



**HEALTH CARE RENEWAL IN CANADA | CLEARING THE ROAD TO QUALITY**

**EXECUTIVE SUMMARY**



**ANNUAL REPORT TO CANADIANS 2005**

February 2006

## About the Health Council of Canada

### Who We Are

Canada's First Ministers established the Health Council of Canada in the 2003 Accord on Health Care Renewal and enhanced its role in the 2004 10-Year Plan to Strengthen Health Care. We are 26 Canadians who care about the future of Canada's health care system and want to ensure its future sustainability. We are committed to advancing the renewal of Canada's health care system and the health of Canadians. The Council includes representatives of federal, provincial and territorial governments, experts and citizens, and we have a broad range of experience from government, health care management, research and community life from across Canada.

Funded by Health Canada, we report to the Canadian public and operate as a non-profit agency. Members of the Council are the ministers of health of the participating jurisdictions: British Columbia, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Nunavut, Northwest Territories, Yukon, and the Government of Canada. The Governments of Alberta and Quebec are not members of the Health Council of Canada.

### What We Do

The Health Council of Canada monitors the provisions of the 2003 Accord on Health Care Renewal and the 2004 10-Year Plan to Strengthen Health Care and provides constructive advice on how to improve health care access, quality, effectiveness and population health. We address progress on commitments made and advise on whether or not those commitments are likely to bring about the widespread improvements desired.

While many national health organizations have important roles in health care, including research, data collection and dissemination, quality improvement, funding and advocacy, the mandate of the Health Council makes it unique. The Council speaks directly to Canadians, offering a national, system-wide perspective and impartial assessment on the status of health care renewal in Canada.

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## PATHWAYS FOR HEALTH CARE RENEWAL

Canada has seen extraordinary investment in health care over the last two years as a result of major commitments by all levels of government to build new ways of improving health and delivering care. The role of the Health Council of Canada is to monitor the country's progress in meeting these commitments and to report back to the public. As an independent, impartial observer, we offer a system-wide perspective on health care renewal.

In our first report to Canadians, *Health Care Renewal in Canada: Accelerating Change* (January 2005), we stressed that the pace of change was too slow. Some examples of vision and determination were evident across the country but they were, and still are, too few and far between. In this, our second annual report, a common theme is that Canada's system – for all its strengths – is a patchwork of provincial, territorial and federal programs that have led to inconsistent and inequitable coverage. The publicly-funded care available to each of us depends on where we live. In the report, we present a fictional family with a number of common health issues to illustrate this reality.

How did Canada do in 2005? Table 1 (at the end of this Executive Summary) briefly outlines the 2003 and 2004 government agreements and the key activities underway. Overall, progress has been halting. The Health Council believes that the biggest roadblock is a general reluctance among governments and health care leaders to set targets and be held accountable for progress. At the current pace, key aspects of renewal that are fundamental to success – such as the shift to primary health care teams and electronic health records – won't be fully in place for many years. Can our highly valued health care system afford to wait? What needs to be done to loosen the gridlock?

To a great extent, the focus of government action so far has been on access to health services. This approach was a response to legitimate public concerns – Canadians have a right to expect that their health care system will be there for them when they need it. But the Health Council believes that renewal should set its sights on a higher destination: better health for Canadians. To get there, we propose a balanced journey along three pathways: quicker access to needed care; better quality of services; and a focus on determinants of population health outside the health care system. To keep these pathways clear, the Health Council believes three conditions must be met. These conditions are:

- **Sustainability** – Reforms and renewal initiatives need sustained funding and efficient infrastructure;
- **Coordination** – Governments and health care providers must work together to break the gridlock and move beyond the fragmented progress to date; and
- **Accountability** – Governments and health care leaders must be accountable for progress on health care renewal through meaningful public reporting.



## **PATHWAY ONE**

### **Improve Access to Needed Health Care**

Access to necessary health care will continue to be a problem for Canadians as long as services are fragmented, coverage is inconsistent, and individuals wait too long for needed care. For example, 600,000 Atlantic Canadians remain without public drug coverage and millions more across the country have coverage that fails to protect them from catastrophic costs. There has been real improvement in pockets of the country, but we need change to be more widespread and comprehensive.

The Health Council proposes five areas for sustained action to improve access to needed care.

#### **Primary health care:**

- Focus aggressively on faster implementation of interprofessional teams and greater use of telehealth technologies to improve access to the most timely, most appropriate care with the least long-distance travel for patients;
- Ensure that successful models of innovation in primary health care delivery are sustained and expanded on.

