Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act (the Act) [Our File #: HCS 24 2014]

On July 2, 2014, the Department of Health and Community Services received your request for access to the following records/information:

“I am requesting under the Access to Information Act any briefing notes, information sheets, documents compiled on the Health Accord, dating back no further than Feb 22, 2012.”

On July 15, 2014, the Department wrote to notify you that it was extending the 30-day time limit for responding to your request for an additional 30 days in accordance with subsections 16(1)(a) and 16(1)(b) of the Act. The Department advised at that time that it expected to respond to your request on or before September 2, 2014.

The Department has reviewed your request in the context of the Act and is pleased to inform you that access to these records has been granted. A copy of the requested records is attached.

Please be advised that a copy of our response to your request will be published on the Office of the Public Engagement’s website five business days after the response is mailed to you. If you have any further questions, please feel free to contact Cheryl Joy, ATIPP Coordinator, at (709)729-7010, or by email at cheryljoy@gov.nl.ca.

Sincerely,

[Signature]

BRUCE COOPER
Deputy Minister

/Encl.
EXECUTIVE SUMMARY

A. Introduction

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

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

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

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

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

Throughout the course of this study, witnesses were emphatic that health care reform could only be achieved by breaking down the different silos within health care systems. They insisted that different health care sectors such as primary, acute, continuing care and mental health services be integrated through common governance structures and funding arrangements and supported by seamless information systems. The integration of different health care professionals into primary vi
health care teams requires the adoption of different methods of remuneration that allow for different health care professionals to work together. Furthermore, they underscored the vital importance of making patients' needs and perspectives central to these reform efforts. Witnesses provided exciting examples of reforms occurring at the front lines of health care delivery in Canada. However, they indicated that systemic change had stalled. When compared internationally, they noted that Canada is no longer seen as a model of innovation in health care delivery and financing. They therefore identified the need for specific mechanisms to promote the implementation of new practices in health care systems across the country. Otherwise, they feared that health care reform in Canada would never evolve beyond a pilot project. Finally, many witnesses said that resources currently committed to federal, provincial and territorial health care systems are sufficient to provide Canadians with a high standard of quality health care, but they also told the committee that innovation-based transformation is needed to achieve and sustain these systems. These witnesses were unequivocal in their insistence that any increases in health care funding be used to promote change rather than maintain the status quo. They therefore argued that governments need to focus on creating incentives to transform health care systems. The committee heard that there is a real appetite among health care professionals to truly transform the way that they do business and achieve lasting reform. The committee believes that the time for this transformative change is now. It therefore recommends:

RECOMMENDATION 1
That the committed annual increase in funding transferred from the federal government to the provinces and territories, through the Canada Health Transfer, be used by governments in great part to establish incentives for change that focus on transforming health care systems in a manner that reflects the recommendations outlined in this report, and the overarching objectives of the 2004 10-Year Plan to Strengthen Health Care, including the need for measurable goals, timetables and annual public reporting through existing mechanisms.

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

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


- reducing wait times and improving access;
- strategic health human resource (HHR) 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 research and innovation;
• accountability and reporting to citizens; and
• dispute avoidance and resolution.

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

1. Reducing Wait Times and Improving Access to Care

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

• Establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be produced by December 31, 2005;

• Establish evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration by December 31, 2005 through a process developed by Federal, Provincial and Territorial Ministers of Health;

• Establish multi-year targets to achieve priority benchmarks by December 31, 2007; and

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

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

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

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

**RECOMMENDATION 2**
That provinces and territories continue to develop strategies to address wait times in all areas of specialty care, as well as access to emergency services and long-term care, and report to their citizens on progress.

**RECOMMENDATION 3**
That the federal government work with provinces, territories and relevant health-care and research organizations to develop evidence-based pan-Canadian wait-time benchmarks for all areas of specialty care that start when the patient first seeks medical help.
RECOMMENDATION 4
That the federal government provide the Canadian Health Services Research Foundation—or the Canadian Institutes of Health Research with funding to:

a) commission research that would provide the evidence base for the development of pan-Canadian wait-time benchmarks for all areas of specialty care; and

b) commission research to evaluate the appropriateness of existing pan-Canadian wait-time benchmarks related to cancer, heart, sight restoration, and joint replacement.

RECOMMENDATION 5
That the Health Council of Canada examine best practices in reducing wait times across jurisdictions, through improvements in efficiency, focusing in particular on management practices such as pooling waitlists, the adoption of queuing theory and the development of referral guidelines and clinical support tools.

RECOMMENDATION 6
That the federal government work with provincial and territorial governments to develop a pan-Canadian vision statement that would foster a culture of patient-centred care in Canada through the establishment of guiding principles that would promote the inclusion of patient needs and perspectives in an integrated health-care-delivery process.

RECOMMENDATION 7
That the federal, provincial and territorial governments ensure accountability measures be built into the Canada Health Transfer agreement, to address the needs of disabled persons.

2. Health Human Resources

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

RECOMMENDATION 9
That the Canadian Institutes of Health Information include linguistic variables in their collection of data related to health human resources and populations served by health-care systems across Canada.

RECOMMENDATION 10
That the federal government work with the provinces and territories and relevant health-care organizations to reduce inequities in health human resources, such as rural and remote health care, vulnerable populations, and Aboriginal communities.

RECOMMENDATION 11
That the federal government, through its Foreign Credential Recognition Program, take the lead in working with provincial and territorial jurisdictions and relevant stakeholders to accelerate their efforts to improve the assessment and recognition of the foreign qualifications of internationally educated health professionals and their full integration into Canadian healthcare systems, in line with the principles, obligations and targets agreed upon in the Federal/Provincial/Territorial Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications.

RECOMMENDATION 12
That the federal, provincial and territorial governments work with universities and colleges to increase inter-professional training of health-care practitioners to continue the development of multi-disciplinary health-care teams in Canada.

3. Home Care

Under the 10-Year Plan, First Ministers recognized the importance of home care as an essential part of an integrated patient-centred health care system and to provide first dollar coverage11 for certain home care services by 2006:12

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

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

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

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

The 10-Year Plan further required that jurisdictions report on progress towards the implementation of these services with Health Ministers providing an additional report to First Ministers on the next steps in fulfilling home care commitments by December 31, 2006. The committee’s review found that jurisdictions had made progress in improving access to acute home care services; acute community mental health home care services; and end-of-life care. However, the review also found that governments did not meet their reporting requirements relating to home care due to a lack of agreement regarding developing indicators and targets for progress in this area. The committee also shares the concerns of witnesses related to the increased costs of drugs and supplies experienced by patients and families as a result of being treated out-of-hospital, as well as the reduction of chronic home care services currently being offered, given the increasing burden of chronic diseases in Canada. The committee also heard from witnesses that overall, the 10-Year Plan adopted a narrow approach to addressing home care that did not include ensuring access to a broad range of services that were considered by witnesses to be important parts of home care. In addition, the committee heard that home care needs to be better integrated with the acute and primary care sectors, mental health services, as well as the full range of continuing care services that includes palliative care and facility-based long-term care. Finally, the committee agrees with witnesses that
governments need to take further action to promote access to high quality palliative and end-of-life care in Canada, as well as raise awareness among Canadians regarding the importance of planning end-of-life care. The committee therefore recommends:

RECOMMENDATION 13
That the federal government work with provincial, territorial governments and other relevant stakeholders to develop indicators to measure the quality and consistency of home care, end-of-life care, and other continuing care services across the country.

RECOMMENDATION 14
That where necessary, jurisdictions expand their public pharmaceutical coverage to drugs and supplies used by home care recipients.

RECOMMENDATION 15
That the Mental Health Commission of Canada work with the home care sector to identify ways to promote the integration of mental health and home care services.
RECOMMENDATION 16
That Health Canada, taking the lead, work with provinces and territories to create and implement an awareness campaign for Canadians about the importance of planning end-of-life care.

RECOMMENDATION 17
That the federal government work with provincial and territorial governments to develop a pan-Canadian Homecare Strategy, which would include a focus on reducing the burdens faced by informal caregivers.

RECOMMENDATION 18
That the federal government work with the provinces and territories to increase access to palliative care as part of end-of-life health services in a broad range of settings including residential hospices.

RECOMMENDATION 19
That the federal, provincial, and territorial governments develop and implement a strategy for continuing care in Canada, which would integrate home, facility based long-term, respite and palliative care services fully within health care systems. The strategy would establish clear targets and indicators in relation to access, quality and integration of these services and would require governments to report regularly to Canadians on results.

