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**CANADA**  
**HEALTH SERVICES SYSTEM PROFILE**  
(27, March 2000)

ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES PROGRAM  
DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT  
**PAN AMERICAN HEALTH ORGANIZATION**

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## **EXECUTIVE SUMMARY**

Canada is a constitutional monarchy, a federal state, and a parliamentary democracy. The country is a confederation of 10 provinces and three territories. The division of powers between the federal and provincial jurisdictions of government was established in the founding Constitution of the country in 1867, which designated the responsibility to the provinces for most social programs, including the provision of health care services.

The 1996 census determined Canada's population to be 30.6 million, with over 60% living in urban areas. About 3% of the population are Aboriginal in origin. In 1995, almost 50% of single-parent mother-led families were in low-income situations. From 1990 to 1995, the percentage of married couples with children in low-income situations rose from 9.5% to 13% (a total of almost 460,000 families). The Toronto Centre for Social Justice has shown that the average incomes of the top 10% of families with children in 1973 were 8.5 times those of the bottom 10%; in 1996, this ratio had increased to 10.2 times those of the bottom 10% of families with children. In December 1999, Statistics Canada reported the national unemployment rate to be 6.9%. However, Canada has topped the United Nations Human Development Index (HDI) six consecutive years in a row (1994-1999).<sup>55</sup> The Health System was consolidated in 1984, when the Canada Health Act (CHA) was passed in response to concern over inequitable access to health care services owing to user charges and extra-billing practices in some provinces. The policy intent was to ensure that all residents of Canada have access to necessary health care on a prepaid basis. Canada has a predominantly publicly financed, publicly administered, privately delivered (on a not-for-profit basis) health care system, known to Canadians as "Medicare". The system provides access to universal, comprehensive coverage for medically necessary hospital, in - patient and out - patient physician services.

In 1998, total health expenditures in Canada (in current dollars) were CAD\$81.8 billion or CAD\$2,700 per capita (approximately US\$2,250 per capita when using the Purchasing Power Parity (PPP) measure of conversion).<sup>34</sup> Health expenditures accounted for 9.1% of Gross Domestic Product (GDP) in 1998, down from the 1992 peak level of 10% of GDP. Health care spending accounts for around one-third of provincial program expenditures. Public sector funding represents about 69.6% of total health expenditures. The remaining 30.4% is financed privately through supplementary insurance, employer-sponsored benefits or directly out-of-pocket.<sup>5</sup> In the 1999 Budget, the Government of Canada announced key steps to strengthen health care in Canada, improve the health of Canadians and enhance health research. Transfer payments to the provinces/territories for health services will increase by \$11.5 billion over 5 years from 1999 to 2004. The 1999 Budget also injected \$1.4 billion over three years into such key areas as research,

information and technology, First Nations and Inuit health systems and programs, and enhancements to health promotion and health protection programs. In the 2000 Budget, the government announced an additional \$2.5 billion in transfers to the provinces through the CHST. This brings the total transfers to \$15.5 billion in 2000-2001.

In 1994, the National Forum on Health was launched to engage the public and health stakeholders in dialogue on the future of health and health care in Canada. The Forum was set up as an advisory body, with the Prime Minister as Chair, the federal Minister of Health as Vice Chair, and 24 volunteer members who contributed a wide range of knowledge founded on involvement in the health system as professionals, consumers and volunteers. The Forum examined the current federal role in the two areas of its mandate – improving the health of the population and supporting the health care system. National discussions and cross-Canada consultations focussed on health service organisation and infrastructure, health care policies, management, financing and quality of care. By 1997, the authors of more than 42 studies released their 5 volume report entitled, "Canada Health Action: Building on the Legacy." The overall prescription for sustaining Canada's health system for the future is a balance of actions between non-medical determinants and actions for the health system itself.

In Canada, the general objective of restructuring the health system has been to streamline the roles and responsibilities such that the federal government is involved with overall policy, setting standards, and auditing; provincial governments have an oversight function; and local governments are implicated in the provision of infrastructure and services. Canada is stressing approaches which place less emphasis on hospitals and physicians, and focus on non-institutional care, a broader array of multidisciplinary health service providers, and a greater reliance on other forms of community-based care, including health promotion and disease prevention. While it is recognised that resources should be reallocated toward community care, fiscal pressures make this difficult to accomplish.

Canadian strategies have emphasised leadership and capacity building and have included the participation of provincial and local governments and civil society; added attention has been placed on evidence-based decision-making, accountability, and developing the means to measure the attainment of planned health objectives. More recently, the Canadian Health Infoway is deemed to become the key information and communications foundation for the health care system in the 21st century.<sup>19</sup> Canada's approach to health, health care, decentralisation, health information and health financing complements the basic values embodied in the internationally endorsed policy frameworks and the requirements of the 21st century which regard health as a key goal for societal development and an essential component of the quality of life itself.

## 1. CONTEXT

**Political Context:** Canada is a constitutional monarchy, a federal state, and a parliamentary democracy with two official languages (French and English) and two systems of law (civil law and common law). The country is a confederation of ten provinces and three territories. The division of powers between the federal and provincial governments was established in the founding Constitution of the country (1867), which designated the responsibility to the provinces for most social programs, including the provision of health care services.<sup>27</sup> The system was consolidated in 1984, when the Canada Health Act (CHA) was passed in response to concern over inequitable access to health care services. The policy intent was to ensure that all residents of Canada have access to necessary health care on a prepaid basis.

At the highest governing level, most priority issues pertaining to health policy and social programming are developed through mechanisms such as the *Standing Parliamentary Committee on Health*, and the *Federal/Provincial/Territorial (F/P/T) Advisory Committees of Ministers and Deputy Ministers of Health*. In addition, special *Advisory Councils* of experts from across the country provide advice to the Minister on issue-specific topics. Examples of these are the F/P/T Advisory Committee on Health Services, the Advisory Council on Health Infrastructure, the Pharmaceutical Advisory Committee (PAC), the Scientific Advisory Panel (SAP), the National Council on Ageing, and the Canadian Population Health Initiative (CPHI) Council, amongst others. The principal political and social issues influencing the health situation or the delivery of services in Canada are: 1) a mounting perception that the basic quality of care is deteriorating because of curtailments in fiscal expenditures<sup>30,43</sup>; 2) at the provincial level, the existence of new regional funding envelopes that are challenging the traditional approach to budgeting amongst the various health care stakeholders<sup>21</sup>; 3) the steady growth in spending on pharmaceuticals which has outpaced other components of health care<sup>4, 31</sup>; 4) the high correlation between social, economic and cultural factors to health<sup>25</sup>; 5) the growing health care costs.<sup>9</sup>

### **Economic context:**

INDICATOR	Year					
	1994	1995	1996	1997	1998	1999
GDP per capita in constant prices, in local currency and US\$	25,652* 20,522*	26,573* 22,330*	26,947* 22,645*	27,782* 23,745*	ND	ND
Total public expenditure as a percentage of GDP	22.5*	21.7*	20.8*	20.0*	ND	ND
Public social expenditure as a percentage of GDP	15.6	15.0	14.9	ND	ND	ND
Total health expenditure as a percentage of GDP	9.4*	9.1*	8.9*	8.9	9.1	9.2

Sources: OECD health data 1999 \* in NCUs and in US dollar purchasing power parities. Statistics Canada, Consolidated Government Revenue & Expenditure. Public Institutions Division

The Canadian economy surged ahead in late 1999, lead by the manufacturing industry (automobiles) and the construction industry (housing starts). Other leading economic sectors are the energy and mining sectors (petroleum and metals), and the high technology sector.<sup>45</sup>

