HEALTH CARE RENEWAL IN CANADA | CLEARING THE ROAD TO QUALITY

Health Council of Canada / Conseil canadien de la santé

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February 2006

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Health Care Renewal in Canada: Clearing the Road to Quality

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Chair, Health Council of Canada

The First Ministers' Health Accord of 2003 and the 10-Year Plan to Strengthen Health Care in 2004 moved from debating health care renewal to delivering it. And in the process, the Health Council of Canada was uniquely charged with tracking that renewal and reporting its progress to Canadians. The Council sees its job as one of witness and advisor: we review progress, we assess success and we advocate for change where we see a need.

We delivered our inaugural report in January 2005, highlighting the jurisdictions and projects where renewal had taken root, identifying priority areas for action, and issuing an overall message of "Hurry up!"

We said four things needed attention and focus:

1) The people who provide health care – sufficient numbers of health care providers trained in teams must be in place otherwise all other efforts would flounder;
2) The health of First Nations, Métis and Inuit peoples – we must reduce the huge disparity in health status between Aboriginal Peoples and other Canadians;
3) The organization of primary health care – patients' first point of contact must be a team of health care professionals who can provide health promotion and disease prevention services;
4) The modernization of health records – electronic patient health information must be available where patients receive services.

Twelve months later our view has not changed. The challenges remain despite large investments. We still need health care renewal to happen faster and on all fronts.

This, our second report to Canadians, states our priorities for health care improvement. The Health Council has a blunt and simple message – the health of Canadians will not be improved by a focus only on access to health care services.

There is no single route to a healthier Canada. There are several important pathways to reach that goal. We recommend three: quicker access to needed care; better quality services; and a focus on determinants of population health outside the health care system.

Are we providing the safest, most suitable 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. It is the Council's belief that we already have strong evidence and enough experience to pursue a quality agenda. But clearing the road to quality health care will require sustainable investments, coordination between governments and health care providers, and accountable leadership.

In all the areas we monitor, we see pockets of activity with exciting results. These innovations need to be championed and we need more of them. What is lacking is an overall sense of urgency to accelerate the pace of renewal. That collective sense of urgency must emanate from all the people who sustain and support the health care system. Waiting too long for renewal is as damaging to our health care system as waiting too long for appropriate care is to individuals. Canadians deserve more.

Michael Decter

HEALTH CARE RENEWAL IN CANADA: WHAT HAVE GOVERNMENTS PROMISED?

2003 First Ministers' Accord on Health Care Renewal

In February 2003, the prime minister and premiers signed the Accord on Health Care Renewal. The purpose of the Accord was to ensure that Canadians:

- have access to an appropriate health care provider 24 hours a day, seven days a week;
- have timely access to diagnostic procedures and treatments;
- do not have to repeat their health histories or undergo the same tests for every provider they see;
- have access to quality home and community care services;
- have access to the drugs they need without undue financial hardship;
- are able to access quality care no matter where they live; and
- see their health care system as efficient, responsive and adapting to their changing needs, and those of their families and communities, now and in the future.

The 2004 10-Year Plan to Strengthen Health Care

In September 2004, the prime minister and premiers signed a second health care agreement based on the following principles:

- universality, accessibility, portability, comprehensiveness, and public administration;
- access to medically necessary health services based on need, not ability to pay;
- reform focused on the needs of patients to ensure that all Canadians have access to the health care services they need, when they need them;
- collaboration between all governments, working together in common purpose to meet the evolving health care needs of Canadians;
- advancement through the sharing of best practices;
- continued accountability and provision of information to make progress transparent to citizens; and
- jurisdictional flexibility.

2005 Annual Conference of Ministers of Health

The ministers of health made the following commitments at their annual meeting:

- to collaborate on research to develop evidence that demonstrates how wait times affect patients' health;
- to accelerate work to develop options for catastrophic drug coverage;
- to collaborate on time-limited research programs, including clinical studies for patients meeting treatment guidelines for two rare diseases;
- to expand the Common Drug Review to all drugs and to work towards a national formulary;
- to give the Patented Medicine Prices Review Board responsibility to monitor and report on prices for non-patented drugs;
- to work together to collect, integrate and disseminate information on the real-world risks and benefits of drugs; and
- to agree on a set of goals for improving the health of Canadians.

STARTING OUT

STARTING OUT

The Road to Quality

Canada has seen extraordinary investment in health care over the last two years from all levels of government. The 2003 First Ministers' Accord committed $36 billion of federal funds over a five-year period, and the 2004 10-Year Plan to Strengthen Health Care increased that amount by $41 billion. For Aboriginal health, First Ministers have pledged to invest $2 billion more over the next five years.

All of this funding is in addition to what provincial and territorial governments, and individual Canadians, already spend on health care every year – an estimated $142 billion in 2005.[1] A decade ago, we spent only about $75 billion annually.

The new money came with a commitment to build new ways of delivering care. Governments agreed to create teams for primary health care, improve access to home care and medicines, and reduce the time Canadians wait for certain surgeries and diagnostic tests. They also recognized the need to invest in the health care workforce, in strategies to help Canadians make choices for healthy living, in information technology to make health care safer and more efficient, and in reporting to the public on how the system is performing.

How have we done? Table 1 provides a brief summary of the key elements in the agreements and activities underway. If we compare ourselves to other places that have transformed their health services in recent years – most notably the National Health Service in the UK and the Veterans Health Administration in the US – progress in Canada has been slow. 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. It appears that leaders are waiting for change to be universally endorsed before they vigorously pursue it. Greater leadership is required; without it, renewal efforts will drift. At the current pace of change, critical aspects of renewal – such as the widespread introduction of primary health care teams and the electronic health record – 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 unlock the gridlock?



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)

	Key commitments	Summary of progress	Assessment of progress
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 report expected December 2006. (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.
	Federal government to create compassionate care benefit. (2003 Accord)	Compassionate care benefit is in place and 10 jurisdictions have passed job protection laws. 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) Health ministers agreed in October 2005 to work on: • catastrophic drug coverage; • expanded scope for Common Drug Review; • a common national formulary; • broader role for the Patented Medicine Prices Review Board; • research on the rare diseases; • data on drug risks and benefits.	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.
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. Wait Times Reduction Fund established. 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: • comparable indicators of access to health professionals and diagnostic and treatment procedures, with a report by December 2005; • evidence-based benchmarks for medically acceptable wait times in five areas by December 2005; • multi-year targets to achieve priority benchmarks by December 2007. (2004 Plan)	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. 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	Collaborate on strategies to ensure the supply of needed health providers: • strengthen the evidence base for national planning; • promote interdisciplinary provider education; • improve the recruitment and retention of health professionals. (2003 Accord)	Projects are underway in interprofessional education, assessment of international graduates and development of planning models. 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.	There are not enough interprofessional education programs in Canada, and numbers should be expanded.
	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)	8 jurisdictions released their plans.	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.
	Federal government commits to: • accelerating and expanding the assessment of internationally trained health care graduates for participating jurisdictions; • targeting efforts to increase the supply of health care professionals in Aboriginal and Official Languages Minority Communities; • reducing the financial burden on students;	$70 million earmarked to assist jurisdictions to increase their capacity to assess international graduates.	Assessment processes for international graduates should be standardized.
	• participating in health human resources planning with interested jurisdictions. (2004 Plan)	Pan-Canadian Planning Framework document released in fall 2005.	There are a number of projects underway in the priority areas identified but there is no national HHR strategy in place.
	The Government of Canada commits to doubling the number of Aboriginal physicians and nurses within 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
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. 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. 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. 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.	Most jurisdictions are not reporting separately on their allocation of the federal transfers.
	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.	

PATHWAYS FOR HEALTH CARE RENEWAL

The 2003 and 2004 First Ministers' agreements were a starting point for greater public investments in health care. They put us on a path to action, with a focus largely on access to health services.

Renewal needs to set its sights on a higher destination: better health for Canadians. To get there, we need to go down several roads at once. We need to tackle the roadblocks affecting the quality of health care, and we also need to focus on actions to improve population health.

The Health Council proposes three pathways for continued renewal:

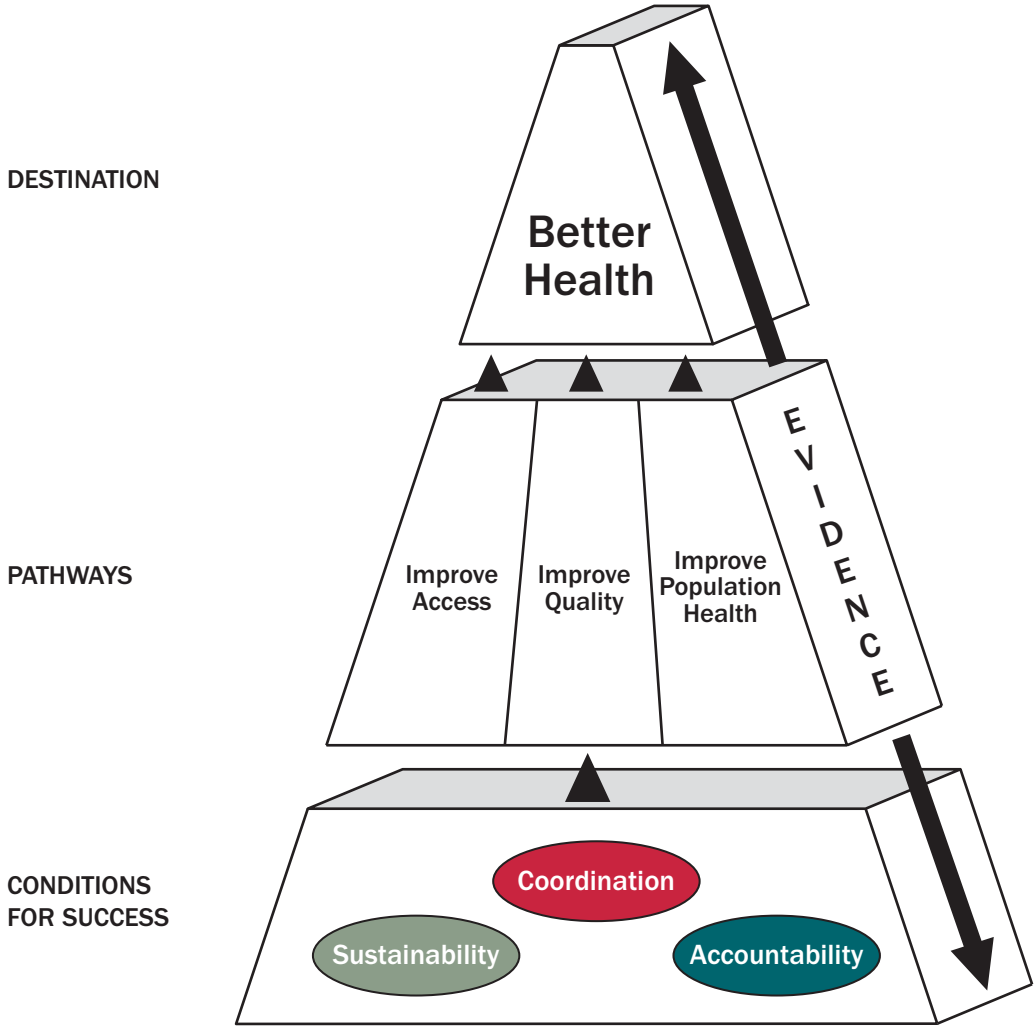
- **Improve access to needed health care** – This means improving access to primary health care teams, expanding home care services that deal with acute and chronic health conditions, approving only safe and effective pharmaceuticals, ensuring reasonable time frames for patients to undergo surgical and diagnostic procedures, and educating adequate numbers of health care workers equipped to practice in new models of delivery.
- **Improve quality of care** – This means focusing on patient safety, accelerated investments in electronic health records and systems for e-prescribing, developing quality councils and indicators for high-quality public reporting, and delivering widespread, on-the-ground quality improvement training to providers.
- **Improve population health** – This means investing in healthy living and chronic disease management and improving socio-economic conditions that lead to health inequalities.

Implementing reform with a balanced approach along all three pathways will get us to the destination of better health. The success of this journey depends also on our commitment to several conditions for success that, in the Health Council's view, are essential in order to keep the roads clear. 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.

At every step, decisions about change should be supported by the best available **evidence**. Figure 1 illustrates these ideas.

Figure 1. Pathways for Health Care Renewal



ABOUT THIS REPORT

This report explores Canada's progress along three pathways to health care renewal and better health. We outline what the governments have committed to do in their health care accords, describe where we are today and what is preventing greater progress, and identify what, in the Council's view, needs to be done to clear the way to real change.

We also highlight some of the work done by a number of other national organizations with whom the Health Council collaborates. Appendix A describes the roles of these organizations.

Again this year we provide information about provincial, territorial and federal activities on the 2003 and 2004 commitments (Appendix B and tables throughout the report). To compile the tables, we requested information from jurisdictions that are members of the Health Council: British Columbia, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Nunavut, Northwest Territories, Yukon, and the Government of Canada. Because Alberta and Quebec are not members, we did not request information directly from these governments; however, we have included information available from them through public reports and websites. Some tables report on activities in selected jurisdictions only.

This report reflects information available as of time of printing. Because governments were due to report in several key areas at the end of December, we are publishing separate commentaries on jurisdictions' action plans for health human resources and on comparable indicators of access to health professionals and diagnostic and treatment procedures. These updates will be available on our website, *www.healthcouncilcanada.ca.*

We also report on specific areas of progress related to the Health Council's advice from our January 2005 report, *Health Care Renewal in Canada: Accelerating Change* (Appendix C).

Innovations in health care are showcased in the report and in six new videos, a mini-documentary series we are calling "Connecting the Dots." And we introduce you to a fictional Canadian family and their experiences with health care to illustrate how health care policies and programs affect people. You will meet them at various points along this journey.



MEET THE JOHNSONS

Frank and Juanita are married and have two children. Frank, 52, is self-employed, earning $50,000 a year. He has been diagnosed with type 2 diabetes. Juanita earns $22,800. Their daughter, Ellie, has severe asthma. With no private health insurance through their jobs or other supplemental insurance, Frank and Juanita rely on their provincial health plan and out-of-pocket spending to support their family's heath care needs.

Frank's 75-year-old mother, Maria, lives in a small town in another province, in her own apartment. She is on a wait list for hip replacement surgery. She lives on a pension income of $25,000 and has no health care coverage except her province's medicare program.

How the Johnsons are able to access needed care – and how much they must pay for it – depends on where they live.

CONNECTING THE DOTS

An Overview of This Year's Mini-documentary Series

Change is never easy, especially in a system as complex as health care. Yet the Health Council continues to find settings where bold steps have been taken to improve patient care, using vision and determination. We travelled coast to coast to coast to document some of these pioneers of change.

In the Kootenay region of British Columbia, a pilot project illustrates the benefits of **collaborative practice** in critical care. And in Twillingate, Newfoundland and Labrador, a **primary health care team** discusses the ins and outs of treating its hemophiliac population, which is many times the national average. At Baycrest, a renowned long-term care facility in Toronto, doctors, nurses and the pharmacy are all linked to a computerized prescribing system aimed at increasing **patient safety** for its elderly at-risk residents. In Toronto's east end, **home care** has gone electronic using telehomecare technology – a unique disease management system that allows patients with chronic diseases to monitor their routine vital signs at home. In Alberta, the Hip and Knee Replacement Project has reduced **wait times** for surgery dramatically. Up north in Rankin Inlet, a maternal care training program for **Inuit** students has just been launched as part of Nunavut's multi-faceted "Closer to Home" strategy.

We know that there are many stories of change, and we look forward to hearing about them from health care providers across the country. Please see our call for **innovative practices in health care** and watch these videos at *www.healthcouncilcanada.ca*.

PATHWAY ONE

PATHWAY ONE

Improve Access to Needed Health Care

Access to needed health care will continue to be an issue for Canadians as long as our services are not well integrated, coverage for services is not equitable across the country, and individuals experience long waits for necessary care. Pockets of the country have achieved real improvement, but change needs to be more widespread and comprehensive. The Health Council proposes five areas of continued focus:

- faster implementation of **interprofessional primary health care teams**;
- immediate efforts 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;
- expansion of services to be delivered under a **standardized home care program**;
- implementation of **standardized public coverage for prescription medications** and better decision support tools to link the best available evidence to prescribing decisions;
- continued efforts to **reduce wait times** but with a focus on examining system design and determining whether patients are waiting for appropriate care.

PRIMARY HEALTH CARE

What did governments promise?

The 2003 First Ministers' Accord on Health Care Renewal committed governments to accelerate primary health care renewal so that citizens routinely receive needed care from an appropriate health care provider. The First Ministers agreed to the goal that by 2011 "at least 50 per cent of their residents have access to an appropriate health care provider, 24 hours a day, seven days a week." In the 2004 10-Year Plan to Strengthen Health Care, this target was described differently as "the objective of 50 per cent of Canadians having 24/7 access to multidisciplinary teams by 2011."

First Ministers also agreed in 2003 to use comparable indicators on key health outcomes and to develop the necessary data infrastructure for reporting to Canadians. The 2004 Plan also committed governments to establish a best practices network and to continue work with Canada Health Infoway to realize the vision of an electronic health record.

Where are we now?

For more than 20 years, we have been talking about reforming primary health care by creating interprofessional teams to provide a wide range of health promotion and treatment services. Yet progress has been slow. The First Ministers' agreement spoke of a renewed commitment to this reform, and all provinces and territories are now implementing some form of a team approach. But primary health care renewal is far from complete. As we stated in last year's report, we view primary health care as the foundation of Canada's health care system. It is the first point of contact Canadians have with the system. Without a comprehensive and integrated entry point for primary health care, citizens are not well served, and the prospects for a vastly better system are not promising.

Our message to Canadians one year later has not changed: The pace of implementing primary health care renewal is still too slow, left largely to a voluntary process with interested health professionals.

Common Language

The fact that different terms are being used to describe primary health care services and types of providers makes the measurement of progress difficult. A recent survey conducted by the Primary Care Awareness Strategy showed that 60 per cent of respondents said they have "heard or seen" the term primary health care.[2] However, only 40 per cent of all survey respondents were able to describe primary health care in even its broadest application. When provided with a brief description of primary health care, 73 per cent of all survey respondents gave primary health care a high rating (between 8 and 10 on a 10-point scale) for its importance to their future health. These findings suggest that we face considerable challenges to improve the public's awareness and knowledge of primary health care.

What do we mean by tele-triage?

Telephone advice to provide basic health information and to help a caller determine what level of care they need (e.g. going to an urgent care clinic or managing the problem at home).

Access 24/7

Jurisdictions have reported progress towards achieving the goal of 24/7 access to primary health care services. Nine jurisdictions now provide after-hours access to a province-wide or territory-wide telephone service, often called tele-triage (Table B.1). Nova Scotia and PEI do not have a province-wide tele-triage service; after-hours access may be available from individual providers or organizations. In the Yukon and Nunavut, although there are no territory-wide tele-triage services, most residents have 24/7 access to information and advice through community health services or hospitals.

Although round-the-clock access seems to be the norm, the type of services provided by phone varies across the country. Some jurisdictions provide health information and advice, while others also refer people to appropriate services. Most importantly, only five jurisdictions have a mechanism to inform the patient's primary health care provider about the encounter. This link is crucial to providing seamless care and avoiding medical errors. Provinces and territories that do not link after-hours services to patients' primary health care providers should do so if the full benefits of 24/7 access are to be realized.

COPING WITH ELLIE'S ASTHMA ATTACK

Now 12 years old, Ellie has had severe asthma since she was five. She sees her doctor regularly to review her condition and monitor her medication. One night, Ellie suffered a serious asthma attack. Where would her parents turn for help?

If the Johnsons lived in **Ontario** and were registered with a Family Health Team, after-hours help would be available for Ellie from Monday to Thursday and one day on the weekend. Her health record would be updated by the attending nurse or physician and returned to her primary health care provider; both are part of the same Family Health Team. If the Johnsons were not registered with a Family Health Team, her family doctor might not offer after-hours care (not all do), so Ellie could either call the provincial telehealth line for advice or go to a hospital emergency department.

However, if Ellie lived in **Edmonton**, she could visit the Northeast Community Health Centre where she would be assessed and, if needed, sent to the Health Centre's 24-hour emergency department. A record of her visit would be sent to her physician. In Alberta, the Johnsons would also have the option of calling the provincial health line for advice or going to the local hospital emergency department, but the record would not go back to their primary health care provider.

If Ellie lived in **Whitehorse**, she would have to go directly to the emergency department at the local hospital. The records would be sent to her physician.

Telehealth

Some jurisdictions – particularly in the North – are investing significantly in telehealth technology and activities to improve service delivery in rural and remote communities (Tables 2 and B.1). In these areas, an encouraging level of activity is taking place through telehealth, including delivery of clinical services, education, consultation and supervision, and family visits with patients.

Jurisdictions that are lagging behind need to commit more aggressively to implementing telehealth to ensure that Canadians in rural and remote communities have access to the care they need, when they need it, and – as much as possible – without having to leave their communities. The Council repeats its message from last year: Canadians should support their governments in investing in this type of service delivery.

What do we mean by telehealth?

A wide range of services using communications technology to deliver health services over long distances. Telehealth includes advice and information services but also consultation, diagnosis, treatment, family visiting and provider education services.

Table 2. Telehealth Services, Selected Jurisdictions, 2005

Jurisdiction	Health education	Patient-provider consultation	Patient visits* by family members	Provider-provider consultation	Radiological and diagnostic services	Discharge planning	Administration and meetings
British Columbia	✓	✓	✓		✓	✓	
Alberta		✓		✓		✓	
Saskatchewan	✓	✓	✓	✓	✓		✓
Manitoba	✓	✓	✓	✓	✓		
Ontario	✓	✓	✓				✓
New Brunswick		✓	✓				
Nova Scotia	✓	✓	✓	✓			✓
Prince Edward Island		✓		✓			
Newfoundland and Labrador	✓	✓ (emerging)	✓ (emerging)	✓ (emerging)	✓		
Nunavut	✓	✓	✓				✓
Northwest Territories	✓	✓		✓		✓	
Yukon	✓	✓		✓	✓		✓

*To allow patients in one location to see and speak with family members in another location.

Interprofessional Teams

While there has been progress in providing care through interprofessional teams, the composition of teams differs widely across regions. Most often, teams consist of physicians and nurses. A few include nurse practitioners, and even fewer include pharmacists or other professionals, for example social workers, psychologists or physiotherapists (Tables 3 and B.2). Progress is not occurring as fast as the Health Council had expected.

What do we mean by interprofessional teams?

Groups of at least three health professionals (including a nurse, physician and at least one other type of provider) who collaborate to deliver primary health care services. Team members may or may not work in the same location, but they are accountable to one another for the patients' care.

Table 3. Composition of Primary Health Care Teams, Selected Jurisdictions

Jurisdiction	Composition of teams, as described by jurisdictions
Manitoba	Manitoba has not formally defined what constitutes a multidisciplinary team. Manitoba has identified in the primary health care policy framework the need for teams to be developed based on community population health needs.
Ontario	Each Family Health Team will be made up of physicians, nurses, nurse practitioners and other health care providers.
New Brunswick	Multidisciplinary teams are designed based on a community needs assessment process, which determines the services required to meet the health care needs of each community serviced by a Community Health Centre.
Nova Scotia	The composition of interdisciplinary, collaborative teams tends to be family physicians, family practice nurses, nurse practitioners and pharmacists. These core team members are usually in place, though other team members and extended providers and contributors work interdependently in many areas.
Prince Edward Island	Teams include physicians and registered nurses. Two of the family health centres have also included part-time dietitians and mental health workers as members of the collaborative practice team.
Newfoundland and Labrador	There is not a standard composition. All publicly funded professional groups are involved both in the community and Primary Health Care Centres.
Nunavut	Teams include nurses, physicians, clerk interpreters, mental health workers, social workers and others; although not always co-located, team members work in cooperation to provide health care.
Yukon	Teams include physicians and nurse practitioners.

Data Collection

The importance of having good data to measure the progress of primary health care renewal and its impact on health outcomes cannot be overstated. For example, one of the measures that jurisdictions have agreed to use is the percentage of Canadians who report having difficulty accessing routine and ongoing health care. A great deal of data collection activity goes on across Canada, but often missing are the necessary baseline data to understand how changes in the delivery of health care actually improve (or harm) individuals' health and whether the system is delivering the best possible quality of care.

The primary health care indicator project led by the Canadian Institute for Health Information (CIHI) will provide a framework for data collection on primary health care reform in the future. This is an important step towards developing capacity to measure health outcomes related to primary health care. However, the Health Council is concerned that there is no plan for data collection once the indicators have been developed and CIHI's project is complete in the spring of 2006. The Health Council recommends that a data collection strategy be put in place and adequately funded to ensure that the indicators currently under development are used to evaluate the impact of primary health care reform.

What do we mean by comparable indicators?

Indicators are a set of measures to demonstrate achievements (or failures) over time, such as whether people use primary health care services instead of hospital emergency rooms on a regular basis. Comparable indicators allow comparison between jurisdictions or among different population groups.

Where are the roadblocks?

- The vision of true interprofessional teams making the best use of a variety of health professionals has been diluted. A lack of planning to increase the range of providers who make up primary health care teams is a key obstacle.
- Many of the innovative initiatives across the country are supported by the Primary Health Care Transition Fund. This funding ends in March 2006, and there is serious concern that the end of funding will prevent promising innovations from becoming more permanent and widespread.
- Funding for primary health care services flows largely through physicians and can therefore become caught up in negotiations between governments and medical associations. This process slows down the movement to new forms of payment that would support team care.
- Tele-triage and telehealth technologies have not been used to their full advantage. Their underuse inhibits efficiency and access for both patients seeking advice and professionals seeking support services.
- High-quality data and indicators to measure progress are being developed, but their implementation is not guaranteed for the long term. Effective monitoring, evaluation, public reporting and quality assurance cannot happen without high-quality data.

What needs to be done?

1. **Focus aggressively on increasing the number of interprofessional teams providing primary health care.** The goal set out in the 2003 and 2004 agreements is modest (50 per cent of residents in each jurisdiction will have 24/7 access to a multidisciplinary team by 2011). Action towards this goal should be accelerated. The Council makes further recommendations on this issue in the section "Health Human Resources."

2. **Ensure that successful models of innovation in primary health care delivery are sustained and expanded on.** Cooperation among jurisdictions is essential to track how these initiatives are repeated in different parts of the country and how quickly they become part of the regular health care landscape.

3. **Make greater use of tele-triage and telehealth technologies.** Although there is encouraging activity on the use of tele-triage and telehealth technologies, continued support and commitment to ensure expansion of current activities and long-term sustainability are required.

4. **Sustain indicator development and data collection.** Efforts now being led by CIHI should be supported and expanded so that Canadians receive ongoing information about specific improvements in both their access to primary health care and the management of their health. The indicators should relate to meaningful outcomes and be geared towards quality improvement.

HEALTH HUMAN RESOURCES

What did governments promise?

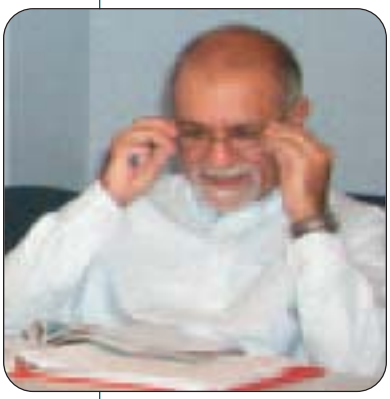
The 2003 First Ministers' Accord on Health Care Renewal committed governments to collaborative strategies to strengthen the evidence base for national planning, to promote interprofessional education, to improve recruitment and retention, and to ensure the supply of needed health providers. The 2004 First Ministers' 10-Year Plan to Strengthen Health Care committed governments to increase the supply of health professionals based on their assessment of the gaps. The federal government agreed to expand the assessment of internationally trained graduates, to target efforts in Aboriginal communities, to reduce the financial burden on students, and to participate in health human resources planning with interested governments.

In our first report to Canadians, the Health Council stressed the importance of focusing on the health care workforce – both the recruitment of new professionals and the retention of those currently working in the system. We argued that without an appropriate health human resources strategy, all other health care renewal efforts would fail.



TEAMS MANAGE CHRONIC DISEASE

Meet Ross Dalley of Twillingate, Newfoundland and Labrador. Ross is one of the 120 people with hemophilia living in this town of 7,500. Twillingate is one of the province's eight project areas undergoing sweeping changes to make sure that primary health care teams are working together to provide care as close to home as possible. Heading the interprofessional team at Twillingate's Notre Dame Bay Memorial Health Centre is Dr. Mohammed Ravalia, who realized 21 years ago that team-based care was the only way to serve such a large, high-risk population dealing with a chronic disease.



Ross's team now consists of a doctor in St. John's linked via telehealth technology to Notre Dame, as well as the Twillingate group consisting of Dr. Ravalia, a licensed nurse practitioner, a community care nurse, lab and X-ray technicians and a physiotherapist.

Watch this video at *www.healthcouncilcanada.ca.*

Where are we now?

Efforts to ensure that we have the right mix of health professionals must take into account that different aspects of the problem require different solutions. For example:

- We have real shortages of particular groups. *The solution here is to train more workers.*
- We have shortages of services as a result of professionals spending time on activities that could be delegated to others. *The solution here is to reorganize the work to get the best use of the skills in our existing workforce.*
- In some areas, we have a sufficient pool of workers, but many are retiring early, changing careers or reducing their hours of work. *The solution here is to focus on ways to reverse the exodus or provide alternative career tracks that prevent the loss of their skills and experience in health care.*
- We have access problems for certain services due to growing demands, some of which may not yield additional health benefits for individuals. *The solution here is to eliminate inappropriate and redundant use of health services.*
- Some areas of the country have an adequate or even an over-supply of some types of workers, while others experience shortages. *The solution here is to implement policies and practices to achieve a better distribution of personnel in relation to need.*

The Health Council sponsored a national summit on health human resources in June 2005 at which we examined four themes:

- interprofessional education and training;
- scope of practice;
- issues in the workplace; and
- planning efforts.

A full report is available on the Council's website, *www.healthcouncilcanada.ca*.

Interprofessional Education and Training

There is an urgent need for interprofessional education that supports new models of primary health care delivery. Simply put, we need to change the way we are educating and training health professionals. This will require different programs, an expansion of current approaches that are educating and training health professionals together, the creation of workplaces that support team-based care, new funding models, and the removal of barriers that prevent professionals from putting their skills to the best use.

A number of schools are on their way to introducing an interprofessional curriculum, and Health Canada has approved funding for the development of 11 collaborative programs. However, it will be some time before students will actually complete these programs and enter the workforce. The projects listed in Table 4 are all due to be completed by March 31, 2008.