4. Primary Care Reform

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

5. Electronic Health Records and Tele-health

In the 10-year plan, first priority was focused on the development of Electronic Health Records (EHRs) and Tele-health services. The government committed to allocate an additional $100 million in the development of EHRs. The Royal Commission on Health, echoed by national health leaders, emphasized the importance of EHRs in patient care and record keeping. EHRs were described as critical to improving the quality of care, reducing errors, and enhancing patient outcomes. The plan also highlighted the need to improve access to health care services, particularly in remote and underserved communities. Over the next decade, the government invested in infrastructure and technology to support the widespread adoption of EHRs.

RECOMMENDATION Z

Policy on Electronic Health Records: To ensure that all health care providers have access to electronic health records in order to enhance patient care and improve health outcomes.

RECOMMENDATION Z

Policy on Tele-health: To expand access to tele-health services, particularly in rural and remote areas, to improve patient access to health care services.

Policy on Health Professional Regulation: To strengthen the regulation of health professionals to ensure quality care and patient safety.

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

**RECOMMENDATION 22**
That the Government of Canada continue to invest in Canada Health Infoway Inc. to ensure the realization of a national system of interoperable electronic health records.

**RECOMMENDATION 23**
That Canada Health Infoway Inc. target its investments to:

a) projects aimed at upgrading existing components to meet national interoperability standards set by the organization; and

b) promoting the adoption of electronic medical records by health professionals in Canada, including working with stakeholders to identify effective incentives in this area.

**RECOMMENDATION 24**
That Canada Health Infoway Inc. work with provinces and territories and relevant stakeholders to:

a) establish a target that would outline when all existing components of the EHRs would be upgraded to meet national interoperability standards;

b) establish a target that would outline when at least 90 per cent of all physicians in Canada will have adopted electronic medical records;

c) ensure that electronic health record systems are currently being designed and implemented in a way that would allow for secondary uses, such as health system research and evaluation; and

d) develop a systematic reporting system in relation to access to tele-health services in Canada.

**RECOMMENDATION 25**
That the federal government work with provinces and territories to examine approaches to addressing differences in privacy laws across jurisdictions in relation to the collection, storage and use of health information.
6. Access to Care in the North

The 10-Year Plan also recognized the importance of improving access to health care services in northern communities. As a result, the federal government provided $1.50 million over five years to the Territorial Health System Sustainability Initiative (THSSI) in order to: facilitate long-term health reforms; establish a federal/territorial working group to support the management of the fund; and enhance direct funding for medical transportation costs.\textsuperscript{17} The federal government also agreed to develop a joint vision for the North in collaboration with the territories.\textsuperscript{18}

\textsuperscript{17} Health Canada, \textit{A 10-year Plan To Strengthen Health Care}, 16 September 2004.
\textsuperscript{18} Ibid.

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

**RECOMMENDATION 26**

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

**RECOMMENDATION 27**

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

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

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

7. The National Pharmaceuticals Strategy

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

The nine elements included the following: develop, assess and cost options for catastrophic pharmaceutical coverage; Establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness; Accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process; Strengthen evaluation of real-world drug safety and effectiveness; Pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines; Enhance action to influence the prescribing behaviour of health care professionals so that drugs are used only when needed and the right drug is used for the right problem; Broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record; Accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs; and Enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies. Health Canada, *First Minister’s Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*, 16 September 2004, http://www.hc-sc.gc.ca/hc-ss/delivery-prestation/prixcollab2004-fniim-rpm/index-eng.php.

21 Ibid.

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

**RECOMMENDATION 28**
That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability; including a national catastrophic drug coverage program and a national formulary.

**RECOMMENDATION 29**
That governments, acting together, work with private health insurance companies to encourage their adoption of best practices in cost containment strategies.

**RECOMMENDATION 30**
That Health Canada report on progress towards the development of a regulatory framework for expensive drugs for rare diseases as part of its annual performance report to Parliament.

8. Prevention, Promotion and Public Health

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

The committee found that the objectives outlined in the 10-Year Plan relating to the development of a Pan-Canadian Public Health Network and increasing investments in the National Immunization Strategy had been met, though there is also an on-going need to fund and elaborate on the NIS to address the risks posed by communicable diseases. The committee's study also found that efforts towards the development of a pan-Canadian Public Health Strategy had been unsatisfactory. Though witnesses recognized the importance of addressing current priorities such as chronic diseases, promoting healthy lifestyles, and preventing childhood obesity, they explained that the public health needed to be broader, including focusing on widening health disparities by addressing the social determinants of health and recognizing that addressing mental health issues represent a key component of overall health and well-being. They also identified the need to reduce the number of injuries in Canada and their associated burden on the acute care system as another priority. The committee recognizes the importance of these issues, as well as the fact that important work has already been undertaken in these areas by the Mental Health Commission of Canada and this committee's own Subcommittee on Population Health. The committee therefore recommends:

RECOMMENDATION 31
That the Public Health Agency of Canada continue its efforts to renew the National Immunization Strategy, including the establishment of goals, objectives and targets.

RECOMMENDATION 32
That the federal government work with provincial and territorial, and municipal governments to develop a Pan-Canadian Public Health Strategy that prioritizes healthy living, obesity, injury prevention, mental health, and the reduction of health inequities among Canadians, with a particular focus on children, through the adoption of a population-health approach that centres on addressing the underlying social determinants of health.

RECOMMENDATION 33
That Health Canada, upon receipt of the Mental Health Commission report, use data developed on pan-Canadian child and youth mental-health issues to inform policy and program decisions relating to child and youth mental health.

9. Health Innovation
In the 10-Year Plan, the federal government committed to continuing its investments in science, technology and research to promote the adoption of new, more cost-effective approaches to health care, as well as facilitate the adoption and evaluation of new models of health protection and chronic disease management. The committee’s study revealed that the federal government was making significant investments in health research that was allowing for discoveries, which were reducing adverse reactions and mortality rates, and were cutting costs across health care systems. However, the committee heard that there were concerns among witnesses that insufficient resources were being dedicated to health services research. The committee also heard that the Canadian Institutes of Health Research (CIHR) had developed a new Strategy for Patient Oriented Research that would provide funding for health innovations in different areas of health care service delivery over ten years. The committee heard that the federal government, in collaboration with provincial and territorial governments, could enhance these efforts through the creation of a specific mechanism dedicated to promoting health innovation in Canada, which would be established to promote collaboration among governments in identifying, disseminating, and leading practices in health care service delivery across health care systems. The committee therefore recommends:

RECOMMENDATION 34
That the federal government, taking the lead, work with provincial and territorial governments to establish a Canadian Health Innovation Fund to identify and implement innovative and best practice models in health care delivery and the dissemination of these examples across the health system.

RECOMMENDATION 35
That the Canadian Institutes of Health Research provide an interim report in five years evaluating the implementation and impact of its Strategy for Patient Oriented Research, including its findings related to new primary care models.

RECOMMENDATION 36
That Health Canada create a network between federally funded pan-Canadian health research organizations, and other interested stakeholders that would focus on identifying leading practices in health care delivery and work together to promote their dissemination in health care systems across Canada.

RECOMMENDATION 37
That the federal government ensure that there is ongoing funding dedicated towards health services and systems research either through the Canadian Institutes of Health Research or the Canadian Health Services Research Foundation

10. Accountability and Reporting to Citizens

In the 10-Year Plan, all governments committed to report to their residents on the performance of their health care systems, as well as on its key components such as wait times, health human resources, and home care through the development of common indicators and benchmarks. The committee heard from witnesses that accountability and reporting requirements of the 10-Year Plan had led to enhanced collection of data and the development of health indicators measuring health system quality and performance. However, they explained that there was a need to develop a pan-Canadian health indicator framework to allow for common measurements of health care system
...xxi quality and performance, inter-jurisdictional comparisons and pan-Canadian reporting. The committee heard that ongoing efforts in these areas were necessary to promote health care reform and quality improvement. The committee also heard that these efforts were being reinforced by the establishment of health quality councils in different jurisdictions across Canada. The committee heard that health quality councils should be established across Canada and be given a mandate focusing on dimensions of quality beyond those outlined in the 10-Year Plan, including patient safety, effectiveness, patient-centeredness, efficiency, timeliness, equity and appropriateness. The committee therefore recommends:
RECOMMENDATION 38
That the federal government through Health Canada work with organizations such as the Canadian Patient Safety Institute to promote the development of health-quality council concepts.

