions in wait times for procedures in five priority areas: cancer, heart, diagnostic imaging, joint replacements and sight restoration by March 31, 2007. In order to demonstrate meaningful progress in reducing wait times in these areas, First Ministers agreed to:[71]

- Establish comparable indicators of access to health-care professionals, diagnostic and treatment procedures with a report to their citizens to be developed by December 31, 2005;
- Establish evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration by December 31, 2005 through a process developed by Federal, Provincial and Territorial Ministers of Health;
- Establish multi-year targets to achieve priority benchmarks by December 31, 2007 and
- Report annually to their citizens on their progress in meeting their multi-year wait-time targets.

B. Progress to Date

The committee heard that by the end of 2005, First Ministers had established benchmarks for medically acceptable wait times for cancer, heart disease, joint replacements and sight restoration.[72] These benchmarks are outlined in Table 1 below. However, the committee heard that insufficient evidence existed at the time for the establishment of benchmarks in the area of diagnostic imagining, including computed tomography (CT) scans and magnetic resonance imaging (MRI).[73] In order to guarantee that jurisdictions meet one of the benchmarks outlined below, the Committee heard that the federal government created the Patient Wait-times Guarantee Trust in 2007 in the amount of 613 million for the provinces and territories to establish a wait-time guarantee[74] for one of the benchmark procedures, which would implemented by March 2010.[75]

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[71] *Ibid.*

[72] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 29 September, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03eva-49055-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[73] *Ibid.*

[74] According to the Health Council of Canada, a wait-time guarantee implies that 100 per cent of cases would be completed within an agreed-upon time frame, and if that time frame is exceeded, there would be recourse available to individual patients to ensure that they receive timely treatment. Health Council of Canada, "Wading through Wait Times: What do Meaningful Reductions and Guarantees Mean?: An Update on Wait Times for Health Care" June 2007, http://www.healthcouncilcanada.ca/tree/2.05hcc_wait-times-update_200706_FINAL_ENGLISH.pdf.

[75] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 8, Evidence, 1st Session of the 41st Parliament, 24 November, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/08evb-49206-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

Table 1. Progress towards Pan-Canadian Wait-time Benchmarks

Priority Area	Service	Wait-time Benchmark	Percentage of Canadians receiving treatment within the benchmark	Percentage increase of number of surgeries performed since 2004[76]
Cancer	Radiation therapy	Within four weeks of patients being ready to treat	98%	N/A
Heart	Cardiac bypass surgery	Within 2 to 26 weeks, depending upon how urgently care is required.	99%	6%[77]
Sight Restoration	Cataract surgery	Within 16 weeks for patients who are at high risk	83%	46%
Joint Replacement	Hip replacements	Within 26 weeks	84%	32%
	Knee replacements	Within 26 weeks	79%	58%
	Surgical repair of hip fracture	Within 48 hours	78%	N/A

Source: CIHI, "Wait Times in Canada-A Comparison by Province, 2011," March 2011, http://secure.cihi.ca/cihiweb/products/Wait_times_tables_2011_en.pdf (submitted as evidence 22 March, 2011).

In terms of progress towards the benchmarks, the committee heard from CIHI that in 2010 at least eight out of 10 Canadian patients were receiving these priority-area procedures within the medically recommended benchmarks, and there had been substantial increases in the number of procedures in these areas since 2004 (see Table 1).[78] CIHI representatives further explained that they used 90 per cent as a target, which in their view reflected the realities of surgery wait times that could be affected by extenuating circumstances, such as patient illnesses or other circumstances. CIHI representatives also noted that due to their population sizes, British Columbia, Ontario and Quebec carried the national-average statistics and those provinces were also leaders at meeting the benchmarks with 75 per cent of Canadians receiving treatment within the defined timeframe. However, the committee heard from CIHI that there was significant variation between the provinces, with some not doing as well as others.[79] For example, the proportion of patients who received knee-

[76] This column is based upon the following document: Dr, Brian Postl, "Wait Times-Canada Appearance before Senate" Brief submitted to the Senate Standing Committee on Social Affairs, Science and Technology, 29 September 2011.
[77] Percentage does not include number of procedures performed in Quebec.
[78] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 22, Evidence, 3rd Session of the 40th Parliament, 10 March, 2011, http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47
[79] *Ibid.*

replacement surgery within benchmark was 42 per cent in Nova Scotia and 57 per cent in Manitoba, in comparison to 83 per cent in Quebec and 89 per cent in Ontario.[80]

Though there were no pan-Canadian benchmarks for diagnostic services to report on, CIHI representatives noted that five provinces were now reporting on diagnostic imaging wait times. The committee also heard that CIHI was working towards bringing the other provinces on board.[81] Other witnesses noted that as a result of investments in diagnostic imaging, the number of CT scans performed in hospitals had increased by almost 50 per cent from 2,768 in 2003-2004 to 4,178 in 2009-2010, while the number of MRIs also increased from 768 to 1,435 during the same period.[82]

The committee also heard from witnesses that jurisdictions had met and often exceeded their reporting requirements related to wait times both in terms of the quality and quantity of the reporting.[83] The committee heard that provinces did not just produce an annual report as required by the agreement, but all provinces had developed wait-time websites that were being upgraded.[84] There was variation in the timeliness of data reporting, ranging from less than two months to six months.[85] Some provinces were also reporting related to wait-time access targets, noting the number and/or percentage of patients receiving the procedure within the benchmark. Finally, the committee heard that jurisdictions were also going beyond the five priority areas to address and report on wait times in other areas, such as emergency department wait times and pediatric surgery.[86] The committee heard that the Government of Saskatchewan had promised that by 2014, no patient would wait longer than three months for any surgery.[87]

Despite the progress achieved in meeting the wait-time objectives outlined in the 10-Year Plan, witnesses appearing before the committee provided mixed reviews of the wait-time benchmarks. On one hand, witnesses saw the wait-times agenda as a whole as an example where clear focus areas, the establishment of measurable benchmarks, and targeted funding had achieved results.[88]

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[80] CIHI, "Eight out of 10 Canadians receive priority-area procedures within recommended wait times," *Media Release* Communiqué, 21 March, 2011, submitted as evidence 22 March, 2011.

[81] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 22, Evidence, 3rd Session of the 40th Parliament, 10 March, 2011, http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47

[82] Dr. Brian Postl, "Wait Times-Canada Appearance before Senate" Brief submitted to the Senate Standing Committee on Social Affairs, Science and Technology, 29 September 2011.

[83] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011. http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47

[84] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 29 September, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03eva-49055-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[85] Wait Time Alliance, "Time out! Report Card on Wait Times in Canada," June 2011, submitted to the Senate Standing Committee on Social Affairs, Science and Technology 29 September, 2011. http://www.waittimealliance.ca/media/2011reportcard/WTA2011-reportcard_e.pdf

[86] *Ibid*.

[87] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 22, Evidence, 3rd Session of the 40th Parliament, 10 March, 2011, http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47

[88] *Ibid*.

Furthermore, the reporting requirements associated with measuring progress in this area had increased CIHI's capacity, as well as that of individual jurisdictions, to measure health-system performance and generate a significant amount of comparable data in this area, though some gaps continued to persist.[89]

However, witnesses also raised concerns with respect to both the focus areas highlighted in the 10-Year Plan and the development of the benchmarks themselves. The committee heard from witnesses that it remained unclear why the five areas were chosen as priorities for wait-time reductions. The committee heard that the five priority areas were a response to public views at the time rather than the views of the medical community.[90] Consequently, some witnesses felt that the wait-time agenda should focus on other areas, or be expanded to include all areas of specialty care.[91]

Furthermore, the committee heard that there was insufficient scientific evidence at the time to establish appropriate benchmarks in the five priority areas, and therefore those established were seen as a "guess based on some consensus building, or a review of the literature," and some research provided by the Canadian Institutes of Health Research.[92] The lack of research evidence supporting the current benchmarks meant that increasing the number of some of the surgeries prioritized in the wait-times agenda may not be considered appropriate in all cases. For example, the committee heard that some research suggests that the number of cataract surgeries performed in some jurisdictions is substantially beyond what would be expected or needed, but further research was necessary in this area.[93]

Moreover, the established benchmarks were also seen by witnesses as the maximum acceptable waiting period, rather than "ideal" wait-time benchmarks that have been developed by health-professional organizations themselves.[94] Consequently, despite current progress towards meeting the existing benchmarks, witnesses considered wait times for health services in Canada to be long in comparison to other countries, particularly in regard to access to primary-care services. For example, the committee heard that Canada ranked 10th in the 2010 Commonwealth Fund International Health Policy Survey in providing access to same-day or next-day appointments when sick or needing care, and highest in terms of use of emergency-room services.[95]

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[89] *Ibid*.
[90] Wait Time Alliance, "Time out! Report Card on Wait Times in Canada," June 2011, submitted to the Senate Standing Committee on Social Affairs, Science and Technology 29 September, 2011. http://www.waittimealliance.ca/media/2011reportcard/WTA2011-reportcard_e.pdf
[91] *Ibid*.
[92] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 29 September, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03eva-49055-e.htm?Language=E&Parl=41&Ses=1&comm_id=47
[93] *Ibid*, p. 3:12
[94] *Ibid*.
[95] Michael Schull, "Standing Senate Committee on Social Affairs, Science and Technology: Reducing wait times and improving access to care," submitted to the Standing Senate Committee on Social Affairs, Science and Technology 29 September, 2011.

Finally, the committee heard that the wait-time benchmarks established as part of the 10-Year Plan did not measure the complete wait times experienced by patients for a procedure.[96] The committee heard that the benchmarks measured the wait time between the booking of a service, where the patient and the appropriate physician agreed to a service and the patient is ready to receive it, and commencement of the service. However, it did not include the wait time the patient experiences in gaining access to the primary-care physician for referral to a specialist, wait times for diagnostic tests and the subsequent wait to see the specialist. This was seen as significant,[97] as approximately 1.9 million Canadians report not having access to a regular family physician.[98] Witnesses therefore recommended the establishment of a Federal/Provincial/Territorial patient charter that would include access commitments that would reflect a patient's experience of the health-care system.[99]

Most significantly, witnesses explained that investments in reducing wait times as a consequence of the 10-Year Plan had not resulted in substantial reform of health-care systems. The committee heard that jurisdictions were achieving the wait-time benchmarks by increasing the volume of services offered, but making few changes to improve the efficiency of the system to reduce wait times. The committee heard that jurisdictions were only beginning to reduce wait times through the adoption of improved management practices, such as the establishment of single wait lists for procedures[100], applying queuing theory[101] and referral guidelines.[102]

Furthermore, the committee heard that significant reductions in wait times could be achieved by undertaking meaningful reforms within and across health-care systems, changes aimed at addressing the root causes of wait times for acute health-care services in Canada.[103] For example, the committee was told that a significant cause of wait times in Canada is alternative-level-of-care (ALC) patients, who occupy one in five hospital beds in Canada but no longer require acute care,

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[96] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 29 September, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03eva-49055-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[97] *Ibid.*

[98] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 22, Evidence, 3rd Session of the 40th Parliament, 10 March, 2011, http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47

[99] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 29 September, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03eva-49055-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[100] The committee heard that most jurisdictions do not have single master wait lists for procedures, but rather each physician maintains their own wait list rather than pools them with other physicians. Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 29 September, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03eva-49055-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[101] Queuing theory refers to the mathematical study of wait lines or queues. It is a methodology that seeks to match random demand with fixed capacity. In health care, queuing theory is used to determine how health-care organizations such as hospitals can align their fixed capacity such as numbers of staff, beds and medical technology with patient demand. For example, queuing theory can be used to determine the number of nurses required for an intensive-care unit in which patient utilization can vary from day to day, both in terms of the number of patients and their length of stay. Stacey Butterfield, "A new Rx for crowded hospitals: Math," HCP Hospitalist, November 2007, http://www2.acponline.org/archives/2007/12/math.htm

[102] *Ibid.*

[103] *Ibid.*

and are waiting for appropriate placement in home- or long-term care. By occupying a significant proportion of acute-care beds in hospitals, ALC patients create backlogs in emergency departments and elective surgery. In order to reduce the number of ALC patients in acute care, witnesses told the committee that numerous reforms to health-care systems as a whole needed to be undertaken, including: enhanced access and monitoring of these patients by primary health-care teams once discharged from the hospital; investing in long-term care and community-based alternatives like home care, and promoting their integration with acute-care systems; and the use of case managers to facilitate the transition of these patients between different points in the health-care system. As reductions in wait times could not be separated from reforms to other parts of the health-care system, witnesses therefore were of the view that any further investments in wait time reductions had to be conditional on "buying change" within the system rather than increasing the volume of services offered.[104]

C. Moving Forward on Wait Times: Committee Observations and Recommendations

The committee found that governments had, for the most part, met their obligations in relation to the establishment of benchmarks in four of the five priority areas (cancer, heart, sight restoration, and joint replacement) and reporting on progress. In addition, the committee heard that targeted funding had resulted in an increase in the number of surgeries in the priority areas, as well as the number of diagnostic-imaging services performed. Moreover, the committee heard that eight out of 10 Canadians were indeed receiving treatment within the established time frames. However, the committee also heard from witnesses that there were significant variations among provinces in meeting the benchmarks in some of the priority areas, and considers this to be a concern.

The committee was pleased to hear that the establishment and investments in the development of pan-Canadian benchmarks for wait times had the added benefit of increasing the availability of national comparable data on the quality and performance of Canadian health-care systems. These data were seen by witnesses as integral to measuring and promoting health-care reform in Canada, by allowing for jurisdictional comparison and the identification of best practices.[105] The committee was also pleased to learn from witnesses that five jurisdictions were reporting on diagnostic imaging, despite the lack of pan-Canadian benchmarks, and were going beyond the five priority areas to develop strategies to reduce wait times for procedures and services in other areas.

However, the committee also found that the wait-time agenda had certain limitations. The committee heard that the benchmarks established were not based on sufficient research, which in some cases, led to questioning of their appropriateness by health-care providers and policy makers. Moreover, they were not patient-centred, in that they did not reflect the complete wait times

[104] *Ibid*.

[105] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 22, Evidence, 3rd Session of the 40th Parliament, 10 March, 2011, http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47

experienced by patients across the continuum of care, with witnesses emphasizing the lack of timely access to primary-care physicians as being of particular concern.

The committee also agreed with witnesses that further meaningful reductions in wait times could best be achieved through reforms to health-care systems and increasing efficiencies through management practices, rather than by increasing funding alone. Some of the suggestions received to achieve this aim included: improving system efficiency through the adoption of better management practices and addressing other components of the health-care system, including increased access to home care and primary care. The committee agreed with witnesses that further efforts are needed to improve access to home care and primary care and will treat these topics in greater depth in subsequent chapters. With respect to moving the wait-times agenda forward, the committee recommends:

RECOMMENDATION 2

That provinces and territories continue to develop strategies to address wait times in all areas of specialty care, as well as access to emergency services and long-term care, and report to their citizens on progress.

RECOMMENDATION 3

That the federal government work with provinces, territories and relevant health-care and research organizations to develop evidence-based pan-Canadian wait-time benchmarks for all areas of specialty care that start when the patient first seeks medical help.

RECOMMENDATION 4

That the federal government provide the Canadian Health Services Research Foundation[106] or the Canadian Institutes of Health Research with funding to:

a) commission research that would provide the evidence base for the development of pan-Canadian wait-time benchmarks for all areas of specialty care; and
b) commission research to evaluate the appropriateness of existing pan-Canadian wait-time benchmarks related to cancer, heart, sight restoration, and joint replacement.

[106]The Canadian Health Services Research Foundation is an independent not-for-profit corporation established through endowed funds from the federal government and its agencies that is dedicated to accelerating health-care improvement and transformation, by converting innovative practices and research evidence into practice. It commissions research that focuses on the following areas: health-care financing and transformation, primary care, and Canada's aging population. http://www.chsrf.ca/AboutUs.aspx

RECOMMENDATION 5

That the Health Council of Canada examine best practices in reducing wait times across jurisdictions, through improvements in efficiency, focusing in particular on management practices such as pooling waitlists, the adoption of queuing theory and the development of referral guidelines and clinical support tools.

RECOMMENDATION 6

That the federal government work with provincial and territorial governments to develop a pan-Canadian vision statement that would foster a culture of patient-centred care in Canada through the establishment of guiding principles that would promote the inclusion of patient needs and perspectives in an integrated health-care-delivery process.

RECOMMENDATION 7

That the federal, provincial and territorial governments ensure accountability measures be built into the Canada Health Transfer agreement, to address the needs of disabled persons.

4. HEALTH HUMAN RESOURCES

A. Overview of Health Human Resources Commitments in the 10-Year Plan

Statistics Canada defines health human resources (HHR) as paid health-care providers within health-care systems that are responsible for the delivery of high quality, safe, effective and patient-centred care to Canadians, a definition based upon the National Occupational Classification.[107] It is important to note that HHR refers to a comprehensive range of health professionals not all of whom are directly involved in health-care delivery, such as: physicians, nurses, midwives, chiropractors, naturopathic doctors, dentists, pharmacists, laboratory workers, environmental and public-health professionals, health statisticians, epidemiologists, health-information managers, health economists, and community-health workers. The World Health Organization uses an even broader definition of HHR, considering a health-care provider to be anyone engaged in actions whose primary intent is to enhance health, regardless of whether they are paid to do so.[108]

In the 10-Year Plan, First Ministers recognized the need to increase the supply of health-care professionals in Canada, including doctors, nurses, pharmacists and technologists, as shortages were seen as particularly acute in some parts of the country[109]. As such, federal, provincial and territorial governments agreed to increase the supply and ensure an appropriate mix of health-care professionals, based on their assessment of the gaps and to make their action plans public, including targets for the training, recruitment and retention of professionals by December 31, 2005. In addition, the federal government committed to:[110]

- Accelerating and expanding the assessment and integration of internationally trained health-care graduates for participating governments;
- Targeting efforts in support of increasing the supply of health-care professionals for Aboriginal communities and Official Languages Minority Communities;
- Take measures to reduce the financial burden of students in specific health-education programs; and
- Participate in health-human-resource planning with interested jurisdictions.

[107]This is based upon Statistics Canada's definition of health-care providers, whose National Occupational Classification limits the definition of health-care providers to those in paid positions. This varies from the World Health Organization's definition, which considers a health-care provider to be anyone engaged in actions whose primary intent is to enhance health. CIHI, "Canada's Health Care Providers, 2007," 2007, http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf.
[108]*Ibid*.
[109]Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php
[110]*Ibid*.

B. Progress to Date

1) Action Plans to Increase the Overall Supply and Mix of Health Professionals in Canada

The committee heard from provincial and territorial government officials that jurisdictions had used federal funds received as part of the 10-Year Plan to develop and implement action plans to address health-human-resource issues in their respective jurisdictions. For example, the Province of Ontario published *Laying the Foundation for Change: A Progress Report on Ontario's Health Human Resources Initiatives* in response to the 2004 agreement, which outlined its main achievements since 2004, including expanding first-year undergraduate medical spaces, more than doubling the number of training positions and assessments available to international medical graduates, increasing the number of physicians and other health professionals and creating the Health Professions Database.[111] Meanwhile, the committee heard from provincial officials that investments in health-care reform had enabled Manitoba to recruit and retain record numbers of health professionals, including doctors, nurses and nurse practitioners.[112]

The committee heard from federal government officials that Health Canada was also contributing to increasing the supply and mix of health professionals through its *Pan-Canadian Health Human Resource Strategy*, which had supported over 100 projects to advance health-human-resources planning; increase inter-professional education and practice; recruit and retain health-care providers and receive $20 million in annual funding.[113] The committee heard that through this strategy, Health Canada was also investing $39.5 million over six years to train more than 100 family medicine residents in rural and remote communities.

The committee heard from witnesses that HHR investments and action plans by F/P/T governments since 2004 had resulted in substantial increases in the number of physicians and nurses in Canada.[114] Between 2004 and 2009, the total number of physicians increased by 12.4 per cent, resulting in an increase of the physician per 100,000 population ratio from 189 to 201. The committee heard that there had also been an increase of 25 per cent in medical-school enrolment during the same period and in 2010, 33 per cent of Canadian medical school graduates had chosen family medicine as their preferred career. Meanwhile, the total number of international medical graduates (IMGs) had also increased by 16.7 per cent between 2004 and 2009. With respect to

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[111] Ontario Ministry of Health and Long Term Care, "Senate Standing Committee on Social Affairs, Science and Technology: Examine Progress in implementing the 10-Year Plan to Strengthen Health Care," written submission 28 November, 2011.

