

Public Priorities for Ontario's Health System

A report of the
Citizens' Reference
Panel on Ontario
Health Services



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Introduction

Ontarians rely on the province's health system to get the care they need. They trust the system to help them stay healthy and independent, and to support them when they are at their most vulnerable. That trust is hard-earned. Looking back over the past several decades, Ontario's health system has achieved many advances. Ontarians are living longer; when they do get sick or require medical attention, they spend less time in hospital; and medical science has made it possible to treat diseases and restore health to more patients than ever before.



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MASSLBP

This is the good news. More challenging is the fact that as the population ages, demands on the health system will grow. The health conditions of tomorrow's elderly patients will be more complex and require extensive therapies and more support services. Simultaneously the province's youngest members are growing up with unhealthy eating and exercise habits. Poor lifestyle choices are threatening the health of a generation—choices that will later become very costly and difficult for the health system to treat.

A constrained fiscal environment adds a different sort of challenge, placing greater pressure on the health system to deliver more and better care with fewer dollars. Spending on health care has grown rapidly over the past decade. Already, nearly half of Ontario's provincial budget goes to fund the health system, crowding out discretionary spending for other important programs such as education and social services.

Facing these pressures, it is no wonder that the sustainability of Ontario's publicly funded health care system is being called into question. Politicians, policy-makers, academics, health professionals and the media are each looking for new and better ways to improve the care Ontarians receive while ensuring that it remains accessible and affordable.

As calls grow for major reforms to Ontario's health system, PwC, one of Canada's leading professional services firms, decided to take a new and original approach to listening to the one constituency whose voice can sometimes be hard to hear: the Ontario public.

PwC approached MASS LBP, a respected Toronto-based firm specializing in public engagement, to convene a Citizens' Reference Panel on Ontario Health Services. The Reference Panel model is a tool developed by MASS LBP that decision-makers use to involve citizens in complex public policy discussions. These panels are comprised of randomly selected citizens and operate much like

a jury. They are designed to provide decision-makers with a clearer sense of the public's priorities and values.

A Reference Panel has a number of advantages over more traditional forms of public consultation, including polls, focus groups and public meetings.

First, it gathers a representative group of citizens who commit to spending several weekends over a period of two to three months learning about and discussing a policy issue from many different angles. More than merely testing top-of-mind public opinion, a Reference Panel is asked to deliberate on behalf of a broader community and reach a high degree of consensus before tabling its recommendations. In this way, a Citizens' Reference Panel offers its members the insights and tools to translate their opinions and ideas into credible advice that decision-makers can use to inform their choices. The process encourages its members to speak to their shared interests, and not just to their own personal experience.

A comprehensive evaluation of Ontario's health system requires more than three weekends. Nevertheless, the work of the Citizens' Reference Panel helps to demonstrate the overwhelming interest and ability of members of the public to play a more constructive role in this debate. The panellists took their task seriously, gave generously of their time and did not receive compensation. Where they could not agree, they did help to clearly delineate the terms of debate and explain public perceptions. Where they did agree, they clearly proposed recommendations that would have significant implications for how Ontario's health system is organized and delivers care.

Conceived as a demonstration project rather than an exhaustive review, this process is an important model for civic engagement that can help illuminate difficult, highly charged policy issues and provide new clarity.



What policy-makers should know

The members of the Citizens' Reference Panel affirmed that confidence in the public health system remains high but that support is increasingly contingent on performance. Pressure for greater transparency and more accountability, including public reporting of patient satisfaction and health outcomes across the system, is growing.

The panellists recognize and strongly support the need to deliver health services in new and more efficient ways. This includes altering the mix of health providers, and they strongly endorse the transition towards family health teams that would see physicians working collaboratively with a wider array of allied health professionals.

They are profoundly impatient for the benefits of electronic health records to become widespread and join up disconnected parts of the health system. Looking to other jurisdictions in northern Europe that have enjoyed the benefits of electronic records for more than a decade, they are baffled by what appears to be constant delays and regret the extent to which Ontario's eHealth debacle soured support for aggressive public investment.

The panellists chafe at the administrative silos and professional divides that frustrate collaboration, as well as the sheer complexity of a system they find difficult to navigate. They remain unconvinced that adding new fiscal resources is a solution to the challenges ahead and would prefer to see the kind of system-wide transformation that leads to more cost-effective approaches to delivering care.

They also place a heavy emphasis on improving communication across the health system and with the wider public. Many found the notion of a more patient- and family-centred model of care not only attractive but radical, and several of their recommendations point to their desire to see care become more personalized and responsive. The panel also regretted the lack of public awareness concerning the

health system and believe that Ontarians need to become better informed if public confidence in the health system is to be sustained.

The panellists broadly agreed that the shift in emphasis from hospital-based care to receiving care in the community and home was critical to blunting the full force of the growing demands placed on the system by an aging population. They encourage the government to continue to redirect resources towards the provision of more sophisticated models of community-based care that can keep people active and out of hospitals.

Finally, they urge strong action to address the declining health of the province's young people, insisting that schools reinstate mandatory physical education for all ages and do more to model the habits of active living and healthy eating.

They also ask government to re-examine food labelling requirements and direct a share of "sin" taxes from alcohol and cigarettes towards more aggressive health promotion campaigns.

Absent from their recommendations are any dramatic proposals to shift the funding model or cost burden of the health system. Critics may contend that nothing less is required to meet what has been characterized as a growing funding crisis. The panellists were in no way naïve to these very real fiscal pressures or to the challenges of "bending the cost curve" in health care. Instead, they took a measured view of the data and ultimately concluded that involving new forms of either private or public financing would not solve the challenges of a system that already enjoys a total level of investment commensurate with other comparable jurisdictions. Instead, they encourage greater innovation within the confines of the current fiscal envelope to meet the health needs of all Ontarians.

Working with the public



In addition to offering policy-makers an informed perspective on the public's priorities for health reform, the Citizens' Reference Panel underscores the value of taking a more sophisticated approach to gauging public attitudes and opinions. Demands for an "adult conversation" with the public about health care have come from many quarters, but any meaningful conversation with the public will require substantial investment by a trusted and impartial authority to first increase public awareness and knowledge.

Too much of current public opinion concerning the health system is freighted with mythology and anecdotal evidence. Interpretations of fact differ among many of the province's health experts. The terms of the debate itself are unclear, and the potential choices or policy responses are many. It's reasonable to assume that simplistic approaches that yield to the temptation to reduce the complexity of this debate to yes/no, more/less, public/private dichotomies will only compound public apprehension and mistrust.

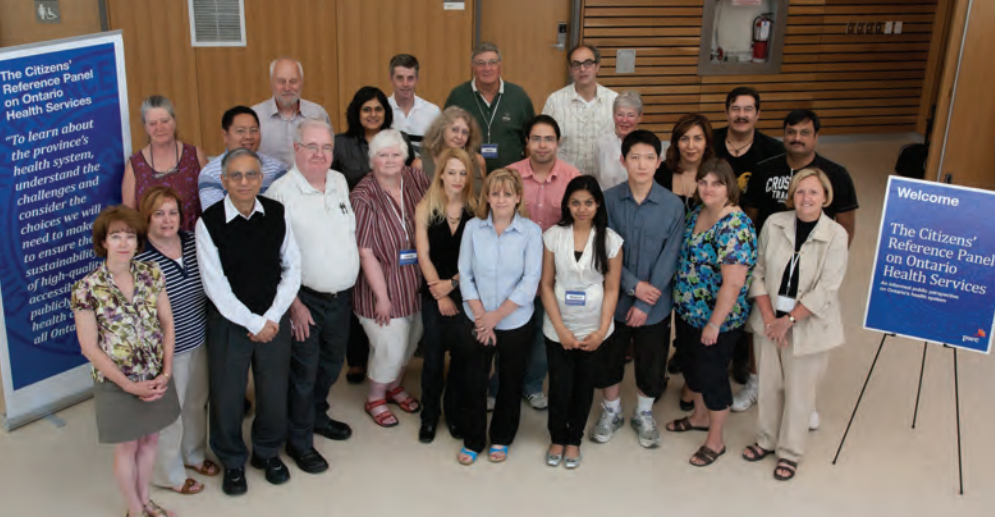
While it's true that few people welcome added costs or reduced services or dramatic change, the careful work undertaken by this small group of Ontario residents does demonstrate that citizens will accept trade-offs when they are well explained and favour long-term solutions when the return on investment is clear. Their voice is an essential one, and the public deserves to be a full partner in any discussion concerning the future of the health system.

A report of the Citizens' Reference Panel
on Ontario Health Services

Who were the members of the Citizens' Reference Panel on Ontario Health Services?

The members of the Citizens' Reference Panel on Ontario Health Services broadly match the composition of Ontario's population. On the following pages you can read about each of them, in their own words.





Elham Abaei, North York

I am originally from Tehran, Iran, and immigrated to Canada in 1998 with my husband. Since living here, I have worked with Celestica and have recently pursued my CMA designation. I was a decision-support specialist and worked in corporate finance planning and analysis. I graduated with a degree in business administration from Eastern Mediterranean University in Northern Cyprus in 1994. Between 1994 and 1998, I worked as a librarian at Girne American University and an executive assistant at the Junior Chamber of Commerce. I speak English, Farsi and Turkish.

Nusrat Ali, Toronto

I am a student at the University of Toronto, pursuing a double major in health studies and biology and a minor in French. I am a very enthusiastic and approachable person who loves studying, reading, watching TV and spending time with friends and family. I am planning to pursue a career in the health sciences field, considering Graduate programs of dentistry, medicine, public health or law. I am a true supporter of public health care and many other publicly funded programs. I volunteer at the Sick Kids Hospital, as well as Mount Sinai Hospital, and am also the current president of the “Students for Literacy” at the University of Toronto, who have helped to build two schools in Afghanistan and Tanzania in the last two years. I am a director of Dignitas Youth, which is an AIDS and HIV awareness organization that supports a clinic in Malawi. This summer, I am volunteering at various medical clinics in Costa Rica and Nicaragua.

Gladia Biswas, Cambridge

My parents immigrated to Canada via Europe in 1980; I was born in Toronto and grew up in Cambridge. I am a contracts administrative coordinator at COM DEV Space and a part-time business student at Conestoga College. I’ve always enjoyed being an active member of the community and jump at any new chances to get involved. When I received the letter from MASS LBP + PwC, I was immediately intrigued and excited for the opportunity to be a part of something big. I myself am fortunate enough to have a family doctor and get fairly good health care when I need it. That being said, I do feel there is major room for improvement and not every Ontarian receives the same kind of health care I do. I’m a firm believer in “actions speak louder than words”... the problems are well known, so this is our opportunity to provide solutions.

Steve Bowden, Collingwood

I was born in Toronto and moved to Collingwood at the age of 12. I have resided there ever since. I am 52. I have been a general contractor and run my own business. I enjoy hiking, kayaking, biking, snowshoeing and an avid skier.

Arden Bruyere, Thunder Bay

I am 51 years old and was born in Fort Frances Ontario. I grew up in a musical family of Ojibwa descent, and began my musical performing career at the age of 10. I studied classical voice technique at Bemidji State University in Minnesota for four years before returning to Thunder Bay, where I now live as a member of the Couchiching First Nation. As a solo act, I have opened for the Doobie Brothers, CCR, Loretta Lynn, and many more, as well as toured with bands throughout the United States. I am a dog specialist, a professional bass player for five bands in Thunder Bay, and a bona-fide busker (street singer).