Table 4. Plans for New Interprofessional Education Programs

Jurisdiction	Participating organizations	Focus of project
British Columbia	University of British Columbia	To foster and advance collaborative patient-centred practice in health care settings. Interprofessional practice education activities will also be provided for students in a variety of rural, urban and specialty clinical settings. In addition, curriculum development for students, preceptors and health professionals will be implemented.
Alberta	Calgary Health Region University of Alberta University of Calgary Capital Health Region	To create a conceptual model of interprofessional lateral mentorship, within "communities of practice," including multicultural and contextual considerations.
	SAIT Polytechnic Bow Valley College Mount Royal College	To develop an interprofessional learning environment and evaluation tools.
Saskatchewan	University of Saskatchewan	To train future health care professionals to work in teams in the areas of children's mental health, the transition of elders from hospital to community, chronic illness in middle-aged adults, and community health in Aboriginal communities.
Manitoba	University of Manitoba	To educate health professionals with the knowledge, skills, attitudes and behaviour for collaborative patient-centred practice in community-based geriatric settings.

Table 4. Plans for New Interprofessional Education Programs - continued

Jurisdiction	Participating organizations	Focus of project
Ontario	Queen's University	To implement and evaluate activities at pre-and post-licensure levels. Examples include: • *Pre-licensure:* Family Violence Workshops; courses in the School of Rehabilitation Therapy; Professionals in Rural Canada course; Interprofessional Rural Maternity Care course; and an interprofessional program of lectures, workshops and clinical placements. • *Post-licensure:* Educating future physicians in interprofessional psychotherapy, palliative and end-of-life care; and a practicum in bioethics.
	University of Toronto	To create a professional development program to aid in the implementation and adaptation of "Structuring Communication Relationships for Interprofessional Teamwork" communication tools.
	Council of Ontario Universities	To facilitate interprofessional collaboration in educational and practice settings through the use of web and team-based learning activities.
Quebec	Université Laval Social Services Centre of Quebec South	Starting with courses already offered, to provide training in theory and practice necessary for patient-centred collaborative practice. To develop an interprofessional clinical training placement to develop the supports for collaborative practice. To offer workshops to develop and refine the skills required for collaborative practice. To develop a virtual community of practice with modules on the three axes that will support self-learning of the participants.
	McGill University	To establish an increased number of faculty, students and practitioners involved in interprofessional education, thus enhancing the delivery of inclusive programs within academic and clinical sites using appropriate learning environments.
Nova Scotia	Dalhousie University	To extend the interprofessional learning program and foster greater collaboration among project partners.
Newfoundland and Labrador	Memorial University	To develop and implement an interprofessional education curriculum framework continuum that embeds teamwork, experiential and service components starting at the undergraduate/pre-licensure level, with required components for students in nursing, medicine, pharmacy and social work in collaborative settings; a post-licensure continuing interprofessional education component for primary health care teams designed to enhance collaborative mental health competencies of primary health care providers and other community-based professionals; faculty development workshops; and an extensive project evaluation component.

Scope of Practice

It is impossible to achieve a sound workforce strategy in health care without addressing scopes of practice. In any industry, getting the division of labour right is crucial. Making the best use of the full spectrum of skills is key to primary health care renewal, recruitment and retention of providers, high-quality patient outcomes, cost-effectiveness and flexibility to meet community needs. Our own research on scope of practice shows that:[3]

- There are no common definitions of scope of practice in Canada.
- Scopes of practice are determined by a number of different players, including educators, legislators, regulators, employers, professional associations and providers themselves, and their perspectives and aspirations often collide.
- Individual professions have worked on their own scope of practice issues, often isolated from what others are doing (Table B.3).

What do we mean by scope of practice?

The division of labour in health care; who does what.

Simultaneously, the credentialing process in Canada is becoming increasingly complex. Self-regulating professions are setting "entry to practice" standards at higher and higher levels. For example, physiotherapists are proposing a master's degree (MSc) to enter independent practice, and pharmacists are proposing a doctoral level (PharmD) entry credential. There are competing views about the justification for this trend.

One view is that "credential enhancements" are based on concerns about patient safety and performance, and reflect the rising expectations of front-line health care. Others view the trend as "credential creep" and question whether it arises from professional self-interest and whether it may work against the development of team-based care by perpetuating professional isolation. In the Health Council's view, a highly educated workforce and a commitment to lifelong learning are essential to support the delivery of safe and effective health care. However, increases in credential requirements should occur only when there is evidence that existing standards compromise the quality of patient care and therefore standards need to be raised.

The provinces and territories have agreed to a standardized process for reviewing changes to entry-to-practice credentials for health professionals. Professions proposing a change in the entry-to-practice credential are required to complete a detailed submission outlining the rationale for and evidence supporting the change. Each proposal will be reviewed by an expert panel that will make a recommendation based on its findings. While the process is standardized, jurisdictions retain the authority to make their own final decisions.

CRITICAL CARE TEAMWORK IN RURAL BC

In British Columbia, it's all about achieving the right balance and finding flexibility so that front-line health care workers can deliver critical care in remote and rural regions. In the Interior Region of BC, thanks to an innovative partnership between the Health Authority and BC Ambulance Services, critical care patients can now be treated more comprehensively while being transported from a small community to a rural or regional hospital.

We visited the Kootenay Regional Hospital where a paramedic and a critical care nurse are teamed up to respond by ambulance to a call for help in a remote community, perform immediate triage services and transport the patient to either the local hospital or directly to a waiting aircraft. It's a win-win-win situation: the patient receives timely treatment; the paramedic and the nurse work collaboratively with increased skills; and the doctor or nurse practitioner in the remote community can remain in place to treat other patients.

Watch this video at *www.healthcouncilcanada.ca.*

Workforce Planning

Workforce planning in health care has been a challenge for policy makers for quite some time. Canada does not have a national health human resources strategy that is linked to a clear picture of future delivery models. Instead, provinces and territories are doing this work separately, often in isolation from one another. The good news is that some governments have joined forces to plan together on a regional basis.

Every provincial and territorial primary health care plan refers to newer professions, but efforts to increase their numbers are lukewarm. For example, nurse practitioners have a 30-year history in Canada, but there are fewer than 900 of them in the country and they are not licensed in all jurisdictions. This lack of uptake inhibits the development of different models of delivery and compromises access in rural and remote areas where it is difficult to recruit physicians.

Health human resources planning must take into account a number of factors, including changing practice patterns, appropriate scopes of practice, changing demographics and the delivery models of the future. This requires an abundance of good data with good models to project future needs and, most importantly in our view, a desire to work together across jurisdictions.

Work is underway to improve planning capacity; Table B.4 outlines specific activities in the jurisdictions. At the intergovernmental level, the federal/provincial/territorial ministers of health have released a Pan-Canadian Health Human Resources Planning Framework for consultation. The framework has some promising elements that will likely promote collaboration. These elements include articulating

a common vision, setting goals and objectives, and linking these goals and objectives to desired outcomes. In addition, the framework identifies short-, medium- and long-term activities and commits jurisdictions to plan on the basis of the health needs of their populations. However, the framework does not address the issue of coordination across governments and with other organizations such as provider groups, regulators, employers, unions and researchers. Their work needs to be integrated with that of governments. Jurisdictions were due to have released their separate action plans on health human resources by December 31, 2005. As of mid-January, eight had released plans: Saskatchewan, Ontario, Quebec, New Brunswick, Nova Scotia, PEI, Northwest Territories, and Nunavut.

Steps are also being taken to get more and better data. CIHI is leading efforts to develop a minimum data set, which will ensure that all data collectors gather similar information about health care professionals. Currently, Canada has substantial amounts of usable data only related to nurses and physicians. Data on other professions is vital if interprofessional teams are to be the vehicle for primary health care delivery.

In conjunction with efforts to improve data collection, governments are working on projection modelling – a set of tools that planners and policy makers can use to assess future demand for health care professionals. The work is being done under the auspices of a federal/provincial/territorial advisory committee. It would be useful for the committee to inform the stakeholder community about the models being developed, when they might be publicly available, and when they might have an impact on improving access to health care professionals.

Greater self-sufficiency in producing our own health care professionals is an important national goal. In fact, it may be most prudent to develop a modest surplus in the supply of some types of health professionals to keep the system flexible, able to adapt to quickly changing demands.

Part of these developing health human resources strategies will involve the use of internationally educated health professionals. It is important to recognize that Canada is a country that welcomes immigrants and that immigration policies in Canada facilitate the entrance of skilled workers. A clearly articulated role for these professionals is needed. At the same time, the Council believes that the *active* recruitment of health care professionals from countries that are experiencing their own shortages is not an ethical, long-term strategy. Other alternatives are required.

Where are the roadblocks?

- Current training programs and work environments, as well as planning models, are not geared towards interprofessional delivery of care. Without this directional shift, a population-based approach to health needs cannot take hold and the skills of other health professions cannot be fully tapped. Ultimately, health professionals will not be able to truly understand how they could work together differently.
- The skill sets of existing health professions could be put to better use, but real and perceived legal and regulatory barriers are preventing progress.
- Requirements for licensure and entry to practice vary widely across jurisdictions, making it difficult for jurisdictions and professions to plan collaboratively.
- Planning efforts need to be coordinated across jurisdictions to reduce duplication and variability in supply.

What needs to be done?

1. **Focus aggressively on increasing the number of interprofessional education and training programs available in Canada.** The Council recommends that:
   - each university health sciences program in Canada offer an interprofessional education program. If we want health professionals to work together, they need to learn and train together;
   - education and training opportunities allow already-educated professionals to add skills without having to pursue extensive new training programs;
   - tuition subsidies be made available for students and post-graduate trainees to enter interprofessional programs;
   - a collaborative practice workplace fund be established to support primary health care settings that implement true interprofessional teams;
   - the shift to payment models that encourage interprofessional teamwork be accelerated; and
   - concerns about professional insurance schemes and liability be addressed by developing joint liability programs that would apply to a team rather than an individual.

   Specific targets and timeframes for these recommendations are included in the Health Council's November 2005 report, Modernizing the Management of Health Human Resources in Canada: Identifying Areas for Accelerated Change.[4]

2. **Clarify and report to the public on who will provide what services, especially in primary health care.** Governments must take the lead in bringing together the necessary players to assess how scopes of practice align, complement or even duplicate each other, and to clearly articulate who is capable of providing different types of patient care. Those who need to be involved in this effort include health profession associations and regulators, unions and employers. Health human resources plans should be publicly available and specify clear targets and timelines so that local citizens can understand what type of professionals will be delivering care in their communities.

3. **Remove barriers to optimizing skills sets.** Governments, health professions, employers, unions, educators and planners must work together to identify specific legislative, regulatory, financial and policy impediments to optimally using the knowledge and skills of all health professions. The focus must be to support, rather than prevent, interprofessional collaboration and teamwork.

4. **Integrate provincial, territorial and regional health workforce plans.** Unless jurisdictions collaborate in their planning, there will continue to be competition for scarce human resources. Common approaches are needed to address such issues as barriers to mobility and the mismatch between training opportunities and forecasted needs. The education and practice environment for health care workers needs to become simpler, not more complex.

5. **Make decisions about supply in conjunction with addressing scope of practice issues.** For example, changes in the number of training places in various programs should be related to developments in scope of practice to avoid serious under-supply or over-supply of needed health care providers.

HOME CARE

What did governments promise?

The 2003 First Ministers' Accord on Health Care Renewal committed governments to determine by September 30, 2003, the minimum "basket of services" to be provided in homes and communities. First Ministers agreed to provide first-dollar coverage for short-term acute home care, including community mental health and end-of-life care. First Ministers also agreed that access to these services be based on an assessment of need and that they be available by 2006. The Government of Canada agreed to establish compassionate care benefits and job protection for Canadians who need to temporarily leave their jobs to care for a gravely ill or dying child, parent or spouse.

The 2004 10-Year Plan added the following specifics on the types of services to be covered, based on assessed need:

- short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;
- short-term acute community mental health home care for two-week provision of case management and crisis response services; and
- end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life.

Health ministers agreed to explore next steps to fulfill the home care commitment – including plans for staged implementation and annual reporting to their citizens – and to report to First Ministers by December 31, 2006.

Where are we now?

Because governments are not due to report on meeting national home care goals until the end of 2006, we are unable to report to Canadians about progress on these services. The situation is much the same as it was a year ago: access to home care depends on where you live, and different provinces and territories pay for different types of services (Table B.6). Knowing that work on these goals continues, we strongly encourage governments to take a broader view of two key commitments: the home care basket of services and the Compassionate Care Benefits Program.

What do we mean by first-dollar coverage?

Insurance benefits that pay the entire amount of a service, without requiring an out-of-pocket contribution by individuals.

HOME CARE SUPPORT FOR MARIA

Maria needs personal support while she waits for hip surgery, and after she comes home from hospital. Hiring a personal caregiver is not an option she can afford, and there are no relatives living in her community. Maria has applied for home care support.

The level of home care support she will receive depends on an individual assessment; how this is done – and what services are available – differs in each jurisdiction.

In **Alberta**, the regional health authority would assess Maria's situation. To be eligible, Maria must not require round-the-clock health care, and the total cost of the services she needs cannot exceed $3,000 per month. If eligible, she will receive nursing, personal care, and rehabilitation services.

In **Ontario**, a Community Care Access Centre worker would assess Maria. Depending on her assessed needs, Maria could be eligible for up to 80 hours of personal care and support services in the first 30 days and then up to 60 hours in any subsequent 30-day period.

In **Newfoundland and Labrador**, Maria would automatically be eligible to receive home visits by health care professionals such as nurses and physiotherapists, with costs covered by the provincial health plan. To receive personal care services such as help with meals and housework, Maria needs to complete a financial assessment, which determines how much public coverage she is entitled to and how much she would be expected to contribute on her own. Based on her income and savings (she can keep up to $5,000 in savings), she could receive personal care services costing up to $2,707 per month, which buys about 7.5 hours per day. If eligible, Maria will also receive equipment and medical supplies as well as a drug card to cover the cost of prescription medications.

Basket of Services

Between 1995 and 2002, the number of Canadians receiving publicly-funded home care increased by 60 per cent to approximately 850,000.[5] Yet home care accounts for only 3.5 per cent of the total public health care expenditures in Canada. Meanwhile, the need for home care services continues to grow – smaller family size, greater numbers of women in the workforce, and increasingly mobile families have reduced the number of individuals able to take care of family members at home.

All three types of home care services addressed in the health care agreements are important – post-hospital care, mental health care and palliative care – but the Health Council believes the goals are too modest:

- By focusing exclusively on preventing repeat admission to hospital, the goals fail to capitalize on the potential of regular home care visits to prevent hospital admission in the first place. Limiting these programs to people with short-term acute illness ignores the fact that chronic diseases – such as cardiovascular and respiratory disease, cancer and diabetes – are among the most common and costly health problems. A redesigned home care program would not only be more equitable, it could help address major quality-of-life problems for people with chronic disease and prevent or delay health breakdowns and their attendant costs in the future.
- The nature of mental illness is such that treatment is more often thought of in terms of management rather than cure. Two weeks of home care is highly unlikely to address many individuals' problems effectively.
- End-of-life home care will have an impact on most Canadians as patients and as family members. Surveys show that most Canadians wish the option of dying at home. Innovations and expansion in palliative home care have the potential to save governments substantial money, while also satisfying what Canadians have clearly stated they desire.

Current program limitations are particularly problematic for people needing mental health and palliative care. Neither situation can be addressed fully within arbitrary and limited time frames, and both require flexible support.

Two recent Senate reports on palliative care recommended that the federal government immediately assess the need for home care and pharmacare for the dying and establish the funding required for these programs, in collaboration with the provinces and territories. The reports urge governments to:[6]

- implement consistent programs to eliminate disparities between different jurisdictions;
- integrate services to make the transitions between all health care settings seamless (including hospital, long-term care, home and hospice); and
- enhance home care and pharmacare, including the provision of respite care for family or volunteer caregivers.

In general, we find that there continues to be a preoccupation with the provision of care in residential care facilities rather than a community-focused approach that would help people remain in their homes. Both the frail elderly and younger disabled people typically prefer community support services and independent living. The cost and, in some cases, the quality of life in residential care homes are issues that will be addressed fully only when home care is used optimally.

Compassionate Care Benefits Program

The Government of Canada committed to establishing a Compassionate Care Benefits Program through the Employment Insurance fund, and job protection through changes to the *Canada Labour Code*, to provide protected, paid, time-off work to care for a dying family member. The program was launched in January 2004 and provided up to eight weeks of leave – six weeks of paid benefits following a two-week waiting period. Most, but not all, provinces and territories agreed to complementary changes to labour laws to provide further job protection. As of December 2005, British Columbia, Alberta and the Northwest Territories have yet to enact this kind of job protection law.

A recent report commissioned by the Health Council demonstrates that the Compassionate Care Benefits Program has not lived up to expectations.[7] Key concerns include the following:

- Only four per cent of the annual $190 million budget was spent in 2004/05 (Table 5);
- 70 per cent of applications received in 2004/05 were approved;
- The definition of a family member is too narrow; and
- Only those eligible for employment insurance (EI) can access the benefit, thus it is not available for unemployed people, or self-employed, contract, part-time, temporary or seasonal workers. This creates a systemic inequity that denies eligibility to large numbers of people on limited incomes.

The program is laudable, but more is needed to improve its uptake and increase its availability.

Table 5. Compassionate Care Benefits Program, 2004/05

Jurisdiction	Total benefits paid	Applications	Claims allowed
British Columbia/Yukon	$1,348,000	859	644
Alberta/NWT/Nunavut	826,000	546	344
Saskatchewan	225,000	173	133
Manitoba	321,000	246	167
Ontario	2,902,000	2,206	1,352
Quebec	1,000,000	898	710
New Brunswick	155,000	126	106
Nova Scotia	243,000	180	151
Prince Edward Island	46,000	25	24
Newfoundland/Labrador	84,000	75	55
Canada (totals)	**$7,150,000**	**5,334**	**3,686**

In December, the federal government announced that it would broaden access to the program by easing restrictions on the types of family members and non-relatives eligible to receive the benefit; the government has also said it will work to extend the benefit to part-time workers.

TELEHOMECARE IN TORONTO

When a patient with a chronic disease such as congestive heart failure leaves the Toronto East General Hospital, it is very likely that there will be some form of ongoing care, either through the East York Community Care Access Centre (CCAC) or the hospital's outpatient department. But on a cold and snowy day, patients who are lucky enough to be part of the telehomecare program won't have to leave their homes to have their vital signs monitored. Better still, if the patient runs into trouble after hours, help is available through a special telehealth phone line.

Thanks to technology, routine checkups (including checking blood oxygen levels and heart and lung sounds) take place at appointed times using video technology over a telephone line – between a registered nurse and the patient. Patients using this system are much more in tune with what they need to do on a daily basis to stabilize their own conditions because the nurse can spend more time with each patient, doing health care teaching along with the clinical assessments. Training to support this emerging role for nurses is provided through an innovative web-based course in telehomecare, offered through Centennial College in Toronto.

Watch this video at *www.healthcouncilcanada.ca.*

Where are the roadblocks?

- Home care programs are undervalued and underfunded relative to population need. This is short-sighted, as it leads to higher costs elsewhere in the health care system, as well as poorer quality of life for individuals.[8]
- The focus on home care services following acute health problems is important but ignores many Canadians with chronic illnesses, including those with mental illness, who could manage at home with some support.
- The two-week time limit is particularly problematic for people needing mental health and palliative care. Neither situation can be addressed fully within arbitrary time limits and both require flexible support.
- Services to support Canadians who wish to die at home are largely unavailable or, where they do exist, are not integrated with other parts of the health care system.
- Existing programs to assist individuals wishing to support family members dying at home need significant improvements.

What needs to be done?

1. **Expand the level of home care services currently being considered under the health care agreements.** Necessary services should be available beyond the two-week time limit, and home care services for Canadians with chronic disease should be phased in as part of a large-scale expansion of the program.

2. **Change the Compassionate Care Benefits Program to allow larger numbers of Canadians to take advantage of it.** This would include extending the length of the benefit beyond six weeks (eight weeks minus the two-week waiting period) to a full 16 weeks, allowing some flexibility in the requirement to use the benefit within the last 26 weeks of the dying person's life (it is hard to predict when people will die), and enacting the proposed regulations to allow the ill person to choose his or her caregiver. Extending the benefit to those Canadians who do not pay into EI should also be investigated.

3. **Harmonize labour legislation.** Those jurisdictions that have not yet amended their labour laws to provide job protection should do so immediately so that all Canadians can access the federal Compassionate Care Benefits Program without fear of losing employment.

PHARMACEUTICALS MANAGEMENT

What did governments promise?

The 2003 First Ministers' Accord on Health Care Renewal committed governments by the end of 2005/06 to ensure that Canadians, wherever they live, have reasonable access to catastrophic drug coverage. As a priority, the First Ministers agreed to further collaborate to promote optimal drug use and best practices in drug prescribing, and to better manage the costs of all drugs, including generic ones, to ensure that drugs are safe, effective and accessible in a timely and cost-effective fashion.

The 2004 10-Year Plan to Strengthen Health Care directed health ministers to establish a task force to develop and implement a National Pharmaceuticals Strategy and report on progress by June 30, 2006. The strategy was to include: cost options for catastrophic drug coverage, a national formulary for participating jurisdictions, faster access for breakthrough drugs, better monitoring for safety and effectiveness, purchasing strategies, action to influence prescribing behaviour, action to support electronic prescribing, and an analysis of cost drivers and cost-effectiveness in drug plan policies.

In October 2005, health ministers met and reaffirmed their commitment to the National Pharmaceuticals Strategy. At that time, they asked their officials to:

- Accelerate the work on catastrophic drug coverage and to undertake research on expensive drugs for two rare diseases – Fabry's disease and MPS1-Hurler Schie syndrome;
- Expand the scope of the Common Drug Review (the national committee that recommends whether drugs should be funded) to consider all drugs, not just new ones;
- Work towards a common national formulary (a listing of drugs that are approved for public funding);
- Give the Patented Medicine Prices Review Board (PMPRB) responsibility to monitor and report on non-patented drug prices; and
- Collect, integrate and disseminate information on the real-world risks and benefits of drugs.

MANAGING FRANK'S DIABETES

Frank requires medications and supplies to manage his diabetes. He follows his doctor's recommended regimen, which includes two anti-hyperglycemic oral medications to maintain required blood glucose levels. Frank takes additional medications to prevent heart disease, stroke and kidney disease - complications of the diabetes.

Depending on where the Johnsons live, Frank's personal out-of-pocket expenses vary significantly.

In **Newfoundland/Labrador**, he would pay $3,895 annually for these medications; in **Ontario**, $2,046; and in **Nunavut**, $40.[9]

Where are we now?

The 2003 Accord commitment to ensure reasonable access to catastrophic drug coverage by the end of 2005/06 was substantially reduced in the 2004 10-Year Plan, which requires governments only to report on progress on the National Pharmaceuticals Strategy by June 30, 2006, not to actually ensure that drug coverage is in place by that time. Although cost options for catastrophic drug coverage will be part of this reporting, it is not at all clear whether Canadians without catastrophic drug coverage can expect to have it by the end of June 2006. Meanwhile, 600,000 Atlantic Canadians remain without drug plan coverage and more than two million Canadians have coverage that does not protect them from catastrophic costs.

Prescription drugs have become a major part of Canadian health care. CIHI estimates that we spend more on drugs – $20 billion a year – than on any other health care sector except hospitals.[10] Drugs are the fastest growing component of health care budgets, with 10 per cent increases annually over the last 10 years – a rate of increase several times faster than general economic growth over the same decade. Canadian research shows that we are spending more on drugs because more people are being prescribed drugs for longer periods of time, and prescribing providers often select newer and more costly drugs over effective and safe but cheaper alternatives.[11]

The National Prescription Drug Utilization Information System (NPDUIS) is a joint initiative of the PMPRB and CIHI. The system is a national database coupled with analytical capacity that tracks and analyses prescription drug use across the country. NPDUIS is helping public drug plans make informed decisions and create evidence-based management policies.

Appropriate Prescribing

Without population-based information about the appropriateness of these changing utilization patterns, it is hard to assess whether increased usage has resulted in improved health. Are the right drugs getting to the right people at the best price? Indeed, while we witness huge growth in spending on prescription medications, concerns are also growing about prescribing behaviours and their effect on patient outcomes. Studies in Canada have shown:

- Approximately one-third of seniors are prescribed drugs that are either ineffective in the elderly or that put them at unnecessarily high risk when safer alternatives are available.[12]
- More than 30,000 Ontario seniors in one year were given at least one drug that should be avoided in the elderly.[13]
- In a study in Saskatchewan, over 15 per cent of seniors living in the community and 28 per cent living in long-term care facilities regularly received at least one drug from a list of high-risk, potentially avoidable medications for the elderly.[14]
- In another Ontario study, heart failure patients with a high risk of death were the least likely to receive life-sustaining prescription medications (such as ACE inhibitors, which dilate the blood vessels).[15]
- For most patients who experience an adverse event after being discharged from hospital, the cause is related to the use of multiple medications with known interactions, medications that should not be used together, or inadequate monitoring of medication use.[16]

Electronic Information Management

A growing number of provinces are developing electronic drug information systems that will track the use of prescription medications by all residents and ultimately provide useful information to assess safety, costs, access and health benefits. "E-Therapeutics" is another emerging system with information on clinical practice guidelines for prescribing, drug costs, coverage and safety. Both of these systems should be linked with other patient health information systems to create a fully integrated record of patient care and health status. (Electronic drug information systems and e-Therapeutics are discussed further in the section "Pathway Two: Improve Quality of Care.")

Drug Costs and Public Coverage

Drug expenditures vary across jurisdictions, as does the amount covered by public drug plans (Table 6).[17]



Table 6. Drug Expenditures by Jurisdiction, 2002*

Jurisdiction	Total drug expenditure (prescribed and over-the-counter) ($ millions)	Public per capita for total drug expenditure ($)	Private per capita for total drug expenditure ($)	Total (public and private) drug expenditure per capita ($)	Share of prescribed drugs publicly covered (%)
British Columbia	2,001.9	189	298	487	50.6
Alberta	1,625.8	186	336	522	45.7
Saskatchewan	511.8	189	325	514	46.4
Manitoba	597.0	208	309	517	50.1
Ontario	7,663.5	226	408	634	44.9
Quebec	4,575.6	259	355	614	49.5
New Brunswick	454.5	162	444	606	33.5
Nova Scotia	567.2	178	428	606	37.1
Prince Edward Island	77.3	148	417	565	34.7
Newfoundland and Labrador	292.9	191	373	564	39.8
Nunavut	6.1	74	137	211	55.9
Northwest Territories	19.5	294	177	471	75.0
Yukon	15.5	260	253	513	66.2
Canada	**$18,408.7**	**$219**	**$368**	**$587**	**46.4**

*Most recent actual expenditures available; data for years after 2002 are forecast only.

Both public and private drug plans have used a variety of financial policies in an attempt to control costs. Some have focused on increasing co-payments and deductibles for patients. Others have focused on ensuring access to expensive drugs for those patients who can benefit from their use, while not funding patients who would be well served by less expensive but equally effective therapies.

Particular success has been achieved in some jurisdictions in Canada with reference-based pricing, which limits the amount a plan will pay for interchangeable drugs.[18] Usually the price is set at the lowest cost drug that is equally safe and effective as higher cost alternatives. Research shows that reference-based pricing is a valuable tool to control drug costs without sacrificing effectiveness or safety.

As public drug plans attempt to manage costs, there is increasing evidence from the United States that private employer plans are struggling with similar issues. For example, Wal-Mart is considering a shift to hiring more part-time workers, who are not eligible for drug coverage, and adding physically demanding duties to job descriptions to discourage less healthy people from applying for positions.[19] General Motors has announced a reduction in health benefits for their employees and retirees.[20]

Direct-to-Consumer Advertising

Complicating the story is an increase in advertising for prescription drugs directed at consumers. Canada's *Food and Drugs Act* contains a broad prohibition on advertising prescription-only drugs to the public. However, gradual changes in the interpretation of this legislation and increased exposure to US advertising have led to a greater presence of prescription drug ads in the Canadian media. So-called "help-seeking" ads are those that do not mention a specific brand name but suggest that people speak with their physician about an unspecified treatment. "Reminder" ads include only a brand name but make no health claims. Both of these types of ads are allowed under Canadian law, yet neither type is required to provide any information on the health risks, the cost of the product, or how it compares with similar drugs.

The Health Council recently reviewed the existing research on direct-to-consumer advertising to assess whether advertising results in positive patient outcomes or patient safety benefits.[21] In summary, we found no reliable evidence that direct-to-consumer advertising improves patient compliance in taking medications, leads to a more appropriate early diagnosis of an under-treated condition, or prevents hospitalizations or serious disease consequences. As well, physicians report that there is a direct link between requests for medication and exposure to advertising: patients who have a higher exposure to direct-to-consumer advertising ask for specific medications more so than patients who are less exposed. The Council could not find any evidence to support a relaxation of direct-to-consumer advertising rules in Canada.

Where are the roadblocks?

- Coverage for prescription medications continues to be uneven across Canada, leaving an unacceptably large number of Canadians with minimal or no protection against catastrophic drug costs.
- Increasing costs and evidence of patient safety concerns underscore the need for better management of prescription medications.
- Not all jurisdictions have adopted practices such as reference-based pricing. We can save money while maintaining the quality of care if we focus policies and drug plan management on "good but less expensive" products. Some jurisdictions have already realized savings from directly linking evidence-based prescribing protocols and policies with lowest cost therapies.
- Electronic systems are needed to link information about drug products, patients and their medications. This will ensure that prescribing is based on scientific evidence and reduce adverse events caused by medication errors.
- Despite a lack of evidence of benefit, US-to-Canada broadcasting of direct-to-consumer prescription drug advertising continues, along with made-in-Canada "help-seeking" and "reminder" ads. Further relaxing Canada's prohibitions on direct-to-consumer advertising would not be in the best interests of Canadian patients or the health care system.

What needs to be done?

1. **Focus on individuals without drug coverage.** In Atlantic Canada, 600,000 people remain without drug coverage and millions more have coverage that does not protect them from catastrophic costs. They need to be reassured that the National Strategy on Pharmaceuticals will give them access to needed medications at a reasonable personal financial cost. Canadians deserve an actual plan for implementation with clearly specified target dates by June 30, 2006.

2. **Continue to develop processes that support evidence-based decision-making about prescribing and drug coverage.** To manage costs, it is more equitable and more supportive of population health to base prescribing and coverage decisions on science, rather than arbitrarily reducing the number of beneficiaries or increasing deductibles and co-payments. Governments can save money through tighter management of their drug plans, cross-jurisdictional cooperation and improved prescribing behaviours. Such improvements will also enhance government ability to provide coverage for high-cost medications with a proven health benefit.

3. **Continue to develop population-based drug information systems linked to other patient health information.** Electronic record systems are the only way to create fully integrated patient information and the only way to assess the impact of prescription medications on patient outcomes and the cost to the health care system. This information should be made readily available to support national initiatives that inform governments and support the monitoring of the safety and effectiveness of prescription drugs.

