

THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA

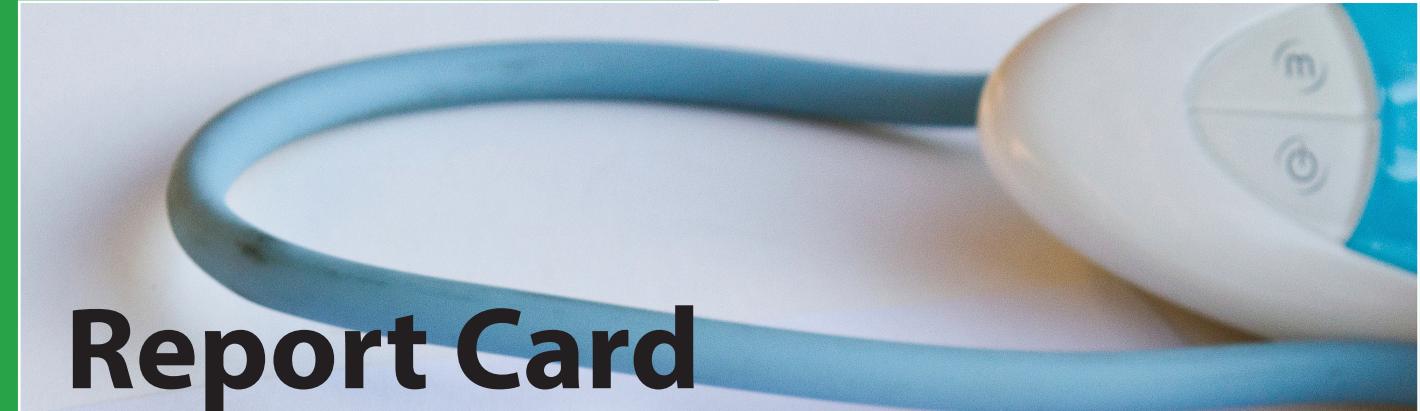


LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

The Role of the Federal Government in Health Care

Report Card 2013
Reference Document

OCTOBER 2013



Report Card



GREEN

A **green grade** shows that the federal government is demonstrating strong leadership; we encourage an ongoing commitment in these areas.



YELLOW

A **yellow grade** shows that the government is somewhat involved but could do even more.



RED

A **red grade** indicates that the federal government has shown no involvement. These red areas need attention now. A red grade is a call to action!

1. Putting Care Front and Centre

a. A Family doctor for every Canadian	YELLOW
b. Support for the Patient's Medical Home	RED
c. Timely access	YELLOW
d. National immunization strategy	RED
e. Support for electronic records	YELLOW
f. National home care program	RED
g. National pharmaceutical strategy	YELLOW

2. Caring for the Most Vulnerable

a. National poverty plan	RED
b. National homelessness plan	GREEN
c. Aboriginal health programs	YELLOW
d. National mental health and addiction strategy	YELLOW
e. Child and youth strategy	RED

3. Having Enough Health Care Providers

a. Tracking supply and demand and getting the mix right	YELLOW
b. Taking care of the care providers	YELLOW

4. Establishing the Vision for Health Care and Measuring Performance

a. National health strategy	RED
b. Health funding	YELLOW
c. National health goals	RED
d. Rural and remote care	YELLOW
e. Primary care support	RED

5. Supporting Health Care Research

a. Appropriate funding for health care research	YELLOW
b. Appropriate funding for primary care research	YELLOW
c. Appropriate evidence for new policies	YELLOW
d. Communicating research into policy and action	YELLOW

We welcome questions or comments on this document at healthpolicy@cfpc.ca

AREA 1

Putting Care Front and Centre

AREA 1 - PUTTING CARE FRONT AND CENTRE

a) A Family doctor for every Canadian

- 85% of Canadians have their own family doctor
- Non-standardized provincial plans are created to deal with “orphan” patients. Lack of national strategy leads to disparity in how well different provinces are able to connect patients with family doctors.
- The federal government can help to facilitate the CFPC’s PMH vision that by 2020, every person in Canada has their own family physician and that by 2022, every person in Canada should have a personal family physician whose practice serves as a PMH

