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STATUTORY PARLIAMENTARY REVIEW OF THE *10-YEAR PLAN TO STRENGTHEN HEALTH CARE*

Report of the Standing Committee on Health

Joy Smith, MP
Chair

JUNE 2008
39th PARLIAMENT, 2nd SESSION

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SIXTH REPORT

Pursuant to Standing Order 108(2) and section 25.9 of the *Federal-Provincial Fiscal Arrangements Act*, the Committee has completed the Statutory Review of the progress in implementing the “10-Year Plan to Strengthen Health Care” and presents its findings and recommendations.

STATUTORY PARLIAMENTARY REVIEW OF THE *10-YEAR PLAN TO STRENGTHEN HEALTH CARE*

INTRODUCTION

Section 25.9(1) of the *Federal-Provincial Fiscal Arrangements Act* provides for a parliamentary committee review every three years on progress in implementing the *10-Year Plan to Strengthen Health Care* (10-Year Plan) endorsed by First Ministers in 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 federal government mandated the House of Commons Standing Committee on Health to undertake the first statutory review.

The Committee initiated the review on March 13, 2008 and completed the public meetings on May 27, 2008. In total, four hearings were held with witnesses including representatives from the federal government, health professionals, unions, pharmaceutical industries, Aboriginal organizations, and the academic and research community. The Committee also received evidence from the Health Council of Canada (hereafter the Health Council) and the Canadian Institute for Health Information (CIHI) both of which were mandated under the 10-Year Plan to publicly report on progress in strengthening health care. This report presents the Committee's findings and observations on its review of overall progress in implementing the 10-Year Plan.

THE 10-YEAR PLAN

For many years, Canadians from across the country have been increasingly concerned about wait times for health care. They worry about a lack of access to needed health services and products – such as home care and prescription drugs – and they want reforms to ensure that the health care system is effective, efficient, safe and equitable. In response to these concerns, First Ministers in September 2004 reached an historic agreement – the 10-Year Plan – to renew health care, improve access and enhance accountability to citizens. The plan committed federal, provincial and territorial (F/P/T) governments to move forward on a comprehensive and ambitious set of health care renewal initiatives, through collaboration on solving common problems. The plan recognized an asymmetrical federalism and established separate arrangements between the federal and Quebec governments. This report acknowledges this.

The shared agenda for health care reform envisioned under the 10-Year Plan encompassed ten components:

- reducing wait times and improving access;
- strategic health human resource action plans
- home care;
- 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 innovation;
- accountability and reporting to citizens; and
- dispute avoidance and resolution.

In support of the 10-Year Plan, the federal government provided additional funding to the provinces and territories amounting to $41.3 billion over the 2004-05 through 2013-14 period. This funding includes $35.3 billion under the Canada Health Transfer (CHT), as well as targeted funds amounting to $5.5 billion under the Wait Time Reduction Fund and $500 million under the Medical Equipment Fund.

In undertaking this statutory review of the 10-Year Plan, Committee members asked two fundamental questions: What has been accomplished since 2004? What progress has been achieved by all levels of government for each of the ten components included in the plan?

ASSESSMENTS OF PROGRESS

A. Wait Times

Under the 10-Year Plan, governments committed to establish evidence-based benchmarks for medically acceptable wait times in five priority areas: cancer, heart, diagnostic imaging, joint replacement and sight restoration. In December 2005, jurisdictions announced that they had fulfilled their commitment with respect to setting benchmarks, except those for diagnostic imaging. To date, there are still no benchmarks for diagnostic imaging. Given that many diagnoses are dependent on imaging, some witnesses questioned whether the lack of benchmarks in this area has reduced the usefulness of benchmarks for the other priority areas of treatment.

Another wait time commitment was to establish, by 31 December 2007, multi-year targets for achieving the benchmarks announced in December 2005. This deadline passed with only a few provinces setting timetables to achieve some of the wait time benchmarks. For this reason, most jurisdictions cannot report annually on progress in meeting these multi-year targets as required under the plan.

According to the Health Council, the Wait Time Reduction Fund has helped jurisdictions to move forward on wait times; jurisdictions have used the funds to build capacity and address wait-list backlogs. In particular, they have invested in equipment, human resources, training/education of professionals, technology and information systems. The Council also noted that many jurisdictions have created websites where patients can view wait times for a variety of procedures. In its view, these websites are a good first step to providing patients access to more information on wait times and rebuilding confidence in the system.

The 10-Year Plan mandated CIHI to report on the progress on wait times across all jurisdictions. CIHI has fully complied and produced four reports on wait times since 2004. CIHI's latest data show that the volume of surgeries in the priority areas increased by 13% in Canada (excluding Quebec) between 2004-05 and 2006-07. Over the same period, the amount of diagnostic imaging equipment increased by 27% for

MRI scanners and 12% for CT scanners and the number of exams performed went up even more. Despite the increase in surgical volumes and the additional diagnostic equipment in use, CIHI representatives told the Committee that they cannot conclude that this has led to meaningful reductions in wait times.

A major barrier to assessing progress on wait times is the fact that CIHI uses data and information on provincial websites and that this information remains limited. For example, only five provinces are reporting wait times for the five priority areas; the others are reporting wait times for only four priority areas. Similarly, only three provinces are reporting the percentage of procedures completed within national benchmarks or province-specific targets for radiation therapy. A further challenge faced by CIHI is that provincial data is reported in diverse ways, such as using different measures, and this makes it difficult to compare and evaluate progress on wait time reductions from a pan-Canadian perspective. For example, CIHI was able to compare only three provinces in terms of their wait-time performance on joint replacements and four provinces for cataract surgeries. Moreover, trend data are not available across the board; they are only beginning to emerge for some jurisdictions.

The report cards by the Wait Time Alliance showed that some jurisdictions made some progress in reducing wait times in the five priority areas but noted that, on the whole, governments were not fully living up to the commitment they made under the 10-Year Plan. Like CIHI, the Alliance stressed that a lack of comparable data was undermining efforts in assessing progress.

A number of witnesses raised the concern that efforts to shorten wait times for the priority areas may have had the unintended consequences of lengthening wait times for other procedures. This issue highlights the need to measure, monitor and manage wait times for all, or at least more, procedures. Witnesses indicated that the establishment of wait time benchmarks in five key areas serves as a good first step but that efforts cannot end there. The Wait Time Alliance reported that it had developed benchmarks for seven additional specialty procedures and encouraged governments to use them to establish multi-year targets.

B. Health Human Resources

The 10-Year Plan committed governments to increase the supply of health professionals based on an assessment of the gaps, including targets for the training, recruitment and retention of professionals by 31 December 2005. All governments committed to making their plans public and to report regularly on progress. The Health Council reported that most jurisdictions submitted reports on their health human resource action plans; however, these reports often lack detail. Only four include population health needs; some do not have targets; and only four link their targets to the Pan-Canadian Health Human Resource Planning Framework. This F/P/T framework is intended to facilitate planning and management of health human resources, but it is not receiving the attention and support from all stakeholders that it must have to succeed.

The Health Council also told the Committee that jurisdictions have increased enrolment in professional schools and initiated new recruitment and retention strategies in order to address shortages in health human resources. Nonetheless, a number of

witnesses indicated that there are still not a sufficient number of seats in health education programs to produce enough new graduates to replace those who will leave the workforce. In fact, the Committee heard repeatedly that there is a nationwide shortage of health human resources. Information on the extent of these gaps suggests that Canada may even be on the brink of a "crisis" in health human resources.

Currently, much of the data on health professionals relate to physicians and nurses, with little information on other health professions. CIHI data show that the number of physicians and nurses increased only slightly between 2004 and 2006; an insignificant increase given the growth in population during this period. CIHI is currently developing five new databases on: occupational therapists, pharmacists, physiotherapists, medical laboratory technologists and medical radiation technologists. This improved data is expected to measure the current supply of professionals, discern the appropriate mix and distribution, and forecast future requirements. This, in turn, will help inform policy and planning decisions in health human resources.

Witnesses told the Committee that some jurisdictions lose their graduates to other provinces as they compete for the same doctors, nurses and other health professionals. While a number of provinces are working together to plan and manage their health human resources more effectively, the nationwide collaboration envisioned in the 10-Year Plan has not yet resulted in coordinated planning. Again, witnesses suggested that this should be addressed under the Pan-Canadian Health Human Resource Planning Framework.

Witnesses also pointed out that the shortage of health human resources is international in scope and, accordingly, they expressed concerns about the increased recruitment of internationally trained health professionals. In their view, Canadian employers are "poaching" workers from developing countries. Rather than encouraging the immigration of internationally educated health professionals, they suggested that governments support the upgrading, language training, and credential recognition for internationally-educated health care workers already in Canada and employed in health care.

As part of the 10-Year Plan, the federal government committed $100 million to increase the number of Aboriginal health care professionals. In 2005, it launched an Aboriginal Health Human Resources Initiative, a five-year program. Health Canada told the Committee that approximately $36 million had flowed to this initiative before the end of March 2008. The Health Council reported that the Initiative appears to be on track to meet or surpass a number of goals. It noted, for example, that the number of bursaries and scholarships available to Aboriginal health care students has tripled since the Initiative was launched. The federal government plans to release a detailed report on the progress achieved under this initiative by the end of this fiscal year.

C. Home Care

Under the 10-Year Plan, First Ministers agreed to provide first dollar coverage for certain home care services, based on assessed need, by 2006. The specific services included short-term acute home care, short-term community mental health care and end-of-life care; "short term" refers to two weeks of services. Health Ministers were to

report to First Ministers on a staged implementation of the home care commitment by December 31, 2006. The Committee was told, however, that this report is not yet available.

Witnesses who discussed the home care commitment pointed to the limited scope of services covered under the 10-Year Plan. While they agreed that it is a positive start, they felt that this was a narrow and unrealistic view of home care. They stressed that the plan did not include other important home support services such as housework and meal preparation. Nor did the plan address the issue of long term facility care. They advocated for programs to provide both acute care replacement services and long-term (or continuing) home care.

Other witnesses noted that home care services continue to be poorly integrated with primary health care in many parts of the country. In their view, no matter where people live, home care services should be seamlessly coordinated with other aspects of primary health care.

For its part, the Health Council of Canada noted that there are insufficient efforts to monitor and publicly report on the progress of home care renewal. CIHI built a home care reporting system, but only a few jurisdictions participate. As a result, there is not a clear picture of the state of home care across Canada.

D. Primary Health Care, Electronic Health Records and Telehealth

With respect to primary health care, governments committed to meet the objective of 50 percent of Canadians having 24/7 access to multidisciplinary teams by 2011. They also agreed to establish a best practices network to share information on primary care reform and to regularly report on the progress of reform.

The Health Council told the Committee that some parts of the country are on track to meet the goal set in the 10-Year Plan of having 50% of people served by teams by 2011. Progress, however, is uneven and often difficult to measure. As a matter of fact, few governments have set targets or have implemented strategies for measuring, monitoring and reporting on progress. The difficulty in assessing and reporting on progress in primary health care reform is in part attributable to the lack of consensus on the definition of the term “multidisciplinary teams” envisioned under the 10-Year Plan. In some jurisdictions, it simply refers to a nurse working alongside a family doctor; in others, it strictly means a group of physicians; and in a few jurisdictions, it includes a wider range of health professionals. There is also conflicting information on the number and types of patients enrolled or registered in these teams. In its 2007 report, the Council stressed the need to develop common definitions or parameters of measurement and appropriate data and indicators to track progress in primary health care reform.

As promised in the 10-Year Plan, governments established the Best Practices Network to help health care professionals and managers share information and solve problems in their efforts to reform primary health care. However, after conducting a series of activities in 2005 and 2006, the network was dissolved due to a lack of targeted funding.

Under the 10-Year Plan, First Ministers recognized the significant investment that has been made in Electronic Health Records (EHRs) to enable health system renewal and agreed to accelerate its development and implementation. They declared that 50% of Canadians would have an interoperable EHR by 2010. They also asked for acceleration of efforts on telehealth to improve access for remote and rural communities.

Some witnesses told the Committee that an EHR is pivotal for moving forward on health care renewal initiatives. Improved access to care, quality of service, patient safety, and efficiency and effectiveness are some of the positive outcomes linked to the use of EHRs. Other witnesses stressed that not only can EHRs improve the efficient exchange of patient information, minimize the duplication of diagnostic tests, improve health outcomes and patient safety, they can also be a significant driver of how health professionals organize themselves and work together to provide care. The Committee learned that Canada Health Infoway investments now total $1.6 billion, with an estimated return on investment of 8 to 1.

Despite recent investments through Infoway, governments have been slow to make progress in the implementation of EHRs. Estimates by the Health Council show that only 7% of Canadians had an electronic health record as of March 2008. As a result, governments are not on track to meet the goal of 50% of Canadians having a secure EHR linked to other aspects of health care delivery by 2010 – a goal that the Health Council had said was too modest from the start. Slow progress in this area is attributable to the lack of matched funding by P/T governments. According to the Council, public support for these investments is strong and, accordingly, governments must find ways to fund and accelerate this essential part of health care renewal. Some witnesses recommended that Infoway funding be increased and accelerated to realize the First Ministers' vision of the EHRs.

With respect to telehealth, some witnesses noted that the technology has been particularly helpful in jurisdictions that face the challenge of delivering primary health care in remote areas. It is also used to monitor people with health problems in their own homes through data collection and to send information about patients electronically to distant health care providers for assessment. Despite demonstrable benefits, the use of telehealth to improve quality of care and collaboration among health professionals separated by distance still has not reached its full potential.

E. Access to Care in the North and Aboriginal Health

In the 10-Year Plan, the federal government made two commitments to improve access to health care in Northern communities. First, it proposed to establish a Territorial Health Access Fund to provide $150 million over five years in additional funding to the Territories to facilitate long-term health reforms and enhance direct funding for medical transportation costs. Second, it agreed to develop a joint vision for the North in collaboration with the Territories.

The Committee did not receive any evidence during its hearings on the Territorial Health Access Fund. It is unclear whether the Fund has been established and, if so,

which initiatives have been developed to facilitate long-term reforms and provide additional support for medical transportation costs. Similarly, the Committee did not obtain any information on the development of a joint vision for health in the North.

Although the 10-Year Plan had a few specifics about Aboriginal peoples, First Ministers and national Aboriginal Leaders agreed to work together to develop a blueprint to improve the health status of Aboriginal peoples and enhance access to health services. The *Blueprint on Aboriginal Health* was considered by the First Ministers and Aboriginal Leaders at their meeting in Kelowna, British Columbia, in November 2005. At the time, the federal government committed $1.3 billion over five years: $870 million to stabilize the First Nation and Inuit Health System; and $445 million to promote transformation and to build capacity. The *Blueprint* also called for implementation of the Aboriginal Health Reporting Framework to report on progress towards key health outcomes. This framework was to be completed by 2007 with actual reporting to begin by 2010-11.

Aboriginal organizations told the Committee that relatively little funding has flowed from the 2005 Kelowna communiqué and the *Blueprint*. This was confirmed by the Health Council which also noted that some provinces are working closely with Aboriginal communities and the federal government to improve health care and living conditions on a regional basis, but developments are on a much smaller scale than initially envisioned.

Recognizing some of the urgent needs of Aboriginal populations, the federal government announced a series of pilot projects in 2007 to establish patient wait time guarantees in the delivery of prenatal and diabetes care in First Nations communities. In addition, the Aboriginal Health Transition Fund ($200 million over 2005-2010 period) is supporting over 100 projects to integrate health services for Aboriginal peoples, improve access to services, and increase local participation in the design, delivery and evaluation of health programs and services.

F. National Pharmaceuticals Strategy

As part of the 10-Year Plan, First Ministers directed Health Ministers to establish a ministerial task force to develop and implement a National Pharmaceuticals Strategy (NPS) and to report on progress by June 30, 2006. The strategy was to include a series of actions in the following areas: catastrophic drug coverage; national drug formulary; improvements to the drug approval process; evaluation of real-world drug safety and effectiveness; purchasing strategies for drugs and vaccines; prescribing behaviour; e-prescribing; access to and international parity on prices of non-patented drugs; cost drivers and best practices. The F/P/T Ministerial Task Force on the NPS was established in October 2004 and released a progress report in June 2006.

Several witnesses told the Committee that progress on the various elements of the NPS has been slow to date and there has been a relative lack of progress as well on an overall pan-Canadian strategy. In their view, the process has not been very transparent, consultation with stakeholders took place relatively late in the process and still not much is known about what is happening in many of the key areas (e.g. expensive drugs for rare diseases).

Similarly, the 2008 Health Council report stated that governments have not made acceptable progress in creating the NPS that was promised in 2004. It noted, for example, that progress on catastrophic drug cost coverage has stalled and that Canadians still do not have a common drug formulary. Some witnesses raised the concern that, in the absence of federal leadership and an active F/P/T working group, many of the issues identified as priorities under the NPS are still being addressed in isolation. The Health Council will report later this year on the progress of this strategy.

G. Prevention, Promotion and Public Health

Under the 10-Year Plan, governments agreed to collaborate in the development of coordinated responses to infectious disease outbreaks and other public health emergencies through the new Public Health Network. They also committed to establish a pan-Canadian public health strategy and work collaboratively in developing health goals and targets in addition to fostering intersectoral work, building on initiatives such as Healthy Schools. For its part, the federal government committed to provide ongoing investments for needed vaccines through the National Immunization Strategy. The Strategy will provide new immunization coverage for Canadian children.

Witnesses told the Committee that the federal government is making progress in the area of public health and disease prevention. The government has invested $1 billion over five years for pandemic influenza preparedness at the federal level and is supporting the F/P/T National Immunization Strategy. In addition, it has launched the first national cancer control strategy, supported the development of the Canadian Heart Health Strategy, and established the Mental Health Commission.

Despite these developments, in its 2008 report the Health Council expressed concern that the idea of an integrated pan-Canadian healthy living strategy that cuts across specific diseases seems to have been shelved. Overall, public spending to foster healthy living still represents only a fraction of what Canada spends on treating preventable illness and injury.

H. Health Innovation

The 10-Year Plan committed the federal government to continue investing in health science, technology and research. Government representatives told the Committee that significant investments in health research have been made by the federal government over the last four years, including $440 million in new funding for health specific innovation. Several witnesses stressed that sustained investment is needed in order to attract and retain world-class researchers, make advances in discovery and innovation and benefit from health research findings.

I. Accountability and Reporting

The 10-Year Plan includes three different types of reporting provisions. First, and as noted in the previous sections, several reports are required from each jurisdiction for specific components of the plan (e.g. wait times, health human resources, home care, primary care reform); some of these reports have specific deadlines, while others must

be produced annually or regularly. It should be noted that some components have no required reports from the federal, provincial or territorial governments (e.g. access to care in the North, prevention, promotion and public health, health innovation, dispute avoidance and resolution).

Second, the 10-Year Plan stipulates that: "All funding arrangements require that jurisdictions comply with the reporting provisions of this communiqué." For some witnesses, this meant that all jurisdictions were expected to report in order to get the funding provided under the plan. Funding arrangements and reporting compliance were endorsed by First Ministers in 2004.