4. **Strengthen legislation to ban all forms of direct-to-consumer advertising of prescription drugs in Canada.** Legislation should clearly prohibit "help-seeking" and "reminder" ads.

WAIT TIMES

What did governments promise?

In response to strong public concern about wait times, the First Ministers made five specific commitments to Canadians in their 10-Year Plan to Strengthen Health Care:

- First Ministers committed to providing, by the end of December 2005, evidence-based wait time benchmarks for cancer, cardiac, diagnostic imaging, joint replacement and sight restoration (cataract surgery).
- They also agreed to develop comparable indicators of access to health care professionals and diagnostic and treatment procedures by the end of 2005.
- The provinces and territories made a commitment to set targets, by the end of 2007, to achieve the wait time benchmarks.
- They agreed to report annually on their progress in meeting these targets.
- To assist the provinces and territories in their efforts in reducing wait times, the federal government established a $5.5 billion Wait Time Reduction Fund allocated on a per capita basis.

REPLACING MARIA'S HIP

Because of her age and the fact that she lives alone, Maria is considered at risk and should have hip surgery as soon as possible.

Available wait time information indicates that if Maria lived in **Ontario**, the median wait time would be 17 weeks.

In **British Columbia**, she could wait from 2 to 102 weeks depending on her surgeon's schedule. In **Alberta**, the median wait time would be 18 weeks, but only 4.7 weeks if she were part of the Alberta Hip and Knee Replacement Project.

Where are we now?

Significant attention has been paid to wait times in Canada over the last year with considerable progress.

Benchmarks

On December 12, 2005, provinces and territories announced their first set of common benchmarks for wait times for radiation therapy (four weeks), cardiac bypass surgery (two to 26 weeks), and hip and knee joint replacement (26 weeks), with further targets to follow as more research becomes available (Table 7). Later in December, Ontario also released its own targets including levels of urgency for all five clinical areas called for in the 2004 Accord.

Prior to the governments' announcement in December, some provinces and hospital managers have set their own performance goals and measured compliance. A selection of these benchmarks is presented in Table B.10.

Reporting to Citizens

Information on wait times for individual provinces and territories is becoming more available, for example through publication on public-access websites, and the data are improving in quality (Table B.9). At the same time, in the absence of commonly accepted standards and definitions and measures, comparing data from different jurisdictions continues to be difficult. Some sites provide a target so that patients can judge how long they will likely be waiting. Some sites provide the actual wait times for specific procedures from the previous three or six months. Very few provide real-time information that indicates the expected wait at different locations or with different providers.

The Wait Times Reduction Fund

Table B.8 describes investments made by each jurisdiction with their share of this new 10-year fund to reduce wait times. Many governments have purchased new equipment or reported an increase in the number of surgeries provided. Other initiatives include training health care professionals, expanding community care and creating information systems. Some governments have concentrated their efforts on the five priority clinical areas identified in the health care accords. Others have invested in different areas that are important in their provinces/territories, such as emergency rooms (Nova Scotia) and rehabilitation (Northwest Territories).

Table 7. Actual Wait Times for Selected Treatments, Selected Provinces Public Website Information as of December 2005

	Cardiac surgery	Radiation therapy	Cataract surgery	Hip replacement	Knee replacement
Common benchmark* (time within which care should be provided)	**(Bypass only, by level of urgency) Level I: 2 weeks Level II: 6 weeks Level III: 26 weeks**	**4 weeks from being ready to treat**	**16 weeks for patients who are at high risk**	**26 weeks**	**26 weeks**
British Columbia	Median wait: 10.4 weeks *Aug–Oct 2005*	Median wait: 0.9 weeks *Aug–Oct 2005*	Priority 2 & 3 cases: median wait 1.0–52.9 weeks *Aug–Oct 2005*	Priority 2 & 3 cases: median wait 2.1–102.7 weeks *Aug–Oct 2005*	Priority 2 & 3 cases: median wait 2.4–116.2 weeks *Aug–Oct 2005*
Alberta	(Bypass only) Median wait: 3.9 weeks *(% of cases done)* 46.1% in < 3 weeks 19.3% in 3–6 weeks 27.2 % in 7 weeks–3 months 5.6% in 4–6 months 1.8% in 7–12 months *Aug–Oct 2005*	(Breast and prostate cancer) 2–5 weeks from referral to appointment with oncologist; < 2–3.5 weeks from appointment to therapy *As of Oct 31, 2005*	Median wait: 10.9 weeks *(% of cases done)* 3.5% in < 3 weeks 12.2% in 3–6 weeks 48.8% in 7 weeks–3 months 23.7% in 4–6 months 8.1% in 7–12 months 2.9% in 13–18 months *Aug–Oct 2005*	Median wait: 18.0 weeks *(% of cases done)* 7.9% in < 3 weeks 12.5% in 3–6 weeks 27.1% in 7 weeks–3 months 25.8% in 4–6 months 18.6% in 7–12 months 5.8% in 13–18 months 2.3% in 18+ months *Aug–Oct 2005*	Median wait: 23.9 weeks *(% of cases done)* 3.2% in < 3 weeks 7.4% in 3–6 weeks 24.3% in 7 weeks–3 months 24.9% in 4–6 months 26.4% 7–12 months 9.2% in 13–18 months 4.6% in 18+ months *Aug–Oct 2005*
Manitoba	(Bypass only) Median wait: 25 days *Jul - Sep 2005*	Median wait: 1 week *Jul - Sep 2005*	not posted	not posted	not posted
Ontario	(Bypass only) Median wait: 14 days 90% cases done in 49 days *Aug–Sep 2005*	(Breast only) Median wait: 3.1–12.9 weeks *Jun–Aug 2005*	Median wait: 99 days 90% cases done in 311 days *Aug–Sep 2005*	Median wait: 119 days 90% cases done in 351 days *Aug–Sep 2005*	Median wait: 147 days 90% cases done in 440 days *Aug–Sep 2005*
Nova Scotia	*Average waits:* In-House Urgent done in 3 days; Semi-Urgent A done in 28 days; Semi-Urgent B done in 67 days; Elective done in 187 days *Oct 2005*	*Average waits:* (Capital Health & Cape Breton regions) Emergency done in 1 day; Urgent done in 7 & 5 days; Semi-urgent done in 21 & 20 days; Less urgent done in 36 & 32 days *Oct 2005*	*% cases done:* 33% in 30 days 54% in 60 days 67% in 90 days 90% in 180 days 95% in 270 days 99% in 360 days *Jan–Jun 2005*	*% cases done:* 7% in 30 days 15% in 60 days 26% in 90 days 49% in 180 days 63% in 270 days 75% in 360 days *Jan–Jun 2005*	*% cases done:* 4% in 30 days 9% in 60 days 17% in 90 days 40% in 180 days 57% in 270 days 74% in 360 days *Jan–Jun 2005*
Saskatchewan	(Bypass only) Median wait: 4 days *Apr–Sep 2005* *% cases done:* 32% in 24 hours 46% in 24 hours–3 weeks 7% in 4–6 weeks 13% in 6 weeks–3 months 2% in 4–6 months *Apr–Sep 2005*	Median wait: 3.2 weeks from first appointment with oncologist to start of treatment *Apr 2004–Mar 2005*	Median wait: 21.9 weeks *Apr–Sep 2005* *% of cases done:* 2% in 24 hours 9% in 24 hours–3 weeks 9% in 4–6 weeks 15% in 6 weeks–3 months 24% in 4–6 months 28% in 7–12 months 9% in 13–18 months 3% in > 18 months *Apr–Sep 2005*	Median wait: 14.4 weeks *Apr–Sep 2005* *% of cases done:* 20% in 24 hours 3% in 24 hours–3 weeks 5% in 4–6 weeks 18% in 6 weeks–3 months 20% in 4–6 months 16% in 7–12 months 7% in 13–18 months 11% in > 18 months *Apr–Sep 2005*	Median wait: 40.3 weeks *Apr–Sep 2005* *% of cases done:* 1% in 24 hours 1% in 24 hours–3 weeks 3% in 4–6 weeks 9% in 6 weeks–3 months 20% in 4–6 months 24% in 7–12 months 9% in 13–18 months 32% in > 18 months *Apr–Sep 2005*

*The provinces and territories announced these common benchmarks on December 12, 2005.

SHORTER WAITS FOR NEW HIPS AND KNEES

The knee bone and the hip bone are definitely connected in this innovative assessment and wait times story unfolding at the Alberta Bone & Joint Health Institute. Dr. Cy Frank is Vice-Chair of the Institute and part of a provincial team managing the Alberta Knee and Hip Replacement Project that is underway in the Calgary, Capital and David Thompson health regions. With the project's combination of a new process of central assessment clinics and an emphasis on reducing wait times for orthopedic surgery, patients are already giving it the thumbs-up.

After eight months the project has reported, among other successes, dramatically decreased wait times for patients to complete their surgery, as well as shorter hospital stays. But Dr. Frank also tells of the opportunity for prevention: an early arthritic patient who receives treatment sooner rather than later may avoid surgery altogether.

Watch this video at *www.healthcouncilcanada.ca.*

The Health Council commends governments for their efforts in the area of wait times – they have listened to Canadians and made a serious attempt to respond to their concerns. In particular, the agreement on benchmarks demonstrates that jurisdictions can cooperate to achieve common goals in the public interest. Provinces and territories are increasingly posting wait times information on their websites. Some jurisdictions have been able to demonstrate reduced wait times for some services.

However, the Council does have concerns that some of the approaches being taken are too narrow. A much broader package of reforms is required.

First, wait times websites for the public are an important accountability measure but they need to provide real-time information. Canadians are interested in knowing how long they have to wait once they are referred for a procedure – not how long they would have waited in the past. And Canadians should be able to compare wait times from one province or territory to another.

In our recent background paper, *10 Steps to a Common Framework for Reporting on Wait Times* (November 2005),[22] the Health Council proposed a set of guidelines to assist jurisdictions in coming up with a standard way of managing and presenting information on wait times. These include: defining wait time as the time from the initial referral to the completion of the procedure (the clock should not restart every time a procedure is rescheduled); prioritizing cases and setting benchmarks on the basis of need using no more than three levels of urgency; and tracking the impact of changes to ensure that reductions in wait times for targeted procedures do not inadvertently increase waits in other areas.

Second, the focus has been on reducing overall wait times for specific procedures, rather than a targeted review of those who are waiting too long. Even where average wait times are reduced, it is the outliers – those who wait unusually long – who should cause concern. Mechanisms should be put in place to identify those patients and take appropriate action.

Third, it is important to look at how we are tackling wait times. In Canada, the typical policy response to deal with backlogs has been to increase capacity by allocating additional resources through selective one-time funding. This may reduce waits for some patients in current queues, but without better management and redesign of patient flows, this strategy will not reduce waits for the long term. Research has demonstrated that applying principles of system engineering and flow management can be dramatically effective at little additional cost. For example, the Alberta Hip and Knee Replacement Project reported in December 2005 that the average wait time to receive a first consultation for hip or knee replacement surgery declined from an average of 35 weeks to six weeks, and time from consultation to surgery has gone from 47 weeks to 4.7 weeks. These remarkable results were achieved in just eight months by introducing a series of system changes, including central assessment clinics and a streamlined referral process.[23]

Fourth, Canada has yet to deal adequately with the issue of appropriateness: do patients placed on wait lists for procedures really need those services? Operating on people when their potential benefit from surgery does not outweigh the risks can actually cause more harm than good.[24] Success in reducing wait times can turn into another form of failure if it simply leads to the provision of a greater volume of service without better health outcomes.

Guidelines to determine when a procedure is appropriate would help us manage waiting lists more efficiently in two ways. They would ensure that our health care resources are spent treating those patients who stand to benefit most from treatment. And they would enable us to measure the true need for a particular procedure in each community; we could then design the capacity of the health care system to meet that need. Some Canadian health care providers have taken steps to better manage access through standardized decision-making consistent with the best clinical evidence. For example, the Cardiac Care Network of Ontario successfully manages the queue for cardiac surgery across the province using validated tools for ranking patients according to medical need. Their approach has been adopted by other jurisdictions. But programs like this to manage wait lists remain the exception rather than the rule in Canada, especially for very high-volume, low-risk procedures such as cataract surgery and MRI/CT scans.

Where are the roadblocks?

- There is an increasing amount of information about wait times available on government websites, but a lack of consistency makes it difficult to compare information and reduces the ability of citizens to hold governments accountable for progress.
- We are not asking the right questions about wait times. For example, measuring the volume of care and the length of overall waits is important but we also need to focus on the patients who are waiting too long.
- Measuring wait times is important but must be accompanied by a major analysis and redesign of the care process.
- Work on reducing wait times must not be separate from work to ensure that the care patients are waiting for is medically appropriate. Evidence on the benefits and risks of specific interventions should be the underpinning of treatment decisions.

What needs to be done?

1. **Improve public information on wait times.** How long Canadians can expect to wait for treatment is the information of most interest to people. Public information on wait times should tell Canadians what wait times they might expect, be easy for them to use and understand, and be simple to compare, no matter where they live.

2. **Develop a package of reforms to reduce wait times including:**
   - a common service queue for each of the major services, so that patients can be served in accord with their urgency and have the option of seeking physicians with shorter wait lists;
   - a central information system that identifies patients whose waits are becoming unusually long and triggers an audit to investigate accordingly;
   - an appeal process for patients who feel their waiting was prolonged or excessive; and
   - secure real-time wait list registries to assist managers to deliver timely health care by identifying bottlenecks in the queue and producing up-to-date information on wait times for comparison with others institutions and jurisdictions.

3. **Focus on appropriateness of care and on health outcomes.** We need better methods to integrate information on wait time targets and the appropriateness of interventions.

PATHWAY TWO

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

- a focus on **patient safety efforts**;
- significant investments in **information management systems** to support quality care;
- the establishment and support of **quality councils** and research bodies to produce clinically relevant patient outcome data; and
- the development of **health outcome indicators and public reporting** linked directly to health care renewal goals.

PATIENT SAFETY

What did governments promise?

In 2003, First Ministers agreed to establish the Canadian Patient Safety Institute.

Even with the best systems in place, things sometimes go wrong. The first Canadian study on patient safety estimated that about 185,000 patients in this country suffered an adverse event while in hospital in the year 2000 resulting in injury or death and that close to 70,000 of these events were potentially preventable. Most patients in the study sample recovered from the adverse event, but 21 per cent died.[25] That means that up to 23,750 people per year could die after experiencing an adverse event in hospital. A recent survey found that 23 per cent of Canadians – over five million people – report that either they or a family member had experienced an adverse health care event at some point in their lives.[26]

What do we mean by adverse event?

An unintended injury or complication, caused by the delivery of health care, which results in disability, death or prolonged hospital stay.

Added to the human toll is the cost of these events – researchers estimate that adverse events result in more than a million in-hospital days. If more events were prevented, these resources could be used elsewhere. Safer care is also cheaper care.

Where are we now?

The creation of the Canadian Patient Safety Institute has brought a new focus to the issue of avoidable errors in Canadian health care settings. Currently, the Institute is sponsoring a grassroots campaign to enlist health care organizations to reduce avoidable errors. Called *Safer Healthcare Now!*, the campaign focuses on six interventions that have been shown to reduce death and disability:

- deployment of rapid response teams;
- delivery of evidence-based care for heart attack patients;
- prevention of adverse events related to medication;
- prevention of catheter-related bloodstream infections;
- prevention of infections related to surgery; and
- prevention of pneumonia for patients on ventilators.

What do we mean by patient safety?

Strategies to reduce unsafe acts during the delivery of health care, to prevent unintended injury or complications to patients. Contracting infection in hospital or receiving the wrong medication or wrong dose are examples of problems that patient safety measures should address.

The campaign is voluntary and, to date, more than 135 hospitals and other health care organizations in Canada have joined.

Accreditation of health care facilities provides another avenue to improve patient safety. Accreditation is a voluntary, external review program that evaluates health care facilities against a set of national standards. A team of assessors visits the facility, reviews information on quality of care, interviews clients and staff, makes recommendations for improvement, and monitors compliance.

In Canada, this service is provided by the Canadian Council on Health Services Accreditation (CCHSA), which has created patient safety goals as part of its accreditation program. Compliance with these goals and practices will be considered in the accreditation decisions in 2006. Health care organizations will need to demonstrate that they meet these patient safety practices to achieve accreditation. Six broad goals must be met:

- *Create a culture of safety within the organization.* This includes establishing a reporting system for adverse events, producing quarterly reports on patient safety to the board of directors, and developing a formal policy of disclosure on adverse events to patients and families.
- *Improve the effectiveness and coordination of communication among service providers and patients.* This includes focusing on patient education, and developing effective mechanisms for the transfer of information and reconciliation of patient medications upon admission and transfer to other settings.
- *Ensure the safe use of high-risk medications.* This involves developing protocols for every step: the purchasing, ordering, dispensing, administering and monitoring of high-risk drugs.
- *Ensure the safe administration of infused medications.* This includes focusing on safe storage, limiting the number of drug concentrations available and delivering ongoing training on all infusion pumps.

- *Create a workplace environment that supports the safe delivery of care.* This involves providing education and training for the workforce and preventive maintenance for all devices, equipment and technology.
- *Reduce the risk of infections acquired while in a facility.* This entails adhering to infection control guidelines, providing education and training for staff and volunteers, monitoring infection rates and using only sterilized equipment and facilities.

Although accreditation is largely voluntary, the vast majority of Canadian health care facilities or regions participate in the process. However, few institutions release their full assessment reports to the public. Some provinces and territories have made accreditation a requirement – for example, both private and public health care facilities in Quebec must be accredited. Other jurisdictions make participation in accreditation an incentive by providing funding; Ontario does this for its long-term care facilities and some other provinces share costs directly for initiatives such as education. As well, the Royal College of Physicians and Surgeons of Canada requires all teaching hospitals to be accredited through CCHSA. With a greater national focus on patient safety and accountability, it is time to ask whether accreditation and the public release of detailed results should remain voluntary.

Creating a culture of safety within health care organizations – one of CCHSA's six patient safety goals – will be difficult without making changes to our current system of liability protection, which creates an adversarial relationship between injured patients and health care professionals. When Robert Prichard investigated this issue in 1990 at the request of the federal, provincial and territorial governments, he recommended that Canada develop a no-fault system to compensate patients who suffer an avoidable health care injury – much like workers' compensation systems – but his advice was not adopted.[27] Prichard estimated that the system at that time took in $200 million in annual insurance premiums and paid out claims to some 250 patients, representing only about 10 per cent of patients injured during health care. Given that in some provinces these costs are largely borne by the public (for example, Ontario subsidizes malpractice insurance for physicians), it seems prudent to re-examine the pros and cons of no-fault compensation with costing and claims information that reflects the situation today.

Where are the roadblocks?

- Patient safety efforts in Canada are in their infancy and need the support of policy levers to increase participation and public accountability. Evidence-based programs with demonstrated quality improvements for patients should be mandatory, not voluntary.
- Professional liability protection for health care providers continues to be individually-based and injured patients have no option but to sue the responsible provider. This inhibits disclosure of errors in health care workplaces and decreases the likelihood that patients will receive compensation.

What needs to be done?

1. **Make accreditation for health care facilities mandatory.** Accreditation is a powerful lever to move us towards improved quality of care and better patient safety. Governments should make it a condition of public funding.

2. **Require the public release of accreditation reports.** To ensure accountability, health care facilities should publish the results of their accreditation reviews and explain their plans to improve patient safety and quality of care.

3. **Re-examine the issue of no-fault compensation for victims of adverse health care events.** We need a fresh look at how injured patients are compensated and whether current insurance schemes inhibit the development of a culture of safety; the issue of job protection for whistleblowers should be included in this effort. Professional liability protection organizations, governments, regulators and patient safety organizations should collaborate to develop recommendations and take action.

INFORMATION MANAGEMENT SYSTEMS TO SUPPORT QUALITY CARE

In the last 12 months, 322 million visits were paid to Canadian physicians, 382 million prescriptions were filled in Canada, 300,000 clinical trials were conducted worldwide, and 1.8 million new research papers appeared in 20,000 medical journals.[28] In modern day health care, providers need reliable and accurate patient health information at the point of care and the best evidence available to determine treatment options. Electronic tools to manage patient information and guide treatment decisions cannot be viewed as a luxury; they are a critical part of ensuring safe and appropriate care.

What did governments promise?

In the 2003 Accord, First Ministers agreed to place priority on implementing electronic health records and telehealth technology, particularly for rural and remote areas. The Government of Canada committed to provide additional support to Canada Health Infoway to help achieve these objectives.

Where are we now?

Electronic Health Record

Canadians can access their personal financial information online anywhere in the country, yet their health information remains largely in paper files in unconnected offices and institutions. A comprehensive electronic health record would give every Canadian a secure and private record of their health care, which an authorized health care provider could access at any time.

Making the record available electronically enhances the quality of care by ensuring that accurate information is available immediately at the point of care. Electronic health records improve patient safety by reducing errors caused by multiple files and data entry points, and they make the overall system more efficient by reducing duplication and improving the flow of information. Work is underway to develop systems for electronic health records (Table B.11), and significant progress has been made on joint initiatives. For example, all jurisdictions have agreed to use a common "architecture" for electronic health record projects, and jurisdictions are using one set of standards for data and technology to ensure that systems can talk to each other. Some governments are also collaborating on common purchasing.

Canada Health Infoway, the agency mandated to foster the development of electronic health information systems, has set the following target: 50 per cent of Canadians will have an accessible electronic health record by 2010. In March 2005, Canada Health Infoway increased its level of funding for programs to implement electronic health records. The Health Council applauds Infoway for accelerating its investments in the electronic health record.

The Health Council recognizes that there are complex issues regarding implementation of electronic health records that require resolution, including funding, privacy, the integration of information from different sources, and the willingness of providers to adopt new technology. However, progress on the implementation of the electronic health record is still too slow (Table 8). The Health Council repeats its message from last year's report: the targets are not aggressive enough. In our view, 100 per cent of the population should have an electronic health record by 2010.

Table 8. Progress Report from Canada Health Infoway on Achieving its Goal of Electronic Health Records for 50% of Canadians by 2010

Element of electronic health record	Anticipated progress by March 31, 2006	Anticipated progress by March 31, 2008
Client registry	25.2% of Canadians	100% of Canadians
Provider registry	29.3% of key providers	100% of key providers
Diagnostic imaging	46.1% of exams digitally stored	79.7% of exams digitally stored
Drug information systems	30.4% of Canadians	60.7% of Canadians
Lab information systems	8% of Canadians	65.2% of Canadians
Interoperable EHR	4% of targeted population	30% of Canadians

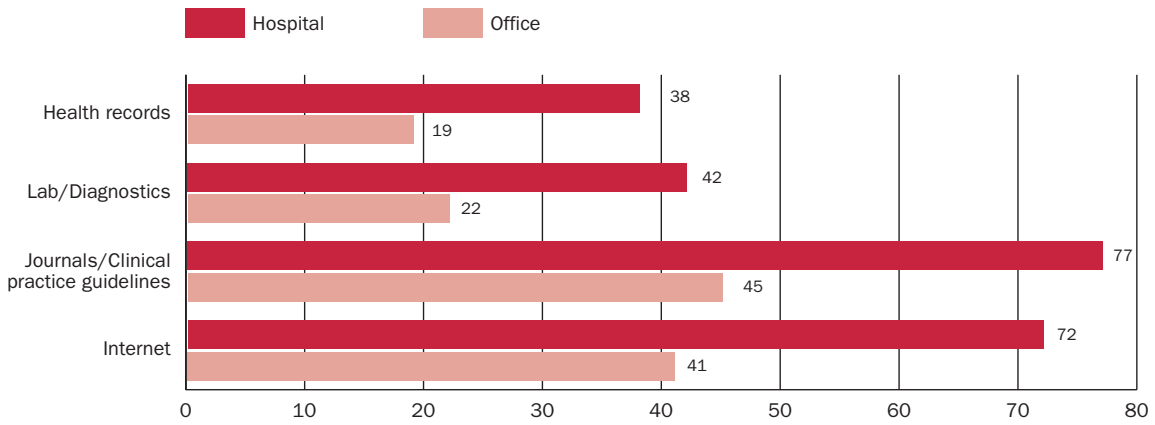
As we wait, the quality of care provided to Canadians is regularly jeopardized due to errors caused by the manual entry of health information. Canada lags behind other countries in adopting technologies that would support evidence-based clinical decisions, reduce errors and improve population health.[29] In New Zealand, 95 per cent of family physicians have computerized records, and 75 per cent use their systems to send and receive laboratory and radiology results, discharge information and referrals. Denmark also reports high levels of electronic information management: 90 per cent of physician offices are computerized and using networks to send and receive clinical information.

In Canada, physicians do report increasing use of the Internet, but access to various types of information technologies varies (Chart 1).[30] Hospital-based physicians clearly have greater access than do those in office-based settings.

What do we mean by interoperable EHR?

An electronic health record (EHR) that integrates information from many sources into a single patient record to provide a secure, private, lifetime record of an individual's key health history and care, including test results, medications and past treatments.

Chart 1. Canadian Physicians' Use of Health Information Technologies in Office- and Hospital-Based Care Settings, 2004



In 1998, the United Kingdom embarked on an aggressive campaign to convert paper files to an electronic format as well as to link all health care providers to a national network. Their time frames are quite different (Table 9).

Table 9. UK National Health Service "Connecting for Health" Timelines

Summer of 2005	All outpatient appointments booked online Basic patient information available online
Spring 2006	Detailed information for all patients available online All orders for diagnostic images and pathology made electronically All emergency and after-hours encounters noted in the system
Fall 2006 – 2008	Decision-making support tools available for physicians and nurses Electronic prescribing available Remote links to health professionals available from home
2010	Health care integrated with social services

Governments in Canada need to get in the driver's seat to accelerate progress on electronic health records. Greater resources, protected from the pressures of regular health care spending, are required. A recent study done for Canada Health Infoway estimates that the total cost of implementing an electronic health record for 100% of Canadians will be $10 billion.[31]

This is an expensive job, but the investments are critical. Governments and the public should not be deterred by the expected stop and go of implementing huge technological change. If we don't modernize the management of patient information, all other activities for health care renewal will stall. Despite the best of intentions, efforts to improve quality, safety, and team-based primary health care, among other aspects, will be gridlocked until we build streamlined and integrated information systems.

Where are the roadblocks?

- Canada is not doing enough to accelerate the implementation of information management systems that electronically link patient health information. These systems can improve patient outcomes and efficiency; decrease duplication, error and costs; and reduce waits.
- Canada has not committed the sustained funding required to ensure that 100% of Canadians have an electronic health record by 2010. The UK is spending the equivalent of $300 per person to implement electronic health records; in Canada, current funding is only $30 per person.
- Without electronic health records, national goals to create an integrated primary health care system with 24/7 access for patients cannot be met.

What needs to be done?

1. **Speed up the development of electronic health records.** Canada Health Infoway should move its timelines forward, with the goal of creating electronic health records for all Canadians by 2010.

2. **Increase the upfront investment to reach the 100% target.** These are expensive undertakings but vital to health care renewal.

3. **Strengthen the public and political commitment to this investment.** The value of electronic health records and other forms of information technology needs to be reinforced widely, so that the public clearly understands the benefits and supports the commitments required to adopt these tools rapidly.

4. **Stimulate the rapid adoption of electronic health record systems by health care providers.** Providers need support in making the transition to electronic information systems.

Electronic Drug Information Systems

An electronic drug information system (sometimes called "pharmanet") is a secure computer network that links all pharmacies within a particular province or territory to a central set of data systems. These systems give health care providers quick access to the most up-to-date information on drug safety and interaction, as well as to individual patient histories. An electronic drug information system increases drug safety by preventing overuse of drugs through unintended duplication or fraud; it also increases safety by checking for drug interactions and proper dosage.

Hospital emergency rooms and community clinics can also be linked into an electronic drug information system so that front-line providers can be alerted to a patient's allergies and potential drug interactions or other safety issues. The system also enables patients and providers to reap the full benefits of electronic prescribing, another vital information management tool, described in the next section. British Columbia's PharmaNet system and Manitoba's Drug Programs Information Network are the most advanced of these systems in Canada; Saskatchewan has begun to introduce its Pharmaceutical Information Program into emergency departments, pharmacies and other sites; and other jurisdictions are in various stages of development in this important area.

Electronic Prescribing

Once the electronic health record is in place, we could still have a situation where the diagnosis has been made, the physician has entered the information directly into the patient record and then reaches for his or her prescription pad to hand-write a prescription. Illegible physician handwriting has been the subject of jokes over the years, but it is no laughing matter when it results in a patient getting the wrong drug or an incorrect dose.

Electronic prescribing (or e-prescribing) is a new method that health care providers can use to order prescriptions for their patients – by computer. Once the prescription is verified as safe and effective, a legible prescription is generated, either in print or electronically, which the pharmacist then uses to dispense medication. The information becomes part of a larger database that stores all prescriptions for the jurisdiction.

Research about e-prescribing shows the following:[32]

- It decreases adverse drug events and improves patient care by providing critical information about such things as patients' allergies and potential drug interactions.
- It helps physicians make timely and optimal clinical decisions.
- It improves cost control in public drug plans by providing information on what drugs are approved for coverage.
- It reduces hospitalizations resulting from adverse drug reactions.
- It reduces the time pharmacists spend calling back health care providers to clarify handwritten prescriptions.
- It provides information to continue improving the quality of prescribing practices.
- It reduces the time patients have to wait to have a prescription filled.

E-prescribing is not the standard practice in Canada even though the benefits are known. Canada Health Infoway estimates that approximately eight per cent of Canadian physicians are using some form of e-prescribing. Significant barriers to a Canada-wide adoption of this technology include a lack of access to complete patient information, an absence of technology at the point of care, failure to integrate the technology into the care process, and a lack of legislation and regulation to support its use. However, these barriers are not insurmountable.

Leadership is required to assess the current legal and regulatory environment, to communicate the case for change, to work with physicians and pharmacists to achieve buy-in, to identify data elements, and to plan for a phased adoption of information management systems.

E-PRESCRIBING FOR PATIENT SAFETY

On any given day, the pharmacy at Baycrest, a long-term care residence in Toronto, dispenses well over 5,600 medications to the more than 700 frail and elderly people who live in the home and hospital. One of the greatest risks in any health care setting is the possibility of an adverse drug event – an unwanted outcome from a prescribing error that can, in the most dire situations, be fatal. In an average 100-bed facility, nine adverse drug events typically occur each month, and it is estimated that almost half of these can be prevented. At Baycrest, a team of doctors, pharmacists, researchers, and information systems experts set about to design a computerized prescribing system that would serve as a support tool for clinical decision-making for everyone in the "prescribing chain" and reduce adverse drug events. Among other benefits, the system eliminates handwritten paper prescriptions and alerts the staff to potential drug interactions and contraindications.

