

CARING FOR MEDICARE

SUSTAINING A QUALITY SYSTEM



SASKATCHEWAN

Commission on Medicare

COMMISSIONER KENNETH J. FYKE, APRIL 2001

Caring for Medicare: Sustaining a Quality System

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Commission on Medicare



April 6, 2001

Honourable Lorne Calvert
Premier of Saskatchewan

Dear Premier Calvert:

I am pleased to submit my recommendations to you and to the Government and people of Saskatchewan on the future of Medicare.

The Commission on Medicare, appointed by Premier Romanow in June 2000, was given a three-fold mandate. The first was to identify key challenges facing the people of Saskatchewan in reforming and improving Medicare. As you know, in October 2000 the Commission released *Caring for Medicare: The Challenges Ahead*. This document and the associated questionnaire provided a framework for starting dialogue with the people of Saskatchewan on the future of Medicare.

I was also asked to recommend an action plan for delivery of health services across Saskatchewan and to investigate and make recommendations to ensure the long-term stewardship of a publicly funded, publicly administered Medicare system. This final report provides my recommendations in these areas. I am recommending significant change to the health system. I believe such change is essential to allow Saskatchewan to achieve and sustain a just and fair modernization of Medicare.

The health system in Saskatchewan and indeed in much of the rest of Canada has already experienced a great deal of change in the past decade. This next effort will require continuing vision, leadership and support from everyone. As I spoke with people around the province, I found a readiness and commitment to find solutions that meet the changing needs of the province.

Saskatchewan pioneered Medicare in North America, and I am optimistic the province can adapt and care for Medicare in a way that responds to new circumstances unimagined by its creators. As people around the province told me over the past several months, Medicare can be changed for the better without abandoning the founding principles.

In closing, I would like to thank the Government of Saskatchewan for the privilege and opportunity to be part of this Saskatchewan journey.

Sincerely,



Kenneth J. Fyke

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SASKATCHEWAN

EXECUTIVE SUMMARY

The mandate¹ of the Commission on Medicare is three-fold:

- To identify key challenges facing the people of Saskatchewan in reforming and improving Medicare.
- To recommend an action plan for delivery of health services across Saskatchewan through a model that is sustainable and embodies the core values of Medicare.
- To investigate and make recommendations to ensure the long-term stewardship of a publicly funded, publicly administered Medicare system.

The first part of the Commission's mandate was addressed in an earlier report, *Caring for Medicare: The Challenges Ahead*, along with a process of public dialogue and discussion initiated by the Commission in the Fall and Winter of 2000-01².

This report makes a series of recommendations³ which together constitute an action plan for the delivery of health services, a plan that will, when implemented, ensure that Medicare is not just preserved, but substantially enhanced and improved.

The first two chapters of this report emphasize a plan to organize and manage health services delivery. Chapter One focuses on everyday services, those parts of the health system people come into contact with first and most often. To address everyday health needs in a way that ensures quality and long-term sustainability, the Commission on Medicare recommends the development of an integrated system for the delivery of primary health services. While there are many models of primary care or primary health services that also incorporate the use of teams, the Commission recommends the creation of truly

interdisciplinary Primary Health Service Networks. Networks would provide strong links between teams and bring together a range of health care providers to deliver everyday health services. The Commission recommends that the Network be integrated and organized to include community and emergency service providers. The Commission also recommends use of a telephone health advice line, so in effect, the office would never be "closed". Outside of office hours, telephone calls would be forwarded to a nearby Team member or to another part of the Primary Health Network or to a provincial call centre. A high quality and sustainable system of primary health services is only possible by carefully knitting together the existing providers - family physicians, health district staff, emergency medical personnel, and pharmacists - who often work in isolation from one another.

The Commission also recommends that health districts have the mandate to organize and manage Primary Health Teams and be responsible for contracting with or otherwise paying family physicians, primary care nurses and other health providers. The Commission further recommends the integration of many of the existing hospitals and integrated facilities in the province into Primary Health Networks. Specifically, the Commission recommends a network of Primary Health Centres as well as Community Care Centres in 25 - 30 locations to allow for overnight stays for convalescence, respite, and palliative care.

Occasionally, people need more specialized services, which include a wide range of services requiring advanced equipment and skills. For example, assessment of childhood autism requires a team with pediatric and developmental expertise. Acute medical care and surgery require physicians, nurses and other providers with special training. Diagnostic tests such as Computed

¹ The complete Terms of Reference of the Commission on Medicare can be found in Appendix A.

² A summary of the public dialogue initiated by the Commission can be found in Appendix D.

³ A complete listing of the recommendations of the Commission can be found in Appendix B.



Tomography (CT), ultrasound or Magnetic Resonance Imaging (MRI) require specialized equipment, skilled technicians to operate the equipment and radiologists to interpret results. However, as described in Chapter Two, the current manner in which these services are delivered in Saskatchewan is not sustainable and does not always allow physicians, nurses, technicians and other health care providers to deliver high quality services on a timely basis.

This is why the Commission recommends that health districts contract for the services of specialists, further integrating physicians into the health services delivery system. The Commission also recommends the development of a province-wide plan for the location and delivery of specialized services based on standards established by a Quality Council. As described in greater detail in Chapter Two, the Commission recommends that this province-wide plan include the consolidation of tertiary services delivered in Saskatoon, Regina and Prince Albert and a network of 10 to 14 Regional Hospitals for basic acute and emergency care.

A public, universally accessible health system is designed not only to treat illness when it occurs, but also to produce better health for individuals, and population groups. A fair and sustainable health system is one in which there is a balance between spending on “downstream” activities: diagnosis and treatment, as well as investments in “upstream” activities: disease prevention, health promotion and protection. As a result, the Commission recommends in Chapter Three the continuation of public health, health promotion, and disease and injury prevention strategies. The Commission also recommends the development of regular reports on defined and measurable health goals, strategies to address the broader determinants of health, and specifically, a Northern Health Strategy to meet the unique and urgent needs of people in northern Saskatchewan.

Quality can be defined as doing the best job possible with the resources available. Simply put, the health system has yet to achieve an

appropriate level of quality. The delivery of health services in Saskatchewan and in Canada must be infused with a quality culture. While there are numerous health care quality initiatives underway in Saskatchewan, there is no overall framework or coordinating body, nor are there regular and comprehensive reports to either providers or the public. To begin to address these gaps, in Chapter Four of this report the Commission supports the continuing work in Saskatchewan and elsewhere in Canada on performance indicators. The Commission recommends these indicators be included in revised annual reports on the health system by Saskatchewan Health and health districts along with incentives and funding to ensure accountability and quality. The Commission also recommends the creation of a Quality Council with a mandate to improve the quality of health services in the province. The Council should be an evidence-based organization, arm’s length from government and reporting to the Legislative Assembly. In so doing, Saskatchewan will lead the country in the pursuit of a quality culture that will be the next great revolution in health care.

Much of the Commission’s report is focused on change - changes to the way in which health care is organized and delivered as well as changes leading to a sustainable, system of health services, that emphasizes quality and accountability. To support and enable change Chapter Five of this report contains a series of recommendations dealing with governance, accountability, health human resources, education and research, and information technology. Specifically, the Commission recommends a move to 9 to 11 health districts, and a clarification of their relationship to the Government of Saskatchewan. In order to improve health services delivery to Aboriginal communities in the province, the Commission is also recommending a structured dialogue between the federal and provincial governments as well as representatives of Aboriginal peoples on the delivery of health services. To address staff shortages, poor morale, and general frustration with the health system the Commission recommends



coordinated, province-wide human resources planning and management. Other sectors, and indeed whole industries, faced with broadly similar challenges, have reacted by investing heavily in information systems. In this same spirit, the Commission recommends continuing investments in information and communication technology including the development of an Electronic Health Record.

The Commission has concluded that education and research are critical supports to the process of change required for the health system. Along with a renewed mandate for health sciences education the Commission recommends that the Government of Saskatchewan increase its investment in health research to a figure equalling one per cent of its health spending.

The fiscal challenge facing the health sector should not be underestimated. As outlined in Chapter Six, if major changes are not made quickly, the Commission projects Government expenditures on health will grow more quickly than Government revenues, leading to a gap of over \$300 million at the end of four years. To meet this fiscal challenge and ensure the long-term stewardship of Medicare, the Commission does not recommend increasing health care funding to prop up the status quo, either in the form of higher taxes or through public insurance premiums or user charges. The Commission does recommend that future investments in the health sector be directed to change: changing the organization and delivery of primary and specialized services; enhancing

the overall health of the population; research to support health services education, and to develop and report on performance measures, service quality and value for money; and, finally managing change and creating a quality-oriented health services culture.

Finally, Chapter Six comments on the broader social context required to sustain the health system. For a social program like Medicare to succeed, all parties must honour the implicit terms and conditions of the social contract that underlies it. Health workers must help create incentives that reward good practice, abandon obsolete practices, and realign the division of labour. Governments must report to the public about system performance, ensure accountability for the quality of the services provided, and resist promising more than can be reasonably expected. The public must demand quality and pay attention to value for money, so that other societal needs can be met.

All parties have, to varying degrees, underestimated the fragility of Medicare and have focused on their own entitlements rather than their obligations. There are no villains in the piece; it has been a collective loosening of our grip on the terms and conditions of a sustainable quality system.

There are many recommendations in this report about structure, organization, quality, and standards. Success will follow only if there is a change in perspective, behaviour, and rhetoric.



INTRODUCTION

Why another report about health care? It's a good question. The system seems in almost constant review; barely six months goes by without another major report from one province or another. Why Saskatchewan, and why now?

One reason is that Saskatchewan has been reforming its system for nearly a decade, and a decade is a long time in health care. There is no doubt that the province embarked on the right road for the right reasons in the early 1990s. The province was among the first out of the gate with many reforms subsequently embraced by others. The creation of health districts was the main structural change, combining both centralization and decentralization. Districts have made major progress in integrating services and advancing the wellness model. Yet many districts have smaller populations than those established in the eight other provinces that have followed Saskatchewan's lead, and the changing demographics continue to make them smaller. The ideas that underlay the journey to date remain sound; however, inevitably, some of the enormously ambitious goals set in the early 1990s have not been realized. It is therefore timely to assess accomplishments to date and make the changes needed to guarantee future progress.

Another reason is that health care is always changing. Medical science develops new drugs, equipment, surgical techniques, and other therapies. Health care professionals acquire new skills and new approaches to care. Strategies to improve population health become increasingly sophisticated and multi-dimensional. All of this innovation raises questions about how to organize services, how to evaluate existing and new technologies, what to pay for publicly, and what not to buy at all. Each change affects the system, and eventually the system we once had becomes almost unrecognizable. It makes sense from time to time to take a big picture view of these ground level changes to see if all the parts continue to fit together.

The mandate of the Commission, outlined in detail in Appendix A, is to recommend a sustainable, affordable, equitable, and high quality system for all residents of the province. It calls for addressing the long-term stewardship of a publicly funded, publicly administered Medicare system. All the analyses and proposals in this report seek to achieve these goals and respect these principles. Quality and careful stewardship of public funds go hand in hand and are together the bedrock of sustainability.

One of the most rewarding aspects of this Commission has been the opportunity to engage with people in the health system and the public. The meetings, focus groups, and interactive videoconferences were informative, candid, and helpful. Over 33,000 people completed *The Challenges Ahead* questionnaire. In addition to sharing their concerns and suggestions, many organizations chose to provide submissions. The two central themes that unified all of these interactions were a commitment to an accessible, high quality system, and the need for change.

This report reaffirms insights on primary health services, population health, health care financing, equity, and access that have been in circulation for some time. The challenge is to implement strategies that will align the system more closely with these ideals and improve quality. These insights must be more than the subject of drawing room discussions and the unfulfilled dreams of planners.

Many analyses have dealt persuasively with funding and organization, and these are addressed here as well. Primary health services are the foundation of a system that promotes and maintains health as well as providing everyday health care to all. The foundation is cracked, with many gaps, and until it is repaired and strengthened, the whole structure of health care will wobble. Building a comprehensive, needs-based, accessible primary health services system creates an



unmatched opportunity to maximize the skills, creativity, and contribution of the people who work in the system. Put simply, many people are doing things that others could do, while many professionals are unable to contribute to the extent their skills should allow. Investment in primary health services, integrated with a well functioning specialized service delivery system, will ensure the organizational structure is in place to support a quality health system. These service delivery changes will result in comprehensive, accessible high quality care to many residents of rural Saskatchewan – a major problem this report seeks to address.

The originality of this report is its focus on sustaining a quality system. The public, according to polls, appears to believe that access and money problems plague the health system but the services actually delivered are very good. This level of confidence in the quality of the services is no doubt rewarding for providers and reassuring to the public, but there is growing evidence that it may be unwarranted.

Unfortunately, there are pervasive design features in health care that result in an enormous number of avoidable errors. The safety of the blood supply across Canada and the avoidable baby deaths in Winnipeg are but the tip of the iceberg. We are entering a new era of performance measurement and accountability, and once the reports are in, public perception will change. We have not made quality the central preoccupation of health care, and as a result we do not achieve it. This judgment will unsettle and even anger people, but it is amply substantiated by evidence. The quality problems are almost never the results of misdeeds solely attributable to individuals. The 36,000 people involved in health care in the province work hard and want to serve the public well. They are working in a system that is ill designed to provide quality service in a complex environment. Fixing these design flaws requires concerted effort and investments.

Reduction and eventual elimination of error is an important contribution of a quality orientation. But the more significant thrust is

to pursue quality on a continuous basis. This is not a fad or a gimmick; it is the basis for innovation and excellence. It is as much a perspective as a set of processes, and it is fundamentally about aspiring to make the ordinary good, the good better, the better superior. The quest for better quality never ceases in first-rate organizations; indeed that perpetual quest is what makes them first-rate. Every component of the system must be driven by it. Otherwise, system failures will limit the quality achievable by the most Herculean individual efforts.

Many attribute the quality problems to a lack of money. This claim has been convincingly refuted by evidence and analysis. In health care, good quality often costs considerably less than poor quality. Because this is a controversial statement I go to some length to provide the evidence for it. There is good news embedded in this critique: it is possible, to get better results with less. Where there is abundant funding, it must not be used to paper over quality problems or diminish the commitment to quality improvement. Where money is tight, a quality agenda is imperative.

The word “crisis” fuels political rhetoric and is prominent in the vocabulary of health care workers and the media. Some say the crisis is in the very idea of Medicare because it is unsustainable – its principles are too open-ended and too costly. There is nothing wrong with the principles of Medicare (as a solid majority of Canadians continue to believe); one can make a strong case that they are essential in a humane and efficient society. Others locate the crisis in the aging of the population, whose needs will create unsustainable funding needs. That gloomy prediction persists in the face of increasingly persuasive evidence that aging has never been, and is not likely to be, the financial ruin of the system. Finally, there is the alleged crisis of technology – there will be too many irresistible new and useful machines and procedures to pay for with tax revenues. This may prove to be a problem, but prudently introduced and well-used technology need not push up costs beyond a tolerable level, particularly if the system is able to prune major waste and inefficiency.



Hence part of this report consists of dispelling myths and misperceptions. I do not believe the system is in crisis for reasons usually cited. Yet there is a crisis. It lies in our failure to identify the real problems and to act on their root causes. The usual response to problems is to add money to the system – enormous amounts in the past four years. Dissatisfaction remains high and the headlines are the same year after year, proving yet again that adding money without changing the culture of the system provides only temporary relief. Health care in Canada is under measured and under managed. Health care personnel may be working harder, but in a system unintentionally designed to produce an unacceptable degree of error and waste. The most talented and committed individual can neither overcome bad system design nor compensate for the absence of timely and comprehensive information.

The culture of health care has to change. Again, this message will be unwelcome to those who believe that what we need is the status quo, only more of it – more money, more beds, more doctors, more nurses. The economic history of the twentieth century is largely about the rise and fall of great industries, with success dependent on adaptation to new conditions and the achievement of quality. Industries and companies that changed their cultures produced better quality and provided more value for money. Those that didn't disappeared.

A fundamental change in the culture of the system requires further reorganization. The realities of contemporary health care and the experiences of the past decade demand it. A province of only a million people spread across a vast landscape faces enormous challenges in ensuring the accessibility of high quality service to all its citizens. A fragmented and isolated approach to personnel recruitment and retention cannot succeed. Rather there must be collective ownership of the problems and a coordinated, creative approach to finding solutions. Many solutions will require tough choices and in some cases, abandoning the pursuit of the unachievable.

It is likewise fundamental to recognize that innovation and high quality service are built on strong intellectual foundations. Health care is research-intensive, as is health science education. Neither service quality and efficiency, nor health science education will be sustainable in the long run without a major investment in research. For their part, the health science education programs need to find their niches so that they can compete nationally and internationally as centers of excellence while doing a better job of meeting the province's unique needs. Without a major increase in provincial research funding, the university-based health science education programs will disappear. This is not an alarmist exaggeration designed to get attention; it is the predictable outcome of existing conditions and trends given the national and international competitive environment and the realities of accreditation.

The themes and directions of this report confront the two biggest challenges of modern health care: accountability and sustainability. The Canadian system has focused on accessibility, while accountability has been largely defined in terms of volume: the more, the better. This emphasis indeed raises questions of financial sustainability if the response to every perceived problem is to add volume and money. As public reporting on system performance improves, the focus will shift to the quality and efficiency problems that are the true enemies of sustainability.

Saskatchewan can only find the right solutions if it tackles the real problems. Decades ago it became apparent that too many people faced too many barriers to receiving health care. After a monumental struggle, the province gave Medicare to Canada. The next great barrier to overcome is quality service. A revolution in quality also enhances accountability, efficiency, and sustainability. If Saskatchewan transforms its system, its leadership in delivering quality health services will be a gift to the country, as profoundly important as was Medicare in its time.



CHAPTER ONE:
EVERYDAY SERVICES

Recommendation

To address everyday health needs, the Commission on Medicare recommends the development of an integrated system for the delivery of primary health services by:

- **Establishing Primary Health Service Teams bringing together a range of health care providers including family physicians;**
- **Integrating individual teams into a Primary Health Network, managed and funded by health districts, which includes enhanced community and emergency services;**
- **Converting many small existing hospitals into Primary Health Centres designed to support Primary Health Teams; and,**
- **Ensuring that comprehensive services are available 24 hours a day, seven days a week, including a telephone advice service.**

“Travelling to Regina or Saskatoon is not always an option. Some people can’t afford it and have no means of arriving there. Rural Saskatchewan is left out in the cold”

(Public Dialogue, 2000).

Introduction

A lot has changed since the days when a local doctor tried to answer every health care need. The single doctor working alone cannot meet a community’s needs around the clock. Medicine now goes far beyond what any small town hospital can provide. While cities have bigger hospitals, million-dollar MRI machines and centres to treat cancer and heart disease, rural residents feel that small town health care has been left behind. Community doctors come and go. Services and staffing in local hospitals aren’t secure. People wonder: “Do I have to go to the city for everything?” “Are rural citizens stuck with second class health care?”

High-tech medicine and emergency room dramas may get all the media attention, but a quiet revolution has been taking place at the other end of the health system that is just as important. The evidence from around the world is clear. When it comes to improving health, high-tech care takes a back seat to primary health services. The “miracles of modern medicine” are not limited to drugs and surgery. Research on heart disease and diabetes, for example, demonstrates that years can be added to people’s lives by healthy lifestyles, early intervention, monitoring, and health management - simple, everyday health services.

Non-Medical Miracles

In the United States between 1965 and 1976, mortality from heart disease was reduced by 21%. Coronary bypass surgery is credited with less than four percent of the total improvement. Better diets and reduced smoking made the biggest difference – accounting for more than 50% of the change (Goldman, 1984).

Early and intensive intervention with diabetes patients helps control their disease and reduce health care costs. Patients whose blood sugar has been stabilized make less use of the health system and the associated cost savings are evident within one to two years of having brought the disease under control (Wagner, et al., 2001).



It is a myth to think that rural and northern people have to settle for second class health care. Every community, large and small, can have 24 hour access to high-quality primary health services that improve health, and meet

everyday needs. What's required is getting beyond yesterday's ideal of a hospital in every town. Instead, we need a plan for everyday services that is based on today's realities, and can meet tomorrow's needs.

The Case For Change - Making The Best Use Of Resources And Preparing For The Future

"If some of the local fiscal and human resources in under-utilized rural hospitals were redirected to other primary care activities in the same and surrounding communities, the benefits to the local communities would increase"

(Saskatchewan Association of Health Organizations, Submission to the Commission on Medicare, December 2000).

"We need to retain our doctors and nurses!"
(Public Dialogue, 2000)

Tomorrow's challenges are real. Physicians, nurses and other health care service providers are in high demand, and rural areas have difficulty recruiting them. Rural populations are shrinking, yet there remain many elderly citizens who wish to stay in their communities. People are living longer with chronic disease and disability, and they need health services in the community to support a good quality of life. The health effects of poverty and

inequality are becoming more evident, particularly in the case of Aboriginal peoples. And expectations for health services are changing, with more readily available information, and growing concern about social and caregiver needs. To respond to this changing environment, communities need the skills of nurses, physicians, social workers, emergency medical technicians and home care aides more than they need a hospital.

What Does the Public Say?

Overall, 51% of respondents to *The Challenges Ahead* questionnaire said we should keep hospitals open in as many communities as we can. About 32% said we could have fewer local hospitals with improved emergency services and access to hospitals in larger centres. Only 22% of rural respondents agreed with this approach. About 50% of respondents thought that Primary Health Service Teams would have a positive effect on health care, while 14% thought the effect would be negative, and 25% were unsure.

What are we to make of these results? The Commission believes that underlying the concern about rural hospitals lies a genuine need for everyday health services that are easy to obtain, predictable and safe. Meeting these needs requires nurses, physicians, home care, emergency and other services that can be offered through Primary Health Centres or Community Care Centres.

A province that has always had trouble recruiting physicians cannot sustain a model of health care based on solo physician practice. Many everyday health needs can be met by nurses and other providers whose range of skills are not fully utilized today. The resources that could give us the kind of care we need for tomorrow should not be directed toward yesterday's solutions - small hospitals that no longer meet our needs.

Saskatchewan has skilled and caring professionals who can provide good quality care in communities large and small. But these skills are not employed as effectively as they could be. Physicians, in today's model, are isolated from the rest of the health system. Working in independent practice, and paid a fee for each service, doctors cannot easily share work with nurses, nutritionists, mental health counsellors or other professionals.



Instead of services coordinated to meet people's needs, our emergency services, home care, physicians, and public health are fragmented and separate from each other.

There are opportunities to do things differently, but the system we have today stands in the way. Using new information technology, nurses could offer advice over the telephone, or direct people to the most appropriate source of care. Pharmacists could work more closely

with patients and prescribers to make sure drug therapies work as intended. Primary care nurses could work with physicians to make services available around the clock.

Physicians could check up on patients by telephone, teach and learn from others, and get off the treadmill of volume-based practice. All of these things are possible, but they require changes to the way health care providers are organized and paid, and a new way of working together.

A Better Way – Primary Health Services Uses Teamwork

“The success of health care reform in Canada will rest with the establishment of family medicine group practice networks, and with closer collaboration of family physicians with other health care providers as part of effective multi-disciplinary health teams. The success of health care reform will be realized with a strengthened rather than diminished role for Canada's family physicians”

(College of Family Physicians of Canada, 1996, p.1).

“Physicians recognize the value and contributions of other health care providers such as registered nurses, advanced clinical nurses, licensed practical nurses, dietitians, therapists, technologists and other caregivers. Physicians also recognize the importance of using a team approach to patient-centered care”

(Saskatchewan Medical Association, Submission to the Commission on Medicare, 2001).

Team-based delivery of primary health services is recognized around the world as the most effective way to deliver everyday health services. Doctors, nurses, therapists and social workers operate as interdisciplinary teams, each contributing unique skills which, taken together, ensure a comprehensive range of services. Community clinics in Saskatchewan and Quebec's *Centres locaux de services communautaires* (CLSCs) are based on this model. Saskatchewan, along with every other province in the country, has launched primary health care demonstration projects along similar lines. The Federal Government has also encouraged innovative approaches to primary care through the recent federal/provincial/territorial funding agreement (See Appendix C for more information on Canadian development of primary health services).

Many health districts and health care provider organizations, including the Saskatchewan Union of Nurses (SUN) and the Saskatchewan Association of Health Organizations (SAHO), urged the Commission to focus on changes to the delivery of primary health services.

“Saskatchewan citizens need 24-hours/seven days a week access to a full range of primary health care services including telephone access to physicians, registered nurses and other health care providers. Primary health care services should be provided in community health centre settings, employing teams of multi-disciplinary and salaried health providers”

(Saskatchewan Union of Nurses, Submission to the Commission on Medicare, 2000).

“Hospitals should be only in communities where they can be adequately staffed.... the use of Nurse Practitioners like in Lucky Lake, Beechy, Kyle works very well”

(Public Dialogue, 2000).



What Are “Primary Health Services”?

What Are Primary Health Services?

Primary health services are generally the first point of contact and provide the basis to address the main health needs of individuals and communities. They:

- Serve to enhance people’s physical, mental, emotional and spiritual well being;
- Address the factors which influence health (determinants of health);
- Encompass preventive, promotive, curative, supportive, and rehabilitative and palliative services;
- Are provided by a range of providers; and
- Are designed and delivered in conjunction with other community service providers and the public.

Primary health services are first line services that everyone needs. This includes prevention, diagnosis and treatment of common illness or injury, support for emotional and mental health, protection from infection, advice on taking care of ourselves, and ensuring healthy environments and communities. Family physicians specialize in primary health care, along with nurses, mental health counsellors, dieticians, pharmacists, midwives and others.

The professionals involved in primary health care are, in many ways, the unsung heroes of health care. In the shadow of dramatic, high-tech medicine, these doctors, nurses, physiotherapists, health educators and others ensure better health for all of us, at only a fraction of the costs of hospital care. Given the chance to put the full measure of their skills to work as part of a team, these professionals could all accomplish a lot more.

Making Primary Health Service Networks A Reality – What it Means

Organizing everyday services into Primary Health Service Networks is a new approach that can bring many improvements, particularly for people with complex needs.

- **Continuity Of Services 24 Hours A Day.** Primary health service providers work as a team to ensure services are available around the clock – whether in person or by phone. This maintains a link with a team that knows the individual, their situation and can respond most appropriately to their needs. A side benefit is that there’s less pressure on emergency rooms and no need to bounce around to medi-centres.
- **Considering The Person, Not Just The Disease.** Health needs can involve physical symptoms, social concerns, and emotional and mental health. Working as a team, health care providers including primary care nurses, family physicians, social workers, pharmacists

and others ensure the right set of skills is applied in each situation. Information is shared so “the whole person” is considered in care. Approaches like these can make a real difference, especially for chronic conditions like diabetes or mental illness.

- **Promoting Health And Wellness.** Primary health services are more than just a pathway into the treatment system. Providers can assess and treat common illnesses, but they can spend time promoting health as well. Each team will take responsibility for a community or neighbourhood, reaching out to those with unmet needs, and using proactive public health approaches like screening programs, callbacks and health education. They will link with public health services, voluntary groups and organizations to work together to support local needs. This is discussed further in Chapter Three.



- **Connecting Services Across The System.** Bringing all services under the umbrella of health districts will help close the gaps between physician care, home care, specialist care and hospitals. Local teams of physicians, nurses and home care workers would be part of larger Primary Health Service Networks including public health, mental health and emergency services providers. The communication across these networks will mean a smoother transition when people move from hospital to home, or from hip surgery to rehabilitation.
- **Meeting Complex Needs More Effectively.** People with complex needs or chronic conditions may be faced with conflicting advice from various providers, needless duplication of tests, and inconveniently

scheduled multiple appointments. Primary Health Service Networks would mean easier sharing of information among providers, the ability to schedule more effectively, and involvement of local caregivers in the overall care plan. Health district links with recreational, educational, and social agencies would go beyond medical needs to improve quality of life.

- **Making Best Use of Resources.** By enhancing services to promote health at the “upstream” end of the health system through prevention, protection, promotion, disease management and comprehensive care, the need for more cost-intensive treatments “downstream” can be reduced.

What Can Be Achieved By Prevention, Early Detection And Management Of Illness?

Research shows that outreach, screening and follow-up strategies can effectively improve health status, reduce pain and suffering, and avoid or delay the need for treatment:

- A study on management of high blood pressure found that participants who received intensive monitoring and follow-up services experienced, on average, a four to five percent reduction in blood pressure after 12 months. This equates to a 34% reduction in the risk of stroke and 21% in the risk of heart disease (Saskatchewan Advisory Committee on Diabetes, 1998).
- A Health Services Utilization and Research Commission (HSURC) study found that 21% of women aged 18-69 received no Pap test over a five year period (1988 to 1992). It is estimated that 90% of deaths from cervical cancer can be prevented through appropriate screening and follow-up (Health Service Utilization and Research Commission, 1998a).
- In a U.S. study of the use of telephone follow-up, telephone-care patients had 19% fewer total clinic visits, scheduled and unscheduled, than usual care patients. They had fewer admissions, 28% shorter stays in the hospital and 41% fewer days in intensive care units. The estimated total expenditures for patients receiving telephone-care were 28% less (\$1656 US) during the two year study period (Wasson, et al., 1992).

Making Primary Health Service Networks A Reality – How It Would Work

Most organizations of health care professionals support the idea of Primary Health Service Teams, but there are different ideas about how it should work. The Commission recommends that:

- Health districts have a mandate to organize

and manage a co-ordinated network of primary health services, contracting with or otherwise employing all providers including physicians.

- Primary Health Teams include providers such as physicians, primary care nurses, home



care nurses, and dieticians, as well as providers from Mental Health, Rehabilitation, Public Health, and Addictions.

- All members of Primary Health Teams are responsible for ensuring a comprehensive range of services is available to meet client needs. This consists of a standard set of services, including 24 hour telephone access.
- Primary health practitioners are co-located whenever it is practical and feasible to do so, to promote a positive environment for integrated practice.
- Primary Health Teams serve a defined population, with citizens free to choose or change providers.

- Primary care physicians are integral members of one or more Primary Health Teams.
- Primary Health Teams work collaboratively with each other to form a Primary Health Service Network.
- Team members with specialized expertise provide direct service, consult and advise other members of the Team, and act as a resource for clients and families. In rural areas where the population is very dispersed, these professionals would likely be members of more than one Team in the Network. In larger centres the Teams would have more members on site.

Making Primary Health Service Networks A Reality – New Physician Relationships

One key element of the Primary Health Network model is closer integration between physicians and other health care professionals. Currently, the majority of general practice or family physicians operate their practice alone or in partnership with other physicians. Similarly, other types of services such as home care, physiotherapy or social work are organized in separate program sites. Responsibility is passed from one provider to another, rather than shared within the team.

Participants in the public and health care provider dialogue suggested that the fee-for-service system for physicians is a barrier that prevents innovative approaches to health services. The case for a new relationship was also made strongly by the Saskatchewan Union of Nurses, who argued that the current structure sacrifices quality for quantity.

“Rather than rewarding physicians who succeed in reducing unnecessary patient visits and procedures and who practice more preventative medicine, these doctors are financially penalized...”

(Saskatchewan Union of Nurses, Submission to the Commission on Medicare, 2000).

How physicians are paid is important, but the larger challenge is including physicians as part of a seamless, integrated health system, so

clients get better service. The new relationships must increase the capacity of all Team members to contribute. All Team members should be rewarded appropriately and be allowed to use the full scope of their training and skills. It is also a matter of making the best use of skills and resources. For example, should both public health nurses and doctors offices do well baby visits? In a primary health service, the Team would ensure the best care of the baby while not requiring two visits at each age.

For physicians, the new arrangements would improve quality of working life, increase security, reduce on-call responsibilities, and help make Saskatchewan a more attractive place to work. For all health care providers, there would be new opportunities to employ their full range of skills, improving services to the community. The goal is to free up family physicians to make the best use of their training and expertise, as well as to give full scope to the skills of **all** primary health service providers.

For communities, organizing primary health services within the envelope of district-delivered services would mean a more predictable, stable and assured level of local services, working together more effectively.



Everyday Services Close to Home

For everyday services that are most commonly needed, access should be close to home. For the sake of security and convenience, the following services should be close at hand for everyone:

- One or more members of a Primary Health Team;
- Telephone access to health care advice, 24 hours a day;
- Home care nursing and support services;
- Public health services;
- Emergency medical response.

