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## In Search of a Magic Bullet: An overview of Canada's Health System Challenges.

All developed countries are searching for a magic bullet to solve the problems of their stressed health care systems and Canada is often cited as being the maker of the best bullet. Does Canada have the model we should be adopting? Mark Rochon, President and Chief Executive Officer of the Toronto Rehabilitation Institute eloquently provided members and guests at our October branch seminar with an overview of challenges facing the Canadian healthcare system.

His message was clear. Canadian health care reform faces a conundrum and their bullet has wobbles. The Canadian model does not have the solution we are all seeking. We should not be surprised. As Mark pointed out, there is no perfect system – choosing from among policy options is as much about selecting problems as it is about selecting solutions and hopefully the balance aligns with the values of the citizens.

Increasingly Canada is running into a contradiction that was built into their Medicare health insurance plan at the time it was created. As health economist Dr Robert Evans noted, "there is a basic conflict in a policy that says the government must control its budget, healthcare must be universally available, physicians must retain their professional autonomy, and the consumers must have free choice of providers." There is no obvious mechanism for resolving this conundrum and no politician wants to pull down the system that is in place.

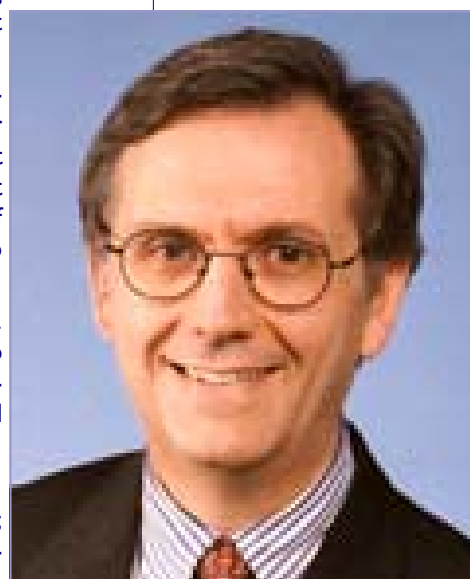
Canada has a separation of jurisdiction between Federal and provincial levels. Healthcare is primarily but not solely a provincial matter and this contributes to the challenge of creating a truly national system. And to add a little extra seasoning to the mix, there is continued stress between the province of Quebec and the rest of Canada.

The areas of most concern to Canadians are similar to ours. They are:

- \* Access - the waitlists for ER; for diagnostic services and for treatment; access to appropriate care by the right provider and to the extent possible, access to services within their communities.
- \* The quality of care.
- \* The supply of health professionals.
- \* The delisting of services and growing out of pocket expenses for medically necessary services.
- \* Concerns about who is making decisions about what is medically necessary and to what ends.
- \* The potential impact of globalisation on the publicly administered healthcare system and failure of the country's political leadership to make progress on meeting unique health needs of First Nation population

In land area Canada is the second largest country in the world, with a population of 31 million, 90% of whom are within 160km of the US/Canadian border. Its polyglot multicultural society has an ethnic make up of 28% from the British Isles, 23% of French origin, 15% other European, 26% of other mixed background (mostly Asian, African, Arab 6%) and 2% American Indian.

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**Mark Rochon**

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The official languages are English 59.3% and French 23.2%. 17.5% speak other languages.

A major worry is the aging of the population. Over the next 35 years the 80+ demographic will grow from 3.13% to 8%. This dependency ratio is seen as a real problem. Aboriginal health is also a significant issue. Aboriginals have a higher risk of poor health and early death than the Canadian population as a whole. Infant mortality is twice as high, life expectancy significantly lower, and there are higher rates of suicide and fatal unintentional injuries among First Nation and Inuit young people. In particular, there is a prevalence of major chronic diseases with diabetes growing at a substantial rate. Heart problems, cancer, hypertension and arthritis/rheumatism are also significantly higher in Aboriginal communities and appear to be increasing.

Does all this start to sound rather familiar?