#### **Health human resources:**

- Intensify efforts to educate adequate numbers of health care workers equipped to practice in new models of delivery;
- Take immediate steps to enable each health care professional to practise to his or her full potential so that health human resources strategies can make the best use of skill sets;
- Collaborate in workforce planning to reduce the competition among jurisdictions for scarce health professionals.

#### **Home care:**

- Expand the range of publicly-funded home care services to assist people with chronic health conditions, not just short-term needs after hospital stays;
- Change the Compassionate Care Benefits Program – by removing restrictions on who is eligible to be the caregiver; by extending the length of the benefit to 16 weeks; and by making provision for caregivers who do not pay into EI – to allow more Canadians to take advantage of this benefit;
- Harmonize home care programs and job protection for caregivers taking compassionate care leave, so that all Canadians have equal access to services that allow them to stay at home as long as possible.

### Pharmaceuticals management:

- Standardize public coverage for prescription medications and focus on individuals without drug coverage to ensure that drug costs are not a barrier to necessary health care;
- Develop and use better drug information tools for health care providers to ensure that prescribing decisions are based on the best scientific evidence and that patients receive only the safest and most effective medications;
- Strengthen Canadian legislation to ban all forms of direct-to-consumer advertising of prescription drugs; research shows that advertising increases patient requests for drugs but does not necessarily lead to better health or more appropriate prescribing.

### Wait times:

- Focus on improving the design of wait list management systems through such reforms as a common service queue for each of the major services and a central information system that identifies patients whose waits are becoming unusually long;
- Make better use of decision-making tools to ensure that patients on wait lists are waiting for the most appropriate care – meaning that the potential benefits of the procedure outweigh the risks;
- Improve public information on wait times, so that Canadians can understand how long they may expect to wait for needed care and can compare information from different parts of the country.





## PATHWAY TWO

### Improve Quality of Care

Our health care system delivers safe and appropriate care to Canadians every day. However, there is a large body of evidence from international and Canadian research showing that health care services can fail to deliver all of their potential benefits and can harm people. This is a source of great frustration to those who provide health care. No one sets out to provide poor quality care, but poorly organized processes or the lack of integrated information systems can lead to errors.

What must be done? Despite substantial research demonstrating that electronic prescribing reduces medication errors and controls costs, the use of e-prescribing is much more the exception than the norm in Canada. Quality councils are a success story in health care renewal, but only some regions have the benefit of these research organizations. Properly resourced and designed, quality councils help to improve the quality of care by working with health care providers to put relevant research into action. And we need clearer information for health care managers and the public to understand how the health care system is performing and whether our huge public investments are improving the quality of care and the health of Canadians.

The Health Council proposes four elements for a strategy to improve quality of care.

#### Patient safety:

- Strengthen efforts to reduce preventable harm resulting from the delivery of health care by making accreditation of health care facilities mandatory and requiring the public release of accreditation reports;
- Re-examine the issue of no-fault compensation for victims of adverse health care events, so that health care providers are more open to disclosing errors and injured patients can be compensated without having to sue the provider.

#### Information management systems:

- Speed up the development and use of linked electronic systems for patient records, prescribing, and clinical decision-making. These are powerful tools to support the delivery of safer, more appropriate health care;
- Increase the upfront investment to create and implement electronic systems. They are costly but essential and deserve strong public and political support.



### Quality councils:

- Expand the development of quality councils and similar research institutions that produce high-quality reporting on how health care affects patient outcomes;
- Ensure the delivery of widespread, on-the-ground quality improvement training for health care providers.

### Health indicators and public reporting:

- Make reporting on the health of Canadians and the performance of the health care system more transparent. One annual report comparing national, provincial and territorial information should replace the current patchwork of hard-to-locate and inconsistent government reports;
- Include financial reporting in annual reports so that Canadians can see, clearly and consistently, how the funding is being spent;
- Link reporting strategies to health care goals, so that Canadians can see whether funding and renewal activities are helping to improve the health of the population over time.





## **PATHWAY THREE**

### **Improve Population Health**

By international standards, Canadians are a relatively healthy lot. We have one of the highest life expectancies in the world: 77 years for men and 82 years for women. And 60 per cent of the general population rates their health as excellent or very good. On the public policy level, the past year has seen the creation of broad, national public health goals – an important step in collaboration among governments – and the significant expansion of publicly-funded vaccines for children through the National Immunization Strategy. As well, governments and national Aboriginal leaders agreed on an historic 10-year plan to improve health and health care delivery for Aboriginal groups.