Making Primary Health Networks A Reality - Complete Everyday Services

To complement Primary Health Teams, a strong core of services close to home requires improvements to institutions, programs, and provincial services, including:

- Home Care, Special Care Homes, and interagency support for housing options;
- Public health, mental health and other community services personnel linked in a Network with several Primary Health Teams;
- A provincially coordinated emergency response/ambulance system;
- Primary Health Centres as a location for primary health services in many communities;
- Community Care Centres in 25 - 30 locations to allow for overnight stays for convalescence, respite, and palliative care; and,
- A telephone advice line as back up for Primary Health Services 24 hour access.

Home Care, Supportive Housing and Special Care Homes

Health services offered in the home let individuals remain as independent as possible. Home care has grown considerably in recent years, but Saskatchewan still spends less than many other provinces on home care. Much of the increased funding has gone to support earlier discharge from hospital and to meet acute care needs at home. While these trends

are appropriate and valuable, more services are needed to support older persons and people with disabilities, including the mentally ill, to help them avoid institutionalization. A recent HSURC study suggests that social housing for seniors may be of greater benefit than home care in maintaining independence (Health Services Utilization and Research Commission, 2000c). Interagency strategies to create more housing options should continue.

Home care also serves adults living with disabilities and others with high needs. To allow more flexible and customized service, a model of self-managed care is particularly important for individuals who may depend on services for many years. The terms of collective agreements should not prevent individuals who need care from managing their funds and choosing the caregivers that can best meet their needs.

Saskatchewan's number of nursing home beds, at 121 per thousand people over age 75, remains higher than the Canadian average of 101 beds (Data supplied by Saskatchewan Health, 2001). Scandinavian countries have lower rates of institutionalization than Canada. Estimating the appropriate number of beds is not easy. Given its dispersed population and long distances between small communities, Saskatchewan must take into account the desire for local access. The need for beds also depends on the availability of other housing and service options. Surely institutionalization should be avoided where it is possible to help

“Our first goal should always be to maintain people in their community, living as independently as is possible”

(Public Dialogue, 2000).



people remain independent. On the other hand, when nursing home care is required, maximizing quality of life must be a priority. The best examples of current nursing home programs deserve to be adopted across the system.

Networking of Primary Health Services with Public Health, Mental Health and Other Community Services

Mental health, public health and chronic disease management are too often overshadowed by medical acute care. It has long been recognized that mental illness gets short shrift in our current system. In Saskatchewan, an estimated 12% of the population have an identifiable mental health condition, and mental illness is a major contributor to disability.

“While first-world nations have been tackling diseases such as cancer and heart disease, and less developed nations have been waging a battle against malnutrition and AIDS, mental illness has sat on the backburner around the globe in terms of medical and public health attention and resources” (Pirisi, 2000, p.1908).

Public Health services are part of the foundation for ensuring safe food, clean water, protection from disease, as well as population health promotion, and disease and injury prevention. Often working in the background, whether identifying needs, providing programs, facilitating the work of others or ensuring protections are in place, it is essential that this broader public health work is linked effectively with the Primary Health Teams.

Primary Health Teams would work within larger Networks encompassing Mental Health, Rehabilitation, Public Health, Addictions and other services. When required, Primary Health Teams would help individual clients access these services. As well, all primary health disciplines providing service to individuals and families would work together to develop care plans, programs and services. This approach will help make the best use of available

resources, although additional staff positions will be required in key areas to ensure services for all parts of the province.

“If psychiatry in Canada is to prepare itself for a future where primary care will have an enhanced role and likely be the health care sector that is “calling the shots”, then it must be realized that the role of specialists will increasingly become one of education, consultation supervision, and research and evaluation. Delegation of many care functions to primary care workers must increase, and these workers will need improved support from the specialist sector” (Bland, 1998, p. 808-809)

Emergency Response And Medical Transportation

To feel safe and secure, citizens need to be able to count on emergency response services. In spite of improvements in technology and the excellent contribution made by volunteer first responders, the quality of Saskatchewan’s emergency services is uneven across the province. Improved and standardized response times, training levels and fees would go a long way toward making the system more effective and fair. A recent Emergency Medical Services (EMS) Review, commissioned by Saskatchewan Health, recommended a substantial investment to ensure faster response times, increase training levels, and coordinate dispatch across the province. The Commission supports several key recommendations. These recommendations should be implemented in collaboration with the appropriate partners:

- The Review called for centralized province-wide emergency dispatch to coordinate both emergency medical services and medical transportation. The dispatch operation could be co-located with a call centre supporting primary health telephone services, in order to capture opportunities for service coordination and back-up.
- The Review recommended a minimum standard of one basic emergency medical technician and one emergency medical responder for each ambulance. This

“We must make a major attitude adjustment, and stop simply warehousing the disabled and elderly”

(Public Dialogue, 2000).

“We feel that we need improved emergency services and if closing hospitals or changing to health centres is what we have to do to achieve this then so be it, but we feel that ambulance services at health centres is a must. We feel that we need at the hospitals an advocacy telephone service (caring person) that know the system inside out to properly direct the incoming call”

(Public Dialogue, 2000).



increased standard is appropriate provided that ambulance staff are integrated into the rest of the health system. In smaller communities, emergency personnel spend a very small proportion of their duty hours responding to calls. Increased standards for these positions may not be practical unless these individuals can be deployed in nursing homes, community care centres, hospitals and community programs. This will require greater flexibility in collective agreements. In the interests of quality of care, and effective use of resources, all parties must be prepared to make such changes.

- Ambulance fees should not be based on distance. Rural citizens are inherently disadvantaged by their distance from more specialized services. It is unfair that they should also pay higher rates when transport to services is required.

Institutional Support: Primary Health Centres and Community Care Centres

Health care providers insist that “health care is about services, not buildings”, but the fact remains that for many people their local hospital is a symbol of security and community viability. The realities of modern health care, however, have simply made the small hospital obsolete. As the following chapter will show, when acute care is needed, quality of care requires a critical mass of service that only larger centres can provide.

Primary Health Networks will become the focus for local health services. Many institutions now operating as small hospitals may take on a new role as Primary Health Centres, which would generally be open eight to twelve hours a day as a location for primary health services visits and programs. Acute care services will be offered in fewer centres,

where they can be strengthened and improved to serve all provincial residents. Many of the people who now use small hospitals have needs that could be met by the Primary Health Team, or through home care. Others, however, require convalescence, respite or palliative care. These individuals do not need an acute care hospital, but they do require 24 hour care. To meet these needs, the Commission proposes a system of 25 - 30 Community Care Centres across the province, incorporating some of the existing Integrated Facilities and Health Centres.

Respite care is important to support people living at home, and give family members a break. Palliative care beds are needed for individuals who cannot or do not wish to be cared for at home. And convalescent beds may be needed following a hospital stay. All of these services should be provided as close to home as possible, within the framework of Primary Health Services. Community Care Centres, integrated with nursing homes, would meet these needs. Non-acute Community Care Centres would complement the acute care services provided by Regional Hospitals and Tertiary Hospitals as described in Chapter Two.

24 hour Telephone Advice

Primary Health Teams would make services available around the clock. In effect, the office would never be “closed”. Outside of office hours, telephone calls would be forwarded to a nearby Team member or to another part of the Primary Health Network. To ensure 24 hour back up, a provincial call centre would be required. Nurses, trained specifically for this role, would offer advice, direct people to the most appropriate care centre or arrange for follow-up by the local Primary Health Team.

*“Hospital closures are a necessity, **but** there must remain adequate ambulance/emergency medical technical support in the smaller communities”*

(Public Dialogue, 2000).



Some Canadian Experiences with Telephone Services

Other provinces and other countries have implemented, or are in the process of expanding, telephone advice lines. In rural areas, such a service offers secure and reliable access to help. Telephone advice can help people determine if they need to get help immediately, or whether they can manage on their own. Such services have been successful at reducing unnecessary visits to hospital emergency centres, as well as improving care for symptoms like chest pain by counselling callers to seek hospital care quickly.

JURISDICTION	STATUS	SUCCESS TO DATE
British Columbia	<ul style="list-style-type: none"> • Victoria-based pilot telecare project has been extended province-wide • Strategy to increase self care skills and encourage appropriate use of health care resources 	<ul style="list-style-type: none"> • Of 33% of callers to the information line who initially said they intended to visit the emergency, 60% changed their mind after talking with the service about their symptoms
Ontario	<ul style="list-style-type: none"> • Service began in Northern Ontario June 1, 1999 • The project has recently been extended province-wide 	<p>In Northern Ontario,</p> <ul style="list-style-type: none"> • 41% of callers were referred to physicians • 34% required information only • 17% referred to the closest emergency department • 5% went to emergency as only available option • Most calls were on weekends and nights when clinics are closed
New Brunswick	<ul style="list-style-type: none"> • Province-wide, centrally organized telephone health and triage service staffed by registered nurses 	<ul style="list-style-type: none"> • Fewer ER visits related to colds/flu, ear infections, increased visits for chest pain • 12-14% of callers referred to the emergency department • 40% referred to physician • 40% instructed on self-care
Quebec	<ul style="list-style-type: none"> • Offers telephone advice in 150 Community Health Centres (CLSCs) • Introduced province-wide in 1994 	<ul style="list-style-type: none"> • 1999 evaluation showed residents satisfied • Reduction in physician and emergency department visits • 8.5% of callers referred to hospital • 20% of callers referred to physician • 57% needed no further follow-up
Alberta	<ul style="list-style-type: none"> • Currently telephone services are available only in the Capital Health Authority through Capital Health Link. • Introduced on September 26, 2000 • Open 24 hours a day, 7 days a week with Primary Care Nurses answering all calls 	<ul style="list-style-type: none"> • 65% require only basic health advice • 55% are given self-care advice • 27% are referred to a primary care physician • 11% are referred to the ER • 7% are referred to other health professionals • There has been a decrease in visits to the ER and to primary care physicians resulting in changes regarding appropriateness of care

Making Primary Health Networks a Reality – Accommodating Community Needs

Even when good quality health services are available, citizens are often frustrated by the inconvenience of travel for services and personal hardships involved when family members need care. While the health system has only a limited capacity to solve these problems, things can be done to address important community needs like transportation

to services and support for volunteer caregivers.

Supporting Volunteer Caregivers

Family, friends and community volunteers have always provided crucial care, nurturing and support that is depended on by the formal health care providers. The role of informal



caregivers has been accentuated by a growing emphasis on home-based care. The health system must acknowledge the importance of family caregivers, and support family and friends by providing respite programs, day programs along with information, education, respect and appreciation.

Transportation

The need to travel for health services may be a fact of life, but it is one that many rural citizens resent. Given Saskatchewan's geography it is not possible to equalize the burden of travel entirely, but there are opportunities to make things better for people

in rural and remote areas. Bringing Primary Health Team members into the community can reduce patient travel, and coordinate multiple appointments that would otherwise require more than one trip. Outreach and itinerant specialist consultation, along with new uses of communications technology, are important strategies for regional service delivery, as described in Chapter Two. When travel is required, it can be particularly challenging for seniors and low-income families. Primary Health Networks can be instrumental in supporting municipal governments and voluntary service organizations in their efforts to address these needs.

“Many times rural people drive 2-5 hours for a 10 minute pre-check and then have to return later. Many appointments could be done the same day”

(Public Dialogue, 2000).

Implementing Primary Health Service Networks

The Commission believes that implementation of Primary Health Service Networks should begin in rural areas, accompanied by the conversion of some small hospitals to Primary Health Centres operating during the day. These changes should be coordinated with improvements to emergency medical services, incorporating trained emergency personnel into the overall staffing plan. The telephone advice services and strengthening of home care and other community services would be integral to

this change. Rural areas, where physicians are often in short supply and confidence levels are lowest, will be able to benefit relatively quickly from the improved access and coordination inherent in the design of this model. Implementation in larger towns and cities may be more complex. However, quality health services require an integrated, coordinated approach whether they are rural or urban.

Conclusion

Primary health services are generally undervalued, compared to high-tech treatment services. Dramatic medical interventions are more likely to attract investment than sensible, longer-term approaches to improve health. Canadians often prefer buying machines to test bone density rather than building good bones by daily physical activity and giving milk to young children. In Saskatchewan we often insist on the latest technology for our hospitals while northern communities go without safe drinking water.

There is considerable evidence that gains in health status and quality years of life are more likely to be achieved by investment in primary health services than by a similar investment in sophisticated medical technology and treatment. This calls for a shift of emphasis to put primary health services at the top of the

health care agenda. Doing so will not only improve our health and well being, it will also contribute to containing the ever-growing costs of health services. Expenditure reduction can be expected from a variety of sources:

- Reduction in the number of small hospitals;
- Using all providers to the maximum of their scope of practice, and using higher cost providers and services only when most appropriate;
- Less need for services through prevention, early intervention and disease management;
- Reduction in duplicate tests and inappropriate medication through improved information and prescribing practices;



- Reduction in unnecessary emergency rooms visits through improved services and telephone advice.

Containing costs is not in itself the goal of the Primary Health Service Network approach: the goal is to use health care resources, both human and financial, to the best effect - to

accomplish improved health with the money we spend on health. While cost savings may occur in the long term, investments will be required to bring about the change. These investments are essential to building a strong system of everyday health services across Saskatchewan.

Recommendation for Everyday Services

To address everyday health needs, the Commission on Medicare recommends the development of an integrated system for the delivery of primary health services by:

- **Establishing Primary Health Service Teams bringing together a range of health care providers including family physicians;**
- **Integrating individual teams into a Primary Health Network, managed and funded by health districts, which includes enhanced community and emergency services;**
- **Converting many small existing hospitals into Primary Health Centres designed to support Primary Health Teams; and,**
- **Ensuring that comprehensive services are available 24 hours a day, seven days a week, including a telephone advice service.**

Key Points

- Primary health services are the first point of contact and provide the basis to address the main health needs of individuals and communities. They serve to enhance people's physical, mental, emotional and spiritual well being; address the factors which influence health (determinants of health); encompass preventive, promotive, curative, supportive, rehabilitative and palliative services; are provided by a range of providers and are designed and delivered in conjunction with other community service providers and the public.
- Health districts responsible for organizing and managing interdisciplinary, team-based primary health services, including contracting with or otherwise paying family physicians, nurses and the other health professionals.
- Improvements to emergency services including centralized dispatch, higher standards for training, and standardization of fees.
- Services close to home supported by Primary Health Centres, with a system of 25 - 30 Community Care Centres providing respite, convalescent, and palliative care in co-operation with long-term care services.
- Community services networked with Primary Health Service Teams to provide direct service, consult with providers and family members, and improve the client referral process.
- Development of a 24 hour telephone advice system, co-located with emergency dispatch, as back up to the services offered by Primary Health Networks.



CHAPTER TWO:
SPECIALIZED CARE

Recommendation

To ensure high quality diagnosis and treatment, the Commission on Medicare recommends the development of a province-wide plan for the location and delivery of specialized services that include:

- Tertiary services delivered in Saskatoon, Regina and Prince Albert;
- A network of 10 to 14 Regional Hospitals to provide basic acute care and emergency services;
- Districts contracting with specialists; and,
- Utilization of beds and resources based on standards established by a Quality Council.

Introduction

When Manitoba launched an enquiry into the deaths of 12 infants at a Winnipeg hospital, Justice Murray Sinclair concluded the surgery program should likely never have been started in the first place. “The evidence suggests that Manitoba lacks a sufficient population base to assure the establishment of a high-quality, full-service Pediatric Cardiac Surgery Program”, he wrote. According to the *Globe and Mail* “the heart surgery unit originated in the sort of overweening ambition that high-tech, heroic medicine is often heir to. It was set up with the explicit hope that it would become world-class.... show the world what the province was capable of.” The editors concluded that “The first order of good doctoring everywhere is to accept your own limitations, and to say these words to patients: However much it hurts our regional pride to say this, you would be better treated elsewhere” (*Globe and Mail*, November 30, 2000, p. A18). There are many lessons for Saskatchewan in this report.

The one million people who live in Saskatchewan are spread across a large area. The province is the second most sparsely populated, after Newfoundland. Serving a small population across a vast area is a challenge for the delivery of public services in general. This is particularly true for

specialized health care services that include a wide range of services requiring advanced equipment and skills. For example, acute medical care and surgery require physicians, nurses and other providers with special training. Assessment of childhood autism requires a team with pediatric and developmental expertise. Diagnostic tests such as Computerized Tomography (CT), ultrasound or Magnetic Resonance Imaging (MRI) require specialized equipment, skilled technicians to operate the equipment and radiologists to interpret results.

Attracting and keeping the physicians and other highly trained staff needed to deliver services like these have never been easy in Saskatchewan. A critical mass of patients who need care is essential to allow specialists to maintain their skills. Specialists must work where they can consult with their peers and have access to special diagnostic equipment and treatment facilities. As health care becomes increasingly specialized, and skilled practitioners are in high demand around the world, it is even more difficult to attract needed skills. These are arguments for concentrating specialized services in larger centres.



Some Requirements for a Quality Specialist Care Program

- In most cases, a minimum of three to five specialists in a service to meet emergency needs around the clock.
- Anaesthetists, surgical and intensive care nurses, rehabilitation specialists, and other skilled staff for assessment, treatment and care.
- Advanced diagnostic and monitoring facilities along with appropriate specialists and technicians to interpret results, operate and maintain equipment.
- Opportunities for all the required specialists to handle a sufficient volume of cases to maintain skills.
- Support of peers, opportunities for professional development and continuing education.
- A sufficient number of specialists to carry on if one practitioner leaves.

“The forces that have changed agriculture in rural Saskatchewan have also changed health care: changes in technology and increased specialization have resulted in acute care services being expanded in fewer larger centres”

(Health Services Utilization and Research Commission, 1999, p.10).

Saskatchewan people, like others across Canada, need and want ready access to health services. They also want quality services. And indeed quality must be sustained. A balance must be struck between convenient access to services and ensuring the quality of advanced technological and specialized services. The everyday services described in Chapter One can, and clearly should, be provided as close to home as possible. For more specialized care, centralization makes sense. True, it can be inconvenient and expensive to travel from rural areas to Regina or Saskatoon or, in some cases outside the province, for specialized care. However, the lessons from the baby deaths in Winnipeg are clear: quality must come first, and quality for highly specialized techniques depends on a critical mass of skills and cases.

This chapter outlines:

- What the Commission heard from both the public and health care providers;
- The need to ensure quality is not sacrificed for the sake of proximity;
- The need for provincial planning and coordination of specialist services, human resources and capital;
- Organization of specialist physicians under contract to health districts;
- A plan for the delivery of acute care services for Saskatchewan; and,
- A description of tertiary services and a new direction for Regional Hospitals.

What Do the Public and Health Providers Say?

Saskatchewan people are practical, and they know that services like surgery and advanced diagnostic tests can't be available in every town. Respondents to *The Challenges Ahead* questionnaire generally agreed that centralizing specialist services makes sense. Fifty-nine percent of all respondents, (50% in rural areas), agreed that in the interests of quality, specialized services should be concentrated in fewer centres, even if that means some people have to travel farther. However, people in rural areas are often quick to point out that the consolidation of specialized services means the burden of more travel for people from rural areas.

The hardship and expense of travel is a reality. In the view of many health care providers, however, quality cannot be sacrificed for the sake of proximity. Many specialized services are needed only rarely, during a defined episode of illness. In these cases the burden of travel is probably acceptable. On the other hand, chronic care treatments, like kidney dialysis, which may be needed several times a week over many years, can result in much more personal hardship. And progress has been made in Saskatchewan to ensure that chronic care services are more accessible by means of outreach and satellite programs. For example, over the past decade there has been a



gradual extension of kidney dialysis and chemotherapy outreach services across the province. The network of Primary Health Services described in Chapter One is also designed to ensure better management of chronic disease and minimize, or at the very least, coordinate the need to travel for services.

Some people who responded to the survey also thought that surgeons could travel to smaller centres to provide care, rather than patients traveling to them. There is no reason why some very routine surgical interventions cannot be done close to home. However, surgery should only be provided where adequate personnel and equipment can be assured. Operating room nurses, intensive care nurses, diagnostic equipment and specialists, anaesthetists and other experts are often required. And there needs to be follow-up care in case of complications. Quality guidelines would dictate that itinerant surgery be limited to day surgery procedures that do not require overnight stays.

Organizations such as the Saskatchewan Medical Association (SMA), the Saskatchewan Union of Nurses (SUN), the Saskatchewan Cancer Agency, the Saskatchewan Association of Health Organizations (SAHO), all told the Commission they'd like to see an overall plan for the location of specialities within the province. There is strong support among health care providers for a provincial plan for the delivery of services. And many of these organizations agreed that this central plan would likely mean some consolidation of service delivery to ensure quality and sustainability.

"...the [location] of specialty services cannot be decided by popular choice. Their siting and medical supervision must be carefully planned to ensure medical viability, sustainability over time, and high quality. A province-wide plan for specialty services needs to be laid out"

(Saskatchewan Association of Health Organizations, Submission to the Commission on Medicare, 2000).

Quality First

When a family member is facing serious or undefined illness, surgery or complex treatment, quality is our first concern. Even when services are available locally, citizens often vote with their feet, going to larger

centres for services. Many people, either on their own or as a result of referrals by their family physician, bypass services offered in many of the smaller hospitals and travel directly to Regina or Saskatoon.

Specialized Care to Meet Our Needs

A population of only one million may require only a few specialists in a given discipline. For instance, in 1999 there were 714 family practice physicians in the province, but only 13 cardiologists. More than 80% of the population uses medical services in any given year, but fewer than four percent see a heart specialist (Saskatchewan Health, 2000d).

Specialized services are, by definition, needed by a smaller percentage of the population. Outside the larger centres, there may not be enough cases to allow specialists to maintain their skills. Quality also depends on having the right equipment, diagnostic tools and the expertise of colleagues in other disciplines. Even Saskatchewan's largest cities - relatively small next to most provinces - find it difficult to attract and sustain all of the expertise required for high quality services.

"...for a specialty service referral centre to be sustainable and to guarantee safe, quality specialty services, it must provide full service (i.e. 24 hours, 365 days) in such basic specialties as general surgery, internal medicine, obstetrics, pediatrics, psychiatry, and public health (Medical Health Officer). In order to provide such service, a minimum of three physicians is generally required in each specialty area. Even with three people, coverage for holidays, medical education and



sickness is stressful and can jeopardize stability. The optimal would be five person practices”

(Working Group on Physician Need, 1997, p.23).

With quality as the priority, the existing trend to centralize specialized services will continue. Concentrating specialists in a few locations offers many advantages: an adequate volume of patients to allow them to retain their skill levels, availability of backup, and opportunities for professional growth. These are important

factors in recruiting, and essential for quality. As medical practice continues to divide into sub-specialities, some programs should be offered in a single location for the whole province. By avoiding duplication of services and equipment, the health system can deliver more services in a cost-effective manner. More importantly, a single, larger, specialty program is more stable than two small ones. Smaller programs are vulnerable to the loss of a single practitioner.

Getting There 1 - Provincial Coordination and Planning

Ensuring quality is not sacrificed for the sake of proximity is sometimes a challenge. It is a challenge to decide upon the best use of available resources including beds, equipment, and specialist expertise. Currently, it is largely up to health districts to make initial decisions about what services will be provided and where they will be located. Government's role is to approve these individual plans and provide funding. However, this planning process is ineffective.

- Districts often plan in isolation from one another, leaving it to the Government to ensure that the individual plans for each district make sense when considered as a whole.
- Districts compete with each other for physicians and other professionals. Decisions to close operating rooms or intensive care units made by one district can adversely affect surrounding districts.
- District planning is often unduly influenced by well-meaning pressure from local health

providers and citizens who may equate quality with proximity.

- The Government's annual budget cycle is a weak instrument for planning and may not be consistent with longer-term trends and the need for stability.

This is why the Commission recommends that Saskatchewan Health take lead responsibility for the development of a province-wide plan for the location and delivery of specialized services based on standards established by a Quality Council (see Chapter Four). Once that plan is in place, districts and Government must work together to deliver services effectively and maintain quality standards. The mandate of Saskatchewan Health for overall planning should include a province-wide strategy for human resources, as outlined in Chapter Five, as well as an overall strategic plan for the purchase and maintenance of capital equipment and construction and maintenance of facilities.

Planning Equipment, Planning Buildings

Right now, each health district does its own planning for the purchase and maintenance of capital equipment, and for the construction and maintenance of facilities. District foundations and key donors are often influential in the priorities identified for capital purchase, and decisions may be made with little or no reference to what is happening in adjacent districts. Moreover, it is far too common that equipment is replaced only when it has failed completely, resulting in interrupted service and leaving no time to negotiate favourable prices.



Managing the use of acute care beds, diagnostic and other specialized services also requires a province-wide approach. In recent years districts and Government have worked

together to make the best use of available staffed beds at peak times. This type of coordination must be expanded.

Getting There 2 – The Role of a Quality Council

To ensure a consistent approach to quality, the delivery of specialized services must be based on accepted national and international standards. Location of specialized services should be determined according to the required level of skills and training, the number and type of specialists, and the equipment and staffing needed to ensure quality. Similarly, it is of critical importance to meet benchmarks for the volume of procedures necessary to allow a team of specialists to maintain their

skills. These standards must be consistent across the province. This is why the Commission recommends that such standards be developed by an independent agency such as the proposed Quality Council, described in greater detail in Chapter Four. The Quality Council would secure expert advice and draw upon research to advise the Government and districts on standards for quality health services.

Getting There 3 – Coordination and Management of Specialist Services

Achieving quality and value through monitoring, evaluation and management of specialized services will require a closer relationship than currently exists between specialist practitioners and other parts of the health system. Specialist services must be an integral part of district operations, with funding flowing from Government to districts to allow districts to contract with specialists.

Like most family physicians, many physician specialists work independently, collecting a fee for each service provided. In the future, these services must be more closely integrated with other parts of the health system, based on teamwork and group practice. With quality as the goal, incentives should encourage the achievement of best practice goals and standards of excellence in patient care. Adopting a culture of evidence-based practice using decision support tools, measurement, and evaluation will bring significant improvements to the quality of specialized care.

Contracts for specialists could include providing outreach services, consulting with

Primary Health Teams, and other activities in support of the overall health system. Under this model, specialists not only serve their own patients, but they become a resource to the health system at large. The Saskatchewan Cancer Agency provides an example of a contractual model of services where patient-centred care, interdisciplinary teamwork, peer review and evaluation are encouraged and practiced.

Within an integrated system of acute care, specialists working in Tertiary Hospitals in Regina, Saskatoon and Prince Albert would network with the Regional Hospitals described later in this chapter. Specialists in Tertiary Hospitals would provide consultation and support primary caregivers engaged in follow-up or chronic care management. The Acquired Brain Injury program is one successful model where specialists consult with family physicians, occupational therapists and community workers to support individuals with complex health needs. Individuals with multiple sclerosis, diabetes, and other chronic conditions could benefit from a similar approach.



A Model of Outreach Program Delivery

The Acquired Brain Injury (ABI) outreach teams located in Regina, Saskatoon and Prince Albert are a resource to all health districts. The teams can include physiotherapists, occupational therapists, psychologists, social workers, nurses, speech and language pathologists, and recreational therapists among others.

The teams provide assessment, service planning and co-ordination, treatment, rehabilitation and outreach support for individuals with an acquired brain injury and their families.

ABI outreach teams also:

- Link with discharge planners in hospitals;
- Provide education and training for local community caregivers;
- Promote successful integration of those with ABI into their home communities, for example through employment and education;
- Serve as a resource for community caregivers and family.

Getting There 4 – Addressing Poor Morale and Staff Shortages

No model of delivering specialized services can be effective unless there are the right staff available in sufficient numbers and with the appropriate training.

Unfortunately this is not currently the case in Saskatchewan. As described in somewhat

more detail in Chapter Five, Saskatchewan (and indeed most other jurisdictions in North America) is facing a serious health human resource challenge. Meeting this challenge will require hard work and planning on the part of employers, unions, individual staff and Saskatchewan Health.

How Many Acute Care Beds Does Saskatchewan Need?

Most specialized services are inextricably linked with hospitals. As such, overall planning for these services will require that decisions be made about hospital services in the province.

Per capita, Saskatchewan already has more hospital beds than most other provinces. There are approximately 2900 acute care beds staffed and in operation in Saskatchewan today. As a result, Saskatchewan has nearly three beds for each thousand residents while provinces such as British Columbia and Ontario have fewer than two beds for each thousand residents (Data provided by Saskatchewan Health, 2000).

More is done in hospitals in Saskatchewan compared to hospitals in other provinces. This is not necessarily a sign of success - on the contrary. High rates of surgery and admissions

to hospitals and long term care homes suggest failure to make full use of other less invasive, less expensive alternatives. For example:

- In 1997-98, in a list of 16 categories of surgical procedures, Saskatchewan's age-sex adjusted rate was higher than the national average in 12 categories, the same in two, and lower in two. It was highest in four categories (Canadian Institute for Health Information, 2000b).
- Among the western provinces for these 16 surgical categories, Saskatchewan had the highest rate in 11, the second highest rate in four, and the lowest in one (Canadian Institute for Health Information, 2000b).
- In 1997-98, Saskatchewan's admission rate to hospital was 41% higher than the national



average; 25% higher than Manitoba; 28% higher than Alberta; and 41% higher than British Columbia (Canadian Institute for Health Information, 2000d).

- In 1999, 56 of every 1,000 Saskatchewan residents aged 65 and over lived in nursing homes compared to 55 in Manitoba, 41 in Alberta, and 44 in British Columbia. For the 75+ age group, the rates per 1,000 were 101 in Manitoba, 100 in Saskatchewan, but only 82 in Alberta, and 85 in British Columbia. And Canada's rates are high by international standards. In Denmark, for example, only 41 of every 1,000 people aged 85 and over

reside in a nursing home compared to over 200 in Canada (Lazurko and Hearn, 2000).

Of course, Saskatchewan is not quite like other places - the population of this province is generally older, travel distances are great, and there may be fewer alternatives to hospitals. Even taking into account these factors, however, Saskatchewan's use of hospital beds is high in comparison to other places. Since data shows that Saskatchewan people are at least as healthy as those in other provinces, the implication is that Saskatchewan is using hospitals differently.

Saskatchewan Residents Use Hospitals More than Other Canadians

Hospital Visits per 1,000 Residents, 1998-99
(Adjusted for Age and Sex)

Saskatchewan	133.4
Manitoba	112.8
Alberta	107
British Columbia	94.5
Ontario	87.9
Canadian Average	96.7

Source: Canadian Institute for Health Information, 2001.

The number of acute care beds in the province needs to reflect the demographic reality of Saskatchewan and accepted standards of quality. In developing a plan for acute care, determining a target for beds is less important than a thorough examination of the way health care resources are used. Do we rely on specialists when other practitioners have the needed skills? Do we insist upon an MRI when an x-ray or a thorough examination by a physician would suffice? Do physicians do what nurses could be doing, and do registered nurses do what licensed practical nurses are fully capable of? Do we immediately turn to long term care when instead home care and primary health services could help people live in the community with a better quality of life? Are hospitals used for care that can be more effectively provided elsewhere? Getting the

best value for money means using all of the tools at our disposal - not always using the most sophisticated technology or the most highly trained professional. "Having the best" does not always mean going up the scale of expertise and technology. Having the best means using the tools and training best suited to provide an effective service.

Based on available evidence, there is room to reduce the number of acute care hospital beds in Saskatchewan. For example:

- **Reducing length of stay in hospital.** Many patients admitted to hospital in Saskatchewan could be released earlier, in line with national and international standards (Health Services Utilization and Research Commission, 2000a,d).



- **Providing convalescent care, palliative and respite care outside of the hospital setting.** This will assist in reducing lengths of stay and assist people to live in the community, closer to home, and achieve a higher quality of life. These kinds of care are often provided more appropriately at home or in a Community Care Centre as described in Chapter One.
- **Using advance directives to avoid unwanted intervention at the end of life.** Programs that assist people in making informed choices about their end-of-life care reduce the use of services people do not want. (Molloy, et al., 2000).
- **Province-wide management and coordination of acute care beds.** Close coordination across districts will ensure follow-up care can be provided at home or in a facility closer to home, freeing up beds for others awaiting treatment.
- **Improving admission and discharge practices.** Protocols for admission and discharge, developed in cooperation with physicians, implemented and monitored across the province, would ensure access to beds based on need.
- **Avoiding unnecessary admissions to hospitals by using home care services.** For example, in Saskatoon, a dedicated team goes out into the community to assess and provide services to seniors who would otherwise have been admitted to hospital.
- **Investing in primary health services.** The services recommended in Chapter One will alleviate some of the need for a hospital stay. For example, for people with chronic conditions such as diabetes, depression, or heart disease, careful monitoring and treatment in the community can keep these conditions under control with fewer visits to hospital.
- **Ensuring enough long term care facilities in the right place.** As populations shift toward urban centres, the distribution of beds will need to keep pace. Timely and carefully measured access to long term care and home care is key if we are to avoid having seniors admitted to hospital and staying far too long because there is no alternative available in the community.