Post war, changes in the Canadian healthcare system began in 1948 with the introduction of Health Grants and Hospital Construction Grants where the cost of training and hospital construction was shared between the Federal and Provincial governments. The Hospital Insurance and Diagnostic Services Act of 1958 introduced financial incentives assessed on cost sharing and specified conditions criteria. In 1968 the Medical Care Act provided financial support for a publicly administered universal insurance program. This programme was rolled out to all provinces by 1971. The shift from cost sharing to bulk funding took place in 1977 under Established Program Financing. That funding shift brought with it a natural shift in power and the 1984 Canada Health Act banned extra billing and user fees. The Act also restated 5 fundamental principles of health care for Canadians. They are:

**Universality:** equal right to health care for all Canadians regardless of who they are or where they live. (Canadians have a right to necessary services)

**Accessibility:** equal opportunities to access health care services for all Canadians regardless of who they are or where they live. (where one lives has a significant influence on access and travel is an issue)

**Portability:** ability of Canadians from one Province to get equal access to health care in other provinces even though they do not live there. (despite this there is inconsistent coverage within provincial plans – especially for pharmaceuticals).

**Public Funding:** that all the basic health care in Canada is paid by the government and there is no second private system. (tax based funding to a degree)

**Public Administration:** that the system is run by public servants who are accountable to elected officials, who ultimately answer to the Canadian public. (therefore overall governance of the system is in public hands).

As an inducement to provinces to join the Federal Medicare scheme there was 50:50 cost sharing, initially without limit. The focus is on hospitals and doctors to protect

## Population Characteristics

Age structure

0-14 = 19%, 15 – 64 = 68%, 65+ = 13%.

Population growth rate 1.025.

Birth rate = 11.41 births/1000 population.

Death rate = 7.39 deaths/1000 population.

Net migration rate = 6.2 migrant(s)/1000 population.

Infant mortality rate = 5.08 deaths/1000 live births.

Life expectancy at birth = 79.4 years (total population) – male 76.02 years, female 83 years.

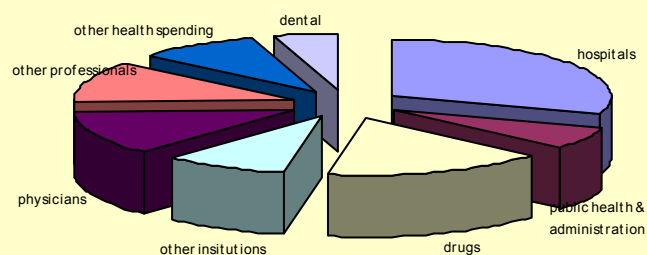
Total fertility rate 1.64 children born/woman.

against catastrophic illness. The Federal share which dropped to 15% in the late 90's is now approaching 20% of hospital and medical service cost.

Healthcare costs in Canada follow the steep upward spiral experienced in all developed countries. The insatiable hunger for funds generates political tensions between Federal and provincial governments.

Public spending on healthcare is over CAN\$80 billion, which is about 70% of all health spending. 30% of that spending goes on hospitals. There is more spent on drugs than physicians. In 2003-04 healthcare consumed about 40% of all government expenditure and about 46% of program spending. The concern is that healthcare is crowding out other important public programs like education. Despite that spending level, 65% of people surveyed believed the health care system was in crisis. The common perception of the Canadian health system is influenced by the US. Canadians often look with envy at the seemingly shorter waiting times and access to service in the US while ignoring the US shortcomings of higher costs and a lack of access for the uninsured and under insured. As one Canadian Prime Minister said, "it is like sleeping with an elephant – regardless of the temperament of the beast, you are affected by every move or grunt.

Projected Total Health Care Expenditure by Use of Funds



The key drivers for health reforms change in Canada have been the cutback of federal transfer payments to provinces in the early and mid 1990's and the consequent cash squeeze/deficit balancing and realignment of budgets by provinces. Emerging cost drivers, such as technology and drugs; the retooling and rationalisation of health care services and provincial health reforms, which apart from Ontario, have been focussed on regionalisation are significant issues. The provincial health systems began to change in

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the 90's largely due to cost (funding) issues. The aging population and changing health needs/demands, and the growing recognition of impact of the broad determinants of health have also been influential.