And third, the 10-Year Plan mandated the Health Council of Canada to report annually on the health status of Canadians and health outcomes as well as to report on progress on all the components in the plan. The plan also gave CIHI the specific task of reporting on progress in reducing wait times across all jurisdictions. To ensure accountability to Canadians on health care renewal, the federal government financially supports the Health Council and CIHI. Since 2004, the Health Council has released four annual reports, as well as some reports on various components of the plan, while CIHI has published four annual reports on wait times. (See Appendix A for links to these reports.)

The reports required from the jurisdictions on the plan components and on the funding arrangements can be useful tools in assisting the Health Council and CIHI to fulfill their reporting mandates. However, not all jurisdictions report on progress as required under the plan and when reports are available, they do not always provide comprehensive or comparable information. In addition, some witnesses argued that Alberta and Quebec do not participate in the Health Council, leaving two provinces entirely outside the 10-Year Plan reporting mechanism. Moreover, it is difficult to monitor the progress of the components of the plan that are not subject to any reporting requirements.

The lack of standardized, uniform, comparable health data and information was noted as a serious barrier to monitoring and reporting on the implementation of the 10-Year Plan. The Committee was told that an F/P/T advisory committee was set up to develop common performance indicators to report on health care renewal, but it was disbanded after a year. Although that committee developed 18 indicators, witnesses stated that some are not useful for reporting on the components of the 10-Year Plan, while those with value are not widely used for public reporting. Without more standardized and collaborative reporting by all governments, Canadians cannot be confident that the new money and new practices intended to improve health care are making a difference.

Government officials who appeared before the Committee did not indicate whether the federal government has reported or will report on the components of the 10-Year Plan. The Health Council reports provided information on federal activities in the areas of home care and health human resources in 2005 as well as on wait times, pharmaceutical management, home care and primary health care in 2006. The 2007 report did not contain any federal information in its comparative jurisdictional tables, while the 2008 report did not include any comparative F/P/T tables at all. As such, to

date there is little information on progress achieved under the 10-Year Plan by the federal government.

With respect to provincial and territorial accountability, some witnesses were concerned that the federal government placed few conditions on the transfer payments provided under the 10-Year Plan. Similarly, the 2007 Health Council report noted: "We are unable to specify where the provinces and territories are investing funds from the federal health care agreements because no financial breakdowns are provided." The reporting provisions as stated in the 10-Year Plan were not included in the *Federal-Provincial Fiscal Arrangements Act*. It must be acknowledged, however, that most of the 10-Year Plan funding is provided under the CHT and, as such, falls under the purview of the *Canada Health Act* and its reporting requirements. The targeted funds for wait time reduction and medical equipment are easier to identify than those for the CHT. Nonetheless, most jurisdictions are not living up to their commitment to provide annual public reports on any of the funding elements in the 10-Year Plan.

Since jurisdiction over health care delivery is primarily a provincial/territorial responsibility, some witnesses argued that the federal government should only provide the funding, without linking it to conditions or objectives. Others, however, stressed that the federal government has a constitutional right – or duty – to use its spending power to achieve health objectives for the good of all Canadians. In their view, leadership by the federal government is required to maintain the integrity of the *Canada Health Act* and any withdrawal of leadership will result in a system that is increasingly fragmented. In addition, as the fifth largest provider of health services to meet the needs of its client groups, the federal government has a role as a direct participant.

The Committee was told that the F/P/T Advisory Committee on Governance and Accountability was a key partner for the Health Council as it would share information on how governments spend the funds provided under the 10-Year Plan. However, this intergovernmental committee has been disbanded and information on funding is not easily accessible or, in most cases, not available at all.

J. Dispute Avoidance and Resolution

Under the 10-Year Plan, First Ministers formally agreed to the Canada Health Act Dispute Avoidance and Resolution (DAR) process that was outlined in a 2002 letter of the Federal Health Minister.

The DAR process itself was not discussed during the Committee's hearings on the 10-Year Plan. Nonetheless, a number of witnesses raised the concern that the annual reports on the *Canada Health Act* do not provide sufficient information on matters concerning compliance (or lack thereof) under the legislation. They suggested that Health Canada use its discretionary powers to enforce the principles of the *Canada Health Act* with respect to transfer payments and report back to Parliament. Others recommended that the Auditor General of Canada perform an audit on the federal funds transferred to the provinces in support of health care delivery.

TOWARDS A COMPREHENSIVE HEALTH CARE RENEWAL AGENDA

The previous section assessed the extent or lack of progress achieved under each component of the 10-Year Plan on the basis of the testimony heard and briefs received during the hearings. In this section, the Committee makes recommendations to move forward on the comprehensive health care agenda set out in the plan, with a particular focus on the role of the federal government.

A. Reporting

Public reporting is a key component of the 10-Year Plan. It was agreed that Canadians would be kept regularly informed on the pace of health care reform and that they would be able to see how their governments were doing on meeting the 10-Year Plan commitments. Although some of the required reports have been prepared, and despite the work already done by the Health Council and CIHI, the reality is that jurisdictions have not reported to their citizens in a systematic and timely manner as initially agreed.

Unfortunately, this is particularly true for the federal government. When they appeared before the Committee, government officials did not provide details on the progress achieved by the federal government under each of the ten components of the 10-Year Plan. This information was requested in writing following a motion to that effect adopted on April 17, 2008 and again on June 4, 2008. Health Canada's response was received after the end of the Committee's deliberations and is provided in Appendix B of this report. The Committee is concerned that such information has not been provided in a timely manner. This would have greatly facilitated the statutory review of the 10-Year Plan. It is of paramount importance that all jurisdictions, including the federal government, provide the reports required under the 10-Year Plan.

On the basis of the testimony received, the Committee concludes that both the Health Council and CIHI comply with their requirement of reporting to the public on an annual basis. However, there appears to be no systematic and uniform reporting by all jurisdictions on the plan's implementation. This makes it difficult for the Health Council and CIHI to show Canadians how governments are doing on meeting their commitments under the 10-Year Plan. In its view, the provision of relevant information by all jurisdictions is needed to assess and report on progress in health care renewal and to make progress transparent to citizens. And again, this applies to all jurisdictions, the federal government included. Therefore, the Committee recommends:

> **RECOMMENDATION 1: That the federal government comply with the requirement of reporting on its progress on all components of the 10-Year Plan; that it fulfill this requirement by the end of the 2008-09 fiscal year; and that it encourage all jurisdictions to provide the required public reports within the specific 10-Year Plan deadlines.**

B. Data Collection

Monitoring and reporting on the implementation of the 10-Year Plan is further complicated by a lack of data and, when data do exist, by a lack of uniformity. As

mentioned earlier, wait time data are measured in diverse ways, statistics on health human resources are insufficient, multidisciplinary teams is not a term well defined, etc.

The Committee concurs with witnesses that the lack of consistent, comparable data creates significant challenges in evaluating reform and in reporting on progress. Despite the commendable work of existing organizations devoted to health information, the Committee and all Canadians need more data and comparable indicators, as well as the improved collaboration and sharing of information among all jurisdictions to assess progress on the 10-Year Plan. Therefore, the Committee recommends:

RECOMMENDATION 2: That the federal government, in collaboration with the provinces and territories and in partnership with the Health Council of Canada and the Canadian Institute for Health Information, agree on a set of comparable data and indicators to ensure proper assessment of progress under the 10-Year Plan; that the federal government ensure that this set of indicators is relevant to its client groups; and that this work be completed by the end of 2008-09 fiscal year.

C. Federal Funding

The Committee acknowledges that no legislative or other provision was put in place whereby the provinces would be penalized if they did not comply with the 10-Year Plan, leaving the provinces to be voluntarily accountable to their citizens, but not to the federal government. This is why improved public reporting by all jurisdictions on progress in health care renewal must be given priority, as the Committee's first recommendation suggests. Canadian taxpayers deserve greater transparency for the billions of tax dollars invested under the 10-Year Plan.

The Health Council's reports have noted repeatedly that, while the federal government provides its allocation estimates for each jurisdiction on the Department of Finance website, it does not provide separate reports for the populations under its own direct responsibility. Therefore, the Committee recommends:

RECOMMENDATION 3: That the federal government specifically report on funding provisions relevant to the populations for which it has direct responsibility.

D. Pan-Canadian Collaboration

When they agreed on the 10-Year Plan, First Ministers envisioned that governments would collaborate to solve common problems for the benefits of all Canadians, wherever they live. Numerous witnesses told the Committee about the need to revive the idea of a common pan-Canadian vision to strengthen health care and to put mechanisms in place to make this vision a reality.

Some mechanisms already exist, like the Pan-Canadian Health Human Resource Planning Framework, but it is not receiving the attention and support from all stakeholders that it must have to succeed. Canada Health Infoway is another existing

common pan-Canadian framework, which is dedicated to the development of electronic health records (EHRs) and telehealth, two other components of the 10-Year Plan. In these areas, progress could be accelerated through enhanced intergovernmental collaboration. And with respect to pharmaceutical management, the National Pharmaceuticals Strategy (NPS) has been established as a pan-Canadian framework to address pharmaceutical issues in a collaborative manner, but there has been little, if any, activity since 2006.

Other processes established to facilitate pan-Canadian collaboration have simply been disbanded, such as the Best Practices Network (primary health care reform) and the F/P/T Advisory Committee on Governance and Accountability (information sharing on funding provisions).

The Committee is aware that the reality of health care in Canada is that we do not have a single system, we have at least 14, including the care that the federal government delivers or directly funds. This reality presents challenges for coordinating reform on a large scale. But it agrees with witnesses that a coordination that transcends both geographic and political boundaries is needed to address the critical issues related to many components of the 10-Year Plan. Therefore, the Committee recommends:

> **RECOMMENDATION 4: That the federal, provincial and territorial governments publicly recommit to the nationwide collaboration envisioned in the 10-Year Plan; and that the federal government ensure collaboration among its client groups across the country.**

E. Aboriginal Health

Members on the Committee are concerned about the lack of information on progress in implementing the *Blueprint on Aboriginal Health*. Moreover, little is known about the promising Aboriginal Health Reporting Framework, which could significantly improve Canada's ability to understand and monitor the health status of Aboriginal peoples. Therefore, the Committee recommends:

> **RECOMMENDATION 5: That the federal government table a report to Parliament on the progress in the implementation of the *Blueprint on Aboriginal Health*, the development of the Aboriginal Health Reporting Framework, and specifically on the fulfillment of its work for First Nations and Inuit populations before the end of 2008-09.**

CONCLUSION

The Committee believes that these recommendations will accelerate the pace of progress of the *10-Year Plan to Strengthen Health Care*. In its view, the implementation of its recommendations will also facilitate the next statutory parliamentary review, which is to be undertaken in 2011.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1

That the federal government comply with the requirement of reporting on its progress on all components of the 10-Year Plan; that it fulfill this requirement by the end of the 2008-09 fiscal year; and that it encourage all jurisdictions to provide the required public reports within the specific 10-Year Plan deadlines.

RECOMMENDATION 2

That the federal government, in collaboration with the provinces and territories and in partnership with the Health Council of Canada and the Canadian Institute for Health Information, agree on a set of comparable data and indicators to ensure proper assessment of progress under the 10-Year Plan; that the federal government ensure that this set of indicators is relevant to its client groups; and that this work be completed by the end of 2008-09 fiscal year.

RECOMMENDATION 3

That the federal government specifically report on funding provisions relevant to the populations for which it has direct responsibility.

RECOMMENDATION 4

That the federal, provincial and territorial governments publicly recommit to the nationwide collaboration envisioned in the 10-Year Plan; and that the federal government ensure collaboration among its client groups across the country.

RECOMMENDATION 5

That the federal government table a report to Parliament on the progress in the implementation of the *Blueprint on Aboriginal Health,* the development of the Aboriginal Health Reporting Framework, and specifically on the fulfillment of its work for First Nations and Inuit populations before the end of 2008-09.

APPENDIX A

Annual Reports by the Health Council of Canada:

2005: *Health Care Renewal in Canada: Accelerating Change*
http://healthcouncilcanada.ca/en/index.php?page=shop.product_details&flypage=shop.flypage&product_id=39&category_id=14&manufacturer_id=0&option=com_virtuemart&Itemid=170

2006: *Health Care Renewal in Canada: Clearing the Road to Quality*
http://healthcouncilcanada.ca/en/index.php?page=shop.product_details&flypage=shop.flypage&product_id=32&category_id=14&manufacturer_id=0&option=com_virtuemart&Itemid=170

2007: *Health Care Renewal in Canada: Measuring Up?*
http://healthcouncilcanada.ca/en/index.php?page=shop.product_details&flypage=shop.flypage&product_id=20&category_id=14&manufacturer_id=0&option=com_virtuemart&Itemid=170

2008: *Rekindling Reform: Health Care Renewal in Canada, 2003-2008*
http://healthcouncilcanada.ca/en/index.php?page=shop.product_details&flypage=shop.flypage&product_id=92&category_id=14&manufacturer_id=0&option=com_virtuemart&Itemid=170

Annual Reports by the Canadian Institute for Health Information:

2005: *Understanding Emergency Department Wait Times: Who is Using Emergency Departments and How Long are They Waiting?*
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_451_E&cw_topic=451&cw_rel=AR_1266_E

2006: *Waiting for Health Care in Canada: What We Know and What we Don't Know*
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_549_E&cw_topic=549&cw_rel=AR_1385_E

2007: *Wait Times Tables – A Comparison by Province, 2007*
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1909_E

2008: *Wait Times Tables – A Comparison by Province, 2008*
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1909_E

APPENDIX B

Forwarded by e-mail to the Clerk of the Committee on Tuesday, June 10, 2008 at 10:15 a.m.

Carmen DePape
Clerk, Standing Committee on Health
Sixth Floor, 131 Queen Street
House of Commons
Ottawa ON K1A 0A6

Dear Ms. DePape:

I am writing in response to the June 5, 2008 motion adopted by the Standing Committee on Health,

> That the Ministry of Health, together with the Public Health Agency of Canada, table by June 10, 2008 their analysis of the progress to date in each of the sections of the First Ministers' Meeting on the 2004 Health Accord, as previously requested by the Committee on April 17, 2008; and that the Provinces not be bound by the current motion.

In our response to a similar motion from the Committee, dated April 17, 2008, we supplied the most comprehensive information available from the Health Council of Canada on progress on each of the aspects of the 2004 Accord.

As the current motion asks specifically for analysis by Health Canada and the Public Health Agency of Canada, we are pleased to provide the Committee with an analysis of implementation of each of the 10 aspects of the Accord, which was prepared for our internal use prior to our appearance before the Committee on this matter.

I wish the Committee every success in its deliberations.

Yours sincerely,

Karen L. Dodds, Ph.D
Assistant Deputy Minister

Enclosures (10)

ANALYSIS OF IMPLEMENTATION

REDUCING WAIT TIMES AND IMPROVING ACCESS

F/P/T governments are making significant progress on their commitments in the 2004 Health Accord to achieve meaningful reductions in wait times and to collect and provide information to Canadians on their progress.

Reducing Wait Times

2004 Health Accord Funding

The Government of Canada has met its commitment under the 2004 Accord by providing $5.5 billion to provinces and territories through the Wait Times Reduction Fund, as part of $41 billion in additional federal transfers over 10 years to strengthen health care. The Wait Time Reduction Fund has allowed P/Ts to augment their existing investments to support diverse initiatives to reduce wait times. Investing in this way recognizes the P/Ts' responsibility for the delivery of health care and supports their efforts to ensure timely access to quality care.

National Wait Times Initiative

In addition, the Government of Canada has invested in the development and dissemination of knowledge to inform wait times management and reduction strategies through the National Wait Times Initiative (NWTI). Budget 2005 originally allocated $15 million over four years for the NWTI, in order to support wait times initiatives that would build on and complement P/T initiatives. However, as the 2005 Supplementary Estimates were not passed, the NWTI did not receive the first year's $2 million allocation. As a result, the NWTI was budgeted for $13 million over three years (2006/07 to 2008/09).

Examples of outcomes to date include: new partnerships between surgeons, other health care professionals and provincial governments to improve management of wait times for orthopaedic surgery; the adoption of lessons learned through a model to promote appropriateness of diagnostic imaging; and the establishment of the first national database on paediatric surgical wait times.

Benchmarks

On December 12, 2005, governments announced ten common wait times benchmarks in the four priority areas of cardiac and cancer care, joint replacements and sight restoration. These benchmarks, based on research and clinical evidence, cover hip and knee replacements, hip fracture fixation, cataract surgery, breast and cervical cancer screening, and radiation therapy for cancer and cardiac bypass surgery.

While governments have not yet established an evidence-based benchmark for diagnostic imaging, this is in large part because appropriate use of such technologies and associated evidence on acceptable wait times are under debate. Governments have committed to develop more benchmarks as new evidence is produced and are collaborating with the Canadian Institutes of Health Research and clinicians on work that could support the establishment of additional benchmarks.

Targets

In the 2004 Accord, P/Ts committed to establish multi-year targets to achieve priority benchmarks by December 31, 2007. As of March 2008, five provinces (Alberta, Ontario, Quebec, Prince Edward Island and Saskatchewan) had declared targets. These sets of targets vary; only Alberta has publicly declared targets in relation to all the benchmarks. Saskatchewan's publicly available surgical targets were established prior to the

2004 Accord. Quebec's targets are tied to its guarantee of access as set out in Bill 33. In addition, several provinces (Manitoba, Nova Scotia and New Brunswick) have publicly stated that they remain committed to establishing targets. It is important to note that all P/Ts have stated that they consider the benchmarks to be goals they will strive to meet.

Wait Time Reductions

Since the 2004 Accord was signed, governments have implemented a variety of measures to reduce wait times, particularly in the five priority areas specifically identified (cancer, heart, diagnostic imaging, joint replacements and sight restoration). P/T strategies to improve the way wait times are monitored, measured and managed include:

- building capacity;
- using technology to monitor and measure wait times;
- managing access to help patients navigate the health system;
- clarifying how hospitals, health service organizations and health providers are responsible for making health care more accessible and accountable to Canadians; and,
- evaluating patients' access to health care and health outcomes to help governments determine where resources should be directed for the most effective results.

While activities and progress vary across clinical areas and jurisdictions, all P/Ts are working to achieve further reductions in wait times within and beyond the five priority areas. Concrete improvements have been achieved as a result. For example:

- In Alberta, 90% of patients were receiving cardiac bypass surgery within 11 weeks in January 2008, down from 17.5 weeks in January 2007.[1]
- In Manitoba, the median wait time for cancer radiation therapy was one week in January 2008.[2] In 1999, cancer patients would have waited six weeks or longer for this treatment.[3]
- In Ontario, between November 2004 and April 2007, wait times for hip replacements dropped by 27% (or 94 days), while waits for knee replacements fell 30% (or 133 days) and wait times for cataract surgery decreased 41% (or 128 days).[4]
- The Quebec government has reported sharp reductions in long waits for such procedures as cataract surgery (down 64%) and hip and knee surgery (down 45% and 60% respectively) between 2003 and 2007.[5]
- In Nova Scotia, the rate of mammograms for women 50-69 years old has nearly doubled since the start of the decade, and the average wait time for mammography screening in hospitals dropped from 44 weeks in 2005 to 11 weeks in 2006.[6]

[1] Alberta Health and Wellness Waitlist Registry, Monthly Provincial Trends Report - Selected Interventions (AWR - 1003), for 13 months ending January 2008. Available: http://www.ahw.gov.ab.ca/waitlist/DownloadTrendReports.jsp (Accessed: March 31, 2008).

