Chapter 29

Federal Support of Health Care Delivery

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Exhibits

Federal Support of Health Care Delivery

Main Points

29.1 The federal government is not in a position to determine what its total contribution to health care really is. Federal funds are transferred under the Canada Health and Social Transfer in a block, providing provinces and territories with the flexibility to allocate these funds among health care, post-secondary education, and social assistance and social services. As a result, Parliament and the general public do not have a clear picture of the amount of federal funding directed to health care.

29.2 Health Canada strives to administer the *Canada Health Act* in a non-intrusive manner. This approach has not brought about the speedy resolution of non-compliance issues and differences in interpretation of the Act. A new approach, using the provisions of the Social Union Framework Agreement, offers a process for avoiding and resolving disputes.

29.3 Deficiencies in the Department's annual reports to Parliament compromise their usefulness: Parliament cannot readily determine the extent to which each province and territory has satisfied the criteria and conditions of the *Canada Health Act*. When the Department cannot provide this information in its reports, it should clearly explain the reasons.

Background and other observations

29.4 The delivery of health care is a primarily provincial/territorial responsibility. However, the federal government administers a significant piece of legislation in this area, the *Canada Health Act*. To many Canadians, the *Canada Health Act* provides for a health care system that helps to define this country. It articulates health care as a basic right and describes the features of the health care system.

29.5 The *Canada Health Act* establishes five criteria and two conditions as well as extra-billing and user charge provisions. All of these must be met if a province or territory is to receive the full federal cash contribution under the Canada Health and Social Transfer. The five criteria mean that regardless of where people live in Canada, they have universal access to a comprehensive, publicly administered health care insurance plan that will cover them if they move to another province and when they travel in Canada. With certain limitations, it also covers them when they travel outside Canada. The two conditions of the Act require provinces and territories to supply information that the federal government may reasonably require and to publicly recognize federal transfers.

29.6 Federal funding is provided to provinces and territories and other organizations to assist them in carrying out their health care mandates and related health activities. Health Canada is responsible for the administration of the *Canada Health Act* and other programs in health and related areas, including recent initiatives to renew health care and strengthen health information and technology.

29.7 We found that Health Canada does not have the information it needs to effectively monitor and report on the extent of compliance with the *Canada Health Act*. The only departmental evaluation undertaken in this area was limited in scope, and it was five years before results were reported to Parliament.

29.8 The federal government is funding efforts to meet a wide range of information needs. Information is a critical tool for allocating resources and reporting on how well the health care system has served the public. This work presents major challenges that all parties concerned with national health information need to manage

carefully. In addition, Health Canada needs to move expeditiously to meet its commitment to report on the performance and effectiveness of its programs.

29.9 The federal government has established the Health Transition Fund to support provinces in undertaking pilot projects to assess ways in which Canada's health care system can be improved. It has also introduced the Health Infostructure Support Program to help organizations involved in health care services further test and assess their use of information technologies. We found weaknesses in the management of both initiatives that, in our view, could compromise their usefulness as tools for helping planners to make sound decisions on health care delivery.

Responses to our recommendations from Health Canada and the federal government are included in the chapter. Health Canada has agreed to take corrective action on those recommendations directed to the Department. The federal government is committed to improving information generally but has not responded to our recommendations on the provision of specific information.

Introduction

The federal government is a significant player in health and health care

29.10 The delivery of health care is considered to be a primarily provincial/territorial responsibility. However, the federal government has developed a significant presence in health care across the country by transferring funds to the provinces and territories to assist them in carrying out their health care mandates. It also provides funds to individuals and organizations, and participates in various health-related activities such as health promotion, health protection, disease prevention and health research.

29.11 The federal government also delivers health care services directly to specific groups of people. These include First Nations and Inuit, the Canadian Forces, veterans, inmates of federal penitentiaries and members of the Royal Canadian Mounted Police. In addition, the federal government participates in collecting, analyzing and disseminating health-related information.

Publicly financed health care began some 50 years ago

29.12 At the time of Confederation, government involvement in health care services was minimal. For the most part, health care was seen as an issue of private or local concern. Until the late 1940s, private medicine dominated health care in Canada, with access to care essentially based on ability to pay.

29.13 The path toward national health insurance. The evolution to universal, publicly financed health care began in 1947 (Exhibit 29.1 presents a summary of some of the key milestones in this evolution). In that year, Saskatchewan introduced a public insurance plan for hospital services that covered all of its residents, regardless of their ability to pay. In 1957, the federal government introduced the *Hospital Insurance and Diagnostic Services Act* in order to encourage the development of hospital insurance plans in all provinces. Through the provisions of the Act, the federal government offered to share the cost of eligible services with the provinces on a roughly 50–50 basis. As a condition for receiving federal money, the provinces and territories agreed to make insured services available to all of their residents, under uniform terms and conditions. By 1961, all 10 provinces and the two territories had signed agreements establishing public insurance plans that provided universal coverage for in-patient hospital care.

The federal government transfers funds to the provinces and territories to assist them in carrying out their health care mandates.

29.14 In 1962, Saskatchewan extended public health insurance to physician services provided outside of hospitals. In 1966, the federal government introduced the *Medical Care Act*, under which it paid approximately half the cost of visits to physicians and of services they provided. To qualify for federal funding, provincial and territorial medical insurance plans were required to satisfy four criteria relating to public administration of the plan, portability, universality and accessibility of insured services. By 1972, all provinces and territories had extended their health insurance plans to include physician services.

29.15 Also in 1966, the *Canada Assistance Plan* was introduced; this was a federal-provincial program for cost-sharing comprehensive welfare services. The program also covered the cost of certain health services required by needy persons but not funded through the public health care insurance plans. In 1977, the federal government established the Extended Health Care Services Program to provide financial assistance to the provinces and territories for ambulatory care, nursing home intermediate care, adult residential care, and home health care services.

The *Canada Health Act* reaffirmed the federal commitment to universal, accessible, comprehensive, portable, and publicly administered health insurance.

29.16 The advent of block funding. As federal transfers to provinces and territories were tied to provincial/territorial health care spending initiatives (which were increasing), cost-sharing arrangements were proving to be expensive for the federal government, and the costs were unpredictable. The provinces were also concerned that the funding formula was inflexible because it was limited to hospital and physician services. In 1977, these cost-sharing arrangements were replaced by the Established Programs Financing (EPF), a block-fund transfer mechanism that combined federal transfers for hospital and medical services with transfers for post-secondary education and the Extended Health Care Services Program.

29.17 EPF transfers were provided in the form of cash payments and tax points, and were calculated independently of provincial health care costs. They were based on an equal per capita contribution, which could be adjusted annually. EPF transfers were notionally earmarked at 67.9 percent for health care and 32.1 percent for post-secondary education.

29.18 The enactment of the *Canada Health Act.* In response to concerns that extra-billing by doctors and user fees levied by hospitals were creating a two-tiered system that would threaten accessibility to care, the *Canada Health Act* was enacted in 1984. The Act reaffirmed the federal government's commitment to universal, accessible, comprehensive, portable and publicly administered health insurance.

29.19 The *Canada Health Act* consolidates the previous legislation on hospital and medical care insurance. It clarifies the requirements for insured

Exhibit 29.1

Key Milestones in the Evolution of Universal, Publicly Financed Health Care in Canada

1947	Saskatchewan introduced a public insurance plan for hospital services.
1957	The federal government introduced the *Hospital Insurance and Diagnostic Services Act*, a cost-shared program providing insurance coverage and access to hospital services.
1958–61	Provinces and territories joined the national hospital insurance program.
1961	Saskatchewan extended public health insurance to cover physician services outside hospitals.
1966	The federal government introduced the *Medical Care Act* to cost share medical care insurance plans in provinces.
1966	The federal government introduced the *Canada Assistance Plan* (*CAP*), a cost-sharing plan for comprehensive welfare programs. The plan also covered certain health services.
1968–72	Provinces and territories joined the national medical care program.
1977	The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* was enacted. Established Programs Financing (EPF) included transfers covering hospital insurance, medical care insurance and post-secondary education, and those for the Extended Health Care Services Program introduced at the same time as EPF.
1984	Parliament enacted the *Canada Health Act.*
1996	The federal government replaced EPF and *CAP* with the Canada Health and Social Transfer (CHST).
1999	The Prime Minister and all premiers and territorial leaders except Quebec signed the Social Union Framework Agreement.
1999	The federal Budget announced a new five-year funding arrangement for CHST.