Other health reform issues include conflicting visions of what constitutes the optimal approach to meeting the health care needs of Canadians and a lack of clear goals for the health system. Medicare, was established as a hospital and MD program and has not changed to reflect the actual health care that Canadians receive and expect. "Crisis mongering" in the media and a lack of clear lines of accountability between the public and the providers and managers of health care also contribute to the mix.

So what is the current situation in Canada today? Healthcare is seen as a public trust and universal accessible health care is a treasured facet of public policy. Medicare is a defining characteristic community/societal obligation to one another, as opposed to every person for herself. At the same time there is a growing public perception of a sense of decline and crisis in the universality and accessibility of the health care system. Private vs public financing is confused with private financing and public delivery. The debate is often referred to as the Americanisation of healthcare. Prior to the Federal election this year the Minister of Health talked about expansion of services with private delivery and had to beat a hasty retreat. Canadians want certainty with a clear sense of what will be with respect to needs accessibility and quality.

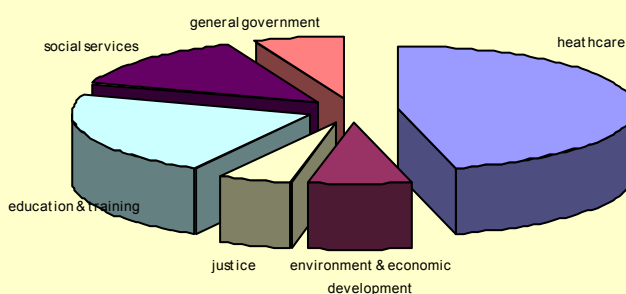
Healthcare has been well reviewed with five significant federal and provincial reviews undertaken in response to health pressures and concerns. At a Federal level they were the Federal level commission on the future of health care in Canada (the Romanow Commission) and the standing senate committee on social affairs, science and technology (Kirby Commission). At the provincial level the Quebec Clair Commission; Saskatchewan's Fyke Commission, and Alberta's Mazankowski's report provided individual reviews of the state of health care.

April 2001 the Government of Canada appointed the former Premier of Saskatchewan, Roy Romanow to lead a national review of the healthcare system. The Commission on the Future of Healthcare in Canada's mandate was to recommend policies and measures that are respectful of the jurisdiction and powers in Canada; to ensure the long term sustainability of a universally accessible publicly funded health system; and to balance investments in prevention and health maintenance with investments directed to care and treatment.

The interim report in February 2002 presented four approaches to addressing the challenges facing Medicare. They were:

1. Meeting the needs of the system by more public investment through the tax system - either by re-allocating spending from other government department programs or by raising taxes.

2003 04 Program Spending by Sector



2. Meeting the needs of the system through user fees and co payment schemes.
3. Increase private choice – meeting the needs of the system by allowing Canadians to access healthcare services from a private sector provider (either for profit or not for profit) and pay for these out of pocket or through private insurance.
4. Reorganise service delivery –preserving and enhancing the system by restructuring how care is provided – this will probably need some more \$dollars but the issue is considered largely organisational.

Romanow's Commission's recommendations included increased Federal funding for hospitals and GPs, improved access for diagnostic, cancer, and heart services. They recommended the establishment of a health council with a quality focus and the modernisation of coverage through home care, drugs and primary care reform.

Is there an answer to the Canadian (and New Zealand) health care reform conundrum?

It is an issue of political leadership. There is a need to have a renewed conversation with Canadians about choice when considering how Canadians view their desire for high quality services and the need to pay for them. As their last prime minister said, "everyone wants to go to heaven but no one wants to die.

In the recent Canadian Federal election campaign there was a focus on health care with continued jurisdictional tension between Federal and provincial politicians on accountability and public reporting issues. Despite quite different agendas, after prolonged debate there are elements of an agreement. There will be additional Federal contribution with a focus on accessibility for specialist services and a human resource strategy. ■

## A SHORT HISTORY OF MEDICINE:

"Doctor, I have an ear ache." .....

