Current Issue Review **93-4E**

HEALTH POLICY IN CANADA

Nancy Miller Chenier
Political and Social Affairs Division

Revised 4 December 2002

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ISSUE DEFINITION

Canadian health policy has led to one of the best health services systems in the world. The demands for these health services are, however, growing at the same time as economic resources are diminishing. Health policy initiatives have achieved the 1964 Royal Commission on Health Services goal of access to medical care for all Canadians. The current challenge is to enable all Canadians to achieve the best possible state of health and to do this within the constraints imposed by a changing social, economic and political climate.

This challenge of creating policies for health was reflected in the mandate of the Commission on the Future of Health Care in Canada (the Romanow Commission). In 2002, the Commission recommended policies and measures that, while respecting all relevant jurisdictions and powers, would ensure long-term sustainability of a universally accessible, publicly funded system offering quality services. Its proposals attempted to strike an appropriate balance between those for prevention and health maintenance and those for care and treatment.

This paper addresses some of the forces involved in the process of creating health policy or policies for health, focusing on the federal government's responsibilities and some of the intricacies of federal-provincial cooperation. It outlines the way health care is currently financed and what this means in terms of organization, as well as highlighting some of the challenges as new policy goals are identified.

BACKGROUND AND ANALYSIS

This focus on the concept of health, rather than illness, has occupied considerable space in policy discussions over the past two decades. At the federal level, the Lalonde Report in

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* The original version of this Current Issue Review was published in October 1993; the paper has been regularly updated since that time.

1974 established that the setting of health goals or strategies was essential and emphasized that health care organization, particularly the provision of services, was only one of several elements affecting health. This view was reiterated in the Epp Report in 1986, which stressed that all public policy sectors – income security, employment, education, housing, agriculture and others – have a bearing on health. In 1994, a federal, provincial and territorial advisory committee identified five categories of factors that determine the health of Canadians: social and economic environment; physical environment; personal health practices; individual capacity and coping skills; and health services. It argued that these could provide the basis for developing broad population health strategies for improving the health status of the Canadian population.

In spite of these attempts to refocus public policy, the belief that improvements in health can be attributed to services provided by doctors and hospitals is still dominant. While health is generally defined as a state of complete physical, mental and social well-being, rather than merely the absence of disease, the strong relationship between health and social and economic conditions is only gradually becoming part of the broader public knowledge.

A. Government Responsibility for Health

At Confederation, the *Constitution Act, 1867* made few specific references to health responsibilities. The federal government was allocated jurisdiction over marine hospitals and quarantine while the provinces were to establish, maintain and manage hospitals, asylums, charities and charitable institutions. From 1867 to 1919, the Department of Agriculture covered any related health concerns.

In the 74 years between the establishment of the first federal health department and the emergence of a reconstituted health department in 1993, federal government responsibility grew to include health services for Indian and Inuit people, federal government employees, immigrants and civil aviation personnel. It also included investigations into public health, the regulation of food and drugs, inspection of medical devices, the administration of health care insurance, and general information services related to health conditions and practices.

Its role in health is derived from the federal government's constitutional powers over criminal law, spending, and peace, order and good government. Criminal law is the basis for legislation such as the *Food and Drugs Act* and *Controlled Substances Act*. Spending power

comes from the federal role in levying taxes and appropriating funds and is the basis for the Canada Health and Social Transfer (CHST) and the *Canada Health Act*. The peace, order and good government clause of the Constitution gives the authority to maintain and improve national standards in areas affecting health such as water and air quality.

Over time, the provinces, by virtue of their jurisdiction over matters of a local or private nature, also assumed an increasing role in health matters. The advances made in public health in the last decade of the nineteenth century were attributed to a combined effort by health professionals, the voluntary community, and the departments of health established at the municipal and provincial levels in the 1880s. The provinces oversee the licensing of physicians, nurses and other health professionals and determine the standards for licensing all hospitals. In addition, departments of health administer provincial medical insurance plans and finance health care facilities and the delivery of certain public health services.

These divisions of health responsibility, both those emanating from constitutional interpretation and those derived from practices established over time, contribute to the other complexities facing Canadian health policy such as geographical diversity, socio-economic divisions, and international pressures. Over the decades, various governments, both federal and provincial, established health inquiries to appraise and review the beliefs and structures forming the foundation for policy.