[2] Manitoba Health, Manitoba Wait Time Information. Available: http://www.gov.mb.ca/health/waitlist/radiation/body.html (Accessed: March 27, 2008).

[3] Manitoba Health, "Working for Better Health Care Sooner: Report to Manitobans on Health Care Services", (May 2006). Available: www.gov.mb.ca/health/waitlist/report2006.pdf

[4] Ontario Ministry of Health and Long-Term Care, News Release (April 27, 2007). Available: www.health.gov.on.ca/english/media/news_releases/archives/nr_07/apr/nr_20070427_2.html

[5] Philippe Couillard, Journal des débats, Assemblée nationale du Québec (October 16, 2007).

[6] Health Council of Canada, *Wading through Wait Times* (June 2007).

Recognizing these efforts, in 2007, the Health Council of Canada reported that a significant amount of activity was underway in every jurisdiction, and the Wait Time Alliance noted that progress has been made in reducing wait times. The Canadian Institute for Health Information (CIHI) recently reported that the number of surgeries in priority areas for wait times reductions increased by 7% in 2005-06 from the previous year, while surgeries outside the priority areas increased by 2%.

Patient Wait Times Guarantees

One of the federal government's current priorities is to support the development and implementation of Patient Wait Times Guarantees (PWTGs) across the country. In Spring 2007, all P/Ts agreed to establish a PWTG in a priority area by 2010. This commitment to establish PWTGs marks a new milestone in wait times reduction efforts. Guarantees will move the health care system further toward more responsive patient-centred care, providing patients with greater certainty of timely access.

PWTGs include two key elements:

- a defined time frame to establish when medically necessary health care services should be delivered; and,
- access to alternative care options that are automatically offered to patients if the system fails to deliver treatment within the defined time frame.

As committed in Budget 2007, more than $1 billion in new federal funding is being provided to P/Ts and Canada Health Infoway to support the development and establishment of PWTGs. This includes:

- $612 million for a Patient Wait Times Guarantee Trust, which will assist P/Ts in their diverse initiatives to improve certainty of timely access to insured health care services. Under the guiding principles of the PWTG Trust, P/Ts may choose to:
  - build surge capacity to meet a PWTG;
  - reconfigure service delivery to facilitate improved use of system resources;
  - purchase new or replacement medical equipment necessary to realize a PWTG;
  - train and hire health care professionals, including patient navigators or care coordinators;
  - support patient travel assistance for timely care within or outside the home jurisdiction;
  - develop and implement wait times management practices and efficiency measures to improve patient flow; and,
  - develop and implement public, patient and provider education related to the introduction and implementation of a PWTG.
- $400 million in funding to Canada Health Infoway, to support the implementation of guarantees through the development of health information systems and electronic health records.
- A $30 million PWTG Pilot Project Fund, which will assist P/Ts in testing innovative approaches PWTGs, including options for alternate care (recourse) when time frames are exceeded. To date, three pilot projects have been announced under this initiative:
  - Nova Scotia will receive up to $8 million for two pilot projects which will test PWTGs in the areas of diagnostic imaging and orthopaedic surgical services.
  - Manitoba is receiving up to $5.8 million for a pilot project which will streamline referrals from general practitioners to specialists, in areas including cancer services orthopaedics, ophthalmology and mental health.
  - Contribution agreements for seven other PWTG pilot projects have been finalized, for innovative projects across a range of clinical areas.

The Government of Canada is also funding four federal pilot projects to test guarantees:

· In November 2006, the Government of Canada announced the development of two pilot projects in the areas of diabetes and prenatal care in selected First Nations (FN) communities. Funding for these two pilot projects come from existing First Nations and Inuit Health Branch (FNIHB) programs.

- On January 5, 2007, the Government of Canada announced that Saint Elizabeth Health Care would receive up to $3.7 million over 18 months for a pilot project to establish a wait times guarantee in the area of diabetic foot ulcer care for First Nations people living on reserve in Manitoba. This pilot project is funded through the NWTI.
- On January 11, 2007, the Government of Canada announced a pilot project in the area of paediatric wait times. The Hospital for Sick Children (SickKids), on behalf of Canada's 16 Paediatric Academic Health Science Centres (PAHSCs), is receiving up to $2,901,678 over 15 months for a pilot project that will improve access and certainty of timely care for paediatric surgery. This pilot project is funded through the NWTI.

The work on guarantees builds on governments' accomplishments to date on wait times and contributes to overall improvements in the health care system.

Public Accountability

Comparable Access Indicators

In March 2006, P/T governments endorsed comparable indicators of access to healthcare professionals, diagnostic imaging, joint replacement, sight restoration and cancer and cardiac care. P/Ts have worked with CIHI on the further development of data and definitions for reporting on comparable access indicators. CIHI noted in February 2008 that while "publicly available wait time information has increased significantly over time," comparable provincial data are still evolving. CIHI points to initiatives in many jurisdictions to improve data quality, while noting that the variations across provinces in wait time measures mean that reported wait times are not yet comparable from one jurisdiction to the next.

Reporting

All jurisdictions have taken steps to inform their residents about wait times through such means as public reports and news releases and websites. In fact most P/Ts are now reporting regularly on publicly accessible websites dedicated to wait times information. While the quality of reporting varies by jurisdiction, the Health Council in 2007 noted "a significant step forward" in wait times reporting. In February 2008 CIHI reported that publicly available wait times information has "increased significantly," with provinces reporting on more priority areas, providing more recent data and enhanced detail. CIHI also noted that many provinces are working to improve the quality of their wait times information and that it has become possible to look at progress over time in selected priority areas in some provinces.

CIHI has met its commitment to report on progress on wait times across jurisdictions. For example, it has released three annual editions of *Wait Times Tables - A Comparison by Province*, the most recent in February 2008, as well as *Waiting for Health Care in Canada: What We Know and What Don't Know* (March 2006). The Heath Council of Canada also releases regular updates on wait times progress as well as full reports on the issue, such as *Wading Through Wait Times: What Do Meaningful Reductions and Guarantees Mean?* (June 2007). In addition, Statistics Canada's *Health Services Access Survey* provides a comparable measure of Canadians' experiences and perceptions at the national and provincial level.

Health Council of Canada Comments

The Health Council of Canada in June 2007 released a report, *Wading Through Wait Times: What Do Meaningful Reductions and Guarantees Mean?*, which provided an update on progress in reducing wait times in the five priority areas set out in the 2004 Accord. The report noted that there is a significant amount of activity underway to improve wait times in every jurisdiction, and suggests that P/T public reporting on wait times has made a "significant step forward". Citing "a lack of comprehensive and comparable data," which are important

to track progress, the report was not conclusive on whether meaningful reductions were achieved by the March 2007 deadline.

ANALYSIS OF IMPLEMENTATION

HEALTH HUMAN RESOURCES

Overall, there has been substantial progress in meeting the 2004 Accord health human resources (HHR) commitments, with progress in HHR planning reported in every jurisdiction across Canada. The majority of the jurisdictional **HHR Action Plans** were posted on the Health Council's web site by December 2005. The two remaining jurisdictions (British Columbia and the Yukon) are in the final stages of their consultation processes and will release plans shortly.

The jurisdictional Action Plans build on the health renewal agenda established in the 2003 Accord and benefited from the work funded by the federal government through its pan-Canadian HHR Strategy. It was agreed in the 2004 Accord that the HHR Action Plans would build on ongoing work in four areas (i.e., **health labour relations, interdisciplinary (interprofessional) education, investments in post-secondary education, and credentialing of health professionals**). A few highlights follow:

- Partnering jurisdictions have access to information on health sector **labour relations** collected in a Cross-Jurisdictional Labour Relations Database which is supported by F/P/T funding. British Columbia initiated this project in 2002 and continues to have the lead for database development and implementation across the country.

- **Interdisciplinary training** (now referred to as Interprofessional) and **investments in post-secondary education**: Jurisdictions are benefiting from twenty learning projects that have been funded through the HHR Strategy's Interprofessional Education for Collaborative Patient-Centred Practice. The goal of this initiative is to further interprofessional training in post-secondary education institutions so that health professionals have the attitudes, skills, knowledge and behaviours to work effectively in interprofessional teams.

- A new process for managing proposals to change **entry-to-practice credentials for health professions** was approved by F/P/T Ministers of Health in 2004 and is now contributing to HHR planning activities. This process aims to provide a consistent, unbiased assessment of proposals, while still meeting jurisdictional requirements.

The F/P/T governments continue to implement the ***Pan-Canadian Framework for Collaborative HHR Planning***. This framework was funded and developed by the F/P/T Advisory Committee on Health Delivery and Human Resources and endorsed by the Council of Ministers of Health (Quebec agreed in principle) in June 2005. The framework has an Action Plan with goals and objectives, as well as activities that have been designated as either short-, medium- or long-term priorities.

The Government of Canada allocated $75 million to the **Internationally Educated Health Professionals Initiative**. The Initiative reflects collaboration among federal departments, P/T governments, regulatory bodies, educational institutions, employers, professional associations and immigrant settlement organizations and contributes to solutions to reduce HHR shortages in Canada. It is aimed at immigrant health professionals who are living in Canada, but are unable to practice in their chosen professions. The Initiative supports a range of upgrading programs, communication courses, assessment tools and other programs that are increasing access to licensure and employment in Canada among highly skilled immigrants.

The number of internationally educated health professionals (IEHP) who have been assessed has increased. The Internationally Educated Health Professionals Initiative has allocated funding to Nova Scotia, British Columbia and Ontario through its provincial and territorial funding stream, to create new centres and services for IEHPs

within their jurisdictions. These centres provide front end information, counselling and referral to ensure that IEHPs can quickly access the services and supports they need. In Ontario, federal funding has been allocated to expand assessment services at the Centre for the Evaluation of Health Professionals Educated Abroad to include professions beyond medicine. This approach capitalizes on existing Ontario expertise in international medical graduate assessment and builds capacity for other health professions.

Alberta's model for the assessment and integration of internationally educated nurses is being expanded to jurisdictions across Western and Northern Canada and in Nova Scotia. In 2007/08, the Government of Canada, through the IEHPI, also funded a pilot project in the amount of $536,112 to allow internationally educated nurses to be assessed prior to immigrating to Canada, thereby expediting the licensure process.

The Faculty of Pharmacy at the University of Toronto is receiving $1,065,415 to develop and pilot a pan-Canadian orientation program for IEHPs. This program meets a common need for a structured and systematic orientation to the many dimensions of practising as a health care provider in Canada. The program is being piloted at sites across the country and will also be offered through on-line delivery to allow the curriculum to be accessed by all IEHPs seeking to practice in Canada regardless of geographic location, potentially including those individuals seeking information about the Canadian health care system before immigrating to Canada.

Efforts to **increase the supply** of health human resources in Canada are already showing progress. As noted by the Canadian Institute for Health Information (CIHI), the number of practising physicians in Canada reached 62,307 in 2006, increasing by 4.9% since 2002, a rate that exceeds population growth (4.0%). In addition, the supply of interns and residents has also been increasing. In 2006, there were 8,563 interns and residents, an increase of 7.1% over the 7,997 that were in the system in 2005.[7] As well, CIHI reports that in 2006 there were 325,299 nurses as opposed to 321,590 in 2005, an increase of 1.2%.[8]

Specific Federal Commitments

There has been substantial progress in meeting federal commitments in the 2004 Accord. The following is merely an overview:

- ***Accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments:***

  Notable accomplishments have been achieved through the federal government's $75 million Internationally Educated Health Professionals Initiative. Early successes have resulted, in part, from effective collaboration between federal departments working in close partnership with P/T governments and a range of non-governmental organizations. A sample of accomplishments include:

  - The creation of web portals and other communication tools that provide access to clear and relevant information about licensure and practice in Canada. For example, website traffic on www.img-canada experienced a 79% increase between July 2006 and June 2007 from the same time-period a year prior.

[7] *The Supply, Distribution and Migration of Canadian Physicians*, 2006, CIHI

[8] *Highlights From the Regulated Nursing Workforce in Canada*, 2006, CIHI

- Close to 4,000 internationally educated health professionals have benefited from newly created counselling and assessment services, and from centres offering specialized advice and programs on licensure and employment.
- A multi-media faculty development program for physicians has been developed and is now in use in every faculty of medicine across Canada.
- Upgrading orientation programs to quickly fill skill gaps are being developed for physiotherapists, nurses, midwives, medical laboratory technologists and medical radiation technologists.

- ***Targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities:***

The federal government established the **Aboriginal Health Human Resources Initiative** (AHHRI), which identified four targets to reach its goals:

Double the number of Aboriginal health career scholarships/bursaries in 5 years:
- The AHHRI has increased the amount of funding available to Aboriginal health career students from $500K in 2004 to its present level of $3M per year, tripling the number of bursaries and scholarships that are awarded each year.

Double the number of Aboriginal health professionals in 10 years:
- The increased number of bursaries and scholarships now being awarded is leading to increases in the number of Aboriginal health career students, which will translate into increases in the number of Aboriginal health career professionals over the next several years.

Increase the number of certified health directors/administrators on reserves by one third in 5 years:
- Work is now underway with the Assembly of First Nations which will lead to the development and validation of core competencies for health managers on reserve within the next year. This process will result in certification through accredited educational institutions for all First Nations health managers.

A 50% increase in the number of post-secondary educational institutions with support programs for Aboriginal health care students in five years.
- Work is underway across Canada to implement student support programs for Aboriginal health career students. They expect to meet this target in the next two to three years.

The P/T governments have participated in the AHHRI through representation on F/P/T Advisory Committees to facilitate linkages to P/T health human resources plans. As well, Saskatchewan and Manitoba have formed strong partnerships with the First Nations and federal partners at the regional level to work jointly on a number of AHHRI projects. British Columbia, through its recently signed *Tripartite First Nations Health Plan*, is also actively engaged in HHR planning with the AHHRI and First Nations.

Health Canada's **Official Language Minority Community Program** was allocated $75 million over five years (2003/04 to 2007/08) to fund projects to improve access to health services (in the official language of choice) for those living in such communities. The federal government is also funding two additional projects that target efforts to these communities:

Consortium National de Formation en santé is receiving $1 million over four years (2006/07 to 2009/10) from the Internationally Educated Health Professionals Initiative. The project promotes training and integration of internationally trained francophone health care professionals who want to be licensed to practice in Canada.

Consortium National de Formation en santé is receiving $1.2 million over six years (2007/08 to 2012/13) from the pan-Canadian HHR Strategy. The project aims to encourage the planning and training of French-language HHR according to the current and future needs of the francophone linguistic minority communities.

· ***Participate in HHR planning with interested jurisdictions.***

As noted above, the federal government is working collaboratively with the P/T governments to implement the pan-Canadian Framework for Collaborative HHR Planning. An accompanying Action Plan focusses on four areas:

- planning for the appropriate number and mix of health care professionals;
- working closely with employers and the education system to develop a workforce that has appropriate skills and competencies;
- achieving the appropriate mix of health care providers and deploying them in appropriate models of care, and
- building a sustainable workforce with healthy workplaces.

Federal populations

The federal government has direct healthcare responsibilities on two fronts. It is responsible for ensuring delivery of health services to specific client groups within the Canadian population and for the overall health of the Canadian population in the context of pandemic outbreaks and domestic healthcare crises.

In 2005 the six permanent members of the Federal Healthcare Partnership (Citizenship and Immigration, Correctional Service, National Defence, Health Canada, the Royal Canadian Mounted Police and Veterans Affairs) developed and published a *HHR Action Plan - Status Report*. In July 2006, the Federal Healthcare Partnership established a Health Human Resources Committee to:

- identify and deal with common challenges related to health human resources in their respective healthcare programs;
- allow a better understanding of barriers/obstacles federal organizations are experiencing; and
- provide recommendations to address issues faced by personnel in the health services sectors who are delivering care to populations under federal jurisdiction.

As a first priority, the Committee completed a pilot project to study recruitment and retention of federally employed physicians. A final report, entitled *Study on Recruitment and Retention of Federal Physicians*, was published in March 2007. It provides valuable information from each of the six federal organizations regarding shortages of federally employed physicians. The study also identifies key challenges facing federally employed physicians and puts forward six recommendations for facilitating recruitment and retention of physicians for the federal public service.

Future Progress

F/P/T Collaboration:

The F/P/T Advisory Committee on Health Delivery and Human Resources is currently implementing *the pan-Canadian Framework for Collaborative HHR Planning.* The Action Plan, which includes short-, medium- and long-term priorities, is being used to guide priority setting for the next phase of the Strategy. Health Canada will continue to promote collaboration with health stakeholders. It will also extend collaboration to the education and labour market sectors.

Internationally Educated Health Professionals Initiative:

A key focus for the internationally educated health professionals initiative (IEHPI) will be the harmonization of assessment standards and processes for internationally educated nurses and international medical graduates (IMGs) across the country. Building on the important foundational work that has been achieved to date on creating a more streamlined, consistent and transparent approach to IMG assessment, work will focus on both the assessment of IMGs into the postgraduate medical training system and the completion of "practise ready" assessments that will enable IMGs to fast-track through the licensure process and enter practice.

A further focus for the IEHPI will be the full implementation of the over 50 programs that have been launched since the initiative began. These will create new bridging programs; centralize and make more easily accessible information sources for internationally educated health professional; build collaborative partnerships; and transfer knowledge across jurisdictions and professions.

Health Canada, in partnership with other federal departments, will continue to bring together provinces/territories and health professions on an annual basis to share progress on the IEHPI, facilitate linkages and undertake strategic planning to identify common policy priorities in working to accelerate and expand the assessment and integration of internationally educated health professionals in Canada.

REPORTING COMMITMENTS

Twelve out of fourteen jurisdictions completed **HHR Action Plans** and these are posted on the Health Council of Canada's web site. The two remaining jurisdictions (British Columbia and the Yukon) are in the final stages of their consultation processes and will release plans shortly.

STAKEHOLDER PERSPECTIVES

Health Council of Canada comments

The Health Council's 2005 Annual Report acknowledges the important role of HHR, saying that training of health professionals in teams in sufficient numbers was an urgent priority and that "without sufficient providers of care working together, all other efforts will flounder." The report outlines five priority areas to improve Canada's health care workforce:

- Focus aggressively on increasing the number of interprofessional education and training programs available in Canada.
- Clarify and report to the public on who will provide what services, especially in Primary Health Care.
- Remove barriers to optimizing skills sets.
- Integrate provincial, territorial and regional health workforce plans.
- Make decisions about supply in conjunction with addressing scopes of practice issues.

The Health Council's 2006 Annual Report highlights HHR improvements including progress in implementing interprofessional education programs, increased medical and nursing school enrolments, the initiation by P/Ts of recruitment and retention strategies, and the establishment of a Pan-Canadian Human Resources Planning Framework.

In the same report, the Council also expressed concern over issues such as competition for HHR among jurisdictions, the lack of well defined recruitment and retention targets in some provinces, and the absence of a national plan for future delivery models.

The Council's analysis led to two key recommendations:

- Promote coordinated national/provincial/territorial strategies on HHR, with specific targets based on the health care needs of their populations, and create a national coordinating mechanism; and

- Develop appropriate measurement tools so that Canadians can evaluate whether investments in health human resources are resulting in improved patient access, better coordination of care, and improved outcomes.