Source: Health Canada

health services and extended health care services that the health care insurance plan in each province and territory must meet in order to receive the full cash contribution from the federal government. Exhibit 29.2 describes the purpose of the *Canada Health Act* as well as the criteria, conditions and provisions. The five criteria apply to insured health services, and the two conditions pertain to both insured health services and extended health care services. The provisions relate to extra-billing and user charges.

29.20 In an effort to reduce and eliminate its deficit, from the mid-1980s

Exhibit 29.2

***Canada Health Act:* Purpose and Requirements**

Purpose

The *Canada Health Act* aims to ensure that all residents of Canada have access to necessary health care on a prepaid basis.

The purpose of the *Canada Health Act* is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

Criteria

1. **Public administration.** The health insurance plan of a province/territory must be administered and operated on a non-profit basis by a public authority accountable to the provincial/territorial government.
2. **Comprehensiveness.** The plan must insure all medically necessary services provided by hospitals and physicians and, where permitted, services rendered by other health care practitioners.
3. **Universality.** The plan must entitle 100 percent of eligible residents to insured health services on uniform terms and conditions.
4. **Portability.** Residents are entitled to coverage when they move to another province/territory and when they travel within Canada or abroad (with some restrictions).
5. **Accessibility**. The plan must provide reasonable access to insured hospital and physician services on uniform terms and conditions. Additional charges to insured patients for insured services are not allowed. No one may be discriminated against on the basis of income, age, health status, etc.

Conditions

1. **Provision of information.** Provincial/territorial governments are required by regulations to provide annual estimates and statements on extra-billing and user charges. They are also required to voluntarily provide an annual statement describing the operation of their plans as they relate to the criteria and conditions of the Act. This information serves as a basis for the *Canada Health Act* annual report.
2. **Provincial recognition of federal contributions.** Provincial/territorial governments are required to give public recognition of federal transfers.

Provisions on Extra-billing and User Charges

1. **Extra-billing** for an amount in addition to any amount paid or to be paid for an insured health service by the health care insurance plan of a province.
2. **User charge** for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by the plan, but does not include any charge imposed by extra-billing.

Penalty Provisions

1. **Mandatory financial penalty** for extra-billing and user charges. Direct patient charges are subject to dollar-for-dollar deductions from federal transfer payments.
2. **Discretionary financial penalty** for non-compliance with the five criteria and two conditions. Financial penalties will reflect the gravity of the default.

Source: Health Canada, *Canada Health Act* Annual Report, 1997–98

to the mid-1990s, the federal government made a number of changes to the EPF transfers and imposed freezes on them. In effect, the federal government reduced the rate of growth and froze the per capita transfers for several years. In addition, in 1992 it modified the EPF in order to extend financial penalties under the *Canada Health Act* to other transfers to provinces and territories.

29.21 The Canada Health and Social Transfer. In 1996, partly to provide more flexibility to the provinces and territories, the federal government introduced the Canada Health and Social Transfer (CHST). It replaced federal funding for social assistance and welfare services under the *Canada Assistance Plan* and transfers for funding of health care and post-secondary education under EPF. The CHST provides block funding while upholding the principles of the *Canada Health Act*, in that the provinces and territories must meet the five criteria, two conditions, and extra-billing and user charge provisions in order to be eligible for the full cash transfer.

29.22 Governed by the *Federal-Provincial Fiscal Arrangements Act*, the purposes of the Canada Health and Social Transfer include:

- financing social programs in a manner that provides provincial flexibility;
- maintaining the *Canada Health Act* criteria and conditions as well as extra-billing and user charge provisions;
- maintaining the national standard that no period of minimal residency be required or allowed for access to social assistance; and
- promoting any shared principles and objectives for the operation of social programs.

29.23 The 1996 legislation reduced transfers to provinces and territories for health care, post-secondary education, and social assistance and social services by $3.0 billion to $26.9 billion in 1996–97; and by another $1.8 billion in 1997–98. Like the EPF, the CHST includes an equalized tax transfer (in the form of personal and corporate income tax points) and a cash transfer, which is subject to a floor. The cash floor was initially set at $11.0 billion in 1996–97. It was raised to $12.5 billion in 1997–98, resulting in an increase in the total value of CHST transfers to approximately $25.7 billion for that year. Subsequent changes were announced in the 1999 federal Budget (see paragraph 29.35).

The delivery of health care has evolved over time

29.24 In 1997, the Prime Minister launched the National Forum on Health to involve and inform Canadians and to advise the federal government on innovative ways to improve our health system. The Forum noted that the delivery of health care in Canada was under enormous pressure. Rising expenditures, an aging society, rapid advances in health science and new technologies, and changing practice patterns are all contributing to the pressures on health care delivery. As well, the delivery of health care has changed. It now encompasses more than the services of hospitals and physicians. Increasingly, health care services are provided in the community and at home. Provinces and territories have begun to respond to these challenges. However, they remain concerned that previous reductions in federal transfers and increases in costs have limited their ability to adjust.

29.25 Public and private spending on health care. The shifting of care from hospitals means that costs increasingly are passed on directly to consumers. As Exhibit 29.3 shows, the privately funded portion of health care expenditures is increasing steadily, accounting for about 30.4 percent of total health care

expenditures in 1998; Canada now ranks second among the G–7 countries in the portion of health care expenditures that are privately funded, behind only the United States. Exhibit 29.3 also shows that the pattern of health care spending has changed significantly over the past decade. Hospital expenditures have declined as a percentage of total health care spending, while the proportion spent on drugs has increased. The percentage of total public health care spending that has gone to public home care has also increased.

29.26 Current concerns about health and health care. A major concern is that for most indicators of health status, there are very large contrasts among Canada's provinces and territories in the health of the population overall. Large gaps in health status also exist between geographic areas within provinces. In addition, the 1996 and 1999 Reports on the Health of Canadians by the Federal, Provincial and Territorial Advisory Committee on Population Health note that Canada's overall high standard of health is not shared equally by all sectors of Canadian society. Children, youth and Aboriginal people are particularly vulnerable.

29.27 Canadians are also very worried about access to good-quality comprehensive health services. According to a recent survey, Canadians feel it is becoming more difficult to gain access to medical specialists and family physicians. The shortage of physicians in parts of rural Canada is also a concern.

Canadians are very worried about access to good-quality comprehensive health services.