[112] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 24 November 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49219-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[113] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[114] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 22, Evidence, 3rd Session of the 40th Parliament, 10 March, 2011, http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47

nurses, the committee heard that the total number of regulated nurses increased by 11 per cent to 348,999, increasing the number of regulated nurses per 100,000 population from 983 in 2004 to 1,028 in 2009.

Despite this increase in the supply of physicians and nurses, the committee heard that there are ongoing shortages of health professionals in Canada. According to witnesses, physician shortages continued to result in increased wait times for patients referred to specialists and long working hours that take their toll on physicians.[115] Meanwhile, current nursing shortages were estimated at approximately 11,000 that were resulting in high turnover rates and absenteeism in the profession.[116] The committee received written submissions from other health-professional organizations noting shortages in the number of dieticians and medical-laboratory technologists available across Canada.[117] Consequently, witnesses articulated an ongoing need to invest in the education, training, recruitment and retention of health professionals.[118]

In addition, though some efforts were currently being made in medical schools to promote team-based practice, the committee heard that medical professionals were, for the most part, still being trained separately as part of their respective individual health professions.[119] Consequently, the committee heard that greater efforts were needed to integrate the education and training of different health professionals. This in turn would promote the establishment of multidisciplinary health-care teams across the country and the breaking down of some of the silos in health-care delivery.

2) Accelerating the Assessment and Integration of Internationally Educated Health Professionals

The committee heard from witnesses that the federal government had undertaken numerous initiatives to accelerate the assessment and integration of internationally educated health professionals (IEHPs).[120] With respect to the assessment of the credentials of IEHPs, the committee heard from federal government officials that in 2009, First Ministers established a *Pan-Canadian*

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[115]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[116]Canadian Federation of Nurses Unions, "Submission to the Senate Standing Committee on Social Affairs, Science and Technology: *Examination of Progress on the implementation of the 10 Year Plan to Strengthen Health Care*," written submission, November 2011.

[117]Canadian Society for Medical Laboratory Science, "Submission to the Senate Standing Committee on Social Affairs, Science and Technology: Examine the progress in the implementation of the 2004 10-Year-Plan to Strengthen Health Care," written submission, November 2011 and Dieticians of Canada, "Strengthening the Canadian Health Care System: A Call to Action from Dieticians," written submission to the Senate Standing Committee on Social Affairs, Science and Technology, November 2011.

[118]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[119]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 6, Evidence, 1st Session of the 41st Parliament, 3 November, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/06evb-49160-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[120]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

Framework for the Assessment and Recognition of Foreign Qualifications that establishes a national vision, guiding principles and timeliness targets for the improvement of the labour-market integration of internationally-trained workers. The Framework establishes a pan-Canadian commitment to timely services, which requires that "within one year, an individual will know whether their qualifications will be recognized or be informed of the additional requirements necessary for registration, or be directed towards related occupations commensurate with their skills and experience."[121] The committee heard that the Framework targets 14 occupations over three years, nine of which are health-related, such as physicians, registered nurses and medical radiation technologists. The Framework specifies that by December 31, 2010, medical laboratory technologists, occupational therapists, pharmacists, physiotherapists and registered nurses will have the processes and supports in place to meet the objectives outlined in the agreement, while dentists, physicians, licensed practical nurses, and medical radiation technologists will have until 31 December, 2012.[122]

The committee also heard from witnesses that Human Resources and Skills Development Canada (HRSDC) is working to facilitate the recognition of the foreign credentials of IEHPs through its Foreign Credential Recognition Program, which has been providing strategic support to health professional organizations and regulatory bodies to develop processes and practices for foreign-credential recognition.[123] The committee heard that the program had funded over 160 projects, including those under taken by the Medical Council of Canada, the Canadian Nurses Association and the Association of Canadian Occupational Therapy Regulatory Organizations that had allowed for the establishment of pan-Canadian assessment systems for IEHPs.

In addition, the committee heard that Health Canada was also providing $18 million annually for the Internationally Educated Health Professionals Initiative, aimed at integrating IEHPs into the health-care system though improving access to information and path-finding, competency assessment and training and orientation. The committee heard that the initiative is supporting programs in British Columbia that provided IEHPs with courses and skills training aimed at addressing language and communication barriers.[124] Health-professional organizations that submitted written briefs to the committee highlighted the importance of Health Canada`s funding of these types of bridging programs and recommended that the federal government provide sustained funding to these programs[125]. They also noted that IEHPs faced significant cost barriers related to having their credentials assessed, as well as challenges associated with obtaining loans from

[121]Forum of Labour Market Ministers, "A Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications," 2009, http://www.hrsdc.gc.ca/eng/workplaceskills/publications/fcr/pcf_folder/PDF/pcf.pdf
[122]*Ibid*.
[123]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47
[124]*Ibid*.
[125]Canadian Society for Medical Laboratory Science, "Submission to the Senate Standing Committee on Social Affairs, Science and Technology: Examine the progress in the implementation of the 2004 10-Year Plan to Strengthen Health Care," written submission, November 2011.

Canadian financial institutions to help cover these costs. The committee heard from federal officials that HRSDC is attempting to address this issue through a pilot project that would help IEHPs cover the costs associated with foreign-credential recognition, funded through Budget 2011.[126]

3) Increasing the Supply of Health Professionals in Official-Language Minority Communities

The committee also heard from witnesses about the federal government's efforts to increase the supply of bilingual health practitioners, particularly in areas where Francophone communities comprise a very small percentage of the population (less than two per cent in Newfoundland and Labrador, British Columbia, Alberta and Saskatchewan.)[127] The Official Languages Health Contribution Program has provided funding to a consortium of 11 colleges and universities offering 90 post-secondary health training programs in French across Canada. This initiative has resulted in over 2,200 post-secondary graduates from the French-language component since 2004, and 8,200 health personnel have received English-language training in Quebec as part of the same program. The committee heard from witnesses that these investments had also enabled the provision of emergency services in French in Nova Scotia, as well as providing a French tele-health service for the province`s Acadian population.[128]

While witnesses felt that there had been an increase in the availability of francophone health professionals, they felt that these resources were not being used most efficiently in the health-care system.[129] They further noted a need to collect data on the languages spoken by health professionals and patients to measure the results of efforts to improve access to health services for Official-Language Minority Communities and ensure that language needs were being met within health care systems.

4) Increasing the supply of health professionals for Aboriginal communities

In addition to initiatives aimed at increasing the number of health professionals to serve Official-Language Minority Communities, the committee heard from witnesses that Health Canada had introduced the $100 million Aboriginal Health Human Resources Initiative (AHHRI) to meet its HHR commitments under the 10-Year Plan. According to federal officials, the AHHRI has provided support to over 2,200 Aboriginal students studying in a wide range of health careers, through the provision of bursaries and scholarships. In a follow-up to questions asked by committee members, Health Canada noted that 91 per cent of AHHRI bursary and award recipients, including 436 nurses and 62 doctors, indicated that the bursary and scholarship funding was instrumental in their ability to

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[126] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[127] *Ibid*.

[128] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[129] *Ibid*.

attend post-secondary health education. In addition, the committee heard that AHHRI had funded over 240 projects with post-secondary institutions that provided student supports, bridging and access to post-secondary health programs, curricula adaptation and other projects. The AHHRI has also resulted in the development of frameworks for cultural competency for medicine and nursing that are currently being implemented in universities and colleges across Canada.

Officials further noted in a follow-up to the committee that since 2004, the percentage of Aboriginal people in the health workforce had doubled. For example, the number of Aboriginal registered nurses and physicians has increased by 130 per cent and 246 per cent respectively. The committee also heard that the AHHRI had been renewed for another five years in Budget 2010, with $80 million in funding, and was now focussing its efforts on training First Nations and Inuit community-based health workers, to ensure that they have skills and certification comparable to workers in provincial/territorial health systems.

Aboriginal organizations appearing before the committee articulated that the AHHRI represented a successful program that demonstrated the federal government's commitment to Aboriginal health.[130] While these organizations appreciated the funding provided through the AHHRI, they found that it was short term, which made program planning difficult. Further, witnesses noted that the AHHRI represented a pan-Aboriginal approach to HHR issues rather than taking into account the unique needs and circumstances of Canada`s different Aboriginal peoples. These issues were also raised with respect to other initiatives introduced as a result of the *Communiqué on Improving Aboriginal Health*.

5) Reducing the Financial Burden of Students in Specific Health Professions

The committee heard from federal officials that the Government of Canada had introduced several measures through Budget 2011 to address the financial burden of students in specific health professions, including family physicians, nurse practitioners and nurses who agree to practise in under-served rural or remote communities, including those who provide health services to First Nations and Inuit communities.[131] Loan forgiveness for family physicians will range from $8,000 to $40,000 per year, while nurses and nurse practitioners will receive between $4,000 to $20,000 per year in loan forgiveness.

6) Health-Human-Resource Planning with Interested Jurisdictions

Based on a written submission from the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR), the committee learned that ACHDHR was

[130] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 7, Evidence, 1st Session of the 41th Parliament, 17 November, 2011 http://www.parl.gc.ca/Content/SEN/Committee/411/soci/07mn-49183-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[131] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

undertaking work in the area of pan-Canadian HHR planning.[132] However, the submission noted that this work originated out of their mandate to provide policy and strategic advice to Deputy Ministers on the planning, organization and delivery of health services, including HHR issues, rather than specific commitments made in the 10-Year Plan. Supporting the principles of the 10-Year Plan, the ACHDHR developed the *Framework for Collaborative Pan-Canadian Health-Human-Resources Planning* that was endorsed by F/P/T Ministers of Health in October 2005 and updated in 2007. The *Framework* has four main goals: enhancing planning capacity; aligning education and workforce goals; achieving the effective mix and use of provider skills and fostering a sustainable workforce and healthy workforce environments. In their submission, the ACHDHR noted that jurisdictions had reported that the *Framework* had enabled them to make progress in each of these areas.

However, the committee heard from witnesses that the federal government needs to enhance its leadership role in promoting pan-Canadian collaboration in health-human-resource planning.[133] In the absence of more robust leadership, they asserted, there is ongoing competition between different jurisdictions for health professionals, creating shortages in some areas. Furthermore, the committee heard that not enough planning is being done to ensure that the right health professionals are being trained to meet the needs of health systems and the population, particularly in professions outside of the acute-care sector, such as home-care support workers, social workers, and psychologists, a problem that was also recognized in the ACHDHR's submission.

In response to these challenges, witnesses recommended the establishment of a pan-Canadian health-human-resource observatory, which would be responsible for developing the evidence base to support HHR planning and serve as a forum for pan-Canadian collaboration and sharing of best practices in this area.[134] A pan-Canadian health-human-resource observatory would bring together researchers, governments, employers, health professionals, unions, and international organizations to monitor and analyze trends in health outcomes, health policy and HHR to provide evidence-based advice to policy makers. The observatory could further serve as a knowledge-translation mechanism, in which best practices in addressing HHR challenges would be shared among stakeholders. The committee heard that HHR observatories had been established in other countries, including the United Kingdom and the United States, and efforts were being made to evaluate their impact.

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[132]Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, "Submission to the: Senate Committee on Social Affairs, Science and Technology," Ottawa, Canada, November 2011.

[133]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47 and Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.

[134]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 5 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evb-49076-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

C. Moving Forward: Committee Observations and Recommendations

Overall, the committee heard from witnesses that there have been significant increases in the supply of health professionals in Canada since the 10-Year Plan was signed in 2004, including in areas of federal responsibility such as Official Language Minority Communities and First Nations and Inuit communities. The committee heard that the F/P/T governments had made significant investments in HHR initiatives that have resulted in these increases. However, the committee heard that shortages remained an ongoing concern, particularly in rural and remote areas and Aboriginal communities. The committee also heard that there is a need to make greater efforts to promote the inter-professional education and training of health professionals in order to foster the development of multi-disciplinary health-care teams across Canada and reduce the number of silos in health-care delivery. In addition, the committee believes that current efforts to support the integration of IEHPs into health-care systems need to be accelerated. The committee is also of the view that the federal government needs to play a greater leadership role in promoting pan-Canadian collaboration HHR planning with interested jurisdictions, as it was one of its commitments outlined in the 10-Year Plan, either through existing mechanisms or the creation of new ones. As witnesses articulated, this is necessary to support jurisdictions in identifying which health professionals need to be trained to meet and reflect the differing needs of their populations, such as the need to provide health services in a manner that reflects different languages and cultures of Canadians. The committee therefore recommends:

RECOMMENDATION 8

That the federal government take the lead in working with the provinces and territories to:

a) **evaluate the impact of health-human-resource observatories in other jurisdictions;**
b) **conduct a feasibility study, and determine the benefit of establishing a pan-Canadian health-human-resource observatory and report on the findings.**

RECOMMENDATION 9

That the Canadian Institutes of Health Information include linguistic variables in their collection of data related to health human resources and populations served by health-care systems across Canada.

RECOMMENDATION 10

That the federal government work with the provinces and territories and relevant health-care organizations to reduce inequities in health human resources, such as rural and remote health care, vulnerable populations, and Aboriginal communities.

RECOMMENDATION 11

That the federal government, through its Foreign Credential Recognition Program, take the lead in working with provincial and territorial jurisdictions and relevant stakeholders to accelerate their efforts to improve the assessment and recognition of the foreign qualifications of internationally educated health professionals and their full integration into Canadian health-care systems, in line with the principles, obligations and targets agreed upon in the Federal/Provincial/Territorial *Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications*.

RECOMMENDATION 12

That the federal, provincial and territorial governments work with universities and colleges to increase inter-professional training of health-care practitioners to continue the development of multi-disciplinary health-care teams in Canada.

5. HOME CARE

A. Overview of Home-Care Commitments in the 10-Year Plan

Home care has been defined by the Canadian Home Care Association "as an array of services for people of all ages, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver," a definition that is also shared by most provinces.[135] Though it is considered to be an "extended health service" under the Canada Health Act and is therefore not considered an insured service, CIHI reports that all of the provinces and territories provide and pay for varying types of home-care services.[136] The federal government provides home-care services to veterans, First Nations living on reserves and Inuit in certain communities.[137] The Canadian Home Care Association estimates 1.8 million Canadians receive publically funded home-care services annually, at an estimated cost of $5.8 billion and accounting for 4.3 per cent of total public health-care spending in Canada.[138]

Under the 10-Year Plan, First Ministers recognized the importance of home care as an essential part of an integrated patient-centred health-care system.[139] They also saw home-care services as a cost-effective means of delivering services that could prevent hospitalization, as well as provide follow-up care. Consequently, they agreed to provide first-dollar coverage[140] for certain home-care services, based on assessed need, by 2006[141]:

- short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;
- short-term acute community-mental-health home care for two-week provision of case management and crisis-response services; and
- end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life.

Reporting requirements under the 10-Year Plan included jurisdictions providing a report on progress towards the implementation of these services, and Health Ministers providing a report to First Ministers on the next steps in fulfilling home-care commitments by December 31, 2006.

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[135]Canadian Home Care Association, "Homecare Facts," http://www.cdnhomecare.ca/content.php?doc=226 and Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 6 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evc-49078-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[136]*Ibid*.

[137]*Ibid*.

[138]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 6 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evc-49078-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[139]Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

[140]First dollar coverage refers to an insurance policy that provides full dollar coverage of the service without the payment of a deductible by the client.

[141]Health Canada, "A 10-year plan to strengthen health care," *Health Care System: First Minister's Meeting on the Future of Health Care 2004*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

B. Progress to Date on Home Care

The committee heard from witnesses that commitments in the 10-Year Plan related to the provision of short-term acute home-care services for two weeks resulted in a marked increase in the volume of services offered and the individuals served.[142] Furthermore, the focus on the provision of acute home-care services had the added benefit of promoting the integration of the acute and home-care sectors, which in turn was addressing the Alternative Level Care (ALC) patient issue discussed with respect to wait times.[143] For example, the committee received written submissions describing an initiative in Ontario called *Home First*, an evidenced-based person-centered transition management philosophy that aims to support patients' return to home on discharge, prior to assessment for and/or admission to a Long Term Care (LTC) home or another appropriate care setting.[144] Under the program, transferring patients from a hospital to a LTC home is considered only after all other community options are examined. The initiative had resulted in a reduction of 75,000 ALC days in Ontario hospitals. Overall, the committee heard that home-care services could benefit between 30 per cent to 50 per cent of all ALC patients, and that ongoing investments and initiatives aimed at the integration of acute and home-care sectors were necessary, including promoting a shift in mindset among health-care providers that home was the best place for patients and families to make decisions about care.

However, the committee also heard that the focus of the 10-Year Plan on the provision of acute home-care services had some negative unintended consequences.[145] First, the focus on acute-care services meant that jurisdictions reduced chronic home-care services for the elderly. Second, it resulted in a shift in the burden of costs for drugs and medical supplies to patients and their families, as these costs would have been covered under the Canada Health Act, if these patients remained in hospital. Consequently, witnesses further articulated that this cost burden had resulted in some patients choosing to remain in hospital instead, as these drugs and supplies were also not covered under existing public drug-insurance plans. Witnesses therefore recommended that a national catastrophic-drug-coverage program be implemented to reduce the costs borne by patients and families in home care.

With respect to short-term, acute, community-mental-health home-care services, the committee heard from witnesses that mental-health services were not currently included in the mandate of most home-care programs. Instead, jurisdictions provided funding to ministries or other government

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[142]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 6 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evc-49078-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[143]*Ibid*.

[144]Ontario Ministry of Health and Long Term Care, "Senate Standing Committee on Social Affairs, Science and Technology: Examine Progress in implementing the 10-Year Plan to Strengthen Health Care," written submission 28 November, 2011.

[145]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 6 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evc-49078-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

departments or provided services through established mental-health organizations.[146] The committee heard that Saskatchewan is the only province that provides mental-health services through home care. Witnesses articulated that some of the reasons behind the lack of integration between mental-health and home-care services included eligibility rules and/or needs assessments for home care that did not include mental-health assessments and home-care providers lacking the skills or expertise to manage mental-health issues.

The committee heard from witnesses that jurisdictions had met their obligations with respect to end-of-life care. In particular, they noted that in 2011, all jurisdictions had introduced coverage for palliative-care-specific pharmaceuticals, though there were some access issues related to these programs.[147] However, witnesses noted that there is significant variation in the quality of end-of-life care across the country, with only 30 per cent of Canadians having access to what is considered high-quality end-of-life care. Moreover, they also pointed out that Canada ranks 9th against 40 countries in the world with respect to the costs of its palliative-care services, and 27th with respect to the cost of the last year of life. The committee heard that the high costs and inefficiencies in the provision of end-of-life care are due in part to the fact that Canadians pay out of pocket for these services.[148] They further articulated that the commitments in the 10-Year Plan related to end-of-life care did not include other important elements, such as: greater support for family caregivers through the adoption of a Canadian caregiver strategy that would focus on reducing financial burden through a variety of financial supports; and an awareness campaign to encourage Canadians to discuss and plan for end-of life care.

In regards to the home-care reporting requirements outlined in the agreement, witnesses indicated that jurisdictions have not produced any reports outlining their progress in meeting commitments related to home care. Federal officials appearing before the committee noted that this is due to the lack of agreement among jurisdictions regarding the appropriate measures and indicators for progress in this area.[149] However, they noted that the Health Council of Canada is expected to report on progress in this area in early 2012.

