REKINDLING REFORM

HEALTH CARE RENEWAL IN CANADA, 2003–2008

JUNE 2008

Health Council of Canada
Conseil canadien de la santé

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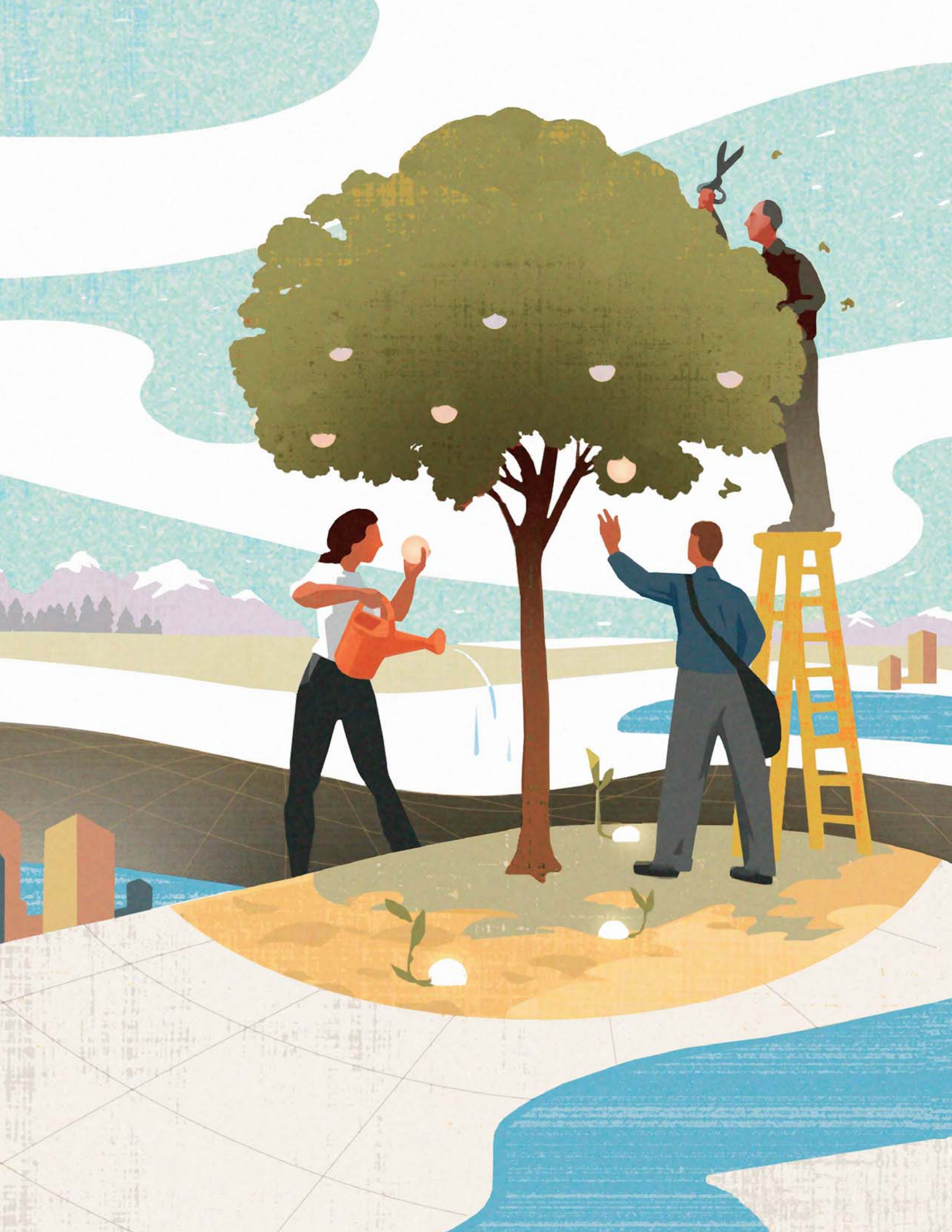
CANADIANS CARE PASSIONATELY ABOUT THEIR HEALTH CARE system and are eager for reforms that will sustain and improve it. In 2003, First Ministers created the 2003 *Accord on Health Care Renewal*, in which they resolved to work together to strengthen the publicly funded health care system. Five years later, we find much to celebrate and yet much that falls short of what could – and should – have been achieved by this time. We remain confident that the public system can deliver more accessible, more equitable, and higher-quality care. And we call on governments to rekindle their commitments to health care renewal across Canada.



FOREWORD

Taking the pulse of health care renewal

Canadians care passionately about their health care system and are eager for reforms that will sustain and improve it.

At the start of the new millennium, federal, provincial, and territorial governments acknowledged that Canadians were increasingly dissatisfied with both the level of access to and the quality of health care. In response, First Ministers created the 2003 *Accord on Health Care Renewal,* in which they resolved to work together to strengthen the publicly funded health care system and ensure its long-term sustainability. They also established the Health Council of Canada to report to Canadians on the progress of health care renewal. In 2004, First Ministers expanded their commitments through the *10-Year Plan to Strengthen Health Care.*

This report reviews the five years of progress under these agreements. We find much to celebrate and yet much that falls short of what could – and should – have been achieved by this time. Overall, we remain confident that the public system can deliver more accessible, more equitable, and higher-quality care. And we believe Canadians will continue to support the changes necessary to make this happen. Therefore, we call on governments to rekindle their commitments to health care renewal across Canada.

At this juncture, the Health Council of Canada also reflected on our first five years and refined how we want to approach our work. New strategic directions, which will guide our activities over the next half decade, focus on helping the country move towards the high-performing health care system that Canadians deserve and expect – a system that is accessible, safe, equitable, patient-centred, efficient, effective, integrated, appropriately resourced, and focused on population health.

OUR FUTURE WORK HAS THREE BROAD GOALS:

- to deepen public understanding of the features of a sustainable and high-performing health care system;
- to support the health care community in its pursuit of high-potential opportunities to achieve a sustainable and high-performing health care system; and
- to monitor and report on the successes achieved and challenges encountered in the pursuit of a sustainable and high-performing health care system.

At the Health Council of Canada, our vision is an informed and healthy Canadian public, confident in the effectiveness, sustainability, and capacity of the public health care system to promote their health and meet their health care needs. We invite you to visit our website, *www.healthcouncilcanada.ca,* to read more about our strategic plan, *Taking the Pulse: Toward Improved Health and Health Care in Canada.*

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INTRODUCTION

Promise and potential

In February 2003, Canada's premiers and prime minister signed the *First Ministers' Accord on Health Care Renewal*. This agreement ushered in major new funding aimed at improving the delivery of publicly funded health care services over the next five years. The money was not intended to simply buy more of the same. First Ministers said they expected the accord would "result in real and lasting change." They agreed "that public health care in Canada requires more money, but that money alone will not fix the system."[1]

On top of governments' routine spending on health care, the accord added $36 billion in new federal dollars. Most of this money would flow through transfers to the provinces and territories, with some direct federal spending for national initiatives. The new funding was earmarked to buy needed reform in these areas:

- primary health care;
- home care;
- catastrophic drug coverage;
- wait times for diagnostic tests and medical procedures;
- electronic health records and other information technology for health care;
- patient safety;
- the supply of health care providers *(health human resources)*, with an emphasis on pan-Canadian planning and interprofessional training;
- the scientific basis for decisions about resources in health care *(technology assessment)*;
- innovation and research;
- public health initiatives, including new immunization programs and the promotion of healthy living *(healthy Canadians)*; and
- Aboriginal health.

Accountability and transparency were themes running through the accord. Collectively, governments announced that they would give Canadians more information about what their health care money buys. They agreed to issue annual public reports on how they spent the special new funds, and to report using similar measures *(comparable indicators)* that would allow people to compare changes across the country and get a nationwide picture of progress. The accord also established the Health Council of Canada to monitor and report annually to Canadians on the progress of health care renewal.

This report looks back at the first five years since the signing of the 2003 accord and the *10-Year Plan to Strengthen Health Care,* which followed a year later.[2] The 10-year plan brought a further $41 billion in federal funding associated with the promised reforms and added an annual 6% increase to the general cash transfers for health care, to run from 2006 to 2014. How far have we come toward realizing the goals committed to in 2003? Do we have more timely access to care and better quality care? Are Canadians more confident that public health care – which they value highly – will be responsive to their needs for generations to come?

In this report, the Health Council uses a nationwide lens to look broadly across the country at major developments. As always, we champion positive change while pointing out where progress is lacking and which barriers need to be addressed. And we shine a light on stories of innovation across Canada that we have told in our videos and earlier reports.

But first, a little history.

Look for "stories of health care renewal" throughout this report, and watch (= video) or read these and other stories on our website at *www.healthcouncilcanada.ca/stories*.