So where should we be concerned? We have a high burden of chronic diseases, such as diabetes, asthma, heart disease and cancer, with an estimated \$80 billion price tag in health care costs and lost productivity to our economy each year. With the right investments, these costs can be reduced substantially and the quality of many lives can improve. And we have a growing level of health inequality between different groups in Canadian society. As the economic gap between social groups widens, so do the health effects of poverty and marginalization.

The Council recommends three elements for a strategy to improve population health.

#### **Chronic diseases:**

- Invest in programs to prevent chronic diseases, ensuring that strategies are integrated with the work of primary health care teams;
- Modernize the management of chronic diseases by ensuring that health care teams have access to information tools to help them manage patients with complex disease in the safest, most effective and most appropriate way possible.

#### **Healthy living strategies:**

- Collaborate on measuring meaningful progress towards reaching Canada's public health goals;
- Initiate a dramatic shift in funding priorities to stimulate progress in healthy living and to meet public health goals.

#### **Health inequalities:**

- Take an aggressive and collaborative approach to reducing health inequalities by setting clear targets with an emphasis on improving the health and well-being of children and Aboriginal groups;
- Recognize that the health care system is relatively powerless to overcome those effects on its own. We need broad public policy to respond to the health effects of inequality and, to measure progress, we need high-quality data linking health outcomes with the social and economic factors that influence health.



## THE ROADS CONVERGE

In recent years, the First Ministers' agreements on health care renewal tackled some important roadblocks to accessing services. This is necessary, but it is not enough. The agreements bypass some of the fundamental problems that beset the Canadian health care system. By focusing on access as the principal objective, health care renewal efforts are not forcefully addressing the increasing evidence that our more deep-rooted problem is quality of care.

Rather than pose the single question – is there adequate access to services? – we must also ask: access to what? Are we providing the safest, most appropriate care? Are we investing enough in prevention? Are we reducing inequalities in health? The answer to these questions is no, not yet. But we could.

Two other pathways must be traveled. The information management systems highlighted in this report must be championed, funded and adopted. And they need to be linked to good data and performance reporting at all levels of the system to improve patient safety and health outcomes. It has been done elsewhere. It needs to be done in Canada. Secondly, significant investments are required to achieve healthy living. This includes supporting interprofessional primary health care teams that can deliver effective chronic disease management, public policies that will support individuals to make healthy choices, the reduction of current inequalities in health for specific groups in the population, and more measurable targets to chart our progress in healthy living.

These paths are not easily walked but the journey must be taken. Efforts must be **sustained** – health care renewal needs long-term commitments, both political and financial. Efforts must be **coordinated** – health care renewal needs the power of many. Efforts must be **accountable** – health care renewal needs openness and transparency. We are indeed at a crossroads and we have the opportunity to demonstrate that the Canadian health care system is capable of moving in new directions. Canadians deserve no less.



## LEARNING MORE

The complete report is available on our website, [www.healthcouncilcanada.ca](http://www.healthcouncilcanada.ca), along with a new series of mini-documentary videos showcasing innovative practices in health care across Canada. The series visits a critical care collaboration in rural British Columbia, a primary health care team in Newfoundland and Labrador, two programs that have improved the quality of care for patients managing chronic disease and for elderly patients in Ontario, a surgery service with greatly reduced wait times in Alberta, and a training program for maternal care workers in Nunavut. We invite you to watch these videos online and consider our call for innovative practices in health care. We welcome your suggestions for other stories of change and progress in health care renewal in Canada.



**Table 1. Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care** (2003 Accord, 2004 10-Year Plan, 2005 Aboriginal Blueprint)

|                     | <b>Key commitments</b>   | <b>Summary of progress</b>  | <b>Assessment of progress</b>  |
|---------------------|--|---|--|
| Primary health care | 50% of residents to have access to an appropriate health care provider 24/7 as soon as possible. The target is to be fully met by 2011. (2003 Accord)  | After-hours access by telephone in 9 jurisdictions with other primary health care services available in limited areas.  | Initial vision of teams has been diluted.  |
|                     | 50% of Canadians to have 24/7 access to multidisciplinary teams by 2011. (2004 Plan)   | Development of teams underway in all jurisdictions (mainly physicians and nurses).  | Innovation is occurring largely through pilot projects, and it is not clear how it will be sustained in the long term.                 |
|                     | Each jurisdiction to set out its own multi-year targets for verifiable progress. (2003 Accord)   | Outcome indicators to be finalized for March 2006.  | Indicators to measure progress are being developed, but their use is not guaranteed for the long term.                                 |
| Home care           | First-dollar coverage for a basket of services for short-term acute home care, including acute community mental health, and end-of-life care. (2003 Accord)  | Health ministers are working on the basket of services.   | Current focus ignores Canadians with chronic illness.  |
|                     | First-dollar coverage by 2006 for short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care; short-term acute community mental health home care for two-week provision of case management and crisis response services; end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life. (2004 Plan) | Progress is unknown on a number of items as health ministers are not due to report on progress until December 2006.   | Some jurisdictions already provide a broader range of services.  |
|                     | Progress report expected December 2006. (2004 Plan)  |   |  |
|                     | Federal government to create compassionate care benefit. (2003 Accord)   | Compassionate care benefit is in place and 10 jurisdictions have passed job protection laws.<br><br>Federal government has proposed changes to the program to expand eligibility. | Compassionate care program is not well designed and needs to change to support more Canadians taking care of dying loved ones at home. |