C. Moving Home Care Forward: Committee Observations and Recommendations

The committee's review found that jurisdictions had made progress in improving access to acute home-care services; acute community-mental-health home-care services; and end-of-life care. The committee was also pleased to hear that the prioritization of acute home-care services in the 10-Year Plan had resulted in innovative approaches in integrating the acute and home-care sectors. However,

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[146] *Ibid*.
[147] *Ibid*.
[148] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 6 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evc-49078-e.htm?Language=E&Parl=41&Ses=1&comm_id=47
[149] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 24 November 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/08evb-49206-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

the review also found that governments did not meet their reporting requirements relating to home care under the 10-Year Plan, due to a lack of agreement regarding developing indicators and targets for progress in this area. The committee also shares the concerns of witnesses related to the increased costs of drugs and supplies experienced by patients and families as a result of being treated out-of-hospital, as well as the reduction of chronic home-care services offered, given the increasing burden of chronic diseases in Canada.[150] The committee also heard from witnesses that overall, the 10-Year Plan adopted a narrow approach to addressing home care that did not include ensuring access to a broad range of services that were considered by witnesses to be important parts of home care, such as health prevention and promotion, home-maintenance programs, providing adequate follow-up with patients; and supports to meet the needs of informal caregivers. In addition, the committee heard that home care needs to be considered an integral part of health-care systems and better integrated with the acute- and primary-care sectors, as well as the full range of continuing care services that includes palliative care and facility-based long-term care. Similarly, the committee found that there is a need to integrate the provision of home care and mental-health services. Finally, the committee agrees with witnesses that governments need to take further action to promote access to high-quality palliative and end-of-life care in Canada in a broad range of settings, as well as raise awareness among Canadians regarding the importance of planning end-of-life care. The committee therefore recommends:

RECOMMENDATION 13

That the federal government work with provincial, territorial governments and other relevant stakeholders to develop indicators to measure the quality and consistency of home care, end-of-life care, and other continuing-care services across the country.

RECOMMENDATION 14

That where necessary, jurisdictions expand their public pharmaceutical coverage to drugs and supplies utilized by home-care recipients.

RECOMMENDATION 15

That the Mental Health Commission of Canada work with the home-care sector to identify ways to promote the integration of mental health and home-care services.

[150] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 6 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evc-49078-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

RECOMMENDATION 16

That Health Canada, taking the lead, work with provinces and territories to create and implement an awareness campaign for Canadians about the importance of planning end-of-life care.

RECOMMENDATION 17

That the federal government work with provincial and territorial governments to develop a pan-Canadian Homecare Strategy, which would include a focus on reducing the burdens faced by informal caregivers.

RECOMMENDATION 18

That the federal government work with the provinces and territories to increase access to palliative care as part of end-of-life health services in a broad range of settings, including residential hospices.

RECOMMENDATION 19

That the federal, provincial, and territorial governments develop and implement a strategy for continuing care in Canada, which would integrate home-, facility-based long-term, respite and palliative-care services fully within health-care systems. The strategy would establish clear targets and indicators in relation to access, quality and integration of these services and would require governments to report regularly to Canadians on results.

6. PRIMARY CARE REFORM

A. Overview of Primary-Care Reform Commitments in the 10-Year Plan

Health Canada defines primary health care as an approach to health and a spectrum of services beyond the traditional health-care system, and includes all services that play a part in health, such as income, housing, education and environment.[151] Primary health-care services are wide ranging and include: prevention and treatment of common diseases and injuries; basic emergency services; referrals and coordination with other levels of care; primary mental-health care; palliative and end-of-life care; health promotion; healthy child development; primary maternity care; and rehabilitation services. Primary care is an element within primary health care that focuses specifically on the delivery of health services. In Canada, primary-care services have traditionally been delivered by family physicians and general medical practitioners, who focus on the diagnosis and treatment of illness and injury. However, this model came to be seen in the late 1990s as less than satisfactory, and raised a number of concerns, including:[152]

- The lack of emphasis on health promotion and disease prevention which has been linked to high rates of preventable illness;
- A lack of continuity in services between different health providers and institutions;
- Problems in accessing services in both rural and remote areas and urban centres, which increases the use of emergency rooms for non-urgent care; and
- Provider concerns regarding their working conditions, including long hours and work-life balance.

As a result of these concerns, primary health-care reform has shifted focus from a physician-based model to team-based care, in which family physicians, nurses and other health professionals work together to improve access to health services; make more efficient use of resources; and are able to address a broad range of health-care needs, from health promotion to the management of chronic diseases.

The 10-Year Plan highlighted timely access to family and community care through primary health-care reform as an ongoing priority, and reinforced the commitment made by First Ministers in the 2003 Accord on Health Care Renewal to ensure that 50 per cent of Canadians have 24/7 access to multidisciplinary teams by 2011.[153] They further agreed to establish a best-practices network to share information and find solutions to barriers to progress in primary health-care reform, such as

[151]Health Canada, "About Primary Health Care," 21 June, 2006, http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos-eng.php
[152]*Ibid*.
[153]Health Canada, "First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care," 16 September, 2004," http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

broadening the scopes of practice of health professionals. First Ministers agreed to report regularly on progress in these areas.

B. Progress to Date

The committee heard from witnesses that insufficient progress had been made towards the goal of ensuring that 50 per cent of Canadians have 24/7 access to multidisciplinary teams by 2011. Though exact figures regarding the number of Canadians enrolled as patients in multi-disciplinary health-care teams is unknown, witnesses reported that 32 per cent of Canadians had access to more than one type of health-care provider. As noted in earlier sections of the report, the committee heard from witnesses that Canadians also continue to face difficulty in having 24/7 access to primary health care services, as approximately 42 per cent of Canadians have access to a same-day or next-day appointment when sick or needing care, and a high usage rate of emergency departments, with approximately 44 per cent of Canadians reporting use of the emergency department in the last two years.[154] Furthermore, the committee heard that though there had been much expansion of tele-health services across Canada, there was no current inventory or combined reporting mechanism to determine the degree to which Canadians had 24/7 access to this type of service.[155]

Despite being behind on the primary-care reform targets outlined in the 10-Year Plan, the committee heard that innovative primary-health-care team models had been implemented in many jurisdictions across Canada, as a result of the $800 million Primary Health Care Transition Fund established in 2000. Some innovative models included Ontario's family-health teams, Alberta`s primary-care network and Quebec's family-medicine groups.[156] Witnesses also pointed to the Family Medical Centre in Manitoba as a collaborative model, in which nurses had been successfully integrated into physician practices, allowing nurses to provide routine care, health promotion, health screening and other preventative care, thus freeing up physicians to see patients with more complex needs. The committee heard that the College of Family Physicians had also developed its own concept of a comprehensive primary-health-care model called the "Patient's Medical Home Initiative," which identifies ways to improve access, coordination and delivery of a more comprehensive basket of services, building on the current strengths of family practice and primary care in Canada, which could serve as a model for jurisdictions as they implement the objectives of the accord.[157]

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[154]Michael Schull, "Standing Senate Committee on Social Affairs, Science and Technology: Reducing wait times and improving access to care," submitted to the Standing Senate Committee on Social Affairs, Science and Technology 29 September, 2011.
[155]Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.
[156]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 19 October 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49095-e.htm?Language=E&Parl=41&Ses=1&comm_id=47
[157]*Ibid*.

The committee heard that these types of models have proven effective in the prevention and management of chronic diseases, which in turn has eased pressure on the acute-care sector.[158] For example, the committee heard that including prevention interventions in primary-care health services, such as providing adequate foot care to diabetes patients, could reduce the number of leg amputations. Moreover, these types of prevention services did not need to be provided by highly skilled health professionals and are low cost. Witnesses articulated that there was a greater need for primary health-care-team models in order to address population health needs in Canada, as it is estimated that 80 per cent of health-care needs in North America currently relate to chronic-disease management rather than acute care.

Furthermore, the committee heard that implementation of collaborative primary-health-care models in different jurisdictions has also improved access to mental-health-care services and increased the capacity of primary care to manage mental health and addiction problems, resulting in improved clinical outcomes, reductions in health-care costs and a greater likelihood of return to the workplace.[159] The inclusion of mental-health-care services in primary-care models was seen as important, given that mental illnesses represent 15 per cent of the disease burden in Canada.[160]

Though primary-health-care reform is occurring across Canada, the committee heard that it remains in the form of pilot projects rather than systemic change. According to witnesses, there are ongoing systemic barriers that continued to undermine the adoption of multidisciplinary health-care teams across Canada.[161] In particular, witnesses highlighted the remuneration of health-care professionals as a key challenge. The committee heard that traditional fee-for-service payment models meant that physicians could only hire other health-care professionals that they could afford to pay with their salary. In contrast, the committee heard that the establishment of global funding models had allowed for different health-care providers to be hired within the context of a team that was created around the needs of the patients served. The committee heard that fee-for-service payment schemes also undermined the incorporation of mental-health services into primary care. For example, the committee heard that mental-health-care services could be integrated into primary care by having psychiatrists offer consultations and advice to physicians. However, psychiatrists are only paid based upon face-to-face patient visits which are not always necessary and therefore, there is no way to reimburse them for this type of service. Moreover, the committee heard that family physicians were not remunerated in a fashion that reflected the time and skills needed to manage patients with complex chronic conditions, and as a result there were insufficient incentives in the system for physicians to take on these patients.

Furthermore, the committee heard that this entire remuneration system is reinforced by the Canada Health Act, which was designed to support an acute-health-care system focused on physician

[158] *Ibid.*
[159] *Ibid.*
[160] *Ibid.*
[161] *Ibid.*

services, rather than the financing of a primary-care system that offers services from a broad range of health-care providers outside of the hospital setting.[162] While witnesses articulated that there is no one set remuneration model that could work for all sectors of the health-care system, they indicated that health-care reform could be achieved by establishing funding models that are in line with the types of health-care services currently needed by Canadians and overarching public-health goals, including focussing on the prevention of hospitalizations to begin with.[163]

Finally, the committee heard from witnesses that there is a need for the establishment of management structures to steer and monitor the renewal of primary health care within jurisdictions.[164] According to witnesses, the bulk of primary health care in Canada is currently delivered by physicians who operate private practices and bill public insurance systems for the services provided.[165] Therefore, the way their services are delivered does not necessarily have to be in line with the primary-health-care reform objectives established by provincial and territorial health departments.[166] To address this issue, the committee heard that some jurisdictions had established new management structures to ensure alignment between health ministries and primary-health-care delivery, with some jurisdictions linking funding agreements to public-policy goals for primary care, such as the provision of preventative health-care services, adoption of electronic health records and the provision of afterhours care.[167] The committee heard that more efforts are needed in the development of these types of governance structures in order to advance primary-health-care reform across systems.

To accelerate primary-health-care reform in Canada, the committee heard from witnesses that there is a need to evaluate the new models of primary health care to identify which are most successful and what underlying factors within the system had enabled reform in this area.[168] The committee heard from officials from the Canadian Institutes of Health Research (CIHR) that their new Strategy for Patient Oriented Research is intended to address this issue over the next five years

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[162] *Ibid*.

[163] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 2 December, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49228-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[164] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.

[165] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 19 October 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49095-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

[166] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.

[167] These specific examples were noted in the following report cited by the Health Council of Canada in their submission to the Standing Senate Committee on Social Affairs, Science and Technology on 10 March, 2011: McMaster Health Forum, "Issue Brief: Strengthening Primary Health Care in Canada," January 2010, http://fhswedge.mcmaster.ca/healthforum/docs/Strengthening%20Primary%20Healthcare%20in%20Canada_issue-brief_2010-01-08.pdf.

[168] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011 and Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 24 November 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/08evb-49206-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

by testing new models of primary care, monitoring their success and working with policy makers to investigate conditions necessary to implement them in other parts of the country, an initiative that would involve 30 per cent of Canadians from coast to coast.[169]

Some witnesses articulated that further targeted federal funding for primary-health-care reform is also necessary. They recommended that new targeted funding should focus on providing seed funding for the implementation of best-practice models in primary health care in other parts of the country, in the form of the Canadian Health Innovation Fund. Other witnesses noted that any further provision of federal funding for primary-care reform should include enhanced accountability mechanisms. For example, the committee heard that one reason that the Primary Health Care Transition Fund and/or other federal transfers did not result in systematic health-care reform is because they do not include accountability mechanisms, such as conditions requiring that the funding be targeted to certain areas. Consequently, jurisdictions did not have to meet the targets outlined in the 10-Year Plan in order to receive money from the federal government. They therefore recommended that any future federal funding provided to promote primary-care reform should include greater accountability mechanisms, such as establishing an overall vision for the health-care system, which would include goals, targets and indicators to measure whether results were being achieved and that funding be provided based upon results.

C. Moving Forward in Primary-Care Reform: Committee Observations and Recommendations

The committee's study revealed that though many innovations are occurring in primary care to ensure that 50 per cent of Canadians had 24/7 access to a multi-disciplinary health-care team, jurisdictions have yet to meet this goal. The committee heard from witnesses that key challenges relating to achieving systematic primary-care reform are current remuneration models; the lack of governance mechanisms to manage and steer reform efforts; and the need for targeted conditional funding arrangements. The committee is of the view that jurisdictions need to find ways to address these key challenges and re-commit to meeting the goal established in the 10-Year Plan. The committee also heard that there is a need to evaluate the new innovative models of primary health care that resulted from the Primary Health Care Transition Fund, including the underlying factors that have made them a success, a task currently being undertaken by CIHR. The committee did not hear testimony regarding the current status of the best-practices network that was to be established to share information and discuss common challenges associated with primary-care reform. However, it notes that in 2008, the Health Council of Canada reported that though governments created the Best Practices Network to share information and solve common problems related to primary-health-care reform, as per their commitments in the 10-Year Plan, the network had been dissolved in 2006, due

[169]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 1st Session of the 41st Parliament, 27 October, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47

to a lack of targeted funding to sustain its existence.[170] Furthermore, the committee also heard from witnesses that there was an ongoing need to share best practices in the area of primary-health-care reform and work together to address the common challenges in this area. Witnesses felt that the federal government could play a leadership role in this area by promoting the sharing of best practices in these areas. The committee therefore recommends:

RECOMMENDATION 20

That the federal, provincial and territorial governments share best practices in order to examine solutions to common challenges associated with primary-care reform, such as: the remuneration of health professionals; the establishment of management structures to guide primary-care reform; and the use of funding agreements linked to public health goals.

RECOMMENDATION 21

That the federal government work with the provinces and territories to re-establish the goal of ensuring that 50 per cent of Canadians have 24/7 access to multi-discliplinary health-care teams by 2014.

[170]Health Council of Canada, "Rekindling Reform: Health Care Renewal in Canada, 2003-2008," June 2008, http://www.healthcouncilcanada.ca/tree/2.46-HCC_5YRPLAN_WEB_FA.pdf.

7. ELECTRONIC HEALTH RECORDS AND TELE-HEALTH

A. Electronic Health Record and Tele-Health Commitments in the 10-Year Plan

An electronic health record (EHR) refers to a secure and private record that provides, in a digital or computerized format, lifetime information on a person's history within the health-care system.[171] Patient health information comes from various sources such as physicians, hospitals, diagnostic laboratories and pharmacists. That information is shared electronically by practitioners from different health care delivery units in a same region, provincial/territorial jurisdiction, as well as across the country. In order to achieve the goal of sharing information across region and jurisdiction, a common, interoperable or compatible network needs to be developed. EHR is sometimes confused with Electronic Medical Record (EMR). The EMR stores complete patient's health information (i.e. lab results, images, consultant or hospital notes) in a single location, such as a physician's office or a community health centre; this information is only accessible by authorized professionals working in that location.[172] EMRs are thus a key component of a comprehensive EHR.

To be fully functional across Canada, the following three core components of an EHR system must be developed: Storage, Point of Care Systems and Connection:

- The Storage component includes six core databases in all provinces and territories: patient registry; provider registry; diagnostic imaging repositories; laboratory information repositories; drug information repositories; other information repositories.

- The Point of Care Systems component requires that all health-care providers and facilities – family-doctor offices, hospitals, walk-in clinics, pharmacies, laboratories, etc. – use consistent systems to send, retrieve and manage health information. While some may have systems ready to adopt EHR right away, others need to update them, or need electronic systems to be built.

- The Connection component requires the installation of a secure pathway that allows all types of health information to move between all points of care in a region, within a province and eventually across the country.[173]

In the 2004 10-Year Plan to Strengthen Health Care, First Ministers recognized the development of EHRs and tele-health as integral parts of health-care renewal, particularly in rural and remote areas.[174] They further recognized the importance of building upon previous investments made in this area as part of earlier health accords and agreed to accelerate the development of EHRs across the country and tele-health in rural and remote areas. Consequently, the federal government agreed to

[171] Denis J. Protti, *Primary Health Care Transition Fund: Information Management and Technology*, March 2007, p. 2, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/prim/2006-synth-tech-eng.pdf.
[172] *Ibid*.
[173] Canada Health Infoway Inc., *EHR Advancements in Canada*, https://www.infoway-inforoute.ca/lang-en/about-ehr/advancements.
[174] Health Canada, *Health care system: A 10-year plan to strengthen health care*, 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

invest an additional $100 million in the development of electronic health records through Canada Health Infoway Inc. (Infoway), the private not-for-profit cooperation, which was established in 2001 with the mandate of building the foundations of an interoperable EHR, as well as of defining and promoting standards to ensure interoperability.[175]

B. Progress to Date

The committee heard from witnesses that since 2001, the federal government had invested a total of $2.1 billion in Canada Health Infoway Inc. to foster the development of EHRs and tele-health across Canada.[176] Witnesses appearing before the committee explained that Infoway's investments in health IT projects differed from most of the federal government's health spending. The committee heard that jurisdictions are responsible for the development of their overall EHR strategies, and proposing and implementing projects that are in line with Canada Health Infoway's interoperability standards and eligibility criteria. Canada Health Infoway shares the capital costs of the IT infrastructure with the provinces and territories, but only provides funding when the deliverables have been achieved. Therefore, jurisdictions have control over the pace of the projects.

The committee heard that following the 2004 Accord, Infoway, the provinces and territories had agreed to set two goals in relation to the development of electronic health records.[177] The first goal was that every jurisdiction would see benefits from new health-information investments by 2010. The second goal was that the core elements of the electronic health record would be available for 50 per cent of the Canadian population by 2010. The committee heard that the Office of the Auditor General had found that the first goal was met well before the deadline and the second goal was achieved in March 2011.

Witnesses appearing before the committee articulated that these investments in Electronic Health Records are integral to promoting health-care reform across the continuum of care and would allow health-care professionals to share patient information more quickly and efficiently, which would reduce health-care costs and improve quality of care through reduced medical errors and better monitoring of patient outcomes.[178] For example, the committee heard that investments in drug-information systems, which allow authorized clinicians to access, manage and share patient medication histories have been successful in preventing harmful drug interactions. The committee heard that these types of systems are currently in place in one third of community pharmacies in Canada and half of all hospital emergency rooms. The committee heard that research had demonstrated that the benefits of drug-information systems could be valued at $436 million per year

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[175] *Ibid*.
[176] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47
[177] *Ibid*.
[178] *Ibid*.

and had resulted in increased patient safety, reductions in fraudulent medications and increasing gains in productivity among pharmacists.

Other examples presented to the committee included the role of digital diagnostic imaging in reducing wait times and improving access. Digital imaging collects, stores, manages and shares patient X-rays, CT scans, MRIs and other images and reports. The committee heard that 90 per cent of most common radiology examinations in Canadian hospitals are now digital with research showing that this has increased radiology and technician productivity by 25 per cent and increased the number of exams performed by approximately 11 million exams annually.

Witnesses also provided the committee with examples regarding how tele-health is increasing access to care in remote areas. For example, the committee heard that Canada has the world's largest video conferencing network, with 5,700 tele-health sites in 1,200 communities, which has resulted in 250,000 sessions delivered in 2011, eliminating the need for 47 million kilometres of travel to receive medical services. However, it is important to note that the committee also heard from other witnesses that there is no standardized reporting system to determine how many Canadians had access to these types of services.

The committee also learned about "Rosie the Robot," a mobile machine able to bring the physician to the patient's bedside through a television screen, who can then guide local health professionals through different emergency medical procedures.[179] Though Rosie cost $150,000, she eliminated the need for 28 patients to undertake emergency medical evacuations in a 15-month period, at a cost savings of approximately $32,000 per hour of flight scheduled.

Despite the importance of electronic health records and tele-health for health-care reform, the committee heard that there are some significant challenges to accelerating their adoption across Canada.[180] In particular, the number of primary-care doctors using computerized record systems or electronic medical records was low compared to other countries: in 2009, a Commonwealth Fund International Health Policy Survey shows that only 37 per cent of primary-care physicians in Canada used electronic medical records, compared with over 90 per cent of doctors in Australia, Italy, the Netherlands, New Zealand, Norway, Sweden and the United Kingdom.[181] The committee heard that Canada Health Infoway and jurisdictions are currently making investments to address this issue by focussing their efforts to enrol 12,000 physicians and nurse practitioners in electronic medical

[179]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 2 December, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49228-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[180]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[181]Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.

records programs, which would increase the percentage uptake among Canadian physicians to 60 per cent.[182]

In order to further promote the adoption of electronic medical records among physicians, the committee heard from witnesses that incentives need to be provided, such as tying the use of EMRs to remuneration, or demonstrating the meaningful use of these tools to physicians such as how e-prescribing can improve their work.[183] Others suggested that user input is important, as information systems that are responsive and most reflective of local needs are most likely to be adopted.