RECOMMENDATION 39
That the Canadian Institute for Health Information work with provincial and territorial governments and relevant stakeholders to develop a pan-Canadian patient-centred comparable-health-indicator framework to measure the quality and performance of healthcare systems in Canada.

11. Dispute Avoidance and Resolution

The 10-Year Plan also included a provision that formalized a dispute avoidance and resolution process related to the interpretation and enforcement of the principles of the Canada Health Act, which was agreed to through a series of letters between the Premier of Alberta and then Prime Minister Jean Chrétien in April 2002.24 During the course of its review, the committee heard from witnesses that the dispute avoidance activities undertaken by Health Canada had been successful in preventing the need for using the formal dispute resolution process agreed to by governments. The committee also heard that the process had allowed for transparency in the enforcement of the Canada Health Act through its reporting requirements. However, the committee also received written submissions outlining instances of violations of the Canada Health Act by private for-profit health delivery clinics in Canada. They therefore called for the federal, provincial and territorial governments to take a more proactive role investigating these violations and enforcing the principles of the Act. The committee therefore recommends:

RECOMMENDATION 40
That all governments put measures in place to ensure compliance with the Canada Health Act and more accountability to Canadians with respect to implementation of the Act.

C. Implementing the Communiqué on Improving Aboriginal Health

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


• Improving delivery and access to health services to meet the needs of all Aboriginal peoples through better integration and adaptation of all health systems;

• Measures that will ensure that Aboriginal peoples benefit fully from improvements to Canadian Health systems; and

• A forward looking agenda of prevention, health promotion and other upstream investments.

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

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

RECOMMENDATION 41
That Health Canada work with provincial and territorial partners to ensure equitable access to programs and initiatives related to improving Aboriginal health.

RECOMMENDATION 42
That Health Canada work with provinces and territories to ensure that the design and delivery of its programs and initiatives meet the unique needs and culture of Inuit people.

RECOMMENDATION 43
That Health Canada work closely with provincial and territorial governments to ensure improvements in Aboriginal health through the federal, provincial and territorial multi-year funding agreements.

RECOMMENDATION 44
That the federal government work with Aboriginal communities to improve the delivery of health-care services in Canada, and deal specifically with removing jurisdictional barriers.

RECOMMENDATION 45
That Health Canada establish a working group with provincial and territorial partners and all national Aboriginal organizations to identify ways in which the role of Aboriginal organizations could be strengthened in the policy-making and development process.

RECOMMENDATION 46
That the federal government work with the provinces and territories to address the social determinants of health, with a priority focus on potable water, decent housing and educational needs.

D. Conclusion

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

However, the committee’s review revealed that real systematic transformation of health care systems across the country had not yet to occurred, despite more than a decade of government commitments and increasing investments. For witnesses appearing before the committee, the way forward was clear: long lasting transformative change could only occur through the breaking down silos between sectors within health care systems; facilitating collaboration among different health care professionals; adopting compatible health information systems; and establishing health governance and funding arrangements to support these developments. In addition, health care systems need to be reoriented towards the prevention of disease and injury; the needs of patients; and a holistic view of health which sees physical and mental wellbeing as inextricably linked, while not forgetting that many of the factors that affect the health and wellbeing of Canadians remain outside of health care systems. Our witnesses spoke with conviction and experience. It is now time for us to act.
2004 Health Accord

- Health care costs are continuing to rise throughout the country, while the contributions of the federal government continue to shrink. This province spends 40% of the overall budget on health care.

- We are calling on the federal government to provide adequate, sustainable and predictable transfers to help meet the challenges in providing health care and other valued services.

- The 2004 Health Accord is a ten-year plan to strengthen health care which was endorsed by First Ministers. The 2004 Accord committed the federal government to provide $41.3B over 10 years, in addition to the ongoing transfer of income tax points.

- Valuable insights have been gained since the 2004 Health Accord and past efforts will guide our future actions. We will continue to work on our commitment to sustainability and accountability.

- We plan to continue to address cost pressures in the health care system, while maintaining the level of quality service that our residents require.
Information Note
Department of Health and Community Services

Title: Senate Committee Review of the 2004 Health Accord.


Background and Current Status:
- In January 2011 the federal Health Minister asked the Committee to conduct a second statutory review of the Health Accord. The Committee held 13 hearings between March and December of 2011. The first statutory review was initiated in March 2008 and the report was released in June of that same year.
- The federal government has 180 days to respond to the latest Senate Committee report. The Report, seen as a means of informing the federal Health Minister about issues in advance of renewal of the Accord in 2014, has been impacted by the new funding formulas imposed on PTEs by Minister Flaherty on December 19, 2011.
- The Health Council of Canada (HCC) has publicly stated that it is encouraged by the Senate Committee’s report, and is pleased that many of its recommendations made it to the Report such as the need for measurable goals, timetables and public reporting.
- The Accord saw $41.3 billion invested in health care over a 10 year period, indexed at 6 per cent. The investment included funding for:
  - reducing wait times and improving access for certain procedures, including hip and knee replacements, cataract surgery, cancer radiotherapy and diagnostic imaging;
  - strategic health human resources (HHR) action plans;
  - home care;
  - primary health care reform, including electronic health records (EHRs) and telehealth;
  - access to care in the North;
  - National Pharmaceuticals Strategy (NPS);
  - Prevention, promotion and public health;
  - Health research and innovation;
  - Accountability and reporting to citizens; and
  - Dispute avoidance and resolution.
- The Senate Committee report does not call for more money but for money to be spent more efficiently. The Report points out some successes and areas where slow progress has been made, including the implementation of EHRs and providing improved access to primary health care.

Key Recommendations:
- The Senate report makes 46 recommendations in eleven different areas.

RECOMMENDATION 1: That the committed annual increase in funding transferred from the federal government to the provinces and territories, through the Canada Health Transfer, be used by governments in great part to establish incentives for change that focus on transforming health-care systems in a manner that reflects the recommendations outlined in this report, and the overarching objectives of the 2004 10-Year Plan to Strengthen Health Care, including the need for measurable goals, timetables and annual public reporting through existing mechanisms.

Provincial Context:
- This links the Canada Health Transfer (CHT) to accountability measures that effect innovation, enabling the transformation of health care systems. The report recommendations are based on
the premise that current fiscal commitments to health care provide PTs with the means of effecting "transformative change".

- On December 19, 2011 the Conservative government surprised the provinces by unveiling its long-term funding plan for health and social transfers. Without any prior commitment to reform by the provinces, the federal Finance Minister said he would maintain increases in health-care transfers at 6 per cent for 2014 and 2015.

Reducing Wait Times and Improving Access to Care

RECOMMENDATION 2: That provinces and territories continue to develop strategies to address wait times in all areas of specialty care, as well as access to emergency services and long-term care, and report to their citizens on progress.

RECOMMENDATION 3: That the federal government work with provinces, territories and relevant health-care and research organizations to develop evidence-based pan-Canadian wait-time benchmarks for all areas of specialty care that start when the patient first seeks medical help.

RECOMMENDATION 4: That the federal government provide the Canadian Health Services Research Foundation or the Canadian Institutes of Health Research with funding to:

a) commission research that would provide the evidence base for the development of pan-Canadian wait-time benchmarks for all areas of specialty care; and

b) commission research to evaluate the appropriateness of existing pan-Canadian wait-time benchmarks related to cancer, heart, lung, joint replacement.

RECOMMENDATION 5: That the Health Council of Canada examine best practices in reducing wait times across jurisdictions, through improvements in efficiency, focusing in particular on management practices such as pooling waitlists, the adoption of queuing theory and the development of referral guidelines and clinical support tools.

Provincial Context:

- In February 2012, two five-year provincial wait time strategies, which will focus on reducing wait times in emergency departments and orthopedic surgery for hip and knee joint replacement, were released.

- More evidence-based national benchmarks are needed, with the federal government taking the lead. A review of the existing pan-Canadian benchmarks would also be beneficial as they were established 7 years ago.

RECOMMENDATION 6: That the federal government work with provincial and territorial governments to develop a pan-Canadian vision statement that would foster a culture of patient-centered care in Canada through the establishment of guiding principles that would promote the inclusion of patient needs and perspectives in an integrated health-care-delivery process.