**Social Context:** The 1996 census determined Canada's population to be 30.6 million, with over 60% living in urban areas. About 3% of the population are Aboriginal in origin and 17%, or 5 million people, are immigrants predominantly from Asia, the Middle East and Africa.<sup>25</sup> About 17% of Canadians aged 16 to 65 were determined as fitting in the lowest level of prose literacy. These Canadians can read only simple material that does not contain complex instructions. From 1971 to 1996, there was a significant decline in the proportion of Canadians aged 15 and over with less than a Grade 9 education (from 32% to 12%) and a corresponding increase in the proportion of Canadians who had completed some post-secondary schooling (from 17% to 34%). One of the most significant changes between 1971 and 1996, however, was the increase in the number of women attaining university degrees. Aboriginal people were less likely to have high levels of formal education than Canadians 15 years and over. Comparisons of 1981 and 1996 data show that Aboriginal Canadians with less than a high school education dropped from 59% to 45%.<sup>46</sup>

In 1995, almost 50% of single-parent mother-led families were in low-income situations. From 1990 to 1995, the percentage of married couples with children in low-income situations rose from 9.5% to 13% (a total of almost 460,000 families). One in five seniors (mostly unattached women) is still likely to be living in a low-income situation. Aboriginal people and visible minorities continue to be over-represented in the population with low-income status. In 1995, about 36% of the visible minority population and 44% of the Aboriginal population lived in low-income situations.<sup>47</sup>

The Toronto Centre for Social Justice has shown that the average incomes of the top 10% of families with children in 1973 were 8.5 times those of the bottom 10% of families with children; in 1996, this ratio had increased to 10.2 times those of the bottom 10% of families with children.<sup>60</sup>

In December 1999, Statistics Canada reported the national unemployment rate to be 6.9%, the lowest in ten years. Western provinces report the lowest rates of unemployment: Alberta (5.7%), Manitoba (5.9%) and Saskatchewan (6.3%). Much of the growth in the labour force has been in part-time jobs and self-employment, both of which do not provide benefits and pensions. In 1998, about 30% of adult women working part-time were doing so involuntarily, and an additional 20% worked part-time so they could care for their children.<sup>50</sup>

Canada has topped the United Nations Human Development Index (HDI) 6 consecutive years in a row (1994-1999). When gender is factored into the HDI, Canada continues to rank at the top. However, Canada's HDI standing drops to 10th place when the UN Human Poverty Index for industrialised countries is applied.<sup>55</sup>

## 2. HEALTH SERVICES SYSTEM

**General Organization:** Canada has a predominantly publicly financed, privately delivered health care system known to Canadians as "Medicare". The system provides access to universal, comprehensive coverage for medically necessary hospital, in-patient and outpatient physician services.<sup>58</sup>

Canada's Health Care System has been built upon the five principles of the *Canada Health Act* (HCA): a) Universality requires that the provincial plan must entitle 100% of the insured population to insured services on uniform terms and conditions; b) Comprehensiveness requires that all insured health services provided by hospitals and medical practitioners must be covered by the plan; c) Accessibility means that health services must be provided without barriers, including additional charges to insured patients for insured services; d) Portability ensures health coverage for insured persons when they move within Canada or when they travel within Canada or abroad; e) Public Administration requires that the plan must be administered and operated on a non-profit basis by an accountable public authority appointed or designated by the provincial government.

The direct management of health services falls within the responsibility of each individual province or territory. Through their respective health ministries, they plan, finance, and evaluate the provision of hospital care, physician and allied health care services, as well as some elements of prescription care and public health. They also supervise those specific responsibilities delegated to other non-governmental agencies. Provincial Health Ministries fund public hospitals, negotiate salaries of allied health professionals, and negotiate fees for physician services with provincial physician associations. In all cases, a schedule of benefits for physician services under the Health Insurance Act is published and available to the public.

A defining characteristic of most health care in Canada is that it is publicly financed - primarily through taxation, both federal and provincial, personal and corporate income taxes - but privately delivered on a not-for-profit basis. The Funding Structure of the Health System in Canada indicates that the flow of funds from individuals in the form of payment of taxes and premiums to governments, employers and private insurers, finance the health care delivery system and providers. General practitioners (GPs) and family physicians (FPs) provide the majority of primary health care in Canada and account for about 51% of all active physicians in Canada. They are usually the initial contact with the formal health care system and control access by referral to most specialists, allied providers, admissions to hospitals at which they have admitting privileges, diagnostic testing and prescription drug therapy. Most GPs are private practitioners who work in independent or group practices and enjoy a high degree of autonomy. They are accountable to their patients who are free to choose their own physicians. Some doctors work in community health centres, hospital based

group practices or in affiliation with hospital outpatient departments, while still enjoying the same level of autonomy. Private practitioners are generally paid on a fee-for-service basis and submit their service claims directly to the provincial insurance plan for payment. No extra-billing to patients for publicly -insured services is permitted.

Dentists work independently of the health care system, except where in-hospital dental surgery is required. While nurses are generally employed in the hospital sector, they also provide support for primary services in the community clinics physicians' practices. There has also been a trend toward the independent provision of midwifery, and of nurse practitioners who may eventually play a larger role in primary health care and remote care. Pharmacists dispense prescribed medications and drug preparations and also act as an independent knowledge source, by providing information on prescribed drugs, or by assisting in the purchase of non-prescription drugs.

Specialised ambulatory physician care is provided on much the same basis as general practitioner care. Specialists control access by referral to other specialists and allied providers, admissions to hospitals, and prescribe necessary diagnostic testing, treatment and prescription drug therapy. Many specialists maintain private practices and are more likely to have a staff appointment in a hospital or affiliation with a hospital outpatient clinic.

Canadian hospitals are generally operated as non-profit entities guided by community boards or trustees. As such, hospitals in Canada are highly autonomous entities, with the provincial governments' role limited to broad planning functions, funding and capital budgeting. Currently, the only hospitals directly run by provinces tend to be psychiatric institutions, however, many provinces are in the process of divesting these institutions. The Federal Government operates a number of hospitals for the military and some facilities for the health of Aboriginal peoples. Privately- run, for-profit hospital operations account for less than five percent of the total and are predominately long-term care facilities or specialised services such as addiction centres or mental health institutions that are not covered under the *Canada Health Act*.

Community care services are organised on two fundamental levels: institutional-based care and home-based care. Community institutional care is largely focused on the provision of long-term care and chronic care. The provincial governments pay institutional based long-term health care services, while accommodation costs (room and board) are primarily the responsibility of the individual. These costs may be paid out-of-pocket or through private insurance, if available.

In Canada, the private sector is excluded by law as a payer from most health care. The private sector's role as a payer is limited to those services which are not completely covered by provincial health programs. These include out-of-hospital pharmaceuticals, vision care, dental care, and the services of allied health professions such as chiropractors, podiatrists, dentists, and plastic surgeons.

The private sector health care payers include private insurance companies, employers who provide supplementary health benefits as an employment benefit, and individuals who pay for supplementary health care out-of-pocket. Health care providers are predominantly private. Institutions in provincial hospital systems are also largely individual private, not-for-profit organizations with their own governance structures. They operate under the auspices of provincial Ministries of Health (MoH) and funded by public money, but are not owned by the public sector.

### Health System Resources

#### Human Resources:

#### Human Resources in the Health Care Sector

Type of Resource	Year							
	1991	1992	1993	1994	1995	1996	1997	1998
Total No. of physicians*	ND	ND	55,955	55,040	55,006	54,958	55,243	56,203
Total No. of nurses*	ND	ND	235,630	ND	ND	ND	229,813	227,651
Total No. of medical laboratory technicians**	55,385	ND	ND	ND	ND	71,395	ND	ND
No. of holders of graduate degrees in public health***	729	731	762	821	788	858	1079	1148
Ratio of physicians to 10,000 pop.	ND	ND	ND	ND	ND	ND	18.3	18.5
Ratio of professional nurses to 10,000 pop.*	ND	ND	81.6	ND	ND	ND	76.3	74.8

Sources: \* Canadian Institute for Health Information. \*\*Statistics Canada 93-327 Census 91. Statistics Canada The Nation, Labour Force 15 Years and Over by Detailed Occupation. Census 96. \*\*\* Statistics Canada. Centre for Education Statistics, Special Tabulations.