Service Beyond the Hospital

Sheila is an 85 year old widow who developed leg ulcers and went to the eight bed hospital 80 km from home. She stayed in hospital for three days. A nurse dressed her ulcers three times a day. Once her confidence returned, she was able to manage at home. Because she lived on a remote farm and her bachelor son was very busy tending cattle, Sheila needed services more frequently than is cost effective for home care, but her needs for technology and intensity for service are less than “acute care”. She did not require a hospital, and could have been cared for very appropriately in a Community Care Centre where round the clock nursing was available with a physician on call.

Paul is a 60 year old man recently diagnosed with diabetes. He was admitted to the local small hospital for ten days to be taught how to manage his own insulin and monitor his blood sugar. His wife came to the hospital every day to participate in learning about his care. Rather than being in hospital, Paul might have gotten his guidance from the Primary Health Team including home care.



What About Waiting Lists?

“Research needs to be done locally and nationally to determine the correlation between the length of time on wait lists and surgical outcomes. It is only then that we will know if waiting times are indeed appropriate” (Task Team on Surgical Waiting Lists, 1999, p.9).

Some people in Saskatchewan (and in the rest of Canada) wait too long for diagnostic tests or surgery. Many argue that the solution is more money to hire doctors and nurses. However, like so many other things in the health system, we do not have good information about waiting lists. This makes it that much more difficult to know how serious the problem is, or how best to address it.

Experts differ in their opinions on waiting lists, but nearly everyone agrees that those who need services most should get them first. To make this happen, several things must occur:

- Develop protocols so that waiting lists for surgery or diagnostic testing can be based on consistently-applied assessment of need or urgency;

- Remove incentives for specialists to compete for patients which leads to some specialists having much longer waiting lists than others;
- Establish specialist group practices to share workloads;
- Provide more information to family physicians, patients and the public about specialists, including which ones have shorter waiting times;
- Appropriate screening by family physicians to determine need for specialized services.

The Saskatchewan health system has begun to move in this direction in cooperation with other provinces through the Western Canada Waiting List Project.

The Western Canada Waiting List Project

The Western Canada Waiting List Project (WCWL) involves a partnership among four medical associations, seven regional health authorities, the four western ministries of health and four health research centres. The Project is developing priority-setting tools to better manage waiting lists for cataract surgery, children’s mental health services, general surgery, hip and knee replacement and MRI scanning. These tools will make it possible to compare wait times across regions, hospitals, or individual physicians, for patients with the same priority score awaiting the same service or procedure. They are intended to eliminate - or at least reduce - the wide variation in wait times experienced by patients with comparable conditions and circumstances, but on different physicians’ wait lists. By making explicit the relationships between priority scores and wait times, these tools should also help identify areas of priority for additional resources.

Addressing waiting times for surgery requires more efficient use of existing resources, for example by doing more day surgery. Standard practice for gall bladder surgery, for example, used to mean a six-inch incision, cutting through abdominal muscles, several days in hospital, and six weeks recovery time. This kind of surgery can now be done with a laparoscope, requiring a tiny incision. Patients

can leave hospital as soon as the same day, recover at home, and return to work in a week.

Yet if the rate of day surgeries is an indicator of progressive surgical practice, Saskatchewan is lagging behind. For some procedures, the province has one of the lowest rates of day surgery in Canada. While Saskatchewan compares well to other provinces in some



areas, only 2% of gall bladder surgeries are done on a day surgery basis compared to the national average of 29% and 44% in Manitoba. Twenty per cent of hernia repair is day surgery in Saskatchewan, compared to the national average of 53%. And only 3% of tonsillectomies in the province are day surgery compared to a national average of 54% and 72% in Ontario (Canadian Institute for Health Information, 2000b). Improving the rates of day surgery would not only be better for patients, it would free up hospital beds and staff time, ultimately contributing to improved waiting times. This is one example of changes in practice and improvements in management that could reduce waiting times without additional resources.

While waiting times for surgery have received more attention, equitable and appropriate access to medical treatment, assessment and diagnostic procedures are equally important. Waiting for an assessment on an autistic child or a delay in obtaining an MRI can cause great anxiety, as well as delay treatment. Waiting for physiotherapy treatment or addictions counseling may slow recovery. Many of the same techniques for waiting list management can also be applied to these services. The goal must be to ensure that services are used appropriately, and those with the greatest need are served first so that waits for service do not adversely affect outcomes.

“We found the [hospital conversions] did not adversely affect rural residents’ health status or their access to health services. Despite widespread fears that health status would decline, residents in these communities reported that the loss of the acute funding did not adversely affect their own health...”

(Health Services Utilization and Research Commission, 1999, p.1).

Where Should Acute Care Services be Located?

If Saskatchewan’s population was concentrated within a single community, acute care for one million people might be provided by four or five large hospitals. Clearly this is not possible or desirable. On the other hand, currently 70 institutions are designated as hospitals. There are five Tertiary Hospitals in Regina and Saskatoon, six or seven “regional” hospitals offering a more limited range of specialist services, and dozens of smaller hospitals whose services vary widely.

plan for hospital care. The role of each facility type must be clearly defined. Some preliminary definitions are offered below, which could be further refined based on the recommendations of a Quality Council. The application of the framework will result in a smaller number of facilities designated as “hospitals”, with an improved level of services offered in new ways.

To ensure a high quality of everyday health services close to home, Chapter One recommends an enhanced primary health system, including home care and community health services, and complemented by a strengthened emergency response system. Primary Health Centres would serve as the location for many Primary Health Teams, and strategically located Community Care Centres would provide overnight beds for convalescence, respite or palliative care. With this strong array of services closer to home, a simplified framework for hospitals can meet Saskatchewan’s acute care needs across the province. A diagram in Appendix C illustrates the relationship between local, regional and provincial services.

The underlying assumption of this plan is that emergency services, and services needed most often, should be provided close to home. For treatment services required less frequently, considerations of convenience are secondary to the requirements of quality and efficiency.

This plan for hospitals in Saskatchewan does not include the North of the province. The three Northern health districts, Keewatin Yatthé, Athabasca and Mamawetan Churchill River, have a total population of less than 35,000 people occupying a very large area with few roads. Planning for the North must reflect their distinct society, geography and health needs. As these three health districts are just beginning to create a strategic plan designed to meet their population’s needs, it is recommended that the four hospitals and five health centres remain as they are for the present time.

The public and health care providers alike have called upon the Government to provide a clear



Projected Plan for Acute Care Services in Saskatchewan (Excludes the North):

Acute Care	Maximum 60 minute travel time to a Hospital for 88% of the population. Maximum 80 minute travel time for 98% of the population.	
Tertiary Hospital System	Full range of services operating 24 hours/day including: <ul style="list-style-type: none"> • Critical/intensive care • Full trauma services • Advanced diagnostics • Urgent, emergent and elective surgeries • Extensive range of general, specialist and sub-specialist services 	<ul style="list-style-type: none"> • Regina • Saskatoon • Prince Albert (a smaller range of services, links to the North) • Some tertiary services would be offered in a single site.
Regional Hospital System	Possible range of services open 24 hours/day: <ul style="list-style-type: none"> • Assessment and triage of emergencies • Stabilization and transfer as required • Lab and x-ray • Medical care • Selected elective and day surgeries • Basic obstetrics • Targeted chronic care programs • Outreach • Telehealth services 	<ul style="list-style-type: none"> • 10 to 14 Communities • Minimum 3 to 5 physicians in stable group practice • Serving population of 30,000 - 50,000
Non-Acute Care		
Community Care Centres (See Chapter One)	Open 24 hours for convalescent, respite and palliative care, in conjunction with long term care beds.	• 25 - 30 communities

What Would Regional Hospitals Provide?

The Commission recommends the province move to a system of 10 to 14 Regional Hospitals. These hospitals should offer a range of commonly needed services such as medical care, basic emergency and outpatient services, x-ray and laboratory. Obstetric and pediatric programs should also be provided where there are family physicians with appropriate credentials. All Regional Hospitals should be mandated to offer a basic program of internal medicine and general surgery to meet the needs of their area.

Depending on the availability of staff and the criteria set by a Quality Council, some of these hospitals could offer selected surgical specialities, although these would likely be more modest than some regional centres currently offer.

For example, a Quality Council might determine that a surgical program requires at least three surgeons to ensure continuity of care 24 hours per day, seven days per week. This is a standard that is supported by many

physicians (Working Group on Physician Need, 1997). To retain three or more surgeons and the associated staff to deliver a surgical program requires an acceptable volume of patients to ensure skills can be maintained. A move to this standard and others like it will lead to a reduced number of locations in which inpatient surgery is performed. At the same time, it will allow for a high standard of quality available to all citizens no matter where they live.

Some hospitals now offer general surgical programs with one or two surgeons and orthopedics with a single orthopedic specialist. The surgeons must be on call for extended periods, making recruitment difficult and leading to burnout. These are not sustainable programs - it will not be possible to reliably recruit and retain the required specialists and associated technical staff.

Rather than attempting to offer specialized programs in which quality cannot be sustained,



“Strong regional centres provide a necessary link between rural centres and tertiary care centres. A regional centre network could provide high quality primary and specialist care on a regional basis. This would relieve some of the pressure on tertiary centres and provide patient care closer to home”

(Saskatchewan Medical Association. Submission to the Commission on Medicare, 2001, emphasis in the original).

Regional Hospitals could deliver other services required by the people of the area in partnership with a larger centre. These could include itinerant day surgery, mental health programs, consultation and assessment through telehealth, or chronic care programs. For example, radiology services are currently offered in a number of centres by radiologists from the larger districts. Programs like these may be more appropriate than surgical specialities for Regional Hospitals. As well, the travel burden for patients is more effectively reduced by decentralizing services that are needed repeatedly or by a larger segment of the population.

Close cooperation among physicians working in different facilities and districts is essential to this plan for specialized care. Strong organizational links will be required to provide continuity for patients and make the best use of all skills. Just as the Pasqua and General hospitals in Regina have integrated their medical staffs into one medical staff on two sites, coordination between Regional and Tertiary Hospitals can achieve better integration and improved quality.

What Would Tertiary Hospitals Provide?

Tertiary Hospitals in Regina and Saskatoon should provide highly specialized services for all residents of the province, as well as meeting a full range of acute care needs for local residents. Typically the services of a Tertiary Hospital include medical, psychiatric and surgical specialties, intensive care and critical care units, and the more highly specialized diagnostic services such as CT scans and MRI. They also include critical services like neonatal intensive care and cardiac care.

A more limited tertiary care service should be offered in Prince Albert, with the goal of networking to Northern health programs. Prince Albert has been able to maintain a reasonably stable base of specialized services. This District plays a unique role in hospital service delivery. Offering less than a full Tertiary Hospital, but more in the way of diagnostics and surgery than Regional Hospitals, Prince Albert should begin to play a larger role in alleviating some of the capacity pressures from Saskatoon for those who are transferred in from the North of the province. This is critical. As the population of the northern part of Saskatchewan continues to

grow and as the numbers of seniors in the North increases, the demand for health services will necessarily rise (Health Services Utilization and Research Commission, 2001).

Tertiary Hospitals operated by districts, joint district-Government planning, standards set by a Quality Council, and province-wide health human resource planning would, in effect, operate as a province-wide system. For example, a Quality Council will consider what is required to deliver cardiac care, neurology, or a burn program and may recommend that these services be consolidated in one centre in the province. This type of specialized program delivery exists today in such facilities as Wascana Rehabilitation Centre, psychiatric rehabilitation at Saskatchewan Hospital North Battleford, and children’s diagnostic and treatment services at the Alvin Buckwold Child Development Program. For services with exceptionally small volumes and where specialists cannot be secured for the province, cooperative arrangements with other provinces will continue, and individuals will need to travel outside Saskatchewan to receive services.

Conclusion

Specialized services and acute care consume by far the largest portion of health dollars, and account for much of the growth in health spending. The recommended framework of specialized services for Saskatchewan is designed to ensure quality is sustainable into the future. This framework is also based on an overall shift of emphasis toward everyday health care services outlined in Chapter One. These “upstream” investments, along with

quality improvement and careful management, can be expected to ensure that Saskatchewan gets the best possible value from our health care providers and facilities. By making more effective use of all health care resources and coordinating services effectively, we help ensure that the most sophisticated and expensive technologies and treatments will be available and accessible when needed.

Recommendation for Specialized Care

To ensure high quality diagnosis and treatment, the Commission on Medicare recommends the development of a province-wide plan for the location and delivery of specialized services that include:

- **Tertiary services delivered in Saskatoon, Regina and Prince Albert;**
- **A network of 10 to 14 Regional Hospitals to provide basic acute care and emergency services;**
- **Districts contracting with specialists; and,**
- **Utilization of beds and resources based on standards established by a Quality Council.**

Key Points

- Province-wide planning for acute care and specialized services led by government, including human resource planning, bed management, construction and maintenance of buildings, and purchase and maintenance of equipment.
- Standards for the delivery of specialized services established by Saskatchewan Health based on recommendations from a Quality Council.
- Management of specialist services by districts; specialists on contract to districts.
- Concentration of tertiary services in Regina, Saskatoon and Prince Albert as appropriate to population need. Consolidation of some tertiary services in a single provincial location, or joint planning with other provinces for the delivery of services.
- Regional Hospitals in 10 - 14 communities focused on general medical care, incorporating a limited range of commonly needed specialties and drawing upon the expertise of specialists in tertiary centres to develop innovative chronic care and consultation programs.



CHAPTER THREE: **MAKING THINGS FAIR**

Recommendation

To maximize the health of the people of Saskatchewan, the Commission on Medicare recommends the continuation and/or the development of:

- Public health, health promotion, and disease and injury prevention strategies;
- Regular reports on defined and measurable health goals;
- Strategies to address the broader determinants of health; and,
- A Northern Health Strategy.

Health vs. Health Care

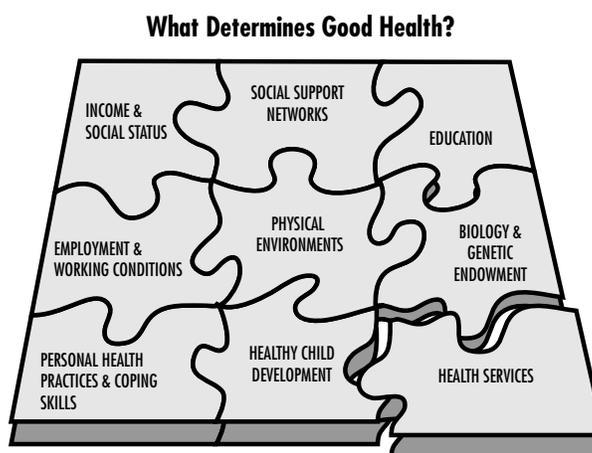
There are endless challenges to both producing and maintaining good health and treating sickness. Avoiding disease or injury is preferable to even the most magical cure.

A public, universally accessible health system is designed not only to treat illness when it occurs, but also to produce better health for

individuals, and for population groups. Investing “upstream” to improve health can prevent the need for costly treatment “downstream”. For example, programs that provide prenatal care to support young women during pregnancy can lead to healthier babies and children down the road.

What Determines Good Health?

Health is influenced by many factors not related to health care at all, including socioeconomic status, education, social support networks, and physical environments. Put simply, the biggest cause of poor health in populations is inequality (Wolfson, 1999; Townson, 1999; Hertzman, 1994). In general, people with more education are healthier than people with less. People with secure, well-paying jobs are healthier than those without them. Children born to middle-class families are healthier than children born to the poor. It is not simply an issue of any one factor, but a combination of these factors that reduce our risk of disease or increase our chances at good health. And there is no relationship at all between a nation’s health spending (beyond \$500 US per capita per year), and the health of its population (Leon, et al. 2001). Canada spends four times this amount.



“Achieving and maintaining health are not just matters of curing illness. The ways in which society regulates employment and economic cycles, provides education, assists its members in times of economic or other difficulties, sets up strategies to counteract poverty, crime, and drug abuse and to stimulate economic and social growth have just as much, if not more, impact on health than do the quantity and quality of resources being invested in the detection and care of illness” (Renaud in Evans, et al. 1994, p. 318).

The good news is that, as a province, Saskatchewan’s overall health is actually improving. On average residents are living longer and healthier lives than ever before.

Why have some groups, such as First Nations and Métis people, benefited less from these positive trends? Why do families on low-income, the unemployed or those with less education experience higher rates of disease, injury and death than the general population even if they are just minutes from a hospital? It’s often due to inequalities in the other determinants of health, because these determinants form the foundation on which an effective health system can be built.

Consider the case of Simon. Imagine what Simon’s life (and other children in similar circumstances) will be like over the next 20 years if we do not create the conditions that improve the chances of a healthy adulthood.

Simon is in the fifth grade in the year 2010 and finds school to be quite a struggle. He manages to just scrape by. Simon lives with his mom - his parents split up when Simon was three. She does her best to pay the bills. Four different child care workers looked after Simon before he started school; his mom was relieved when he began going full-time in grade one. Simon spends most of his time watching television and hanging out at the mall with his friends. His school used to have an after class recreation program, but that was dropped in the latest round of budget cuts. He also used to get extra help with his homework, but now that’s gone too. Simon has asthma and his mom finds it difficult to cope. As a result, he spends a lot of time in hospital emergency waiting rooms. By 2016, after being held back in school twice, Simon is a sixteen-year-old ninth grader, but his marks are poor. He



Source: Saskatchewan Health Vital Statistics, Interim Annual Report, 1999.

spends less and less time at school and decides that it’s not really what he should be doing with his life anyway. He leaves school partway through the year and tries to keep up with the demands of the part-time jobs he has taken. Unfortunately, he has messed up the balance on the cash register too many times and his boss, the kindly Mr. Green, has to let him go. Simon gravitates to the seamier side of his neighbourhood, and his mother wishes they could move, but they’re trapped. He spends many nights getting drunk and taking drugs. By 2020, he has been in and out of jail several times for dealing drugs. When he’s not in jail, he’s often in hospital for his asthma, complicated by hepatitis C. Simon will be lucky to see 2050, and society will spend hundreds of thousands of dollars to incarcerate him and treat his illnesses.

No one wins in Simon’s case. He is miserable, desperately seeking relief from his dead-end existence through drugs, alcohol, and crime. Society loses three times: it does not benefit from the contributions of a healthy, productive



citizen who pays taxes; it also loses the contributions of the kids who Simon turns to drugs; and the treatment and jail costs are prohibitive.

But how would Simon's life look in 2020 if his community, his environment, and enlightened programs were able to prevent this downward spiral? Here's the happier version of Simon's story:

Simon lives with his mom, Ruth. His parents split up when Simon was three and his mom struggled to make ends meet. Working at a minimum wage job, living in poor quality housing, dealing with Simon's asthma, and struggling to find suitable childcare were taking a toll on her health. At a periodic visit to the Primary Health Centre, Ruth broke down and disclosed her situation to the nurse. Seeing the complexities of the situation, the primary care nurse told her about an asthma management program for Simon. She also referred her to the social worker at her health centre who talked to Ruth about the almost-completed new low-income housing project. The project will have a daycare, with a preschool based on a Head Start program. He also told her about the plans for an adult upgrading program to be held evenings at the health centre. Ruth could finish high school

without having to worry about child care for Simon. The provincial budget brought more good news: a new child income benefit and plans for more investment in training and education programs for single parents. The social worker invited Ruth to a single parent support group for their area. The group talked about a wide variety of things like parenting alone, first aid, loneliness, and how to do your taxes. They also had a community kitchen and were organizing a Good Food Box co-operative. Ruth left the appointment with renewed hope. She knew there were no free rides and it would be a long haul as a single parent. Somehow, she felt the playing field had been evened a little, and she and her son might have a fighting chance.

The implication is clear. If more and more of our tax dollars are allocated to treating illness through the health system, there will be less money available for other social programs that contribute to the overall health status of children like Simon. Social program investments for Simon and Ruth pay huge dividends later on. The best health care in the world could not change the course of Simon's life in scenario one. In the happier story, Simon will use far fewer health services and become a net asset rather than a huge liability for himself, his mother, and society.

What Does The Public Say?

Nearly 60% of respondents to *The Challenges Ahead* questionnaire felt that it is the job of the health system to do more than treat disease, illness and injury. They felt the system should promote health through programs that support good parenting, provide nutritional advice, and help people to quit smoking. Over 52% of respondents agreed that the health system should make a special effort to reach out to groups that face higher health risks. Others said that it is not the sole responsibility of the health system to address these issues. In the public forums organized by the Commission, some participants called for outreach services to seniors, poor families, and other groups. Others advocated support for housing and home care initiatives (Public Dialogue, 2000).



An Equal Chance at Good Health

Nearly ten years ago Saskatchewan set out a vision for health dedicated to the ideal of wellness. The wellness approach recognized that health care services account for only a fraction of our overall physical and mental health. Through the creation of health districts, the goal was to integrate institutional and community services, and balance the focus on treatment with an emphasis on health

promotion, protection, prevention and early intervention. Progress has been made, through collaboration among hospitals, community programs, and other sectors to address health issues. Removing barriers to employment such as providing health benefits to low-income families is just one example of how social policies support better health outcomes. But there is always room for improvement.

What Can the Health Sector Do? Health Promotion, Protection, Disease and Injury Prevention

How will Primary Health Service Teams make it easier to adopt a population health promotion approach? By having skilled public health workers as part of, or connected with, the teams described in Chapter One, primary health professionals will be better able to take

a more proactive and far-sighted approach to producing and maintaining health. Not only will these efforts improve the quality of life of the public, but they will also mitigate future costs to the health system.

How Can Primary Health Teams Help?

More intensive monitoring and follow-up of high blood pressure results in a four to five percent reduction in blood pressure over 12 months. This means a 34% reduction in the risk of stroke, and a 21% reduction in the risk of heart disease (Goldman, 1984). Working as teams, primary health professionals are more likely to be able to provide this kind of follow-up care.

How is Diabetes Affecting Saskatchewan?

By the end of 1996 there were approximately 38,124 Saskatchewan people identified as having diabetes. In the same year, 3,224 new cases were found. Approximately 90% of people with diabetes have Type 2. There are likely to be many people who have diabetes who do not yet know they have it. The rates of diabetes will rise as screening improves, as the Aboriginal proportion of the population increases, as levels of physical inactivity and obesity continues to grow, and as the population ages (Saskatchewan Advisory Committee on Diabetes 2000).

Take Type 2 diabetes as an example. It usually appears after age 40, but can occur at a younger age, especially in high-risk populations. While not always the cause, the risk of getting diabetes is greater in those with obesity, poor diet, and lack of physical activity. People with diabetes are at higher risk for heart attacks, strokes, kidney failure, blindness, and gangrene of the lower limbs, leading to amputation. The human and economic costs of these complications are staggering. Health Canada estimates that the economic costs of diabetes in Canada may be as high as \$9B annually (Health Protection Branch 1999). In the case of Saskatchewan in 1998/99, 182 people had limbs amputated as a result of the complications associated with diabetes at an estimated cost of \$1.4 million (Saskatchewan

Health 2001). The health system also provided kidney dialysis for people whose diabetes led to kidney failure, and even more resources were devoted to the care and treatment of people who developed circulatory problems as a result of inadequately managed diabetes. And this doesn't begin to address the untold costs to the mental and spiritual wellbeing of a person with the disease.

These are very often avoidable costs. For many, diabetes is preventable and for those afflicted with the disease, it can be treated early reducing the likelihood of complications including limb amputations. Yet large amounts of money are spent on dealing with the results of diabetes even though many of the complications are avoidable.



The prevention and management of diabetes will be most effective and efficient as an integral part of comprehensive health care services. There are many ways in which the Primary Health Service Networks and Teams can address the disease and work toward prevention in partnership with others. For example, Primary Health Networks would have information about the populations they serve. Knowing they serve a population at high-risk of diabetes, they can better target their patients for whom screening is important. They can also collaborate with public health and others on public education campaigns and health promotion initiatives. Team members can promote and provide advice on fitness and diet, involving the dietician or others as needed. They would also link people to

community-based activities offered by public health, and fitness or recreation centres. For those whose income does not allow for the diet they need, the Primary Health Team would coordinate with someone from social services to determine what support programs might be available.

For those members of the population that already have diabetes, the Primary Health Team can treat the disease with consistent and regular follow-up care, as well as preventive and other advice, to reduce the risk of complications and the resulting poor quality of life. Diabetes can be controlled with proper nutrition, physical activity, insulin or other medications as needed, and support that comes from regular contact with a health professional.

Population Health: What Can the Health Sector Do In Working With Other Key Partners?

Good health is about more than health care. Naturally then, health should not be the only sector involved in aiming to improve health.

The Commission recognizes that Saskatchewan has always had a very broad vision of health and has supported opportunities to improve the health of the population. A number of initiatives have been launched through partnerships and consultation of key players across and outside government.

Inside of Government, a forum on human services was established in 1994. Since then, the Forum and its partners have worked collaboratively to address the socio-economic pressures of the province. This initiative has involved individuals and organizations from a variety of sectors including education, health, justice, social services, and municipal government.

Eleven Regional Intersectoral Committees have also been established across the province to tackle issues at a more local level. Partnerships are formed with other community agencies as opportunities arise.

One promising example of this intersectoral

work is the Saskatchewan Child Action Plan. Since the Plan's inception in 1993, many new programs and services have been launched focusing on the many factors that affect healthy childhood development. Recent examples include Social Housing for Families in the North and Neighbourhood Development Organizations.

Another promising example of intersectoral collaboration is the Moose Jaw Outreach Public Health Clinic. Established in 1993, the Moose Jaw Housing Authority and the Moose Jaw/Thunder Creek Health District sponsor the clinic. Its goal is to bring services closer to where people live and work. It operates from a family housing project - an apartment building that is home to 36 families in Moose Jaw. It takes a more "holistic" look at health, and aims to get at the conditions that help foster good health in the long term. Programs include baby clinics, counseling for parents, and health information for school age children and their parents (ADM's Forum on Human Services, 1996).

Like the Primary Health Service Teams and Networks, the newly amalgamated health districts would also have a responsibility to



“Partnership development (intersectoral collaboration) represents one of the (...) most important strategies that RHAs [health districts] can undertake in fulfilling their mandate for action on health determinants”
(Labonte, Discussion Paper for the Commission on Medicare, 2001, p.4).

pursue population health promotion approaches as part of their mandate. By building capacity in the community, districts would work with other sectors to address the factors that determine good health. They would facilitate and support action at the community level, action that eventually sustains itself. In Saskatoon for example, QUINT, a community-based economic development agency, is creating jobs and improving housing in five inner-city neighbourhoods. This initiative grew out of a health district-sponsored poverty action group that wanted to look at the issues of employment and income. Through the inspired and determined work of some community members, and the support of community developers in health, social services, and economic development, QUINT was formed and has begun working on

housing, jobs, and other concerns of residents. (Saskatoon District Health Community Development & Prairie Region Health Promotion Research Centre, 1999).

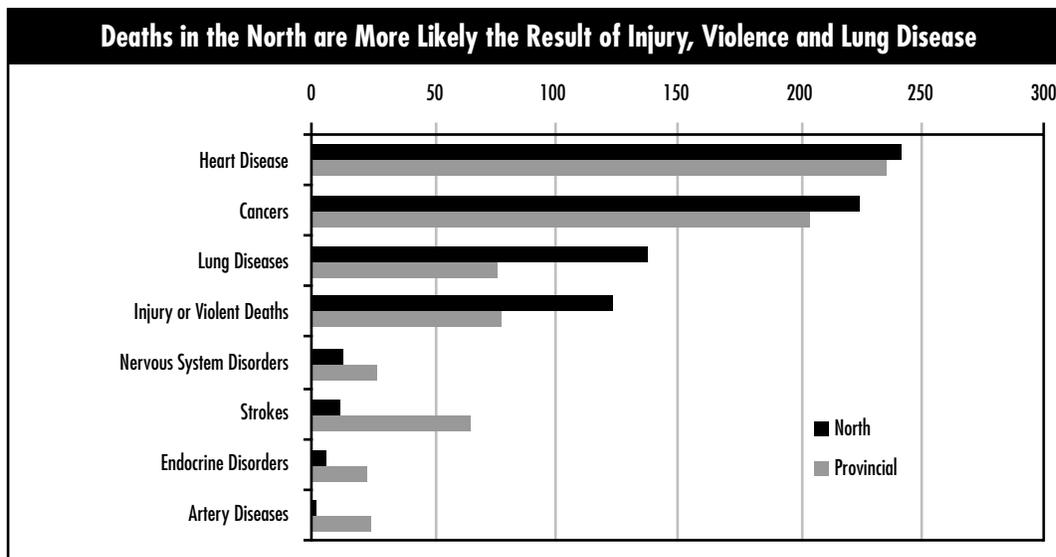
Perhaps more promising is the fact that Saskatoon District Health no longer needs to directly support this program. The District championed this initiative, helped it to develop, and once it began to flourish on its own it moved on with partners to address other important issues.

Finally, the health sector may not need to be involved as actively in all population health promotion strategies. In fact, instead of trying to lead the charge, it can sometimes best act as a cheerleading supporter when other sectors take an active role or lead in population health promotion initiatives.

Meeting the Health Needs of Northern Communities

The Commission recognizes that Saskatchewan’s North faces unique challenges when it comes to ensuring an equal chance at good health. The North experiences high rates of diabetes, increasing rates of heart disease and cancers, largely reflecting the changes in diet, reduced activity and increased smoking.

Poverty, unemployment and low levels of education increase risks while large geographic distances make it more challenging to access services. Basic needs, such as clean drinking water, are not always met, and health professionals are in short supply.



Source: Population Health Unit, Northern Health Board’s Presentation to the Fyke Commission. *Keewatin Yatth&Health District Health Status 2000* . December 7, 2000.



The Commission supports the development of a Northern Health Strategy to address the unique needs of Saskatchewan's Northern communities. In addition to supporting enhanced development of Primary Health Service Networks and Teams in Northern communities, broadly similar to those across the province, the Strategy should include:

- Continued support for a holistic approach to health;

- Assurances of basic needs such as clean drinking water;
- An approach to health that reflects Aboriginal spiritual and cultural beliefs;
- Support for the expansion of efforts to recruit, educate and train Aboriginal peoples into health-related professions (not only for the North, but across the province).

How Will We Know If We've Achieved A More Equal Chance At Good Health?

Part of the challenge health districts and other organizations face is being able to determine the extent to which their efforts have an impact on health outcomes or costs down the road.

This challenge is not unique to Saskatchewan, as organizations across the province and around the globe face similar dilemmas.

“We have to find new ways to meaningfully calculate the social - and economic- value of prevention programs. Without this piece, we will have a difficult job building public support for prevention strategies right across the country. Identifying the “dividend” that comes from prevention and early interventions is something we will have to learn to do better” (Dr. Paul Steinhauer, Sparrow Lake Alliance, <http://prevention-dividend.com>).

While the comparatively low cost and large benefit of public health and population strategies are well recognized, the focus of the past 50 years on personal health services and the immediacy of treatment issues has made providing the investments needed for long-term health and sustainability of the system more difficult. Without an enhanced focus on these upstream efforts, the strong foundation of health on which treatments can be more effective and affordable is lost.

Clearly defined and measurable population health goals should be developed and adopted across the province so that health districts (and other organizations that work with districts) are clear on “good health” targets and objectives. As described in somewhat more detail in Chapter Four, the annual reporting of districts and of the Government of Saskatchewan must be reformed to report not only on outputs - on what was done - but also, and more importantly, on outcomes - what was achieved.