LOOKING BACK

The 2003 accord in context

WHY WAS A PAN-CANADIAN AGREEMENT ON HEALTH care renewal needed? What problems were plaguing the system? Beginning in 2000, Canadians began to name health care as the single most important problem facing the country, overtaking concerns about the economy, which had dominated public opinion surveys throughout the 1990s.[3] People were concerned about the quality of health care and whether it would be there when they needed it. They were frustrated about long wait times for hospital and medical services, the traditional core of publicly funded health care.

These concerns came on the heels of major changes in hospital care. Many hospitals had closed beds, shortened the time people stayed, and increased the number of day surgeries. This required more and more people to turn to home and community services, few of which were covered by governments, nor were they consistently covered province to province. Meanwhile, Aboriginal and northern communities were without some of the basic health and community services that most Canadians had access to.

Public confidence in the system was low, but belief in the importance of fixing it remained high. In 2002, health care was the public's top priority for federal government attention, while support for greater federal spending on health care – even if it meant higher taxes – had been growing steadily over the previous decade.[3]

At the same time, these public concerns were also playing out in debates among health care providers, pundits, and politicians. Experts suggested that there were better ways to deliver health care in Canada, with some advocating a greater role for the private sector and private payments for care. Provincial and territorial governments were adamant that the cupboard was bare and that new federal funding was required to improve the system. They argued that the price of years of federal debt reduction was an underfunded health care system. (Indeed, the federal share of health care funding had flatlined at about 30% throughout the 1990s.) Several provinces commissioned studies for advice on how to address issues related to costs, access, and quality of care.[4, 5, 6] Canadians and their leaders began to coalesce around the need for reform, and the prime minister and premiers laid the groundwork when they met in September 2000.[7]

In April 2001, the federal government asked former Saskatchewan premier Roy Romanow to head a commission to study Canada's health care system. His final report, *Building on Values: The Future of Health Care in Canada*,[8] was released in November 2002. A month earlier, the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby, had published the final report of its examination of the federal role in health and health care.[9] Both reports called for increased federal

1947
Saskatchewan launches Canada's first province-wide universal hospital care plan. Other provinces follow.

1957
Ottawa passes the *Hospital Insurance and Diagnostic Services Act*, funding 50% of costs of certain services covered by provincial and territorial insurance plans.

1958
Provinces and territories sign on to 50/50 cost sharing for hospital and diagnostic services.

1961
All provinces and territories now offer universal, publicly administered coverage for treatment and diagnostic services for patients in hospitals.

Though the funding came with few conditions, the accord set the expectation that governments were moving towards nationwide standards on access, public coverage, and quality of care.

funding, greater accountability by all governments, and strategic reforms to health services that would improve access to and quality of care, and restore public confidence in the system.

Unquestionably, the accord in early 2003 was a response to these developments. Although it didn't go as far as some had advised in imagining a major transformation of health care in Canada, the accord did break ground. Importantly, it represented the first pan-Canadian consensus to extend universal coverage to services (namely, prescription drugs and home care) beyond the insured services described in the *Canada Health Act* and the federal laws preceding it, which have governed medicare since 1957. The accord also turned on the tap to give the provinces and territories some fiscal breathing room so they could begin to address the issues that were making headlines.

The 2003 accord represented an attempt at a new wave of intergovernmental financing of health care in Canada. The agreement expanded the use of money tied to pan-Canadian objectives, a departure from the largely unconditional transfers of cash and tax points that have historically supported the delivery of publicly funded health care services in each province and territory. (These large transfers to the provinces and territories are conditional only on compliance with the *Canada Health Act*.) The accord topped up this customary funding with billions more to support a broad package of reforms agreed to by the federal government and all the provinces and territories.

Some of the new funding was earmarked for specific purposes. For example, the Diagnostic and Medical Equipment Fund (established in 2000 with $1 billion over two years) was given an additional $1.5 billion to help meet the goal of "timely access to diagnostic procedures and treatments." Provinces and territories drew on this fund from 2003 to 2006 to buy equipment for procedures such as magnetic resonance imaging (MRI) and radiation treatment, and to train the staff needed to operate it. Governments were required to report to their residents annually on how they had enhanced their diagnostic and medical equipment.

1962
Saskatchewan creates universal coverage for physicians' services outside of hospitals. Doctors strike for 23 days.

1964
The federal Royal Commission on Health Services recommends a national health care program.

1966
Medical Care Act extends federal 50/50 cost sharing to physicians' services across Canada.

1968
Provinces and territories create medical insurance plans with federal cost sharing.

Other parts of the funding were more loosely linked to reform objectives. For example, the Health Reform Fund ($16 billion over five years) was established to improve 24/7 access to primary health care providers, to protect people from catastrophic drug costs, and to cover short-term home care including community mental health and end-of-life care. Governments could determine how best to achieve these objectives in their own jurisdictions, but they agreed to report publicly each year on these three reform areas, measuring their progress across the country and telling their citizens about current programs and spending.

Though the new federal funding came with few conditions, the accord set the expectation that the federal, provincial, and territorial governments were moving towards nationwide standards on access to care, public coverage, and quality of care. In 2004, a survey showed that Canadians overwhelmingly supported the idea that increased federal funding for health care should come with strings attached, particularly to meet objectives and to monitor how the system is working.[3] Tying federal transfers to specific activities by the provinces and territories may not occur for many reasons, but public opinion certainly calls for it.

The accord met with a generally positive response, echoed by Roy Romanow when he appeared before the House of Commons Standing Committee on Health in April 2003. But Romanow also expressed some concerns:[10]

- He noted an absence of detail about what the new funding was meant to achieve and how Canadians would know if the accord had been effective.
- He was concerned that much of the new funding was scheduled to be transferred towards the end of the term of the accord, which might delay implementation of the reforms.
- He cautioned that the lack of stable and predictable funding transfers would hamper long-term planning and lead to continued federal-provincial disagreements over health care funding.

A year later, First Ministers penned a new agreement, which did bring more and longer-term federal funding for health care reform: $41 billion to be spent over the next 10 years, to 2014. Signed in September 2004, the *10-Year Plan to Strengthen Health Care* also expanded on items in the 2003 accord, notably coverage for home care and prescription

1972
All provinces and territories now provide universal coverage for physicians' services.

1984
The *Canada Health Act* combines the hospital and medical acts, bans user fees and extra billing. Five principles – portability, accessibility, universality, comprehensiveness, and public administration – are enshrined in law.

1987
All provinces and territories comply with *Canada Health Act*.

1994
National Forum on Health begins a three-year public consultation on health care and recommends reforms.

1999
Under the Social Union Framework Agreement, the federal, provincial and territorial governments (except Quebec) pledge a collective approach to developing social policies and programs, including health.

Tying federal transfers for health care to specific activities by the provinces and territories may not occur for many reasons, but public opinion certainly calls for it.

drugs. Still some of the new money was tied to specific activities, particularly to reduce wait times. For the most part, however, the new funds were intended to enlarge the federal transfers for health care over the next decade. The Canada Health Transfer, as this funding is called, was fertilized with an annual "escalator" that began in 2006. The money grows by 6% each year (which is higher than inflation currently) and will continue growing at that rate until 2014.[11]

Meanwhile, other significant events reminded the country that health care is part of ever-changing environmental, social, and political landscapes. For example:

- SARS hit Canada within weeks following the 2003 accord. The outbreak challenged local and national health care systems and revealed weaknesses in their ability to mount a coordinated response to a public health emergency. The creation of the Public Health Agency of Canada was one result of this international event.
- The Chaoulli decision by the Supreme Court of Canada in June 2005, which supported a person's right to purchase private insurance to access a needed health care procedure,[12] fuelled public debate on the usefulness of wait time guarantees and the role that private-for-profit health care delivery should play in Canada. The Quebec government responded with reforms that included the first type of patient wait-time guarantee in Canada.[13] Subsequently, the federal Conservative Party formed a minority government in 2006 with a promise to implement wait time guarantees.

At all levels of government, health portfolios have changed hands and policy priorities have shifted. With improved economic performance, governments have generally been less focused on deficits than they were five years ago. Climate change, security, and the economy, for example, have eclipsed health reform in the minds of many Canadian politicians. Yet health care continues to be a high priority for Canadians – second only to the environment – with wait times and doctor shortages topping the list of public concerns.[14]

In 2003, 93% of Canadians (of 2,000 polled) felt that five years was a reasonable time in which to see substantial results from the pan-Canadian accord on health care renewal.[3] Five years later, would they say that their expectations have been met? Have the promises been translated into "real and lasting change"?

2000
First Ministers' Communiqué on Health increases federal cash for health, sets out key reforms in primary health care, drugs, information technology, and equipment.