Grade  **YELLOW**

b) Support for the Patient’s Medical Home

- The [Patient’s Medical Home](#) (released by the CFPC in Sep 2011) is a vision for better patient-centred team-based care and better health outcomes. Despite being supported by both the Official Opposition (NDP) and the Liberal Party, it is not mentioned in the current government’s health care plans.
- No dedicated funding models exist federally or provincially for practices following the principles of Patient’s Medical Home.
- Practice models that incorporate certain PMH-like qualities exist in most provinces (FHT/FHG in ON, Primary Care Networks in AB, Primary Care Teams in Nova Scotia etc.). Due to lack of federal involvement there is little standardization across the country.

Grade  **RED**

c) Timely access

- The establishment of maximum wait-time benchmarks was a major feature of the 2004 First Ministers’ 10-Year Plan to Strengthen Health Care, covering cancer, cardiac care, diagnostic imaging, joint replacement, and sight restoration. The federal government has not renewed the Health Accords, leading to a lack of strategic leadership and prioritization in health care, especially for ongoing issues such as timely access to care.
- 2012 Wait Times Alliance Report Card shows a decline in performance for patients receiving care in the five priority areas.
- [Patients Wait Times Guarantee Trust](#) was set up 2007/8-2009/10 and provided funding for provinces to establish target wait times for certain procedures. This was a one-time investment and was not repeated since 2009/10, limiting its ongoing effectiveness.
- Minor contributions were provided [National Wait Times Initiative](#) (2006/7-2008/9) – a short-lived program supporting the aims of the 2004 Health Accord. While funding was relatively

low, it was used to fund a number of projects that have contributed significantly to enhancing our knowledge on wait time issues.

Grade  **YELLOW**

d) National immunization strategy

- There is currently no National Immunization Strategy active in Canada.
- The [National Immunization Strategy](#) (NIS) launched in 2003 (\$300-million). The NIS sunset in 2009/2010 and has been “under review” by the Federal Government since 2009. A new NIS is supposedly “imminent”, yet nothing is currently in place.
- NIS provided P/T governments a framework and some common goals. Allowed certain provinces and territories to introduce vaccines already available in other jurisdictions. When the original Trust Fund expired, costs shifted to provinces/territories.
- Differences among P/T programs make equitable access to vaccines difficult to implement.
- The Canadian Immunization Committee’s (CIC) role is to provide guidance towards uniformity for P/T programs but since health is a P/T jurisdiction, their recommendations are seldom applied.
- National Advisory Committee on Immunization provides recommendations on the usage of specific vaccines via thorough product and product research studies review. While valued, their recommendations do not necessarily translate into P/T policy and practice.
- Immunization is seen as/targeted for paediatric use, resulting in a gap in adult vaccine needs.

Grade  **RED**

e) Support for electronic records

- [Canada Health Infoway is funded by federal government](#). Jointly invests with every province and territory to accelerate the development and adoption of information and communications technology projects in Canada.
- While the basic adoption of electronic records is nearing critical mass in Canada, the information management standards are not set and the solutions used by physicians in different jurisdictions are not interoperable. These shortcomings limit the value of data collected through EMRs that would otherwise be an invaluable source of summary information. Ability to extract and use EMR data is limited.
- Infoway has not issued indications to physicians as to which EMRs it endorses.