Another key challenge presented to the committee is the lack of interoperability between different health IT systems within jurisdictions.[184] The committee heard that some EHR projects that had been completed did not meet the standards for national interoperability because they were implemented before the introduction of these standards. Consequently, they were not interoperable with other local systems either. Therefore, the committee heard, jurisdictions need to focus on upgrading existing systems to ensure they also are in line with the national interoperability standards.

In addition, witnesses indicated that issues of privacy of electronic health records still need to be addressed, particularly in the context of a national interoperable electronic health record.[185] The committee heard that differences in federal, provincial, territorial privacy laws related to the collection, use, protection and disclosure of personal health information need to be harmonized, as a national interoperable electronic health record requires that information travel across jurisdictions.

Finally, the committee heard that the full realization of a national interoperable electronic health record system would require significantly more investment than had been made to date, as Canada Health Infoway Inc. has estimated that the total cost could amount to as much as $10 billion.[186]

Witnesses appearing before the committee also raised other concerns.[187] For example, witnesses stressed the importance of ensuring that electronic health records be implemented across the health-care system, including long-term and home care to underpin the integration of these different sectors within the health-care system. They also wanted to ensure that Canada Health Infoway Inc. was

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[182]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[183]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 2 December, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49228-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[184]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[185]*Ibid*.

[186]*Ibid*.

[187]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 2 December, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49228-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

working to design information systems that would allow for secondary uses, including health-system management, evaluation and research.

C. Moving Forward in Implementing Electronic Health Records in Canada: Committee Observations and Recommendations

During the course of the committee's study, the importance of the development of electronic health records to health-care reform in Canada was stressed by almost all witnesses. The committee heard that EHRs would promote the integration of different sectors of the health-care system by allowing patient information to be quickly and seamlessly transferred from primary care to acute care and home and long-term care. EHRs would also promote patient safety through drug-information systems and allow for increased accountability within the system, as information systems would enable better monitoring of patient outcomes. EHRs would also promote health-care-system reform by providing valuable information on health-system management that would in turn enable evaluation and research that could lead to quality improvements. However, the committee also heard the frustrations of health practitioners related to EHRs, in particular, how local systems between doctor's offices and nearby hospitals did not have the same standards and could therefore not communicate. For policy makers, low uptake among physicians, a lack of harmonization in privacy laws across the country, and the overall cost of the system remain key concerns. The committee heard from witnesses that there were some examples of best practices in the implementation of interoperable electronic health records in Canada and, in particular, they noted that the Department of National Defence and Canadian Forces had been successful in implementing a comprehensive system for their members.[188] The committee notes that jurisdictions and Canada Health Infoway Inc. may want to examine what strategies the Canadian Forces used to promote the adoption of EHRs within its health service. Tele-health was also seen as a key resource promoting innovations and reducing costs in health-care delivery in the North, though it remained unclear how many Canadians have access to these services. All witnesses agreed that both EHRs and tele-health were areas in health-care reform that called for federal leadership and ongoing investments. The committee therefore recommends:

RECOMMENDATION 22

That the Government of Canada continue to invest in Canada Health Infoway Inc. to ensure the realization of a national system of interoperable electronic health records.

[188] *Ibid.*

RECOMMENDATION 23

That Canada Health Infoway Inc. target its investments to:

a) **projects aimed at upgrading existing components to meet national interoperability standards set by the organization; and**
b) **promoting the adoption of electronic medical records by health professionals in Canada, including working with stakeholders to identify effective incentives in this area.**

RECOMMENDATION 24

That Canada Health Infoway Inc. work with provinces and territories and relevant stakeholders to:

a) **establish a target that would outline when all existing components of the EHRs would be upgraded to meet national interoperability standards;**
b) **establish a target that would outline when at least 90 per cent of all physicians in Canada will have adopted electronic medical records;**
c) **ensure that electronic health-record systems are currently being designed and implemented in a way that would allow for secondary uses, such as health-system research and evaluation; and**
d) **develop a systematic reporting system in relation to access to tele-health services in Canada.**

RECOMMENDATION 25

That the federal government work with provinces and territories to examine approaches to addressing differences in privacy laws across jurisdictions in relation to the collection, storage and use of health information.

8. ACCESS TO CARE IN THE NORTH

A. Overview of Commitments in the 10-Year Plan on Access to Care in the North

Although all provinces face challenges in containing increasing costs and demand for health care, these challenges are even higher in northern communities due to such factors as shortages of health-care providers, lack of full-service medical care, and high medical transportation costs. Moreover, health status, especially in Inuit communities, is generally much worse than anywhere else in Canada.[189]

In spite of significantly higher health-care costs and spending in the territories, compared with the rest of Canada,[190] indicators of health status in the territories show lower life expectancies, higher infant mortality rates, significantly more years of life lost due to unintentional injuries, higher rates of death from lung cancer, and fewer people who rate their own health as good or excellent.[191]

As part of the 10-Year Plan, First Ministers committed to improving access to health care in northern communities by providing $150 million over five years to: facilitate long-term health reforms; establish a federal/territorial working group to support the management of the fund; and enhance direct funding for medical transportation costs.[192] First Ministers also agreed to develop a joint vision for the North in collaboration with the territories.[193] Funding through the Territorial Health System Sustainability Initiative (THSSI) was introduced in 2005 to facilitate the transformation of territorial health systems toward greater responsiveness to Northerners' needs and improved community-level access to services. The resources were divided between three initiatives:

- Medical Travel Fund ($75 million over five years), allocated according to territories' actual medical transportation expenditures, to offset the high cost of providing medical transportation;
- Territorial Health Access Fund ($65 million over five years), which was allocated equally to each territory to support health reform activities that address one or more of the following three broad goals: reduce reliance over time on the health care system, strengthen community level services, and build self-reliant capacity to provide services in-territory; and
- Operational Secretariat Fund ($10 million over five years), which supported the activities of the Federal/Territorial (F/T) Assistant Deputy Ministers' Working Group, and to fund a number of pan-territorial projects.[194]

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[189] Heather Tait, *Aboriginal Peoples Survey, 2006: Inuit Health and Social Conditions*, Statistics Canada, December 2008, pp. 10–16.
[190] Canadian Institute for Health Information [CIHI], *National Health Expenditure Trends, 1975 to 2010*, October 2010.
[191] *Ibid*.
[192] Health Canada, *A 10-year Plan To Strengthen Health Care*, 16 September 2004.
[193] *Ibid*.
[194] House of Commons, Standing Committee on Health, *Statutory Parliamentary Review of the* 10-Year Plan to Strengthen Health Care, 2nd Session, 39th Parliament, June 2008, pp. 42–43.

B. Progress to Date

The committee heard from witnesses that federal funding through THSSI had played a critical role in the development, implementation and delivery of innovative and transformative health services in the North.[195] For example, the committee heard that the Government of the Yukon was able to improve access to care for its citizens in a number of areas, including enhanced mental-health supports; introducing collaborative care for chronic-disease management; introducing tele-health in all Yukon communities; establishing a team model for palliative care; and the development of a Health Human Resources Strategy. The committee heard that the territory was able to use the funding to extend beyond the health-care system to address other social determinants of health through the development of a Wellness Strategy and a Social Inclusion Strategy.

Meanwhile, the committee heard that THSSI funding in the Northwest Territories had allowed for community-health nurse training, increased use of nurse practitioners and midwives as well as physician staffing and recruitment.[196] The committee heard that specialized training of community-health nurses was especially important because these professionals are often the sole health practitioners in remote communities and enhanced training enables them to deal with the wide range of acute-care issues on their own. THSSI funding had also improved access to basic services, such as expanding the territory's dialysis program and promoting tele-health initiatives. Witnesses further articulated that THSSI funding had been critical in addressing costs associated with medical travel and that the Northwest Territories had been introducing initiatives to reduce reliance on medical travel and improve efficiencies in this area.

Witnesses also noted that THSSI funding had allowed for a number of pan-territorial initiatives, including mass media collaboration; support for the Arctic Health Research Network; Mental Health First Aid; and the evaluation and review of medical travel programs.

The committee also heard from witnesses that the Office of the Auditor General had also reported in 2011 on health-service delivery in the Yukon and the Northwest Territories, and had noted that both territories needed to make improvements in two key areas: the development of health-human-resource strategies, and establishing monitoring systems to measure health-care system performance through the development of performance indicators and performance agreements with health authorities.[197]

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[195] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 6, Evidence, 1st Session of the 41th Parliament, 2 November, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/06eva-49158-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[196] *Ibid*.

[197] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.

Representatives from these territories indicated to the committee that they were working to address these ongoing challenges[198]. To improve the recruitment and retention of health human resources, the committee heard that the territories are focusing their efforts on encouraging their own graduates to pursue health careers. For example, the committee heard that the Yukon had secured a permanent ongoing seat at the medical school at Memorial University, which specializes in remote communities, and developed their own nursing program at Yukon College in Whitehorse.

To improve accountability measures, the committee heard that the Northwest Territories is moving all of its health authorities onto shared financial systems, in order to implement system-wide performance measurements and agreements, as well as implementing electronic medical records that would allow for the tracking of outcomes and better reporting.[199] However, territorial government witnesses also explained that efforts to improve accountability, including establishing common performance measures and indicators, face the added challenge of jurisdictional divisions, as the provision of health care and health-promotion services in the North is divided between federal and territorial governments, with many Aboriginal communities currently negotiating for self-government in these areas.

Witnesses further noted that they also face these jurisdictional challenges in addressing other social determinants of health, such as ensuring that communities had access to clean water, food and adequate housing.[200] To address these jurisdictional issues, the committee heard that the territories are working in close partnership with self-governing First Nations communities and F/T government working groups. In addition, they articulated that THSSI funding had also been used to fund projects examining how services and resources could be shared across jurisdictions and promote integration in the area of health-service delivery. The committee heard from witnesses that overcoming jurisdictional divisions in this area could be facilitated, if the federal government made further effort to clarify its roles and responsibilities in relation to health care.

In addition to these concerns, the committee heard from witnesses that there are other ongoing challenges related to health-care delivery in the North.[201] Though these jurisdictions are making efforts to reduce medical travel costs, these costs continue to rise due to the growing population in these areas, coupled with growing utilization of more complex health services provided by a wider range of specialists in centralized facilities. Meanwhile, northern populations and in particular, Aboriginal communities, continue to experience poorer health outcomes. For example, the committee heard that the largest group of residential-school survivors live in the North and the scale, scope and multi-generational impacts of these experiences, brought to the fore through the Truth and

[198]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 6, Evidence, 1st Session of the 41th Parliament, 2 November, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/06eva-49158-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.
[199]*Ibid*.
[200]*Ibid*.
[201]*Ibid*.

Reconciliation Commission, have dramatically increased the demand for mental-health services in the territories.

In continuing to improve access to care in the North, witnesses appearing before the committee stressed the importance of stable, predictable and adequate funding in enabling the effective planning and implementation of health-care reform programs and initiatives.[202] They explained that one of the issues associated with THSSI funding was that its renewal is unpredictable, resulting in some projects and programs having to stop and restart. For example, the committee heard that THSSI was initially established for five years in 2005. With the funds, the Yukon had just established a dental-health program for children, but it remained a question as to whether the THSSI would be renewed, and consequently, the program had to be suspended because the territorial government could not guarantee people employment or assure communities that the program was going to be continued. However, THSSI was then extended in Budget 2010 for an additional two years and then again, in August 2011, for an additional two years to March 2014, which in turn allowed the program to continue.

They also stressed that this funding needed to continue to reflect the unique health challenges faced by Northern populations, including: high medical travel costs; difficulties in the recruitment and retention of health human resources; a growing population with poorer health outcomes; jurisdictional challenges; the need to address the broader social determinants of health, such as poverty and access to food, water and housing; and a small tax base to support health-care service delivery.

C. Moving Forward in Improving Access to Care in the North: Committee Observations and Recommendations

The committee's study found that funding provided through the 10-Year Plan to improve access to care in the North had enabled the territories to introduce numerous initiatives that addressed their unique challenges related to health-care delivery, including: the high costs of medical travel, addressing the burden of chronic diseases and mental-health issues; collaborating across jurisdictions; improving the recruitment and retention of health human resources; and addressing the broader social determinants of health including access to food, potable water and decent housing. However, the committee heard that these challenges still remained and some, such as the cost of medical travel, were increasing due to demographic changes in the region and the nature of health-care service delivery. The committee therefore heard that future funding arrangements needed to reflect these ongoing unique needs and be provided in a stable, predictable manner. The committee also heard that territorial jurisdictions needed to focus their efforts on developing accountability measures and enhance collaboration in addressing jurisdictional barriers related to health-care

[202] *Ibid*.

delivery and dealing with the broader social determinants of health. The committee therefore recommends:

RECOMMENDATION 26

Recognizing the ongoing unique challenges associated with health and health-care delivery in the North, that the federal government extend its funding of the Territorial Health System Sustainability Initiative beyond 2014 in a manner that is both sustainable and predictable.

RECOMMENDATION 27

That the Federal/Territorial (F/T) Assistant Deputy Ministers' Working Group work with relevant stakeholders and communities to:

a) **improve accountability measures to evaluate the performance of health-care systems in the North; and**
b) **address jurisdictional barriers as they relate to health-care delivery and addressing the broader social determinants of health, including potable water and decent housing.**

9. THE NATIONAL PHARMACEUTICAL STRATEGY

A. Commitments in the 10-Year Plan related to the Development of a National Pharmaceutical Strategy

In Canada, jurisdiction over pharmaceuticals is shared between federal, provincial and territorial governments. The federal government, through Health Canada, is responsible for regulating pharmaceuticals, including authorizing their entry to the market based upon assessments of drug safety, efficacy and quality, as well as monitoring these products once they are on the market.[203]

Under the *Patent Act*, the federal government also has the authority to regulate and report on manufacturers' prices for patented drugs through the Patented Medicines Prices Review Board (PMPRB), an arms-length organization that reports to Parliament through the Minister of Health. The mission of the PMPRB is to "protect consumers and contribute to Canadian health care by ensuring that prices charged by manufactures for patent medicines are not excessive."[204] However, provinces are responsible for the regulation of manufacturers' prices for generic drugs under section 91(13) of the *Constitution Act, 1867*.[205]

With respect to public coverage of the costs of pharmaceuticals, the Canada Health Act mandates that provinces and territories must provide public coverage for physician services and hospital care, but it only requires that the cost of pharmaceuticals used while in hospital be covered by publicly funded insurance plans, not the cost of prescriptions Canadians receive as outpatients.[206] Consequently, provinces and territories are responsible for both the cost and the extent of out-of-hospital public drug coverage offered to their citizens, including formulary decisions. As such, there is variance from jurisdiction to jurisdiction regarding the extent of public drug coverage offered and to which population groups.[207] Therefore, approximately 58 per cent of Canadians receive some degree of drug-insurance coverage from provincial and territorial programs, while 53 per cent of Canadians rely on private drug coverage offered through their employers.[208] Meanwhile, the federal government provides some drug coverage or facilitates drug coverage for population groups under its jurisdiction, including First Nations and Inuit; veterans; refugee protection claimants; Canadian

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[203]Health Canada, "National Pharmaceuticals Strategy: Progress Report," June 2006, http://www.hc-sc.gc.ca/hcs-sss/pubs/pharma/2006-nps-snpp/index-eng.php.

[204]Health Council of Canada, "Pharmaceuticals in Canada," January 2005, http://www.healthcouncilcanada.ca/tree/2.39-BkgrdPharmaENG.pdf.

[205]Health Canada, "National Pharmaceuticals Strategy: Progress Report," June 2006, http://www.hc-sc.gc.ca/hcs-sss/pubs/pharma/2006-nps-snpp/index-eng.php.

[206]Health Council of Canada, "Pharmaceuticals in Canada," January 2005, http://www.healthcouncilcanada.ca/tree/2.39-BkgrdPharmaENG.pdf.

[207]For a complete overview of provincial, territorial and federal drug coverage programs, please see: K Phillips, "Catastrophic Drug Coverage in Canada," Library of Parliament PRB 09-06, http://lpintrabp.parl.gc.ca/lopimages2/prbpubs/pdf/bp1000/prb0906-e.pdf.

[208]These figures are based upon those provided by the Fraser Group, which has conducted research on behalf of Health Canada and the Senate Standing Committee on Social Affairs, Science and Technology. Fraser Group, "Drug Expense Coverage in the Canadian Population: Protection from Severe Drug Expenses," August 2002, http://www.frasergroup.com/downloads/severe_drug_e.pdf.

Forces; veterans; federal inmates and members of the Royal Canadian Mounted Police (RCMP), representing approximately two percent of the population.[209]

As part of the 10-Year Plan, First Ministers agreed to the establishment of a National Pharmaceutical Strategy (NPS) that would address common challenges associated with pharmaceutical management in Canada, including access; safety, effectiveness and appropriate use; and system sustainability. First Ministers agreed that the National Pharmaceutical Strategy would include the following nine elements[210]:

1) Develop, assess and cost options for catastrophic pharmaceutical coverage;
2) Establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness;
3) Accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process;
4) Strengthen evaluation of real-world drug safety and effectiveness;
5) Pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines;
6) Enhance action to influence the prescribing behaviour of health-care professionals so that drugs are used only when needed and the right drug is used for the right problem;
7) Broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record;
8) Accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs; and
9) Enhance analysis of cost drivers and cost-effectiveness, including best practices in drug-plan policies.

First Ministers directed Health Ministers to establish a Ministerial Task Force, which would be responsible for the development and implementation of these nine elements, and they were also responsible for reporting on their progress by 30 June 2006.

B. Progress to Date

The committee heard from witnesses that after the signing of the 10-Year Plan in 2004, jurisdictions began advocating a more focused agenda for the National Pharmaceutical Strategy (NPS) that would focus on five priority areas: costing models for catastrophic drug coverage, expensive drugs for rare diseases, the establishment of a common national formulary, real-world drug safety and effectiveness, and pricing and purchasing strategies.[211] As per the commitments outlined in the 10-Year Plan, the committee heard that a Ministerial Task Force was established to

[209] *Ibid*.
[210] Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.
[211] Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

collaborate on these five elements. The Task Force released a report in 2006 outlining progress in these areas and identifying recommendations for future action, which are outlined in Table 2 below.

Table 2. Summary of F/P/T Ministerial Task Force's 2006 Progress Report and Recommendations for the National Pharmaceutical Strategy

Focus Area	Overview	Achievements	Select Recommendations for Future Action
Catastrophic drug coverage	Catastrophic drug coverage is defined as an upper limit of beyond which payment of drug costs would constitute a financial hardship.[212] However, the level of hardship varies depending upon the financial situations of individuals and families. Some experts define this limit as a fixed dollar figure, while others use a percentage of income.	Undertook a costing analysis examining the cost of establishing a national catastrophic drug plan based on two different upper-limit options. One option defined the upper limit as a variable percentage of family income, ranging from 0 per cent to nine per cent and the other used a fixed percentage of family income (4.3 per cent). The analysis also examined the cost of a program in the context of maintaining the current mix of public and private plans and the cost without private plans.	• Further analysis should be focused on a variable percentage of income threshold option that maintains the private- payer role. • A parallel fixed percentage (five per cent) option should be analyzed and costed. • Feasibility of maintain private-payer coverage should be analyzed.
Expensive Drugs for Rare Diseases (EDRDs)	Though no common international definition exists, rare diseases have sometimes been defined as those affecting fewer than 1 in 2,000 persons.[213] Drug treatment options for rare diseases often lack the support of scientific evidence because there are insufficient numbers of people with these diseases to conduct large-scale clinical trials on their safety and effectiveness. Furthermore, the cost of developing these drug treatments remains high, but the market for these drugs remains small, resulting in drug costs as	Undertook research examining policies and definitions related to rare or orphan drugs and diseases in different jurisdictions. Working on developing a post-market research study of enzyme replacement therapy in the treatment of Fabry's Disease to identify ways of assess the effectiveness of drugs for rare diseases.	• Accelerate the development of a framework for EDRDs focussing on evidence, ethics, regulatory and reimbursement systems.