Watch this video at *www.healthcouncilcanada.ca.*

E-Therapeutics

A new electronic complement to e-prescribing and electronic drug information systems is an initiative of the Canadian Pharmacists Association (CPhA) called e-Therapeutics, funded by the federal government through Health Canada. E-Therapeutics offers prescribers electronic access through computers and hand-held devices to all the information contained in CPhA's long-published annual reference book on pharmaceuticals, the *Compendium of Pharmaceuticals and Specialties* (CPS). E-Therapeutics will provide easy access to contraindication information and to specific warnings or cautions relating to drugs being considered for treatment. The system will also include information on accepted and standard drug interventions for diseases and medical conditions. E-Therapeutics entered its final phase in December of 2005, and we urge prescribers to adopt this new tool to increase the efficiency and accuracy of prescribing while preventing adverse drug events.

Where are the roadblocks?

- The health of Canadians is being compromised by illegible handwriting and errors in the manual entry and processing of drug prescriptions.
- Canada is not taking full advantage of existing e-prescribing technologies and electronic drug information systems, and is behind other countries in this initiative.
- Regulatory and legislative changes are required to overcome significant barriers to fully implementing e-prescribing in Canada. Currently, federal legislation requires that prescriptions be in handwritten or verbal form; electronic signatures are not permitted. Changes to privacy regulations are needed to allow secure access to comprehensive patient information at all points along the continuum of care.

SHARING JUANITA'S CASE

Juanita decided to visit her mother-in-law while she waited for hip surgery. Unfortunately, Juanita had a serious car accident on her way and was rushed unconscious to an emergency department outside of her home province. Because there is currently no Canada-wide electronic health record, the emergency department could not access Juanita's primary health care information and was therefore in the dark about her being on a blood thinner.

With a national electronic health records system Juanita's history and status after the crash could be shared among providers. For example, her X-rays would have been available immediately thanks to digital imaging and could have been transmitted via e-mail to her primary health care provider in her home province. Using teleconference tools, the doctors would be able to discuss the best course of treatment for Juanita until she could return home.

What needs to be done?

1. **Link electronic drug information systems to electronic health records.** Governments should make mandatory, comprehensive electronic drug information systems and e-prescribing a priority and make them part of implementing an electronic health record in every jurisdiction.

2. **Establish formal collaboration to overcome barriers.** Canada Health Infoway should take the lead with appropriate partners in setting up a pan-Canadian collaboration on e-prescribing to accelerate implementation efforts.

QUALITY COUNCILS

A number of jurisdictions have created quality councils, organizations that focus on creating information, processes and resources to improve the quality of care at a local level. With dedicated resources, these organizations are well positioned to make a difference in advancing quality at several levels. They can collect information about population health status and link to information about patient care to assess whether people are getting the most appropriate care. They can work with health care providers to ensure their care is in line with evidence on best practices. They can also monitor and report on overall system performance for their jurisdiction. For example:

- The Health Quality Council of Saskatchewan has identified quality improvement as one of its key theme areas. It regularly produces studies that analyze patient outcomes and recommend strategies for improvement. The Health Quality Council then works with providers and patient organizations to implement these strategies for improved health. *www.hqc.sk.ca*
- The Health Quality Council of Alberta has focused its work on patient safety and quality issues. It has created an Alberta Quality Matrix for Health, which has been adopted by governments, providers, regulators and regional health boards. It has formed the Alberta Medication Safety Collaborative to improve medication use in Alberta's hospitals and is drafting a Provincial Disclosure Framework to address issues of disclosure of adverse events to patients. As well, the Health Quality Council regularly surveys the public on their experiences with Alberta's health care system. *www.hqca.ca*
- The recently established Ontario Health Quality Council will report to the public each year with three purposes: to encourage and promote an integrated, consumer-centred health system; to track the performance of Ontario's health system; and to help the public better understand and benefit from the health system by making it more transparent and accountable. *www.health.gov.on.ca*

- In Quebec, the newly established office of the Health and Welfare Commissioner will assess the effectiveness of the province's health and social services system, engage the public in discussion on how to improve the system, and advise the government on recommended changes. The Commissioner will work with a 27-member council composed of experts and regional representatives. *www.csbe.gouv.qc.ca/site/accueil.phtml*

Where are the roadblocks?

- Quality councils are a success story in health care renewal but they (or research agencies mandated to carry out similar work) are not yet available in every jurisdiction or region.

What needs to be done?

1. **Expand the development of quality councils and similar health outcomes research institutions.** Jurisdictions that currently do not have access to quality and outcomes research organizations should establish a quality council or collaborate regionally to share such resources.

HEALTH INDICATORS AND PUBLIC REPORTING

What did governments promise?

Over the past six years, four separate agreements between the federal, provincial and territorial governments have contained commitments to report publicly on the performance of social programs.

The Social Union Framework Agreement of 1999 committed governments to monitoring and reporting on the outcomes of social programs delivered to Canadians. However, this agreement applied only to new programs, effectively excluding public reporting on existing health care programs.

The 2000 First Ministers' Meeting resulted in requirements for specific health care reporting on existing programs. Governments agreed to produce a comparable public report on the health of Canadians and the health care system in every jurisdiction. Each government agreed to publish a first report in 2002, with subsequent reports to follow every two years. The First Ministers reaffirmed their commitment to produce public comparable health care reports in the 2003 First Ministers' Accord on Health Care Renewal and in the 2004 10-Year Plan to Strengthen Health Care.

Where are we now?

The first set of reports on comparable health indicators was published in November 2002, with a second set released in November 2004. The 2004 reports are available through the website of the Canadian Institute for Health Information at *www.cihi.ca* or on individual government websites.

These processes represent an impressive collaborative effort. It is no small task for all jurisdictions to agree and report on standardized measures to compare the health of their populations and the performance of their health care systems. But we repeat our message from last year: have these efforts produced information that is meaningful to Canadians to help them assess the progress of health care renewal? We do not believe so. The reports are hard to locate on government websites and difficult to compare; they sometimes rely on dated information, and they do not include enough financial information about the funding provided through the health care renewal agreements.

Where are the roadblocks?

- The current reports on comparable health indicators are not useful accountability tools for Canadians because they are not easy to find and read, and they are not clearly linked to the stated goals of the renewal efforts.
- Current reports are also not useful as quality improvement tools for health care providers and managers because the data are not always timely or designed specifically to assess progress.
- Unless health outcome measures are a primary focus of public reporting, it will be difficult to ensure that additional public investments are actually leading to better health for the population overall.

What needs to be done?

1. **Link reporting strategies to health care goals.** Governments and data agencies should create a data collection strategy to support public reporting on the First Ministers' agreements. This may require new data better linked to stated renewal goals, an approach being undertaken in the UK.[33]

2. **Improve the current comparable health indicators process.** This would involve:
   - reducing the number of indicators and making the data more current;
   - creating one annual comparative report with national, provincial and territorial information presented in a consistent manner;
   - including financial reporting in the annual report linked to the stated priority areas of renewal;
   - identifying key population health outcomes for regular reporting; and
   - identifying some key population health outcomes that vary among different groups or regions of the country.

FEDERAL TRANSFERS TO PROVINCES AND TERRITORIES

What did governments promise?

In the 2003 and 2004 agreements, the federal government made major new funding commitments, and the provinces and territories agreed to report on how they spend this funding.

In the 2003 Accord, First Ministers agreed:

- to prepare an annual public report to their citizens on primary health care, home care, and catastrophic drug coverage, commencing in 2004 as part of the objectives funded through the Health Reform Fund.
- to use comparable indicators and to develop the necessary data infrastructure for these reports. This reporting will inform Canadians on progress achieved and key outcomes. It will also inform Canadians on current programs and expenditures, providing a baseline against which new investments can be tracked, as well as service levels and outcomes.
- to report to their citizens on an annual basis, commencing in 2004, on enhancements to diagnostic and medical equipment and services as part of the Diagnostic and Medical Equipment Fund.
- that Canadians are entitled to better and more fully comparable information on the timeliness and quality of health care services. To this end, First Ministers agree that each jurisdiction will report to its constituents on its use of all health care dollars spent on an annual basis.

The 2004 10-Year Plan contains the following references to financial reporting:

- All governments agree to report to their residents on health system performance including the elements set out in the 10-Year Plan.
- All funding arrangements require that jurisdictions comply with the reporting provisions of the 10-Year Plan.



Where are we now?

In this section, we provide an overview of how health care dollars flow in Canada, describe the specific funds set out in the recent government agreements, and outline the status of public reporting on these investments.

In 2005, Canadians spent an estimated $142 billion on health care. We pay for these services in three ways – 70 per cent flows through governments (provincial and territorial, federal and municipal); 15 per cent comes directly out of our own pockets; and 15 per cent flows through private insurance plans and other private sources.

In looking at the history of Canadian health expenditures three things are clear:

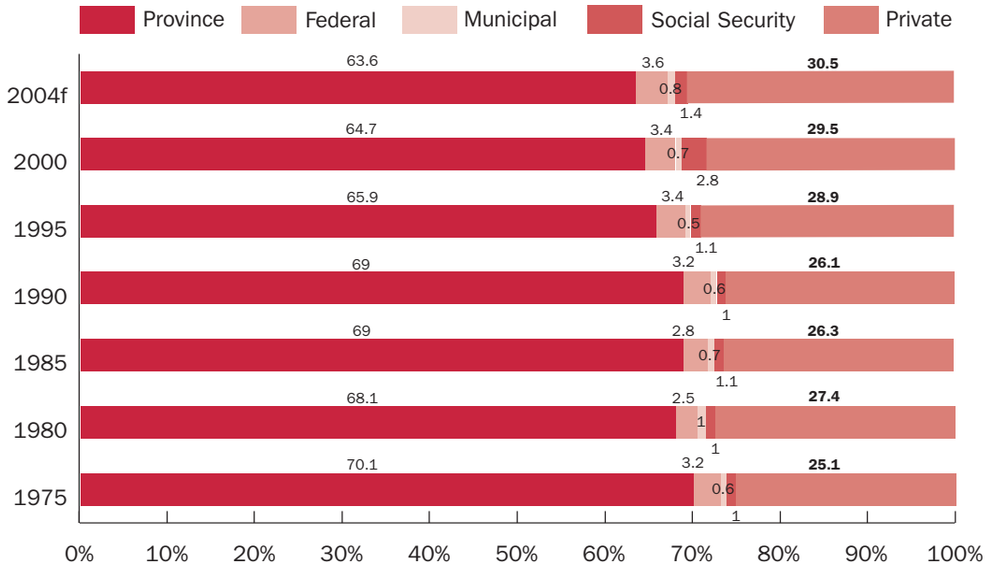
- The amount spent per person on health care has increased dramatically over time in every jurisdiction in Canada. Twenty years ago, the Canadian average per person was $1,559. Estimated spending for 2004/05, adjusted to 1997 dollars, is $2,356 (Table 10).
- Over time, the private sector proportion of total health expenditures has increased from 25 per cent in 1975 to an estimated 30.5 per cent in 2004 (Chart 2).
- In most jurisdictions, health care spending is crowding out other public policy investments (Table 11).

Table 10. Total Government Health Expenditures, Per Capita, Canada (1997$)

1980/81	$1,339
1985/86	$1,559
1990/91	$1,763
1995/96	$1,693
2000/01	$1,962
2004/05	$2,356



Chart 2. Per Capita Expenditures by Source as a Share of Total Health Expenditures, Canada, 1975-2004f*



*2004 data are forecast, not actual. Source: CIHI

Table 11. Health Care Spending as a Share of Government Spending by Provinces and Territories, 2001/02 and 2004/05

	2001/02	2004/05
British Columbia	35.2%	37.9%
Alberta	30.6%	33.8%
Saskatchewan	34.7%	39.5%
Manitoba	35.5%	37.7%
Ontario	36.5%	39.5%
Quebec*	35.4%	37.4%
New Brunswick	27.8%	32.1%
Nova Scotia	34.5%	37.5%
Prince Edward Island*	29.8%	29.4%
Newfoundland and Labrador*	34.5%	36.7%
Nunavut*	20.4%	26.8%
Northwest Territories*	23.2%	25.9%
Yukon*	30.8%	29.6%

*Includes social services.

How does the money flow?

Provinces and territories have the primary role for delivery of health care. However, the federal government contributes to the health care delivered by provinces and territories through a series of funding transfers and program funding. The federal government is also directly responsible for services provided to Aboriginal Peoples, members of the armed forces, the RCMP, veterans, and inmates in federal prisons.

The nature and size of the federal contribution to provincial/territorial health care delivery has been a source of increasing tension between the provinces, territories and the federal government over the last 10 years. Claims and counter claims have been made with each side blaming the other for lack of resources. In the meantime, the Canadian public attempts to understand how much money is being provided – and ends up confused.

Federal government health transfers flow to the provinces and territories through three avenues: general transfers for health spending; targeted or earmarked funds to achieve specific health care objectives; and targeted program funding.

In the 2003 Accord, the federal government committed new funding totaling $36 billion over five years. In 2004, a further $41 billion to be spent over 10 years was added to the funding pool. The agreements flowed this money through four types of federal health transfers, described below. Table 12 shows the amount of funding for each province and territory.

1) *The Canada Health Transfer (CHT).* This is an annual transfer for general health spending. As well as giving direct cash, the federal government also provides "tax room" which allows the provinces and territories to tax their citizens directly to raise revenue in lieu of federal taxation. Previously, the health transfer was bundled with funding for social services, but the 2003 Accord on Health Care Renewal separated out the health portion as of April 1, 2004, in an effort to clearly identify the health component of the transfer.

The Canada Health Transfer flows directly into the general revenues of the provinces and territories, to be allocated according to their own priorities. In order to receive the transfer, provinces and territories must comply with the conditions of the *Canada Health Act;* non-compliance can result in deductions from their federal contribution. The federal government tables a report in Parliament each year describing new developments in provincial and territorial insurance plans and any instances of non-compliance with the *Canada Health Act*. However, this report does not specifically outline how the Canada Health Transfer was allocated in each jurisdiction. Thus, there are no formal reporting requirements for provinces and territories to describe how they spent their CHT allocation, although most do recognize the general contribution of the federal government in their budget and policy documents. It is not possible to actually trace this money directly, leading to recommendations that the "flow through" become more transparent.[34]

2) *The Health Reform Fund.* This $16 billion transfer was created in the 2003 Accord (part of the total $36 billion committed) to provide funds over a five-year period for renewal in primary health care, catastrophic drug coverage and home care. The funding is intended to reach specific objectives outlined in the 2003 Accord, such as increasing 24/7 access to primary health care providers. Governments were to have flexibility in determining the best ways to achieve these objectives and were to prepare annual public reports on these priorities commencing in 2004, using comparable indicators to inform Canadians on progress achieved and key outcomes.

3) *The Diagnostic and Medical Equipment Fund.* This fund was first established in 2000 as a two-year $1 billion fund to support specialized staff training and equipment purchase. The 2003 Accord provided an additional $1.5 billion over three years to be allocated to jurisdictions through a third-party trust. This allows provinces and territories to draw down the money as needed. Governments were required to report to their residents annually on the enhancements to diagnostic and medical equipment.

4) *Wait Times Reduction Fund.* This transfer was created in the 2004 agreement to provide $5.5 billion over 10 years to support provincial and territorial initiatives to reduce wait times. It was created as a third-party trust through which provinces and territories can draw down funding until 2008/09; it then becomes an annual transfer, ending in 2013/14. This fund has no specific reporting requirements. However, Parliament is required by law to review, by March 31, 2008, the country's overall progress in implementing the 2004 10-Year Plan, and to review it again three years later.

Table 12. Selected Federal Health Transfers to Provinces/Territories

	Canada Health Transfer ($ million)		Health Reform Fund ($ million)		Diagnostic & Medical Equipment Fund ($ million)		Wait Times Reduction Fund ($ million)		TOTAL ($ million)		Population (thousands)
	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06	2005
BC	2,119	2,785	197	460	67	–	82	82	**2,465**	**3,327**	4,255
AB	1,369	1,873	150	352	50	–	63	63	**1,632**	**2,288**	3,257
SK	503	693	47	108	16	–	19	19	**585**	**820**	994
MB	591	774	55	128	18	–	23	23	**687**	**925**	1,178
ON	5,644	7,587	582	1,360	194	–	242	243	**6,661**	**9,190**	12,541
QU	3,808	4,987	354	825	117	–	148	147	**4,428**	**5,959**	7,598
NB	380	494	35	82	12	–	15	15	**442**	**591**	752
NS	474	617	44	102	15	–	18	18	**551**	**737**	938
PEI	70	91	7	15	2	–	3	3	**82**	**109**	138
NF/L	262	340	24	56	8	–	10	10	**305**	**406**	516
NUN	17	22	2	3	1	–	1	1	**20**	**26**	30
NWT	16	23	2	5	1	–	1	1	**20**	**29**	43
YUK	17	22	2	4	1	–	1	1	**20**	**27**	31
TOTAL	**15,270**	**20,308**	**1,500**	**3,500**	**500**	**0**	**626**	**626**	**17,896**	**24,434**	**32,271**
TOTAL ANNUAL IN 2013/14			**30,283**		**0**		**250**		**30,533**		
TOTAL OVER 10 YEARS (2004-2014)			**233,484**		**500**		**5,500**		**239,484**		

Who has reported what?

Jurisdictions have reported on the federal financial contribution to their renewal efforts in a variety of ways. All jurisdictions make a general statement in health department documents and budgets recognizing the Government of Canada contribution. Some have produced separate reports outlining how they spent their share of the Health Reform Fund (British Columbia, Saskatchewan) and the Diagnostic and Medical Equipment Fund (British Columbia, Saskatchewan, Ontario and Nova Scotia), although not for all fiscal years. Quebec has published a report on the progress made on its bilateral agreement from the First Ministers meeting in September 2004 but without financial information. Table 13 outlines who has reported what.

The federal government provides its allocation estimates for each jurisdiction on the Department of Finance website, *www.fin.gc.ca.* It does not provide separate reports for the populations for which it has direct responsibility.

It is possible that jurisdictions feel that the current federal/provincial/ territorial efforts to produce general comparable health indicators fulfill the reporting requirements in the 2003 and 2004 agreements. In our view, they do not. These reports do not include specific information about federal transfers, they are not annual, and they do not specifically assess progress against objectives. Much of the health indicator reporting is a blizzard of numbers with little explanation or interpretation.

Information about how federal transfers are spent by provinces and territories is not easily accessible and in some cases is not available at all. The targeted funds are easier to identify than the general Canada Health Transfer, but most jurisdictions are not living up to their commitment to provide annual public reports. In our view, this is not a sufficient accountability and reporting system for billions of tax dollars. Canadian taxpayers deserve greater transparency.



Table 13. Financial Reporting on Federal Transfers from the 2003 Accord and the 2004 10-Year Plan

Jurisdiction	Separate reports on transfers
Canada	Department of Finance reports on annual allocations
British Columbia	Health Reform Fund, 2003/04 Diagnostic and Medical Equipment Fund, 2003/04
Alberta	No separate report
Saskatchewan	Health Reform Fund, 2003/04 Health Reform Fund, 2004/05 Diagnostic and Medical Equipment Fund, 2003/04 Diagnostic and Medical Equipment Fund, 2004/05
Manitoba	No separate report
Ontario	Diagnostic and Medical Equipment Fund, 2003/04 Diagnostic and Medical Equipment Fund, 2004/05 Diagnostic and Medical Equipment Fund, 2005/06
Quebec	Separate report on policy reforms for all aspects of the 2004 agreement; no financial information
New Brunswick	No separate report
Nova Scotia	Diagnostic and Medical Equipment Fund, 2004/05
Prince Edward Island	No separate report
Newfoundland and Labrador	No separate report
Nunavut	No separate report
Northwest Territories	No separate report
Yukon	No separate report

Where are the roadblocks?

- Tracing how federal dollars flow into provincial and territorial spending is not possible because current reporting by governments is sporadic, incomplete and difficult to understand. Canadians should be able to see clearly how the funds are being spent and whether the money is helping to achieve national goals for health care renewal.

What needs to be done?

1. **Increase transparency on the money flow.** Provinces and territories should report clearly and consistently each year on how they spent their share of federal funding transfers for health care.

PATHWAY THREE

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. Our infant mortality rates have fallen over the last 20 years from 11 per 1,000 births to 5 per 1,000. And 60 per cent of the general population rates their health as excellent or very good.

So where should we be concerned? We have a high burden of chronic disease and a growing level of health inequality between different groups in Canadian society. Key factors in health inequalities in Canada are income, Aboriginal identity, gender and disability.[35]

What do we mean by health inequalities?

Differences in health among groups in the population.

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

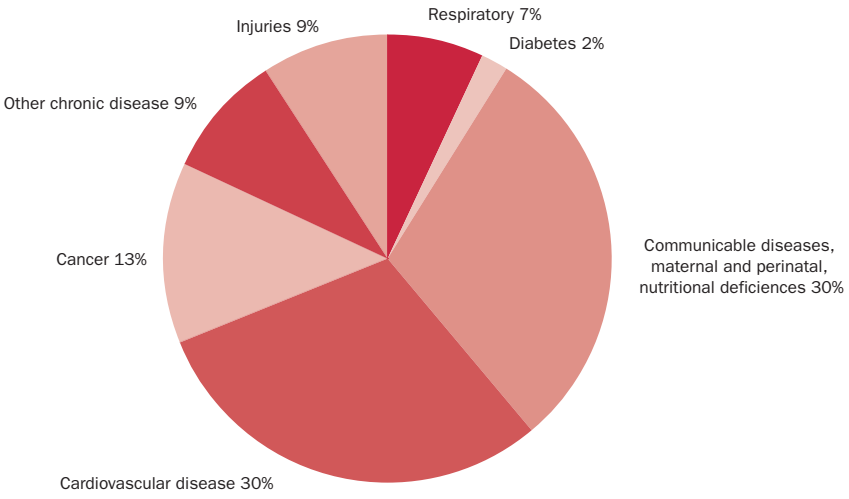
- better **management of chronic disease**, with strategies directly linked to primary health care teams;
- vastly increased **investments in healthy living strategies**;
- an aggressive and **collaborative approach to reducing health inequalities**, with an emphasis on improving the health and well-being of children and Aboriginal groups.

CHRONIC DISEASE

The World Health Organization estimates that 60 per cent of all deaths worldwide result from chronic disease. Fifty-eight million people will have died in 2005, 35 million of them from chronic disease – most of them from communicable diseases, cardiovascular disease and cancer (Chart 3).[36] Except for communicable disease, the pattern in Canada is much the same. (Chart 4).

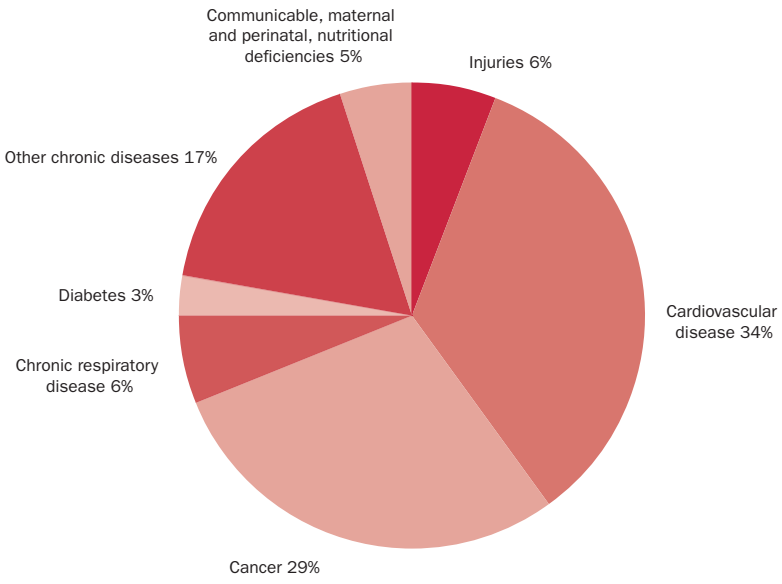


Chart 3. Leading Causes of Death, Worldwide, 2005



Source: World Health Organization

Chart 4. Leading Causes of Death, Canada, 2005



Source: World Health Organization

The burden of these long-term illnesses falls not just on individuals and their families. Chronic disease costs the Canadian economy an estimated $80 billion annually through illness and disability.[37]

With the right investments, these costs can be reduced substantially. We can improve the quality of many lives and redirect tax dollars if we tackle chronic disease in two ways: prevent illness in the first place and manage it better once it has taken hold. There will always be the need to treat illness in Canada – no program will prevent all chronic disease – but as a country, we have failed to shift our spending priorities to do what we have long recognized will really make a difference.

Two-thirds of Canadians can change at least one aspect of their lives – smoking, lack of exercise, unhealthy eating habits, excess weight – to reduce their risk for chronic diseases such as diabetes, cancer, and lung or heart disease. Yet funding for health education and health promotion programs that could prevent or reduce the severity of these diseases is dwarfed by our investments in treatment. A recent report by the Organisation for Economic Co-operation and Development (OECD) calculates that Canada spends just eight per cent of total health care expenditures on public health and prevention.[38]

To support individuals in living healthier lives, we also need to invest in strategies that lie outside of health care. For example, public policies regulating where people can smoke and what gets taxed contribute to preventing chronic disease. So do policies that help create healthy schools, healthy work environments, and healthy communities (with recreational opportunities and reduced air pollution).

Good chronic disease management programs have demonstrated that they can improve patient care and the quality of services while reducing health care costs. The elements of good chronic disease management include:

- identifying patients with chronic disease;
- having access to data on individuals and populations through high-quality information systems;
- organizing patients by risk;
- involving patients in their own care;
- using case managers to coordinate care;
- using interprofessional teams;
- integrating specialist and generalist expertise;
- minimizing unnecessary visits and admissions; and
- providing care in the least intensive setting.

Much of the burden of chronic disease in Canada is unnecessary. This should reinforce the urgency of our efforts to invigorate primary health care renewal and information management systems to support quality care. Research demonstrates that patients with chronic diseases do better when their care is managed by primary health care teams rather than by providers on their own.[39] Electronic systems that integrate health records and evidence-based protocols can provide the tools teams will need to manage complex disease processes.

Without primary health care renewal, we cannot achieve effective chronic disease management. But this is not just a primary health care issue. Improving care and services for people with chronic conditions benefits the entire health care system – it can relieve pressure on emergency care, reduce waiting lists, and help to make the best use of our workforce.

To what degree are we currently using best practices of chronic disease management in Canada? There are some initial efforts, but much more is required. British Columbia has invested in province-wide chronic disease management activities with remarkable results *(www.healthservices.gov.bc.ca\cdm).* Over a one-year period, the percentage of congestive heart failure patients with documented self-management goals skyrocketed from 4.6 per cent to 57.1 per cent, and the proportion of patients appropriately prescribed beta blocker medication went from 17.8 per cent to 89 per cent.[40]

The Health Quality Council in Saskatchewan has created a Chronic Disease Management Collaborative based on methodology pioneered at the US Institute for Healthcare Improvement. Their initial priorities are coronary heart disease, diabetes, asthma and improved drug prescribing for the elderly in long-term care *(www.hqc.sk.ca).* The Calgary Health Region has launched a chronic disease management initiative with a strong public education and information campaign *(www.calgaryhealthregion.ca).*

Where are the roadblocks?

Canada's approach to chronic disease has not focused strongly enough on prevention and good management. The $300 million to be spent on a national healthy living strategy over the next five years pales in comparison to the $79 billion to be spent over 10 years for all other aspects of health reform.

To get to better health, we need to act on the knowledge that:

- Preventing chronic disease is highly complex, and many effective strategies lie largely outside the health sector;
- Preventing chronic disease will pay off in the future, but investments are required now;
- Better management of chronic disease can be achieved by applying what we already know creates better patient outcomes – integrated delivery systems, evidence-based protocols, and information management that supports both; and
- Better chronic disease management can produce immediate payoffs in better health and quality of life, as well as financial payoffs in the longer term.

What needs to be done?

1. **Increase investments in upstream activities to prevent chronic disease.** This includes promotion of anti-tobacco campaigns, healthy diets and regular exercise, as well as public policy to support healthy environments.

2. **Speed up implementation of primary health care renewal.** We need interprofessional teams in place – and quickly – to support the best possible chronic disease management.

3. **Accelerate the implementation of information management systems.** These will provide health care providers with the necessary access to integrated health information and evidence-based protocols to manage patients with chronic disease.

HEALTHY LIVING STRATEGY

What did governments promise?

One of the ways to prevent and manage chronic diseases is through public policies that support healthy living. To this end, at their annual meeting in September 2002, federal, provincial and territorial ministers of health agreed to develop a long-term comprehensive strategy to increase Canadians' engagement in healthy living practices that would reduce the burden of disease. The initial emphasis was on healthy eating and physical activity, and their relationship to healthy weights. In September 2003, the ministers of health agreed to:

- Create an intersectoral healthy living network;
- Explore options for an intersectoral fund;
- Look at a communications or health information strategy; and
- Undertake further discussion with Aboriginal communities.

In 2004, First Ministers agreed to accelerate work on a pan-Canadian public health strategy, set goals and targets for improving the health status of Canadians, and support a national immunization strategy.

Where are we now?

Healthy Living Strategy

The 2005 federal budget announced that $300 million over five years had been earmarked for creation of the Integrated Healthy Living and Chronic Disease Strategy. Activities will be undertaken in six areas:

- community-based programming and community capacity development;
- knowledge development, exchange and dissemination;
- surveillance for healthy living and chronic diseases, and for indicators;
- public information, social marketing and public education;
- leadership, coordination and policy development; and
- evaluation and monitoring.



The Integrated Pan-Canadian Healthy Living Strategy was released in November 2005. It proposes specific targets to improve the health of Canadians. By 2015, the Strategy targets a 20 per cent increase in the proportion of Canadians:

- who make healthy food choices – an increase from 39 per cent to 46.8 per cent;
- who participate in regular physical activity (30 minutes a day of moderate to vigorous activity) – an increase from 50.4 per cent to 60.5 per cent; and
- with a normal body weight (a body mass index of 18.5 to 24.9) – an increase from 46.7 per cent to 56 per cent.

Health Goals for Canada

After a public consultation led by federal Minister of State (Public Health) Carolyn Bennett and Manitoba Minister of Healthy Living Theresa Oswald, the Public Health Agency of Canada recently released *Health Goals for Canada: A Federal, Provincial and Territorial Commitment to Canadians.* This brief document, available at *www.healthycanadians.ca,* presents a set of broad goal statements on basic physical and social needs, belonging and engagement, healthy living, and the health system. The document describes the goals as "guideposts indicating a path to improve health and quality of life of Canadians rather than a detailed map that lays out exactly how to get there."

The creation of common public health goals represents an important collaboration by governments, although the setting of specific targets is being left to each jurisdiction based on its own priorities. Continued collaboration to develop a set of measurable outcomes would help Canadians to see how these goals will translate into public policy changes and eventually better public health. Without specific targets, it will not be possible to measure progress towards achieving these goals.