Grade  **YELLOW**

f) National home care program

- To date, there is no National Home Care Program
- Because home care is not considered a “medically necessary” service under the *Canada Health Act*, publicly funded home care programs vary greatly across the country in terms of eligibility, scope of coverage and applicable user charges.
- 2013-14 Federal Budget introduced tax exemptions for home care services, lightening the financial burden somewhat. Family Caregivers’ Tax Credit further acknowledged this area’s need of support.
- Dedicated Home Care funding was a part of the Health Reform Transfer between 2003-2007-08
 - \$16B dedicated commitment for primary health care, home care and catastrophic drug coverage until 2007-08.
 - Subsequently subsumed into CST/CHT transfers.
- In 2004, federal, provincial and territorial governments agreed on first-dollar coverage for home care services in three areas. Under the 10-Year Plan to Strengthen Health Care(2004 Accord), they agreed to publicly fund:
 - short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;
 - short-term acute community mental health home care for two-week provision of case management and crisis response services; and
 - end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life.
 -
- 2004 Compassionate Care Benefit is introduced by the federal government.
- 2007 Health ministers report that all provinces and territories have taken steps towards fulfilling their commitments for home and community care services as described in the 2004 Accord.
- Differences exist not only among provinces and territories but also within them. There is variability in access to and provision of home care services and differences in the use of and application of co-payments and user fees. The delivery of appropriate home care services will continue to be a challenge until policy-makers realize its importance to the changing health system and focus on making services more equitable across the country.

Grade



RED

g) National pharmaceutical strategy

- National Pharmaceuticals Strategy (NPS) launched in 2004: governments committed to making drug coverage a priority. Resulted in fpt collaboration, however progress stalled following 2008.
- The federal government provides or facilitates drug coverage for populations under its jurisdiction (e.g., First Nations, veterans, Canadian Forces, federal inmates).
- Canadians still don't have this coverage or other important reforms that were promised (reported by the Health Council of Canada, [*The National Pharmaceuticals Strategy: A Prescription Unfilled*](#)). In September 2008, the provincial and territorial ministers of health said publicly that they can't move forward on several key elements – particularly catastrophic drug coverage – unless the federal government is willing to take leadership and share costs.
- Full drug access is granted to social assistance recipients/seniors.
- The federal government invested \$16 billion in a five-year (2003–2004 to 2007–2008) Health Reform Fund to provide provinces and territories with more money to improve health care in a number of ways, including by expanding the provision of catastrophic drug coverage.
 - Later subsumed into Canada Health Transfers.
- Currently all provinces and territories have some form of a catastrophic drug plan in place. The plans all have different criteria at which point these take effect. Usually the threshold where the plan activates is between 2-6% of net family income, although there are also set dollar value limits (Quebec) and 100% coverage options (Nunavut).
- The issue of providing CDT seems to have been fully downloaded to the provinces. Plans exist but are not standardized. Drug shortages legislation is in need of further development (currently underway).

Grade  **YELLOW**

AREA 2

Caring for the Most Vulnerable

AREA 2 - CARING FOR THE MOST VULNERABLE

a) National poverty plan

- **No formal national antipoverty plan exists.** Non-standardized poverty strategies exist on a provincial basis.
- The Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities released a report in 2010 entitled "[Federal Poverty Reduction Plan: Working in Partnership Towards Reducing Poverty in Canada](#)." The Government's response focused on poverty reduction through labour market participation, ensuring economic security, and housing. Economic security was measured in spending for post-secondary education and the CHT/CST, as the Government contends that "many of the initiatives that address the economic security and well-being of Canadians fall under provincial and territorial jurisdiction."
- **Grade**  **RED**

b) National homelessness plan

- In 1999 the Government of Canada launched the National Homelessness Initiative (NHI) which emphasized the importance of community responses to homelessness through funding for 61 'Designated Community' entities, each responsible for planning, decision-making and distribution of funds locally.
- In April 2007, the NHI was renamed the Homelessness Partnering Strategy (HPS.) The HPS provides support to community-level homelessness programs. In September 2008, the Government committed more than \$1.9 billion to housing and homelessness over five years. This included a two-year renewal of the HPS and a commitment to maintain annual funding for housing and homelessness until March 2014. As part of this commitment, the Government of Canada renewed the HPS from April 2011 to March 2014.
- In March of this 2013, HPS was renewed by the Government of Canada for five years, a financial commitment of \$119 million. While this represents a drop in annual expenditures (from \$134.5 million) the renewed commitment also signals a shift in priority.
- Budget 2013 also allocated \$253 million per year over five years, over \$1.25 billion in total, to renew the Investment in Affordable Housing.
- Provinces and territories can use funding for new construction, renovation, home ownership assistance, rent supplements, shelter allowances, and accommodations for victims of family violence.