During the 1980s, every province established a royal commission or other major inquiry to examine its health care system. In 1994, the federal government appointed the National Forum on Health. The Health Forum's final report in 1997 concurred with the earlier provincial assessments that the fundamental principles underlying the funding system for health care and enshrined in the *Canada Health Act* – universality, comprehensiveness, portability, accessibility and public administration – were sound.

All reports argued that health care resources were adequate but called for changes in their management and allocation. They pressed for a definition of health that would address issues other than medical care, such as education, housing, employment and the environment. They advocated a shift from institution-based care to community-based care with more opportunity for individuals to participate in health decisions with service providers. The reports argued for better regional management of services and human resources, including physicians, expressed concern

about the efficiency and effectiveness of the current system, and called for evaluations of medical practice and delivery systems.

Cooperation and coordination of federal with provincial and territorial governments being essential, various mechanisms ensure that health officials meet to discuss issues and solutions. The Conference of Ministers of Health and the Conference of Deputy Ministers of Health are two such mechanisms with important implications for national health policy. **In addition to regular policy directives from these cross-jurisdictional bodies, work continues on the September 2000 commitment by First Ministers to an action plan for health system renewal and, more recently, on the negotiations over the Romanow Commission's recommendations.**

B. Financing Health

Federal-provincial relations and fiscal arrangements have always had a significant impact on health policy. The federal government was constitutionally given the power to generate financial resources through taxation and borrowing and to spend such money on any activity, provided that the legislation authorizing the expenditure did not infringe on provincial powers.

This power led to the National Health Grants Program of 1948, seen by many as the first stage in the development of a comprehensive health insurance plan for all Canada. The grants offering financial support for planning and organization, public health, and hospital construction provided a welcome source of new funds for the provincial health departments. For both levels of government, they gave an opportunity to discuss annual expenditures and to compare problems and solutions. The grants were followed by other cost-sharing measures under the federal *Hospital Insurance and Diagnostic Services Act, 1957* and the *Medical Care Act, 1966*. These statutes, which specified that all provinces must meet certain terms and conditions, were considered to be the second stage of a national health insurance system.

Although all provinces had joined the federal plan by 1971, problems were perceived by both parties to the agreement. The federal government became concerned about its lack of control over expenditures, while some provinces found the restriction to hospital and medical care expenses too limiting at a time when a shift to community-based care and preventive programs offered by non-medical personnel was beginning to be viewed as more effective.

After much discussion between the federal and provincial governments, the previous funding conditions were replaced by the *Federal-Provincial Fiscal Arrangements and Established*

Programs Financing Act, 1977. Each province was given "block-funding," a set amount of federal money based on its population and paid partly in cash and partly in tax points. These per capita EPF payments by the federal government were to be spent on health but did not require that the provinces make equivalent matching expenditures.

As early as 1979, the federal government expressed concern that federal funds allocated for health were being diverted by the provinces into non-health activities such as road building. In 1984, the *Canada Health Act* was passed to "establish criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law." The provisions of the two previous insurance Acts were consolidated in the new law, which reaffirmed the principles – public administration, comprehensiveness, universality, portability, and accessibility – underlying the national programs. Specific conditions were set for provincial receipt of the full federal contribution. The provinces were given three years to end extra-billing and user charges if they wanted to recover withheld funds. After significant federal-provincial debate, all provinces complied with the *Canada Health Act* by 1 April 1987.

After 1977, the federal government made several unilateral modifications to the formula for the federal contribution that limited the overall amount available to the provinces. This action led some observers to conclude that the federal government would be unable to enforce the standards of the *Canada Health Act* as cash transfers to the provinces ceased, since it would not be able to penalize any province that breached the criteria specified in the Act. Provinces claimed that financial pressures made it very difficult for them to maintain the current level of services.

In 1995, the government gave notice that a new block grant to the provinces, to be called the Canada Health and Social Transfer, would begin in 1996-1997. It merged the Established Programs Financing (EPF) and Canada Assistance Plan (CAP). The Finance Minister noted that the new transfer would not be totally unconditional and that the *Canada Health Act* would still be enforced. Critics have argued that the CHST continues the policy of restricting expenditures without providing new approaches for increased efficiency in maintaining or delivering health.