#### Human Resources in Public & Private (Not-for-Profit) Institutions 1996 -1998

Institution	Type of Resource					
	Physicians 1996	Nurses 1998	Nursing auxiliaries	Other Technical	Administrative personnel	General Support
Hospital -	2,801*	142,043	ND	ND	14,615*	71,487*
Community Health	ND	16,202	ND	ND	ND	ND
Nursing Home	ND	26,987	ND	ND	ND	ND
Home Care	ND	9,992	ND	ND	ND	ND
Educational Institution	ND	5,007	ND	ND	ND	ND
Physician's Office	GP/FP: 37,715 Specialists: 21,625	5,881	ND	ND	ND	ND
*Other	8,360	18,492	ND	ND	ND	ND
Not stated	ND	3,047	ND	ND	ND	ND
Total	63,209	227,651	39,895	122,875		165,385

Note: The figures marked with a \* are paid by the hospitals. In order to avoid double counting, they have not been added to the Total. Other Physicians Includes optometrists, chiropractors, other health diagnosing & treating occupations. Other nurses includes Business/Industry, Private Nursing, Self-employed and Association/Government. Other Technical and Related Occupations include: Medical technologists and technicians, dentists, dental hygienists, dental technicians and laboratory bench workers, opticians, midwives and natural healing practitioners, ambulance attendants, paramedics, other therapists. General Services represents all staff in the Support functional centres (MIS Guidelines)

Sources: Statistics Canada 1996 Census Detailed Occupation by Sex. Canadian Institute for Health Information (CIHI) 1998; CIHI Annual Hospital Survey, Fiscal Year 1997/98 (representing 85% response rate).

*Drugs and Other Health Products:*

Indicator	Year						
	1991	1992	1993	1994	1995	1996	1997
Total number of pharmaceutical products marketed	ND	ND	ND	ND	ND	ND	12,000
Sales of brand name drugs Billions of CAD\$	1.9	2.1	2.4	2.4	2.6	3.0	3.7
Sales of generic drugs Billions of CAD\$	2.5	2.7	3.0	3.5	3.4	3.6	3.3
Total sales of drugs (retail price). Billion CAD\$ (includes non-prescription drugs)	7,673.6	8,451.3	8,897.0	9,078.9	9,303.9	9,439.8	9,461.2
Per capita spending on drugs (retail price)	273.8	296.2	310.0	312.74	316.5	317.8	315.4

Source: PMPRB. Looking Back at 1998, Annual Report of the Patented Medicines Price Review Board. Ottawa 1999

Data available to the Patented Medicine Price Review Board (PMPRB) allow it to measure changes in the quantities, as well as the prices of patented drugs sold from year to year.<sup>38</sup> This analysis reveals that quantities of patented drugs sold have consistently increased at a much faster rate than prices. Sales of patented drugs represented 52.3% of total sales (at the manufacturers' level).<sup>8</sup>

According to IMS Canada, generic drugs filled 37.6% of prescriptions in 1995 but represented only 13% of the total pharmaceutical market (for prescription drugs) in terms of expenditures.

From 1988 to 1998, the average annual increase in quantities of patented drugs sold was approximately 10.8% as compared with an average annual increase of 0.9% in their prices. Between 1975 and 1994, Canadian expenditures per person on drugs, adjusted for inflation, more than doubled.<sup>4</sup> Some cost containment is achieved in the following ways: drug evaluation and approval by Health Canada; control of patented drug prices; provincial formularies listing drugs that will be paid for. Provinces who have drug formularies generally target specific population groups such those on social assistance, children, those with certain chronic diseases and seniors. The exact list varies from province to province. For those who are employed, supplementary insurance plans pick up a percentage of the retail cost of the drug. Depending on the group plan and the insurer, it can be as high as 100 percent, but is normally much lower. Annual deductibles and co-payments may reduce actual benefits. In 1997, approximately \$9.6 billion was spent on drugs with most of it (\$7.0 billion) borne by the private sector.

The five largest-selling products on the national market are painkillers, cough and cold remedies, blood pressure medications, antibiotics, and stomach remedies.<sup>51</sup> Standardized treatment protocols are published for the most prevalent pathologies in public health care facilities and are respected by the prescribing physicians and distributing pharmacists. The presence of a pharmacist is mandatory in all private pharmacies and hospitals.

Canada's blood supply system is founded on the principle of gratuity. In 1999, the operators of the blood system, which is composed of the Canadian Blood Services (CBS) and Hema Québec, attracted 680,000 donations and 210,000 blood donations respectively - 30,000 more blood donors

to its clinics than in 1998. One of the benefits of a national blood system is that while periodic shortages may arise, these tend to be confined within a specified region and can be accommodated by moving supply; a region may be net exporter or importer of blood at any given time.

*Equipment and Technologies:*

**Availability of equipment in the health sector and for each 1,000 population, 1998-1999**

Subsector	Type of resource			
	*Countable beds	Clinical laboratories**	Blood banks	Radiodiagnostic equipment*
<b>Public</b>	131,320	3,439	988***	ND
<b>Private</b> (for profit and non-profit)	941	3	ND	ND
<b>TOTAL</b>	132,261	3,441	ND	ND
<b>TOTAL per 1000 population</b>	<b>4.36</b>	<b>0.113</b>	<b>0.032</b>	ND

Notes: \*The count for radiodiagnostic equipment is included under the clinical laboratories column. \*\*Includes separate and combined Medical & Radiological Labs. Other Laboratories can be public or private. \*\*\*Permanent blood bank centres include 14 in 9 provinces and 3 in the province of Quebec. 969 health facilities served include 855 in 9 provinces and 114 in the province of Quebec.

Sources: Canadian Institute for Health Information Annual Hospital Survey Fiscal Year 1997/98. Statistics Canada, Business Register Division, Canadian Institute for Health Information Annual Hospital Survey Fiscal Year 1997/98. Canadian Blood Services, Hema Québec

**Availability of equipment in the health sector by level of care, 1997-1998**

Subsector	Type of resource					
	Delivery rooms		Clinical laboratories		Radiodiagnostic equipment	
	1st. Level	2nd level	1st level	2nd level	1st level	2nd. Level
<b>Public</b>	37	232	595	51	576	52
<b>Private</b>	ND	ND	2	ND	1	ND
<b>TOTAL</b>	<b>37</b>	<b>232</b>	<b>597</b>	<b>51</b>	<b>577</b>	<b>52</b>

Note: Second level refers to Teaching Hospitals

Source: CIHI Annual Hospital Survey Fiscal Year 1997/98 Preliminary Data representing an 85% response rate

According to the 1996/97 Annual Hospital Survey, 1.4% of operating expenses in clinical laboratories of hospitals were for equipment maintenance and replacement of major equipment parts. For diagnostic radiology, the proportion was 4.6%. According to the Capital and Repair Expenditures Survey conducted by Statistics Canada, repair expenditures on machinery and equipment in medical and other health laboratories amounted to \$16.1 million in 1995.