2001
Public consultations on health care are underway or recently completed in BC, AB, SK, MB, ON, QC, NB, and NWT, along with the federally-sponsored Kirby and Romanow studies.

2003
First Ministers' Accord on Health Care Renewal commits governments to structural change in health care to support access, quality, and long-term sustainability.

2004
A 10-Year Plan to Strengthen Health Care expands funding, fleshes out some aspects of the 2003 accord.


08
03

A CLOSER LOOK: HOW FAR HAVE WE COME?

TIMELY AND EQUITABLE ACCESS TO HEALTH CARE, A HIGHER quality of care, a solid future for the public system, a healthier population, and more accountability for where the money goes and what it achieves – these were the broad objectives of the 2003 *First Ministers' Accord on Health Care Renewal.* In this section, we look at each element of the accord, assessing the pace and direction of reform. We also highlight some points of progress, as well as stories of innovation featured in reports and videos by the Health Council of Canada over the past five years.

ACCESS TO CARE

For some time, Canadians have been asking for better access to health care providers and services. In response, First Ministers made improved access a top priority in the 2003 accord and agreed to measure their progress on this front using a set of performance indicators. For example, what portion of Canadians have access to a multidisciplinary primary health care team, or to public coverage of a core set of home care services? How long do Canadians wait for diagnostic tests like MRIs and CT scans, or to see a specialist?

FIRST MINISTERS AGREED THAT:

"This Accord [is] a covenant which will help to ensure that all Canadians have timely access to health services on the basis of need, not ability to pay, regardless of where they live or move in Canada."

Stories of health care renewal

Cataract surgery in Ontario: a vision for change

Hip and knee surgery in BC: connecting the health care dots

Cardiac care in Ontario: back to the future

Getting a grip on waiting lists, patient by patient

Ensuring the sustainability of improved service (hip and knee surgery in Alberta)

www.healthcouncilcanada.ca/stories

= video

In the fall of 2004, the federal, provincial and territorial governments agreed on a set of 18 measures *(comparable indicators)* that they would use to report to Canadians on their progress in improving access to care, along with other aspects of health care renewal. These indicators are not being used as the accord envisioned, and governments have not shared information about their progress in any meaningful way. In fact, there are no nationwide information systems in Canada that can be used to measure progress in improving access to primary health care, prescription medicines, and home care.

However, some national and provincial data are available on improvements in access to certain health care services, such as care delivered in hospitals. More surgeries and diagnostic procedures are being performed[15] and some provinces have reported substantial reductions in wait times for the priority services identified in the accord: cancer care, cardiac surgery, hip and knee replacement, cataract surgery, and diagnostic imaging.[16]

With new funding, hospitals have installed additional diagnostic, clinical, and other kinds of equipment. To make the best use of this equipment, provinces and territories have implemented new ways of managing wait times and new ways of organizing care so that more services can be provided more quickly.[16]

There has been some additional experimentation with private clinics across the country, particularly for diagnostic services. For the most part, these developments have not been encouraged either by governments or the public.

Access to other aspects of care – family physicians, primary health care teams, home care services, and catastrophic drug coverage – has not progressed to the same degree. Some jurisdictions have made strides, but significant gaps still exist across the country. Strategies known to help providers care for patients more efficiently and effectively (improved scheduling systems, for example) need to be implemented more widely across Canada.[17]

SOME HIGHLIGHTS OF PROGRESS IN ACCESS TO CARE:

↗ Among other things, the *10-Year Plan to Strengthen Health Care* of 2004 elevated the priority of wait times by creating the $5.5-billion Wait Times Reduction Fund.

↗ Governments promised – and have delivered on the promise – to establish evidence-based benchmarks for medically acceptable wait times in four of five priority clinical areas identified in the 2003 accord: cancer care, cardiac surgery, hip and knee replacement, and cataract surgery. Establishing multi-year targets to achieve these benchmarks was also on the to-do list for December 2007, but this deadline passed with only a few provinces setting timetables to achieve some of the wait time benchmarks.

FIRST MINISTERS AGREED THAT:

"The ultimate goal of primary health care is to provide all Canadians, wherever they live, with access to an appropriate health care provider, 24 hours a day, 7 days a week. Towards this goal, First Ministers agree to immediately accelerate primary health care initiatives and to make significant annual progress so that citizens routinely receive needed care from multi-disciplinary primary health care organizations or teams. First Ministers agree to the goal of ensuring that at least 50% of their residents have access to an appropriate health care provider, 24 hours a day, 7 days a week, as soon as possible and that this target be fully met within 8 years."

Stories of health care renewal

Changing doctors' schedules makes a difference

Collaboratives improve health outcomes

London clinic translates diabetes care for immigrants

Paving the way through teamwork (managing chronic disease in Twillingate, Newfoundland)

Collaborating for change in primary health care

Putting patients at the centre of care (Group Health Centre in Sault Ste. Marie)

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↗ Committed to providing round-the-clock access to a health care provider for at least 50% of their citizens, most jurisdictions accomplished this by 2006 using a combination of after-hours service in physicians' offices, emergency departments, and 24/7 telephone lines where health care professionals offer health information and advice.[17]

↗ Recognizing some of the urgent needs of Aboriginal populations, the federal government announced a series of pilot projects in 2007 to establish patient wait time guarantees in the delivery of prenatal and diabetes care in First Nations communities.

↗ Other patient wait time guarantee projects are focusing on children's surgery and one priority clinical area (such as heart surgery or cancer care) in each province and territory.[18] The Health Council's June 2007 report *Wading through Wait Times: What Do Meaningful Reductions and Guarantees Mean?* provides summary information on the provincial and territorial projects that shared in $612 million set aside for this purpose in the March 2007 federal budget.

Primary health care

Traditionally, family doctors have delivered most of the primary care in Canada, but a key strategy in primary health care renewal is to expand the use of interprofessional teams to deliver care. Teams can include a range of health care professionals who work together, either in the same location or across several locations. It is believed that team-based care will reduce wait times for appointments, strengthen providers' ability to focus on prevention, coordinate care among different providers, and help patients better manage chronic health conditions. Evidence of the positive impact of this approach is beginning to surface, suggesting that many of these outcomes are indeed attributable to this type of care.[19]

But Canada is a long way from having a system where patients routinely receive coordinated and comprehensive care from interprofessional teams. In the Health Council's 2007 survey, 30% of Canadians reported that a nurse works with their family doctor and is regularly involved in their care, and fewer than one in five (17%) said that other types of providers worked in the same place as their doctor (although these data don't include care by off-site team members who work together but not in one location).[17]

In addition, timely access to primary health care continues to be a problem for too many Canadians. Although most Canadians (96%) report having a regular doctor or place where they receive care, one in four people who needed care said they had difficulty getting it for a minor health problem (24%) or for routine care (26%).[17] By far, Canada appears to have the worst access to primary care among seven countries recently studied. Only 36% of Canadians could get a same-day or next-day appointment with a doctor when they last needed care (compared to 58% in the UK and 75% in New Zealand), and 30% waited six days or more for an appointment (12% in the UK, 4% in New Zealand).[20]

FIRST MINISTERS AGREED THAT:

"Improving access to a basket of services in the home and community will improve the quality of life of many Canadians by allowing them to stay in their home or recover at home."

Stories of health care renewal

Primary health care and home care – a new partnership

Remote monitoring a success in New Brunswick

Technology overcomes geography (telemedicine in Ontario)

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Primary health care was to be a cornerstone of health care renewal. What went wrong? While the 2003 accord and the Primary Health Care Transition Fund (established in 2000) represented a common commitment to reform primary health care, most jurisdictions used the funds to implement small initiatives rather than invest in long-term, sustainable change. Adopting team-based care continues to be a challenge for a number of reasons, including misgivings and misconceptions among the different professions about one another's roles and responsibilities in a team environment.[21]

SOME HIGHLIGHTS OF PROGRESS IN PRIMARY HEALTH CARE:

↗ The $800-million Primary Health Care Transition Fund was intended to support the transitional costs of implementing sustainable, large-scale initiatives to reform the delivery of primary health care over a six-year period (2000–2006). This federal funding went to individual provinces and territories as well as to various collaborative and national efforts to support common objectives of renewal.[22]

↗ As promised in the 2004 *10-Year Plan to Strengthen Health Care,* governments created the Best Practices Network to help health care providers and managers share information and solve problems in their efforts to reform primary health care. However, after conducting a series of activities in 2005 and 2006, the network has dissolved due to a lack of targeted funding to sustain its existence.