Brian Flippance, Oakville

I earned a BSc in applied science in electrical engineering from the University of Waterloo and have been a practising engineer since 1981. I am an Ivey School of Business, University of Western Ontario alumnus and serve on the boards of several suppliers to Integrays. I have had a long and varied career in the Canadian high-tech industry dating back to 1975, when I joined the ACA after a brief tenure with Urban Transport Development. After being a sales manager at ACA, I became the owner and director in 1985. In 2005, I became the president of ACA. I support Outward Bound and like to golf, play squash and ski. I am married with three sons and five grandchildren.

Lucian Glussich, North Bay

I grew up and attended school in Toronto until joining the Royal Canadian Air Force in 1959. I served as a pilot in several locations in Canada, the United States and Europe and retired in 2004. I have been a resident of North Bay since 1980 and I am still involved in flying.

Tammey Graff, Leamington

I am a mother of four boys and a grandmother to two beautiful girls. I remarried six months ago to a wonderful man. Family is the most important part of my life. I work in telecommunications, for a company called Selectcore. In my spare

time I like to read, knit, sew and cook. I am an avid NASCAR fan; I also enjoy watching hockey and football. I prefer the Discovery and History Channels to all other channels, although I do enjoy the *CSI* series. I like the simple things in life.

Mary Knox, Orangeville

I grew up in Etobicoke but moved to Orangeville 25 years ago. I teach English and visual arts at a small high school in Tottenham. I have four amazing grown children. I earned my master's degree in English at Queen's University, and when my children started kindergarten, I went back to school to study drawing and painting at OCAD.

Derek William Levinsky, Windsor

I have a degree in business administration and a Juris Doctor degree. I am currently seeking legal employment in the United States, but in the interim I am assisting my parents with their floor coverings business. I look forward to participating in this interesting and democratic process.

Ann Lotter, Toronto

I read, review and edit scientific literature and lead seniors' fitness classes. I enjoy the amenities of Toronto and taking my dogs to the lakeshore.

Konstantino Mathioudakis, Hamilton

I was born and raised in Hamilton, Ontario, the son of Greek island immigrants. I am currently employed at Mohawk College in Hamilton as an Oracle technologist/DBA and professor. I am active in my community and did not hesitate to take part in the Citizens' Reference Panel on Ontario Health Services.

Mary McCreadie, Kenora

I moved to Kenora about two years ago after living for more than two decades in Yellowknife. I am a self-employed researcher, writer and editor who specializes in plain language communication. I volunteered for the Reference Panel because I'm interested in public policy development and believe that public processes have an important role in maintaining democracy.

Julie Noël, Crysler

In 1996, I graduated from La Cité Collégiale with a diploma in social work. I pursued my studies at the Université du Québec à Hull, from which I obtained a bachelor's degree in social work. I have been a federal public servant since 1998. I've been working for the Office of the Commissioner of Official Languages for the last eight years in various positions, including administrative officer for the commissioner, media relations advisor and currently as a senior information officer. Being a francophone myself, I value the benefits of bilingualism and know the importance of the vitality of minority language communities, including offering them services in the language of their choice.

Linda Novak, St. Catherines

I have lived in St. Catherines for 36 years. I'm happily married to a university professor. We have one daughter and a wonderful son-in-law. I have a BA in English literature from Western Carolina and a BS in broadcasting from the University of Florida. I've worked in radio news and produced talk radio shows, as well as taught in the Virgin Islands. I have been a triage clerk in a big hospital emergency room and an aide in a retirement home. I am now 63 years old and recently retired from a 25-year career in real estate sales. My main interests are writing and enjoying life. I have written one science fiction book, *Earth-Watching*, and am currently writing a second book.

David Onion, Perth

I am 62 years old and am married with two children and two grandchildren. I was an auto, truck and coach service technician for 10 years, after which I went to Queen's and became a technical teacher for 29 years. I retired, but still work part-time at Algonquin Employment Services, helping people find jobs and apprenticeships. I have had one heart stent and a kidney stone and was well treated!

Jiayi Pang, Toronto

I moved to Canada in 2000 and recently finished the undergraduate life sciences program at the University of Toronto. I am currently enrolled in a master of public health program at the University of Toronto that will begin in September 2011.

Lorrie Powless, Tavistock

I am a 54 year old female that lives in Tavistock, a small farming community just outside of Stratford Ontario. I have Lupus and have had it for over 35 years. I have two brothers and a sister all younger than me. I lost my husband 4 and a half years ago to cancer. I have also lost a brother to cancer. I was with the Lupus society of Hamilton for over 25 years until it folded. I organized eight golf tournaments, did TV spots and was a “jack of all trades and a master of none”. I was a hairdresser for almost ten years until I had to give it up.

Shiraz Rehmani, Richmond Hill

I was born in Bombay, India, in 1949. My family migrated to Pakistan, where I received my education and graduated with a degree in mechanical engineering, being honoured with a gold medal for attaining top position. I completed my technical education with a master’s degree from Lehigh University in Pennsylvania.

I worked with a number of multinational companies prior to starting my own engineering consultancy firm in 1982. I successfully ran this firm for 12 years until my migration to Canada in August 1994. My wife and two children, who migrated with me, all completed their education in Ontario and are well established in their respective professions. In Ontario I have worked in engineering management positions with a number of engineering and manufacturing firms, including Atomic Energy of Canada Limited.

Céline Roi, Penetanguishene

I grew up on a farm located in a small bilingual community called Lafontaine. I am fluent in French, English and Spanish. After attending a French high school, I studied public health at Ryerson University, where I then obtained my bachelor’s degree in applied science. I then decided to pursue my education in public health, which led me to complete a master’s program at Andrew Taylor Still University in Missouri. I believe that my educational background and some of my public health experience will help me deliver insight to and share my opinions with the Citizens’ Reference Panel. In addition, this experience may help me to develop a better understanding of Ontario’s health services.

Manmohan Seth, Brampton

I am of Southeast Asian descent and have lived in Canada for the past seven years, currently in Brampton. I work with Pitney Bowes as an account manager, though I was originally trained as a pharmacist. I am married and have one son.

Tina Stuart, North Bay

I was born in Milan and speak Italian. I have three sons and five grandchildren. I am a university graduate and coach Special Olympics bowling, pool and track & field. I am a board member of the Multiple Sclerosis Society of North Bay.

Margit Thompson, Kingston

I am a retired social worker who worked in acute care hospitals for 26 years. I was the regional coordinator and lecturer for the McGill School of Social Work Kingston programs and graduated with one BSW and three master programs. Politically, I would describe myself as a liberal conservative. I have been married for 42 years to my husband, who is a professor. We have two sons, both of whom work in the sciences. We have three wonderful grandchildren.

Christian Randy Villanueva, Scarborough

I hold a BS in mathematics with a major in computer science. I currently work as the manager of a business solutions development group and am responsible for technical development, delivery and maintenance of enterprise and online solutions that support strategic and operational efficiencies within this organization. I was born and raised in the Philippines and lived there for 23 years before moving to work in Sharjah, UAE, as an expatriate for five years. I have been living with my wife in Canada for 10 years and currently reside in Scarborough.

Larry Root, London

I was born in 1939 in London, Ontario. I worked for Canadian Tire for 48 years and was a general manager until I retired in 2007. I am married with two children and two grandchildren. I have

served as the president of the Hockey Referees Association and was a certified official. I served as commissioner of the midget/juvenile hockey organization on behalf of the OMHA and local organizations.

Alireza Sanieipour, Ottawa

I was born in Tehran, Iran, and came to Canada when I was 12 years old. I am currently an Honours Economics student at the University of Ottawa. I am planning to pursue my studies further in Economics by doing a master’s degree, especially within the Macro and Social Policy field. Since 2008, like many other students, I have been working in the retail industry. However, I am now looking to find a job in my own field of study. I believe that the information gained from this panel can make me a better candidate for potential employers.

John Wightman, Kitchener-Waterloo

I was born in December 1943 in Wingham, Ontario. In my youth, I enjoyed 4-H club and Junior Farmers activities, receiving several honours in judging, cattle showing and debating. I received a BA(honours) in business administration from Atkinson College of York University during my early work life. This included two years of farming, five and a half years in various accounting positions and 18 years with a major trust company in various positions to a final level of assistant vice president, corporate services. I sold my final business venture, Lakeview Books, in 2009 and retired to spend more time with my church and community volunteer activities. I am married with two children, two stepchildren and three (soon to be five) grandchildren.

Loretta Wojciechowski, Milton

I have been married for 30 years and have two boys. My husband works for CN Canada as an owner/operator. I was born in Poland and moved to Canada about 30 years ago. I studied business administration at Sheridan College.

A report of the Citizens' Reference Panel
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In their own words: The Report of the Citizens' Reference Panel on Ontario Health Services

What follows is the report of the Citizens' Reference Panel on Ontario Health Services. The report was drafted in point form by the panel members and edited by MASS LBP staff. The entire report was sent to each panel member for comment and further revision before being released to the public. In this way, it has been vetted and authorized by panel members as an accurate account of their findings, intentions and recommendations.



Who we are and why we volunteered

In April 2011, the call went out across the province: 10,000 invitations were mailed out to Ontario households. Approximately 550 residents responded. Out of this group, 28 people were randomly selected. We are the 28 individuals representing a cross-section of the Ontario population based on gender, age and geography. We are not health care professionals—we are Joe and Jane Citizen—ranging in age from 19 to over 70. Incidentally, our group also represents a highly accurate cross-section of the province's ethno-cultural diversity.

We were invited to spend three weekends in Toronto in the beautiful new Li Ka Shing Knowledge Institute attached to St. Michael's Hospital and were accommodated a few blocks away at the Hilton Garden Inn.

Our reasons for agreeing to participate in the panel initially ranged widely from the mundane to the highly personal. As we gained insight in the task before us and learned more about the health care system, we quickly sensed our moral responsibility to work hard on behalf of all Ontarians. Our commitment should be clear from the fact that not one panellist dropped out. In fact our attendance was nearly perfect, barring only a very few instances where individuals had long-standing family or professional commitments. We were particularly impressed by the expertise and passion of the speakers, who presented us with many facts and insights concerning the health care system. Much of what we learned gave us cause for concern but also occasional celebration. In all, it left us with a much greater appreciation for the complexity and scale of Ontario's health system.

In total, we spent 54 hours working together, beginning each morning at 8 a.m. and working until well past 9 p.m.

For many of us, this rigorous weekend schedule followed long weeks in full-time jobs or in school. In addition, we spent many more hours reading, discussing and consulting with our friends, neighbours and other local groups about Ontario's health system.

What we learned...

We learned that the health system is like any industry: filled with jargon, acronyms and terminology that can be difficult for an outsider to understand. We also learned that Ontarians are living longer and better than ever before and much of this is because of the skill with which the health system manages chronic conditions. We also learned more about wait times, alternative level care (ALC) beds and other impediments to care. We took care to properly understand the role of the ministry, LHINs, CCACs, community support services, public health units and the administrative functions they each play. As we learned, the health system is so much more than GPs, specialists and hospitals.

