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## National Priorities 2016

# Challenging Vested Interests: National Priorities for Healthcare in 2016

by  
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“Canadians spend a lot of money on healthcare but get middling results. Canada performs middle-of-the-pack on a number of OECD health measures but is one of the highest spenders.”

Canadians are passionate supporters of their provincial healthcare systems. In healthcare, Canada does better than the United States – which operates an incredibly expensive healthcare system grappling with cost control and access issues – and patients are generally satisfied with the services they receive once they get them. But compared to the healthcare systems of a large group of peers, Canadian systems do not produce enough high-quality care for the money spent.

The widespread support is also puzzling in light of the many gaps in coverage: for prescribed drugs, continuing care and mental health. And prospects for improvement seem stymied by a state of policy gridlock – a general reluctance to try new things to get more efficient services. Other countries have undertaken initiatives to change the way physicians and hospitals are paid, sharply realign scopes of practice between caregivers, clearly define public and private roles to ensure adequate coverage, and set in place incentives to guide better care quality at lower costs. For its part, Canada is entrenched in a state of affairs where vested interests effectively prevent change.

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It will, however, become more difficult to maintain the status quo. Global economic headwinds and the retirement of babyboomers dim the prospects for strong economic growth. This – plus government deficits at the provincial and federal levels – means the resources devoted to health may grow more slowly for years to come. Meanwhile, policymakers are confronted with increasing demands for services from an aging population, the need for greater attention to gaps in health coverage, and the desire to access new medical technology that increases quality of life. Getting better value for money in healthcare is needed to meet these demands and allow access to effective technologies in the future.

## Value for Money – Not More Money

A report from the Organization for Economic Cooperation and Development (OECD), *Health at a Glance*, provides a 30-country comparison of healthcare performance. Canada performs in the middle of the pack when compared to other countries, but remains one of the highest spenders for healthcare at about 11 percent of GDP. On quality of care, patient safety remains an issue, wait times are problematic and Canada has relatively high rates of avoidable hospital admissions. It seems Canada's ability to improve quality of care and access while containing costs has been limited.

Similar results emerge from the Commonwealth Fund's International Health Policy Surveys. Ever since the Commonwealth Fund began international rankings based on survey results,<sup>1</sup> Canada has maintained its position at the back of the pack – always one spot ahead of the US, but well below the performance of other advanced nations. On measures of quality, access, efficiency and equity, Canada lags.

## Policies to Improve Value for Money

There are many policies that can achieve better value for healthcare money. One promising general approach is to introduce incentives to produce the highest-quality care at a low cost. To do so, we need funding models that revise how providers – doctors, caregivers, hospitals, etc. – are paid to match efficiency goals. Despite our history of paying family doctors on a fee-for-service basis, there are many good reasons why well-designed reforms that pay family doctors more with a per patient (capitation) model and less with fee-for-service should give better value for money (Blomqvist and Busby 2012).<sup>2</sup>

Primary care doctors today act more as patient managers within the health system – they diagnose, then prescribe or refer – and deliver fewer direct services than in the past. This management role fits better with a per-patient method of compensating physicians than the predominant fee-for-service model. Paying doctors more according to the number of patients under their care would give family doctors greater incentive to keep patients healthy and add more patients to their rosters.

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1 The first year of rankings was 2004.

2 Some provinces may see Ontario's experience with capitated payments for family doctors as an expensive experiment that has not produced good value. While we are sympathetic to these concerns, there were major issues related to the rollout of Ontario's reforms, including the voluntary participation of physicians and poor design of capitated payments. These implementation issues have compromised the original stated principles of the reforms. While Ontario's model has not rolled out smoothly, a case can be made that team-based family health teams paid mainly by capitation are a strong base for the province in moving forward with primary care reform.