↗ To promote the benefits of inter-professional team-based care, governments and health care organizations collaborated on the National Primary Health Care Awareness Strategy, a seven-month $9.5-million advertising campaign, in 2005 – 2006.[23]

Home care

In the 2003 accord, First Ministers agreed to determine a minimum set, or basket, of services that all jurisdictions would cover to provide short-term home care, including community mental health services and end-of-life care, for patients who meet specific criteria. They stated that public coverage for these services would be available by 2006. The federal government agreed to establish compassionate care benefits and job protection for Canadians who need to leave their jobs temporarily to care for a dying family member.

Despite strong public support for home care and numerous studies that conclude that it can be cost-effective,[24] progress in ensuring access to broad, equitable home care services has been slow and piecemeal. Some jurisdictions have expanded the range of services covered and have made publicly funded home care easier to access.[17] But overall, home care is not the integral part of health care that Canadians deserve and expect – a well-coordinated system of services that provides people with continuing care when they need it, ultimately contributing to the best possible quality of life.

Governments have been reluctant to commit to a comprehensive, publicly funded home care program, even though the need for these services has grown as the population ages and as hospitals discharge patients earlier than in the past. As a result, there has been a proliferation of private agencies – with some services being

FIRST MINISTERS AGREED THAT:

"No Canadian should suffer undue financial hardship for needed drug therapy…First Ministers will take measures, by the end of 2005/06, to ensure that Canadians, wherever they live, have reasonable access to catastrophic drug coverage."

covered by public insurance plans and others that Canadians must pay for privately – and a substantial amount of unmet need. In a 2005 Statistics Canada survey, 2–5% of Canadian adults (depending on where they live) reported using home care services not funded by government, slightly more than those who used government-funded services. Among Canadians 65 years and older (the group most likely to use government-funded services), 3–4% said they had needed home care services in the past year but had not received them.[17]

The federal government created the Compassionate Care Benefits program in 2004 and, in response to concerns raised by the Health Council and others,[25] two years later expanded the range of eligible caregivers to include more family members as well as close friends. We continue to question why many Canadians are not taking advantage of the short-term income support available, and suggest it may be because they are not aware of the program.

SOME HIGHLIGHTS OF PROGRESS IN HOME CARE:

↗ In 2004, First Ministers defined the basket of services for publicly funded home care as two weeks of care after discharge from hospital, two weeks of home care services for mental health needs, and end-of-life care.

↗ In January 2007, provincial and territorial health ministers reported that they had taken steps toward fulfilling their commitments on home care, but no specifics were provided.

↗ The Canadian Institute for Health Information (CIHI) built a Home Care Reporting System with input from several provinces and territories and wrote about the challenges of nationwide reporting.[26] In February 2007, Yukon fully submitted its home care data to CIHI, the first jurisdiction to do so. When more jurisdictions participate, this new database will give us better information about who is using publicly funded home care and what services they receive, helping to fill in the picture of the state of home care across Canada.

Catastrophic drug coverage and pharmaceuticals management

In Canada, we collectively spend more on prescription medicines than we do on doctors. But in contrast to physician and hospital services, we must pay privately for most drugs (through private insurance plans and out-of-pocket spending). In a 2007 survey of seven countries, 6% of Canadians reported spending more than $1,000 (US) in the past year out-of-pocket on prescription drugs. We were second only to the US (13%), and much higher than other countries (e.g. UK at 1%).[27] About one in 12 Canadians (8%) said they had not filled a prescription or had missed a dose of medicine in the previous year because of cost.[20]

FIRST MINISTERS AGREED:

"To further collaborate to promote optimal drug use, best practices in drug prescription and better manage the costs of drugs including generic drugs, to ensure drugs are safe, effective and accessible in a timely and cost-effective fashion."

The 2003 accord promised to ensure that all Canadians would have reasonable access to *catastrophic drug coverage,* public drug insurance to prevent financial hardship. Some provinces have enhanced coverage for people who have low incomes and/or high drug costs, but we have not seen the nation-wide action to establish catastrophic drug protection that the accord promised by March 2006. Instead, governments created a task force to make a plan and report in 2006. The report recognized the need for action and presented cost options, but did not present a plan.[28] Progress on catastrophic drug coverage has stalled. Meanwhile, the current patchwork of government drug plans leaves millions of Canadians with little or no protection against financial hardship due to the cost of needed medicines.

Fortunately, not all areas have experienced such gridlock. Governments' promise in 2003 to collaborate on action to improve the way prescription medicines are managed, prescribed, and used, for example, has seen some progress. The Common Drug Review (CDR) is gradually expanding the range of drugs it assesses. The CDR is a centralized service that reviews research on drug effectiveness to help all of Canada's drug benefit programs decide which new medicines they will cover.

A parliamentary review of the CDR in 2007 praised its "valuable service to the Canadian public" but noted the need for improvements. Among other things, the review recommended steps to increase public involvement and transparency in the CDR's work.[29]

However, Canadians still do not have a common formulary – a list of drugs that all government drug plans cover. Nor has there been adequate progress on ensuring that medicines prescribed are safe and appropriate, an issue explored in the Health Council's symposium "Safe and Sound: Optimizing Prescribing Behaviours" in 2007.[30] Too many Canadians are not prescribed medicines they could benefit from, receive inappropriate prescriptions, or do not use prescribed medicines correctly.[31]

Overall, the consensus among governments on the need for a National Pharmaceuticals Strategy (a commitment in the 2004 10-year plan) appears to be eroding, yet the issues that gave rise to the idea remain. The Health Council will report in 2008 on the progress of this strategy.

SOME HIGHLIGHTS OF PROGRESS IN CATASTROPHIC DRUG COVERAGE AND PHARMACEUTICALS MANAGEMENT:

↗ 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, consisting of nine elements, and to report on its progress by June 30, 2006. The task force released its report in September 2006.[28]

↗ The Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) was launched in 2004. In partnership with all ministries of health, COMPUS supports safe and appropriate prescribing and use of medicines through information for health care providers and consumers.

FIRST MINISTERS AGREED THAT:

"Enhancing the availability of publicly funded diagnostic care and treatment services is critical to reducing waiting times and ensuring the quality of our health care system. To this end, First Ministers agree to make significant new investments, including support for specialized staff training and equipment, which improve access to publicly funded diagnostic services."

Stories of health care renewal

Cancer care in Nova Scotia: wait times are one piece in the continuum of care

Diagnostic imaging in Saskatchewan: learning from success in surgery

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↗In 2005, health ministers agreed to: (1) expand the CDR to include all drugs and work towards a common national formulary, which will lead to more consistent access to drugs across the country; (2) expand the role of the Patented Medicine Prices Review Board, an independent tribunal that sets prices for all patented medicines sold in Canada (both prescribed and over-the-counter) to ensure they are not excessive; and (3) work together to collect, integrate, and disseminate information on the real-world risks and benefits of drugs.[32]

↗Health officials sponsored a working conference in 2005, "Strengthening the Evaluation of Real World Drug Safety Effectiveness," as part of the development of the National Pharmaceuticals Strategy. The conference focused on how to achieve better health outcomes and fewer adverse events related to prescription medicines.[33]

↗In April 2008, the federal government introduced Bill C-51 to amend the *Food and Drug Act*. The proposed changes would, among other things, require more rigorous monitoring of prescription drugs after they have entered the market, including better reporting of harmful drug reactions.

Diagnostic and medical equipment

One of the problems behind Canada's wait time challenges in the 1990s was a shortage of equipment and skilled people to operate it. With the help of federal funding, all provinces and territories have increased their spending to purchase more diagnostic and medical equipment and to hire associated staff. However, shortages of skilled technicians to operate the more advanced equipment continue to be reported.

The accord called for annual reporting by all governments on how the new funds were spent and what impact they had on services and patient outcomes, but reporting has been sporadic and inconsistent.

Provincial health care systems have also tackled wait times by looking at better ways of managing the queues for costly equipment like MRI technology. This approach recognizes that the solution lies not simply in buying more but also in using the technology appropriately and efficiently.[16] For example, it has been argued that reducing unnecessary use of diagnostic equipment has the potential to contribute to shorter wait times, not only for these services but also for other steps in the patient's journey that may be delayed until test results are available.[34]

SOME HIGHLIGHTS OF PROGRESS IN DIAGNOSTIC AND MEDICAL EQUIPMENT:

↗To help the provinces and territories purchase diagnostic and medical equipment and train specialized staff, the federal government provided $1.5 billion for 2003–2006 through the Diagnostic and Medical Equipment Fund.

↗In December 2006, CIHI provided an update on medical imaging in Canada. It revealed that although the distribution and use of MRI and CT scanners varies across the country, the number of these scanners in Canada has grown steadily since 1990.[35]

QUALITY OF CARE

Quality in health care means doing the right thing at the right time for the right person. Collecting and using data on quality of care is important to show health care providers and managers what is working well and what is not. Is care patient-centred and effective? Is it safe? Does care match expert-recommended guidelines? Does care help to prevent avoidable health problems? Is care coordinated and efficient? These are important quality-of-care questions, but – with our current information systems – the answers are difficult to find.