Recommendation for Making Things Fair

To maximize the health of the people of Saskatchewan, the Commission on Medicare recommends the continuation and/or the development of:

- **Public health, health promotion, and disease and injury prevention strategies;**
- **Regular reports on defined and measurable health goals;**
- **Strategies to address the broader determinants of health; and,**
- **A Northern Health Strategy.**

Key Points

- Primary Health Service Teams working within broader Primary Health Service Networks to address the population health needs of the people they serve (i.e., prevention of illness and injury and management of chronic conditions).
- Continued emphasis on multisectoral collaboration at the provincial level to improve the health status of the population. Key partnerships between districts and other sectors at the local level.
- Health districts and the health sector as champions and supporters of population health approaches.
- Addressing the unique needs of the North through a Northern Health Strategy.
- Enhanced focus on “upstream” efforts.
- A commitment to develop clearly defined and measurable goals as a standard across the province.



CHAPTER FOUR:
**GETTING RESULTS – QUALITY
AT THE CENTRE OF THE SYSTEM**

Recommendation

To sustain a quality health system, the Commission on Medicare recommends:

- Continuing development of performance indicators;
- The establishment of a Quality Council;
- Annual reports on the health system; and,
- Incentives and funding to develop accountability and quality.

A Tale of Three Information-Seekers

Emily Pelletier wants to buy a new car. Bill Kozak needs surgery. The Middletons want to know what they're getting for the taxes they pay to support the health care system. All want the best possible information to answer their questions and enable them to make informed judgments and decisions. In Saskatchewan at the dawn of the millennium, what will their quest for information find?

Emily Pelletier, a savvy consumer who knows her way around the Internet, the library, and the newsstand, is in great shape. The specifications for the car – dimensions, features, engine size and power, fuel efficiency – are supplied by the manufacturer. There are numerous magazines, journals, and web sites that publish independent comparative reviews of cars in the same class. She can find out the dealer cost and the typical mark-up. She can consult buyers' guides to find out how the car holds up over time, what components are most likely to break down, what repairs will cost, and the typical rate of depreciation. She can read real-time, up-to-date customer satisfaction survey information. And Emily's car will come with a warranty that guarantees quality and service for a defined period of time.

Thirty years ago, Emily would have had a much more difficult time finding any of this information. Buying a car in those days was much more of a gamble. For such a major purchase, the public wanted reliable, comprehensive information to aid their decisions. As the information got better and easier to get, the auto industry transformed. In the 1980s, for example, it became clear that Japanese cars were better than American cars – mainly because of advanced design and manufacturing processes, and a commitment to quality. Millions of buyers bought Japanese cars as a result. After surveying the wreckage of their market share, the American manufacturers responded by making better cars. Today almost every car is much better than the cars of twenty years ago. Quality improvement has been driven by consumer expectations and fuelled by sound evaluative data.

Now let us consider Bill Kozak, the patient about to undergo surgery. What information is available to him? Not very much. He probably knows little about his family physician – where she graduated, where she placed in her class, what type of continuing medical education she has pursued, even her main areas of interest. She may refer him to a specialist, whose characteristics are similarly unknown. How many procedures has the specialist done? What is the complication



rate, and how does this compare to the peer group? Are there other specialists around and if so, why refer to one and not the others? How does the hospital compare to others in terms of outcomes? If Bill is a sophisticated, energetic, and assertive patient, he might get a smattering of the information he requires. But much of it is not available to either Bill, his providers, their managers, or the provincial ministry of health. They are in a sense shopping unarmed, much like the car buyer of a few decades ago.

The Middletons are a middle-income family with two kids. Each year the government collects about \$7,000 from the family in various forms of tax to pay for health care. As they review their finances, plan for the kids' post-secondary education, think about replacing their aging car, and contemplate their big mortgage, they can't help but notice what a big chunk of their income goes to the health system. So they ask themselves, are we getting good value for our money? The province spends 40% of its budget – and a lot of our tax dollars – on health care. Is it really making us healthier? Is all that money being spent efficiently? Will the government have enough money to support their children's education?

Energized by their initial discussion, the Middletons start to pay attention. They read the newspaper, occasionally surf the Internet, and watch the health features and documentaries on television. They learn that there is rampant over-prescribing of drugs, especially among the elderly like their parents. Amid this waste, many people face financial hardship paying for drugs that aren't covered by Medicare. They have friends who have waited for months for surgery in real pain; one of them went to the media and got front-page coverage. Yet on the Christmas cocktail party circuit they hear stories of people getting surgery within weeks, some exclaiming that they were summoned so quickly that they elected to delay the surgery on their own. A friend's mother-in-law was called for cataract surgery she didn't think she needed, and didn't know she was "waiting for." Their local hospital has been fundraising to support the purchase of a new MRI. While the Middletons think it is a wonderful piece of technology, Sandra Middleton called the organizer of the campaign and asked her what a new machine would do for the community. How many lives would be saved? How many more diagnoses would be made that could be helped? Could the money be better spent elsewhere? The fundraiser thanked her politely for her call and said she'd try to get the answers to the question. None came.

Their curiosity piqued, the Middletons devoured annual reports from their health district, Saskatchewan Health, the Provincial Auditor, and anything else they could get their hands on. They learned a lot about how much service is provided but almost nothing about its impact. They could find little about quality and nothing about value for money. And they observe, now a little ruefully, that as a family they are paying almost \$1,500 more in taxes to fund the health care system than they were only three or four years ago. Strong supporters of Medicare, the Middletons wondered: Is anyone minding the store? How come Emily Pelletier had such fabulous information while the Middletons and Bill Kozak remain in the dark about the health care system?

Defining Quality

There are many definitions of quality. For example, according to the Institute of Medicine in the U.S.: "Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Chassin, et al., 1998b, p. 1001). Essentially it boils down to doing the best job possible with the resources available. It means achieving

stated goals and targets. It is measurable against accepted and valid standards. It is incompatible with waste, duplication, and fragmentation. It is about minimizing underuse, overuse and misuse. It is not about heroic effort or the futile pursuit of the impossible. It is unlikely to be achieved by a demoralized workforce or inadequately trained personnel. It does not thrive where there is conflict or lack of consensus on goals and



mission. It is about leadership, goal setting, teamwork, process, measurement, commitment, incentives and accountability.

There are numerous quality initiatives underway in Saskatchewan's health care system. However, there is no overall framework or coordinating body, nor are there regular and comprehensive reports to either providers or the public. The health care system is data-rich, and information poor: there is little that tells managers, the public or providers about the quality of their labours in relation to agreed-upon goals and standards. There are no benchmarks for either utilization (how many procedures should be done in a population) or outcome (what difference should we expect from a service, what is an acceptable failure rate). To return to the automotive analogy, the health care system runs on the fumes of tradition and opinion, with few parts of the fleet converted to the more powerful and efficient fuel of evidence-based decision making leading to higher performance.

One of the assumptions underlying the Canadian health care debate is that more money will produce better quality. In a perfectly efficient system this may be true. But it is not in our system, nor in any known

health care system. There are countless studies that demonstrate how better quality costs less money (Findlay, 2000; Berwick, 1998). On reflection it is apparent why this is often the case. The failure to ensure that people with chronic heart disease take aspirin can result in heart attacks that cause death and/or interventions costing in the tens of thousands of dollars. Substandard diabetes control results in poor health and costly complications. Success in tobacco use counselling can save lives and huge amounts of health care money. These are but three examples that illustrate that better quality would cost less.

Experts on quality agree on one key point: it is the design of systems, and not the misdemeanours of individuals, that cause error (Berwick, 2001). Health care needs to learn from the airline industry where errors are openly acknowledged, where the goal is "to find out what's to blame, not who's to blame" (W-5, 2001). Finger-pointing and punitive reviews of individual performance will not solve quality problems in health care. Nothing less than a fundamental rethinking of how we organize, pay for, and define success in our systems will transform Saskatchewan into a quality leader and ensure value for money for our citizens.

How Good Is Health Care Quality?

Many people report very high levels of satisfaction with services actually received in the health care system, and low levels of satisfaction with the system as a whole (Saskatchewan Health, 2000b; Merck Frosst Canada, et al., 2000). We may have it wrong on both counts. That is a hard message to accept: it raises concerns among the public, and is taken as a personal criticism by providers who without question are motivated to serve. Put plainly, we do not have a quality-oriented health care system because we have not made quality a priority. Consequently there is waste, error, and harm. The problem is not unique to Saskatchewan or Canada but we can no longer afford to overlook its extent or its consequences.

When Canadians do express concerns about the quality and processes of health care, we often compare ourselves unfavourably to the U.S., with its Harvards and Stanfords and Mayo Clinics, its fabulous technology, its state-of-the-art treatments, and - for the insured - no waiting. Listen to the guru of health care quality improvement, Dr. Donald Berwick, a physician, on the reality. Berwick asserts, based on copious evidence, that American health care quality is substandard for various reasons. It is inconceivable that American health care organizations pay less attention to quality and service than ours given their competitive insurance structure and their litigation-friendly jurisprudence. In fact, given that quality has more funding and champions



in the U.S. than in Canada, it is likely that if anything, our circumstances are worse. Berwick argues that there are three primary barriers that stand in the way of achieving quality health care:

First: fear of the truth. So long as health care leaders and the patients and communities they serve regard quality problems primarily as sources of embarrassment and as indications of bad faith and carelessness, the patients will accuse and the caregivers will defend themselves. That is only human. All improvement begins with the intention to improve, with the whole-hearted admission that a gap exists between what is and what should be. But, identifying a gap does not necessarily require fixing blame. It is equally possible to admit a need to improve, without blame, and then to begin the never-ending process of learning how to do things better. We do that every day in our schools, our hobbies,

and our daily lives. The “quality improvement” slogan goes: Every defect is a treasure. Health care is loaded with treasures.

The second barrier - once we overcome the fear of the truth - is the problem of finding plausible alternatives to the status quo, examples that can build confidence in the feasibility of improvement and that give us ideas for approaching tasks differently. Better ways. Best practices.

The third barrier is more subtle: health care is missing a comprehensive example of breakthrough performance - a model for all to emulate. Even though, case-by-case, problem-by-problem, excellent examples exist of success by health care providers for almost every quality problem we have, no one - no one at all - in health care has ever yet “put it all together” (Berwick, 1998, pp.6-7).

“Additional barriers to fundamental improvement are structured into the habits and environment of health care. The financing system often rewards fragmented, non-cooperative behaviors, instead of fostering reduced redundancy, complexity, and interruptions of the entire care experience from the patient’s viewpoint. A test done in a hospital is repeated unnecessarily in the nursing home, and then repeated again upon rehospitalization. A medical center opens a new cardiac surgery unit in already-oversupplied region. Lay health care executives, by tradition and training, often leave improvement of care vaguely up to physician staffs, rather than assuming full, corporate responsibility for improving overall performance. It is as if airline executives left airline safety up to pilots, rather than assuming primary responsibility for running a safe system. Health care also lacks well-developed infrastructures for transfer of best practices. The widespread adoption of sound system changes and programs is left to weak methods, like publication, rather than strong, carefully managed methods of deployment” (Berwick, 1998, p. 7).

People in Saskatchewan often have to wait, sometimes for several months, to see a specialist. Here’s what Berwick has to say about the allegedly no-wait American system:

The waiting and delay so familiar to all in health care, both patients and providers, are not inevitable. Relatively simple changes in scheduling and information exchange, engineered by...Kaiser-Permanente’s Rosemont Medical Center, have produced “same-day access” and nearly wait-free patient flow for ill patients, have reduced delays for routine appointments from over two months to one

day, and done so without any expansion in staff at all. A team at Sewickley Valley Hospital in Pennsylvania reduced delays in start times for surgery (a chronic, costly, and annoying problem for surgeons, operating room staffs, patients, and their pacing families) in less than three months from an average of 80 minutes to less than 10 minutes, again with no changes in staffing. And the Pediatric and Adolescent Medicine Unit at Mayo Clinic in Rochester, Minnesota, cut waiting times for routine appointments from an average of over 30 days to less than five days. What each of these “delay-reducers” did was to apply in health



care some simple rules and methods for profiling demand, scheduling services, and streamlining procedures – and rules and methods that have been standard in many service industries other than health care for decades (Berwick, 1998, p.16).

Not only is the technical quality of service substandard; as a service industry health care widely misses the mark as well. Again in Berwick's words:

[...] the service levels of much of health care would frankly be an embarrassment in any other human service industry. Long waits, anonymity, isolation, embarrassment, confusion, non-response, physical discomfort, and infantilization are all common characteristics of health care settings from patients' and families' point of view, excused and permitted socially perhaps only because of

durable and justified trust in the underlying samaritanism, skill, and professionalism of the people who work in those service-poor systems. In fact, patients more often sympathize with and excuse the doctors and nurses than blame them or complain (Berwick, 1998, p.16).

The consequences are not merely inconvenience. According to the landmark US Institute of Medicine Report, clinical error is among the leading causes of death in that country. It kills more people than breast cancer, traffic accidents, or AIDS. If we apply the American estimates to Saskatchewan, one person a day dies because of clinical error. Even the possibility that this is the case - and it is more probable than unlikely - should focus public and provider attention on the urgent need for quality improvement.

Enhancing Performance

The achievement of a quality health care system in Saskatchewan requires nothing less than a cultural transformation. Commitment to quality is the only way to get quality. Every person in every program must have a quality orientation and a set of tools to make practices better. A number of concrete suggestions are outlined below, but these in themselves will not effect the profound changes proposed.

Among the great merits of the work of Berwick, Kizer and others is that it points the way forward with real examples of turnarounds. Interestingly, many of these quality improvement advances originate outside the major academic centres, in places like Albany, Georgia and Kokomo, Indiana. Very large cities hold no monopoly on leadership and commitment.

Both nationally and in Saskatchewan, work is underway to define performance indicators and the information required to support them. The Canadian Institute for Health Information, the Canadian Council on Health Services Accreditation, and others have launched efforts to refine indicators for population health and the health care system. Saskatchewan Health

has released a series of district-specific indicators and data on the health status of specific population groups, such as children and youth, as a guide to planning for health districts. HSURC has published a discussion document that describes the conceptual and practical issues inherent in producing indicators (Health Services Utilization and Research Commission, 2000d). While the field is increasingly active (one might say crowded), there is no obvious "solution" to performance measurement and reporting. Particularly difficult is distinguishing the performance of a system from that of its constituent parts.

The Commission is in no position to recommend one approach or set of indicators over others. However, the Commission strongly supports the ongoing development of performance indicators that relate to clearly articulated goals. Ideally the goals should be outcome-oriented, spanning health status improvements in the overall population, to gains in specific disease groups achieved through health care interventions. Some will be more process-oriented, reflecting user satisfaction criteria such as timely access,



convenience, coordination, shared decision-making, and the quality of information received. Any such measures should respond to the suggestions and information requirements of government, the health districts, and the Quality Council (described in detail later in this chapter).

Once developed, performance indicators should drive the entire system. They will be the foundation for quality improvement and a guide to resource allocation. They will pinpoint areas in need of support and allow the public to make more informed judgments of both individual sectors and services, and the overall system. The indicators and ratings will replace anecdote, opinion, and interest group pressures as influences on policy and resource allocation. The more robust and comprehensive the measures, the greater the prospects for optimizing the use of whatever resources are available.

The key elements of performance measurement and reporting:

- Utilization analysis - are services appropriate, is there duplication, does practice conform to accepted guidelines, is there overuse, underuse or misuse?
- Health status variations - by district, age, gender, socio-economic status - and explorations of the underlying causes.
- Practice variations - why more procedures are done in some places than others, and the consequences of these differences.
- Waiting lists - are lists standardized and well-managed; what proportion of people are served within a “reasonable” length of time; consequences of waiting on quality of life, general health status, prospect to benefit from the intervention.
- Procedure-specific outcomes - how does Saskatchewan compare with other provinces, which procedures produce the most and least dramatic improvements?
- Costs of programs and services, cost per unit of added health status.
- Relationship of health status to use of health services.
- Comparative impact on health status of health care vs. “determinants of health” interventions and characteristics (social services, education, recreation, unemployment rates).
- Trends in health status disparities (gaps between population groups).
- Disease or condition-specific outcomes associated with services.
- Ranking institutions on the quality of services such as surgery.
- Ranking districts on the basis of disease rates in various categories, and how well they are treated and managed.
- User satisfaction along several dimensions.
- Workforce morale, satisfaction with role.

All of these activities are important. But as Berwick notes, measurement and reporting alone will not improve quality. People must be moved to action based on what they have observed and measured. Funding, incentives, and rewards must be geared towards quality. There must be resources to educate and tools to transform. As will be explored in Chapter Six, money is not the problem. Indeed, quality improvement typically saves money.

Improving Quality: The Example of Drugs

Quality is of course about producing benefits and eliminating harm. It is also related to access and affordability. The example of drug use and drug coverage illustrates the connection.

Drugs are a prominent part of the health care system, with total expenditures exceeding the amount spent on doctors. When used appropriately, they improve health and quality of life, and in some cases create a net financial



saving by preventing the need for other, more expensive services. Yet drugs outside the hospital are not covered by the *Canada Health Act* and no province has a universal, publicly funded drug program, despite their being “medically necessary” by any common-sense definition. On the surface this seems irrational, but on closer inspection, the quality problems surrounding drugs makes these policy decisions more understandable.

Quite simply, wherever drugs were or are publicly funded, expenditures have grown at a sometimes alarming rate. There was limited analytical capacity and virtually no policy to reveal and control excess utilization. There were few tools to reduce ineffective prescribing, poor compliance, or polypharmacy. The strong tradition of medical practice autonomy, rapid new development of drugs in unprecedented quantities, and low cost to users created an environment ripe for greatly increased utilization. Facing annual increases that in some years reached 30% alongside a growing general fiscal crisis, the Saskatchewan government perceived little choice but to scale back eligibility for the program. Today, Saskatchewan’s publicly funded drug program assists those (families) with low income, those with high drug costs and those with a combination of the two conditions. The average citizen has no public coverage until costs exceed \$850 in a six-month period.

Governments are wary of expanding Medicare to include prescription drugs. They are wary of establishing entitlements that create enormous demands on the treasury with little likelihood of controlling costs. Most government decision-makers recognize the fundamental injustice and illogic of current policies. But they view drugs as a Pandora’s Box, their views coloured by a checkered past.

All of this has created a policy gridlock.

- Large numbers of people cannot or will not purchase required medications because of their cost (or will sacrifice other basic needs to pay for medications).
- Drug prescribing practices are heavily

influenced by industry marketing, which often results in needlessly high volumes and the choice of expensive drugs that confer no more therapeutic benefit than cheaper drugs in the same class.

- There is little incentive for comprehensive analysis of utilization and documenting the positive and adverse impacts of drug therapy.
- Even though the government pays for only a fraction of total drug costs, annual increases remain very high compared to other elements of the system.
- Public confidence in and loyalty to the health care system may be eroded by the exclusion of drugs from the publicly covered spectrum of services.

From the standpoint of the health system, these realities constitute poor quality. Drugs may be wasted, such as antibiotics unhelpfully prescribed. Drugs can be harmful, as shown by admissions to hospital and injuries caused by polypharmacy. They are needlessly expensive at times, when costly drugs are prescribed and bought where cheaper versions would be just as effective. Poor compliance and the unavailability of drugs have consequences for both the individual and the system where complications arise or health deteriorates needlessly. Yet without the means to ensure quality prescribing and compliance, one can understand why governments will not open the vault to a Medicare-style program - burnt once, twice cautious.

There is a solution centred on a major quality improvement plan for the drug sector. The elements of the plan would include policy, principles, information, and education, such as:

- Incentives to adopt best practices in prescribing and disincentives to ineffective practices;
- Reference-based pricing to ensure that the lowest cost product of equivalent therapeutic benefit is used;
- Enhanced basic and continuing medical education for physicians on evidence-based prescribing;



- An enhanced role for pharmacists as part of Primary Health Teams, allowing them to apply their knowledge as full participants in prescribing decisions (see Chapter One);
- Improved, real-time information systems that allow the relevant providers access to individuals' drug prescribing histories;
- Installation and use of software that flags contraindicated drug combinations, provides menus of drugs with equivalent therapeutic benefit, etc. to improve prescribing;
- Practice guidelines, especially for those drugs that tend to be subject to misuse;
- Refinement of policies and templates for making formulary decisions and "fair price" calculations based on therapeutic effectiveness rather than the cost of production or the price in effect in other jurisdictions;
- Feedback to prescribers, health districts, and Primary Health Teams on how well they are performing with respect to prescribing and compliance;
- Public education on the importance of compliance, and prudent use;
- Clear, defensible, and transparent criteria for determining which experimental drugs and populations warrant special status for coverage that would ordinarily be denied by standard policy.

The Driving Force: A Quality Council for Saskatchewan

This report proposes a profound transformation of the health care culture of Saskatchewan. It needs a guiding mechanism to see it through. The government should establish and fund a Quality Council (QC) with a mandate to improve the quality of health services in the province. It should be an evidence-based organization, arm's length from government and reporting to the Legislature.

Who Would Make Up the Quality Council?

The QC must consist of informed, independent people rather than representatives of organizations whose particular interests they are expected to advance. It should be headed by a dynamic leader who can pursue a quality agenda with stakeholders and the public. It will require expert staff.

The main criterion for appointment to the Council should be commitment to improving quality in health care. One would expect that Council members might be drawn from:

- The various health care professions
- The general public
- The universities

- Health care organizations; and,
- Quality experts and leaders from other sectors

It is essential that the Council membership include experts drawn from outside the province to ensure the most objective assessment and evaluation of health services delivery in Saskatchewan.

What Would Be the Role of the Quality Council?

The QC should be a high profile organization that analyzes, comments on, and recommends, but does not have authority or responsibility for implementation. It must preserve an independent voice and its views and conclusions must not be compromised by everyday contingencies and pressures. In addition to reporting formally to the Legislative Assembly, the Council should report frequently and transparently to the public. The specific duties of the QC are outlined below, but should not be viewed as restrictive-it should be an open organization to which a wide range of quality and performance-oriented matters should be referred for study and advice.



Responsibilities of the Quality Council:

- Develop a general quality assessment and performance framework for the province.
- Determine the population, volume, and infrastructure required to deliver high quality specialized services (see Chapter Two).
- Promote quality development and improvement through training, support, workshops, site visits, etc.
- Develop performance benchmarks for the various components of the system, including utilization targets.
- Review and make quality-oriented recommendations on the scope of practice and division of responsibilities among health care occupational groups, in cooperation with the newly created Health Human Resource Council (see Chapter Five).
- Examine and make evidence-based recommendations on the relationship of formal academic and educational credentials to practice quality and outcomes, in cooperation with the newly created Health Human Resource Council.
- Report on clinical error, make recommendations, and support initiatives to reduce its incidence and impact.
- Report on the quality performance of the system as a whole as well as its constituent parts.
- Identify and report on significant variations in practice within the system and to recommend benchmarks and other means of narrowing the range.
- Participate in the development of performance indicators for specific services and programs, and the health system as a whole.
- Evaluate and comment on the value of new technology, drugs, and other clinical development, from a quality and value-for-money perspective.

The functions described for the QC overlap significantly with those of the current drug review committees that advise the Minister of Health on what new drugs should be included in the provincial formulary. The work of the QC would also overlap with that of HSURC, which also serves as the province's research granting agency. This report recommends a major increase in health research funding (see Chapter Six). Should this recommendation be implemented, it will be necessary to reorganize as follows:

- The mandate of the Quality Council should be combined with the utilization research mandate of HSURC. The QC and HSURC could be merged into a new organization called the Quality Council;
- HSURC's granting agency function should be separated out into an independent organization in anticipation that its budget and range of activities will grow substantially. Once this occurs there are no economies of scale to be realized by combining the QC and the granting functions. Each will require the undivided attention of strong and energetic governance and operational leadership; and,
- The Drug Quality Assessment Committee and the Saskatchewan Formulary Committee should be merged into the Quality Council.

Getting There

To fulfill its broad and central mandate the QC will need first-class research, training, and communications staff, and a significant budget. If it is to be a permanent resource to the system as well as producing analyses and reports, it will have to be outward looking and responsive to current and anticipated needs. Eventually the work of the QC may justify an expenditure of as much as 1% of the public health care budget. These funds might support, among other activities:

- Independent, on-the-ground research and analysis of the performance of the system;
- Development of benchmarks and standards;



- Quality leadership training programs for organizations and personnel;
- Fellowships for intensive periods of quality-oriented clinical and administrative education;
- Seminars and workshops by the world's leading quality improvement experts;
- Site visits to innovative quality and performance health care organizations;
- Syntheses and dissemination of scientific information;
- District quality improvement projects in response to proposals;
- Regular internal and external review processes; and,
- Co-sponsorship of national and international research and development projects.

Quality Improvement in Reports

A shift toward quality, outcome, value and performance must be paralleled by a new approach to reporting on what the system does. All reports to the public and its representatives should include greater emphasis on goal attainment, outcomes, and meaningful performance indicators and less “counting” statistics devoid of context. The redesign of Annual Reports should be coordinated and linked to the work of the Quality Council. Among the desirable elements of an Annual Report from Saskatchewan Health and the district health boards would be:

- Tables ranking districts and, where appropriate, facilities on important indicators;
- A general value-for-money series of tables that describe the costs and benefits of various “upstream” (prevention, health promotion, early intervention) and “downstream” (intensive health care) services such as smoking cessation vs. bypass surgery, diabetes prevention vs. diabetes intervention programs, standardized as cost per additional life-year, per unit of improvement of quality of life, etc.;
- Thematic reports highlighting particular program areas or population needs, for example heart disease, health inequalities, seniors' health;

- Reports on system errors (clinical error, preventable deaths, outcomes compared to benchmark standards, etc.);
- Health status of the population by age, sex, district, socio-economic status;
- Provider performance on key dimensions—percentage of providers meeting acceptable standards, comparisons with peers across the country; and,
- As a general rule, performance in relation to targets and goals.

Consistency in format is highly desirable. In the future, one could envision, for instance, district health board Annual Reports containing a standard, identical set of tables in addition to the more local content. The districts would report on progress toward quality goals recommended by the Quality Council and efficiency targets. The public would be able to assess performance in a more informed manner, and standardized reporting would presumably lead to healthy competition for excellence.

Quality improvement, monitoring, and reporting will require state-of-the-art information systems and an electronic health record. Chapter Five outlines these essential components of the system in more detail.



Quality-oriented Incentives and Funding

If there is to be a quality-oriented, evidence-based system, the incentives must align to achieve it. The perverse incentives inherent in traditional funding systems have been recognized for decades, yet despite some improvements – the move towards needs-based funding of health districts, for instance – the

system remains volume-driven. Work done is work paid for, regardless of whether it is appropriate, effective, or efficient. Funding follows activity that need not be related to goals or outcomes. Essentially the system pays for activity and is indifferent to result.

In the words of one perceptive nurse in Prince Albert: “We do because we can, not because we should!”

Remarkably, there has been no comprehensive review of the incentives – financial and otherwise – that motivate behaviours throughout the system, from managers and providers to citizens and users of services. Such a review would almost certainly reveal an abundance of worrisome reward practices, with ostensible partners in the system working at cross-purposes because they are responding to different and conflicting motivations.

A quality-oriented, accountable, and performance-driven system would entail at least the following corrective measures.

- Payments and reward systems should be geared towards quality, illness prevention, health promotion, effectiveness, and efficiency. This will be partly achieved by implementing the Primary Health Service Teams outlined in Chapter One.
- The achievement of goals should be part of performance contracts with managers. Clinical teams should participate in goal setting and receive regular reports on performance. This will be partly achieved when specialists sign performance contracts with health districts as recommended in Chapter Two of this report.
- The funding formula for districts should continue to be refined to ensure that it rewards quality and health status improvements and supports effective

interventions. Organizational units that achieve or surpass quality targets should be rewarded; if their initiatives save money it should not all be “taxed back” to the common pool.

- Eventually the provincial funding system should be based at least partially on performance, not just volume or population need, and all funding and payment mechanisms should be tailored to promote higher levels of achievement. Examples of incentives might include higher immunization rates, lower rates of surgical wound infection, and fewer avoidable admissions to facilities.
- Resource allocation decisions should be supported by the best available science and evaluation rather than interest group pressures or opinion leader advocacy.
- Hands-on training and practical experience in quality improvement should be part of any organization’s culture and every employee’s job description. No process is too small to benefit from quality initiatives, and all personnel can devise and implement quality improvement measures given a supportive environment. These can range from changes in the operation of the Intensive Care Unit to revising forms to ensure that unnecessary information is eliminated and test results are more clearly presented.



The Health System of the Future

Experiences in large and complex systems such as Veterans Health Affairs in the U.S. and multi-million enrolment health maintenance organizations demonstrate, happily, that change can happen quite quickly given commitment and leadership. There is no reason why Saskatchewan cannot lead in the drive for quality. It has a timely opportunity to reorganize both its structures and its incentives. If it pursues these changes with vigour, the province could become the first jurisdiction to fulfill Berwick's vision for tomorrow's system:

It does not yet exist, but this organization need not remain a dream. All its elements of excellence, and many more, exist either in reality somewhere already, or are firmly supported by sound, scientific evidence. The aggregate can be a... health care [system] that operates at a total cost per capita 30% lower

than that spent on the average [person's] health care today; with health status outcomes for specific acute and chronic illness at or above the very best known profile of outcomes; trimmed of hazardous, costly excess and waste in ineffective medical procedures, drugs, diagnostic tests, supplies, and equipment; reinvesting those savings in forms of care, service, and prevention currently unaffordable; involving patients and families totally in their own care, with the fullest possible control (to the extent they want it) over the decisions and circumstances under which they receive that care; characterized by levels of service, smooth flow, dignity, responsiveness, clarity, and optimism that we today associate only with world-class service organizations; and 100 times safer than the health care of today (Berwick, 1998, p. 21).

Recommendation for Getting Results

To sustain a quality health system, the Commission on Medicare recommends:

- Continuing development of performance indicators;
- The establishment of a Quality Council;
- Annual reports on the health system; and,
- Incentives and funding to develop accountability and quality.

Key Points

- The ongoing development of performance indicators for the health system in Saskatchewan.
- The creation of a Quality Council with a mandate to improve the quality of health services in the province.
- A redesign of the Annual Reports of Saskatchewan Health and health districts to include a greater emphasis on goals, outcomes, and performance indicators.
- A quality-oriented, accountable, and performance-driven system with the appropriate incentives and funding mechanisms.



CHAPTER FIVE:
IN SUPPORT OF CHANGE

Recommendation

To support the proposed changes to the health system in Saskatchewan, the Commission on Medicare recommends:

- **9 to 11 health districts, and clarification of their relationship to the Government of Saskatchewan;**
- **A structured dialogue on the delivery of health services to Aboriginal people;**
- **Co-ordinated human resources planning and management on a provincial basis;**
- **The renewal of health science education programs, including increased funding for health research, equalling 1% of public health spending; and**
- **Investments in information systems including the development of an Electronic Health Record.**

Introduction

In addressing the challenges facing our health system, this report makes recommendations for a number of significant changes to the way services are organized and delivered. To ensure that the needed changes are made to the delivery of health services in Saskatchewan - organized primary health services, coordinated specialized care, a Quality Council - a number of other supporting changes have to be made as well. The Commission's proposals in support of change have been organized into four general areas: Governing and Managing the System; Human Resources Planning and Management; a Commitment to Research and Education; and finally Information

Management. Within this framework, the Commission offers a number of specific recommendations. These include reducing the number of health districts, and clarifying their relationship to the Government of Saskatchewan. The Commission also recommends that health human resource planning be coordinated on a provincial basis, and that, in support of this, change and renewal is required in the health science education programs in the province. Finally, the Commission recommends continuing investments in information systems including the development of an Electronic Health Record.

Governing and Managing the System

Saskatchewan was among the first provinces to move to a system of health districts or regions. Nine of ten provinces now have some form of regionalized health services delivery. This approach brings many benefits, for example:

- Health districts ensure that the different parts of the health system - acute care hospitals,

home care, long term care, public health, mental health programs, - are more integrated and coordinated at the local level. The result is better service to the people of Saskatchewan.

- Health districts have made a significant contribution to raising the profile of community care and the determinants of



health. Rather than simply waiting until people present themselves to the health system with lung cancer or heart disease, for example, some health districts have invested in health promotion and disease prevention. Other districts have led efforts to reduce the number of people who smoke. Others still have created partnerships with community organizations, school districts, and other government agencies to address the root causes of poor health such as poverty, poor housing, and unhealthy diets.