The distribution of high technology units and equipment is determined in a step-by-step planning and consultation process between the respective provincial Ministers of Health and the various regional and district hospital boards and their planning committees.<sup>44</sup> Generally, dialysis equipment is placed in teaching hospitals, neonatology equipment will be found in children's hospitals, or those designated for emergency or regular hospitals offering maternity care etc. In most provinces, the restructuring processes have involved a degree of downsizing and consolidation of hospital services and special functions, which in turn have had a direct impact on the number and distribution of high technology equipment. For example, the province of Ontario is undertaking

reform on a sector by sector basis. In the process of streamlining the diagnostic and therapeutic services available, Cancer Centre services have been regionalized, and are now established in four cities. Together, they provide a full range of cancer diagnostic and treatment services ranging from prevention to palliative care. Similar regional networks have been established for Ontario's dialysis treatment system. The necessary equipment is distributed according to function. Neonatology services have also been consolidated to provide normal and emergency services.

### ***Functions of the Health System***

*Steering Role:* The federal government's role in health care involves the setting and administering of national principles or standards for the health care system (Canada Health Act, 1984), and assisting in the financing of provincial health care services through fiscal transfers (Canada Health and Social Transfer (CHST), 1996). The Federal Government also has direct responsibility in the health of the military, First Nations peoples, the Royal Canadian Mounted Police (RCMP), veterans and inmates. By using the full range of policy instruments including direct spending and taxation measures, regulation and information services, the Federal Government has become more active in supporting the provinces to develop health status objectives, produce comparative health status reports, conduct research on medical practice organisations, conduct economic analyses of medical intervention alternatives, and assess new technologies.<sup>30</sup>

An additional area of federal responsibility in health is to promote strategies such as health promotion, illness prevention and education. In addition, the Federal Department of Health fulfils functions for which it is constitutionally responsible such as ensuring that Canadians have accurate and timely health information upon which to base individual choices and decisions. In this regard, policy and program development within the country is supported by a wide range of separate and integrated health surveillance and information systems, all of which are used as a basis for evidence-based decision making. Other instruments used by the Federal Government for policy development include: theoretical research; statistics, applied research and modelling; environmental scanning, trends analysis and forecasting; policy analysis and advice; consultation and managing relations; communications; program design, implementation, monitoring and evaluation.<sup>40</sup> Within the federated structure of government, the Canadian provinces and territories plan, finance, and evaluate the provision of hospital care, physician and allied health care services, some aspects of prescription care and public health. Provinces typically control facilities by monitoring budgets and expenditures.<sup>58</sup>

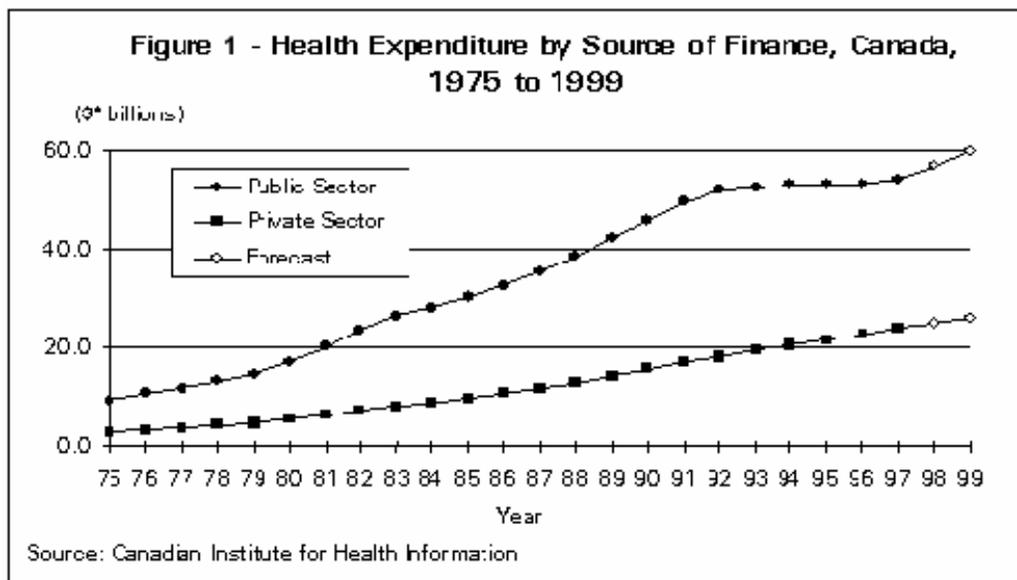
The Royal College of Physicians and Surgeons regularly evaluates hospitals for inclusion in residency training programs, and allied professions, such as physiotherapists, assess individual hospital programs and departments as candidates for internships. The Canadian Council for Health

Facility Accreditation monitors the quality of Canadian hospitals. The accreditation process requires hospitals to meet minimum standards to maintain their status. Failure to meet these standards may lead to a ratings change, loss of teaching hospital status, or, in some cases, a reduction in funding.

*Financing and Expenditure:* Canada's universal health insurance system for necessary hospital and medical services is publicly financed and administered. The extent of public sector involvement, as the payer for services, is important.

Beginning in fiscal year 1996-97, the federal government's contribution to provincial health and social programs was consolidated in a new single block transfer, *the Canada Health and Social Transfer (CHST)*. Federal funding is transferred to the provinces as a combination of cash and tax transfers. The CHST gives provinces and territories the flexibility to allocate payments among social programs according to their priorities, while upholding the principles of the CHA and the condition that there is no period of minimum residency with respect to social assistance. As with the previous transfer arrangement, provincial health insurance plans must adhere to the principles of the *Canada Health Act* in order to be eligible for the full federal transfer payments.

Although most public sector funding comes from central revenue streams, two provinces (Alberta and British Columbia) utilise supplementary health care premiums. The premiums are not rated by risk in either province and prior payment of a premium is not a pre-condition for treatment (Alberta and British Columbia utilise supplementary health care premiums). Premium assistance is offered to low-income individuals and families. Health care premiums also accrue to provincial central revenues and are considered an alternative form of taxation.<sup>58</sup>



Some provinces use additional funding methods for health such as sales taxes, payroll levies (Ontario, Manitoba, Newfoundland, Quebec) and lottery proceeds. In general, the population-based funding approaches across the Canadian provinces have commonly adopted a three-part structure: i) a per capita payment adjusted for age and gender of the population; ii) a second level of adjustment for socio-economic status and, in some cases, aboriginal status; iii) an allowance for the increased cost of doing business as a result of distance from the supply centres and population sparsity.

The most important distinction in the financing of hospitals is the separation of operating budgets from capital budgets. Capital projects and the purchase of capital equipment is closely controlled and only partially funded by the provinces. The residual funds are raised within each community as capital needs are identified and approved. As a result, most hospitals maintain a fundraising arm or foundation to provide an ongoing fund pool for capital purchases. Decisions on capital spending are determined on a project-by-project basis through a separate process, which involves negotiation between hospital boards, provinces, providers, and increasingly, citizens. In the past, hospital operating budgets were determined on a line-by-line basis. Most hospitals now work from global budgets, which curb creeping inflation caused through line-by-line budgeting. In addition to the provincial funding that hospitals receive, they are also free to raise revenue from ancillary services such as parking and preferred accommodation. Recent fiscal concerns have resulted in overall reductions in hospital budgets, as well as in hospital restructuring, mergers and closings as provinces attempt to control the most costly segment of health care. Some provinces have also put further pressure on hospitals by insisting that new community care initiatives be funded out of hospital savings.<sup>58</sup>

Most of the Canadian provinces have developed 4 approaches to paying physicians: a) Activity-based methods, otherwise known as fee-for-service (FFS); b) Input-based methods – based on a salary or sessional rates; c) Needs-based methods, which include age, gender, and risk adjusted capitation; d) Combinations of the above three.

As private practitioners, the payment of physicians and specialists is primarily on a fee-for-service basis. Fee schedules increases/decreases and more recently overall physician service budgets are negotiated between each provincial government and their respective medical association. Relative fee determination, i.e., the actual fee for a particular service, is usually delegated to the profession. Physicians send their charges directly to the provincial health insurance plan for reimbursement.