We also learned about some of the successes in other jurisdictions and found much to admire in the Netherlands' use of eHealth technologies to promote system integration, Australia's advanced pharmacare plan that reduces drug costs and, here in Canada, the role of health care teams in Quebec and nurse practitioners in northern Ontario.

We came to understand the progress being made to improve many cancer treatments and counter the impact of heart disease. Equally we were alarmed to learn about the growing prevalence of diabetes and obesity, particularly among young Ontarians. Given the complexity of the health system, the demands placed upon it and the fragmentation that continues to frustrate efforts at deeper integration, we were ultimately impressed that the system delivers as well as it does.



...and how we learned it

We spent significant time hearing from many experts, asking questions and discussing the implications of their ideas. We worked through more than 500 slides and several reports as we tried to get up to speed on the state of the province's health system, and the issues affecting it. On the second weekend, the balance shifted as we spent more and more time working in small groups to zero in on the ideas that would be the basis for our recommendations. Throughout the process, we were guided by a highly skilled team of facilitators who ensured that we kept on track and would reach our goals.

Understanding the task

From the initial letter we received inviting us to volunteer as members of the Citizens' Reference Panel, we understood that our task was *“learn about the province's health system, understand the challenges and consider the choices we will need to make to ensure the sustainability of high-quality, accessible and publicly funded health care to all Ontarians.”*

We hope readers of this report will agree that we have largely accomplished this task and that we have offered a useful public perspective.

You will note three main concerns in the following recommendations.

First, we want to urge a much **closer integration of the health system's many providers and institutions**. It is patients who fall between the gaps of organizations that are not well integrated or that do not collaborate effectively. The costs of poor integration are carried by citizens—both as patients and as taxpayers—and they deserve to be addressed by overcoming the technological, professional and historic barriers to better partnerships and collaboration.

Second, we want to see **eHealth systems deployed across the health system**. We recognize the complex task of creating and linking new digital systems, but we are nevertheless frustrated that despite significant public investment, realizing the full promise of these investments and electronic health records still remains years away.

Finally, we want to urge the government to continue to **focus on improving access to care**. In particular, we want to stress the importance of ensuring the availability of consistent primary care for families, especially in underserved areas of the province, as well as expanded community care services that will help meet the needs of an aging population and reduce pressure on hospitals and long-term care facilities.

Recommendations:

What follows are our recommendations for ensuring the sustainability of high-quality, accessible and publicly funded health care for all Ontarians. Each series of recommendations is based on a premise that we have included so the reader can better understand our reasoning and the outcome we hope to achieve. These premises and recommendations are listed under 13 headings:

1. Navigation
2. Access and timeliness
3. Patients as partners
4. Primary care
5. System integration
6. Information sharing, eHealth and privacy
7. Accountability and incentives
8. Community care
9. Communication
10. Language
11. Disease prevention and health promotion
12. Pharmaceuticals
13. Mental health and addiction

1. Navigation

Premise: The public doesn't know how to navigate the health care system and access appropriate care.

Recommendations:

- We urge the government to develop a more aggressive approach for disseminating information on the health care options available to the public, with particular attention paid to providing assistance for those trying to navigate the system.
- We recommend the use of new multimedia technologies to reach different audiences and that the government continues to improve the dissemination of this information by actively distributing better health services literature through community access points and health service providers.
- Lastly we recommend the training and mobilization of dedicated staff and volunteers who can provide navigational services to guide people—especially those patients receiving complex care—through the health care system and ensure that they access the appropriate service.

2. Access and timeliness

Premise: There are many inefficiencies in the health system that impede timely and appropriate access to health services.

Recommendations:

- We urge the immediate expansion of the family health team model throughout the province.
- We recommend the government expand the use of nurse practitioners and other allied health professionals in primary care clinics to supplement the work of physicians.

- We encourage the government to widen the use and scope of practice of nurse practitioners in emergency departments to make the triage and treatment process more efficient.
- We would like to see the development of a centralized specialist referral system to expand referral options for physicians and patients and allow for faster scheduling of appointments with specialists.
- We urge the ministry, LHINs and hospitals to investigate and invest in best practices for improving efficiency in emergency departments and patient flow throughout the hospital, ensuring that these practices are adopted system-wide. (We note, in this regard, the success at Credit Valley Hospital.)

3. Patients as partners

Premise: Patients need to be empowered as active and knowledgeable partners in the health care process.

Recommendations:

- We want to encourage a culture of patient- and family-centred care throughout Ontario's health system. This means developing a culture in which providers actively respect and respond to patient needs, preferences and values, and which engages patients to routinely evaluate patient-provider interactions to promote learning and improvement.

4. Primary care

Premise:

1. Not all Ontarians can access primary care in the time they need.
2. There are not enough primary care providers for the number of people who need them.
3. People in rural areas have greater difficulty accessing primary care than people in the province's major urban centres.

Recommendations:

- We urge the Ministry of Health and Long-Term Care to accelerate the expansion of integrated family health teams throughout the province.
- We encourage the use of advanced access programs and better coordination and scheduling to help patients access timely primary care.
- We support the use of financial incentives to encourage health providers to practise in rural and underserved areas.
- We would like to promote and continue to increase the training opportunities for primary care providers with the goal of raising the total number of primary care providers in the province.

5. System integration

Premise: The inability of service providers to share information and communicate more effectively undermines quality and patient satisfaction.

Recommendations:

- We urge the government to accelerate development of integrated electronic patient health records and ensure that these records are accessible to all provincially funded health providers.
- We should strengthen the role of LHINs as lead communicators for the health system with a focus on raising public awareness and knowledge about the health system and healthy living. LHINs should also work to ensure that local health service providers and physicians make public education a stronger focus of their activities.

- We encourage the expansion of self-referral and direct access to services by better promoting the use of 310-CCAC and 211 (where available).
- We urge the health system to adopt a more aggressive approach to standardizing its information and communication systems to facilitate more immediate and responsive information-sharing.

6. Information sharing, eHealth and privacy

Premise: People are concerned about maintaining the privacy of their personal health data.

Recommendations:

- We urge government to mandate the right of patients to access and control their electronic health record.
 - A patient's history should be freely available to the patient; however, we also believe that safeguards need to be in place to ensure that patients can interpret their health data correctly.
- Mindful of public mistrust and misunderstanding, we recommend that the ministry develop a major cross-media public information campaign to highlight the benefits of electronic health records and address public concerns regarding privacy and the implementation of the system.
- We urge the ministry to report on the province's standing against international eHealth benchmarks and to meet or exceed these standards.
- We believe the public should be directly involved in designing and evaluating the system prior to implementation.

7. Accountability and incentives

Premise: We applaud the increase of transparency and accountability achieved with the Excellent Care for All Act. However, we believe its scope should be extended to include all aspects of the health system, including primary care. We endorse linking compensation and other incentives to patient outcomes and satisfaction.

Recommendations:

- We urge the ministry to introduce or expand alternative funding models for physicians and other health service providers that link compensation to measurable patient outcomes and patient satisfaction. These new models would supplement or replace the fee-for-service model.
- We endorse incentives that will encourage physicians and other health professionals to form interdisciplinary primary health teams.
- We recommend the expansion of existing reporting and feedback mechanisms in hospitals that measure quality and patient satisfaction, and the introduction of similar reporting requirements at primary care sites. We believe these results should be made public to increase accountability.

8. Community care

Premise: Poor public awareness regarding the availability of community care services and a shortage of those services contribute to inappropriate hospitalization (and potential ALC designations) and the unnecessary institutionalization of patients in long-term care and other facilities. We foresee the need for a dramatic expansion of community services to meet the demands of Ontario's aging population.

Recommendations:

- We support and encourage efforts to shift health funding towards community services and believe this shift should be accelerated; however, we caution that this transition should not undermine emergency access to acute care services.
- We encourage local health service providers to strengthen their partnerships with community care support services and relevant voluntary, not-for-profit organizations to ensure better patient support in the community.
- We encourage local providers to invest in programs that connect and mobilize volunteers to support individuals to function more independently and continue to live at home.
- We encourage the creation and promotion of patient and community support groups which can reduce demand for formal health services.
- We ask that the ministry and LHINs work to resolve cyclical funding constraints that force CCACs and local service providers to reduce or ration services towards the end of their fiscal year.

9. Communication

Premise: Patients don't always receive the information they need or understand the information they get. Providers get little or no communication training to help patients understand health information. Providers don't make full and clear communication a priority. There are major deficiencies in how providers communicate with each other and with their patients.

Recommendations:

- We ask the ministry, LHINs and professional associations to develop ongoing and mandatory communications courses for all health professionals. Training should cover techniques for improved inter-professional and provider-patient communication. Excellent communication should be a hallmark of first-class care.
- To reinforce a culture of empathy and accountability, we encourage all providers to use feedback tools, such as exit surveys concerning patient satisfaction and experience, and to follow-up on the feedback they receive.
- We would like the province's health service providers to do more to give patients information in formats that are appropriate, effective and meet their specific needs.

10. Language

Premise: Language barriers and weak comprehension mean that patients cannot access effective, appropriate care. Too many patients do not understand or accurately share information about their illness or care.

Recommendations:

- We encourage major health service providers to better integrate and make consistent use of volunteer or professional language interpreters. (Sign language services should also be available.)
- We recommend the value of tools such as body charts and other simple visual aids and forms to help bridge language barriers and ensure better patient comprehension.

- We remind all health service providers to minimize the use of professional jargon and instead to use clear, plain language when addressing patients and their families. In complex cases, we advise the use of medical interpreters, either professionals or volunteers, who can take the time patients need to help them fully understand their condition and options and identify questions to ask their physician.
- We remind all health service providers of the importance of serving their patients in both official languages and to make services available in the language of the patient's choice. Where English or French language services are not available on site, providers should have access to communications technologies to facilitate the service. Where appropriate, providers also need direct or remote access to Aboriginal language interpreters, to provide First Nations peoples with access to services in their own languages.

11. Disease prevention and health promotion

Premise: Ontario's current disease prevention and health promotion strategies are not effective. A greater emphasis on prevention is the key.

Recommendations:

- We recommend the province direct revenue from tobacco and alcohol taxes towards health promotion initiatives.
- We advise the government to expand or introduce mandatory nutrition and physical education programs for all grade levels (1–12) taught by qualified instructors to ensure all children acquire healthy habits for eating and exercise.
- We urge the government to launch an ongoing multi-platform public education program that encourages

Ontarians of all ages to live more active and healthy lives.

- We strongly believe the food industry must be held to account for the sale of unhealthy products. We ask that the government mandate manufacturers and retailers to:
 - promote healthy lifestyles through mandatory user-friendly warning labels on nutritionally poor foods and beverages (including alcohol);
 - work with the federal government and other provinces to improve the national “nutrition facts” food labelling system to be more informative and user-friendly;
 - work with other government ministries and industry to better regulate the contents of prepared and packaged foods in order to improve their nutritional value.

12. Pharmaceuticals

Premise: The high cost of pharmaceuticals hurts patients who can’t afford their medications. Drug costs represent a significant and growing percentage of public and private health care costs in Ontario.