Grade  **GREEN**

c) Aboriginal health programs

- National Aboriginal Health Organization (NAHO) was established in 2000 as a result of the Royal Commission on Aboriginal Peoples to address health issues among First Nations, Inuit, and Métis. The federal government, through Health Canada, cut all funding for the National Aboriginal Health Organization (NAHO) in April of 2012.
- In 2006, the First Nations Statistical Institute was created under the federal government's First Nations Fiscal and Statistical Management Act. In its March 2012 budget, Canada's federal government announced that it was cutting all funding for the First Nations Statistical Institute (FNSI) by 2014.
- Budget 2013 included several additions related to First Nations:
 - \$52 million over two years to enhance health services for First Nations and Inuit, including mental health services.
 - \$24 million over two years for the Family Violence Prevention Program.
 - Funds shelter services and violence prevention programming on reserve
 - \$4 million over two years to increase the number of mental health wellness teams serving First Nations communities.
 - \$33 million over two years to support policing in First Nations and Inuit communities, and \$3 million over two years for additional police officers in First Nations police services focusing on contraband tobacco
 - This policy shift toward policing may have negative health impacts on First Nations communities.
 - \$54 million over two years to ensure specific claims are addressed promptly.
 - In addition Public Health Agency of Canada will reallocate \$2 million to improve data collection and reporting of mental illness and mental health, as recommended in the Mental Health Strategy for Canada.
- Worked in partnership with to create the First Nations Health Council in British Columbia in 2008. This includes a Tripartite Aboriginal Maternal and Child Health Committee, with representatives from First Nations, Inuit and Métis communities and the federal and provincial health systems, to lead the implementation of maternal and child health actions.
- The Canada Prenatal and Nutrition Program is a broad-based funding program that is locally implemented and community-based, is delivered through the Public Health Agency of Canada (PHAC).
- Aboriginal Head Start On Reserve is part of four community-based programs (Maternal and Child Health, Canada Prenatal Nutrition Program- First Nations and Inuit Component, and the Fetal Alcohol Spectrum Disorder Program) aimed at improving the health status of First Nations and Inuit individuals, families and communities. The Cluster Evaluation Report, which includes the AHSOR program, was completed in 2009-10
- Maternal and Child Health (MCH) is a national program that is delivered through partnerships and builds on other community programs. It is a proactive, preventative and strategic approach to promoting the good health and development of on-reserve pregnant First Nations women and families with infants and young children. The program aims to reach all pregnant women and new parents, with long-term support for those families who require additional services.

Grade



YELLOW

d) National mental health and addiction strategy

- Health Canada funded the Mental Health Commission of Canada, a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues with a 10-year mandate (2007-2017). Through its unique mandate from Health Canada, the MHCC brings together leaders and organizations from across the country to accelerate these changes.
 - The MHCC released a [mental health strategy](#) in 2012. To date, the federal government has not directly enacted those recommendations in legislation.
- The federal government released its [National Anti-Drug Strategy](#) in 2007. The strategy is based on three pillars: prevention, treatment, and enforcement. However, much of the legislation enacted by the federal government has been focused on the enforcement pillar, neglecting the importance of treatment, presentation, and harm reduction as a fourth pillar of drug policy.
- The federal government's action on mental health and addictions has involved several critical policy changes.
 - Bill C-54 (The Not Criminally Responsible Reform Act), the policy changes of which are in direct contravention to the current evidence base on mental health treatment and recidivism.
- The Federal Government has attempted to curb the adoption of a public health approach to drug addiction policy, as seen with their [new legislation's impact on Supervised Drug Consumption Sites](#).
- The federal government, through the Correctional Service of Canada, [closed the Addictions Research Centre \(ARC\) in Montague, Prince Edward Island](#). The ARC was established in 1999 to advance the research of addiction issues within the criminal justice environment.