ANALYSIS OF IMPLEMENTATION

HOME CARE

Based on the available information, there has been varying degrees of progress on meeting the commitments, with some jurisdictions clearly providing all elements of the agreed-upon home care commitment at first-dollar coverage, while others have partially met the commitments. Some jurisdictions provide some home care services, but may not be able to provide all elements of each basket item (e.g., intravenous medications related to the discharge diagnosis, case management, crisis response and personal care).

Short-term acute (i.e. following hospital discharge) home care and end-of-life services have progressed the furthest, although not all services specified are currently available in all jurisdictions at first-dollar coverage. In particular, the availability of personal care services on a first-dollar basis varies among jurisdictions.

In terms of **palliative care**, first-dollar coverage for case management and nursing at the end-of-life is generally provided where jurisdictions have well-integrated home care programs. Access to pharmaceuticals for palliative care clients is variable. Where it exists, it may be delivered through a palliative-specific pharmaceutical plan; in other jurisdictions, necessary drugs may be covered under existing plans for target populations (e.g., those for seniors, persons with cancer or AIDS, or with special financial needs or disabilities). Many jurisdictions provide personal care for palliative care patients, but not necessarily with first-dollar coverage.

Short-term acute community mental health home care is the least advanced service in many jurisdictions and remains the most difficult commitment to meet.

The health care service delivery structure of many P/T systems means that most home care services are delivered at a local level through regional health authorities (such as Local Integrated Health Networks (LHINs) in Ontario, and *Centres locaux de services communautaires* (CLSCs) in Quebec). Therefore, there may also be variations within provinces and territories with regard to service provision.

Federal Accomplishments

Veterans Affairs Canada (VAC) has one of the most comprehensive national home care programs and exceeds the 2004 Health Accord home care commitments. VAC continues to evaluate and augment the Veterans Independence Program (VIP) in response to changing needs of eligible clients. Many of the services offered are based upon eligibility and need and include screening and assessment tools, ground maintenance, and housekeeping and personal care services. All benefits and services must be pre-authorized by VAC. The VIP offers nursing care to clients but not continuous nursing (i.e., on-going care of more than two hours per day by a registered nurse). Budget 2008 provided $282 million over three years to ensure that surviving primary caregivers in need receive the help they require to remain independent in their own homes.

Health Canada's First Nations and Inuit Home and Community Care program is funded to provide basic home and community care services (nursing, case management, respite and personal care) to people with chronic or acute illness, disabilities and the elderly in their home communities.

Health Council comments

As the deadline for reporting on progress on home care was December 31, 2006, until recently the Health Council had little opportunity to assess progress (its third annual report, issued in February 2007, did not have the benefit of the December 2006 reporting). Generally speaking, the Health Council has expressed concern regarding the lack of reporting and data collection challenges.

In a January 2008 report, the Health Council noted that in 2005, 2-5% of Canadians used home care services while 3-4% of seniors 65 years of age and older said they needed home care services they did not receive. The Health Council noted that while governments have expanded home care services since the 2004 Accord, more needs to be done. It notes that in 2006, one in four Canadians said they cared for a family member or close friend with a serious health problem in the last 12 months, with 22% of those caregivers missing one or more months of work and 41% using personal savings. The report recommends that all jurisdictions expand their coverage of home care services and make this expansion a priority in health care renewal.

Report:
Fixing the Foundation: An Update on Primary Health Care and Home Care Renewal in Canada, January 2008.

ANALYSIS OF IMPLEMENTATION

PRIMARY HEALTH CARE AND ELECTRONIC HEALTH RECORDS

Primary Health Care

50% have 24/7 Access

Though all provinces and territories (P/Ts) have introduced variations of multidisciplinary teams, most Canadians still do not have 24/7 access to high-quality primary health care. PHC is still chiefly delivered by family physicians, most of whom provide services only during office hours.

Most P/Ts have **telephone information lines** providing 24/7 access to health advice.

Through the $800 million **Primary Health Care Transition Fund (PHCTF)** from 2000 to 2006, there was a significant amount of PHC renewal activity. Since then, many provincial/territorial governments have sustained renewal activity in the sector.

Most jurisdictions continue to implement some form of PHC renewal post-PHCTF. In some cases, provinces are encouraging the uptake of a particular model (e.g., Primary Care Networks in Alberta or Family Health Teams in Ontario), while others are encouraging certain activities, such as improved chronic disease management, within existing frameworks. To this end, many P/Ts have devoted substantial funding to PHC activities, and Alberta was a leader in this regard, using $100 million of its Health Reform Transfer allocation to its Primary Care Network initiative.

Best Practices Network

Health Canada funded and led three events under the **Best Practices Network** commitment. The Canadian Health Services Research Foundation has developed a Primary Healthcare Network designed to promote partnerships and knowledge exchange between decision makers, policy makers and researchers throughout Canada.

Future Work on Primary Health Care Renewal

Notwithstanding concerns that activity in primary health care renewal might lag or slow down following the wrap-up of the PHCTF, in fact many jurisdictions have sustained momentum and devoted significant resources to PHC activities. As noted, most P/Ts continue to support key targeted areas of PHC reform in their jurisdictions (for example, continued implementation of information and communication technology in Alberta, enhanced chronic disease management throughout British Columbia, and emphasis on evaluation, and therefore ability to report on system change, in Saskatchewan).

Future efforts should continue to support the shift to team-based care. PHC has a significant role to play in the prevention and management of age-related illness, as well as ensuring continuity of care (across sectors and over time). Better management of chronic conditions within the primary health care sector through a team-based approach will contribute to reducing the incidence of complications and secondary illnesses.

Health Council comments

The Health Council has placed a very high premium on the role of primary health care renewal in health care system reform. Recent reports have acknowledged that progress is occurring, but are qualified in their assessment.

The Health Council released a report on primary health care and home care renewal in January 2008 which noted that the vast majority of Canadians (96 percent) report having either a regular medical doctor or regular place they go to for primary health care. However, the Health Council also reported that one-quarter of people who needed care for minor health problems had difficulty getting timely appointments. More than one-third of people who used an emergency department believed their conditions could have been treated by their family doctor if he/she had been available. The Health Council recommended several measures to accelerate change: 24/7 access to health information and care providers, electronic patient records and interprofessional primary care teams.

Report: *Fixing the Foundation: An Update on Primary Health Care and Home Care Renewal in Canada*, January 2008.

Electronic Health Records (EHRs)

All jurisdictions are working with Canada Health Infoway (Infoway) to implement EHRs and telehealth, and it would be fair to conclude that there has been an acceleration of efforts by P/Ts on both telehealth and the electronic health record.

All P/T's have accelerated the development and implementation of the **EHR** commitment in their jurisdictions, in part by working on projects with Canada Health Infoway.

Infoway has also invested in P/T projects to expand and sustain **telehealth** initiatives in Canada including Aboriginal, rural and remote communities. Infoway also continues to work on linkages between telehealth and electronic health records systems, and the integration of telemedicine activities into mainstream healthcare service delivery. Telehealth strategic plans are now in place in most jurisdictions, with the goal of implementation of telehealth solutions by all jurisdictions by December 31, 2009.

Since 2001, the Government of Canada has provided $1.6B, including $400M in Budget 2007, to Infoway to support the development and adoption of health information systems, including electronic health records, public health surveillance systems, telehealth and tools to support wait times reductions.

<u>Future Work on EHRs and Telehealth</u>

Canada's goal for Electronic Health Records by all F/P/T jurisdictions with Infoway was initially set out in 2002-03. Canada's goal for EHR development (agreed to by all jurisdictions) is for 50% of Canadians to have an electronic health record by 2009 (the target date was subsequently changed to "by the end of 2010").

Adoption of health information technologies by clinicians and other health professionals is key to successful EHR implementation. This requires change management strategies, including training; Infoway and most jurisdictions are working on this issue.

<u>Health Council comments</u>

The Health Council believes that electronic information management systems offer tremendous potential to reduce error and improve patient safety, through the timely transmittal of accurate information. According to the Health Council, about one half of Canada's 13 P/T jurisdictions are doing very well on EHR development, comparing favourably to the "ambitious plan/associated investment' aspect mentioned in the Accord. While the Health Council has acknowledged the progress that Infoway and P/Ts have made, the Council believes progress on the EHR is too slow and the goals too low, and in its 2006 Annual Report released in February 2007, for the second year in a row, called for 100 percent coverage of EHRs for all citizens by 2010, well ahead of Infoway's goal of a fully interoperable EHR for 50 percent of Canadians by 2010.

In its January 2008 report on primary health care renewal, the Health Council noted that the majority of physicians in Canada still rely on hand-written records. The Health Council noted that while more than $1 billion has been spent on implementing EHRs, only 5 percent of Canadians have an electronic health record. The Health Council urges all jurisdictions to make this a priority.

Report: *Fixing the Foundation: An Update on Primary Health Care and Home Care Renewal in Canada*, January 2008.

ANALYSIS OF IMPLEMENTATION

ACCESS TO HEALTH CARE IN THE NORTH

The federal and territorial governments are meeting their commitments on improving access to health care in the North.

Following the Accord, the $150 million commitment became the Territorial Health System Sustainability Initiative (THSSI) and was divided into three separate funds:

1. **Medical Travel Fund** ($75 million over five years): provided as an annual grant to each territorial government in order to offset the high cost of providing medical transportation.
2. **Territorial Health Access Fund** ($65 million over five years): provided equally to each territory to support health reform activities that address one or more of the following three broad goals:
   - to reduce reliance over time on the health care system;
   - strengthen community level services; and
   - build self-reliant capacity to provide services in-territory.
3. **Operational Secretariat Fund** ($10 million over five years): provided to support the activities of the Federal/Territorial (F/T) Assistant Deputy Ministers' Working Group, and to fund a number of pan-territorial projects.

Medical Travel Fund

The Medical Travel Fund has been provided annually by the federal government to territorial governments. The grant directly offsets territorial medical travel costs, allowing territories to re-allocate resources to address other priorities. Health Canada funds approximately 50 percent of medical transportation costs in each of the territories.

Territorial Health Access Fund

Each territory has developed and is implementing a Territorial Health Access Fund workplan to undertake long-term health reforms. Each territory has dedicated substantial resources from the THAF towards health human resources issues such as recruitment and retention, training, scope of practice/regulatory, and professional development. Other THAF initiatives include the establishment of pilot projects for cancer screening, addressing mental health issues, enhancing emergency preparedness measures, and supporting a Nurse Info Line.

As part of their THAF workplan, the Northwest Territories is implementing an Integrated Service Delivery Model (ISDM) throughout their Health and Social Services System. The ISDM emphasizes the importance of building regional and territorial support teams. It has three key elements: service integration and professional collaboration; organizational integration; and a set of core services available within the health and social services system. The ISDM is the guiding strategic direction within the NWT health and social services strategic plan, system action plan and the Regional Health Authorities strategic and business plans.

The Yukon has initiated a comprehensive Health Human Resources (HHR) Strategy using THAF resources. The strategy will establish Nurse Practitioner regulations, solidify baseline HHR information, examine and enhance physician and nursing retention activities, support medical, nursing and other health professional students, and strengthen professional development for existing care providers.

Nunavut is implementing a suite of education and training programs to develop local capacity in several health professions and para-professions. These include professional development courses for nurses for Neo-Natal

Resuscitation, Emergency Pediatric Care and Acute Cardiac Life Support. New diploma programs are being established for Mental Health and Community Therapy Assistants and the successful Nunavut Midwifery and Maternal Care Program is being expanded to additional communities.

Operational Secretariat Fund

An ADM-level working group was established in late 2004 to support the management of the THSSI and undertake targeted "pan-territorial" projects. These projects allow territorial governments to collaboratively address common priorities and to work with the federal government to find solutions to long-standing issues. The following projects have been approved for funding and are at varying stages of implementation:

- an exploration of opportunities and best practices around children's oral health;
- supporting the Arctic Health Research Network to become a self sustaining leader in pan-territorial health research coordination and dissemination;
- a pan-territorial mass media campaign to encourage healthy lifestyle choices; and
- an evaluation of territorial medical travel systems.

Reporting

While there were no specific reporting commitments identified in the Access to Care in the North section of the 2004 Accord, territories did make subsequent reporting and accountability commitments through the negotiating of specific agreements related to the $150 million Territorial Health System Sustainability Initiative.

As per their funding agreements, Territorial governments are primarily responsible for reporting on the use of funds as part of their "regular annual reporting to residents." Each Territorial Governments' annual Audited Financial Statements (i.e. Public Accounts) are required to reflect THAF, OS and Medical Travel Funding. This is done at a high level and does not include any detail regarding specific expenditures under each fund. 2006-2007 statements were available in December 2007. 2007-2008 statements will be available by December 2008.

Territories have also agreed to prepare an annual Progress Report to F/T Deputy Ministers of Health. These reports, the first of which was forwarded to F/T Deputies in August 2007, highlight how the Territorial Health System Sustainability Initiative is helping to address challenges in the development and delivery of health care services in the North.

In addition, an evaluation process was agreed to by Federal and Territorial ADMs including both a Formative Evaluation (completed in December 2007) and a Summative Evaluation of the THAF and the Operational Secretariat Fund. The results of the Formative Evaluation provide insight into the successes and challenges of territorial governments in implementing their respective THAF workplans and in working together to undertake pan-territorial projects.

Although there is no formal evaluation of the Medical Travel Fund, territories have agreed to use Operational Secretariat Funding to undertake a comparative evaluation / assessment of their respective medical travel systems that will establish a base of information to inform decisions and identify best practices for managing these systems. This work will be completed in 2008/09.

Future Work

In the Speech from the Throne on October 16, 2007, the Government committed to bringing forward an integrated Northern Strategy focussed on strengthening Canada's sovereignty, protecting the environmental heritage, promoting economic and social development and improving and devolving governance. Health Canada participates in DM- and ADM-level committees to develop the Strategy.

Health Council

The Health Council of Canada has not undertaken a separate review or made specific statements about the $150 million Territorial Health System Sustainability Initiative.

ANALYSIS OF IMPLEMENTATION

NATIONAL PHARMACEUTICALS STRATEGY (NPS)

The NPS was one of many competing areas of focus within the Accord. While there has been criticism that the NPS has not progressed as quickly as some had expected, meaningful progress has been made on the priority elements of the NPS over the past four years.

Background

Pharmaceuticals play an increasingly important role in Canadians' health and Canada's health care system. They save lives, prevent the spread of disease, improve quality of life, and control pain and suffering. Their role is likely to grow in the future as technological advances result in new drug therapies that replace earlier treatment methods or provide new options where no treatment existed before. Health Canada is working with provinces and territories to improve timely and affordable access to safe, effective, high-quality pharmaceuticals.

Federal regulation of the pharmaceutical sector focuses on three objectives: protecting the Canadian population against safety-related risks by determining whether a drug can be sold on the Canadian market; stimulating pharmaceutical innovation through the granting of patents while protecting consumers against excessive patented drug prices; and, providing drug benefits to federal populations.

The federal government plays a leadership and funding role in helping to improve the efficiency of the system across federal and P/T governments. While drug coverage is a provincial and territorial responsibility and management may occur differently across jurisdictions (e.g., different fee schedules, reimbursement methods and coverage) collaboration across jurisdictions can help identify best practices, strengthen negotiating power with drug manufacturers, and, ultimately, lead to greater efficiency.

Federal drug plans, combined, represent the fifth largest payer among all public drug plans in Canada. (The six federal plans are managed by Health Canada, Veterans Affairs Canada, National Defence, the Royal Canadian Mounted Police, the Correctional Service of Canada, and Citizenship and Immigration Canada.) As such, the federal government benefits, in a similar manner to P/T jurisdictions, from improvements in such areas as drug assessments and pricing and purchasing strategies.

Federal Work

The federal government has devoted significant human and financial resources to joint leadership with British Columbia of the NPS itself and individual NPS element working groups.

The federal government is contributing to many NPS elements through other mechanisms, such as Canada Health Infoway and the Canadian Optimal Prescribing and Utilization Service (COMPUS). Since it was created in 2001, Canada Health Infoway has received $1.6B in federal funding. Infoway's mission is to foster and accelerate the development and adoption of electronic health information systems across the country that have compatible standards and technologies, building a necessary basis for further initiatives such as e-prescribing. Similarly, the federally-funded COMPUS is contributing to the appropriate prescribing and utilization element of the NPS through its products and services, as well as its linkages and partnerships with F/P/T governments and other stakeholders. COMPUS identifies and promotes evidence-based, clinical and cost-effectiveness information on optimal drug prescribing and use.

Beyond the nine elements of the NPS, the federal government has undertaken other initiatives to improve pharmaceuticals management in areas of clear federal jurisdiction, i.e., the development of a product lifecycle

approach to drug regulation; the review of the Special Access Program; and the updating of the Patented Medicine Prices Review Board's Excessive Price Guidelines.

Health Canada has also worked in conjunction with other federal departments to seek and provide necessary information related to the NPS. For example, the federal Competition Bureau has been invited to discuss their assessment of the competitive environment for generic drugs at NPS working group meetings.

Provincial and Territorial Work

We are preparing for discussions with our provincial and territorial colleagues on our ongoing collaboration on pharmaceuticals management. This is an opportunity for us to define the next phase of the NPS, and the outcome of this dialogue is likely to guide our approach to collaborative work in other areas of shared interest in pharmaceuticals.

Health Council of Canada comments

In its 2006 Annual Report to Canadians, the Health Council of Canada expressed its disappointment and criticized the slow progress in implementing the elements of the NPS. In particular, it was disappointed at the slow progress toward catastrophic drug coverage. It recommended that governments "proceed quickly" on meeting the commitment on catastrophic drug coverage, "a timeline for implementation should be established and communicated, and work should begin immediately on an implementation plan."

The Health Council released a report on the prescribing behaviour of health professionals in October 2007 as a follow-up to its policy symposium in June 2007. Though not directly about the NPS, this report is relevant given that enhanced prescribing behaviour was included as an element of the NPS, though not one of the five priority elements.

ANALYSIS OF IMPLEMENTATION

PREVENTION, PROMOTION AND PUBLIC HEALTH

Accomplishments

There were three main commitments related to prevention and promotion in the 2004 Accord:

- collaboration and coordination in responding to infectious disease outbreaks and other public health emergencies;
- building on recent investments in immunization, through the National Immunization Strategy; and
- work on a pan-Canadian Public Health Strategy, with efforts to address common risk factors and integrated disease strategies.

Overall, the federal, provincial and territorial governments are meeting their commitments to address these issues. Specifically:

- In the area of infectious disease outbreaks, governments have supported the creation of the *Pan-Canadian Public Health Network* as a collaborative body in April 2005, have released the *Canadian Pandemic Influenza Plan for the Health Sector* in December 2006 and have worked together on Memoranda of Understanding related to mutual aid during an emergency and information sharing for public health emergencies;
- In the area of immunization, P/T governments are working to align their immunization schedules for vaccines recommended under the National Immunization Strategy, while the federal government has provided two waves of funding worth $300 M over three years in Budgets 2004 and 2007 for the P/T implementation of recommended vaccines (i.e. pneumonia, meningitis, chicken pox and whooping cough under the first wave of funding; human papillomavirus under the second); and
- Although development of a pan-Canadian Public Health Strategy was put on hold, the issues identified in this area have been addressed through the F/P/T *Pan-Canadian Healthy Living Strategy*, which provides the mechanisms for collaboration on chronic diseases and their risk factors, and the federal *Healthy Living and Chronic Disease Initiative*, which includes a combination of investments to address common risk factors together with disease-specific strategies for major chronic diseases.