Recommendations:

- We recommend that the ministry study Australia and New Zealand’s drug plans and policies to determine whether they represent a feasible model for Ontario.
- We ask the government to adopt proactive measures to determine the affordability of pharmaceuticals in Ontario and expand government assistance as required.
- We encourage the government to study the cost-savings potential of a provincial pharmacare plan and to act on the evidence.

13. Mental health and addiction

Premise: One in five Ontarians will experience serious mental illness or substance abuse issues in their lifetime. An aging population will also put increased pressure on available mental health services; for example, the rate of dementia among older Ontarians is expected to double within 20 years.

Recommendations:

- We encourage the ministry to allocate appropriate resources to fund more early detection programs with the goal of reducing wait times for the assessment and treatment of mental health or addiction illnesses and ensure that the cost of treatment is affordable. We believe these measures would considerably reduce the societal costs of untreated mental illness.
- We urge the ministry to open more specialized mental health clinics to divert patients from emergency departments. These clinics are especially critical after hours and on weekends.
- We commend the efforts of many agencies and institutions to combat the stigma associated with mental illness.
- We urge the provision of more detox and rehabilitation programs throughout the province.
- We believe that funding should be increased for supportive housing, as well as for counselling and psychotherapy programs where they are proven effective.

A report of the Citizens' Reference Panel
on Ontario Health Services

Understanding the Citizens' Reference Panel Process

The Citizens' Reference Panel on Ontario Health Services consisted of 28 randomly selected Ontario residents, including one man and one woman from each of the province's 14 Local Health Integration Networks (LHINs). Over three weekends beginning in April and ending in early June 2011, the panel met to complete its stated task to *“learn about the province's health system, understand the challenges and consider the choices we will need to make to ensure the sustainability of high-quality, accessible and publicly funded health care to all Ontarians.”*

Their job wasn't easy. Time was short, and they quickly realized they had a lot to learn and discuss if they were to reach a series of recommendations that each of them could support.



Over the course of three weekends the panel worked through three distinct phases. A learning phase was designed to ensure that each panellist became better informed about Ontario's health system. Twenty of Ontario's most respected health leaders agreed to participate and offered the panellists an unparalleled first-hand account of the issues facing the health system within their field of expertise. A second phase asked the panel to identify the issues they felt were most pressing and identify responses that could help to address them. A final deliberation phase required the panellists to develop different health scenarios that served as the basis for contrasting different policy options and establishing agreement for a broad range of recommendations.

A six-member Advisory Board comprising several of Ontario's most respected doctors, researchers and health executives guided the development of the panel process and curriculum. They volunteered their time to oversee the process and ensure that it was focused, balanced and fair. Many Advisory Board members also made presentations to the panellists, sharing their expertise and helping to ensure that the panellists's recommendations were feasible.

The civic lottery

The Citizens' Reference Panel members were selected by civic lottery. Ten thousand invitations were sent to randomly selected households across the province. Transferable to any member of the household over the age of 18, the letter invited residents to volunteer three full weekends of their time to learn about Ontario's health system and provide an informed public perspective. Health professionals, including those involved in the administration of health services, and currently elected political representatives were ineligible to participate.

More than 550 people responded to the invitation, either volunteering to be part of the panel or regretting their inability to participate but requesting to be kept informed about the process. From among the pool of volunteers, one man and one woman from each LHIN were selected in a blind draw to be panellists. In addition to guaranteeing gender parity and geographic distribution, the draw was designed to ensure that the 28 panel members would be broadly representative of the age distribution of the province's population. Special selection was not made for ethnicity, income, educational attainment or other attributes. These supplemental characteristics have been found to emerge proportionately within the pool of lottery respondents and are carried forward to the membership of the panel. In short, the panel was composed in such a way as to deliver good demographic diversity and ensure that it was broadly representative of all Ontario's residents.



The members of the Advisory Board are:

Barbara Pitts, associate partner, PwC (chair, Citizens' Reference Panel)

Dr. Adalsteinn Brown, assistant professor, Dalla Lana School of Public Health, University of Toronto

Dr. Wendy Levinson, MD, University of Toronto Faculty of Medicine

Margaret Mottershead, CEO, Ontario Association of Community Care Access Centres

Dr. Michael Rachlis, MD, Dalla Lana School of Public Health, University of Toronto

Dr. Judith Shamian, RN, PhD, president & CEO of the Victorian Order of Nurses; president of the Canadian Nurses Association

Dr. Carolyn Tuohy, professor, School of Public Policy and Governance, University of Toronto

The Panel Process

Weekend One: April 29–May 1, 2011



Friday evening: First impressions

The panellists met for the first time at a reception and dinner at the Hilton Garden Inn, located at the corner of Dundas and Jarvis streets in Toronto. At the hotel, panellists were welcomed by the panel coordinators, who helped them to get checked in and settled. At registration, each panellist was given a binder with reports from leading independent health authorities and copies of the next day's presentations. They were also asked to hand in their signed Public Service Pledge, a one-page document that each panellist had witnessed, attesting to his or her commitment to work diligently throughout the process.

As panellists began to mill about, it was clear they were curious about each other and eager to get to know one another.

There was an immediate sense of camaraderie and no small amount of talk about how unusual it was to be invited to participate in such an intensive and important public discussion.

Once everyone had arrived, Peter MacLeod, principal of MASS LBP and the panel's moderator, and Barbara Pitts, associate partner at PwC and chair of the Advisory Board, welcomed the panel. Panellists were briefed about their task and told what they could expect from the process and over the coming weekend.

Following dinner, the panel heard from the first of many keynote speakers, Steven Lewis, a noted health policy consultant and adjunct professor, Department of Community Health Sciences at the University of Calgary. Lewis spoke about the history of Canada's medicare system. He also described many of its current challenges, noting that the system has evolved dramatically since the introduction of public-funded health insurance in the 1960s. Lewis welcomed comments and questions from the panel throughout the presentation, and what followed was a lively discussion as the panellists tried out different hypotheses about their health system.

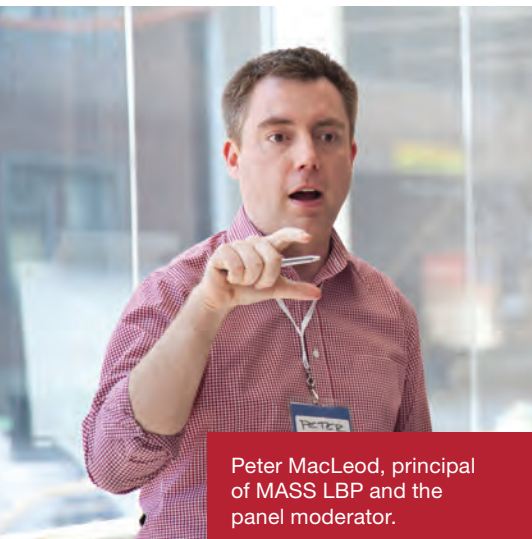
As the discussion came to a close, the panel was encouraged to keep track of their questions and comments for the many speakers they would hear from the next day. Panellists retired for the evening, energized for an early start on Saturday.

Saturday morning: Understanding Ontario's health system

Panellists arrived at the newly opened Li Ka Shing Knowledge Institute, just two blocks from their hotel, prepared for the full day ahead. After an early breakfast the program began promptly at 8 a.m.



Citizen panellists strike up a conversation with Barbara Pitts (centre) chair of the Citizens' Reference Panel Advisory Board, associate partner at PwC.



Peter MacLeod, principal of MASS LBP and the panel moderator.

Again, MacLeod, acting as the panel’s moderator, reviewed the panel process and took several questions. Next, he invited panel members to spread out across the lobby of the building, as if it were a large map of the province, and to stand in the approximate location of their hometown. It was quickly evident that the panel was drawn from every corner of the province. Panellists took turns as they introduced themselves and shared why they had volunteered. Several members reported having had extensive experience with the health system. Others were simply curious about the health system and wanted to learn more. Many panellists expressed their sense of civic responsibility and felt they had an obligation to contribute what they could to an important public discussion.

For the remainder of the morning, the panel embarked on an intensive orientation to the province’s health system. The curriculum was designed iteratively, with each presentation building on the last and becoming increasingly focused as the process unfolded. First, Dr. Jeff Kwong, a family physician and scientist at Ontario’s prestigious Institute for Clinical Evaluative Sciences, presented a demographic overview of the province, highlighting the growing incidence of many major diseases and the pace of aging across different parts of the province.

Next, Donna Cripps, CEO of the Hamilton Niagara Haldimand Brant Local Health Integration Network, discussed the architecture of the province’s health system. Likening it to a set of gears, she discussed different efforts being made by the LHINs to better integrate local health services. She also explained many of the barriers to deeper integration and helped to familiarize panellists with the many acronyms and concepts used by health system planners.

Completing the first morning, Professor Raisa Deber from the Department of Health Policy, Management and Evaluation at the University of Toronto addressed a topic that many panellists were anxious to better understand: the economics of a health system that currently accounts for nearly half of Ontario’s budget. Deber’s presentation challenged conventional wisdom about runaway health care costs and described both the likely impact of increasing the supply of private dollars to the health system and the projected costs of aging boomers.

Following lunch, panellists completed a short group activity that reinforced much of what they had learned in the morning. As panellists worked together to answer a series of questions about the roles of the various organizations and actors, they were consistently surprised by the complexity of the system.

They then turned their attention from the providers of health services to the recipients. Splitting into groups, panellists received a series of fictional health biographies representing different segments of the population. Each group was tasked with completing the personal history of a persona and inventing a second persona of their own choosing. At the end of the hour, with the assistance of a professional illustrator, each group presented their personae, covering a wide range of health system users. Most of the personae represented challenging cases, and returning to the personae over the coming sessions would challenge panellists to consider all segments of the population as they considered Ontario’s health issues.

In their last activity of the day panellists began to discuss the values that underlie the health system. They reviewed the Ontario Health Quality Council’s nine “attributes of a high performing health system” and their definitions. Back in their small groups, each table of panellists explored two to three of the values in greater detail. During their conversations, they identified instances from their experience when the care they received met the standard described by the value and other times when the system fell short.



Citizen panellists working through group activity which reinforced learning from the morning session.



After a full day, the panel adjourned at 5 p.m. for a short break before returning to the Hilton Garden Inn for dinner and the day's final presentation.

Saturday evening: Discussing sustainability

That evening the panel heard two perspectives on the sustainability debate. Mark Stabile, associate professor of business economics and the director of the University of Toronto's School of Public Policy and Governance, reviewed the evidence concerning health system spending and suggested several alternate models for generating new revenue. Dr. Michael Rachlis, a physician and associate professor at the Dalla Lana School of Public Health at the University of Toronto, argued passionately that a transformation in how services are delivered, not additional funding, was the key to solving the sustainability debate.

Their contrasting—but not contradictory—perspectives put in sharper relief many of the questions panellists had asked throughout the day, and the debate provided a good occasion to clarify their understanding of the how the health system is funded.

Sunday morning: Health Perspectives Panels

Early Sunday morning the panel reconvened at the Knowledge Institute. They began by recapping the previous day, and Barbara Pitts again reviewed the relationships between major health providers such as hospitals, primary care clinics and community care access centres, which had been the subject of many questions the previous day. Panellists were surprised by the complexity of the system and the often circuitous paths of accountability and decision-making.