29.28 Finally, there are indications that Canadians are increasingly bypassing the public health care system in order to avoid long waits for treatment or care. Some provinces, for instance, have allowed private health care facilities to offer, for a fee, selected services that public health

Exhibit 29.3

Health Care Spending in Canada, 1990 to 1998

	1990	1992	1994	1996	1998[1]
Total health care expenditures (in billions of dollars)	$61.2	$70.0	$73.4	$75.2	$80.0
Total health care expenditures as a percentage of GDP	9.0%	10.0%	9.6%	9.2%	9.1%
Public health care expenditures as a percentage of total	74.6%	74.2%	72.1%	70.2%	69.6%
Private sector's share of health care spending	25.4%	25.8%	27.9%	29.8%	30.4%
Total health care expenditures by use of funds (percentage of total):					
Hospitals[2]	39.3%	38.4%	36.2%	34.4%	33.5%
Physicians	15.1%	15.0%	14.7%	14.2%	14.2%
Drugs	11.3%	12.1%	12.7%	13.6%	14.0%
Other	34.3%	34.5%	36.4%	37.8%	38.3%
Public home care expenditures as percentage of public health care expenditures[3]	2.3%	2.6%	3.4%	3.8%	4.0%

1 Forecast
2 Includes prescribed and non-prescribed drugs used in hospitals
3 Percentages are based on fiscal years from 1990–91 to 1998–99

Source: Canadian Institute for Health Information and Health Canada

care institutions also offer. There have also been media reports of Canadians going to the United States to obtain more quickly the services they need. These concerns and the pressures on the delivery of health care indicate a need for renewal.

Supporting and renewing health care

29.29 As stated in the *Canada Health Act*, "The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers." Consistent with this policy, Health Canada is responsible for a range of programs and initiatives in health care and related areas. These include the administration of the *Canada Health Act*, and recent initiatives to renew health care and strengthen health information and technology, namely, the Health Transition Fund, the Health Infostructure Support Program, and the Health Information Roadmap Initiative.

29.30 Administering the *Canada Health Act* is the responsibility of Health Canada's Health Insurance Division, located in the Policy and Consultation Branch. The Division has 23 full-time equivalent staff and had a budget of just under $1.5 million in 1998–99. The Canada Health and Social Transfer, the mechanism by which federal transfers are made to provinces and territories for health care, post-secondary education, and social assistance and social services, is administered by the Department of Finance. Among other activities, Health Canada officials monitor compliance with the Act and advise the Minister of Health on non-compliance issues and on whether payments to provinces and territories can be made without deductions. When the Minister of Health authorizes a deduction, Health Canada officials communicate the amount to Finance officials who will deduct it from the cash contribution payments.

29.31 The Health Transition Fund Secretariat in the same Branch is responsible for managing the Health Transition Fund, a $150 million contribution program created in 1997. It funds pilot projects designed to test and evaluate new health care delivery models or approaches and to evaluate existing approaches where this has not yet been done.

29.32 Health Canada's Information, Analysis and Connectivity Branch has a mandate to promote the development of a national strategy for a Canadian Health Infostructure. It manages the two-year, $10 million Health Infostructure Support Program, which provides contributions to health services organizations to test and assess the use of information technologies in their respective domains. The Branch is also involved in funding and monitoring the implementation of the Health Information Roadmap Initiative, created in response to health information needs.

The Social Union Framework forms the basis of a new federal-provincial/ territorial partnership

29.33 In 1995, provincial premiers made a commitment at their annual conference to improve co-operation on social policy issues. To further this commitment, they created the Ministerial Council on Social Policy Reform and Renewal, with a mandate to define the principles of the Canadian social union. The Council's 1996 progress report set out principles to guide social policy reform, and contained a framework for rebalancing roles and responsibilities. By 1998, negotiations had begun with the federal government on a framework agreement for Canada's social union.

29.34 On 4 February 1999, the Prime Minister and all premiers and territorial leaders, except Quebec, signed the agreement on a Social Union Framework. This agreement forms the basis of a new partnership between the two levels of government to achieve common goals that

are expected to secure strong and sustainable health, post-secondary education and social services for the future. It also reaffirms the commitment made by governments to respect the five criteria of the *Canada Health Act*. In addition, it offers a process to avoid and/or resolve intergovernmental disputes over the interpretation of the *Canada Health Act* criteria.

The 1999 federal Budget announced increases in federal support for health care

29.35 According to the Minister of Health, the 1999 federal Budget represented the federal government's first step toward restoring the confidence of Canadians in their health care system. The Budget put the Canada Health and Social Transfer under a new five-year funding arrangement that includes additional transfers to the provinces and territories totalling $11.5 billion, specifically for health care. A new high in transfers for health care, post-secondary education, and social assistance and social services will be reached by 2001–02, surpassing the level of transfers before the expenditure restraint in 1996–97 (see Exhibit 29.4).

29.36 The Budget also provided for additional investment in the field of health information. It recognized that better information is essential to assessing the effectiveness of health services and promoting accountability. More specifically, the Budget announced that $95 million would be provided to the Canadian Institute for Health Information (CIHI) to strengthen its capacity to report regularly on the health of Canadians and the functioning of the health care system. In addition, $43 million would be allocated to a health-related Federal Accountability Initiative under which Health Canada reports annually on the expenditures, performance and outcomes of its own programs and policies.

Focus of the audit

29.37 The focus of our audit was on federal support for health care delivery. We examined the way Health Canada implements various federal initiatives to support health care delivery and renewal, including the *Canada Health Act*, the Health Transition Fund, and the Health Infostructure Support Program. We looked at health-care-related transfers to the provinces and territories under the Canada Health and Social Transfer, which is administered by the Department of Finance. We also looked at current efforts to improve health information, performance reporting and accountability. Further details on the audit scope, objectives and criteria are described at the end of the chapter in **About the Audit**.

Observations and Recommendations

The *Canada Health Act*

The *Canada Health Act* is an important symbol for Canadians

29.38 To many Canadians, the *Canada Health Act* provides for a health care system that helps to define this country. The Act symbolizes the values that represent Canada; it articulates a social contract that defines health care as a basic right and it describes the features of the health care system.

29.39 The importance of health care to all Canadians is seen in the fact that although the delivery of health care is considered a primarily provincial and territorial responsibility, Canada has health care legislation that sets out "principles" that are national in scope. The Act establishes criteria and conditions for insured health services and extended health care services, as well as provisions on extra-billing and user charges, that must be met if a province or territory is to receive the full federal cash contribution. The five criteria mean that regardless of

where people live in Canada, they have universal access to a comprehensive, publicly administered health care insurance plan that will also cover them if they move to another province and when they travel in Canada and, with certain limitations, when they travel outside Canada.

29.40 Public opinion polls consistently show that Canadians value their health care, and feel that it should be a top priority of government. However, polls also show that issues such as hospital restructuring and attempts at "renewal" (efforts to find new models for delivering health care services) have raised concerns among many Canadians about the future of health care and the quality of services.