Greater detail on each of these areas is provided below.

Infectious disease outbreaks and other public health emergencies

F/P/T governments have successfully collaborated on and improved their pandemic preparedness and response through the **Public Health Network**, which was created as the mechanism for F/P/T collaborative action on public health. All jurisdictions actively participate on and are engaged in the Public Health Network Council at the Chief Medical Officer of Health/Assistant Deputy Minister level, and participate in the Public Health Network's Expert Groups responsible for developing coordinated responses to outbreaks and emergencies. Two Expert Groups, two Task Groups and a number of Issue Groups contribute to this work. The PHAC has demonstrated significant support for the Public Health Network by funding Secretariats to the various components of the Public Health Network and by compensating members for travel.

GoC investments against **Infectious Disease Outbreaks and Other Public Health Emergencies** include $1B over 5 years for avian and pandemic influenza preparedness ($600M) and contingency purposes ($400M) in Budget 2006. The $600M was shared between PHAC, Health Canada, the Canadian Institutes for Health Research and the Canadian Food Inspection Agency ($195M to manage avian influenza issues). Within the health portfolio funding is focussed on seven key areas: prevention and early warning ($40M); vaccines and antivirals ($162M); surge capacity ($29.5M); emergency preparedness ($47M); critical science and regulation ($112.5M); risk communications ($8.4M); and F/P/T collaboration ($22.2M).

This funding will strengthen federal capacity to prepare and respond to pandemic influenza, and each of these activities will directly or indirectly benefit P/Ts, including: enhancing pandemic preparedness and response capacity in First Nations on reserve and Inuit communities; strengthening surveillance across jurisdictions; supporting research on pandemic vaccines to expedite reviews of submissions for new antiviral drugs; and purchasing and positioning across Canada necessary antiviral drugs for the national stockpile.

Collaborative efforts include:

- releasing the *Canadian Pandemic Influenza Plan for the Health Sector* in December 2006;
- agreeing to increase the national stockpile of antiviral drugs to 55.7 million doses by the end of fiscal year 2007/08. As of March 2008, the stockpile stood at 53 million doses;
- agreeing on an antiviral early treatment strategy to treat all Canadians who become ill during a pandemic and to contain or prevent an outbreak of pandemic (i.e. use of antivirals in treatment and prophylaxis scenarios);
- developing a draft policy on the use of antivirals for prevention to contain or prevent an outbreak of pandemic;
- agreeing on the need for several MOU to inform joint emergency management efforts in regard to: mutual aid during an emergency (expected to go forward to F/P/T Ministers of Health September 2008); information sharing for public health emergency, including pandemic (expected to go forward to F/P/T Ministers of Health September 2008);
- ongoing work on an F/P/T governance approach to pandemic planning and decision making to ensure maximum effectiveness and timely decision making by the Council and ultimately by health ministers.

The Public Health Network's main 2007/08 activities included Pandemic and Avian Influenza Preparedness; an MOU on Mutual Aid; an MOU on Information Sharing; and National Health Emergencies Management. The focus of 2008/2009 will be to continue with these efforts and include work in other areas such as chronic disease management and surveillance and work on indicators of health disparities.

Pandemic and Avian Influenza Preparedness has focussed on six elements: Antivirals for early treatment and prevention; a Canadian Pandemic Influenza Plan; a Pandemic Vaccine Strategy; Real-Time Pandemic Exercise Planning; and Laboratory Response Capacity.

- The Public Health Network's Task Group on **Antivirals** for Prophylaxis has developed national policy recommendations on providing prophylactic antivirals during a pandemic influenza. The recommendations were approved by F/P/T Deputy Ministers of Health in November 2007 and are pending F/P/T Ministers of Health approval.
- In December 2006, F/P/T Ministers of Health approved the **Canadian Pandemic Influenza Plan** for the Health Sector, which was produced by the Public Health Network's Pandemic Influenza Committee. A number of annexes are currently under review and will be released in Summer 2008 (e.g., vaccines, infection control and prevention measures, laboratory services, clinical care).
- The Public Health Network will develop recommendations on a pan-Canadian **pandemic vaccine strategy**, including considerations for vaccine development and clinical trial design; approaches to immunization; adverse event surveillance and monitoring; and distribution. Final recommendations are expected during Spring 2008.
- The Public Health Network is coordinating the development of a **Real Time Planning Exercise**, to exercise and validate the capacity and capability of the Canadian health system to prevent, detect and respond to a pandemic in accordance with the Canadian Pandemic Influenza Plan for the Health Sector,

and to allow gaps to be identified and addressed.

- **Laboratory Response Capacity** depends on collaboration and cooperation between laboratories in F/P/T jurisdictions to ensure an integrated and effective approach to epidemiologic investigation and control, particularly during public health events. Laboratories will be able to respond to testing needs for diagnostic purposes and to support related work, such as the antiviral and vaccination strategies and surveillance.

Two Memoranda of Understanding were developed and approved in principle by F/P/T Ministers of Health in December 2006, with the provision that wording changes be made to address concerns and legal requirements identified by Quebec. The *Memorandum of Understanding on the Sharing of Information During a Public Health Emergency* (MOU on Information Sharing) and the *Memorandum of Understanding on the Provision of Mutual Aid in Relation to Health Resources during an Emergency Affecting the Health of the Public* (MOU on Mutual Aid) have been approved by the Public Health Network Council.

The National Health Emergency Management System is intended to facilitate emergency cross-jurisdictional planning and communication by clearly defining roles and responsibilities and by establishing operational guidelines and protocols to ensure coordinated planning. The System will also include protocols for requesting and receiving mutual assistance, as identified in the F/P/T MOU on Mutual Aid.

First Nations and Inuit have expressed concerns about engagement in all levels of planning and response capacity, and availability of culturally-adapted communication materials. Both the PHAC and Health Canada are currently working with the Assembly of First Nations and the Inuit Tapiriit Kanatami to develop culturally appropriate pandemic fact sheets as well as trilateral work plans on pandemic preparedness and response. In May 2006, the F/P/T Ministers of Health reaffirmed that antivirals from the joint Stockpile, vaccines and essential supplies will be available to First Nations and Aboriginal communities on the same basis as other Canadians Funding to support training, planning and testing was directly devoted to First Nations and Inuit community pandemic preparedness in Budget 2006 ($6M).

The National Microbiology Laboratory is at the forefront in developing and applying modern public health technologies to diagnostic, vaccines and molecular epidemiology. The Laboratory is also recognized internationally for its capacity to transfer and deploys its expertise to other countries and through its support to professional interchange.

Canada works with a number of international partners including the WHO and the Pan-American Health Organization in developing coordinated responses to infectious disease outbreaks and other public health emergencies. A key initiative was the development of the International Health Regulations, which are legally binding regulations adopted by most countries to contain threats from diseases that may rapidly spread from one country to another.

According to a UN survey on avian and pandemic influenza published in December 2007, most developed countries now have pandemic preparedness plans. As well, an increasing number of low and medium incomes countries are in the process of making pandemic preparedness plans.

A comparative analysis of pandemic plans done in the context of the Global Health Security Initiative (G7+ Mexico) demonstrates a number of similarities among countries, such as a wide spectrum of public health measures, antiviral stockpiles, surveillance, as well as some differences due mainly to contextual contingencies (unpublished). Canada is one of the few countries to have a pandemic vaccine contract in place with a domestic manufacturer. A number of G7 (Canada, UK, US, Japan, France) countries are now focussing on the implementation of their respective plans.

Canada is an active contributor to international dialogues about global preparedness via several international bodies: the Global Health Security Initiative; the International Partnership on Avian and Pandemic Influenza;

the World Health Organization and the Health Task Force of the Asian Pacific Economic Cooperation. Between 2005 and 2006, Canada contributed $105M to international Avian and Pandemic Influenza preparedness. Specific achievements include a North American Plan for Avian and Pandemic Influenza, which was adopted at the Security and Prosperity Partnership Leaders Summit in Quebec in August 2007 and Canada's technical and financial assistance to developing countries and international organizations. In 2007, Canada was listed by the United Nations as one of the top four donors for international avian and pandemic influenza preparedness.

Immunization

The F/P/T governments have met their **immunization** commitments through the National Immunization Strategy. Key outcomes are reduction in vaccine preventable diseases, equitable and timely access to recommended vaccines, improved efficiencies of immunization programs, better vaccine safety monitoring and response, and improved security of vaccine supply. The F/P/T Vaccine Vigilance Working Group was developed to address vaccine safety issues of greatest relevance to F/P/T jurisdictions.

The GoC provided $300M over three years in Budget 2004 to the P/Ts to support the introduction of and equitable access across Canada to four new recommended childhood vaccines (pneumonia, meningitis, chicken pox and whooping cough for adolescents). All P/Ts now have publicly funded immunization programs. More than twice as many children are now protected from these diseases than were in 2003.

In Budget 2007, the GoC announced federal funding of $300M over three years to the P/Ts to support the introduction of Human Papillomavirus (HPV) vaccine programs. Since then, Ontario, Nova Scotia, Prince Edward Island and Newfoundland and Labrador have announced HPV vaccine programs in fall 2007. Other P/Ts are expected to launch programs in 2008.

Federal investments have supported Canada Health Infoway's Pan-Canadian Health Solution for a public health surveillance system that includes the development of an immunization registry module. Efforts are underway to ensure the module is compliant with existing national standards. By 2009, all jurisdictions will have access to such a registry.

Two priority federal population groups were identified in the 2007 work plan: First Nations people living off reserve, and immigrants and refugees. A Task Group is being created with its first priorities being to develop linkages with national and local key organizations and to conduct an environmental scan of F/P/T activities, approaches and material.

Pan-Canadian Public Health Strategy (Chronic Disease Prevention)

Health Goals for Canada were developed through a broad consultation and validation process that involved the F/ P/T governments, public health experts, stakeholders and citizens. The Public Health Agency of Canada (PHAC) led the development of the Goals through extensive consultations with the P/Ts and over 300 public health experts and stakeholders in twelve P/T roundtables, five thematic events and five regional deliberative dialogues and in consultations with parliamentarians. Almost 400 individuals, groups, and organizations also provided input via an e-survey or by holding their own consultations. The Goals were agreed on by the F/P/T Ministers of Health at their annual meeting in October 2005, and are intended to act as guideposts toward improving Canadians' health and quality of life and do not reflect a detailed map.

Health promotion, and disease and injury prevention commitments are being met through the implementation of the Pan-Canadian Healthy Living Strategy and the Healthy Living and Chronic Disease initiative. The Strategy was approved by F/P/T Ministers of Health at their annual conference in October 2005. The Strategy represents a set of common principles intended to provide a national context, reference point and blueprint for greater alignment and coordination across sectors.

The Healthy Living Issue Group reports on progress in meeting the targets and outcomes contained in the Strategy to the Pan-Canadian Public Health Network Council, through the Population Health Promotion Expert Group.

Through the PHAC, the GoC provides Secretariat support to the Healthy Living Issue Group, which provides a forum to foster collaborative efforts that contribute to improving overall health outcomes and reducing health disparities – the goals of the Pan-Canadian Healthy Living Strategy. This includes: establishing an Intersectoral Healthy Living Network, a virtual Pan-Canadian network dedicated to healthy living; fostering partnerships; and improving collaboration and information exchange among sectors and across jurisdictions.

The Healthy Living and Chronic Disease (HLCD) initiative involves collaboration between regional, provincial, territorial, federal and international governments, and stakeholders on HLCD's three inter-related pillars: health promotion, chronic disease prevention, and detection and management of chronic disease. Progress has been achieved with Enhanced Surveillance for Chronic Disease initiatives; the Canadian Best Practices Portal for Chronic Disease Prevention, which supports decision makers in practice, policy and research, and in assessing chronic disease risk factors.

To support the HLCD initiative, in February 2007, a fully elaborated GoC Results-Based Management and Accountability Framework was approved by the Treasury Board Secretariat. P/T involvement in the implementation of the HLCD initiative, mainly through the Pan-Canadian Public Health Network, has facilitated implementation of HLCD initiatives, such as the work of the Population Health Promotion, and Chronic Disease and Injury Prevention, and Control Expert groups. P/T representatives are also involved in the implementation of HLCD disease-specific initiatives, such as the development of the Canadian Heart Health Strategy and Action Plan.

The GoC Healthy Living initiative targets all Canadians with an emphasis on children, youth and Aboriginal Canadians. Actions include the re-establishment of ParticipACTION in 2007/08 with an investment of $1.6M to help Canadians improve their health through regular physical activity.
GoC progress on HLCD disease-specific strategies includes:

- GoC investments of $4.2M for 2007/08 and $5.2M a year ongoing from 2009/10 to support development of the Canadian Heart Health Strategy and Action Plan, and to fund early federal efforts to address hypertension (a CVD-specific risk factor) and CVD surveillance.
- GoC action on diabetes (e.g. funding community based projects) and has renewed the Canadian Diabetes Strategy at $18M a year, ongoing.
- GoC investments of $13M in 2007/08 and $17M in 2008/09, and ongoing, to support cancer activities, including surveillance; screening and early detection; risk factor analysis and assessment; intramural and extramural research; and public information, community-based programming and capacity building targeted at Aboriginal, seniors and childhood cancer organizations. The GoC has provided $800K to National Aboriginal Organizations to enable participation in the Canadian Strategy for Cancer Control.

GoC progress on healthy living activities within HLCD includes:

- The GoC announced an investment of $4.36M in 2007/08 in national healthy living projects through the Physical Activity and Healthy Eating Contribution Fund, the national stream of the Healthy Living Fund.
- The GoC committed $2.66M in 2007/08 to support regional physical activity and healthy eating projects to be developed through bilateral agreements with P/T governments.
- The GoC invested $1.044M in 2007/08 in national projects to support knowledge development on healthy living.

The Framework of the HLCD initiative is consistent with the World Health Organization's (WHO) Global Strategy on Diet, Physical Activity and Health, which supports a collaborative approach where responsibilities for action to bring about changes in dietary habits and patterns of physical activity rest with many stakeholders from public, private and civil society.

F/P/T discussions have taken place with the **Pan-Canadian Public Health** Network Council concerning the development of a Pan-Canadian Public Health Strategy and the consensus was to continue to lay a foundation for the Strategy and revisit its development once short term priorities are met.

To address the **Healthy Schools** commitment, the F/P/T governments have successfully established the Joint Consortium for School Health (JCSH). This consortium brings together key representatives of F/P/T departments and ministries responsible for health and education. It builds collaborative capacity and promotes understanding of and support for comprehensive school health initiatives. Each member jurisdiction now has one or two school health coordinators who report to the department of health or education or both.

The GoC contributes annual funding of $250,000 toward its commitment to the JCSH lead province (currently British Columbia). The P/Ts contribute $217,000 annually (based on a per capita calculation). A notable GoC accomplishment is the creation of an internal Federal Coordinating Committee to act as an information exchange forum for the various federal departments/agencies involved in school health. The Committee has compiled a synthesis of current federal school health activities in a range of departments, including Heritage/Sport Canada, Statistics Canada and Human Resources and Social Development Canada.

Some of the Consortium's key accomplishments include:

- Networking: established a national network of school health coordinators in every participating P/T and a PHAC representative to support collaboration and information sharing;
- Communications: established a Consortium Internet portal for Canadian school health issues and resources; established a Consortium newsletter about Consortium activities, including news, links to relevant research and information on events and opportunities;
- Promotion and advocacy: organized and hosted a 2006 National Conference on School Health; presentations at various fora on the Consortium and promoting comprehensive school health approaches (Chronic Disease Prevention Alliance of Canada's Second National Conference, Integrated Chronic Disease Prevention: Building It Together, 2006; International Union of Health Promotion and Education Conference, 2007; etc.); and
- Governance: established a regular schedule of teleconferences and meetings among member jurisdictions, including for school health coordinators and for senior representatives.

The Consortium has been recognized as a model of collaboration, with worldwide potential. The World Bank and the Pan American Health Organization have both expressed interest in the Consortium model, and in working with the Consortium more closely. The Consortium is also working with the European Network of Health Promoting Schools.

Reporting

There are no reporting commitments, other than the pre-existing requirements for the *Pan-Canadian Healthy Living Strategy*. For these, the F/P/T Healthy Living Issue Group reports to the Pan-Canadian Public Health Network Council, through the Population Health Promotion Expert Group, on progress in meeting the targets and outcomes contained in the Strategy.

Future Work

Infectious Disease Outbreaks and Other Public Health Emergencies

Future action on **Infectious Disease Outbreaks and Other Public Health Emergencies** was addressed in May 2006, when the F/P/T Ministers of Health met, and activities for 2008-09 include:

- The GoC will continue to work with industry and international partners on development, testing and licensing of an effective influenza vaccine. Canada also participates in the WHO technical working group on vaccine production and regulation.

- The GoC is reviewing its 10 year contract with the domestic vaccine manufacturer to ensure access to new technology and to harness its vaccine production capacity. The GoC also invests in clinical trials of H5N1 pre-pandemic vaccines.
- Additional investments will be made to ensure First Nations and Inuit needs and concerns are taken into consideration, and a trilateral work plan is being developed to improve pandemic preparedness and response in First Nations and Inuit communities.
- Non-governmental and private sector organizations participation in developing appropriate pandemic preparedness and business continuity plans is needed and beneficial. Governments and the private sector will work together to ensure continuity of supply of key goods and services. Cross sectoral workshops will continue to take place and documents, such as Frequently Asked Questions or guidance for the development of business continuity plans, are under development.
- The GoC will achieve the National Antiviral Stockpile target by end of fiscal year 2008-09 by purchasing 2 million pediatric doses of antivirals
- A new version of the Canadian Pandemic Influenza Plan for the Health Sector and related annexes on vaccines, laboratory services, clinical care, infection control and prevention will be released in 2008;
- Annexes on public health measures, surveillance, psychosocial preparedness and planning recommendations for the use of antivirals during a pandemic will also be reviewed for a release in 2009.
- Final recommendations of a pan-Canadian pandemic vaccine strategy will be developed.
- A series of table-top real-time exercises of F/P/T mechanisms for responding to pandemic will take place and each jurisdiction's effectiveness will be assessed.
- An online certification course for early detection, management and reporting of emerging infectious disease, including influenza will be launched in 2008.

Immunization

The GoC is committed to build on recent success in expanding **immunization** programs and improving access, and is continuing to work with the P/Ts through the National Immunization Strategy to strengthen immunization infrastructure and programs. New vaccines will have a major impact on immunization programs and the epidemiology of vaccine-preventable diseases in the coming years.

Pan-Canadian Public Health Strategy (Chronic Disease Prevention)

The **Health Goals** may provide a tool to guide jurisdictions' further action on the determinants of health and may help to strengthen the management of horizontal issues with experts.

Health Promotion, and Disease and Injury Prevention plans for 2007/08 will involve activities related to governance, coordination and continued implementation of the HLCD initiative, including through monitoring and evaluation.