Then the panel heard from the first of four Health Perspectives Panels. Robert Biron, CEO of Northumberland Hills Hospital, Lisa Droppo, chief, analytics, policy and programs, Ontario Association of Community Care Access Centres, and Michael Kates, family physician and chief of family medicine at Trillium Health Centre, each presented an insider's view of one major facet of the health system. Following their presentations they engaged the panellists in a discussion that sought to highlight the connections and barriers between the provision of primary, acute and community care. The three also discussed emerging models of organizing and funding care, such as family health teams and the much anticipated impact of electronic health records.

In their final task of the weekend, the panellists returned to their groups from the previous day and the values activity. In plenary, each group presented their assessment of the values. They began to notice that the health system lived up to some of its values better than others. In a final plenary session, the panel agreed to add three values—communication, continuous improvement, and environmental responsibility—to the Ontario Health Quality Council's list and to remember these values in their deliberations.

The panel adjourned for a two-week break. In the interim, each member was asked to talk to friends, neighbours and colleagues about the weekend's discussion and inquire about their experiences with Ontario's health system. They were also asked to review the most recent reports of the Ontario Health Quality Council, as well as a primer on health care published by Health Canada.

The first health perspective panel gave citizen panellists an insider's view of their segment of the health system.

From left to right: Robert Biron, president and CEO, Northumberland Hills Hospital; Dr. Michael Kates, chief of family medicine and director of the Trillium Summerville Family Medicine Teaching Unit, University of Toronto; and Lisa Droppo, chief analytics, policy and program, Ontario Association of Community Care Access Centres.



Weekend Two: May 13–15, 2011



Adalsteinn Brown addressed gains achieved by the Excellent Care for All Act.



Mary Kloosterman, CEO of the Kingston YMCA shared some of the initiatives her YMCA is undertaking to help people make healthier choices.

Friday evening: Reunions

When panel members met again at the Hilton Garden Inn, they greeted one another warmly, eager to catch up on any news from the previous weeks and discuss the weekend ahead. Many shared the views they had heard from friends and neighbours over the break, while others passed around newspaper clippings and other information they wanted to share. Clearly the spirit of the process had taken hold.

Following dinner, the panel was welcomed back by Peter MacLeod and Barbara Pitts, who introduced the weekend's first keynote speaker, Adalsteinn Brown. A former assistant deputy minister of health, Brown was responsible for encouraging greater health system accountability and the passage of the 2010 Excellent Care for All Act, which created new incentives to improve quality and responsiveness within the health system. Brown told the panel flatly that in order to change the system for the better, "we have to know what we want out of health care." It was a simple message that stuck with panelists, who would invoke it later in their deliberations.

Brown also encouraged the panellists to consider the sustainability issue from different angles. *"It's not only about where the money comes from. It's about who's doing the work and how they do the work. That's where real value can be found."*

Panellists stayed long after the presentation to discuss what they had heard, and the moderator gently encouraged them to get a good night's rest in advance of a heavy program the next day.

Saturday morning: Concluding the Health Perspectives Panels

Panellists returned to the Li Ka Shing Knowledge Institute for a prompt 8 a.m. start. Once again, MacLeod reminded the panellists of their task and reviewed what they had learned during their first weekend. Next, he set out the agenda for the day, which would include three Health Perspectives Panels over the course of the morning and an extensive brainstorming exercise to begin identifying and sorting the many issues affecting the health system later that afternoon.

The first panel was led by Dr. Rob Cushman, former chief medical officer of Ottawa and CEO of the Champlain LHIN, and Mary Kloosterman, CEO of the Kingston YMCA. Cushman and Kloosterman each spoke about the importance of preventing disease and promoting good health, especially among youth.

Cushman began by admonishing the "Toronto-centric" approach of those who think greater centralization is the answer to improving health care. He also cautioned that health promotion and disease prevention are "no magic bullet" but the result of hard-won campaigns to fundamentally change public behaviour.

Kloosterman described how organizations such as the YMCA work alongside the health system and government to help people make healthier choices and become more active. She also noted how organizations such as the Y fill important gaps by teaching underprivileged kids to do basic tasks like shop for fresh groceries and cook nutritious meals. She also pointed to the extensive work done by the Y with disabled youth, whom they encourage to participate in physical activity and develop new skills.



Kurtis Bishop, the managing director of eHealth at PwC (centre), is joined by Janet Davidson, OC, president and CEO of Trillium Health Centre (left), and Carl Vendette from the Conference Board of Canada.



Weekend Two health perspective panel, from left to right: Dr. Catherine Zahn, president and CEO, Centre for Addiction and Mental Health; Judith Shamian, president and CEO of the Victorian Order of Nurses; Michael Hindmarsh, president of Hindsight Healthcare Strategies; and Mark Smithyes, Health Policy Ontario, Novartis Pharmaceuticals Canada and vice chair, Ontario Committee.

During the morning's second panel, Janet Davidson, president and CEO of Trillium Health Centre in Mississauga, spoke about health administration and human resources, describing health care as "a people business." She stressed the importance of integration and inter-professional collaboration among health professionals and described several initiatives intended to bring professionals together. Kurtis Bishop, the director of eHealth at PwC, spoke about the promise of the province's long-awaited eHealth system and why future health reforms will rely on sophisticated information systems that can harmonize patient data. Then Carl Vendette, a last-minute addition to the program from the Conference Board of Canada, spoke about the Conference Board's own initiative to promote a public discussion about the future of the health system.

The final Health Perspectives Panel focused on chronic disease, mental health and aging. Catherine Zahn, CEO of the Centre for Addiction and Mental Health, told the panel that while important advances have been made to reduce the stigma of mental illness, more work must be done to lessen the social and economic cost and promote mental

health as actively as we promote physical well-being.

Judith Shamian, CEO of the Canadian Nurses Association and president of the Victorian Order of Nurses, talked about the growing importance of nurse practitioners, who provide more affordable and versatile access to primary care. She also stressed the importance of home and community care, explaining that for many elderly, the help they most need is with home-making. Shamian explained that minimal investments made to keep people in their homes would go a long way to keeping people out of hospitals and reducing the economic burden of an aging population. Michael Hindmarsh, a chronic care expert and health policy consultant, discussed the importance of using advanced information analysis to tackle the rise of chronic disease. He argued that changing the fee-for-service model in primary care, expanding the use of electronic health records, and increasing the use of population-based information could lead to dramatic improvements in health outcomes and system affordability. Finally, Mark Smithyes, manager of health policy for Ontario at Novartis, spoke about the role of pharmaceuticals in healthcare.

He described the process of developing new drugs and the promise of pharmaceuticals to treat chronic diseases while allowing patients to remain at home.

Saturday afternoon: Identifying the issues

With their orientation to the health system now complete, panellists returned from lunch to address the issues in their own terms. Seated in small groups at roundtables, panellists spent an hour sharing the results of their “homework” discussions with neighbours and peers. Each panellist was asked to list his or her top priorities for reform. In groups they compared their lists before compiling a new, shared list of issues and reforms they felt were most notable.

Each table presented their list to the room, and in a final plenary session the panel members worked to synthesize the four lists into one. This session challenged the panellists to adopt the language they had learned from the many expert presenters and focus their attention on the issues they believed were most significant.

Following more than an hour of plenary discussion, the panel had settled on a list of 20 major issues they felt deserved attention.

1. Seamless flow of communication about patients between services
2. Streamlining points of service (System navigation - misuse)
3. Access to primary care
4. Access to specialists
5. Access to community care
6. Access across geography
7. Linguistic access
8. Access across socio-economic levels
9. Access to information for the patient and family members
10. System funding, and resource allocation, financial accountability / value for money, personal costs of care
11. System integration
12. Health promotion and wellness / education, disease prevention

13. Information-sharing between patients and providers
14. Service model: treating patient not illness (Patient-centredness)
15. Better support for research and innovation
16. Wait times
17. Evidence and integrity
18. Quality care
19. Access to supporting services, housing
20. System complexity

They agreed that this list would need to be further refined the following day. Panellists then adjourned for a brief break before supper.

Saturday evening: Comparing Ontario with other jurisdictions

That evening, the panel reconvened at the Hilton Garden Inn for dinner and a special presentation. Carolyn Tuohy, professor emeritus of political science and senior fellow at the University of Toronto School of Public Policy and Governance, made a lengthy and very popular presentation on how other jurisdictions run their health systems and how those systems compare with the performance and cost of Ontario’s health system.

After pausing the presentation to answer many questions from the floor, Tuohy checked her watch and apologized to the group for going over time. When she said she would skip a slide to go faster, the panellists protested. After a long day, her presentation would last nearly two hours.

Before concluding, Tuohy cautioned the panel against a number of common pitfalls for health reform. She acknowledged that policy-makers often feel the need for drastic restructuring. She urged the panel to exercise care: “*Build on what’s there. Work with what’s there. Work with the actors and institutions that are already established and have a basis for being there.*”



Sunday morning: From issues to responses

Early Sunday morning the panel reconvened at the Knowledge Institute, to hear an overview of what was still to come. MacLeod explained to the group the time they had left, assuring them they had everything they would need to reach some good decisions. He expressed confidence that the group could strike the right balance and make a useful contribution.

They began by reviewing the list of issues they had produced. After deliberating overnight the panellists had a clear idea of how they wanted to revise their list. In half an hour they had arrived at a list of 17 issues they wanted to pursue. Each table was given four issues to explore in detail. The tabletops had been covered in craft paper, on which each facilitator wrote the names of the issues. The panellists were tasked with brainstorming all of the possible responses to each issue, and mapping the options on the tabletops. Panellists were encouraged to move from table to table, exchanging ideas and referring to their notes to ensure that the broadest range of options was recorded.

The next two hours passed quickly as panel members recorded the ideas. Some flipped through their work binders that contained copies of the speakers' presentations. Others spontaneously came up with new ideas and worked with their groups to define and specify the "who" and "how" of each policy option. After, each table transferred their responses onto cards and placed them up on the wall, grouped under each of the 17 issues.

In the final activity for the weekend, each panellist received a large sheet of paper with a series of circles that looked like a bull's-eye. At the centre circle were the words "central to the future health of Ontarians." The panellists were asked to consider the full list of possible responses, now totalling more than 100 ideas, and select the ones they felt were most important.

The room fell silent as panellists wandered up and down the wall of responses and selected their preferences. After almost half an hour of reflection, the panellists had completed the activity and were satisfied with their choices. Over lunch they compared their sheets, asking one another about their selections and their motivations for choosing one response over another.

In a concluding plenary, panel members considered their accomplishments over the first two weekends. Everyone acknowledged the vast quantity of material they had absorbed. Some expressed doubts that their final report would be useful to policy-makers. Then one panellist said, *"What we are proposing may be ambitious but we need to give a clear sense of direction. We should consider the ramifications of what we're putting forward here, so that we can show what the average Joe – what regular citizens really think."*

Another added, *"We've got a big broad way to look at things, but at least we know the options now. I think a lot of us will change our minds as we get more comfortable with the issues."*

With that the panel adjourned, reassured of their capabilities and confident of their purpose.