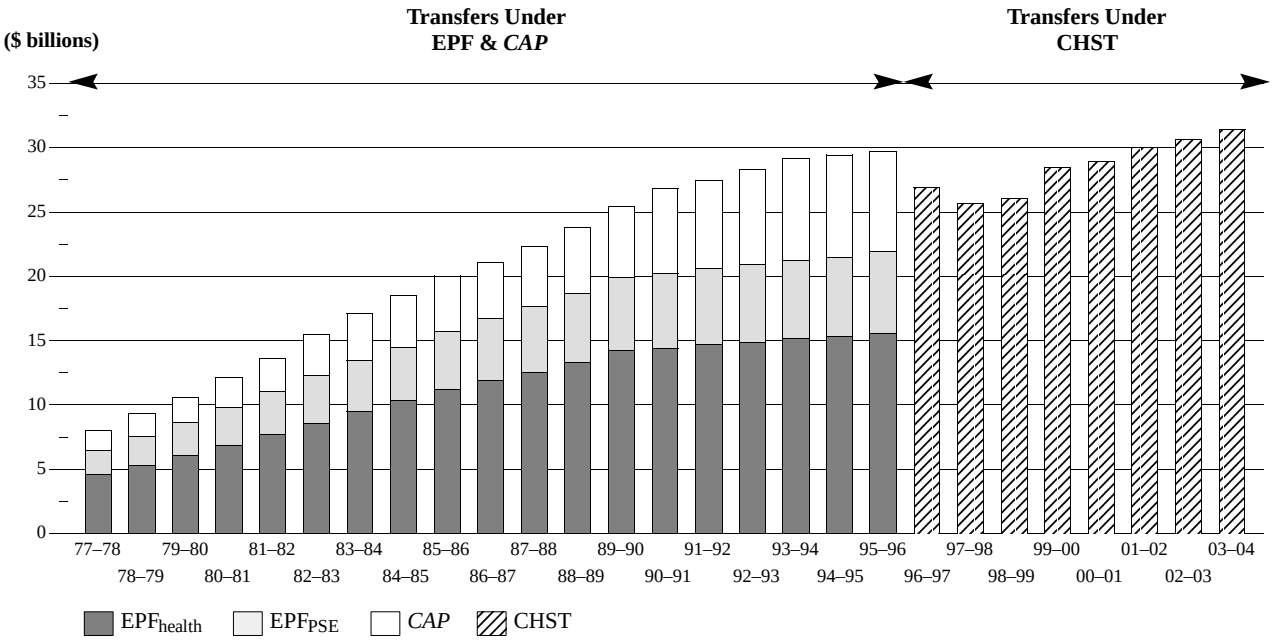
Compliance with the *Canada Health Act*

Health Canada strives to administer the *Canada Health Act* in a non-intrusive manner

29.41 Requirements of the Act. Health Canada has tended to take a non-intrusive

Exhibit 29.4

Federal Transfers to Provinces and Territories for Health Care, Post-Secondary Education, and Social Assistance and Social Services



Legend

EPF:	Established Programs Financing
CAP:	*Canada Assistance Plan* — Cost-sharing program for comprehensive welfare activities and certain health services
CHST:	Canada Health and Social Transfer — Block fund transfer in support of health, post-secondary education, and social assistance and social services
EPF_{health}:	Established Programs Financing, health portion
EPF_{PSE}:	Established Programs Financing, post-secondary education portion

Source: Department of Finance

approach to administering the *Canada Health Act*. Nevertheless, the Act does have certain clear requirements. It requires the Minister of Health to monitor the extent to which the provinces and territories are complying with the Act's criteria and conditions, and to report annually to Parliament on this matter. It also requires provinces and territories to meet all five criteria and the two conditions in the Act and to comply with extra-billing and user charge provisions in order to receive the full federal cash contribution.

29.42 Enforcing compliance. Various mechanisms exist to encourage or enforce compliance. These include education and communication, incentives, self-regulation, consultation, discussion, persuasion and negotiation, and penalties. These mechanisms can take the form of practices, policies, and regulations.

29.43 Health Canada relies heavily on discussion, negotiation and persuasion to enforce compliance with the criteria and conditions of the *Canada Health Act*. Under the Act, the Minister of Health has the power to take action to levy two types of financial penalties. Mandatory financial penalties are imposed on provinces and territories that allow extra-billing and user charges. Regulations require the provinces and territories to estimate and report the amount of extra-billing and user charges for insured services in their respective jurisdictions. These estimates are often used, after discussions with provinces, to calculate dollar-for-dollar deductions from the federal payments to those provinces. Through orders-in-council, discretionary financial penalties can be imposed for not complying with the Act's five criteria and two conditions. The Act states that the order to reduce or withhold any cash contribution will reflect the "gravity of the default".

Financial penalties have been imposed for extra-billing and user charges

29.44 Mandatory financial penalties have been used on a number of occasions to discourage provinces from continuing to allow extra-billing and user charges. For example, from 1984 to 1987 approximately $245 million was withheld from the cash contribution to seven provinces. As provided for in the Act, this money was returned to the provinces once they had eliminated direct charges. From 1992 to 1995, some $2 million was deducted from transfer payments to one province that permitted extra-billing. Under the federal policy on private clinics, a total of approximately $6 million has been withheld since November 1995 from four provinces where patients were charged a "facility fee" for medically necessary services. One province is still not complying with the federal policy on private clinics and is being penalized in the amount of $4,780 per month.

There are non-compliance issues that remain unresolved

29.45 We found that the federal government has never imposed discretionary financial penalties on provinces and territories for non-compliance with the five criteria of the *Canada Health Act*. In its interactions with provinces and territories, the federal government has attempted for the most part to adopt a non-intrusive approach to compliance, based on discussion, negotiation and persuasion.

29.46 In the last five years, six cases of non-compliance have been resolved through this approach. They include a requirement in one province that residents obtain a social insurance number (SIN) in order to register for coverage under the public health insurance plan; loss of coverage by residents for non-payment of premiums; and charges to patients in

association with an insured service provided in a physician's office. Four of these cases took 14 to 48 months to resolve, while the remaining two went on for as long as five years without penalty.

29.47 There are other cases that have not been resolved. For example, Health Canada believes that five provinces currently may be considered in breach of the out-of-country hospital rate requirement (portability criterion) of the *Canada Health Act*. The portability criterion requires that payments for hospital services outside Canada be based on the amount that would have been paid for similar services in the patient's home province. According to Health Canada, these five provinces are paying less than their own provincial rates.

29.48 Health Canada has found that one province is not complying with the portability criterion in cases involving out-of-province physician services. The criterion requires that hospitals and doctors providing care to residents from other provinces be paid at the fee schedule rates in their own provinces (the host province rate). However, the province in question generally reimburses other provinces only at its own rate for physician services, which for certain services is lower than that of some provinces. This can result in residents having to pay the difference between these rates.

The federal government's approach to administering the *Canada Health Act* has not brought about the speedy resolution of non-compliance issues.

29.49 Other examples of suspected non-compliance with the comprehensiveness and accessibility criteria have been the subject of considerable discussion between the federal government and the provinces and territories. These have remained unresolved for a number of years.

29.50 The federal government's approach has not brought about the speedy resolution of these issues and several others. Discussions in this area are further complicated by concerns about national unity.

Health Canada does not have the information it needs to effectively monitor and report on compliance

29.51 The Department has taken a passive stance toward gathering the information it needs for purposes of reporting and accountability. We expected that Health Canada would have a monitoring system that would include a mechanism for routinely collecting from the provinces and territories all the information it needs to report to Parliament on the extent to which provincial and territorial health care insurance plans have satisfied the Act's criteria, and the extent to which the provinces and territories have satisfied the conditions for payment required by the Act. We found, however, that the Department does not routinely collect this information.

29.52 Provinces and territories voluntarily submit a statement each year that describes the operation of their health care insurance plans in relation to the Act. They discuss this information with Health Canada before it is published. However, there are no regulations that require them to submit specific information to Health Canada apart from extra-billing and user charges. Regulations setting out information requirements were drafted in 1984 but were never promulgated because provinces and territories were concerned that meeting these requirements would be time-consuming and costly.

29.53 We found that the Health Insurance Division's primary sources of information for monitoring provincial and territorial health insurance plans are regional staff reports, correspondence and complaints from the public, newspaper clippings and other media reports. The Division also monitors changes to provincial and territorial legislation and reports, and analyzes developments in health care delivery in the provinces and territories through, for example, participation in federal/provincial/territorial working groups or review of

reports by provincial/territorial task forces. As well, it has begun to pay more attention to system-wide issues as a result of a 1993 evaluation of its monitoring and compliance activities. However, these sources alone do not provide sufficient information to monitor compliance and to determine the extent of compliance.

29.54 For example, under the Act a province's or territory's health care insurance plan must ensure that medically necessary services are accessible. This means the plan must provide reasonable access to insured hospital and physician services on uniform terms and conditions. However, the sources the Department relies on do not provide detailed, reliable information on waiting lists, the geographical location of services, hospital-bed-to-population ratios, the extent to which Canadians are bypassing the public system and using privately available resources, and the impacts — information that could help determine the degree to which provinces' health insurance plans are meeting the accessibility criterion.