The PHAC will work through the Public Health Network to continue to identify emerging public health priorities and will gauge readiness to move forward on the **Pan-Canadian Public Health Strategy** via the Public Health Network Council.

Future work on **Healthy Schools** includes facilitating a more coherent system for reporting on the health and social development of children and youth in school settings; publishing reports on emerging issues and trends on nutrition/healthy eating, physical activity, social behaviours, sexual health and others; implementing an evaluation framework; and collaborating with international agencies, including the WHO, the Pan American Health Organization, the World Bank and the European Union Healthy Schools Collaborating Centre.

ANALYSIS OF IMPLEMENTATION

HEALTH INNOVATION AND RESEARCH

The health innovation and research commitment of the 2004 Accord applied exclusively to the federal government. Overall, the Government of Canada has met its commitment through increased investments in innovative science, technology and research.

There have been significant regular investments by the federal government in health innovation since the 2004 Accord. Through funding for the direct and indirect costs of world-class research in priority areas, research capacity building, and state-of-the art infrastructure development, the government is ensuring that Canada's science and technology (S&T) enterprise is well-equipped to contribute to a strengthened health care system (e.g., through innovative health products), improved health outcomes, and other socio-economic benefits for Canadians.

Assessment of Government of Canada Accomplishments

The Government of Canada has continued its investments to sustain activities in support of health innovation. According to Statistics Canada, in total, federal health S&T expenditures have increased nearly 17% since 2004 (from $1.25 billion in 2004-2005 to $1.46 billion in 2006-2007). Of this amount, $407 million was expended on intramural health S&T activities and $1.05 billion was for extramural health S&T activities.

The Government's intramural investments have supported research and development and related scientific activities (e.g., risk management, risk assessment, evaluation and surveillance), including in health, to address current and emerging challenges to Canadians.

The Government has directed its extramural investments to four key areas:

- ***direct costs of research*** (investigator-driven and targeted priority initiatives) (Canadian Institutes of Health Research - CIHR, Natural Sciences and Engineering Research Council - NSERC, and Social Sciences and Humanities Research Council - SSHRC). Note that as a result of investments in Budgets 2006, 2007, and 2008, CIHR's annual base budget is currently $820.1 million, a 17.5% increase from its $697.8 million annual budget in 2005/06;

- ***indirect costs of research*** (chiefly through Industry Canada's $315 million per year Indirect Costs of Research Program which serves more than 140 post-secondary institutions across the country);

- ***people*** (through the federal granting councils and the Canada Research Chairs (CRC) Program. The CRC Program invests $300 million a year to attract and retain among the world's most accomplished and promising minds. As of November 2007, the Program had awarded 1,851 Chairs).

- ***infrastructure*** (chiefly through the Canada Foundation for Innovation - CFI. The CFI normally funds up to 40% of a project's infrastructure costs; the remainder is provided by provincial/territorial governments, and the private and voluntary sectors. Since 1997, the CFI has invested $3.75 billion in infrastructure projects across Canada).

  Detailed investments from Budgets 2005, 2006, 2007 and 2008, can be found in Appendix A.

The Government of Canada's investments have:

- enabled Canada's universities, research hospitals and colleges to contribute to social and economic

development across all regions of the country through undertaking research, development of research capacity, knowledge translation and commercialization;

· maintained and enhanced the international competitiveness of Canadian research institutions, and

· ensured that these institutions attract and retain the best researchers and students, and continue to build the capacity for innovation for improved health and other socio-economic benefits for Canadians.

Future Work

A Federal Science and Technology (S&T) Strategy for Canada - Building Advantages for Canada

In recognition of the priority the government places on S&T and innovation as an enabler of prosperity, competitiveness and improved health and quality of life for Canadians, on May 17, 2007, Prime Minister Harper released a federal S&T Strategy (Strategy), entitled, "*Mobilizing Science and Technology to Canada's Advantage*".

Setting out a comprehensive, multi-year S&T agenda for Canada, this Strategy seeks to foster three distinct Canadian S&T advantages:

· an ***Entrepreneurial Advantage*** (competitive business environment that encourages private sector innovation and facilitates public-private research and commercialization partnerships),

· a ***Knowledge Advantage*** (leading edge research in priority areas, including health and related life sciences and technologies, that generate health, environmental, societal and economic benefits), and

· a ***People Advantage*** (attracting and retaining highly skilled people). It is expected that the Strategy will help to provide individuals, families, and communities with better medicines and health care, a cleaner and safer environment, stronger research and educational opportunities, and greater prosperity.

The S&T initiatives announced in Budget**s** 2007 and 2008 demonstrate the government's commitment to take early action to achieve these goals for Canadians.

More Integrated Federal Research Programming

The Strategy also directs the three federal research granting councils (CIHR, NSERC, and SSHRC) to work together and with others in the science community to build a critical mass of expertise in priority areas, including health and life sciences. Health research increasingly requires a collaborative effort and mechanisms that support the integration of activities across a broad spectrum of disciplines. This multi-disciplinarity of research is well-recognized by the councils: elements of health research are pervasive in NSERC's and SSHRC's programs.

Other key players in the federal science community are also working to further align their programs and initiatives with the S&T Strategy, including focusing on health and the Strategy's other priority areas. For example, the National Research Council (NRC), the federal government's premier organization for R&D, has been investing approximately $60 million per year on health-related research since 2004 in infectious and aging diseases, cancer and diagnostics. The NRC is also working to ensure that its institutes' business plans are well-aligned with the NRC's 2006 Science Strategy, entitled *Science at Work for Canada*, the objectives of which are well aligned with the federal Strategy.

Appendix A

New Federal Investments from Recent Budgets:

Budget 2005

Funding for health-specific innovation

- $32 million increase in the annual base budget of the Canadian Institutes of Health Research (CIHR), resulting in an overall budget of $697 million.
- $10 million to the Terry Fox Foundation in recognition of the 25th anniversary of the Terry Fox Marathon of Hope, which through the National Cancer Institute of Canada funds cancer research.
- $35 million over the next seven years for a new Network of Centres of Excellence (NCE).

Funding which involves a health innovation component

- $165 million to Genome Canada to sustain its support for breakthrough genomics research.

- $30 million to the Canadian Academies of Science (CAS) to sustain the basic operation of the organization for 10 years, through 2015.
- $20 million per year for five years to Precarn in support of research and development (R&D) in intelligent systems and advanced robotics, extending the previous sun-setting five-year commitment.
- $15 million annual increase to the Indirect Cost of Research Program for federally funded research at universities and colleges, bringing the total annual funding to $260 million.

Budget 2006

Increased funding for health-specific innovation

- $17 million increase in the annual base budget of CIHR, resulting in an overall base budget of $723.5 million, enabling new programs: a Global Health Research Initiative, a Clinical Research Initiative, and a Regenerative Medicine and Nanotechnology Initiative.

Funding which involves a health innovation component

- $17 million per year for the Natural Sciences and Engineering Research Council (NSERC).
- $260 million over five years to the Public Health Agency of Canada and Health Canada to implement the Canadian Strategy for Cancer Control (CSCC) for screening, prevention, and research activities, and to enhance coordination among the federal government, cancer community groups, and the provinces and territories.
- In November 2006, the Government announced the creation of the Canadian Partnership Against Cancer (CPAC), an independent, not-for-profit corporation responsible for the implementation of the CSCC. CPAC will help support a pan-Canadian approach to cancer control and will, therefore, need to collaborate closely with all relevant partners to facilitate better coordination of activities and efforts across the country. Of the $260 million for the CSCC, the Public Health Agency of Canada and Health Canada each receive $1 million per year over five years to support linkages between the CPAC's knowledge translation activities and other cancer portfolio members, and to promote international activities and federal leadership on cancer.
- $40 million per year for the Indirect Costs of Research Program.
- $20 million per year for the Leaders Opportunity Fund (LOF) of the Canada Foundation for Innovation (CFI).

Budget 2007

Funding for health-specific innovation

- $37 million increase in the annual base budget of CIHR, resulting in an overall base budget of $780 million. This represents an increase of 17% to the annual base budget since 2004.
- $30 million over five years to the Rick Hansen Man in Motion Foundation (Foundation) for the Spinal Cord Injury Translational Research Network (SCI-TRN).
- $10 million over the next two years and $15 million per year thereafter for the establishment of a Canadian Mental Health Commission (the Commission) to lead the development of a national mental health strategy. .

Funding which involves a health innovation component

- $37 million for NSERC, targeted to research in energy, the environment and information and communications technologies, including health (e.g., electronic health records).
- $11 million for the Social Sciences and Humanities Research Council (SSHRC), targeted to research in management, business and finance, as applied to health and other priority sectors.
- $46 million ($11 million in 2008-2009) to fund, over a 4-year period, up to 5 new business-led, large-scale collaborative networks of centres of excellence (B-NCEs) in priority areas, including health.
- $350 million over 2006-2007 and the next two years to support eight large-scale Centres of Excellence in Commercialization and Research (CECR) in priority areas where Canada has the potential to be a global leader, including in health.
- $100 million in 2006–07 to provide Genome Canada with sustained funding for its six regional genome centres and related technology platforms, extend promising research projects, and support Canada's participation in strategic international research collaborations.
- $10 million over the next two years to the Canadian Institute for Advanced Research (CIFAR) to enhance its activities and enable it to raise funds from other stakeholders.
- $15 million per year to support the Indirect Costs of Research Program.
- $35 million over two years and $27 million per year thereafter to expand scholarships to enable additional young Canadians to pursue graduate-level studies .
- $510 million to the CFI .
- $120 million in 2006–07 to CANARIE Inc., a not-for-profit corporation that manages CA*net, a sophisticated research broadband network that links Canadian universities, research hospitals as well as other science facilities in other countries.

Budget 2008

Funding for health-specific innovation

- $34 million per year to CIHR for research that addresses the health priorities of Canadians, including the health needs of northern communities, health problems associated with environmental conditions, and food and drug safety.
- $20 million endowment to the Gairdner Foundation to create Canada Gairdner International Awards (medical science);
- $21 million over two years to strengthen the ability of Canadian universities to attract and retain top science leaders through the establishment of up to 20 Canada Global Excellence Research Chairs, including in health;
- $100 million to the Mental Health Commission of Canada to support innovative mental health best practices.

Funding which involves a health innovation component

- $140 million to Genome Canada to launch a new competition in the priority area of genetic research, support six regional genome centers and help Canadian researchers participate in an international genomics project.
- Providing an additional $15 million per year to the Indirect Costs of Research program to help institutions support the research activities made possible by the new resources provided to the federal granting councils.
- $25 million over two years to establish a new Canada Graduate Scholarship (CGS) award for top Canadian and international doctoral students.
- $3 million over the next two years to the federal granting councils to establish a new study stipend for CGS recipients who study at institutions outside the country. These new stipends will be worth up to $6,000, and will be available to 250 CGS recipients each year for one semester of foreign studies.
- $12 million per year to SSHRC for research that contributes to a better understanding of how the environment affects the lives of Canadians and of the social and economic development needs of northern communities.

ANALYSIS OF IMPLEMENTATION

ACCOUNTABILITY

Health Council of Canada

The 2003 Accord created the Health Council of Canada (the Council) to monitor and report on Accord commitments (measuring progress on health system reforms). In the 2004 Accord, First Ministers expanded the Council's mandate to include reporting on the health status of Canadians and health outcomes.

F/P/T Ministers of Health (except Alberta and Quebec) participate as Corporate Members of the Council. In addition, there are 26 government- and non-government-appointed Councillors. Currently, they are a mix of officials and experts in specific health fields (patient/client issues, health care systems, performance measurement, community leaders).

The Council publishes an annual report that provides a broad overview and assessment of Accord initiatives, with a focus on the health care system. This report regularly includes information on some comparable health indicators. In addition, the Council releases issue-specific reports on health care and population health issues including: progress on wait time reduction; primary health care and home care; chronic health conditions; lessons in diabetes; and pharmaceuticals related issues.

F/P/T Reporting under the 2004 Health Accord

- Jurisdictions ultimately are accountable to their publics on the quality and availability of reporting on the priorities under the 2004 Accord.

- Jurisdictions report to their publics regularly on health outcomes and health system performance (e.g., Ministries of Health annual reports and issue-specific reports).

Future Work on Data and Indicator Development

- The ability and interest of all jurisdictions to report comparably is affected by the availability of relevant and technically adequate indicators. The federal government is working to improve data and indicators as a means of encouraging P/Ts to improve reporting. The Canadian Institute for Health Information (CIHI), a neutral third party independent not-for-profit F/P/T organization, is well positioned to continue the indicator development work. CIHI provides essential data and analysis to support reporting on Canada's health care system, and works in collaboration with F/P/T governments on data development and reporting of health care system performance.

- To this end the federal government provided additional funding to CIHI in Budget 2007 ($22 million per year for five years) towards increasing capacity to work with P/Ts on the development of comparable indicators and data to better enable health reporting.

- In summary the federal government:
  - continues to provide a leadership role in the collection and publication of health information to Canadians (i.e., Statistics Canada and CIHI reports);
  - has made significant investments in CIHI so that more and improved data is available to Canadians and P/Ts. Budget 2007 provided an additional $22 million to CIHI ($110 million over five years) in large part to continue development of comparable health indicators. This is in additional to $35 million per year in renewed Roadmap I and II + funding. This brings the

total annual funding to CIHI to $81 million;

- is leading by example through the Federal Report on Comparable Health Indicators, which has been published bi-annually since 2002 to report on the accord commitments; and most recently, is participating on an F/P/T task group to develop comparable Aboriginal health data and indicators.

ANALYSIS OF IMPLEMENTATION

ABORIGINAL HEALTH

Blueprint on Aboriginal Health

The First Ministers' Meeting (FMM) on Aboriginal Issues, held in Kelowna B.C. on November 24-25, 2005, fulfilled the F/P/T commitment to convene a meeting of First Ministers dedicated to Aboriginal issues. The *Blueprint on Aboriginal Health* was tabled at FMM 2005 and fulfilled the F/P/T commitment to develop a Blueprint for concrete initiatives to improve the health status of Aboriginal peoples. The *Blueprint* also fulfilled the commitment to explore practical ways to clarify roles and responsibilities and report back in one year.

Federal Investments of $700 million

The $700 million investment for the Aboriginal Health Human Resources Initiative (AHHRI), Aboriginal Health Transition Fund (AHTF) and upstream investments in health promotion and disease prevention was confirmed in Budget 2005. Work with provincial/territorial governments and Aboriginal organizations on implementing the initiatives is ongoing.

Aboriginal Health Transition Fund (AHTF) – $200 million over five years
The Government of Canada is making steady progress in the development and implementation of plans and projects in the three funding envelopes of the AHTF.

Adaptation Envelope:

- Supports provincial and territorial governments in the adaptation of their existing health programs to the unique needs of all Aboriginal peoples, including those in urban areas and Métis settlements and communities. Most provinces have submitted their request for planning dollars, and to date, six provincial adaptation plans have been approved with one more currently being reviewed.

Integration Envelope:

- Supports First Nations and Inuit communities in activities to improve the coordination and integration between provincial/territorial health systems and federal health services provided in First Nations and Inuit communities. All regional integration plans have been submitted and approved. In addition, 81 integration projects have been approved (as of March 2008) and are proceeding in the implementation phase.

Pan-Canadian Envelope:

- Supports cross jurisdictional integration and adaptation initiatives in three streams: First Nations, Inuit and Métis; capacity funding to National Aboriginal Organizations and Health Canada regions to facilitate the engagement of Aboriginal peoples in the AHTF; evaluation and knowledge transfer activities; as well as the overall administration of the AHTF. Pan-Canadian plans have been approved for AFN, ITK and MNC, and a total of 11 projects have been approved to date.

Aboriginal Health Human Resources Initiative (AHHRI) – $100 million over five years
The Government of Canada is meeting its program commitments related to the AHHRI. The AHHRI has set out four targets in order to meet program goals:

- Double the number of Aboriginal health career scholarships/bursaries in 5 years:
  - The AHHRI has increased the amount of funding available to Aboriginal health career students from $500,000 in 2004 to its present level of $3 million per year, tripling the numbers of bursaries and scholarships that are awarded each year.

· Double the number of Aboriginal health professionals in 10 years:
  - The increased numbers of bursaries and scholarships now being awarded is leading to increases in the numbers of Aboriginal health career students. This will translate into increases in the number of health career professionals over the next several years.

· Increase the number of certified health directors/administrators on reserve by one third in five years:
  - Work now underway in partnership with the Assembly of First Nations will see the development and validation of core competencies for health managers on reserve within the next year, and a process that will result in certification through accredited educational institutions for all First Nations health managers.

· A 50% increase in the number of post-secondary educational institutions with support programs for Aboriginal health care students in five years:
  - Work is underway in each Health Canada region to implement student support programs for Aboriginal health career students, and expect to meet this target in the next two to three years.

Upstream Investments in Health Promotion and Disease Prevention – $ 400 million over five years

Budget 2005 confirmed $400 million over five years for the Aboriginal Diabetes Initiative($190 million), National Aboriginal Youth Suicide Prevention Strategy ($65 million), Maternal and Child Health Program ($110 million), and Aboriginal Head-Start On Reserve ($17.5 million), Health Canada) and Aboriginal Head Start Urban and Northern Communities ($17.5 million, Public Health Agency of Canada).

The Government of Canada has met or is on schedule to meet policy and program commitments in relation to upstream investments. Collaboration with P/Ts in upstream investments varies from region to region and is based on regional differences with regard to service delivery models, existing jurisdictional issues and priorities. Overall, program collaboration with P/Ts has increased over time.

Aboriginal Diabetes Initiative (ADI):
· Expanded in 2006, the ADI is a community-based primary prevention, screening and treatment program. More than 600 First Nations and Inuit communities have access to health promotion and diabetes prevention activities funded through the ADI.
· ADI's main objective is to reduce type 2 diabetes in Aboriginal people through a range of health promotion, prevention, screening and treatment services, delivered by an increased number of trained health service providers and diabetes workers.
· The ADI also supports Métis, Aboriginal people living off-reserve and urban Inuit by funding primary prevention projects through ongoing national Requests for Application and approximately 50 projects are being funded in 2007-08.
· In 2007-08, 86 community diabetes prevention workers were recruited into training, bringing the total number having received training to over 130.
· In 2006-07, funding was provided to two peer-reviewed First Nations diabetes surveillance projects. By the end of 2007-08, a diabetes surveillance project will have been initiated in up to 20 First Nations communities across Canada and a partnership will have been established with the Canadian Institutes of Health Research to support intervention research.

National Aboriginal Youth Suicide Prevention Strategy (NAYSPS):
· The goal of NAYSPS is to increase protective factors such as resiliency and reduce risk factors associated with suicide. The strategy has four key elements:
  1. Primary prevention activities focus on mental health promotion and public education;
  2. Secondary prevention activities focus on supporting community-based approaches to suicide prevention in First Nations and Inuit communities;

3. Tertiary prevention activities focus on improving crisis response in First Nation and Inuit communities; and
4. Knowledge development aims to improve what we know about suicide and its prevention in Aboriginal communities.

- Currently, approximately 140 projects are being funded across Canada, which are community-based in order to respond to specific needs and circumstances in youth suicide prevention.
- To engage youth and strengthen the evidence base regarding safe and effective suicide prevention practices, NAYSPS is funding the implementation of five Mental Health Promotion Demonstration Projects.