A Smaller Number of Health Districts in Saskatchewan

The original blueprint for the regionalization of health services developed by the Murray Commission in 1990 provided for 15 “health service divisions”. The creation of 32 health districts, and the Athabasca Health Authority in the far North, was a compromise that reflected Saskatchewan’s tradition of highly localized government.

Some people have told the Commission that without this compromise, it would have been impossible to create health districts in the first place. Others assert that a large number of small districts is essential if the needs of rural Saskatchewan are to be met. Others have called for fewer districts, often without specifying precisely how many. A few have called for the abolition of health districts altogether.

The Commission has concluded that a smaller number of health districts is essential. The districts would have larger populations, and would therefore be able to sustain a wider range of services. Larger districts with more resources would have more latitude for innovation. Having fewer districts would increase the capacity of districts outside of Regina and Saskatoon, creating more equality between districts. Moreover, a move to a smaller number of districts would respond to the following challenges.

Shifts in Population

Several of the existing health district populations are shrinking. Four districts now serve populations of less than the 12,000 originally established as the minimum number

for a district. In another 16 districts, the population served is less than 20,000. Moreover, the number of people living in some districts will continue to decline. For example, a recent report by the Health Services Utilization and Research Commission (HSURC) suggests that by 2015 seven districts will serve fewer than 12,000 residents, and another 16 districts will have populations of less than 20,000 (Health Services Utilization and Research Commission, 2001). This population size may be far too low to deliver health services effectively.

Many of the services provided by districts (e.g. addiction services, pre- and post-natal care, mental health programs) are needed by relatively small numbers of people. As a result, to deliver these services effectively, a health district requires a reasonably large population base. For example in Alberta, there are 17 Regional Health Authorities (RHAs) that serve populations between 20,000 and 900,000, and there are suggestions Alberta wants to move to even fewer RHAs. In Manitoba there are 12 Regional Health Authorities, with most serving populations of 30,000 to 50,000. Moreover, some suggest that 100,000 people is the minimum population size for a health district or region (Institute for Research on Public Policy, 2000a). Admittedly, in Saskatchewan, the sheer geographic size of the province has to be taken into account. We also must acknowledge that the population of this province is not as concentrated in major cities as it is elsewhere in Canada. Nevertheless, to better plan and deliver health services to the people of Saskatchewan, larger districts are required.

The Need for Better Planning and Coordination

Saskatchewan cannot afford extensive overlap, duplication, and inefficiency. These are signs of bad public policy and poor service delivery. This report frequently highlights the need for more central coordination and central planning. As outlined elsewhere in this report, the Commission believes that Saskatchewan Health must be given a stronger mandate to plan and coordinate the delivery of health services, including human resource planning, while working closely with the districts. This



is very difficult to do when there are 32 health districts.

The Need for More Qualified Management

The health districts are responsible for spending over half of the approximately \$2 billion allocated to health services each year in Saskatchewan. The districts also employ approximately 29,400 direct service employees, of whom over 11,700 are nurses (Registered Nurses, Licensed Practical Nurses and Registered Psychiatric Nurses). Managing this amount of money and working with this number of employees is a major management challenge. Splitting this responsibility up among 32 districts makes the challenge even larger. Districts have difficulty recruiting and retaining capable managers, leading to excessive turnover and instability. Some members of the public told the Commission that the system is over-managed. In fact, within the current structure, there are too few managers, not too many. The existing managers in the system are spread too thinly, making it extremely difficult to recruit and retain 32 qualified management teams, especially given the complexity and pressures inherent in these jobs.

The recommendations contained in this report present formidable challenges for management. For example, taking responsibility for changes in the delivery of primary health services is a major management challenge for districts. This will require districts to contract with, or otherwise employ, physicians and develop integrated primary health services. Similarly, changes to the delivery of specialized services will require districts to carefully assess where to locate services, which facilities to close, and which facilities to convert to other uses.

Public Participation and Public Engagement

One of the biggest benefits of regionalization and the creation of health districts is that it created the potential for increased citizen participation in decision-making about health care. Has this potential been realized? Do the people of Saskatchewan feel more involved in the running of the health system? Based on what the Commission heard, and the

available research evidence, the answer is a decided *maybe*.

On the one hand, the public has a weak understanding of the role of health districts and very often directs their concerns to the Minister of Health, bypassing districts entirely. Moreover, voter turnout in elections of health district boards is very low, which suggests that electing board members has not been a particularly effective means for increasing citizen participation. Low voter turnout may mean that the public does not perceive districts to be important or worth getting involved in.

On the other hand, there are examples of health districts having made significant strides in involving the public in district decision-making, quite apart from the process of electing board members (Lewis, et al., 2001). Different districts have experimented with a variety of techniques to engage the public in the work of the district: public meetings, annual reports in the local newspaper, citizen access to the members of the district board and board meetings, among others. And there are examples in other provinces and around the world of local authorities that have had considerable success in engaging the public in decision-making on health care. Public health panels and citizen juries in the United Kingdom (Mort, et al., 1999), referenda in Oregon (Ham, 1998), and planning cells in Germany (Dienel, 1999), show promise as a way of engaging the public about health and health care. Moreover, these more elaborate tools of engagement are often useful in encouraging citizens to confront the fact that the “solution” to the “problem” of health care must be more than simply a call to defend the status quo or a call for “more” - more doctors, more nurses, more money (Bowling, 1996).

Many of these forms of citizen involvement are being implemented in jurisdictions with populations much larger than most Saskatchewan health districts. A small population size is one way of encouraging public participation, but it is by no means a guarantee. There is considerable evidence to suggest that larger districts can find ways to engage the public about how health services can and should be delivered.



Why 9 to 11 Health Districts?

Though the Commission heard a strong consensus that the number of health districts should be reduced, there was little agreement about what that number should be. The Commission recommends six to eight districts in the southern part of the province. As a result of this recommendation, not only would districts have larger populations, be better able to co-ordinate service delivery, and recruit top flight managers, but:

- Each district would include at least one Tertiary or Regional Hospital based on the recommendations contained in Chapter Two.
- Each district would be large enough to deliver primary health, hospital, and community services. There would no longer be a need for multi-district service areas.

Given the sheer geographic size and small population of Northern Saskatchewan, as well as the challenges associated with delivering health services to such a dispersed and culturally distinct populations, the Commission recommends that the two existing districts in the North and the Athabasca Health Authority be retained.

In addition, to keep the legislative and legal complexities of the transition to a minimum, the Commission also recommends that the new districts should be amalgamations of existing districts rather than entirely redrawing boundaries. Please refer to Appendix C for examples of two possible configurations for a smaller number of health districts.

Clarify Roles And Responsibilities

The Health Districts Act and the associated accountability framework document (Saskatchewan Health, 1995), jointly developed by health districts and Saskatchewan Health, both assume a relationship between the two parties based on equality and partnership. However, districts and government are neither equal nor are they real partners (McIntosh, 2001).

First, the people of Saskatchewan hold the Minister of Health and the Government accountable for most of what happens in the health system. To some extent, in a province of only a million people, this is not surprising. However, this is inconsistent with the notion of districts and government as equal partners.

Second, to better coordinate the health service delivery system, the Minister and the Government have intervened in the internal workings of districts. Some of this intervention has been appropriate:

- When districts developed larger deficits;
- When coordination between districts has broken down;

- When targeted funding outside the needs-based funding formula was required to pursue certain provincial priorities (e.g. waiting lists).

In other cases, the intervention has been inappropriate (or at the very least controversial). For example, in an effort to optimize the delivery of services and live within their budget, districts have sought to close or convert facilities – obviously controversial decisions. In such cases, it is inappropriate for the Minister to intervene, except if the local decision had been shown to have a negative system-wide impact. Either the districts have authority, or they don't. This confusion has been at the heart of tensions between the districts and government (Lomas, et al., 1997; Lewis, et al., 2000).

The result is that, today, the division of responsibility between health districts and the provincial government is by no means clear. And if the districts and the government are not clear about who is responsible for what, we can hardly expect the general public to understand the respective roles and responsibilities either. (If the public perceives

“The existing service areas do not work at all. There is too much competition between the districts in our service area”

(Public Dialogue, 2000).

“It currently appears to be the government’s position that it should have the power to effect its own chosen solution at the local level in response to direct complaints by citizens and health workers.”

(Saskatchewan Association of Health Services Organizations, Submission to the Commission on Medicare, 2000).



that Government is primarily responsible for decisions, this may account for the low voter turnout in district board elections). One of the results is that even more issues are referred to the Minister for resolution, even though they could better be handled at a district level.

A clear and workable set of rules and division of authority are needed to achieve system goals. The Government of Saskatchewan must provide overall planning and leadership to the health districts. The coordinated specialized service delivery model outlined in Chapter Two requires extensive cooperation between districts. The network of Primary Health Services outlined in Chapter One will require extensive leadership and direction from the provincial government. The recommendations

later in this chapter with respect to a coordinated Health Human Resources Strategy will, of necessity, constrain the autonomy of health districts. Above all else, the districts and the Government must develop mutual respect for their respective roles and authority.

After the move to a smaller number of districts, one of the first tasks will be to develop a new accountability framework that balances a stronger central planning role for Saskatchewan Health with delegating authority to the districts to organize and deliver the services. This can be achieved by a commitment from Government to revise the *Framework of Accountability* and by modification of the funding formula through which tax money is allocated to districts.

How a New Relationship Between Districts and Government Might Look

Selected Roles and Responsibilities for the Delivery of Primary Health Services

Provincial Government

Districts

Consultation

- Set a policy framework for primary health service reform
- Define how physicians and other providers are to be integrated into district operations
- Set standards

- Decide precisely where Primary Health Teams will be established
- Integrate individual Primary Health Teams into existing district services
- Recruit and pay physicians and other providers
- Manage and evaluate services

Selected Roles and Responsibilities for the Delivery of Specialized Services

Provincial Government

Districts

Consultation

- Determine the location of Tertiary and Regional Hospitals
- Based on the recommendations of the Quality Council, define the services to be provided in each Tertiary and Regional Hospital

- Manage individual hospitals
- Implement and manage the specialized services plan
- Ensure quality of services and reporting in accordance with Quality Council guidelines

Governing the Districts – Elected versus Appointed Boards

The people of Saskatchewan have a right and a responsibility to engage in decision making about the delivery of health services, and to

comment on the future direction of the health system. Indeed, Saskatchewan residents have many opportunities to participate in decision-



making about the health system. Two of the most important are elections to the district board of directors and participating in the public dialogues organized by individual districts.

During the course of its work, the Commission heard a range of views on the merits of electing members of health district boards. A number of people argued that it was fundamentally inconsistent to elect people to the board of a district as long as almost all of the district funds are provided by the Government of Saskatchewan. Opponents of

elected health district boards also cited the very low turnout in recent elections. For example, in the last round of elections in 1999, the average participation rate was 10.2% with a high of 52% in the North Valley health district and a low of 4% in the Saskatoon health district.

Others argued that all the members of a health district board should be elected. In order to address the low participation rate, many have argued that the elections for health district boards should be held on the same three year cycle as municipal and school board elections.

“One of the major challenges faced by regional boards is to confront provider interests, such as pay levels, working conditions and work location, when they conflict with community or provincial government objectives. Putting health care providers on boards may add opportunities for them to resist change when such inevitable confrontations arise”

(Lomas, 2001, p.356).

“The district health board system is an excellent model for ensuring citizen participation in the planning, governance and delivery of local health services, and this participation needs to be fostered and celebrated...”

...One of the most important components designed to empower and substantiate the concept of community ownership of the district health system, its service directions, programs and practices was the development of an elected district health board system. SAHO believes this system remains the best model to ensure more community involvement in planning and delivering health services...having active community members sitting as representatives on the district health board allows for optimum input in the decision making process”
(Saskatchewan Association of Health Organizations, Submission to the Commission on Medicare, 2000).

Still others argued that the existing system, with a mix of appointed and elected board members works well and should not be changed. Research suggests that, whether elected or appointed, board members have very similar views and behave quite similarly in carrying out their duties as board members (Lomas, et al., 1997; Lewis, et al., 2001).

However, if the very low voter turnout persists, the Government should retain the option of moving to fully appointed boards. The purpose of elected boards is democratic: it allows the people to run for office and to choose their representatives. If many good people refuse to run, and if too few citizens exercise their right to vote, at some point it may be reasonable to look to other mechanisms to foster public participation. However, the experiment is still young, and not every avenue for increasing voter turnout and candidacies has been exhausted.

Whether elected or appointed, some current members of health district boards are employees of the district. This creates a very difficult situation - these board members are often in a conflict of interest when matters come to the board that affects their workplace. The problem will become even more acute when payments to physicians become the responsibility of the health district board, as recommended elsewhere in this report. If practicing physicians continue to serve on health district boards, they will find themselves in a more pointed conflict of interest over the negotiation of physician contracts and the creation of the proposed Primary Health Service Network. Physicians, and other employees, clearly should have access to the board to advance their views and concerns. However, there are other mechanisms to ensure access. It is inappropriate for physicians, or anyone else who is on contract to, or directly employed by, the district to serve on its board.



Aboriginal Governance of Health Services

During the course of its work the Commission heard from the Northern Intertribal Health Authority, the Métis Nation of Saskatchewan, the Federation of Saskatchewan Indian Nations, and other individuals and organizations concerned with health services for Aboriginal peoples in Saskatchewan. The concerns of the Authority were less about ensuring access to state-of-the-art diagnostic technology or life-saving surgery than preventing the need for them. Thus, they emphasized the need for good primary health services, health promotion and disease prevention—many of the issues and concerns discussed elsewhere in this report.

However, the Commission was also told that the current administrative structures often make it harder to deliver much needed services to Aboriginal people across the province, specifically persons living at least part of the time on reserve. First Nations people routinely move back and forth from homes on reserve to the major cities. They travel or relocate to cities and towns seeking medical care and other health services including long term care.

Unfortunately, the administrative structures do not reflect these patterns. Jurisdiction and authority and in some cases responsibility for the actual delivery of services, is divided. The Government of Canada, the Government of Saskatchewan, individual health districts, and individual First Nations are all involved, to varying degrees, in delivering services. Moreover, the federal and provincial governments have adopted policies that sharply distinguish between different kinds of health services and different kinds of individual status and residency.

The result is two or three sometimes quite unconnected service delivery networks:

- The Government of Saskatchewan has invested considerable sums of money into the Saskatchewan Health Information Network

(SHIN), which is, among other things, working on developing an electronic patient record. At the same time the Government of Canada is funding the development of a First Nations Health Information System. Unless these two initiatives are coordinated and integrated to some degree, it will be very difficult, if not impossible, to develop a single electronic patient record for First Nations people living on reserve, even though they make extensive use of health services delivered by the province and health districts.

- First Nations are looking to improve the delivery of Primary Health Services. The federal government allocated \$800 million for primary care reform as part of the agreement signed by First Ministers in September 2000. While 70% of these funds will be transferred directly to the Government of Saskatchewan and other provincial and territorial governments, 30% will be managed centrally by the Federal Government. It is expected that some of these funds will be allocated to primary care reform for First Nations people living on reserve. The risk is that the federal and provincial reform efforts remain uncoordinated, and therefore less effective in meeting the primary health service needs of First Nations people living in Saskatchewan.

In order to begin to improve the coordination and integration of health service delivery for First Nations people, the Commission recommends a structured dialogue involving representatives of First Nations people, and the Federal and Provincial Governments. This dialogue should be focused on how to improve and coordinate the delivery of services. It must be a catalyst for change. It cannot be allowed to get bogged down in issues of jurisdiction. The latter are important, but more pressing is the need to meet the health care needs of First Nations people better, wherever they live and whatever their status.



Human Resources Planning and Management

One of the biggest challenges facing Medicare is the poor morale among staff. These problems are not universal, and there are undoubtedly some dynamic, adaptive organizations that create excellent work environments, despite the stresses of contemporary health care. Nevertheless, many staff members are faced with heavy workloads and overtime, and are consequently less inclined to see the health care sector as an interesting, rewarding, and valuable place to

work. Students may be less attracted to a career in health care due to the perceived pressures and the wider range of career options available these days. Many who do graduate from health science education programs in Saskatchewan often find more attractive offers of employment in other jurisdictions. Some promising trends exist - in recent years more Saskatchewan graduates are staying in the province.

Keeping Graduates at Home

In 1998, the proportion of family medicine residents that chose to stay and practice in Saskatchewan increased sharply to 72% compared to 52% in 1997 and 44% in 1996. The situation continues to improve - 76% of the 1999 family medicine graduates, and 80% of the 2000 graduates remained in the province (Data provided by Saskatchewan Health, 2000).

People are the most important resource of Saskatchewan's health system. Many of the recommendations contained in this report will have an impact on both existing health professionals and on planning for, educating and training future professionals. At the same time, some of the other changes recommended in this report are designed to address the challenges associated with recruiting and retaining health care providers. For example, health care organizations that systematically

emphasize quality are also the best places to work. They respect and maximize the contributions of all staff, they reduce the amount of unnecessary and ineffective work, they reduce error rates, and they produce better outcomes and job satisfaction. Saskatchewan can and will become a "preferred site" to work in if it leads a quality revolution in health care. Service excellence breeds success, and presents no trouble in recruiting and retaining staff.

Health Human Resources Council

The recent creation of the Health Human Resources Council is a positive step toward addressing health human resource issues in a more coordinated and centralized fashion. This is imperative. Health districts simply cannot compete with one another to recruit health professionals, particularly those from outside the province. A coordinated approach to health human resource planning is not unique to Saskatchewan. New Zealand, for example, is also contemplating a country-wide centralized human resource approach (New Zealand Department of Health, 2001).

The Commission views the Health Human Resources Council as an excellent vehicle to bring together knowledge and expertise in health human resources. The Council should have enough resources to conduct research in areas such as scope of practice, education, and magnet environments to name a few. The Council can also study the implications of government policy and planning on human resources in the province. It should also be linked to the national work on health human resource issues.

"Human resources development is one of the most important elements in health systems development. However, it has seldom been included as an integral part of health sector reform which has tended to focus on financing and organizational changes"

(Adams & Hirschfield, 1998, p.30).



Province-wide Health Human Resource Strategy

The Commission suggests that the Government of Saskatchewan, in consultation with health districts and others, develop a health human resource strategy that would include the following components:

Labour Adjustment Strategy

The implementation of a new Primary Health Service model will require the re-deployment and reorganization of existing staff, including those now working in small hospitals. Staff positions for primary care nurses will increase. Nurses who currently have the required qualifications could fill some of the additional positions, while training and hiring strategies will need to be developed to prepare additional staff. However, new measures will be required to ensure that health workers are not adversely affected by the changes. There is ample need

for all health care workers currently in the system, and every effort to retrain or relocate should be made, rather than losing the people currently employed.

The Primary Health Service model is built on the principle of making the best use of the skills and training of all members of the team. Successful implementation of the model could easily be thwarted by professional turf protection and inflexible collective agreements. The system must respect and make the best use of all personnel, while unions and professional associations will have to be creative and flexible partners in building a better workplace. All parties will have to redefine their interests and adopt a more collaborative and service-oriented perspective.

We Cannot “Widgetize” Health Care Workers

“... we mustn’t ‘widgetize’ the health care worker’. Teams will need to have complementary skills, learn how to self-manage, and teach patients how to self-manage” (Canadian Health Services Research Foundation, 2000, p. 14).

It is also important that the strategy support the training, retraining and hiring of more primary care nurses. In particular, the strategy should address areas where the needs are the greatest. Recruitment and retention of health professionals in the North should be one of the priorities. There are good models in place to ensure greater retention of staff. For example, the RAIN (Recruitment/Retention of American Indians into Nursing) Program at the University of North Dakota has increased the retention rate for nurses by one third. (University of North Dakota, College of Nursing, 2001).

Clearly Communicated Plans for Managing Change in the Labour Force

Clear communication is essential to the successful implementation of many of the recommendations in this report. The x-ray

technician working in the local hospital, the physiotherapist working down the hall, the mental health worker based in the community, and the family physician working from her office in the suburbs must all participate in change. To “bring these people along” will require that Saskatchewan Health partner with the health districts and keep everyone informed about what is happening and why, welcoming and promoting staff participation.

Fostering Healthy Workplaces

Health providers work to maximize the health and well-being of their patients. And, for their part, patients are quite satisfied with the care they receive. Nevertheless, the Commission repeatedly heard that low morale among staff remains a major challenge. Workplaces where workers feel valued and recognized is critical to the improvement of morale and the



assurance that quality health services are being delivered. This will go a long way in retaining staff.

The Nursing Council, an advisory body to Saskatchewan Health, has made good strides in addressing these issues. One of its working groups has begun to explore the concept of a “magnet” environment that attracts and retains health providers and leads to enhanced quality and client outcomes.

Using All Staff to Their Fullest Potential

“Compared to many other countries, Canada lags behind in using health human resources substitution as a policy tool in health care reform. In fact, ‘reverse substitution’ is often practiced in this country. Highly qualified or extensively trained practitioners are taking over functions that have been adequately performed by lower-level personnel” (Health Canada, 1995, p.55).

The Commission heard from providers that their skills were not being used to their fullest potential. A recent study of the health workplace revealed similar concerns. As stated in that report, “[m]ost groups indicated that their members were not utilized to the full extent of their scopes of competencies and that the full use of their skills could result in better patient outcomes and savings to the health system”

(Backman, 2000). There are many opportunities for better use of staff to occur, and some of this is already happening. For example:

- Registered nurses can serve as first assists in surgery rather than relying solely on general practitioners (McGarvey, et al., 2000; Barnes, 2000);
- Licensed practical nurses can administer medications and can be trained to serve as operating room technicians, rather than relying solely on registered nurses (Greenslate & Creehan, 2000; DiSario & Sanowski, 1993; Rubino & Bouchard, 1992);
- Therapy aides can work with patients in doing a range of movement exercises, thereby freeing up the time of physiotherapists who are in short supply (Bashi & Domholdt, 1993).

Making better use of the skills of all health care providers does not mean a reduction in quality. On the contrary, as long as the appropriate training and protocols are in place, the health workplace can be better organized to deliver patient care that is timely, more efficient, and more responsive to the needs of patients.

A Commitment to Research and Education

Recently, we have seen an enormous growth in health-related research in Canada. However, Saskatchewan has not had an easy time keeping pace and, as a result, stands to miss out on significant opportunities. Moreover, our capacity to offer world class research facilities has a major impact on medical education. The ability of our institutions, chief among them the College of Medicine at the University of Saskatchewan, to provide excellence in education and service delivery demands not only a commitment to research, but a hard look at the role of the College and its relationship with the rest of the health care system.

A Commitment to Research

Health research has exploded throughout Canada over the past five years. At the national level, the Canadian Institutes of Health Research (CIHR) and the Canadian Health Services Research Foundation (CHSRF) have created a dramatically new landscape. Provinces, notably Alberta, Quebec, British Columbia and Ontario, invest heavily in health research. The Canadian Foundation for Innovation (CFI) and the Canada Research Chairs program also represent an investment of hundreds of millions of dollars annually in research infrastructure and new researchers, a significant portion of which goes toward the health sector. Total public sector investment in

“Rigidities in collective agreements prevent labour force restructuring and reskilling”

(Institute for Research on Public Policy, 2000a, p.6).



health research will likely double in the next five years.

This is great news for Canada, and potentially a great opportunity for Saskatchewan. However, it also poses some challenges to this province. Among the problems are:

- Saskatchewan is increasingly less competitive in health research. In the early 1980s, for example, the province attracted about 2.5% of Medical Research Council (now the CIHR) funding. In the last competition it received only 0.5% of the open competition grants from the CIHR.
- Saskatchewan researchers tend to be spread very thinly over a large number of areas, partly due to the requirement of staffing a diverse array of fields in support of health science education. The research world has become much more institute, group, and program oriented in the past twenty years. Because we do not have a critical mass of expertise and proven excellence in most areas, we are at a severe disadvantage in both grant competitions and the recruitment and retention of personnel.

The trends suggest that research in the province is at a crisis level, and the gap between Saskatchewan and its neighbours will grow, unless there is a policy backed by funding to reverse the decline. Put more starkly, there is a real danger that Saskatchewan will have no future in health research as scarce talent leaves and new recruits choose more hospitable locations.

Why does this matter? First, at the most basic level, the health science education programs are ultimately unsustainable without the contribution of good researchers. Both the transmission of knowledge and program accreditation increasingly demand a strong research presence. Program reputations are largely built on research, and those with declining reputations tend to spiral downward. Saskatchewan programs continue, for now, to produce high quality graduates, who do well on national examinations, but there is no guarantee that this level of performance will be sustainable.

Second, research is the source of an evidence-based health system. Without adequate local capacity to produce, transmit, and apply research, there is little chance that evidence and analysis will supplant interest groups, tradition, and personal preferences as the bases for policy, practice, and resource allocation. A diverse and well-respected research community creates role models for tomorrow's practitioners, champions the cause of evidence-based decision-making, and adds a powerful voice for improved quality and accountability.

Third, a strategic research program can help solve problems unique to or prominent in the province. For example, Aboriginal health, rural health, and the social determinants of health have obvious and profound relevance to Saskatchewan. While there are pockets of excellence in these areas, achieving world-class levels of activity and accomplishment could result in advances that both improve health and reduce the demands for ineffective services.

Fourth, research should be a major driver of ongoing reform and adaptation in the health system. Saskatchewan has been a leader in structural reform and organization, but it has not excelled in developing quality and performance measures, reducing variations in practice, or transferring clinical and other knowledge to the front lines. Researchers and health science education programs should be incubators of change and leaders in the move toward quality and accountability. Without the progressive mediating presence of the research community, health system debates become political, focused on incomplete information, and needlessly acrimonious.

Given these realities, Saskatchewan has no choice but to make a strong commitment to research. Without such a commitment, the health care system will never achieve the quality to which it should aspire, and evidence-based decision-making will remain an unachieved goal. The education programs will decline in quality and prominence, even to the point of non-viability. Our best and brightest will leave, and prospects for recruiting excellence from other jurisdictions will be poor.



The core elements of a research strategy should include:

- A commitment of at least 1% of the provincial health budget to research (and possibly as much as 1.5% to 2% in the long term). This translates to at least \$20 million annually. These investments can be predicted to attract at least equal amounts in external funding within two to five years.
- A strategic direction that is consistent with the reorientation and revitalization of the health science education programs.
- A strategic focus on areas where Saskatchewan has a comparative advantage. The province has, and should seize upon, the opportunity to become a world leader in Aboriginal and rural health research, education, and delivery. Increased investment in research should be targeted in part to the development of these areas. The constitutional responsibility of the Government of Canada for Aboriginal health could result in partnerships with the federal government in this area.
- A strong emphasis on internal and external partnerships and alliances involving the universities, health districts, HSURC, the Quality Council, and Saskatchewan Health.

To accompany the realignment of health sciences education, the Commission recommends a strong commitment to research funding. Quality health science education programs are unsustainable in today's world without a significant base of research activity. Provinces that fail to invest significantly in health research will be unable to retain and recruit first class faculty, or produce and apply the knowledge that underlies quality service. The Commission recommends, therefore, that the Government should, in the short run, increase its investment in health research to a figure equalling one per cent of its health spending. This greatly expanded research investment should be strategically aligned with the renewed mandate and orientation of the programs.

The Role of the Health Sciences Colleges at the University of Saskatchewan

“In the end our view is the College of Medicine is not only able to be improved, but in fact it must be. The College of Medicine must develop the capacity and resilience to deal with perpetual change in health and the health care delivery system. There is no question that the collective will shall be tested” (Noseworthy, et al., 1998, p.8).

Not only must we confront the challenge of recruiting and retaining health care providers, and building healthy workplaces for them, much needs to be done in the education and training side of things as well. Many of the recommendations in this report will require the support and creativity of leaders in health science education. Reinvigorated and reoriented health science education programs are crucial to the accomplishment of Saskatchewan's collective goals for health services. The needs of the province and its people should strongly (but not exclusively) influence the nature and orientation of the programs, and the choice of priorities for research.

Saskatchewan presents unique challenges and opportunities in service delivery, Aboriginal and rural health. This report recommends Primary Health Service Teams as the focal point for the future, encompassing prevention, health promotion, and the continuum of care. A focus on these challenges, and the pursuit of excellence in both research and service delivery, should forge the identity of health science education in the province. All health science education programs should be training graduates to work in these settings and to function more effectively as teams.

There are six different health sciences Colleges at the University of Saskatchewan. Of these, the College of Medicine is most often cited for review and change. In the last twelve years, the College of Medicine has been subject to two comprehensive and thoughtful reviews: White in 1989 and Noseworthy et al. in 1999. Each raised serious concerns about the sustainability of the College and interpretation



of its mandate. Each also noted the opportunities available to the College, given greater focus and commitment in a number of key areas. The Commission supports the work currently underway to implement some of the changes recommended in the Noseworthy report.

The relationship between Saskatoon District Health (SDH) and the College of Medicine has been the subject of much debate. The tensions between them are chronic and serious. A constructive partnership must recognize two fundamental realities: first, educational requirements must not compromise equitable and reliable service delivery; and second, the service environment must be hospitable to first-class educational and research opportunities. How this partnership can be restored is not the purview of this report. However, one proposed solution - placing

Royal University Hospital (RUH) under the authority of the College of Medicine - would be counterproductive. RUH is not only an academic institution; it is a pivotal link in the tertiary service delivery system for the province.

In the interests of striking the right balance between service and education objectives, the Commission proposes the transformation of SDH into an academic health science centre. Educational requirements would be acknowledged as central to the mission of SDH, which will work with other health districts to fulfil service, education and research mandates across the province. At the same time, the College must not have a monopoly of power over any part of the service sector. The government should no longer fund the College directly for clinical service, but should flow these funds through SDH.

“The point is, health care is a shared responsibility, a partnership of many agencies. To plan wisely and effectively for Saskatchewan’s future, all concerned must understand the role each is expected to play and be provided the resources necessary to carry out that role. In other words, the terms of the social contract must be clear...”

(White, 1989, p.7).

Information Management

In today’s world, information drives quality, effectiveness, and efficiency. The more complex and multi-faceted the system, the greater the management challenge. Health care is often described as the most complex system in the world, yet we run it with inadequate information. The results of this neglect are profound, including:

- A poor understanding of how the system and its parts perform in terms of outcome, efficiency, and avoidable error;
- A lack of real-time information accessible to providers, hampering their ability to deliver high quality care;
- Few mechanisms to identify problems and intervene before they become serious and costly;
- Poor information on which to base decisions such as the location of services;
- A tendency to assume that money is the solution to perceived problems rather than other tools to improve performance and accountability;

- A tradition of policy-making that is more interest-group-based and responsive than evidence-based;
- A poor historical performance in key areas of health research at least partly owing to inaccessible and/or inadequate data.

Information and Communication Technology

There have been promising developments both provincially and nationally to improve the quality and comprehensiveness of health information and communication technology. The Saskatchewan Health Information Network (SHIN) has a strategic plan for developing an electronic health record and using technologies to facilitate the delivery of services (e.g. Telehealth, Telemedicine). The National Health Infostructure program has created momentum for both developing and standardizing information and enhancing information technologies. SHIN and its sister agencies in other provinces have begun to explore the potential of partnerships to accelerate development and achieve efficiencies.



The Commission strongly endorses a long-range plan for sustained and stable investment in information systems and the accompanying technology. Partnerships with other provinces and leverage of federal government funding for accelerated development should be vigorously pursued.

In addition to the information system components and technology initiatives already underway, a focus on quality and accountability will require complementary measures. Among the core elements essential to the achievement of quality and accountability is the development of an electronic health record.

Electronic Health Record

The electronic health record (EHR) is the cornerstone of an efficient and responsive health care delivery system, quality improvement and accountability. Without it the prospects for a patient-friendly health system, optimal teamwork, and efficiency are dim. An EHR is essential if the Primary Health Service Networks described in Chapter One are to be realized. Therefore, the Commission recommends further development of an electronic health record.

In implementing such a record of health information the protection of privacy must not be compromised. Fortunately, an electronic health record is far easier to protect than a manual one. Furthermore, encryption technology and well-developed professional and health research ethics processes can virtually guarantee protection by ensuring that access is on a “need to know” basis for practitioners, and records used for research purposes are stripped of personal identifiers. On those few occasions when confidentiality has been violated, human error, and not the design of health records, resulted in the inappropriate identification of an individual

case. There have been no Canadian incidents of any violation of confidentiality or privacy arising from research or analysis. Finally, the Government of Saskatchewan is about to proclaim *The Health Information Protection Act (HIPA)*. This legislation provides protection for privacy of personal health information, while still ensuring that information is available, as needed, to monitor, evaluate and improve the health system in Saskatchewan. The protections afforded by HIPA would, of course, apply to any electronic health record.