[212]Health Council of Canada, "Pharmaceuticals in Canada," January 2005, http://www.healthcouncilcanada.ca/tree/2.39-BkgrdPharmaENG.pdf.

[213]House of Commons Standing Committee on Health, "Evidence," 3rd Session of the 40th Parliament, 3 June, 2010, http://www.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4582704/HESAEV20-E.PDF.

	high as $300,000 per year.[214] However, governments also have an ethical obligation to provide Canadians with access to EDRDs.		
Common National Formulary	A formulary is a list of drugs that will be covered by a drug- insurance program. A common national drug formulary is seen as a means of improving consistency and achieving harmonization across F/P/T plans to promote equity.	Undertaken work to examine the feasibility of expanding the mandate of the Common Drug Review to include all publicly funded drugs, including new indications for old drugs; oncology drugs; and therapeutic-class reviews. Conducted an analysis comparing drug formularies across jurisdictions with the aim of establishing a common list of benefits.	• Pursue a staged expansion of the CDR; • Continue work to design a common national formulary.
Drug Pricing and Purchasing Strategies	As prices for non-patented medicines are not regulated in Canada, Canadian prices for non-patented drugs are 21-51 per cent higher than international median prices. Consequently, there is a need for common strategies to obtain best prices for prescription drugs and vaccines in Canada.	The PMPRB has begun monitoring non-patented prescription drug prices. Discussions have been undertaken with the generic pharmaceutical industry and academics to identify ways of achieving more competitive prices for non-patented drugs.	• A non-regulated, business-management approach to drug pricing issues, with priority on non-patented drugs be pursued. • Regulatory approaches should also be considered.

[214]Health Council of Canada, "A Status Report on: The National Pharmaceuticals Strategy: A Prescription Unfilled," January 2009, http://www.healthcouncilcanada.ca/tree/2.35-HCC_NPS_StatusReport_web.pdf

Real World Drug Safety and Effectiveness	While pharmaceuticals undergo rigorous pre-market clinical testing, Canada lacks a strong system for evaluating safety and effectiveness once they have reached the market place. Therefore, new mechanisms for data collection are necessary for the post-market surveillance of pharmaceuticals.	Working towards creating broad-based support for a post-market surveillance system that is based upon shared responsibility. Working towards the development of four interdependent strategies focussing on establishing a national oversight body, research networks and Adverse Drug Reaction reporting centres, engagement of frontline workers; and development of clear standards and transparency of scientific evidence.	• Undertake consultations on proposed interdependent strategies for the strengthened system of post-market surveillance. • Collaboration with the Canadian Institutes of Health Research (CIHR) and researchers to develop a business plan for a pharmaceuticals research network.

Source: Health Canada, "National Pharmaceuticals Strategy: Progress Report," June 2006, http://www.hc-sc.gc.ca/hcs-sss/pubs/pharma/2006-nps-snpp/index-eng.php.

Though witnesses articulated that no further collaborative work is currently being undertaken by the Ministerial Task Force on the NPS, the committee heard that its recommendations formed the basis of further work undertaken in the five priority areas of the NPS from 2006 onwards.[215] The committee heard that this work was being undertaken by individual jurisdictions at both the federal and provincial/territorial levels with some joint initiatives as well.

1) Catastrophic Coverage

The committee heard that since 2006, individual jurisdictions had made efforts to establish universal catastrophic-drug-coverage programs for their citizens. While all four Atlantic provinces lacked catastrophic drug coverage in 2006, now Nova Scotia and Newfoundland had added programs. The committee heard that Prince Edward Island and New Brunswick remained the only provinces without universal catastrophic drug coverage, along with the Yukon, as these jurisdictions only offer coverage to select groups.[216] Despite this expansion of catastrophic drug coverage in individual jurisdictions and a costing analysis undertaken by the F/P/T Ministerial Task Force in 2005, witnesses appearing before the committee were dissatisfied that no further progress towards the development of a universal national catastrophic-drug-coverage program had been made.[217] Witnesses noted that though there was some convergence on income-based catastrophic-drug-benefit structures implemented in different jurisdictions, there were significant and important disparities in

[215] *Ibid*.
[216] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.
[217] Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

the coverage offered. For example, the committee heard that there was variation among jurisdictions regarding decisions to cover certain cancer drugs as part of their public drug-coverage programs, which could amount to approximately in $20,000 a year in out-of-pocket expenses for Canadians with these diseases.[218] Though efforts were being made to harmonize cancer-drug coverage across Canada through the pan-Canadian Oncology Drug Review, the committee heard that there is still clear evidence that many Canadians are foregoing filling prescriptions due to their costs.[219] As noted in the testimony on home care, witnesses explained that a lack of out-of-hospital drug coverage meant that many were choosing to stay in hospital to avoid these costs.[220] They concluded that this lack of uniform universal catastrophic drug coverage across jurisdictions created inequities that resulted in negative health outcomes for Canadians and undermined the principles of the Canada Health Act.[221]

Witnesses attributed this lack of progress towards the development of a national catastrophic drug coverage program to disagreements between jurisdictions over the funding of this model.[222] Other witnesses noted that while there was no further F/P/T collaborative work being undertaken in relation to catastrophic drug coverage, the commitments in the 10-Year Plan only related to the costing of such a model and not its implementation.[223] To address this seeming impasse on catastrophic drug coverage, witnesses recommended that jurisdictions set the financing discussion aside and begin a discussion with Canadians regarding what type of pharmacare program would best meet their needs, as some witnesses suggested that the F/P/T Ministerial Task Force needed to focus beyond a national catastrophic-drug-coverage model of pharmacare towards a universal pharmacare program covering the ordinary drug costs of Canadians. They therefore recommended that the Government of Canada consider holding a commission on pharmacare, where governments solicit the views of Canadians and experts and examine best practices in other jurisdictions in order to develop a vision for pharmacare in Canada.

2) Expensive Drugs for Rare Diseases

The committee heard from witnesses that the federal government had implemented the recommendations of the Ministerial Taskforce and had provided approximately $35 million for a

[218]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 6 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evc-49078-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.
[219]Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.
[220]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 3, Evidence, 1st Session of the 41st Parliament, 6 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/03evc-49078-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.
[221]*Ibid*.
[222]Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.
[223]*Ibid*.

three-year study examining therapies used to treat Fabry's disease.[224] However, the committee did not hear any testimony regarding whether efforts were currently being made to develop a framework for EDRDs focussing on evidence, ethics, regulatory and reimbursement systems, as recommended by the Taskforce in 2006.

3) Common National Drug Formulary

The Canadian Agency for Drugs and Technologies in Health (CADTH), an independent, not-for-profit agency established by Canada's Ministers of Health to provide them with evidence-based information about the effectiveness and efficiency of health technologies, provided the committee with a written submission outlining progress towards the establishment of a common national drug formulary.[225] CADTH houses the Common Drug Review (CDR), which is a pan-Canadian process for conducting objective, rigorous reviews of the clinical and cost-effectiveness evidence and patient inputs for drugs. Based upon these reviews, the CDR makes recommendations for formulary listings for all of Canada's publicly funded drug plans, except Quebec, which has its own process. Though jurisdictions do not have to comply with the recommendations made by the CDR, the submission indicated that participating jurisdictions followed its recommendations 90 per cent of the time. The submission noted that according to Ministers of Health and the Health Council of Canada and other experts, this high compliance rate had meant that the commitment made in the NPS for the establishment of a national drug formulary had therefore been met.

CADTH further noted in its written submission that it was implementing other recommendations made by the Ministerial Task Force by expanding its Common Drug Review to include: therapeutic reviews of biologics for the treatment of rheumatoid arthritis and diabetes; specialty drugs for the treatment of cancer and HIV/AIDS; and blood products.

In addition to meeting requirements associated with the establishment of a national drug formulary, the committee heard from witnesses that the CDR was considered an effective means of reducing the costs associated with public drug-coverage programs, by providing policy makers with the evidence necessary to make cost-saving decisions.[226] For example, the committee heard that CADTH had conducted a review of the use of blood glucose test strips in Type 2 diabetes in adults, which demonstrated that $500 million a year in savings could be achieved by reducing the current utilization of glucose blood test strips in Type 2 diabetes, without having any impact on health outcomes for that condition. However, the committee also heard from witnesses that governments sometimes faced difficulties in implementing the CDR recommendations due to pressure from the public and the aggressive marketing practices of drug-manufacturing companies.[227] Consequently,

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[224] *Ibid*.
[225] Canadian Agency for Drugs and Technologies in Health (CADTH), "Submission Brief to the Senate of Canada Standing Committee on Social Affairs, Science and Technology," November 2011.
[226] Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05mn-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.
[227] *Ibid*.

they indicated that there was a need to link Health Canada's entry-to-market decisions more closely to drug-effectiveness research, as well as educate the public on drug utilization.[228]

4) Drug Pricing and Purchasing Strategies[229]

The committee heard that jurisdictions have made progress in pursuing the generic drug-pricing and purchasing strategies that were providing an approximate annual savings of 20 per cent. The Committee heard that Ontario, British Columbia, Alberta, Quebec, Saskatchewan and Nova Scotia are pursuing initiatives such as addressing the system of professional allowances that generic drug companies were providing community pharmacists, to fund patient services that are being offered by pharmacists, which in turn were added to the costs of generics. The committee heard that now jurisdictions are eliminating this system and instead paying for pharmacists' fees themselves. However, the committee also heard from witnesses that these reforms had negatively impacted community pharmacy businesses, and there was an ongoing funding gap between the cost of providing pharmacy services and what provincial governments were paying for those services.[230]

The committee also heard that in August 2010, the provinces and territories announced plans for a pan-Canadian purchasing alliance for common drugs, medical supplies and equipment, an initiative that aimed to achieve further savings through collective purchasing power. However, the committee heard from some witnesses that bulk-purchasing strategies should be pursued with caution as they were seen as factor contributing to major drug shortages currently being experienced in Canada and globally.

5) Real-World Drug Safety and Effectiveness[231]

In order to meet its commitments in relation to developing a post-market surveillance system for pharmaceuticals that examines both their safety and efficacy outside the context of clinical trials, the committee heard that the federal government had established the Drug Safety Effectiveness Network (DSEN) in 2009, a research and knowledge-application network created in partnership between the Canadian Institutes of Health Research and Health Canada. The committee heard that the mandate of the DSEN was to provide authoritative, research-based answers to questions posed by health-care decision-makers regarding medicines approved for marketing in Canada, and to build capacity in Canada for pharmaceutical research. The committee heard that DSEN will focus on the issue of pharmaceutical safety that arises when approved pharmaceuticals achieve wide-spread use, but are later found to be harmful in subsets of the population not included in clinical trials. In addition, the

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[228]Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 24 November 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49219-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[229]Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05mn-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[230]*Ibid*.

[231]*Ibid*.

committee heard DSEN would also examine issues such as off-use labelling, where some drugs are not approved in Canada for use in certain population groups such as children, but are approved for these uses in other jurisdictions, which poses challenges for physicians. The committee heard that this work would be further facilitated by other investments related to health-care reform. In particular, the committee heard that development of electronic health records and electronic prescribing would provide researchers with data that captures all medicines dispensed to patients within their respective provinces, and track their outcomes.[232]

Finally, the committee heard that DSEN would also address a key concern of policy makers, namely assessing the effectiveness of newer costly drugs in comparison to older and less costly alternatives.[233] The committee heard that this is a particularly pressing issue, as newer biologics and specialized drugs for cancer and chronic diseases were coming onto the market at costs ranging from $15,000 to $20,000 per year, and therefore, there is a need to determine whether these treatments offer value for money. Witnesses also articulated a need to engage private drug-insurance companies in adopting the cost-saving measures and tools used by public drug-coverage plans, such as evidence provided by DSEN and the CDR to ensure that these plans remain affordable to employers and citizens.

C. Moving forward on the National Pharmaceutical Strategy: Committee Observations and Recommendations

The committee's review of the implementation of the National Pharmaceuticals Strategy found that progress towards its five main priorities was mixed, and that F/P/T collaboration in this area slowed substantially after 2006. Though some jurisdictions had moved forward in the provision of catastrophic drug coverage, the committee heard that disparities and inequities in the provision of pharmacare across the country persist. Consequently, the committee heard that there was a need for governments to continue to work together to develop a national pharmacare program, reflecting the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability, that would focus on catastrophic drug coverage and a national formulary. Meanwhile, the committee heard that the Common Drug Review had helped jurisdictions achieve harmonized drug formularies and contain costs by evaluating the cost-effectiveness of drugs approved for use. Witnesses articulated a need to engage private drug-insurance companies in these cost-saving efforts to ensure the sustainability and affordability of the drug-coverage programs that the majority of Canadians currently rely on. The committee heard that these efforts were being supplemented by the federal government through its establishment of the Drug Safety and Effectiveness Network that aims to conduct research evaluating the safety and effectiveness of drugs in real-world settings. Witnesses appearing before the committee highlighted

[232]Written follow-up provided by Dr. Robert Peterson, Executive Director of the Drug Safety Effectiveness Network, Canadian Institutes of Health Research, December 2011.

[233]Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

the importance of both DSEN and the CDR, as the rising costs of newer specialized drugs represented a key threat to the sustainability of both private and public drug-coverage programs in Canada. Meanwhile, the committee did not receive testimony as to whether Health Canada intended to develop a regulatory framework to address expensive drugs for rare diseases. The committee therefore recommends:

RECOMMENDATION 28

That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability; including a national catastrophic drug-coverage program and a national formulary.

RECOMMENDATION 29

That governments, acting together, work with private health-insurance companies to encourage their adoption of best practices in cost-containment strategies.

RECOMMENDATION 30

That Health Canada report on progress towards the development of a regulatory framework for expensive drugs for rare diseases as part of its annual performance report to Parliament.

10. PREVENTION, PROMOTION AND PUBLIC HEALTH

A. Overview of Commitments in the 10-Year Plan in Relation to Prevention, Promotion and Public Health[234]

In the 10-Year Plan, First Ministers recognized the importance of public-health efforts, including health promotion, disease and injury prevention, in improving health outcomes for Canadians and ensuring the sustainability of the health-care system. Key issues identified in this area were improved chronic-disease management and promoting the healthy development of children. First Ministers therefore committed to accelerate their ongoing work towards the establishment of a pan-Canadian Public Health Strategy that would set goals and targets for improving the health status of Canadians, and focus on common risk factors for diseases, as well as integrated disease strategies.

They further agreed to collaborate and cooperate in developing coordinated responses to infectious-disease outbreaks and other public-health emergencies, through the Pan-Canadian Public Health Network, an intergovernmental mechanism established to: strengthen and enhance Canada's public-health capacity; enable Federal/Provincial/Territorial (F/P/T) governments to work together on public health, and anticipate, prepare for, and respond to public-health events and threats. In addition, the federal government committed to increasing its investments in the National Immunization Strategy, which was to provide new immunization coverage for Canadian children.

B. Progress to Date[235]

1) The Establishment of a Pan-Canadian Public Health Network

In evaluating progress towards public-health commitments made in the 10-Year Plan, witnesses identified collaboration and cooperation in developing coordinating responses to infectious diseases as the main success of the agenda outlined in the plan. The committee heard that as a result of the agreement, the Pan-Canadian Public Health Network had been established and was able to play an effective leadership role designing and implementing a more robust national disease-outbreak surveillance and response system. The committee heard that this system was tested with the outbreak of H1N1 in 2009, and was able to respond effectively, with new lessons learned. The committee heard that the Pan-Canadian Public Health Network also promoted information-sharing between jurisdictions through the negotiation and signing of two Memoranda of Understanding on information-sharing and the provision of mutual aid during health emergencies with provinces and territories.

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[234] Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

[235] Unless otherwise noted, the sections that follow reflect testimony provided during the following hearing: Standing Senate Committee on Social Affairs Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Issue 6, Evidence, 1st Session of the 41st Parliament, 3 November, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/06evb-49160-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

2) Enhancing Investments in the National Immunization Strategy

With respect to increasing federal investments in the National Immunization Strategy (NIS), the committee heard from witnesses that the Government of Canada had established a 3-Year, $300-million trust fund to introduce four new childhood and adolescent vaccine programs to prevent meningitis, pneumonia, chickenpox and whooping cough. The committee heard that the federal government also created a second 3-year, $300-million trust fund in 2007 to support the introduction of human papilloma virus (HPV) vaccine programs. Despite these investments, the committee also heard from witnesses that the NIS lags behind in several ways, including: the development of a national immunization registry network; a national immunization research plan; training programs for health professionals; educational programs for the public; and a nationally harmonized pediatric immunization schedule. Witnesses were therefore of the view that there was an ongoing need for a renewed NIS, with goals, objectives and targets and associated funding, as the risk of exposure to preventable communicable diseases remains.

3) Accelerating the Development of a Pan-Canadian Public-Health Strategy

The committee heard that efforts to accelerate the development of a pan-Canadian Public-Health Strategy had led to the Pan-Canadian Healthy Living Strategy, which was a commitment from all jurisdictions to take more coordinated action in prevention and promotion that established three main targets:[236]

- By 2015, increase by 20 per cent the proportion of Canadians who make healthy food choices according to the Canadian Community Health Survey (CCHS) and Statistics Canada/Canadian Institute for Health Information (CIHI) health indicators.

- By 2015, increase by 20 per cent the proportion of Canadians who participate in regular physical activity based upon 30 minutes/day of moderate to vigorous activity as measured by the CCHS and the Physical Activity Benchmarks/Monitoring Program.

- By 2015, increase by 20 per cent the proportion of Canadians at a "normal" body weight based on a Body Mass Index (BMI) of 18.5 to 24.9 as measured by the National Population Health Survey (NPHS), CCHS, and SC/CIHI health indicators.

The committee heard that the federal government is contributing to this strategy through its Integrated Strategy on Healthy Living and Chronic Disease, which provides $69.9 million in annual funding to promote healthy eating and healthy weights, increasing physical activity, and implementing disease-specific prevention strategies for diabetes, cardiovascular disease, and cancer.

The committee also heard from witnesses that these efforts were enhanced through the F/P/T Declaration on Prevention and Promotion, which aimed to achieve a better balance within the health-

[236]Secretariat for the Inter-sectoral Healthy Living Network in partnership with the F/P/T Healthy Living Task Group and the F/P/T Advisory Committee on Population Health and Health Security, *The Integrated Pan-Canadian Healthy Living Strategy*, 2005, http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/ipchls-spimmvs/pdf/ipchls-spimmvs-eng.pdf.

care system between prevention and treatment of disease. The committee heard that F/P/T efforts in this area are currently being targeted towards the prevention of childhood obesity through *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framwork for Action to Promote Healthy Weights*, which recognizes childhood obesity as a national crisis, and identifies strategies that governments intend to take to address this issue, such as increasing access to nutritious food, providing supports to mothers during pregnancy; protecting children from the marketing of foods high in fat, sugar and sodium and promoting physical activity within schools.[237]

Despite these efforts, some witnesses appearing before the committee were of the view that the goal of establishing a true pan-Canadian Public Health Strategy, with the settings of goals and targets for improving the health status of Canadians, and efforts to address common risk factors, had not been met. The committee heard that a pan-Canadian Public Health Strategy was supposed to cut across diseases and address health inequities and disparities that result from the social determinants of health, such as housing, socio-economic status and geography. The committee heard that there was a growing need to address this issue, as health disparities among Canadians are continuing to grow, particularly among Canada's Aboriginal populations.

Witnesses further highlighted the Standing Senate Committee on Social Affairs, Science and Technology's Subcommittee on Population Health's 2009 report that called for a pan-Canadian population strategy that adopts a population-health approach as a means of addressing health inequities and disparities in Canada.[238] According to the report, a population-health approach recognizes that a range of inter-related factors beyond the health-care system affect health status, such as income and social status, education, employment, culture, geography and gender, factors collectively referred to as the determinants of health. It also focuses on improving the overall health status of a population as a whole, or subpopulation groups, rather than the health of individuals. Due to the interrelated nature of the determinants of health, population health requires a horizontal approach, which brings together different departments and agencies and breaks down the silos in dealing with health-related issues. Witnesses articulated that it was unclear what government action had been taken in response to the recommendations outlined in this report.