National Immunization Strategy

The National Immunization Strategy (NIS) is a collaborative federal/provincial/territorial approach to strengthen immunization in Canada. The Conference of Deputy Ministers of Health endorsed it in 2003, and the Government of Canada committed $45 million over five years to implement it. In 2004, the federal government also provided $300 million directly to the provinces and territories over three years to support the introduction of new and recommended childhood and adolescent vaccines. The NIS will also help governments work together to purchase vaccines more efficiently and to plan and manage vaccine supplies collaboratively for the benefit of public health.

Following the 2004 funding announcement, a number of provinces and territories launched new public programs to pay for and promote: conjugate pneumococcal vaccine, conjugate meningococcal vaccine, varicella (chickenpox) vaccine, and a new whooping cough vaccine for adolescents (Table 14). This funding has helped to achieve a good deal of harmonization across the country, so that parents have free access to the same vaccines – some of which are quite expensive – no matter where they live.

Table 14. Schedules for Selected Publicly-Funded Vaccines, by Jurisdiction, 2005

Jurisdiction	Tetanus, diphtheria and whooping cough	Chickenpox	Meningitis	Pneumonia and meningitis
British Columbia	Grade 9	12 months	2, 12 months	2, 4, 6, 18 months
Alberta	Grade 9	12 months	2, 4 ,6 months	2, 4, 6, 18 months
Saskatchewan	Grade 8	18 months	12 months	2, 4, 6, 18 months
Manitoba	Grade 9	12 months	High-risk Grade 4 students	2, 4, 6, 18 months
Ontario	14-16 years	15 months	12 months	2, 4, 6, 15 months
Quebec	Grade 10	n/a	12 months	2, 4, 12 months
New Brunswick	Grade 9	12 months or 4 years	12 months or Grade 9	2, 4, 6, 18 months
Nova Scotia	Grade 10	12 months	12 months	2, 4, 6, 18 months
Prince Edward Island	Grade 9	12 months	12 months	2, 4, 6, 18 months
Newfoundland and Labrador	Grade 9	12 months	12 months	2, 4, 6, 18 months
Nunavut	Grade 9	12 months		2, 4, 6, 15 months
Northwest Territories	Grade 9	12 months	2, 4 months	2, 4, 6, 18 months (starting 2006)
Yukon	Grade 9	High-risk	2, 6 months	2, 4, 6, 12 months

Where are the roadblocks?

- The creation of health goals for Canada is a first step in collaboration among governments, but without measurable outcomes linked to these goals, we will not know if we are making progress.
- Public spending to foster healthy living still represents only a tiny fraction of what we spend on treatment of preventable illness and injury.

What needs to be done?

1. **Collaborate on measuring meaningful progress towards reaching Canada's public health goals.** Governments should build on their collaborative and consultative work to create a set of common targets for improving public health and well-being in such areas as early childhood development, environmental health and safety, and the quality of working life.

2. **Initiate a dramatic shift in funding priorities and strategic activities to stimulate progress in healthy living.** A greatly expanded, sustained and coordinated effort is needed to bring disease prevention and health promotion activities in line with health care spending. Healthy living strategies should be better integrated into current and emerging aspects of the health care system (e.g. prevention activities should be a vital part of primary health care renewal).

HEALTH INEQUALITIES

The biggest health problem in Canada is inequality. The overall improvement in our health status masks the grim reality that health inequalities among social classes are growing – as they are in most highly developed countries. In Canada:[41]

- Healthy life expectancy is three to four years less in low-income neighbourhoods than in high-income neighbourhoods.
- The infant mortality rate in low-income neighbourhoods is almost double that in high-income neighbourhoods.
- The average birth weight for babies born in low-income neighbourhoods is one-quarter pound less than for those born in high-income neighbourhoods.
- People living on low incomes report higher rates of smoking and lower levels of physical activity than people with higher incomes.

Inequality takes many forms: income is a crucial factor, but there are others. In our society, lower income often leads people to feel undervalued. This marginalization is a complex phenomenon, and its consequences vary among individuals. But on the whole, the fewer resources you have, the more likely you are to be in poor health, which in turn reduces your prospects for financial success. Inequality begets inequality, and the effects span generations. Poverty rates are predictors of things to come. Poverty has a detrimental impact on the health of children, and unhealthy children will, in time, affect the health of the nation.[42] The health care system is relatively powerless to overcome these health effects.

What do we mean by healthy life expectancy?

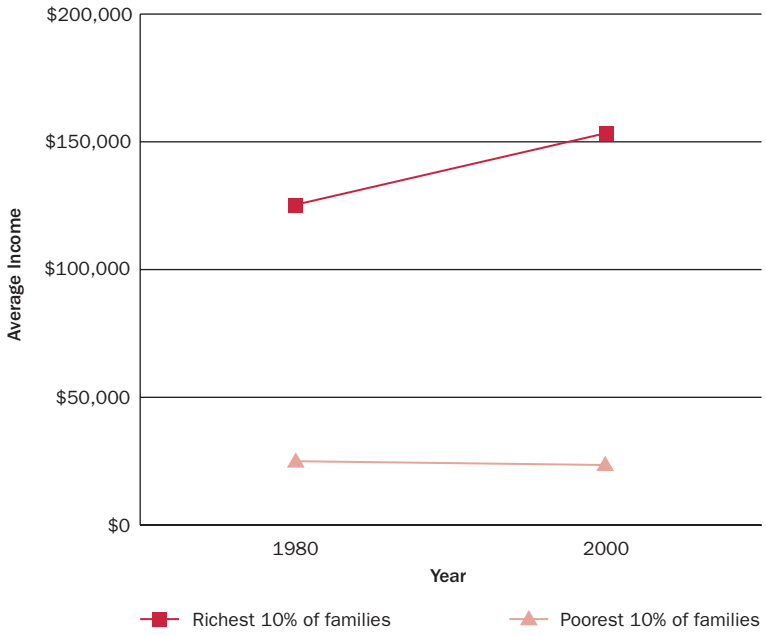
The average number of years of full health. The measure known as health-adjusted life expectancy combines life expectancy, health status and quality of life information.

Recent work in Canada has focused on the differences between lower and higher income groups and the threshold at which health is affected. Some intriguing research has shown that the health of the entire population is better in cities where wealth is more evenly distributed.[43]

Canadian cities have become more segregated along income lines in recent years, and this raises concerns for social policy and population health. For example, in Toronto, the average income of the richest 10 per cent of families rose by 23 per cent between 1980 and 2000, while the average income for the poorest families fell by four per cent (Chart 5).[44]



Chart 5. Changes in Family Income, Toronto, 1980 - 2000



Source: Toronto Community Foundation

The numbers are not getting better over time; in fact, they are getting worse. They need to be tracked in a comprehensive and systematic way so that programs and policies can be targeted to reduce the gap. To decrease this segregation and improve living standards, we need stronger policies in several areas: universal health care, high-quality public education, adequate housing, safe communities and workplaces, and healthy physical environments.



NUNAVUT – REDUCING HEALTH INEQUALITIES

Meet Rachel and Diane, the first Inuit students in an important pilot program offered in Rankin Inlet, Nunavut. Their story is about the early days in the territory's "Closer to Home" strategy – a multi-year initiative to build a sustainable health workforce that reflects the territory's mostly Inuit population.

In Nunavut, 25 cents of every health dollar pays for transporting patients to southern locations. This included expectant mothers at risk of difficult delivery; the nearest operating room is almost two hours away by jet. What did the Nunavut program consider? If Inuit maternal care workers and midwives could be trained in Nunavut, then more babies could be delivered at home by a recognized health care provider with whom the expectant mother can relate.

This midwifery program has adopted a "laddered" approach whereby students can learn and apply their new skills in stages. After Rachel and Diane complete just one year of their two-year program, they have a choice: stay in the community and work at the birthing centre as a certified maternal care worker, or study a second year and complete the midwifery diploma. In the future, they can build on their training to acquire higher credentials.

Watch this video at *www.healthcouncilcanada.ca.*

Where are the roadblocks?

- Canada, like most highly developed countries, is experiencing a widening gap between high- and low-income individuals. Gaps in health status related to income can be reduced through targeted efforts to improve standards of living, but such efforts are not widespread or coordinated in Canada.
- There is a lack of good comparative information that links health outcomes with the social and economic factors affecting health.

What needs to be done?

1. **Set targets for reducing health inequalities.** Targets for reducing health inequalities should be incorporated into the current public health goals proposed for Canada.

2. **Build a health inequalities focus into the development of comparable health indicators.** Efforts are underway to create a set of measures to compare health outcomes across Canada. These measures must be designed to give us the ability to understand how social and economic factors influence health outcomes. For example, wait times are a basic indicator of how well the health system is meeting the demand for health care, but do we know whether people with lower incomes wait longer than those with higher incomes?

ABORIGINAL HEALTH

As the Health Council reported in its first annual report to Canadians, the health status of Aboriginal Peoples is worse than that of other Canadians on all measures. They have shorter life expectancies and higher rates of infant mortality, smoking, obesity and suicide (Table 15).

Table 15. Comparative Health Statistics, First Nations and General Canadian Populations*

Indicator	First Nations	Canadian	Year
Life expectancy:			
· males	70 years	77 years	2001
· females	76 years	82 years	2001
Infant mortality	6 per 1,000 people	5 per 1,000 people	2000
Deaths from heart attack	73 per 100,000 people	56 per 100,000 people	2000
Deaths from stroke	71.5 per 100,000 people	36 per 100,000 people	2000
Years of life lost:			
· suicide	1,080 per 100,000 people	403 per 100,000 people	2000
· unintentional injury	2,572 per 100,000 people	594 per 100,000 people	2000
Smoking rates (regularly or occasionally)	58% (of people aged 20+)	23% (of people aged 12+)	2002/03
Overweight and obesity (children aged 2-17 years)	41%	26%	2004

*Data are for years for which the most recent comparable data are available.
First Nations data are for on-reserve and/or off-reserve populations, depending on indicator.

What did governments promise?

In September 2004, First Ministers met with Aboriginal leaders to discuss Aboriginal health and committed to developing the Blueprint on Aboriginal Health to improve the health status of Aboriginal Peoples and health services in Canada. Specific goals of the Blueprint are to:

- Close the gap between the health of Aboriginal Peoples and the rest of the Canadian population;
- Improve the delivery of and access to health services through integration and adaptation of all health services;
- Ensure Aboriginal people benefit fully from Canadian health care improvements; and
- Ensure greater upstream investments in prevention and health promotion.

The federal government has committed $700 million to this initiative, including $100 million dedicated to a health human resources fund.

Where are we now?

The Blueprint on Aboriginal Health – an unprecedented collaboration and statement of common commitment among governments and national Aboriginal organizations – was presented at the Meeting of First Ministers and National Aboriginal Leaders in Kelowna, BC, in November 2005.[45] The Blueprint is non-binding but is intended for use by governments and national Aboriginal organizations as a guide in making decisions to close the gap in health status for Aboriginal Peoples.

The federal, provincial and territorial governments announced their support of the Blueprint and set targets to:

- reduce rates of infant mortality, youth suicide, childhood obesity and diabetes by 20 per cent within five years and by 50 per cent in 10 years; and
- double the number of Aboriginal health professionals within 10 years, from the current number of approximately 150 physicians and 1,200 nurses.

Subtitled "a 10-year transformative plan," the Blueprint will serve as a framework for collaborative action and for the investment of more than $1.3 billion over the next five years to reach these goals and to transform health care for Aboriginal people. Of this amount, $870 million is earmarked to stabilize the First Nations and Inuit health system, and $445 million will go towards promoting transformation and building capacity.

The Blueprint also calls for implementation of the Aboriginal Health Reporting Framework – which was committed to in the 2003 Accord – to report on progress towards key health outcomes. This framework will use distinct indicators for reporting on the health of First Nations, Inuit and Métis people, and will have the ability to report on various population segments such as women, non-status, off-reserve, Inuit living outside the land claims settlement areas and Aboriginal Peoples living in urban settings. The framework is to be completed by 2007 with actual reporting to begin by 2010/11.

The Health Council recognizes the historic importance of this agreement and its tremendous potential to advance Aboriginal health in the next decade. In our November 2005 report on health human resources, we stressed the critical need to increase the number of Aboriginal health professionals. The Aboriginal Health Reporting Framework will significantly improve Canada's ability to understand and monitor the health status of Aboriginal Peoples. It has the potential to yield high-quality data that are distinct for different population groups – data that have been lacking in Canada. Without such information, we cannot understand where we have been or whether we are making any progress.

THE ROADS CONVERGE

THE ROADS CONVERGE

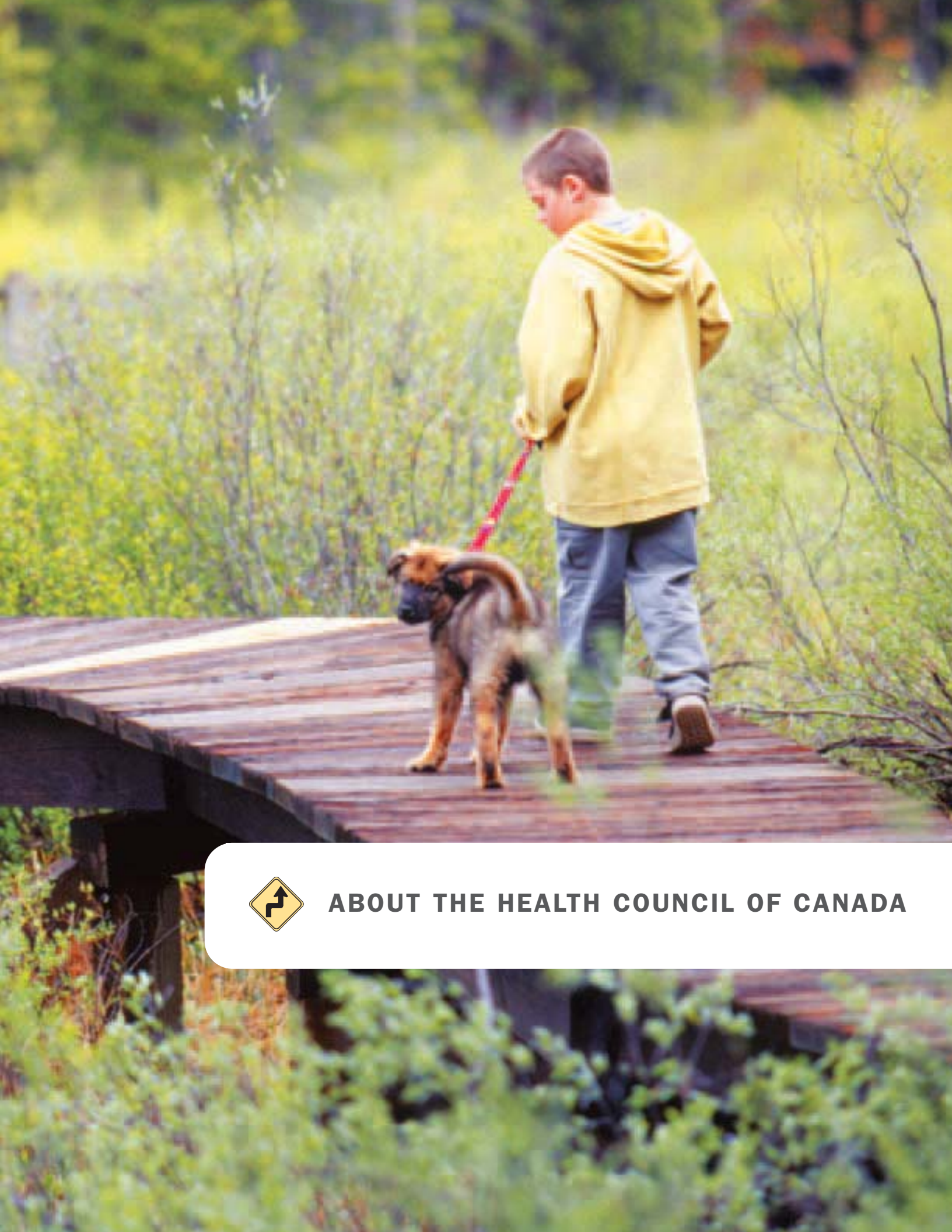
In recent years, the First Ministers' agreements on health care renewal tackled some roadblocks to accessing services. This is an important pathway to improving the health of Canadians but it is not enough.

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. Rather than ask only whether there is enough access to services, we should 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 measurable targets (beyond the current three) 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, 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.



ABOUT THE HEALTH COUNCIL OF CANADA

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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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*as of December 2005

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Appendix A – National Organizations

Appendix B – Jurisdictional Tables on Health Care Renewal

Appendix C – Progress on Council Advice from the 2005 Annual Report

A.1 Roles of National Organizations

Canada Foundation for Innovation
www.innovation.ca
The Canada Foundation for Innovation funds research infrastructure. Its mandate is to strengthen the capacity of Canadian universities, colleges, research hospitals and non-profit research institutions to carry out world-class research and technology development that benefits Canadians.

Canada Health Infoway
www.infoway-inforoute.ca
Canada Health Infoway is focused on fostering and accelerating the development and adoption of electronic health information systems with compatible standards and communications technologies on a pan-Canadian basis with tangible benefits to Canadians.

Canadian Coordinating Office for Health Technology Assessment (CCOHTA)
www.ccohta.ca
CCOHTA's vision is to facilitate the appropriate and effective utilization of health technologies within health care systems across Canada. They provide decision makers with timely, relevant and rigorously derived evidence-based information on health technology assessment, on the clinical and cost-effectiveness of new drugs, and on best practices in drug prescribing and use.

Canadian Council on Health Services Accreditation (CCHSA)
www.cchsa.ca
The Council assists health care organizations in examining and improving the quality of care and service they provide to their clients. It provides an accreditation program that is based on national standards developed and updated by experts in the field, peer review and knowledge exchange. Through self-assessment and external evaluation, this accreditation program helps drive improvements in health care.

Canadian Health Services Research Foundation (CHSRF)
www.chsrf.ca
CHSRF supports the evidence-based management of Canada's health care system by facilitating knowledge transfer and exchange — bridging the gap between health care management research and policy. The Foundation funds policy research in health services and nursing, supports the synthesis and dissemination of research results, and supports the use of research results by managers and policy makers.

Canadian Institute for Health Information (CIHI)
www.cihi.ca
CIHI is an independent, pan-Canadian, not-for-profit organization working to improve the health of Canadians and the health care system by providing quality, reliable and timely health information.

Canadian Institutes of Health Research (CIHR)
www.cihr-irsc.gc.ca
The CIHR is Canada's leading health research agency. It funds research and investigators in four areas: biomedical research, clinical research, health systems and services research, and population and public health research.

Canadian Patient Safety Institute (CPSI)
www.patientsafetyinstitute.ca
CPSI has a mandate to provide leadership on patient safety issues through advising governments, stakeholders and the public on effective strategies; fostering information sharing; influencing culture change; supporting system change; and collaborating with stakeholders.

Canadian Population Health Initiative (CPHI)
www.cihi.ca/cphi
CPHI, a part of CIHI, has a dual mission: to foster a better understanding of factors that affect the health of individuals and communities; and to contribute to developing policies that reduce inequities and improve the health and well-being of Canadians. CPHI provides analyses of population health evidence to inform policies that improve health, funds research, develops policy options, and works to improve public knowledge of the determinants of health.

Public Health Agency of Canada
www.phac-aspc.gc.ca
The Public Health Agency of Canada promotes and protects the health of Canadians through leadership, partnership, innovation and action in public health. It is focused on effective efforts to prevent chronic diseases, prevent injuries, and respond to public health emergencies and infectious disease outbreaks.

Statistics Canada
www.statscan.ca
Statistics Canada produces statistics that help Canadians better understand its population, resources, economy, society and culture. With respect to health, Statistics Canada has a number of surveys including the Canadian Community Health Survey, Access Survey, and the National Population Health Survey, which provide data on health determinants, health status and health services utilization. Statistics Canada also produces annual reports on the health of Canadians and the health care system.

B.1 Primary Health Care – 24/7 Access

	Proportion of patients having access 24/7 to primary health care providers	Proportion of 24/7 access provided through patient's own primary health care provider	Clinical information reported to the patient's own primary health care provider
Federal: Canadian Forces	After-hours service provided chiefly by the civilian health care system. Forces have engaged a teletriage service for personnel to access to identify the most appropriate health care service after hours or when travelling away from a military base. On a few bases, urgent care services at the clinic are made available during certain times on weekends or in the evening. Many of the base clinics support a relatively small population, making the direct provision of after-hours services cost ineffective.	Urgent care is provided by the patients' regular team of providers during regular working hours for the majority of Canadian Forces members and during extended hours for a smaller proportion of members.	For teletriage encounters, the clinic receives regular reports outlining the calls managed. If medical advice was given during the call and the caller consented to identify him or herself, then a record of the call is sent to the clinic for the regular provider's review and inclusion on the member's chart. In cases where a member seeks care within a civilian system after hours or while travelling, the encounter is billed through Blue Cross, and, as part of that process, brief clinical information is sent to the patient's home clinic for review by the regular provider and inclusion on the patient's chart.
First Nations and Inuit Health Branch	With the exception of a very small number of tiny communities (pop <100), virtually all remote, isolated First Nations communities have access to 24/7 primary health care providers. In a small number of cases (e.g. nursing station satellites), this access is accomplished through a resident community health representative who communicates via telephone to the nurse based in the nursing station. Health Centre clients in non-remote areas generally have access to 24/7 services through the provincial health care system, although their access to 24/7 services is equivalent to the rural provincial services.	In the remote, isolated communities, the registered nurses practicing in an expanded scope of practice provide all services.	When clients are referred or independently seek care outside their own community, follow-up clinical information can be communicated in any number of ways (e.g. hardcopy with client, telephone, fax); however, it often may not be requested. In the case of satellite communities, the community health representative accesses the primary health care provider via telephone.

B.1 Primary Health Care – 24/7 Access (continued)

	Proportion of patients having access 24/7 to primary health care providers	Proportion of 24/7 access provided through patient's own primary health care provider	Clinical information reported to the patient's own primary health care provider
Veterans Affairs Canada		All services provided in this manner.	
British Columbia	All residents of British Columbia who have a telephone can access primary health care services 24 hours a day, seven days a week. British Columbia's 24/7 access infrastructure includes the following components: • Open and advanced access in physician offices and new primary health care models. • Specific contractual 24/7 coverage with community health centres. • After-hours call groups and primary health care networks. • BC NurseLine. British Columbians who do not have 24/7 access to a local physician can call the BC NurseLine to receive health information and advice 24 hours a day, or a pharmacist between 5 p.m. and 9 a.m. every day. BC NurseLine's registered nurses are specially trained to answer questions about health topics and procedures, identify symptoms and help callers decide when to see a health professional. Information and referrals to other services are also provided. In 2004/05, the BC NurseLine received more than 331,000 calls — an increase of approximately 33% over the previous year. British Columbians also have access to free information and advice from nutritionists Monday to Friday from 9 a.m. to 5 p.m., through Dial-a-Dietitian. To meet the needs of BC's large and dynamic multicultural population, translation services are available in more than 130 languages.	As required by the BC College of Physicians and Surgeons, physicians must provide 24/7 access for their own patients. An individual who chooses to go to a walk-in clinic, call BC NurseLine or visit the emergency room may do so outside of the regular access protocol. However, physicians are required by the College to set up 24/7 protocols so that all British Columbians have access to their own health care provider at all hours of the day.	

B.1 Primary Health Care – 24/7 Access (continued)

	Proportion of patients having access 24/7 to primary health care providers	Proportion of 24/7 access provided through patient's own primary health care provider	Clinical information reported to the patient's own primary health care provider
Alberta	All Alberta residents have access to HealthLink Alberta, which is a 24 hour a day, 7 day a week nurse telephone advice and health information service.		
Saskatchewan	All Saskatchewan residents have access to HealthLine, which is a 24-hour health advice telephone line staffed by a registered nurse.		
Manitoba	Manitoba operates a provincial call centre — Health Links – Info Santé — that provides 24/7 phone access to health information and advice to all Manitoba citizens who have health questions.	Unknown at this time. 24/7 access is dependent upon a clinic's desire and practice to provide urgent care outside of normal office hours.	The provincial call centre, Health Links – Info Santé, does have the technical capacity to send clinical information forward to client-identified health care providers, but this is not the practice at this time. Privacy legislation and consent processes require further exploration to ensure that compliance with present requirements is met prior to the implementation of a communication process to disseminate an individual's health care record.
Ontario	Through an integrated system, Ontario currently has 4,669 doctors serving 6.83 million patients, 3.76 million of whom are registered to a primary health care model. Patients in these models have access to the after-hours Telephone Health Advisory Service (THAS). The service is available between 5 p.m. and 9 a.m. weekdays, and 24 hours on weekends and holidays. Callers to the service can speak to Ontario registered nurses who will provide health advice, triage and health information.	In the integrated system, the service is provided through the patient's own provider or a member of their primary health care group for daytime and extended evening, weekend and holiday coverage. This provider group is also required to be on call to the Telephone Health Advisory Service (THAS). The Service ensures that the patients' provider receives a report back the following business day.	The Telephone Health Advisory Service (THAS) is an integrated telephone triage service available to patients enrolled in the aligned primary health care models. The service is available after hours, between 5 p.m. and 9 a.m. weekdays, and 24 hours on weekends and holidays. Callers can speak to Ontario registered nurses who will provide health advice, triage and health information. THAS nurses also have access to an on-call physician from each of the primary health care groups it services.

B.1 Primary Health Care – 24/7 Access (continued)

	Proportion of patients having access 24/7 to primary health care providers	Proportion of 24/7 access provided through patient's own primary health care provider	Clinical information reported to the patient's own primary health care provider
	In addition, Telehealth Ontario provides 24/7 telephone health advice and triage information to all Ontarians. This service is not directly linked with any of the primary health care models.		These physicians are contacted if callers' symptoms warrant secondary triage. Patient encounters are communicated to callers' primary health care provider through an encounter report, which is sent back to the provider with the callers' consent. The report is sent by the following business day and outlines the reason for the call and advice provided to the patient.
Quebec	All Quebec residents have access to an Info-Santé Community Health Centre Help Line, 24 hours a day, 7 days a week. Their nurses give advice and information on health problems and social services and can refer residents to the right people or organizations.		
New Brunswick	All New Brunswickers have 24/7 access to primary health care providers through the Tele-Care telephone triage service.	These services are available 16 hours a day, 7 days a week.	Registered nurses employed by the Tele-Care service report encounters to physicians.
Nova Scotia	100% of Nova Scotia's population has access to primary health care providers, whether through emergency rooms, out-patient departments at acute care facilities or rural hospitals, community health centres or family physician offices. Through Primary Health Care Renewal activities, they are attempting to address an appropriate distribution of access to care from the right provider, at the right time, in the right place. The evaluation of broad primary health care renewal efforts in Nova Scotia is ongoing.		

B.1 Primary Health Care – 24/7 Access (continued)

	Proportion of patients having access 24/7 to primary health care providers	Proportion of 24/7 access provided through patient's own primary health care provider	Clinical information reported to the patient's own primary health care provider
	A proposed telehealth system has not been approved for Nova Scotia in this fiscal year. However, integral to movement on Nova Scotia's Primary Health Care Renewal agenda has been the relationships with the District Health Authorities, community health boards and community engagement strategies that have enabled local priority-setting and decision-making around the best model to meet the health care needs of individual communities. This work includes: • Development of collaborative teams by the District Health Authorities, including support for the formation of an expanded multi-disciplinary team collaborative model • Incorporation of 19 funded primary health care nurse practitioner positions in various locations across the province • Establishment of a Primary Maternity Care Working Group to facilitate the integration of midwives into collaborative practice teams delivering primary maternity care in Nova Scotia. A completed report was presented to the Department of Health in August 2005 and recommendations are being reviewed.		

B.1 Primary Health Care – 24/7 Access (continued)

	Proportion of patients having access 24/7 to primary health care providers	Proportion of 24/7 access provided through patient's own primary health care provider	Clinical information reported to the patient's own primary health care provider
Prince Edward Island	100% of PEI's population has access to primary health care providers, whether through emergency rooms/outpatient departments at 2 acute care facilities or 5 rural hospitals, family health centres or family physician offices.	Data not available.	Copy of the emergency room/outpatient deparment record is sent to the family health centre or family physician office.
Newfoundland and Labrador	100% of residents have access to 24/7 primary health care in various formats. With the status of Primary Health Care Renewal activities at this point, approximately 22% of the population have access to new models of multidisciplinary teams.	This information is not available.	This information is not available.
Nunavut	80% of the population resides in communities served by health care centres. In these communities, the first responders are community health nurses who provide services 24/7 either by telephone or face-to-face. These are the same personnel who see patients in the clinic during regular working hours. The rest of the population (approximately 20%) live in Iqaluit and have 24/7 care in emergency room off hours and by appointment or walk-in during regular hours. Care is usually provided by a physician.		Reporting is done mostly via telephone followed by hard copy between a health centre and Baffin Regional Hospital (this also applies to patients who are treated in the south).
Northwest Territories	Access to primary health care providers in the home community depends on the size of the community, on population health indicators, facility development and other capacity/resource factors. A referral system to regional, territorial and out-of-territory services is in place along with a Medical Travel Policy. The NWT's approach to supporting		

	Proportion of patients having access 24/7 to primary health care providers	Proportion of 24/7 access provided through patient's own primary health care provider	Clinical information reported to the patient's own primary health care provider
	the provision of core services for all residents is as follows: • In all communities, regardless of their population size, limited basic services are available: first aid; and basic CPR for urgent/ emergency care, assessment and crisis response services. In the smaller communities, transfer to a regional or territorial centre may be required. • In communities where professional nursing and mental health/addictions counselling staff are available, services extend to urgent and non-urgent clinics, and emergency clinics during regular work hours. Emergency on-call systems are in place after regular hours (nights and weekends). • In larger communities, the delivery of primary health care is extended to include physician services. Clinic (non-urgent and urgent) and emergency services are provided during regular work hours and may be provided in community health centres, medical clinics and/or at a facility/hospital. Emergency services are available on-call or 24/7 where hospitals exist. In May 2004, the Department introduced Tele-Care NWT, a toll-free family health and support line, operated 24/7, staffed by bilingual (French/ English) nurses registered in the NWT. Tele-Care NWT nurses have the ability to contact the local primary health care providers by phone and/or fax, depending on the urgency.		

B.1 Primary Health Care – 24/7 Access (continued)

	Proportion of patients having access 24/7 to primary health care providers	Proportion of 24/7 access provided through patient's own primary health care provider	Clinical information reported to the patient's own primary health care provider
Yukon	100% have access through the hospital emergency room in Whitehorse or community health centres in other Yukon communities. All Yukon residents also have 24/7 access to the Health Guide website, as a reference source. In Whitehorse, it is practical to consider hospital emergency as part of primary health care. Most of the physicians practicing in the emergency department are primary care physicians who take their turn to be on call for emergency. This may be different than the practice elsewhere in Canada.	This information is not available.	The emergency department at Whitehorse General Hospital provides primary health care. A copy of the treatment record of a Whitehorse resident treated at the emergency department is sent to their physician's office.