FIRST MINISTERS AGREED THAT:

"This Accord [is] a covenant which will help to ensure that the health care services available to Canadians are of high quality, effective, patient-centred and safe."

Stories of health care renewal

US veterans' health agency transforms care, sees results

Critical care teamwork in rural BC

University Health Network streamlines care with electronic patient records

Improving quality and efficiency through technology (BC's PharmaNet)

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In public surveys, Canadians tend to be satisfied with their own interactions with the health care system but express concern about the overall quality of care. In general, public confidence in the system is not high.[3, 36] With better data on quality of care, Canadians would have more reliable information about the strengths and weaknesses of their health care system.

Extensive public reporting on the quality of care was promised in the 2003 accord, but the Canadian system is a long way from achieving this goal. The accord says that performance indicators should include the number of reported medical errors and adverse events, the degree of patient satisfaction with health care services, and health outcomes for selected conditions. Today, we have only limited data and scant public reporting on the quality of health care services in Canada.

The Health Council's work on quality of care has focused on chronic health conditions and illustrates how improvements in the current quality of care can improve patients' health and result in more effective use of health care resources. We found, for example, that when Canadians with diabetes receive the regular tests and preventive procedures recommended by experts, patients are less likely to use emergency departments and stay overnight in hospital. Patients receive more appropriate care and experience fewer health emergencies, and the system saves money.[37]

A number of quality improvement projects are underway across Canada, but much remains to be done. Better information tools (to track the impact of changes in practice), a stronger focus on patient safety, and a renewed commitment to public reporting are important building blocks to improve quality of care.

SOME HIGHLIGHTS OF PROGRESS IN QUALITY OF CARE:

↗ The Canadian Patient Safety Institute (CPSI) was established in December 2003, with a national mandate to build and advance a safer health care system. As one of its first initiatives, CPSI sponsored a national voluntary campaign called "Safer HealthCare Now!" that promotes a series of evidence-based interventions to improve safety in participating health care organizations.

↗ Five provinces have created health councils (Saskatchewan, Ontario, Alberta, Quebec, and New Brunswick) with mandates to support and/or monitor quality improvements in health care.

↗ CIHI has played an important role in developing methods to compare quality of care across Canada using data about care in hospitals. One of its recent reports discusses trends in death rates following hospital admission for strokes and heart attacks (30-day in-hospital mortality rates).[38]

Information technology and electronic health records

Electronic information in health care is an essential transformative tool. Information technology – systems such as telehealth, electronic health records, electronic prescribing, and wait-list management systems – offers tremendous opportunity to advance the quality of care in many ways.

Information technology can prompt health care providers to consider guidelines for care that may get missed otherwise. It can speed the delivery of diagnostic images across a city or across the country. It can give patients access to health care expertise through long-distance consultations. It can reduce errors, improve the coordination of care, and manage wait times by

FIRST MINISTERS AGREED THAT:

"Improving the accessibility and quality of information is critical to quality care, patient safety and sustainability…[and] better utilization of resources. First Ministers agree to place priority on the implementation of electronic health records and the further development of telehealth applications, which are critical to care in rural and remote areas."

Stories of health care renewal

Improved safety through online prescribing (long-term care in Toronto)

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ensuring that the right people are in the right queue for care they truly need. Yet, while information technology has transformed banking, travel, and many other aspects of our daily lives, it has yet to convert the paper-laden world of health care in Canada.

Change is underway, but too slowly. Through funding and expertise from Canada Health Infoway, each province and territory is investing at its own pace. We are still a long way from the promised goal of a national system of electronic health records. Clearly, Canada is not moving aggressively enough to realize the potential of information technology. These are big investments but the payoff is big too.

SOME HIGHLIGHTS OF PROGRESS IN INFORMATION TECHNOLOGY AND ELECTRONIC HEALTH RECORDS:

↗ The 2004 *10-Year Plan to Strengthen Health Care* promised to accelerate the development of electronic health records, as well as e-prescribing and telehealth.

↗ Canada Health Infoway, the agency charged in 2001 with leading the electronic revolution in health care, has invested in nearly 250 electronic health record projects across Canada, as well as projects to develop electronic systems for diagnostic imaging, drug and laboratory information, public health surveillance, and telehealth.

↗ In addition to cost-sharing projects sponsored by Infoway, the provinces and territories have invested significantly in their health information technology and management systems.

↗ As of March 2008, 7% of Canadians have an electronic health record, 64% of all diagnostic images taken in hospitals and clinics are digital, 30% of published lab test results are available electronically to health care providers, and 24% of Canadians now benefit from drug information systems that provide their physicians and pharmacists with a personal medication profile.[39]

Patient safety

Canada's health care providers deliver safe and appropriate care every day, but mistakes happen. The 2003 accord recognized the mounting evidence that these *adverse events,* as they are formally called, can and should be prevented. The promotion of patient safety is still a relatively new but welcomed phenomenon in the Canadian health system, and the creation of the Canadian Patient Safety Institute (as recommended by the 2002 National Steering Committee on Patient Safety[40]) to lead these efforts was an important step forward.

Because information about adverse events is not collected and evaluated in a coordinated fashion, it is difficult to determine whether real progress is being made. Canada needs a mandatory system for reporting all defined adverse events.

Accreditation – a review by an independent agency that assesses the quality of health care facilities and recommends ways to improve their practices – is an established but voluntary process across Canada (and mandatory only in Quebec). Some facilities and regional health authorities make their accreditation reports public, while others do not. The Health Council of Canada has said that accreditation should be a mandatory condition of public funding and that institutions should make their accreditation reports

FIRST MINISTERS AGREED THAT:

"The implementation of a national strategy for improving patient safety is critical. Health ministers will take leadership in implementing the recommendations of the National Steering Committee on Patient Safety."

"Applied research and knowledge transfer are essential to improving access and the quality of care."

public.[41] This important measure would help health care institutions become more accountable to the public they serve.

When patients are harmed and need compensation, the only option currently available to them in Canada is to sue their health care provider. Litigation may satisfy the compensation aspect of an inquiry into the situation, but it focuses on finding fault, rather than learning from mistakes. It inhibits health care providers from disclosing problems and creates an adversarial relationship between provider and patient. Alternative systems – such as no-fault compensation, in which injured patients can receive compensation without suing – have been successful in other countries. The Health Council continues to urge governments to take a fresh look at whether no-fault compensation would help to support the development of a culture of safety in Canadian health care.[42]

SOME HIGHLIGHTS OF PROGRESS IN PATIENT SAFETY:

↗ Among other activities, CPSI developed a Patient Safety Officer Course in 2007 to teach health care professionals how to build vigorous patient safety programs into their organizations.

↗ CPSI, Saskatchewan Health, and the Institute for Safe Medication Practices Canada developed a Canadian tool ("the Canadian root cause analysis framework") to help identify and address the root causes of critical incidents in health care.

↗ Some provinces and territories have enacted or are considering legislation to require reporting of adverse events in health care.

↗ Accreditation Canada (formerly the Canadian Council on Health Services Accreditation) has integrated patient safety goals into its standards for assessing health care facilities.

↗ In 2008, CIHI released its first report comparing rates of in-patient deaths for many hospitals across Canada (hospital standardized mortality ratios).[43] CIHI will regularly update these public reports so that hospitals can use them to monitor the safety of the care they provide.

↗ Also in 2008, CPSI released guidelines for health care providers on talking to patients about medical errors that occur during their care.[44]

Innovation and research

Canadian governments invest billions of dollars each year in health research, fuelling world-class discoveries that have the potential to improve health and health care. The ongoing challenge for health care decision-makers is to be willing to implement and innovate based on the results of research. In Canada, we have considerable knowledge about how to renew health care, but we lack focus on putting that knowledge into action, particularly at the system level.

SOME HIGHLIGHTS OF PROGRESS IN INNOVATION AND RESEARCH:

↗ To facilitate the adoption and evaluation of new models of health protection and chronic disease management, the federal government committed – in the 2004 *10-Year Plan to Strengthen Health Care* – to continue investing in science, technology, and research.

FIRST MINISTERS AGREED THAT:

"Canadians are entitled to better and more fully comparable information on the timeliness and quality of health care services. Enhanced accountability to Canadians and improved performance reporting are essential to reassuring Canadians that reforms are occurring."

↗ The Canadian Institutes of Health Research, established in 2000 as the major federal granting agency, funds research through its 13 institutes and assists scientists and decision-makers to translate knowledge from research into changes in policy and practice in health care.