While health care expenditures on a per capita basis increased by 9.8% between 1975 and 1991, between 1991 and 1996 the per capita rate of growth in spending fell dramatically to 1.4%. The health care spending per person in Canada was an estimated CAD\$2,598 in 1997 and is expected to reach CAD\$2,700 in 1998 and CAD\$2,815 in 1999.<sup>4</sup>

On average, the percentage of public expenditures going to health in the provinces ranges from 30 – 37%. Spending on health care by the public sector represented 69.4% of total health expenditures in 1997. In 1998, this share is expected to increase slightly to 69.6%, and remain at the level in 1999. The remaining 30.4% is financed privately through supplementary insurance, employer-sponsored benefits or directly out-of-pocket.<sup>4</sup> Public sector spending in Canada includes direct payments by federal, provincial/territorial, municipal governments and Worker’s Compensation Boards. Private sector funding consists primarily of health expenditures by households (out-of-pocket) and private insurance firms.

**Total Health Expenditures by Use of Funds. Percentage distribution. Current Dollars.**

	Year				
	1990	1995	1996	1997	1998 (f)
Hospitals	39.2	34.6	34.0	32.5	32.2
Other institutions	9.4	9.9	10.0	9.9	9.9
Physicians	15.1	14.2	14.1	14.2	14.0
Other Professionals	10.6	11.5	11.9	12.5	12.7
Drugs	11.3	13.4	13.6	14.5	14.9
Capital	3.5	3.0	2.8	2.6	2.6
Other Health Spending	11.0	13.5	13.7	13.8	13.7
<b>TOTAL</b>	100.0	100.0	100.0	100.0	100.0

Source: Canadian Institute for Health Information. f = forecast

**Public and Private Shares of Total Health Expenditure, by Use of Funds, 1997.**

	Public	Private	Total
Hospitals	90.6	9.4	100.0
Other institutions	69.1	30.9	100.0
Physicians	98.8	1.2	100.0
Other Professionals	11.1	88.9	100.0
Drugs	30.6	69.4	100.0
Capital	80.8	19.2	100.0
Other Health Spending	80.3	19.7	100.0

Source: Canadian Institute for Health Information.

The above table demonstrates that 90.6 % of public spending went to hospital tertiary care, leaving 9.4% for primary health care and other expenses.

*Insurance:* Canadians do not pay directly for insured hospital and physician services, nor are they required to fill out forms for insured services. There are no deductibles, co-payments or dollar limits on coverage for insured services. The insured health services defined by the *Canada Health Act* include all medically necessary hospital services and medically required physician services, as well as medically or dentally required surgical-dental services requiring a hospital for their proper performance. Extended health care services as specified in the *Canada Health Act*, means nursing home intermediate care, adult residential care, home care and ambulatory health care. The services

are part of a broad range of health and social services offered by a variety of community and institutional programs and facilities to residents of a province.

While the cost of the physician service component of the care has traditionally been covered by provincial health insurance plans, the accessibility principle of the *Canada Health Act* does not permit extra patient charges to be levied in private clinics.

In most provinces the administration and payment for insured services is also managed by a provincial health insurance plan accountable to the provincial government. These plans are taxation-based, non-profit, and single-payer for insured services. They operate either from within the MoH, or through a separate agency closely linked to the ministry. These plans administer payment to service providers on behalf of eligible provincial residents. The operation of these plans must respect the principles of the *Canada Health Act* for the province to qualify for full federal transfers. Most provinces provide some coverage for non-insured services for social assistance recipients and the elderly. Health related benefits for social assistance recipients and the elderly typically include prescription medicines and vision care. These programs are usually operated from within the health ministries. All provinces offer some "additional benefits" beyond those services covered by the *Canada Health Act* and which are deemed complementary to single tier services. These include drugs and services provided by chiropractors, optometrists, psychologists, and products like splints, walkers, and wheelchairs. Given the fact that the benefits need not be universal, they have different coverage provisions from coast to coast, and frequently involve the payment of additional charges in the form of deductibles and/or co-payments. Finally, there are services, which are not deemed to be medically necessary (such as cosmetic surgery) which are largely left to private financing.

*Delivery of Services:*

Population-Based Health Services: Public health services in Canada were originally established to control the spread of infectious diseases, ensure public sanitation and, to some degree, provide basic health education to the populace. Over time, the role for public health services has tended to focus more on disease prevention and the needs of certain under-serviced segments of the population.

Today's public health services are funded separately from the main components of health care, and are administered through local or regional health units. As the focus of health care services have shifted toward a "wellness" model, public health services have become a far more important component of the health care system. For example, public health services across Canada provide child and maternal health counselling programs, and have been at the forefront of the effort to control the spread of AIDS. In addition, most public health services have also taken on a role coordinating or directly providing personal and home care services such as meals-on-wheels programs, and home nursing care. As such, they are an integral part of community health care.

Canada's Federal/Provincial/Territorial (FPT) Advisory Committee on Population Health (ACPH) has recognised the importance of highlighting three broad priority areas for action for short- and long-term strategies.<sup>30</sup> These are:

1. *Renewing and reorienting the health sector by continuing efforts to:* a) respond to the emerging challenges in health promotion, disease and injury prevention and health protection as well as in treatment services as outlined in the Ottawa Charter for Health Promotion; b) increase the accountability of health services through improved reporting on the quality of health services and increasing access to needed services; c) increase the general understanding of how the basic determinants of health influence collective and personal well-being; d) evaluate and identify policy and program strategies that work; and e) influence sectors outside of health which can significantly affect health status.
2. *Investing in the health and well being of key population groups, among them: children, youth and Aboriginal people.*
3. *Improving health by reducing inequities in income distribution and in literacy and education.*

An example of the above is the Childhood and Youth Program which has developed a wide range of community-based programs to facilitate the development and delivery of successful interventions for the children of at-risk populations living in communities across Canada through the *Community Action Program for Children (CAPC)* and the *Canada Prenatal Nutrition Program (CPNP)*.

In March 1995, the Diabetes Council of Canada (DCC) was formed to unify efforts in approaching the problem of Diabetes Mellitus. The Council monitors the progress made to establish a rational and coherent approach to finding solutions for the major problems associated with diabetes. Within the Federal Government, the First Nation & Inuit Health Programs Directorate (FNIHP) has successfully worked with the National Health Research and Development Program to fund eleven research projects on Aboriginal diabetes. The Canadian Cancer Society is a national, community-based organization whose mission is to eradicate *cancer* and to improve the quality of life of people living with cancer. Across Canada, the Society's 350,000 volunteers, supported by approximately 450 staff, carry out public education programs, provide services for cancer patients and their families, support healthy public health policies and organize fundraising events.

Immunization cannot be made mandatory because of the Canadian Constitution. Only three provinces have legislation or regulations under their health-protection acts to require proof of immunization for school entrance. Ontario and New Brunswick require proof for diphtheria, tetanus, polio, measles, mumps, and rubella immunization. In Manitoba, only measles vaccination is covered. In these three provinces, exceptions are permitted for medical or religious grounds and reasons of conscience; legislation and regulations must not be interpreted to imply compulsory

immunization. Between 1992 –1994, goals and targets were developed within the framework of the Expanded Program on Immunization for poliomyelitis, measles, mumps, rubella and congenital rubella syndrome, tetanus, diphtheria, pertussis, Haemophilus influenzae type b (Hib), and hepatitis B. These goals involve either achieving or maintaining the elimination of disease (e.g. polio, measles), or reducing morbidity and mortality (e.g. pertussis). Targets include vaccine-coverage levels (set at achieving between 95 –97% coverage) and quantifiable decreases in diseases. At the December 1995 Conference of Deputy Ministers, the goal of eliminating measles by the year 2005 was adopted.