B.2 Primary Health Care – Interprofessional Teams

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
Federal: Canadian Forces	The Canadian Forces provides primary health care through the combined efforts of physicians, physician assistants, nurses and medical technicians. The Care Delivery Unit (CDU) is an interdisciplinary team composed of Canadian Forces and civilian health care providers who work consistently with each other in a collaborative manner to meet the in-garrison health needs of its rostered personnel and units, ensuring seamless continuity of care over time. A CDU's civilian staff consists of 1 civilian physician, 1 nurse practitioner and administrative support staff. The Canadian Forces personnel includes 2 medical officers (each expected to spend 50% of their time engaged in clinical activities within the CDU), 1 primary care nurse (PCN), 1 physician assistant, and 3 medical technicians. The Department of National Defence is currently in the midst of a primary health care renewal initiative (PCRI) that will better coordinate the various practitioners involved in primary care into defined, collaborative	PCRI is anticipating that 1 CDU (multidisciplinary team) will be able to provide standard primary care to approximately 1,500 Forces members while also fulfilling occupational and operational health responsibilities. At this stage of implementation, 11 CDUs have been established at various bases across Canada. Due to the fact that 60,000 regular and 18,000 reserve Forces members are dispersed throughout Canada and supported medically by 40 different CF medical establishments (some so small they do little more than coordinate care received through the civilian sector), it is difficult to compare DND patient/provider ratios to those of the civilian sector where populations are more clustered and economies of scale are more likely to exist.		The medical clinic roster is a list detailing the base's regular Forces and reserve Forces unit personnel and the specific CDU to which each unit is assigned. All entitled personnel will be registered with a CDU through rostering. All members of a particular ship, squadron or regiment may be assigned (i.e. rostered to a specific CDU).

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
	practicing interdisciplinary teams. PCRI has been trialed and evaluated at 4 Canadian Forces clinics. Implementation is underway at a number of sites, with conversion of all 32 sites to the new clinic model targeted for completion by 2010. Like the civilian health care sector, however, the Department faces challenges to successful and timely implementation in the form of infrastructure barriers, health care human resources shortages, and long-term budgetary uncertainty.			
Federal: Aboriginal Peoples	Not applicable.	Multidisciplinary teams exist in all nursing stations and health centre facilities, which number approximately 550.		No
Federal: Veterans	Interprofessional teams have been in place for more than 20 years, with the inception of the Veteran's Independence Program. These teams have evolved over time to meet current needs and trends. Since the implementation of the client-centred service approach in 1999, each local office has at least one interdisciplinary team, and all regional offices and head office have such teams as well.	Currently, there is a multidisciplinary team at Head Office, one in each of the five regional offices, and more than 40 client service teams in local offices throughout the county.		Veterans are assigned to a local case manager and also fall within regional boundaries. The client service and multidisciplinary teams responsible are determined, usually, by the veteran's geographical location.

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
British Columbia	British Columbia is accelerating its team approach to primary health care through its transformation strategy. This strategy includes: • understanding the patient as the most important and under-utilized resource on the primary health care team • informing the makeup of multidisciplinary teams based on patient diversity, expectations and realities for care • focusing multidisciplinary teams on populations at risk for development of chronic disease • implementing policy and regulation changes • supporting new funding models • developing and utilizing information management • engaging a variety |of health care professionals to enable long-term prevention of illness and to reduce pressure on acute care and emergency services • collaborating with a range of health care providers, professional organizations, health authorities and academia to develop and train	In British Columbia, multidisciplinary teams have developed as clinicians have changed their practice to improve patient health outcomes. A team approach has emerged through these quality improvement initiatives. To date, more than 1,000 clinicians are providing team care utilizing population recall, review and reporting technology. In addition to teams involved in quality improvement, BC has 91 new primary health care models (these include teams and networks). These models include some or all of the following: • a multidisciplinary approach • access to more integrated patient health record data • quality assurance mechanisms • extended hours • education and professional development, and • integration with community-based services.	Services of British Columbia's new primary health care models include: • diabetes education • drug and alcohol counselling • health promotion • immunization • meals on wheels • new baby clinics • on-site ambulatory care • on-site laboratory services, and • smoking cessation programs. Innovative services for patients with complex needs include: *Patient Self-management:* This service ensures decision-making is shared between the team of health care providers and the patient. *Group Patient Clinical Visits:* Groups of patients with complex health concerns meet together along with a team of professionals to discuss and educate one another. The clinical content includes: symptom management, drug therapies and strategies to reduce complications. *Structured Prevention:* British Columbia's Prevention Support Project focuses on chronic disease prevention in individuals at risk	Depending on the primary health care model, patients will either be rostered to their primary health care physician or the group.

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
	health human resources on a long-term basis, and • continuing development and clarity with regard to roles and scope of practice.		between the ages of 50 and 70. There are currently 35 teams engaged in exploring the benefits and system barriers of structured prevention.	
Saskatchewan	34 primary health care teams cover approximately 23% of the population.	34 primary health care teams cover approximately 23% of the population.		
Manitoba	To date, each region has, to some degree, developed and/or implemented multidisciplinary teams based on regional and community needs. Configuration of multidisciplinary teams is based on community needs and regional capacity and resources in providing the most appropriate care provider at the most appropriate time.	Data are not available at this time.	Team composition and development are evolving based on Regional Health Authority planning to address community health assessment findings. The management of chronic diseases, such as diabetes, is an area where Manitoba is fostering the development of multidisciplinary teams to provide specific services for diabetes prevention and management.	Information communications technology (ICT) is an essential element to the process of registering patients and providing team-oriented health programs and services. Manitoba is addressing ICT needs in the development of team-delivered health services. The intent is that patients will be enrolled and participate in specific programs provided that efficient, effective ICT is in place to support collaborative team health services and practices.

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
Ontario	There is no standard composition for multidisciplinary teams in Ontario. The interdisciplinary component of the existing models varies depending on the practice type and setting. Some of the models are provider-led, while others are run by a community board and have a broader interdisciplinary approach to care. The ministry will establish 150 family health teams across the province by 2007. Each team will be made up of doctors, nurses, nurse practitioners and other health care providers who will focus on health promotion, disease prevention and the treatment of disease/conditions. On April 15, 2005, the ministry identified the first 69 individual family health teams which, when implemented, will support patients in 47 communities across Ontario. At present, there are more than 75 existing interdisciplinary teams within Ontario, working in various Community Health	The number of interdisciplinary teams per 10,000 population is not currently available and would not provide an accurate reflection of the team's makeup. Teams can vary in size, from small teams serving 2,000 to 3,000 patients to the largest team, such as the Group Health Centre, which serves 58,000.	Patients will have access to comprehensive primary health care services provided by a team of primary health care providers. Each family health team will provide patients with access to after-hours care through extended office hours and the Telephone Health Advisory Service (THAS). Family health teams will provide health services in chronic disease management, health promotion and disease prevention, addressing the specific and unique needs of their communities. The makeup of other existing primary health care models varies, but the goal of providing comprehensive access to primary health care services is a shared throughout these models.	Depending on the primary health care model, patients will either be rostered to their primary care physician or the group.

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
	Centres (CHCs), Health Service Organizations (HSOs), and the Group Health Centre in Sault. Ste. Marie. Teams are composed of physicians, nurse practitioners and nurses, and may include various other interdisciplinary providers, such as social workers, chiropodists, physiotherapists, speech pathologists, dietitians and community health workers. Additionally, there are a number of family health networks (FHNs) and primary care networks (PCNs) that have interdisciplinary components. In most cases, these include nurse practitioners and nurses.			
Quebec	1,128 doctors and 185 nurses work in family medicine groups (FMGs). There are currently 104 FMGs, with the target being 300 FMGs covering 70% of the population by 2010.	An estimated 104 FMGs provide services to nearly 1,550,000 people.		As of September 17, 2005, 637,674 patients were registered with a FMG.
New Brunswick	New Brunswick has established multidisciplinary teams in its 8 Community Health Centres and in 1 collaborative practice now established in the province. Multidisciplinary teams are designed	New Brunswick has established multidisciplinary teams in its 8 Community Health Centres and in 1 collaborative practice now established in the province.	Primary health care.	In some cases — mostly in collaborative practice settings.

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
	based on a community needs assessment process, which determines the services required to meet the health care needs of each community serviced by a Community Health Centre.			
Nova Scotia	The composition of NS interdisciplinary, collaborative teams tends to be family physicians, family practice nurses, nurse practitioners and pharmacists. These core team members are usually in place, though other team members and extended providers and contributors work interdependently in many areas. Team members differ based on District Health Authority and community needs. The Duffus Street Integrated Family Medical Centre in Halifax is an example of an expanded multidisciplinary team.	An overall evaluation of primary health care efforts is in progress and data are not available at this time on the number of teams in existence across the province.	While basic primary health care services are in place across the province, some additional services provided by interdisciplinary, collaborative teams differ. Team members either directly meet the needs of clients or facilitate and ensure access to the appropriate provider or community resource.	Registration or enrolment of primary health care patients/clients is not widespread in NS.
Prince Edward Island	Over the past 4 years, 5 family health centres have been established across the province, beginning with physician/registered nurse combinations. Two of the family health centres have also included part-time dietitians and mental health workers	Five family health centres have been established across the province.	Collaborative teams provide diagnosis, acute (non-emergency) and chronic disease treatment and management, health promotion and illness prevention.	Patients are registered with their family physician at the family health centre in their geographic region.

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
	as members of the collaborative practice team. Beginning with a minimum of 4 permanent physicians and 2 registered nurses, the original intent was to add other health providers over time.			
Newfoundland and Labrador	There are 8 primary health care project areas (minimum population of 6,000 and maximum population of 25,000), with multidisciplinary teams providing services to the populations in the various geographic area. Processes include the following: • team development • scope of practice review • diabetes collaborative implementation • development of a physician funding and payment model • relationship building with various professionals and groups.	8 teams are in various stages of implementation. 6 more will be initiated within the next 6 months. It is anticipated that approximately 30 teams will provide services to 100% of the population. As noted earlier, teams would provide service to populations of a minimum of 6,000 people, maximum 25,000.	Formalized scope of practice processes have been initiated in all project areas, with development of action plans to allow the most appropriate provider service to a client.	Pilot-testing registration process in rural and urban setting is in the planning stages, and will be implemented by early fall 2006. The goal is to have all patients/clients enrolled with a personal health care team.
Nunavut	No teams at present.	None at present.		
Northwest Territories	The Department of Health and Social Services has started the implementation of its Integrated Service Delivery Model			

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
	(ISDM). As part of this process, facilities and medical services are being reviewed and the utilization of health professionals will be considered. The NWT's approach to Primary Health Care reflects the geographic and demographic challenges of its jurisdiction, basically a small population of which 50% live in small remote communities. Primary Health Care professionals include: Community Health Workers/Lay Dispensers, Community Wellness Workers, Community Health Nurses (expanded nursing role), Nurse Practitioners, Family Physicians, Social Workers, Mental Health/Addiction Counselors.			
Yukon	The Yukon does not have a formal definition of a multidisciplinary team but is moving towards increased collaborative care among a range of health care providers, who may or may not be co-located. Collaborative care projects are underway in chronic disease management, starting with diabetes, and among caregivers for people with	This information is not available. (The total Yukon population is 32,000, with all Yukon communities other than Whitehorse having a population of 2,000 or less.)	No	In the Yukon Diabetes Collaborative, which is just getting underway, a patient will be registered with a "most responsible provider" who may be a physician or a community nurse practitioner in a participating community. Registration is only for purposes of collection and monitoring of information to improve management of their diabetic condition. Other members of

B.2 Primary Health Care – Interprofessional Teams (continued)

	Progress in implementing interprofessional teams	Number of interprofessional teams per 10,000 population	Interprofessional teams required to provide specific services	Patients registered to specific team of health care providers
	concurrent mental health and addictions disorders. Less formal collaboration occurs and is being encouraged, for example, through visiting physicians working with community nurse practitioners in rural communities. The Yukon also has two multidisciplinary teams of health care providers working in the communities, comprising physicians and nurse practitioners. The providers in each of these teams work together to jointly serve the communities they cover.			the team will be given access to the information by the "most responsible provider." Otherwise, patients are not enrolled or registered with a specific team of care providers.

B.3 Health Human Resources – Scopes of Practice

	How does your jurisdiction define the term *scopes of practice* as it relates to health professionals?	Are there specific reviews or legislative or regulatory initiatives underway that deal with scopes of practice issues in your jurisdiction? Do you have any plans to undertake a comprehensive review of the scopes of practice for any of your regulated health professions?	What barriers impede the resolution of scopes of practice issues in general?
British Columbia	*Scopes of practice* is not specifically defined in British Columbia legislation. Under the *Health Professions Act*, government has the authority to make regulations establishing what services may be performed by a regulated profession, and to impose any limits or conditions on those services.	British Columbia is moving toward a shared scopes of practice/reserved actions model for all regulated professions, based on recommendations set out in the Health Professions Council 2001 report *Safe Choices: A New Model for Regulating Health Professions in British Columbia.* It is expected that the Council's recommendations will increase overlapping scopes of practice. The Council believes that it is not necessary or useful to itemize every facet of a profession's scopes of practice. Rather, a scopes of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.	Barriers include: • The lack of coordination between national professional organizations that set entry-to-practice requirements, establish certification processes and control post-secondary program accreditation and the provincial health system planning and strategic management apparatus. • Differing scopes of practice and entry-to-practice requirements across the jurisdictions. • Insufficient coordination between policies adopted by post-secondary education and the health ministries. Post-secondary institutions tend to be slow in responding to necessary curriculum changes that would allow enhanced scopes of practice. • Lack of understanding or accountability among professions as to what constitutes the public interest, and no process for reaching a common understanding with government. • Increased specialization/division of labour. • The economic interests of different disciplines competing for the same scopes of practice. • Lack of understanding and mutual respect for the skill sets of different disciplines.

B.3 Health Human Resources – Scopes of Practice (continued)

	How does your jurisdiction define the term *scopes of practice* as it relates to health professionals?	Are there specific reviews or legislative or regulatory initiatives underway that deal with scopes of practice issues in your jurisdiction? Do you have any plans to undertake a comprehensive review of the scopes of practice for any of your regulated health professions?	What barriers impede the resolution of scopes of practice issues in general?
Saskatchewan	There is an overall scope of practice for the profession that is defined through regulation/legislation/ professional bylaws. This sets the outer limits of practice for the profession. Individual scope of practice is generally narrower than the scope for the profession itself. It is based on the professional's knowledge base, practice setting, employment requirements and needs of the patient. Working to full scope means that professionals work within the legislated scopes of practice to their individual level of competency based on their education, experience and need within their employment.	No plans for review at this time. However, in the development of the provincial health workforce action plan, scopes of practice and the role of regulatory bodies in defining this scope were raised as issues that need to be addressed. We have been working with our nursing regulatory bodies to better understand the overlapping scopes of practice between registered nurses, registered psychiatric nurses and licensed practical nurses.	Barriers include: • Lack of understanding of each other's professional and individual scopes of practice and how best to utilize each health professional in the work environment. • Need for greater clarity around the role of governments, regulatory bodies and employers regarding who defines scopes of practice.
Manitoba	*Scopes of practice* describes the activities that a health professional can safely perform as a result of his or her education and training.	In recent years, there has been continuous review of one or more health profession's scopes of practice. For the past number of legislative sessions, new or amended health professions' regulatory legislation has been introduced. Scopes of practice for currently regulated professions seem to be constantly expanding, and Manitoba has received numerous requests for self-governing legislation from unregulated groups. No decision has been made to date on future plans to review scopes of practice.	Efforts to turf-protect and expand impede resolution. What formerly were "exclusive scopes of practice" are no longer. For example, a variety of health professionals now deliver "medical services" (e.g. midwives, nurse practitioners) and "dental services" (e.g. dental hygienists).

B.3 Health Human Resources – Scopes of Practice (continued)

	How does your jurisdiction define the term *scopes of practice* as it relates to health professionals?	Are there specific reviews or legislative or regulatory initiatives underway that deal with scopes of practice issues in your jurisdiction? Do you have any plans to undertake a comprehensive review of the scopes of practice for any of your regulated health professions?	What barriers impede the resolution of scopes of practice issues in general?
Ontario	Each regulated health profession has in its profession-specific legislation a scopes of practice statement that describes in a general way what the profession does and the methods that it uses. The scopes of practice of regulated health professions in Ontario are not exclusive and may overlap such that more than one health profession may perform the same activities, providing choice to Ontarians.	On February 7, 2005, the Minister of Health and Long-Term Care asked the Health Professions Regulatory Advisory Council (HPRAC), a body established under the *Regulated Health Professions Act, 1991* (RHPA), to provide independent advice to the minister on matters related to the regulation of health professions in Ontario, considering, among other things: • whether pharmacy technicians/assistants, homeopaths, kinesiologists and psychotherapists should be regulated under the RHPA, and, if yes, what their scopes of practice should be; and • whether the scopes of practice of opticianry (refractometry) and optometry (prescribing therapeutic pharmaceuticals agents) ought to be amended. The minister has asked HPRAC to provide its advice by April 2006. In Ontario, there are 23 regulated health professions.	Legislative, regulatory, and institutional (e.g. employer policies and practices) barriers may impede the resolution of scopes of practice issues.
Quebec		Over the past 12 months, work has been carried out jointly between the Quebec College of Physicians, the Quebec Order of Nurses, the Quebec General Practitioners Federation and the Ministère de la Santé et des Services Sociaux to put	

B.3 Health Human Resources – Scopes of Practice (continued)

	How does your jurisdiction define the term *scopes of practice* as it relates to health professionals?	Are there specific reviews or legislative or regulatory initiatives underway that deal with scopes of practice issues in your jurisdiction? Do you have any plans to undertake a comprehensive review of the scopes of practice for any of your regulated health professions?	What barriers impede the resolution of scopes of practice issues in general?
		in place the regulations required for introducing new professional practices, such as nurse practitioners specialized in cardiology, in neonatology and in nephrology.	
New Brunswick	The term *scopes of practice* refers to the roles and responsibilities of a health care professional's (or employee's) competency profile (i.e. the right skill-set obtained and transferred from formal training, on-the-job-training and other relevant life experiences to efficiently and effectively perform the demands inherent to the current position or occupation held).	In September 2005, New Brunswick announced changes relating to the role of nurses working in hospital emergency rooms, permitting registered nurses to examine, treat and discharge patients who do not require a physician's attention. Collaborative work with the rehabilitation associations has also been initiated in preparation for the introduction of a "formally trained" rehab support personnel to deal with scopes of practice issues, including delegation of tasks, supervision and other, as it relates to patient care. New Brunswick has established a provincial network examining the optimization of roles for nursing care providers, focusing on licensed practical nurses.	Among health professionals, there is often a poor understanding of others' roles and responsibilities, possibly due to a lack of exposure to interprofessional collaboration. Literature indicates that such exposure is critical from a very early start —from training (pre) to post-licensure — to adequately prepare health care professionals to the challenges and opportunities they will encounter as front-line care providers. This exposure is especially critical in New Brunswick, as primary health care reforms and population health are the main goals of the new Provincial Health Plan 2004–08.
Nova Scotia	*Scopes of practice* is the range of skills for which a clinician is appropriately trained.	There are no plans at present.	Liability issues/Tort law

B.3 Health Human Resources – Scopes of Practice (continued)

	How does your jurisdiction define the term *scopes of practice* as it relates to health professionals?	Are there specific reviews or legislative or regulatory initiatives underway that deal with scopes of practice issues in your jurisdiction? Do you have any plans to undertake a comprehensive review of the scopes of practice for any of your regulated health professions?	What barriers impede the resolution of scopes of practice issues in general?
Prince Edward Island	PEI uses the professional regulatory bodies as the guide to define *limits* and *scopes of practice*, as well as what may be identified in legislation. They also look to define *scope* within the limits of the education of the workforce, in general, and specific individual skill sets.	The Licensed Practical Nurses Regulatory Board and Association have recently completed the LPN competency project to define entry-level competencies. Work is underway to introduce nurse practitioners into the PEI health system. The government is not aware of similar work relating to other professions at this time.	Lack of clarity and some confusion about roles • between employers and staff and • among professions.
Newfoundland and Labrador	*Scopes of practice* is generally described as the range of roles, functions, responsibilities and activities for which a particular health occupation is educated and authorized to perform.	Several legislative reviews are underway or have concluded involving the expansion or clarification of scopes of practice. These include amendments to the *Pharmacy Act* and the *Optometry Act*, and proposed changes to the regulations on nurse practitioners within the *Registered Nurses Act.* There are no immediate plans to undertake comprehensive reviews of the scopes of practice for regulated professions; however the Office of Primary Health Care has proposed a process to address scopes of practice issues within primary health care teams.	Barriers to scopes of practice issues include: legislation; collective agreements; a lack of or inconsistent staffing patterns for ancillary or other staff; differing levels of competency within members of a particular profession; geographic limitations; and policies, procedures and preferences at the employer level. Alternatively, rigidity in enforcing scopes of practice could mean increasing staffing levels in some rural areas, divisions of labour that reduce workplace flexibility, and other unforeseen effects.
Nunavut		Work on new midwifery legislation and regulations are being planned. An expanded scopes of practice for nurse practitioners and legislative/regulatory changes	

B.3 Health Human Resources – Scopes of Practice (continued)

	How does your jurisdiction define the term *scopes of practice* as it relates to health professionals?	Are there specific reviews or legislative or regulatory initiatives underway that deal with scopes of practice issues in your jurisdiction? Do you have any plans to undertake a comprehensive review of the scopes of practice for any of your regulated health professions?	What barriers impede the resolution of scopes of practice issues in general?
		are pending, and a review of RPN scopes of practice has been initiated.	
Northwest Territories	Health professional legislation for doctors, dentists, licensed practical nurses, dental mechanics, psychologists, optometrists and pharmacists does not contain a defined scopes of practice and mainly consists of a registration framework to license these professionals. In the newer legislation governing nursing and midwifery, the Minister also approves standards and/or guidelines for the practice of these professions. Small numbers of professionals and lack of colleges in the NWT will continue to be a challenge for the resolution of scope of practice issues.	The NWT has recently completed changes to the *Nursing Profession Act* to include the role of nurse practitioners and implemented a *Midwifery Profession Act*. The NWT does not plan any other legislative or regulatory initiatives in the near future that deal specifically with scopes of practice.	Some barriers are legislative in nature, which may be addressed by introducing legislative changes as was done with the governing legislation for nurse practitioners and midwives. Resistance to change, such as a client's preference to see a physician instead of a nurse practitioner, is a potential barrier to appropriate utilization of health professionals.
Yukon	Territorial legislation doesn't specifically define *scopes of practice*, but the *Health Professions Act* refers to the power to make regulations respecting "services that may be performed by registrants of the profession," with the annotation that this paragraph refers to regulations specific to the services that a health profession may perform and any limitations on those services.	No specific reviews are planned at this time. Recent work has mostly been related to professions wishing to become a Yukon registered and regulated profession under the Yukon's *Health Professions Act* (as occurred recently with physiotherapists). The Yukon is also examining where clarification may be needed about the authorities of and requirements for various health professions during a health emergency, through emergency preparedness planning work.	Barriers include various factors: protection of professional interest; an increasing amount of overlap among professions as they are now trained to do a wider range of skills; broader training makes clear distinctions/ boundaries in scopes of practice more difficult to determine.

B.4 Health Human Resources – Plans and Studies

	Action plan released (Yes or No)	Reviews to determine the under-utilization or over-utilization of skills by any health professions in the jurisdiction
Federal Government	No	
British Columbia	No	There are currently no reviews underway.
Alberta	No	
Saskatchewan	Yes	The province has not undertaken a review; however, the Saskatchewan Association of Licensed Practical Nurses (SALPN) and the Saskatchewan Registered Nurses' Association (SRNA) did survey their members about workplace issues and utilization of skills.
Manitoba	No	The government has examined scope of practice with regard to licensed practical nurses working in acute care settings.
Ontario	Yes	The *Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario* was commissioned by the Ontario Ministry of Health and Long-Term Care and was released in 2004. The report identified facilitators and barriers to the integration of primary health care nurse practitioners (PHCNPs), as well as described the practice settings in which they work. A joint task team that includes external stakeholders has been established to oversee the implementation of the report's 29 recommendations.
Quebec	Yes	
New Brunswick	Yes	
Nova Scotia	Yes	No reviews planned at this time.
Prince Edward Island	Yes	The LPN competency project looks to determine ways to increase the utilization of licensed practical nurses. PEI is currently conducting a nursing education survey in which all LPNs and RNs in the province are asked to identify their education needs and wants.
Newfoundland and Labrador	No	*Under-utilization of skills:* The government of NL is committed to working with regional integrated health authorities to achieve a skill mix framework that ensures that the right mixture and utilization of health professionals are achieved. Some preliminary work has been completed in this regard; however, system reorganization has delayed this initiative. More activity is expected in fall 2005.
Nunavut	Yes	
Northwest Territories	Yes	The Department of Health and Social Services has started the implementation of its Integrated Service Delivery Model (ISDM). As part of this process, facilities and medical services are being reviewed and the utilization of health professionals will be considered.
Yukon	No	No specific reviews.

B.5 Health Human Resources – Federal Programs

Health Human Resources Planning	Interprofessional Education	Recruitment and Retention
Activities to enhance data collection, including: • The funding of the development of a minimum data set. • The funding of the data collection on two educational indicators — career choice and change, and attrition. Activities to improve capacity to plan for health human resources including funding and participating in the: • Development of an evidence base on jurisdictional modelling capacity. • Development of a pan-Canadian health human resources (HHR) planning framework with all provinces and territories except Quebec. • Demand, modelling and working with jurisdictions to prepare an inventory of HHR models.	Supported the development of best practices, information gathering, discussion papers. Funded 11 projects focused on interprofessional education.	Funding projects to develop strategies for recruitment and retention of rural physicians. Funding a project to increase the image of family medicine, to raise the role of family medicine in medical school curricula, and to increase support for family physicians in primary care. Jointly funding a promotional campaign to raise awareness about the positive aspects of being a health care professional. A number of initiatives aimed at improving the country's capacity to licence internationally educated health care providers, including: • Funding provinces and territories to increase their capacity to assess internationally educated health care providers. • Funding the development of common approaches to assessing internationally educated health care providers. • Funding the development of website information on the licensure process for internationally educated physicians. • Establishment of a national credential verification service. • Funding the development of a self-assessment tool for physicians. • Funding the development of a web-based learning program on the cultural, legal, ethical and organizational aspects of medical practice in Canada.

B.6 Home Care – Current Coverage for Services

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
Federal Government	The federal government delivers home care services to First Nations on-reserve and to Inuit in designated communities, members of the armed forces and RCMP, federal inmates, and eligible veterans.			Where delivery of services is possible, the federal government provides home and community care services to the populations it serves beyond the level of the two-week baskets of services committed to in the 2003 Accord and 2004 10-Year Plan.
British Columbia	Home care nursing includes professional services delivered to clients in the community by registered nurses who provide non-emergency, in-home nursing care. They assist clients with short-term acute care needs resulting from a hospital stay. ***Intravenous medications*** BC provides medically necessary medications as well as intravenous infusion supplies and equipment to clients with short-term acute care needs resulting from a hospital stay. ***Personal care*** British Columbia has a home support program across all health authorities, for	There has been a significant investment in the last year in community mental health strategies. BC has developed various initiatives to improve health outcomes for individuals with mental disorders and/or substance use disorders, their families and the communities in which they live. Crisis response and case management are part of this continuum of care. ***Crisis response*** BC provides assessment and crisis intervention to individuals: to minimize the risk of harm to self/others; and to return the person to a level of functioning that does not require continued		

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
	clients with short-term acute care needs resulting from a hospital stay. The program is income tested, but as of April 1, 2005, the co-payment for the first two weeks of post-acute personal care home support has been removed in response to commitments made in the 2003 First Ministers' Accord. ***Case management*** The province provides assessment and care coordination services to clients with short-term acute care needs resulting from a hospital stay.	provision of an urgent/emergent level of care. Individuals are also referred to follow-up treatment and care. Crisis response includes both pre- and post-hospitalization services such as in-home stabilization, mobile crisis response teams and community crisis stabilization beds. ***Case management*** The province provides assessment and care coordination services to clients with short-term acute care needs resulting from a hospital stay. Both short-term and longer-term case management services are provided through existing community mental health services.		
Alberta	Current program details were not available for this report.	Current program details were not available for this report.	Current program details were not available for this report.	The Business Plan for Alberta Health and Wellness strategies include working with the regions to coordinate access to continuing care services like home care.

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
				The Government of Alberta established the Mental Health Innovation Fund, which will receive $25 million for each of the next three years: to establish more community- and facility-based mental health alternatives; to address current need areas in services, such as children's mental health; and to facilitate advancement of regional mental health priorities.
Saskatchewan	Services include: case management, nursing, personal care and home IV, without fees to the patient. Personal care services (effective October 1, 2005) are provided without patient fees for up to 14 days.	At present, post acute community mental health services for individuals leaving psychiatric inpatient wards are available without charge but at inconsistent levels among regional health authorities: · Some case management and support services are offered. · The home support offered is inconsistent. · A crisis response service is available only in select centres; but the province is enhancing the HealthLine to augment crisis response.	End-of-life home care includes case management, nursing, personal care and palliative pharmaceuticals, without fees to patients or families, and with no specific time frame.	Acute community mental health home care will require the greatest degree of development and implementation by the province to meet the Accord commitments.

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
Manitoba	Case management, nursing, personal care and IV medications are provided across the province without charge to the client through the Regional Health Authority's Home Care program, based on assessed need and up to a level comparable to services in a personal care home.	Short-term acute community mental health needs in Manitoba are most often met through the mental health program in the respective Regional Health Authority, separate and apart from the Home Care program. In addition, Manitoba's Home Care Program has funded some longer-term home care services for individuals with mental health needs: *1) Health Co-ordination Model:* Crisis intervention and life skills teaching and support provided by community mental health proctors to the 40 clients serviced by this model in the Winnipeg Regional Health Authority community. *2) Cross-Training Project:* Home Care health care aides are also trained to provide proctor services accessible from one specific housing site that provides service to individuals with complex health care and mental health needs. Aides/proctors	End-of-life care case management, nursing and personal care are provided in all regions in Manitoba by the Home Care program, except in Winnipeg, where it is housed within Medicine. Access to palliative-specific medication is provided through the Palliative Care Drug Access program, funded by the Government of Manitoba.	Manitoba's current level of services exceeds the First Ministers' commitment in the 2004 10-year plan.