Weekend Three: June 3–5, 2011

Friday night: Hitting the ground running

As the panel gathered for their final weekend together, they were, for the first time, each assigned a specific seat at dinner, marked with their bull's-eye chart from the previous weekend. Accompanying their chart was a newly prepared coloured grid that illustrated the choices each panellist had made. This would be a working dinner. It was the first step in what would be a marathon weekend.

Peter MacLeod welcomed the panellists and provided an overview of how they would spend their remaining time together, explaining why they were seated now in specific groups. Each bull's-eye had three rungs and had been assigned points in order to compare the panellists' responses. Panellists were seated with a group of peers who had each recorded similar preferences.

That evening the five different groups were tasked with sketching a health scenario that would evolve from their agreed preferences. Each scenario would explore a selection of issues highlighting the benefits, drawbacks and importance for each idea for reform. The following day the groups would combine their scenarios to select the best

from each to form the basis of their final recommendations.

Over dinner each table identified the specific issues they shared as a group. Many groups shared several issues in common. There were heated discussions over which issues were the most important as the groups worked to narrow their focus. The tables conferred with one another, exchanging ideas and plotting the strategies.

By the end of the evening each table had selected a focus for their scenario. Panel members challenged each other to incorporate all they had learned, and expressed confidence in each other to meet the challenge of the days ahead.

Saturday morning: Final presentation, developing scenarios

As panellists arrived for the day's discussions, there was a sense of urgency among the group that they still had a long way to go. Panellists returned to the same discussion groups from the previous evening. To start the day, MacLeod had prepared a summary of each of the presentations the panellists had heard during the previous two weekends. The presentation reminded the panellists of everything they had heard, and quickly demonstrated just how far they had come.

Next, Dr. Wendy Levinson, chair of the Department of Internal Medicine at the University of Toronto, made the final presentation to the panel. A renowned expert on physician-patient communication, she emphasized the role of good communication in creating better patient outcomes. Panellists had many questions about patient- and family-centred care, but they also used this last opportunity to ask clarifying questions that arose during their scenario discussion the night before.



Citizen panellists in heated discussions over which issues were of most importance.



Following Levinson's presentation, the groups focused on developing their scenarios. They chose a name, overarching goals, as well as a set of premises intended to underpin their recommendations. After each group had developed the details of their scenario, they were asked to evaluate its merits from a series of different perspectives. They also scrutinized how well their scenario realized the health system values they had identified and met the needs of each of the patient personae that had been developed.

The following hours were filled with intense deliberation. Then, each group presented their scenario in plenary. Panellists provided feedback and asked questions. Not surprisingly, the presentations revealed that many of the ideas identified by each group were variations on similar themes. The panel could begin to see where it agreed, and where there was still more discussion to be done. After a demanding morning the rapport among the panellists was positive; it was clear they were working hard to arrive at a clearer, more meaningful result. Now it would come down to the details.

Each group returned to their scenario for the remainder of the morning to integrate the feedback they received and further expand and refine their recommendations.

Saturday afternoon: Developing integrated scenarios

Following lunch, one or two members from each of the five scenario groups recombined in four new groups to draft "integrated" scenarios. Their job now was to take the best ideas from each scenario to create a more cohesive and balanced vision. Identifying and eliminating duplication among the individual categories was simple. Reconciling the similar but distinct recommendations proved very challenging. Panellists struggled to find the right language to describe their intentions and develop thoughtful recommendations.

After several more hours of heated debate, each of the four groups presented their integrated scenario. This presentation emphasized the priorities and recommendations the panel shared. Many of the goals and recommendations were shared across groups, but there remained several key areas of disagreement. Together, the panel members identified the issues that required further deliberation, including, for instance, access to specialists and several issues concerning the privacy and ownership of electronic health records. Other issues surfaced that would require new discussions, including the importance of placing a special emphasis on mental health care and the illicit sale of prescription drugs. Several panellists volunteered to lead discussion groups during what would be the second working dinner of the weekend.

Saturday evening: The discussion continues

Through dinner panellists continued to discuss and brainstorm ideas they hoped they would be able to incorporate in their recommendations on their final day. Despite the hard work, the mood was buoyant as the panellists enjoyed their final supper together. One panellist had brought his guitar, and as the tables were cleared, the room began to feel more like a campfire sing-a-long among friends than a group of relative strangers focused on difficult public policy issues.

Before the group adjourned, MacLeod presented a synthesized version of the four scenarios they had developed that afternoon. The result—a very tentative draft of their findings—contained more than 50 recommendations organized under 13 headings.

One panellist reflected on the accomplishments of the day: *"I was overwhelmed this morning. But seeing it all organized like this I feel like it's coming together. We have a lot of good ideas here."* Another remarked, *"I don't know what to say, except that we should all be proud of what we did today."*



Citizen panellists draft sections of the final report.

Sunday morning: Drafting the report

At the start of the final session, MacLeod presented the panel with a series of large paper templates. Each page stated one of their 13 headings, and included draft text from the previous day’s scenario groups. Over the course of the morning the panel would revise this text, refine their recommendations and, page-by-page, write their final report.

The panel broke into small groups of three to four to write each section. One group focused on writing an introduction that explained the purpose of the panel. Other groups spread out across the building, working for more than an hour on refining the language of their premises and recommendations. The building was quiet as the working groups focused on their task. After a small break, the groups convened for a “dress rehearsal.” Each group presented their section and took comments and

suggestions. They received constructive feedback about the wording of certain recommendations and made careful notes where they found disagreement.

Each group took these suggestions and spent the remainder of the morning revising their sections. Some panellists joined other groups to work on revising a section where they thought they could help. At noon, the panel returned to plenary to make the final presentations. They understood that the words and bullet points they chose would be used by the panel organizers to develop their report. The pages were bound together into book form, and a representative from each group took the podium to read their section outloud. Each chapter reading was followed by a warm round of applause. With the completion of their report, the process had reached its end.

Following lunch, a brief ceremony was staged to recognize panellists for their dedication to the panel process and its goals. Each panellist received a certificate and a frame that featured photos of the panellists and the emblem of the Citizens’ Reference Panel on Ontario Health Services. With a mixed sense of exhaustion and pride, the panel adjourned its final deliberation.



In small groups, citizen panellists presented chapters of the final report.



A report of the Citizens' Reference Panel
on Ontario Health Services

Appendix

About PwC

To better understand health industry trends and delivering sustainable health care in the face of increased pressures, PwC conducted research by listening to consumers, health leaders and governments from around the world. Our most recent global report *HealthCast, The customization of diagnosis, care and cure* examined the opportunities and challenges that exist to get Canadians the health care they deserve. But with the growing demand from health care professionals and the public to re-examine how provinces fund the health care system and provide access to care, PwC decided to take a new and original approach to listen to the one constituency whose voice can sometimes be hard to hear: the public. That's why we've commissioned the Citizens' Reference Panel on Health Services in Ontario—to offer a platform where Ontario residents and health leaders can share their perspectives and provide insight on their proposed recommendations towards sustainable health care.

pwc.com/ca/healthcare

About MASS LBP

MASS LBP is a new kind of advisory firm that works with visionary governments and corporations to make better decisions while deepening and improving their efforts to engage and consult with citizens. Fundamentally we believe in people. Given the opportunity to participate in a thorough, fair and inclusive process, citizens are ready to provide constructive advice, offering officials the intelligence, perspective and sensitivity that difficult public issues require.

Since 2007, MASS LBP has led some of the Canada's most original and ambitious efforts to engage citizens in tackling tough policy options while pioneering the use of Civic Lotteries and Citizen Reference Panels on behalf of a wide array of clients.

Our work goes far beyond polling and focus groups. From conception to execution to evaluation, MASS LBP designs and delivers highly innovative engagement strategies that increase public understanding, legitimacy and support for complex decisions and policy choices.

MASS LBP is based in Toronto and works with partners across Canada and the United Kingdom.

masslbp.com

Advisory Board Members

Barbara Pitts

Panel Chair
Associate Partner, National Health Lead

Barbara Pitts is the National Leader of the Health Services Practice of PwC in Canada and works from the Toronto office.

Barbara advises health service leaders in the design and implementation of new health systems and integrated service delivery models, in the development of strategy and the supporting performance management system, in the improvement of quality and operational performance and in the area of access, patient flow and the impact on system metrics, as well as developing solutions for health human resources and organizational design. She has recently completed leading an engagement that reviewed patient flow across 10 hospitals in four LHINs, which resulted in specific detailed action plans for change to address ALC and wait times that will be reported to the MOHLTC, the design of the integrated regional program for maternal, newborn, children and youth within Mississauga Halton LHIN and the transformation of patient flow and access and financial effectiveness at the William Osler Health System. Prior to joining PwC, Barbara was a partner and the COO of Stage-Gate Inc. and held a faculty position at the Michael G. DeGroot School of Business at McMaster University. She holds a BA, a BEd and an MBA.

Barbara has co-authored publications and delivered numerous presentations on topics such as implementing winning innovation programs, strategic performance management and leadership.

Adalsteinn (Steini) D. Brown

Assistant Professor, Dalla Lana School of Public Health, UofT

Adalsteinn (Steini) D. Brown is the inaugural chair in public health policy at the Dalla Lana School of Public Health at the University of Toronto and a scientist in the Keenan Research Centre at the Li Ka Shing Knowledge Institute of St. Michael's Hospital.

Until late 2010, he held senior posts in strategy and policy at the Ontario Ministries of Health and Long-Term Care and of Research and Innovation. He has served as an advisor to the World Health Organization, major hospital networks, HMOs, insurance companies, and investment banks in Canada, the United States, Europe and the Far East.

Steini graduated magna cum laude (government) from Harvard in 1993. He received his D.Phil from the Department of Public Health and Primary Care at the University of Oxford in 2002, where he was a Rhodes Scholar. In recognition of his work on performance measurement, he was named one of Canada's Top 40 Under 40 in 2003.

Dr. Wendy Levinson MD

University of Toronto, Faculty of Medicine

Dr. Wendy Levinson is the Sir John and Lady Eaton professor and chair of the Department of Medicine at the University of Toronto. She worked in the United States on the faculty of the Oregon Health Science University and the University of Chicago Medical School. She is a past president of the Society of General Internal Medicine and a past chair of the American Board of Internal Medicine. She presently is a member of the American Board of Internal Medicine Foundation and American Board of Medical Specialties Board of Directors.

Dr. Levinson is a national and international expert in the field of physician-patient communication. Her research has spanned a number of highly relevant policy issues, including the relationship of medical malpractice to breakdown in communication, the effectiveness of primary care physicians and surgeons in helping patients to make informed decisions, and the disclosure of medical errors to patients. Dr. Levinson has contributed to large-scale training programs to enhance the skills of primary care physicians and surgeons in effective communication with their patients.

Margaret Mottershead

CEO, Ontario Association of Community Care Access Centres

Margaret Mottershead is the CEO of the Ontario Association of Community Care Access Centres and president of Mottershead & Associates Inc., a management consulting firm specializing in health care. For the past eight years Margaret has provided executive, management and negotiations expertise to several large health care initiatives. She has been chief negotiator for the Ontario government on contract negotiations with the medical profession on alternate payment plans for all specialists in two Academic Health Sciences Centres and hundreds of specialists in regional programs across the province. She was also the project manager for the CCAC Alignment Project that saw Ontario's 42 CCACs transformed to 14 new CCACs in 2007. Margaret is a former deputy minister of health and senior assistant deputy minister of health, with many years of experience in public service.