29.55 The comprehensiveness criterion requires provincial and territorial health care insurance plans to insure all medically necessary services provided by hospitals and physicians and, where permitted, services rendered by other health care practitioners. We expected that the Department would actively monitor differences among provinces in what they determine is medically necessary in terms of the listing and de-listing of services in provincial legislation. We also expected that Health Canada would undertake some analysis of compliance with the comprehensiveness criterion and report its conclusions to Parliament. It has undertaken some active monitoring and analysis but has not reported any findings to Parliament.

Deficiencies in the annual report to Parliament are long-standing

29.56 Our Office has called attention in previous years to weaknesses in the information that Health Canada provides to Parliament in its annual reports on the administration and operation of the Act. In our 1987 audit and our 1990 follow-up, we noted that these reports had not, as required by section 23 of the Act, indicated either the degree of compliance with the Act in general or the extent to which each province had satisfied the five criteria and two conditions. Instead, the annual reports focussed primarily on describing each provincial health care insurance plan in general terms, and summarizing the deductions from cash payments to provinces that had allowed extra-billing and user charges.

Parliament cannot readily determine the extent to which each province and territory has satisfied the criteria and conditions of the *Canada Health Act*.

29.57 In our view, deficiencies in these annual reports compromise their usefulness: Parliament cannot readily determine the extent to which each province and territory has satisfied the five criteria and the two conditions of the Act. The ability to make this determination is important, given the continued existence of suspected cases of non-compliance with the Act that Health Canada has identified.

29.58 Health Canada should assess the capacity of the information sources it uses for monitoring the operation of the *Canada Health Act* and determining the extent to which provinces and territories have satisfied the Act's criteria and conditions.

Health Canada's response: *Agreed. Health Canada will assess the adequacy of its current information sources to determine what more can be done to strengthen its capacity to monitor the operation of the* Canada Health Act.

29.59 In its annual reports to Parliament, Health Canada should clearly indicate the extent to which each

provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions. Where it does not provide this information in the reports, it should clearly explain the reasons.

Health Canada's response: *Health Canada agrees and will work with its provincial and territorial partners to improve reporting to Parliament on the extent to which provincial and territorial health care insurance plans have satisfied the* Canada Health Act *criteria and conditions. Relevant information and explanations will be provided to Parliament through the* Canada Health Act *Annual Report, beginning with the 1999–2000 Annual Report.*

The Social Union Framework offers a process for avoiding and resolving disputes

29.60 The federal government recognizes that interpretation and enforcement of the *Canada Health Act* criteria has been a source of friction in federal-provincial relations. It also recognizes that it cannot solve continuing problems without the co-operation of the provinces and territories. The federal government has therefore made efforts to develop a process that would help avoid or resolve such disputes.

29.61 In September 1997, federal and provincial/territorial ministers of health (except Quebec) agreed to establish a working group on *Canada Health Act* interpretation issues to consider and develop a protocol by April 1998. The federal government believed that building on the principles of openness and transparency through a protocol was a good idea, but it would retain the right to administer, interpret and, if necessary, enforce the Act. The work on the protocol was halted in 1998, pending the outcome of Social Union Framework negotiations. On 4 February 1999, the Prime Minister and all premiers and territorial leaders, with the exception of Quebec, signed the Social Union Framework Agreement. This agreement describes how the federal, provincial and territorial governments will work together to sustain Canada's social programs.

29.62 In signing the agreement, the governments committed themselves to working collaboratively to avoid or resolve intergovernmental disputes over social programs. The agreement states that, respecting existing legislative provisions, mechanisms to avoid or resolve disputes will be simple, timely, effective, efficient, and transparent. It also states that processes should be designed that are appropriate to each sector and that will rely on joint fact-finding to resolve differences in interpretation in a non-adversarial way. It calls for governments to report publicly each year on the nature of any intergovernmental disputes and how they were resolved. Accordingly, the dispute avoidance and resolution process will apply to the interpretation of the *Canada Health Act* criteria. The agreement calls for governments to jointly undertake a review of its implementation within three years.

29.63 We expected that a process described in the agreement would be used to help avoid or resolve disputes over the interpretation and application of the five criteria of the *Canada Health Act*. We also expected that this process would be designed, as appropriate, in a manner that helps deal with new or outstanding disputes regarding the interpretation of these five criteria. At the time of our audit, this process had not yet been used in the resolution of outstanding issues.

29.64 The Social Union Framework Agreement represents a new, more collaborative, co-operative approach. Federal, provincial and territorial governments have taken an important step forward, with a process for more open collaboration. It is important that the process described in the agreement be used to help promote a collaborative

approach to future discussions between the federal and the provincial/territorial governments on the *Canada Health Act* criteria.

29.65 Health Canada, in collaboration with the provincial and territorial ministries of health, should build on the Social Union Framework Agreement and work together to avoid and resolve disputes over the interpretation of the *Canada Health Act* criteria in a manner compatible with the agreement.

Health Canada's response: *Health Canada will exercise the processes of the Social Union Framework Agreement to work together with provincial and territorial ministries of health to avoid and resolve disputes over the interpretation of the* Canada Health Act *criteria.*

Departmental Evaluation

Evaluation limited in scope and reporting to Parliament delayed

29.66 In 1993, Health Canada evaluated its Health Insurance Division's effectiveness in monitoring and assessing the extent to which provincial and territorial health care insurance plans were complying with the criteria and conditions in the *Canada Health Act*. The evaluation report described Health Canada's interpretation of the criteria and conditions, discussed issues of interpretation, and described and assessed the adequacy of the Division's procedures for addressing these issues.

29.67 In particular, the evaluation focussed on the Division's procedures for monitoring and assessing the accessibility criterion of the Act. It found that the Division relied on a non-intrusive approach to monitoring, given the absence of regulations requiring the provinces and territories to provide information (except on extra-billing and user charges). The Division essentially assessed potential cases of non-compliance that came to its attention through newspaper clippings, other media reports, and correspondence and complaints from the public. The evaluation noted that it was not clear how effectively the Division monitored the status of the health care system, including the implications of emerging issues that affect the underlying principles of the Act.

29.68 Our review of the evaluation found that its focus was on the Division's monitoring activities only; it did not question, for example, whether the Act was in fact ensuring that Canadians have reasonable access to health services across the country. Nor did it solicit the views of provinces, territories or other organizations (with one exception) on the Division's monitoring activities and related issues. We found that the Department's plans do not currently include undertaking additional evaluations that would address these and other issues.

29.69 We also found that although the evaluation report was completed in 1993, it was not until 1998 that the results were reported to Parliament in the Department's Performance Report for the period ended 31 March 1998. There was a significant delay in submitting the report to senior management for approval. The delay was due to extended discussions among the evaluators, program management, and senior management on the implications of releasing the evaluation report publicly once it had been approved, given the sensitive issues it dealt with. There was also a significant delay before the Department responded formally to the evaluation findings — an implementation plan, stating what the Department had done since the 1993 evaluation and what it still intended to do, was not submitted to senior management until late 1997.

29.70 Health Canada should ensure that the scope of any future evaluations deals with key issues of the *Canada Health Act*. The Department should also ensure that it promptly reports the

results of its evaluations in its Performance Reports to Parliament.

Health Canada's response: *Agreed.*

The Canada Health and Social Transfer

Funding for health care is not distinguished from funding for other social programs

29.71 The Canada Health and Social Transfer (CHST) represents the largest federal transfer to provinces and territories. It is intended to provide the provinces and territories with flexibility in allocating funds among health care, post-secondary education, and social assistance and social services. As a result of the 1999 federal Budget, the value of the CHST to provinces and territories is expected to increase from $28.4 billion in 1999–2000 to $31.4 billion by 2003–04 (in cash and tax points combined).

Parliament and the general public have not had a clear idea of the amount of federal funding directed to health care.