Provincial Context:

- This proposed vision is consistent with the strategic issues outlined in the current departmental Strategic Plan regarding quality and safety, improved access and increased efficiency.

RECOMMENDATION 7: That the federal, provincial and territorial governments ensure accountability measures be built into the Canada Health Transfer agreement, to address the needs of disabled persons.

Provincial Context:

- In April 2012, the Government of Newfoundland and Labrador released Access, Inclusion, Equality - a strategy for the Inclusion of persons with disabilities. The Strategy is taking a long-term cross-disability approach designed to bring about substantive change within policies,
services, programs and attitudes. Budget 2012 allocated $6.5 million towards initiatives to advance inclusion.

**Health Human Resources**

**RECOMMENDATION 8:** That the federal government take the lead in working with the provinces and territories to:

a) evaluate the impact of health-human-resource observatories in other jurisdictions;

b) conduct a feasibility study, and determine the benefit of establishing a pan-Canadian health-human-resource observatory and report on the findings.

**RECOMMENDATION 9:** That the Canadian Institutes of Health Information include linguistic variables in their collection of data related to health human resources and populations served by health-care systems across Canada.

**RECOMMENDATION 10:** That the federal government work with the provinces and territories and relevant health-care organizations to reduce inequities in health human resources, such as rural and remote health care, vulnerable populations, and Aboriginal communities.

**RECOMMENDATION 11:** That the federal government, through its Foreign Credential Recognition Program, take the lead in working with provincial and territorial jurisdictions and relevant stakeholders to accelerate their efforts to improve the assessment and recognition of the foreign qualifications of internationally educated health professionals and their full integration into Canadian health-care systems, in line with the principles, obligations and targets agreed upon in the Federal/Provincial/Territorial Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications.

**RECOMMENDATION 12:** That the federal, provincial and territorial governments work with universities and colleges to increase inter-professional training of health-care practitioners to continue the development of multi-disciplinary health-care teams in Canada.

**RECOMMENDATION 13:** That the federal government work with provincial, territorial governments and other relevant stakeholders to develop indicators to measure the quality and consistency of home care, end-of-life care, and other continuing care services across the country.

**RECOMMENDATION 14:** That where necessary, jurisdictions expand their public pharmaceutical coverage to drugs and supplies used by home care recipients.

**Provincial Context:**

- An evaluation and feasibility study will be beneficial to determine the benefit of an HR observatory. While an observatory could address the limited supply of certain health professionals, there is a need to ensure it would not duplicate existing resources or efforts.

- Many health workforce issues are amplified in rural and remote areas of the province. Alternative training and delivery models need to be considered to enhance services to these communities in both primary and specialty care. The Strategic Health Workforce Plan 2012 – 2015 identifies related issues and potential actions for improvement.

- Internationally trained health care professionals have provided exceptional service to rural and remote areas of this province but recruitment and retention has been challenging. It is important to consider ways to integrate these individuals into communities both professionally and personally. This is related to overall health human resource planning and sustainability.

- Provincially, the turnover rate for internationally trained physicians is higher than for those educated in Canada. Within the last ten years the province has shifted its focus to recruiting graduates from Canadian schools. Current data shows low vacancies for registered nurses and other health professionals.

- In order to develop and support inter-professional training, elements need to be clearly defined. For example, remuneration models need to be explored, EHR and EMRs need to be
Implemented and integrated. This concept is strongly supported by the work of the Centre for Collaborative Health Professional Education (CCHPE) at Memorial University.

- The Long-term Care and Community Support Services Strategy is under development and will consider options for a client-centered model of care, with an array of services that optimizes the individual's independence and maintains people in their homes and communities.
- The Newfoundland and Labrador Prescription Drug Program was enhanced through budget 2012 initiatives with $4.4 million for the coverage of new drug therapies. There was an investment of $155 million in the drug program in 2012-13. As a result of the agreement with the provincial Pharmacists' Association, government will invest approximately $37 million over the next four years to support rural and urban pharmacies. In addition, $29 million will be provided over four years for enhancements to the 85+ plan, which will protect seniors from paying more for their drug costs.

Home Care
Recommendation 15: That the Mental Health Commission of Canada work with the home care sector to identify ways to promote the integration of mental health and home care services.

RECOMMENDATION 16: That Health Canada, taking the lead, work with provinces and territories to create and implement an awareness campaign for Canadians about the importance of planning end-of-life care.

RECOMMENDATION 17: That the federal government work with provincial and territorial governments to develop a pan-Canadian Homecare Strategy, which would include a focus on reducing the burdens faced by informal caregivers.

RECOMMENDATION 18: That the federal government work with the provinces and territories to increase access to palliative care as part of end of life health services in a broad range of settings including residential hospices.

RECOMMENDATION 19: That the federal, provincial, and territorial governments develop and implement a strategy for continuing care in Canada, which would integrate home, facility based long-term, respite and palliative care services fully within health care systems. The strategy would establish clear targets and indicators in relation to access, quality and integration of these services and would require governments to report regularly to Canadians on results.

Provincial Context:
- Mental health is currently not included in provincial home support policies. There is some home support funding (“supportive care”) for case managers for a small portion of their caseload. The Eastern and Western health regions have used the supportive care funding they received to hire and train workers. Stella Burry uses this model and Central Health is exploring the idea.
- Through Budget 2012, $1.9 million is provided to implement the assessment tools to help determine the best level of care for an individual as well as to provide access to personal care homes. These investments will help individuals avail of home support services, improve access and quality of care as well as provide a greater financial incentive to people to enter this area of work.
- In the delivery of person-centered services through the Long-term Care and Community Support Services Strategy, individuals will receive the most suitable type and level of support in the most appropriate location. Increasing palliative and end-of-life services and capacity will also be considered.

Primary Care Reform
RECOMMENDATION 20: That the federal, provincial and territorial governments share best practices in order to examine solutions to common challenges associated with primary-care reform, such as: the
RECOMMENDATION 21: That the federal government work with the provinces and territories to re-establish the goal of ensuring that 50 per cent of Canadians have 24/7 access to multi-disciplinary health-care teams by 2014.

**Provincial Context:**
- The Province supports re-establishing the goal to ensure 50 per cent of Canadians have 24/7 access to multidisciplinary health care teams and to finding solutions to common challenges associated with primary health care reform. The timeframe of 2014 however, is not realistic; a longer timeframe and commitment would need to be made.
- This would build on and enhance the continued work in the RHAs on the primary health care initiatives from 2004. An FPT structure would need to be created for jurisdictions to share information and work together on priorities.
- One of the policy areas in the provincial chronic disease policy framework “Improving Health Together” focuses on health care delivery and models of care including team-based care. An Atlantic Collaborative for Chronic Disease currently exists as well.

**Electronic Health Records and Tele-health**

**RECOMMENDATION 22:** That the Government of Canada continue to invest in Canada Health Infoway Inc. to ensure the realization of a national system of interoperable electronic health records.

**RECOMMENDATION 23:** That Canada Health Infoway Inc. target its investments to:
- a) projects aimed at upgrading existing components to meet national interoperability standards set by the organization; and
- b) promoting the adoption of electronic medical records by health professionals in Canada, including working with stakeholders to identify effective incentives in this area.

**RECOMMENDATION 24:** That Canada Health Infoway Inc. work with provinces and territories and relevant stakeholders to:
- a) establish a target that would outline when all existing components of the EHRs would be upgraded to meet national interoperability standards;
- b) establish a target that would outline when at least 90 per cent of all physicians in Canada will have adopted electronic medical records;
- c) ensure that electronic health record systems are currently being designed and implemented in a way that would allow for secondary uses, such as health system research and evaluation; and
- d) develop a systematic reporting system in relation to access to tele-health services in Canada.

**RECOMMENDATION 25:** That the federal government work with provinces and territories to examine approaches to addressing differences in privacy laws across jurisdictions in relation to the collection, storage and use of health information.