Grade  **YELLOW**

e) Child and youth strategy

- There is no federal strategy or framework on child and youth health in Canada.
- Since 2009, a number of governments have introduced mental health plans, including British Columbia, Alberta, Manitoba, Ontario, New Brunswick, Nunavut and Northwest Territories. There is a need for federal leadership on child and youth mental health, particularly that of Aboriginal children and youth.
- Federal investment in early childhood development and the percentage of children in regulated spaces is one of the lowest amongst Canada's counterparts in the Organisation for Economic Co-operation and Development (OECD). In Canada, significant variation exists across the Provinces/Territories on a series of critical variables, such as funding per child, programme standards, teacher certification and school readiness assessment.
- The Federal Government introduced the Universal Child Care Benefit in 2007, which provides parents of children aged 6 and under with \$100 per month per child to support costs associated with child care. This benefit was introduced concomitantly with the cancellation of the intergovernmental framework on child care.

Grade  **RED**

AREA 3

Having Enough Health Care Providers

AREA 3 - HAVING ENOUGH HEALTH CARE PROVIDERS

a) Tracking supply and demand and getting the mix right

- Building on the 2004 Accord commitments to health human resources, the Pan-Canadian [HHR Strategy](#) (HHRS) was launched in 2004/2005 to attract, prepare and retain health care providers to give Canadians access to appropriate and timely care. The Advisory Committee on Health Delivery and Human Resources (ACHDHR) was struck to provide policy and strategic advice in planning, organization and delivery of health services for health human resources.
- Developed a [framework for pan-Canadian Health Human Resource Planning](#) in 2007.
- Developed “[How many are enough](#)” in 2009 - A guide to help federal, provincial and territorial governments work together with the education system, employers and health providers to develop, implement and evaluate a comprehensive range of strategies for building and maintaining a stable health workforce
- Developed a [Pan-Canadian Health Human Resources Planning Toolkit](#) – a national web-based toolkit for HHR planning and forecasting. The Toolkit consists of evidence based knowledge and addresses the national demand for HHR planning information and tools. The toolkit will establish a common understanding and consistent knowledge of HHR policies and programs. The information will be constantly evolving as it is tested and best practices are shared.
- Funding several health human resources-based initiatives through the Health Care Policy Contribution Program. These initiatives were developed by a variety of health stakeholders appropriate for any given area.
- Funded [Canadian Health Human Resources Network](#) aimed at generating HHR research, policy and planning.
- [Interprofessional Education for Collaborative Patient-Centred Practice \(IECP\)](#) – Part of HHR Strategy to promote interprofessional education and collaborative patient-centred practice by implementing projects relating to the development of IPE learning tools for faculty and students, the development of offices for collaborative learning; the development of partnerships between faculties, collaborative learning units and communities; and enhanced understanding and mutual respect within health professional groups.
- Funded several related supplementary projects through the Health Care Policy Contribution Program, including
 - **The Future of Medical Education in Canada—Postgraduate Project** – In collaboration with the CFPC and the Royal College
 - **Health Care Quality Enhancement Through E-Learning for Providers**
- Through the work of CIHI and Statistics Canada improved national HHR data and database development, including the first national, supply-based database and reporting systems for five health professions: pharmacists, occupational therapists, physiotherapists, medical laboratory technologists, and medical radiation technologists.

- Supported the creation of [the Health and Education Task Force \(HETF\)](#), a task force of the F/P/T Advisory Committee on Health Development and Human Resources (ACHDHR), is developing a ROI analysis framework to assess Interprofessional Care (IPC) and Interprofessional Education (IPE).
- However, the majority of the specific supply/demand estimation activity still lies with the provinces (e.g. [Ontario's model](#), [Alberta's model](#)).
- Despite the auxiliary projects described above, a national HHR observatory to monitor and direct the development of the physician workforce has not been implemented.