Reporting to Canadians on change

Governments agreed in 2003 to develop the necessary data systems so that they could report regularly to their citizens about the progress being made on the accord commitments, and so that Canadians could see how changes in one part of the country compare with changes elsewhere. The accord also established the Health Council of Canada to monitor the progress of health care renewal nationwide and report its findings to the public.

A great deal of reporting on the state of health care in Canada has been produced by all governments and numerous organizations in the past five years. Data systems have been expanded and refined. Yet, these efforts have not led definitively to the "enhanced accountability" and "improved performance reporting" that the accord promised. Too much of current reporting takes place in isolation, and most governments do not use or report the standardized data to which they committed. To the detriment of greater information sharing among all governments, a federal/provincial/territorial group that the accord identified as a partner for the Health Council of Canada – the Advisory Committee on Governance and Accountability – has been disbanded.

Without more standardized and collaborative reporting by all governments, Canadians cannot be confident that the new money and new practices intended to improve health care are making a difference.

SOME HIGHLIGHTS OF PROGRESS IN REPORTING TO CANADIANS ON CHANGE:

↗ The Health Council of Canada was created in 2003, with participation by all governments except Alberta and Quebec. (See page 40 for a list of the Health Council's reports.)

↗ The federal, provincial, and territorial governments have each released two reports (in 2002 and 2004) using a set of comparable indicators that all governments agreed to report on. These accounts provide a national snapshot of some aspects of Canadians' health status and the performance of the health care system. Only the federal government reported on the comparable health indicators in 2006.[45]

↗ Provincial and territorial governments prepared individual reports on various aspects of progress related to priorities in the 2003 accord and the 2004 10-year plan. These reports reflect their commitment to report to their citizens, but they differ in scope and level of detail and are therefore not easy to compare.

↗ To assist in understanding the efficiency and effectiveness of our health care system, CIHI reports have described what we are spending on various components of health care and what type of care that money buys. Data on what we get for our money are still largely limited to counts of procedures and the amount of time that patients spend in hospital, rather than the impact on people's health, but the range and quality of data are improving.

SUSTAINABILITY

Recognizing concerns about the rising cost of health care, First Ministers suggested that making our health care system more efficient and effective would help ensure it is sustainable and affordable. To report on their progress, governments agreed to work together to answer a wide range of questions that can help track the impact of health care reforms.

FIRST MINISTERS AGREED THAT:

"This Accord [is] a covenant which will help to ensure that our health care system is sustainable and affordable and will be here for Canadians and their children in the future."

Stories of health care renewal

Increasing Aboriginal access to careers in health care

Bringing it all back home for community health (midwifery training in Nunavut)

Reforming education to build team-based care at Memorial University of Newfoundland

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These questions would include, for example, what does the health care workforce look like now and what will it look like in 10 years? Are provincial and territorial governments sharing lessons from their experiences in attempting to reform health care? Are they collecting and sharing standardized information to make sound decisions on the best use of equipment, technology, and people? How healthy are Canadians?

In many respects, the Canadian health care system is being sustained by ongoing improvements in the design and delivery of various services, by predictable funding, and by growth in the number of students training to become health care professionals at a time when many are retiring. Whether the system is becoming more efficient and effective overall is difficult to say, however, given the kind of data currently available.

At the same time, several provinces have again raised the spectre that publicly funded health care is not sustainable if it continues to consume a rising share of their budgets. Viewed from another perspective, though, the cost of health care is not soaring through the roof. Canada's health care spending as a share of the country's overall wealth (gross domestic product) has remained fairly constant in recent years.[46] In other words, health care spending has been keeping pace with growth in the national economy. Still, the reality is that some jurisdictions struggle with maintaining their current infrastructure, much less financing new ways of delivering care.

The concept of sustainability in publicly funded health care embraces a wide range of complex questions from "what is socially and ethically acceptable?" to "how do societies decide what they can afford?" Ultimately, in the Health Council's view, it is most important to ask what kinds of investments are most cost-effective to improve the health of Canadians. After all, the key to a sustainable health care system is a healthier population – a piece of the equation that is too often absent from discussions on health care funding. So, what do Canadians mean when we talk about getting value for money from our public health care system? What kinds of health care are we buying and for what purposes? In what ways does the system deliver good value for the money we spend now, and where can we do better? Later this year, the Health Council will launch a public conversation on value for money in health care.

Health human resources

Without an adequate supply of qualified professionals – working where patients need them and in effective and co-ordinated ways – the health care system cannot deliver high-quality care.

Governments have made important strides in expanding the health care workforce, in collaboration with the professional associations and educational institutions that form an integral part of the landscape of health human resources. Enrolments are up in medical and nursing schools. In a range of health professions (such as pharmacy, social work, physiotherapy), more students are learning how to provide team-based care through the growing number of interprofessional education programs.

FIRST MINISTERS AGREED THAT:

"Collaborative strategies are to be undertaken to strengthen the evidence base for national planning, promote inter-disciplinary provider education, improve recruitment and retention, and ensure the supply of needed health [care] providers (including nurse practitioners, pharmacists and diagnostic technologists)."

Federal and provincial programs are helping more foreign-trained health care professionals to work in Canada. In several provinces and territories, some types of health care professionals are being allowed to take on new roles (e.g. nurse practitioners and pharmacists prescribing drugs).

There have also been some important activities to help governments and educators meet Canada's future needs for various health care providers. For example, CIHI now collects pan-Canadian data on a range of health professions beyond nurses and doctors. And governments have created a collaborative action plan with objectives, actions, and timelines for health human resources planning that considers the evolving needs of populations across Canada.[47] These are significant achievements and provide a necessary foundation for more positive steps.

Still, the reality is that planning remains fragmented. Except for some valuable efforts in regional collaboration, each province and territory does its own planning, without the benefit of pan-Canadian information needed for reliable decision-making. The result is burnout in the workforce and continued competition between jurisdictions for health care providers – and continued public frustration with wait times, uncoordinated care, and finding appropriate providers.

At the Health Council's national summit in June 2005, health care leaders recommended that governments more clearly link their workforce planning to the needs of patients.[48] For example, if we want to create more primary health care teams to better serve the growing population with chronic health conditions, we will not simply require more family doctors, but also other professionals who can support and supplement what doctors do. We will also have to re-examine the roles of possible team members and determine how they might share in the care of patients differently.

SOME HIGHLIGHTS OF PROGRESS IN HEALTH HUMAN RESOURCES:

↗ In the 2004 *10-Year Plan to Strengthen Health Care,* governments agreed to increase the supply of health professionals and report publicly on their action plans.

↗ Health ministers adopted a new coordinated approach for assessing proposals for changes in entry-to-practice credentials for health professions to ensure that the additional educational requirements are indeed essential to safe and high-quality practice and do not create unnecessary barriers for new professionals to begin working.

↗ To help more internationally trained health care professionals secure work in Canada, the federal minister of health announced $18.3 million for the Internationally Educated Health Professionals Initiative in November 2006.

FIRST MINISTERS AGREED THAT:

"Managing new technologies and treatments is critical to ensuring that our health system remains relevant to the evolving needs of Canadians. Health Ministers are directed to develop, by September 2004, a comprehensive strategy for technology assessment which assesses the impact of new technology and provides advice on how to maximize its effective utilization in the future."

Stories of health care renewal

ActNow BC supports healthy lifestyles

Supporting families for better health outcomes (Healthy Child Manitoba)

In Motion uses a combination of universal and targeted interventions to promote physical activity

Saskatoon Public Health uses home visiting to reduce inequities in immunization

Toronto First Duty integrates children's services and encourages parents to be active participants in their child's early learning

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↗ In addition to provincial and territorial investments to build effective team-based care, the federally sponsored initiative Interprofessional Education for Collaborative Patient-Centred Practice has invested in projects to change the way health care providers are educated.

↗ The Canadian Interprofessional Health Collaborative, based at the University of British Columbia and funded by Health Canada, began in 2007 to serve as a hub for information about interprofessional education, collaboration in health care practice, and patient-centred care.

Technology assessment

Health technology refers to any drugs, equipment, and procedures that can be used to prevent, diagnose, or treat disease, or aid in rehabilitation or long-term care. The process called *technology assessment in health* provides independent reviews of the quality or value of these interventions.

The challenge is to produce assessments that are credible to the manufacturers, the health care providers, and the health system managers and governments that will use the reviews to decide about adopting new technologies (or abandoning old ones). Canada has access to a variety of existing assessment systems, but the results need to influence decision-making more routinely.

SOME HIGHLIGHTS OF PROGRESS IN TECHNOLOGY ASSESSMENT:

↗ The Canadian Agency for Drugs and Technology in Health (CADTH) – the national agency for technology assessment – provides health care decision-makers with objective assessments of drug therapies and new technologies, including their clinical and cost-effectiveness, prior to use in Canada's health care system.