**Provincial Context:**
- NL continues to work closely with Infoway to enhance and further electronic health record projects (EHR) and initiatives. EHR projects include Registries, DI-PACS, Pharmacy, Tele-Health, and IEHR Labs. Infoway funding and expertise was instrumental in the implementation of these initiatives.
- Standards development is important to the successful implementation of jurisdictional EHR systems. The province is involved with the Infoway Standards Collaborative.
- Expected timelines for the NL electronic medical records (EMR) project (if approved) will extend beyond the current Infoway EMR funding window. NL would like to see Infoway’s EMR program extended. Much of the background work has been completed, including approval of the governance model, completion of the demonstration project; preparation of an RFP. The development and implementation of the EMR has not started yet.
• NL’s Telehealth initiatives have been very successful in bringing specialized clinical healthcare services to remote parts of the province. To date, more than 50 certified sites offer Telehealth throughout the province. The Newfoundland and Labrador Centre for Health Information (NLCHI) continues to work with the RHAs and provincial partners to identify opportunities for Telehealth.

• Standardizing the rules governing the collection, use, and disclosure of health information by and amongst PTs would result in greater “interoperability”. Currently, the privacy laws in each province and territory can differ significantly. In April 2011, NL proclaimed the Personal Health Information Act (PHIA), a health-information specific privacy law. Proclamation of PHIA brought the province into alignment with other health information legislation initiatives in several other PTs in Canada.

**Access to Care in the North**

**Recommendation 27** (b): That the Federal/Territorial (F/T) Assistant Deputy Ministers’ Working Group work with relevant stakeholders and communities to address jurisdictional barriers as they relate to health care delivery and addressing the broader social determinants of health, including potable water and decent housing.

**Provincial Context:**

- Collaboration around the social determinants of health extends to HCS participation on such interdepartmental committees as Poverty Reduction, Food Security, and Violence Prevention. Initiatives under development, such as Cultural Safety Training, will be adaptable for use in addressing other social determinants of health.

**National Pharmaceuticals Strategy (NPS)**

**RECOMMENDATION 28:** That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability; including a national catastrophic drug coverage program and a national formulary.

**RECOMMENDATION 29:** That governments, acting together, work with private health insurance companies to encourage their adoption of best practices in cost containment strategies.

**RECOMMENDATION 30:** That Health Canada report on progress towards the development of a regulatory framework for expensive drugs for rare diseases as part of its annual performance report to Parliament.

**Provincial Context:**

- While the federal government collaborated on the NPS, their approach to areas of federal responsibility (e.g. financial commitment for Catastrophic Drug Coverage (CDC)) was evasive and non-committal. In September 2006 the PT Ministers of Health released the NPS Progress Report to the public, without federal endorsement.

- NL made significant financial investments in the NLPDP – Access Plan in Budget 2006 and Assurance Plan in Budget 2007. These investments enhanced the goal of protecting all residents from undue financial hardship but did not provide the level of protection envisioned by the NPS.


- HCS also manages the NL Interchangeable Drug Products Formulary (NIDPF) which falls under The Pharmaceutical Services Act. The objective of the legislation is to assist all people of NL to
obtain prescription drugs of acceptable quality at reasonable prices. The NIDPF applies to
every prescription filled in the province, regardless of payer.

- Access to lower cost generic drugs plays an important role in containing expenditures on
prescription drugs, both for Government (through the NLPDP), and for employers (through the
drug benefit plans they provide). It also provides important cost savings for residents who pay
out of pocket for their drug costs.

- NL has concerns based on the Federal Government pulling out of the Fabry initiative, which
forced PTs to fund the study and provide the medication themselves.

Prevention, Promotion and Public Health

RECOMMENDATION 31: That the Public Health Agency of Canada continue its efforts to renew the
National Immunization Strategy, including the establishment of goals, objectives and targets.

RECOMMENDATION 32: That the federal government work with provincial and territorial, and municipal
governments to develop a Pan-Canadian Public Health Strategy that prioritizes healthy living, obesity,
Injury prevention, mental health, and the reduction of health inequities among Canadians, with a
particular focus on children, through the adoption of a population-health approach that centres on
addressing the underlying social determinants of health.

RECOMMENDATION 33
That Health Canada, upon receipt of the Mental Health Commission report, use data developed on pan-
Canadian child and youth mental-health issues to inform policy and program decisions relating to child
and youth mental health.

Provincial Context:

- Immunization is one of the most successful strategies in the prevention of
infectious/communicable diseases and their related deaths around the world. Provincial efforts
to harmonize and enhance programs across the country are supported by the National
Immunization Strategy (NIS).

- A Pan-Canadian Health Strategy would compliment the provincial Wellness Plan as well as the
FPT Framework for Promoting Healthy Weights and Curbing Childhood Obesity. The focus in
NL is on healthy eating, physical activity and mental health promotion. HCS works with many
partners, including the RHAs, municipalities, and community and professional organizations, as
well as other provincial government departments.

- NL supports using data from the Mental Health Commission Report to inform policy and
program decisions.

Health Innovation

RECOMMENDATION 34: That the federal government, taking the lead, work with provincial and territorial
governments to establish a Canadian Health Innovation Fund to identify and implement innovative and
best practice models in health care delivery and the dissemination of these examples across the health
system.

RECOMMENDATION 35: That the Canadian Institutes of Health Research provide an interim report in five
years evaluating the Implementation and Impact of its Strategy for Patient Oriented Research, including
its findings related to new primary care models.

RECOMMENDATION 36: That Health Canada create a network between federally funded pan-Canadian
health research organizations, and other interested stakeholders that would focus on identifying leading
practices in health care delivery and work together to promote their dissemination in health care systems
across Canada.
RECOMMENDATION 37: That the federal government ensure that there is ongoing funding dedicated towards health services and systems research either through the Canadian Institutes of Health Research or the Canadian Health Services Research Foundation.

Provincial Context:
- These recommendations build on the work that is taking place in the province. Some best practice models being explored or implemented include the Chronic Disease Self Management Program (Stanford Model), the Chronic Pain Mentorship Program and the Mental Health Anti Stigma Campaign.
- The NL Centre for Applied Health Research is doing some contextualized research - Contextualized Health Research Synthesis Program (CHRSP). CHRSP focuses on three types of projects: health services/health policy projects; health technology assessment projects; and projects that combine the two to examine processes for the organization or delivery of care involving a health technology and currently synthesizing and contextualizing evidence about a variety of topics that will help guide decision makers in the provincial healthcare system.

Accountability and Reporting to Citizens
RECOMMENDATION 38: That the federal government through Health Canada work with organizations such as the Canadian Patient Safety Institute (CPSI) to promote the development of health-quality council concepts.

Provincial Context:
- Many provinces have implemented or are implementing Health Quality Councils. Although the mandates may differ slightly, the emphasis is on public reporting, accountability and transparency.
- The primary objectives of the provincial Quality and Patient Safety Committee (made up of the four RHA Vice-presidents and representatives from HCS - Office of Adverse Events, Acute Health Service and Emergency Response, ADM Policy and Planning) includes:
  o promoting and fostering a patient safety culture in each RHA and supporting a provincially consistent approach to patient safety; developing/maintaining relationships with provincial/national agencies to inform and facilitate evidence based, best practices in the areas of patient safety and quality improvement; reporting to CEOs on patient safety/quality improvement issues and opportunities; and developing an evaluation strategy.
- HCS is involved with CPSI collaboratives such as, Safer Healthcare Now, the Atlantic Health Quality and Patient Safety Collaborative, review of the Root Cause Analysis and Disclosure Reporting Frameworks.

RECOMMENDATION 39: That the Canadian Institute for Health Information (CIHI) work with provincial and territorial governments and relevant stakeholders to develop a pan-Canadian patient-centred comparable-health-indicator framework to measure the quality and performance of health-care systems in Canada.

Provincial Context:
- A national Health Quality Council/Accreditation Canada Network with provincial representatives from the Office of Adverse Events, and Acute Health Service and Emergency Response Divisions, has been established. The Network coordinates the work of various groups, including Quality Councils, Accreditation Canada, CPSI, Health Council of Canada, CIHI, and Atlantic Collaborative representatives.
- A Health Care Quality and Patient Safety Measurement Working Collaborative has been established and will: develop an inventory of current indicators, develop standardized templates for indicator definitions and indicator development processes, create a community of practice to coordinate measurement activity, to streamline indicators and reduce the collection burden.
The province’s four RHAs have agreed to share their scorecard templates with each other and the Department.

**Dispute Avoidance and Resolution**

**RECOMMENDATION 40:** That all governments put measures in place to ensure compliance with the Canada Health Act and more accountability to Canadians with respect to implementation of the Act.

**Provincial Context:**
- In the past, PTs have been hesitant to open up the Canada Health Act (CHA). Currently, there is accountability under the CHA in terms of ‘financial penalties’ for PTs who are in contravention of the Act. The federal government has indicated it wishes to discuss accountability with PTs in the future.