C. Organizing Health

In reality, Canadian health policy has been predominantly health care policy, with the focus on the treatment of diseases and injuries rather than on prevention. In Canada, where a

universal public insurance system called medicare provides for medical and hospital services, the two areas of financing and of organizing health services have been closely interwoven. The acceptance of medicare as a way of financing existing services has also implied acceptance of existing ways of organizing those services.

Canada provides universal health insurance coverage for its population through health insurance programs financed by federal and provincial revenues. Provincial authorities design their own programs according to national standards codified in the *Canada Health Act*. The health insurance plans currently cover services offered mostly in the offices of physicians paid on a fee-for-service basis and in hospitals, largely run by private, non-profit boards and operating on global budgets.

Across the country, hospitals and physicians take almost half of the estimated $100 billion for health care spending. Physicians have a major influence on all the costs of the health care system, including the number and type of procedures and interventions offered in both private offices and publicly funded hospitals. As much as 78% of the increase in health care costs in industrialized countries over the past 25 years has been attributed to the number of physicians and the extent and level of services they provide for each patient. **By 2000, pharmaceutical drugs, particularly those prescribed by physicians, accounted for a major portion of health expenditures.**

Beyond the traditional health care organization involving hospitals and physicians is a range of other services and programs that contribute to health. Other health professionals, such as nurses, chiropractors, midwives and physiotherapists, and other institutional arrangements, such as community-based clinics, can deliver health services, perhaps more effectively and less expensively than the existing methods. Changing the widely held belief that medical care and hospital care are the major determinants of long-term improvements in health status will be a major challenge for the next decades.

D. Groups with Particular Needs

The *Canada Health Act* is intended to guarantee equal access to health services and health care; however, it does not guarantee access to the conditions that lead to good health, which, as numerous studies have pointed out, can include a person's economic status, age, gender, occupation and ethnicity. In Canada, geographic location in urban or rural areas is another

influence. Addressing the health concerns and particular needs of different groups requires varied initiatives.

Economic status is a primary factor affecting mortality, morbidity, and disability. Thus, low-income groups die younger, experience fewer years free of disability, and are more likely to have conditions such as high blood pressure, chronic respiratory disease and mental health disorders. In addition, they are less likely to use health services and to practise health protective behaviour. Within the low-income category, groups identified as having a higher chance of experiencing poor health include older people, the unemployed, welfare recipients, single women supporting children and minorities such as natives and immigrants.

Age is also a factor in health; young people and the elderly have distinct health concerns. For young people of both sexes, who in the teen and early adult years face major biological and social changes, motor vehicle accidents are the largest single cause of death, followed by suicide, cancer and homicide. For older Canadians, age-related chronic conditions include heart disease, arthritis, and hypertension. Forms of senile dementia, including Alzheimer's Disease, are a growing concern.

Gender brings another dimension to health policy considerations. Women live longer than men but suffer more from chronic poor health. Women use health services more than men, at least partly because of their childbearing role. Heart disease is the number one killer of women, yet heart treatments have been developed particularly for men and evidence suggests that women receive less medical care. Young women face particular problems, such as eating disorders and unintended pregnancies.

The nature of jobs and the workplace affects the health of workers. Men and women often face daily exposure to hazards such as chemicals, noise, radiation, infectious agents, and psychosocial stress that lead to poor health. While injuries and deaths are acknowledged to be related to industrial jobs, the fact that long-term illnesses often result from exposure to hazards in non-industrial settings is taking longer to be accepted.

Services responsive to the linguistic and cultural differences of Aboriginal people, immigrants and cultural minorities are often unavailable. Adverse social and economic conditions among native people contribute to the high suicide rate of the young and the high rate of diabetes and tuberculosis among older people.

E. Health Policy Challenges

Several common but not mutually exclusive themes have emerged from the reports of federal, provincial and territorial inquiries and policy negotiations. Serving as the base for current policy deliberations and decisions, these broad themes include: (1) Identifying and acting on shared values concerning health; (2) Shifting to health from health care; (3) Controlling health costs while sustaining health and health care; (4) Organizing health providers and health services appropriately; (5) Measuring, tracking and reporting on health system performance.

1. Identifying and Acting on Shared Values Concerning Health

One broad policy challenge is to ensure that decisions affecting the health status and the health care of Canadians are based on a clearly understood and widely held set of principles and values. A health system that reflects the values of Canadians will, in turn, shape them through decisions on delivery of health care. Like other components of any health system, cost and values are interconnected. It is probable that Canadians will ultimately decide as a country that they can afford to make expenditures on things that they value more highly.