2000 B.C. - "Here, eat this root."

1000 B.C. - "That root is heathen, say this prayer."

1850 A.D. - "That prayer is superstition, drink this potion."

1940 A.D. - "That potion is snake oil, swallow this pill."

1985 A.D. - "That pill is ineffective, take this antibiotic."

2004 A.D. - "That antibiotic is artificial. Here, eat this root!"

# BECOME A NZ HEALTH INNOVATION AWARD EVALUATOR

Individuals working in all areas of the health and disability sector including public health, accident and emergency care, general practice, community care, primary health care and rehabilitation are invited to be an evaluator for the 2005 New Zealand Health Innovation Awards. The Awards were jointly established in 2003 by the Ministry of Health and the Accident Compensation Corporation to raise public awareness of the outstanding contribution that dedicated health innovators are making to the treatment, care and recovery of New Zealanders. They have quickly become recognised as a supreme accolade and those appointed to evaluate the award applications play a key role in the process.

The role of an award evaluator provides a unique opportunity to learn through direct involvement in the evaluation process. It will appeal to those people interested in developing their knowledge, skills and understanding of managing innovation in the health and disability sector and being exposed to new practices.

As an evaluator you will:

- \* Expand your understanding of creating and managing innovation within an organisation.
- \* Learn about other organisations in the health and disability sector.
- \* Develop your ability to assess an organisation against prescribed criteria.
- \* Develop your ability to identify and prioritise strengths and areas for improvement.
- \* Gain team participation and consensus decision-making skills. Develop networks
- \* Meet people interested in improvement and innovation within the health and disability sector.

The opportunity to be an HIA evaluator provides a unique learning experience but it also requires a significant amount of time and commitment from the end of February to the beginning of May 2005. In 2005 there will be more evaluators so the time commitment should be less than it was in the first two years.

Workshops are also being held for Award applicants so they have a clearer idea of what to put into their application. This should improve the consistency of applications and will make the evaluators' jobs a bit easier.

The Awards, sponsored by Telecom, are administered by the New Zealand Business Excellence Foundation.

## Evaluator Person specification

<b>Personal profile</b>	<p>Strong desire to learn.</p> <p>Ability to analyse information complemented by a healthy attention to detail.</p> <p>High personal integrity and professionalism.</p> <p>Self-management and commitment to deliver to deadlines.</p>
<b>Skills</b>	<p>Ability to work with others and be a team player.</p> <p>Strong interpersonal skills.</p> <p>PC literacy in MS Word and MS Excel.</p> <p>Strong written communication skills.</p> <p>Ability to be a constructive contributor to team activities and discussions.</p> <p>Ability to communicate ideas clearly.</p>
<b>Knowledge</b>	<p>Good health and disability sector knowledge and awareness.</p> <p>Good intuitive understanding of management systems and performance results.</p> <p>Understanding of project management philosophies.</p>

Reimbursement for travel and related expenses is on a reasonable and prescribed basis. In addition, a nominal fee of \$250 per day is available to evaluators. Evaluators will also receive an invitation to attend the awards ceremony.

Application forms to become an evaluator for the 2005 HIA are available on the Health Innovation Awards' website. The completed form is due to the NZBEF by 19 November 2004.