Canadian women enjoy close to 100% coverage for prenatal care, and their deliveries are always attended to by trained personnel.

New communications and information tools are demonstrating their value in improving the quality, accessibility and efficiency of health care services. At the primary health care level, *the spatial Public Health Information exchange (SPHINX)* is a tool for presenting information from existing databases and allowing users to analyze and display this information in a variety of formats, including graphs and maps. The rapid development of an *electronic health records system* is increasingly allowing patients to ensure ready access to their medical histories by health care professionals and providers in different care settings is rapidly growing.<sup>19</sup> Access to these health records, however is also being stringently safeguarded in order to ensure the confidentiality and security of the health services practices. In addition, the use of *Telehealth* in certain parts of Canada is also rapidly becoming an example of a technology used to link the many health care services into an integrated and coordinated whole network.

Primary Health Care Level:

Close to one hundred percent of primary care facilities and the great majority of physicians' offices have computerized information systems for administrative and personnel management.

**Health Care Services Production, 1995-1996**

	<b>Number</b>	<b>Rate per 1,000 population</b>
Consultations and check-ups by a physician (excluding Special Calls)	186,284,736	6,307
Consultations and check-ups by a non physician	ND	ND
Consultations and check-ups by dentist	ND	ND
Emergency consultations (Special Calls Out-of Hours + Regular Hours)	6,447,808	218
Laboratory tests	ND	ND

**Source:** National Grouping System Categories Report, Canada 1994/95 & 1995/96; Canadian Institute for Health Information (CIHI)

Secondary and Tertiary Care level:

All hospitals with more than 50 beds have computerized management information systems which are used for medical records, admissions, nursing units, lab results, pharmacy sales, radiology services, human resources and risk management software for incident reporting.

**Health Care Services Production. 1996/97**

Indicator	
Total No. of discharges	3,156,787
Occupancy rate	
Average stay in days	10.7

Source: The Hospital Morbidity Database 1996/97

About 15% of the discharges were related to the circulatory system such as heart disease. Another 14% involved pregnancy and childbirth, 11% pertained to the digestive system, such as hernias or ulcers, 9% were related to asthma, pneumonia and other respiratory illnesses and 8% involved an injury or poisoning.<sup>49</sup>

*Quality:*

Technical Quality:

In Canada, all levels of government, health care organizations, and facilities have made a commitment to maintaining and improving the quality of the services and programs. At the national level, the Canadian Medical Association's *Quality of Care Program* is addressing pertinent quality issues. The majority of Canadian hospitals have established and functioning committees on ethics and for the review of professional behaviour. The major ethical issues being addressed by the Canadian Medical Association pertain to reproductive and genetic technologies, and privacy in health information. Other ongoing ethics activities include the revision of policies on organ donation and transplantation, medical records, relationships between physicians and industry, and testing for HIV and Hepatitis. From 1991 to 1996 cesarean sections have dropped from 17.9% of births to 17.7%.<sup>51</sup> In the early nineties the percentage was closer to 17.4%. Longer time series would show that rates of cesarean section have declined in Canada in response to pressures from inside and outside the health care system.

Each Canadian province and territory has a Vital Statistics Act and a Coroner's or Medical Examiner's Act which identify deaths which must be investigated including all deaths that are sudden or unexpected. Of those deaths occurring in hospitals some 15,146 or 9.8 per cent resulted in autopsies being performed. However there were also 6,281 deaths where no mention was made of autopsy. In particular maternal deaths are reviewed for the cause of death and its accompanying classification to ICD-9.

Perceived Quality:

At the institutional level, most hospitals have information systems to document users' perceptions about the quality of care of: 1) Ambulatory Services 2) Day Surgery or 3) Acute Care Hospitals.

Reliable and validated satisfaction questionnaires have also been developed for clients of geriatric services (elderly and caregivers).<sup>17</sup> With the introduction of the Client-Centred Accreditation Program by the Canadian Council on Health Services Accreditation (CCHSA) in 1995, the principles of quality improvement were incorporated into the accreditation standards.

### **3. MONITORING AND EVALUATION OF HEALTH SECTOR REFORM.**

#### *Monitoring the Process*

##### **Monitoring the Dynamics**

The National Forum on Health was launched in 1994 by the Governor General of Canada with a mandate to "involve and inform Canadians and to advise the federal government on innovative ways to improve our health system and the health of Canada's people." The Forum was set up as an advisory body, with the Prime Minister as Chair, the federal Minister of Health as Vice Chair, and 24 volunteer members who contributed a wide range of knowledge founded on involvement in the health system as professionals, consumers and volunteers. The forum also deliberately engaged a variety of communities that might otherwise experience barriers to participating, including homeless men, street kids, new Canadians, low-income mothers, senior citizens and First Nations. The Forum examined the current federal role in the two areas of its mandate. It was followed by a second consultation phase (1996).<sup>32</sup>

All revisions to existing and new programs were analysed according to the same basic principles and objectives articulated in the international debate on health and health sector reform. These are how to: a) Allocate and organise resources in health and health care so as to ensure equity in health conditions, access and use of services and financing of services; b) Move from research to action on the determinants of health; c) Encourage evidence-based analysis and research in decision making about health and health care with a view to improving the quality of care from the technical standpoint and user's perspective; d) Identify the values Canadians hold about health and health care and ensure these values influence decisions.

By 1997, the authors of more than 42 studies released their 5 volume report entitled "Canada Health Action: Building on the Legacy." To support innovation in the directions outlined above, the Forum recommended that the federal government establish a transition fund of CAD\$50 million/year. The fund would subsidise pilot projects, disseminate results and promote implementation of the best models.

Most of the provinces have now completed their respective reforms pertaining to decentralization and the appropriate administrative, governance, and accountability structures. As a whole, Canada is stressing approaches which place less emphasis on hospitals and physicians, and focus on non-

institutional care, a broader array of multidisciplinary health service providers, and a greater reliance on other forms of community-based care, including health promotion and disease prevention activities. While it is recognised that resources should be reallocated toward community care, fiscal pressures often make this difficult to accomplish.

The provinces that have introduced decentralization and/or some degree of devolution of their own systems defend it on the basis of the following rationale:<sup>58</sup> a) better population health; b) greater cost and spending control; c) improved integration and coordination of services; d) enhanced public participation and community involvement; e) greater flexibility and responsiveness; f) increased equity; g) improved accessibility.

Evaluation criteria has varied among the Canadian provinces. The provinces of Nova Scotia, New Brunswick, Newfoundland, Saskatchewan, Alberta and British Columbia have all published formal *accountability framework* documents which set out three means by which accountability and governance can be measured. These are: i) macro-public accountability; ii) opportunity for public interaction and influence; and iii) provincial capacity for reporting on health system performance.

In addition, *national consensus indicators* have also been developed to allow for improved evaluation of the health sector reforms. At the same time, specific *provincial indicators* in Prince Edward Island, Nova Scotia, Newfoundland, Saskatchewan have been defined and selected according to the following general categories: i) social and economic environment; ii) physical environment; iii) health care; iv) lifestyles and coping skills; v) human biology vi) child development vii) health status viii) health system performance.<sup>10</sup>

The results of these strategies and projects will be coming in and analyzed by the policy makers between September 2000 and March 2001.

### **Monitoring the Contents**

#### Legal Framework:

The reform processes that have been introduced in Canada have not made it necessary to modify the national constitution, nor the *Canada Health Act of 1984*. The *Canada Health and Social Transfer (CHST)* that was introduced in the 1995 Budget Bill did not affect any of the criteria or conditions of the Canada Health Act, nor any of the provisions for their enforcement. Nonetheless, at the provincial level, the reforms have required the passage of a number of legislative changes in the basic health regulations and procedures. In most cases, the legal changes favor an intersectoral approach within the decentralization processes and structures, and recognize the linkages between health and the other determinants of health such as education, decent housing, or a healthy environment. The following chart outlines the various pieces of legislation that were passed in the 1990s in each of the provinces.