At both the federal and the provincial levels, efforts have been made to identify values to guide health policy decisions. The Romanow Commission found that quality and accessibility stand out as the principles most strongly supported by Canadians. The 1997 National Forum on Health, as well as the Clair and the Fyke provincial commissions, identified health-related values such as accountability, quality, equality of access, efficiency and effectiveness, collective and personal responsibility. There appears to be a broad consensus that Canadians see health care as an entitlement for all, while accepting that some trade-offs are necessary.

While opinion polls continue to find strong public support for the principles outlined in the 1984 *Canada Health Act* of public administration, comprehensiveness, universality, portability and accessibility, some observers suggest that they are not consistent with the need to manage and adjust the health care system. There are renewed suggestions that greater public participation can contribute to defining and implementing shared national values. Technological and other innovations in health care that give

society the ability to create life, to improve life and to prolong life raise numerous ethical questions that affect all stages of human life. The value that Canadians place on each of these stages is among the variables that will ultimately affect the allocation of resources.

2. Shifting to Health from Health Care

Although not yet reflected in reality, policy discussions have long acknowledged the need for a shift of resources from health services designed to control, cure, or alleviate disease to efforts to maintain and enhance health by addressing a broad range of social, economic, genetic and other health determinants. The intent is to develop new initiatives designed to reduce the long-term demand for health care services.

Provincial and territorial governments have made a commitment to promote programs and policies which extend beyond care and treatment and which make a critical contribution to the health and wellness of their citizens. The federal government is strongly supportive of population health approaches and is working to develop strategies to promote overall wellness. All levels of government, recognizing that the health care sector cannot act alone, have explored an intersectoral approach that links health to relevant economic, educational, social, environmental and employment interventions.

Children are one group to which all governments are making efforts to apply this approach. Here, interventions are designed based on evidence that, for every dollar invested in a young child, future savings from reduced health, welfare and criminal justice costs amount to seven dollars. The notable disparities between the health of Canada's Aboriginal population and the health of the general Canadian population present another area where it is argued that intersectoral coordination across social, economic, and other areas could increase general health status and life expectancies and lower rates of infant mortality and chronic illnesses.

3. Controlling Health Costs While Sustaining Health and Health Care

Questions about health care costs, the adequacy of public funding and its sustainability in the future are an enduring part of health policy discussions. Achieving consensus on how much public money to spend, what future spending priorities to

establish, where to obtain any additional money, and whether the funding can achieve the desired health outcomes continues to be difficult, if not impossible.

Concerns about costs have been central from early days, and perceptions continue that the health care system is in the midst of a funding crisis. In the late 1960s, the Conference of Ministers of Health established a committee and seven task forces to enquire into ways of restraining health service costs. The CHST currently dominates funding discussions between the federal and provincial governments. Provincial governments regularly call on the federal government to restore the cash component of the CHST and to establish an appropriate escalator so that transfers keep pace with economic and social factors, such as ageing and health-care technology, that affect the health care system. The federal government, in turn, regularly produces figures that show substantial federal support for health care in Canada. In 2002, the Romanow Commission argued that current expenditure patterns provide slim grounds for arguments that the system is fiscally unsustainable.

Several factors recur in debates over cost and sustainability. The proportion of Canadians aged 65 and over and the related health costs continue to increase, with recent data suggesting that they account for over 40% of provincial and territorial health care expenditures. This leads some to see the elderly as an expensive problem and others to see a need to adapt services and technologies to the needs of the group. Drugs continue to consume an increasing share of Canada's health care dollar, recently constituting the second-largest category of health expenditures next to hospital services. The importance of drugs in treating disease, maintaining health and quality of life, and preventing and reducing the need for surgery and hospital stays is well recognized. Currently, public coverage for prescription drugs varies considerably from province to province, generating calls for a national pharmacare program. New and emerging technologies range from those used in cardiac care to organ transplantation to diagnostic imaging to genetic manipulation to telehealth, and are expected to increase dramatically in use. Decisions about their use and about resource allocation have been a shared federal and provincial concern for several years. Although such technologies can improve the speed and accuracy of diagnosis, cure disease, lengthen survival, alleviate pain, facilitate rehabilitation, and maintain independence, concerns have been raised about the availability, assessment and cost.