Similarly, it is not at all clear why hospital-based physicians should be paid out of a different envelope than other hospital costs (Blomqvist and Busby 2013). Two envelopes for payment means hospital decisionmakers do not need to consider all costs of their activities. Bundling the two payments together would create a market for these physicians' services with the hospitals as buyers. Competition in such a market might help reduce the problem of unemployed specialists (Blomqvist et al. 2015). Further, with a couple of exceptions, provinces are not seriously redesigning how hospitals are paid even though nearly all advanced countries pay hospitals more according to the services they perform than by lump sum annual budgets (Sutherland et al. 2013). Closer matching of financing with services delivered would align system incentives with efficiency goals. Finally, renegotiating scopes of practice among health professionals – preferably in a way that focuses on team-based care models – could improve both access to care and efficiency.

### Gaps in Public and Private Coverage

A major reason for Canada's poor performance in international comparisons is the very uneven coverage in our publicly funded system. Our way of financing healthcare is unique among developed countries. Although the public share in total healthcare costs in Canada is comparable to the OECD average, the distribution of coverage is askew. There is nearly 100 percent public coverage for doctors and hospitals, but for all remaining healthcare costs – in particular for drugs, continuing care and mental health – the public share is much lower. No other advanced country takes this approach, which is best described as a “narrow but deep” way of financing healthcare (Blomqvist and Busby 2015a).

Almost everyone recognizes that this ought to change, with a focus on improving coverage for drugs, continuing care and mental health. But passionate discussions on these issues during past decades have not led to any resolution. Debates between “camps” of opinion have been fierce but the status quo prevails, in part, because of an unwillingness to seek out achievable progress. Delaying change in how Canadians finance healthcare has also made it harder, if not politically impossible, to pursue some once feasible options – a stark reminder of the costs from inaction. This lack of progress is even more frustrating when one considers the widespread acceptance of main coverage goals among medical professionals, industry, and Canadians alike – the key one being the need to ensure that any Canadian can access needed care regardless of their means.

Discussion on public and private financing often founders before it gets off the ground. Opponents on one hand focus on the downsides of change while others muddy the discussion with their strict interpretations of the *Canada Health Act's* (CHA) principles. A more productive approach would acknowledge that there are tradeoffs in all models, and that almost all peer countries have found a better balance of public and private funding for all healthcare costs, from hospitals through to continuing care, while being guided by principles such as universality, accessibility and portability. True, reforms produce winners and losers. Yet the inability of leaders to make the appropriate compromises to bring about change is both baffling and frustrating.

Breaking the logjam will not be easy. Take prescription drugs, for instance. While it is constructive to have a vision for what universal drug coverage in Canada might look like, it should not act as an obstacle to serious consideration of incremental steps forward. These steps could include bulk purchasing of drugs by the federal and provincial government on behalf of all insurers in Canada, both public and private, and allowing Ottawa to place conditions on transfers to the provinces that would make their public drug plans respect basic requirements for citizens most likely to be un- or under-insured (Blomqvist and Busby 2015b). In doing so, we should seriously consider how Quebec's model for prescription drugs, which has demonstrated the most progress in coverage among the provinces, could be improved upon.

Similar issues apply to continuing and long-term care, where the public discourse about appropriate public and private contributions often gets bogged down in a discussion of the CHA. The often overlooked fact that Canadians have to pay privately for a large share of continuing care costs contributes to an already challenging financing issue, where rising demands for care will put pressure on government costs. Plus, the likelihood that babyboomers will be disappointed about the current lack of choice around the location of care options may force changes to delivery models for continuing care. The French model of providing care for dependent elderly at home and in institutions was designed as a compromise between public and private financing. In that country, more clearly defining the public share has allowed growth in private savings and insurance to fill the gaps (Blomqvist and Busby 2014). It is a model that merits thorough consideration in Canada (Blomqvist and Busby 2016).

This discussion is not complete without mentioning mental health, where poor access negatively affects many Canadians. Scant numbers of Canadians with depression are able to access care, and there is very little follow up with primary care doctors for psychiatric patients after a hospitalization. Plus, far too many youths in need of mental health services end up in emergency departments (Brien et al. 2015).

Filling the gaps in coverage and getting better value for money in primary and hospital care should be our national priorities in healthcare. The logjams that block reform will have to be broken province by province. But the federal government obviously has a role to play as well. Given Canada's history of federal-provincial sharing of healthcare costs, how it tries to do so may be the difference between failure and success.