Legislation Newfoundland Department of Health Act – 1990 Hospitals Act – 1990 Auditor General Act – 1991	Legislation Prince Edward Island Health and Community Services Act - 1993 Audit Act – 1988
Legislation Nova Scotia Act to Establish Regional Health Boards - 1994 Auditor General’s Act - 1989 Ombudsman Act - 1989 Health Council Act – 1990	Legislation New Brunswick Hospital Act - 1992 The Right to Information Act - 1978 Health Services Act - 1997 Auditor General Act - 1981
Legislation Québec Loi sur les services de santé et les services sociaux, Lois refondues du Québec (L.R.Q.) chapitre S-4.2, 1994.	Legislation Ontario Accountability Improvement Act (Bill89), 1996 Audit Act, revised statutes 1990 The Savings and Restructuring Act (Bill 26), April 1996 Health Protection and Promotion Act, revised statutes 1990
Legislation Manitoba The Department of Health Act - 1987 The Health Services Insurance Amendment Act - 1998 The Ombudsman Act - 1987 The Personal Health Information Act - 1997 The Regional Health Authorities and Consequential Amendments Act - 1997	Legislation Saskatchewan The Department of Health Act - 1973 The Health Districts Act - 1993 The Health Services Utilization and Research Commission Act - 1994 The Prescription Drugs Act - 1973 The Provincial Auditor Act - 1983 The Saskatchewan Medical Care Insurance Act - 1974 The Vital Statistics Act - 1995
Legislation/Alberta Cancer Programs Act (1985) Government Accountability Act (1994) Hospitals Act (1994) Mental Health Act (1990) Public Health Act (1985) Regional Health Authorities of Alberta Act (1994)	Legislation British Columbia. Auditor General Act (1996), Ministry of Finance and Corporate Relations Financial Administration Act (1996), Ministry of Finance and Corporate Relations Freedom of Information and Protection of Privacy Act (1997), Ministry of Advanced Education, Training and Technology Health Authorities Act (1996), MoH and Ministry Responsible for Seniors Health Act (1996), MoH and Ministry Responsible for Seniors Hospital Insurance Act (1998), MoH and Ministry Responsible for Seniors Mental Health Act (1998), MoH and Ministry Responsible for Seniors MoH Act (1996), MoH and Ministry Responsible for Seniors Seniors Advisory Council Act (1996), MoH and Ministry Responsible for Seniors

Right to Health Care and Insurance:

The right to the health care is not overtly guaranteed through the Constitution of 1867 although many Canadians believe it is a constitutional right. However, the mechanism applied for ensuring universal access to health care services is explicitly laid out in the *Canada Health and Social Transfer (CHST) Act*, which was updated in 1996.

Because of the changing demographics and new demands being placed on the health care system, new approaches to funding integrated service delivery, primary care reform, home care, and coverage for medically-necessary drugs purchased outside the hospital (pharmacare), are being carefully analyzed at the Federal, Provincial, Territorial levels of government.

Steering Role: A central component of the process of regionalisation has been the establishment of Regional or District Health Authorities which are governed by boards composed of residents of the particular region. The regional and district health boards of three provinces, Quebec, New Brunswick, and Saskatchewan are partially filled through an electoral process, while the great majority of health-related boards at all organisational levels (hospitals to advisory councils) are appointed. The processes involve the allocation of certain portions of budgetary control to regions and communities by the MoHs of the respective provinces. All financing arrangements are designed to match the flexibility being given to the Regional Health Authorities (RHAs) to allocate funds for services based on the health needs of the local residents (ie: population based) rather than committing them to specific funding levels for hospitals or any other program (ie: traditional service or provider-based).

For example, Prince Edward Island has introduced a single-level regional model in which each Region receives a global budget for the provision of most health care services. The authorities draft their own budgets, but their funding levels are set by the central department. British Columbia has adopted models with interlocked regional authorities controlling the block funding and developing the appropriate programs with local or community health boards. Saskatchewan, has used a devolution model of District Health Boards composed of democratically elected representatives charged with the responsibility to manage the planning, finances, and reporting to the constituents and the Government on the health status of the residents and the effectiveness of the District Health Boards' programs.<sup>58</sup>

Funding arrangements, however, simultaneously require that the RHAs meet the quality and safety standards in all programs they administer. New approaches for population-based funding for regions are being designed along with better information systems and closer linkages with teaching and research. Many of the provinces in Canada have developed their own health needs assessments in order to provide a basis for policy development and program implementation, and as a practical tool for the planning cycle.<sup>41</sup> These comprehensive health needs assessments involve systematically collecting and analysing information about health, illnesses, and injuries, and looking beyond the obvious causes to understanding the underlying causes as well. The assessments encompass a geographical area or a particular group of people. They include studying the overall health of a community and the factors that determine the particular situation, not just the circumstances affecting any single individual. The information is usually shared with planners, staff, other partners and community members who can use the information to develop policies and programs to improve and maintain health.

Separation of Functions: The resulting values-driven contract model of health systems embodies a separation of payer, or purchaser, from provider. The provincial governments act as the single-payer for insured hospital and medical services.

With respect to the administrative, governance, and accountability structures, the provincial governments are committed to decentralising the health care services and to placing greater emphasis on priority setting at the local level. Nevertheless, there is considerable variation among the Canadian provinces in the way accountability mechanisms are being linked together into a conceptual framework for the health system. The provinces of Nova Scotia, New Brunswick, Newfoundland, Saskatchewan, Alberta and British Columbia have all published a formal accountability framework document. A general framework, which summarises three means by which accountability can be measured, incorporates the following: i) macro-public accountability; ii) opportunity for public interaction and influence; and iii) provincial capacity for reporting on health system performance

Decentralization Modalities: Most of the provincial governments have now completed what they had planned in terms of structural reform, including the transfer of authority from the province to the regions. All have expressed a commitment to shifting the emphasis of their health systems away from institutionally based delivery models to community based models which place increased emphasis on health promotion and prevention. Institutional restructuring is also occurring including the consolidation of certain speciality services at designated hospitals, the closure of hospitals and the redesignation of facilities previously classified as hospitals to community health centres. All provinces have taken some steps to develop "wellness" strategies, have begun to develop primary care models and networks, and have increased funding for home care.

Social Participation and Control: In February 1999, the spirit of collaboration between the different levels of government was reinforced when federal, provincial and territorial governments (with the exception of Quebec) signed the Social Union Framework Agreement (SUFA). SUFA acknowledged that citizens have an important role to play in shaping their society. Among other commitments, within SUFA, governments agree to: a) Respect the principles of Medicare: comprehensiveness, universality, portability, non-profit public administration and accessibility; b) Work in partnership with individuals, families, communities, voluntary organisations, business and labour, and ensure appropriate opportunities for Canadians to have meaningful input into social policies and programs.

Many new initiatives (referred to above) have begun since 1997 when the Forum underscored the importance of a broad, integrated child and family strategy involving both programs and income

support; the creation of a national foundation to strengthen community action; an Aboriginal Health Institute; and help for people trying to enter the work force.