In addition, witnesses found that the current pan-Canadian healthy-living strategy and F/P/T public-health agenda also did not focus on two other key areas: injury prevention and mental health. First of all, the committee heard that in order to reduce pressures on the acute-care system, there is a need to focus on injury prevention.[239] The committee heard that the development of a pan-Canadian injury-prevention strategy would address the impact injuries have on the health-care system, as

[237] Government of Canada, "Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights," September 2010, http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/framework-cadre/pdf/ccofw-eng.pdf

[238] Senate Standing Committee on Social Affairs, Science and Technology, "A Healthy Productive Canada: A Determinant of Health Approach," June 2009, http://www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/rephealth1jun09-e.pdf

[239] Royal College of Physicians and Surgeons of Canada, "Reaching the Patient-centred Target: A review of the progress in implementing the 2004 ten-year plan to strengthening health care and recommendations to improve it," written submission to the Standing Senate Committee on Social Affairs, Science and Technology, 5 October, 2011.

injuries account for a quarter million hospital visits and 14,000 deaths annually. The committee heard that a pan-Canadian injury-prevention strategy, which would target a reduction of injuries by 30 per cent, would create a savings of $60 billion in health-care costs by 2015. The committee heard that a pan-Canadian injury-prevention strategy could focus on: the establishment of partnerships across sectors; knowledge exchange and an awareness and education campaign.

The committee heard from witnesses that health promotion and prevention initiatives outlined in the 10-Year Plan were also limited because they did not address the importance of mental health to overall health and well-being. The committee heard that the success of prevention and promotion initiatives depended on the inclusion of mental health, as psychological factors play a key role in determining healthy behaviours and the development of many diseases. Witnesses also stressed the importance of addressing child and youth mental health, as 50 per cent of adults have reported that mental illness appeared prior to the age of 14 and 70 per cent report that it occurred prior to age 18. Finally, the committee heard from witnesses that it is important to prioritize mental health as part of the pan-Canadian public-health agenda, because of the burden of mental illness in Canada, with one in five Canadians experiencing a mental-health disorder in Canada resulting in economic costs amounting to $51 billion.

Though witnesses recognized that the Mental Health Commission of Canada would be releasing their Mental Health Strategy for Canada in 2012, they identified actions that could be taken to address mental-health issues in Canada, such as developing means of ensuring that federal transfers to the provinces and territories target increasing access to mental-health services; that the provision of mental-health services be collaborative and integrated across the spectrum, from primary care, acute care and home care through screening efforts and other interventions; and further investments in research into the full biological, psychological and social determinants and treatments for mental-health problems.

In terms of addressing child and youth mental health in particular, the committee heard that investments in services and supports geared towards children and youth that reduce conduct disorders and depression; deliver parenting skills; address bullying and stigma; and enhance screening in primary care, were most effective, based on research evidence. The committee heard that there is also a need to develop a pan-Canadian child and youth mental-health surveillance system to obtain ongoing national data on the incidence and prevalence of mental-health disorders among this population group, in order to inform policy decisions. The committee heard that there is also a need to focus on suicide prevention, including addressing it in the context of the broader social determinants of health, such as social cohesion and community development.

C. Moving Forward in Prevention, Promotion and Public Health

The committee found that the objectives outlined in the 10-Year Plan related to the development of a Pan-Canadian Public Health Network and increasing investments in the National Immunization

Strategy had been met, though there is also an ongoing need to fund and elaborate on the NIS to address the risks posed by communicable diseases. The committee's study found that according to witnesses, efforts towards the development of a pan-Canadian Public Health Strategy have been unsatisfactory. Though witnesses recognized the importance of addressing current priorities such as chronic diseases, promoting healthy lifestyles, and preventing childhood obesity, they explained that the public-health agenda needs to be broader, including focussing on widening health disparities by addressing the social determinants of health; reducing the number of injuries in Canada and their associated burden on the acute-care system; and recognizing that addressing mental-health issues represent a key component of overall health and well-being. The committee recognizes the importance of these issues, as well as the fact that important work has been undertaken in these areas by the Mental Health Commission of Canada and this committee's own Subcommittee on Population Health. The committee therefore recommends:

RECOMMENDATION 31

That the Public Health Agency of Canada continue its efforts to renew the National Immunization Strategy, including the establishment of goals, objectives and targets.

RECOMMENDATION 32

That the federal government work with provincial and territorial, and municipal governments to develop a Pan-Canadian Public Health Strategy that prioritizes healthy living, obesity, injury prevention, mental health, and the reduction of health inequities among Canadians, with a particular focus on children, through the adoption of a population-health approach that centres on addressing the underlying social determinants of health.

RECOMMENDATION 33

That Health Canada, upon receipt of the Mental Health Commission report, use data developed on pan-Canadian child and youth mental-health issues to inform policy and program decisions relating to child and youth mental health.

11. HEALTH INNOVATION

A. Overview of Commitments in the 10-Year Plan in relation to Health Innovation

In the 10-Year Plan, the federal government recognized that investments in science, technology and research were necessary for the adoption of new, more cost-effective approaches to health care, as well as facilitating the adoption and evaluation of new models of health protection and chronic-disease management.[240] As such, the federal government committed to continuing its investments in science, technology and research in support of health innovation.

B. Progress to Date

The committee heard from witnesses that the federal government had met its obligations in relation to increasing its investments in science, technology and research in support of health innovation, namely the implementation of new ideas and research discoveries into practice in health-care service delivery.[241] Witnesses highlighted for the committee how federal investments in research had brought innovation in health-care delivery.[242] The committee heard that through federal funds, Genome Canada had invested over $400 million in 80 large-scale projects in the health-care sector, which has led to discoveries in a number of areas. For example, researchers were able to identify genetic mutations that were leading to early deaths from heart failure among men under the age of 50. As a result of this discovery, the committee heard that the province of Newfoundland and Labrador was now making genetic screening and diagnosis more widely available. Other examples included how research funded by Genome Canada was able to identify a particular genotype that resulted in some nursing mothers converting codeine into morphine more rapidly, placing their infants at risk for toxicity following breast feeding, a discovery that led to labelling changes for codeine use in Canada and the United States.

The committee also heard how research funded by the Canadian Institutes for Health Research (CIHR) is creating new knowledge that is promoting cost-effective health innovations in health-service delivery.[243] For example, the committee heard that CIHR had provided funding for a clinical trial that demonstrated that Aprotinin, a drug commonly used to prevent haemorrhaging during heart surgery, was responsible for a 50-per cent increase in the risk of mortality, while costing much more than other safer drugs of the same class. As a result of this research, the committee heard that this drug is no longer used in Canadian operating rooms. Other research funded by CIHR demonstrated how the inclusion of pharmacists in family practices had prevented 241 potential adverse events

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[240] Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

[241] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.

[242] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[243] *Ibid*.

among seniors, and resulted in jurisdictions funding full-time pharmacist positions in primary-health-care teams.

Though the federal government was making significant investments in research, the committee heard that insufficient funding was being targeted towards health-care-systems research.[244] For example, the committee heard that the Canadian Health Services Research Foundation (CHSRF)'s endowment has a finite life course, unless they receive further federal funding. The committee also heard that CIHR's research investments tend to focus on commercialization rather than the improvement of health-care systems as a whole. They therefore recommended that a certain portion of CIHR's budget be dedicated to health-systems research, including knowledge translation that does not have a broader commercialization mandate.

The committee heard from witnesses that CIHR is trying to address some of these issues through the establishment of its Patient-Oriented Research Strategy that aims to bring together researchers and policy makers from different levels of government, charities, health-care organizations, patient representatives and private organizations to address key issues related to health-care delivery.[245] For example, the committee heard that the Patient-Oriented Research Strategy was investing in a 10-Year initiative to transform community-based primary health care, by evaluating new models of primary care currently being delivered across the country.

The committee heard from other witnesses that the federal government could promote innovation further by either promoting collaboration among, or establishing, networks between its existing pan-Canadian health-research organizations, such as CIHR, CHSRF, and the Canadian Patient Safety Institute, the Health Council of Canada, to work together to identify leading practices occurring in different jurisdictions and find ways to disseminate these practices across the country.[246]

C. Promoting Health Innovation: Committee Observations and Recommendations

The committee's study revealed that the federal government was making significant investments in health research that was allowing for discoveries currently being implemented in health-care systems across Canada. The committee heard that these innovations were reducing adverse reactions, mortality rates and costs. However, the committee heard that there were concerns among witnesses that insufficient resources were being dedicated to health services or health-systems research. The committee also heard that CIHR had developed a new Strategy for Patient-Oriented Research that aimed to close the gap between health research and policy development and implementation, which

[244] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 9, Evidence, 1st Session of the 41st Parliament, 2 December 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/09mn-49228-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[245] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 5, Evidence, 27 October, 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/05evb-49133-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[246] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 9, Evidence, 1st Session of the 41st Parliament, 2 December 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/09evc-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

would provide funding for health innovations in different areas of health-care service delivery over 10 years, such as new primary-care models. The committee heard that the federal government, in collaboration with provincial and territorial governments, could enhance these efforts through the creation of a specific mechanism dedicated to promoting health innovation in Canada, which would be established to promote collaboration among governments in identifying, disseminating, and implementing leading practices in health-care service delivery across health-care systems. The committee therefore recommends:

RECOMMENDATION 34

That the federal government, taking the lead, work with provincial and territorial governments to establish a Canadian Health Innovation Fund to identify and implement innovative and best-practice models in health-care delivery, and the dissemination of these examples across the health system.

RECOMMENDATION 35

That the Canadian Institutes of Health Research provide an interim report in five years, evaluating the implementation and impact of its Strategy for Patient-Oriented Research, including its findings related to new primary-care models.

RECOMMENDATION 36

That Health Canada create a network between federally funded pan-Canadian health-research organisations and other interested stakeholders that would focus on identifying leading practices in health-care delivery, and work together to promote their dissemination in health-care systems across Canada.

RECOMMENDATION 37

That the federal government ensure ongoing funding dedicated towards health services and systems research, either through the Canadian Institutes of Health Research or the Canadian Health Services Research Foundation.

12. ACCOUNTABILITY AND REPORTING TO CITIZENS

A. Accountability and Reporting Commitments in the 10-Year Plan[247]

Accountability and transparency in reporting to citizens were two of the main principles behind the 10-Year Plan. Therefore, all governments committed to report to their residents on the performance of their health-care system, as well as on the key components of the 10-Year Plan, through the development of common indicators and benchmarks, such as wait times, health human resources, and home care. In addition to government reporting, the 10-Year Plan established the Health Council of Canada as the main body to report to all Canadians on the health status of Canadians and health outcomes, as well as on progress towards achieving the objectives of the plan. As part of the plan, the Canadian Institute for Health Information (CIHI) was also mandated to report on wait times across jurisdictions, and overall health-system performance.

B. Progress to Date

The committee heard that the 10-Year Plan had resulted in increased reporting on the state of health-care systems in Canada, with data systems being expanded and refined.[248] In particular, the committee heard that seven jurisdictions had established health-quality councils, which have enabled them to build their capacity to collect data on health outcomes and report to their citizens on different aspects related to the quality and performance of their health-care systems that extend to priorities beyond those identified in the 10-Year Plan, such as hospital quality and safety and long-term care. The committee heard from witnesses that there was a need to expand the establishment of quality councils across Canada, and have them focus on all dimensions of quality, including patient safety, effectiveness, patient-centeredness, efficiency, timeliness, equity and appropriateness.[249]

In addition, the committee also heard that federal departments and agencies, including Health Canada, the Canadian Institutes of Health Information and Statistics Canada, were supporting these efforts by also developing a broad range of health indicators to evaluate the performance of health-care systems across the country[250].

The committee heard from witnesses that these efforts in different jurisdictions had led to the development of myriad health indicators measuring the performance of health systems, but no common national indicator framework that could guide jurisdictions in their reporting, or allow for

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[247] Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

[248] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.

[249] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology," Evidence, 1st Session of the 41st Parliament, 19 October 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49095-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

[250] Health Council of Canada, "Health Council of Canada review of the 10-Year Plan to Strengthen Health Care," Report to the Standing Senate Committee on Social Affairs, Science and Technology, 10 March, 2011.

inter-jurisdictional comparison in health-system performance.[251] Moreover, without a uniform pan-Canadian health-indicator framework, the Health Council of Canada and other federal agencies faced difficulties in reporting on pan-Canadian health-system quality and performance. In the absence of this data, the committee heard that the Health Council of Canada was focussing its efforts on identifying best practices in different aspects of health-care reform. It further noted that it only provide a broad overview of progress towards the implementation of the 10-Year Plan every two to three years, as there were often no new data to report on an annual basis.

During the course of the committee's study, witnesses stressed the importance of accountability mechanisms in implementing health-care reform in Canada. Many were of the view that enhanced investment in the development and expansion of data systems to measure the quality and performance of health-care systems was an important way to ensure accountability in health-care reform, as it would provide citizens with the information necessary to determine whether health-care governing bodies were meeting goals and objectives in relation to reform efforts.[252] In building performance-measurement systems, witnesses emphasized the importance of choosing outcomes and measures that were patient-centred rather than provider-focussed.[253] The committee heard from witnesses that one way this could be achieved was through the establishment of an overall pan-Canadian vision outlining principles for guiding health-care reform, such as those advocated by the Canadian Medical Association and the Canadian Nurses Association[254], or a Charter for Patient-Centred Care, outlined in previous chapters of this report.

C. Accountability and Reporting to Citizens: Committee Observations and Recommendations

Throughout the course of the committee's study, witnesses highlighted the importance of accountability mechanisms in promoting health-care reform. The accountability and reporting requirements of the 10-Year Plan had led to enhanced collection of data and the development of health indicators measuring health-system quality and performance. This was reinforced by quality- and patient-safety initiatives also being undertaken by many jurisdictions, such as the establishment of health-quality councils. The committee heard that health-quality councils should be established across Canada, and given a mandate focussing on key dimensions of quality beyond those outlined in the 10-Year Plan, including patient safety, effectiveness, patient-centeredness, efficiency, timeliness, equity and appropriateness. The committee agrees with witnesses that there is a need to develop a pan-Canadian health-indicator framework to allow for common measurements of health-care-system quality and performance, inter-jurisdictional comparison and pan-Canadian reporting. The committee is of the view that this pan-Canadian comparable health-indicator framework should

[251] *Ibid*.
[252] The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 9, Evidence, 1st Session of the 41st Parliament, 2 December 2011, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/09mn-49228-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.
[253] *Ibid*.
[254] Canadian Nurses Association and the Canadian Medical Association, "Principles to Guide Health Care Transformation in Canada," July 2011, submitted to the Standing Senate Committee on Social Affairs, Science and Technology, October 2011.

also be patient-centred, reflecting patient views and experiences of health-care systems. The committee therefore recommends:

RECOMMENDATION 38

That the federal government through Health Canada work with organizations such as the Canadian Patient Safety Institute to promote the development of health-quality council concepts.

RECOMMENDATION 39

That the Canadian Institute for Health Information work with provincial and territorial governments and relevant stakeholders to develop a pan-Canadian patient-centred comparable-health-indicator framework to measure the quality and performance of health- care systems in Canada.

13. DISPUTE AVOIDANCE AND RESOLUTION

A. Commitments in the 10-Year Plan related to the Establishment of a Dispute-Avoidance and Resolution Process for the Canada Health Act[255]

In addition to health-care reform initiatives, the 10-Year Plan also included a provision that formalized a dispute avoidance and resolution process related to the interpretation and enforcement of the principles of the Canada Health Act.[256] The need for the establishment of a dispute-avoidance and resolution process related to the Canada Health Act and the use of federal spending power initially identified and agreed to by all governments, except Quebec, after the signing of the Social Union Framework Agreement in February 1999. In the years following, the dispute-avoidance and resolution process was developed by provincial and federal government officials, and agreed to through a series of letters between the Premier of Alberta, and then Prime Minister Jean Chrétien, in April 2002. The formal acceptance of this dispute-avoidance and resolution process was then formalized as part of the 10-Year Plan.

The dispute-avoidance and resolution process agreed to by First Ministers has three main elements: dispute avoidance, dispute resolution and public reporting. Dispute-avoidance activities include: the establishment of ad hoc intergovernmental committees to discuss issues of interest to all governments; government-to-government exchanges relating to specific issues that arise with the government in question's implementation of the Act; and the advanced assessment of a provincial or territorial proposal or initiative to determine whether the proposal or initiative would be in compliance with the Act.

If the dispute-avoidance mechanisms have been unsuccessful, either the federal or provincial or territorial minister of health may initiate the dispute-resolution process, where governments involved will jointly collect and share all information regarding the issue and prepare a fact-finding report. They will enter into negotiations to resolve the issue. If negotiations fail, the ministers of health involved may refer the dispute to a third-party panel, which comprises one appointee from the province or territory and one federal appointee, who together select a chairperson and must then undertake a fact-finding mission, and provide advice in a report to the involved governments. The federal minister would then take the panel's findings into consideration in determining whether or not to invoke the non-compliance provisions outlined under the Canada Health Act, namely a reduction or withholding of Canada Health Transfer payments to the province or territory under the Act. Finally, when the dispute-resolution process is completed, governments must publicly report on the process.

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[255]Unless otherwise noted, this section is based upon testimony received during the following hearing: Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 22, Evidence, 3rd Session of the 40th Parliament, 10 March, 2011, http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47.

[256]Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

B. Progress towards the Implementation of the Dispute-Avoidance and Resolution Process

The committee heard from witnesses that the dispute-avoidance and resolution process was in place and marked the daily activity of the Canada Health Act division at Health Canada.[257] The committee heard that most of its efforts centred on dispute-avoidance activities, and to date, no formal panel had been convened to resolve an issue. From the perspective of federal departmental officials, the lack of a formal panel to date marked the success of dispute-avoidance mechanisms in addressing issues related to the enforcement of the principles of the Canada Health Act. The committee heard from witnesses that Health Canada reported on jurisdictions' compliance with the Act, including any deductions in Canada Health Transfer payments resulting from the conditions under the act related to user fees and extra-billing, through its annual report to Parliament on the Canada Health Act.

However, many of the written submissions received by the committee expressed concern over the federal government's enforcement of the Canada Health Act. In particular, written submissions focused on how private for-profit health-care clinics were extra-billing for services provided under the Canada Health Act, by charging access fees for those services. For example, they highlighted a study in the Canadian Journal of Gastroenterology that found that 31.7 per cent of patients in private clinics were being charged for access to colonoscopy services covered under the Canada Health Act.[258] They therefore called upon the federal government to take a more proactive role in enforcing the Canada Health Act, including extra billing and user fees, as it is the government's main accountability leaver in health care. Furthermore, they recommended the establishment of an accountability framework that requires provinces and territories to proactively investigate clinics for compliance with the Act.

C. Committee Observations and Recommendations Regarding the Implementation of the Canada Health Act Dispute-Avoidance and Resolution Process

The committee heard from witnesses that the dispute-avoidance activities formalized under the 10-Year Plan had successfully prevented the need for using the formal dispute-resolution process agreed to by governments in 2002. The committee also heard that the dispute avoidance and resolution process also allowed for transparency in the enforcement of the Canada Health Act through its reporting requirements. However, the committee also received written submissions outlining instances of violations of the Canada Health Act by private for-profit health-delivery clinics, and calling for the federal, provincial and territorial governments to take a more proactive role investigating these violations and enforcing the principles of the Act. The committee therefore recommends:

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[257] Senate Standing Committee on Social Affairs, Science and Technology, "Proceedings of the Senate Standing Committee on Social Affairs, Science and Technology," Issue 22, Evidence, 3rd Session of the 40th Parliament, 10 March, 2011, http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47.

[258] See for example, Canadian Doctors for Medicare, "A Strong Federal Role in Improving Canada's Health Care System," submission to the Standing Senate Committee on Social Affairs, Science and Technology," submitted 4 November, 2011.

RECOMMENDATION 40

That all governments put measures in place to ensure compliance with the Canada Health Act and more accountability to Canadians with respect to implementation of the Act.