Maternal and Child Health Program (MCH):

- On reserve, the Maternal Child Health Program builds on the foundation provided by nursing services, the Canada Prenatal Nutrition Program and the Fetal Alcohol Spectrum Disorder Program to improve health outcomes for pregnant women and families with infants and young children. Program elements include home visitation, screening and assessment, case management and culturally appropriate care.
- In the North, funding is provided to enhance the health promotion programs that Health Canada already supports for pregnant women and families with young children to complement services from the province or territory in which they live.
- By the end of 2007-08, the Program will be providing home visiting by nurses and home visitors for pregnant women and families with young children in approximately 70 First Nations communities.
- This target of approximately 70 communities does not include the Ontario region, whose situation is unique. In Ontario, there is a high level of collaboration around planning between the federal government and the provincial government. In the case of Ontario, the federal funds, which began to flow to communities in the Fall of 2007, will fund up to 50 projects as well as enhance services in other communities.
- The Quebec Region began implementation of five projects in early 2008 following successful discussions with First Nations organizations to identify options to implement the program in Quebec.

Aboriginal Head-Start On Reserve (AHSOR)

- AHSOR prepares First Nations children from birth to six years of age for school by meeting their emotional, social, health, nutritional, cultural and psychological needs.
- The program focuses on First Nations languages, educational activities to prepare children for school and activities promoting nutrition, healthy lifestyle choices and physical activity.
- The AHSOR program has expanded to reach over 9000 children. In 2006-07, existing AHSOR capital infrastructure was enhanced, with $7 million transferred to the regions to support capital projects.

Further Investment in Health Services Historically Provided to First Nations and Inuit

The Government of Canada has continued to invest in health services historically provided to First Nations and Inuit in the 2006, 2007 and 2008 budgets.

- Budget 2006 investments of $234 million were made in the areas of health promotion and disease prevention, early childhood development, and the adaptation of the health systems in order to more better meet the needs of First Nations and Inuit peoples.

- Budget 2007 increased funding for First Nations and Inuit health by $126 million dollars to approximately $2.1 billion in total spending. This increase includes $60 million dollars to sustain existing health services for First Nations and Inuit and $15 million dollars to support new innovations in health service delivery, including tripartite agreements with the provinces and territories, and First Nations and Inuit.

- Budget 2008 commits $147 million over the next two years to stabilize current programs and put in place concrete improvements aimed at better health outcomes for First Nations and Inuit. Funds will support improvements in health care delivery through greater integration with provincial and territorial health. Budget 2008 also invests over $330 million over the next two years to extend the Plan of Action for Drinking Water in First Nations Communities. Of the $330 million, Health Canada will receive approximately $55 million.

Explore Métis Health Issues

The Government of Canada continues to work to explore Métis health issues in collaboration with other orders of government and Métis leadership, including a $10 million agreement signed in February 2007 through the AHHRI to support Métis health human resources, and a $714,000 agreement signed in January 2007 through the AHTF to support the Métis in planning the improved adaptation and integration of health services to better meet the needs of the Métis peoples. An additional $625,000 in capacity funding through the AHTF has been provided through agreements signed in 2005-06 and 2006-07 to support Métis work in the AHTF.

Reporting

The Special Meeting of First Ministers and Aboriginal Leaders saw the commitment to "explore practical ways to clarify roles and responsibilities of the various parities and [to] report back to First Ministers and Aboriginal Leaders within one year." This reporting commitment was part of the development of a blueprint to improve the health status of Aboriginal peoples.

The *Blueprint on Aboriginal Health* was tabled at First Ministers' Meeting on Aboriginal Issues, held in Kelowna B.C. on November 24-25, 2005. The *Blueprint* fulfilled the commitment to explore practical ways to clarify roles and responsibilities and report back in one year. Through the *Blueprint*, new arrangements were to be explored and developed to improve seamless health care delivery in a manner that addressed mandate and jurisdictional issues to the satisfaction of First Ministers and National Aboriginal Leaders.

COMMENTS BY THE HEALTH COUNCIL OF CANADA

The Health Council of Canada's 2006 Annual Report was critical of the federal government on a number of key issues, including:

- perceived inaction on the *Blueprint on Aboriginal Health*;
- questions around the adequacy of investments in building Aboriginal health human resources capacity and increasing the number of Aboriginal health professionals;
- funding for the Aboriginal Health Transition Fund; and
- the federal government's overall plan and direction for funding Aboriginal health programs.

The 2006 report recommend that "the federal government should provide clear direction with respect to the Blueprint on Aboriginal Health and the Kelowna accord and outline its overall plan and direction in support of Aboriginal health." The report did not focus on other federal governments commitments such as the AHHRI or upstream investments in health promotion and disease prevention.

APPENDIX C
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Department of Finance	2008/04/17	24
Krista Campbell, Senior Chief, Federal-Provincial Relations Division, Federal-Provincial Relations and Social Policy Branch, Director's Office		
Yves Giroux, Director, Social Policy, Federal-Provincial Relations and Social Policy Branch		
Jonathan Roy, Senior Policy Analyst, Health/Justice/Culture, Social Policy, Federal-Provincial Relations and Social Policy Branch		
Department of Health		
Karen Dodds, Assistant Deputy Minister, Health Policy Branch		
Kathryn McDade, Director General, Health Care Policy Directorate, Health Policy Branch		
Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch		
Public Health Agency of Canada		
Jane Billings, Senior Assistant Deputy Minister, Planning and Public Health Integration Branch		
Arlene King, Director General, Centre for Immunization and Respiratory Infectious Diseases		
Canadian Institute for Health Information	2008/05/06	27
Glenda Yeates, President and Chief Executive Officer		
Kathleen Morris, Consultant		
Health Council of Canada		
Jeanne Besner, Chair		
Albert Fogarty, Councillor		
Donald Juzwishin, Chief Executive Officer		
Association of Canadian Academic Healthcare Organizations	2008/05/13	29
Jean Bartkowiak, President and Chief Executive Officer, SCO Health Service		
Arthur S. Slutsky, Vice-President of Research, St. Michael's Hospital		

Organizations and Individuals	Date	Meeting
Canada's Research-Based Pharmaceutical Companies (Rx & D)		
Russell Williams, President		
Canadian Federation of Nurses Unions		
Linda Silas, President		
Canadian Generic Pharmaceutical Association		
Jim Keon, President		
Canadian Healthcare Association		
Denise Desautels, Director, Policy and Communications		
Pamela Fralick, President and Chief Executive Officer		
Canadian Labour Congress		
Barbara Byers, Executive Vice-President		
Teresa Healy, Senior Researcher, Social and Economic Policy Department		
Canadian Pharmacists Association		
Jeff Poston, Executive Director		
Canadian Society for Medical Laboratory Science		
Kurt Davis, Executive Director		
Canadian Union of Public Employees		
Paul Moist, National President		
Wait Time Alliance		
Lorne Bellan, Co-Chair		
Jean-Luc Urbain, Co-Chair		
Canadian Health Coalition	2008/05/27	31
Michael McBane, National Coordinator		
Canadian Health Food Association		
Anne Wilkie, Vice-President, Head of Regulatory Affairs		
Canadian Health Professionals Secretariat		
Elisabeth Ballermann, Co-Chair		
Canadian Medical Association		
Brian Day, President		
William Tholl, Secretary General and Chief Executive Officer		

Organizations and Individuals	Date	Meeting
Canadian Nurses Association		
Lisa Little, Acting Director, Public Policy		
Marlene Smadu, President		
Inuit Tapiriit Kanatami		
Onalee Randell, Director, Department of Health and Environment		
McGill Institute for the Study of Canada		
Antonia Maioni, Director		
National Aboriginal Health Organization		
Paulette Tremblay, Chief Executive Officer		

APPENDIX D
LIST OF BRIEFS

Organizations

Association of Canadian Academic Healthcare Organizations
Canada's Research-Based Pharmaceutical Companies (Rx & D)
Canadian Federation of Nurses Unions
Canadian Healthcare Association
Canadian Health Coalition
Canadian Health Food Association
Canadian Health Professionals Secretariat
Canadian Medical Association
Canadian Nurses Association
Canadian Pharmacists Association
Canadian Society for Medical Laboratory Science
Canadian Union of Public Employees
Inuit Tapiriit Kanatami
McGill Institute for the Study of Canada
National Aboriginal Health Organization
Research Canada: An Alliance for Health Discovery
Wait Time Alliance

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 24, 27, 29, 31, 34 and 35) is tabled.

Respectfully submitted,

Joy Smith, MP
Chair

Liberal Report for Review of 2004 Accord (Supplementary Opinion)

In September 2004 the First Ministers met with Aboriginal leaders and then went on to sign a historic Accord on the future of Health and Health Care for Canada. There was an overwhelming sense of consensus and hope.

Since their election in January 2006, The Conservative Government has demonstrated that honoring the commitments for the Government of Canada in the Accord is not a priority for them. They have provided no leadership in the areas of shared responsibility and virtually no action on the areas in federal jurisdiction.

Rereading the Accord reminds us of a better time:

> "In recent years, through an ongoing dialogue between governments, patients, health care providers and Canadians more generally, a deep and broad consensus has emerged on a shared agenda for renewal of health care in Canada. This agenda is focused on ensuring that Canadians have access to the care they need, when they need it."

The 'ongoing dialogue' has virtually ceased. Meetings of federal and provincial Health Ministers have been repeatedly cancelled. Working groups on commitments such as Health Human Resources and a National Pharmaceutical Strategy have virtually no federal presence. This Conservative government has taken a rigid stance on health care being a provincial responsibility and has therefore refused to participate. The responsibility for the health of Canadians is clearly a shared responsibility across all government departments, across all jurisdictions and across all sectors. There is no partner in Ottawa for Health and Health Care.

At the time of the Accord, it was clear that Canadians' confidence in the system was eroding because of concerns about long Wait Times -

> "First Ministers agree that access to timely care across Canada is our biggest concern and a national priority." First Ministers came together "and agreed on an action plan based on the following principles:

- universality, accessibility, portability, comprehensiveness, and public administration;
- access to medically necessary health services based on need, not ability to pay;
- reforms focused on the needs of patients to ensure that all Canadians have access to the health care services they need, when they need them;
- collaboration between all governments, working together in common purpose to meet the evolving health care needs of Canadians;

- advancement through the sharing of best practices;
- continued accountability and provision of information to make progress transparent to citizens;
- and jurisdictional flexibility.

Unfortunately, the failure to properly enforce the Canada Health Act means that there are places in Canada where citizens can pay to get to the front of the line. There has been a total breakdown in the collaboration agreed to in the principles as outlined above. Sharing of best practices is still being down on an ad hoc base and the areas of federal responsibility like Aboriginal Health, Military, Veterans, etc. are not learning from the provinces as they would be if there was the proper structure and communication.

The biggest disappointment is the commitment to accountability and provision of information to make progress transparent to citizens is virtually non-existent. It is patently obvious citizens must be able to compare the progress in their jurisdiction to others. Data and information must be comparable and easy for citizens to understand. The Conservative Government has interpreted the provision of 'jurisdictional flexibility' to one of total abdication of the federal role without any accountability for outcomes. The $42 billion was to 'Buy Change'. Without the appropriate reporting mechanisms, Canadians have no idea whether or not their money was well spent.

Reducing Wait Times and Improving Access

First Ministers committed to achieving meaningful reductions in wait times in priority areas such as cancer, cardiac care, diagnostic imaging, joint replacements, and sight restoration by March 31, 2007; recognizing the different starting points, priorities, and strategies across jurisdictions. Canadians expected reporting on all 5 priority areas from all jurisdictions. Instead, each province chose one area to report on.

First Ministers agreed to collect and provide meaningful information to Canadians on progress made in reducing wait times, as follows:

> "Each jurisdiction agrees to establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be developed by all jurisdictions by December 31, 2005."
>
> This was done.
>
> "Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established by December 31, 2005 through a process to be developed by Federal, Provincial and Territorial Ministers of Health."

This was done.

“Multi-year targets to achieve priority benchmarks will be established by each jurisdiction by December 31, 2007.”

Not done

“Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait time targets.”

Not done.

Strategic Health Human Resource (HHR) Action Plans

There is an acknowledged crisis in the shortages of health care professionals in Canada; including doctors, nurses, pharmacists, and technologists. These shortages are particularly acute in some parts of the country.

First Ministers agreed to continue and accelerate their work on Health Human Resources action plans and/or initiatives to ensure an adequate supply and appropriate mix of health care professionals.

Federal, provincial and territorial governments agreed to “increase the supply of health 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.” Federal, provincial and territorial governments pledged to make these commitments public and regularly report on progress. Unfortunately, Canadians are still in the dark about any such progress.

The federal government committed to:

“accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments”

Canadians are still worried that there has been little progress on this. The federal government committed to help. The federal government has a responsibility to report clearly on the progress in this area.

“targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities”

The federal government has an obligation to clearly report on the progress in increasing their supply of health care professionals in Aboriginal Communities and Official Languages Minority communities. One hundred million dollars in the Accord was dedicated to Aboriginal Health Human Resources. In order to improve the health status of our aboriginal peoples, we urgently need more aboriginal health professionals. The federal

government has a moral and constitutional responsibility to let Canadians know the progress on this essential file and invest more dollars if the progress is too slow.

> “measures to reduce the financial burden on students in specific health education programs”

The federal government must do more to reduce the financial burden of students in health disciplines. Since the time of the Accord the average debt of medical students has continued to escalate. The average income of the parents of medical students is rising. The federal government must intervene as student debt is an unacceptable deterrent to students from lower income families.

> “participate in health human resource planning with interested jurisdictions.”

The federal government has totally abdicated any active role in HHR planning; it must provide the appropriate incentives and resources to ensure an optimal supply of health human resources for an ageing population. Canada should follow the lead of Norway in establishing ethical guidelines for attracting foreign-trained health professionals.

Home Care

Even though there was no consensus on a comprehensive Home Care Strategy for Canada within the Canada Health Act, all governments recognized the value of home care as a cost-effective means of delivering services and they are developing home care services to prevent or follow hospitalization.

First Ministers agreed ‘’to provide first dollar coverage by 2006 for certain home care services, based on assessed need.” Each jurisdiction was to “develop a plan for the staged implementation of these services, and report annually to its citizens on progress in implementing home care services.” First Ministers tasked their Health Ministers to explore next steps to fulfill the home care commitment and report to First Ministers by December 31, 2006.

Although certain provinces have made progress in this area there is no real ability for Canadians to know how their province compares with other provinces. There has been no leadership from the federal government in collecting the promised implementation plans or exploring the next steps necessary to fulfill the home care commitment or for jurisdictions to report to Canadians as promised in the Accord.

Primary Care Reform

Although the Communiqué stated that “Timely access to family and community care through primary health care reform is a high priority for all jurisdictions’, between 4 and 5 million Canadians are still without a family doctor. Canadians deserve to know how far we are towards achieving the objective of 50% of

Canadians having 24/7 access to multidisciplinary teams by 2011." The First Ministers agreement to establish a best practices network to share information and find solutions to barriers to progress in primary health care reform such as scope of practice and to regularly report on progress has received no support from the federal government. The popular Primary Care Transition Fund was allowed to sunset. The abdication of a federal role on Health Human Resources has been a huge barrier to progress.

Although First Ministers acknowledged 'Electronic health records and telehealth are key to health system renewal, particularly for Canadians who live in rural and remote areas.' the commitment to accelerate the development and implementation of the electronic health record, including e-prescribing and provide telehealth to improve access for remote and rural communities has been underwhelming. Health infostructure is expensive but is intimately linked with access, quality of care, and patient safety. Therefore it should be a priority for the federal government, as important as building the Canadian Pacific Railway 100 years ago.

Access to Care in the North

The federal government agreed to help address the unique challenges facing the development and delivery of health care services in the North on a priority basis, including the costs of medical transportation. The Paul Martin Government increased funding to the Territories totaling $150 million over 5 years through a Territorial Health Access Fund, targeted at facilitating long-term health reforms, and established a federal/territorial working group to support the management of the fund, and additional direct funding for medical transportation cost. In 2005, the Government of Canada and the Territories announced their vision for the North as promised in the Accord.

National Pharmaceuticals Strategy

First Ministers agreed that no Canadians should suffer undue financial hardship in accessing needed drug therapies. Affordable access to drugs is fundamental to equitable health outcomes for all our citizens.

Even though the Health Ministers did establish a Ministerial Task Force to develop and implement the national pharmaceuticals strategy as promised in the accord, this Task Force is now moribund. The federal government has refused to provide a federal co-chair. Therefore there has been very little progress on the actions outlined in Accord except that done independently by individual jurisdictions. The dream of a National Pharmaceutical Strategy is a distant memory.

> 'Develop and assess and cost options for catastrophic pharmaceutical coverage'

Not done.

‘establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness’

Not done

accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process

Progress made under the leadership of Minister Dosanjh

strengthen evaluation of real-world drug safety and effectiveness;

A beginning has been made. MED EFFECT - http://www.hc-sc.gc.ca/dhp-mps/medeff/advers-react-neg/index-eng.php

pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines;

Not done

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;

Not done

broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record;

Glacial pace.

accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs;

Not done

enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies.

Not done

[It is understood that Quebec will maintain its own pharmacare program.]

Prevention, Promotion, and Public Health

Even though the First Minister’s recognized the importance of the healthy development of children and the extensive collaboration by governments through

the Early Childhood Development initiative, the Conservative government immediately tore up the agreements that the Government of Canada had signed with the provinces.

The commitment to further collaboration and cooperation in developing coordinated responses to infectious disease outbreaks and other public health emergencies has thankfully continued to take place because of the new Public Health Network co-chaired by Dr. David Butler Jones and Dr. Perry Kendal.

In spite of the commitment by the federal government for ongoing investments for needed vaccines through the National Immunization Strategy and to provide new immunization coverage for Canadian children, the new Conservative Government sunsetted the funds for the new children's immunizations and unilaterally decided to provide dollars for HPV vaccine outside the collaborative process with all jurisdictions for prioritizing vaccines in the National Immunization Strategy.

Although governments committed to accelerate work on a pan-Canadian Public Health Strategy, there has been no progress since the election of the Conservative Government. In December 2005, Health Ministers approved the Health Goals for Canada as promised in the Accord. However, there has been no action on the necessary next step of choosing indicators and targets through a collaborative process with experts and stakeholders. The Strategy was to have increased efforts to address common risk factors, such as physical inactivity, and integrated disease strategies, yet the 300 million dollars dedicated to integrated disease strategies was used to fund individual diseases instead of funding work on common modifiable risks and social determinants of health. It is even difficult to assess whether there has been any support from the federal government for the First Ministers' commitment to working across sectors through initiatives such as Healthy Schools.

Health Innovation

The First Ministers acknowledged a strong, modern health care system is a cornerstone of a healthy economy. The federal government commitment to continued investments to sustain activities in support of health innovation have not been realized. Investments in CIHR, Genome Canada have plateaued to a worrying level and support for bodies such as the Health Council of Canada and CIHI and Health Infoway are not sufficient to stimulate optimal innovation in health and health systems.