Grade  **YELLOW**

b) Taking care of the care providers

- Through its [Health Human Resources Strategy](#), the federal government
 - Developed supporting evidence on the impact of healthy workplace interventions
 - Improved awareness regarding the implications of healthy workplace environments on health workforce recruitment and retention, and its relationship to the quality of patient care
 - Collected evidence that highlighted leading practices and strategies to improve the health care work environment
 - Developed standard quality of worklife indicators to be used for national benchmarking purposes
 - Supported the creation of Quality Worklife - Quality Healthcare Collaborative (QWQHC), a national multi-disciplinary coalition of healthcare leaders working together to improve the quality of work life for Canada's healthcare providers to improve patient care
- Many personal/professional life issues that keep coming up remain unaddressed. Examples include :
 - Resident physical well-being due to long hours,
 - Daunting on call hours for physicians especially in rural areas
 - Road safety for physicians driving post call
 - Physician burnout
- Canadian Physician Health Institute sees a role for the federal government in ensuring physician wellness is supported and suggested national standards for this area are in development.

Grade  **YELLOW**

AREA 4

Establishing the Vision for Health Care and Measuring Performance

AREA 4 - ESTABLISHING THE VISION FOR HEALTH CARE AND MEASURING PERFORMANCE

a) National health strategy

- Current federal government involvement with health care is largely limited to directly providing health care to :
 - i. First Nations people living on reserves;
 - ii. Inuit;
 - iii. serving members of the Canadian Forces;
 - iv. eligible veterans;
 - v. inmates in federal penitentiaries;
 - vi. Some groups of refugee claimants.
- Majority of Canadians receive health care through provincial plans. These plans are funded by federal government through Canada Health Transfers.
- Federal government continuously highlights its position that administering health care is the jurisdiction of provinces and distances itself from specific planning and prioritization in the area.
- This approach results in health care system consisting of a fragmented set of provincial plans, each with its own priorities and methodologies, with little standardization (e.g. in selecting interoperable electronic records).
- Certain areas (e.g. home care) are further fragmented by being governed through regional health authorities, introducing additional level of variety and non-compatibility.
- The federal government's position is to distance itself from the health care, maintaining its role purely as a funder and not as a leader.

Grade  RED

b) Health funding

- 2004 Health Accord set annual growth of 6% for CHT amounts, weighted by province personal and corporate taxes.
- Starting with 2014-15 the funding allocation will shift towards an equal per-capita distribution. This change is going to result in higher distribution to AB with lower distributions to every other provinces.
- Starting in 2017-18, CHT amounts will grow in line with a three-year moving average of nominal Gross Domestic Product, with funding guaranteed to increase by at least **3 per cent over the prior year's funding**.
 - i. Due to this change the provinces are set to receive \$36B less over the ten-year period following the change.

Grade  YELLOW

c) National Health Goals

- In 2005, the F/P/T Ministers of Health established health goals for Canada that, to date, have neither evolved into a national strategy nor have resulted in measurable actions. Moreover, national targets have not been set to reduce health disparities.
- Provinces are only required to meet the basic principles of the Canada Health Act without any specific performance targets in place.
- Health Council of Canada, implemented to ensure accountability, sunsetted in 2013.
- The federal government downloads planning and implementation of health initiatives, including their evaluation, to provinces. No checks exist to measure provincial agencies' progress.

Grade  **RED**

d) Rural and remote care

- No portion of Canada Health Transfers for provinces is locked for rural health care.
- Family Physicians and nurses who chose to practice in rural areas are eligible for the federal [Student Loan Forgiveness](#) program. Over a period of 5 years FPs receive \$40,000 and nurses \$20,000 in loan forgiveness.
- Most of incentive programs to encourage physicians to practice in rural/remote areas are administered through provincial jurisdictions ([Health Force Ontario](#), [BC Ministry of Health Rural Recruitment](#), [Rural Physician Incentive Program of SaskDocs](#), [Provincial Incentive Programs of Nova Scotia](#), etc.)
- These incentive programs vary by province – e.g. Ontario incentive starts at \$80,000 over 5 years while BC only offers \$20,000 over same period of time.
- Outside of the loan forgiveness program, the federal government does not participate in allocating funds for rural recruitment/retention (up to provinces) or training of health professionals for rural areas (up to individual schools).