4. Organizing Health Providers and Health Services Appropriately

Current policy analysis focuses on the issue of appropriate care by appropriate providers in appropriate settings. At present, the dominant model involves solo practice physicians serving as the first line of entry into a health care system where the hospital is the central setting for care delivery. Overall, the health care sector employs about one in ten Canadians and depends on a steady supply of well-trained health care providers who can be appropriately distributed throughout the country.

Ways to shift boundaries between physicians and providers of alternative therapy, such as chiropractors and naturopaths, and between physicians and others who play important educational roles, such as nurses, pharmacists and nutritionists, are being re-examined. Analysts agree that primary care activities focusing on health promotion, illness and injury prevention, and chronic disease management would be appropriate for an interdisciplinary team as the first contact point in the health care system. Quebec's Clair Commission emphasised primary care through group physician services for medical care, along with the existing network of Centres locaux de services communautaires (CLSCs) for the broader social dimensions. Saskatchewan's Fyke Commission called for Primary Health Service Networks employing providers such as physicians, nurses, dieticians, etc. The Romanow Commission has also added its recommendations on primary care to the debate. Beyond primary care, statutory and professional barriers have changed, and exclusive scopes of practice have been replaced with shared responsibilities and more interdisciplinary practices, such as using midwives and nurse practitioners to alleviate and share demands on physicians.

Pressure is also being exerted to find new ways to deliver services necessary for health outside institutional settings and within the community. Questions about the appropriate setting for health care service delivery arise when issues like home care are considered. As individual provinces gradually reduced the use of inpatient hospital services due to factors such as increased day surgery procedures, expanded discharge planning programs, and reduced hospital beds through restructuring in the early 1990s, there was a renewed focus on home care. Nationally, the increased need for home care services raised questions about access, costs and standards. Although many home care services are currently aimed at the frail elderly, they may be appropriate for people with

minor health problems and disabilities as well as for those who are acutely ill and require intensive and sophisticated services and equipment. Services extending along a continuum that incorporates medical interventions as well as social supports could be available to children recovering from acute illness, adults with chronic diseases such as diabetes, persons with physical or mental disabilities, and individuals needing end-of-life care.

5. Measuring, Tracking and Reporting on Health System Performance

Renewed attention has been directed to measuring, tracking and reporting on the performance of Canada's health system. Such information is intended to assist individuals, governments, and health care providers in making more informed choices; promoting the identification and sharing of best practices; and increasing understanding of the desired use and outcomes of health services.

Most observers concur that decisions about health and health care should be based on reliable and valid evidence that can then be used to determine whether particular current practices, procedures, programs or general approaches are working effectively to achieve the desired result. Access to good health data can document both the level of resources consumed by health care and the benefits thereby produced. There is a need for overall co-ordination to ensure that definitions and concepts are consistent among provinces and that systems for collecting and synthesizing data are compatible. At the national level, the Canadian Institute for Health Information is already collecting information required for establishing sound health policy, managing the health system, and increasing awareness of health determinants. Provincially, organizations such as Saskatchewan's Health Services Utilization and Research Commission are working to refine indicators for population health and the health care system.

Frequent questions include how well the health system delivers services and whether they can be delivered in a more cost-effective way. Health researchers suggest that these questions need to be asked across all sectors: in standard medical care, where many hospitalizations and surgical procedures may be inappropriate or unnecessary; in new diagnostic and treatment technologies, where their introduction might occur without proper evaluation of the full costs and benefits and without withdrawal of the older

technologies; and in the area of health promotion, where interventions may have limited effect on health behaviours.

6. Conclusion

Health policy development in Canada faces many challenges. One of the most significant is defining health and designing the means of achieving it. There is clear recognition that we need to move from a system focused predominantly on health care to one more oriented to improved health status. To accomplish this, Canadians must identify those aspects of their society that they value the most; examine carefully what approaches will provide the best results; and support any shifting of resources deemed necessary to move in the direction of greater health for all. Many players will be involved: governments, physicians, hospital administrators, insurance companies and, ultimately, individual Canadians.

PARLIAMENTARY ACTION

The *Constitution Act, 1867* granted legislative authority over quarantine and the establishment and maintenance of marine hospitals to the federal government, and over the establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions to the provinces.

The *Hospital Insurance and Diagnostic Services Act, 1957* provided conditional grants from the federal government to the provinces for the development of a national hospital insurance program. The plans were to be universally available to provincial residents, portable, and publicly administered. In addition, they were to ensure that adequate hospital standards and complete records and accounts were maintained.