Dr. Michael Rachlis MD

Dr. Michael Rachlis practises as a private consultant in health policy analysis. He has consulted to the federal government, all 10 provincial governments, and two royal commissions. In 1988 he was made a fellow of the Canadian Royal College of Physicians. He is also an associate professor (status only) with the University of Toronto Dalla Lana School of Public Health. In 2010, the University of Manitoba conferred upon Dr. Rachlis a doctor of laws in recognition of his service to Canadian health policy. Dr. Rachlis has lectured widely on health care issues and has been invited to make presentations to committees of the Canadian House of Commons and the Canadian Senate as well as the United States House of Representatives and Senate. He is a frequent media commentator on health policy issues and the author of three national bestsellers about Canada's health care system.

Presenters

Dr. Judith Shamian RN, PhD

President & CEO of the Victorian Order of Nurses; President of the Canadian Nurses Association

Judith Shamian is currently the president and CEO of the Victorian Order of Nurses. She formerly held the title of executive director of nursing policy and Health Canada and is a professor in the Faculty of Nursing at the University of Toronto. Judith was also the president of the RNAO from 1998 to 1999.

Dr. Shamian obtained her PhD from Case Western Reserve, Cleveland, Ohio, her master's in public health from New York University and her baccalaureate in community nursing from Concordia University in Montreal.

Dr. Carolyn Tuohy

Professor, School of Public Policy and Governance, UofT

Carolyn Tuohy is professor emeritus of political science and senior fellow at the School of Public Policy and Governance. Her research and teaching focuses on comparative public policy, with an emphasis on social policy. Professor Tuohy has served in senior academic leadership roles at the university, as deputy provost, vice-president of policy development and associate provost, and vice-president of government and institutional relations.

Weekend 1

Steven Lewis BA, MA

President, Access Consulting Limited; Adjunct Professor, Department of Community Health Sciences

Steven Lewis is a health policy and research consultant based in Saskatoon and adjunct professor of health policy at Simon Fraser University. Prior to resuming a full-time consulting practice, he headed a health research granting agency and spent seven years as CEO of the Health Services Utilization and Research Commission in Saskatchewan. He has served on various national boards and committees, including the Governing Council of the Canadian Institutes of Health Research, the Saskatchewan Health Quality Council and the Health Council of Canada. He is an associate editor of the *Journal of Health Services and Policy Research* and is a member of the editorial board of *Open Medicine*.

Mark Stabile BA, MA, PhD

Associate Professor of Business Economics and Public Policy Director, School of Public Policy and Governance

Mark Stabile is professor of economics and public policy at the Rotman School of Management and director of the School of Public Policy and Governance. His current research interests include the economics of child health, economics of health care and health insurance, and tax policy and health insurance. His work has been published widely in journals, including the *Journal of Health Economics*; *Journal of Health Politics, Policy, and Law*, and *American Economic Review*, among others. Professor Stabile's past honours include a 2007 Excellence in Teaching Award from the Rotman School of Management, and he was the recipient of the John C. Polanyi Prize in Economics in 2003 and the Harry Johnson Prize in 2002. Professor Stabile received his BA from the University of Toronto, and his MA and PhD degrees from Columbia University.

Dr. Michael Rachlis

(Please see Advisory Board.)

Jeff Kwong MD, MSc, CCFP, FRCPC

Dr. Jeff Kwong is a scientist at the Institute for Clinical Evaluative Sciences (ICES), a family physician at Toronto Western Hospital, an adjunct scientist at Public Health Ontario (PHO) and an assistant professor in the Department of Family and Community Medicine and the Dalla Lana School of Public Health at the University of Toronto. He uses health administrative data to conduct epidemiological research in the area of infectious diseases, particularly vaccine-preventable diseases.

Lisa Droppo BSc, MHsc

Chief Analytics, Policy and Programs, OACCAC

Lisa Droppo is the chief analytics, policy and programs, at the Ontario Association of Community Care Access Centres. Lisa and her team support the 14 member CCACs as they work collectively on activities and projects in the areas of client services, policy and research, performance management and accountability, including procurement, information management and education. Lisa plays a significant role in strategic projects and partnerships with other health care associations. Lisa has worked in the health care sector for more than 20 years holding leadership roles in teaching, acute, rehabilitation and continuing care hospitals and in the community in Canada and the United Kingdom. She has published in the area of patient safety and risk management.

Donna Cripps MBA

CEO at Hamilton Niagara Haldimand Brant Local Health Integration Network

Donna Cripps is the CEO of the Hamilton Niagara Haldimand Brant Local Health Integration Network. Prior to joining the LHIN she was president of St. Peter's Hospital, and executive lead, for Rehabilitation and Seniors' Health at Hamilton Health Sciences. In the past Donna has been chair of the Complex Continuing Care and Rehabilitation

Provincial Leadership Council, OHA and a member of the boards of directors of Participation House and the United Way of Burlington and Greater Hamilton. Her previous community involvement has included presiding as chair of the Niagara District Health Council and president of the Ontario Physiotherapy Association. Donna holds a Bachelor of Physical Therapy (BSc (PT)) degree from the University of Toronto and a Master of Business Administration (MBA) degree from Queen's University and is a chartered director.

Robert Biron MHS, CHE, CA IT

President and CEO, Northumberland Hills Hospital

Robert Biron has worked in the hospital sector for more than 19 years in various capacities, primarily at the senior executive level. His professional credentials include a Master of Health Science (MHS), Health Administration degree from the University of Toronto and a Canadian Health Executive (CHE) designation. He is a chartered accountant (CA) with a designated specialty in information technology (CA•IT). Robert has served on a number of working groups and committees for the Ontario Hospital Association.

Dr. Michael Kates

Chief and Director of Family Medicine and Director of the Trillium Summerville Family Teaching Unit, University of Toronto.

Raisa Deber PhD (MIT)

Raisa Deber is a professor in the Department of Health Policy, Management and Evaluation in the Faculty of Medicine at the University of Toronto. A noted scholar, Professor Deber works in the areas of health policy, health financing, medical decision-making, as well as health

services organization and management. Born in Toronto, she obtained her PhD in political science at the Massachusetts Institute of Technology. In 2009 Professor Deber received one of Canada's most prestigious lectureships, the Emmett Hall Memorial Lectureship, recognizes outstanding contributions to the health ideals articulated by Justice Hall: equity, fairness, justice and efficiency.

Weekend 2

Adalsteinn (Steini) D. Brown

(Please see Advisory Board.)

Mary Kloosterman

CEO, YMCA Kingston

Mary Kloosterman is the CEO of the YMCA of Kingston. She has previously worked for the YMCA of Sarnia-Lambton and the YMCA of Western Ontario. She was involved in the opening of the Goderich YMCA, which was an innovative partnership between the YMCA and the Town of Goderich.

Dr. Rob Cushman

Dr. Rob Cushman is the former CEO of the Champlain Local Health Integration Network, where he was responsible for allocating more than \$2 billion to 200 health service agencies, including 20 hospitals, 60 nursing homes and community-care services in the region. As CEO, he established unprecedented partnerships among hospitals and community-care providers to prevent patients falling through the cracks when transferred from one place to another.

A decade ago, Dr. Cushman was the architect of the bylaw that banned smoking in Ottawa restaurants and bars, a move that was later adopted in other cities across North America. Throughout

his career, he has worked hard to translate science into policy: he has developed needle-exchange programs, bicycle helmet laws and contributed to banning the cosmetic use of pesticides.

Michael Hindmarsh MA, PhD (ABD)

President at Hindsight Healthcare Strategies

Hindsight Healthcare Strategies is an established health care improvement consulting firm that offers strategic planning, project direction and technical assistance for implementing chronic disease management programs in primary specialty and ancillary care settings. Mike Hindmarsh founded Hindsight Healthcare Strategies in Toronto, Ontario, in order to continue his work that began as the associate director of clinical improvement under the guidance of Ed Wagner, MD, MPH, of the MacColl Institute in Seattle, Washington. Along with Dr. Wagner, Mike and his colleagues created the Chronic Care Model—a system redesign strategy to improve the care for chronically ill patients. During his 17 years with Group Health, Mike managed federally funded research studies, and directed the creation of the country's first electronic chronic disease registry. For the last 20 years Mike has directed and advised more than 200 clinical improvement efforts, many based on the Institute for Health Improvement's Breakthrough Series learning collaboratives. As president of Hindsight Healthcare Strategies, Mike continues his work and offers his expertise in the design and development of dissemination strategies for implementing the Chronic Care Model and the Patient-Centered Medical Home in the United States, in Canada, and internationally.

Judith Shamian

(Please see Advisory Board.)

Janet M. Davidson O.C, BScN, MHSA, LLD (Hon)

President and CEO, Trillium Health Centre

Janet Davidson is president and CEO of Trillium Health Centre in Mississauga, Ontario, Canada. From July to December 2008, she also acted as interim president and CEO of the Kingston General Hospital while that hospital was under government supervision.

Janet graduated as a nurse from the Toronto East General Hospital. She has a BScN from the University of Windsor and a MHSA from the University of Alberta. She has more than 30 years health care management experience in the voluntary, hospital and government sectors in Alberta, BC and Ontario. Prior to joining Trillium, she was chief operating officer – Vancouver Acute with the Vancouver Coastal Health Authority. Her portfolio included Vancouver General Hospital, G.F. Strong Rehabilitation Centre and UBC Hospital. Prior to her arrival in BC in November 2003, Janet served as the president and chief executive officer of Toronto East General Hospital (TEGH.) She has also served as chief operating officer for the Alberta Mental Health Board and chief operating officer of the University of Alberta Hospital. She also held the position of assistant deputy minister of health for Alberta.

Mark Smithyes

Manager, Health Policy, Ontario Novartis Pharmaceuticals Canada Inc.

Mark Smithyes directs health policy in Ontario for Novartis and has done so for almost four years. In this capacity, Mark leads Novartis's interactions and partnerships with the government, economic stakeholders and patient groups in the province of Ontario. Additionally, Mark has recently taken on responsibility for national health policy on some key issues facing

the organization. In addition to this leadership role at Novartis, Mark was also appointed in 2008 to the position of vice chair of the Ontario Regional Committee of Canada's Research-based Pharmaceutical Companies (Rx&D). Mark also serves on the board of directors of Life Sciences Ontario.

Mark's extensive work in health policy is part of a successful career in the pharmaceutical industry spanning 15 years. Prior to his current responsibilities, Mark managed various sales teams across most of Canada from 2001 to 2007. He was the first Canadian to be awarded the Novartis Global's highest honour for outstanding management performance given every second year to the top 2% of the worldwide management team. Before then Mark was a key member of the marketing group successfully managing and rebranding Novartis's flagship cardiovascular product.

Carl Vendette

Senior Manager, Executive Networks – Health Programs at the Conference Board of Canada

Carl Vendette has recently joined the Conference Board of Canada to assist in the growth and direction of the three Conference Board's health networks. Prior to joining the Conference Board of Canada, Carl spent the last 12 years active in business development at the director level introducing, selling and managing complex technology solutions to the Canadian and US life science industries, predominately in the eLearning and e-Marketing arenas.