## A Renewed Federal Role

In Canada, it's hard to talk about national priorities in a meaningful way without clarifying how they relate to federal and provincial roles. With increasing calls for national strategies for seniors, drugs, and other things, the risk is forgetting there are important advantages in a federation. There are unique economic and social challenges in each province, as well as differing demands for care. It is hard to envision a set of national policies that could adequately meet all health needs of all Canadians, wherever they live. Rather than imposing national strategies in all areas of healthcare, the federal government could play a valuable leadership role by advocating core principles while encouraging diverse strategies. The critical drawback of getting this wrong is a blurred public view of which level of government is a responsible for financing and delivering care.

## The Canada Health Transfer – Hold the Line and Tweak

Although the provinces were surprised by the way that the post-2017 Canada Health Transfer (CHT) was announced by the previous federal government,<sup>3</sup> there is nothing obviously wrong with the size of the new transfer. It ties the pace of growth in transfers to that of the economy, with a minimum increase of 3 percent per year. All else being equal, health spending as a share of federal revenues would remain the same or increase over

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3 During a lunch at the annual meeting of provincial and territorial finance ministers in 2011, the Finance Minister made the announcement about the CHT to the surprise of the provincial representatives without prior negotiations. This led to newspaper headlines like “Premiers Split over Flaherty Health-Funding Bombshell” and “Flaherty Betrayed Ontario over Health Transfers.”

time. Maintaining the previous formula of 6 percent annual increases to the CHT would be neither sustainable nor desirable.

Over the last decade, total transfers to the provinces have increased rapidly – they now make up about one-third of all federal program spending and over 20 percent of all provincial revenues (Robson and Laurin 2015). While federal transfers for health help support a basic level of services across the country, they also imply a risk that provincial accountability for financing and delivering health services is undermined. The opportunity for provincial politicians to pass the buck contributes to gridlock in Canadian medicare.

The federal transfer masks the fact that the money to pay for healthcare comes from provincial budgets. Federal contributions for healthcare are “fungible” in the hands of the provinces, meaning that money transferred to the provinces for healthcare can be used on things other than health. That transfers have increased by 6.0 percent each year over the last 4 years and health spending has risen by around 1.5 percent annually is proof of this point. Ottawa’s inability to impose conditions on provincial actions explains why the recent federal panel on innovation recommended another tool – an innovation fund to scale up promising health innovations – as a way to engage and encourage improvement at the provincial level (Naylor 2015). This idea deserves further exploration.

A more legitimate quibble is how the CHT distributes funds to provinces based on their total population without recognizing higher demands for health services in provinces with relatively older populations, like the Atlantic provinces. Although the federal government should consider an adjusted transfer based on age, in practice this is far from a simple change. There are an unlimited number of ways to classify needs for healthcare and other provincial services, and a transfer that aims to classify needs based on age risks opening the door to an endless number of additional factors – such as rural concentration of population, Aboriginal population shares, etc. – that would enter the discussion. Arguably, reengaging the provinces in a discussion about the equalization program would be a better option to accomplish a redistribution of federal monies based on provincial needs. The federal government should also consider tax point transfers or encouraging provincial uptake of now vacant GST points forgone by Ottawa to encourage better alignment of accountability in healthcare. And there will always be an important role for the federal government in a number of specialized policy areas (see Appendix A)

## A New Health Accord

In light of an upcoming health accord with the provinces, some commentators are calling for the federal government to impose stricter conditions on financial transfers to the provinces to compel change. Ottawa should proceed with caution. As we discuss in the Appendix B, there is a great deal of provincial variation in performance: some provinces do well in some areas, but not in others. The underlying issue is that not all provinces are taking advantage of the lessons learned in other provinces and abroad. In such cases, the focus of federal leadership should be to facilitate improvement and coordination between provinces.<sup>4</sup>

When it comes to healthcare reform, whether in the form of better value for money from doctors and hospitals, or in the form of reduced gaps in coverage, it is the provinces that have to do the heavy lifting. The

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<sup>4</sup> A number of successful examples of federal coordination are highlighted in Naylor (2015).

federal government can animate the discussions in which provinces compare notes on their reform efforts and international experience. But, Ottawa should make it crystal clear that failure to make the system better will not result in an implicit bailout in the form of increased federal transfers for healthcare.