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
		are able to provide crisis intervention and life skills teaching and support, as well as direct service for physical needs.		
Ontario	Meets and exceeds the First Ministers' commitment. Nursing, personal support and homemaking are provided for up to 2 weeks without user fees,* in accordance with the legislated maximums. There are no service maximums on other home care services. Home care clients are Ontario Drug Benefits (ODB) beneficiaries; as such, they receive ODB formulary medications, IV solutions and supplies for which they pay a co-payment of $2 to $6 per prescription, depending on their income; those receiving professional health services, regardless of income, pay only $2 per prescription. * The right to subrogate is retained. Agencies are allowed to charge fees on a cost-	Case management and crisis response are provided for up to 2 weeks without user fees* for residents, including homeless people, in accordance with the MOHLTC Operating Manual for ministry-funded mental health and substance abuse agencies. * The right to subrogate is retained. Agencies are allowed to charge fees on a cost-recovery basis for related services that are not funded by the MOHLTC, with written approval.	Case management, nursing, palliative-specific medication and personal care are provided at end of life. Levels of services are in accordance with the legislated maximums for short-term acute care. In extraordinary circumstances, service maximum number of hours for personal support and homemaking may be exceeded for up to 30 days.	

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
	recovery basis for related services that are not funded by the Ministry of Health and Long-Term Care (MOHLTC), with written approval.			
Quebec	The home support policy "Home is the Option of Choice" was introduced for people whose health requires them to stay at home or return home after receiving care in an institution, regardless of their challenge, as well as for their families and loved ones. Current program details were not available for this report. Since July 2004, 31 innovative projects have been implemented in partnership with local housing authorities, community organizations or home service co-ops to enable 500 senior citizens who have lost major autonomy to remain within a familiar living environment with their loved ones, thus preventing the breakdown of their	Current program details were not available for this report.	Current program details were not available for this report.	A policy has been announced for implementation of palliative care services over the next few years, with the objective to increase the number of individuals receiving a greater level of palliative care services at the end of life. The policy supports: · Needs and choices of users · Maintaining users in their natural living environment and · Supporting the family and loved ones. The policy will promote continuous access to quality services (medical, nursing and pharmaceutical), whether at the person's home, in an institution or in palliative care, as well as access to palliative care beds, especially in Quebec.

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
	social ties (i.e. being sent to institutional accommodation). Institutions in the health and social services network provide health and social services; other services, such as accommodation, are taken care of by another partner.			
New Brunswick	The Extra-Mural Program provides home health care services including assessment, intervention (treatment, education and consultation), service planning and coordination by teams of nurses, dietitians, respiratory therapists, physiotherapists, occupational therapists, social workers and speech language pathologists based in each of the Regional Authorities. Enhancements are underway to meet the Accord's 2-week short-term acute home care commitments by 2006/07.	The Extra-Mural Program provides home health care services including assessment, intervention (treatment, education and consultation), service planning and coordination (see first column). Enhancements are underway to meet the Accord's 2-week short-term acute community mental health case management and crisis response commitments by 2006/07.	The Extra-Mural Program provides home health care services including assessment, intervention (treatment, education and consultation), service planning and coordination (see first column). Enhancements are underway to meet the Accord's end-of-life care case management, nursing, palliative-specific medication and personal care commitments by 2006/07.	Per the *Healthy Futures* health plan, work on the commitment to expanded acute care, mental health crisis and palliative services is in progress, with the introduction of 32 new positions in January 2005 and 15 slated for 2005/06, plus funding for short-term personal care. Work on the remaining commitments under the Accord is slated to begin in 2006/07.

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
Nova Scotia	Case management, intravenous medications related to the discharge diagnosis, and nursing and nursing supplies are currently offered at no cost. Personal care, home support services and home oxygen services are offered with sliding scale charges based on family size and income.	The District Health Authorities and Pediatric Provincial Health Care Authority administer a network of 50 community-based mental health clinics, inpatient beds, day treatment centres, psychosocial rehab programs and drop-in centres. The Community Mental Health Program covers all residents in Nova Scotia at no charge.	NS currently does not offer end-of-life services.	NS is developing plans to improve access to mental health services in order to provide better community support, crisis or emergency services and services for children. There have been recommendations from a hospice palliative care group regarding end-of-life care, which Nova Scotia plans to act on over the next year.
Prince Edward Island	PEI's Home Care and Support Program currently admits a relatively small proportion of clients to a short-term acute care core component designation. First dollar coverage is already in place for nursing and for limited case management. The cost for personal care is on a sliding scale fee-for-service, while the cost of supplies and medications (including IV medication and supplies) is the responsibility of the client.	Community mental health in PEI is under the jurisdiction of Mental Health and Addictions rather than Home Care and Support. Crisis response teams and limited case management are in place with no charge to the client.	PEI's Integrated Palliative Care Strategy aims to remove disincentives to home/community-based care and provide a realistic option for clients wishing to receive palliative care services at home. First dollar coverage is in place for case management/ coordination and for services in home care nursing and home support for personal care. The current level of palliative care services is meeting the needs of just over half of PEI's existing palliative care population.	Preliminary planning for home care services arising from the 2004 First Ministers' Health Plan commitments has been initiated.

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
			The integrated model includes resource teams consisting of family physicians, social workers, pharmacists, nurses, spiritual advisors and coordinators of volunteers. These teams have received enhanced education to support front-line health care providers in a collaborative team approach in looking after palliative care clients and families. There is no charge to the client for any of these services. Palliative care–specific pharmaceuticals remain the responsibility of the client.	
Newfoundland and Labrador	Community health nursing and some limited allied health services, such as social work, occupational therapy and physiotherapy, are offered at no charge; there is a medical equipment program for eligible clients; limited home support is based on means testing.	No current service for short-term acute mental health case management.	Community health nursing services are available; limited home support is available based on means testing. There is a pilot project in the Western region: limited home support available.	2005 Budget announcement: There will be an expansion to post-acute home care and end-of-life care in the province, starting in the western region and building on the current pilot project, as follows: • The acute home care program will further assist patients recovering from surgery or other medical

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
	The Home IV Antibiotics Program is available in one region only.			interventions and those requiring wound management and related drug therapy as well as personal care for a two-week duration. • End-of-life care will also be offered.
Nunavut	Culturally appropriate, holistic home care services, including nursing care, personal care, case management and homemaking, are covered for the Inuit population (approximately 750 clients), and non-Inuit population (negligible population), subject to the availability of resources, at no charge to the patient. All services provided under the Home and Community Care (HCC) program are initiated with a referral followed by an assessment of care needs. Home IV therapy is provided. In addition, the HCC program provides equipment loans, respite care, chronic disease management, foot care, rehab services, and group programs.	Community mental health services are provided by mental health personnel, with home care staff providing follow up care, such as housekeeping and medication compliance, at no charge to the patient.	The territory is providing end-of-life care services.	The Home and Community Care program will support a chemotherapy pilot program, scheduled for the New Year.

B.6 Home Care – Current Coverage for Services (continued)

	Two-week Basket Now Covers (without charge):			Expansions Anticipated
	Short-term acute home care, including case management, nursing, personal care and IV medications related to the discharge diagnosis	**Short-term acute community mental health care, including case management and crisis response**	**End-of-life care, including nursing, palliative-specific medication and personal care**	
Northwest Territories	The range of home care services includes: acute care, post-hospital care, chronic illness care, nutrition services, and personal care. The full range of services is not available in smaller communities.	Acute community mental health home care services are provided to anyone assessed by a mental health counsellor, psychiatrist or therapist as being in need. A distinction between short and long term is not made. Prescription drugs are not funded under this program. There are no user fees and no limits on services.	Home care is based on need and is available to NWT residents without charge. The range of end-of-life services includes: acute care, post-hospital care, nutrition services, palliative care, personal care and respite care. The full range of services is not available in smaller communities.	
Yukon	The Yukon government provides, without fees, home-based nursing, social work, occupational therapy, physiotherapy, and home support (which includes personal care), and respite for all Yukoners, based on assessed need. For acute clients, the Yukon also provides dressing supplies for two weeks if the client has no other coverage for that. The Yukon does not provide home-based IV medical support.	The Yukon government's home care program provides home care for persons with physical needs who may also have mental health issues. The Yukon government's mental health program addresses mental health crisis management.	End-of-life services are included under the Yukon government's program, at no charge. The Department of Health and Social Services provides medications and supplies for individuals who are on the palliative care list.	

B.7 Pharmaceuticals Management – Current Initiatives

	Catastrophic drug coverage	Recent initiatives to influence the prescribing behaviour of health care professionals
Federal Government	There are six drug benefit plans under federal jurisdiction. • Health Canada (benefits for First Nations and Inuit) • Veterans Affairs (veterans) • National Defense (Canadian Forces members) • RCMP (members) • Citizenship and Immigration Canada (certain designated classes of immigrants) • Correctional Service Canada (inmates of federal prisons and some former inmates on parole) If an individual is covered by one of these plans, there are no deductibles or co-payments and no limitation on coverage for those drugs included on the particular formulary of a given plan.	Representatives of the federal drug plans are participating in the development of the National Pharmaceutical Strategy (NPS). In November 2004, the Auditor General of Canada issued a report on the management of the federal drug benefit plans. Among many recommendations was one that highlighted the need to systematically analyze claims processing databases for high risk patterns of drug use. It was then recommended that the various analyses should be used to: • communicate drug use information, as appropriate, to health care providers, and • provide client-specific, retrospective information on drug use to pharmacists and doctors to assist them in achieving the best possible outcomes. The federal plans agreed with the Auditor General's recommendation and have committed to conducting more systematic analyses and coordinating efforts to identify high risk patterns of drug use and communicate this information to health care professionals as appropriate. As with other jurisdictional drug benefit plans, privacy and security are issues that must be addressed. The federal drug benefit plans will work toward the implementation of electronic health records (EHR) which is a significant component of the NPS commitments of the First Ministers. The availability of valuable EHR patient/pharmaceutical information will greatly assist prescribers in the attainment of best practices in their prescribing behaviors. The federal plans also pursue best practice initiatives through participation with COMPUS (Canadian Optimal Medication Prescribing and Utilization Service). COMPUS among other activities, collects existing information on best practices in drug prescribing and use, such as clinical practice guidelines and systematic reviews. The federal plans participate in the Federal Health Care Partnership involving several federal departments and agencies. A pharmaceutical consultant sits as a representative of the Partnership on the COMPUS Advisory Committee.

B.7 Pharmaceuticals Management – Current Initiatives (continued)

	Catastrophic drug coverage	Recent initiatives to influence the prescribing behaviour of health care professionals
British Columbia	Catastrophic drug coverage (CDC) is an integrated component of the BC Fair PharmaCare program. It protects BC families from spending more than 4% of their annual net income on eligible prescription drugs. As determined by net income, contributions by BC families to prescription drug costs are made until either a deductible level or a family maximum has been reached. After this, Fair PharmaCare enrollees qualify for financial assistance. Fair PharmaCare assists families in paying for their eligible drug costs for the remainder of the year. In addition, British Columbia is working to develop capacity and guidelines for pharmacosurveillance for high-cost new drugs, to monitor their use and effectiveness and ensure better clinical outcomes.	***Academic detailing*** Academic detailing involves the use of trained individuals (usually physicians or clinical pharmacists) who conduct face-to-face visits with physicians and other prescribers to encourage adoption of a desired behaviour (e.g. prescribing of a particular drug or treatment regimen). The BC Community Drug Utilization Program (BC CDUP) is managed by the Pharmacy Department at Lions Gate Hospital in North Vancouver and is funded by the provincial PharmaCare program. It is an internationally recognized academic detailing program aimed at assisting physicians in selecting the most appropriate and cost-effective drug therapy for patients. British Columbia is awaiting an evaluation of CDUP and is collaborating with the University of BC to assess the feasibility of the program's expansion to other areas of the province. Another partnership pilot is underway between the BC Ministry of Health and the University of Victoria that will measure the effect of academic detailing in the treatment of high blood pressure and diabetes. ***e-Therapeutics*** The Ministry has started an initial assessment process. The e-Therapeutics program will be brought to the attention of the Special Physician Engagement Expert Delegate Committee and the eDrug Project Steering Committee for review. Currently PharmaNet provides drug-to-drug interaction checking and patient monographs to pharmacists, emergency rooms and physicians registered with Medical Practice Access to PharmaNet (MPAP). ***Best practices in prescribing*** A senior BC pharmacist with PharmaCare sits on the cross-Canada Advisory Committee for Canadian Optimal Medication Prescribing and Utilization Service (COMPUS), an independent centre for information and education on best practices in drug prescribing and utilization. COMPUS promotes and facilitates the adoption of evidence-based practices, initiatives and interventions while providing implementation strategies, advice and tools.

B.7 Pharmaceuticals Management – Current Initiatives (continued)

	Catastrophic drug coverage	Recent initiatives to influence the prescribing behaviour of health care professionals
		PharmaCare is currently in discussion on strategies for the utilization of COMPUS best practice information and implementation of initiatives in BC. British Columbia rolled out MPAP province-wide in December 2005. MPAP provides physicians with access to PharmaNet, the secure computer network that links community pharmacies and hospitals throughout the province. By allowing health care providers with controlled access to view client medication profiles, British Columbians can be protected from potentially dangerous medication interactions, duplications, prescription fraud, and drug abuse. PharmaNet also permits authorized individuals in hospital emergency departments to access patient medication profiles to assist in determination of patient therapy.
Alberta	Alberta has several categories of drug plan coverage through the Alberta Health Care Insurance Plan. Drugs eligible for coverage are listed on the Alberta Health and Wellness Drug Benefit List. Individuals pay 30% of the cost up to a maximum of $25 for each drug prescribed. For clients of certain programs, no co-payment is required. Alberta Health and Wellness contracts with Alberta Blue Cross to offer supplementary health plans. The Blue Cross Plan providing Non-Group Coverage does not cover benefit expenses exceeding a total of $25,000 per subscriber in a benefit year (July 1- June 30). On an exception basis, this annual maximum may be raised.	The Alberta Drug Utilization Program (ADUP) is the arms-length entity for the Alberta Management Committee on Drug Utilization (AMCDU) that provides educational and quality improvement initiatives for physicians, pharmacists and other health professionals to increase adherence to best practices for optimizing medication use. AMCDU develops and directs drug utilization review and management initiatives that facilitate improvements in the prescription and use of drugs in Alberta. AMCDU members come from various disciplines and sectors and are appointed by the Minister of Health and Wellness. The committee meets 5-6 times per year.
Saskatchewan	Coverage under the Saskatchewan Drug Plan's Special Support Program is designed to help those whose drug costs are high in relation to their income. Based on an application along with drug plan records, the Drug Plan determines the amount of benefit for which the beneficiary is eligible. The family's co-payment is determined by the amount that the family drug costs exceed 3.4% of the adjusted combined family income, where $3,500 is deducted for each dependent under 18 years of age.	Activities to encourage appropriate use of drugs: • The use of Exception Drug Status coverage where drugs are intended for use under certain circumstances only. • Funding support for the Drug Evaluation Services and Roving Professor Program, which assists in the drug review process, provides expert opinions on an ad hoc basis and delivers drug information to promote the optimal use of pharmaceuticals in the province. • Funding support for the Saskatchewan Drug

B.7 Pharmaceuticals Management – Current Initiatives (continued)

	Catastrophic drug coverage	Recent initiatives to influence the prescribing behaviour of health care professionals
	Families with a deductible due to receiving the Guaranteed Income Supplement (GIS), Saskatchewan Income Plan (SIP) or Family Health Benefits (FHB) may be eligible for further benefits under the Special Support Program. Saskatchewan is working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	Information Service, which provides drug information to consumers and professionals (pharmacists, physicians and others) throughout Saskatchewan. • Funding support for the Triplicate Prescription Program operated by the College of Physicians and Surgeons, to monitor the prescription of certain drugs, with the intent to reduce abuse. • A province-wide drug utilization program managed by the Saskatoon Health District as an educational resource to assist physicians in selecting the most appropriate and cost-effective drug therapy for their patients (RxFiles). • The pharmacy-claims processing system, which performs various checks on each prescription that is filled. • The maintenance and use of the Drug Plan database for internal and external drug studies and research. • The use of product assurance agreements with drug manufacturers to monitor the use of a particular drug and ensure that utilization and health outcomes occur as stated in the manufacturer's documentation. • The Trial Prescription Program under which the pharmacist is encouraged to dispense a 7-or 10-day supply for the initial prescription of certain drugs, monitor the effect on the patient, and if the outcomes are positive, dispense the full prescription as directed by the physician. There is no additional cost to the resident for this service.
Manitoba	The comprehensive, tax-financed pharmacare model found in Manitoba limits out-of pocket drug prescription expenditures to a given percentage of income. The pharmacare deductible is based on the annual total adjusted family income: 2.44% for families with incomes equal to or less than $15,000; 3.65% for incomes greater than $15,000 and less than or equal to $40,000; 4.2% for incomes greater than $40,000 and less than or equal to $75,000; and 5.25% for incomes greater than $75,000. Manitoba is participating with other federal/provincial/territorial jurisdictions in developing the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	Manitoba will be analyzing, adapting and disseminating the best practice information developed by the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) once it becomes available.

B.7 Pharmaceuticals Management – Current Initiatives (continued)

	Catastrophic drug coverage	Recent initiatives to influence the prescribing behaviour of health care professionals
Ontario	The Trillium Drug Program (TDP) provides catastrophic drug coverage to all Ontarians who have high out-of-pocket drug costs (approximately 4%) relative to their net household income. Applicants with private insurance must use this first. TDP applicants pay an annual deductible based on their income and number of household members before becoming eligible. They then pay up to $2 per prescription. The annual deductible is paid in quarterly installments over the program year to make it easier for TDP applicants to access drug benefits. Ontario is working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	Ontario is supportive of initiatives such as the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS), which was created to gather and evaluate best practice information and to develop tools to promote optimal prescribing and use. The Emergency Department (ED) Access to Drug History Project has developed and implemented the Drug Profile Viewer System to enable the secure sharing of provincial (Ontario Drug Benefit [ODB]) drug claims information with ED health care providers. Effective October 2005, the Drug Profile Viewer Program became operational and available on a pilot basis to a selected number of hospitals. Full provincial deployment will begin in January 2006, and will be completed by summer 2006. Through electronic access, doctors and nurses can provide more informed patient care in an emergency situation, benefiting patients by: • Allowing quick identification and prevention of harmful drug reactions • Helping doctors and nurses make faster emergency assessments and provide diagnosis and treatment sooner • Making sure a patient's current medications are continued in hospital, if needed • Assisting those who can't communicate or may not remember their medication name and strength • Reducing the need for patients to repeat their drug information to several health care providers involved in their care.
Quebec	Current program information concerning the availability of catastrophic drug coverage was not available for this report. In December 2004, the Quebec government tabled a draft drug policy involving: • accessibility to medication • establishment of a fair and reasonable price for medication • the optimal use of medication • maintenance of a dynamic pharmaceutical industry in Quebec. The intent is to table draft legislation to implement the provisions of the policy that require legislative amendments. Following its adoption, the final version of the drug policy will be published.	In May 2004, at the initiative of the Ministère de la Santé et des Services Sociaux, a symposium on optimal drug use was held with the goal of bringing together all parties involved in the optimal use of drugs to make everyone aware of the problems, to share and exchange ideas and to make it easier to find concrete solutions and foster their application in each of the areas represented.

B.7 Pharmaceuticals Management – Current Initiatives (continued)

	Catastrophic drug coverage	Recent initiatives to influence the prescribing behaviour of health care professionals
New Brunswick	At present, New Brunswick does not provide catastrophic drug coverage. The provincial Health Plan, *Healthy Future*s, committed to establishing a catastrophic drug program from savings realized through the implementation of the other elements of the Plan by 2008. NB is working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	The NB Prescription Drug Program (PDP) identifies and promotes best practices through formulary initiatives. NB participates in COMPUS and will be utilizing their materials.
Nova Scotia	At present, Nova Scotia does not provide catastrophic drug coverage. NS is working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	Since 2001/02, the Nova Scotia Department of Health has provided Dalhousie Continuing Medical Education with a grant to operate an Academic Detailing Service (ADS) for primary care physicians across the province. Nova Scotia's ADS participates in the national Academic Detailing Collaboration with British Columbia, Alberta, Saskatchewan and Manitoba. The Nova Scotia Department of Health has been closely monitoring the progress of the e-Therapeutics initiative since its inception. The Nova Scotia Department of Health is represented on the National e-Therapeutics Network. In 1998/99, the Nova Scotia Department of Health established funding for the Drug Evaluation Alliance of Nova Scotia (DEANS). The mission of DEANS is to contribute to the health of Nova Scotians by encouraging appropriate drug use. DEANS provides Nova Scotia with a single structure under which all of the provincially funded drug program management components can be considered in the context of addressing drug care issues. DEANS is able to develop interventions beyond the standard policy interventions and to coordinate both approaches to maximize impact. To determine the impact of interventions on practitioner behaviour and consumer outcomes, DEANS develops evaluation criteria. Through linkages with academic evaluators, DEANS encourages evaluations that generate new evidence to inform drug policy. Nova Scotia intends to implement e-prescribing as soon as it is legal to do so in Canada

B.7 Pharmaceuticals Management – Current Initiatives (continued)

	Catastrophic drug coverage	Recent initiatives to influence the prescribing behaviour of health care professionals
		and the appropriate secure infrastructure is available. Nova Scotia is now very actively engaged with increasing the use of electronic patient record (EPR) systems within primary health care through its Primary Healthcare Information Management (PHIM) program. The EPR software used in Nova Scotia includes drug interaction functionality that alerts providers to drug–drug and drug–allergy interactions, enabling providers in Nova Scotia to reduce prescribing errors.
Prince Edward Island	At present, PEI does not provide catastrophic drug coverage. PEI is working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	*e-Therapeutics and e-prescribing:* Work on these initiatives is currently being done through the project aimed at expanding the Pharmaceutical Information Program (PhIP) to capture information on all prescriptions filled in PEI (all drugs/all people). PEI is a full participant in the COMPUS (Canadian Optimal Medication Prescribing Utilization Service) system currently being developed and implemented by Canadian Coordinating Office for Health Technology Assessment.
Newfoundland and Labrador	At present, Newfoundland and Labrador does not provide catastrophic drug coverage. NL is working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	NL has developed and implemented a number of initiatives over the years to influence prescribing behaviour: • Some are policy-based initiatives (e.g. restricting drugs to special authorization to ensure adherence to evidence-based prescribing). • Some are educational-based initiatives (e.g. informational inserts in professional association newsletters or direct-to-prescriber mail-outs). • Some have been multi-faceted interventions combining policy and educational objectives through live continuing education events (e.g. the forthcoming launch of a multi-faceted "best practice" initiative regarding the use of certain asthma therapies). Academic detailing has not yet been implemented in this province but is being considered.

B.7 Pharmaceuticals Management – Current Initiatives (continued)

	Catastrophic drug coverage	Recent initiatives to influence the prescribing behaviour of health care professionals
Nunavut	Nunavut's population is almost entirely Inuit, and catastrophic drug coverage is provided under the Non-Insured Health Benefits program. Nunavut is working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy.	Nunavut operates on a territorial formulary, and all physicians are employed by the territory. Approaches to treatment are being developed under "best practices guidelines." There is currently no formal academic detailing. There are no initiatives with respect to e-Therapeutics. Nunavut is currently upgrading its systems capabilities, utilizing specialist consultants, and the literature to optimize approaches to treatment. When complete, the systems and data will allow analysis of pharmaceutical treatment in the territory and adherence to best practice guidelines.
Northwest Territories	Currently, the Government of the Northwest Territories is conducting a review of its Supplementary Health Benefits, including catastrophic drug coverage. Presently two programs offer 100% coverage for eligible clients: Métis Health Benefits (MHB) and Extended Health Benefits (EHB). The Northwest Territories are working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	A new *Pharmacy Act* is currently being drafted. It is anticipated that it will be enacted in 2006. The Act covers licensing/continuing competency of pharmacists and pharmacy practices but not the prescribing practice of other health professionals. The Act will enable the implementation of electronic prescribing if it becomes feasible in the Northwest Territories in the future. The Department of Health and Social Services is also considering prescription monitoring for narcotics as well as options that would address issues around crystal meth (i.e. accessibility).
Yukon	At present, the Yukon government does not provide catastrophic drug coverage. They are working with the other federal/provincial/territorial jurisdictions towards the development of the National Pharmaceutical Strategy. Catastrophic drug coverage is one of the priority elements of this strategy.	There are no academic detailing initiatives at present, but the Yukon is a participant in development of the Canadian Optimal Medication Prescribing and Utilization Services (COMPUS) system and will review opportunities for academic detailing when these "tool kits" are available. The Yukon drug plan is assessing whether the e-Therapeutics program is appropriate for the new Yukon system, which is now in the planning stages. Discussions at the Formulary Working Group meetings, development of appropriate criteria for coverage of formulary drugs, and communication of criteria are some of the steps being taken to promote best practices in prescribing in the Yukon. Topics for future continuing education sessions for physicians have been suggested.

B.8 Wait Times – Recent Investments

	Description of Investments
Federal Government	With the $15 million, Health Canada will pursue a federal role in research, knowledge transfer, facilitation and communications with Canadians. It will engage all players to address this key priority of Canadians. National wait times initiatives will complement ongoing provincial and territorial work on wait times, including investments from their share of the federal $5.5 billion Wait Times Reduction Fund. More specifically, national wait times initiatives will focus on three core activities: advancing wait times commitments; communications with Canadians; and knowledge development, transfer and dissemination.
British Columbia	Since 2003, British Columbia has targeted more than $45 million in additional funding to provide more surgeries and diagnostic procedures. Since 2001, BC has added 8 MRI and 8 CT scanners. In July 2005, the province purchased BC's first publicly funded positron emission tomography (PET) scanner. Additional investment in CT, MRI and PET scanners is planned for the period 2005/06 to 2007/08. Government has also invested funds to increase cataract, hip and knee replacement and heart surgery, radiation therapy and cancer treatment in order to reduce wait lists and wait times, as well as to improve access to kidney disease treatment and guidance and screening mammography for women. More than half of all surgeries are emergent and performed immediately. As a result, fewer than 50% of all surgeries were wait listed in 2004/05. The percentage of patients receiving radiotherapy treatment within 4 weeks of being ready to treat increased from 90.3% in 2003/04 to 95.5% in 2004/05, above the target of 90%.
Alberta	Access to health care across the province will improve as a result of an injection of $1.4 billion in funding approved for 20 capital projects. The announcement means additional bed capacity will be provided in the form of new buildings and renovations and expansion of existing facilities. A total of at least 657 new and upgraded acute care beds and 85 new long-term care beds will be added across the province. (Source: Government of Alberta news release, October 14, 2005) $189 million investment by the Alberta government and Canada Health Infoway will digitize X-rays and CT and MRI scans across the province to improve quality of care for Albertans by providing doctors and patients faster access to reports and images. Alberta Health and Wellness and Canada Health Infoway will contribute a total of $143 million and $46 million respectively to the project. The project will invest in sophisticated new diagnostic imaging systems that will allow hospitals and clinics throughout Alberta to electronically share patient X-rays and CT and MRI scans through Alberta's Electronic Health Record (EHR). (Source: Government of Alberta news release, July 25, 2005) The Government of Alberta has provided $20million to a pilot project that will use and evaluate new care pathways for the treatment of hip and knee replacement patients. The pilot began in Spring 2005 and involves a single assessment intake clinic in each of three cities (Edmonton, Calgary, Red Deer) and the provision of post-surgical health care support.
Saskatchewan	Since January 2004, the number of patients waiting in the 7 largest health regions has decreased from 32,711 to a low of 29,340 in June 2005 (a reduction of more than 3,200 patients). $5.3 million will go to 5 Regional Health Authorities for surgical equipment to increase efficiency. Additional federal funding will help with the purchase of diagnostic equipment. (Source: Sask Health news release, March 10, 2005)

B.8 Wait Times – Recent Investments (continued)

	Description of Investments
Manitoba	Manitoba has a Wait Times Reduction Plan, which specifically addresses cancer treatment, cardiac care, diagnostics and orthopedics. The Plan has 5 components: · Improved information services, including an expanded Health Links and posting of wait lists on the Manitoba Health website, to allow patients to make choices that will reduce their wait times; · Expansion of day surgery and out-patient diagnostics to free up hospital beds; · Investments in new diagnostic equipment, for all regions of the province; · Expanded use of rural diagnostic equipment and operating theatres; and · Stabilizing and renewing the nursing workforce to get nurses to where they are needed.
Ontario	In 2004/05, the Minister allocated $35 million to Ontario hospitals to increase the number of procedures in 5 selected areas. In 2004/05, an additional 1,700 cancer surgeries, 1,680 hip and knee replacements, 2,000 cataract surgeries and 13,000 more MRI hours were performed. For 2005/06, $154 million was provided to provide additional services as follows: · $27 million for 4,800 cancer surgeries · $47 million for 7,000 cardiac procedures · $53 million for 6,700 hip and knee replacements · $12 million for 16,000 cataract surgeries, and · $15 million for 58,500 more MRI exams.
Quebec	Selected 2004-06 results and actions: · Reduction in tertiary cardiac wait lists (of 40.6% for diagnostic catheterization and angioplasty and 35% for heart surgery). · $18.4 million to add 3 cardiac operating rooms at the Montreal Heart Institute, part of a $22 million total investment at that facility. · Wait times over 8 weeks for radio-oncology dropped from 206 patients in March 2003 to 21 patients in September 2005. · $3 million in May 2005 to allow overtime work in radio-oncology centres. · In 2005-06, Quebec will have 50 MRI machines in its public network and 101 CT scan machines. · Between 2002/03 and 2004/05, the number of cataract surgery, knee replacement and hip replacement patients increased by 16.5%, 23% and 9.6% respectively. (Source: Adapted from report on progress made on 2004 bilateral agreement)
New Brunswick	For 2005/06, New Brunswick will invest $4.3 million to reduce wait times, including investments in new medical equipment and personnel and an initial investment in establishing a patient registry and standardized patient assessment processes.
Nova Scotia	Nova Scotia's $18 million fund for 2004/05 was spent the following way: · $2.5 M: oncology · $4.75 M: ortho · $1.4 M: ERs · $683 K: dialysis · $800 K: mental health · $4.9 M: cardiac cath lab, and · $2.94 M: general med/surgery. The Nova Scotia Department of Health is working on a wait times reduction strategy.
Prince Edward Island	Initatives include the following: · Transition Unit staffed by licensed practical nurses · Agreement on priority access to long-term care beds, and · Provincial policy on personal preference to location of long-term care bed. (Source: Adapted from presentation to Taming of the Queue, March 2005)

B.8 Wait Times – Recent Investments (continued)

	Description of Investments
Newfoundland and Labrador	Budget 2005 allocates $23.2 million ($14.2 million one-time and $9 million ongoing) to acquiring new medical equipment and expanding select services, including: • $2.6 million for an MRI in St. John's, delivering 2,500 new exams a year and reducing wait times by 4 months. • $2 million towards replacing 2 CT scanners to deliver 4,000 more exams a year and shorten wait times to 2 weeks. • $1 million for a new and enhanced endoscopy unit, shortening wait times by approximately 40%. • $1.2 million for increasing cardiac surgeries by 184 cases annually and delivery of 900 more echocardiograms each year. • $2.6 million to increase surgical capacity resulting in an additional 340 joint replacements each year. • $3.5 million resulting in an additional 740 cancer surgeries a year and a 30% reduction in wait times. • $350,000 to introduce Visudyne, a new photo dynamic therapy used to treat age-related macular degeneration. • $1.05 million for a CT scanner in Burin. (Source: Adapted from government news release March 21, 2005, *http://www.releases.gov.nl.ca/releases/2005/exec/0704n01.htm*.) Additional activities include determination of current processes used in regions to measure wait times, consultation on common definitions, and hiring a Provincial Wait Time Management Coordinator.
Nunavut	Investments planned and under consideration: • Augment Ultrasound Program to include 2 new portable ultrasound units and 1 new technician position. • Increase capacity in the BHR Specialists Clinic Program for asthma by 3 positions and infrastructure to enable increased services to smaller communities. • Increase capacity of speech language services by 1.5 new positions. • Create an electronic tracking and reporting system for managing wait times.
Northwest Territories	Surgical services in the NWT are provided in large part through the Stanton Territorial Hospital. A review of this facility's operating room services was done. The review focused on streamlining the decision-making process as well as the utilization of resources already dedicated to the operating room system in order to improve overall performance and to reduce wait times. A number of other initiatives are underway. For example, arrangements have been made with the Capital Health Authority to provide regular cancer clinics with visiting oncologists and train nurses in chemotherapy administration to expand the cancer treatment available in Yellowknife for all NWT residents. Although we acknowledge the wait time priorities as outlined in the 2004 10-Year Plan, wait times for rehabilitation services is also an important issue in the NWT. The introduction of a central patient registry is underway.
Yukon	*Cataract surgery:* This procedure is now being done in the Yukon, rather than requiring people to travel out-of-territory. We expect that the current backlog of people will be cleared by end 2006. *Uncomplicated knee replacement surgery:* This procedure is now done locally, providing quicker access and less travel/disruption. Increased visits by *ear, nose and throat specialists* have substantially reduced wait times for consultations and surgeries in this field. Increased visits by a *wider variety of orthopedic sub-specialty specialists* have reduced consultation wait times, thereby reducing wait times from initial referral until treatment occurs.