Kurtis Bishop

Managing Director, eHealth, PwC

Kurtis Bishop is a managing director in PwC's Advisory Service. He is the lead for PwC's eHealth practice in Canada. Kurtis is a certified management

consultant with more than 30 years of experience in information management and technology consulting. Over the past decade, Kurtis has focused on eHealth with senior executive roles at eHealth Ontario, CGI, Smart Systems for Health Agency and Canada Health Infoway.

Dr. Catherine Zahn

President and Chief Executive Officer of Centre for Addiction and Mental Health (CAMH)

Dr. Catherine Zahn joined the Centre for Addiction and Mental Health (CAMH) as president and chief executive officer in December 2009. Prior to this appointment, she was executive vice president, clinical programs and practice, at the University Health Network. An honours graduate of the Faculty of Medicine at the University of Toronto, she is a fellow of the Royal College of Physicians and Surgeons of Canada (Neurology) and a professor in the U of T Faculty of Medicine. Dr. Zahn is also a fellow of the American Academy of Neurology and is internationally recognized for her contributions to neurologic education and to standards of practice in neurology. She continues to practise in her area of clinical and academic interest, epilepsy and women with epilepsy. She is a champion for the integration of psychiatry and neuroscience, and for steering mental illness and addictions into the mainstream of medicine and the public spotlight.

Carolyn Tuohy

(Please see Advisory Board.)

Weekend 3

Wendy Levinson

(Please see Advisory Board.)

Citizens' Reference Panel Coordinating Team

PwC Project Staff

Barbara Pitts, Panel Chair
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Director of Research and Learning

Aaron Ettinger

Gillian Savigny

MASS LBP Assistants

Nathan Perkins

Josh Taylor

Minority Reports

This section is reserved for those panel members who endorsed the findings of the report but would also like to include their own commentary. Their recommendations and opinions, including any inaccuracies, are their own and do not represent the views of the panel. This space is provided to affirm the importance that all perspectives in a discussion are welcome and should be voiced.

Panellist A:

1) I recommend that the Ministry of Health and Long-Term Care turn public health protocols into public health regulations when it comes to inspecting Personal Service Settings (e.g., tattoo parlours) and Day Care in order to enforce disease prevention strategies (at this point we can't enforce anything until there's already an outbreak—public health inspectors lack authority).

2) I recommend that the provincial government creates public health regulations regarding toxic mould control in public buildings and then enforce them, in order to prevent acute and chronic diseases related to toxic mould (no such regulation in place and hence no enforcement).

3) I recommend that new doctors be obligated to work in rural/remote areas for a year before being able to work in their desired area in order to provide better health care in rural/remote area and to encourage new doctors to practise medicine in rural/remote communities.

Panellist B:

I was disappointed in the presentations that there was no discussion of the possible role of supplementary private sector services. It is not the government's role to encourage private sector health care, nor is it their role, in a democratic country, to make it illegal.

We have the example of our education system. We all benefit from a strong, publicly funded educational system, however, we do not exclude independent education.

Whether or not private clinics/physicians help in the reduction of public wait lists is not the issue. The freedom to assume some degree of responsibility, if desired, should be left to the discretion of the individual.

Allowing a dual health care system could also stem the tide of competent practitioners from choosing to practise in the free enterprise system south of the border. I am personally acquainted with talented specialists who have, for this reason, opted to leave Ontario. This is a question of rights and freedoms, not an indictment of the public health care.

Given the concerns of maintaining and improving a viable public health care system, future discussions should give an adequacy of time to speakers who support private options.

Panellist C:

The formula to calculate OHIP premiums should be adjusted so that it is based on household income rather than individual income. At present the formula discriminates against two income households that has the same income as a single income household.

I encourage the LHINs to organize and coordinate regular, informal roundtables to allow all stakeholders to share information. Stakeholders include professionals and volunteers, public health, primary care providers, CCACs, hospitals, community groups and patients.

Personae

During their first session, the panel developed nine personae, representing a variety of health users. These characters helped the panellists consider how their recommendations would affect different demographic groups. Below are the nine health personae created by the panellists.



Name: Tony

Gender: Male

Age: 43

Ethnicity: South Asian

Biography: Tony is from a small community of 4,000 outside of North Bay, Ontario. Tony is married and has two children (ages 13 and 15). His wife works full-time in a low-paying job. After working in the forestry industry for several years, Tony established his own carpentry business, but he lacks insurance. His family's combined annual income does not exceed \$45,000. Tony enjoys fishing, hockey, gardening, cross-country skiing, playing cards, and belongs to local community organizations such as the Lions and Elks Clubs.

Tony is an active man who does not smoke or drink. There was no known family health history of heart problems. Until being flown to Sudbury for a triple bypass, Tony did not know he was genetically predisposed to heart disease. Tony's carpentry business does not afford him as much money as his previous occupation; his family's financial insecurity results in added stress, and his family cannot afford to visit him in Sudbury. His stress levels, already high as a business owner, have increased since being away from his family while receiving treatment in Sudbury. Tony is unsure when he will be able to return to work, and wonders whether he will be healthy enough to return to carpentry. His family worries about their future options if his income is lost.

Name: Ethel

Gender: Female

Age: 92

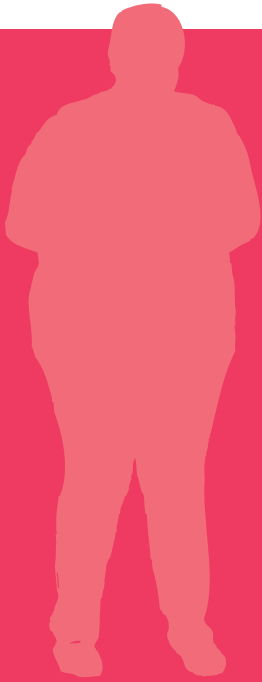
Ethnicity: Caucasian

Biography: Ethel lives alone in St. Thomas, Ontario, population 18,000. She has two sons, both over 70 years old. One son lives in western Canada and is in frequent contact, while the other lives in Australia. Ethel is a retired teacher, who spends much of her time active in her community. She is active in her church, loves playing bridge and teaches it at the local seniors' centre. Ethel is fiercely independent and hates hospitals and doctors, only seeing them when she feels she absolutely

must. She has a sharp mind, is a non-smoker and only has a nip of brandy or scotch during the evenings.

Two years ago, Ethel was hit by her neighbour, who was backing her car out of her driveway. Ethel broke her leg in the accident, but she recovered completely. A neighbour recently brought her to the emergency room, presenting with confusion, a urinary tract infection and dehydration but she was quickly discharged. The doctor speculated that her illness might have been provoked by Ethel's unwillingness to drink water at night so she won't have to leave her bed to visit the bathroom.





Name: Albert

Gender: Male

Age: 10

Ethnicity: Caucasian

Biography: Albert lives in a small town ninety-five kilometres outside of Thunder Bay. Both of his parents earn high salaries but work late. He is looked after by his older sibling while their parents are away. Albert has been obese since age four and developed juvenile diabetes at age eight. He takes his medication inconsistently and hasn't changed his diet since diagnosis. His mother does not see a problem with

his weight and feeds him generously. After school, Albert likes to play video games, watch television, play on his computer and send text messages to his friends. He doesn't understand his illness, nor does he closely follow treatment recommendations. He hates going to the doctor and his mother doesn't have time to take him, so he rarely visits. Their family doesn't have a GP; for this reason, they often go to the emergency room instead. Albert is picked on and bullied about his weight by his classmates. This discourages him from socializing and he prefers to stay home instead.

Name: Mary Jane

Gender: Female

Age: 58

Ethnicity: African Canadian

Biography: Mary Jane lives in Toronto with her husband of 38 years and her two children, 28 and 25. Her younger child still lives at home, while the elder just had a baby boy. Mary Jane is a non-smoker and a social drinker. She loves running and gardening. She has been fighting breast cancer for three years and recently received a terminal diagnosis. Mary Jane can no longer work but was a former economics professor at the University of Toronto. She is in a lot of pain, is depressed

and has lost hope. Her grandmother also died of cancer. Until now, Mary Jane has been very healthy all of her life, running marathons and following the *Canadian Food Guide* closely. She has had a mastectomy, undergone chemotherapy and radiation and was in remission until the cancer returned recently, spreading to her lymph nodes. She has an excellent oncologist.

Mary Jane has trouble accessing her GP. She wonders about home care and what her final months will look like. She had a positive experience at the hospital with the oncology unit and would now like to arrange services with the CCAC for homecare. She can afford the cost of extra care services.





Name: Rustlana

Gender: Female

Age: 70

Ethnicity: Ukrainian

Biography: Rustlana has lived alone in Toronto since her husband passed away. She was a factory worker in Ukraine before she immigrated to Canada at

age 15, where she was a homemaker in Toronto. Recently, she has been very frustrated with the local hospital ER and has difficulty communicating with health practitioners. She generally feels alienated from the system. She had respiratory problems, related to being a heavy smoker. She relies on her children to fill her prescriptions. Rustlana is on a fixed income and her living conditions are poor.

Name: Michael

Gender: Male

Age: 17

Ethnicity: Chinese

Biography: Michael was adopted by his parents (a real estate agent and a construction worker) at six months old and lives in a town of 50,000. He doesn't like public spaces, is a computer nerd, and

spends most of his time online gaming. He hates taking his medication, is depressed and moody, and is self-destructive. His mother is trying to find the appropriate services to deal with her son's bipolar disorder, drug and alcohol abuse and his mistreatment of his medications. Michael struggles in school, and says he struggles as a visible minority. The health staff he encounters are disheartened by his situation and anticipate seeing him again.



Name: Brooke
Gender: Female
Age: Infant
Ethnicity: Caucasian

Biography: Brooke lives in Toronto and has fetal alcohol spectrum disorder. Her mother, who has since abandoned her,

benefited from neo-natal care and had a natural birth. Brooke was born prematurely with a low birth weight. She cries all the time and required a respirator when she was born.



Name: Monica
Gender: Female
Age: 30
Ethnicity: Aboriginal Caucasian

Biography: Monica is from Thunder Bay and was raised by an alcoholic single mother. Her father was absent and she had an abusive older brother. She is schizophrenic. She was in foster care as a child, dropped out of school at 16 and was pregnant by 17. She lived with the father of her child for one year, during which time she

suffered from post-partum depression and her schizophrenia worsened.

She is currently unemployed, but is interested in tattoo art. She doodles often and gets tattoos every now and then instead of buying food. She goes to the ER and is often defensive, paranoid and combative with health care providers, although other times she visits the ER just for company. She has an unknown STD, hepatitis C, smokes and takes T3s and oxycontin. Her child is being raised by the province and may suffer from fetal alcohol spectrum disorder.

Name: Phil
Gender: Male
Age: 52
Ethnicity: Caucasian

Biography: Phil is from Scarborough and has been happily married for 20 years and has two children. He is an accountant and likes astrology, basketball and baseball

statistics, and running. He is diligent about keeping in good health, is a medical know-it-all and an online medical “expert.” He suffers from hypertension, high blood pressure and is hyperactive. Phil is a label reader. He dotes on his children and often takes them to professional sports games. He often stops taking his medication when he feels better but keeps the remaining pills, just in case.



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