Financing and Expenditure: The Forum concluded that the single-payer model of public health insurance (Medicare) is the best approach to controlling overall spending on health since it ensures Canadians receive medical attention when they need it and avoids the duplication, overlap and inefficiencies of a system made up of hundreds of private plans. It recommended that the reduction in federal-provincial transfer payments be halted and a floor established below which the transfer payment would not sink. This would give the provinces some certainty and stability in funding arrangements, as well as ensure that the federal government could still enforce the principles of the Canada Health Act. The Federal Government acted upon these recommendations in its 1997 Budget. A Health Transition Fund was established of CAD\$ 150 million over three years to allocate funds to the provinces for pilot projects leading to better approaches to health care delivery, including home care, Pharmacare and primary care reform. To strengthen the health care system, the federal government announced in the 1999 Budget that provinces and territories will receive an additional CAD\$11.5 billion over the period from 1999-2000 to 2003-2004, specifically for health care, under the Canada Health and Social Transfer. In addition, the 1999 Budget introduced measures to eliminate disparities among provinces in per capita CHST entitlements (cash transfer plus tax transfer). By 2001-02, all provinces and territories will receive the same amount on a per capita basis. In the 2000 Budget, the government announced an additional \$2.5 billion in transfers to the provinces through the CHST. This brings the total transfers to \$15.5 billion, or an all-time high of close to \$31 billion in 2000-2001.

By early 1998, most provinces were slightly increasing the overall health spending. The general trend toward increased expenditure has favoured investment in community-level initiatives, but in the form of acute care substitution rather than initiatives that are associated with "community action." Resources allocated previously to health prevention activities in the community and in the home are being directed to providing services and care to those who have been discharged from hospital. But all Health Ministers believe that, over the longer term, future decisions must be based on a plan that responds to Canadians' desire for health care that is a more integrated approach, from a person's first contact with health professionals, through to health care in hospitals and longer term care in home or community settings. New resources in future must be based on shared evidence that as a country we are meeting Canadians' objectives for quality care.

A number of mechanisms have been developed to contain physician costs such as setting global budgets as opposed to line-item budgets; negotiating fee schedules and increases; developing alternative payment schemes (such as salaries or capitation). Other micro level instruments include

individual physician caps, differential fees and/or restricted billing numbers. To contain hospital costs some mechanisms are applied through setting global hospital budgets, establishing a separate capital funding approval process. All provinces have imposed medical expenditure caps at the level of individual practitioners as another approach to gain predictability and control over medical expenditures. There is, however, widespread concern about the potential cost of insured home care and pharmaceutical programs, and divergent perspectives on home care and Pharmacare. In response to the need to measure the impact of these changes, new accountability mechanisms are emerging to provide useful direction on the design of future frameworks.

Health Care Services Offer: The Forum recognised that there were a number of unexplained Canada-wide variations in rates of surgical procedures, hospital days being used by those who do not require acute care, and inappropriate use of drugs. It therefore recommended that resources be used more efficiently within the system (as opposed to being increased). Steps should also be taken to bring home care and medically necessary drugs under the umbrella of the publicly funded health care system. In other words, out-of hospital services should be made an integrated part of publicly funded health services and would reflect an approach to "funding the care, rather than the provider or site"<sup>32</sup> The Forum recommended that primary care services be carefully restructured. It did not put forward any particular model, but suggested that any reform of primary care include: i) a realignment of funding to the patients, not services; and ii) a remuneration method that is not based on volume of services provided by physicians, but promotes a continuum of preventive and treatment services and the use of multidisciplinary teams.

Changes in the health care system have put considerable pressure on the hospital sector. A common trend has emerged in all categories of public hospitals: the number of outpatient visits and day surgery has increased, while inpatient days and inpatient surgery has decreased.<sup>49</sup>

This widespread shift has reduced the use of some hospital services and a growing demand for community and home care. These pressures have forced many hospitals to restructure, merge or consolidate their services. From 1986-87 to 1994-95, hospital expenditures declined, while the number of public hospitals decreased by 14% and the number of approved beds in public hospitals declined by 11%.<sup>49</sup> Re-configuring the numbers of hospitals and the way they deliver services Hospitals are now organised as general or acute care facilities, community or secondary care and long-term or chronic care. Depending on affiliation with a medical school, any of these hospitals may also be classified as a teaching hospital. In larger centres, hospitals may be more specialised into maternity hospitals, children's hospitals, rehabilitation facilities or cancer treatment centres. In the largest cities, some institutions have become highly specialised, with hospitals focused on arthritis care, orthopaedics and women's health. Moreover, as part of the restructuring of the health

system, many highly specialised services are being consolidated in single urban centres responsible for servicing the entire province or region.

Increasing interest in and need for services provided outside of institutions has in turn spurred growth in the home care sector.<sup>21</sup> This takes many forms, ranging from physician visits, specialised nursing care and homemaker services to meals-on-wheels programs and adult day care. Home care takes place in the context of both the community and the health system. Some services needed for the individual to be able to receive home care may actually take place in the surrounding community. Other components of home care include drugs, equipment, or medical supplies.

In addition, almost every province has been moving toward improved service integration, which spans the full continuum of care. However, there is no single model to integration. This is consistent with a population-centred approach, which dictates that integration initiatives should reflect the unique needs of the population served and take into account gender and age. Methodologies across the provinces include: a) integration of programs at a provincial level (PEI and Newfoundland); b) using regional health authorities as the integrating body (Saskatchewan); c) targeting services to a population segment (seniors in Edmonton, Alberta); d) a particular disease category (Cancer Care in Ontario), to community-level initiatives in East York, City of Toronto).<sup>21</sup>

Management Model: While there is increasing privatisation of some services, the impact of this tendency of regionalisation has been negligible. Most privatisation that has occurred is at the institutional level, with hospitals contracting out non-medical support services such as laundry, meal preparation or inventory control.

Human Resources: A number of mechanisms have been developed to help to contain physician costs such as: licensure; controlling the general practitioner/specialist split; expanding the role of alternative providers; and pooling malpractice insurance into a single scheme.

Quality and Assessment of Health Technologies: In 1997, the Forum concluded that a range of concerted actions based on informed decisions is needed to make the health care system more efficient, effective and reflective of contemporary practice in health care delivery. A key objective for the health sector should therefore be to move rapidly toward the development of an evidence-based health system, in which decisions are made by health care providers, administrators, policy makers, patients and the public on the basis of appropriate, balanced and high quality evidence. In so doing, the potential role of information technology should be explored and the resources required to reach this objective should be put into place. The challenge, therefore, confronted at the time was how to focus on developing national capacities to undertake evidence-based decisions as a result of more systematic research, and to design interventions which focus on factors outside the health care system that affect the health of a population - i.e. the implications of social and economic factors

which are non medical determinants of health (unemployment, poverty, gender roles, ethnic and cultural influences and practices, community solidarity etc.).

Federal leadership in developing a nation-wide population health information system was considered essential. Such a system would bring together a standardised set of longitudinal data on health status, determinants of health and health system performance, and would ensure patient privacy and confidentiality. In this direction, better information gathered at the community or municipal levels and fed into a national system would strengthen the national processes of standardising norms, and transferring the required resources based on proven evidence in order to undertake more effective, culturally appropriate interventions that do in fact improve the health status of the target group or community. Other micro level instruments are the developing of clinical practice guidelines, the establishment of accreditation standards and evaluating compliance for hospitals, and the creation of health technology assessment organisations at the provincial level, which will regulate the appropriate use of expensive technologies.

***Evaluation of Results.***

Evaluating the results of the health reform process in improving levels of equity, effectiveness, quality, efficiency, sustainability, and social participation is a dynamic and evolving endeavour. All Health Ministers in Canada believe that, over the longer term, new resources in future must be based on shared evidence that meet Canadians' objectives for quality care. A significant contribution to that evidence is now being made from the work of groups like *the Canadian Institutes for Health Information*, the *Canadian Health Services Research Foundation* and the *Health Transition Fund*, initiatives funded in previous Budgets.

The results of Canada's Health Reform Processes are coming in, consultations and analyses are occurring, and decisions are increasingly being made by policy-makers based on the best available evidence. The challenge all Canadians recognize is how to achieve the most efficient and effective integration of all the current sources of information into a uniform picture of the functioning and passage of an individual through the health care system.

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