Table 1. Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care – continued

|                            | Key commitments  | Summary of progress  | Assessment of progress   |
|----------------------------|--|--|--|
| Pharmaceuticals management | Take measures, by the end of 2005/06, to ensure that Canadians have reasonable access to catastrophic drug coverage. (2003 Accord)   | Ministerial Task Force reports that it is working on the strategy, including catastrophic drug coverage.   | Reduced commitment to implementing catastrophic drug coverage between the 2003 and 2004 agreements.                          |
|                            | Develop and implement the National Pharmaceuticals Strategy and report on progress by June 2006. (2004 Plan)   | Progress is unknown on a number of items as health ministers are not due to report on progress until June 2006.  | Health ministers recommitted to this work at their 2005 meeting; 5 of 6 key commitments were in the area of pharmaceuticals. |
|                            | Health ministers agreed in October 2005 to work on: <ul style="list-style-type: none"> <li>• catastrophic drug coverage;</li> <li>• expanded scope for Common Drug Review;</li> <li>• a common national formulary;</li> <li>• broader role for the Patented Medicine Prices Review Board;</li> <li>• research on the rare diseases;</li> <li>• data on drug risks and benefits.</li> </ul>                                   |  |  |
| Wait times                 | Meaningful reductions in wait times in cancer treatment, heart procedures, diagnostic imaging, joint replacement and sight restoration by March 2007. (2004 Plan)  | Strategies are being developed by individual provinces and territories.<br><br>Wait Times Reduction Fund established.<br><br>Federal government appointed Dr. Brian Postl as Special Adviser on Wait Times.  | More information is available to the public on actual waits.   |
|                            | Each jurisdiction agrees to create: <ul style="list-style-type: none"> <li>• comparable indicators of access to health professionals and diagnostic and treatment procedures, with a report by December 2005;</li> <li>• evidence-based benchmarks for medically acceptable wait times in five areas by December 2005;</li> <li>• multi-year targets to achieve priority benchmarks by December 2007. (2004 Plan)</li> </ul> | Benchmarks were announced in December 2005 for cancer, hip fracture, hip and knee replacements, and cataract and cardiac bypass surgery. Benchmarks were not announced for diagnostic imaging.<br><br>Comparable indicators were not announced by December 31, 2005. | Lack of comparability of reporting methods makes comparison of wait times difficult.   |
|                            |  |  |  |

Table 1. Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care – continued

|                        | Key commitments  | Summary of progress  | Assessment of progress  |
|------------------------|--|--|---|
| Health human resources | <p>Collaborate on strategies to ensure the supply of needed health providers:</p> <ul style="list-style-type: none"> <li>strengthen the evidence base for national planning;</li> <li>promote interdisciplinary provider education;</li> <li>improve the recruitment and retention of health professionals. (2003 Accord)</li> </ul>   | <p>Projects are underway in interprofessional education, assessment of international graduates and development of planning models.</p> <p>Initial work has begun to redesign education and training programs, which involves almost all medical schools but only a limited number of other professional schools.</p> | <p>There are not enough interprofessional education programs in Canada, and numbers should be expanded.</p>   |
|                        | <p>Jurisdictions agree to increase the supply of health professionals, based on their assessment of gaps and to make their action plans public by December 2005, including targets for the training, recruitment and retention of professionals. (2004 Plan)</p>   | <p>8 jurisdictions released their plans.</p>   | <p>Only 4 plans provide targets. Action plans should be more comprehensive, include specific future-oriented targets, and be based on sound evidence of the health needs of the population.</p> |
|                        | <p>Federal government commits to:</p> <ul style="list-style-type: none"> <li>accelerating and expanding the assessment of internationally trained health care graduates for participating jurisdictions;</li> <li>targeting efforts to increase the supply of health care professionals in Aboriginal and Official Languages Minority Communities;</li> <li>reducing the financial burden on students;</li> <li>participating in health human resources planning with interested jurisdictions. (2004 Plan)</li> </ul> | <p>\$70 million earmarked to assist jurisdictions to increase their capacity to assess international graduates.</p>  | <p>Assessment processes for international graduates should be standardized.</p>   |
|                        |  | <p>Pan-Canadian Planning Framework document released in fall 2005.</p>   | <p>There are a number of projects underway in the priority areas identified but there is no national HHR strategy in place.</p>   |
|                        | <p>The Government of Canada commits to doubling the number of Aboriginal physicians and nurses within 10 years. (2005 Blueprint)</p>   | <p>Too early to report on progress.</p>  | <p>Too early to assess progress.</p>  |