### Direct Federal Health Programs

Although much public attention will focus on the federal government's relationship with the provinces, this should not take away from the work needed on the federal government's own health programs. Taken together, federal health programs make Ottawa the 5<sup>th</sup> largest health provider in Canada. Federal programs for First Nations and Inuit, as well as veterans, refugees, Canadian Forces and Royal Canadian Mounted Police, all need attention. On Aboriginal health, there are major concerns. An early step would see the federal government identify the gaps relative to non-Aboriginals for a set of key health measures, such as life expectancy, enrolment with a family doctor, and early diagnosis of cancer. Next, Ottawa should set out a plan to eliminate these gaps over a reasonable timeframe (Truth and Reconciliation Commission 2015).

### Conclusion

Canadians spend a lot of money on healthcare but get middling results. Canada performs middle-of-the-pack on a number of OECD health measures, but is one of the highest spenders on healthcare. National figures mask some superior results among the provinces – there are lessons to be learned.

With dim prospects for government revenue growth, healthcare systems need to get better value for money in order to cope with increasing demand for services and access to effective new technologies. Were Ottawa to increase the CHT, this would take away some of the pressure on the provinces to put in place efficiency improving policies. Furthermore, undesirable gaps in healthcare coverage need fixing.

The precise federal role in healthcare is tricky. The general perception by Canadians that medicare is a national program impinges on the ability of provincial government officials to deal with vested interests who can appeal to both levels of government to prevent change. Commitment to overcoming this problem should start by encouraging opportunities for change and not politicizing them.<sup>5</sup> Clarity on federal and provincial roles would help.

A willingness by Ottawa to play a more active role on healthcare should be welcomed. There are areas where the federal government can facilitate the dissemination of successful policies between provinces and encourage diverse approaches to others. But caution is advisable: some approaches to federal intervention risk further blurring the accountability for healthcare financing and delivery.

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5 This point applies both for the party in power and for opposition parties. It could also be dismissed by astute political followers as “wishful thinking.”

## Appendix A: The Federal Role in Canadian Healthcare

The need for diverse provincial strategies within the federation is obvious in a number of areas. Take vaccination policy, for example, where national vaccination coverage targets are only consistently hit in one province – Newfoundland and Labrador. There are plenty of good lessons for other provinces to learn from the design of its vaccination model, but there are also a number of reasons to doubt that it could be scaled up efficiently in provinces with large, densely populated cities (Busby and Chesterley 2015). There is no one-size-fits-all model. However, it is the appropriate federal role to set national immunization targets,<sup>6</sup> continue as bulk purchaser, coordinate responses to outbreaks and encourage the uptake of standardized data keeping and databases among the provinces.

There are other obvious areas where Ottawa should take on a clear role – which should be done while addressing the issues Ottawa has for delivering its own health programs. For instance, because patent laws are set federally, the federal government should strengthen pricing regulation and participate in bulk purchasing of drugs with the provinces. Also, because people may move between provinces as a result of differing provincial lists of approved medicines – formularies – the federal government should help develop a national “basic” formulary.<sup>7</sup> One example of differing, and often very costly, coverage among the provinces and private insurers is for drugs to address rare diseases – this should be an area for federal leadership and intervention.

Another example with a legitimate and valuable federal role is in economic evaluation of drugs and devices, where it should disseminate better information as the basis for provincial formularies or decisions with respect to devices (Blomqvist, Busby and Husereau 2013). And finally, due to the implications for criminal law, the federal government must take a lead role in developing policies towards end-of-life care. The list of potentially important federal contribution is long. It also includes coordinating a response to antibiotic immunity, and data gathering to reduce misuse and overuse of drugs, among many others.

The following is a starting, non-comprehensive list for federal action:

- Identify the gaps between Aboriginals and non-Aboriginals for a set of key health measures, such as life expectancy, enrolment with a family doctor, and early diagnosis of cancer. Then set in place a plan to eliminate them.
- Support improved data. This includes expanded samples of the Commonwealth Fund and OECD data at the provincial level, plus improved records of misuse and overuse of drugs, among others.
- Join the provinces in bulk purchasing of drugs, invite private insurers as well, and help establish a national “basic” formulary.
- Disseminate better information as the basis for provincial formularies or decisions with respect to funding devices.