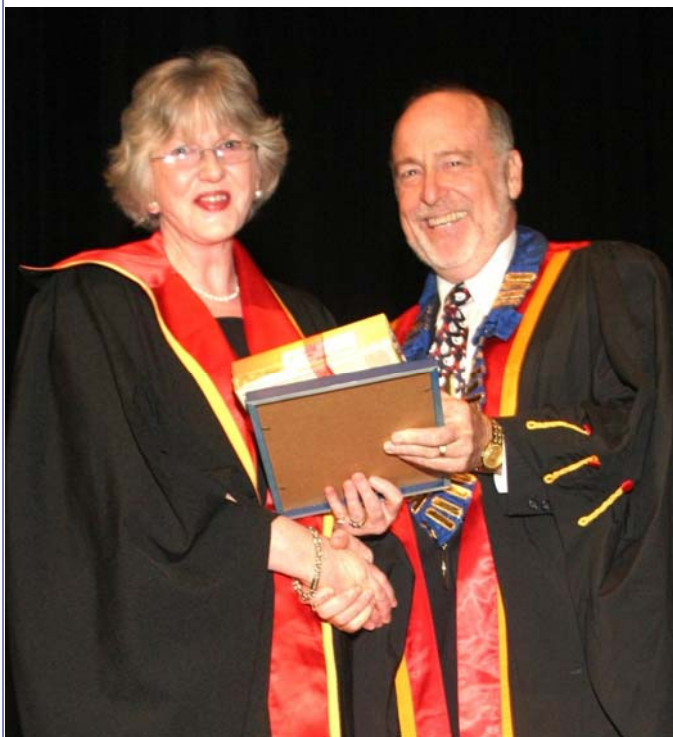
When selecting the panel of evaluators the NZBEF seeks to constitute a panel of experts that has a broad representation to minimise disproportionate involvement of one sector, region, single organisation or functional skill.

More information is available at [www.healthinnovationawards.co.nz](http://www.healthinnovationawards.co.nz) or contact the New Zealand Health Innovation Awards Co-ordinator at the New Zealand Business Excellence Foundation Phone 09 489 8791 or email: [hia@nzbef.co.nz](mailto:hia@nzbef.co.nz) ■

## Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at [admin@nzihm.org.nz](mailto:admin@nzihm.org.nz)

## Anthea Penny recipient of inaugural NZIHM Silver Fern Award



The inaugural recipient of the NZIHM Silver Fern Award is Anthea Penny. Trevor Canning, ACHSE Federal President, presented the Award to Anthea during the Awards Ceremony held during the NZIHM/RACMA combined conference at Rotorua.

Modelled on the ACHSE Gold Medal Award, the NZIHM Silver Fern Award has been introduced as a mechanism for the Institute to promote, encourage and acknowledge the pursuance of excellence in health services management in New Zealand. Nominated by fellow members, it recognises outstanding effort and achievement in management and leadership in the New Zealand health sector today. The inaugural award was generously sponsored by Microsoft New Zealand.

Anthea's contribution to NZIHM has been long-standing. Her role as President from 1992 to 1994 assisted in establishing our close links with ACHSE, which eventually resulted in NZIHM becoming a full branch some years later. Anthea is a regular attendee and contributor at national conferences. She established our first learning sets in 2003, is running the Australian-based ACHSE Leadership Development Programme, was on this year's conference Organising Committee and is an active member of the current NZIHM National Council. Anthea's passion for professional development brings the academic and clinical worlds together. She has developed and managed short courses, workshops and forums, many in conjunction with the Auckland University Centre for Health Service Research and Policy, covering subjects such as: Clinical Governance, Clinical Accountability and Change Management, Risk Management and Disease-based Management.

Coming from a nursing background, much of Anthea's

work contributes directly to patient care in both the public and private sectors, across both disability and personal health funding streams. As a consultant since 1993, she has worked with a range of clients and customer groups to gain feedback on services, their accessibility, safety, client's rights, advocacy, equity and effectiveness. In these endeavours she has consistently demonstrated her commitment to excellence in health service management.

Since 1990, Anthea has regularly participated in overseas study trips to Singapore, England, USA, Europe and Australia. More recently she has lead groups of senior health managers and clinicians from throughout New Zealand on International Master Class Study Tours.

As CEO of Nurse Maude from 1988 to 1993, Anthea restructured that organisation, introducing a General Management team structure and case management approach to patient care. A new management information system was introduced and the financial performance of the organisation turned into a positive result.

In her consulting role with RH Penny Ltd, Anthea has facilitated strategic planning sessions and developed plans with and for purchasers and providers of disability and community health, home care, rehabilitation and consumer groups. She has worked with Regional Health Authorities, the New Zealand Health Funding Authority, Accident Compensation Corporation of NZ, Hospital and Health services and District Health Boards.