29.72 There has been considerable public debate in recent years about the state of health care now and in the future and about federal funding for health care. For example, federal support for health care delivery has been a central topic in discussions on the Social Union Framework. It has dominated recent Budget debates, and has been reviewed by various task forces and coalitions. Much of the debate has been about incremental funding for health care — discussions over reductions or additions to the federal government's contribution. However, these debates and discussions have made no mention of exactly how much federal funding the provinces and territories are allocating for health care delivery.

29.73 Under the CHST, federal transfers are made to the provinces and territories as a combination of cash contributions and tax points for the delivery of health care, post-secondary education, and social assistance and social services. However, there has been no distinction made, not even a notional one, among funds intended for health care, post-secondary education, and social assistance and social services. The federal government maintains that the design of the CHST as a block transfer reflects a policy decision to provide provinces and territories with increased flexibility in allocating federal transfers to these areas. As a result, however, Parliament and the general public have not had a clear idea of the amount of federal funding directed to health care. Nor can the federal government say what its total contribution to health care really is.

29.74 We would expect the federal government to be in a position to provide Canadians with information on its contribution to health care. The federal government believes that while public discussion about the extent of federal support for health care would be easier if the CHST were apportioned notionally or legislatively into specified amounts for each of the areas it supports, this consideration is outweighed by the policy factors that led it to create the CHST in the first place.

Some new funding is specified for health purposes

29.75 As we have noted in paragraph 29.35, the 1999 Budget announced an increase of $11.5 billion over five years in federal support for health care through the Canada Health and Social Transfer. Of that amount, $8 billion will be provided through future-year increases in the cash portion of the CHST; $3.5 billion was an immediate one-time cash supplement to the CHST in 1998–99, to be drawn down over the three subsequent years at the discretion of each province and territory.

29.76 Pursuant to the *Budget Implementation Act, 1999*, the additional funds are provided specifically for the purposes of maintaining the criteria and conditions of the *Canada Health Act* and "contributing to providing the best

possible health care system for Canadians and to making information about the health system available to Canadians".

Reporting requirements for new funding yet to be developed

29.77 While the new health care funding is clearly identified for supporting health care and making health information available to Canadians, no specific requirement has been established for reporting on the additional CHST funds announced in the Budget.

29.78 Without clearly specified requirements for information and reporting, it will be difficult to identify and assess whether the extra investment has helped the provinces and territories to deal with immediate concerns, such as waiting time and crowded emergency rooms. It will also be difficult to assess whether the additional federal funding has helped to renew health care in the longer term to better reflect the changing health needs of Canadians.

29.79 The federal government should explore options to improve information on its total contribution to provinces and territories for health care.

Federal government's response: *The federal government provides full information on its own direct health-related spending through the Main Estimates and the Health Canada Web site. It also provides full information (in Budget booklets, the Finance Canada Web site and the Main Estimates) on its transfers to provinces and territories, which, in the case of the CHST, are provided to support provincial and territorial spending on health care, post-secondary education and social assistance and social services.*

The CHST block fund provides provinces and territories with the flexibility to allocate funds as they deem appropriate, and all the CHST cash is available to maintain the Canada Health Act. *The federal government will explore options to improve health care information, but it does not consider a notional allocation of the CHST to be necessary or desirable — for the reasons that led to the current design.*

29.80 The federal government should work with provinces and territories to determine the requirements for information and reporting on the spending of additional funds provided under the Canada Health and Social Transfer specifically for health care and for making health information available to Canadians.

Federal government's response: *The federal government is working with provinces and territories to improve reporting on the health care system generally. With respect to the incremental CHST funds announced in the 1999 Budget, provincial First Ministers made a commitment, at their meeting with the Prime Minister in February 1999, that any additional funds made available for health care through existing CHST arrangements would be committed to core health services and programs in accordance with health priorities in their respective jurisdictions. They also agreed to work together to make health care as effective as possible and to make information about the health system available to Canadians. Federal, provincial and territorial governments are working on a number of initiatives, such as health system reports, to improve data gathering and to provide accurate information on the health of Canadians and the performance of the health system.*

Health Information

29.81 Health information is another area where the federal government invests significantly in support of health care delivery. There is widespread agreement on the need for more and better health information. Such information is a critical tool for allocating health care dollars to yield the best return in health outcomes. It

There is widespread agreement on the need for more and better health information.

is also central to testing the cost effectiveness of new ways of delivering health care and assessing the effectiveness of new technologies and treatments. Finally, information is needed for accountability — to report to the public on the effectiveness of the health care system and on the health of the Canadian population.

29.82 In 1991, the National Task Force on Health Information reported that the state of health information in Canada was "deplorable". In response to these findings, the Canadian Institute for Health Information (CIHI) was established in 1994. This is an independent, not-for-profit organization funded mainly by the provinces and the federal government. Its mandate is to develop and maintain a comprehensive, nation-wide health information system.

Funding efforts to meet a wide range of information needs

29.83 Health information means different things to different stakeholders. For example, the provinces and territories need information on health priorities and the health status of the population in their own regions. Planners in provincial and territorial health departments use the information as a basis for allocating health care resources — that is, to make sound, evidence-based decisions on health care. Health information is also used to tell the public how well their health care systems are performing. As part of its support for health care delivery, the federal government supports efforts to meet the provinces' and territories' need for better health-related information. It is also committed to obtaining the information required to report on its own programs.

29.84 The federal government is committed to supporting a number of initiatives aimed at providing better health-related information to meet the varied needs of health-care providers, other levels of government and the general public. For example, the 1999 federal Budget provided $95 million to the Canadian Institute for Health Information over a four-year period to implement the Health Information Roadmap Initiative. This initiative is intended to strengthen CIHI's ability to report regularly on the health of Canadians and the functioning of the health care system, provide comprehensive and reliable information for the use of health care providers and all levels of government, and foster greater accountability to the public for how well the health care system is serving them.

29.85 With the $95 million grant from Health Canada, CIHI will work with the provincial and territorial governments and others over the next four years to build consensus on which health indicators to measure, to develop standards for data, to fill key gaps in information and to build the capacity to collect and analyze data and disseminate information to those who need it. Part of the grant ($20 million) is directed to the Canadian Population Health Initiative, undertaken jointly by Health Canada, CIHI and Statistics Canada to address gaps in the analysis and reporting of data on population health. Another $28 million of the grant is allocated to the Canadian Community Health Survey, with Statistics Canada playing the lead role.

29.86 Under the grant, CIHI agrees to ensure that this work is monitored in accordance with an evaluation plan to be developed during the first year. A copy of the evaluation report will be provided to the Minister of Health. Respecting privacy and confidentiality requirements, CIHI also agrees to provide Health Canada with data collected through the Roadmap Initiative. Finally, it will publish an annual report on the initiative that will include the objectives for that year and the extent to which CIHI has met them, as well as other results it has achieved.

29.87 CIHI has already undertaken consultations with its stakeholders and has developed a preliminary list of health

indicators. These indicators are an important first step toward developing a national health information system. The first public report on the initiative is expected to be published in April 2000.

29.88 The work of creating a nation-wide health "infostructure" has begun. In several respects, this work presents major challenges that all parties concerned with national health information need to manage carefully.

29.89 It will be a complex and costly task to harmonize the diverse, widely dispersed and often incompatible databases and information systems that currently exist. However, it will be essential to do so if the ambitious objectives of the initiative are to be achieved.

29.90 A critical task for Health Canada will be to bring all of the players (government, hospitals, not-for-profit agencies, physicians and others) together. They all need to work diligently to develop and maintain a spirit of collaboration and co-operation. Health Canada can play a leadership role here. It can also play a key role in building capacity, by funding well-chosen projects aimed at helping organizations contribute to the pool of sound data. This is central to developing sound health information. As well, Health Canada can play an important role in maintaining the momentum that has already been established, along with the commitment of the provinces and other players.