The benefits of an EHR include:

- Information accessible to providers regardless of wherever and whenever the person is obtaining services;
- Diagnostic tests and interviews do not have to be repeated;
- In complex cases, members of the care team have access to the information they need to ensure that the care is complementary and seamless;
- Individuals do not have to worry about carrying with them or transferring information to obtain service, reducing the need for rescheduling, and explaining the same things to many people;
- There can be up-to-the-minute analysis of which interventions are successful and which less so, ensuring that all people receive the best quality therapies and providing performance feedback to health care personnel and facilities;
- Evidence is available to describe services, to make decisions, respond to current needs, predict future trends and contribute to reforming health services.



Recommendation in Support of Change

To support the proposed changes to the health system in Saskatchewan, the Commission on Medicare recommends:

- **9 to 11 health districts, and clarification of their relationship to the Government of Saskatchewan;**
- **A structured dialogue on the delivery of health services to Aboriginal people;**
- **Co-ordinated human resources planning and management on a provincial basis;**
- **The renewal of health science education programs, including increased funding for health research, equalling 1% of public health spending; and,**
- **Investments in information systems including the development of an Electronic Health Record.**

Key Points

- Health district boards constituted by a combination of elected and appointed members.
- Persons having a salaried or contractual relationship with a health district prohibited from standing for election to a Board or from being appointed to the Board.
- Strengthening of the recently created Health Human Resources Council.
- The development of a province-wide health human resource strategy.
- Funding for clinical services offered by staff of the College of Medicine, funded by the Government of Saskatchewan via Saskatoon District Health.



CHAPTER SIX:
PAYING THE BILLS

Recommendation

To ensure the sustainability of a publicly funded health system, the Commission on Medicare recommends that future investments be directed to:

- Changing the organization and delivery of primary and specialized services;
- Enhancing the overall health of the population;
- Research to support health services education, and to develop and report on performance measures, service quality and value for money; and,
- Managing change and creating a quality-oriented health services culture.

Introduction

Money is the grist for the health care mill. How much money should we spend on health care? This question has dominated the agenda for decades. To address this question this chapter is structured around a series of closely related questions and arguments.

- Has funding for health care been reduced?
- Are we getting value for money in health care today? Is there enough service in Saskatchewan? Is more health care spending required to meet the needs of an aging population? Does quality improvement require more money?
- The significant costs of the **existing** health service delivery system in Saskatchewan and the costs of an investment in **change**; and finally, irrespective of how much,
- How should we pay for health services?

Health Funding Reductions: Fact or Fiction

Through periods of growth and restraint, general economic optimism and pessimism, and varying levels of public concern about health care, one theme remains constant: there is never enough money. In the 1970s and 1980s, if governments even thought to reduce the rate of growth in health care expenditures, there was always an opponent to promise more. Sobered by mounting debt and balanced budget expectations in the 1990s, politicians were not so quick to promise more cash, but many provider and advocacy groups could reliably be called upon to foretell the dire consequences of a slow - or no - growth scenario. For four years in the mid-1990s

health care expenditures in Canada actually declined at a rate of 0.6% a year, taking inflation and population growth into account. The restraint ended resoundingly in 1999. The Canadian Institute for Health Information (CIHI) suggests that, after inflation, health spending nationally grew by 4.4% in 1999 and another 4.9% in 2000. In Saskatchewan, health spending is estimated by CIHI to have grown by 7.0% in 1999 and 3.1% in 2000. We have now had four consecutive years of major expenditure increases, yet many continue to believe that the system is under funded (Merck Frosst Canada, et al., 2000).



Poor organization, weak accountability, and especially the lack of quality and fairness-not money - are the main shortcomings of the health care system. This is why these are the central preoccupations of this report. However, no review of the health system can be silent on whether the current budget is adequate.

The question of how much money is required is addressed later in this chapter. First, we need to consider the broader question of whether the health system needs a major investment of new cash to make things better. In other words, should we invest in a bigger or different ship?

Our Health System is an Economic Asset

“...I believe it is high time that we in the private sector went on record to make the case that Canada’s health care system is an economic asset, not a burden, one that today, more than ever, our country dare not lose.” (A. Charles Baillie, Chairman and CEO, TD Bank, 1999).

According to a recent study, 96% of physicians do not have accurate information on what drugs their patients are taking

(National Post, 2001).

Questions For Consideration

Before we conclude that more money is required for the health system careful consideration should be given to the following questions:

Are We Getting Value for Money in Health Care Today?

Here it is useful to observe the health care system more closely. The claim that it must have more money to do more good assumes that all of the money is being spent well. That would mean that it does nothing known to be harmful or useless, allocates resources to where the benefits will be greatest, and encourages prudent use of resources by both providers and the public. None of these conditions is optimally met, as elaborated below. This is lamentable: public funds are being wasted, often in large quantities, at the same time as some people are truly suffering for want of access to timely, quality services. The positive aspect is the opportunity to improve health care without perpetually spending more money, while simultaneously pursuing a broader and more effective health agenda.

No system as complex as health care can operate with perfect efficiency. However before we decide to spend more money on health services, there are many things we could do to ensure we are getting good value for what we’re already spending.

- We continue to use many of our hospital beds for non-acute care (HSURC, 1994, 1998, 2000; CIHI, 2000d). This is neither good for patients nor efficient. Saskatchewan spends considerably less on home care than other provinces, which may compound the problem.
- There is solid evidence from Ontario (Anderson, et al., 1997) and Quebec (Tamblyn, et al. 1997) that we prescribe drugs poorly. Antibiotics are often prescribed for viruses, where they are totally ineffective. An estimated 20% of elderly admissions to hospital are associated with an adverse drug reaction (Canadian Medical Association, 1993). Evidence from Ontario and British Columbia suggests that expensive drugs are routinely prescribed when cheaper drugs will do (Institute for Clinical Evaluative Sciences, 1994).
- Front-line services are still organized in a traditional fashion. As discussed elsewhere in this report, there are still many solo physician practices struggling to provide coverage and continuity of care. Few of the province’s trained advanced clinical nurses are making full use of their skills. Doctors do many things nurses can do, and nurses do many things aides can do. The division of labour is inflexible and inefficient.



Professions fight over turf and the public pays the bills.

- Many obsolete practices persist despite evidence and guidelines suggesting they be discontinued. Examples are electrocardiograms during a routine checkup in patients without symptoms, routine preoperative chest x-rays on low-risk patients, and routine obstetrical ultrasound in low-risk pregnancies. What is defended as a standard of care may have no scientific basis, yet each procedure costs the public money.
- Hospitals remain open in many communities despite evaluations that they do not benefit the health of their communities (HSURC, 1999). Such facilities cost hundreds of thousands of dollars a year or more.

These problems are not new, there are other examples, and they are all remediable. Their persistence costs us money, quality, and health. Understanding and fixing these problems is critical before we decide whether or not we want to pay more for health care either through increased taxes, or in the form of private payment.

These realities lead to three central observations. First, pouring more money into a system with known inefficiencies will not improve it. Indeed new money may provide yet more excuses for not becoming more efficient. Second, almost all of the inefficiencies described above are also examples of poor quality service. Finally, the programs and services that can alter the determinants of health, particularly for the disadvantaged, are funded from the same government pot as Medicare. More money for an often poorly functioning health care system often means less money for education, job creation, and tax relief, all things that can contribute to improving the health of the people of Saskatchewan. Thus, spending more on the current health care system without addressing its underlying problems would be irresponsible.

Is There Enough Service in Saskatchewan?

Saskatchewan is often thought to have poor

access to health care services because of its remoteness, shortages of specialists, and cyclical economy. Waiting lists for elective procedures are large and growing - over 13,000 in Saskatoon alone in early 2001. Is the province underserved, suggesting a need to invest more in health care?

The facts suggest otherwise. As outlined in Chapter Two, Saskatchewan's utilization rates are typically above the national average and often the highest in the country. This suggests not only that Saskatchewan is well supplied in certain program areas in comparison to other jurisdictions, but also that more money to buy more services will not necessarily resolve accessibility issues.

Is more spending needed for an aging population?

Some analysts and forecasters predict that health care needs and utilization will skyrocket due to an aging population. This claim is repeated regularly in the media and is often assumed by governments and think tanks (Robson, 2001). The evidence available suggests that these scenarios are exaggerated.

The impact of aging per se on health utilization and costs in Canada was shown long ago to be quite small (Barer & Evans, 1987). Recent research from Canada and elsewhere strongly suggests that the elderly are healthier now than decades ago, and tomorrow's elderly are likely to be even healthier (Doblhammer & Kytir, 2001; Khaw, 2000; Manton & Stallard, 1996, 1997; Statistics Canada, 2000). Moreover, patterns of care can change dramatically: hospitalization rates have been declining for thirty years, and long term care institutionalization rates halved between 1981 and 1999. Thus, there is little reason to believe that, on its own, the aging of the population will require a massive infusion of cash into the health system.

Does Quality Improvement Cost More?

Quality improvement saves money in health care, sometimes in the short run, and almost invariably in the long run. All systems, including those that are funded at far lower levels than Saskatchewan's, can and do benefit



from quality improvement initiatives. Systems that commit to quality will become more efficient and free up some of those precious dollars for innovation.

To many this is counterintuitive. Nevertheless, research in the United States and in Canada, cited throughout this report, suggests that savings from quality improvement can be considerable, as high as 30% to 35% (Berwick, 1998). In addition to the examples provided elsewhere in this report, consider:

- Ensuring post-heart-attack patients receive appropriate beta-blockers or aspirin can

prevent a second attack, preserving health and saving thousands of dollars; and,

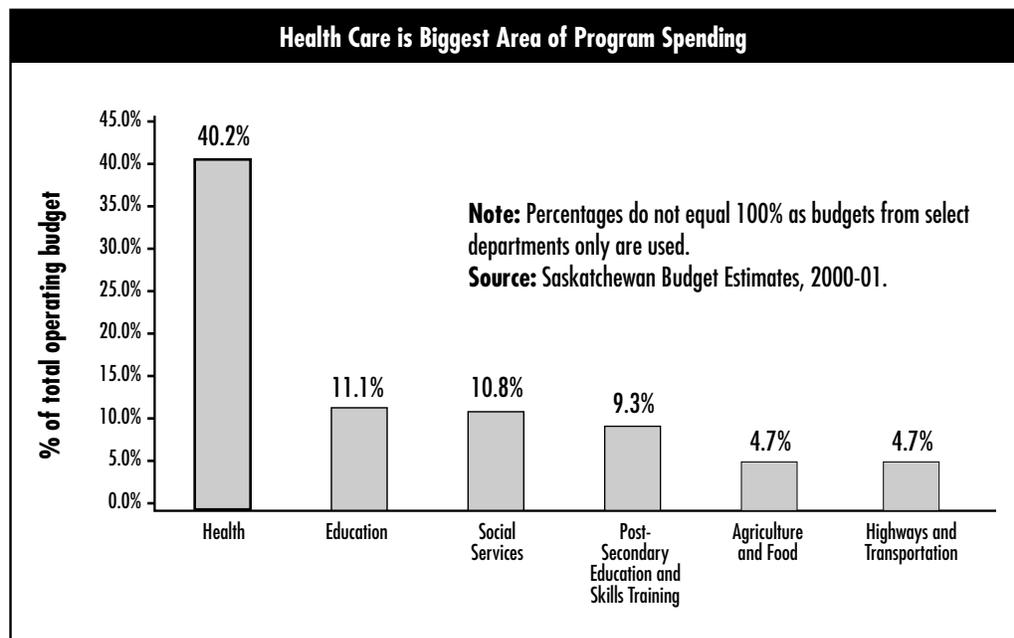
- Controlling cholesterol levels can prevent heart problems. A Saskatchewan analysis revealed that only 25% of patients actually stay on their medications long enough to have a preventive effect (HSURC, 1995).

Of course, some important and useful innovations cost money. But the health care system must look at innovations critically because not all result in better care or quality of life - they are merely new and expensive.

Paying For Today and Investing In Tomorrow

Nobody knows what the health budget “should” be because there is no way to calculate, with precision, what it would take to achieve a wide range of complex goals. However, every year the government must decide, with great precision, how much it will spend on health care. This is art and negotiation, not science.

Moreover, the health budget does not stand alone - its needs and claims compete with other goals and departments. Health expenditures consume the largest part of our provincial budget and far exceed investments in such areas as education, highways, or agriculture.



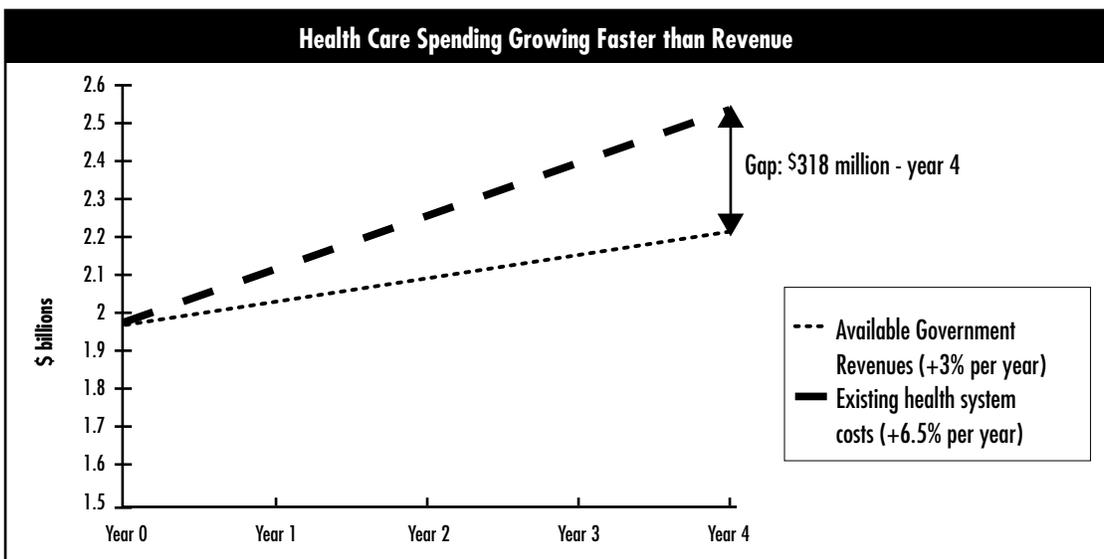
For our purposes here, two issues require elaboration. First, what are the financial realities facing the government and how will they affect the health sector? Second, what funding is required to bring about the core changes recommended in this report?

Funding for the Existing Health Service Delivery System in Saskatchewan

The overall health funding situation is in itself a wake-up call. Simply to maintain health services as they are, with no additional services or personnel, and no new programs, the health budget will have to grow about 6.5% a year merely to cover inflation, collective agreements, and other cost pressures. On the other hand, government

revenues to fund health are estimated to grow by a maximum of 3% per year, which includes the additional \$175 million a year in federal funding the province will receive by 2003-04. The costs to change the health system would be additional to this. Since the province spends 40% of government revenues, a growth rate of 6.5% for health translates into an increase of 2.6% (i.e., 6.5% x .4) for the government as a whole. *That is, the province is already locked into spending almost all if its forecast increase in revenues on health.*

Based on these future costs and revenue estimates, a “health gap” of over \$300M is projected by the end of four years as illustrated below.



Investing in Change

The recommendations contained in this report will in the short run cost several millions of dollars annually. Improving quality and efficiency in the long run requires spending money in the short run. Put another way, only if the system spends more than current levels now will it be possible to moderate the increases in future expenditures in the future and achieve a sustainable health system.

The essential core investments are:

- Primary Health Services Network (Chapter One);
- Rationalized system of specialized services (Chapter Two);
- Continuing investments in health promotion, disease prevention and action on health determinants (Chapter Three);



- Strategic investments in quality - performance measures, Quality Council (Chapter Four); and,
- Carefully targeted investments in health research, information technology, and perhaps most importantly, health human resources (Chapter Five).

What will these changes cost? Preliminary estimates indicate that the incremental costs will be in excess of \$100M at the end of four years although this figure could vary significantly depending on how fast changes are made and how soon they begin to have an impact on costs.

Should the province decide not to make these investments, the health sector will consume ever-higher proportions of the provincial budget. At some point the government will be forced to bring this escalation to a halt if it is to preserve any freedom to support other public policies and programs that contribute to health such as education, economic development and housing. Put another way, a “straight line” projection of no change other than inflationary pressures becomes rapidly unsustainable. That will occur if the quality and performance transition is not made, and when it does, the future cuts can be expected to cause harm and will likely lead to an erosion of the principles of Medicare.

The question then becomes: how can we diminish the rate of increase, and how quickly can we flatten or even reverse the upward trend? In the short run, the answer is clear: it is not possible to reduce health expenditures prior to a major change in culture without throwing the system into yet more turmoil, further eroding public confidence and damaging workforce morale. This lesson was learned the hard way in the 1990s. In the absence of the fundamental quality shift proposed, a failure to fund the system at the projected growth rate for the next few years

will destabilize the system and indiscriminately reduce both needed and unnecessary utilization.

However, there is an optimistic scenario for the future:

- We can have a system of higher quality - producing better outcomes for more people.
- We can have a system that is more efficient - producing clearly defined benefits at lower cost.
- We can have a more innovative system - money saved by eliminating error and faulty processes can be reinvested in proven new technologies.
- An emphasis on Primary Health Services moves the system “upstream”: the rhetoric of prevention becomes the reality, paying the long-promised fiscal dividends.
- The rate of growth and cost pressures will decrease: purchasing and innovation decisions will be more informed; obsolete practices will be more quickly eliminated; personnel will be used more effectively; and people will be healthier and have fewer needs.

Even the best-case scenario will not be immune to fiscal pressures. When, for example, science yields a host of new, effective, but very expensive technologies (e.g. arising from the sequencing of the human genome), society will have to make very difficult decisions, and the sustainability of a tax-based system may be called into question. The prospect of such a choice increases the urgency of implementing the recommendations of this report. The affordability of innovation depends significantly on whether we are able to wring the poor quality and its attendant inefficiencies out of the system.

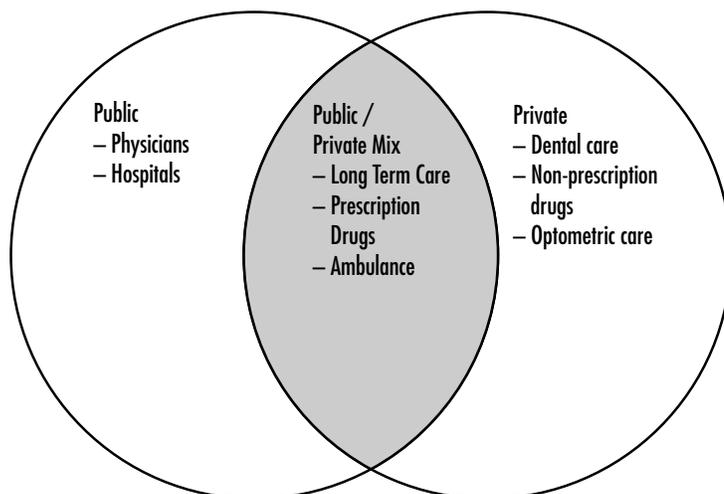


How Should We Fund Health Services?

Given the likelihood that costs, over time, will continue to increase, the question remains, what is the best way to pay for health care?

In Canada we pay for health services in three main ways, as illustrated in the figure below:

Today's Split of Public and Private Funding



These arrangements may be summarized as follows:

- *100% publicly funded:* Hospital and physician services deemed “medically necessary” are provided without charge to an individual, and are paid for by government from general taxation. These services are covered under the *Canada Health Act* and form what is often referred to as Canada’s “single tier health system”.
- *Mix of public and private funding:* There are a wide range of other programs (home care, long term care, prescription drugs, ambulances) paid largely, but not exclusively, by provincial governments. Some individual or private payment is usually required for these services, and coverage or benefits vary from province to province.

- *Privately funded:* Certain services are paid for mostly, if not exclusively, by individuals or private insurance firms. These include such services as dental care, non-prescription drugs, and optometric care.

Which mechanism works best? It depends, of course on what you want to achieve. If one goal is fairness, to ensure access to services based on need regardless of the ability to pay, 100% public funding is best. If the goal is to keep administration and paperwork costs down, and simplify budgeting and negotiations, again 100% public funding is best. If the goal is to keep government costs as low as possible, private payment and third-party insurance systems are best - though both *increase* service costs and administrative overhead, and *decrease* equity.

A Private Sector View

In a speech to the Vancouver Board of Trade in April 1999, A. Charles Baillie, Chairman and CEO of the TD Bank said: “The fact is, moving away from a single payer publicly funded system might cost **government** less. But it would cost the **country** more.” (Baillie, 1999, emphasis in the original).



Regardless of the payment mechanism, it is ultimately the people's money. The reason why we have chosen a tax-based system for "medically necessary" services is equity: the wealthy and healthy subsidize the poor and the sick, which need and use more services. Nearly 30% of health spending in Canada (but less in Saskatchewan) is paid for privately one way or another. When we resort to private payment, there are far more inequities than in the publicly funded domains of hospitals and doctors. Since equity and access are the core principles of Medicare, any proposals to deviate from these principles will compromise what Medicare was intended to be.

There are some non-tax based methods of financing the system that do not, in theory, weaken the equity features of Medicare. They tend to be administratively clumsy; if they truly preserve equity, they amount to a tax without being called a tax (e.g., income-related mandatory premiums or co-payments), and are in this sense a disguise. These options are reviewed in Appendix C to illustrate the possibilities and examine their logic and mechanics. Other measures, such as user fees or point-of-service charges, present issues of

access and equity, and are similarly discussed in Appendix C. In the view of the Commission, unless user fees are substantial, they will provide limited revenue, and if substantial, they will pose a barrier to access, particularly for certain disadvantaged groups.

Some options are discouraged by legislation. The *Canada Health Act* (CHA) requires public funding (called public insurance) of almost all services provided by physicians, and in hospitals. It is silent on other services that collectively comprise about half of all health expenditures. One consequence of the CHA is that it assigns privileged status to physician and hospital services even though as the system evolves, more and more services are appropriately provided elsewhere by others. Many have observed that the CHA is, in this sense, an unintended barrier to change because it creates incentives to continue to serve people in traditional and often inefficient ways to avoid creating a financial barrier to service. Others argue that the CHA is not the problem; it is the failure of the system to measure, monitor, and eliminate the inefficient use of doctors and hospitals, and to remove the incentives that promote illogical behaviours.

Should Public Funding Cover More Services?

During the course of its work the Commission on Medicare heard several calls for an expansion of the services covered by Medicare. Several participants in the public forums and several health care organizations in the province argued that, rather than reducing the scope of publicly funded services, the Government should expand Medicare to include all drug costs, all the costs associated with long term care, travel costs associated with health care, etc.

It is clear that drugs, and other services that are left to the private sector, become commodities subject to marketing, rapidly increasing costs,

and hard-to-control inappropriate utilization. These realities argue in favour of expanding Medicare's scope, and therefore government costs.

On the other hand, this chapter has examined the financial sustainability of the system, the anticipated high rates of expenditure growth in the next few years, and the importance of government retaining the room to invest in programs that will have a more profound impact on the determinants of health, and ultimately population health. These realities argue strongly against expanding coverage.



Is there a solution to this apparent contradiction? Again, the answer lies in the longer term, and is contingent on achieving a performance-oriented quality culture. Without eliminating unnecessary and inefficient utilization, without reforming the delivery of everyday services and without realizing the effects of successful prevention and health enhancing social and economic programs, expanding Medicare will be unaffordable, however desirable it may be. As illustrated in the drug example, even if money were available, it would be imprudent to expand coverage without good mechanisms in place to

achieve value for money. These delays will compromise access based on need, and doctors, hospitals, and nursing homes will have to deal-expensively-with a great deal of preventable breakdown in health.

Thus, expanding public funding would be an investment in quality and performance that can help control growth of health care costs. Achieving a health care system that delivers high quality at lower cost can in time allow for public funding to expand into more parts of the system. This is the performance dividend to which the system should aspire.

Conclusion

Health care is expensive. It will get more expensive before it gets more efficient. Every delay in starting the cultural transformation towards a quality-based system will compound current and future problems. Unless the Government increases spending in the next few years, it may compromise equity or destabilize the system even further. However, new funding must buy change, not time, and must buy quality not merely more volume. Well-targeted money spent on evidence-based social programs is almost sure to have a greater impact on population health than improving high-tech health care at the margins.

Public financing of insured services remains by far the best method of paying for health care. A tax-based single payer system is fair and decent. Yet, if Medicare is to remain mostly tax financed, more must be done to slow down the growth of spending. Cost containment can best be achieved by changes such as those outlined in this report. Changing the delivery of primary health services, carefully planning the delivery of specialized care, continuing to invest in wellness, and making a commitment to quality improvement are the keys to an effective and sustainable health system.

Recommendation for Paying the Bills

To ensure the sustainability of a publicly funded health system, the Commission on Medicare recommends that future investments be directed to:

- **Changing the organization and delivery of primary and specialized services;**
- **Enhancing the overall health of the population;**
- **Research to support health services education, and to develop and report on performance measures, service quality and value for money; and,**
- **Managing change and creating a quality-oriented health services culture.**



CONCLUSION

Some recommendations in this report are neither new or, for many, unexpected. The insights of the public, professional associations, managers and unions are prominently featured in both the analysis and suggestions. It is probably no surprise that I have recommended fewer districts, although the number may be controversial. The emphasis on Primary Health Service Networks, consistent with a growing body of policy recommendations from many jurisdictions, incorporates features particularly tailored for rural Saskatchewan such as a focus on Emergency Medical Services, and Community Care Centres with overnight stay capacity as part of the Network.

I have argued strongly that the problems of Medicare cannot be solved with money alone. Health care workers who feel overwhelmed by demands, who are working longer hours, and who have little time to interact meaningfully with the public and patients often believe that money is the remedy. It has not been in the past, and it will not be in the future, without fundamental system redesign. The utilization data confirm that Saskatchewan residents typically use more services than those in other provinces, sometimes by a huge margin. The system is not short of service, and more service will not eliminate the frustrations. The system needs to be rethought: an “inversion of the pyramid” that focuses on everyday, comprehensive services.

I have also concluded that the quality of services is far short of what it could and should be. This statement is neither an indictment of the people who work in the system nor a criticism of their skills and commitment. Quality is not a problem of individuals; it is a problem of system design – a lesson learned from other industries, and from leaders in quality improvement in health. The irony and tragedy – a death toll of 300 people a year, if we assume the rate of clinical error in the province is the same as it is in the U.S.A. – is that health care is staffed by excellent and highly skilled people whose performance is thwarted by

outmoded design, inadequate information, and perverse incentives. Workers are demoralized because they sense they are on a treadmill. They do not feel a sense of accomplishment, they do not see a way out of the disorder, and they are frustrated by changes over which they have no control.

Research is a pillar of the transformation to a high quality system that is accessible and efficient. A research orientation is essential to a quality system, and to the sustainability of the health science education programs. Evidence-based practice is needed to ensure quality and research is the foundation of evidence. Research-based evidence – not tradition, anecdote, or unsubstantiated opinion – should guide practice and resource allocation.

Poor quality costs more than good quality: this is also a lesson learned both in healthcare, and other industries. Huge gains can accrue from better quality – often in the order of 30% to 35% in the American experience. Reducing error reduces medication-induced illness, readmissions to hospital, missed diagnoses, hours spent deciphering a prescription or chasing down information that should have been on a chart – the list goes on. Based on numerous studies and experiences elsewhere, it is a virtual certainty that quality problems in Saskatchewan cost hundreds of millions of dollars annually, not to mention the adverse effects on people’s health. In health services better costs less.

The establishment of a Quality Council with a broad mandate including standards, analysis, and reporting on performance is vitally important. It has the potential to depoliticize decisions, find creative solutions to long-standing problems, free the public from the tyranny of anecdote and ill-informed opinion about the state of care, and reveal where the system provides value for money and where it does not. It can provide guidance on the acquisition of technology and compare the relative benefits of health and wellness



initiatives and health care. It can both interact with and be a beacon for health science education and research, exposing the province to the best the world has to offer through fellowships, seminars, site visits, visiting scholars, and interactions with other industries. Finally, with a Quality Council, Saskatchewan will lead the country in the pursuit of a quality culture that will be the next great revolution in health care.

Saskatchewan cannot afford to lag behind, or even be in the middle of the pack, in terms of fundamental change. Both its geography and its demography are challenging. Other provinces are materially richer, and their health science education programs are not in danger. Saskatchewan can neither buy its way out of personnel shortages nor reduce the exodus of professionals by matching the increases of richer provinces. Saskatchewan's comparative advantage must be in creating a better-designed system that gives workers a sense of pride, accomplishment, and the freedom to use all of their talents. A renewed Primary Health Network, a modernized, team approach to service, a quality orientation, and a commitment to research collectively create this advantage.

For a social program like Medicare to succeed, all parties must honour the implicit terms and conditions of the social contract that underlies it. Health workers must help create incentives that reward good practice, abandon obsolete practices, pursue innovation, temper their enthusiasm for unproven technologies, and realign the division of labour. Governments must report to the public about system performance, ensure accountability for the quality of the services provided, and resist promising more than can be reasonably expected. The public must demand quality, prudently use the system, and pay attention to value for money, so that other societal needs can be met.

All parties have, to varying degrees, underestimated the fragility of Medicare and have focused on their own entitlements rather than their obligations. There are no villains in the piece; it has been a collective loosening of our grip on the terms and conditions of a sustainable system. There are many recommendations in this report about structure,

organization, quality, and standards. Success will follow only if there is a change in perspective, behaviour, and rhetoric.

I grew up and worked most of my career in Saskatchewan and return to it often. I cannot help but observe that both provincial universities are at the bottom of their categories in the Maclean's rankings. These are the institutions that in large measure hold the keys to the future of the province. I see how hard it is to maintain a vast network of paved highways – more mileage than Quebec or Alberta. I see the way the international market has ravaged the agricultural economy. I see the numbers of talented young people working in other provinces, with more leaving than coming. And to the west is Alberta, whose current annual 'bonus' from oil and gas royalties exceeds the entire provincial budget of Saskatchewan. Alberta will be debt free in under two years while Saskatchewan still staggers under an \$11 billion burden. There are both internal and external threats to prosperity, and as always, Saskatchewan people will have to face them shrewdly and competitively.

I am recommending that additional funds be added to promote the transformation to a new system. I am, however advising against increasing health care funding, either in the form of higher taxes or through premiums or user charges, to prop up the status quo. Funding should not be added to the base of the current system except to honour current contractual obligations to health workers.

I am optimistic about the future of Medicare in Saskatchewan because of the province's track record in facing difficult times. The province is justly renowned as a leader in public policy development and public administration. Its history of vision and commitment has changed the Canadian landscape. A small province can change with more agility than a larger one. Social capital and community action are staples of Saskatchewan life. Given its geographic and economic challenges, the province must live on the edge of innovation to thrive. Saskatchewan has been a leader before; it can and must be a leader now. If it can achieve a just and fair modernization of Medicare, it will have created a legacy not only for its own future, but also for the nation's – again.



APPENDIX A:
***THE COMMISSION
ON MEDICARE***

- Commissioner Kenneth J. Fyke
- Commission Staff and Consultants
- Terms of Reference



APPENDIX A:

THE COMMISSION ON MEDICARE

Commissioner Kenneth J. Fyke

Mr. Fyke currently provides consultative services in the areas of public policy and operational reviews within the health services sector. He has contributed to health services restructuring in the cities of Calgary, Toronto and Regina. In 1999, he led a team of Canadian health professionals, to review the health services in Abu Dhabi, United Arab Emirates.

Ken has over 35 years of experience in senior administrative positions in the Canadian health field. He is the founding Chair of the Board of Directors, Canadian Blood Services (CBS), a new agency responsible for providing Canadians with safe blood and blood products. He is a former Deputy Minister of Health in the provinces of Saskatchewan and British Columbia, working with governments lead by numerous political parties. He was the first President and Chief Executive Officer of the Greater Victoria Hospital Society, one of Canada's earliest amalgamated hospital systems (1984). He was also the first Chief Executive Officer of the Capital Health Region in Victoria, where he developed a regional-integrated health service (1996).