Grade  **YELLOW**

e) Primary care support

- In 2000 the federal government committed about CAD 800 million over five years through the Primary Health Care Transition Fund to stimulate system-level changes and transitional costs to improve primary care in Canada. Since then, the commitment has been extended through the 2003 CAD16 billion Health Reform Transfer.
- Since the term of that funding agreement ran out, the funding for the primary care reform is included as part of the overall Canada Health Transfers to the provinces. No funds are locked to be specifically used for primary health reform.

- As a result every province approaches the primary care reform in their own way, leading for example to the uncoordinated variety of interdisciplinary primary care models available across the country: FHT/FHG in ON, Primary Care Networks in AB, Primary Care Teams in Nova Scotia etc.
- Varied approach with no standardization (like that offered by the Patients' Medical Home model) leads to patchwork, uncoordinated deployment.
- A federal program for Contributions for First Nations and Inuit Primary Health Care is in place, providing CAC 700 million per year in order to ensure delivery of primary care delivery to these populations.
- Federal government does not play a leadership role in highlighting the importance of primary care to all Canadians and assigning dedicated funding to ensure necessary reforms occur.

Grade  **RED**

AREA 5

Supporting Health Care Research

AREA 5: SUPPORTING HEALTH CARE RESEARCH

a) Appropriate funding for health care research

- Canadian Institute of Health Research (CIHR), which is included under Health Canada, accounted **for 14.4% of total federal direct health expenditure**. The funding is estimated to be reduced by 4% in the 2013-14 budget.
- CIHR has developed several “signature initiatives” that offer funding opportunities related to identified health priority areas. The [Institute of Health Services and Policy Research](#) (IHSPR) is involved in the following initiatives:
 - Personalized Medicine
 - Community-Based Primary Health Care
 - Evidence Informed Healthcare Renewal
- [Health Care Policy Contribution Program](#) (HCPCP)
 - HCPCP is a national program designed to promote policy research and analysis, evidence-based pilot projects, and evaluations on current and emerging health care system priorities.
 - The HCPCP uses contributions to fund non-profit, non-governmental organizations, professional associations, educational institutions, and provincial, territorial and local governments, in order to develop, implement and disseminate knowledge, best practices and strategies for innovative health care delivery.
 - Former components of the program included:

[Health Care System Innovation](#)

- Three main themes of HCSI include:
 - Health Care Policy Conferences and Events
 - Health Care System Responsiveness to Population Aging
 - Canadian Medication Incident Reporting and Prevention System

[National Wait Times Initiative](#)

- Was announced in February 2005
- NWTI was provided \$13M over three years (06/07-08/09)
- [Tools](#) developed through the NWTI

[Patient Wait Times Guarantee Pilot Project Fund](#)

- Provinces/Territories agreed to establish a patient wait time guarantee in one clinical area by March 2010
- Federal government funded up to \$30M over three years (07/08-09/10)
- Eleven projects covering a broad range of clinical areas and innovative approaches received funding under this initiative

- Personalized Medicine
 - The goal of this initiative is to engage biomedical, clinical, population health, health economics, ethics and policy researchers, as well as provincial health authorities, in an undertaking to identify health care burdens in disease that are suitable for a personalized medicine approach. This initiative will ultimately support translational research for the effective prevention, diagnosis, and treatment of disease.
- In January 2012, the Federal government announced a \$67.5 million dollar investment (\$22.5 million from the CIHR, \$40 million from Genome Canada and \$5 million from the Cancer Stem Cell Consortium) to support funding of research teams in the area of Personalized Health.
- In the 2013 budget, the Federal government announced it would be providing \$165 million in multi-year funding to support genomics research through Genome Canada, including new large-scale research competitions and participation by Canadian researchers in national and international partnership initiatives.