The *Medical Care Act, 1966* established the basis for national insurance to cover medical services provided outside hospitals.

The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977* changed the cost-shared conditional funding arrangements for health insurance and replaced them with block funding involving tax transfers and cash payments tied to the GNP. The previous legislation relating to hospital insurance and to medical care insurance was repealed.

The *Canada Health Act, 1984* established criteria and conditions that had to be met before full payment could be made under the Act of 1977 in respect of insured health services and

extended health care services provided under provincial law. The five criteria were comprehensiveness, universality, portability, public administration and accessibility.

The *Budget Implementation Act, 1996* set out new criteria for transfers to the provinces. The aim is to give the provinces more discretion over how funds are divided among health, post-secondary education, and social assistance.

CHRONOLOGY

1867 – The *British North America Act*, now the *Constitution Act, 1867*, contained few specifics about health.

1948 – The Health Grants Program offering federal cost-shared financial support provided the first stage in the development of a national health insurance plan.

1957 – National hospital insurance was established through the *Hospital Insurance and Diagnostic Services Act*.

1964 – The Royal Commission on Health Services under Emmett Hall pressed for a national health service that was universal, comprehensive, accessible, portable and publicly administered.

1966 – Federal funding for insured medical services was provided under the *Medical Care Act*.

1974 – Marc Lalonde, Minister of National Health and Welfare, published *A New Perspective on the Health of Canadians: A Working Document*.

1977 – The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* made it a condition of federal payments that the provincial plan would satisfy certain criteria.

1980 – Emmett Hall released the report of the Health Services Review ’79, called *Canada’s National-Provincial Health Program for the 1980s*. Extra-billing by physicians and hospital user fees were seen as endangering the principle of reasonable access to health care.

1981 – A House of Commons Task Force on Federal-Provincial Fiscal Arrangements concurred that extra-billing and user fees were detrimental. It concluded that federal funding for health care was adequate.

1984 – The *Canada Health Act* consolidated previous federal legislation and strengthened the federal commitment to the principles of universality, accessibility, portability, comprehensiveness and public administration.

1986 – Jake Epp, Minister of National Health and Welfare, published *Achieving Health for All: A Framework for Health Promotion*.

1990 – The Senate Standing Committee on Social Affairs, Science and Technology tabled its report *Accessibility to Hospital Services – Is There a Crisis?* It concluded that inefficiencies in acute-care hospitals could be and were being addressed through innovative administrative responses to recognized problems.

1991 – The House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women tabled its report *The Health Care System in Canada and Its Funding: No Easy Solutions*. The report concluded that increased spending on the existing system would not solve its problems. Instead, more cost-effective and appropriate distribution of human and other resources was needed.

1994 – Diane Marleau, Minister of Health, nominated 22 Canadians as members of the National Forum on Health. **With a four-year mandate and a budget of $12 million, four working groups focused on determinants of health, evidence-based decisions, societal values, and resource balancing.**

1994 – Federal, provincial and territorial Ministers of Health adopted the population health framework and strategic directions proposed in the discussion paper *Strategies for Population Health: Investing in the Health of Canadians*.

1997 – The National Forum on Health final report, ***Canada Health Action: Building on the Legacy,*** recommended that the key features of the health care system be preserved with adaptations to include home care, pharmacare, and primary care reforms. It also recommended development of an integrated child and family strategy, strengthening of community action, establishment of an Aboriginal Health Institute, and acknowledgement of the link between health, social and economic policies. It advocated the development of an evidence-based health system where decisions would be made on the basis of appropriate, balanced, and high-quality evidence.

2000 – The First Ministers produced an Action Plan for Health System Renewal addressing issues related to funding, access to care, health promotion and wellness, supply of health providers, health information, home care, pharmacare, and accountability.

2002 – The Standing Senate Committee on Social Affairs, Science and Technology, after a multi-year and multi-faceted study of the state of the Canadian health care system and the evolving role of the federal government, produced its final report.

2002 – The Commission on the Future of Health Care in Canada under Roy Romanow, established with a broad-ranging and multidimensional mandate, released its final report titled *Building on Values: The Future of Health Care in Canada.* It called for its recommendations to serve as a roadmap for a collective Canadian journey to renew health care.

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