**Implementing the Communiqué on Improving Aboriginal Health**

**Recommendation 41:** That Health Canada work with provincial and territorial partners to ensure equitable access to programs and initiatives related to improving Aboriginal health.

**Recommendation 42:** That Health Canada work with provinces and territories to ensure that the design and delivery of its programs and initiatives meet the unique needs and culture of Inuit people.

**Recommendation 43:** That Health Canada work closely with provincial and territorial governments to ensure improvements in Aboriginal health through the federal, provincial and territorial multi-year funding agreements.

**Recommendation 44:** That the federal government work with Aboriginal communities to improve the delivery of health-care services in Canada, and deal specifically with removing jurisdictional barriers.

**Recommendation 45:** That Health Canada establish a working group with provincial and territorial partners and all national Aboriginal organizations to identify ways in which the role of Aboriginal organizations could be strengthened in the policy-making and development process.

**Recommendation 46:** That the federal government work with the provinces and territories to address the social determinants of health, with a priority focus on potable water, decent housing and educational needs.

**Provincial Context:**
- All recommendations will have positive impacts on directions and actions addressing Aboriginal Health in the province. Ongoing federal support is essential.

- Health Canada and First Nations Inuit Health have supported initiatives under the Aboriginal Health Transition Fund and the Health Services Integration Fund. The Department partners with Eastern Regional Health Authority and the Aboriginal governments and organizations to provide Aboriginal Patient Navigators to ensure improved access, particularly for those travelling from isolated and semi-isolated reserves and Inuit communities to larger urban centres.

- Health Canada’s commitment to partner with the province should include financial support for the delivery of training. The Inuit Healthy Living Project is a provincial initiative to improve the cultural relevance of health curriculum for Inuit children. The province also supports the provision of Applied Suicide Intervention Skills programming. Cultural relevance is a goal of the Northern Strategic Plan.

- Multi-year funding to address the social determinants of health and to support full inclusion of all Aboriginal partners is essential to closing the gap in health status. Project based funds, when available, initiate activities to improve Aboriginal Health but are constrained by time limitations and national criteria that is more Pan Canadian than Aboriginal governments and organizations in this province require.
• The Aboriginal Health Liaison Division (AHLD) is actively engaged in partnering with Aboriginal governments and organizations, and RHAs in the development of a Provincial Aboriginal Health Policy Framework. This Framework will provide priority directions and actions, strengthen partnerships and increase Aboriginal engagement in programs and services impacting the health status of Aboriginal communities.

Prepared/Approved by: Vanessa Reddick/Wanda Legge
Approved by:
Approved by:
Date:
February 29, 2012

Honourable Kathy Dunderdale
Premier of Newfoundland and Labrador
Confederation Building, East Block
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St. John’s, NL A1B 4J6

Honourable Susan Sullivan
Minister of Health and Community Services
Confederation Building
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St. John’s, Newfoundland A1B 4J6

Dear Premier Dunderdale and Minister Sullivan,

Please accept this submission from the BC Recreation and Parks Association with regards to the renewal of the Federal Health Accord.

Sincerely,

Suzanne Allard Strutt
Chief Executive Officer
BC Recreation and Parks Association
Renewal of Federal Health Accord

Introduction

As discussions on the new Health Accord continue between Canada's Premiers, the BC Recreation and Parks Association (BCRPA) would like to inform and support this critical dialogue.

Public health research and expert commentary on the current health care funding crisis are urging the health care system to move the focus away from traditional reactive measures of treatments and cures to a strengthened commitment to proactive initiatives such as health promotion and prevention. Prevention through an increase in physical activity and improved citizen access to recreation will significantly lower the incidence of chronic disease and its related health care costs.

The BCRPA urges Provincial and Territorial Premiers to prioritize and direct funding to the promotion of health and the prevention of chronic disease as a means by which to address the national escalation of health care costs and the deterioration of our nation's health.

A focus on health promotion and prevention

It has been reported that the largest proportion of health care costs in Canada – both direct (health care) and indirect (lost production) – are attributable to chronic diseases (52.7%) and injuries (7.9%)\(^1\). Chronic diseases alone are costing the Canadian economy around $93 billion annually.\(^2\)

Yet, chronic disease is preventable. Reductions in its occurrence and severity will dramatically reduce the strain on health care spending and resources. Investing in prevention keeps people healthy and reduces the need for more costly treatment later on. Prevention also supports a healthy population that can generate greater economic growth as healthy people are more likely to maximize their potential\(^3\).

Federal, Provincial, and Territorial governments have already acknowledged the importance of health promotion and prevention in two significant ways. The first is within the current (2004) Health Accord which recognizes that in order to improve the health outcomes of Canadians strategic investments are needed in the areas of health promotion and disease prevention. The second is within the Declaration on Prevention and Promotion adopted in September 2010 by Canada’s F/P/T Ministers of Health and of Health Promotion/Healthy Living. The Declaration reflects the important role that health promotion and disease prevention play in

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\(^1\) Kendall P.R.W., OBC, MBBS, MSc, FRCPA Investing in Prevention: Improving Health and Creating Sustainability. The Provincial Health Officer's Special Report. September 2010. Provincial Health Officer, British Columbia

improving the health of Canadians, and makes the promotion of health and the prevention of disease a priority for action.

Health Promotion and Prevention has the best return on health dollar investment compared to other forms of healthcare related to curing sickness and disease.

The role of recreation in active healthy living and chronic disease prevention

One specific health promotion and prevention strategy that is universal in application - across all provinces and territories and to Canadians of all ages - is that of promoting and supporting active and healthy lifestyles through recreation.

Recreation is an effective health promotion and disease prevention tool that is available within virtually every community throughout Canada. Prioritizing funding for community based recreation initiatives and recreation infrastructure renewal will have a significant effect in reducing the occurrence of chronic disease and its related health care costs, and provide the greatest return on investment.

Recreation is a key factor in combating the high physical inactivity rates in our country. Physical inactivity is a leading contributor to obesity, type 2 diabetes, heart disease, stroke, certain types of cancers, and fall-related injuries and chronic conditions in older adults. Community-based recreation supports physical activity and leads to healthier lifestyles, stronger civic and social engagement, improved mental health, increased productivity and economic growth.

Estimates have placed the cost of physical inactivity in Canada at $5.3 billion in health care expenditures\(^3\). A 10% reduction in the prevalence of physical inactivity has the potential to reduce direct health care expenditures by $150 million a year\(^4\). Even modest reductions in inactivity levels could result in substantial cost savings.

With appropriate levels and types of physical activity, Canadians of all ages and abilities can experience improvements in physical, mental and emotional wellbeing\(^5\).

The role of recreation infrastructure in active healthy living

Community recreation infrastructure is a means through which people achieve the benefits of recreation and reach their healthy living goals and as the need for recreation services increases so too does the need to support these facilities. Recent investment has not kept up with rising and changing demands and investment in our nation’s recreation facilities is now critical. 66% of Canadian municipalities report that their sport and recreation facilities are in need of repair/ maintenance\(^6\). In BC alone, upwards of 70% of indoor recreation facilities are over 25 years of age and require and investment of $7B to adequately address the indoor recreation facility infrastructure deficit and population growth\(^7\).

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\(^6\) 2009 Survey of Physical Activity in Canadian Communities www.cfrl.ca/media/node/119/files/Municipalities_B11_PA_small.pdf

Community recreation facilities are one of the most cost-effective prescriptions for our good health

Investment in recreation infrastructure is an investment in public health. It is a preventative approach for individual and community health that offsets spending on reactive investments in health care. Resources required to provide adequate recreation facilities are significantly less on a per user basis than medical facilities such as hospitals, medical laboratories and care facilities.

Recreation infrastructure investment also supports economic goals and objectives by maintaining the economic and social viability of BC communities; increasing property values and tax revenue; generating construction and operations job opportunities; and supporting tourism.

The Recreation sector remains committed to working collaboratively with the health sector and related stakeholders in identifying the health issues most seriously afflicting Canadians. We do this through partnerships with provincial and local public health authorities in developing strategies that leverage the resources available through community recreation.

The BCRPA asks that Premiers continue to invest in public health and prioritize financial support to the areas of health promotion and chronic disease prevention, ensuring good health and a high quality of life for all Canadians.