14. COMMUNIQUÉ ON IMPROVING ABORIGINAL HEALTH

A. Background Information on the Role of the Federal Government in Aboriginal Health

1) First Nations and Inuit and the Constitution Act, 1867

The federal government has primary jurisdiction over "Indians and Land reserved for the Indians," under section 91 (24) of the *Constitution Act, 1967*.[259] In 1939, the Supreme Court decision *RE ESKIMOS* further brought the Inuit within the meaning of "Indians" under section 91(24).[260] Though section 35 of the *Constitution Act, 1982*, defines Aboriginal peoples as including the "Indian, Inuit and Métis peoples of Canada,"[261] the status of the Métis and the non-registered Indian population [262] under section 91(24) remains undetermined. [263] The federal government therefore maintains that it does not have exclusive responsibility for these groups and its financial responsibilities for these groups are thus limited.[264] Federal jurisdiction over First Nations and Inuit means that the federal government has the exclusive authority to enact legislation over First Nations and Inuit, which it exercises primarily in relation to on-reserve, registered, status Indians and, to a lesser extent, the Inuit.[265]

2) Indian Health Policy 1979

Despite having jurisdiction over First Nations and Inuit, the federal government has not enacted legislation in relation to the provision of health care to First Nations and Inuit[266], but rather provides certain health programs and services to on-reserve First Nations and Inuit as a matter of policy. The 1979 Indian Health Policy outlines the federal role in the provision of health care to First Nations and Inuit, indicating that this policy is based upon “constitutional and statutory provisions, treaties and customary practice.”[267] The 1979 Indian Health Policy articulates that due to the integrated nature of the health-care system, responsibility for First Nations and Inuit health may be shared between federal, provincial or municipal governments, Indian bands, or the private sector. It

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[259]Tonina Simeone, "Federal-Provincial Jurisdiction and Aboriginal Peoples" February 1, 2001, Library of Parliament Publication TIPS-88E, http://lpintrabp.parl.gc.ca/apps/tips/tips-cont-e.asp?Heading=14&TIP=95.

[260]*Ibid.*

[261]*The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, Part II, s.35 (2).

[262]Non-Status Indian refers to people who are of Indian ancestry and cultural affiliation, but are not registered as Indians under the *Indian Act* or lost their right to be registered as Indians under the *Indian Act* before it was amended in 1985. [22] Tonina Simeone, "Federal-Provincial Jurisdiction and Aboriginal Peoples" February 1, 2001, Library of Parliament Publication TIPS-88E, http://lpintrabp.parl.gc.ca/apps/tips/tips-cont-e.asp?Heading=14&TIP=95.

[263]*Ibid*.

[264]*Ibid*.

[265]*Ibid*.

[266]It is important to note that the most significant piece of federal legislation dealing with Indian and lands reserved for them is the *INDIAN ACT*, which governments almost all aspects of the lives and lands of status Indians. The Act "defines who is an Indian and regulates band membership and government, taxation, lands and resources, money management, wills and estates and education." However, the Inuit are not covered by the *ACT*, nor does the *ACT* include provisions for the governance and provision of health care. Tonina Simeone, "Federal-Provincial Jurisdiction and Aboriginal Peoples" 1 February, 2001, Library of Parliament Publication TIPS-88E, http://lpintrabp.parl.gc.ca/apps/tips/tips-cont-e.asp?Heading=14&TIP=95.

[267]Health Canada, "About Health Canada: Indian Health Policy 1979," http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php.

identifies the federal role in the interdependent health-care system as including: "public health on reserves, health promotion, and the detection and mitigation of hazards to health in the environment."[268] Meanwhile, the provincial and private role includes the diagnosis and treatment of acute and chronic disease, and the rehabilitation of the sick. Finally, First Nations and Inuit communities are also identified as having a significant role to play in health promotion and the adaptation of health-services delivery to their specific needs.

It is also important to note that this view point differs from that of Aboriginal peoples, who argue the federal government is required to provide health programs and services based on existing treaty rights and the Crown's fiduciary responsibility[269], rather than as merely a matter of policy.[270] This viewpoint was articulated in the Royal Commission on Aboriginal Peoples final report in 1996.[271]

3) Health Canada's Roles and Responsibilities

In accordance with the 1979 Indian Health Policy, the federal government provides certain health services and benefits to on-reserve First Nations communities and Inuit, which are now delivered primarily through Health Canada's First Nations and Inuit Health Branch (FNIHB). FNIHB employs 800 nurses and home-care workers who provide community-based health services to First Nations and Inuit communities across the country.[272] However, some First Nations and Inuit communities are responsible for the administration of these community-based health services through contribution agreements, or Health Service Transfer Agreements with FNIHB, reflecting alternative health-governance arrangements that have been established either through land-claim agreements, or other agreements between Aboriginal communities and federal, provincial and territorial governments. Meanwhile, provinces and territories are responsible for the delivery of all medically necessary acute- and primary-health-care services to on-reserve First Nations and Inuit communities on the same basis as all other Canadians under the Canada Health Act. The federal government provides

[268] *Ibid*.

[269] In broad legal terms, a "fiduciary" is "one who holds anything in trust," or "who holds a position of trust or confidence with respect to someone else." Hence, a "fiduciary relationship" is one in which someone in a position of trust has "rights and powers which he is bound to exercise for the benefit" of another. Such relationships include those between trustees and their beneficiaries, solicitors and their clients, and so forth. The Crown's fiduciary relationship to Aboriginal Peoples has not yet been fully defined, but the Supreme Court of Canada has indicated that it includes certain principles and obligations, such as: the Crow must act in the best interests of Indian peoples when dealing with Indian property and lands; and that in dealing with a possible infringement of a constitutionally protected right, the Crown's first consideration must be to its special trust relationship with Aboriginal peoples. Mary Hurley, "The Crown's fiduciary relationship with Aboriginal peoples," August 10, 2001, Library of Parliament Publication PRB 00-09E http://lpintrabp.parl.gc.ca/lopimages2/PRBpubsArchive/bp1000/prb0009-e.asp.

[270] Commission on the Future of Health Care in Canada," Building on Values: The Future of Health Care in Canada," June 2002, http://www.cbc.ca/healthcare/final_report.pdf, p.212.

[271] RCAP, "Highlights from the Report of the Royal Commission on Aboriginal Peoples," http://www.ainc-inac.gc.ca/ap/pubs/rpt/rpt-eng.asp#toc.

[272] Health Canada, "First Nations and Inuit Health: Health Care Services," http://www.hc-sc.gc.ca/fniah-spnia/services/index-eng.php.

funding for these acute- and primary-care services to the provinces and territories through the *Canada Health Transfer*.[273]

4) Jurisdictional Disputes in First Nations and Inuit Health: Jordan's Principle

It is important to note that disputes between the federal and provincial governments have arisen over First Nations and Inuit health as result of jurisdictional complexity in the delivery of health care to these population groups. This became evident in the case of Jordan River Anderson, a child from Norway House First Nation who suffered from a rare muscular disorder that required years of medical treatment in a Winnipeg hospital located 800km from his home community. Jordan died in hospital, while the federal and provincial governments negotiated who would pay for him to return home from the hospital in Winnipeg. In response to his death, the House of Commons unanimously passed Jordan's Principle in 2007, which stipulates that in the event of a jurisdictional dispute over funding for a First Nation child, the government of first contact will pay for services and seek cost-sharing later.[274] It is intended to guarantee that the services delivered to Aboriginal children will not be delayed by jurisdictional disputes.[275]

B. Overview of Commitments in Communiqué on Improving Aboriginal Health[276]

In the 10-Year Plan, First Ministers recognized the importance of working together to improve Aboriginal health and agreed that their commitments in this area would be outlined in a separate communiqué.[277] On 13 September, 2004 First Ministers met with the Leaders of the Assembly of First Nations, the Inuit Tapiriit Kanatami, the Métis National Council, the Congress of Aboriginal Peoples and the Native Women's Association of Canada. Subsequent to this meeting, they released a communiqué in which they agreed to develop a blueprint to improve the health status of Aboriginal peoples and health services in Canada through concrete initiatives that would focus on:

- Improving delivery and access to health services to meet the needs of all Aboriginal peoples through better integration and adaptation of all health systems;
- Measures that will ensure that Aboriginal peoples benefit fully from improvements to Canadian Health systems; and
- A forward-looking agenda of prevention, health promotion and other upstream investments.

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[273]Health Canada, "Blueprint on Aboriginal Health: A 10-Year Transformative Plan," Prepared for the Meeting of First Ministers and Leaders of National Aboriginal Organizations, 24-25 November, 2005, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-blueprint-plan-abor-auto/plan-eng.pdf.

[274]INAC, "Backgrounder-Implementation of Jordan's Principle in Saskatchewan," http://www.ainc-inac.gc.ca/ai/mr/nr/s-d2009/bk000000451-eng.asp.

[275]*Ibid*.

[276]Canadian Intergovernmental Conference Secretariat, "Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting," Special Meeting of First Ministers and Aboriginal Leaders, Ottawa ON, 13 September 2004, http://www.scics.gc.ca/english/conferences.asp?x=1&a=viewdocument&id=1167.

[277]Health Canada, *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

In addition to the development of a blueprint, the *Communiqué* also announced funding that the federal government would provide for three initiatives in support of these objectives, including[278]:

- $200 million for the Aboriginal Health Transition Fund that would enable F/P/T governments, First Nations governments and Aboriginal communities to devise new ways to integrate and adapt existing health services to better meet the needs of all Aboriginal peoples, including First Nations, Inuit and Métis.
- $100 million for the Aboriginal Health Human Resources Initiative (AHHRI) that would increase the number of Aboriginal people choosing health-care professions; adapt current health-professional curricula to provide a more culturally sensitive focus; and to improve the retention of health workers serving all Aboriginal peoples, including First nations, Inuit and Métis.
- $400 million for programs of health promotion and disease prevention, focussing on suicide prevention, diabetes, maternal and child health and early childhood development.

C. Progress towards the Implementation of the Communiqué on Improving Aboriginal Health

The committee heard from witnesses that the *Communiqué on Improving Aboriginal Health* had led to the development of a blueprint that outlined a 10-year plan to close the gap in health outcomes between the general Canadian population and Aboriginal peoples, including First Nations, Inuit and Métis, entitled: *Blueprint on Aboriginal Health: A 10-Year Transformative Plan*.[279] A work in progress, the *Blueprint* was to serve as a guide for federal, provincial and territorial governments and Aboriginal decision makers in their efforts to provide Aboriginal peoples with comprehensive holistic and coordinated health services. The *Blueprint* includes three separate frameworks for First Nations, Inuit and Métis respectively. Each of these frameworks focussed on: health-care delivery and access to services; sharing equitably improvements being made within Canadian health-care systems; promoting health and well-being; clarifying roles and responsibilities; and monitoring progress. The committee heard from witnesses that this document, though a work in progress, created a solid framework for action in improving Aboriginal health, while reflecting the unique needs of different Aboriginal groups.[280]

The committee also heard that federal investments made in support of the objectives of the communiqué and the blueprint had also had an impact on improving Aboriginal health and health-

[278]Health Canada, "Commitments to Aboriginal Health," *Health Care System: Information*, September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/fs-if_abor-auto-eng.php.

[279]Health Canada, "Blueprint on Aboriginal Health: A 10-Year Transformative Plan," Prepared for the Meeting of First Ministers and Leaders of National Aboriginal Organizations, 24-25 November, 2005, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-blueprint-plan-abor-auto/plan-eng.pdf.

[280]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 7, Evidence, 17 November, 2011, 1st Session of the 41st Parliament, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/07mn-49183-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.

care service delivery.[281] In terms of promoting the integration of health-service delivery for Aboriginal peoples across jurisdictions, the committee heard that the Aboriginal Health Transition Fund had resulted in the completion of 311 projects, 75 per cent of which were directly led by First Nations, Inuit or Métis organizations and communities. The committee heard that these investments had enabled enhanced collaboration and cooperation that resulted in the development of innovative integrated health-governance models, including the historic signing of the British Columbia Tripartite Framework Agreement on First Nations Health, which established First Nations control over health-care delivery, with improved fiscal arrangements in support of health and health care, as well as mechanisms of inter-jurisdictional cooperation. The committee heard from witnesses that the federal government was building on the Aboriginal Health Transition Fund through the creation of a new Health Services Integration Fund, which will provide support for similar projects that have a broader scope and reach.

The committee heard from witnesses that the federal government had also introduced community-based health promotion and disease-prevention programs that have resulted in increasing the capacity in First Nations and Inuit communities to address key health risks.[282] For example, the committee heard that the Aboriginal Diabetes Initiative had trained 330 community workers in diabetes clinical practice guidelines and best practices in the management of chronic diseases. The committee also heard that the Maternal Child Health Program had trained community members as home visitors, which had lead to improved healthy birth weights, increased breastfeeding rates and improved oral health preventative care, and increased knowledge of positive parenting and good health choices. Finally, the committee heard that the National Aboriginal Youth Suicide Prevention Strategy had helped to develop cultural engagement and community involvement, which served as protective factors against suicide.

Though the committee heard that Aboriginal community members greatly value these programs, witnesses also highlighted some challenges associated with the delivery of these programs. The committee heard that not all national Aboriginal groups benefitted equitably from these federal initiatives. For example, the committee heard that the majority of projects funded under the Aboriginal Health Transition Fund were directed towards on-reserve First Nations communities and groups, rather than off-reserve Aboriginal communities and groups. The committee heard that its successor program, the Health Services Integration Fund, allocated $1 million per year to the Assembly of First Nations, $500 thousand to Inuit Tapiriit Kanatami, and $100 thousand per year respectively to the Métis National Council, the Congress of Aboriginal Peoples and the Native Women's Association of Canada.[283] Some witnesses felt that this distribution of funds was inequitable, as off-reserve Aboriginal peoples and Métis accounted for approximately 80 per cent of

[281] *Ibid*.
[282] *Ibid*.
[283] The Congress of Aboriginal Peoples, "Presentation by the Congress of Aboriginal Peoples: Progress in implementing the 2004 10-Year Plan to Strengthen Health Care," submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 17 November 2011.

Aboriginal peoples in Canada and also faced poor health status resulting from poverty and other factors.[284]

The committee also heard that jurisdictional divisions played a role in some Aboriginal organizations facing difficulties not gaining equitable access to funding under these programs.[285] The committee heard that the funding for these initiatives is transferred to provincial governments which then narrow the focus of the programs. For example, the committee heard that only one provincial/territorial organization affiliated with the Congress of Aboriginal Peoples had gained access to the Aboriginal Diabetes Initiative.

However, other witnesses pointed out that federal investments tended to target on-reserve First Nations communities and some Inuit communities in Newfoundland and Labrador and Quebec, because these population groups do not have access to comparable programs offered by provincial and territorial governments. The committee heard that as a consequence, the federal government has developed some specific investments for off-reserve Aboriginal communities, including $32 million per year under the Aboriginal Head Start Program, which focusses on improving children's language and literacy skills and their overall readiness to learn.

The committee heard from witnesses that another difficulty associated with federal Aboriginal health programs and initiatives was they tended to be pan-Aboriginal in nature and did not reflect the unique cultures and needs of different Aboriginal populations. Witnesses pointed to the Aboriginal Health Human Resources Initiative, which did not recognize the differences in health-human-resource needs between Inuit communities and other groups.

Witnesses also found that the funding contributions through these programs are irregular, unpredictable and do not reach recipients until well into the fiscal year, making program planning difficult.[286] They therefore recommended that Health Canada provide multi-year funding agreements through these initiatives to allow for predictable and sustainable programs to be delivered.

Finally, despite the investments made by the federal government and commitments made in the communiqué, the committee heard that overall the gap in Aboriginal health outcomes and those of other Canadians remained.[287] For on-reserve First Nations, the committee heard that tuberculosis rates on reserve were 31 times higher than non-Aboriginal Canadians and infant mortality rates were 1.5 times higher than the national average. The committee heard from witnesses that the tuberculosis rates among the Inuit were 127 times higher than the non-Aboriginal Canadian rates and life expectancy among the Inuit remained 12 years below the Canadian average. The committee heard that health outcomes for Aboriginal women were also poor in comparison to other Canadians. The

[284]The Standing Senate Committee on Social Affairs, Science and Technology, "Proceedings from the Standing Senate Committee on Social Affairs, Science and Technology," Issue 7, Evidence, 17 November, 2011, 1st Session of the 41st Parliament, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/07mn-49183-e.htm?Language=E&Parl=41&Ses=1&comm_id=47.
[285]*Ibid*.
[286]*Ibid*.
[287]*Ibid*.

committee heard that the life expectancy of Aboriginal women was three years lower than that of non-Aboriginal women; their suicide rates were three times higher than the national average and they were three times more likely to contract HIV/AIDS than non-Aboriginal women.

The committee heard that these disparities in health outcomes between Aboriginal and non-Aboriginal Canadians continued to persist due to numerous factors.[288] In particular, witnesses highlighted jurisdictional challenges as an ongoing barrier to access to health care for Aboriginal people. For example, the committee heard that individuals in remote communities in Northern Alberta are often forced to leave their communities to receive treatments in urban health centres, such as kidney dialysis. However, the committee heard that there is often a gap between how long those services are funded by Health Canada's First Nations and Inuit Health Branch's Non-Insured Health Benefits Program, and when provincial health insurance systems begin to offer coverage. The committee heard from witnesses that if there were greater collaboration between jurisdictions, some of these health services could be provided closer to remote communities, both eliminating the strain of travel on the patients and ensuring uniform coverage for those services.

The committee heard that the gap in health outcomes was also the result of factors beyond access to health-care services, including the social determinants of health, such as poverty, housing, education, food security, the justice system, culture and gender.[289] For witnesses, addressing some of these issues involved promoting the inclusion of all Aboriginal groups as equal players at the table in the development of policies, programs and services.

D. Promoting the Implementation of Communiqué on Improving Aboriginal Health: Committee Observations and Recommendations

The committee heard that the federal government had invested in a wide variety of programs aimed at addressing the health needs of Aboriginal peoples in Canada. While these programs were seen as important initiatives by witnesses, they outlined several ways in which they could be improved, including: ensuring that all Aboriginal organizations had equitable access to funding; providing stable multi-year funding arrangements; and ensuring that these initiatives reflected the unique needs and cultures of different Aboriginal peoples. Though the *Blueprint on Aboriginal Health* aspired to close the gap in health outcomes between Aboriginal and non-Aboriginal Canadians, the committee heard that this gap remained and consequently, there was a need to addresses ongoing challenges such as jurisdictional issues related to health-care financing and delivery, and the social determinants of health, such as ensuring access to decent housing, potable water and meeting educational needs. The committee heard that the way forward in this area was the establishment of new health governance models, such as the historic tripartite health agreement in British Columbia, as well as ensuring that Aboriginal organizations had a voice in the design and delivery of the programs affecting them. The committee therefore recommends:

[288] *Ibid*.
[289] *Ibid*.

RECOMMENDATION 41

That Health Canada work with provincial and territorial partners to ensure equitable access to programs and initiatives related to improving Aboriginal health.

RECOMMENDATION 42

That Health Canada work with provinces and territories to ensure that the design and delivery of its programs and initiatives meet the unique needs and culture of Inuit people.

RECOMMENDATION 43

That Health Canada work closely with provincial and territorial governments to ensure improvements in Aboriginal health through the federal, provincial and territorial multi-year funding agreements.

RECOMMENDATION 44

That the federal government work with Aboriginal communities to improve the delivery of health-care services in Canada, and deal specifically with removing jurisdictional barriers.

RECOMMENDATION 45

That Health Canada establish a working group with provincial and territorial partners and all national Aboriginal organizations to identify ways in which the role of Aboriginal organizations could be strengthened in the policy-making and development process.

RECOMMENDATION 46

That the federal government work with the provinces and territories to address the social determinants of health, with a priority focus on potable water, decent housing and educational needs.

15. CONCLUSION

The purpose of the committee's study was to evaluate progress towards the implementation of the 10-Year Plan to Strengthen Health Care, and the Communiqué on Improving Aboriginal Health, as required by section 25.9(1) of the Federal-Provincial Fiscal Arrangements Act. The committee's review found that overall the 10-Year Plan and its associated financial investments resulted in improvements in many of the areas identified by the agreement, including: improving access to certain health services related to cancer, heart, joint replacements, cataracts and diagnostic imaging; increasing the supply of health-care professionals and acute home-care services. Meanwhile, all jurisdictions had at least one component of an electronic health record, and tele-health was providing for innovative health-care delivery in the North.