Ken was instrumental in the development of the Victoria Health Project, which received national recognition and an international award for its innovations in community based care. He served as a member of the British Columbia Royal Commission on Health Care and Costs (Closer to Home) (1990-91). He has represented Canada at the World Health

Assembly in Geneva, Switzerland and at the Pan-American Health Conference in Washington, D.C.

Ken has appeared before the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women of the House of Commons and the Standing Committee on Social Affairs, Science and Technology of the Senate to discuss reform of the Canadian Health Care System. He is Past-Chair of the Physician Manager Institute Advisory Committee (CCHSE-CMA), and is a former member of the Board of the Canadian Health Services Research Foundation.

Mr. Fyke has a Bachelor of Science in Pharmacy from the University of Saskatchewan and a Master of Health Services Administration from the University of Alberta. He received the Robert Wood Johnson Award for the outstanding graduate in Health Services Administration in 1971. In 1999, he received a Doctor of Laws (LLD), honoris causa from Royal Roads University for his leadership in Canada's health care system. In 2000, he received the Lieutenant Governor's Silver Medal for Excellence in the Public Service (BC).

Mr. Fyke frequently contributes to educational events, has served as a preceptor for students of several universities and has written, spoken and consulted widely on health policy, management and governance issues.



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I would like to thank the Government of Saskatchewan, especially the Departments of Health and Finance, for providing invaluable support throughout the process of writing this report. The individuals who aided Commission staff were very helpful in providing assistance with data requests on very short notice. I would also like to thank Lynda Lee and Jackie Smith for their time and patience in editing the report.



COMMISSION ON MEDICARE
TERMS OF REFERENCE

Values

The people and the Government of Saskatchewan share a profound commitment to a publicly funded, publicly administered health system.

In particular, Saskatchewan is committed to a health system that:

- Embodies the principles of *The Canada Health Act*: Universality, Portability, Accessibility, Comprehensiveness and Public Administration;
- Promotes the collective good and overall health and well being of the population;

- Provides a high standard of quality in the services provided;
- Treats people in a caring and compassionate manner;
- Clearly defines accountability and responsibility;
- Distributes costs in a way that is fair and equitable;
- Ensures access to services based on health need and not on the ability to pay; and,
- Uses public resources effectively.

Mandate

The Commission on Medicare will provide recommendations to the people and the government on the continuation of publicly funded, publicly administered Medicare in a manner that responds to the unique needs of Saskatchewan people, contributes to improved health and well being, and will be sustainable and affordable to citizens over the long term. Within this context, the Commission on Medicare has a three-fold mandate:

- 1. To identify key challenges facing the people of Saskatchewan in reforming and improving Medicare, including but not limited to:**
 - Improving an accessible, equitable, quality health system that serves the collective good of all residents of Saskatchewan;
 - Understanding the effect of changing populations on future health service needs;

- Identifying financial challenges; and,
 - Considering the supply and roles of health care providers.
- 2. To recommend an action plan for delivery of health services across Saskatchewan through a model that is sustainable and embodies the core values of Medicare. This action plan will:**
 - Describe what services are needed, how and where to deliver them, taking into account the health needs of citizens;
 - Balance and integrate services (i.e., prevention and treatment, institutional and community-based care) to improve the health and well being of Saskatchewan residents; and
 - Consider the share of public spending allocated to the health system relative to



other program priorities and health spending as a percentage of the provincial gross domestic product (GDP);

3. To investigate and make recommendations to ensure the long-term stewardship of a publicly funded, publicly administered Medicare system. These recommendations should ensure that we:

- Have an accessible, quality health system for all;
- Consider the appropriate criteria for services to be publicly funded and administered into the future;
- Understand the need to balance health spending with other areas of public investment; and,
- Consider the balance between health services and other underlying factors that contribute to the health of individuals.

So that the people of Saskatchewan have an opportunity to participate in the Commission's work, the Commission shall solicit comment and information from the public and health sector stakeholders.

The Commission will provide the first of its reports to the Premier in the Fall of 2000 on the challenges facing the people of Saskatchewan in reforming and improving Medicare. The Commission will provide a second report to the Premier before the end of 2000 with an action plan for delivery of health services across Saskatchewan, and will provide a final report by the Spring of 2001 on the long-term stewardship of our publicly funded, publicly administered Medicare system.

June 14th, 2000



APPENDIX B:
***SUMMARY OF
RECOMMENDATIONS***



APPENDIX B:

SUMMARY OF RECOMMENDATIONS

Recommendation for Everyday Services

To address everyday health needs, the Commission on Medicare recommends the development of an integrated system for the delivery of primary health services by:

- **Establishing Primary Health Service Teams** bringing together a range of health care providers including family physicians;
- **Integrating individual teams into a Primary Health Network, managed and funded by health districts, which includes enhanced community and emergency services;**
- **Converting many small existing hospitals into Primary Health Centres designed to support Primary Health Teams; and,**
- **Ensuring that comprehensive services are available 24 hours a day, seven days a week, including a telephone advice service.**

Key Points

- Primary health services are the first point of contact and provide the basis to address the main health needs of individuals and communities. They serve to enhance people's physical, mental, emotional and spiritual well being; address the factors which influence health (determinants of health); encompass preventive, promotive, curative, supportive, rehabilitative and palliative services; are provided by a range of providers and are designed and delivered in conjunction with other community service providers and the public.
- Health districts responsible for organizing and managing interdisciplinary, team-based primary health services, including contracting with or otherwise paying family physicians, nurses and the other health professionals.
- Improvements to emergency services including centralized dispatch, higher standards for training, and standardization of fees.
- Services close to home supported by Primary Health Centres, with a system of 25 - 30 Community Care Centres providing respite, convalescent, and palliative care in co-operation with long-term care services.
- Community services networked with Primary Health Service Teams to provide direct service, consult with providers and family members, and improve the client referral process.
- Development of a 24 hour telephone advice system, co-located with emergency dispatch, as back up to the services offered by Primary Health Networks.



Recommendation for Specialized Care

To ensure high quality diagnosis and treatment, the Commission on Medicare recommends the development of a province-wide plan for the location and delivery of specialized services that include:

- Tertiary services delivered in Saskatoon, Regina and Prince Albert;
- A network of 10 to 14 Regional Hospitals to provide basic acute care and emergency services;
- Districts contracting with specialists; and,
- Utilization of beds and resources based on standards established by a Quality Council.

Key Points

- Province-wide planning for acute care and specialized services led by government, including human resource planning, bed management, construction and maintenance of buildings, and purchase and maintenance of equipment.
- Standards for the delivery of specialized services established by Saskatchewan Health based on recommendations from a Quality Council.
- Management of specialist services by districts; specialists on contract to districts.
- Concentration of tertiary services in Regina, Saskatoon and Prince Albert as appropriate to population need. Consolidation of some tertiary services in a single provincial location, or joint planning with other provinces for the delivery of services
- Regional Hospitals in 10 - 14 communities focused on general medical care, incorporating a limited range of commonly needed specialties and drawing upon the expertise of specialists in tertiary centres to develop innovative chronic care and consultation programs.



Recommendation for Making Things Fair

To maximize the health of the people of Saskatchewan, the Commission on Medicare recommends the continuation and/or the development of:

- Public health, health promotion, and disease and injury prevention strategies;
- Regular reports on defined and measurable health goals;
- Strategies to address the broader determinants of health; and,
- A Northern Health Strategy.

Key Points

- Primary Health Service Teams working within broader Primary Health Service Networks to address the population health needs of the people they serve (i.e., prevention of illness and injury and management of chronic conditions).
- Continued emphasis on multisectoral collaboration at the provincial level to improve the health status of the population. Key partnerships between districts and other sectors at the local level.
- Health districts and the health sector as champions and supporters of population health approaches.
- Addressing the unique needs of the North through a Northern Health Strategy.
- Enhanced focus on “upstream” efforts.
- A commitment to develop clearly defined and measurable goals as a standard across the province.



Recommendation for Getting Results

To sustain a quality health system, the Commission on Medicare recommends:

- Continuing development of performance indicators;
- The establishment of a Quality Council;
- Annual reports on the health system; and,
- Incentives and funding to develop accountability and quality.

Key Points

- The ongoing development of performance indicators for the health system in Saskatchewan.
- The creation of a Quality Council with a mandate to improve the quality of health services in the province.
- A redesign of the Annual Reports of Saskatchewan Health and health districts to include a greater emphasis on goals, outcomes, and performance indicators.
- A quality-oriented, accountable, and performance-driven system with the appropriate incentives and funding mechanisms.



Recommendation in Support of Change

To support the proposed changes to the health system in Saskatchewan, the Commission on Medicare recommends:

- **9 to 11 health districts, and clarification of their relationship to the Government of Saskatchewan;**
- **A structured dialogue on the delivery of health services to Aboriginal people;**
- **Co-ordinated human resources planning and management on a provincial basis;**
- **The renewal of health science education programs, including increased funding for health research, equalling 1% of public health spending; and,**
- **Investments in information systems including the development of an Electronic Health Record.**

Key Points

- Health District Boards constituted by a combination of elected and appointed members.
- Persons having a salaried or contractual relationship with a health district prohibited from standing for election to a Board or from being appointed to the Board.
- Strengthening of the recently created Health Human Resources Council.
- The development of a province-wide human resource strategy.
- Funding for clinical services offered by staff of the College of Medicine, funded by the Government of Saskatchewan via Saskatoon District Health.

Recommendation for Paying the Bills

To ensure the sustainability of a publicly funded health system, the Commission on Medicare recommends that future investments be directed to:

- **Changing the organization and delivery of primary and specialized services;**
- **Enhancing the overall health of the population;**
- **Research to support health services education, and to develop and report on performance measures, service quality and value for money; and,**
- **Managing change and creating a quality-oriented health services culture.**



APPENDIX C:
***SUPPLEMENTARY
MATERIALS***

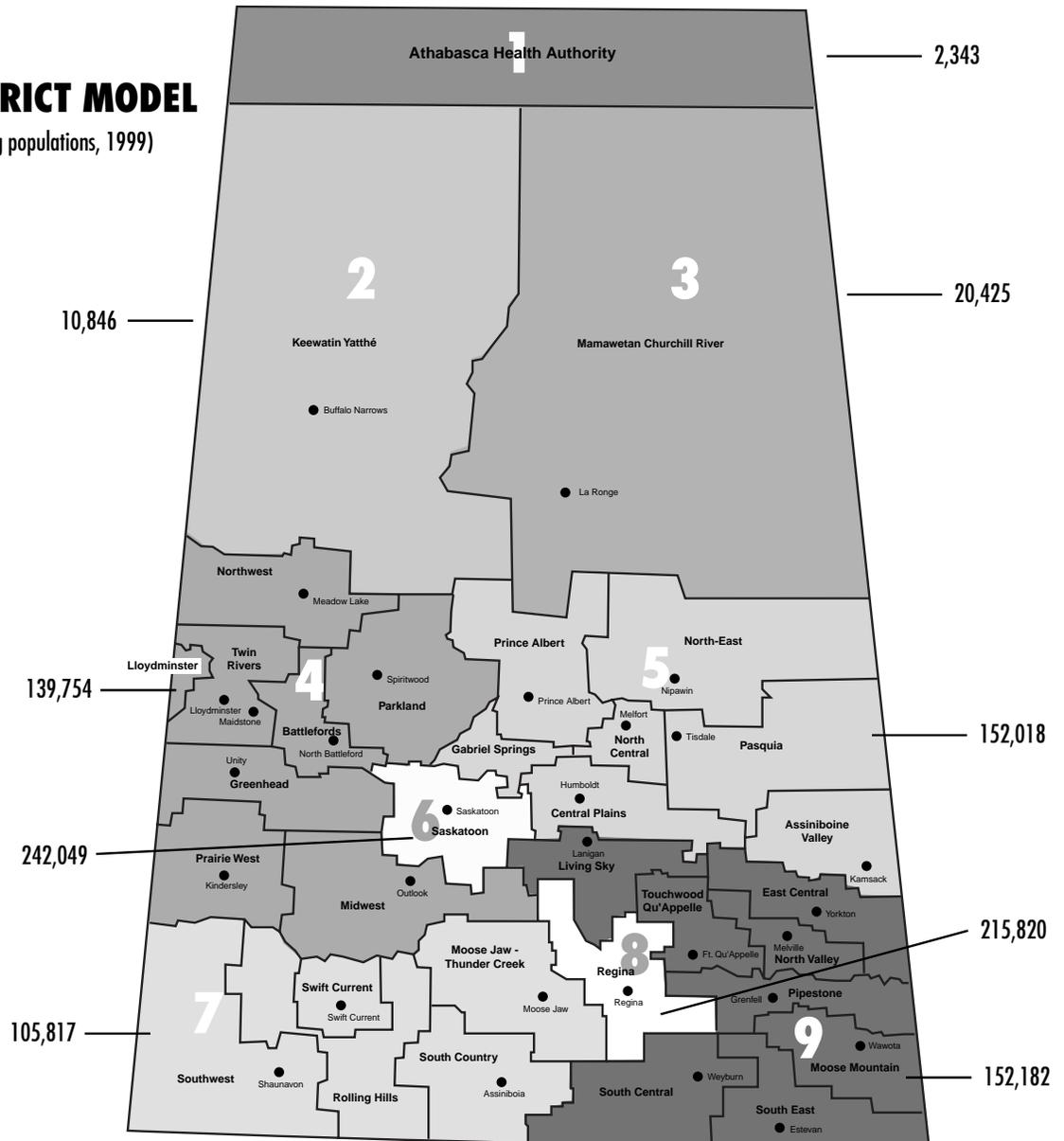
- Two Possible Configurations for a Smaller Number of Health Districts
- Summary of Primary Health Care Developments Across Canada
- Bridging the Cost Gap: Options and Choices
- Service Delivery Model



APPENDIX C:
SUPPLEMENTARY MATERIALS

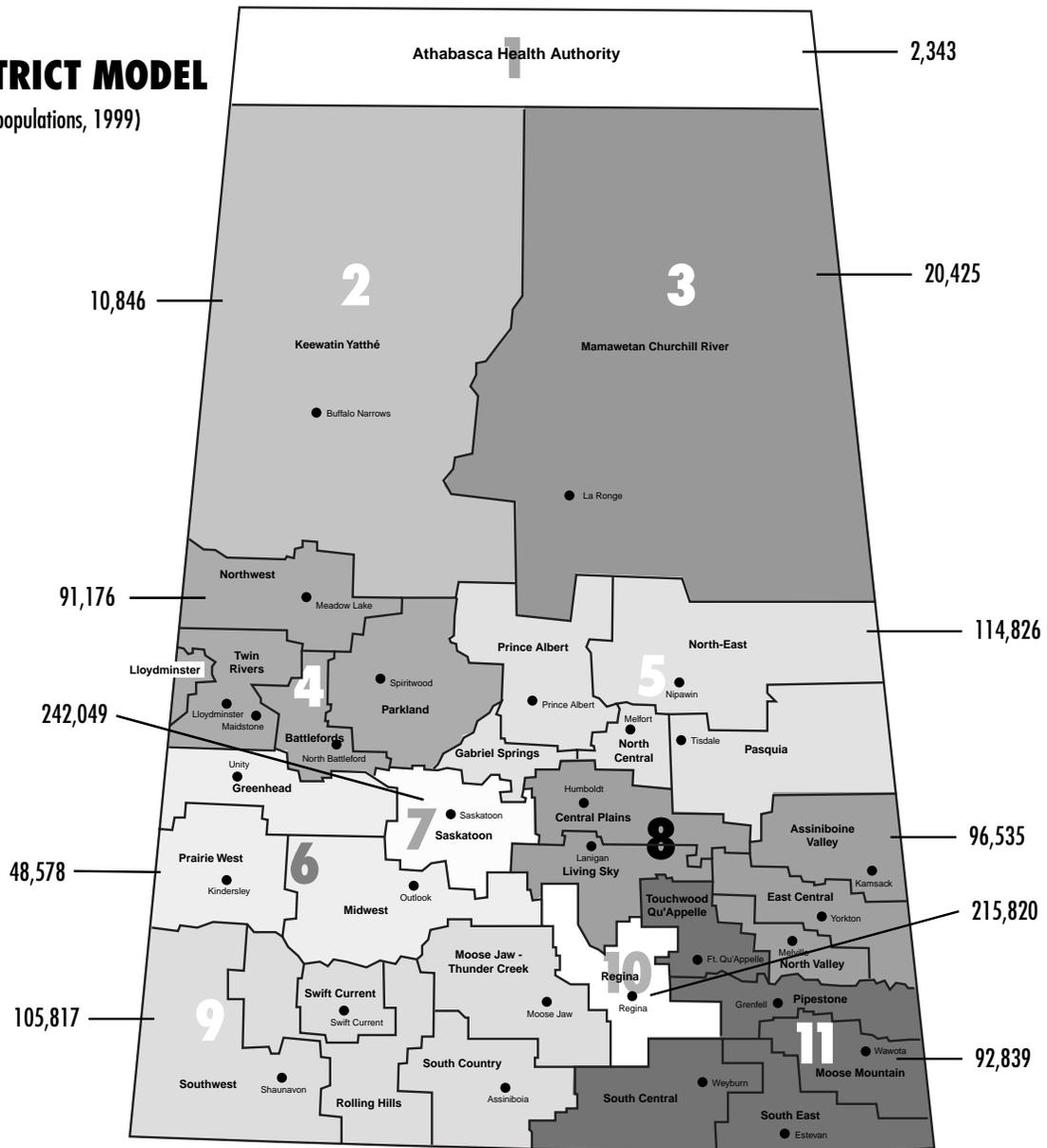
Two Possible Configurations For A Smaller Number of Health Districts

9 DISTRICT MODEL
 (Including populations, 1999)



11 DISTRICT MODEL

(Including populations, 1999)



Summary of Primary Health Care Developments Across Canada

Province	Initiatives	Site Funding	Site operator ¹	Interdisciplinary approach	Nurse in an expanded role	Physician remuneration
Prince Edward Island	1 family practice model	HTF - No Province: Reallocated: Yes New Provincial \$: No	Physician Practice	Yes, linked with other community services; initiative supports collaboration between nurse and physician	No, but has a nurse as part of the team	Contract
Nova Scotia	4 demonstration sites	HTF - Yes Province: Reallocated: No New Provincial \$: No	Physician Practice Community Based Organizations	Yes. Work with members of the interdisciplinary primary care team	Yes	Varies - fee-for-service, capitation, blended capitation, contract/salary
New Brunswick	2 projects	HTF - No Province: Reallocated: Yes New Provincial \$: No	Physician Practice Regional Authorities	Yes. Trying to use a collaborative model to a team approach	No, but has a nurse as part of the team	Fee-for service and blended funding
Newfoundland	4 projects	HTF - Yes Province: Reallocated: Yes New Provincial \$: No	Physician Practice	Yes. Working collaboratively with other health care professionals	Yes	Physicians at sites are either salaried or contract
Quebec	Approximately 150 CLSCs throughout the province	HTF - No Province: Reallocated: Yes New Provincial \$: No	Community Boards	Yes. Broad range of health care professionals working collaboratively	No, but has a nurse as part of the team	Salary
Ontario	7 pilot sites	HTF - Yes Province: Reallocated: Yes New Provincial \$: No	Physician Practice	No. There is minimal opportunity for other health professionals	Yes - five projects funded	Reformed fee-for-service/global contract
Manitoba	11 initiatives	HTF - No Province: Reallocated: Yes New Provincial \$: No	Physician Practice Regional Health Authority	Implementing a multidisciplinary primary care practice	Yes	Contract
Alberta	27 projects (6 PHS sites)	HTF - Yes Province: Reallocated: Yes New Provincial \$: No	Regional Health Authority Community Based Organizations	Developing a multidisciplinary primary care practice	Yes	Varies depending on site - most are salary or contract
British Columbia	7 demonstration sites	HTF - Yes Province: Reallocated: Yes New Provincial \$: No	Regional Practice Regional Health Authority Community Based Organizations	Yes. Broad range of health care professionals. At minimum two other health professionals must be employed as primary care providers	No, but has a nurse as part of the team	Capitation
Saskatchewan	18 sites	HTF - Yes Province: Reallocated: No New Provincial \$: Yes	District Health Board Health Organization College of Medicine	Yes. Links with other community services and other human service sectors such as Education, Social Services, Municipal government, as well as the public.	Yes	Alternate Payment Arrangements (contract, salary)

NOTE: The three territories have not been included in this summary.

Table provided by Saskatchewan Health - August 2000

¹Agency/Group that receives Provincial/Health Transition Funds (HTF) and employs/contracts with a health provider.



BRIDGING THE COST GAP: OPTIONS AND CHOICES

More Money for Health: How Much, How Soon

As described earlier in this Report, the status quo requirements of the existing health system will exceed available resources by over \$300 million by 2004-05 - an amount far surpassing current funding for provincial highways. Expressed another way, an additional \$300 million for health care would require an increase from current revenue of 10 per cent in overall provincial taxes, or 25 per cent in personal income taxes.

This means additional money for the health system, either by massive tax increases or

severe budget restrictions, but only to maintain a system already regarded by some as being under-funded.

In fact, in the face of calls for more spending on health care, there is a range of choices available to the people of Saskatchewan. This appendix is designed to survey briefly these choices and describe their advantages and disadvantages. A more detailed treatment of health funding and financing is presented in the Working Paper of the Commission (Hickey, 2001).

Bridging the Gap: What Choices

Complex situations can often have simple and effective approaches. And for health care, the general approaches are relatively straightforward - bridging the gap may be done by either decreasing expenditures or increasing revenues.

Within these broad approaches, however, a number of specific choices or options exist. Although described separately, the size of the cost gap suggests that any one strategy is unlikely to be successful. A combination of initiatives will therefore represent a more tenable plan.

In general terms, six policy options are available:

1. Make better use of existing resources;
2. Increase share of budget directed to health care;
3. Increase taxes or other revenues;
4. Introduce user charges for services;
5. Decrease insured services and coverage; and,
6. Establish alternate insurance options.

However, these options are by no means equal. This Report argues the following key points:

- Quality and fairness, not money, are the main shortcomings in health care and are hence the central focus of this Report;
- Public financing of insured services is and remains the optimal method of health financing;
- If Medicare is to remain mostly tax financed, and other public services (education, employment, housing) promoting health status preserved, then the current rate of health expenditures needs to be lessened; and,
- Better use of existing resources, and improvements to service quality, can be attained through changes to our primary and specialized health services.

The recommended changes will be controversial and will require a significant initial investment. However, this Report argues that a commitment to quality, accountability and performance is necessary before the public is able to make an informed judgement about whether it wishes to commit more resources to provide more health care.



Better Use of Resources

One frequently mentioned option to reduce health costs is to ensure the proper and appropriate use of current resources - for the health system to be as “efficient” as possible. This is discussed at length in the Report of the Commission, particularly the sections concerning primary health services, specialty services and various initiatives designed to ensure all services are of the highest quality. For example, better use of resources may be attained by:

- Providing for better integration and co-ordination of services through changes in the primary health and specialized service systems;
- Delivering care in less intensive and costly settings but with the same quality outcomes;

- Investing in health prevention and promotion services;
- Using evidence based decision-making, and other health research, to promote good practices and discourage inappropriate activities.

These changes will result in improvements inpatient and provider satisfaction as well as better use of current resources. They will however take time to implement and will assist in, but not close, the cost gap. Further investments will also be required to establish Primary Health Services Networks and Teams. Other revenue or cost reduction options will therefore need to be considered.

Increase Budget Share

Another approach to bridging the cost gap is to increase the share of government operating resources directed to health care - to increase spending on health and decrease spending in other areas such as education, highways or agriculture.

Increasing health expenditures as a proportion of overall government spending is the practice that has been followed over the last 25 years at both the national and provincial level. However, there are two major problems with this approach.

Health is more than health care. By increasing health care expenditures at the expense of other important services, we are in fact mortgaging our future ability to support and provide for good health status and outcomes.

Further, the magnitude and the cost gap is substantial - an amount of \$300 million exceeds the current funding of highways or agriculture. Reducing resources to other provincial services by an amount approximating this anticipated shortfall is neither feasible nor practical.

Increase Taxes For Health Care

A third considered approach for providing more money to health, and reducing or eliminating the forecasted cost gap, is to increase provincial taxes and direct these funds to health care.

This view is reflected by a number of individual responses and submissions received by the Commission. These views expressed a general willingness to pay more for health - whether this be achieved by increasing the

budget share for health care (as discussed in the above section), increasing taxes for the designated purpose of health spending (discussed in this section) or allowing individuals to pay directly for health services (to be discussed in the following section).

Increasing provincial taxes for health care has three general implications. Tax levels have an impact on economic growth, and a competitive tax structure is suggested as important to



future growth in the provincial economy. Additional taxes in support of health care may have the unintended impact of lessening the competitive position of Saskatchewan relative to other jurisdictions, thereby reducing future economic opportunities and presenting problems for the long-term sustainability of a publicly funded health system. Further, relatively high taxation levels pose problems for the recruitment and retention of health and other professionals. Finally, the level of additional tax revenue required to fund future health costs is significant - the example referenced earlier indicated that to provide an additional \$300 million for health care by 2004-05 would require an increase from current revenue of 10 per cent in overall taxes

(sales, tobacco, fuel, etc.), or 25 per cent in personal income taxes.

It may be noted that the Federal Government has made a commitment to add additional money to the financing of provincial social programs, especially health care. The total impact on Saskatchewan is estimated to be an additional \$175 million by 2005-06. It should be recognized that much of this additional federal monies is provided through a block funding arrangement for social programs (includes health, social services and post-secondary education). These additional federal monies are included in the 3 per cent revenue growth forecast.

Introduce User Charges

User charges (also described as direct charges, point-of-service charges) are an additional cost charged for a health service. They have been cited as a means not only of raising revenue for the health sector, but also as a way of discouraging unnecessary use of services and providing priority access to or individual choice of health service. Some respondents to the Commission on Medicare questionnaire indicated a clear desire to pay directly for health services. This is confirmed by a number of national and provincial polls.

A charge of \$2.50 per hospital day was also introduced.

Subsequent research on the Saskatchewan experience concluded that user charges did not result in overall cost reductions but rather, "the effect of the user charge is simply to transfer costs from public to private budgets with the burden of such transfers falling disproportionately on the sicker members of the population." (Barer, 1979). This observation is echoed by other research on the impact of user charges.

In addition to being the birthplace of Medicare, Saskatchewan has experience in the implementation of patient user charges. Residents may recall that during the period 1968 to 1971, Saskatchewan implemented a user fee of \$1.50 for a physician office visit.

In the view of the Commission, unless user charges are substantial, they will provide limited revenue, and if substantial, they will present issues of access and equity.

Decrease Services

Current services or coverage may be decreased as a means to curtail future costs.

Respondents to the Commission on Medicare survey expressed a general opposition to decreasing the number of services covered by Medicare and a similar objection to limiting or restricting the introduction of new technology.

Further, it has been argued that in certain instances, program reductions simply shift costs from the public sector to individuals or employer programs.

As a result, program reductions may be an immediate response to a current problem but are not a viable long-term strategy and,



dependent on the circumstances, may simply result in a cost transfer rather than an overall cost reduction. However, program changes contributing to improved quality and efficiency

of operations as described elsewhere in this Report are a viable means of responding to the financial pressures in the health system.

Implement Insurance Options

A further option to address the gap between costs and revenues in the publicly funded health system is to consider a new arrangement for non-*Canada Health Act* or supplementary health services.

As discussed earlier in the Report, The *Canada Health Act* defines insured services as those delivered in hospitals by physicians, and these services are funded entirely by the government sector through general revenues. Other services are paid for in a myriad of ways - public funding, individual contributions, employer sponsored plans and/or private insurance plans.

Given these different and differing arrangements, one alternative to establish a more integrated arrangement for supplementary health services involving some

combination of public financing and premium payments.

The principles established for a new supplementary insurance arrangement have a significant impact on the characteristics and design of a specific plan. For example, the principle of “universal coverage” if applied to insurance for supplementary health services implies that no resident is under-insured or uninsured. While this may be highly desirable, “universal coverage would mean a more costly insurance package.

The Commission on Medicare initiated a more detailed examination of alternative insurance arrangements for supplementary health services, and the study is included among the working papers of the Commission (Schubert, 2001).

Other Proposals

Other proposals to reduce future health costs were raised with the Commission. Chief among these suggestions was to reduce administrative costs. The Commission found no evidence to suggest that current expenditures on administering and managing the provincial health system were excessive in

comparison to other sectors or to the health sector in other provinces or other countries. Moreover, given the complexity of the system and the substantive recommendations for change advanced by the Commission, a case may be made for more, and not less, administrative and managerial expertise.



Conclusion

In the opinion of the Commission on Medicare, public financing is and remains the preferred and optimal means of funding insured or mandated health services for reasons of equity of access and cost containment. There is however also a need to balance this view with the recognition that our current system includes, and provides for, individual choice and direct payment for a number of other health services (e.g., drugs, ambulance services, long term care).

It is important to remember that health costs are increasing at a rate faster than general government revenue. Should current trends continue, future health expenditures will exceed available resources by a significant and substantial amount. The historical practice of increasing health expenditures at the expense of other important public services is not a feasible, practical or advisable approach.

If Medicare is to remain publicly financed, then the current rate of growth in health

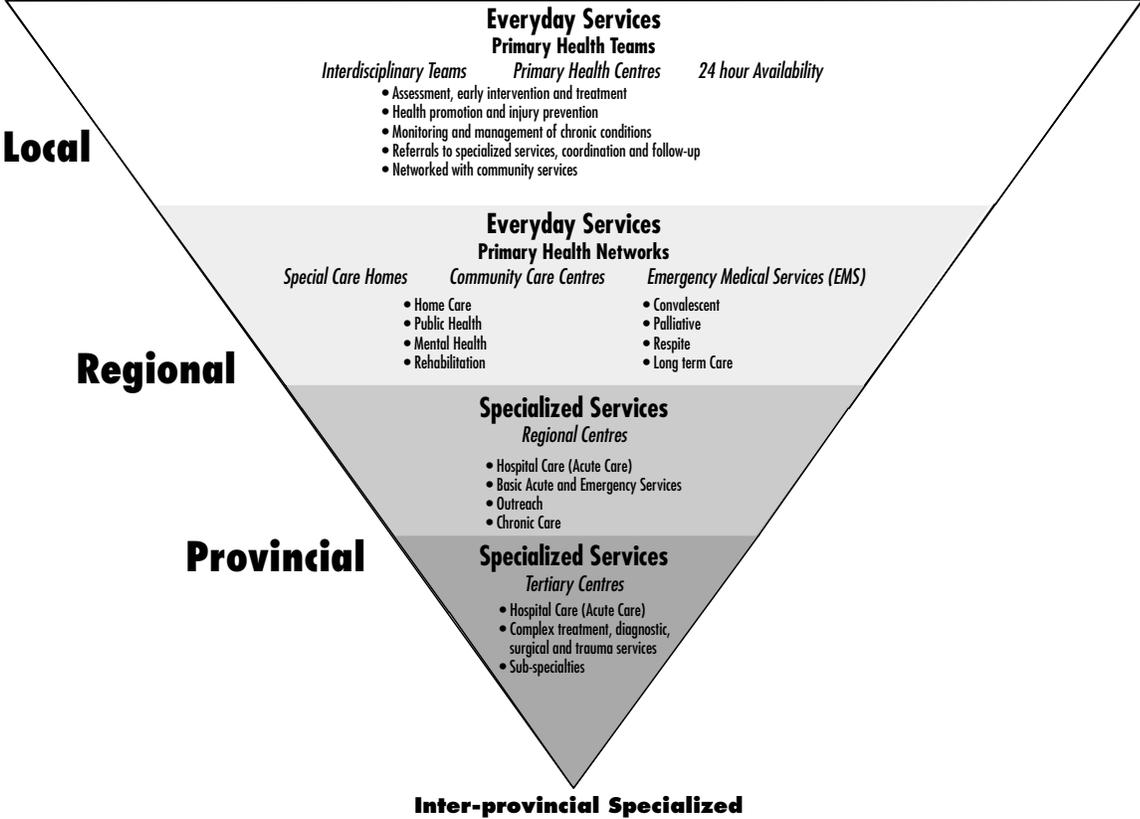
spending needs to be reduced. Moreover, any subsequent increases to the sector need to be compatible and consistent with our future capabilities and capacity as a province. The Commission on Medicare believes that this is best achieved through changes in our primary and specialized care delivery system and other measures aimed at improving the quality and effectiveness of our health service system.