**Table 1. Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care – continued**

|                                  | <b>Key commitments</b>   | <b>Summary of progress</b>   | <b>Assessment of progress</b>  |
|----------------------------------|--|--|--|
| Information management           | Place priority on the implementation of electronic health records and further development of telehealth applications. (2003 Accord)          | Additional funding to Canada Health Infoway.<br><br>Established goal of 50% of Canadians to have electronic health record by 2010.           | Implementation of the electronic health record is too slow. Technology is not being used to its fullest. Fruitful collaboration on system standards and purchasing is encouraging. |
|                                  | Accelerate electronic health record, including e-prescribing, and telehealth. (2004 Plan)  | Canada Health Infoway has increased its share of funding for electronic health record implementation to 75% of total costs.                  | Electronic drug information systems are in place only in some jurisdictions.<br><br>E-prescribing is not widespread.   |
| Healthy living and public health | Work on healthy living strategies and other initiatives to reduce disparities in health status. (2003 Accord)                                | Healthy Living Strategy has been developed and 3 targets have been released for 2015: healthy eating, physical activity and healthy weights. | Targets do not address inequalities in health.   |
|                                  | Pursue a national immunization strategy. (2003 Accord)   | Funding given to provinces and territories for vaccine purchase.   | Funding has standardized immunization coverage across the country.   |
|                                  | Accelerate work on a public health strategy with goals and targets to improve health status. (2004 Plan)                                     | Development of national public health goals is complete, and goals have been released.   | Goal statements are broad and do not include measurable outcomes.  |
| Aboriginal health                | Develop Aboriginal health reporting framework. (2003 Accord)   | Federal government established \$700 million Aboriginal Health Transition Fund.  | Significant investment has been made, but roles, responsibilities and accountabilities need to be clarified.   |
|                                  | Aboriginal Health Reporting Framework will be completed by 2007, with reporting to begin in 2010-2011. (2005 Blueprint)                      | Too early to report on progress.   | Too early to assess progress.  |
|                                  | Aboriginal Health Blueprint released in November 2005 with an additional \$1.3 billion for health initiatives.                               | Too early to report on progress.   | Too early to assess progress.  |
|                                  | Targets to reduce infant mortality, youth suicide, childhood obesity and diabetes by 20% in 5 years and by 50% in 10 years. (2005 Blueprint) | Too early to report on progress.   | Too early to assess progress.  |

Table 1. Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care – continued

|                  | Key commitments   | Summary of progress  | Assessment of progress   |
|------------------|---|--|--|
| Public reporting | Annual public reports on primary health care, home care, pharmaceuticals, diagnostic imaging and medical equipment using comparable indicators starting 2004. (2003 Accord) | All jurisdictions have participated in the comparable health indicators reports in 2002 and 2004.  | The comparable health indicator reports are not a useful reporting mechanism for the general public. |
|                  | Governments are to report to their residents on health system performance, including the elements set out in the Plan. (2004 Plan)  | British Columbia and Saskatchewan have reported specifically on the Health Reform Fund spending on primary health care, home care and pharmaceuticals. | Most jurisdictions are not reporting separately on their allocation of the federal transfers.        |
|                  |   | British Columbia, Saskatchewan, Ontario and Nova Scotia have reported specifically on the Diagnostic and Medical Equipment Fund.                       |  |
|                  |   | Province of Quebec has published a report on all of the 2004 commitments.  |  |
|                  |   | Federal Departments of Finance reports on annual allocations.  |  |
|                  | Health Council of Canada to report on elements in the agreements. (2003 Accord and 2004 Plan)   | Health Council of Canada annual reports released in January 2005 and February 2006.  |  |
|                  | CIHI to report on progress on wait times. (2004 Plan)   | CIHI will report on progress on wait times in February 2006.   |  |