On behalf of the BC Recreation and Parks Association,

Suzanne Allard Strutt
Chief Executive Officer

23 February 2012
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To the Health Council of Canada Corporate Members

Dear Colleagues:

I am writing to inform you of the Government of Canada’s decision, as part of deliberations on the 2013 federal budget, regarding federal funding for the Health Council of Canada. This decision will be of interest to you both as Ministers of Health and in your capacity as Corporate Members of the Council.

As you are aware, the Council was established to monitor and report on progress in relation to the commitments made in the 2003 and 2004 Health Accords. With the 10 year term of the 2004 Accord coming to a close in 2014, the Council will have completed its primary mandate once it releases its final report on progress under the Accords. In this context, and given the fiscal environment, the federal government has decided to wind down federal funding for the Council.

Funding reductions will be phased in over two years. In 2013/14, we will provide up to $6.5 million to support the Council’s activities. For the fiscal year 2014-15, the final year of federal support for the Council, funding will be further reduced to $4 million. This will provide sufficient resources for the Council to complete its work.

I should emphasize that this is a decision about federal funding for the Council, and that formal decisions about its future as an entity will need to be made collectively by us, the Council’s Corporate Members. I have asked my Deputy Minister, Glenda Yeates, to follow-up with her provincial and territorial colleagues to identify a timely process for us to make these decisions.

In closing, I would like to acknowledge the support that you and your officials have provided to the Council over the years. The active involvement of provincial and territorial governments has played a key role in enabling the Council to fulfill its role in reporting to Canadians.
I look forward to working with you in determining next steps for the Council as federal funding comes to an end.

Sincerely,

Leona Aglukkaq

c.c. Dr. Jack Kitts,
PT Deputy Ministers of Health
Provincial/Territorial Joint Response
Health Council of Canada Report
"Better health, better care, better value for all
Reflections on a decade of health reform in Canada and
setting out a better path toward a high performing health system"

Brief Overview of Report:

On August 2 the Health Council of Canada (Health Council) distributed a draft of a report which looks back over the last decade (since the signing of the 2003 Accord and subsequent 2004 Accord). The report also attempts to identify what worked and what didn't and based on the lessons learned, to outline how a better path to a high-performing system in Canada can be achieved. The report identifies three common themes: 1. the limitations of "buying change"; 2. the shift to a focus on quality; and 3. a call for pan-Canadian leadership.

The Health Council recommends that the Triple Aim approach to health reform: better health, better care, and better value be adopted. The Health Council report recommends adding a fourth goal – equity for all Canadians. Together these four goals would form an overall vision for health reform in Canada. To achieve and sustain the four goals the Health Council describes 5 enablers that must be actively supported and sustained: leadership, policies/legislation, capacity building, innovation and spread, and measurement and reporting.

PT Feedback

In reviewing the report PTs noted the following:

1. While PTs accept the findings of the report, we suggest it would be more beneficial and balanced to highlight the successes that have been achieved as well. Currently, the report is focused more on the disappointments which we can learn from, but it is also important to highlight success so our system can benefit from the best practices in innovation and collaboration. (See specific additions identified in Tracked Changes in the report). Such successes include:
   - COF’s establishment of the Health Care Innovation Working Group (HCIWG)
   - The accomplishments of the HCIWG such as the announcement on generic drug pricing
   - COF’s Pan-Canadian Purchasing Alliance
   - FPT collaboration during the H1N1 Influenza Pandemic

2. It is understandable that the Health Council is looking back over the 10 years since the 2003 Accord was signed, but there are a number of challenges in conducting a proper review of the last decade and this should be clearly explained in the report. Some of the issues PTs have identified are as follows:
   - The 2003 Accord was signed in February 2003 and it was a 5-year arrangement.
   - The 2004 Accord was not signed until September 2004 and it is the accord that had a commitment of 10 years. That 10 year period is not yet completed.
   - Much of the available data referenced in the report and in reports used as source material for the report do not cover the 10 year period. For example in the table on pages 16-17 ‘recent’ data refers to 2008, 2009, 2010 and 2012. PTs understand the challenges in obtaining current data and of course we have to work with the data
available, but we feel that the reader should be apprised that the overviews do not capture the full decade, which the text suggests.

3. Canada's health status is linked directly with health care investments in the past decade. Examples include: p. 15 “...the data show we didn't achieve the results we should have.” p. 18 – “More importantly, the health of Canadians improved marginally over the past decade – a disappointing lack of progress given our health care investments.”

Population health status is not an area where there are likely to be significant gains in the short term. Areas where lifestyle factors are key—such as increasing physical activity and reducing tobacco have goals which are long term and gains may not be realized for many years after the policies and programs are introduced. Furthermore, as stated by the Public Health Agency of Canada, population health is influenced by a dozen key determinants of health, of which health services is only one (see http://www.phac-aspc.gc.ca/ph-sp/determinants/).

4. The report devotes a significant portion to comparing Canada with other countries. PTs caution that picking examples of measures does not provide a complete picture. The report itself indicates (page 8) “Although the ways in which these countries organize, finance, manage and deliver health services vary, they were selected as they provide similar social, political and economic contexts to allow useful comparisons on health system performance.” We note that when comparing ourselves to the experience of other countries we must also consider the types of health systems to which we are comparing ourselves. For example are all systems at the same level of development (e.g., use of electronic health records); how are systems funded (e.g., level of taxation; public/private mix; skill mix, etc.)

5. It is unclear from the report what is meant by “equitable care”, but it appears to mean that all citizens will receive the same level of services. PTs question how reasonable this approach is given that constitutionally each province and territory is responsible for its own individual health system. Each jurisdiction is accountable to its own constituents and each health system is organized to meet the needs of the province’s residents within that specific geographic, demographic and fiscal environment. The term “equitable care” needs to be clarified in the report.

6. The report proposes a vision for health care reform: the Triple Aim, with the addition of equity. PTs support the Triple Aim principles, and note that while not specifically stated in the original 2003 and 2004 Accord, the ultimate goal was to provide the best level of care to Canadians within the fiscal realities of the jurisdictions. It is true that PTs were concerned about the sustainability of the system, as they are now and as they should be, but it was also true that the primary focus then, as it continues to be now, was the care of the individual and the achievement of good health.

7. It could be useful to identify that the funding provided by the federal government through the 2004 Accord was its contribution both to the specific areas of strategic focus under the Accord, and to the costs of the country’s “core business” of providing insured health services. In the past, Canada had contributed 50% of the costs for insured health services. By the time of the Accord, the federal funding represented around 20% of the costs of insured health services, with PTs paying the difference. These core business services are essential to Canadians and ought to be mentioned.

8. Page 35 - the document says: "Most Canadians assume that their provincial or territorial health systems provide similar care and outcomes. In fact, this has not been the case for some
time and the current malaise in intergovernmental collaboration will only exacerbate this situation further."

PT governments would not describe their extensive collaboration with the term ‘malaise’ and strongly question the evidence for such a sentiment. PT collaboration occurs on many levels on a regular basis and we suggest that highlighting this collaboration would give a more fulsome picture of activities over the past ten years. Examples of such collaboration include the following:

- There are a number of shared services across jurisdictions such as Poison Control, Canadian Blood Services, organ and tissue transplantation and centres of excellence.
- Many jurisdictions rely on health services located in other jurisdictions.
- PTs have also established collaborative processes such as common drug reviews, pricing alliances and the on-going work of COF’s Health Care Innovation Work Group.
- PTs have developed agreements on radiation therapy and coronary artery bypass grafts and have also collaborated on issues such as drug shortages and prescription drug abuse.
- Numerous requests for information flow between PTs on a daily basis to enable the sharing of best practices.

9. The statement on Page 13 states: “Furthermore, one in 10 Canadians report they do not fill prescriptions or they skip doses because of cost.” It is recommended that the survey limitations are articulated in the report. It may be a stretch to draw conclusions from a smaller Canadian survey and characterize that it is “one in 10 Canadians report”.

10. The statement on page 16 states: “At 10%, Canada ranks third worst in the percentage of patients who did not fill a prescription due to cost. Percentages ranged from 21% in the United States (worst) to 2% in the United Kingdom (best).” It is recommended that the survey limitations are articulated in the report. It may be a stretch to draw conclusions from a smaller Canadian survey and characterize that it is “one in 10 Canadians report”. The average of the comparators (i.e., 8%) should also be noted, not just the range.