29.91 Careful, thoughtful management by all stakeholders will be necessary to ensure that the potentially very expensive information systems associated with the initiative will deliver — at reasonable cost — what they are intended to deliver to those who need it.

The federal government is committed to reporting on the performance and effectiveness of its own health programs

29.92 The 1999 Budget also announced the allocation of $43 million to a health-related Federal Accountability Initiative. Under this initiative, Health Canada is committed to becoming more accountable to Canadians for the performance of its own health programs. For example, it will develop benchmarks and indicators for measuring performance. From the year 2000 onward, it will report annually on the expenditures, performance and outcomes of its own programs and policies. This is an important initiative that, when implemented, will enable Health Canada to better assess the effectiveness of its health programs and, where they are not performing as expected, to make adjustments.

29.93 The Department has established a new directorate for this initiative, but at the time of our audit it was not fully staffed. As a result, it did not yet have the capacity to undertake the initiative. It had not yet decided how information on accountability would be presented and what type of data would be provided.

29.94 Health Canada should expeditiously explore options to meet the commitment it has made to report on the expenditures, performance and outcomes of its own programs.

Health Canada's response: *Health Canada strongly supports strengthening its accountability to Canadians for the performance of its programs. The Department is taking action to more clearly define the objectives, planned key results and performance measures for key health programs and services provided to Canadians. As well, the Department is engaged in improving its capacity to support evidence-based decision making within Health Canada, across the health system and by Canadians. The Department*

is committed to reporting to Canadians on the performance of its programs.

Health Care Renewal

A recognized need for renewal

29.95 Factors such as demographic changes, hospital restructuring and the availability of new treatments and technologies have created new pressures on the health care system. They have also prompted efforts to "renew" the delivery of health care. Renewal involves searching for new, more effective ways to provide health care services. It also implies a shift away from the traditional hospital/physician setting of care delivery toward a model that includes delivering it in non-institutional settings. This change in focus means a greater reliance on home care and other forms of community-based care as well as on other health care providers.

29.96 In its 1997 report, the National Forum on Health indicated that the key to successful restructuring was to maintain the role of public funding for health care and, where appropriate, to expand it. The Forum saw a need to reorganize the health care system to ensure that medically necessary care is funded regardless of where it is delivered, or by whom.

29.97 The Forum identified three areas — home care, pharmacare and primary care — where it would be possible to move toward developing a more integrated system, one that funds the care, not the provider or the site. It recommended that the government support the development of knowledge and information that health care planners need as a basis for sound decisions in these areas. Specifically, the Forum recommended that the government create a multi-year fund to fund pilot projects with sound evaluation and research components, finance evaluations of existing projects, disseminate the results and promote the implementation of the best models identified by the evaluations. The Forum also suggested that the potential role of information technology needed to be explored.

Health Transition Fund and Health Infostructure Support Program

29.98 In response to the Forum's recommendation, the 1997 federal Budget announced two initiatives: the Health Transition Fund (HTF) and the Health Infostructure Support Program (HISP). We found weaknesses in the management of these initiatives that, in our view, could compromise the usefulness of the HTF and HISP as tools for helping planners make sound, evidence-based decisions on health care delivery.

29.99 Health Transition Fund. The Health Transition Fund is a four-year, $150 million contribution program; $120 million of this amount has been reserved for projects sponsored by the provinces and territories. The remaining $30 million has been allocated to funding national pilot and evaluation projects, three national conferences (on home care, pharmacare and health information), the operation of the HTF Secretariat and the dissemination of results across Canada.

29.100 The objective of the HTF is to support provinces and territories in undertaking projects that will enable them to assess ways of improving Canada's health care system. The federal government believes that modernizing the health care system is essential if it is to be sustainable and responsive to the current and future health needs of Canadians. The HTF funds pilot projects designed to test and evaluate new health care delivery models or approaches and to evaluate existing approaches that have not yet been evaluated. The output of the projects will be information or "lessons learned" that can be applied to improve the delivery of health care services. To date, approximately 130 projects have been approved in two rounds of funding. Examples include a project to evaluate the

impact of integration of health services delivery to seniors, and a project to evaluate the quality of life of children receiving home chemotherapy compared with that of children receiving it in a hospital.

The process for selecting projects was flawed

29.101 The Treasury Board approved the establishment of the Health Transition Fund in 1997. It approved funding on several conditions, one of which was that Health Canada report to the Treasury Board Secretariat any significant changes to the proposed project core selection and ranking criteria (Exhibit 29.5) as well as any significant changes to the mechanisms for administering the Fund. We expected to find that the projects chosen for funding met all of those criteria. Health Canada developed review guides to assess projects but they did not include the full range of core selection criteria. As a result, two of the selection criteria were not considered consistently in reviewing all projects. We also found that the ranking criteria had not been applied consistently. We found no evidence that the HTF Secretariat had reported this to the Treasury Board Secretariat.

29.102 The selection and ranking criteria are of critical importance in vetting proposed HTF projects. They are the mechanism for maximizing the likelihood that projects will provide valuable information and guidance for decision makers searching for new approaches to delivering health care services. In our view, the usefulness and effectiveness of the Fund has been compromised because selected projects may not be the ones that would best meet the Fund's criteria and objectives.

It will be difficult to evaluate a number of supported projects

29.103 The usefulness of the HTF projects will also depend directly on the quality of their evaluation component, because generating and sharing the information flowing from evaluations are central to the HTF. In turn, the quality of this information will largely determine the ability of planners and health care providers to implement the most promising health-renewal strategies.

29.104 Each project was to include an evaluation component. A framework was developed that defined the evaluation component for all projects. The framework required evaluations to cover

Exhibit 29.5

Health Transition Fund: Criteria for Project Selection and Ranking

Minimum core criteria for project selection:

- Support for at least one of the priority areas identified by federal/provincial/territorial governments
- National relevance (that is, the project will generate lessons and evidence that will be of interest and use to other jurisdictions)
- An expectation that the piloted model will result in pragmatic, effective and efficient reform
- Avoidance of duplication of projects already funded with federal moneys
- Consistency with the principles of the *Canada Health Act* with respect to insured services
- Demonstrated capacity to complete the project
- Application of consistent project evaluation criteria
- A plan to disseminate results

Ranking criteria for projects that meet the core selection criteria:

- Importance to provincial/territorial health systems
- Attention to health inequities
- Extent to which the project supports improvements to the health and well-being of the population

Source: Health Transition Fund Secretariat, Health Canada

four areas: cost effectiveness; quality of service (including client satisfaction); health outcomes; and transferability (whether project results or lessons learned could be applied — that is, transferred — to other provinces or environments). These four areas were to be covered by asking six key evaluation questions (see Exhibit 29.6).

29.105 Given the importance of the evaluation exercise to the success of the HTF initiative, we expected that projects would include an evaluation plan reflecting the requirements of the framework. We took a random sample of 40 approved projects and assessed the extent to which the six questions were covered in their evaluation plans. We found that three of the approved projects had no evaluation plan at all. Of the remaining 37, nine addressed only four of the questions or fewer (with no explanation as to why some questions were not covered).

29.106 Given that several projects in our sample had incomplete evaluation plans, it may be difficult to assess whether projects are contributing significantly to meeting a key objective of the HTF, namely, to assess the merits of a range of innovative approaches to health care delivery. The Department needs to ensure that the necessary information is gathered through project monitoring and evaluation.

29.107 Health Infostructure Support Program. The Health Infostructure Support Program exhibited weaknesses similar to those we found in the Health Transition Fund. Introduced in 1997, the HISP is a $10 million, cost-shared contribution program. It provides funding to organizations involved in health care services to further test and assess their use of information technologies. It is one of the key elements of the federal approach to promoting the development of an integrated Canadian health infostructure. A total of 36 projects have been approved under this program. Examples include a project to establish a satellite communications link to clients in remote communities who require ultrasound examinations, and a project to design, develop, implement and test a centralized database of pathology information from Ontario laboratories that process tumour specimens.