B.9 Wait Times – Reporting on Wait Times

	Information on Wait Times
British Columbia	*www.healthservices.gov.bc.ca/waitlist* British Columbia maintains a public website with information on 19 specific surgical services. For each procedure, the website shows the hospitals where the service is provided, the number of cases completed in the past 3 months and the number remaining on waiting lists. Within each institution there is a listing of surgeons who provide the care, the number of cases on each of their lists and the median wait times for different levels of urgency. On its website BC highlights its strategy to reduce wait times and reports on progress and initiatives such as the Provincial Surgical Services Project.
Alberta	*www.health.gov.ab.ca/waitlist/WaitListPublicHome.jsp* Alberta Wait List Registry covers 20 surgical and diagnostic specialties. Wait time information is available for individual physicians, institutions and regional health authorities, and describes the 90 days prior to the report date. The site shows the actual wait times, median wait time, the time in which 25%, 50% and 75% of patients are served, the number of patients served and number waiting. For cancer care, wait times are reported from referral to appointment and wait time to start of treatment, compared to targets. Alberta reports significant progress in its efforts to reduce waiting time for hip and knee replacement surgery through the introduction of a new care pathway and also in mental health.
Saskatchewan	*www.sasksurgery.ca* The Saskatchewan Surgical Care Network (SSCN) website reports on 10 surgical specialties. SSCN reports the distribution of actual waits for care across time intervals corresponding to priority levels. The website also reports the percentage of patients completed in a specified time period and the number waiting at the end of the period. This information is provided for each specialty by regional health authority and by major procedure. The website also reports median wait times for surgeries performed and target time frames. Saskatchewan reports increased number of surgeries leading to reductions in the number of patients waiting for surgery. Through its province-wide network it can accurately track and measure surgical wait lists and patients' needs.
Manitoba	*www.gov.mb.ca/health/waitlist/index.html* The Manitoba Wait Time Information Site covers diagnostic imaging tests, cancer treatment and cardiac surgery. For diagnostic imaging, the website shows, by hospital, the average wait time for the most recent month and the number of procedures completed in the most recent year. For radiation therapy and cardiac surgery, the site reports median wait time for cases completed in the most recent quarter and the number of treatments or cases performed in the most recent year. Current data on volume of service and waiting time is provided alongside that from 1998/99.

B.9 Wait Times – Reporting on Wait Times (continued)

	Information on Wait Times
	The Manitoba Wait Time Reduction Plan shows new investment in education of health care professionals, and in major capital investment in hospitals and diagnostic equipment. A government report was planned to meet the December 31, 2005, deadline for public information on wait times.
Ontario	*www.ontariowaittimes.com* The Ontario Wait Times Strategy website presents information on cancer surgery, cardiac procedures, cataract surgery, hip and knee replacement, and MRI and CT scans. The public website reports the number of procedures completed in a specified time period, the median and average wait times as well as the time by which 90% of cases were completed. A restricted-access website presents local level information and listing of hospitals with the lowest median wait time. A report by the Institute for Clinical Evaluative Sciences (*Access to Health Services in Ontario,* April 2005, available at *www.ices.on.ca*) covers access to cancer surgery, cardiac procedures, cataract surgery, total hip and knee replacement and CT and MRI scanning; the report includes wait times for 2001/02–2003/04, service rates per population and analysis thereof.
Quebec	*www.msss.gouv.qc.ca/sujets/listesdattente/* The Quebec website covers wait times in 9 clinical areas and reports, by region and hospital, the total number of patients waiting 3 months or longer for surgery. Quebec has initiated a computerized service access management system (SGAS) to track access within a clinically acceptable periods defined by committees of medical experts.
New Brunswick	New Brunswick government does not provide public information on wait times, as of December 2005. A government report was planned to meet the December 31, 2005, deadline for public information on wait times.
Nova Scotia	*www.gov.ns.ca/health/waittimes/default.htm* The Nova Scotia website provides wait time information for referrals to selected specialists as well as diagnostic and treatment services. The website reports average wait time (cancer and diagnostic imaging) or percentage of patients treated within a specific period of time (30 to 360 days) by facility or by district health authority. On its website Nova Scotia describes a strategy and initiatives to achieve the wait time benchmarks.
Prince Edward Island	*www.gov.pe.ca/news/getrelease.php3?number=4418* PEI does not have a website dedicated to wait time information, but a recent report presents median wait times for the clinical areas identified as priorities in the 2004 health accord.
Newfoundland and Labrador	*www.releases.gov.nl.ca/releases/2005/health/1221n02.htm* On its website, Newfoundland and Labrador has posted a report on how wait times in the province compare to the pan-Canadian benchmarks announced on December 12, 2005.

B.9 Wait Times – Reporting on Wait Times (continued)

	Information on Wait Times
Nunavut	Nunavut does not provide public information on wait times, as of December 2005.
Northwest Territories	NWT does not provide public information on wait times, as of December 2005. A government report was planned to meet the December 31, 2005, deadline for public information on wait times.
Yukon	*www.gov.yk.ca/news/2005/05-327.html* Yukon does not dedicate a website to wait time information. On its website the Government of Yukon reports that it currently provides only 4 of the services for which benchmarks exist and that wait times in these clinical areas are well within the pan-Canadian benchmarks. A government report was planned to meet the December 31, 2005, deadline for public information on wait times.

B.10 Wait Times – Wait Times Standards

The following are a selection of wait time standards, benchmarks or targets (different governments and providers use different terms) with a focus on the five priority clinical areas as identified in the 2004 10-Year Plan as at December 1, 2005.

	Standard/Benchmark/Target	Available at:
British Columbia	The Ministry of Health's service plans (2002–06) and performance agreements with the Provincial Health Services Authority (2003–05) recommend benchmarks and target median wait time for procedures. The results are to be reported in the Annual Report on Health Authority Performance.	Ministry of Health Service Plans *www.bcbudget.gov.bc.ca/annualreports/hs/default.htm* Provincial Health Services Authority Performance Agreements *www.healthservices.gov.bc.ca/socsec/performance.html*
Alberta	The Alberta Cancer Board has a target of 4 weeks from referral to appointment with a radiation oncologist and from oncologist to radiation therapy for breast and prostate cancers.	Alberta Cancer Board website *www.health.gov.ab.ca/waitlist/CancerChemotherapy.jsp*
Saskatchewan	The Saskatchewan Surgical Care Network has set performance goals across 7 categories of urgency for surgical care. For example, priority goals are to perform 95% of cancer surgeries (and other Level II surgeries) within 3 weeks and 100% of all surgical cases within 18 months.	Saskatchewan Surgical Care Network *www.sasksurgery.ca/target_timeframes.htm*
Manitoba	The cardiac program of the Winnipeg Regional Health Authority has adopted the clinical guidelines and benchmarks for medically acceptable wait times from the Cardiac Care Network of Ontario.	Association of Canadian Academic Healthcare Organizations. March 2005. "Wait" Watchers: Weighing In on Wait Time Initiatives Across ACAHO Members. Survey Collation. *www.acaho.org/docs/pdf_2005_wait_watchers_survey_collation.pdf*
Ontario	The Cardiac Care Network of Ontario has established recommended maximum wait times for cardiac catheterization, angioplasty and cardiac surgery based on the seriousness of the patient's condition.	Cardiac Care Network of Ontario *www.ccn.on.ca*
	St Joseph's Health Care has a 2-week maximum wait time target for the diagnosis of breast abnormalities.	Association of Canadian Academic Healthcare Organizations. March 2005. "Wait" Watchers: Weighing In on Wait Time Initiatives Across ACAHO Members. Survey Collation. *www.acaho.org/docs/pdf_2005_wait_watchers_survey_collation.pdf*
	The Toronto Rehabilitation Institute provides stress tests and the commencement of an exercise program 6 to 8 weeks after a cardiac event.	Association of Canadian Academic Healthcare Organizations. March 2005. "Wait" Watchers: Weighing In on Wait Time Initiatives Across ACAHO Members. Survey Collation. *www.acaho.org/docs/pdf_2005_wait_watchers_survey_collation.pdf*

B.10 Wait Times – Wait Times Standards (continued)

The following are a selection of wait time standards, benchmarks or targets (different governments and providers use different terms) with a focus on the five priority clinical areas as identified in the 2004 Ten-Year Plan as at December 1, 2005.

	Standard/Benchmark/Target	Available at:
	The University Health Network reports performance against targets for a number of services such as: joint replacement referral to elective surgery; cataract booking to surgery; medical oncology referral to first available appointment; and radiation medicine referral to consult.	University Health Network *www.uhn.ca/patient/wait_times/index.asp*
	Kingston General Hospital has developed an in-house urgency scoring system and associated target time frames.	Association of Canadian Academic Healthcare Organizations. March 2005. "Wait" Watchers: Weighing In on Wait Time Initiatives Across ACAHO Members. Survey Collation. *www.acaho.org/docs/pdf_2005_wait_watchers_survey_collation.pdf*
Nova Scotia	In early 2004, Nova Scotia established wait time targets for a number of areas, including selected specialty consults, diagnostics, cancer referrals and surgical services. Additionally, the Nova Scotia Cancer Centre has set target wait times for the referrals it receives based on the location of the cancer and other clinical criteria.	Report of the Provincial Wait Time Monitoring Project Steering Committee. January 2004. *www.gov.ns.ca/health/wait_times/full-Wait%20Time.pdf*
Newfoundland and Labrador	The former Health Care Corporation of St Johns' cardiac/cardiovascular surgery program has a policy to complete urgent inpatient cases within 2 weeks.	Association of Canadian Academic Healthcare Organizations. March 2005. "Wait" Watchers: Weighing In on Wait Time Initiatives Across ACAHO Members. Survey Collation. *www.acaho.org/docs/pdf_2005_wait_watchers_survey_collation.pdf*

B.11 Information Management – Electronic Health Record and E-prescribing

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
British Columbia	In 2003/04, British Columbia established an Electronic Health Steering Committee to accelerate the development and implementation of e-Health for the province. British Columbia intends to have a provincial electronic health record (EHR) accessible to all primary care physicians by 2008. Web-based technology will enable access to patient laboratory results, medication history, diagnostic images/reports and the ability to manage specific populations (for example those with chronic disease). To date, approximately 9% of physicians in British Columbia use electronic medical record (EMR) systems within their practice. e-Health projects are moving ahead in all regions of the province. In the north, many physicians working in offices and small medical centres in remote communities can link into the Health Authority's secure, high-speed wireless communications network to connect to	British Columbia is taking steps towards development of an e-Health drug strategy, with discussion well underway. The province has set a target of having 50% of prescriptions submitted and filled electronically within the next 3 years. A project is underway in partnership with Canada Health Infoway to develop the detailed approach and implementation plan for drug components of the electronic health record, including electronic prescribing. The MPAP program, providing physicians with access to PharmaNet, is another step towards implementation of electronic prescribing. MPAP allows physicians to enter sample medications in the patient profile on PharmaNet. Expansion of PharmaNet drugs to include in-patient hospital medication and other drugs dispensed in the community setting and increasing access to PharmaNet is planned within the e-Health Drug Project. Planning is underway	Telehealth in BC includes: *Health education:* Video conferencing is used as a means of providing continuing medical education, for medical rounds, for surgical services meetings and clinical information-sharing and education. *Patient–provider consultation including supervision:* The province currently provides telethoracic surgery, tele-oncology, telepsychiatry, telenephrology, medical genetics, tele-echocardiology, wound care management and various rehabilitation consultations using telehealth services. *Provider–provider consultation:* In British Columbia, most provider-to-provider consultations occur over the telephone. To date, video conferencing technology is not being widely used for this purpose. *Patient visits by family members via video conference:* British Columbia has made video conference technology available to family members who have an ill or injured loved one	Based on the Subsidiary Agreement for Physicians in Rural Practice (RSA) rating system, 125 communities in British Columbia currently meet the minimum point requirements to be considered rural or remote. Telehealth services are available in 28 of those communities. On April 7, 2005, Network BC announced a partnership with TELUS to bring broadband access points to 366 BC communities. The agreement will see 119 of the province's remaining 151 underserved communities connected by the end of 2006. The province will work with other providers to connect the remaining 32 communities in the same time frame. The percentage of British Columbians accessing primary health care services through telehealth continues to grow. To date, approximately 10% of British Columbians use the BC NurseLine service. However, video conferencing services are still not widely used, with less than

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
	a wide range of medical services and support. Fully 95% of the region's doctors are taking advantage of this system. More than 13,000 health care providers, including 1,200 physicians in the Interior, have online access to patient information relating to 700,000 residents anywhere in the region. This cuts down on time they once spent ordering and waiting for patient records, or interviewing patients about their medical history. The EHR will eventually link to other regional systems to provide province-wide access to accurate, up-to-date patient information.	within the e-Health Drug Project to develop an electronic special authority tool for physicians that is integrated into the e-prescribing solution.	recovering in a centre that is not close to the family home. (e.g. pediatric palliative care situations). Additional centres are planning to make similar services available for maternity patients recovering in tertiary care centres. *Radiological and other diagnostic services:* The province has made significant investments in diagnostic imaging systems as one of the key building blocks of the electronic health record. Currently, most health authorities transmit live echocardiogram and ultrasound images for interpretation, and provide store-and-forward transfer of digital images for review and assessment. *Other:* British Columbia has active telehealth services available in many clinical program areas, including: oncology, mental health/ psychiatry, maternal/fetal medicine, medical genetics, orthopedics, pharmacy, thoracic surgery, trauma, wound care, rehabilitation and development, eating	1% of the population accessing and utilizing this technology. British Columbia recently received Canada Health Infoway approval and funding to develop a provincial telehealth strategic plan to ensure those living in rural, remote and under-serviced areas are given a high priority for expanding telehealth services.

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
			disorders/nutrition, neonatology, cardiology, palliative care, physiotherapy, and speech therapy. By 2006, a telehealth video conference scheduling system will help maximize the efficient utilization of personnel and equipment.	
Alberta	The Alberta EHR has been deployed to all 9 health authorities. The total number of individual health providers with access to the Alberta EHR is 10,261.		There are 261 telehealth sites in Alberta. Services include psychiatric counselling, pediatric care, physiotherapy, clinical discharge planning, case conferencing and family visitation.	
Saskatchewan			Educational and clinical.	There are 18 telehealth sites in 16 communities: *Educational:* 5,381 people attended. *Clinical:* 137 sessions with 309 patients seen.
Manitoba	Manitoba is working collaboratively with regional health authorities and other jurisdictions, provincially and federally, towards the development of a provincial electronic health record. The goal is to have an electronic provincial health record that is used by all health care providers. In the absence of a		• *Health education:* yes • *Patient–provider consultation including supervision:* yes • *Provider–provider consultation:* yes • *Patient visits by family members via video conference:* yes • *Radiological and other diagnostic services:* yes, provided through the	Telehealth technology is currently utilized in 20 remote, rural or northern Manitoba communities through the MbTelehealth Network. The proportion of this population that receives primary health services is unknown at this time. MbTelehealth's report for 2004/05 did indicate that clinical activity comprised

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
	provincial electronic health record, some private physician clinics have chosen to proceed and incorporate electronic health records into their practice sites.		provincial diagnostic services program.	68.5% of network activity.
Ontario	The Ontario Electronic Health Record (EHR) is a foundation element of Ontario's e-Health strategy. Ontario's e-Health Strategy is aligned with Canada Health Infoway's blueprint for a pan-Canadian EHR and is consistent with the goal of 50% of Canadians having a shareable EHR by the year 2009. A component of Ontario's e-Health Strategy consists of specific Clinical Management System (CMS) and electronic medical record (EMR) implementation through primary care physician initiatives, as well as specific centralized electronic records like the Electronic Child Health Network (eCHN) anchored at the Hospital for Sick Children in Toronto. Ontario's efforts are not targeted exclusively towards primary care providers.	No new initiatives in the area of electronic prescribing.	In 2004/05 more than 25,000 video conference events were coordinated across the province, 17,000 of which were clinical events. Telehealth clinical application service activity accounts for 75% of telehealth usage. This includes: • the delivery of over 70 clinical subspecialty services (e.g. psychiatry, dermatology, pediatrics, cardiology); and • telestroke, neurology, burn management, internal medicine, oncology, surgery, anesthesia, dietary encounters, physical medicine rehabilitation, geriatrics, pathology. The remaining 25% of service activity consists of education and training, consultations between health professionals, and administrative events.	Northeast • There are 10,000 distinct patients in the northeast. • This is 1.7% of the population of northeastern Ontario. Northwest • There are 5,780 distinct patients in the northwest. • This is 2.4% of the population of northwestern Ontario. While citizens in the north may be more reliant on telehealth services, more than 250 communities across Ontario are designated as rural, underserviced or belonging to First Nations. As of 2004, more than 70 of these remote communities have been linked to major centres via telehealth and receive as much care via this service delivery channel as is available and practical at this point in time.

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
	Current figures indicate that no more than 10% of primary care physicians in Ontario have implemented and are using a full EHR in their practice. Also, the Ontario e-Health Strategy includes the development of key clinical systems for laboratory and drug services that will drive EHR adoption through integration with primary care, continuing care, and hospital information systems. Access to these province-wide clinical repositories and the EHR will be facilitated through implementation of a common infrastructure by the Smart Systems for Health Agency and through development of the Physician Portal in conjunction with a subsidiary of the Ontario Medical Association.		Currently, video conferencing is being rolled out to public health units across the province to play a critical role in preparation, early detection and management of epidemic disease crisis. Satisfaction for telehealth among patients and clinicians is over 90%. Reasons for high satisfaction include decreased travel time and cost, decreased waiting times for services and the ease of use of medical peripherals such as high-resolution cameras, digital stethoscopes and otoscopes. At current volumes, telehealth saves the Northern Health Travel Grant Program more than $3 million per year in travel grant costs.	
New Brunswick	It is intended that the electronic health record system in New Brunswick would be available to physicians working in hospitals or in private practice, as well as to other health professionals working in hospitals or in Community Health Centre or collaborative practice environments.	The Office of e-Health is coordinating New Brunswick's effort to introduce new information management technology, including electronic prescribing.	Services offered via telehealth in New Brunswick include health education, patient–provider consultation and patient visits via video conference. In addition, New Brunswick offers treatment via tele-psychiatry, uses tele-health techniques	All New Brunswickers living in rural and urban areas have access to primary health care services through the Tele-Care telephone triage service.

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
			to triage acute coronary care, and is currently running a pilot program on tele-rehabilitation.	
Nova Scotia	In Nova Scotia, the electronic health record is interpreted as a comprehensive health record that would integrate all the pieces of one's health care across the continuum. This has not yet been achieved in Nova Scotia, which is still in the implementation phase of a hospital-based electronic patient record. In addition, the Nova Scotia Primary Healthcare Information Management (PHIM) program is a voluntary program that will enable all providers across the province to use approved electronic patient record systems. Nova Scotian providers can now access this electronic patient record system that is hosted through a robust, secure data centre. It is estimated that currently 3% of family practitioners access such a system. With the planned implementation of 150 more licences over the next year, access will approach 20%.		*Network focus:* The Nova Scotia Telehealth Network (NSTHN) assists in delivering a wide range of clinical services and educational programs to patients and health care providers, including: • patient-related services (clinical care, patient education, patient visitation) • health professional education sessions (including specialty rounds, continuing medical and nursing education, • Administrative Meetings. *Number of sites:* 46 *Current technology:* ISDN-based network Primary care site is currently being utilized to provide education sessions and administrative meetings from tertiary care facilities to primary health care location. Future plans include delivery of clinical care from the tertiary care facility to the primary health care location. Applications identified include	The NSTHN is a video conferencing communications network providing services to 46 health care–focused facilities in Nova Scotia. The Network has telehealth technologies in tertiary and regional and community hospitals as well as in several community health centres and a youth justice facility.

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
			TeleDermatology and TeleMental Health. The costs and benefits of large-scale implementation of video conferencing capability in primary health care locations will need to be assessed.	
Prince Edward Island	Prince Edward Island has announced it will develop an electronic health record that will allow health care providers in PEI hospitals and family health centres to access a patient's complete health record.			The western region of the province has benefited from a telehealth project involving nurses. Physicians do provide consultation and direction. This area of the province represents 10.5% of PEI's population.
Newfoundland and Labrador	Newfoundland and Labrador is in the process of pilot testing access to records, including use of the electronic medical record by all primary health care providers in a rural and urban project area. A formal evaluation process is being developed to inform the provincial plan.	The Pharmacy Network is one of 3 core clinical components of the EHR. Among other clinical, administrative and financial benefits, this initiative will provide pharmacists, physicians and other authorized health care providers access to complete patient-specific medication profiles. This increased access to appropriate medication information will enhance the quality of care, improve patient safety and facilitate accountability.	• *Health education:* Well established. • *Patient–provider consultation including supervision:* emerging. • *Provider–provider consultation:* emerging. • *Patient visits by family members via video conference:* emerging. • *Radiological and other diagnostic services:* well established. The provincial Telehealth Plan has been recently developed and the implementation plan	Most of the population receives some delivery of their primary health care services through a variety of telehealth systems (e.g. telephone, video conferencing), but it is sporadic and uncoordinated.

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
		The NL Pharmacy Network will be built in stages, eventually linking physicians, pharmacists, hospitals and other authorized health care providers to a virtual private network. *Stage 1:* Establish a provincial clinical database. *Stage 2:* Integrate hospital pharmacy systems with the Pharmacy Network. *Stage 3:* Introduce electronic prescribing and all available functionality to community physician practices. Electronic prescriptions will require legislative changes.	is in the process of being finalized. This will provide a more comprehensive and coordinated direction for provincial telehealth.	
Nunavut	None. Data collected for health insurance purpose only.		• *Clinical activity:* 36% • *Visitation:* 4% • *Education:* 45% • *Administration:* 8% • *Health research or that used by other Government of Nunavut departments:* 7%	Telehealth is available in all 25 communities in Nunavut.

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
Northwest Territories	The Department of Health and Social Services has recently entered into a planning agreement with Canada Health Infoway to assess its readiness for the implementation of an electronic health record system with linkages to the provinces and territories that provide referral care to NWT residents. It is anticipated that a developmental plan will be available in fiscal year 2006/07 and that implementation will start in 2007/08. The Department has also funded an electronic medical records pilot project.	A new *Pharmacy Act* is currently being drafted. It is anticipated that it will be enacted in 2006. The act will enable the implementation of electronic prescribing if it becomes feasible in the NWT in the future.	Telehealth includes consultation services in the following areas: general medicine, orthopedics, internal medicine, nephrology, obstetrics/gynecology, ear/nose/throat, dermatology, ophthalmology, urgent/emergent X-ray, ultrasound, speech therapy, physiotherapy, occupational therapy, dietary, psychiatry, and addictions services. Telehealth is being used to provide diabetes and pre-dialysis education as well as foster family training. Telehealth is also being used for discharge planning, surgeon mentoring, biomedical services and continuing medical education.	0f the 33 NWT communities, nine have Telehealth sites.
Yukon	EHRs are still in the early developmental stage in the Yukon.		*Health education:* • Diabetes education, as well as a few other sessions geared to the client or public. *Patient–provider consultation including supervision:* • for diabetes; mental health; one patient from Edmonton for renal problems; several clients from Edmonton for speech therapy; for follow-up with a few cancer patients; alcohol and drug services to Watson	At this time, telehealth is in a developmental stage in the Yukon, and perhaps 1% of its population receives primary health care services through telehealth.

B.11 Information Management – Electronic Health Record and E-prescribing (continued)

	Primary health care providers who have/will have access to electronic health records	Electronic prescribing	Telehealth services	Proportion of population receiving services through telehealth
			Lake provided from Whitehorse. *Provider–provider consultation:* • mostly for mental health, specifically with Yukon Family Services Association; some for nurse-to-nurse consultations between health centres; and the Child Development Centre uses it to provide assistance to their workers in communities outside Whitehorse. *Patient visits by family members via video conference:* • Very minimal. Telehealth can be used *as a triage tool,* for radiological and other diagnostic services (e.g. where a picture of an x-ray is sent to the emergency department at Whitehorse General Hospital to assist with decision making). *Other:* • Administration requirements, which includes job interviews, meetings, and community consultations.	

C.1 Progress on Council Advice from the 2005 Annual Report

Topic	Advice	Progress
Primary health care	Use common definitions for primary health care.	Some progress – A national awareness campaign has been launched to educate the public on primary health care; however each jurisdiction is still using its own definition and terms to describe local activities.
	Accelerate new delivery models.	Some progress – Provinces and territories are creating interprofessional teams but not as fast as Council had hoped. There has been no change to the Accord goals for primary health care implementation.
	Create a forum for sharing innovative practices.	Progress – Health Canada has established the Primary Health Care Transition Fund Best Practices Network.
	Remove regulatory barriers.	No progress.
	Change education and training models.	Some progress – 11 pilot projects to be completed in 2007.
	Accelerate the introduction of information technology – electronic health records should be 100% in place across the country by 2010.	No progress – Canada Health Infoway goal remains unchanged.
Health human resources	Planning efforts should focus on teams rather than individual health professionals.	Some progress – Jurisdictions are planning on the basis of individual health professions but have recognized the need to shift to team models.
	Provide training opportunities to existing health professionals to learn to work effectively together.	Some progress – Four of the interprofessional education projects contain continuing professional development components.
	Develop non-financial recruitment and retention incentives.	Some progress – Canadian Health Services Research Foundation, Canadian College of Health Service Executives, and Health Canada's Office of Nursing Policy have all focused on the contribution of workplace health for recruitment and retention.
	Plan collaboratively.	Some progress – Pan-Canadian planning framework has been created and both the western and eastern provinces have created regional HHR agencies.

C.1 Progress on Council Advice from the 2005 Annual Report (continued)

Topic	Advice	Progress
Home care	Progress is unknown on a number of items as health ministers are not due to report on progress until December 2006.	
	Treat community mental health home care as part of primary health care programs.	Unknown.
	Discuss extending the two-week time frame.	Unknown.
	Pay attention to chronic home care needs.	Unknown.
	Link home care planning efforts to a health human resource strategy.	Unknown.
	Take advantage of information technology.	Some progress – Telehealth technologies are being used in some rural communities.
Pharmaceuticals management	Progress is unknown on a number of items as health ministers are not due to report on progress until June 2006.	
	Define a minimum standard for drug coverage that applies across the country.	Unknown.
	Establish a process to review and compare the catalogue of drugs covered by drug programs.	Unknown.
	Identify drugs that cost more than $5,000 per person a year and assess current levels of public coverage across public plans.	Unknown.
	Build upon the existing common review process for new products and include existing products.	Progress – Common Drug Review now has responsibility for existing medications.
	Invest in the development of unbiased, evidence-based drug information.	Some progress – Canadian Pharmacists Association e-Therapeutics project is up and running.
Wait times	Ensure a comprehensive approach to protect equity between areas of competing demand for limited health care resources.	Some progress – Five priority areas continue to be the focus of activity, but there is a need to assess waits for non-surgical services.
	Make information publicly available.	Progress – Seven jurisdictions have websites containing wait times information.
	Standardize terms and definitions.	Some progress – Currently there is not a common reporting framework for wait times but jurisdictions have agreed to common benchmarks with reports to begin in 2007.

C.1 Progress on Council Advice from the 2005 Annual Report (continued)

Topic	Advice	Progress
	Evaluate health outcomes.	No progress – Health outcomes are not part of the current work on wait times.
	Enhance capacity where needed.	Progress – Wait Times Reduction Fund has been allocated, providing for more capacity in the system.
Patient safety	Consider mandating electronic prescribing over a reasonable time period.	No progress.
Indicators and public reporting	Health ministers should review their approach to generating comparable health indicator reports to make their reports more useful for the public.	No progress.
	One consolidated report should be published using consistent presentation methods.	No progress.
	Socio-economic variables should be included in the comparable health indicators reports.	No progress.
Healthy living/ health disparities	Broaden the Healthy Living Strategy to move beyond lifestyle issues to focus on health disparities.	Some progress – Reducing health disparities is one of the stated goals of the Strategy. However, the targets that have been released (healthy eating, physical activity and healthy weights) are for the population as a whole, as opposed to specific targets for groups that suffer greater inequality.
	Set specific targets for reducing health disparities and build a health disparity focus into the comparable health indicators process.	No progress.
Aboriginal health	Develop an Aboriginal health workforce. Target education programs at Aboriginal youth to encourage them to consider a health career. Develop health professions training programs that recognize traditional Aboriginal healing practices and are focused on providing services to northern and remote communities. Develop primary health care models to address the broader social determinants of health. Accelerate the use of information technology to improve services in Aboriginal communities.	Progress – The Blueprint for Aboriginal Health addresses all of these recommendations.