Accountability and Reporting to Citizens

All governments agreed to report to their residents on health system performance including the elements set out in this communiqué. Governments agreed to seek advice from experts and health providers on the most appropriate indicators to measures of health system performance. But without a common template for reporting and a process to develop common indicators the accountability to citizens is meaningless. The Saskatchewan reporting system could provide an

excellent template. The Saskatchewan report presents the areas that are doing well, making good progress, and still providing challenges.

Even though the Communiqué funding arrangements required jurisdictions to comply with the reporting provisions of this communiqué, there have been no consequences for the lack of meaningful reporting.

Although the Health Council does prepare an annual report to all Canadians, on the health status of Canadians and health outcomes, the Council's report is handicapped by the lack of good data. This year the Council has not even been able to provide a table comparing province by province results.

Dispute Avoidance and Resolution

Even though the provinces acknowledged their acceptance of the letters of 2002 with respect to Dispute Avoidance, the federal government has avoided disputes by pretending that none exist.

Conclusion

This Review is akin to assigning a mark when the student skipped class all term and then didn't even write the exam. When asked to prepare a report for the Standing Committee on Health on the federal perspective of progress to date on the Accord the Minister merely submitted other pre-existing reports. The Government has not only failed in its accountability to this Parliamentary Committee, it has failed the people of Canada.

NDP Supplementary Report to the Standing Committee on Health's Review of Progress on the 10-Year Plan to Strengthen Health Care, June 2008
by Judy Wasylycia-Leis, MP

As the driving force behind public health care in Canada, the NDP has had, from its very beginnings, a clear vision of a comprehensive, universal, non-profit health system where access to health services is based on need, not wealth. We share ordinary Canadians' pride at what we have achieved together so far and are committed to protecting and expanding that accomplishment. We are now actively engaged in completing what Medicare founder Tommy Douglas called the "second phase" of public health care – broadening it to include other essential elements such as home care, drug coverage, long-term care and dental care and reorganizing it system-wide to more effectively deliver primary care and programs to prevent illness.

The 2004 10-year Plan and the 2003 First Ministers' Health Accord that spawned it came at a critical juncture in time. Canadians had identified health care as their number-one priority, but were seeing it seriously eroded by underfunding and neglect. Privatization pressures had been mounting and, with no federal government opposition, 'privatization by stealth' was spreading – for-profit clinics had emerged in several provinces along with a proliferation of supplementary fees. The Canada Health Act was under attack by governments in Alberta and elsewhere, and the unilateral Liberal cutbacks of 1995 – the greatest single cut ever to our public health care budget – had played out in service cuts and personnel shortages leading to longer waits for medical procedures.

The Romanow Commission had just reported on its extensive two-year study on the future of health care. With no government endorsement, concerns were mounting that this grand national undertaking to draft an evidence-based blueprint to save Medicare would be for nought. There was an expectation that a significant government response was due.

The 10-year Plan was a call for renewal. It recommitted governments at all levels to the principles of the Canada Health Act and to making strategic improvements in 10 key areas to strengthen health care. To the extent that its objectives coincided with our vision of expanded, rejuvenated public health care, we welcomed the Plan.

How has the 10-year Plan lived up to that promise so far? According to the Health Council of Canada, the body that tracks the Plan's progress, not well overall. The Health Council told the Committee "These accords have laudable, much needed and ambitious goals. But have they had the broad national impact that government leaders intended? In short, the answer is no." What's wrong and how can we improve areas that are of priority concern?

National Pharmaceutical Strategy (NPS)

The growing use of drug therapies and their rise to the number one cost driver in health care has made bringing drug costs under the public health system a priority for the NDP. The 10-year Plan's National Pharmaceutical Strategy (NPS) includes steps in the right direction such as a focus on catastrophic drug coverage, expensive drugs for rare

diseases, a common national formulary, pricing and purchasing strategies, and real world drug safety and effectiveness. An interim report with concrete steps for action was issued in June 2006. It was endorsed by the provinces and territories, but waning federal government support for the NPS was immediately signalled when the federal Health Minister didn't show up at the follow-up intergovernmental meeting. This lack of federal interest and leadership continued, leaving the Report gathering dust and causing the Health Council to conclude "governments have not made substantial progress" in this area. In fact, the Committee was told, the Conservatives are even working against the Plan by extending brand name patents and increasing, rather than reducing, provincial drug costs – not to mention animosity. The result of this leadership void: drug costs rose to $27 billion in 2007 with about 60% still coming from people's own pockets and private insurance.

Home Care

Home care is another NDP priority we had hoped the Plan would advance. The Plan reiterates First Ministers' previous recognition that home care is an essential part of health care. (Romanow devoted a whole chapter to this "Next Essential Service"). The Plan aims low at only two weeks of public coverage for acute and mental health services, along with end-of-life coverage. Still, the Health Council told us, there remain "clear disparities in the availability of publicly-funded homecare across the country", and that "few jurisdictions have considered any form of evaluation of their home care renewal efforts to date, or have any intent to monitor or report on accessibility and quality".

Again, the lack of federal leadership has been a key factor. The Health Minister, ignoring the 80% of Canadians who want more home and community care added to the health system, has stated flatly that he is "not going to get involved" in home care because he sees it as a provincial matter. As if to underscore his point, the government has dismantled the Secretariat set up in 2001 to coordinate the development of a national strategy on end-of-life care. Meanwhile, a quarter of Canadians – mostly women –had to provide care to a family member or close friend last year, more than 40% of whom had to draw on their savings and 22% lose at least a month's work to do so.

Wait times

The NDP had hoped, after its long fight to counter the devastating impact of Liberal mid-90s budget cuts, that the 10-year Plan would help Canadians to regain access to timely care. In pockets across the country, there have been some notable improvements *within* the public system and *because of* the public system where the reorganization of public resources has been turned to our advantage. However, the Health Council reports that data for across-the-board comparisons and evaluations is still not available and that the benchmarks for the timing of diagnostic imaging are still not in place. Again, despite incorporating wait times into the Conservative election platform, active federal leadership has been absent and this absence is costly. The Conservative answer to failures to meet our national targets has been to simply 'move the goal posts', lessen the objectives. Further, the government has been sitting on the report of the Wait Times Advisor for two full years. Positive recommendations, including a more multidisciplinary approach and gender analysis, have been side-tracked.

Just as damaging as this inaction, has been the federal government's silence while for-profit forces have exploited public concern over wait times to resurrect their false promise of salvation through parallel for-profit care. Transferring health personnel from public to private systems would not add resources, just costs. It's neither good math nor good public policy. It does serve, however, to point to the growing personnel shortages throughout the health system – a problem that extends far beyond wait times.

Health Human Resources (HHR)

For the NDP, addressing the urgent health human resourcing crisis is at the heart of preserving and strengthening public health care. The skill shortage facing Canada's health care system is critical and growing. No corner of care is unaffected and no region immune. For example:

- we're graduating only 8,000 of the 12,000 nurses needed each year to keep up with attrition and population growth;
- we have the lowest doctor/population ratio in the G8 (an estimated 5 million Canadians don't have a family physician).
- 50% of our medical lab technologists could retire by 2016; and
- we're already short 100 full-time radiologists and predicting a shortage of 400 more by 2016.

The 10-year plan recognized this, but after developing the Framework for Collaborative Pan-Canadian Health Human Resources Planning, the action plan so urgently needed has hit the doldrums just when it should be energized by an active federal government. The Health Council has said planning remains "fragmented" – "each province and territory does its own planning, without the benefit of pan-Canadian information needed for reliable decision-making". Provinces are left to compete for resources, as are smaller communities desperately trying to entice the basic health providers they need. The extent of the problem is daunting and the need for a national strategy on human resourcing is urgent.

Aboriginal health

The NDP vision for health care has always recognized, as a priority, the urgent need to address the health deficit faced by aboriginal Canadians with improvements to both health services and the determinants of health for aboriginal communities. The need for immediate government action -- particularly federal government action stemming from its direct responsibility for on-reserve First Nations and Inuit health – has been well outlined by the Royal Commission on Aboriginal Peoples, numerous reports by the Auditor General and countless others. Although the 10-year Plan includes health care in Northern communities and has incorporated the 2004 Blueprint for Aboriginal Health, the Health Council reports that "preventable health problems… continue to be of concern across the country", and that "relatively little funding seems to have flowed". Meanwhile, aboriginal health continues to fall behind with disproportionate rates of diabetes and other preventable diseases. Clearly there is an urgent need to mobilize the federal government action that has been missing.

Conclusion and Recommendations
Canadians care passionately about their public health care system and are depending on their governments to sustain and improve it. Together, we have a lot riding on the success of this renewal effort. In the course of the Committee's review, we have identified the following key concerns and make recommendations to meet these concerns.

Federal leadership needed in a system-wide, pan-Canadian approach
We are concerned that the federal government's decentralized approach to national health care priorities has resulted in the loss of a national vision for health care and a directionless, leaderless renewal process at the national level.

We recommend, therefore, that the federal government commit itself to a national, pan-Canadian, system-wide approach to public health care renewal anchored in Canada Health Act principles and enforcement, and with the jurisdictional flexibility and asymmetrical federalism found in the 10-Year Plan to Strengthen Health Care.

Urgent need to rekindle renewal effort
We are concerned that we are approaching the mid-way point in the 10-Year Plan to Strengthen Health Care and have been told by witnesses that insufficient progress being made to meet Plan objectives on time.

We recommend, therefore, that the government take urgent actions to get the Plan back on track in each of its areas of focus as quickly as possible, including:

- acting on the recommendations of the 2006 Interim Report of the National Pharmaceutical Strategy and the Report of the Wait Time Advisor;
- advancing the action plan under the Framework for Collaborative Pan-Canadian Health Human Resources Planning;
- energetically pursuing the objectives of the 2004 Blueprint for Aboriginal Health (most particularly where it relates to measures under direct federal jurisdiction);
- working with the provinces and territories to re-establish the Advisory Committee on Governance and Accountability as a functioning part of the renewal process; and
- convening a meeting of ministers of health to identify roadblocks that are impeding progress and to develop strategies to overcome these obstacles.

Fortifying the Canada Health Act
We are concerned that the Canada Health Act, our main tool in protecting public health care, to which the 10-Year Plan to Strengthen Health Care is committed, is being undermined through inadequate monitoring and enforcement. The for-profit health industry continues to grow unabated undermining public health care and creating a two-tier health system by stealth. The Canada Health Act annual reports to Parliament do not reflect this due to their limited scope and the government's failure to make improvements identified by the Auditor General back in 2002.

We recommend, therefore, that the Health Minister fully enforce the Canada Health Act by:

- setting data collection standards for reporting and enforcement that capture all for-profit activities that may impact on public health delivery;
- working collaboratively with the provinces and territories to fill gaps in reporting;
- stipulating that federal transfers should only be used for non-profit health care delivery; and
- removing any requirements that health infrastructure endeavours consider for-profit options such as public-private partnerships.

Bloc Québécois Supplementary Opinion
10-Year Plan to Strengthen Health Care

THE FACTS: QUEBEC AND THE AGREEMENT OF SEPTEMBER 15, 2004

Appended to the September 2004 agreement—the 10-Year Plan to Strengthen Health Care—is a separate communiqué for Quebec, known as the "Quebec clause."

This clause confirms Quebec's full authority to intervene and make decisions with respect to health, over which it has sole jurisdiction. Furthermore, the agreement, which recognizes an asymmetrical arrangement between the federal government and Quebec, states that "funding made available by the Government of Canada will be used by the Government of Quebec to implement its own plan for renewing Quebec's health system."

The only constraint placed on Quebec by this specific agreement is that Quebec support "the overall objectives and general principles set out by the federal, provincial and territorial first ministers" in the agreement, including the objectives of "timely access to quality care and reduced wait times." As it happens, reduced wait times were already a priority for the Government of Quebec well before September 2004. However, it bears re-emphasizing that Quebec's health system differs from that of the other provinces and that the Government of Quebec must be able to make its own decisions, not have them imposed on it by the rest of Canada.

In this respect, the agreement explicitly states that "Quebec will apply its own wait time reduction plan, in accordance with the objectives, standards and criteria established by the relevant Quebec authorities."

Lastly, the communiqué concludes by stating that "nothing in this communiqué shall be construed as derogating from Quebec's jurisdiction." Consequently, Quebec is the sole decision-maker on health-related matters.

THE BLOC QUÉBÉCOIS' POSITION ON THE 10-YEAR PLAN TO STRENGTHEN HEALTH CARE

From the moment the agreement was announced, the Bloc Québécois has denounced the restrictions underlying the specific agreement with Quebec. Because the agreement established benchmarks based on scientific evidence, Quebec will certainly be compared with the other provinces that publish similar data. Therefore, despite having no specific obligation with respect to how it manages its health system, it will have a political obligation to show results. It must remain on par with the other provinces in terms of wait times, investment and development or face criticism by its own population, regardless of the distinctive nature of care in Quebec or the variety of social services available.

Moreover, in reaching the agreement, the Bloc Québécois felt that Quebec should have been granted the "Quebec clause" automatically, since it is only right that Quebec receive unconditional federal funding, since health clearly falls under provincial jurisdiction.

Furthermore, it bears pointing out that the great difficulty Quebec and the other provinces have today in guaranteeing health care within respectable and reasonable wait times is because of the cuts, particularly to the Canada Health and Social Transfer, ravaged by the Liberals in 1994 to achieve a zero deficit. Quebec and the other provinces had to make snap decisions to make up for these shortfalls, and their respective health systems were certainly hard hit by the then Liberal government's withdrawal. Still today the amount of money invested cannot alone close these massive gaps created by the cuts to Quebec and provincial budgets.

The Bloc Québécois therefore maintains its opposition to the federal government's interference in the areas of jurisdiction of Quebec and the other provinces on the pretext of various pan-Canadian strategies, including the 10-Year Plan to Strengthen Health Care.

STATUTORY REVIEW OF THE 10-YEAR PLAN TO STRENGTHEN HEALTH CARE—TRUE RESPECT FOR JURISDICTIONS

A. The report must state that Quebec and the other provinces are accountable to their populations only with respect to their progress in achieving wait time objectives.

While the report sets out in paragraph 3 the special status of the 2004 agreement with Quebec, in which the federal government recognized an asymmetrical federalism and therefore established separate arrangements with Quebec, the Bloc Québécois deplores that the report does not fully cover this separate agreement with Quebec. In our view, these parameters must be brought to attention wherever necessary in the current report.

Therefore, Recommendation 1,

> **"that the federal government comply with the requirement of reporting on its progress on all components of the 10-Year Plan; that it fulfill this requirement by the end of the 2008-09 fiscal year; and that it encourage all jurisdictions to provide the required public reports within the specific 10-Year Plan deadlines,"**

must take into account the fact that Quebec and the other provinces are accountable to their population only with respect to the progress made in attaining their objectives and have no such obligation to the federal government.

Again in the interest of respecting the specific agreement of September 2004 between Quebec and the federal government alongside the 10-Year Plan to Strengthen Health Care, the Bloc Québécois believes that Recommendation 3 must be expanded on to address this specific status.

Therefore, Recommendation 3,

> **"that the federal government specifically report on funding provisions relevant to the populations for which it has direct responsibility,"**

must be amended to reflect what is put forward in paragraph 59, namely that Quebec and the other provinces are voluntarily accountable to their citizens, not to the federal government. Furthermore, no such obligation may be imposed on Quebec or the other provinces, given that health falls under provincial jurisdiction and that they are not accountable with respect to spending in their own areas of jurisdiction. Accordingly, federal health transfers cannot be subject to conditions or objectives.

B. Pan-Canadian collaboration on health care must respect the areas of jurisdiction of Quebec and the other provinces.

We also have reservations about the wording of Recommendation 2 in the report:

> **"That the federal government, in collaboration with the provinces and territories and in partnership with the Health Council of Canada and the Canadian Institute for Health Information, agree on a set of comparable data and indicators to ensure proper assessment of progress under the 10-Year Plan; that the federal government ensure that this set of indicators is relevant to its client groups; that this work be completed by the end of 2008-09 fiscal year."**

This recommendation refers to the establishment of indicators by the provinces, territories and the federal government to ensure proper assessment of progress under the 10-Year Plan. Yet it does not refer to the agreement with Quebec, which addressed this exact subject from the perspective of asymmetrical federalism. To be acceptable to the Bloc Quebecois:

- consideration must be given to the "Quebec clause," whereby Quebec has its own plan to reduce wait times based on its own standards, criteria and objectives;
- the Quebec authorities shall agree to work closely with the provincial and territorial governments and the federal government, by sharing information and best practices;
- the Quebec authorities shall promote the use of comparable indicators, mutually agreed upon with the other governments;
- Quebec shall continue to work with the other governments on the development of new comparable indicators.

Finally, **recommendation 4** refers to the need "to revive the idea of a common pan-Canadian vision to strengthen health care and to put mechanisms in place to make this vision a reality," while also suggesting that "the federal, provincial and territorial governments publicly recommit to the nationwide collaboration envisioned in the 10-Year Plan." Although pan-Canadian collaboration may be helpful, the fact remains that health falls under the jurisdiction of Quebec and the provinces. As such, they have the power to decide whether or not they wish to work together, and collaboration must not be used as a pretext for federal interference in their areas of jurisdiction.

In our opinion, the 2004 agreement with Quebec should accordingly be reflected in the Committee's recommendations. The "Quebec clause" should be reaffirmed, whereby in matters of health Quebec exercises its responsibility for planning, organizing and managing health services within its jurisdiction. Similarly, Quebec shall implement its own plan to reduce wait times, based on the objectives, standards and criteria established by the appropriate Quebec authorities.

C. The federal government must look after its own client groups

The Bloc Québécois wishes to take this opportunity to point out that the federal government too often seeks to interfere in the areas of jurisdiction of Quebec and the provinces, as regards health in this case, citing national strategies as a justification. How can the federal government justify these too frequent incursions relating to health when the First Nations, one of its client groups, receive mediocre services?

Consider the overwhelming statistics regarding the health of Aboriginal peoples:

- The infant mortality rate is 2 to 3 times higher among the First Nations than in the general population;
- The life expectancy of status Indians is 5 to 7 years less than in the general population;
- The suicide rate is from 2 to 7 times higher than in the general population;
- At least 33% of First Nations and Inuit live in housing that does not meet the standards for quality, size and affordability, according to Canada Mortgage and Housing Corporation figures. Yet there is a known link between inadequate housing and a whole range of health problems;
- In the 1990s, the rate of tuberculosis among the First Nations was seven times higher than in the general population;
- Smoking is much more prevalent among the First Nations (over 50%: 56% among Aboriginals and 71% among Inuit in 2004) than the general population. Despite these figures, the Conservative government cut ten million dollars from the anti-smoking program designed to raise awareness among pregnant women and young Inuit and Amerindians of the harmful effects of smoking;
- Aboriginal peoples continue to be overrepresented in the HIV epidemic in Canada. They represent 3.3% of the population of Canada, but account for an estimated 7.5% of all existing cases of HIV;
- 9% of new HIV cases reported in 2005 were among Aboriginals, 53% of them related to intravenous drug use, as compared to 14% among the general population.

Based on these figures, which amply demonstrate how much has to be done to improve the health of Aboriginal peoples, the Bloc Québécois is of the opinion that instead of asking the provinces to report on progress on wait times and how federal health transfers are used, the federal government should address the alarming health problems among the First Nations and report to them on the progress they have made.