However, achievements in many of the areas identified by the accord were mixed. For example, though primary-care reform was occurring across the country, it remained at the pilot-project stage, despite the creation of the $800-million Primary Health Care Transition Fund aimed at systemic change. Indeed, many of the discussions during the committee's hearings focussed on how funding as part of the accord had increased the provision of services, but had not resulted in reform of health-care systems, including the much-needed integration of different health-care sectors and the breaking down of silos, as well as the re-orientation of health-care systems towards population-health needs, including the management of chronic diseases. As a result, Canadian health-care systems remain the most costly and continue to rank 24th among 34 OECD countries based upon benchmarks such as life expectancy at birth and infant mortality.[290] This led witnesses to call for increased accountability for funding and the focussing of discussions on system reform rather than increased financing alone. In short, witnesses wanted governments to buy change in health care and create incentives for adopting evidence-based innovations.

Meanwhile, the committee heard that the collaborative agenda for the National Pharmaceutical Strategy had resulted in advancements in drug safety through the creation of the Drug Safety and Effectiveness Network and cost-effectiveness through the Common Drug Review, but a stalemate on issues such as catastrophic drug coverage had prevented further collaboration in this area. The committee therefore believes that governments need to re-establish their collaboration in this area by committing to a national pharmacare program that supports the principles of universal and equitable access for all Canadians; improved safety and appropriate use; and cost controls to ensure value for money and sustainability.

The 10-Year Plan also marked the establishment of public health as a national priority and fostered a new era of close pan-Canadian collaboration in this area, allowing for concerted efforts to address key public-health challenges such as childhood obesity and the 2009 outbreak of H1N1. Yet the committee also heard that important aspects beyond the healthy-living agenda, such as action on

[290] Jeffery Simpson, "Economic Challenges to Medicare," 4th Annual Conference of the McGill University Health Centre's Institute for Strategic Analysis and Innovation (MUHC-ISAI) October 26 and 27, 2011, Montreal.

the social determinants of health and health inequalities, injury prevention and mental health remained by the wayside, issues that are also critical factors in the ongoing health disparities between Aboriginal and non-Aboriginal Canadians.

The committee's study also found that there is a need for federal leadership in promoting health-care reform across jurisdictions. For witnesses, federal investments in electronic health-record systems are critical to promoting the integration of different health-care sectors and promoting collaboration among health professionals, though there was a need to prioritize interoperability and uptake among health-care professionals. The committee also heard that they would result in increased accountability by allowing for the monitoring of quality and performance of health systems. Though provinces and territories are primarily responsible for health-care delivery in Canada, the committee heard that it was important that the federal government, working in collaboration with the provinces and territories, take a leadership role in establishing a Canadian Health Innovation Fund that would identify and promote the adoption of best practices across health-care systems. Furthermore, it could ensure that its investments in research are resulting in innovation in health-care delivery across Canada.

The committee believes that it is important to keep in mind that two years remain before the expiry of the 10-Year Plan in 2014. The committee's review found that the objectives of the 10-Year Plan continue to be relevant to health-care providers, policy makers and Canadians, and therefore governments should stay committed to achieving them by increasing efficiencies through the integration of health-care services, collaboration of different health-care providers and the adoption of health-information systems. Governments also need to continue their efforts to re-orient their health systems towards disease and injury prevention; the needs and experiences of patients; and a holistic view of health that sees physical and mental wellbeing as inextricably linked, while not forgetting that many of the factors that affect the health and well being of Canadians remain outside of the health-care system. The committee recognizes the importance of continued dialogue and collaboration in health-care reform and sees this report and its recommendations as supporting this aim.

APPENDIX A - LIST OF RECOMMENDATIONS

RECOMMENDATION 1

That the committed annual increase in funding transferred from the federal government to the provinces and territories, through the Canada Health Transfer, be used by governments in great part to establish incentives for change that focus on transforming health-care systems in a manner that reflects the recommendations outlined in this report, and the overarching objectives of the 2004 10-Year Plan to Strengthen Health Care, including the need for measurable goals, timetables and annual public reporting through existing mechanisms.

RECOMMENDATION 2

That provinces and territories continue to develop strategies to address wait times in all areas of specialty care, as well as access to emergency services and long-term care, and report to their citizens on progress.

RECOMMENDATION 3

That the federal government work with provinces, territories and relevant health-care and research organizations to develop evidence-based pan-Canadian wait-time benchmarks for all areas of specialty care that start when the patient first seeks medical help.

RECOMMENDATION 4

That the federal government provide the Canadian Health Services Research Foundation[291] or the Canadian Institutes of Health Research with funding to:

a) commission research that would provide the evidence base for the development of pan-Canadian wait-time benchmarks for all areas of specialty care; and
b) commission research to evaluate the appropriateness of existing pan-Canadian wait-time benchmarks related to cancer, heart, sight restoration, and joint replacement.

RECOMMENDATION 5

That the Health Council of Canada examine best practices in reducing wait times across jurisdictions, through improvements in efficiency, focusing in particular on management practices such as pooling waitlists, the adoption of queuing theory and the development of referral guidelines and clinical support tools.

[291] The Canadian Health Services Research Foundation is an independent not-for-profit corporation established through endowed funds from the federal government and its agencies that is dedicated to accelerating health-care improvement and transformation, by converting innovative practices and research evidence into practice. It commissions research that focuses on the following areas: health-care financing and transformation, primary care, and Canada's aging population. http://www.chsrf.ca/AboutUs.aspx

RECOMMENDATION 6

That the federal government work with provincial and territorial governments to develop a pan-Canadian vision statement that would foster a culture of patient-centred care in Canada through the establishment of guiding principles that would promote the inclusion of patient needs and perspectives in an integrated health-care-delivery process.

RECOMMENDATION 7

That the federal, provincial and territorial governments ensure accountability measures be built into the Canada Health Transfer agreement, to address the needs of disabled persons.

RECOMMENDATION 8

That the federal government take the lead in working with the provinces and territories to:

a) evaluate the impact of health-human-resource observatories in other jurisdictions;
b) conduct a feasibility study, and determine the benefit of establishing a pan-Canadian health-human-resource observatory and report on the findings.

RECOMMENDATION 9

That the Canadian Institutes of Health Information include linguistic variables in their collection of data related to health human resources and populations served by health-care systems across Canada.

RECOMMENDATION 10

That the federal government work with the provinces and territories and relevant health- care organizations to reduce inequities in health human resources, such as rural and remote health care, vulnerable populations, and Aboriginal communities.

RECOMMENDATION 11

That the federal government, through its Foreign Credential Recognition Program, take the lead in working with provincial and territorial jurisdictions and relevant stakeholders to accelerate their efforts to improve the assessment and recognition of the foreign qualifications of internationally educated health professionals and their full integration into Canadian health-care systems, in line with the principles, obligations and targets agreed upon in the Federal/Provincial/Territorial *Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications*.

RECOMMENDATION 12

That the federal, provincial and territorial governments work with universities and colleges to increase inter-professional training of health-care practitioners to continue the development of multi-disciplinary health-care teams in Canada.

RECOMMENDATION 13

That the federal government work with provincial, territorial governments and other relevant stakeholders to develop indicators to measure the quality and consistency of home care, end-of-life care, and other continuing-care services across the country.

RECOMMENDATION 14

That where necessary, jurisdictions expand their public pharmaceutical coverage to drugs and supplies utilized by home-care recipients.

RECOMMENDATION 15

That the Mental Health Commission of Canada work with the home-care sector to identify ways to promote the integration of mental health and home-care services.

RECOMMENDATION 16

That Health Canada, taking the lead, work with provinces and territories to create and implement an awareness campaign for Canadians about the importance of planning end-of-life care.

RECOMMENDATION 17

That the federal government work with provincial and territorial governments to develop a pan-Canadian Homecare Strategy, which would include a focus on reducing the burdens faced by informal caregivers.

RECOMMENDATION 18

That the federal government work with the provinces and territories to increase access to palliative care as part of end-of-life health services in a broad range of settings, including residential hospices.

RECOMMENDATION 19

That the federal, provincial, and territorial governments develop and implement a strategy for continuing care in Canada, which would integrate home-, facility-based long-term, respite and palliative-care services fully within health-care systems. The strategy would establish clear targets

and indicators in relation to access, quality and integration of these services and would require governments to report regularly to Canadians on results.

RECOMMENDATION 20

That the federal, provincial and territorial governments share best practices in order to examine solutions to common challenges associated with primary-care reform, such as: the remuneration of health professionals; the establishment of management structures to guide primary-care reform; and the use of funding agreements linked to public health goals.

RECOMMENDATION 21

That the federal government work with the provinces and territories to re-establish the goal of ensuring that 50 per cent of Canadians have 24/7 access to multi-discliplinary health-care teams by 2014.

RECOMMENDATION 22

That the Government of Canada continue to invest in Canada Health Infoway Inc. to ensure the realization of a national system of interoperable electronic health records.

RECOMMENDATION 23

That Canada Health Infoway Inc. target its investments to:

a) projects aimed at upgrading existing components to meet national interoperability standards set by the organization; and
b) promoting the adoption of electronic medical records by health professionals in Canada, including working with stakeholders to identify effective incentives in this area.

RECOMMENDATION 24

That Canada Health Infoway Inc. work with provinces and territories and relevant stakeholders to:

a) establish a target that would outline when all existing components of the EHRs would be upgraded to meet national interoperability standards;
b) establish a target that would outline when at least 90 per cent of all physicians in Canada will have adopted electronic medical records;
c) ensure that electronic health-record systems are currently being designed and implemented in a way that would allow for secondary uses, such as health-system research and evaluation; and
d) develop a systematic reporting system in relation to access to tele-health services in Canada.

RECOMMENDATION 25

That the federal government work with provinces and territories to examine approaches to addressing differences in privacy laws across jurisdictions in relation to the collection, storage and use of health information.

RECOMMENDATION 26

Recognizing the ongoing unique challenges associated with health and health-care delivery in the North, that the federal government extend its funding of the Territorial Health System Sustainability Initiative beyond 2014 in a manner that is both sustainable and predictable.

RECOMMENDATION 27

That the Federal/Territorial (F/T) Assistant Deputy Ministers' Working Group work with relevant stakeholders and communities to:

a) improve accountability measures to evaluate the performance of health-care systems in the North; and

b) address jurisdictional barriers as they relate to health-care delivery and addressing the broader social determinants of health, including potable water and decent housing.

RECOMMENDATION 28

That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability; including a national catastrophic drug-coverage program and a national formulary.

RECOMMENDATION 29

That governments, acting together, work with private health-insurance companies to encourage their adoption of best practices in cost-containment strategies.

RECOMMENDATION 30

That Health Canada report on progress towards the development of a regulatory framework for expensive drugs for rare diseases as part of its annual performance report to Parliament.

RECOMMENDATION 31

That the Public Health Agency of Canada continue its efforts to renew the National Immunization Strategy, including the establishment of goals, objectives and targets.

RECOMMENDATION 32

That the federal government work with provincial and territorial, and municipal governments to develop a Pan-Canadian Public Health Strategy that prioritizes healthy living, obesity, injury prevention, mental health, and the reduction of health inequities among Canadians, with a particular focus on children, through the adoption of a population-health approach that centres on addressing the underlying social determinants of health.

RECOMMENDATION 33

That Health Canada, upon receipt of the Mental Health Commission report, use data developed on pan-Canadian child and youth mental-health issues to inform policy and program decisions relating to child and youth mental health.

RECOMMENDATION 34

That the federal government, taking the lead, work with provincial and territorial governments to establish a Canadian Health Innovation Fund to identify and implement innovative and best-practice models in health-care delivery, and the dissemination of these examples across the health system.

RECOMMENDATION 35

That the Canadian Institutes of Health Research provide an interim report in five years, evaluating the implementation and impact of its Strategy for Patient-Oriented Research, including its findings related to new primary-care models.

RECOMMENDATION 36

That Health Canada create a network between federally funded pan-Canadian health-research organisations and other interested stakeholders that would focus on identifying leading practices in health-care delivery, and work together to promote their dissemination in health-care systems across Canada.

RECOMMENDATION 37

That the federal government ensure ongoing funding dedicated towards health services and systems research, either through the Canadian Institutes of Health Research or the Canadian Health Services Research Foundation.

RECOMMENDATION 38

That the federal government through Health Canada work with organizations such as the Canadian Patient Safety Institute to promote the development of health-quality council concepts.

RECOMMENDATION 39

That the Canadian Institute for Health Information work with provincial and territorial governments and relevant stakeholders to develop a pan-Canadian patient-centred comparable-health-indicator framework to measure the quality and performance of health- care systems in Canada.

RECOMMENDATION 40

That all governments put measures in place to ensure compliance with the Canada Health Act and more accountability to Canadians with respect to implementation of the Act.

RECOMMENDATION 41

That Health Canada work with provincial and territorial partners to ensure equitable access to programs and initiatives related to improving Aboriginal health.

RECOMMENDATION 42

That Health Canada work with provinces and territories to ensure that the design and delivery of its programs and initiatives meet the unique needs and culture of Inuit people.

RECOMMENDATION 43

That Health Canada work closely with provincial and territorial governments to ensure improvements in Aboriginal health through the federal, provincial and territorial multi-year funding agreements.

RECOMMENDATION 44

That the federal government work with Aboriginal communities to improve the delivery of health-care services in Canada, and deal specifically with removing jurisdictional barriers.

RECOMMENDATION 45

That Health Canada establish a working group with provincial and territorial partners and all national Aboriginal organizations to identify ways in which the role of Aboriginal organizations could be strengthened in the policy-making and development process.

RECOMMENDATION 46

That the federal government work with the provinces and territories to address the social determinants of health, with a priority focus on potable water, decent housing and educational needs.

APPENDIX B - WITNESSES

Thursday, March 10, 2011	
Canadian Institute for Health Information	John Wright, President and CEO
Health Canada	Abby Hoffman, Assistant Deputy Minister, Strategic Policy Branch Gigi Mandy, Director, Canada Health Act Division
Health Council of Canada	Dr. Jack Kitts, Chair John Abbott, Chief Executive Officer
Statistics Canada	Gary Catlin, Director General, Director General, Health, Justice and Special Surveys Branch Claudia Sanmartin, Senior Analyst, Health Analysis Division
Thursday, September 29, 2011	
As an individual	Dr. Brian Postl, Dean of Medicine, University of Manitoba
Association of Canadian Academic Healthcare Organizations	Glenn Brimacombe, President and CEO Christine Power, Chair, Board of Directors
Institute for Clinical Evaluative Sciences	Dr. Michael Schull, Senior Scientist
Wait Time Alliance	Dr. Chris Simpson, Chair Stephen Vail, Director, Policy and Research
Wednesday, October 5, 2011	
Health Canada	Shelagh Jane Woods, Director General Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch Robert Shearer, Acting Director General, Health Care Programs and Policy Directorate, Strategic Policy Branch
Human Resources and Skills Development Canada	Jean-François LaRue, Director General, Labour Market Integration Marc LeBrun, Director General, Canada Student Loans
Royal College of Physicians and Surgeons of Canada	Dr. Andrew Padmos, Chief Executive Officer Danielle Fréchette, Director, Office of Health Policy
Société Santé en français	Dr. Brian Conway, President
Thursday, October 6, 2011	
Canadian Cancer Society	Daniel Demers, Director, National Public Issues
Canadian Healthcare Association	Pamela Fralick, President and CEO
Canadian Home Care	Nadine Henningsen, Executive Director

Association	
Canadian Hospice Palliative Care Association	Sharon Baxter, Executive Director
Wednesday, October 19, 2011	
Canadian Medical Association	Dr. John Haggie, President Stephen Vail, Director, Research and Policy
Canadian Nurses Association	Barbara Mildon, President-elect Rachel Bard, Chief Executive Officer
Canadian Psychiatric Association	Dr. Fiona McGregor, President
The College of Family Physicians of Canada	Dr. Robert Boulay, President
Wednesday, October 26, 2011	
As an individual	Dr. Steve Morgan, Associate Director, Center for Health Services and Policy Research, University of British Columbia
Canadian Pharmacists Association	Jeff Poston, Executive Director
Drug and Safety Effectiveness Network	Dr. Robert Peterson, Executive Director
Health Canada	Abby Hoffman, Assistant Deputy Minister, Strategic Policy Branch
Thursday, October 27, 2011	
Canada Health Infoway	Richard Alvarez, President and Chief Executive Officer Mike Sheridan, Chief Operating Officer
Canadian Academy of Health Sciences	Dr. Paul Armstrong, Founding and former President
Canadian Institutes of Health Research	Dr. Alain Beaudet, President Dr. Robyn Tamblyn, Scientific Director
Genome Canada	Dr. Pierre Meulien, President and CEO
Office of the Auditor General of Canada	Neil Maxwell, Assistant Auditor General Louise Dubé, Principal
Wednesday, November 2, 2011	
Government of the Northwest Territories	Debbie DeLancey, Acting Deputy Minister, Department of Health and Social Services Robert Dana Heide, Assistant Deputy Minister, Operation Support, Department of Health and Social Services
Government of Yukon	Stuart J. Whitley, Deputy Minister, Health and Social Services

	Sherri Wright, Assistant Deputy Minister, Health and Social Services
Thursday, November 3, 2011	
Canadian Psychological Association	Karen Cohen, Chief Executive Director
Canadian Public Health Association	Debra Lynkowski, Chief Executive Officer
Canadian Task Force on Preventative Health Care	Dr. Richard Birtwhistle, Vice-president
Ontario Centre of Excellence for Child and Youth Mental Health	Ian Manion, Executive Director
Public Health Agency of Canada	Dr. David Butler-Jones, Chief Public Health Officer
Thursday, November 17, 2011	
Assembly of First Nations	Jonathan Thompson, Director, Health and Social Secretariat
Congress of Aboriginal Peoples	Betty Ann Lavallée, National Chief Barbara Van Haute, Director of Population Health
Health Canada	Valerie Gideon, Director General, First Nations and Inuit Health Branch
Inuit Tapiriit Kanatami	Elizabeth Ford, Director, Health and Social Development Udloriak Hanson, Special Advisor to the President
Native Women's Association of Canada	Erin Corston, Director of Health
Thursday, November 24, 2011	
Appearing The Honourable Leona Aglukkaq, P.C., M.P, Minister of Health	
Department of Finance Canada	Chantal Maheu, General Director, Federal-Provincial Relations and Social Policy Branch
Health Canada	Glenda Yeates, Deputy Minister Abby Hoffman, Assistant Deputy Minister, Strategic Policy Branch
Public Health Agency of Canada	Dr. David Butler-Jones, Chief Public Health Officer
Wednesday, November 30, 2011	
Government of Manitoba	Milton Sussman, Deputy Minister, Manitoba Health
Government of Nova Scotia	Kevin McNamara, Deputy Minister, Health & Wellness

Friday, December 2, 2011	
As an individual	Dr. Steve Morgan, Associate Director, Center for Health Services and Policy Research, University of British Columbia
Canadian Home Care Association	Nadine Henningsen, Executive Director
Canadian Medical Association	Dr. John Haggie, President
Government of the Northwest Territories	Debbie Delancy, Deputy Minister, Health and Social Services
Government of Nova Scotia	Kevin McNamara, Deputy Minister, Health & Wellness
Health Canada	Abby Hoffman, Assistant Deputy Minister, Strategic Policy Branch
Health Council of Canada	Dr. Jack Kitts, Chair
Institute for Clinical Evaluative Sciences	Dr. Michael Schull, Senior Scientist
Ontario Centre of Excellence for Child and Youth Mental Health	Ian Manion, Executive Director
Public Health Agency of Canada	Dr. Gregory Taylor, Director General, Office of the Public Health Practice

APPENDIX C – WRITTEN SUBMISSIONS RECEIVED

Association of Faculties of Medicine of Canada
Canadian Agency for Drugs and Technologies in Health
Canadian Alliance for Long Term Care
Canadian Association of Occupational Therapists
Canadian Association of Speech-Language Pathologists and Audiologists
Canadian Blood Service
Canadian Centre for Policy Alternatives
Canadian Diabetes Association
Canadian Disability Policy Alliance
Canadian Doctors for Medicare
Canadian Federation of Nurses Unions
Canadian Health Coalition
Canadian Life and Health Insurance Association Inc.
Canadian Society for Medical Laboratory Science
Canadian Union of Public Employees
The Conference Board of Canada
Consortium national de formation en santé
Dietitians of Canada
Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources
Heart and Stroke Foundation
Mental Health Commission of Canada
Ministry of Health and Long-term Care for the province of Ontario
National Association of Federal Retirees
National Union of Public and General Employees
Neurological Health Charities Canada
Safe Kids Canada
SickKids
Secure Wireless Health Network
Turner & Barrable