↗ Health ministers approved a new Canadian Health Technology Strategy in October 2004, a collaborative approach to ensure that Canadians have ongoing access to appropriate health care technology.[49]

↗ The Common Drug Review, a collaborative system of reviewing cost-effectiveness research on medicines, was established as one of the three programs of CADTH. (See also page 19.)

Healthy Canadians

Most Canadians feel a strong sense of responsibility for their own health.[36] In fact, people have more influence on their daily health and well-being than the health care system does, except perhaps in times of emergency or crisis.

Both within and outside of health care services, public policies and programs that help people avoid preventable health problems can do a great deal to improve Canadians' quality of life and reduce their need for costly health care. The Health Council of Canada has looked at these issues in reports on children and youth,[50] and on chronic health conditions.[37,51] Where people live, how they care for and nurture their children, what people do for a living, and how much they earn – these and many other factors outside of health care are important influences on health. Within the health care system, providers can, for example, screen high-risk populations and refer patients to preventive services to help them stop smoking or lose weight.

FIRST MINISTERS AGREED THAT:

"An effective health system requires a balance between individual responsibility for personal health and our collective responsibility for the health system. Coordinated approaches are necessary to deal with the issue of obesity, promote physical fitness and improve public and environmental health."

The 2003 accord directed health ministers to continue work begun several years earlier to develop strategies to promote healthy living and, more generally, to continue work on initiatives to reduce disparities in health status. The accord also gave the green light to creating a National Immunization Strategy.

Despite considerable investments by all governments in activities to promote healthy living,[51] the idea of an integrated pan-Canadian strategy that cuts across specific diseases (which health ministers agreed to in 2005) seems to have been shelved. Overall, public spending to foster healthy living still represents only a fraction of what we spend on treating preventable illness and injury.

SOME HIGHLIGHTS OF PROGRESS TOWARDS HEALTHY CANADIANS:

↗ The Public Health Agency of Canada was created in 2004 to lead the health promotion and protection activities that were formerly part of Health Canada's responsibilities.

↗ In the 2004 *10-Year Plan to Strengthen Health Care*, governments agreed to collaborate in responding to public health emergencies through the new Public Health Network and in accelerating the work on a pan-Canadian public health strategy.

↗ To strengthen information sharing and collaboration among governments, non-government organizations, researchers and health professionals, the Public Health Agency created six National Collaborating Centres for Public Health in Canada, beginning in 2005.

↗ The National Immunization Strategy, launched in 2003, received $45 million in federal funds over five years. In 2004, the federal government provided $300 million directly to the provinces and territories to fund childhood and adolescent vaccines, resulting in more consistent immunization programs across Canada.

↗ Created in 1999, the Canadian Population Health Initiative (CPHI), a project of CIHI, fosters public understanding of the social determinants of health and promotes the use of research evidence in the development of policies. CPHI's recent work has focused on youth, urban and rural environments, healthy weights, and the links between mental health and homelessness.

↗ Health ministers set the goal of achieving, by 2015, a 20% increase in the proportion of Canadians who are physically active, eat healthy food, and are at healthy body weights. Each province and territory was to develop its own initiatives to reach this 10-year target.[52] However, no federal funding has been released under the umbrella of this 2005 agreement, the Integrated Pan-Canadian Healthy Living Strategy.

↗ Later in 2005, the federal budget announced $300 million for an Integrated Strategy on Healthy Living and Chronic Disease. Since then, funds have been released for disease-specific activities (diabetes, heart disease, and cancer).

↗ With an emphasis on how social, physical, and emotional environments influence health and well-being, the Health Goals for Canada – adopted by the federal, provincial, and territorial governments in 2005 – present a collective vision for a healthy society.[53]

FIRST MINISTERS AGREED THAT:

"Addressing the serious challenges that face the health of Aboriginal Canadians will require dedicated effort… Governments will work together to address the gap in health status between Aboriginal and non-Aboriginal Canadians through better integration of health services."

Aboriginal health

For Aboriginal people in Canada life expectancy is, on average, 10 years less than for non-Aboriginal Canadians. Infant mortality, suicide, and diabetes rates are several times higher.[54] The 2003 accord recognized the need for action on these and other preventable disparities.

In the accord, the federal government agreed to increase funding for Aboriginal health services, and all governments agreed to consult with Aboriginal peoples to develop ways of reporting more consistently about trends in health among this population.

Two historic agreements followed in November 2005. In Kelowna, BC, all jurisdictions collectively pledged $5 billion over five years to improve the lives of Aboriginal people. Then, in *The Blueprint on Aboriginal Health: A 10-Year Transformative Plan,* First Ministers and national Aboriginal leaders laid out a framework for a decade of action to tackle the gaping inequalities in health, housing, and education between Aboriginal peoples and Canadians generally. With the change of federal government in 2006, however, these agreements have languished and funding has dwindled to a fraction of what was promised. Instead, the federal, provincial, and territorial governments continue to work with Aboriginal leaders across the country, but on a much more modest scale than hoped for in 2005.[42]

A number of activities are underway to eliminate gaps in services for Aboriginal Canadians that result from the complex structure of health care funding and delivery for First Nations, Inuit, and Métis people in this country. Depending on where Aboriginal people live and what their needs are, some services are provided by local governments (for example, in most First Nations communities), some by provincial or territorial governments, and some by the federal government. Poor integration of these services has meant that, for Aboriginal people, care that is routine for other Canadians may be delayed or simply not available.

Increasing the number of Aboriginal health care professionals is also an important strategy to stabilize the delivery of health care services and to better meet local needs. In 2005, the federal government launched the Aboriginal Health Human Resources Initiative, a five-year $100-million program, which appears to be on track to meet or surpass a number of goals.

Stories of health care renewal

Island Lake dialysis centre becomes a catalyst for change

Prevention slows diabetes trends in Kahnawake

Technology and education help Nunavut mitigate children's hearing loss

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SOME HIGHLIGHTS OF PROGRESS IN ABORIGINAL HEALTH:

↗ The Aboriginal Health Transition Fund ($200 million, 2005 – 2010) is supporting over 100 projects to integrate services for Aboriginal people, improve access to services, and increase local participation in the design, delivery, and evaluation of health programs and services.

↗ The Tripartite First Nations Health Plan – signed by Health Canada, British Columbia, and the BC First Nations Leadership Council in 2007 – has become a model for improving health service delivery, integration, and governance for Aboriginal people. Part of the $147 million earmarked for Aboriginal health in the federal budget of February 2008 will be used to explore similar three-way agreements with other provinces and Aboriginal organizations.

↗ In collaboration with the Inuit Tapiriit Kanatami (a national organization representing the Inuit of Canada), Health Canada created the Office of Inuit Health in 2007 to provide a focal point within the federal government to better address Inuit health issues.

↗ To attract and assist more First Nations, Inuit, and Métis people to pursue careers in health care, the federally funded Aboriginal Health Human Resources Initiative has tripled the number of bursaries and scholarships (helping 623 students currently) by boosting funding from $500,000 in 2004 to $3 million per year today. Other projects under this initiative are building support programs for Aboriginal health care students in post-secondary institutions and developing a certification program for First Nations health managers.[55]

CONCLUSION

Time to renew

THE 2003 *ACCORD ON HEALTH CARE RENEWAL* HAD LAUDABLE, much-needed, and ambitious goals. But has the accord had the broad national impact that government leaders intended? In short, the answer is no. The glass with which we toast this fifth anniversary is at best half full. Undoubtedly, the accord has been a catalyst for change in some areas. Major purchases of medical equipment and information technology have boosted the number of services delivered, some jurisdictions have improved the way they manage waiting lists, and most provide wait time information for some procedures on public websites.

As a result, many patients now know approximately when their cataract surgery or hip or knee replacement is likely to occur, and in many cases they undergo their surgery with less waiting than they might have five years ago. Most Canadians have better access to health information and advice through telephone help lines. Some Canadians have better access to publicly insured prescription drugs, to primary health care teams, and to a range of health care services at home or in their communities. And albeit slowly, but surely, the health care system is adopting information technology to deliver safer, more efficient, and better-informed care. Throughout this report, we've noted other steps forward on the road to health care renewal.