11. Page 32, Table 3: Regarding the column “Home and Community Care,” for accuracy purposes, we recommended clarifying that this column is centered on home care services and does not reflect the entire continuum of home and community care services.

12. Page 33, Table 3, Measurement and Reporting section: RAI-HC is an assessment tool. We recommend rephrasing this sentence as “Expand use of the RAI-HC and other specialized interRAI assessment tools (used to assess need for home care services including for specialized populations).”

13. Error. Page 21 – the majority of Canadian Blood Services funding comes from the PTs, not the federal Government.

14. Quebec is not a member of the Health Council of Canada. This PT response is sent on behalf of all PTs, except Quebec

HCS, NL
August 21, 2013
March 14, 2014

Dear First Ministers and Ministers of Health of Canada:

Subject: The Health Council of Canada’s departing message in support of future health care reform

We are writing to you in our final gesture as the Health Council of Canada before operations cease on March 31st, 2014. Our message is that governments need to remain committed to health care reform, they must prioritize, they must work collaboratively and they must engage the public more fully in this endeavour to achieve the best health, the best care and the best value for Canadians. We do not believe this can happen without strong federal leadership; and without it there is the real possibility of increasing inequality of health outcomes and health status across the country.

The 2003 and 2004 health accords, which created and refined the role of the Health Council, outlined a shared federal/provincial/territorial set of commitments to achieve health care renewal across Canada. Ten years later, those same accord elements still require attention, but need renewed leadership and political will to be fully realized. As part of an ongoing renewal effort, governments and health leaders must be more responsive to Canadians’ experiences as health care consumers and taxpayers, while helping the public better understand the rationale for the needed reforms.

Support for a strong federal role in Canada’s health system is reflected consistently in opinion survey polls, and Canadians want the federal government to lead discussions with the provinces and territories on future reforms in our healthcare system. With less active federal participation in health system planning at the pan-Canadian level, there is greater potential for increasing disparities and inequities in terms of access and quality of care across jurisdictions. We strongly encourage the federal government to recommit itself to working with the provinces and territories so that the national interest in health care is not lost and that health care reform proceeds in a more effective and efficient manner. At the same time, we encourage the provinces and territories to be more constructive in their engagement with the federal government.

In the Health Council’s summative report on the accords, Better Health, Better Care, Better Value for All, (September 2013) we examined the performance of Canada’s health system over the last decade and found the results to be less than optimal given the significant level of government investment over the past 10 years. At this point we need to ask why it remains the case that we are not getting the results Canadians need. Our report emphasized that going forward the country needs to have a clear vision along with integrated health system goals supported by action in five key areas: (i) leadership, (ii) policies and governance, (iii) capacity building, (iv) innovation and spread, and (v) measurement and reporting.

Whole system reform is not a simple challenge; however, governments could see more noticeable impact over the next decade by concentrating their efforts on specific priorities such as primary health care, inclusive of seniors care and mental health, and Aboriginal health, and acting on the five areas discussed above. This would require collaboration to develop a national plan designed to achieve...
measureable improvements in these areas. Based on the success achieved here, governments may find a path forward to tackle the broader health issues facing the country.

We believe that the Health Council was uniquely positioned to speak to and hear from the Canadian public. We worked hard to raise public understanding of the myriad of health system issues Canada faces, and avoided having regional, sectoral and professional biases unduly influence our work. We also promoted accountability at all levels in the system, which we know is the largest component of public spending by governments. The positive impact and influence of our work was confirmed by a recent independent evaluation of the Health Council’s operations. Now, in our absence, we believe a trusted national voice of accountability for both Canadians and their governments is lost with no successor organization in sight.

In conclusion, we recognize there will always be a need to implement improvements in our health system; and for them to succeed public support is paramount. We trust that governments will commit to work collaboratively to achieve these improvements and consider putting in place a new mechanism to help hold them accountable and ensure public confidence in their actions. This is the only way Canada will make real progress and be able to move towards having the best health system in the world along with a more healthy population.

Sincerely,

Dr. Jack Kitts, Chair
Dr. Dennis Kendel, Councillor
Dr. Ingrid Sketris, Councillor
Dr. Charles Wright, Councillor

Dr. Catherine Cook, Councillor
Dr. Michael Moffatt, Councillor
Dr. Les Vertesi, Councillor

Dr. Cy Frank, Councillor
Mr. Murray Ramsden, Councillor
Mr. Gerald White, Councillor

Dr. Charles Wright, Councillor
Department of Health and Community Services
Fact Sheet: 2004 Health Accord

- The Health Accord – also known as the 10-year plan to Strengthen Health Care – was signed in September 2004 by all First Ministers (except for Quebec which entered into a similar but separate agreement with the federal government).

- The 2003 Accord was a five-year agreement. However, after signing the agreement, provinces and territories (PTs) were concerned about their ability to deliver on the commitments with the funding provided. PTs sought a new agreement with a more substantial investment. This led to the 2004 Accord.

- In broad terms, the Federal Government committed $41 billion in new funding and a 6 per cent annual escalator beginning in 2008-07. In addition, $4.5 billion was allocated over six years (beginning in 2004-05 on a per capita basis) in a Wait Times Reduction Fund and $500 million was committed towards purchasing medical equipment.

- In 2005, the Federal Government provided the territories with a five-year $150 million targeted fund (the Territorial Health System Sustainability Initiative) to help facilitate the transformation of Territorial health systems related to Accord commitments.

- The 2004 Health Accord identified the following areas of focus:
  - Reducing Wait Times and Improving Access;
  - Strategic Health Human Resource Action Plans;
  - Home Care;
  - Primary Care Reform;
  - Access to Care in the North;
  - National Pharmaceuticals Strategy;
  - Prevention, Promotion and Public Health;
  - Health Innovation; and
  - Accountability and Reporting to Citizens.

- While the Accord facilitated some improvements in health care delivery, there were challenges and shortcomings including:
  - Federal funding and benchmarking ignored individual jurisdictional context causing inefficiencies in health delivery. For example, rigid benchmarks set for reducing wait times and improving patient access, tended to skew resources, especially for small jurisdictions, into that benchmark at the expense for other priorities, thus creating new challenges.
  - Inadequate support for populations that fall within federal jurisdiction (e.g., Aboriginals, veterans).
• Failure of the Federal Government to participate in a meaningful dialogue that addresses the increasing demand for and cost of drugs, particularly as it pertains to pharmaceuticals for catastrophic coverage and those for rare diseases. The Federal Government abandoned its commitment towards a national pharmaceuticals strategy.

• Ineffective federal cooperation on certain files (e.g., the integrated healthy living strategy and the national immunization strategy). The Federal Government made unilateral decisions such as funding only one specific immunization and the time-limited nature of federal funding created inefficiencies within the system.

• In anticipation of the expiry of the Accord in 2014, provinces and territories began to prepare for negotiations with the Federal Government; however prior to a scheduled meeting of Finance Ministers in 2011, the Federal Finance Minister (Minister Flaherty) unilaterally announced the Canada Health Transfer (CHT) funding arrangement up to the year 2024. This preempted any discussion on the arrangements by Health Ministers.

• Beginning in 2014-2015, the CHT allocation to PTs will be determined on an equal per capita cash basis only. It will no longer include tax point transfers. As announced in December 2011, total CHT cash levels are set out in legislation to grow at 6 per cent until 2016-17. Starting in 2017-18, total CHT cash will grow in line with a three-year moving average of nominal Gross Domestic Product, with funding guaranteed to increase by at least 3 per cent per year.

• In the absence of federal engagement on a new Accord, PTs, through the Council of the Federation (COF), have established a Health Care Innovation Working Group (HCIWG). The purpose of this group is to identify joint initiatives which can enhance patient care and improve value for taxpayers. The HCIWG is chaired by Ontario Premier Kathleen Wynne, Yukon Premier Darrell Pasloski, and Alberta Premier Dave Hancock. Its members consist of Health Ministers in all provinces and territories.

• This working group has been overseeing the work in the health sector and, at Premiers direction, will continue to oversee work for a further three years. The three theme areas of focus are: appropriateness, seniors’ care and pharmaceuticals. The most recent report and recommendations of the HCIWG were received by Premiers at their meeting on July 24-26, 2013.

• The Health Care Innovation Working Group last met on April 2-3, 2014. The next COF meeting is scheduled for August 2014 in PEI.

Prepared by: Vanessa Reddick/Kathy Rodway/Tara Power
Approved by:
May 12, 2014