Grade  **YELLOW**

b) Appropriate funding for primary care research

- CIHR Announced dedicated \$34M funding for community-based primary health care projects. ([Press Release from April 2012](#))
 - **CIHR funding:** \$30 million from the CIHR Institute of Health Services and Policy Research (plus \$2 million from provincial partners; \$3.5 million from international partners).
 - The proportion of funding dedicated to primary care is disproportionate to the role primary care plays in ensuring health of Canadians.
- [Community-Based Primary Health Care](#) (CBPHC)
 - CIHR launched a Signature Initiative to fund research that supports the delivery of high-quality, Community-Based Primary Healthcare (CBPHC) across Canada.
 - CBPHC will support researchers to conduct original research on innovative models of care delivery, build capacity for research excellence, and translate evidence for uptake into practice and policy. It will achieve this through two major funding tools.

Grade  **YELLOW**

c) Appropriate evidence for new policies

- Many of the recent initiatives launched by the Government advocate evidence-informed research.
- However, several legislative decisions recently have been carried on despite contrary to existing scientific evidence, e.g.:
 - Bill C-54, **Reform to the Non-Criminally Responsible Act**: Made it more likely mentally ill offenders would be classified as “high risk” and would be steered towards incarceration in general penitentiaries. This is contrary to Mental Health Commission of Canada’s data that those not criminally responsible are less likely to re-offend.
 - Changes to the **Interim Federal Health Program** were made despite the universal opposition from multiple medical organizations citing evidence that the change would have a negative effect on population health and would result in higher costs to the health care system.
 - The private bill C-460 on **Sodium Reduction Strategy** was defeated, despite basing itself on evidence of the negative impact on population health, specifically on chronic diseases.
 - Bill C-65, the Respect for Communities Act (Supervised Injection Sites), does not rely on evidence around harm reduction approaches to illicit drug use. There is good evidence that supervised injection sites reduce transmission of diseases such as HIV and Hep C, and most importantly, greatly reduce the risk of overdose deaths. Bill C-65 introduces significant obstacles to establishing safe injection sites and is a reflection of ideological concerns with harm reduction rather than evidence.
- **Evidence Informed Healthcare Renewal**
 - The Evidence-Informed Healthcare Renewal (EIHR) initiative will support researchers and decision makers to work together to advance the current state of knowledge, generate novel and creative solutions, and translate evidence for uptake into policy and practice to strengthen Canada’s healthcare systems.
 - This initiative aims to provide timely and high-quality evidence - both in the short term and beyond for the perennial topics of how best to finance, sustain and govern provincial, territorial and federal healthcare systems.

Grade



YELLOW

d) Communicating research into policy and action

- Certain guides that Health Canada releases (e.g. the recent [Guide to Health Professionals on Medical Marijuana](#)) contain information in dense and non-user friendly format. There is room for improvement in the way that some of the policies are communicated to ensure both clarity in communication and foundation in evidence.
- “[Show Me the Evidence](#)” reports
 - *Show me the Evidence* are reports released by CIHR, which showcase some of the evidence being produced by Canadian health researchers.
 - Past “success” stories featured in the reports included CIHR-funded research projects that have delivered:
 - a 20% improvement in cardiovascular fitness among BC primary school students;
 - a new approach to physical activity in schools;
 - a model for participatory research; and
 - Affordable, convenient stroke rehabilitation.
- [Evidence Informed Healthcare Renewal Portal](#) (launched Apr 2012)
 - The EIHR Portal is a continuously updated repository of policy-relevant documents that address ‘healthcare renewal’ in Canada.
 - It contains 24 types of documents, including jurisdictional reviews, stakeholder position papers, and intergovernmental communiqués. The documents address priority areas identified by Canadian federal, provincial and territorial governments, such as primary healthcare, patient safety, health human resources and performance indicators (e.g., timely access).
 - The EIHR Portal is integrated within McMaster Health Forum’s *Health Systems Evidence* to provide a single point of access to the ever-growing body of evidence that can inform healthcare renewal activities and policy.

Grade  **YELLOW**



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