Other options exist to address the issue of health costs, and in many ways, these choices represent less difficult - but ultimately less successful - approaches to the financial challenges ahead. The path proposed by the Commission will involve difficult decisions, a sustained and planned commitment to change over a period of time and the co-operation and assistance of all stakeholders.

It remains to be seen whether these factors critical to success exist and are able to be achieved.



Service Delivery Model



APPENDIX D:

SUMMARY OF PUBLIC DIALOGUE

- Individuals and Groups Who Provided Information to the Commission Through Meetings, Letters and Submissions
- Summary of SCN Forums
- “Caring for Medicare: What Do You Think?” Survey Summary of Responses



APPENDIX D:
**SUMMARY OF
PUBLIC DIALOGUE**

**Individuals and Groups Who Provided Information to the
Commission Through Meetings, Letters and Submissions**

I would like to thank all those who contributed their thoughts on the future of our health care system. Throughout the mandate of the Commission, I also had the opportunity to visit a number of Health Districts, facilities and front line workers around the province. I would like to express my appreciation to those individuals and groups who extended their time and hospitality.

Adams, Duane
Alzheimer's Society of Saskatchewan
Apesland, Warren
Association of Saskatchewan Home
Economists
Atherton, Jack
Atkinson, Michael - *University of
Saskatchewan*

Backman, Allen
Barr, Mary-Jo
Beck, Carol - *Prince Albert Health District*
Blackman, David
Blakeney, Hon. Allan
Bosshard, Marguerite
Bowen Rudy - *University of Saskatchewan*
Bray, Scott
Bulger, Victor

Canadian College of Health Service Executives
Canadian Federation of University Women
Canadian Healthcare Association
Canadian Mental Health Association
Canadian Taxpayers Federation
Canadian Union of Public Employees
Catholic Health Association of Saskatchewan
Chiropractor's Association of Saskatchewan
College of Physicians and Surgeons of
Saskatchewan
Community Health Co-operative Federation
Limited
Conference Board of Canada
Crescent, Robin

Desmarais, Dale

Early Childhood Intervention Program
Saskatchewan Incorporated

Farah, Ahmed Hashi, M.D. - *Association of
Foreign Trained Physicians of Canada,
London, Ontario*

Feather, Joan
Federation of Saskatchewan Indian Nations
Fergusson, Jim - *Saskatoon District Health*
Florizone, Dan - *Moose Jaw Health District*
Findlater, Ross - *Medical Health Officers'
Council of Saskatchewan*

Finley, Sandra
Foley, Dennis
Four Directions Health Centre
Friends & Relatives of People with Mental Illness
Froh, James - *Metis Addictions Council of
Saskatchewan Inc.*

Galen, Peter
Gantfoer, Rod - *Saskatchewan Party*
Gardiner, Nap - *Keewatin Yatthe Health District*
Gelhorn, Don, M.D. - *College of Family
Physicians of Canada*
Gilbert, John
Gow, H. F. M.
Gubbels, Victoria - *Aboriginal Development
Consultant, SAHO*

Health Sciences Association of Saskatchewan
Health Services Utilization and Research
Commission
Heart Health Promotion Group
Hemming, Timothy
Hermanson, Elwin - *Saskatchewan Party*
Hildebrand, Gerry - *South East Health District*
Hjertaas, Paula
Houston, C. Stuart

Institute for Research on Public Policy
Integrated Primary Health Care Working Group



Kent, Tom - *School of Policy Studies, Queens University*

Klippert, Lorne M.D. - *East Central Health District*

Krause, Wally

Lau, Victor

Ledding, M. David, M.D.

Leeson, Ede - *Saskatchewan Association of Licensed Practical Nurses*

Leeson, Howard - *University of Regina*

Leitch, Don - *Moose Jaw-Thunder Creek Health District*

Lesbian Bisexual Gay Health Initiative

Lipon, Shelly - *Saskatchewan Health Information Network*

Maber, Barry M.D. - *Saskatoon District Health*

Macdonald, Georgina - *Athabasca Health Authority*

Mahaffey, Suzanne - *Saskatoon District Health*

Martin, Tom - *Saskatoon Health Oasis*

MacKinnon, Peter Ph.D. - *University of Saskatchewan*

Melenchuk, Jim M.D. - *Minister of Education, Liberal Party of Saskatchewan*

Metis Nation of Saskatchewan

Midwives' Association of Saskatchewan

Migowsky, Jack

Milne, Mary A.

Milton, Gordon - *Herbert Nursing Home Inc.*

Milward, Earl

Morrison, Jean - *Parkland Health District*

Mulhaire, Raymond

Neudorf, Corey M.D. - *Saskatoon District Health*

Northern Health Conference

Northern Inter-Tribal Council

Patient's Rights Association of Saskatchewan Incorporated

Perry, Robert

Pepper, Tom Ph.D.

Perkins, Jean

Phoenix Residential Society

Piepenburg, Roy - *Principal, Liberation Consulting*

Popkin, David M.D. - *College of Medicine, University of Saskatchewan*

Poulin, Louis M.D.

Prince Albert Grand Council

Public Management Development Partnership

Registered Psychiatric Nurses Association of Saskatchewan

Remus, Gail - *College of Nursing, University of Saskatchewan*

Representative Board of Saskatchewan Pharmacists

Reynolds, Millie

Rice, Stan - *Prince Albert Health District*

Roberts, Joe and Shelia

Rolls, Bernice

Romancia, George

Rosenberg, Allan M.D. - *Saskatoon District Health and Saskatchewan College of Medicine*

Saskatchewan Association of Chemical Dependency Workers

Saskatchewan Association of Health Organizations

Saskatchewan Association of Licensed Practical Nurses

Saskatchewan Association of Optometrists

Saskatchewan Association of Rural Municipalities

Saskatchewan Cancer Foundation

Saskatchewan Catholic Health Corporation

Saskatchewan Chiropractic Association

Saskatchewan Council on Disability Issues

Saskatchewan Emergency Medical Services Association

Saskatchewan Government Employees Union

Saskatchewan Government Insurance

Saskatchewan Government Superannuates Association

Saskatchewan Health Coalition

Saskatchewan Heart Health Program

Saskatchewan Instructional Development & Research Unit

Saskatchewan Medical Association

Saskatchewan Nursing Council

Saskatchewan Paramedic Association

Saskatchewan Parks and Recreation Association

Saskatchewan Pharmaceutical Association

Saskatchewan Population Health and Evaluation Research Unit

Saskatchewan Registered Nurses' Association

Saskatchewan Safety Council

Saskatchewan Seniors Association

Incorporated

Saskatchewan Society of Medical Laboratory Technologists



Saskatchewan Society of Occupational Therapists
 Saskatchewan Union of Nurses
 Saskatchewan Urban Municipalities Association
 Saskatchewan Voice of People With Disabilities Incorporated
 Saskatoon Chamber of Commerce
 Saunders, Jim - *Regina Health District*
 Schissel, Bernard - *University of Saskatchewan*
 Service Employees International Union
 Skraba, Charlene - *Rolling Hills Health District*
 Smith, Michael N.
 Smith-Windsor, Gren - *Gabriel Springs Health District*
 Sokaloski, Tom
 Staseson, Sharon
 Stubel, Daryl - *Office of Disability Issues*

Tamara's House: Services for Sexual Abuse Survivors Incorporated
 The Community Cancer Programs Network
 Thomson, Darrell - *British Columbia Medical Association*
 Thornton, K., M.D.
 Toni, Dale - *Moose Jaw-Thunder Creek District Health Board*

Wagner, Susan - *College of Nursing, University of Saskatchewan*
 Weiler, Robert, MD
 White, Gil M.D. - *Department of Family Medicine, Regina General*
 Wiens, Louise - *Mamawetan Churchill River Health District*
 Wood, R., M.D.

Yarske, John - *North Battleford Health District*
 Yeomans, Elaine - *University of Regina Seniors Education Centre*

Zbeetnoff, Peter, M.D.
 van Zyl, C.J., M.D.



SCN Forum Summaries

Shortly after the release of the first report of the Commission on Medicare, “Caring for Medicare: The Challenges Ahead”, two televised forums were held to benchmark public opinion on key health care issues. Drawing on this regionally diverse cross-section of citizens, the dialogue process included small group discussions and problem-solving based on the challenges facing health care in Saskatchewan as discussed in the first report. Within the context of four specified challenges, participants were asked a number

of questions relevant to the future sustainability of health care. These challenges were based on the questions outlined in the first report. They are:

- i. Everyday Services;
- ii. Specialized Care;
- iii. Making Things Fair; and,
- iv. Getting Results.

Facilitators

The Commission would like to extend its appreciation to the following individuals, who served as facilitators at the SCN Forums:

Bahrey, Don
Beattie, Kate
Benoit, Ann
Berg, Lynda
Chase, Myrna
Cleaveley, Julie
Dima, Anda
Dixon, Lois
Dorsch, Helen
Favel, Marie
Feschuk, Sharon
Fisher-Phillips, Heidi
Franc, Lydia
Fredrick, Shannon
Galloway, Dave
Garratt, Sharon
Green, Dianne
Haley-Callaghan, Anne
Halland, Susan
Hamilton, Michelle
Hardie, Maureen
Hunchak, Jackie
Kirtzinger, Brenda

Leischner, Rick
Martin, Bryce
Matheson, Valerie
Morgan, Yvonne
Nolan, Carol
Paidel, Linda
Park, Gloria
Patterson, Rhonda
Petit, Richard
Poirier, Norm
Puritch, Bernice
Renwick, Mary-Kay
Roberts, Melanie
Roy, Louis
Rutherford, Joyce
Schultz, Duane
Shipwich, Gail
Smith-Fehr, Julie
Staseson, Sharon
Stevens, Faye
Warkentin, Ruth
Woods, Ann
Wiebe, Maxine



Consultation with Health Care Providers October 28, 2000 Summary of Participant Views

Consultations were held with over 500 health care professionals at the following sites:

Assiniboia	Moose Jaw
Biggar	Nipawin
Buffalo Narrows	North Battleford
Canora	Prince Albert
Estevan	Regina
Fort Qu'Appelle	Saskatoon
Humboldt	Spiritwood
Kindersley	Swift Current
LaRonge	Tisdale
Lloydminster	Weyburn
Meadow Lake	Whitewood
Melfort	Wynyard
Melville	Yorkton

The general themes of the reports are outlined below, along with some examples of key statements and ideas forwarded to the Commission by an informed and concerned public.

Challenge #1: EVERYDAY SERVICES

Responding to Emergencies:

Should priority be given to keeping hospitals closer together, or should the emphasis on hospitals be reduced and investments be made in improved emergency services?

Responses: While local residents feel more secure with the hospital in place and beds always available, it is important to weigh those benefits against the cost of maintaining small facilities and the concerns about quality of care and ability of staff to maintain competency when some skills are rarely used.

- Concern about ability to recruit physicians for small rural hospitals;

- Need to balance concerns about travel time for local people with the fact that there will be less money available for other important services if small hospitals remain;
- The costs of small rural hospitals are too great for districts to maintain. With high costs and human resources issues, how can we maintain any level of service in small hospitals?

Primary Health Care:

Should we reorganize primary health services using a team approach, or retain current roles and focus on recruiting doctors and nurses?

Responses: The benefits of reorganizing primary health services (described as better use of resources, easier access to services and greater opportunity for improved health outcomes) must be balanced against physician concerns about private practice.

- Increase continuity of care, however potential decrease in client trust because of decreased

physician participation;

- Potential struggle over who is the “head of the team”;
- Current teams are too limited/need to be expanded/need to value all team members - it’s about more than doctors and nurses.



Challenge #2: SPECIALIZED CARE

Distribution of Services:

*Should we improve convenience by providing more services in mid-size centres **or** centralize services in fewer centres to focus on quality?*

Responses: The potential for better access and the benefits to the public of less travel time by decentralizing services were not seen to be enough reason to provide more services in mid-size centres, when balanced against current difficulties in recruiting professionals, the concern with the overall cost and potential for poorer quality services.

- We need a system that coordinates specialist visits so that people can spend a limited amount of time accessing all of the services

they require (e.g. specialists, physical therapist, dietician - similar to Mayo Clinic but publicly funded);

- Although rural Saskatchewan wants specialists in regional areas it is virtually impossible to have trained people in all regions. Specialty services can be provided via linkages to major centres;
- Support for centralizing services in few centres.

Providing Services within Appropriate Timeframes:

*Should we increase resources for diagnosis and surgery such as beds, equipment, training and personnel **or** improve our use of resources by emphasizing prevention, increasing day surgery and developing research-based guidelines for surgery and diagnosis?*

Responses: General support exists for an increased emphasis on prevention and day surgery, with guidelines for surgery and diagnosis. However it was recognized that it will take years to see results, making it more costly in the short term.

- Clinical guidelines need to be enforced;

- Will mean a better use of resources and shorter waiting lists;
- Better screening of patients, but outcomes may be hard to measure;
- Concern with where the money will come from for just increasing resources for beds, equipment, training and personnel.

Challenge #3: MAKING THINGS FAIR

Focus on Prevention:

*Should we give priority to treatment and leave prevention to the individual **or** organize care so that effective prevention and health promotion receive more emphasis?*

Responses: While giving priority to treatment was viewed as “status quo”, inefficient and expensive, there was concern that it requires a well informed public that understands the changes, as well as physician support for change, to achieve the benefits to be obtained by focusing on prevention and promotion.

- General support from virtually all groups for organizing care with a greater emphasis on prevention and health promotion;
- Will result in a healthier population, and reduced hospital visits;
- Could result in a risk of primary needs not being met and less client satisfaction.



Increased Fairness for Disadvantaged Groups:

*Should we organize services to include outreach to senior citizens, poor families and other groups, **or** continue to focus efforts toward individuals when they seek health care services?*

Responses: The advantages gained by using a proactive approach such as outreach services was offset by concerns about the cost of delivering these services given Saskatchewan's geography. Below are some examples of points made at the consultation:

- High risk people fall through the cracks now, however outreach services are costly and time consuming;
- Individuals only come when in crisis;
- Suggest wellness centres and complementary therapies.

Challenge #4: GETTING RESULTS

Health Care Decisions:

*Should we rely on the judgement of health care providers to make decisions independently, accountable to professional organizations and patients, **or** increase accountability of providers through “report cards”, clinical guidelines or other means?*

Responses: There was a lot of support for “report cards” and clinical guidelines, however there must be recognition that health care providers have expertise and can provide benchmarks.

- Concern that relying on independent judgement of health care providers leads to a volume driven system with little continuity of care;
- Not all providers are aware of current research;
- Clinical practice guidelines need to be implemented at the district level.



Public Consultation November 4, 2000 Summary of Participant Views

Consultations were held with approximately 200 members of the public at the following sites:

Canora	Nipawin
Estevan	North Battleford
Humboldt	Prince Albert
Kelvington	Regina
Kindersley	Rosetown
Lloydminster	Saskatoon
Maple Creek	Swift Current
Meadow Lake	Weyburn
Melfort	Yorkton
Moose Jaw	

Challenge #1: EVERYDAY SERVICES

Responding to Emergencies:

Should priority be given to keeping hospitals closer together, or should the emphasis on hospitals be reduced and investments be made in improved emergency services?

Responses: There is recognition that the cost of maintaining small rural hospitals, and the problems associated with recruiting and retaining trained staff are very real. However, while people acknowledged that the security provided by small hospitals is false - some of the groups still expressed fear and concern about the loss of small hospitals. There was significant support for enhancing emergency services in rural Saskatchewan.

- We need improved emergency services and if closing hospitals/setting up health centres is what we have to do to achieve it then so be it. Ambulance services are a MUST;
- Concern that larger centres become remote, posing access problems for the elderly;
- While EMT's may be well qualified, highway conditions & storms affect ambulance services.

Primary Health Care:

Should we reorganize primary health services using a team approach, or retain current roles and focus on recruiting doctors and nurses?

Responses: Almost all groups indicated support for reorganizing primary health services and developing a much stronger team approach to the delivery of health services.

- Support for centralizing doctor services in one office;
- Support but indicated concern about resistance on the part of medical staff;
- Need to shorten nursing shifts/12 hours is too long.



Challenge #2: SPECIALIZED CARE

Distribution of Services:

*Should we improve convenience by providing more services in mid-size centres **or** centralize services in fewer centres to focus on quality?*

Responses: Overall responses to this question were mixed, with the general recognition that centralizing services will make it easier to attract health professionals and support high quality services, but will increase travel time and costs for rural residents.

- More services in local centres would reduce the workload in Regina and Saskatoon, with recognition that there is resistance to having procedures done locally;
- Concern about ability to maintain competencies, cost of equipment and recruitment of specialists if attempting to maintain local service delivery;
- Centralizing services makes province wide standards more possible/increased ability to monitor services.

Providing services within appropriate timeframes:

*Should we increase resources for diagnosis and surgery such as beds, equipment, training and personnel **or** improve our use of resources by emphasizing prevention, increasing day surgery and developing research-based guidelines for surgery and diagnosis?*

Responses: There was support for the increased emphasis on prevention, day surgery and guidelines for surgery and diagnosis. However most groups found it difficult to support this to the exclusion of increased resources for diagnosis and surgery.

- Need increased resources for diagnostics to reduce waiting times, but also want to emphasize prevention, day surgeries etc.;
- Belief that all professionals should be promoting a wellness model;
- Use utilization management and evidence based decision making.

Challenge #3: MAKING THINGS FAIR

Focus on Prevention:

*Should we give priority to treatment and leave prevention to the individual **or** organize care so that effective prevention and health promotion receive more emphasis?*

Responses: Overall there was significant support for an increased emphasis on effective prevention and health promotion activities.

- Focus on youth and minority groups;
- Start with our youth - it's hard to change "long term" habits.
- What the public does to maintain health is more important than what the health system does;



Increased Fairness for Disadvantaged Groups:

*Should we organize services to include outreach to senior citizens, poor families and other groups, **or** continue to focus efforts toward individuals when they seek health care services?*

Responses: The benefits of increased outreach services for seniors, poor families and other groups were generally perceived to outweigh the cost of increased staffing to provide these services.

- Home care should be available for transport to specialists;
- Have local access to programs such as dialysis for people with kidney failure;
- Support for outreach services to seniors, poor families and other groups.

Challenge #4: GETTING RESULTS

Health Care Decisions:

*Should we rely on the judgement of health care providers to make decisions independently, accountable to professional organizations and patients, **or** increase accountability of providers through “report cards”, clinical guidelines or other means?*

Responses: While there appears to be support for greater accountability, overall responses did not indicate a clear understanding of what a “report card” might look like or how it would be generated.

- Respect the judgement of health care professionals;
- Support for report cards and clinical guidelines - greater accountability;
- Clinical practice guidelines may decrease the use of unnecessary tests, but concern that statistics may be deceiving.

Evaluating procedures, drugs and technologies:

*Should we choose new drugs and technologies only when there is a clear benefit over other available solutions, **or** adopt all new procedures, drugs and technologies as long as they are proven safe?*

Responses: Overall there seemed to be recognition that the cost of new procedures, drugs and technologies may be high, and most groups seemed to want assurance that they would be beneficial and effective. However, several groups wanted to leave these options open, and indicated an interest in flexibility depending on individual situations.

• Recognition that while new procedures, drugs and technologies expand patient choice, they could increase the cost of delivery;

- Choosing new drugs and technologies only when there is a clear benefit is a cost effective way to proceed - not all drugs can be provided as a benefit;
- Support for choosing new drugs and technologies only when there is a clear benefit/concern that drug patent laws are causing great expense as generic drugs could be used at great savings.



SUMMARY OF RESPONSES

Respondent Synopsis

Total responses tabulated: 33855	Region		Residence					Health Worker		Gender		Age Group				
	Urban	Rural	Regina	Saskatoon	Small Cities	Rural Far North	Rural	No	Yes	Male	Female	17 or under	18 - 34	35 - 54	55 - 74	75 or older
Number	16544	13256	5100	6387	5057	194	13062	25898	4033	11160	18407	77	2800	11642	12768	5000
%	48.87%	39.16%	15.06%	18.87%	14.94%	0.57%	38.58%	76.50%	11.91%	32.96%	54.37%	0.23%	8.27%	34.39%	37.71%	14.77%

Challenge #1 Everyday Health

Q1: Below are two different views about how to make sure that people get everyday health services when they need them.

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
We should keep hospitals open in as many communities as we can.	Number %	18208 51.26%	7462 43.09%	8864 63.38%	1882 44.63%
We could have fewer hospitals if there were more ambulances and more trained ambulance staff available, and people could get hospital care in larger centres when needed.	Number %	11319 31.87%	7230 41.75%	3054 21.84%	1035 24.54%
No response	Number %	5993 16.87%	2625 15.16%	2068 14.79%	1300 30.83%
Total	Number	35520*	17317	13986	4217

* Total responses include those respondents who agreed with more than one statement.

Q2: Delivering care through Primary Health Services teams is another idea for everyday health care. These teams would include nurse practitioners, physicians, nutritionists, pharmacists, therapists and others, working together. Some team members could serve more than one community. Services would be on call 24 hours a day, seven days a week. In general, do you think the Primary Health Services team approach would be positive or negative for the quality of health services you receive?

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Positive	Number %	17009 48.73%	9383 55.08%	6162 44.94%	1464 35.18%
Negative	Number %	4885 13.99%	1997 11.72%	2243 16.36%	645 15.50%
Unsure	Number %	8518 24.40%	3936 23.11%	3703 27.01%	879 21.12%
No response	Number %	4495 12.88%	1718 10.09%	1604 11.70%	1173 28.19%
Total	Number	34907*	17034	13712	4161

* Total responses include those respondents who agreed with more than one statement.



Challenge #2 Specialized Care

Q1: Below are two different views about how to make sure that Saskatchewan people receive the best specialized health services, such as MRI tests or surgery.

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Should we emphasise convenience by making these services available in a larger number of mid-sized communities across the province?	Number %	11094 31.56%	4408 25.73%	5471 39.55%	1215 29.04%
To ensure the highest quality, should we concentrate specialized services in Regina, Saskatoon and three or four regional centres, even if it means some people have to travel farther to receive services?	Number %	20069 57.10%	11170 65.20%	7035 50.85%	1864 44.55%
No response	Number %	3986 11.34%	1553 9.07%	1328 9.60%	1105 26.41%
Total	Number	35149*	17131	13834	4184

* Total responses include those respondents who agreed with more than one statement.

Q2: How do you think waiting lists could be reduced?

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Spend more money for new equipment, beds and operating rooms.	Number %	7030 16.80%	3310 16.17%	2910 17.76%	810 16.28%
Spend more money to recruit and retain specialist physicians and nurses.	Number %	18346 43.85%	9103 44.46%	7417 45.26%	1826 36.70%
Make sure we're providing surgeries and tests only when necessary, by working with health professionals to develop guidelines for care based on scientific research.	Number %	10960 26.20%	5753 28.10%	4162 25.40%	1045 21.01%
No response	Number %	5500 13.15%	2308 11.27%	1898 11.58%	1294 26.01%
Total	Number	41836*	20474	16387	4975

* Total responses include those respondents who agreed with more than one statement.

Challenge #3 Making Things Fair

Q1: Below are two different points of view about the health care system.

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Is it the job of the health system to focus only on the treatment of disease, illness and injury?	Number %	10156 28.75%	4563 26.49%	4402 31.71%	1191 28.22%
Is it the job of the health system to do more than treat disease, illness and injury, and also promote health through things like improved parenting skills, better nutrition and helping people to quit smoking?	Number %	21117 59.78%	11113 64.52%	8129 58.57%	1875 44.43%
No response	Number %	4052 11.47%	1549 8.99%	1349 9.72%	1154 27.35%
Total	Number	35325*	17225	13880	4220

* Total responses include those respondents who agreed with more than one statement.

Q2: Below are two opposing statements about what the health system should do to meet the health needs of certain groups in our province.

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Should the health system make a special effort to reach out to senior citizens, and poor families, because they often face higher health risks, and may not always get the health care they need?	Number %	18404 52.54%	9632 56.35%	7154 52.03%	1618 38.62%
Should the health system focus only on helping individuals when they seek health care services?	Number %	11115 31.73%	5253 30.73%	4641 33.76%	1221 29.15%
No response	Number %	5512 15.73%	2208 12.92%	1954 14.21%	1350 32.23%
Total	Number	35031*	17093	13749	4189

* Total responses include those respondents who agreed with more than one statement.

Challenge #4 Getting Results

Q1: Below are two different views about how to ensure delivery of high quality health care in Saskatchewan.

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Should we rely only on the judgement and independence of health care providers to make health care decisions?	Number %	4222 12.11%	2117 12.42%	1657 12.13%	448 10.80%
Should we ensure that decisions made by health care providers are supported by the best research evidence?	Number %	26044 74.73%	13152 77.16%	10446 76.48%	2446 58.97%
No response	Number %	4585 13.16%	1775 10.41%	1556 11.39%	1254 30.23%
Total	Number	34851*	17044	13659	4148

* Total responses include those respondents who agreed with more than one statement.

Q2: Below are two views about the introduction of new drugs and medical procedures.

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Even if it means that some new technologies, procedures or drugs are not available, we should carefully examine the medical evidence and adopt only those that offer a clear improvement over other available solutions.	Number %	13221 38.08%	6878 40.54%	5131 37.71%	1212 29.20%
Even if it means we have to pay more for health care, it is important that all new procedures, drugs, and technologies are made available in Saskatchewan as soon as they are approved.	Number %	17391 50.09%	8469 49.92%	7184 52.80%	1738 41.88%
No response	Number %	4109 11.83%	1618 9.54%	1291 9.49%	1200 28.92%
Total	Number	34721	16965	13606	4150

* Total responses include those respondents who agreed with more than one statement.

Challenge #5 Paying the Bills

Q1: The provincial government currently spends about \$2 billion a year on health, which is nearly 40% of total spending on programs and services. To determine the right level of health spending, should we:

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Maintain spending at no more than the current 40% of the budget, which could mean that there is not enough money to cover increasing costs of existing health services.	Number %	3328 9.46%	1684 9.80%	1307 9.46%	337 8.08%
Match spending increases to the rate of growth in the provincial economy, which could mean higher taxes.	Number %	10333 29.38%	5579 32.46%	3926 28.42%	828 19.84%
Keep spending generally in line with other Canadian provinces.	Number %	11409 32.43%	5593 32.54%	4748 34.37%	1068 25.59%
No response	Number %	10105 28.73%	4331 25.20%	3834 27.75%	1940 46.49%
Total	Number	35175*	17187	13815	4173

* Total responses include those respondents who agreed with more than one statement.

Q2: If more money is required for the health care system, where do you believe this extra money should come from?

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
An increase in taxes.	Number %	7441 20.50%	4296 24.13%	2608 18.37%	537 12.50%
Cuts to other government programs. (For example, Education, Agriculture, Highways)	Number %	3411 9.40%	1743 9.79%	1281 9.02%	387 9.01%
Let individuals pay for more themselves.	Number %	10339 28.49%	5159 28.98%	4221 29.74%	959 22.32%
No response	Number %	15101 41.61%	6603 37.09%	6085 42.87%	2413 56.17%
Total	Number	36292*	17801	14195	4296

* Total responses include those respondents who agreed with more than one statement.



Q3: Having thought about the information in this document, and based on your own experience, which of the following three general directions do you support for the future of Saskatchewan's health care system?

		All Responses	Summary of Responses by Region		
			Urban	Rural	N/A
Most problems that exist within the health care system can be fixed if the provincial government puts more money into health care.	Number %	3850 10.43%	1772 9.83%	1701 11.71%	377 8.60%
Changes are needed in the way the health system is organized, but the principles of Medicare should be preserved.	Number %	25072 67.89%	12664 70.26%	10062 69.29%	2346 53.50%
It is time to move toward a private health care system, which allows people to buy the services they need and want, when the public system cannot meet those needs or wants.	Number %	3608 9.77%	1884 10.45%	1298 8.94%	426 9.71%
No response	Number %	4400 11.91%	1704 9.45%	1460 10.05%	1236 28.19%
Total	Number	36930*	18024	14521	4385

* Total responses include those respondents who agreed with more than one statement.

APPENDIX E:
MAKING CHANGE

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Appendix E:
Making Change



SASKATCHEWAN

APPENDIX E:
MAKING CHANGE

Achieving a quality-focused, accountable and sustainable health system in Saskatchewan will mean change. While the health system has already undergone a great deal of change in the past ten years, it must continue to evolve if it is to meet the needs of the future. Most everyone that participated in the Commission’s public dialogue agreed. Everyone also knows that change is not easy, but Saskatchewan’s successes with regionalization in the last decade are a testimony to the fact that it can be done.

Consultation and Dialogue

Repeatedly, people asked the Commission: “Where’s the plan? We need to see a plan and then we can direct our efforts to making the plan happen.” The implication is clear: people are looking to the Government of Saskatchewan to articulate a clear, overarching plan for the future of Medicare. This report is meant to be the basis for just such a plan and provides a framework for change and renewal. Communities, health care providers and various stakeholders can work within this framework to develop specific local services and programs.

Debates about keeping a hospital open or adding long term care beds should be guided by the principles of the overall system and provincial needs rather than on competing efforts of separate communities investing their energy in preserving the status quo. Communication between the government, districts and the public as well as provider groups will need to focus on how to fulfil the new plan for the health system. This communication should be open, frank and honest and directed to what is best for the overall province, rather than to the special interests of one particular group.

As a result the Government of Saskatchewan should, *as soon as possible*, indicate how and to what extent it wishes to launch a process of renewal of the health system and where it believes the system should go - what it believes “the plan” should be. This sets the stage for the Government, in partnership with health districts, health care providers and their associations, to engage in a process of public dialogue and consultation to consider how best to implement the changes the Government feels are appropriate and necessary. This process can take several forms: conferences, appointment of consultation teams, local district-lead discussions, among others. The goal of these initial discussions is to create an opportunity for both health care providers and the general public to talk about change as well as the details of a new design for the health system.

Within three months of receiving this report, and based on these public consultations, the Government of Saskatchewan should release its formal response to this report clearly indicating how it intends to proceed.

An Investment in Leadership

Re-focusing a health system comprised of more than 36,000 providers and practitioners who manage and deliver services is both an exciting opportunity and a monumental task. Committed and visionary political, administrative, and health provider leadership is absolutely essential.

In addition to committed leaders, skilled teams who can assist with the change and work with individuals and groups inside organizations and within the community will be required. With the magnitude of change proposed, it will not be possible to treat this as an add-on responsibility.



Structural Change Priorities

October 2001 - Quality Council

The Terms of Reference and the Quality Council appointments should proceed within the next *six months*. The Quality Council will be key in setting accountability parameters and ensuring quality is not compromised as the system is reorganized. In addition, the Quality Council could provide guidelines for locating specialized resources and developing performance indicators.

April 2002 - Fewer Districts and a Revised Statement of Roles and Responsibilities

District amalgamation should take place as quickly as possible and be completed within one year to reduce uncertainty for providers and administrators. Strong leadership will be required to support system reorganization.

October 2004 - Integrated Primary Health Services

Implementing and strengthening Primary Health Service Networks is a priority but is by far the most complex change recommended in this report. This work should begin immediately with a target of three years to full implementation. All communities, but especially rural and northern communities, need a secure, strong system of everyday health services. As a result, the implementation of an integrated system for the delivery of primary health services should begin in rural and northern Saskatchewan.

Additional Urgent Tasks

In addition to the main priorities for change listed above, there are several other structural changes that should take place. These include:

- Development of model contracts for health districts to allow them to take responsibility for physician payment;
- Confirmation of the role of the Health Human Resource Council and the development of province-wide Strategy for Health Human Resources;
- Determining the location of Regional Hospitals, and using the standards set by the Quality Council, defining the core programs and services to be offered in each facility;
- Enhancement and improvement of provincial emergency services and the integration of these services into the Primary Health Networks;
- Changes to the internal structure of Saskatchewan Health to reflect the broader changes in the delivery of health services;
- Reviewing any capital construction and renovation already underway and setting priorities for investments in infrastructure.

In summary, there can be success in both the short term and the long term if everyone can focus on a vision of Medicare that meets the interests of Saskatchewan citizens.



APPENDIX F:
BIBLIOGRAPHY



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BIBLIOGRAPHY

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