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6 The last time immunization targets were updated was in 2007. Nearly a decade later, a revised set of targets would be welcome.

7 The notion of a basic formulary would ensure that all provinces list the drugs in this formulary while allowing some provinces to supplement coverage over and above the formulary if they choose to do so.

- Coordinate a strategy, with public and private insurers, to tackle treatments for rare diseases.
- Establish new vaccination targets and encourage uptake of standardized data keeping and databases, preferably that starts at birth, among the provinces.
- Due to the implications for criminal law, the federal government must formulate policies towards end-of-life care.
- Coordinate a domestic response to international efforts on antibiotic immunity.
- Establish a policy environment that is supportive of innovation development and adoption, as highlighted in the Naylor (2015) report.



## Appendix B: International Healthcare Rankings and the Provinces

Starting in its 2012, with a few provinces – Alberta, Ontario and Quebec – paying for additional sampling, the Commonwealth Fund expanded its questionnaire at the provincial level to allow for comparisons between provincial healthcare systems and international ones.<sup>8</sup> It should come as no surprise that there is variation in provincial performance, so much so that if all provinces matched the top provincial performers in each area, the national rankings would improve significantly in quality of care, effective care, coordinated care and cost-related access (Table A-1).<sup>9</sup> There were only enough data to confidently revise 26 percent of data points in the most recent Commonwealth Fund rankings. Still, Canada's overall ranking would jump up one spot and tie with France.

The most recent OECD health statistics can be used to derive provincial results that permit comparisons to international peers.<sup>10</sup> Because not all countries report consistently on OECD health indicators, we first create a reasonable set of comparator countries. We take the top 18 countries in terms of GDP per capita, strip out Luxembourg and the United States, and then compare the remaining countries to Canada and the best provincial results.<sup>11</sup>

After selecting a group of comparator countries, the national results rank middle of the pack on a number of indicators (Table A-2). Adopting the best provincial results would, however, see notable improvements in patient safety, care quality and health status.<sup>12</sup>

There are also areas, such as timely access to specialists or family doctors, where every province is doing poorly. On this score, the federal government can allow for diverse approaches to solutions.<sup>13</sup> The application of federal leadership through core principles, but diverse strategies, is a principle that can be applied in a number of areas, but there are also important areas in healthcare with a clear role for the federal government (see Appendix A for a discussion of specific examples).

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8 This applied to the 2012 International Survey of Primary Care Physicians and was repeated in the 2013 Survey of the General Public.

9 Notably, Ontario and British Columbia were strong performers in effective care measures, Nova Scotia performs well in coordinated care measures, and Quebec reported the lowest cost-related access problems.

10 There is a very important role for the federal government to play in supporting the oversampling of provincial data in the Commonwealth Fund and OECD health statistics. The current provincial results that use the same methodology as the OECD are computed from Statistics Canada data.

11 Luxembourg's GDP per capita figures are an international outlier, and so are the health spending per capita figures in the US. Those are the main reasons why we removed them from the list of comparator countries.

12 In the OECD results, Alberta and Manitoba performed well in patient safety post-operation, and Newfoundland led the way on patient safety and childbirth. There were no consistent provincial standouts for all measures of quality of care. And British Columbia generally performed best on non-medical determinants of health.

13 The last Fed/Prov Health Accord set out, with increases in federal funding, ways to improve wait lists to five priority procedures – such as hip and knee replacement, and cataract surgery – and there has been progress in many provinces but not in all (Wait Time Alliance 2015). The standardized methods of collecting data on wait times and reporting them are helping, and Ottawa has a role to play. The federal government, with the provinces, should encourage data collection and design benchmarks for all procedures while enabling different but shared provincial solutions to waits.