But in other respects, progress on the accord commitments is not cause for celebration. The Health Council of Canada is particularly concerned about the following nine areas of health care renewal where action has been slower, less comprehensive, and less collaborative than First Ministers originally envisioned in their 2003 accord:

- **Drug coverage and safe, appropriate prescribing.** Significant gaps in coverage are still evident across Canada and too many Canadians are vulnerable to personal hardship from needed drugs that cost more than they can afford. Canadians are also not adequately protected from inappropriate prescribing because we do not have the necessary systems in place to keep health care providers and consumers informed about drug safety and effectiveness. Governments have not made acceptable progress in creating the National Pharmaceuticals Strategy that was promised in 2004.
- **Home care.** Two weeks of publicly funded home care coverage is not adequate for what many people need, and home care services continue to be poorly integrated with primary health care in many parts of the country. There are clear disparities in the availability of publicly funded home care across the country. No matter where people live, home care services that are seamlessly coordinated with other aspects of primary health care should be available.
- **Aboriginal health.** The scope of preventable health problems among Aboriginal Canadians continues to be of substantial concern across the country, and relatively little funding has flowed from the promising intergovernmental agreements of 2005 – the Kelowna communiqué and the *Blueprint on Aboriginal Health*. Some provinces are working closely with Aboriginal communities and the federal government to improve health care and living conditions on a regional basis, but developments are on a much smaller scale than envisioned in these agreements.
- **Primary health care.** Growth in the number of inter-professional teams to deliver primary health care is promising, and some parts of the country are on track to meet the target (set in the 2004 10-year plan) of having 50% of people served by teams by 2011. But nationwide, progress is uneven and difficult to measure. More concerning, too many Canadians don't have timely access to their regular medical provider and too often primary health care services are not coordinated or comprehensive.

Canadians pay the price for these shortcomings every day. They pay through missed opportunities to receive appropriate health care and missed opportunities for better health or quality of life.

- **The health care workforce.** Ensuring that we have the right number of needed health care providers in the right places was a central component of the 2003 accord. There have been substantial increases in admissions to professional schools, more integration of foreign graduates, and some changes in how various kinds of professionals can practice. However, we still have serious mismatches between need and supply in Canada's health care workforce. On the regional level, some provinces and territories are working together to plan and manage their health human resources more effectively, but the nationwide collaboration envisioned in the 2003 accord has not yet resulted in coordinated planning.
- **Electronic health records and information technology.** Despite recent investments through Canada Health Infoway, Canadian governments have been slow to make progress in the information systems needed to support the delivery of high-quality care. We are not on track to meet Infoway's goal of 50% of Canadians having a secure electronic health record linked to other aspects of health care delivery by 2010 – a goal that the Health Council has said was too modest from the start. Public support for these investments is strong, however,[56] and governments must find ways to fund and accelerate this essential part of health care renewal.
- **Reporting on progress.** Current and reliable data are fundamental tools to measure and understand which initiatives to improve health and health care are working and which are not. Today, despite the excellent work of a number of national and regional organizations devoted to health information and research, Canada has a myriad of health databases but not a comprehensive, pan-Canadian health information system. In 2003, governments agreed to develop and use comparable indicators to report to Canadians about their progress in health care renewal. From a large group of 70 measures, governments agreed to a set of 18 priority indicators, but some are not useful for reporting on the reform priorities of the accord, while those that are of value are not widely used for public reporting.
- **Accountability.** The accord identified the Federal/Provincial/Territorial Advisory Committee on Governance and Accountability as a key partner for the Health Council of Canada, but this intergovernmental committee has been disbanded. Information about how governments spend targeted funds is not easily accessible or, in some cases, not available at all.
- **Wait times.** Some excellent initiatives are improving wait times for targeted services, but long waits continue to frustrate health care providers and the public.[15] Factors needed for greater progress include committed leadership, information systems, and common definitions to measure and manage wait times. The promised wait-time benchmarks for diagnostic imaging have not been produced, nor have most of the targets (which were due by December 2007) outlining when other priority services will be delivered within benchmarks for medically acceptable wait times.

And because they pay through taxes, Canadians have a right to expect better value and greater accountability for the services that their health care dollars buy.

Canadians pay the price for these shortcomings every day. They pay through missed opportunities to receive appropriate health care and missed opportunities for better health or quality of life. The out-of-pocket costs for some needed prescriptions and health care services create inequities and hardships. And because they pay through taxes, Canadians have a right to expect better value and greater accountability for the services that their health care dollars buy.

WHY HAS PROGRESS ON SO MANY OF THE COMMITMENTS BEEN DISAPPOINTING? WE SEE SEVERAL REASONS.

First, some of the key elements in the accord were not well defined. For example, making team care more widely available was a fundamental element of the 2003 accord, but what is a multidisciplinary primary health care team? Is it a nurse working alongside a family doctor, or does it include other professionals such as nutritionists, psychologists, and pharmacists? We cannot know whether we are reaching our goals if we don't know more clearly what we set out to achieve.

Second, as a vehicle for financing change and coordinating reform, the 2003 accord has its strengths but also some critical weaknesses. All told, the cumulative new funding committed through the 2003 accord and the 2004 10-year plan will amount to well over $230 billion by 2014.[57] While some of the funding is tied to general health care policy goals, much of it comes with no real strings attached, very few requirements for public reporting, and almost no measurable objectives and outcomes. To date, Canadian health care reform has largely created a patchwork of pilot projects, not system-wide change. Many of these projects have been effective and exemplary, but the Health Council is concerned that important initiatives (such as efforts to improve primary health care) will not be sustained as funding for specific projects runs out.

Third, it is the reality of health care in Canada that we don't have one system, we have at least 14 (including the care that the federal government delivers or directly funds for Aboriginal communities, veterans, the armed forces, and the RCMP). This reality presents challenges for coordinating reform on a large scale, but the accord envisioned that governments would collaborate to solve common problems for the benefit of all Canadians, wherever they live. The commitment to cover more home care and catastrophic drug costs were specific promises that have not been fulfilled. As a result, common problems persist. While respecting the rights and responsibilities of the provinces and territories to deliver care, we need to revive the idea of a common, pan-Canadian vision of health and health care and put mechanisms in place to make this vision a reality.

Finally, we are concerned that governments' commitment to the spirit of the accord may be waning. Many of the commitments have not been honoured or at least not to the degree that Canadians expected. The practical marriage between money and the desire for health care renewal held considerable promise in 2003. Governments should either explain what has changed in the interim or signal their recommitment to a clear set of reforms. We encourage governments to renew their vows – to one another and to Canadians.

Future accords should more clearly consider that implementing large-scale reform in health care may require time beyond the life of the agreement. Governments change, but the spirit and intent of the commitments must be maintained long after the people who signed them have moved on. One way to achieve this is to ensure that measuring, monitoring, and reporting on progress toward well-articulated goals become integral to the planning and delivery of health care services.

Canada can look internationally for inspiration. Other countries have transformed their health care systems with remarkable speed. The UK now has a handle on wait times for a wide range of services.[58] In Denmark, virtually the entire country has electronic health records.[41] The US Veterans Health Administration, which serves five million patients a year, has dramatically improved outcomes for people with chronic health conditions.[59] Different political structures may have made it easier to implement reforms in these countries, but – with leadership, focus, and funding – Canada can do the same.

Today's headlines are again full of stories about overcrowded emergency departments, hard-to-find family doctors, fears of unsustainable growth in health care costs, and advocacy for more private-for-profit options for health care. Public opinion about the quality of health care is about the same as it was five years ago. Just over half (57%) feel that Canadians are receiving quality health care services now, compared to 58% in 2003. At the same time, almost half (48%) remain optimistic that access to timely, quality health care will improve over the next five years.[14]

In this report, we have highlighted the good news from the past five years of health care renewal, as well as the challenges that remain. We know that the system is not working as well as it could and that some reform initiatives will take time to bear fruit, but we remain confident that it is possible for Canada to achieve a higher-performing health care system within current public investments.

As we look ahead to the next five years under Canada's *10-Year Plan to Strengthen Health Care,* the Health Council of Canada urges governments to renew their national commitment to system-wide change. They can do this by recognizing the enormous social and economic benefits that result from a healthy population, by building on Canadians' strongly held values in support of public health care, and by strengthening the capacity of the public system to deliver timely, high-quality care. Armed with these tenets and bolstered by Canada's tremendous resources and skills, governments can succeed in bringing the nation-wide vision to life.

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Canada's First Ministers established the Health Council of Canada in the 2003 *Accord on Health Care Renewal* and enhanced our role in the 2004 *10-Year Plan to Strengthen Health Care*. We report on the progress of health care renewal, on the health status of Canadians, and on the health outcomes of our system. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors with expertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government. Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

The Council's vision
An informed and healthy Canadian public, confident in the effectiveness, sustainability and capacity of the Canadian health care system to promote their health and meet their health care needs.

The Council's mission
The Health Council of Canada fosters accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system. Through insightful monitoring, public reporting and facilitating informed discussion, the Council shines a light on what helps or hinders health care renewal and the well-being of Canadians.

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