One example of the many effective projects that Anthea has been involved in that contributes to the development of national health services in this country, is the development of social rehabilitation Pathways or Packages of Care for ACC. Anthea developed these Service Packages based on analysis of retrospective data and current ACC practice, making services available to people who have suffered an injury for which rehabilitation services are required. The introduction of these Packages of care has enabled ACC to improve the timeliness of services for the injured person, reduce costs of assessment and standardise the services based on the type of injury and claimant profile.

Everyone who knows or has worked with Anthea is impressed with her "can do" attitude, her energy and enthusiasm for what she does and the quality of the work she produces. She is a most deserving recipient.

### Special Award to Glenys Baldick

A special award was also made to Glenys Baldick in recognition of her Services to New Zealand Health Management. Glenys has held senior health management roles for nearly 20 years. As CEO of the Nelson/Marlborough DHB, she was the only CEO to have survived the many changes and restructuring the New Zealand Health Service underwent through the 80's and 90's, remaining within the same DHB for the entire time. She has been actively involved in the pre-cursor to NZIHM (the New Zealand Institute of Health Administrators) serving on the Education Committee and Working Party on Management Competencies.

Glenys continued to develop her own skills through ongoing education and was supportive of her management staff in continuing to develop.

During her time in Nelson she brought stability and

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New Zealand Institute  
of Health Management  
A Branch of the Australian  
College of Health Service  
Executives

For all inquiries re Branch  
activities or membership contact  
[admin@nzihm.org.nz](mailto:admin@nzihm.org.nz) or  
(09) 577 5477 Phone/Fax



Inform Editor Bruce Parkes

## Seminar Programme November 16th

@ Middlemore Hospital  
5:30p.m. for 6p.m.

\* Date and location to be  
confirmed by flyer \*

### NHS and Foundation Hospitals

Stephen Boardman : Chief  
Advisor Child and Youth  
Health, Ministry of Health

### Non Members Welcome Cost

Members	\$20
Non Members	\$25



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programme

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consistency through a period of turbulent political change as well as huge growth in population, and now the readjustment to population-based funding.

Glenys has also played an active role in the wider community and in nationally-focused health groups, including being Director of the Health Research Council of New Zealand, Director of the Health Service Welfare Society, previous Board Member of the New Zealand Council of Health Care Standards, member of the National Interim Provider Board in 1991 and '92, Senior Management Development Programme participant in 1983 and mentor on the Senior Management Development Programme 1984 through to 1986.

In addition to this, she has presented at a number of health management conferences, published articles and compiled a book in 1979 "Have a Heart".

Glenys has recently retired from her CEO role due to ill health, and was unable to join us at the conference to receive her award. However, those attending acknowledged and congratulated Glenys for her commitment, dedication and significant contribution to health services' management in this country

## 2004—2005 National Council



National Council members with ACHSE Federal President Trevor Canning and ACHSE National Director Bill Lawrence

(back row) Trevor Canning, Anthea Penny, David Rankin, Stuart Francis (Treasurer), Michael Aitken (Vice President)

(front row) Bill Lawrence, Michelle Branney (Secretary), Fiona Ritsma, Trisha Dunn (President), Debbie McDean, Peter Reynolds

(absent) Denise Udy, Phillipa Nead

**Stephen Boardman**, our November seminar presenter is a Director of Finnmore Management Consultants. His assignments have included a review of the national capital allocation system for the NHS Executive and three county-wide reviews of Trust configurations. His particular interests are in strategic planning, service development, investment appraisal and the Private Finance Initiative.

Stephen was Director of Business Planning with the former South and West Outpost, subsequently the NHS Executive. He had responsibility for developing strategic and business planning systems and for appraising and approving business case submissions. He was a member of the national project board responsible for development of the Capital Investment Manual and was seconded to the Private Finance Unit as a professional advisor. Prior to joining the NHSME Steve was Director of Corporate Development with United Bristol Healthcare Trust, and Director of Planning and Estates with Bristol and Weston DHA