29.108 In 1997, the Treasury Board approved the terms and conditions of the program, including eligibility and selection criteria (see Exhibit 29.7). We found that, as with the HTF projects we reviewed, not all of the selection and

Exhibit 29.6

Questions to Be Addressed in the Evaluation of Each Health Transition Fund Project

Quality of Service

- How does this model or program affect the quality of services/care provided?
- How does this model or program affect access to health services?
- In what ways does this model/program facilitate integration/co-ordination with other parts of the health system and other health stakeholders?

Health Impacts/Effects

- What kinds of changes in the health of your service/target population occurred as a result of your project, and on what basis did you draw these conclusions?

Cost Effectiveness

- How did the model piloted or the program evaluated contribute to a more cost-effective service than what is currently being provided in that region/province?

Transferability/Generalizability

- What lessons did you learn about implementing and testing this model or program that might be useful to other jurisdictions/regions/programs/settings?

Source: Health Transition Fund Secretariat, Health Canada

eligibility criteria approved by Treasury Board had been applied consistently in selecting projects for funding. One selection criterion was not considered in all cases because the Department believed that this would put the smaller organizations submitting proposals at a disadvantage.

29.109 To be eligible, each HISP project was required to include an evaluation component. Proposals were expected to include an evaluation plan that covered six areas: cost effectiveness; health status outcomes; organization and delivery outcomes; impact on planning processes, structures and funding; impact on services; and transferability of results and applicability in other settings or population.

29.110 We found that the general guidelines provided to potential applicants under HISP did request a detailed plan for evaluating results. However, the guidelines did not specify that evaluations must cover the six issues noted above. We selected a random sample of 12 approved projects for review. Two of the projects had no evaluation plan at all. Six of the remaining 10 projects covered only half of the issues or fewer. Because evaluating project results was a critical component that was not addressed properly, we believe that the usefulness of HISP has been compromised.

Criteria approved by Treasury Board were not considered consistently in selecting projects for funding.

29.111 Health Canada should ensure that all projects funded under its contribution programs comply with the criteria approved by Treasury Board.

Health Canada's response: *Agreed.*

29.112 Health Canada should ensure that evaluations of projects under the

Exhibit 29.7

Health Infostructure Support Program: Eligibility and Selection Criteria

Eligibility:

- The program is open to non-profit, non-government groups and organizations in Canada

Eligibility criteria:

- Accelerated use of advanced network-based services
- Direct relevance to the provision of health services
- Aimed at improving the health of Canadians
- Consistent with the *Canada Health Act*
- The project is, or can become, national in scope
- Includes a detailed framework against which the results will be evaluated
- Includes a proposal for the wide dissemination of the results

Project selection criteria following application of eligibility criteria:

- Level of innovation associated with the project
- Ability of the applicant (and any project partners) to successfully complete the project
- Interoperability and scaleability of the technologies associated with the specific service applications
- Extent to which necessary technologies have been proven
- Extent to which the project is driven by practical user needs rather than by the available technology
- Extent to which the project is driven by health-specific applications
- Potential of the project to have a significant impact on the health of Canadians
- Level of involvement by a private sector partner and the potential for the results of the project to be commercialized in Canada

Source: Health Canada

Health Transition Fund and the Health Infostructure Support Program gather the necessary information to support evidence-based innovation in health care delivery.

Health Canada's response: *Agreed.*

Conclusion

29.113 Although the delivery of health care is considered a primarily provincial and territorial responsibility, Canada has health care legislation that sets "principles" that are national in scope. The *Canada Health Act* provides for a health care system that helps to define this country and that symbolizes the values that represent the nation.

29.114 Health Canada has tended to take a non-intrusive approach to administering the Act. However, this approach has not brought about the speedy resolution of issues relating to non-compliance and interpretation of the criteria of the Act. The Department needs to assess the capacity of the information sources it uses to monitor the operation of the Act and to determine the extent to which provinces and territories have satisfied the Act's criteria and conditions. It also needs to work with provinces and territories to build on the Social Union Framework Agreement and avoid or resolve disputes over the interpretation of the *Canada Health Act* criteria in a way that is collaborative, transparent and compatible with the agreement.

29.115 Weaknesses in the information that Health Canada provides in its annual reports to Parliament on the administration and operation of the *Canada Health Act* remain a long-standing problem. In addition, the only departmental evaluation undertaken in this area was limited in scope and there was a very long delay in reporting the results to Parliament.

29.116 The federal government needs to explore options for improving information on its total contribution to provinces and territories for health care. It also needs to work with provinces and territories to determine the requirements for information and reporting on the spending of additional funds under the Canada Health and Social Transfer provided specifically to support health care and make health information available to Canadians.

29.117 The Health Information Roadmap Initiative represents major challenges that all parties concerned with national health information need to manage carefully. Health Canada also needs to expeditiously explore options for meeting its commitment to report on its own programs.

29.118 Finally, Health Canada needs to ensure that all projects funded under its contribution programs meet the criteria approved by Treasury Board, and that evaluation of projects under the Health Transition Fund and Health Infostructure Support Program gather the necessary information to support sound decisions for health care renewal. Modernizing the health care system is essential to ensure that it is sustainable and responsive to the current and future health needs of Canadians.

About the Audit

Objective

We undertook the audit to provide information to Parliament on federal support of health care under the *Canada Health Act* and on how it works, as well as current federal efforts and initiatives to support health care delivery and renewal. Our objectives were:

- To determine the extent to which federal efforts in supporting, monitoring and renewing health care delivery:
  - reflect clear objectives;
  - adequately provide for reporting performance; and
  - facilitate review and renewal.
- To determine whether the projects approved under the Health Transition Fund (HTF) and the Health Infostructure Support Program (HISP) conform with targeting and project selection criteria.

Scope and Approach

The audit examined federal instruments and initiatives to support health care delivery and renewal, including the *Canada Health Act* (and the transfers to provinces and territories for health care made under the Canada Health and Social Transfer), the Health Transition Fund (HTF) and the Health Infostructure Support Program (HISP). We examined the implementation of the *Canada Health Act* and the extent of monitoring and reporting undertaken by Health Canada. We examined the review and approval of projects under the Health Transition Fund and the Health Infostructure Support Program and analyzed in detail a sample of 40 HTF projects and 12 HISP projects. We also looked at current efforts to improve health information, performance reporting and accountability. We had discussions with departmental staff and selected provincial officials involved in health care delivery as well as representatives of the Department of Finance, Statistics Canada and the Canadian Institute of Health Information. In addition, we reviewed the final report issued by the Advisory Council on Health Infostructure, the recent Social Union Framework Agreement, the 1999 federal Budget and other documentation.

The audit did not examine major components of the Canadian Health Infostructure initiative, including the First Nations Health Information System, National Health Surveillance Infostructure and Canadian Health Network. We reviewed the development of the National Health Surveillance Infostructure as part of our audit of National Health Surveillance, reported in our September 1999 Report.

The quantitative information in this chapter that was drawn from government and non-government sources or departmental databases has been checked for reasonableness but has not been audited.

Criteria

We would expect to find:

- a process for interpretation and enforcement of the *Canada Health Act* that is transparent;
- a commitment to achieving consensus on objectives, roles and responsibilities, and standards among the federal and the provincial and territorial governments;

- project selection criteria for the Health Transition Fund and the Health Infostructure Support Program that are consistent with the achievement of program objectives and applied in approving projects in an efficient manner;
- procedures for measuring and reporting performance; and
- a forum for review and renewal.

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