**Table A1: Commonwealth Fund Nation Summary Score of Health System Performance, With Revision Using Best Provincial Performance, 2014**

|  | AUS | CAN | BEST PROV | FRA | GER | NETH | NZ | NOR | SWE | SWIZ | UK | US |
|--|-----|-----|-----------|-----|-----|------|----|-----|-----|------|----|----|
| <b>Overall Ranking</b>   | 4   | 10  | 9         | 9   | 5   | 5    | 7  | 7   | 3   | 2    | 1  | 11 |
| <b>Quality Care</b>  | 2   | 9   | 7         | 8   | 7   | 5    | 4  | 11  | 10  | 3    | 1  | 5  |
| <b>Effective Care</b>  | 4   | 7   | 5         | 9   | 6   | 5    | 2  | 11  | 10  | 8    | 1  | 3  |
| <b>Safe Care</b>   | 3   | 10  | 10        | 2   | 6   | 7    | 9  | 11  | 5   | 4    | 1  | 7  |
| <b>Coordinated Care</b>  | 4   | 8   | 6         | 9   | 10  | 5    | 2  | 7   | 11  | 3    | 1  | 6  |
| <b>Patient-Centered Care</b>                                   | 5   | 8   | 8         | 10  | 7   | 3    | 6  | 11  | 9   | 2    | 1  | 4  |
| <b>Access</b>  | 8   | 9   | 9         | 11  | 2   | 4    | 7  | 6   | 4   | 2    | 1  | 9  |
| <b>Cost-Related Access Problems</b>                            | 9   | 5   | 4         | 10  | 4   | 8    | 6  | 3   | 1   | 7    | 1  | 11 |
| <b>Timeliness of Care</b>                                      | 6   | 11  | 11        | 10  | 4   | 2    | 7  | 8   | 9   | 1    | 3  | 5  |
| <b>Efficiency</b>  | 4   | 10  | 10        | 8   | 9   | 7    | 3  | 4   | 2   | 6    | 1  | 11 |
| <b>Equity</b>  | 5   | 9   | 9         | 7   | 4   | 8    | 10 | 6   | 1   | 2    | 2  | 11 |
| <b>Healthy Lives</b>   | 4   | 8   | 8         | 1   | 7   | 5    | 9  | 6   | 2   | 3    | 10 | 1  |
| <b>Health Spending/Person (2011) [11 = Highest, 1= Lowest]</b> | 3   | 7   | N/A       | 5   | 6   | 8    | 1  | 10  | 4   | 9    | 2  | 11 |

Note: Numbers in shade are improvements.

Source: Davis et al. (2014) and author's calculations.

Table A2: OECD Health System Performance Results, Rankings Among Peers and Revisions Using Best Provincial Performance, 2014

|  | Canada's Ranking | Best Province Ranking | Number of Comparator Countries* |
|--|------------------|-----------------------|---------------------------------|
| <b>Access</b>                                |                  |                       |                                 |
| Surgery wait after specialist visit          | 3                | 2                     | 7                               |
| Access to primary and secondary care (waits) | 10               | 10                    | 10                              |
| Access to primary and secondary care (costs) | 4                | 2                     | 10                              |
| <b>Patient Safety</b>                        |                  |                       |                                 |
| Post-operation                               | 4                | 3                     | 5                               |
| Childbirth                                   | 12               | 5                     | 12                              |
| <b>Quality of Care</b>                       |                  |                       |                                 |
| Avoidable admissions                         | 5                | 3                     | 13                              |
| Primary care                                 | 5                | 3                     | 9                               |
| Cancer survival                              | 6                | 4                     | 13                              |
| Deaths from cancer and post admission        | 7                | 3                     | 13                              |
| Screening best practices                     | 6                | 4                     | 10                              |
| Health Status                                | 7                | 1                     | 13                              |
| <b>Non-Medical Determinants of Health</b>    |                  |                       |                                 |
| Healthy eating                               | 3                | 3                     | 11                              |
| Smoking and Alcohol Consumption              | 3                | 2                     | 12                              |
| Obesity                                      | 10               | 7                     | 10                              |

Note: Numbers in light shade are slight improvements, numbers in dark shade are notable improvements.

\*Number of comparator countries varies based on availability of data reported by each country in target group, as discussed in text.

Source: OECD (2014) and author's calculations.

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